Forthcoming events

**European Heart Failure Awareness Week**
7–13 May 2018

Sessions at the **British Cardiovascular Society Annual Conference**
4–6 June 2018, Manchester Central

**10th BSH Heart Failure Day for Revalidation and Training**
19 June 2018, Birmingham

**8th BSH Heart Failure Nurse and Healthcare Professional Study Day**
20 June 2018, Birmingham

**21st BSH Annual Autumn Meeting**
29–30 November 2018, Queen Elizabeth II Centre, London

For more information visit: www.bsh.org.uk
Twitter: @BSHHeartFailure

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**Session 1: Update session**

**Professor John McMurray** (Glasgow) presented an update of trials and conference highlights from 2017, opening with a focus on comorbidities in patients with heart failure with reduced ejection fraction (HFrEF) (‘the human face of heart failure’). The results of CASTLE-AF (presented at ESC 2017: now published *N Engl J Med* 2018;378(5):417–27) suggest that catheter ablation reduces death or heart failure hospitalisation in patients with HFrEF and atrial fibrillation compared with standard therapy. Other trials examining catheter ablation in heart failure are ongoing, including RAFT AF, AFARC-LVF, CATCH AF and AMICA. Moving to iron deficiency, IRONOUT HF did not support the use of oral iron supplementation in heart failure, whilst EFFECT-HF suggested an improvement in functional capacity in patients treated with intravenous iron. In the field of heart failure and concomitant coronary artery disease, there was positive news from the STICH Extension Study (STICHES), which found that randomisation to bypass grafting resulted in lower all-cause death or cardiovascular hospitalisation than standard therapy at long-term follow-up, with a greater benefit seen in younger patients.

Turning to advanced therapies, two major new trials of left ventricular assist devices (LVADs) were published in 2017. The MOMENTUM 3 trial suggested that implantation of a newer, magnetically levitated, continuous-flow LVAD (the HeartMate 3) – when compared to the older HeartMate II pump – resulted in no greater risk of death or disabling stroke, and less frequent reoperation for pump malfunction. The ENDURANCE trial was of similar design but tested the new HeartWare LVAD against the HeartMate II, finding the former to be non-inferior. Meanwhile, new hope in cardiac transplantation was mooted following the successful inactivation of porcine endogenous retrovirus in pigs using CRISPR-Cas9. The investigators in this study postulated that this may pave the way towards the use of porcine organs for human xenotransplantation.

*A list of study acronyms can be found on page 7.*
There was also disappointing news. In acute heart failure, there were neutral results in the two trials examining pharmacological therapy using endogenous peptides: TRUE-AHF (ularatide) and RELAX-AHF-2 (serelaxin). Meanwhile, GUIDE-IT – a randomised trial of natriuretic peptide-guided therapy in chronic HFrEF – was halted for futility. The EDIFY trial showed no benefit from ivabradine in patients with heart failure with preserved ejection fraction (HFpEF), although the phase 2 REDUCE-LAP HF I trial suggested that an intra-atrial shunt device reduces left atrial pressure in this population.

Finally, turning to heart failure prevention, the CANVAS trial suggested that a sodium-glucose co-transporter-2 (SGLT2) inhibitor (canagliflozin) reduced heart failure hospitalisation in patients with type 2 diabetes, supporting the results of the 2015 EMPA-REG OUTCOME trial of empagliflozin. Whether these drugs might be used to treat heart failure is an exciting question that will be answered by the DAPA-HF trial and the EMPEROR programme of trials.

Whilst these are perhaps the best-known anticancer therapies with prominent cardiotoxic profiles, Dr Lyon also highlighted the cardiovascular toxicity associated with other treatments, such as tyrosine kinase inhibitors utilised in metastatic renal carcinoma, proteasomal inhibitors for multiple myeloma and the emerging problem of myocarditis associated with immunotherapy. A recent 2016 ESC position paper on cardiovascular toxicity associated with cancer treatments is available.

