
To the Editor:

In the article, “The Changing Incidence and Survival for Heart Failure in a Well-Defined Older Population, 1970–1974 and 1990–1994,” Barker et al used an administrative data set to show that the incidence of heart failure has increased 14% during that time period after controlling for population aging. This increase was predominately seen in men and those of advanced age. Interestingly, there was a suggestion of a decrease in the mortality from heart failure among men and women between those 2 time periods.

Several questions and avenues for further research are raised by this analysis. Because many of our most significant advancements, including improved pharmacotherapy, implantable cardioverter-defibrillators, and resynchronization therapy, have occurred since the end of their study period, how should we interpret these findings in the current era? Moreover, recent treatment advances may affect the elderly population differently. Although β-blockers have cut the rate of heart failure-induced mortality by one third and defibrillators by approximately 23% in heart failure patients with systolic dysfunction, how much has this decrease in sudden cardiac death affected older patients who may die more frequently from pump failure? 2,3

Barker et al1 looked at the clinical syndrome of heart failure irrespective of ventricular systolic function. It would be interesting to separate these heart failure patients into those with and without systolic dysfunction, as the pathophysiology and responses to therapies differ. Because heart failure without systolic dysfunction is especially prevalent in the aged4 and most recent treatment advances have been in systolic heart failure, should we anticipate an ever-increasing prevalence of heart failure for the foreseeable future?

The analysis by Barker et al is an important first step. Further study could involve clinical databases with more extensive characterization of comorbidities and heart failure causes and a broader patient population, especially one that is more inclusive of black and Hispanic patients who may have different presentations and response to treatments.5

As our elderly population expands, the differential effects of comorbidities and therapies in this cohort will be especially important. We suggest that it will be effective to assess these differences through Cox proportional hazards multivariable modeling, which examines the interaction between increasing age and characteristics such as cause of heart failure, comorbidities, and treatment received for the determination of clinically relevant end points such as mortality and hospitalization. These age-related differences may prove to be important in managing elderly patients with heart failure.

Sources of Funding

The authors received a grant from the Tom & Lynn Royster Foundation, Durham, NC.

Disclosures

None.

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(Circulation. 2006;114:e255.)
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Circulation is available at http://www.circulationaha.org

DOI: 10.1161/CIRCULATIONAHA.106.632786 e255
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Circulation. 2006;114:e255
doi: 10.1161/CIRCULATIONAHA.106.632786
Circulation is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
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Print ISSN: 0009-7322. Online ISSN: 1524-4539

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circ.ahajournals.org/content/114/7/e255

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