REPORT-HF
The WORLD HEART FAILURE REGISTRY
Investigator Meeting: Introduction & Agenda
Bangkok, 4-Jun-2015
Novartis: A Portfolio of Potentially Breakthrough Treatments for Heart Failure

LZC696
Chronic Heart Failure
- ~50% of patients
- Trial completed
- Trial ongoing

RLX030
Acute decompensations
- Confirmatory mortality trial ongoing

REPORT-HF Investigator Meeting | June 4th 2015 | Business Use Only
REPORT-HF Steering Committee

Gheorghiade, Mihai (Chairperson)
Northwestern University Feinberg School of Medicine, Chicago, IL, USA

Filippatos, Gerasimos (Co-Chairperson)
University of Athens, Athens, Greece

Angermann, Christiane E.
Deutsches Zentrum für Herzenssuffizienz, Würzburg, Germany

Ertl, Georg
University of Würzburg, Würzburg, Germany

Cleland, John G.F.
National Heart & Lung Institute, Imperial College, London, UK

Ghadasanfar, Mathieu
Novartis Pharma AG, Basel, Switzerland

Collins, Sean P.
Vanderbilt University Medical Center, Nashville, TN, USA

Hassanein, Mahmoud
Alexandria University, Alexandria, Egypt

Dahlström, Ulf
Universitetsjukhuset, Linköping, Sweden

Hu, Dayi
Peking University People’s Hospital, Beijing, China

Dickstein, Kenneth
University of Bergen, Stavanger University, Stavanger, Norway

Lam, Carolyn S.P.
National University Heart Center, Singapore

Perrone, Sergio V.
National University of Rosario, Buenos Aires, Argentina
## REPORT-HF Investigator Meeting
### Agenda Part 1

<table>
<thead>
<tr>
<th>Start Time</th>
<th>Duration</th>
<th>TOPIC</th>
<th>Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00</td>
<td>30</td>
<td>Registration</td>
<td>All</td>
</tr>
<tr>
<td>08:30</td>
<td>15</td>
<td>Welcome and Introduction</td>
<td>A. Schweizer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Novartis Commitment to Heart Failure</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Agenda, Logistic, Housekeeping</td>
<td></td>
</tr>
<tr>
<td>08:45</td>
<td>45</td>
<td>Welcome and Introduction</td>
<td>G. Filippatos, M. Gheorghiade</td>
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<tr>
<td></td>
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<td>• From Guidelines Implementation to Registries</td>
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<tr>
<td></td>
<td></td>
<td>• REPORT-HF: Rationale and Scientific Background</td>
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<tr>
<td>09:30</td>
<td>30</td>
<td>REPORT-HF</td>
<td>A. Schweizer</td>
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<tr>
<td></td>
<td></td>
<td>• Overview</td>
<td></td>
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<td></td>
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<td>• Protocol Review</td>
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<tr>
<td>10:00</td>
<td>30</td>
<td>Coffee Break</td>
<td>All</td>
</tr>
<tr>
<td>10:30</td>
<td>60</td>
<td>Who is MAPI?</td>
<td>C. Fernandez</td>
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<tr>
<td></td>
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<td>• REPORT-HF: Operational Aspects, Communication &amp; the Monitoring Plan</td>
<td></td>
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<tr>
<td></td>
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<td>• REPORT-HF: Processes - what do I need to do?</td>
<td>L. Cunningham</td>
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### REPORT-HF Investigator Meeting

