Transcript Details

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Geographic Variation in Heart Failure with Reduced Ejection Fraction: Insights from the VICTORIA Trial

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

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Dr. Ezekowitz:
Hello, my name is Dr. Justin Ezekowitz. I'm a cardiologist and professor of medicine at the University of Alberta. I'm pleased to present the results of the Geographic Variation in Heart Failure with Reduced Ejection Fraction: Insights from the VICTORIA trial. I'm presenting on behalf of my co-authors, Professor Tatsui as well as the rest of the Victoria Study Group.

By way of background, the globalization of clinical trials has highlighted geographic variations in patient characteristics, background therapy as well as clinical outcomes. These issues may affect the benefit afforded by new therapies and the global generalizability of results. The Victoria trial studied 5,050 high-risk patients with a recent worsening heart failure event with a reduced ejection fraction from around the world. But the impact of geographic differences has not yet been explored. Therefore, the objective of this study was to evaluate the geographical differences in patient characteristics such as age, sex, comorbidities, and background therapy, as well as the event rates and the relationship to vericiguat's treatment effect in Victoria.

Victoria enrolled patients from 42 countries across five regions, as seen here on this map. The baseline characteristics varied across these five regions. By way of example, patients in Western Europe were the oldest and had the lowest eGFR and the highest MAGGIC Risk Score indicating the higher risk whereas patients in Asia Pacific and Eastern Europe had the lowest age and the lowest MAGGIC Risk Score indicating lower risk. There were other differences across the regions.

The medication and device use also varied substantially across the regions. For example, triple therapy such as the use of an ACRB, beta-blocker, NMRA, was the highest in Latin and South America as well as Eastern Europe, and the lowest in North America. Conversely, the highest rate of ICD use was in Western Europe and North America and CRT use was mixed across the regions.

Placebo event rates nominally differed by the region but not statistically different after adjustment for the MAGGIC Risk Score as seen here in this table. The P-value for the difference was 0.26 whereas the benefit of vericiguat varied somewhat across the regions as seen in this slide. Looking at the primary outcome cardiovascular death and heart failure hospitalization there is no significant P-value interaction between its effect on the composite outcomes, for each of the components by pre-specified geographic regions.

To summarize the key findings, there was variations in the risk profile across the regions such that patients in Western Europe had a greater elevation in things such as NT-proBNP levels and a higher MAGGIC risk score. There's substantial differences across the use of triple guideline-based therapy as well as cardiac devices across the regions and whereas the benefit of vericiguat varied somewhat across the regions, there was no significant interaction between its effect on the composite outcomes or each of its components by the pre-specified geographic regions. So, in conclusion, in this postdoc evaluation of the regional variations across a large clinical trial of vericiguat in patients with hef-raf and a recent in worsening heart failure event we found substantial regional differences in patient

characteristics and background medical and device therapies. But despite these differences, the overall treatment effect of vericiguat did not differ significantly across the regions. Thanks very much for your attention.

Announcer:
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