ESC Congress 2025 Madrid

TOGETHER WITH

World Congress of Cardiology

29 August to 1 September

L’essentiel de l’ESC

Prof Mohammed Chettibi, MD, PhD, FESC


CARDIAC
TIES
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Lebanese Society of Cardiology
Libyan Cardiac Society
Lithuanian Society of Cardiology
Luxembourg Society of Cardiology
Maltese Cardiac Society
Moldavian Society of Cardiology
Montenegro Society of Cardiology
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Netherlands Society of Cardiology
Norwegian Society of Cardiology
Polish Cardiac Society
Portuguese Society of Cardiology
Romanian Society of Cardiology
Russian Society of Cardiology*
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Syrian Cardiovascular Association
Tunisian Society of Cardiology and Cardio-Vascular Surgery
Turkish Society of Cardiology
THANK YOU TO OUR ESC
CARDIAC SOCIETY PARTNERS
Uniting Experts. Advancing Knowledge.
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Argentine Society of
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Cardiology
Indonesian Heart As
Iranian Heart Ass
Iraqi Cardiothoraci
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Afghan
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As
Asia

The Gift of Time

Transforming Lives for 75 Years


THE PAST 75 YEARS
In 1950, the cardiovascular healthcare community confronted a challenge we still face today:
How can breakthroughs and trustworthy science be shared?
This is why the ESC was born
Join us on a journey through 75 years of the ESC


ALGIERS
Tutorials West (1–8)
Industry Meeting Rooms West
(1–46 & 201–210)
HALL 9
MAIN AUDITORIUM - MADRID
ASTANA
ESC Exchange Area
FESC Lounge
ESC Professional Members Lounge
CV Health Check
MSD


SCIENCE BOX 1
Celebrating
75
Cross-modal
ining Improves Model Performance
Train
Inference
Age
Sex
Afb
LVEF
LVSD
ss sound
your
ne
up
tune
SCIENCE BOX


STATION 8
10
STATION 9
12
HQ
CORNER 3


8
HALL 7
ALGIERS
CLINICAL CASE
CORNER 4
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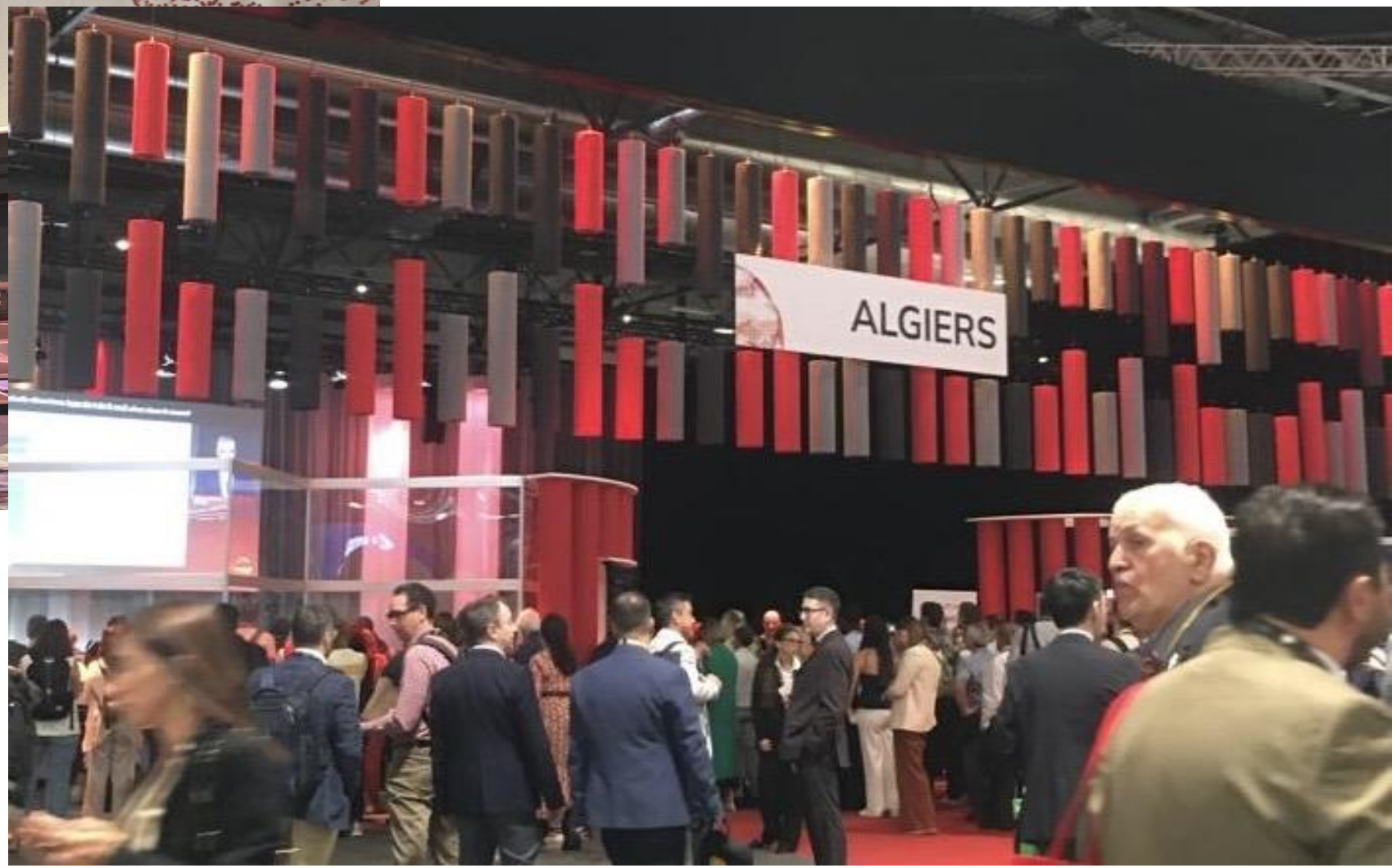
HALL 7
ALGIERS
Exhibition West • Tutorials West (1–8)
Industry Meeting Rooms West
(1–46 & 201–210)