**Agenda Part 2**

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>11:30</td>
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<td><strong>Breakout Session 1</strong></td>
<td>M. Gheorghiade / G. Filippatos</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Group A: Discussion Forum</td>
<td>Mapi</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Group B: Processes</td>
<td>A. Joshi</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Group C: eCRF in-depth Training</td>
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<tr>
<td>12:15</td>
<td>60</td>
<td>Lunch</td>
<td>All</td>
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<tr>
<td>13:15</td>
<td>45</td>
<td><strong>Breakout Session 2</strong></td>
<td>Mapi</td>
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<tr>
<td></td>
<td></td>
<td>• Group A: Processes</td>
<td>A. Joshi</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Group B: eCRF in-depth Training</td>
<td>M. Gheorghiade / G. Filippatos</td>
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<tr>
<td></td>
<td></td>
<td>• Group C: Discussion Forum</td>
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<tr>
<td>14:00</td>
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<td><strong>Breakout Session 3</strong></td>
<td>A. Joshi</td>
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<td></td>
<td></td>
<td>• Group A: eCRF in-depth Training</td>
<td>M. Gheorghiade / G. Filippatos</td>
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<tr>
<td></td>
<td></td>
<td>• Group B: Discussion Forum</td>
<td>Mapi</td>
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<tr>
<td></td>
<td></td>
<td>• Group C: Processes</td>
<td></td>
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<tr>
<td>14:45</td>
<td>30</td>
<td>Coffee Break</td>
<td></td>
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<tr>
<td>15:15</td>
<td>15</td>
<td>Safety Reporting Process &amp; GCP Refresher</td>
<td>M. Tunogbanua</td>
</tr>
<tr>
<td>15:30</td>
<td>30</td>
<td><strong>Expert Panel</strong></td>
<td>M. Gheorghiade / G. Filippatos</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Key Learnings and Take Aways</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Summary and Closing Remarks</td>
<td></td>
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</tbody>
</table>
Housekeeping

- Please switch mobile phones to silent
- Breakout Sessions
- Morning & Afternoon Breaks and Lunch
  - Check-out
- Q&As
- Assistance from Novartis, MAPI & Cashwiththaus personnel
- Remote Voting panels
Gerasimos Filippatos
MD, FESC, FCCP, FACC

- Head of HF Unit at Athens University Hospital, Greece
- President (2014-2016) of the HF Association of the European Society of Cardiology (ESC)
  - Served as Chair of the ESC’s Working Group on Acute Cardiac Care, and in the Practice Guidelines Committee
  - Coordinator ESC Congress Programme Committee
- Associate Editor:
  - European Heart Journal, International J. of Cardiology, Archives of Medical Science
- Reviewer, guest editor and member of the editorial board for major cardiology and critical care journals
- Published over 300 articles in peer-reviewed journals and authored more than 30 book chapters
- Co-chairman REPORT-HF
Outcome in AHF is still poor

DOSE-AHF\(^1\)

Death, rehospitalisation or ER visit

- Low dose
- High dose

Hazard ratio with high dose strategy, 0.83 (95% CI, 0.60–1.16)
p=0.28

40% at 60 days

CARRESS-HF\(^2\)

Death or HF rehospitalisation

- Pharmacological care
- Ultrafiltration

HR=1.01 (0.62–1.64)
p=0.9556

AHF=acute heart failure; CI=confidence interval; ER=emergency room; HF=heart failure; HR=hazard ratio

Outcomes for patients with HF are poor in clinical practice

HF mortality remains high, with ~50% of patients with HF dying within 5 years of diagnosis\(^1,2\)

*From hospital discharge
IN-CHF=Italian Network on Congestive Heart Failure
HF has a detrimental effect on quality of life

- Patients with HF commonly report psychological distress, including¹
  - Depression and anxiety
  - Limitation in their activities of daily living

- Patient quality of life is reduced more by HF than many other chronic diseases, including diabetes, arthritis and chronic lung disease²,³

- Patients with advanced HF had a greater number of physical symptoms, higher depression scores and lower spiritual well-being than patients with advanced cancer⁴

Economic burden of chronic heart failure

Hospitalization accounts for most CHF-associated costs

In-hospital patients: clinical status at discharge (n. 1821 pts)

- **Pulmonary congestion**
  - At admission: 60.9%
  - At discharge: 9.7%

- **Peripheral congestion**
  - At admission: 64.5%
  - At discharge: 18.1%

- **Pulmonary and/or Peripheral congestion**
  - At admission: 81.6%
  - At discharge: 24.1%
Acute HF: persisting congestion at discharge and all-cause mortality during the follow-up

**Pulmonary congestion**
- No: n. 1610, 90.3%
- Yes: n. 173, 9.7%
  - p=0.0007

**Peripheral congestion**
- No: n. 1459, 81.9%
- Yes: n. 323, 18.1%
  - p<.0001

**Pulmonary and/or Peripheral congestion**
- No: n. 1355, 75.9%
- Yes: n. 429, 24.1%
  - p<.0001
HF leads to adverse effects on the heart, lungs, kidneys and vasculature

