

## About the Specialty Treating Patients With Heart Failure. Response



### Sobre la especialidad que trata a los pacientes con insuficiencia cardíaca. Respuesta

#### To the Editor,

We appreciate the interest shown by Dr Trullàs and Dr Miró in our study<sup>1</sup> and would like to address the questions that they raise in their letter.

The differences in the variables analyzed between the RICA and REDINSCOR registries are a reflection of normal clinical practice, in which the 2 specialties (internal medicine and cardiology) manage the care of distinct patient types. However, the validity of the comparative analysis between the 2 specialties lies first in the statistical matching method (propensity score), which provided more than 500 pairs of patients matched for up to 18 prognostic predictors that are widely contrasted in the medical literature and second in the fact that both registries are national, multicenter registries and the quality of their data is guaranteed by their respective scientific societies. In our study, we acknowledge that the lack of information on frailty and dependence in REDINSCOR prevented us from assessing the potential effects of these factors on our results.

Regarding the criteria for the definition of “optimal medical treatment”, we would like to clarify that we refer to the simultaneous prescription of beta-blockers plus angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers plus aldosterone receptor antagonists only in patients with a left ventricular ejection fraction  $\leq 35\%$ . We agree that the percentages obtained were very low. This may be partly explained by the lack of available data regarding reasons for not dispensing, as well as the fact that the inclusion periods for REDINSCOR and RICA began in 2007 and 2008, respectively, when the existing clinical practice guidelines<sup>2</sup> limited the indication for triple therapy to patients in the advanced New York Heart Association functional class.

Last, the reasons for the lack of statistically significant differences in readmission rates were beyond the scope of our analysis and warrant a targeted study. However, we would like to reiterate that an independent data collection committee validated the events during follow-up.

Jesús Álvarez-García,<sup>a,\*</sup> Prado Salamanca-Bautista,<sup>b</sup> Manuel Montero Pérez-Barquero,<sup>c</sup> and Juan Cinca<sup>c</sup>

<sup>a</sup>Servicio de Cardiología, Hospital de la Santa Creu i Sant Pau, IIB Sant Pau, Universidad Autónoma de Barcelona, Barcelona, Spain

<sup>b</sup>Servicio de Medicina Interna, Hospital Universitario Virgen Macarena, Sevilla, Spain

<sup>c</sup>Servicio de Medicina Interna, Hospital Universitario Reina Sofía, Córdoba, Spain

\* Corresponding author:

E-mail address: [jalvarezg@santpau.cat](mailto:jalvarezg@santpau.cat) (J. Álvarez-García).

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## REFERENCES

1. Álvarez-García J, Salamanca-Bautista P, Ferrero-Gregori A, et al. Impacto pronóstico de la especialidad en el paciente ambulatorio con insuficiencia cardíaca: un análisis emparejado de los registros REDINSCOR y RICA. *Rev Esp Cardiol*. 2017;70:347–354.
2. Dickstein K, Cohen-Solal A, Filippatos G, et al. ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure 2008: the Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2008 of the European Society of Cardiology. Developed in collaboration with the Heart Failure Association of the ESC (HFA) and endorsed by the European Society of Intensive Care Medicine (ESICM). *Eur Heart J*. 2008;29:2388–2442.

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## Role of Ivabradine in the Treatment of Heart Failure: Comments on the ESC 2016 Guidelines



### Papel de la ivabradina en el tratamiento de la insuficiencia cardíaca: comentarios a la guía ESC 2016

#### To the Editor,

We have read with interest the recent clinical practice guidelines for the diagnosis and treatment of heart failure (HF) by the European Society of Cardiology (ESC), published in Spanish in *Revista Española de Cardiología*,<sup>1</sup> as well as the comments on these guidelines by the expert group and Guidelines Committee of the Spanish Society of Cardiology.<sup>2</sup> First, we would like to praise the authors of this document for their deep and nuanced analysis of the ESC guidelines, which stresses their most important aspects and helps to clarify their most controversial recommendations.<sup>2</sup>

We would like to make some comments on the role of ivabradine in HF treatment and its consideration in the 2 documents. As noted by the authors of the Spanish Society of Cardiology document,<sup>2</sup> the recommendation for ivabradine use in patients with chronic HF and reduced ejection fraction has undergone subtle changes to more closely reflect the design and results of the study that informed the guidelines (SHIFT),<sup>3</sup> as well as its use in

patients unable to tolerate beta-blockers (IIb in 2012 and IIa C in the current 2016 guidelines<sup>1</sup>). Ivabradine is also listed as a second-line treatment, after beta-blockers, for patients with HF and angina pectoris in the “Comorbidities” section. However, in the translation published in *Revista Española de Cardiología*, made using the original English-language ahead of print version, there was a sentence on the doubts raised by the results of the SIGNIFY study<sup>4</sup> that said, “in the SIGNIFY study, in patients with limiting angina without HF, ivabradine increased the risk of cardiovascular death and nonfatal myocardial infarction, which is why it is not recommended in this context”. Although we agree with the conclusion of the cited article concerning patients with angina and without HF, we believe that this comment is not applicable to patients with HF and reduced ejection fraction because the SIGNIFY trial, in addition to using an ivabradine dose higher than that used for HF, excluded patients with HF, which could be a source of confusion in this matter. Indeed, this sentence has been removed from the latest corrected version of the ESC guidelines,<sup>5</sup> as well as from the translation of the guidelines.<sup>1</sup>

Finally, we would like to thank the authors of the Spanish document for having cited our article on the potential benefits of ivabradine administration during the hospitalization of patients with acute HF.<sup>6</sup> In our work, the first published study of this drug in the acute HF field, the combined use of ivabradine and beta-