Effects of Digoxin on Morbidity and Mortality in Diastolic Heart Failure

The Ancillary Digitalis Investigation Group Trial

Ali Ahmed, MD, MPH; Michael W. Rich, MD; Jerome L. Fleg, MD; Michael R. Zile, MD; James B. Young, MD; Dalane W. Kitzman, MD; Thomas E. Love, PhD; Wilbert S. Aronow, MD; Kirkwood F. Adams, Jr, MD; Mihai Gheorghiade, MD

Background—About half of the 5 million heart failure patients in the United States have diastolic heart failure (clinical heart failure with normal or near-normal ejection fraction). Except for candesartan, no drugs have been tested in randomized clinical trials in these patients. Although digoxin was tested in an appreciable number of diastolic heart failure patients in the Digitalis Investigation Group ancillary trial, detailed findings from this important study have not previously been published.

Methods and Results—Ambulatory chronic heart failure patients (n = 988) with normal sinus rhythm and ejection fraction >45% (median, 53%) from the United States and Canada (1991 to 1993) were randomly assigned to digoxin (n = 492) or placebo (n = 496). During follow-up with a mean length of 37 months, 102 patients (21%) in the digoxin group and 119 patients (24%) in the placebo group (hazard ratio [HR], 0.82; 95% confidence interval [CI], 0.63 to 1.07; P = 0.136) experienced the primary combined outcome of heart failure hospitalization or heart failure mortality. Digoxin had no effect on all-cause or cause-specific mortality or on all-cause or cardiovascular hospitalization. Use of digoxin was associated with a trend toward a reduction in hospitalizations resulting from worsening heart failure (HR, 0.79; 95% CI, 0.59 to 1.04; P = 0.094) but also a trend toward an increase in hospitalizations for unstable angina (HR, 1.37; 95% CI, 0.99 to 1.91; P = 0.061).

Conclusions—In ambulatory patients with chronic mild to moderate diastolic heart failure and normal sinus rhythm receiving angiotensin-converting enzyme inhibitor and diuretics, digoxin had no effect on natural history end points such as mortality and all-cause or cardiovascular hospitalizations. (Circulation. 2006;114:397-403.)

Key Words: digoxin • heart failure • morbidity • mortality

Clinical Perspective p 403

There are an estimated 5 million heart failure (HF) patients in the United States.1 About half of these patients have diastolic HF, defined as clinical HF with normal or near-normal left ventricular ejection fraction (LVEF),2 and this group has substantial morbidity and mortality.1,3–6 Despite this high prevalence of diastolic HF, with the exception of the Candesartan in Heart Failure: Assessment of Reduction in Mortality and Morbidity (CHARM)–Preserved trial, these patients have generally been excluded from randomized HF trials.7

Digitalis glycosides have been used in HF for >2 centuries, are inexpensive, and have been studied extensively in systolic HF.8 The role of digoxin in patients with diastolic HF was evaluated in the Digitalis Investigation Group (DIG) ancillary trial, which was conducted in parallel with the main DIG trial.9–12 The objective of the DIG ancillary trial was to assess the effect of digoxin on the primary combined outcome of HF hospitalization or HF mortality. We analyzed a public-use copy of the DIG dataset obtained from the National Heart, Lung, and Blood Institute (NHLBI) and present the full results of the ancillary DIG trial, which have not previously been reported.

Methods

Study Design

The randomized DIG trial was conducted and supported by the NHLBI in collaboration with the Department of Veterans Affairs Cooperative Studies Program and cardiologists from the United States and Canada. Additional support was received from Glaxo Wellcome, which provided the study drugs, Lanoxin and placebo.

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From the University of Alabama at Birmingham, and VA Medical Center, Birmingham (A.A.); Washington University, St Louis, Mo (M.W.R.); National Heart, Lung, and Blood Institute, Bethesda, Md (J.L.F.); Medical University of South Carolina and Ralph H. Johnson VA Medical Center, Charleston (M.R.Z.); Cleveland Clinic Foundation, Cleveland, Ohio (J.B.Y.); Wake-Forest University, Winston-Salem, NC (D.W.K.); Case Western Reserve University, Cleveland, Ohio (T.E.L.); New York Medical College, Valhalla (W.S.A.); University of North Carolina, Chapel Hill (K.F.A.); and Northwestern University, Chicago, Ill (M.G.).