Inflammatory
- Inflammation
- Anaemia
- Cell death
- Fibrosis/remodelling

Risk factors
- Ageing
- Diabetes
- Hypertension
- Atherosclerosis

Neurohormonal activation

Heart failure

High central venous pressure

Drug therapy

Low cardiac output

(Forward failure)

Diuretics

Dilatation of Efferent arteriole

Low pressure in afferent arteriole

Low urine output

Sympathetic drive + outflow

High intra-abdominal pressure

RAS inhibitors

High pressure on Bowman’s capsule

Low urine output

Sympathetic drive + outflow

Renal dysfunction

Unmet therapeutic need in AHF: 
The evidence base for many commonly used AHF treatments is limited with no proven long-term benefits

<table>
<thead>
<tr>
<th>GROUP</th>
<th>MEDICATION</th>
<th>CLASS OF RECOMMENDATION (I–III)</th>
<th>LEVEL OF EVIDENCE† (A–C)</th>
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<tbody>
<tr>
<td>Diuretics</td>
<td>Loop diuretics</td>
<td>I</td>
<td>B</td>
</tr>
<tr>
<td>Vasodilators</td>
<td>Nitrates</td>
<td>IIa</td>
<td>B</td>
</tr>
<tr>
<td>Vasodilators</td>
<td>Sodium nitroprusside</td>
<td>IIb</td>
<td>B</td>
</tr>
<tr>
<td>Opiates</td>
<td>Morphine</td>
<td>IIa</td>
<td>C</td>
</tr>
<tr>
<td>Inotropes</td>
<td>Dobutamine</td>
<td>IIa</td>
<td>C</td>
</tr>
</tbody>
</table>

†A=data derived from multiple randomised controlled trials (RCTs) or meta-analyses; B=data derived from a single RCT or large non-randomised studies; C=consensus of opinion of experts and/or data from small studies, retrospective studies, or registries

McMurray et al. Eur Heart J 2012;33:1787–1847
### Demographics and comorbidities of patients hospitalised with AHF from various registries

<table>
<thead>
<tr>
<th></th>
<th>ADHERE n=105,388</th>
<th>OPTIMIZE-HF n=48,612</th>
<th>EHFS II n=3,580</th>
<th>ARGENTINA n=2,974</th>
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<tbody>
<tr>
<td><strong>Mean age, years</strong></td>
<td>72</td>
<td>73</td>
<td>70</td>
<td>68</td>
</tr>
<tr>
<td><strong>Women, %</strong></td>
<td>52</td>
<td>52</td>
<td>39</td>
<td>41</td>
</tr>
<tr>
<td><strong>Prior HF, %</strong></td>
<td>76</td>
<td>88</td>
<td>63</td>
<td>50</td>
</tr>
<tr>
<td><strong>Preserved EF, %</strong></td>
<td>40</td>
<td>49</td>
<td>52</td>
<td>26</td>
</tr>
<tr>
<td><strong>Medical history, %</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>CAD</strong></td>
<td>57</td>
<td>50</td>
<td>54</td>
<td>–</td>
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<tr>
<td><strong>Hypertension</strong></td>
<td>73</td>
<td>71</td>
<td>62</td>
<td>66</td>
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<tr>
<td><strong>Myocardial infarction</strong></td>
<td>31</td>
<td>–</td>
<td>–</td>
<td>22</td>
</tr>
<tr>
<td><strong>Atrial fibrillation</strong></td>
<td>31</td>
<td>31</td>
<td>39</td>
<td>27</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td>44</td>
<td>42</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td><strong>Renal insufficiency</strong></td>
<td>30</td>
<td>20</td>
<td>17</td>
<td>10</td>
</tr>
<tr>
<td><strong>COPD/asthma</strong></td>
<td>31</td>
<td>34</td>
<td>19</td>
<td>15</td>
</tr>
</tbody>
</table>

COPD=chronic obstructive pulmonary disease; EF=ejection fraction

The ESC recommend a symptom-based treatment algorithm for HFrEF

ACEI=angiotensin-converting-enzyme inhibitor; ARB=angiotensin receptor blocker; CRT=cardiac resynchronization therapy; CRT-D=CRT-defibrillator; ESC=European Society of Cardiology; HFrEF=heart failure with reduced ejection fraction; H-ISDN=hydralazine-isosorbide dinitrate; HR=heart rate; ICD=implantable cardioverter defibrillator; LVAD=left ventricular assist device; LVEF=left ventricular ejection fraction; NHYA=New York Heart Association

McMurray et al. Eur Heart J 2012;33:1787–1847
Are ambulatory patients with heart failure treated in accordance with ESC guidelines?

