

Tuesday 26 May 2015



Heart Failure Congress News



Heart Failure 2016: see you in Florence

Dear Friends and colleagues,

At the close of the enormously successful Heart Failure 2015 meeting it is with great pleasure that we invite you to join us for Heart Failure 2016, which will be held in the beautiful historical city of Florence, Italy, from 21 to 24 May 2016.

With next year's congress spotlight '**State of the Art**' we will consider the latest ways to make a heart failure diagnosis, predict patient outcomes, manage heart failure with drugs and devices and efficiently structure clinical services. We are also due to launch the latest **ESC Guidelines 'For the diagnosis and treatment of acute and chronic heart failure'**, written under the auspices of the ESC Committee for Practice Guidelines and developed in collaboration with the Heart Failure Association of the ESC. The congress, the biggest international meeting on heart failure, offers an unrivalled opportunity for colleagues from all over the globe to come together and exchange ideas about the impact of new developments.

In continuing our acclaimed scientific programme, we will once again be inviting expert faculty from around the globe to feature in the traditional symposia, debates, 'Meet the Experts' or 'How to sessions' and to give the new Honorary **Eugene Braunwald** and **Philip Poole Wilson** lectures. Later in the year we will be putting out a call for abstracts, clinical cases and Late-Breaking Science: prepare your science!

Successful abstracts are assigned to rapid fire sessions, moderated poster sessions and display posters and considered for the Young Investigator and Nursing Investigator Awards. All accepted abstracts are published in the online supplement of the European Journal of Heart Failure. After an enthusiastic launch in Seville this year, we will renew the call for clinical cases and choose the most challenging ones for presentation in oral abstract sessions. Last, but not least, the call for Late



Dr. G. Rosano
(Roma, IT)

Dr. M. Piepoli
(Piacenza, IT)

Dr. A. Maggioni
(Florence IT)

Heart Failure 2016 Scientific Chairpersons

Breaking Science will unveil the best of Hotlines, Clinical trial Updates, Registries and Basic & Translational Science Hotlines.

Heart Failure 2016 will also be the opportunity for our industry partners to showcase their latest advances in the field and propose alongside the Exhibition a complete programme with Satellite Symposia and Hands-On-Tutorials.

The venue, Firenze Fiera, is housed in the historic sixteenth century fortress 'Fortezza da Basso' located in walking distance to Florence's historical centre with its unsurpassed renaissance art and architecture. The very fact our meeting is being held in Florence is due to HFA members, who in a recent questionnaire identified the city as their absolute favourite location for a congress.

*We look forward to welcoming you
in Florence: Arrivederci a Firenze*



Stem cell recruitment factor boosts ventricular remodelling in heart failure

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Don't miss

- **Regenerative medicine in heart failure.** Fact or fiction? MADRID, 08:30 - 10:00
- **The challenge of palliative care in heart failure:** who, when and how, PARIS, 08:30 - 10:00
- **Results of PARADIGM-HF:** a closer look, ATHENS, 08:30 - 10:00
- **Heart Failure 2015 Highlights** ATHENS, 11:00 - 12:30

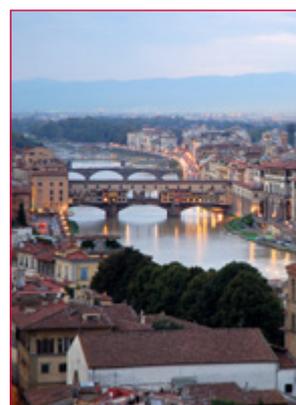
SP&P

All slide presentations, abstracts and electronic posters are available for consultation on the Scientific Programme & Planner
Resources are available to full and online members and fellows of the HFA only.

Why Florence?

It is apt that Heart Failure 2016, with the spotlight "Heart Failure State of the Art" will be hosted in the beautiful city of Florence. "It will be state of the art in the city of art," says Gerasimos Filippatos, President of the Heart Failure Association (HFA). The venue, he adds, enjoys a central location giving delegates plenty of opportunities to explore the artistic heritage of Florence, including The Uffizi Gallery, The Galleria dell'Accademia (with Michelangelo's David), and the Duomo.

With over 260 Italian members and three Italian board members, the HFA enjoys strong connections with Italy. In 1995 the Italian Network on Heart Failure, one of the first HF registries in Europe, was launched, and has revealed how the baseline characteristics, treatments and outcomes of HF patients have changed over the last 20 years. Italian delegates are always enthusiastic supporters of the meeting: Heart Failure 2008 in Milan was a great success and at Heart Failure 2014 in Athens the second largest number of delegates and fourth largest number of abstracts came from Italy. "Our Italian colleagues can be relied on to host great congresses," says Filippatos.



