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Prognostic Implications of Renal Dysfunction in Patients With Aortic Stenosis



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Aortic stenosis (AS) and renal dysfunction share risk factors and often occur simultaneously. The influence of renal dysfunction on the prognosis of patients with various grades of AS has not been extensively described. The present study aimed to assess the prognostic implications of renal dysfunction in a large cohort of patients with aortic sclerosis and patients with various grades of AS. Patients diagnosed with various grades of AS by transthoracic echocardiography were assessed and divided according to renal function by estimated glomerular filtration rate (eGFR). The occurrence of all-cause mortality (primary end point) and aortic valve replacement (AVR) was noted. Of 1,178 patients (mean age 70 ± 13 years, 60% male), 327 (28%) had aortic sclerosis, 86 (7%) had mild AS, 285 (24%) had moderate AS, and 480 (41%) had severe AS. Renal dysfunction ($eGFR < 60$ ml/min/1.73 m²) was present in 440 (37%) patients, and moderate to severe AS was observed more often in these patients compared to patients without (70 vs 62%, respectively; $p = 0.008$). After a median follow-up of 95 [31 to 149] months, 626 (53%) patients underwent AVR and 549 (47%) patients died. Severely impaired renal function ($eGFR < 30$ ml/min/1.73 m²) and AVR were independently associated with all-cause mortality after correcting for AS severity. In conclusion, renal dysfunction is highly prevalent in patients with various grades of AS. After correcting for AS severity and AVR, severely impaired renal function ($eGFR < 30$ ml/min/1.73 m²) was independently associated with all-cause mortality. Independent of renal function, AVR was associated with improved survival. © 2020 The Author(s). Published by Elsevier Inc. This is an open access article under the CC BY license. (<http://creativecommons.org/licenses/by/4.0/>) (Am J Cardiol 2020;125:1108–1114)

Aortic stenosis (AS) and renal dysfunction share several risk factors (e.g., hypertension and diabetes) and often occur simultaneously and with a complex interaction.¹ In patients with end-stage kidney disease, aortic valve calcification has been observed in 28% to 55% of patients, occurs 10 to 20 years earlier and has a faster progression as compared to the general population.^{1,2} Similarly, in patients with milder grades of renal dysfunction, an association between stage of renal dysfunction and grade of aortic valve calcification has been demonstrated and has prognostic implications^{3,4}: moderate and severe AS are present more often in these patients^{5,6} and this has been associated with significantly lower survival as compared to patients with normal renal function⁵ or to patients with renal dysfunction

without AS.⁶ Inversely, renal dysfunction is a frequent finding in severe AS patients undergoing either surgical or transcatheter aortic valve replacement (AVR) and has been associated with poor short- and mid-term outcomes after intervention.⁷⁻¹² The influence of renal dysfunction on the prognosis of patients with various grades of AS has not been extensively described. The present study aimed to assess the prognostic implications of renal dysfunction in a large cohort of patients with aortic sclerosis and patients with various grades of AS.

Methods

From an ongoing registry at the Leiden University Medical Center (Leiden, the Netherlands), 1,178 patients diagnosed with various grades of AS between May 1994 and June 2017 were included in this retrospective study. Patients were selected based on available baseline echocardiographic data for assessment of AS severity (defined as the first available echocardiographic study performed) and renal function measurement. As currently recommended by international guidelines, the grade of AS severity was determined based on mean aortic valve gradient, peak aortic jet velocity and calculated aortic valve area.¹³ Patients were divided according to the following AS severity categories: aortic sclerosis, mild AS, moderate AS, and severe AS.¹³ Clinical history, physical examination, and transthoracic echocardiography were performed at the time of first AS diagnosis for each patient. Clinical data were collected by review of the patient files at the departmental cardiology