Rate of use

ACE-I/ARB

- 1.9% ACE-I / ARB
- 92 pts

Betablockers

- 92.7% YES
- 4439 pts

- 7.3% NO
- 353 pts

MRAs

- 67.0% YES
- 3209 pts

- 33.0% NO
- 1583 pts

Rate of patients at target dosage of recommended pharmacological treatments

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Yes (Dosage)</th>
<th>No (Dosage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE-I</td>
<td>1380 (29.3)</td>
<td></td>
</tr>
<tr>
<td>ARBs</td>
<td>362 (24.1)</td>
<td></td>
</tr>
<tr>
<td>B-blockers</td>
<td>1130 (17.5)</td>
<td></td>
</tr>
<tr>
<td>MRAs</td>
<td>1290 (30.5)</td>
<td></td>
</tr>
</tbody>
</table>

Chronic HF survival rates have improved over time with the advent of new therapies

Temporal trends in 5-year mortality after the diagnosis of HF by gender show improvements in survival …

... nevertheless, the 5-year mortality rate remains high

Population-based cohort study analysing data from the Rochester Epidemiology Project, Minnesota, USA. 4,537 patients with a diagnosis of HF between 1979 and 2000 were included. Framingham criteria and clinical criteria were used to validate the diagnosis.

Roger et al. JAMA 2004;292:344–50
To date, no therapy has been proven to reduce morbidity and mortality in patients with HFP EF.

**I-PRESERVE**

- Placebo vs Irbesartan
- HR=0.95 (95% CI, 0.86 to 1.05); p=0.35

**CHARM-preserved**

- Placebo vs Candesartan
- HR=0.89 (95% CI, 0.77–1.03); p=0.118
- Adjusted HR=0.86, p=0.051

*Primary composite endpoint of death from any cause or hospitalisation for a CV cause (HF, MI, unstable angina, arrhythmia, or stroke) in HF patients with LVEF ≥45%*

‡Primary composite outcome of CV death or admission to hospital for chronic HF in HF patients with LVEF >40%*

CV=cardiovascular; HFP EF=heart failure with preserved ejection fraction; HR=hazard ratio; I-PRESERVE=Irbesartan In Patients With Heart Failure And Preserved Ejection Fraction; MI=myocardial infarction

HEART FAILURE

- There is an unmet need to identify safe and effective therapies for patients with AHF given the high post-discharge morbidity and mortality experienced by this group.
- The majority of AHF patients hospitalized with HF are patients with worsening chronic heart failure.
- Long term Follow up is necessary to understand the disease.
Mihai Gheorghiade, MD, FACC
mgheorgh@nm.org

- Professor of Medicine and Surgery + Director of Experimental Therapeutics at the Center for CV Innovation Northwestern University’s Feinberg School of Medicine + Northwestern Memorial Hospital, Chicago
- Adjunct Professor of Medicine at Duke University
- Author of >600 peer-reviewed publications + >400 abstracts
- Editorial Board:
  American Heart J, American J of Cardiology, J of the American College of Cardiology, Circulation Heart Failure J
- Associated Editor: J of Cardiovascular Medicine
- Chairman of International Trials in Heart failure:
  OPTIME-HF, ACTIV-HF, IMPACT, PRESERVD, HORIZON, COMPOSE, ASTRONAUT, RENO-DEFEND, IMPROVE-HF, EVERST, EPHESUS
- Currently Co-Chair/member of SC:
  SOCRATES, MUST-HF and PARSiFAL trial, ARTS-HF + COMMANDER trial
- Chairman REPORT-HF
REPORT-HF
The WORLD HEART FAILURE REGISTRY

Mihai Gheorghiade
Professor of Medicine and Surgery
Director of Experimental Therapeutics
Center for Cardiovascular Innovation
Northwestern University Feinberg School of Medicine
Hospitalization for Acute Heart Failure

