

CORRESPONDENCE

Letters to the Editor

Advanced Heart Failure and Transplant Cardiology as a Single Subspecialty May Restrict Access to Care

While reading the Viewpoint by Konstam et al. (1), I was dismayed to note that demonstration of competency in caring for patients with severe heart failure is being tied to expertise in cardiac transplantation. This linkage will effectively restrict advanced heart failure care to the relatively few tertiary centers now practicing transplantation, despite the fact that the overwhelming majority of patients with heart failure, including those with the most severe disease, are not candidates for transplantation. Furthermore, transplant volume is static or declining while the disease itself has become a major growing public health and economic problem. The majority of patients with heart failure, including most of the sickest, are cared for in a community setting. The migration of maturing technologies for heart failure therapy to nontransplanting community referral hospitals with demonstrated excellence in heart failure care may be hindered by this decision, effectively limiting therapeutic alternatives available to many sick patients.

It is ironic that in 2004, Konstam (2) noted that “HF is unique among the subspecialties of cardiology, defined by the patient and the disease, rather than by technical skill,” while the proposed heart failure competencies will be tied to rarely utilized procedures such as endomyocardial biopsy and transplantation or “an expanding array of electrophysiologic...and complex percutaneous and surgical procedures” (1). Both the 2004 and 2009 documents note the importance of disease management and suggest that the certified specialist should be “well-suited to provide guidance in the conduct of disease management services” (2). Despite this, the clinical proficiency list does not include any items related to disease management.

Cardiac patients receive excellent care by subspecialists such as electrophysiologists and interventional cardiologists at a community referral level throughout the country. Why should heart failure be different? It would be unfortunate if a well-intended effort to codify requirements for certifying competence in caring for advanced heart failure resulted in limitation of care for the patients who need it the most. Rather than focusing on technical skills, the board emphasis should be on the knowledge tools requisite for providing superior care to patients at a local level without sending them to few and distant referral centers. As our heart failure population grows, one can easily imagine those centers being overwhelmed by the influx of heart failure patients in need of consultation and access to advanced care. Rather than creating potential restrictions on access to care, we should be exploring how to move advanced heart failure care into communities by cultivating and certifying heart failure care at a local level.

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Reply

We thank Dr. Jordan for his thoughtful remarks in response to our commentary (1). In our article, we describe the need for certification of the secondary subspecialty of advanced heart failure and transplant cardiology and the competency requirements that have been enumerated by the American Board of Internal Medicine (ABIM). In his letter, Dr. Jordan challenges the inclusion of technical competencies, including management of patients undergoing cardiac transplant, and raises concerns that these requirements will preclude recognition of competency in heart failure management within the community.

We wish to reaffirm the focus of the Heart Failure Society of America on the cognitive aspects of heart failure patient care and placement of the patient with heart failure at the center of all heart failure management competencies. We favor development of opportunities for recognition of practice competencies in heart failure, short of ABIM secondary subspecialty certification and without requirements for technical competencies. However, the consensus that evolved around the need for secondary subspecialty certification included the necessity of mastering the technical aspects of contemporary advanced heart failure management, including managing patients undergoing transplantation and ventricular assist device placement. We and our colleagues across the cardiology and internal medicine communities believe that competencies in these areas represent key elements that set apart the subspecialist in advanced heart failure from the highly competent cardiologists and internists who will continue to provide the vast majority of care to patients with heart failure.

We do not anticipate that the advanced heart failure and transplant cardiologist will limit his or her care to the transplant center. Many who gain these special competencies will practice within the nontransplant center and community hospital setting. The nature of the technical procedures offered to advanced heart failure patients will evolve in the coming years. As it does, increasing numbers of patients undergoing these procedures will

return to the community and will require care from subspecialists with expertise in their management. The certified advanced heart failure and transplant cardiologist will have recognized expertise in the full range of treatment options available to the patient with advanced heart failure and be fully qualified to care for patients receiving these treatments as they return to the community. We believe that recipients of certification in advanced heart failure and transplant cardiology, having demonstrated their competencies in all aspects of advanced heart failure management, will provide a vital function both in the advanced heart failure center and within the health care community at large.

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Most Would Fail to Benefit From JUPITER Intervention

The recent article by Michos and Blumenthal (1) estimates that 6.5 million Americans are newly appropriate for statin therapy based on JUPITER (Justification for the Use of Statins in Primary Prevention: an Intervention Trial Evaluating Rosuvastatin) study data. The authors fail to recognize, however, that most of these patients will die before they are likely to benefit.

As JUPITER reported an annual control event rate of 1.36% for its primary end point, it would take 50.6 years for one-half of the study population to benefit from the intervention. From this value and published National Center for Health Statistics life expectancies, one can calculate from Table 1 the proportion likely to benefit at any given age.

Risk reduction is not beneficial if it does not prevent an adverse outcome. Subjecting aging patients to an intervention

from which the overwhelming majority will not benefit is clinically inappropriate.

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Reply

We thank Dr. Plonk for his letter regarding our recent publication (1). We agree that the incident rates for the primary end point in the JUPITER (Justification for the Use of Statins in Primary Prevention: an Intervention Trial Evaluating Rosuvastatin) trial were overall moderate in this primary prevention trial (0.77 and 1.36 per 100 person-years of follow-up in the rosuvastatin and placebo groups, respectively) (2).

If we are interpreting Dr. Plonk's analyses correctly, he applied the 1.36% annual event rate found in the JUPITER placebo group equally across age groups in his table, only accounting for decreased life expectancy with age. However, the risk of cardiovascular events, many of which are nonfatal, also increases significantly with age (3). It appears that Dr. Plonk did not account for the increasing risk for the events with age when he stratified by age groups. Therefore, although the life expectancy is shorter at older ages, the risk of cardiovascular events is greater, which means the proportion that may benefit in the older age groups is likely greater than his table suggests.

The median age in the JUPITER clinical trial was 66 years, and the weighted median age group found in our NHANES (National Health and Nutrition Examination Survey) participants representative of the general U.S. population who met JUPITER eligibility was similar at 67 years (interquartile range 57 to 75 years; median age of 60 years for men and 74 years for women). Therefore, even when Dr. Plonk's estimates are used, a significant portion (~20% to 25%) of eligible 55- to 75-year-old patients would likely benefit using this JUPITER strategy.

Furthermore, in JUPITER trial, there are >5,500 patients >70 years of age, and that subgroup had a highly significant ~40% reduction in the trial primary end point (95% confidence interval: 0.45 to 0.82) with about a 2-year average follow-up time (Dr. Paul M. Ridker, personal communication, April 8, 2009). The purpose of our analyses was simply to estimate the number of U.S. adults who would meet the JUPITER eligibility criteria. By increasing decades of age (50 to 59 years, 60 to 69 years, 70 to 79 years, 80 to 89 years), we estimate by using NHANES data that 29.4%, 27.8%, 28.1%, and 14.7% respectively, would meet JUPITER eligibility criteria. Certainly the decision whether to initiate statin therapy should be made on a patient-specific basis, and statin therapy may not be indicated in those patients who are unlikely to

Table 1 Proportion Likely to Benefit From JUPITER Intervention by Sex and Age

	Age, Yrs				
	50	60	70	80	90
Men (%)	32	24	17	10	5
Women (%)	36	28	19	12	6