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Heart Failure Society News

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Jay N. Cohn honored as the recipient of the 2006 HFSA Life-Time Achievement Award

The first HFSA Life-Time Achievement Award was awarded to Jay N. Cohn (Minneapolis, MN) at the 2006 HFSA Annual Scientific Meeting. The purpose of this award is to recognize major achievement by an individual who has made a significant and sustained contribution to the field of heart failure in terms of scientific understanding, epidemiology, clinical care, exemplary leadership or as an inspirational role model.

Presented by President Gary S. Francis (Cleveland, OH), the award represented what he called a new step for a mature Society. The award committee was chaired by Arthur M. Feldman (Philadelphia, PA).



Jay N. Cohn and Gary S. Francis

Dr. Francis noted that Dr. Cohn was always very involved in his laboratory, very "hands on." He said that Dr. Cohn, who made major contributions to the literature on heart failure, still was a bedside clinician, and epitomized translational medicine. He cited the "force and power of his creativity and imagination."

Dr. Cohn accepted the award and was honored that it came

from his peers. He reflected on the many achievements made during the 12 years that the HFSA had been in existence, but said that for him and the Society "there is much left to do."

Information regarding eligibility and applying for the 2007 award can be found on hfsa.org (under membership).

President's Address Focuses on Creativity, Change

Beginning with a brief look at the characteristics of creativity, including persistence and a tolerance for ambiguity, outgoing HFSA President Gary S. Francis (Cleveland, OH) reviewed some of the significant changes in our understanding of heart failure in the last sixty years.

Beginning with the salt-and-water-retention model of the 1940's and 50's, the field moved on to the mechanical model in the 1960's through the 80's, and more recently, the neurohormonal model. The working hypothesis of heart failure starts with an index event, moves on to structural remodeling and progression of disease, and finally to the clinical syndrome of heart failure.

In addition to our increased understanding of heart failure, we have had some notable

successes in treatment. These include the development of neurohormonal therapies and the development of ICDs and CRT devices to address sudden cardiac death, now recognized as a major contributor to mortality in heart failure. Many of these developments, both in understanding and treatment, have been the result of efforts by members of the HFSA.

We still have unresolved problems that require our creative attention: prevention of heart failure, effective therapy for "diastolic" heart failure, management of acute heart failure, identification of patients who will most benefit from an ICD, cardiorenal syndrome, management of stage IV patients, and access to specialized care. Heart failure is a complex syndrome and continues to require our best effort.

Opening Session Targets Access to Health Care

The plenary session at the 10th Annual Scientific Meeting of the Heart Failure Society of America began with a presentation by Kevin Grumbach (Professor and Chair, UCSF Department of Family and Community Medicine, San Francisco, CA) on the single-payer system, which focused on the promise of universal health care. Over 46 million adults in the US are without health insurance, resulting in thousands of unnecessary deaths despite our excessive health care expenditures. He concluded we need a capitated single-payer public health insurance system, in which patients could choose any provider.

Robert E. Moffitt (Director, Center for Health Policy Studies, The Heritage Foundation, Washington, DC) emphasized the private sector is the answer. Most Americans have public or private health insurance but the focus should be on expanding and retaining insurance coverage options for young, low-income, and people in small businesses. His conclusion: tax codes should be structured to give people a credit for health insurance, and catastrophic coverage should be mandated.

Len M. Nichols (Director, Health Policy Program, New America Foundation, Washington, DC) addressed the future of health care. Health insurance is growing increasingly expensive and out of reach. On the one hand, there is a belief that tax

Oral Poster Highlight Sessions

Two new sessions were added to the Annual Scientific Meeting in 2006 to highlight selected posters as oral presentations. Oral Poster Highlight Sessions were held on Monday and Tuesday, each featuring five presentations. Monday's focus was the physiology of heart failure, while Tuesday's presentations targeted remodeling. The information presented in these sessions were also part of the regular poster sessions held later in the day.



