

# HEART OF THE MATTER

## Exercise in Heart Failure

Dr. George Burch, one of the great leaders in cardiology in the mid-20th century, wrote in a 1954 monograph that “the patient with moderate or severe congestive heart failure should be placed at bed rest immediately.” As a result, many patients were kept in bed for many weeks. This was the considered recommendation of many cardiologists, who had at the time little else to offer to their patients.

In the half century that followed, we learned a great deal about exercise physiology and its role in rehabilitating patients after an acute myocardial infarction. It is now part of the standard care of such patients.

More recently, a large body of clinical data has emerged providing insight into the role of exercise in the patient with heart failure. These studies suggest that, contrary to previous concerns, exercise training may be safe and can lead to im-



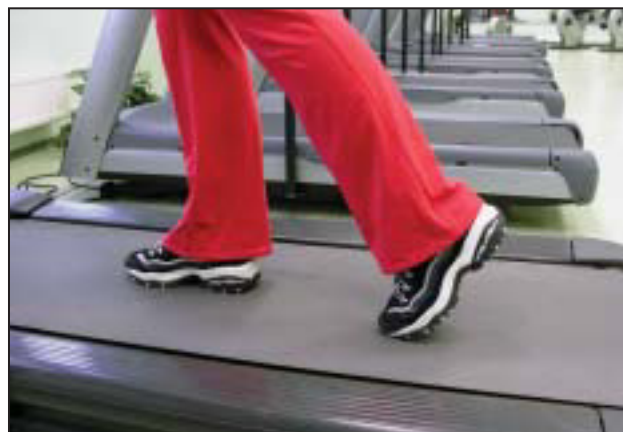
BY SIDNEY GOLDSTEIN, M.D.

patients with varying degrees of heart failure, such as elderly patients, who are becoming an increasingly large part of the heart failure population.

As a result of the progress in this field, in 2002 the National Heart, Lung, and Blood Institute embarked on HF-ACTION (Heart Failure: A Controlled Trial Investigating Outcomes of Exercise Training). The trial, involving more than 2,300 patients with New York Heart Association class I-IV heart failure with ejection fractions of less than 35%, tested the relative morbidity and mortality benefit of exercise training in those who also were receiving optimal medical therapy.

Patients were randomized to usual care or a supervised exercise program for a concentrated 3-month period of exercise 3 days a week for 4 months, followed by home exercise 5 days a week for 2 years (CARDIOLOGY NEWS, Dec. 2008, p. 24).

Although the trial did not achieve statistical significance in its primary goal of decreasing all-cause mortality or all-cause hospitalization, it did demonstrate a significant 14% decrease in the disease-specific clinical outcome of cardiovascular mortality or heart failure hospitalization. This effect on outcome is similar to that achieved with angiotensin receptor blockade when added to de novo heart failure patients. In addition, the trial further supported the safety of exercise therapy



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**It's time to consider making exercise therapy a standard, reimbursable treatment for heart failure.**

proved cardiac physiology. There is now significant evidence that exercise training improves exercise performance, increases peak oxygen consumption, reduces both muscle and systemic sympathetic activity, and favorably modifies systemic and tissue inflammatory markers.

On the basis of these physiologic studies, several clinical trials were performed in the past decade and reported clinical benefits associated with exercise training in heart failure. Although most of the studies have been small, they tended to reinforce the safety and physiologic benefits of exercise training. These studies were designed to include a broad spectrum of

in heart failure.

Many institutions have cardiac rehabilitation programs that include patients with heart failure. In some programs, the therapy is paid for by a third party. In light of the outcomes of HF-ACTION, an important question arises as to whether this therapy, with an expense that might be similar to the cost of providing cardiac rehabilitation for acute myocardial infarction patients, should become part of our standard reimbursement for Medicare and all third parties as an intrinsic part of heart failure therapy. This will be an important issue at a time when the escalating cost of health care is under increasing scrutiny.

Nevertheless, the result of HF-ACTION provides an important additional modality of treatment for heart failure patients and answers the question regarding the safety of exercise. The HF-ACTION investigators will need to provide the information, and some guidance, as to which patients with heart failure can benefit the most from exercise therapy. ■

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#### 10 Most Expensive Conditions Treated in Hospitals

(total national bill in billions of dollars)

|                                   |        |
|-----------------------------------|--------|
| Coronary artery disease           | \$52.6 |
| Pregnancy and delivery            | \$47.8 |
| Newborn infants                   | \$38.2 |
| Acute myocardial infarction       | \$35.1 |
| Heart failure                     | \$32.8 |
| Sepsis                            | \$30.3 |
| Osteoarthritis                    | \$28.0 |
| Pneumonia                         | \$27.5 |
| Device/implant/graft complication | \$27.4 |
| Respiratory failure (adult)       | \$23.7 |

Note: Based on data from the 2006 Nationwide Patient Sample.  
Source: Agency for Healthcare Research and Quality

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