Session 2: 30 years of heart failure

In keeping with the historically commemorative tone, Professor Theresa McDonagh (London) opened this session with a chronological overview of the development of natriuretic peptide biomarkers in heart failure ‘from bench to bedside’. Following on from the discovery of atrial natriuretic peptide in 1981, brain natriuretic peptide (BNP) was subsequently located in the porcine cerebrum, before its predominant source in humans was located in the myocardium. Early mechanistic studies noted the vasodilatory effects of BNP, and characterised its role as a ‘white knight’ antagonist of the renin–angiotensin–aldosterone (RAS) system. The clinical utility of BNP and its cousin, N-terminal-proBNP, was demonstrated in a series of landmark studies, confirming both their strong negative predictive value for excluding heart failure in patients with undifferentiated breathlessness in the acute and chronic settings, and their prognostic value.

Professor John Cleland (Glasgow) similarly led the audience through the development of cardiac resynchronisation therapy (CRT). Tracing a remarkable story back to 1935, he located this as the first documentation that conduction disorders caused ventricular dyssynchrony. Dr Derek Gibson (London) was the first to publish on the effects of bi-ventricular pacing in man (British Heart Journal 1971). Published in 2001, the MUSTIC trial was a key milestone, demonstrating in a single-blinded cross-over trial that randomisation to CRT improved 6-minute walking distance among patients with HFrEF who were in sinus rhythm. In 2005, the CARE-HF
and COMPANION trials reported on the effects of CRT (with or without a defibrillator in the case of the latter trial) in patients who had HFrEF, were in New York Heart Association (NYHA) functional class III or IV and had a QRS duration of at least 120 ms. The landmark results were that CRT reduced mortality by ~40% and improved symptoms, quality of life, systolic blood pressure and LV function. Looking to the future, Professor Cleland forecast that the evolutionary development of CRT might derive from advances in such fields as quadripolar, multisite, leadless or His-bundle pacing.

**Philip Poole-Wilson Memorial Lecture**

**Control of neurohormonal activation – a success in the treatment of systolic heart failure**

Professor Karl Swedberg (Sweden) treated the audience to an historical overview of the research journey that established angiotensin-converting enzyme (ACE) inhibitors as the first prognostic treatment for patients with heart failure. Leading us from his early mechanistic work to the landmark CONSENSUS trial, and onwards to follow-on studies such as SAVE, Professor Swedberg highlighted the progress made over the past 30 years by research into antagonists of the RAS – and subsequently neprilysin – systems. In showcasing this remarkable research journey, this lecture was a fitting tribute to the late Philip Poole-Wilson, in whose memory this biennial lecture is given.

**Session 3: Modern management of the right heart**

In an excellent talk, Professor David Kiely (Sheffield) led the audience through the modern investigation and management of pulmonary hypertension (PH). The aetiology of PH is heterogeneous, and delineation of the underlying cause is clinically meaningful, because defined treatments exist for pulmonary arterial hypertension (PAH) and chronic thromboembolic pulmonary hypertension (CTEPH), whereas the optimal therapeutic strategy is less clear for PH secondary to left heart pathology, pulmonary disease or uncertain aetiology. Having set this scene, Professor Kiely’s message was to refer early if PAH or CTEPH are suspected.

Next, Dr Joseph Davar (London) delivered a detailed exposition on carcinoid heart disease in the contemporary era. Although rare in absolute terms, as many as half of all patients with carcinoid syndrome are affected, and the significant associated morbidity and mortality made this disease an important primer for an attentive audience.

Closing this session, Professor Martin Cowie (London) explored the development and potential of the CardioMEMS™ system, the key feature of which is a wireless pulmonary artery pressure sensor implanted into the distal pulmonary artery of patients. Real-time data – including pulmonary artery pressures – are uploaded from the implanted sensor to the CardioMEMS™ website via a patient transmitter. This potentially enables the clinician to detect rising pulmonary pressures – the cardinal pathophysiological sign of worsening heart failure – before they manifest clinically. CardioMEMS™ was shown to reduce heart failure hospitalisation when tested in the CHAMPION trial, which was conducted in the USA. It is hoped that these exciting results will be borne out by the UK CardioMEMS™ post-approval study currently underway in 16 centres across the UK. Professor Cowie’s rejoinder was to ‘watch this space!’

**Update on the BSH Heart Failure Nurse Forum**

Although patients and clinicians alike know the enormous importance of heart failure nurses, this crucial role has not traditionally been recognised in a specific, national, representational body. Mrs Jayne Masters (Southampton) introduced a new initiative from the Society: the BSH Heart Failure Nurse Forum, which aims to support the heart failure nurse profession nationally on such issues as training, peer-to-peer knowledge sharing and protection from workforce redeployment. A section of the BSH website dedicated to the Forum has now been developed (http://www.bsh.org.uk/nurse-forum/about-bsh-heart-failure-nurse-forum/) and this will continue to be populated over the coming months and years.
Session 4: Research

For the Young Investigators’ Award, three finalists presented their research in the traditional rapid-fire abstract format. Their strict 5-minute slots were enforced with vigour by timekeeper Professor Andrew Clark (Hull).

