Bucindolol reduced mortality and hospitalisation related to cardiovascular causes in advanced chronic heart failure


QUESTION: In patients with advanced chronic heart failure, does bucindolol reduce all-cause mortality, cardiovascular mortality, and hospitalisation for chronic heart failure?

Design
Randomised (allocation concealed*), blinded (clinicians and patients), placebo controlled trial with mean follow up of 2 years (Beta-Blocker Evaluation of Survival Trial [BEST]).

Setting
90 clinical sites in the USA and Canada.

Patients
2708 patients (mean age 60 y, 78% men). Inclusion criteria were New York Heart Association (NYHA) class III or IV chronic heart failure caused by primary or secondary dilated cardiomyopathy; left ventricular ejection fraction < 35%; optimal medical treatment, including angiotensin-converting enzyme inhibitors for > 1 month; and > 18 years of age. Exclusion criteria included reversible heart failure; uncorrected primary valvular disease; active myocarditis; recent myocardial infarction or revascularisation; unstable angina; heart rate < 50 beats/minute; or serious concomitant illness.

Intervention
Patients were allocated to bucindolol, 3 mg twice daily for 1 week, which was then titrated gradually to a maximum dose of 100 mg twice daily (n = 1354) or to placebo (n = 1354).

Main outcome measures
All-cause mortality, cardiovascular mortality, and hospitalisation related to chronic heart failure.

Main results
Analysis was by intention to treat. The groups did not differ for all-cause mortality (adjusted p = 0.13) (table). Patients in the bucindolol group had a lower rate of cardiovascular mortality (p = 0.04) and hospitalisation for chronic heart failure (p < 0.001) than did patients in the placebo group (table).

Conclusions
In patients with advanced chronic heart failure, bucindolol did not reduce all-cause mortality; however, mortality from cardiovascular causes and hospitalisation for chronic heart failure were reduced.

*See glossary.

Bucindolol vs placebo for advanced chronic heart failure (CHF)*

<table>
<thead>
<tr>
<th>Outcomes at mean 2 years</th>
<th>Bucindolol</th>
<th>Placebo</th>
<th>RRR (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-cause mortality</td>
<td>30%</td>
<td>33%</td>
<td>8% (-2 to 18)</td>
<td>Not significant</td>
</tr>
<tr>
<td>Mortality from cardiovascular diseases</td>
<td>25%</td>
<td>29%</td>
<td>12% (0.4 to 22)</td>
<td>29 (15 to 790)</td>
</tr>
<tr>
<td>Hospitalisation for CHF</td>
<td>35%</td>
<td>42%</td>
<td>16% (8 to 24)</td>
<td>15 (10 to 32)</td>
</tr>
</tbody>
</table>

*Abbreviations defined in glossary; RRR, NNT, and CI calculated from data in article.

COMMENTARY
Do β-blockers improve morbidity and mortality in patients with heart failure? 3 large trials have shown the benefits of bisoprolol, carvedilol, and metoprolol on morbidity and mortality among patients with NYHA class II or III heart failure, and have had important implications for how patients with mild-to-moderate heart failure are treated. On the basis of these studies, it has now become standard practice to treat such patients with one of these β-blockers. Whether patients with severe heart failure would also benefit from β-blockade has been unanswered. Patients with severe heart failure have the highest sympathetic outflow and theoretically may benefit most from β-blockade. These patients also have the least inotropic reserve and, thus, are most susceptible to decompensation when treated with β-blockade.

These 2 studies (BEST and COPERNICUS) have provided important data that allow us to assess the benefit of β-blockers in patients with severe heart failure. What is certain is that the benefit of β-blockers is largely dependent on the type of patients who receive them. Unfortunately, assessing the value of β-blockers in patients with severe heart failure is problematic. First, measuring and comparing severity is difficult. The NYHA functional classification is a useful guide, but, as pointed out by Braunwald, it is subjective and inherently imprecise. An alternative way of comparing the severity of heart failure among patients in different trials is to use placebo mortality rates. Subsets of patients in whom the annual placebo mortality rate is high (eg, 20%) are said to have very severe heart failure. This measure also has its limitations because it does not reflect only mortality caused by heart failure and it does not include any measure of severity of symptoms, frequency of hospitalisation, or quality of life.

We are left with 2 well-designed studies, only 1 of which shows a substantial benefit of β-blocker treatment on mortality in patients with severe heart failure. These differing conclusions may have resulted from study populations that were different or from differences in the pharmacological actions of bucindolol and carvedilol. The benefits of carvedilol may be related to its unique α-adrenergic, antioxidant, and antiendothelin effects.

continued on next page
Carvedilol reduced mortality and hospitalisation in severe chronic heart failure


QUESTION: In patients with severe chronic heart failure, does carvedilol, a β-blocker, reduce mortality and hospitalisation?

Main outcome measures
Mortality and combined risk for death or hospitalisation for any reason.

Main results
Analysis was by intention to treat and used Kaplan-Meier survival curves. The cumulative risk for death at 1 year was lower in the carvedilol group than the placebo group (adjusted p = 0.001) (table). The risk for combined death or hospitalisation in the carvedilol group was lower than in the placebo group (p < 0.001) (table).

Conclusion
Carvedilol reduced mortality and the combined risk for death or hospitalisation in patients with severe chronic heart failure.

Sources of funding: Roche Pharmaceuticals and GlaxoSmithKline.

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Carvedilol v placebo for severe chronic heart failure‡

<table>
<thead>
<tr>
<th>Outcomes at 1 year</th>
<th>Carvedilol</th>
<th>Placebo</th>
<th>RRR (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk for death</td>
<td>11%</td>
<td>19%</td>
<td>35% (19 to 48)</td>
<td>15 (10 to 25)</td>
</tr>
<tr>
<td>Combined risk for death or hospitalisation</td>
<td>42%</td>
<td>53%</td>
<td>24% (13 to 33)</td>
<td>10 (7 to 15)</td>
</tr>
</tbody>
</table>

‡Abbreviations defined in glossary; NNT and CI calculated from data in article.

COMMENTARY—continued from previous page
The positive results from the BEST study—namely, the decrease in mortality specific to cardiovascular causes and the decrease in overall mortality among non-black patients—should not be ignored. The results of previous studies and these 2 new investigations, coupled with our increasing understanding of the role of the adrenergic nervous system in heart failure, can be used to derive a rational set of recommendations. First, patients with mild or moderate heart failure should receive β-blockers. As heart failure becomes more severe in these same patients, β-blockade must strike a delicate balance so it is forceful enough to block the adverse effects of the sympathetic nervous system and yet gentle enough to maintain any positive role this system plays in survival. For this reason, patients receiving β-blockers who develop progressive heart failure must be closely monitored. When patients with mild-to-moderate chronic heart failure who are treated with other β-blockers progress to severe heart failure, switching them to carvedilol should be considered. Additional evidence is needed before more widespread use of β-blockers in patients with severe heart failure can be recommended. Because the type of β-blocker may be very important, a trial directly comparing bucindolol and carvedilol would provide valuable evidence.

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