Clinical Trial Registration Information: Information on DIG dataset can be found at the following NHLBI website: http://www.nhlbi.nih.gov/resources/deca/descriptions/dig.htm.


E-mail aahmed@uab.edu

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The purpose of the DIG trial was to evaluate the effects of digoxin on mortality and hospitalizations in ambulatory chronic HF patients with normal sinus rhythm.\textsuperscript{9,10} HF patients with LVEF $\leq 45\%$ \textsuperscript{(n=6800)} made up the main trial, whereas those with LVEF $>45\%$ \textsuperscript{(n=988)} were enrolled in an ancillary study conducted parallel to the main trial. The design and results of the DIG trial have been reported previously.\textsuperscript{9,10}

**Patients**

In the DIG ancillary trial, 988 patients with LVEF $>45\%$ and normal sinus rhythm at baseline were recruited from the United States (186 centers) and Canada (116 centers) between January 1991 and August 1993. Patients received 4 different daily doses of digoxin or matching placebo (0.125, 0.25, 0.375, and 0.50 mg) on the basis of age, sex, weight, and serum creatinine levels.\textsuperscript{13} More than 85\% of patients were receiving angiotensin-converting enzyme inhibitors, and $>80\%$ were receiving diuretics.

**Outcomes**

The primary outcome in the ancillary DIG trial was the combined end point of HF hospitalization or HF mortality. Vital status of all patients was collected up to December 31, 1995, and was 98.9\% complete.\textsuperscript{14} The DIG ancillary trial did not prespecify other secondary outcomes. However, we also studied other outcomes, including all-cause and cardiovascular mortality and all-cause and cardiovascular hospitalizations. In addition, we studied the combined outcome of HF hospitalization or cardiovascular mortality, which was the primary outcome in CHARM-Preserved,\textsuperscript{7} the only other large randomized clinical trial of diastolic HF. The cause of death or the primary diagnosis leading to hospitalization was classified by DIG investigators, who were blinded to the patient’s study drug assignment.

**Statistical Analysis**

Kaplan-Meier analysis was used to construct survival plots, and a log-rank statistic was used to compare the survival distributions in the 2 study groups. To compare the effects of digoxin with those of placebo, we calculated hazard ratios (HRs) and 95\% confidence intervals (CIs) associated with primary and other outcomes using Cox proportional-hazards models. Differences in the number of hospitalizations between groups were estimated with the Wilcoxon rank-sum test. All analyses were repeated for outcomes at 2 years after randomization.

**Results**

**Patient Characteristics**

Baseline patient characteristics are presented in Table 1. Patients had a median age of 67 years; 41\% were women; 14\% were nonwhite; and 73\% had LVEF $\geq 50\%$. There were no significant differences in baseline characteristics between the 492 patients randomly assigned to digoxin and the 496 patients assigned to placebo (Table 1).

<table>
<thead>
<tr>
<th>TABLE 1. Baseline Patient Characteristics by Treatment Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Placebo</strong> (n=496)</td>
</tr>
<tr>
<td>Age, mean±SD, y</td>
</tr>
<tr>
<td>Ejection fraction, mean±SD, %</td>
</tr>
<tr>
<td>Serum creatinine, mean±SD, mg/dL</td>
</tr>
<tr>
<td>Estimated glomerular filtration rate, mean±SD, mL·min$^{-1}$·1.73 m$^{-2}$</td>
</tr>
<tr>
<td>Median duration of HF, mo</td>
</tr>
</tbody>
</table>

**Method of assessing LVEF**

- Radionuclide ventriculography: 67.9 | 70.3
- 2D echocardiography: 27.2 | 25.6
- Contrast angiography: 4.8 | 4.1
- Cardiothoracic ratio $>0.55$: 26.4 | 26.8
- NYHA functional class:
  - I: 20.6 | 19.1
  - II: 56.9 | 59.3
  - III: 21.0 | 20.7
  - IV: 1.6 | 0.8