Len Nichols presenting at the Opening Plenary Session.

breaks will provide individual choice and drive efficiencies. On the other hand, the single-payer system is based on the belief that elite control will drive efficiency. Therefore, only shared responsibility will solve the problem.

Clinical Trial Row

Clinical Trial Row, a new feature of the Exhibit Hall at the 2006 Annual Scientific Meeting, attracted a lot of attention from exhibitors and attendees alike. Companies rented poster boards to share information about heart failure clinical trials (drug and device) in the recruitment or follow-up phase. Information posted included: inclusion/exclusion criteria, list of centers participating, how to become a center, name of trial, payments to centers, brochures describing trial, protocols, recruitment dates, reporting requirements, source of financial support, sponsor, and in some cases, statistical power and trial design.

Forty-five trials were featured. This activity will be offered again in 2007 as part of the Exhibit Hall.

Heart Failure Society
of America

2007 HFSA RESEARCH FELLOWSHIPS

The purpose of the research fellowship is to develop clinician-investigators in the field of heart failure.

Applications available on-line
November, 2006

Receipt Deadline:
Monday, February 5, 2007

www.hfsa.org

2006 Meeting Attendance

The Annual Scientific Meeting continues to attract a growing number of experts working in the field of heart failure. Attendance at the 2006 Annual Meeting was as follows: physicians 38%; scientists 11%; nurses/nurse practitioners 25%; and other (allied health, paramedicals, marketing) 26%. Total attendance, including exhibitors, was 3193 (professionals: 2472, exhibitors/press: 721).

For more information on attendance, go to Annual Scientific Meeting on the HFSA website.



Clinical Excellence in Nursing Award

The first Clinical Excellence in Nursing Award was presented to Kimberly Huck (Cleveland, OH). The award recognizes excellence in heart failure clinical practice, special achievements in clinical practice, or special contributions to the field of heart failure. Presenting the award for the committee was Barbara J. Riegel (Lancaster, PA).

Information about the 2007 Clinical Excellence in Nursing Award can be found on hfsa.org (under membership).



Barbara Riegel presenting award to Kimberly Huck.

What Is the Cost of Heart Failure?

Edward P. Havranek (Denver, CO) and Paul J. Hauptman (St. Louis, MO) moderated a session on the cost of heart failure care. The US significantly exceeds other countries in health care spending with heart failure as the leading driver of increased spending, said Harlan M. Krumholz (New Haven, CT). Physicians face cuts in Medicare payments, and patients face increased co-pays, because resources are finite.

Paul A. Heidenreich (Stanford, CA) addressed the specific costs of heart failure. Approximately \$35 billion is spent on heart failure (2/3 of this cost is for HF hospitalizations) in the US annually, which accounts for approximately 1.5% of health care spending. Drug costs are a substantial part of this cost and continue to increase.

Gillian Sanders (Durham, NC) presented data on the cost-effectiveness of ICD and cardiac resynchronization therapy (CRT) devices for heart failure. The cost per life year of ICDs in a primary prevention population is more favorable the longer the patient lives. The cost per quality life-year for CRT is generally better. The challenge is to improve risk stratification.

Finally, Gregory L. Freeman (San Antonio, TX) focused on the cost-effectiveness of disease management programs, stating that while

early evidence suggests these programs improve health outcomes, they currently do not save money.



Ed Havranek, Paul Hauptman, Paul Heidenreich, Gillian Sanders, Gregory Freeman, Harlan Krumholz

2006 Research Awards Presented

Supporting new researchers interested in pursuing an academic career in heart failure is an important part of the HFSA's mission. Each year at the Annual Scientific Meeting, awards are presented in basic science, clinical/physiology and nursing. Abstracts received for these competitions were reviewed by a panel of experts and the top five were selected for presentation in each group. The winners of this year's competitions were:

Jay N. Cohn New Investigator Award: Clinical/Physiology

- Carolyn S. P. Lam (Rochester, MN), "Diastolic Function in Patients with Heart Failure and Preserved Ejection Fraction: A Population Based Study."