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information system (EPD-vision; Leiden University Medical Center, Leiden, the Netherlands) and hospital electronic medical records (HiX; ChipSoft, Amsterdam, the Netherlands). Baseline clinical data included patient demographics, cardiovascular risk factors, use of cardiovascular medication and laboratory results such as haemoglobin and creatinine level. The Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) formula was used to calculate the estimated glomerular filtration rate (eGFR).¹⁴ Patients were divided into four groups according to the eGFR as recommended by the current guidelines: normal renal function (eGFR ≥ 90 ml/min/1.73 m²), mildly impaired renal function (eGFR 60 to 89 ml/min/1.73 m²), moderately impaired renal function (eGFR 30 to 59 ml/min/1.73 m²) and severely impaired renal function (eGFR < 30 ml/min/1.73 m²).¹⁵ Exclusion criteria included subvalvular or supra-avalvular AS, dynamic sub-aortic obstruction, active endocarditis, and previous AVR. For this retrospective analysis of clinically acquired data, the institutional review board waived the need for patient written informed consent.

Transthoracic echocardiography was performed using commercially available ultrasound systems (System 5, Vivid 7 or E9, General Electric Vingmed, Horten, Norway) equipped with 3.5 MHz or M5S transducers with the patient in the left lateral decubitus position. Images were stored digitally on hard disk and analysed offline (EchoPac version BT13; GE Medical Systems). Measurements of the echocardiographic data were performed de novo by experienced observers. Two-dimensional, color, continuous and pulsed-wave Doppler data from the parasternal and apical views were acquired. Left ventricular (LV) dimensions were measured on the parasternal long-axis view and the LV mass was calculated and indexed for body surface area.¹⁶ The end-diastolic and end-systolic LV volumes were measured on the apical 2- and 4-chamber views using the Simpson's biplane method and the LV ejection fraction was calculated.¹⁶ Continuous-wave Doppler recordings of the 3- or 5-chamber apical views were obtained for estimation of the peak aortic jet velocity.¹³ Using the simplified Bernoulli equation, the peak and mean gradients of the aortic valve were calculated.¹³ On the 3- or 5-chamber apical views, pulsed-wave Doppler recordings of the flow through the LV outflow tract were obtained to derive the velocity-time integral and the aortic valve area (AVA) was calculated according to the continuity equation.¹³ AS severity was classified according to the current recommendations: aortic sclerosis was defined as calcification and thickening of the aortic valve with a peak aortic jet velocity ≤ 2.5 m/s; mild AS was defined as a peak aortic jet velocity of 2.6 to 2.9 m/s, a mean gradient < 20 mm Hg or an AVA > 1.5 cm²; moderate AS was defined as a peak aortic jet velocity of 3.0 to 4.0 m/s, a mean gradient of 20 to 40 mm Hg or an AVA of 1.0 to 1.5 cm²; and severe AS was defined as a peak aortic jet velocity ≥ 4.0 m/s, a mean gradient ≥ 40 mm Hg or an AVA < 1.0 cm².¹³

Occurrence of surgical or transcatheter AVR and all-cause death from the moment of the first diagnosis of AS at baseline echocardiography to the last follow-up was noted for all patients. The primary end point of all-cause mortality was assessed through individual patient record review, linked to the governmental death registry database.

Continuous variables are presented as mean \pm standard deviation when normally distributed and compared across patient groups divided according to the renal function category using the analysis of variance (ANOVA) test. When not normally distributed, continuous variables were presented as median and interquartile range and compared across groups using the Kruskal-Wallis test. Categorical variables were presented as numbers and percentages and compared using χ^2 tests. Cumulative event-free survival from all-cause mortality was calculated using the Kaplan Meier method and log-rank tests were performed for comparison across groups. For the identification of clinical and echocardiographic parameters associated with all-cause mortality, univariable Cox proportional hazard regression analyses were performed. Significant univariable variables ($p < 0.05$) were then introduced as covariates in a multivariable Cox proportional hazards regression model to identify demographic, clinical and echocardiographic variables independently associated with all-cause mortality. The occurrence of surgical or transcatheter AVR was entered as a time-dependent covariate and was forced into the multivariable model. Hazard ratios (HRs) with 95% confidence intervals (CI) were presented. The validity of the assumption of proportional hazards for the Cox regression analyses was confirmed for all categorical variables using log minus log plots. For continuous variables, the proportional hazard assumption was confirmed using partial residuals (i.e., Schoenfeld residuals). SPSS software (version 23.0; IBM, Armonk, New York) was used for the statistical analyses. A 2-sided p value < 0.05 was considered statistically significant.