**Signs or symptoms of HF,** n
- 0: 0.8 | 0.6
- 1: 2.0 | 1.2
- 2: 6.5 | 6.9
- 3: 11.3 | 8.3
- $\geq4$: 79.4 | 82.9

**Primary cause of HF**

- Ischemic: 56.5 | 56.3
- Nonischemic: 43.5 | 43.7
- Hypertensive: 21.0 | 24.0
- Idiopathic: 10.7 | 10.4
- Others\textsuperscript{†}: 11.9 | 9.3

**Concomitant medications**

- Non-potassium-sparing diuretics: 77.0 | 75.0
- Potassium-sparing diuretics: 8.3 | 7.7
- Angiotensin-converting enzyme inhibitors: 86.1 | 86.4
- Nitrates: 38.9 | 39.8
- Other vasodilators\textsuperscript{‡}: 1.4 | 1.2

**Daily dose of study medication, mg**

- 0.125: 22.6 | 22.4
- 0.250: 68.3 | 66.7
- 0.375: 7.7 | 10.4
- 0.500: 1.4 | 0.6

None of the variables differed significantly between the digoxin and placebo groups. NYHA indicates New York Heart Association.

\textsuperscript{*}The clinical signs or symptoms studied included rales, elevated jugular venous pressure, peripheral edema, dyspnea at rest or on exertion, orthopnea, limitation of activity, S$_3$ gallop, and radiological evidence of pulmonary congestion.

\textsuperscript{†}This category included valvular and alcohol-related causes of HF.

\textsuperscript{‡}These drugs included clonidine hydrochloride, doxazosin mesylate, flosequinan, labetalol hydrochloride, minoxidil, prazosin hydrochloride, and terazosin hydrochloride.
HF Hospitalization or HF Mortality: The Primary Outcome

During a follow-up with a mean length of 37 months, 102 patients (21%) in the digoxin group and 119 patients (24%) in the placebo group experienced the primary combined outcome of HF hospitalization or HF mortality (HR for digoxin versus placebo, 0.82; 95% CI, 0.63 to 1.07; \( P = 0.136 \)) (Figure 1A and Table 2), which is consistent with the main DIG report.\(^{10}\) During the first 2 years of follow-up after randomization, 67 patients (14%) in the digoxin group and 90 patients (18%) in the placebo group experienced the primary combined outcome (HR, 0.71; 95% CI, 0.52 to 0.98; \( P = 0.034 \)) (Figure 1A and Table 2).

**HF Hospitalization or Cardiovascular Mortality**

Hospitalizations resulting from HF or deaths resulting from cardiovascular causes, the primary outcomes used in the CHARM-Preserved trial, occurred in 142 patients (29%) in the digoxin group and 154 patients (31%) in the placebo group (HR, 0.88; 95% CI, 0.70 to 1.11; \( P = 0.269 \)) (Figure 1A and Table 2). At 2 years after randomization, 89 patients (18%) in the digoxin group, compared with 113 patients (23%) in the placebo group, experienced HF hospitalizations or cardiovascular mortality (HR, 0.75; 95% CI, 0.57 to 0.99; \( P = 0.044 \)) (Figure 1B and Table 2).

**Effect of Digoxin on Mortality**

There were 115 deaths from all causes in the digoxin group (23%) and 116 deaths in the placebo group (23%) during the study (HR, 0.99; 95% CI, 0.76 to 1.28; \( P = 0.925 \)) (Figure 2A and Table 2). There were 30 deaths resulting from HF among patients randomized to receive digoxin (6%) and 34 deaths (7%) from the same cause among patients randomized to receive placebo (HR, 0.88; 95% CI, 0.54 to 1.43; \( P = 0.598 \)) (Figure 2B and Table 2). There was no difference in mortality resulting from cardiovascular causes (81 in each group; HR, 1.00; 95% CI, 0.73 to 1.36; \( P = 0.978 \)) (Figure 2C and Table 2). Effects of digoxin on mortality from various causes at 2 years are displayed in Figure 2A, 2B, and 2C and Table 2.