Jay N. Cohn New Investigator Award: Basic Science

- Bilal B. Ayach (Toronto, ON, Canada), "SCF/C-KIT Compensates for FL/FLT3 Deficiency to Mediate Myocardial Rescue and Repair Post-MI"

Support for the Jay N. Cohn awards is provided by Novartis Pharmaceuticals.

Nursing Investigator Award

- Jill H. Esquivel (San Francisco, CA), "Socio-Demographic and Clinical Predictors for Rehospitalization in Heart Failure"

The Challenges and Relevance of Global Studies

This session focused on the advantages and disadvantages of global clinical trials. Participants included Cesare Orlandi (Rockville, MD), Beat Knusel (Thousand Oaks, CA), Marc. A. Pfeffer (Boston, MA), Robert M. Califf (Durham, NC), and John G. F. Cleland (Kingston upon Hull, UK). The session was moderated by Uri Elkayam (Los Angeles, CA) and Mary Ann Lukas (Philadelphia, PA).

Dr. Knusel explained that global studies are needed because they expand the potential study pool, facilitate product registration and adoption, and identify differences in treatment effect across regions and ethnic groups. Dr. Pfeffer noted that global trials can reduce

morbidity and mortality and study costs, but often pose difficulties in terms of logistics and trial implementation.

Dr. Califf argued that a perfect global trial in heart failure should answer questions of importance to patients, practitioners, and the health care system; should advance knowledge; and ensure the independence of data monitoring. Dr. Cleland pointed out the need for study populations representative of the target populations and crossover trials that more closely resemble clinical practice and to beware of excessively large studies. Dr. Cesare Orlandi concluded by stressing the complexities involved in global clinical trials and the need to keep things as simple as possible.

Special Scientific Session Continues Tradition of Excellence

Since 2003 the Annual Meeting has included a Sunday Special Scientific Session as part of its continuing commitment to basic science in heart failure. This year's session, "Novel Mediators and Therapies in Heart Failure," was moderated by Thomas Force (Philadelphia, PA) and Yibin Wang (Los Angeles, CA).

The opening presentation by Victor J. Dzau (Durham, NC) focused on "Novel Akt-Regulated Paracrine Cardiac Effectors," a theme that was echoed later in the session by Helmut Drexler (Hannover, Germany), who examined CNN1 as a novel cardiac effector protein. Jeffery Molkentin (Cincinnati, OH) addressed "GDF-15 a Novel Cardioprotective Factor."

The final two talks looked at mediators of hypertrophy, remodeling, and death. John M. Kyriakis (Boston, MA) spoke on "p8 and Gene 33: Novel Mediators of Hypertrophy, Matrix Remodeling, and Cell Death," and Michael D. Schneider (Houston, TX) concluded with "CDK-9 Mediated Regulation of Growth and Death."

The session is planned with basic scientists in mind, but open to clinicians. Both groups gave the 2006 session high marks.

Heart Failure Awareness Week: Good Time to Reach Out

Heart Failure Awareness Week in 2007 will be February 11-17. This is an opportunity for HFSA members to educate patients, individuals at risk, and family members, and professionals about the prevention and treatment of heart failure.

To initiate Heart Failure Awareness Week 2007, HFSA will hold its annual update for primary care physicians on February 10 in San Francisco. The theme of the program will be guideline-driven care. Clyde W. Yancy (Dallas, TX) will chair, and Barry M. Massie and John R. Teerlink (both San Francisco, CA) will co-chair. San Francisco will also be the site of a radio tour comprised of live and taped interviews with Barry H. Greenberg (San Diego, CA) and Ileana Piña (Cleveland, OH) for local, regional, and national stations.

Many HFSA members already hold annual events during Heart Failure Awareness Week. If you do not already have something in place, consider developing an event. Examples include symposia for physicians or nurses, presentations to civic groups, health screening for heart failure risk, or patient-type events, including luncheons with featured presentations on diet, nutrition, and other subjects of general interest. There is a tool kit with resources for such activities on hfsa.org.

This year a set of key slides based on the new guideline recommendations are also available for CME-type events on the Heart Failure Guideline site: heartfailureguideline.org, as well as a set of easy-to-understand slides on the abouthf.org site for patient-family events.



