Weight Gain May Save a Heart Failure Patient's Life

BY MITCHEL L. ZOLER
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DALLAS — Bigger is better for patients with heart failure.

Increased weight was associated with a lower risk of death or hospitalization during nearly 5 years of follow-up in a post hoc analysis of more than 2,500 patients with heart failure.

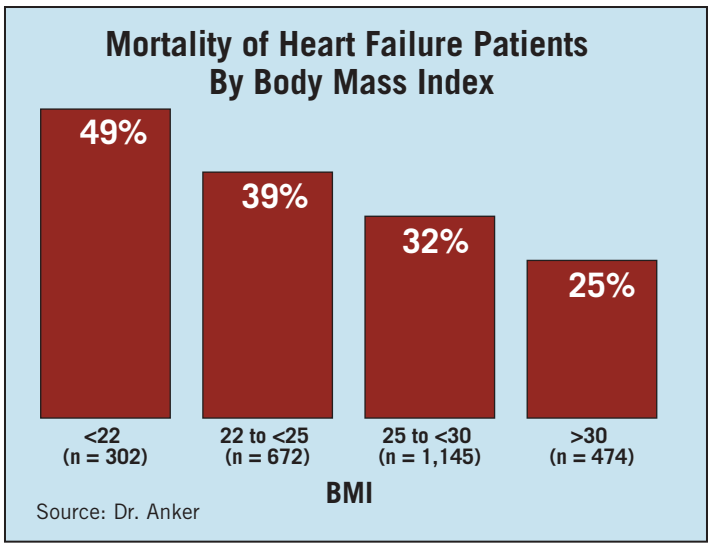
"This is the first time that weight gain has been shown to be related to reduced mortality" in patients with heart failure, Dr. Stefan D. Anker said at the annual scientific sessions of the American Heart Association.

The finding was consistent with previous reports that showed lower survival rates in heart failure patients who had a relatively low body mass index (BMI), said Dr. Anker of the National Heart and Lung Institute in London.

"Obesity is generally good in patients who have heart failure or following a myocardial infarction. Never tell a patient with a BMI of less than 40 kg/m^2 to lose weight," said Dr. Anker. He used a cutoff of 40 kg/m^2 because little information is available on larger patients.

The new analysis used data collected in the Carvedilol or Metoprolol European Trial (COMET), which was designed to compare the efficacy of these two β-blockers in patients with moderate to severe heart failure (Lancet 2003;362:7-13).

The study enrolled patients with New York Heart Association class II-IV disease and a left ventricular ejection fraction of less than 40%. Of the 3,029 patients in the study, Dr. Anker focused his analysis on 86% of patients who did not have edema at baseline. In addition to being treated with one of the two β-blockers in the study, patients received a full panel of medications for heart failure. They were followed for an average of 58 months.



Mortality among 302 patients whose average BMI was less than 22 during the study was 49%, compared with 32% in 1,145 patients with BMI averages of 25-29.9 and a rate of 25% in 474 patients with averages of 30 or more during the study.

For every increased unit of BMI, mortality fell by 6%, and the rate of death or hospitalization for heart failure dropped by 2%. Both of these rate reductions were statistically significant, Dr. Anker said.

In a multivariate analysis that controlled for many demographic and clinical variables, including treatment group in the COMET study and BMI, every 1% of weight loss during the course of the study was linked with a statistically significant 9% increased risk of death or hospitalization. In addition, every 1% of weight gain during follow-up was linked to a significant 2% reduction in death or hospitalization. The effects of weight loss and gain were independent of each other.

"From whatever BMI a patient starts with, gaining weight is positively associated with better survival and lower hospitalization, and losing weight is negative," Dr. Anker said.

Treatment with a β-blocker or with an ACE inhibitor has been linked to weight gain in patients with heart failure. Calorie supplementation may be another way to increase weight and reduce adverse outcomes in heart failure patients, but Dr. Anker said that extra calories might be helpful only if they are in the form of lipids. Future research needs to test the hypothesis that treatments that help heart failure patients gain weight lead to better outcomes. ■

Physicians Unsure About Handling End-of-Life Issues in Heart Failure

BY DAMIAN McNAMARA
Miami Bureau

BOCA RATON, FLA. — When it comes to treatment options, palliative care, and decision making for patients with end-stage heart failure, cardiologists, internists, family physicians, and geriatricians are similarly lacking in awareness, according to a national pilot survey.

