Letters to the Editor

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The Task Force for the diagnosis and treatment of chronic heart failure of the European Society of Cardiology.

Guidelines for the diagnosis and treatment of chronic heart failure: full text (update 2005)

The Task Force for the diagnosis and treatment of chronic heart failure (CHF) of the European Society of Cardiology are to be congratulated on a comprehensive, evidence-based, and practical guide to the contemporary management of this condition.1

However, some discrepancies exist between the document’s text, figures, and tables that may lead to confusion. These discrepancies relate primarily to prescribing recommendations for pharmacological therapy.

Specifically, aldosterone receptor antagonists are recommended in Figure 4 of the guidelines for patients in New York Heart Association (NYHA) functional class I or II who had post-myocardial infarction (MI). No specific time period post-MI is mentioned. Table 22 of the guidelines recommend aldosterone antagonists for these patients if there is a ‘recent MI’. However, the text states that ‘whether an aldosterone antagonist is of proven benefit in patients with class II heart failure or asymptomatic left ventricular (LV) dysfunction remains to be established’.

To resolve these discrepancies, the text, figure, and table should be more definitive on what evidence actually exists for these recommendations. Specifically, the EPESUS study2 randomized patients to eplerenone or placebo 3–14 days post-MI who had LV systolic dysfunction and either symptoms of heart failure or diabetes mellitus, finding significant clinical benefit with the aldosterone antagonist. Whether such benefit exists when treatment is initiated beyond 14 days post-MI or in patients with established CHF of any aetiology is uncertain and requires further investigation, specifically in NYHA class I and II patients (the benefits of aldosterone antagonism in class III and IV patients with established CHF having already been observed in the RALES study).3

Similarly, discrepancies exist with regard to recommendations for angiotensin receptor blockers (ARBs). Figure 4 recommends ARBs for NYHA class II patients only if they are angiotensin-converting enzyme (ACE) inhibitor-intolerant. However, the evidence-base supports the use of ARBs in addition to ACE-inhibitors in these patients to reduce hospitalizations and mortality, as explicitly stated in the text of the guidelines. In this case, appropriate summation of the evidence (from CHARM-Added4 and Val-HeFT5) is provided in the text, documented accurately and concisely in Table 22, yet not followed in the figure.

References

1. The Task Force for the Diagnosis and Treatment of Chronic Heart Failure of the European Society of Cardiology. Guidelines for the Diagnosis and Treatment of Chronic Heart Failure. full text (update 2005); doi:10.1093/eurheartj/ehi205.


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Indications to implantable cardioverter defibrillator in heart failure patients: a comment on the recently released ESC Guidelines on treatment and diagnosis of heart failure

We read with great interest the recently published ESC Guidelines on the diagnosis and treatment of heart failure.1 Particularly noteworthy were the recommendations that updated the indications for implantable cardioverter defibrillators (ICD) in heart failure patients (p. 1132). The three specific recommendations took into account the recently released clinical evidence of ICD benefit on overall survival in heart failure patients, thus founding the basis for making ICD therapy an important tool in managing such patients. The third point, essentially a newly formulated recommendation based on the recently produced clinical evidence primarily derived from MADIT II and SCD-HeFT, the two largest randomized, controlled multi-centre ICD trials,2,3 reads as follows: ‘ICD implantation is reasonable in selected patients with LVEF < 30–35%, not within 40 days of a myocardial infarction, or optimal background therapy including ACE-inhibitor, ARB, beta-blocker, and an aldosterone antagonist, where appropriate, to reduce sudden death (Class of recommendation I, level of evidence A) [references 90, 96, 97]’. Although we generally applaud the task force and the authors for officially recognizing ICD as a Class I indication for heart failure patients, we respectfully question their phrase, ‘to reduce sudden death,’ as this is frankly an incorrect interpretation of the very trials they cite in support of their recommendation.

First, we would like to draw your attention to the fact that the cited trials were powered and designed to evaluate as primary endpoint death from any cause— not sudden death. MADIT II and SCD-HeFT showed that ICDs improved survival from death for any cause (hazard ratio MADIT II: 0.69, CI 0.51–0.93, P = 0.016; SCD-HeFT: 0.77, CI 0.62–0.96, P = 0.007).2,3 Neither MADIT II nor SCD-HeFT provide any mention whatsoever of the effects of ICD on sudden death. Secondly, the phrase specifying that ICD should not be implanted ‘within 40 days of a myocardial infarction’ is based on the negative results of the DINAMIT trial, which surprisingly is not cited here.4 Although this statement is absolutely correct with regard to the primary outcome of the trial (all-cause mortality), it is completely incorrect if sudden death is considered (as done in these guidelines). In fact, DINAMIT showed that ICD therapy significantly reduced sudden death after recent acute myocardial infarct (hazard ratio for risk of sudden death 0.42, CI 0.22–0.83, P = 0.009). Nonetheless, the significant reduction of sudden death obtained...