Results

The total study population consisted of 1,178 patients (mean age 70.1 ± 13.0 years, 60% male) diagnosed with aortic sclerosis and patients with various grades of AS: 327 (27.8%) patients had aortic sclerosis, 86 (7.3%) patients had mild AS, 285 (24.2%) patients had moderate AS and 480 (40.7%) patients had severe AS (Figure 1). The population was divided into 4 groups based on the renal function: normal renal function (eGFR ≥ 90 ml/min/1.73 m²) was present in 170 (14.4%) patients, mildly impaired renal function (eGFR 60 to 89 ml/min/1.73 m²) in 568 (48.2%) patients, moderately impaired renal function (eGFR 30 to 59 ml/min/1.73 m²) in 377 (32.0%) patients, and severely impaired renal function (eGFR < 30 ml/min/1.73 m²) in 63 (5.3%) patients (Figure 1). The distribution of the various grades of AS across the renal function groups is depicted in Figure 1: there was a higher prevalence of moderate to severe AS in patients with moderately to severely impaired renal function (eGFR < 60 ml/min/1.73 m²) compared to normal to mildly impaired renal function (eGFR ≥ 60 ml/min/1.73 m²) patients (69.8% vs 62.1%, respectively; $p = 0.008$).

Baseline clinical and echocardiographic characteristics for the total study population and according to renal function groups are listed in Tables 1 and 2. Compared to patients with normal to mildly impaired renal function, patients with moderately to severely impaired renal function were older, more often had New York Heart Association class ≥ 3 symptoms, more often had cardiovascular risk

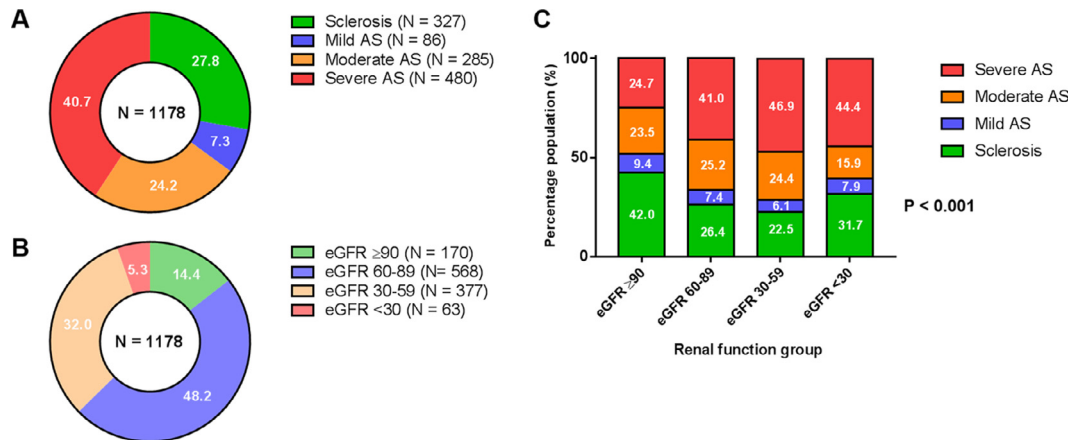


Figure 1. Distribution of grade of aortic stenosis (A) and renal function (B) in total study population and of various grades of aortic stenosis across renal function groups (C). Abbreviations: AS = aortic stenosis; eGFR = estimated glomerular filtration rate.

factors and co-morbidities such as diabetes, coronary artery disease, previous myocardial infarction, and atrial fibrillation and therefore more often used cardiovascular medication (Table 1). On echocardiography, patients with moderately to severely impaired renal function had a larger LV mass index, lower LV ejection fraction and higher mean aortic valve gradient than patients with less than moderately impaired renal function (Table 2).