Epidemiology: North America and Europe

• Three million admissions per year with primary diagnosis of HF
• Six million admissions per year with primary or secondary diagnosis of HF
• Post discharge event rate (readmissions/death): 35%* at 60 days

*50% in pts. with BP<120mmHg at admission

Gheorghiade et al Circulation 2005
Hospitalization for Acute Heart Failure

- Acute decompensated chronic HF
  - 80% of all admissions*
  - (Worsening chronic heart failure (HF))
- Acute de novo
  - 15% of all admissions
  - diagnosed for the first time
- Advanced/end-stage/refractory HF
  - 5% of all admissions

*The majority are managed by a non cardiologist

Gheorghiade et al Circulation 2005
Characteristics of Hospitalization for Acute Heart Failure

<table>
<thead>
<tr>
<th>Data on 200,000 US patients</th>
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<tbody>
<tr>
<td>Median age (years)</td>
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<tr>
<td>Women</td>
</tr>
<tr>
<td>Hx of CAD</td>
</tr>
<tr>
<td>Hx of Hypertension</td>
</tr>
<tr>
<td>Hx of Diabetes</td>
</tr>
<tr>
<td>Hx of Atrial Fibrillation</td>
</tr>
<tr>
<td>Renal abnormalities</td>
</tr>
<tr>
<td>SBP &gt;140 mm Hg</td>
</tr>
<tr>
<td>SBP 90-140 mm Hg</td>
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<tr>
<td>SBP &lt;90 mm Hg</td>
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</table>

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>≤119 (n=12,252)</th>
<th>120-139 (n=12,096)</th>
<th>140-161 (n=12,099)</th>
<th>≥161 (n=12,120)</th>
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</thead>
<tbody>
<tr>
<td>Mean Age, y</td>
<td>72.9 (14.0)</td>
<td>74.0 (13.5)</td>
<td>73.8 (13.6)</td>
<td>72.1 (14.6)</td>
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<tr>
<td>Mean EF (%)</td>
<td>33.3 (17.4)</td>
<td>37.8 (17.6)</td>
<td>40.9 (17.1)</td>
<td>44.4 (16.5)</td>
</tr>
<tr>
<td>Ischemic Etiology</td>
<td>50.7</td>
<td>48.8</td>
<td>44.1</td>
<td>39.2</td>
</tr>
<tr>
<td>HTN Etiology</td>
<td>13.4</td>
<td>18.1</td>
<td>25.4</td>
<td>34.8</td>
</tr>
<tr>
<td>Serum Cr&gt;2 (mg/dl)</td>
<td>20.7</td>
<td>18.0</td>
<td>18.1</td>
<td>21.5</td>
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<tr>
<td>Mean Wt change (kg)</td>
<td>-2.45 (5.00)</td>
<td>-2.68 (4.82)</td>
<td>-2.60 (4.64)</td>
<td>-2.42 (4.62)</td>
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<tr>
<td>Edema Admission</td>
<td>63.9</td>
<td>65.1</td>
<td>65.6</td>
<td>63.9</td>
</tr>
<tr>
<td>Total mortality in-hospital</td>
<td>7.2</td>
<td>3.6</td>
<td>2.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Total mortality 60-90d</td>
<td>14.0</td>
<td>8.4</td>
<td>6.0</td>
<td>5.4</td>
</tr>
<tr>
<td>Readmission</td>
<td>30.6</td>
<td>29.9</td>
<td>30.3</td>
<td>27.6</td>
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<tr>
<td>Mean LOS, days</td>
<td>6.5 (6.6)</td>
<td>5.7 (5.3)</td>
<td>5.4 (5.0)</td>
<td>5.1 (4.8)</td>
</tr>
</tbody>
</table>

Gheorghiade M et al. JAMA. 2008;299:2656-66
Hospitalization for Heart Failure
Pathophysiology

• Cardiac injury is often present (troponin release)
• Rapid worsening of renal function is relatively common
• Very abnormal hemodynamics common
• Very abnormal and fluctuating neurohormonal profile common
• Rapid changes in electrolyte profile (potassium)
Lessons Learned from Hospitalization for AHF Registries

- 80% to 90% of all such patients have worsening chronic HF and only a minority present with de novo or end stage HF.
- Approximately one half of the hospitalized HF patients have preserved EF and their prognosis is similar to those with reduced EF.
- The majority of patients have normal or elevated but not low blood pressure.
Lessons Learned from Hospitalization for AHF Registries

• Dyspnea is the most common symptom and improves rapidly with diuretics in a majority of patients who are discharged with minimal signs and symptoms and stable hemodynamics, suggesting that these patients may not have end stage disease.

