

The British Society

for Heart Failure

The British Society for Heart failure delivered yet again with its well attended 3rd annual training day. The comprehensive programme touched on all aspects of heart failure, from co-morbidities to challenges of device therapy and provided an interactive forum for the discussion of recent advances and everyday clinical dilemmas.

Dr Theresa McDonagh set the ball rolling with an update on neurohormonal blockade and highlighted the need to initiate and uptitrate all the known prognostically beneficial heart failure drugs. The recent National Institute for Health and Clinical Excellence (NICE) guidelines declare beta blockers to be safe in the presence of peripheral vascular disease, chronic obstructive pulmonary disease (COPD) without reversibility, erectile dysfunction, diabetes etc. The HEAL Study (losartan in higher doses was more effective in reducing hospitalisation in heart failure (HF) and cardiovascular (CV) death) and EMPHASIS-HF (epplerone reduced death from CV causes and hospitalisation for heart failure in mildly symptomatic heart failure patients with ejection fraction $\leq 35\%$) were also discussed.

Dr Paul Foley discussed some of the more contentious indications for cardiac resynchronisation therapy (CRT). NICE, for example, currently only recommends CRT for patients in sinus rhythm. The European Society of Cardiology (ESC) has gone one step further and recommends cardiac resynchronisation therapy – pacing / defibrillator (CRT-P/D) as a class IIa indication for patients in atrial fibrillation with slow ventricular rates requiring frequent pacing. The same applies to New York Heart Association (NYHA) class III / IV patients with left ventricular ejection fraction (LVEF) $\leq 35\%$, QRS $\geq 130\text{msec}$ made pacemaker dependent by arteriovenous (AV) nodal ablation. Whilst ESC guidance does not currently support CRT for NYHA class I patients, device therapy is recommended in NYHA class II if QRS $>150\text{msec}$ (based on results of MADIT-CRT, REVERSE and RAFT studies). We do not have convincing

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evidence as yet of the benefits of CRT in narrow QRS and ESC guidelines do not recommend CRT in patients with QRS $<120\text{msec}$ except where there is a class I bradycardia pacing indication.

Whilst optimising AV synchrony post CRT implantation may increase left ventricular (LV) filling time, it remains unclear whether this acute haemodynamic benefit will translate into clinically significant functional improvement. Dr Alison Duncan recommended optimising AV delay using the CARE-HF protocol, to be done at base line, three months and six months thereafter. V-V optimisation is commonly performed by maximising the aortic velocity time integral (VTI), again benefits on outcomes need to be established.

Dr Peter Cowburn discussed ultra-filtration in decompensated heart failure as an effective means of mechanically removing fluid from the vasculature and his local experience has highlighted the need for larger trials to demonstrate cost effectiveness and confirm the clinical benefits seen in UNLOAD.

Dr Derek Connelly and Dr Jay Wright discussed the role of implantable cardioverter defibrillators (ICD) and while there is no doubt about their role in primary prevention in ischaemic cardiomyopathy, NICE guidance has not given similar recommendations for dilated cardiomyopathy patients. Despite positive evidence, the numbers needed to treat are much more in this group and in this age of tight budgeting, careful consideration of cost effectiveness / benefits are required on an individual basis.

Other potential treatment targets discussed included heart rate, anaemia, co-existent sleep disordered breathing (SDB) and activity levels. Dr Martin Cowie discussed the SHIFT study, where Ivabradine, an *I_f* inhibitor by reducing heart rate was shown to have beneficial

effects on the primary composite end point (CV death or hospital admission for HF). Dr Klaus Witte discussed the causes and treatment of anaemia in heart failure patients, in particular focusing on erythropoietin (EPO) and intravenous iron. Dr Anita Simmonds highlighted that obstructive sleep apnoea and central sleep apnoea have a prevalence ranging from 15-37% and 12-38% in heart failure patients but are often overlooked. Obstructive sleep apnoea (OSA) by causing hypoxaemia, negative intra thoracic pressure and oxidative stress may result in cardiac ischaemia, hypertrophy, arrhythmias and cardiac failure. They can be diagnosed easily using sleep studies and treatment with continuous positive airway pressure (CPAP) where indicated has been shown to be beneficial. Dr Andrew Clark discussed the need to encourage exercise training as an adjunct to conventional heart failure therapy. Of note, the HF-ACTION study showed exercise training to be associated with modest significant reductions for both all-cause mortality or hospitalisation and CV mortality or heart failure hospitalisation.

Dr Aisling Carroll's comprehensive overview of heart failure in congenital heart disease was all the more relevant in view of 90% of congenital heart disease patients surviving to adulthood and many presenting in late life with heart failure. Understanding the lesion, the various surgical corrections available and seeking specialist input from grown up congenital heart disease (GUCH) specialists early on are recommended.

The highly informative day included two case presentation sessions, which provided a good mix of day to day management decisions, as well as the more unusual forms of cardiomyopathy. This provided a good opportunity for an interactive discussion.

The meeting fulfilled its aims of delivering a programme primarily aimed at trainees (cardiology, general internal medicine and elderly care) with high relevance for heart failure nurses and general practitioners with a special interest in this field. ●

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