After a median follow-up of 95 [31 to 149] months, 626 (53%) patients underwent AVR (63% had a surgical AVR and 37% a transcatheter AVR) and 549 (47%) patients died. The distribution of all-cause mortality across the renal function groups is shown in Table 3.

Figure 2 shows the Kaplan Meier curves of cumulative event-free survival for the various renal function groups. At 10 years, the cumulative survival rates were significantly

Table 1 Baseline clinical characteristics of the total study population and according to renal function group

Variable	Total population (N = 1178)	Glomerular Filtration Rate (ml/min/1.73m ²)				P value
		≥90 (N = 170)	60-89 (N = 568)	30-59 (N = 377)	<30 (N = 63)	
Men	706 (60%)	114 (67%)	334 (59%)	219 (58%)	39 (62%)	0.209
Age (years)	70.1 ± 13.0	55.2 ± 15.3	70.7 ± 10.7	75.7 ± 9.1	70.8 ± 13.9	< 0.001
Body surface area (m ²)	1.88 ± 0.20	1.90 ± 0.21	1.88 ± 0.20	1.86 ± 0.20	1.87 ± 0.18	0.214
Systolic blood pressure (mmHg)	143 ± 29	140 ± 22	144 ± 26	144 ± 28	143 ± 29	0.323
Diastolic blood pressure (mmHg)	78 ± 14	79 ± 13	78 ± 13	77 ± 14	78 ± 15	0.492
Heart rate (beats per minute)	74 ± 15	73 ± 14	74 ± 15	73 ± 15	76 ± 16	0.613
New York Heart Association class III-IV	295 (26%)	18 (11%)	138 (25%)	124 (34%)	15 (24%)	< 0.001
Hypertension	629 (55%)	63 (38%)	293 (53%)	238 (65%)	35 (56%)	< 0.001
Hypercholesterolemia	376 (34%)	40 (24%)	195 (37%)	126 (36%)	15 (25%)	0.011
Diabetes mellitus	232 (20%)	29 (17%)	97 (18%)	92 (25%)	14 (22%)	0.040
Previous myocardial infarction	199 (17%)	17 (10%)	93 (17%)	73 (19%)	16 (25%)	0.015
Atrial fibrillation	205 (18%)	17 (10%)	97 (18%)	73 (20%)	18 (29%)	0.005
Chronic obstructive pulmonary disease	155 (13%)	14 (8%)	77 (14%)	59 (16%)	5 (8%)	0.061
Creatinin level (umol/L)	89 [74-109]	67 [57-76]	81 [72-93]	115 [100-132]	255 [181-528]	< 0.001
Estimated glomerular filtration rate (ml/min/1.73m ²)	66.6 ± 22.6	100.0 ± 10.7	74.4 ± 8.5	47.6 ± 8.3	18.8 ± 12.3	< 0.001
Hemoglobin (mmol/L)	8.2 ± 1.2	8.3 ± 1.3	8.4 ± 1.1	8.2 ± 1.1	7.0 ± 1.1	< 0.001
Urea (mmol/L)	6.9 [5.4-9.0]	5.1 [4.2-6.1]	6.5 [5.4-7.9]	9.1 [7.2-11.5]	19.2 [13.4-25.8]	< 0.001
Medication use						
Beta blocker	499 (44%)	55 (33%)	234 (43%)	179 (48%)	31 (51%)	0.006
Angiotensin-converting enzyme inhibitor or angiotensin-II receptor blocker	507 (44%)	52 (31%)	236 (43%)	188 (51%)	31 (51%)	<0.001
Diuretics	417 (36%)	33 (20%)	171 (31%)	183 (49%)	30 (49%)	<0.001
Calcium antagonists	257 (22%)	29 (17%)	111 (20%)	99 (27%)	18 (30%)	0.023
Statin	508 (44%)	54 (32%)	250 (46%)	172 (46%)	32 (53%)	0.006
Oral anticoagulation/antiplatelet	598 (52%)	54 (32%)	289 (53%)	220 (59%)	35 (57%)	<0.001

