The benefits of anticoagulation in patients with heart failure (HF) in normal sinus rhythm are unclear. In a post hoc analysis of the COMMANDER HF trial, Greenberg and coauthors examined whether low-dose rivaroxaban added to antiplatelet therapy was associated with reduced thromboembolic events (myocardial infarction, ischemic stroke, sudden/unwitnessed death, symptomatic pulmonary embolism, or symptomatic deep venous thrombosis) in 5022 patients with coronary artery disease and worsening HF in normal sinus rhythm. Over a median follow-up of 19.6 months, rivaroxaban was associated with fewer events (328 [13.1%] vs 390 [15.5%]; hazard ratio, 0.83; 95% CI, 0.72-0.96), with similar results when fatal events were excluded (153 [6.1%] vs 190 [7.6%]; hazard ratio, 0.80; 95% CI, 0.64-0.98). In an Invited Commentary, Konstam addresses the complexity of estimating net clinical benefit of nonfatal morbidity when the potential for harm also exists.

Outcomes in Ischemic vs Nonischemic Cardiomyopathy in AF

Atrial fibrillation (AF) creates challenges in treatment of patients with heart failure. Corbalan and coauthors assessed treatment strategies and 1-year outcomes of antithrombotic and heart failure therapies for 11 738 patients with newly diagnosed AF and concomitant ischemic cardiomyopathy (ICM) and nonischemic cardiomyopathy (NICM) enrolled in the GARFIELD-AF registry. Compared with patients with NICM, patients with ICM received oral anticoagulants with or without antiplatelet drugs less frequently and antiplatelet drugs alone more frequently, but they were also more likely to receive angiotensin-converting enzyme inhibitors/angiotensin receptor blockers. All-cause and cardiovascular death rates were higher in patients with ICM than patients with NICM.

Ambulatory Hemodynamic Monitoring of HF and Outcomes

It is uncertain whether ambulatory hemodynamic monitoring (AHM) with an implantable pulmonary artery pressure sensor improves long-term outcomes in patients with heart failure (HF) in clinical practice beyond the confines of a randomized clinical trial. In a matched cohort study, Abraham and coauthors assessed 12-month HF hospitalization rates in 1087 Medicare beneficiaries who underwent AHM compared with 1087 matched control patients from June 2014 through March 2016. Compared with the control cohort, the HF hospitalization rate was lower in the AHM cohort (hazard ratio, 0.76; 95% CI, 0.65-0.89), as was the percentage of days lost to HF hospitalizations or death (hazard ratio, 0.73; 95% CI, 0.64-0.84).

Required Lp(a)-Lowering Effect Size for Reduction in CHD Events

The magnitude of reduction of lipoprotein(a) (Lp(a)) required for clinically relevant lowering of coronary heart disease (CHD) events is uncertain. In a mendelian randomization analysis involving 62 114 individuals from 2 consortia, Lamina and Kronenberg estimated that Lp(a) would have to be lowered by 65.7 mg/dL (95% CI, 46.3-88.3) to reach the same potential effect on clinical outcomes that can be achieved by lowering low-density lipoprotein cholesterol by 38.67 mg/dL. Thanassoulis notes in an Editorial that such genetic studies make it possible to resolve key trial parameters prior to starting a randomized clinical trial of new therapies targeting Lp(a).