

Editors' perspective

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The COVID-19 pandemic, a significant global crisis, pales in comparison to the pervasive and ongoing threat of climate change. While the pandemic exposed the fragility of our healthcare systems, climate change compounds these vulnerabilities. This urgent, long-term crisis jeopardizes not only our well-being but also the very bedrock of our societies. Mitigating climate change is imperative to secure public health and bolster healthcare resilience, also in acute cardiovascular and intensive medicine. In this journal edition, we present two editorials and an original research paper addressing this healthcare predicament. The editorial 'Time to treat the climate and nature crisis as one indivisible global health emergency' calls for recognizing the intertwined public health impact of climate change and biodiversity loss, urging the WHO to designate it as a Public Health Emergency of International Concern. To rally public support, an online petition will include journal editors and thought leaders. We are wholeheartedly in support.

Related to acute coronary syndromes, in the context of treating patients in cardiogenic shock post-heart attack, a specialized approach is imperative, requiring expert collaboration and considering various factors, including age. Implementing a multidisciplinary approach significantly enhances long-term outcomes for patients with refractory cardiogenic shock and short-term mechanical circulatory support. This success is underscored by a noteworthy single-centre experience in Europe (France) led by Héron *et al.*¹ The elderly population often presents cases of cardiogenic shock post-heart attack, but percutaneous coronary intervention has proven highly effective in reducing in-hospital cardiac deaths for elderly ST-elevation myocardial infarction patients. Age should not preclude potentially beneficial invasive therapy.²

Furthermore, takotsubo and SCAD are increasingly recognized as causes of acute coronary syndromes. While arrhythmias are common in patients with stress-induced cardiomyopathy, research suggests that patient background and clinical status, rather than the arrhythmias themselves, are more closely associated with higher mortality risk. Regarding SCAD, the study by Civieri *et al.*³ reveals the prevalence of angiotensin II type 1 receptor autoantibodies (AT1R-AAAs) and endothelin-1 receptor type A (ETAR-AAAs) in a small cohort of women with myocardial infarction and SCAD. This provides strong evidence, supported by previous literature and biological plausibility, indicating that AT1R-AAAs and ETAR-AAAs play a significant role in SCAD pathogenesis.

Enjoy reading!

Conflict of interest: None declared.

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