Continuous variables are presented as mean ± SD or median [25th to 75th percentile].

Table 2
Echocardiographic parameters of the total study population and according to renal function group

Variable	Total population (N = 1178)	Glomerular Filtration Rate (ml/min/1.73 m ²)				P value
		≥90 (N = 170)	60-89 (N = 568)	30-59 (N = 377)	<30 (N = 63)	
Aortic valve structure						< 0.001
Tricuspid	1079 (92%)	132 (78%)	524 (92%)	363 (96%)	60 (95%)	
Bicuspid	99 (8%)	38 (22%)	44 (8%)	14 (4%)	3 (5%)	
Significant aortic regurgitation	10 (1%)	0 (0%)	5 (1%)	4 (1%)	1 (2%)	0.558
Significant mitral regurgitation	42 (4%)	2 (1%)	20 (4%)	19 (5%)	1 (2%)	0.115
Left ventricular end diastolic diameter (mm)	48.5 ± 7.6	48.5 ± 6.4	48.3 ± 7.5	48.7 ± 8.5	49.2 ± 6.4	0.807
Interventricular septal thickness (mm)	12.2 ± 2.3	11.7 ± 2.3	12.1 ± 2.2	12.5 ± 2.3	12.4 ± 2.2	0.002
Posterior wall thickness (mm)	11.8 ± 2.0	11.4 ± 2.0	11.8 ± 2.0	12.0 ± 2.1	12.3 ± 2.5	0.013
Left ventricular mass index (g/m ²)	121.4 ± 36.6	113.5 ± 35.4	119.7 ± 34.8	126.0 ± 38.2	130.0 ± 39.9	<0.001
Left ventricular ejection fraction (%)	55.7 ± 12.0	59.4 ± 8.3	55.9 ± 11.9	54.5 ± 13.1	53.1 ± 13.1	<0.001
Stroke volume index (ml/m ²)	41.9 ± 12.8	44.8 ± 11.7	42.2 ± 12.9	40.3 ± 12.7	40.8 ± 13.3	0.002
Peak aortic jet velocity (m/s)	3.1 ± 1.1	2.8 ± 1.2	3.2 ± 1.1	3.2 ± 1.1	3.0 ± 1.2	0.001
Mean aortic valve gradient (mmHg)	27.4 ± 19.3	23.2 ± 19.8	27.7 ± 18.6	29.2 ± 19.6	25.6 ± 20.2	0.007
Aortic valve area (cm ²)	1.29 ± 0.65	1.58 ± 0.74	1.27 ± 0.63	1.18 ± 0.58	1.31 ± 0.78	<.0001

Continuous variables are presented as mean ± SD or median [25th to 75th percentile].

Table 3
Outcomes of the total study population and according to renal function group

Variable	Total population (N = 1178)	Glomerular Filtration Rate (ml/min/1.73 m ²)				P value
		≥90 (N = 170)	60-89 (N = 568)	30-59 (N = 377)	<30 (N = 63)	
All-cause mortality	549 (47%)	45 (27%)	242 (43%)	211 (56%)	51 (81%)	<0.001

lower for patients with moderately and severely impaired renal function compared to patients with mildly impaired and normal renal function (43% and 19% vs 61% and 76%, respectively, log-rank $p < 0.001$). To determine the prognostic effect of AS severity grade, the study population was divided by the presence of moderate to severe AS and renal dysfunction (defined as eGFR < 60 ml/min/1.73m²) (Figure 2). Amongst patients without renal dysfunction, patients with moderate to severe AS had lower 10-year cumulative event-free survival rates than patients with less than moderate AS (61% vs 70%, respectively; log-rank $p = 0.015$). However, amongst patients with renal dysfunction, no additional effect of AS severity on 10-year cumulative event-free survival rates was observed (39% for less than moderate AS vs 40% for moderate to severe AS, log-rank $p = 0.636$).

