

EDITOR'S PAGE



Better Quality of Life Over More Quantity of Life: How We View Time Trade-Off



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There is a growing interest in health-related quality of life in heart failure patients. Some patients may value living better over living longer, depending on the trade-off risk-benefit. Thus, it is becoming increasingly important to quantify the value of heart failure therapies. Historically, several methods have been used to assess health-related quality of life. This may involve evaluating monetary value, relative value, health changes, and the health status utilities approach. The most common approach to evaluating heart failure patients has been the health status value approach, which can be translated into quality-adjusted life years. Several different methods have been used to describe this, such as standard gamble, time trade-off, visual analog scales, and patient trade-off (1). The time trade-off evaluation of heart failure has been investigated in previous clinical trials of advanced heart failure. The time trade-off asks the patient to choose between either accepting the current health status for the duration of survival or to trade time for an enhanced health status. For example, would you be willing to accept a reduction of 1 year of life with improved health status versus maintaining your current health status for the full life expectancy of 5 years?

Although it seems intuitive that heart failure patients would trade for improved quality of life, this has not been borne out by clinical investigations. The study by Stevenson et al. (2) prospectively investigated this question in the ESCAPE trial, and found that there was a bimodal response and most patients preferred enhanced survival over improved quality of life. Furthermore, we learned that the status post-discharge was important in determining their preferences. It appeared that those patients with the most

reduced expected survival, the most advanced symptoms, and reduced functional status were more likely to trade time for improved quality of life. During a recent patient panel discussion at the Heart Failure Society of America scientific sessions on quality of life, 10 of 10 patients preferred maximal survival over shortened survival for improved health status. Other studies have shown the preference of quality of life over survival time (3). Thus, it is important for us as a community to continue to study this important concept of what the time trade-off would be. Our community has pushed forward the concept of quality of life as the primary endpoint for therapeutic interventions in disease states which may have a low mortality rate or a very high mortality rate (4). It is time that we define what level of harm we are willing to accept with improvement in health status.

We still have much work to do to agree upon what level of improvement of health status we would exchange for a reduction in quantity of life. Obviously, the home run of therapy, an improved quantity and quality of life, is ideal, but I believe we will be faced with greater and more difficult decisions as the community continues to ask the question: how much quality of life improvement are we willing to accept at the expense of a reduction in quantity of life? We must be prepared with the highest level of evidence to answer this question in short order, and we should require that clinical trials going forward measure patient preferences in relationship to the value of health-related quality outcomes.

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