The Limitations of ICDs

This joint session with the Heart Rhythm Society (HRS) was moderated by Mandeep R. Mehra (Baltimore, MD) and Bruce L. Wilkoff (Cleveland, OH). William G. Stevenson (Boston, MA) opened by asking who should get an ICD. ICDs reduce mortality, but yield a relatively small absolute annual survival benefit. The case for CRT is a bit better. Reduced device cost, better risk stratification, and the extension of benefits beyond mortality might improve the picture in coming years.

Lynne Warner Stevenson (Boston, MA) said that patients overestimate the benefit of ICDs. ICDs for primary prevention reduce mortality by 22%, but 78% of deaths still occur. We need to give patients better, more complete information.

Mark D. Carlson (Cleveland, OH) discussed a timely topic—ICD reliability. In 2005 three product advisories were issued. There were some patient deaths, thousands of devices were explanted, and patient and physician confidence in the therapy was shaken. Guidelines are being developed regarding pacemakers and ICDs.

Dr. Wilkoff concluded with a talk on managing the morbidity of ICD therapy. We need to help our patients with informed decisions. They need to know the risks, but also the effectiveness of ICDs in reducing the mortality of ventricular arrhythmias.

Debates Address Difficult Issues

Should Practice Guidelines Mandate the Management of Heart Failure Patients?

Marvin A. Konstam (Boston, MA) argued that practice guidelines are necessary to manage the increasing number of heart failure therapies that have demonstrated efficacy in clinical trials. A guideline is needed to determine what constitutes standard therapy, given the many options available. The way to improve compliance and care is to mandate selected measures. Following guidelines provides a means for improving patient care.

Jay N. Cohn (Minneapolis, MN) agreed that guidelines are a valuable source of information, but should not mandate care. They are only one contributor to individual therapy decisions. Guidelines do not address issues such as therapeutic goals, individual differences, co-morbidities, and dose-response curves. In some cases, guidelines offer little or no help. The optimal management of patients involves more than just following a guideline. We can and must do better.

Which Drug Should Be Added after a Beta-Blocker and ACE-Inhibitor?

In this three-way debate, Anne L. Taylor (Minneapolis, MN) presented the case for the combination of isosorbide dinitrate and hydralazine. Beta-blockers and ACE-inhibitors

are indicated for everyone with heart failure based on clinical trials, but African Americans are under-represented in those trials. Based on the A-HeFT trial, all African American heart failure patients should have the combination of isosorbide dinitrate and hydralazine in their treatment regimen.

Bertram Pitt (Ann Arbor, MI) presented the case for aldosterone antagonists. Clinical trials suggest an aldosterone antagonist should be added to beta-blocker and ACE-inhibitor therapy before an angiotensin II receptor blocker (ARB). The situation with regard to African American patients is less certain. A large-scale randomized trial is needed to determine whether the combination of isosorbide dinitrate and hydralazine, aldosterone antagonists, and angiotensin receptor blockers (ARBs) should be added as a treatment after beta-blockers and ACE-inhibitors and in which circumstances.

Christopher B. Granger (Durham, NC) began by asserting that the A-HeFT trial had shortcomings and that spironolactone clearly is a good drug for a select group of patients, but potassium monitoring can be time consuming. ARBs have the best evidence from largest contemporary experience across a broad-spectrum heart failure population with long-term follow-up.