Dr Simon Anderson (Manchester) and Dr Li Shen (Glasgow) both presented work on the prognostic significance of atrial fibrillation detected during an index hospitalisation for heart failure. Dr Anderson’s work drew upon data from the National Heart Failure Audit, whilst Dr Shen’s research drew on a number of large trial datasets.

Mrs Nathalie Conrad (Oxford) gave an overview of her research, which utilised linked medical records from primary and secondary care to describe trends in heart failure incidence in a denominator population of four million individuals between 2002 and 2014. The winner was Nathalie Conrad. Congratulations to all three young investigators.

Next, the current BSH Research Fellow, Dr Simon Beggs (Glasgow), presented an update of his first 12 months in post. His work has focused on the development of – and subsequently patient recruitment for – the RHYTHM-HF research study, which examines the association between arrhythmias and adverse events in patients with heart failure. Significant landmarks during the past 12 months include successful application for a clinical study grant worth £429,737 from the British Heart Foundation to support the study.

Session 5: Heart failure question time

In this popular session, Professor Andrew Clark (Hull) played the David Dimbleby role with relish as he marshalled an illustrious panel: Dr Paul Kalra (Portsmouth), Mrs Annie MacCallum (Gloucestershire), Professor John McMurray (Glasgow) and Dr Nigel Rowell (Middlesbrough). Questions – submitted from the audience – ranged from issues involving heart failure with mid-range ejection fraction (HFmrEF), to the ethics of prescribing intravenous iron in clinical practice in the absence of mortality data, to whether funding for innovative systems such as CardioMEMSTM would be better spent on heart failure nurses.

Session 6: 50 years on from the first cardiac transplant

Half a century on from the first human heart transplant on 3 December 1967, Dr Jayan Parameshwar (Cambridge) – introduced as ‘the godfather of UK heart transplant’ – presented an overview of who and when to refer for a heart transplant today. Median life expectancy for contemporary transplant recipients is at least 11 years, and continues to rise; however, Dr Parameshwar emphasised that the potential benefit for the patient must be weighed carefully due to significant peri- and post-procedural risks. Nevertheless, having explained the danger that potential transplant candidates can ‘miss the boat’ due to progressive deterioration to the point of non-candidacy, he impressed upon the audience that it is always best to refer ‘too early’ rather than ‘too late’.

Moving to other forms of advanced therapy for heart failure, Dr Steve Shaw (Manchester) took up the mantle with an exposition on modern LVADs. The UK has seen an exponential rise in LVAD implants over the past 10 years, whilst in the USA the annual implant rate has now surpassed the number of heart transplants being performed. LVAD technology continues to evolve, with the latest iteration of the HeartMate lineage (the HeartMate 3) utilising novel intrinsic pulsatility in the hope of reducing complications, most specifically pump thrombosis. The ELEVATE post-approval study of this device is currently in progress.

Dr Paul Callan (Manchester) continued this theme with an educational and entertaining talk about how to approach the sick LVAD recipient who presents to your hospital. He advised the audience to start with a standard focused history, augmenting this with specific questions about LVAD model, history of device-related complications and current transplant list status. Proceeding to clinical...
examination, those with little experience of LVADs were warned to expect absent heart sounds and reminded that abdominal examination is essential to look for signs of drive-line infection. Overall, the lesson in this talk was to remain systematic in your assessment, considering specific issues relating to the LVAD, but also not being overly distracted by its presence!

**Session 7: Heart failure services**

**Dr Suzanna Hardman** (London) gave an update on best practice tariff (BPT) for heart failure, now in its third year, having become mandatory for Trusts in April 2016. The BPT is an ‘all-or-none’ phenomenon. To receive the tariff, at least 70% of Trust patients admitted with a primary diagnosis of heart failure, as identified through the Trust’s HES statistics, must have had their data submitted to the National Heart Failure Audit. In addition, at least 60% of these patients must have been reviewed during their admission by a member of the specialist heart failure team. Dr Hardman emphasised the importance of ensuring accurate local discharge coding and understanding the complexities of modifying influences on available tariffs. She concluded that the final challenge is to ensure the uplift is, as envisaged, invested in improving the local heart failure services.

