## Letters to the Editor

### About the Specialty Treating Patients With Heart Failure

### *Sobre la especialidad que trata a los pacientes con insuficiencia cardiaca*

**To the Editor,**

Álvarez-García et al.[1] analyze the characteristics of patients with heart failure according to the specialist responsible for their care (cardiologist or internist). Heart failure is a complex syndrome whose management requires the participation of different specialties.[2] Analysis of the impact of each specialty on prognosis is a difficult task, with aspects that require clarification, and one that may generate debate. In our opinion, their study has substantial limitations, some of which have not been addressed, while others require further comment.

There are differences in many of the variables analyzed. Almost all of these are statistically significant and/or clinically relevant. The REDINSCOR registry includes above all patients with reduced left ventricular fraction, whereas the opposite is the case in the RICA registry. Severe valve disease was an exclusion criterion only in the REDINSCOR registry, and so this variable should not have been included in the propensity-matching analysis. Although all patients had a diagnosis of heart failure, their characteristics were completely different in the 2 registries. This raises the question of whether this comparison is meaningful. Recently, we compared the characteristics of patients with heart failure in 2 different registries — EAHFE (created by physicians in the emergency room) and RICA (created by internists).[3] These patients were admitted to the same level of care (internal medicine) in the same disease stage (decompensation) so, a priori, we would not expect to find differences. However, the results did show significant differences in almost all the variables analyzed. We therefore believe that comparisons between registries should be interpreted with caution and can only be recommended when both registries have the same design and use the same methodology.

The low proportion of patients receiving optimal medical treatment in the 2 registries is noteworthy (17% in the EAHFE and 39% in the RICA registry). It would be important to know whether the analysis included patients with preserved left ventricular ejection fraction, as there is no optimal medical treatment for these patients. Even so, it is noteworthy that this percentage was so low in patients in the REDINSCOR registry (which included patients with reduced left ventricular ejection fraction) and also that the percentage was so different from those recently reported for the European Society of Cardiology registry. In that registry, adherence to the clinical guidelines is excellent, and the proportion of patients who do not receive optimal medical treatment is less than 5%.[4] This finding is all the more surprising on analysis of the appendices of the 2 articles, because at least 7 centers participated simultaneously in the 2 registries (REDINSCOR and the European registry).

Moreover, despite matching of 18 variables, others that are highly prevalent in patients in RICA[5] with known impact on prognosis[6] were not included, namely, severe valve disease with indication for surgery (excluded from REDINSCOR), functional capacity (Barthel index), and cognitive status. It is thus likely that the matching was not as rigorous as the authors suggest.

Also of note is the effort to analyze the causes of higher mortality in the RICA registry, while there is no discussion of the reasons for the absence of differences in readmissions. The higher mortality in the RICA registry is attributed to the lower complexity of some centers and a lower availability of resources and/or training. If this were true, should not the readmission rates in the RICA registry also be worse? These differences in outcomes contrast with data from the *SOPICA EN ESPAÑA* study, which show that, after an episode of heart failure, the specialty responsible for follow-up does not influence outcomes in the mid-term.[7]

Thus, although the higher mortality among patients attended by internal medicine is plausible, the differences found could probably be explained by causes that are more difficult to measure and match (greater frailty, dependency and comorbidity) and that were not captured by the study.[5,7]

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