**Effect of Digoxin on Hospitalization**

Hospitalization resulting from worsening HF occurred in 89 patients (18%) randomized to digoxin and 108 patients (22%) randomized to placebo (HR, 0.79; 95% CI, 0.59 to 1.04; \( P = 0.094 \)) (Figure 3C and Table 3). During the first 2 years of the study, 59 patients randomized to digoxin (12%) and 86 patients randomized to placebo (17%) were hospitalized as a result of worsening HF (HR, 0.66; 95% CI, 0.47 to 0.91; \( P = 0.012 \)) (Figure 3C and Table 3).

**Figure 1.** Kaplan-Meier plots for (A) primary combined outcome of hospitalization for worsening HF or mortality resulting from HF and (B) combined outcome of hospitalization for worsening HF or mortality resulting from cardiovascular causes in diastolic HF patients randomized to receive digoxin or placebo. The number of patients at risk at each 12-month interval is shown below the figure.

**Table 2.** Mortality and Composite End Points According to Randomization to Digoxin or Placebo

<table>
<thead>
<tr>
<th>Events at Study End, n (%)</th>
<th>HR (95% CI)†</th>
<th>ARD, %</th>
<th>At 2 y</th>
<th>At Study End</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Placebo</strong> (n=496)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF hospitalization or HF mortality (primary end point)</td>
<td>119 (24.0)</td>
<td>102 (20.7)</td>
<td>−3.3</td>
<td>0.71 (0.52–0.98); ( P = 0.034 )</td>
</tr>
<tr>
<td>HF hospitalization or cardiovascular mortality (CHARM-Preserved end point)</td>
<td>154 (31.0)</td>
<td>142 (28.9)</td>
<td>−2.1</td>
<td>0.75 (0.57–0.99); ( P = 0.044 )</td>
</tr>
<tr>
<td>HF mortality</td>
<td>34 (6.9)</td>
<td>30 (6.1)</td>
<td>−0.8</td>
<td>0.88 (0.43–1.80); ( P = 0.718 )</td>
</tr>
<tr>
<td>Cardiovascular mortality</td>
<td>81 (16.3)</td>
<td>81 (16.5)</td>
<td>−0.2</td>
<td>0.89 (0.59–1.36); ( P = 0.596 )</td>
</tr>
<tr>
<td>All-cause mortality</td>
<td>116 (23.4)</td>
<td>115 (23.4)</td>
<td>0</td>
<td>0.88 (0.62–1.25); ( P = 0.480 )</td>
</tr>
</tbody>
</table>

*Absolute risk difference (ARD) was calculated by subtracting the percentage of deaths in the placebo group from the percentage of deaths in the digoxin group.†HRs and 95% CIs were estimated from the Cox proportional-hazards models.
There were no differences in all-cause hospitalizations between the 2 groups (68% in the digoxin group, 67% in the placebo group; HR, 1.03; 95% CI, 0.89 to 1.20; \( P = 0.683 \)) (Figure 3A and Table 3). Among patients hospitalized for all causes, 332 in the digoxin group had 985 (median, 2) total hospitalizations for all reasons combined, and 330 in the placebo group had 949 (median, 2) such hospitalizations (Wilcoxon test, \( P = 0.811 \)). The effects of digoxin on various causes of hospitalizations at the end of 2 years of follow-up are displayed in Figure 3A, 3B, and 3C and Table 3. Compared with 62 patients (13%) in the placebo group, 82 for all reasons combined, and 330 in the placebo group had 949 (median, 2) such hospitalizations (Wilcoxon test, \( P = 0.811 \)). The effects of digoxin on various causes of hospitalizations at the end of 2 years of follow-up are displayed in Figure 3A, 3B, and 3C and Table 3. Compared with 62 patients (13%) in the placebo group, 82
TABLE 3. Hospitalizations in Patients Randomized to Digoxin or Placebo by Causes of Hospitalization*