**Mrs Jayne Masters** (Southampton) talked about the integrated heart failure service model that she has helped to develop in Southampton and West Hampshire. Disappointing local results in a Healthcare Commission audit were used as leverage to develop a new specialist service integrating a consultant cardiologist, clinical fellow and two dedicated heart failure nurses, with the intention to provide specialist care to patients across the Trust. Examples of integration include cross-working by heart failure nurses in both a community and hospital setting – with the valuable capacity to swap and share workloads this brings – and the resultant ability to use shared documentation, which may be started in hospital before being passed to community heart failure nurses, consequently increasing efficiency.

**Dr Lisa Anderson** (London) gave an overview of a contemporary inpatient heart failure unit, which opened in April 2016 at St George’s Hospital, London. Significant challenges since opening have included 60% nurse vacancy – with a resultant reliance on agency staff – and the absence of a dedicated cardiology fellow/trainee. Nevertheless, total heart failure mortality at St George’s has fallen by 22% and 30-day post-discharge mortality is 1.6% (compared with 5.4% nationally for cardiology). Looking to the future, Dr Anderson emphasised the important role of ongoing data collection and external validation to develop best practice working.

**Session 8: Sports and exercise (Joint BSH / BACPR Session)**

**Professor Sanjay Sharma** (London) kicked off this session – held conjointly by the BSH and the British Society for Cardiovascular Prevention and Rehabilitation (BACPR) – by exploring the challenging issue of sudden cardiac death (SCD) in athletes. A large proportion of conditions implicated in SCD in young athletes can be detected or highlighted by an ECG. However, a normal ECG does not preclude SCD: potential false-negatives include such conditions as anomalous coronary arteries or adrenergically driven ion-channel disorders. Ultimately, Professor Sharma’s message was that ensuring the availability of automated external defibrillators and education regarding cardiopulmonary resuscitation may be the most fruitful strategies in preventing SCD in this cohort, with this being especially true of mature athletes.

**Professor John Somauroo** (Liverpool) continued the theme with a talk on the vexed issue of differentiating between ‘athlete’s heart’ and cardiomyopathy. In 80% of athletes, ECG changes are the result of physiological adaptation of the cardiac autonomic nervous system. In 5%, however, changes are suggestive of cardiac disease, including cardiomyopathies and channelopathies. A detailed family and personal history may unmask inherited or acquired conditions. Echocardiography is a crucial investigation, and Professor Somauroo covered the role of tissue Doppler imaging and speckle tracking in this setting, both at rest and with exercise. Other investigations include cardiopulmonary exercise testing, cardiac magnetic resonance imaging (MRI) and Holter monitoring. However, the stakes are high – involving the potential for erroneous disqualification from sport or the provision of false reassurance to an athlete with a potentially life-threatening condition – and Professor Somauroo thus advocated for expert input where possible.
Next, **Dr Joe Mills** (Liverpool) gave an overview of randomised controlled trials of exercise in heart failure. A 2014 Cochrane Review found that exercise-based rehabilitation appeared to reduce the risk of heart failure hospitalisations and increase health-related quality of life in patients with heart failure, but did not affect all-cause mortality. Rehabilitation programmes are safe, and the benefits appear consistent across participant age, gender, symptom severity and programme characteristics.

**Session 9: Outpatient-based therapies**

Opening this session, **Dr John Sharp** (Glasgow) gave an enlightening talk on the issue of depression in patients with heart failure. The scale of this problem is significant, with over a third of patients experiencing symptoms. The consequences of depression are not ‘just’ psychological: the presence of concomitant depression in patients with heart failure predicts worse functional decline, increased medical costs, and higher rates of readmission and all-cause mortality. Randomised controlled trials of traditional antidepressant pharmacotherapies, such as sertraline and escitalopram, have demonstrated no significant benefit on either cardiovascular outcomes or depression status in the active-treatment groups; however, non-pharmacological interventions, such as a mindfulness-based psychoeducational intervention, have shown reductions in anxiety and depression, and the efficacy of cognitive therapy should be informed by the HOPE-HF trial.