**Information for patients
available in 8 languages**

WWW.HEARTFAILUREMATTERS.ORG

Stem cell recruitment factor boosts ventricular remodelling in heart failure

A factor that promotes tissue repair via increased cell survival, endogenous bone marrow-derived and cardiac stem cell recruitment, and vasculogenesis improves remodelling in heart failure patients, offering hope of a novel treatment in more severe cases, delegates heard today.

In a phase II, double-blind, randomised placebo-controlled trial presented during a Late Breaking Trials session, Marc Penn, from Summa Health System, Akron, Ohio, USA, showed that plasmid stromal cell-derived factor-1 (pSDF-1) leads to sustained improvement in left ventricular remodelling, particularly in patients with a low ejection fraction.

Dr Penn and colleagues began working on SDF-1 after hypothesising that stem-cell-based repair of injured tissue is a natural process but clinically inefficient, “not because we lack stem cells but because the molecular signals that orchestrate how stem cells heal us are dysregulated,” he said.

Speaking to Heart Failure Congress News, he added: “We made the observation early on that stem cells put in the blood stream of an animal having a heart attack go to the heart. Stem cells put in the bloodstream of animals with heart failure do not.”

Dr Penn and colleagues therefore looked for factors that encourage stem cells to go to newly injured tissues, settling on SDF-1 in late 2000/early 2001. Since then, they have determining whether reestablishment of SDF-1 expression in heart failure leads to clinical improvement.



Dr. M. Penn
(Ohio, US)

For the current trial, the researchers randomised 93 ischaemic heart failure patients on stable medical therapy and a left ventricular ejection fraction (LVEF) $\leq 40\%$ to 15 mg or 30 mg plasmid SDF-1 or placebo via endomyocardial injections.

There were no serious adverse events. Overall, there was a nonsignificant trend towards an improvement in LVEF and left ventricular end-systolic volume (LVESV) with SDF-1 ($p=0.44$).

Further analysis revealed that, for patients in the lowest LVEF tertile ($<26\%$), 30 mg SDF-1 was associated with a 7% increase in LVEF at 12 months versus a 4% decrease with placebo ($p<0.01$).

Coupled with improvements in LVESV, SDF-1 patients experienced the equivalent of a 20 ml increase in stroke volume, compared with a decrease of 6.2 ml with placebo ($p=0.07$). Patients receiving 30 mg

SDF-1 also had improvements in N-terminal pro-brain natriuretic peptide, at a decrease compared with placebo of 784 pg/ml at 12 months ($p=0.38$).

Explaining why patients with more severe heart failure had a greater responses than those with a less severe form of the disease, Dr Penn said: “One of the benefits we know we have is we recruit hibernating tissue; so, myocytes that are live but not functioning.”

“The reality is that, the sicker your heart is, the more hibernating tissue you have, the more infarct border zones you have and the more tissue you have to help restore function to. So while we believe there is a preservation effect in hearts that are less sick, the reality is the treatment effect is in sicker hearts because they have more tissue to recover.”

In other words, SDF-1 is more effective in a population that has traditionally had to rely on devices for improvements in symptoms and outcomes.

Dr Penn said: “If you look at the folks we have significant benefit in, those are folks who often would be getting biventricular pacemakers, or, once they have biventricular pacemakers, if they fail they have not much more to do.”

He concluded: “It’s really for class III, IVa heart failure patients where, frankly, there aren’t any drugs that work.”

Late Breaking Trials III - on Monday - review the slideset at the e-Library.

Webinar on “Iron deficiency in Heart Failure patients”

Thursday 25 June 2015 from 16:30 to 17:30 CET

- Are there new valid treatment options to improve exercise intolerance, symptoms, QoL as well as outcome and prognosis in HF patients?
- What is the evidence on the prevalence and impact of iron deficiency (ID) in exercise capacity, and symptoms, QoL as well as outcome and prognosis in HF patients?
- What is the evidence available on the treatment options for ID and IDA in HF?
- What do we know about safety and efficacy of long term treatment with i.v. iron?

If you want the answers to these questions, log on to the HFA webinar

“Iron deficiency in HF patients: A call for action” on June 25.