Recent and Late Breaking Trials

Non-Excitatory Cardiac Contractility Modulation Device for Advanced Heart Failure (FIX-CHF-4) trial

Martin Borggrefe (Mannheim, Germany) presented this trial to determine whether an implantable device providing electrical stimulation during the absolute refractory period can strengthen cardiac contractility, increase exercise tolerance and improve quality of life. Cardiac contractility modulation (CCM) therapy is delivered via an implantable pulse generator and three transvenous pacing leads. The results showed that in the first 12-week phase exercise tolerance measured by peak VO₂ increased steeply in both groups of patients, suggesting a strong placebo effect. In the second 12-week crossover phase, there was further improvement in the patients whose device was switched on and deterioration in those with devices that were switched off

Atrial Fibrillation Clopidogrel Trial with Irbesartan for Prevention of Vascular Events-W (ACTIVE-W) Analysis

Akshay S. Desai (Boston, MA) presented this post-hoc analysis of the ACTIVE-W study, which had found an overwhelming benefit for oral anticoagulation compared to a combination of clopidogrel and aspirin. This analysis found that patients with a prior history of heart failure were much more likely to reach the composite endpoint of death or heart failure-related hospitalization than the general ACTIVE-W trial population.

Effects of the Adenosine A1 Receptor Antagonist KW-3902, Alone or in Combination with Furosemide

Drs. Barry M. Massie (San Francisco, CA) and Michael M. Givertz (Boston, MA) updated the audience on two studies to evaluate the dose-dependent effects of the adenosine A1 receptor antagonist KW-3902. The CKI-201 study involved patients hospitalized with acute decompensated heart failure with renal impairment, while the CKI-202 study involved patients refractory to high doses of conventional diuretics.

Results showed that patients receiving KW-3902 as monotherapy for the first 6 hours of the first day had increased urine volume and required less furosemide than the placebo group. In the CKI-202 study in which patients received a 2-3 hour infusion on KW-3902

after a 3-5 baseline period, results showed a progressive reduction in urine output in the placebo group over the 9-hour period. Combined analysis of both studies showed that about one-third of the patients experienced a serious adverse event.

Results of a First Human Study of a Novel Calcium-Independent Inotrope

John R. Teerlink (San Francisco, CA) presented the first clinical study of the selective myosin activator CK-1827452, which was found in dog studies to increase cardiac output and contractility through an increase in left ventricular systolic ejection time. The primary objective of the Phase 1 study was to determine the maximum tolerated dose. Results will be used to design further studies in heart failure.

Advanced Chronic Heart Failure Clinical Assessment of Immune Modulation Therapy (ACCLAIM)

Guillermo Torre-Amione (Houston, TX) presented updates on the ACCLAIM Trial, whose aim was to determine if targeting inflammation with a novel immune modulation therapy (IMT) will reduce mortality or CV hospitalization in patients with advanced systolic heart failure. The results of pre-specified subgroup analysis found that IMT therapy was better than placebo in patients without a prior myocardial infarction and in those with a prior myocardial infarction whose heart failure symptoms have not progressed beyond NYHA Class II.

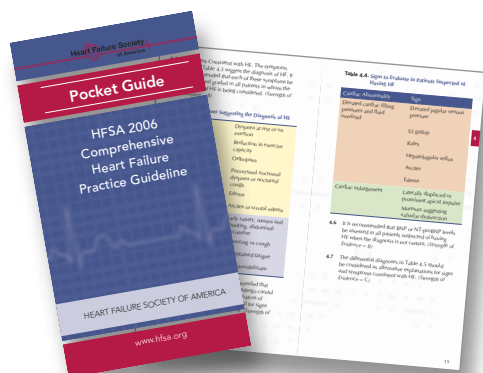
Oxypurinol Therapy for Congestive Heart Failure (OPT-CHF)

Joshua M. Hare (Baltimore, MD) presented this trial which studied the safety and efficacy of oxypurinol, a xanthine oxidase inhibitor. Results showed no effect of oxypurinol on the primary composite endpoint, but showed a statistically significant drop in serum uric acid levels. Patients with high baseline levels of serum uric acid appeared responsive to oxypurinol while those with lower levels did not, suggesting that serum uric acid levels may be a biomarker in heart failure.

To read the abstracts for these studies presented, please see *Journal of Cardiac Failure* 2006;12:762-764.

Guidelines Continue to Generate Interest

The symposium on the HFSA practice guideline was very well attended, and interest in the pocket guideline, the online version, and guideline slide sets continued to build.