For the evaluation of the independent associates of all-cause mortality, a multivariable Cox proportional hazards regression model was constructed (Table 4). To take into account the effect of AVR on survival, AVR was introduced as a time-dependent covariate and forced into the multivariable model. In the univariable analysis, multiple parameters were significantly associated with all-cause mortality: renal function, age, hypertension, diabetes, previous myocardial infarction, atrial fibrillation, LV ejection fraction, LV mass index, and AVA. On multivariable analysis, renal function (HR 0.99; 95% CI 0.98 to 0.99; $p < 0.001$) and surgical or transcatheter AVR (HR 0.67; 95% CI 0.54 to 0.85; $p = 0.001$) were independently associated with all-cause mortality, together with age, diabetes, previous myocardial infarction, and LV ejection fraction

(Table 4). When regarded as a categorical variable, only severely impaired renal function was independently associated with all-cause mortality (HR 3.24; 95% CI 2.02 to 5.21; $p < 0.001$).

Discussion

The present study showed that renal dysfunction (eGFR < 60 ml/min/1.73 m²) is highly prevalent in a large cohort of patients with various grades of AS. Even after correcting for AS severity and surgical or transcatheter AVR, severely impaired renal function (eGFR < 30 ml/min/1.73m²) was independently associated with all-cause mortality. Surgical or transcatheter AVR was associated with improved survival, independent of renal function. This suggests that patients undergoing AVR have a survival benefit, even in the presence of severely impaired renal function.

Renal dysfunction and aortic stenosis share several risk factors (e.g., hypertension, diabetes mellitus, hypercholesterolemia, and smoking) and often coexist.¹ However, the bidirectional interaction between renal dysfunction and AS is complex and not completely understood. It is increasingly recognized that an active process very similar to atherosclerosis underlies aortic valve calcification (AVC), the precursory phase of AS.^{17,18}

An increased prevalence and more rapid progression of AVC and AS has been observed in end-stage renal disease patients: AVC has been observed in 28% to 55% of these patients with a 10 to 20 year earlier onset as compared to patients without renal disease.^{1,2,19} Studies on the prevalence of AVC and AS in patients with less severe renal disease