This programme is supported by Vifor Pharma in the form of unrestricted educational grants



www.escardio.org/HFA



HEART FAILURE
ASSOCIATION
OF THE ESC

*It may be the end of the Congress,
but the HFA still has **more to offer!***

Don't miss:

- Congress slides for HFA members
- Make the most of your European Journal of Heart Failure throughout 2015
- 15 modules of online education all year round
- Webinar on "Iron deficiency in HF patients" - **25 June 2015**
- Apply for a clinical or basic research grant
- Postgraduate Course in Heart Failure application deadline - **15 September**
- Submit your application to become a Fellow of the HFA - **September**
- Apply for a nurse research grant - **deadline 30 October**
- 3rd HFA educational course on Exercise Training and Long Term Management in Heart Failure Patients in Bern in **November**

For more information, contact hfa@escardio.org

The HFA and its National Heart Failure Societies

The HFA is proud to have formed a close-knit network of national heart failure societies; over 40 countries participate in HFA projects and programmes annually. Examples of such collaboration can be found in the Heart Failure Specialist Curriculum which was reviewed by national heart failure societies and the HFA's White Paper on "Heart failure: Preventing disease and death worldwide" which was endorsed by 49 societies worldwide.

Every year in October, the HFA organises a popular one day brainstorming meeting for national heart failure society presidents at which topics and problems common to all countries are discussed. The importance of creating an open dialogue and a tight network of heart failure professionals is recognised and work towards common strategies is prioritised.

In May, the European Heart Failure Awareness Days take place. Every year, more countries organise their own campaigns during the same weekend so that hundreds of thousands of European citizens receive the message of prevention and information about heart failure. Events such as



open house clinics, free blood pressure readings on town squares, conferences about heart failure, tv and radio campaigns take place, all of which correspond to the HFA's mission to improve quality of life and longevity, through better prevention, diagnosis and treatment of heart failure.

The HFA's ultimate goal is to improve the management of heart failure patients, one of the greatest challenges in cardiovascular medicine in the 21st century given the size of this growing epidemic. We strive to achieve this aim by facilitating the communication and exchange of information between the different national heart failure societies.

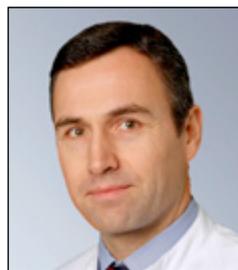
Implantable device improves outcomes and quality of life in heart failure patients

Quality of life and outcomes can be significantly improved in heart failure patients with reduced left ventricular ejection fraction by a device that simulates the carotid baroreceptor, suggests trials results presented today.

Jochen Müller-Ehmsen, Asklepios Klinik Altona, Hamburg, Germany, told delegates during a Late Breaking Trials session that an implantable baroreflex activation therapy (BAT) device is both safe and efficacious in New York Heart Association (NYHA) class III patients not treated with, or eligible for, chronic resynchronisation therapy (CRT).

The device consists of an electrode placed on the surface of the right carotid artery. The energy can then be varied in terms of how much of the QRS cycle its stimulated, how often and how long it is stimulated, and the strength of the stimulus.

Following implantation, the stimulus is provided up to a strength where the patient is able to feel it, and then stopped just below that threshold. The stimulus threshold is then increased every week for 4 weeks, until the maximum tolerable stimulus is reached.



*Dr. J. Müller-Ehmsen
(Hambourg, DE)*

Principle investigator Michael Zile, from the Medical University of South Carolina, Charleston, USA, explained to Heart Failure Congress News ahead of the presentation: "The unique thing about this device...is, rather than this going distal from the carotid to the heart, it goes proximal from the carotid to the brain, and when it gets to the brain, there's an effect both on sympathetic and parasympathetic outputs."

"So it has the advantage in comparison to the vagal stem, which goes distal to the vagus rather than proximal to the brain, that it normalises the sympathetic/parasympathetic balance, which we think has unique properties."

For the trial, 146 NYHA class III heart failure

patients with an ejection fraction $\leq 35\%$ were randomised to BAT or control therapy alongside guideline-directed medical therapy, of whom 45 were receiving CRT at baseline and 95 were not receiving CRT (no-CRT).

Both CRT and no-CRT patients had a major adverse neurological and cardiovascular events-free rate at 6 months of 100% and 96%, respectively. Among no-CRT patients, BAT was associated with significant improvements in 6-minute hall walk distance, quality of life, left ventricular ejection fraction, N-terminal pro-brain natriuretic peptide levels and heart failure hospitalisations compared with control therapy.

No significant differences between BAT and control therapy were observed among CRT patients. This is in line with the mode of action of the device, as CRT patients are thought to have less sympathetic/parasympathetic imbalance than no-CRT patients, and consequently would have less of a response to BAT.

To confirm the findings, final approval is currently awaited from the US Food and Drug Administration for a large, randomised prospective clinical trial

involving approximately 800 patients in over 90 centres in North America, which is expected to start this August.

Dr Zile hopes that the device could be used in more patients than those with NYHA class III heart failure. Discussing the patient choice for the current study, he explained: "You know, it's the usual trial design, where you're going for the maximum effect with the minimum of complication rates."

