from RCTs. Examination of the reasons behind this contradic-
tion by the regulatory agency may help to improve the reliabil-
ity of this new program.

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1. Southworth MR, Reichman ME, Unger EF. Dabigatran and postmarketing

2. Connolly SJ, Ezekowitz MD, Yusuf S, et al; RE-LY Steering Committee and
Investigators. Dabigatran versus warfarin in patients with atrial fibrillation.


4. Schulman S, Kearon C, Kakkar AK, et al; RE-SONATE Trial Investigators;
RE-SOYNAU Trial Investigators. Extended use of dabigatran, warfarin, or placebo in

http://www.fda.gov/downloads/AdvisoryCommittees/CommitteesMeetingMaterials
/Drugs/CardiovascularandRenalDrugsAdvisoryCommittee/UCM226009.pdf. Accessed
July 2013.

boehringer-ingelheim.com/content/dam/internet/opu/clinicaltrial

Editor's Note

Multiple Data Sources, the Best Way to Gather Safety
Information About Medications

The US Food and Drug Administration’s (FDA) Mini-Sentinel Program is an important initiative to identify adverse
effects of new medications during the postapproval
period. The system links electronic data from a vari-
ety of health care providers so as to rapidly determine the safety
of medications in use.

The system is especially useful for identifying adverse
effects that might not be apparent in randomized clinical
trials because they are rare, occur in patient groups not
included in the trials, occur when used in settings less
controlled than randomized trials, or occur in patients taking
the medications for periods of time longer than the
length of the trial. Nonetheless, it must be remembered that
analysis of the data in this surveillance system, however
rich, may suffer from the limitations of any observational
study.

Sipahi et al used a systematic search and meta-analysis of
randomized clinical trials to estimate the rate of gastro-
intestinal tract bleeding with dabigatran vs warfarin.
Their data support a very different conclusion than that of
the FDA Mini-Sentinel Program. While the Mini-Sentinel
Program found that gastrointestinal tract bleeding rates were no higher with dabigatran than warfarin, the
randomized clinical data showed a significantly increased
risk of gastrointestinal tract bleeding compared with
warfarin.

It is not surprising, or uncommon, for different method-
ologies to reveal different answers. Using electronic data from
health care settings is a smart and efficient method of learning
more about medications in real-world settings. However, new
data, especially from observational studies, which are
prone to confounding and underreporting, must always be
judged in the context of biologic plausibility and other data
sources.

Mitchell H. Katz, MD

Digitalis Use in Contemporary Clinical Practice:
Refitting the Foxglove

Over 200 years after William Withering wrote the classic mono-


Graph, An Account of the Foxglove and Some of Its Medicinal
Uses, the indications for and optimal dosing of digitalis gly-


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Inclusion Criteria
Ambulatory patients in sinus rhythm
LVEF of 45% or lower
History of HF
Eligible patients allowed to be taking digoxin

Exclusion Criteria
Age younger than 21 y
Atrial fibrillation or atrial flutter (with or without pacemaker)
MI, cardiac surgery, or PTCA within 4 wk
Unstable or refractory angina within 1 mo
Second- or third-degree AV block (without a pacemaker)
Cor pulmonale
Acute myocarditis
Hypertrophic cardiomyopathy
Amyloid cardiomyopathy
Constrictive pericarditis
Pre-excitation syndromes
Current treatment with IV inotropes
Hypokalemia/hyperkalemia (range, 3.2-5.5 mmol/L)
Need for cardiac surgery or PTCA in near future
Listed for cardiac transplant
SSS without pacemaker
Recognizable noncardiac causes of HF
Renal insufficiency (creatinine level, >3.0 mg/dL)
Hepatic insufficiency
Any noncardiac disease with life expectancy less than 3 years
Baseline LVEF not available
Unlikely to comply with study protocol

Primary Outcome
All-cause mortality

Secondary Outcomes
Mortality from CV causes
Mortality from worsening HF
Hospitalization for worsening HF
Hospitalization for other causes (including digoxin toxicity)