ALGIERS

2025 Valvular Heart Disease

2025 Myocarditis and Pericarditis

2025 CVD and Pregnancy

2025 Dyslipidaemias

2025 Mental Health and CVD

ESC/EACTS Guidelines for the management of valvular heart disease

2025 ESC Guidelines for the management of cardiovascular disease and pregnancy

2025 ESC Guidelines for the management of myocarditis and pericarditis

2025 Focused Update of the 2019 ESC/EAS Guidelines for the management of dyslipidaemias

2025 ESC Clinical Consensus Statement on mental health and cardiovascular disease

ESC/EACTS Guidelines for the management of valvular heart disease

ESC
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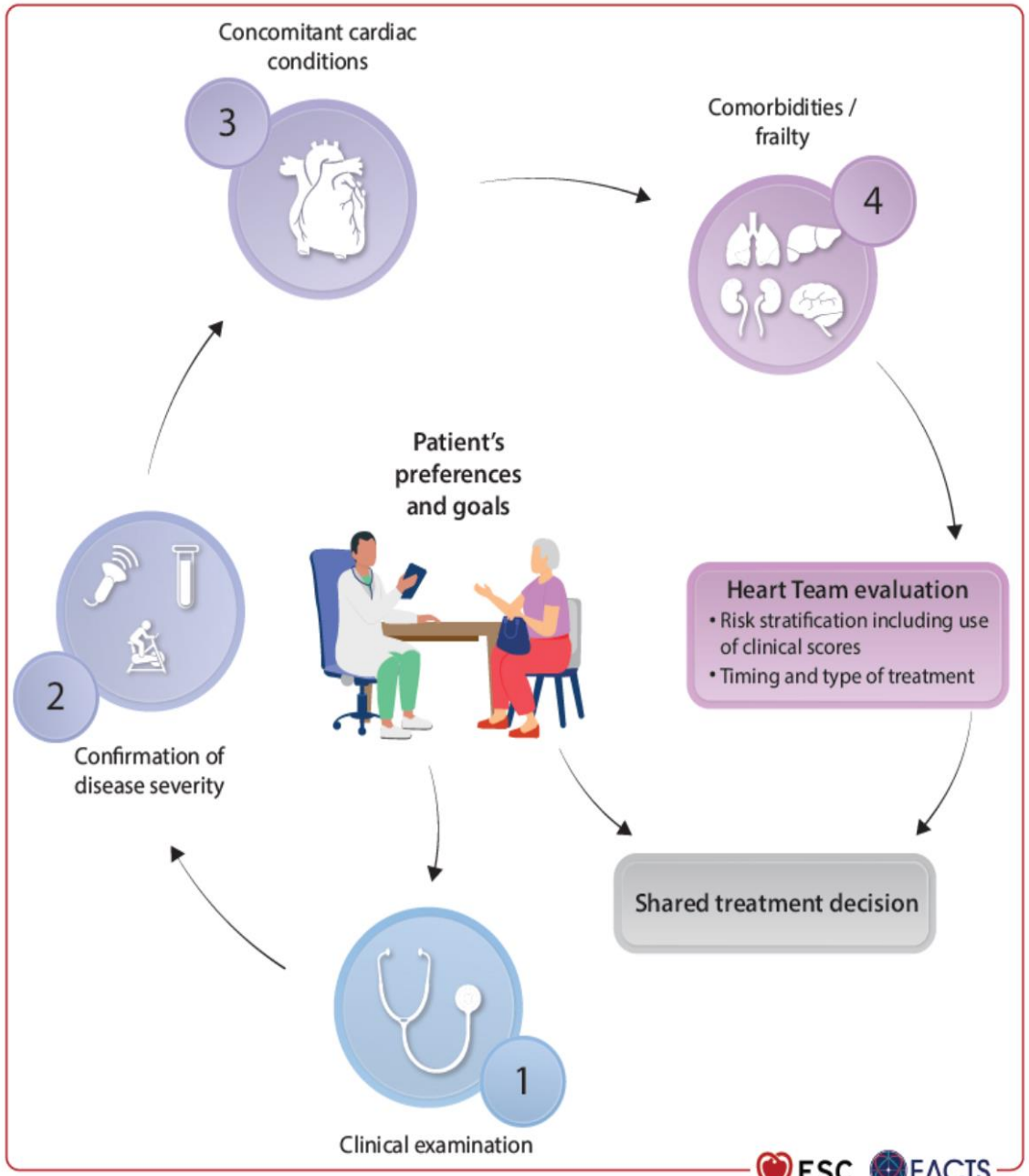
Figure 3

Central illustration
Patient-centred evaluation for treatment



ESC Guidelines for the management of valvular heart disease
(European Heart Journal; 2025 – doi: 10.1093/eurheartj/ehaf194)

Complex procedures ideally performed in the most experienced Heart Valve Centres

Transcatheter interventions	Surgical interventions
• Transfemoral TAVI in patients with high-risk features: o Low coronary ostia o Difficult femoral anatomy o Bicuspid valve o Severe calcification protruding into the LVOT o Severe LV and/or RV impairment o Pure AV regurgitation o Multiple valve disease o Complex coronary artery disease o Severe extracardiac disease (e.g. renal failure, PH) • Non-transfemoral TAVI • Valve-in-valve (including TAV-in-TAV) • All leaflet modification procedures (BASILICA, LAMPOON etc.) • PVL closure • Complex M-TEER • Redo M-TEER procedures • Tricuspid or mitral valve-in-ring or valve-in-valve, valve-in-MAC • TMVI • All tricuspid procedures	• High-risk procedures (especially in patients with LV and/or RV impairment) • Redo procedures • Minimally invasive and robotic valve surgery • Complex MV repair o Barlow disease o Anterior or bileaflet prolapse o High risk of SAM o Severe MAC • AV repair • Ross procedure • Valve surgery combined with complex surgery of the aorta • Endocarditis surgery