• Despite improved symptoms and use of evidence-based therapy, mortality and readmission rates are as high as 15% and 35% respectively within 60 to 90 days post-discharge, and the one-year mortality rate remains 30%.

• To date, no therapies started during hospitalization have altered these outcomes in prospective clinical trials

Butler, Braunwald and Gheorghiade JAMA 2014
The Global Health and Economic Burden of Hospitalizations for Heart Failure

Lessons Learned From Hospitalized Heart Failure Registries

Andrew P. Ambrosy, MD,* Gregg C. Fonarow, MD,† Javed Butler, MD, MPH,‡
Ovidiu Chioncel, MD,§ Stephen J. Greene, MD,‖ Muthiah Vaduganathan, MD, MPH,¶
Savina Nodari, MD,# Carolyn S. P. Lam, MBBS,** Naoki Sato, MD,†† Ami N. Shah, MD,‖
Mihai Gheorghiade, MD||

Palo Alto and Los Angeles, California; Atlanta, Georgia; Bucharest, Romania; Chicago, Illinois;
Boston, Massachusetts; Brescia, Italy; Singapore; and Kanagawa, Japan
## The WORLD HEART FAILURE REGISTRY

<table>
<thead>
<tr>
<th>Registry</th>
<th>Region</th>
<th>Observation Period</th>
<th>PROs</th>
<th>Number of patients</th>
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<tbody>
<tr>
<td>ADHERE</td>
<td>US</td>
<td>In-hospital</td>
<td></td>
<td>118,465</td>
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<tr>
<td>ADHERE AP</td>
<td>Asia-Pacific</td>
<td>In-hospital</td>
<td></td>
<td>10,171</td>
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<tr>
<td>EHFS II</td>
<td>Europe</td>
<td>In-hospital</td>
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<td>3,580</td>
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<tr>
<td>ALARM</td>
<td>International</td>
<td>In-hospital</td>
<td></td>
<td>4,953</td>
</tr>
<tr>
<td>Italian HF Registry</td>
<td>Italy</td>
<td>In-hospital</td>
<td></td>
<td>1,658</td>
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<tr>
<td>OPTIMIZE-HF</td>
<td>US</td>
<td>90 days</td>
<td>-</td>
<td>48,612</td>
</tr>
<tr>
<td>ESC HF Pilot</td>
<td>Europe</td>
<td>1 year</td>
<td>-</td>
<td>5,118</td>
</tr>
<tr>
<td>Asian HF Registry</td>
<td>Asia-Pacific</td>
<td>3 years</td>
<td>VAS, KCCQ</td>
<td>8,000</td>
</tr>
<tr>
<td>REPORT-HF</td>
<td>Global</td>
<td>3 years</td>
<td>EQ-5D, KCCQ, CBQ-HF, WPAI</td>
<td>~20,000</td>
</tr>
</tbody>
</table>
The Global Health and Economic Burden of Heart Failure

“• It is highly desirable to develop a hospital-based registry that is global and geographically representative, employs consecutive or intermittently consecutive enrollment, and captures comprehensive and longitudinal data including hospital course and post-discharge outcomes.”
Hospitalization for AHF

Conclusions

• Unmet need to identify safe and effective therapies for patients with AHF given the high post-discharge morbidity and mortality

• Novel therapies should target homogenous subgroups of patients classified based on pathophysiologic features, particularly non-responders to standard therapy

• Knowing the clinical course during hospitalization and after discharge is important
REPORT-HF
The WORLD HEART FAILURE REGISTRY

- REPORT-HF registry will obtain a continuum of data illustrating the patient’s journey
  - It is global
  - It is long-term
  - It is comprehensive
  - It is consecutive
REPORT-HF
The WORLD HEART FAILURE REGISTRY

• REPORT-HF is designed to:
  – better understand the HF heterogeneous population
  – capture longitudinal data (chronic disease progression) including course and outcomes
  – capture the burden of HF
  – Capture in-hospital WHF events
  – guide / support future HF clinical trials