Next, **Professor Roy Gardner** (Glasgow) discussed the utilisation of device-based diagnostics in the care of patients with heart failure. A wide array of data may be obtained from implanted cardiac devices, including arrhythmia burden, heart rate variability, patient activity and thoracic impedance. Professor Gardner made two overarching points about these data. First, that integrating multiple variables is likely to be the key to their successful use in the future, because this is likely to reduce the false-positive rate of any single data source. Second, he reminded the audience that an unthinking reliance on numbers is never likely to deliver stellar results, cautioning that the key to success is ‘sensible people looking at meaningful data’.

**Mr Paul Forsyth** (Glasgow) explored a model for pharmacist drug titration clinics in heart failure. Although the exact make-up of healthcare professionals needed within such a team is not explicitly defined, the ESC recommends that patients with heart failure are managed by a multi-disciplinary team (MDT), with specific reference to the role of pharmacists. Mr Forsyth provided the illustrative example of a pharmacist-led post-myocardial infarction left ventricular systolic dysfunction clinic in Glasgow, which has effected higher prescription rates of disease-modifying treatments in its patients.

**Session 10: Clinical cases heart failure MDT**

In this ever-popular session, **Dr Jane Cannon** (Glasgow) started by leading the audience through the case of a 55-year-old female with heart failure who was eventually diagnosed with systemic AL (lambda) amyloidosis including cardiac involvement. This fascinating presentation highlighted several discussion points relevant to the diagnosis and management of patients with cardiac amyloid, including the role of cardiac MRI in diagnosis, and the importance of an MDT approach to patient management.

Next, **Dr Oliver Watson** (Sheffield) discussed the case of a 61-year-old postman with new-onset heart failure in the context of severe calcific triple-vessel coronary disease and significant alcohol excess. Dr Watson explored the issue of alcohol cessation in heart failure before addressing the more vexed question of whether or not a strategy of revascularisation would be appropriate in this patient. In this case, the patient improved significantly with medical therapy alone, reminding us that simple steps in heart failure management are often highly effective.
### Study acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AFARC-LVF</td>
<td>Atrial Fibrillation Ablation Compared to Rate Control Strategy in Patients with Impaired Left Ventricular Function</td>
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<td>AMICA</td>
<td>Atrial Fibrillation Management in Congestive Heart Failure with Ablation</td>
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<tr>
<td>CANVAS</td>
<td>Canagliflozin Cardiovascular Assessment Study</td>
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<tr>
<td>CARE-HF</td>
<td>Cardiac Resynchronization – Heart Failure</td>
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<tr>
<td>CASTLE-AF</td>
<td>Catheter Ablation versus Standard Conventional Treatment in Patients with Left Ventricular Dysfunction and Atrial Fibrillation</td>
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<td>CATCH AF</td>
<td>Catheter Ablation vs. Medical Therapy in Congested Hearts with AF</td>
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<td>CHAMPION</td>
<td>CardioMEMS Heart Sensor Allows Monitoring of Pressure to Improve Outcomes in NYHA Class III Heart Failure Patients</td>
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<td>COMPANION</td>
<td>Comparison of Medical Therapy, Pacing, and Defibrillation in Chronic Heart Failure</td>
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<td>CONSENSUS</td>
<td>Cooperative North Scandinavian Enalapril Survival Study</td>
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<td>DAPA-HF</td>
<td>Study to Evaluate the Effect of Dapagliflozin on the Incidence of Worsening Heart Failure or Cardiovascular Death in Patients with Chronic Heart Failure</td>
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<td>EDIFY</td>
<td>Preserved Left Ventricular Ejection Fraction Chronic Heart Failure with Ivabradine Study</td>
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<td>EFFECT-HF</td>
<td>Effect of Ferric Carboxymaltose on Exercise Capacity in Patients with Iron Deficiency and Chronic Heart Failure</td>
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<td>ELEVATE</td>
<td>Early Levosimendan Versus Usual Care in Advanced Chronic Heart Failure</td>
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<td>EMPA-REG OUTCOME</td>
<td>Empagliflozin, Cardiovascular Outcomes, and Mortality in Type 2 Diabetes Trial</td>
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<td>EMPEROR</td>
<td>Empagliflozin Outcome Trial in Patients with Chronic Heart Failure with Preserved Ejection Fraction</td>
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<tr>
<td>ENDURANCE</td>
<td>Prospective, Randomized, Controlled, Un-blinded, Multi-Center Clinical Trial to Evaluate the HeartWare® Ventricular Assist System for Destination Therapy of Advanced Heart Failure</td>
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<td>GUIDE-IT</td>
<td>Guiding Evidence Based Therapy Using Biomarker Intensified Treatment in Heart Failure</td>
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<td>HOPE-HF</td>
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<td>Iron Repletion Effects on Oxygen Uptake in Heart Failure</td>
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<td>MOMENTUM 3</td>
<td>Multicenter Study of MagLev Technology in Patients Undergoing Mechanical Circulatory Support Therapy with HeartMate 3</td>
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<td>MUSTIC</td>
<td>Multisite Stimulation in Cardiomyopathy</td>
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<td>RELAX-AHF-2</td>
<td>Efficacy, Safety and Tolerability of Serelaxin when Added to Standard Therapy in AHF</td>
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<td>RHYTHM-HF</td>
<td>What is the Role of Arrhythmias in Heart Failure?</td>
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<td>SAVE</td>
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<td>STICH</td>
<td>Comparison of Surgical and Medical Treatment for Congestive Heart Failure and Coronary Artery Disease</td>
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<tr>
<td>TRUE-AHF</td>
<td>Trial of Ularitide Efficacy and Safety in Acute Heart Failure</td>
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Message from the incoming BSH Chair – Dr Paul Kalra