ESC Guidelines for the management of valvular heart disease
(European Heart Journal; 2025 – doi: 10.1093/eurheartj/ehaf194)

Requirements for a Heart Valve Centre

Requirements
Centre performing heart valve procedures with on-site interventional cardiology and cardiac surgery departments providing 24 h/7 day services. **Heart Team core members:** Cardiologist with imaging expertise, interventional cardiologist, cardiac surgeon. **Additional specialists, if required (Extended Heart Team):** Specialized nursing personnel, HF specialist, electrophysiologist, cardiovascular anaesthetist, geriatrician, and other specialists (e.g. intensive care, vascular surgery, infectious diseases, neurology, radiology). The Heart Team must meet on a regular basis and work according to locally defined standard operating procedures and clinical governance arrangements. A hybrid cardiac catheterization laboratory is desirable. High volume for hospital and individual operators.
Multimodality imaging (including advanced echocardiography, CCT, CMR, and nuclear techniques) and expertise in peri-procedural imaging guidance of surgical and transcatheter procedures.
Heart Valve Clinic for outpatient assessment and follow-up.
Data review: continuous monitoring, evaluation, and reporting of procedural volumes and quality indicators, including clinical outcomes, as well as PROMs complemented by local/external audits. Education programmes targeting primary care and referring physicians, operators, and diagnostic and interventional imaging specialists.