The American College of Cardiology and the American Heart Association's recommendations for care of heart failure patients include a call for cardiologists to counsel patients about end-of-life issues. However, most of the care of heart failure patients is by noncardiologist physicians, and there is still uncertainty about which physicians should address end-of-life concerns with end-stage heart failure patients.

"The question is, who is going to have 'the talk'?" Dr. Paul J. Hauptman said in an interview.

"More and more patients have heart failure, and more and more patients are going to die from heart failure. What are we going to do with this burgeoning population of patients with heart failure?" asked Dr. Hauptman, professor of medicine, division of cardiology, and director of heart failure/transplantation at St. Louis (Mo.) University.

In an attempt to answer that question, Dr. Hauptman and his associates surveyed cardiologists, family physicians, internists, and geriatricians about the management of patients with end-stage heart failure. The investigators randomly selected physicians from the American Medical Association Master File.

The administration of the 51-question survey is ongoing, with the goal of garnering opinions from 1,450 physicians. Preliminary results from 76 responses were given in a poster presentation at the annual meeting of the Heart Failure Society of America.

The survey indicates a similar lack of awareness about published guidelines for heart failure (44% of cardiologists, 47% of noncardiologists), a similar belief in left ventricular pacing as a life-extending measure (44% of cardiologists, 41% of noncardiologists), and a similar level of uncertainty about when to refer a patient to hospice care (52% of cardiologists, 53% of noncardiologists).

Almost 85% of the noncardiologists believed that they, and not cardiologists, should initiate end-of-life discussions. "The noncardiologists really thought they were better [at that] than the cardiologists," Dr. Hauptman said. However, he added, most of the generalists reported they had never had such a discussion with a patient or a patient's family.

"Cardiologists have an acute-care perspective. We don't really know about what is going on at the end of life," Dr. Hauptman said. "It's going to take education and discussions at national meetings [to understand that]."

The majority of respondents (91% of cardiologists, 67% of noncardiologists) do not use standard quality of life measurements for patients with end-stage heart failure. "This would be kind of shocking" if confirmed by the full survey, he said.

Most of the cardiologists surveyed (65%) have discussed implantable cardioverter defibrillator deactivation with an end-stage patient or family member, compared with 35% of noncardiologists. With the increasing prevalence of heart failure, Dr. Hauptman said, "more patients are going to show up with a device. Do you turn them off or not turn them off?"

Dr. Hauptman said he hopes that the final results of the survey will provide even more insight about physician attitudes toward end-stage heart failure and that the information can be used to design effective interventions in the future. ■

Smaller LVAD May Be Beneficial For Women With Heart Failure

BY DAMIAN McNAMARA
Miami Bureau

BOCA RATON, FLA. — A new and smaller left ventricular assist device now in clinical trials is appropriate for most women and provides similar outcomes, compared with a larger device already used for patients with heart failure, according to a poster presentation at the annual meeting of the Heart Failure Society of America.

The large size of the original HeartMate XVE Left Ventricular Assist System (Thoratec Corp., Pleasanton, Calif.), which is currently approved as a bridge-to-transplant as well as a destination therapy, precluded its use in many women.

"The old device would not fit everyone," Dr. Leway Chen said in an interview.

Only about 9%-16% of women with heart failure received a HeartMate XVE in published studies, said Dr. Chen, director of the heart failure and transplantation program at Strong Memorial Hospital, University of Rochester (N.Y.). Dr. Chen also is an investigator for Thoratec.

In this study, Dr. Chen and his associates assessed 34 patients—including 15 women—with advanced New York Heart Association class IV heart failure at 10 medical centers. All received the HeartMate II, a continuous-flow left ventricular assist device with one-third the mass of a typical implanted electric pulsatile device. The HeartMate II was implanted in each patient as a bridge to cardiac transplantation.

Etiologies of heart failure included ischemic cardiomyopathy, idiopathic cardiomyopathy, myocarditis, and peripartum cardiomyopathy. Median age was 49 years for women and 55 years for men. There was one transient ischemic attack and one stroke in a patient who fully recovered prior to implantation among the women; neither of these events occurred in men.

There were no device failures but minor malfunctions occurred in both groups, Dr. Chen said. "The adverse event numbers are too small to make a conclusion."

Six women received a transplant and five had ongoing therapy after a median of 96 days with the device. Three men received a transplant and 10 continued therapy with the device after a median of 117 days. The longest duration of HeartMate II therapy was 577 days as of June 10, 2005, he said.

Regarding the HeartMate II, Dr. Chen said, "We really like it and expect good durability. There are other smaller devices, but this is the closest to market." A phase II-III study of the device is underway, he added. ■