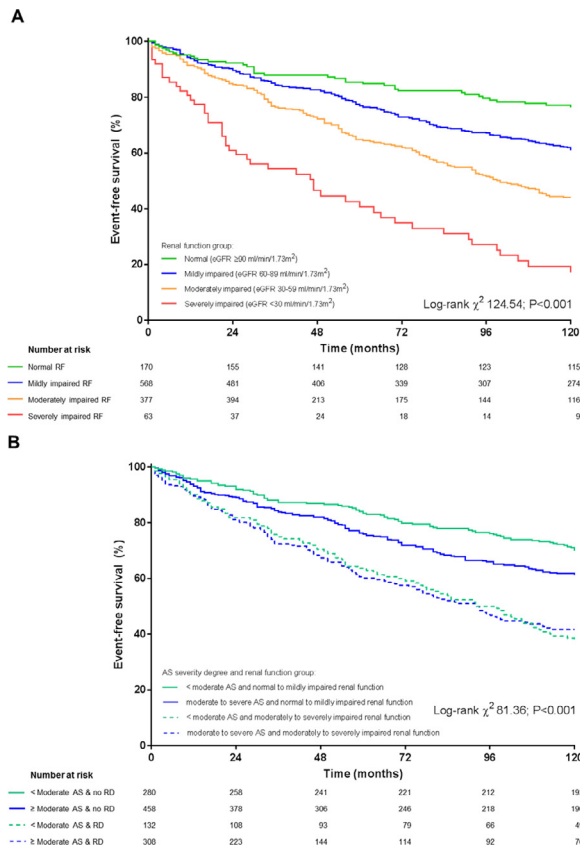


Figure 2. Kaplan-Meier estimates of cumulative event-free survival of study population stratified by (A) renal function group and (B) grade of aortic stenosis and presence of renal dysfunction (eGFR <60 ml/min/1.73 m²). Abbreviations: AS = aortic stenosis; eGFR = estimated glomerular filtration rate; RD = renal dysfunction; RF = renal function.

have reported conflicting results: although Guerraty et al.³ reported an independent and dose-dependent association of eGFR with AVC, the majority of studies did not find a

significant association.²⁰⁻²² Focussing on AS, renal disease was associated with faster progression rate of AS in moderate AS patients.²³ Vavilis et al. recently demonstrated that in 1,121,875 patients (of which 66,949 [6.0%] patients had renal dysfunction), the risk for development of AS was associated with eGFR in a dose-dependent manner.⁴ Furthermore, Samad et al. evaluated 78,059 patients (including 23,727 [30%] patients with eGFR <60 ml/min/1.73 m²), and described that patients with renal dysfunction had higher odds of having mild and moderate AS compared to patients without (odds ratio 1.30 (95% CI 1.18 to 1.43) and odds ratio 1.22 (95% CI 1.07 to 1.40), respectively; p <0.001).⁵ In patients with renal dysfunction, the presence of AS was associated with worse survival as compared to renal dysfunction patients without AS (p <0.001) and lower eGFR was associated with an increased risk for all-cause mortality (HR 1.18 [95% CI 1.08 to 1.29]).⁶ Inversely, renal dysfunction is commonly reported in severe AS patients undergoing AVR, with prevalence rates of 25% to 34% in surgical AVR^{7,24} and of 38% to 70% in transcatheter AVR patients.^{8,10-12,25} The prevalence of renal dysfunction in more varying grades of AS has not been well described. The present study corroborates and extends earlier findings by showing that renal dysfunction is prevalent in a population with aortic sclerosis and patients with AS grades ranging from mild to severe AS.

Preoperative renal dysfunction has been demonstrated to negatively influence both short- and long-term survival of severe AS patients undergoing either surgical or transcatheter AVR.^{7,9-11,24} Importantly, the Euro Heart Survey reported that renal dysfunction was an important reason for denying intervention when indicated.²⁶ The prognostic value of renal dysfunction has not been extensively evaluated in less than severe AS patients. The present study demonstrates and corroborates earlier findings that severely impaired renal function is significantly associated with all-cause mortality, independent of AS severity.⁶ Furthermore, AVR was shown to have a positive effect on outcome, independent of renal function.⁶ This suggests that patients with severely impaired

Table 4
Uni- and multivariable Cox regression analyses to identify independent associates of all-cause mortality