2025 ESC Guidelines for the management of myocarditis and pericarditis

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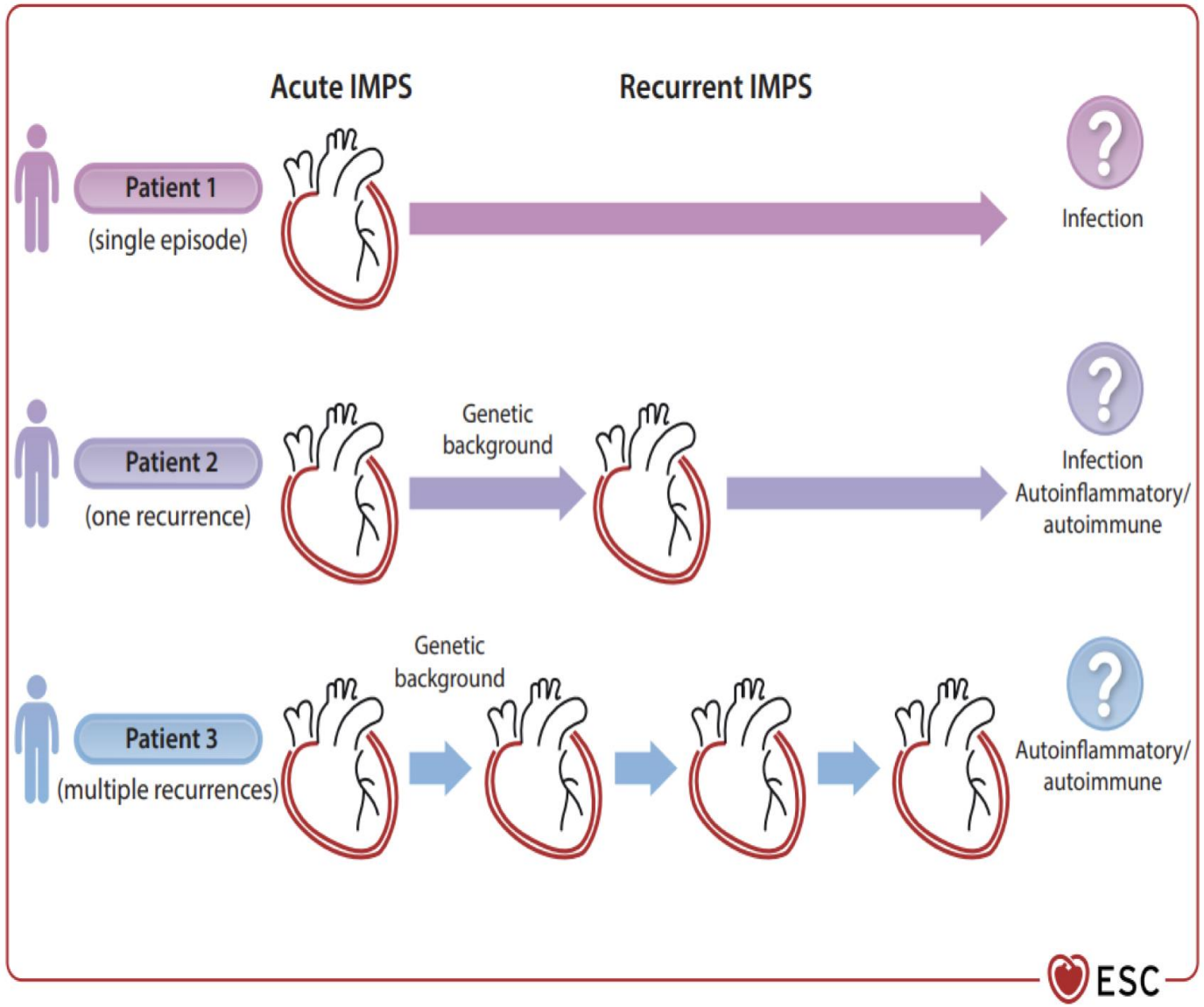
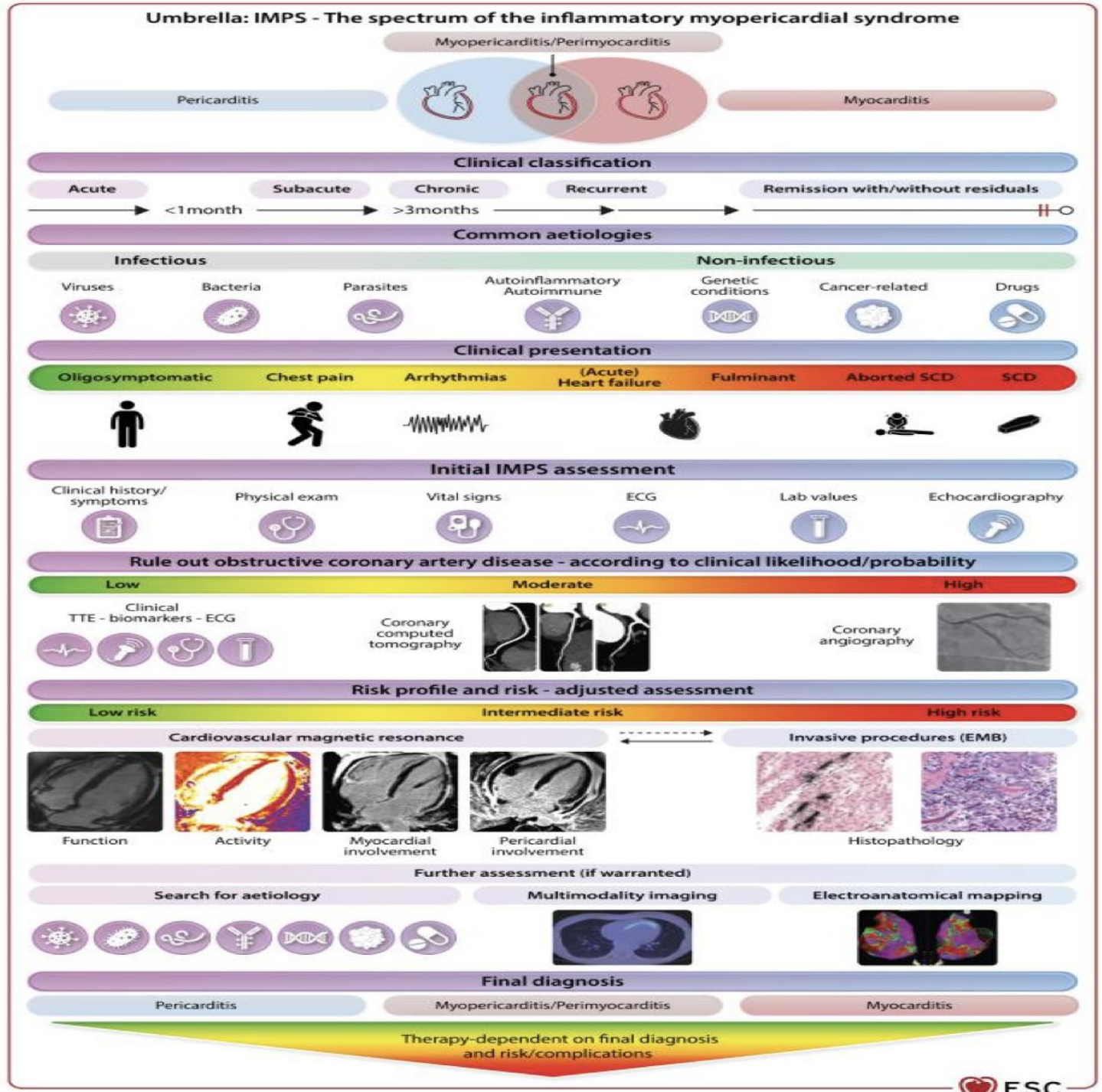
The different courses of inflammatory myopericardial syndromes and the interplay between genetic background inflammation and autoimmunity beyond the initial infectious trigger