He added that NYHA class III heart failure "seems to be the sweet zone for trial, but I don't have any doubts that this will have a much wider audience".

Dr Zile concluded by saying that he believes the device could be used in NYHA class II patients who have hospitalised, as "the likelihood that they're going to be rehospitalised is substantial", through to patients with ambulatory NYHA class IV heart failure.

Late Breaking Trials III - on Monday - review the slideset at the e-Library

Highlights session provides take-home messages for Heart Failure 2015

The Heart Failure 2015 Highlights session this morning gives delegates the opportunity to hear an overview of the Heart Failure 2015 congress summarising the most important take home messages.

“All the major developments in heart failure covered in our congress will be summarised in a concise format by expert speakers who will place everything in context and explain the promise for the future,” says Petar Seferovic, from Belgrade, Serbia, who jointly chairs the session with Frank Ruschitzka, from Zurich, Switzerland.

For the first time the clinical science and translational science Highlight sessions have been combined into a single session. “This underlines the importance of the translational aspects of basic science in HF and provide delegates with a one stop shop,” says Seferovic.

From the outset the Heart Failure congress placed great emphasis on Highlights sessions.



Dr. P. Seferovic (Belgrade, RS)

“In a congress with multiple tracks coming to the Highlights session offers you a fantastic opportunity to catch up and ensure you haven’t missed any of the latest developments. Despite being the last session it’s always wonderfully well attended.”

Distinguished speakers providing their unique perspectives include **Christoph Maack** from Homburg/ Saar, Denmark, who will summarize the meeting from the basic and translational science perspective; **Theresa McDonagh** from London, Great Britain, who will review biomarkers and imaging; **Burkert Pieske** from Berlin, Germany, who will review chronic heart failure; **Tiny Jaarsma** from Norrkoping, Sweden who will review nursing and telemedicine; **Veli-Pekka Harjola** from Helsinki, Finland, who will review acute and advanced heart failure; and **Kenneth Dickstein** from Stravanger, Norway, who will review devices and interventions.

Heart Failure 2015 Highlights - Tuesday 26 May at 11:00 - ATHENS



Heart Failure 2015 Congress News

Editors: Frank Ruschitzka, Theresa McDonagh - Journalists: J. Fricker and L. Davenport - Copyright © ESC 2015 - Contact: hfsecretariat@escardio.org

Heart Failure is the annual congress of the Heart Failure Association of the ESC

What are, in your opinion, the biggest breakthroughs in the management of heart failure of the last decade?



S. Refaat Azab (Cairo, EG)

The **establishment of cardiac rehabilitation (CR)** units was a turning point in the management of heart failure patients. Activities carried out in these units showed a magnificent impact on outcomes of heart failure patients, which could be seen in the decline of mortality and morbidity among heart failure patients. Starting from patient reassurance and patient education, passing through checking all drugs according to guidelines in the best regimen fitting each patient, reporting all drug related problems and taking appropriate actions in an attempt to improve patient’s adherence to therapy. More over CR units provide a close eye on monitoring of drug safety and efficacy.



B. Riegel (Philadelphia, US)

We now recognise that adults with heart failure commonly experience illness-related issues such as impaired cognition and poor sleep that make it difficult for them to participate in self-care. Recognising this has contributed to a robust, worldwide effort to promote patient self-care in spite of these issues. Clinicians now realise that patients may have difficulty remembering to take their medications and may not be able to make thoughtful decisions about their symptoms. **This evolution in our awareness of patients’ issues** has been extremely influential in improving the way that we help patients manage their illness.



Heart failure is a complex syndrome requiring expert management to improve outcomes, yet 10 years ago most heart failure patients were managed by non-specialist physicians who concluded that “anyone can manage heart failure”. Fast forward 10 years to 2015 where in addition to breakthroughs in pharmacological and device therapy and improved understanding of aetiologies and comorbidities, we have developed **the ethos of the heart failure team**: a truly multidisciplinary team striving to continually deliver gold standard, evidence based, person centred care. In my opinion, this has been an enormous breakthrough and it is exciting to be part of the team.

“Definitely devices, drugs and ways of working. The advent of cardiac resynchronisation therapy was a huge step forward, along with the as yet untapped potential of remote monitoring of patients with implanted devices. Knowing that aldosterone blockade benefits nearly all patients with systolic heart failure, and that heart rate control with beta-blockade and/or ivabradine is vital in sinus rhythm, would be highlights of drug therapy changes. And finally, the development of heart failure nurse specialism as a key driver for disease management programmes across the world has had a huge impact. But of course, the best is yet to come!”



C. Murphy (Glasgow, UK)



M. Cowie (London, UK)