



Primary prevention with a defibrillator: are therapies always really optimized before implantation?

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Résumé en anglais

AIMS: Left ventricle ejection fraction (LVEF) \leq 30-35% is widely accepted as a cut-off for primary prevention with an implantable cardiac defibrillator (ICD) in patients with both ischaemic and non-ischaemic cardiomyopathy supposedly on optimal medical therapy. This study reports evolutions of LVEF and treatments of patients implanted in our institution with an ICD for primary prevention of sudden death, after 2 years of follow-up. METHODS AND RESULTS: Among 84 patients with LVEF under 35% implanted between 2005 and 2007, 28 (33%) had improved their LVEF $>$ 35% after the 2 years of follow-up. During this period, even if Beta-blockers (98%) and renin-angiotensin system (RAS) blockers (95%) were already initially prescribed, treatments were significantly optimized with improvement of maximal doses of beta-blockers and RAS blockers at 2 year follow-up compared with initial prescription (62 vs. 37% and 68 vs. 45%, respectively). In patients with improved LVEF, a trend toward a better treatment optimization and revascularization procedures (in the subgroup of ischaemic patients) were observed compared with non-improved LVEF patients. CONCLUSIONS: In our study of patients with prophylactic ICD, one-third of them have improved their LVEF after a 2 year follow-up. Despite an optimal medical therapy at the time of implantation, we were able to further improve the maximal treatment doses after implantation. This study highlights the issue of what should be considered as 'optimal' therapy and the possibility of improvement of LVEF related to a real optimized treatment before implantation.

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