It was a pleasure and a privilege to start my journey as Chair of a flourishing Society at the Annual Autumn Meeting in November 2017. The growth in success and renown of the meeting is a testament to the shoulders of the giants that I stand on (likening myself to a dwarf, to the delight of my Hobbit-loving children). This year’s Annual Autumn Meeting was our most successful yet (in terms of delegate numbers) and the voice of the BSH is increasingly influential at many key levels. The past Chairs and Boards have done a tremendous job in raising the profile of the BSH, and it will be a hard act to follow. The Society has found a winning formula and, as such, I hope that the next two years will build on these successes.

I look forward to working alongside all the Board members and we will work hard to strengthen the Society and take it into the next stage. We will be seeing some important changes over the forthcoming months and the development of the BSH Heart Failure Nurse Forum is at the forefront of this. It is crucial that we see this as ‘our’ Society. Everyone’s opinion is important and if you have suggestions please do contact me, other Board members and/or the Secretariat. We will try and engage people and inspire enthusiasm in a climate of disillusion and negativity by delivering inspirational educational events, and represent the views of healthcare professionals who have a strong passion towards improving care for all patients with heart failure.

Thank you to Iain Squire for his expert leadership over the past two years and to all of the previous Board for their commitment and support to the Society, and to all who made the Annual Autumn Meeting such a success.

20th BSH Annual Autumn Meeting: acknowledgements

Sincere thanks to the meeting Faculty and Programme directors, Dr Parminder Chaggar, Dr Peter Cowburn, Professor Roy Gardner and Dr Simon Williams, for the development of an excellent programme. Great thanks are also extended to Dr Simon Beggs for writing this meeting report and to Professor Roy Gardner for providing the photographs.

We are very grateful to all our sponsors and the Friends of the Society without whom the meeting would not have been possible.

Gold exhibitors
Medtronic, Novartis Pharmaceuticals*, Vifor Pharma*
*Novartis Pharmaceuticals and Vifor Pharma were also Silver Exhibitors

Bronze exhibitors
Abbott, Bayer, Biotronik, Boston Scientific, Pharma Nord, Roche Diagnostics

Other contributors
Alliance for Heart Failure, APC Cardiovascular, British Association for Cardiovascular Prevention and Rehabilitation, British Heart Foundation, Cardiomyopathy UK, Heartfelt Technologies, Life Biomedical, National Institute for Cardiovascular Outcomes Research (NICOR), Pumping Marvellous Foundation

Friends of the BSH
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Becoming a Member or a Friend of the BSH
Membership is open to anyone involved in the diagnosis, management or science of heart failure. If you are interested in becoming a Member or Friend of the BSH, please contact:

The British Society for Heart Failure
‘Nought’ The Farthings, Marcham, Oxfordshire OX13 6QD, United Kingdom
Telephone: 01865 391836 E-mail: info@bsh.org.uk
Website: www.bsh.org.uk Twitter: @BSHeartFailure

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