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Optimizing clinical risk stratification in acute heart failure

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Document Version

Publisher's PDF, also known as Version of record

Publication date:

2017

[Link to publication in University of Groningen/UMCG research database](#)

Citation for published version (APA):

Demissei, B. G. (2017). *Optimizing clinical risk stratification in acute heart failure*. University of Groningen.

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Propositions

Optimizing clinical risk stratification in acute heart failure

1. Competing risks are common in prognostic acute heart failure research and their presence should be accounted for with the appropriate methodology (this thesis)
2. Single biomarkers measured at a single time point provide prognostic information yet serial evaluation of a tandem of biomarkers reflecting diverse pathophysiologic pathways is needed for maximizing prognostic utility (this thesis)
3. Biomarkers are poor at predicting rehospitalizations and to better predict the risk of hospital readmissions for acute heart failure, it is (probably) wiser to focus on diuretic response and better assessment of decongestion
4. Significant procalcitonin elevation, indicating probable undiagnosed/untreated bacterial infection, signals high risk in acute heart failure patients (this thesis)
5. Different sets of biomarkers should be evaluated for more optimal stratification of hospitalized acute heart failure patients into low versus high risk for early post-discharge events (this thesis)
6. While selective adenosine A1-receptor blockade with rolofylline might not be beneficial in low risk patients it could significantly benefit high risk acute heart failure patients (this thesis)
7. Risk stratification tools could help personalize treatment of acute heart failure patients
8. Biomarker-guided treatment monitoring and management is the way forward towards the routine use of novel biomarkers in daily practice
9. Variability is the law of life, and as no two faces are the same, so no two bodies are alike, and no two individuals react alike and behave alike under the abnormal conditions which we know as disease (Sir William Osler)
10. An unsophisticated forecaster uses statistics as a drunken man uses lamp-posts - for support rather than for illumination (Andrew Lang)
11. Just because there are flaws in aircraft design that doesn't mean flying carpets exist (Ben Goldacre)