Variable	Univariable Hazard ratio (95% confidence interval)	P value	Multivariable Hazard ratio (95% confidence interval)	P value
Age (years)	1.05 (1.04-1.06)	<0.001	1.05 (1.04-1.06)	<0.001
Male gender	1.10 (0.93-1.31)	0.261	—	—
New York Heart Association class III-IV	1.15 (0.95-1.41)	0.159	—	—
Hypertension	1.21 (1.02-1.43)	0.031	0.98 (0.81-1.19)	0.854
Hypercholesterolemia	0.84 (0.69-1.02)	0.072	—	—
Diabetes mellitus	1.56 (1.29-1.90)	<0.001	1.50 (1.21-1.86)	<0.001
Previous myocardial infarction	1.80 (1.47-2.19)	<0.001	1.45 (1.16-1.80)	0.001
Atrial fibrillation	1.38 (1.11-1.71)	0.003	0.97 (0.76-1.23)	0.796
Left ventricular ejection fraction (%)	0.98 (0.97-0.98)	<0.001	0.99 (0.98-0.99)	0.003
Left ventricular mass index (g/m ²)	1.01 (1.00-1.01)	<0.001	1.00 (1.00-1.00)	0.230
Peak aortic jet velocity (m/s)	0.99 (0.91-1.07)	0.723	—	—
Mean aortic valve gradient (mmHg)	1.00 (0.99-1.00)	0.566	—	—
Aortic valve area (cm ²)	0.79 (0.69-0.91)	0.001	0.85 (0.71-1.03)	0.096
Aortic valve replacement (surgical or transcatheter)	0.89 (0.74-1.06)	0.189	0.67 (0.54-0.85)	0.001
Estimated glomerular filtration rate (ml/min/1.73m ²)	0.98 (0.98-0.98)	<0.001	0.99 (0.98-0.99)	<0.001
Estimated glomerular filtration rate (vs. ≥90 ml/min/1.73m ²)				
60-89	1.97 (1.44-2.72)	<0.001	1.02 (0.70-1.47)	0.933
30-59	3.23 (2.34-4.46)	<0.001	1.22 (0.83-1.81)	0.313
<30	6.65 (4.43-9.95)	<0.001	3.24 (2.02-5.21)	<0.001

renal function may have survival benefit undergoing AVR, although this needs to be corroborated by future studies.

The present study has limitations inherent to its retrospective design and was performed in a single centre, which is a referral centre for cardiac surgery. This may have introduced selection bias. A considerable part of the study population underwent AVR, which may have a positive impact on prognosis. Although these patients were not equally distributed over the renal function groups, AVR was introduced in the Cox regression analyses as a time-dependent covariate to correct for this potential effect. There can be residual biases due to additional confounders influencing prognosis which have not been taken into account in the analyses (e.g., serum values of calcium and phosphate, systolic pulmonary artery pressure, significant tricuspid regurgitation and right ventricular function) due to lack of systematic recording of these parameters in the database. Classification of patients into renal function groups was based on a single measurement of eGFR, this may have led to misclassification and precluded differentiation between acute and chronic renal dysfunction. Low flow-low gradient severe AS was present in 99 of 480 severe AS patients (20.6%). Data on dobutamine stress echocardiography was unavailable in these patients. In a small proportion of patients (4%), calculation of AVA was not possible due to missing data on velocity-time integral of the LV outflow tract and AS severity classification was based solely on mean gradient and peak aortic jet velocity.¹³ Albuminuria, an important marker for kidney damage,¹⁵ was not taken into account due to lack of systematic determination of these data. For similar reasons, renal replacement therapy and causes of renal dysfunction were not considered in the analyses.

In conclusion, this large single-center study of patients with aortic sclerosis and patients with AS ranging from mild to severe AS, renal dysfunction (defined as eGFR <60 ml/min/1.73 m²) is a prevalent finding. Severely impaired renal function (i.e., eGFR <30 ml/min/1.73²) was independently associated with all-cause mortality (HR 3.24; 95% CI 2.01 to 5.20; p <0.001).

Author contributions

E. Mara Vollema, Conception and design of the study; collection, analysis and interpretation of data; drafting of the manuscript; final approval of the manuscript

Edgard A. Prihadi, Conception and design of the study; collection and interpretation of data; final approval of the manuscript

Arnold C.T. Ng, Conception and design of the study; collection and interpretation of data; final approval of the manuscript

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Jeroen J. Bax, Conception and design of the study; collection, analysis and interpretation of data; drafting of the manuscript; final approval of the manuscript

Victoria Delgado, Conception and design of the study; collection, analysis and interpretation of data; drafting of the manuscript; final approval of the manuscript

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