Results (digoxin, n=3397; placebo, n=3403)
34.8 vs 35.1%: Mortality with digoxin vs placebo (RR, 0.99; 95% CI, 0.91-1.07; \( P = .80 \))
29.9 vs 29.5%: CV mortality with digoxin vs placebo (RR, 1.01; 95% CI, 0.93-1.10; \( P = .78 \))
11.6 vs 13.2%: Mortality from worsening HF with digoxin vs placebo (RR, 1.14; 95% CI, 0.77-1.71; \( P = .17 \))
11.6 vs 13.2%: Mortality from worsening HF with digoxin vs placebo (RR, 1.14; 95% CI, 0.77-1.71; \( P = .17 \))
11.6 vs 13.2%: Mortality from worsening HF with digoxin vs placebo (RR, 1.14; 95% CI, 0.77-1.71; \( P = .17 \))

2.0 vs 0.9%: Hospitalization for suspected digoxin toxicity with digoxin vs placebo (RR, 2.17; 95% CI, 1.42-3.32; \( P < .001 \))

Professional Society Recommendations
ESC (class IIb, level of evidence B): May be considered to reduce the risk of HF hospitalization in patients in sinus rhythm with an LVEF of 45% or lower who are unable to tolerate a β-blocker. Patients should also receive an ACE inhibitor (or ARB) and an MRA (or ARB). May be considered to reduce the risk of HF hospitalization in patients with an EF of 45% or lower and persisting symptoms (NYHA class II-IV) despite treatment with a β-blocker, ACE inhibitor (or ARB), and an MRA (or ARB).4

ACC/AHA (class IIa, level of evidence B): Digoxin can be beneficial in patients with HF with reduced LVEF, unless contraindicated, to decrease hospitalizations for HF. Clinicians may consider adding digoxin in patients with persistent symptoms of HF with reduced LVEF during GDMT. Digoxin may also be added to the initial regimen in patients with severe symptoms who have not yet responded symptomatically during GDMT. Alternatively, treatment with digoxin may be delayed until the patient’s response to GDMT has been defined and may be used only in patients who remain symptomatic despite therapy with neurohormonal antagonists. If a patient is taking digoxin but not an ACE inhibitor or a β-blocker, treatment with digoxin should not be withdrawn, but appropriate therapy with the neurohormonal antagonists should be instituted.5

Heart Failure Society of America (NYHA class II-III, level of evidence B; NYHA class IV, level of evidence C). Digoxin may be considered to improve symptoms in patients with LVEF ≤40%) who have signs or symptoms of HF while receiving standard therapy, including ACE inhibitors and β-blockers.6

Abbreviations: ACC/AHA, American College of Cardiology/American Heart Association; ACE, angiotensin-converting enzyme; ARB, angiotensin receptor blocker; AV, atrioventricular; CI, confidence interval; CV, cardiovascular; EF, ejection fraction; ESC, European Society of Cardiology; GDMT, guideline-directed medical therapy; HF, heart failure; IV, intravenous; LVEF, left ventricular ejection fraction; MI, myocardial infarction; MRA, mineralocorticoid receptor antagonist; NYHA, New York Heart Association; PTCA, percutaneous transluminal coronary angiography; RR, relative risk; SSS, sick sinus syndrome.

* Ancillary study of 988 patients with an LVEF greater than 45% performed, with combined primary outcome of death or hospitalization due to worsening HF, with results consistent with main trial.

\( ^{\circ} \) Current or past symptoms (limitation of activity, fatigue, dyspnea, orthopnea) or signs (edema, elevated jugular venous pressure, rales, S3 gallop), or radiologic evidence of pulmonary congestion.

\( ^{\circ} \) Eligible after surgery/revascularization.

\( ^{\circ} \) Severe valvular disease, planned coronary artery bypass surgery.

* Mean serum digoxin concentration of 0.80 ng/mL at the 12-month visit, with 88.3% of digoxin group within the range of 0.5 to 2.0 ng/mL.
β-blockers, ACE inhibitors and aldosterone antagonists, may have contributed to waning digoxin use.3 We hypothesized that digoxin use for systolic HF has decreased during the past 15 years, despite clinical guidelines supporting its use.4-6

Methods | We used the IMS Health National Disease and Therapeutic Index, an ongoing audit of office-based US physicians that provides nationally representative information regarding disease patterns and treatment. This project was not human subjects research and therefore did not require institutional review board approval. Our primary unit of analysis was a treatment visit, defined as an office visit where digoxin was used for a specific clinical indication. We quantified digoxin use from 1997 through 2012 among all subjects as well as among patient subpopulations. All statistical analyses were performed using SAS 9.2 (SAS Institute Inc). This project was not human subjects research and, as such, did not require institutional review board approval.