<table>
<thead>
<tr>
<th>Event</th>
<th>Placebo (n=496)</th>
<th>Digoxin (n=492)</th>
<th>ARD, † %</th>
<th>HR (95% CI)‡</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-cause</td>
<td>330 (66.5)</td>
<td>332 (67.5)</td>
<td>1</td>
<td>1.06 (0.89–1.25); P=0.533</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>225 (45.4)</td>
<td>241 (49.0)</td>
<td>3.6</td>
<td>1.08 (0.88–1.32); P=0.456</td>
</tr>
<tr>
<td>Worsening HF</td>
<td>108 (21.8)</td>
<td>89 (18.1)</td>
<td>−3.7</td>
<td>0.66 (0.47–0.91); P=0.012</td>
</tr>
<tr>
<td>Ventricular arrhythmia, cardiac arrest</td>
<td>5 (1)</td>
<td>8 (1.6)</td>
<td>0.6</td>
<td>1.67 (1.40–6.98); P=0.484</td>
</tr>
<tr>
<td>Supraventricular arrhythmia§</td>
<td>31 (6.3)</td>
<td>32 (6.5)</td>
<td>0.2</td>
<td>0.92 (0.52–1.62); P=0.775</td>
</tr>
<tr>
<td>AV block, bradyarrhythmia</td>
<td>2 (0.4)</td>
<td>6 (1.2)</td>
<td>0.8</td>
<td>6.06 (0.73–50.37); P=0.095</td>
</tr>
<tr>
<td>Suspected digoxin toxicity</td>
<td>3 (0.6)</td>
<td>9 (1.8)</td>
<td>1.2</td>
<td>8.12 (1.02–64.90); P=0.048</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>22 (4.4)</td>
<td>32 (6.5)</td>
<td>2.1</td>
<td>1.25 (0.65–2.42); P=0.500</td>
</tr>
<tr>
<td>Unstable angina</td>
<td>62 (12.5)</td>
<td>82 (16.7)</td>
<td>4.2</td>
<td>1.76 (1.20–2.59); P=0.004</td>
</tr>
<tr>
<td>Stroke</td>
<td>24 (4.8)</td>
<td>21 (4.3)</td>
<td>−0.5</td>
<td>0.61 (0.29–1.28); P=0.192</td>
</tr>
<tr>
<td>Coronary revascularization</td>
<td></td>
<td>15 (3.0)</td>
<td>17 (3.5)</td>
<td>0.5</td>
</tr>
<tr>
<td>Cardiac transplantation</td>
<td>1 (0.2)</td>
<td>1 (0.2)</td>
<td>0.0</td>
<td>...</td>
</tr>
<tr>
<td>Other cardiovascular¶</td>
<td>57 (11.5)</td>
<td>66 (13.4)</td>
<td>1.9</td>
<td>1.25 (0.82–1.90); P=0.298</td>
</tr>
<tr>
<td>Respiratory infection</td>
<td>46 (9.3)</td>
<td>33 (6.7)</td>
<td>−2.6</td>
<td>0.60 (0.33–1.09); P=0.094</td>
</tr>
<tr>
<td>Other noncardiac and nonvascular</td>
<td>196 (39.5)</td>
<td>194 (39.4)</td>
<td>−0.1</td>
<td>1.06 (0.84–1.32); P=0.647</td>
</tr>
<tr>
<td>Unspecified</td>
<td>5 (1)</td>
<td>2 (0.4)</td>
<td>−0.6</td>
<td>0.33 (0.04–3.21); P=0.342</td>
</tr>
<tr>
<td>Hospitalizations, n</td>
<td>949</td>
<td>985</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

*Data shown include the first hospitalization of each patient for each cause.
†Absolute risk difference (ARD) was calculated by subtracting the percentage of patients hospitalized in the placebo group from the percentage of patients hospitalized in the digoxin group.
‡HRs and 95% CIs were estimated from a Cox proportional-hazards models that used the first hospitalization of each patient for each reason.
§This category includes atrioventricular block and bradyarrhythmia.
¶This category includes coronary artery bypass grafts and percutaneous transluminal coronary angioplasty.
¶This category includes embolism, venous thrombosis, peripheral vascular disease, hypertension, other vascular surgery, cardiac catheterization, other types of catheterization, pacemaker implantation, installation of automatic implantable cardiac defibrillator, electrophysiological testing, transplantation-related evaluation, nonspecific chest pain, atherosclerotic heart disease, hypotension, orthostatic hypotension, and valve operation.

