New HF Indication for Candesartan

BY ELIZABETH MECGATIE
Senior Writer

Orlando, Fla. — A standard 7-week course of enhanced external counterpulsation therapy in patients with heart failure who are on optimal pharmacotherapy improves their exercise duration, quality of life, and New York Heart Association class for at least 6 months afterward, according to the results of a randomized trial presented at the annual meeting of the American College of Cardiology.

“We believe these results suggest that EECP provides adjunctive therapy in patients with New York Heart Association class II–IV heart failure receiving optimal pharmacologic therapy,” said Arthur M. Feldman, M.D., chairman of the department of medicine at Thomas Jefferson University, Philadelphia.

The primary endpoint of the study was at least a 60-second improvement in exercise duration at follow-up 6 months after the last EECP session. This was achieved in 33% of the EECP group and 25% of the control patients, a significant difference. However, there was no between-group difference in a predefined alternative primary endpoint, which was the percentage of patients achieving at least a 1.25 mL/kg per minute increase in peak oxygen consumption (VO2).

Exercise duration improved by a mean of 25 seconds in the EECP group, whereas it declined by 10 seconds in controls.

DR. FELDMAN

Another secondary endpoint was quality of life as measured in terms of change from baseline in scores on the Minnesota Living with Heart Failure questionnaire. One month after completion of the EECP sessions, treated patients had a mean 8.9-point improvement compared with a 3.4-point gain in control patients.

“Both EECP treatment was well tolerated, although one patient developed a pulmonary embolism that investigators believed was therapy related,” said Discussant Andrew D. Michaels, M.D., characterized the PEECH results as “mixed.”

The trial met one of two primary endpoint points. It’s somewhat concerning that the end points that were met—namely increased exercise duration, improved quality of life, and improvement in NYHA class are all subject to the placebo effect,” added Dr. Michaels of the University of California, San Francisco.

Dr. Feldman said that although EECP resulted in a significant gain in VO2, it in an end point was important and meaningful and im---important additional clinical benefit on top of other proven treatments, including β-blockers and ACE inhibitors.

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Christopher Granger, M.D., director of the cardiac unit at Duke University, Durham, N.C., and a member of the CHARM executive committee, said in an interview.

The relative risk of cardiovascular mortality or heart failure hospitalization was reduced by 15% in those on candesartan during a median follow-up of 41 months in CHARM-Added, which compared candesartan to placebo in 2,548 patients with NYHA class II–IV heart failure and an LV EF of 40% or less who were on an ACE inhibitor and standard therapy. Benefits were also seen in patients treated with β-blockers, suggesting there were no adverse interactions between β-blockers, candesartan, and ACE inhibitors.

Improved quality of life was also seen in the study, said Dr. Granger, who was a consultant to AstraZeneca for the FDA’s cardiovascular and renal drugs advisory committee meeting in February, where the panel unanimously recommended approval of candesartan for this population of patients on an ACE inhibitor (Cardiology News, April 2005, p. 10).

The recommended starting dose of candesartan for patients with heart failure is 4 mg/day, with a target dose of 32 mg once daily, according to the label about 2 weeks, as tolerated.

In the CHARM studies, rates of hypotension, abnormal renal function, and hyperkalemia were higher in those on candesartan, as expected, due to a greater degree of renin-angiotensin-aldosterone system inhibition.

Clinicians should monitor for hyperkalemia and renal insufficiency, especially when starting and titrating treatment, Dr. Granger advised.

EECP May Aid Heart Failure Patients on Optimal Therapy

BY BRUCE JANCIN
Denver Bureau

WASHINGTON — Body temperature below 36° C at hospital admission was independently associated with a lower survival rate in a study of 56,659 patients with advanced heart failure.

Disordered thermoregulation is common in patients with advanced heart failure, and body temperature measurements may improve risk assessment in these patients, Brahmajee K. Nallamothu, M.D., wrote in a poster presented at the Clinical Research 2005 meeting sponsored by the American Federation for Medical Research.

Dr. Nallamothu, a cardiologist at the University of Michigan, Ann Arbor, and his associates reviewed data on patients aged 65 years and older who were participating in the National Heart Care Project.

The mean body temperature upon hospital admission was 36.5° C, and most of the patients’ temperature were between 36° C and 38° C. However, 10,754 (18.5%) of the patients had body temperatures below 36° C and 1,145 (1.9%) had body temperatures above 38° C.

After multivariate analysis, patients with body temperature below 36° C had significantly higher mortality, both in hospital (adjusted risk ratio, 1.28) and at 1 year after their hospitalizations (adjusted risk ratio, 1.14). Body temperatures above 38° C were not significantly associated with in-hospital mortality, but they were significantly associated with lower mortality after 1 year (adjusted risk ratio, 0.80).

In EECP therapy, ECG-synchronized cuffs inflate at diastole and deflate at systole, increasing coronary artery blood flow.

Low Body Temp Raises Heart Failure Mortality

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—Heidi Spille