Results | Digoxin treatment visits declined by 86%, from 12.9 million visits in 1997 to 1.87 million visits in 2012 (Figure, A). Declines were greater between 1997 and 2001 (12.9 to 6.8 million visits, averaging a 10% decrease per year over 5 years [P < .001 for trend]) than subsequent years (6.9 to 1.9 million visits, averaging a 6% decrease per year over 11 years [P < .001 for trend]). For patients with HF, digoxin treatment visits declined by 91% overall (Figure, B), averaging an 11.2% decrease per year between 1997 and 2001 and a 7% decrease per year from 2002 through 2012. There were no statistically significant differences in these trends based on patient sex or physician specialty. Of note, 23% of treatment visits for digoxin use over the course of the study period were due to HF, compared with 20% for atrial fibrillation or flutter.

Discussion | There has been a marked reduction in ambulatory digoxin use in the United States since 1997, with the largest declines in use observed from 1997 through 2001, and especially for patients with HF. Our study is limited by the lack of data prior to 1997, and there are a number of potential causes of the declines that we have illustrated. An increasing number of evidence-based therapies for HF, the perceived toxic effects and challenges of digoxin dosing, and the negative results of the DIG trial with respect to its primary end point of all-cause mortality, may all have contributed to reductions in digoxin use. However, the
DIG trial demonstrated a significant decrease in hospital admissions for HF in ambulatory patients receiving digoxin therapy. These changes may be particularly salient to contemporary clinical practice in clinical and policy efforts to reduce inpatient health care utilization for HF. However, whether digoxin use will have any direct effect on hospital readmission for HF remains unclear, given that readmissions were not directly measured. As such, this hypothesis merits caution. Unfortunately, new prospective randomized trials of digoxin are unlikely, leaving its fate as an integral part of HF therapy in contemporary practice uncertain.

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Analysis and interpretation of data: Both authors.

Drafting of the manuscript: Goldberger.

Critical revision of the manuscript for important intellectual content: Both authors.

Statistical analysis: Goldberger.

Administrative, technical, or material support: Alexander.

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4. McMurray JJ, Adamopoulos S, Anker SD, et al; Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2012 of the European Society of Cardiology; ESC Committee for Practice Guidelines. ESC guidelines for the diagnosis and treatment of acute and chronic heart failure 2012: The Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2012 of the European Society of Cardiology: developed in collaboration with the Heart Failure Association (HFA) of the ESC. Eur J Heart Fail. 2012;14(8):803-869.


Contemporary Data About Hospital Strategies to Reduce Unplanned Readmissions: What Has Changed?

Almost 1 in 5 hospitalized Medicare beneficiaries will experience an unplanned readmission within 30 days, with an estimated cost to Medicare of more than $17 billion annually. In response, many hospitals have enrolled in quality collaboratives or campaigns to implement evidence-based strategies to reduce readmission rates. However, we have little information on the changes in practice that have occurred among the nation’s hospitals. Such information is important to understand hospital responses to the policy changes.

Methods We examined changes from 2010 to 2012 in the use of commonly recommended strategies to reduce unplanned readmissions in a national sample of hospitals participating in the Hospital to Home Quality Improvement Initiative, an initiative of the American College of Cardiology and Institute of Healthcare Improvement to reduce readmissions of patients with cardiovascular disease. Of the 594 hospitals that had enrolled in the initiative between October 1, 2009, and July 1, 2010, 537 (90.4%) completed the baseline web-based survey, which was conducted from November 2010 to May 2011. A total of 437 of these hospitals (81.4%) completed a follow-up survey approximately 12 to 18 months later from November 2011 to October 2012. We determined differences in implementation of recommended strategies between the 2 time points using McNemar χ² tests and Bowker tests of symmetry, with a significance threshold of P < .01 to account for multiple comparisons. About 35% of the hospitals were teaching hospitals, 30% had 400 or more beds, 5% were rural, 73% were part of a multihospital system, and 22% were for-profit. Institutional review board approval was obtained for the surveys.

Results Statistically significant changes of substantial magnitude were apparent for several specific strategies (Table 1). At the follow-up survey, significantly more hospitals were partnering with other local hospitals to reduce readmissions (30.7% vs 22.9%; P = .002), were discharging patients with a follow-up appointment already made (61.1% vs 52.4%; P = .005), and were tracking the percentage of patients who were...