Adherence to Study Drugs
The median daily dose of the study drug at randomization was 0.25 mg for both the digoxin and placebo groups. Twelve months after randomization, 384 patients (78%) in the digoxin group and 384 patients (77%) in the placebo group were still receiving the study drug. The median daily dose of the study drug at 12 months was 0.25 mg for both treatment groups. Over the entire follow-up period, the study drug was discontinued in 323 patients (33%), of whom 159 (32%) were receiving digoxin and 164 (33%) were receiving placebo (P=0.802). Compared with 53 patients (11%) receiving placebo, 32 patients (7%) receiving digoxin required prescription of open-label digoxin for worsening HF or atrial fibrillation (P<0.001). Respective numbers for cases of suspected digoxin toxicity during the first 2 years were 15 (3.0%) in the digoxin group and 6 (1%) in the placebo group (P=0.049). Out of the total of 66 patients with suspected or confirmed digoxin toxicity, only 1 such patient was hospitalized for that reason.

Discussion
Results of the present analysis demonstrate that digoxin had no favorable effect on the natural history of ambulatory patients with chronic mild to moderate diastolic HF and normal sinus rhythm. Although the results of the DIG ancillary trial were briefly reported in the original DIG publication,10 the results presented here provide the first detailed analyses about the use of digoxin in diastolic HF.

Clinical Importance
These findings are important for several reasons. Up to 50% of all HF patients experience diastolic HF, and most of these patients are older adults.3–6 Furthermore, with the population aging, the prevalence of diastolic HF is projected to increase disproportionately in the coming decades. Despite better survival compared with patients with systolic HF, older adults with diastolic HF suffer from multiple morbidities and frequent hospitalizations.15,16 Even so, diastolic HF patients traditionally have been excluded from clinical HF trials; thus, there are few evidence-based recommendations for these patients.17 Therefore, despite the age of the dataset used in our study, we believe this may be the largest clinical trial in diastolic HF patients to date, and our findings emphasize additional research on the use of digoxin in diastolic HF.
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the DIG trial was the use of open-label digoxin as a result of
contrast, the primary reason for discontinuation of the study drug in
95% CI, 0.66 to 0.79)10 and the CHARM-Preserved trial (HR, 0.85;
95% CI, 0.72 to 0.1.01).7 The lack of statistical significance of the
effects of digoxin in the ancillary DIG trial is possibly a result of the
small sample size (988 in the ancillary DIG trial, ≈7 times smaller
than the 6800 in the main DIG trial and >3 times smaller than the
3023 in the CHARM-Preserved trial). In addition, >75% of
participants in the ancillary DIG trial had NYHA class I to II
symptoms. Hospitalization as a result of worsening HF was much
lower among these patients than would be expected of diastolic HF
patients in clinical practice.16,18 These relatively low event rates
suggest that a larger study or a study involving patients at higher risk
such as those with more advanced symptoms, age, or morbidities
may have resulted in a greater reduction in the primary end point by
digoxin. Despite the statistical significance of the protocol-
prespecified 2-year outcomes and the fact that they are the basis of
Food and Drug Administration approval of digoxin for use in HF,
the results of the post hoc analyses of 2-year outcomes should be
interpreted with caution. This is particularly important because
digoxin had no favorable effect on the natural history of patients
with HF and normal or near-normal LVEF.

An unanticipated finding of the present analysis is that
digoxin use was associated with increased risk of hospital-
ization for unstable angina, which offset the reduction in HF
hospitalization, resulting in no effect on cardiovascular hos-
pitalizations. It is possible that the amount of viable ischemic
myocardium in diastolic HF is larger than that in systolic HF.
However, the increased incidence of unstable angina did not
translate into increased myocardial infarction or mortality.