The online version at www.heartfailureguideline.org can be accessed directly or through the HFSA website. It is an easily navigated, fully searchable site. Recommendations are followed by background sections that can be opened or closed. Typing in key terms, such as beta blockers or fluid overload, gives a Google-like annotated list of locations in the site relevant to the search. Pop up tables provide additional information and reminders about key concepts.

The pocket guide has been designed as a handy reference guide. It is spiral bound, enabling the clinician to keep the guide open to a particular page. There is a downloadable version on the website, as well as information for ordering additional copies.

Slides have been developed of all recommendations. They are available by section on the HFSA website or as a download option on the online guideline. A separate set of slides on key recommendations is also available as a resource for speakers. Either set could easily be incorporated into planned activities for Heart Failure Awareness Week.

Hyde Park Continues to Captivate Audience

Reprising their roles as moderators of the always-popular Hyde Park Hypotheses, Arnold M. Katz (Norwich, VT) and Carl V. Leier (Columbus, OH) managed to maintain order during a series of thematically diverse and stimulating presentations.

Lynn Warner Stevenson (Boston, MA) began the session by arguing that we should translate from percents into patients per 100 to provide a human perspective to the impact of trial results and treatment decisions. Patricia A. Uber (Baltimore, MD) followed with a convincing presentation of the value of several non-traditional treatments of heart failure in "Poetry and Prayers: Volitional Rhythmic Breathing to Treat Heart Failure."

After Brian Olshansky (Iowa City, IA) argued passionately and ironically in the tradition of Jonathon Swift that ICDs should be implanted in everyone except those with heart failure, Arnold M. Katz (Norwich, CT) expostulated on the premise that therapy that improves prognosis in systolic heart failure cannot be expected to have similar benefits in diastolic heart failure. His reasoning? In patients with systolic heart failure, progressive



Paul Hauptman presenting as veteran moderators Carl Leier and Arnold Katz look on

LV dilation plays an important role in worsening prognosis, but in diastolic heart failure, the LV does not dilate.

Paul J. Hauptman (St. Louis, MO) finished with a presentation capitalizing on the current poker craze: "Texas No-Limit Hold 'Em: Dealing with Patient Preferences and Uncertainty." He pointed out the uncertainty clinicians face—similar to that in poker—when applying similar therapies to heterogeneous groups of patients, selecting ejection fractions for ICD implantation, or predicting the timing of death for late-stage patients.

2007 Meeting in Washington D.C.

The 11th Annual Scientific Meeting of the HFSA, scheduled for September 16-19, 2007, will be held at the Marriott Wardman Park Hotel, a favorite choice among downtown Washington, D.C. hotels. Spanning 16 lush acres of flowering plants and meticulously maintained gardens, this inviting luxury hotel boasts a storied guest list of U.S. Presidents and dignitaries. Just minutes from the National Zoo and National Cathedral, the Marriott Wardman Park Hotel is a showcase of elegance and service. Watch for more information about the 2007 meeting after January 1st.

Future Heart Failure Awareness Weeks

2007: February 11-17

2008: February 10-16

2009: February 8-14

2010: February 14-20

Mark Your Calendars

January, 2007:

Registration opens for the 11th Annual Scientific Meeting

Monday, February 5, 2007:

2007 Research Fellowship Application Receipt Deadline
Online Abstract Process Opens for 2007 Annual Scientific Meeting

Saturday, February 10, 2007:

Primary Care Symposium, San Francisco, CA

February 11 – 17, 2007:

National Heart Failure Awareness Week

Monday, April 9, 2007:

Abstract Submission Deadline for the 11th Annual Scientific Meeting

Monday, May 7, 2007:

Hyde Park Submission Deadline for the 11th Annual Scientific Meeting

Friday, May 25, 2007:

Late Breaking Clinical Trials Submission Deadline for the 11th Annual Scientific Meeting

September 16 – 19, 2007:

11th Annual Scientific Meeting



Heart Failure Society
of America

11th ANNUAL SCIENTIFIC MEETING

September 16 – 19, 2007
Washington, D.C.

ABSTRACT DEADLINE
APRIL 9, 2007

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