

## CORRECTION

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### Prevalence and Prognostic Implications of Longitudinal Ejection Fraction Change in Heart Failure



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Due to an error in the Results section of a preliminary draft of the manuscript, ACE inhibitors/ARBs were reported as associated with improved EF in the Abstract and Discussion section. During the revision process, the error was corrected in the Results section of the manuscript but unfortunately not in the Abstract and Discussion section.

Abstract, Results:

“Predictors of increased EF included use of angiotensin-converting enzyme inhibitors and angiotensin receptor blockers, female sex, cases of less severe HF, and comorbidities. Predictors of decreased EF included diabetes, ischemic heart disease, and cases of more severe HF. Predictors of decreased EF included diabetes, ischemic heart disease, and cases of more severe HF”.

Should have read:

“Predictors of increased EF included female sex, cases of less severe HF, and comorbidities. Predictors of decreased EF included diabetes, ischemic heart disease, and cases of more severe HF. Use of renin-angiotensin-system inhibitors was associated with lower likelihood of EF increase, but not with EF decrease, i.e., stable EF”.

Abstract, Conclusions:

“EF change was associated with a wide range of important clinical, treatment, and organizational factors as well as with outcomes, particularly transitions to and from HF<sub>r</sub>EF”.

Should have read:

“EF change was associated with a wide range of important clinical and organizational factors as well as with outcomes, particularly transitions to and from HF<sub>r</sub>EF”.

Main text, Results section

“Variables independently associated with increased EF included no use of ACE inhibitors/ARBs; shorter HF duration (<6 vs. ≥6 months); absence of ischemic heart disease and coronary revascularization; lower New York Heart Association functional classes (I to II vs. III to IV); lower NT-proBNP levels; higher estimated glomerular filtration rates; higher mean arterial pressures; higher body mass indexes; being married or cohabitating versus living alone; history of hypertension; higher income; history of anemia; planned follow-up in an HF nurse-led clinic; history of atrial fibrillation; history of chronic obstructive pulmonary disease; being an outpatient versus an inpatient; and female sex. On the other hand, variables predicting a decrease in EF included no history of peripheral artery disease; being an inpatient versus an outpatient; male sex; no history of anemia; no planned follow-up in an HF nurse-led clinic; higher NT-proBNP levels; and a history of ischemic heart disease and diabetes.”

Should have read:

“Variables independently associated with increased EF included shorter HF duration (<6 vs. ≥6 months); absence of ischemic heart disease and coronary revascularization; lower New York Heart Association functional classes (I to II vs. III to IV); lower NT-proBNP levels; higher estimated glomerular filtration rates; higher mean arterial pressures; higher body mass indexes; being married or cohabitating versus living alone; history of hypertension; higher income; history of anemia; planned follow-up in an HF nurse-led clinic; history of atrial fibrillation; history of chronic obstructive pulmonary disease; being an outpatient versus an inpatient; and female sex. On the other hand, variables predicting a decrease in EF included no history of peripheral artery disease; being an inpatient versus an outpatient; male sex; no history of anemia; no planned follow-up in an HF nurse-led clinic; higher NT-proBNP levels; and a history of ischemic heart disease and diabetes. Use of

ACE inhibitors/ARB was associated with less likelihood of increased EF but not with decreased EF, i.e. stable EF.”

Main text, Discussion

Important factors associated with increasing EF included use of ACE inhibitors/ARBs, female sex, indicators of less severe HF, specialized HF follow-up, absence of ischemic heart disease but presence of several other modifiable comorbidities (e.g., anemia and atrial fibrillation), and preserved renal function. Predictors of decreasing EF included concomitant diabetes and ischemic heart disease, lack of specialized HF follow-up, and higher NT-proBNP levels

Should have read:

Important factors associated with increasing EF included female sex, indicators of less severe HF, specialized HF follow-up, absence of ischemic heart disease but presence of several other modifiable comorbidities (e.g., anemia and atrial fibrillation), and preserved renal function. Predictors of decreasing EF included concomitant diabetes and ischemic heart disease, lack of specialized HF follow-up, and higher NT-proBNP levels. Use of ACE inhibitors/ARBs was associated with lower likelihood of EF increase, but not with EF decrease, i.e. stable EF.

“Notably, the present authors observed that ACE inhibitors/ARB therapy were a major determinant of EF increase, consistent with the beneficial effects of these drugs on left ventricular remodeling and on hard outcomes shown in previous studies (26). Surprisingly, therapy with beta-blockers or mineralocorticoid receptor antagonists did not predict EF improvement, in contrast to several previously published analyses (4,26-29).

However, understanding the impact of medications in real-world settings is difficult due to confounding by indication and reverse causation.”

Should have read

“Surprisingly, therapy with ACE inhibitors /ARB therapy, beta-blockers or mineralocorticoid receptor antagonists did not predict EF improvement, in contrast to several previously published analyses (4,26-29). However, understanding the impact of medications in real-world settings is difficult due to confounding by indication and reverse causation.”

Main text, Conclusions

“EF changes were associated with a wide range of important clinical, treatment, and organizational factors.”

Should have read:

“EF changes were associated with a wide range of important clinical, and organizational factors.”

The authors apologize for these errors.

The online version has been corrected.

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