Comparison With CHARM-Preserved Trial
In the CHARM-Preserved trial (n=3023), at follow-up with
median length of 37 months, hospitalizations resulting from
HF or deaths resulting from cardiovascular causes, the pri-
mary outcomes of that trial, occurred in 333 patients (22%) in
the candesartan group and 366 patients (24%) in the placebo
group (HR, 0.89; 95% CI, 0.77 to 1.03; P=0.118).7 In the
DIG ancillary trial, on the other hand, during a similar
follow-up (median, 39 months), 142 patients (29%) in the
digoxin group and 154 patients (31%) in the placebo group
experienced the same outcomes (HR, 0.88; 95% CI, 0.70 to
1.11; P=0.269) (Figure 1, bottom, and Table 2).

The primary reason for discontinuation of the study drug in
CHARM-Preserved was drug-related adverse events, including
hypotension, hyperkalemia, or abnormal laboratory values such as
an increase in creatinine, which was noted in 18% of patients in the
candesartan group (versus 14% in the placebo group; P=0.001).7
In contrast, the primary reason for discontinuation of the study drug in
the DIG trial was the use of open-label digoxin as a result of
worsening HF.10,19 Although 66 patients (7%) were identified as
having suspected or confirmed digoxin toxicity, only 1 patient was
hospitalized.

Implication for Future Research in Diastolic HF
Among diastolic HF patients in the DIG trial who received
placebo, only 7% died of HF and 16% died of cardiovascular
causes (11% in CHARM-Preserved);7 overall mortality was
23%. In contrast, among systolic HF patients receiving
placebo, 13% died of HF, 30% died of cardiovascular causes,
and 35% died as a result of all causes combined.10 The low
HF mortality in diastolic HF should be taken into consider-
ation when future clinical diastolic HF trials are planned.15

Clinical Implications: Role of Digoxin in
Diastolic HF
Digitalis is the oldest and one of the least expensive drugs for the
management of HF. Digoxin has historically been thought to be
contraindicated in patients with diastolic HF, often on the basis of
anecdotal reports or nonrandomized studies.12,20 The exact mecha-

nistic explanation of how digoxin may exert any potential beneficial
effect in diastolic HF (as suggested by the trend in HF hospitaliza-
tion reduction) is not clearly understood. Although digoxin appears
to improve the active energy-dependent early myocardial diastolic
function,6,21 this effect has not been well studied.12,22 The effects of
digoxin in diastolic HF may be related to its favorable effects on
neurohormonal profile.17,23 It is now known that, as in systolic HF,
neurohormonal activation is present in diastolic HF and may
contribute to disease progression.24,25 Recent evidence suggests that
in addition to cardiac tissues, digitalis glycosides also inhibit the
sodium-potassium adenosine triphosphatase enzyme in noncardiac
tissues such vagal afferent fibers and the kidneys. Thus, digoxin
may reduce sympathetic neurohormonal activity by sensitizing
cardiac baroreceptors and suppress the renin-angiotensin-
aldosterone system by reducing proximal renal tubular reabsorption
of sodium.26–28 The trend toward an increase in hospitalization for
unstable angina may be related to reported, but not well-studied,
effects of digoxin on platelet and endothelial cell activation.29

Conclusions
In ambulatory patients with chronic mild to moderate diastolic HF
and normal sinus rhythm receiving angiotensin-converting enzyme
inhibitors and diuretics, digoxin use was not associated with any
significant effect on total, cardiovascular, or HF mortality or on total
or cardiovascular hospitalizations.

Acknowledgments
This manuscript has been reviewed by the NHLBI for scientific
content and consistency of data interpretation with previous DIG
publications, and significant comments have been incorporated
before submission for publication.

We dedicate this article to the memories of Thomas W. Smith, MD
(1936–1997), and Richard Gorlin, MD (1926–1997), who played a
crucial role in enhancing our understanding of digoxin in HF and in
the planning and conduct of the DIG trial.

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