Umbrella: IMPS - The spectrum of the inflammatory myopericardial syndrome
Myopericarditis/Perimyocarditis
Pericarditis
Myocarditis
Clinical classification
Acute
Subacute
Chronic
Recurrent
Remission with/without residuals
<1month
>3months
Common aetiologies
Infectious
Non-infectious
Viruses
Bacteria
Parasites
Autoinflammatory Autoimmune
Genetic conditions
Cancer-related
Drugs
Clinical presentation
Oligosymptomatic
Chest pain
Arrhythmias
(Acute) Heart failure
Fulminant
Aborted SCD
SCD
Initial IMPS assessment
Clinical history/ symptoms
Physical exam
Vital signs
ECG
Lab values
Echocardiography
Rule out obstructive coronary artery disease - according to clinical likelihood/probability
Low
Moderate
High
Clinical
TTE - biomarkers - ECG
Coronary computed tomography
Coronary angiography
Risk profile and risk - adjusted assessment
Low risk
Intermediate risk
High risk
Cardiovascular magnetic resonance
Invasive procedures (EMB)
Function
Activity
Myocardial involvement
Pericardial involvement
Histopathology
Further assessment (if warranted)
Search for aetiology
Multimodality imaging
Electroanatomical mapping
Final diagnosis
Pericarditis
Myopericarditis/Perimyocarditis
Myocarditis
Therapy-dependent on final diagnosis and risk/complications
ESC

2025 ESC Guidelines for the management of cardiovascular disease and pregnancy

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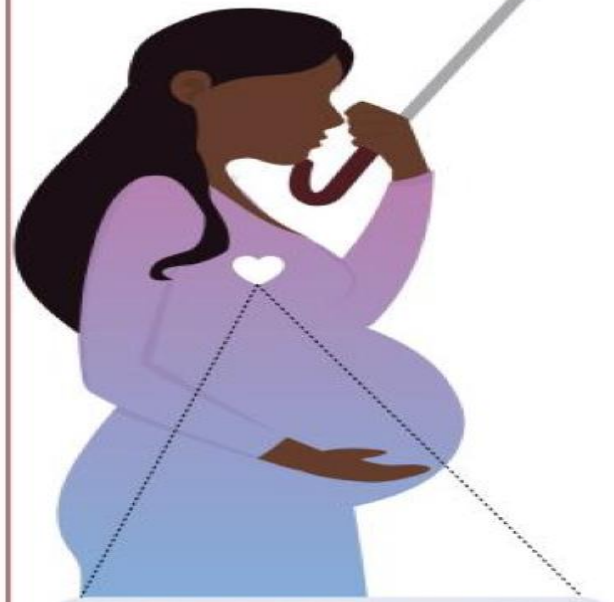
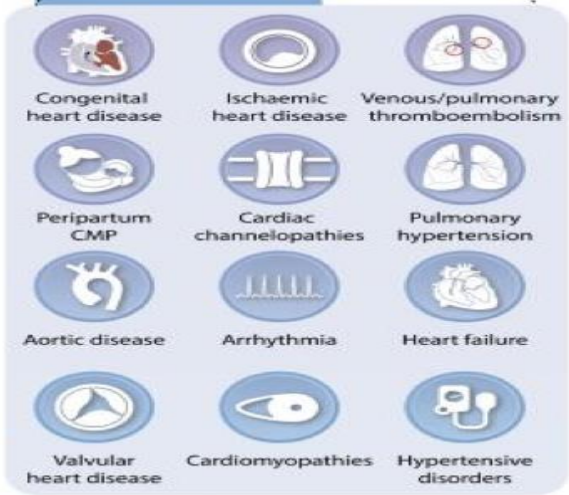
Pregnancy Heart Team

Extended with specific multidisciplinary teams if indicated





Pre-conception

- Risk assessment mWHO 2.0
- Genetic counselling
- Lifestyle counselling
- Reproductive technology
- Drug review
- Clinical optimization
- Contraception

Pregnancy

Disease-specific

- Regular follow-up and risk assessment
- Regular foetal assessment
- Documented delivery plan

Delivery (plan)

- Timing and mode of delivery
- Foetal and maternal monitoring
- Anaesthesia and pain relief methods
- Drug management and bleeding control
- Device management

Post-partum

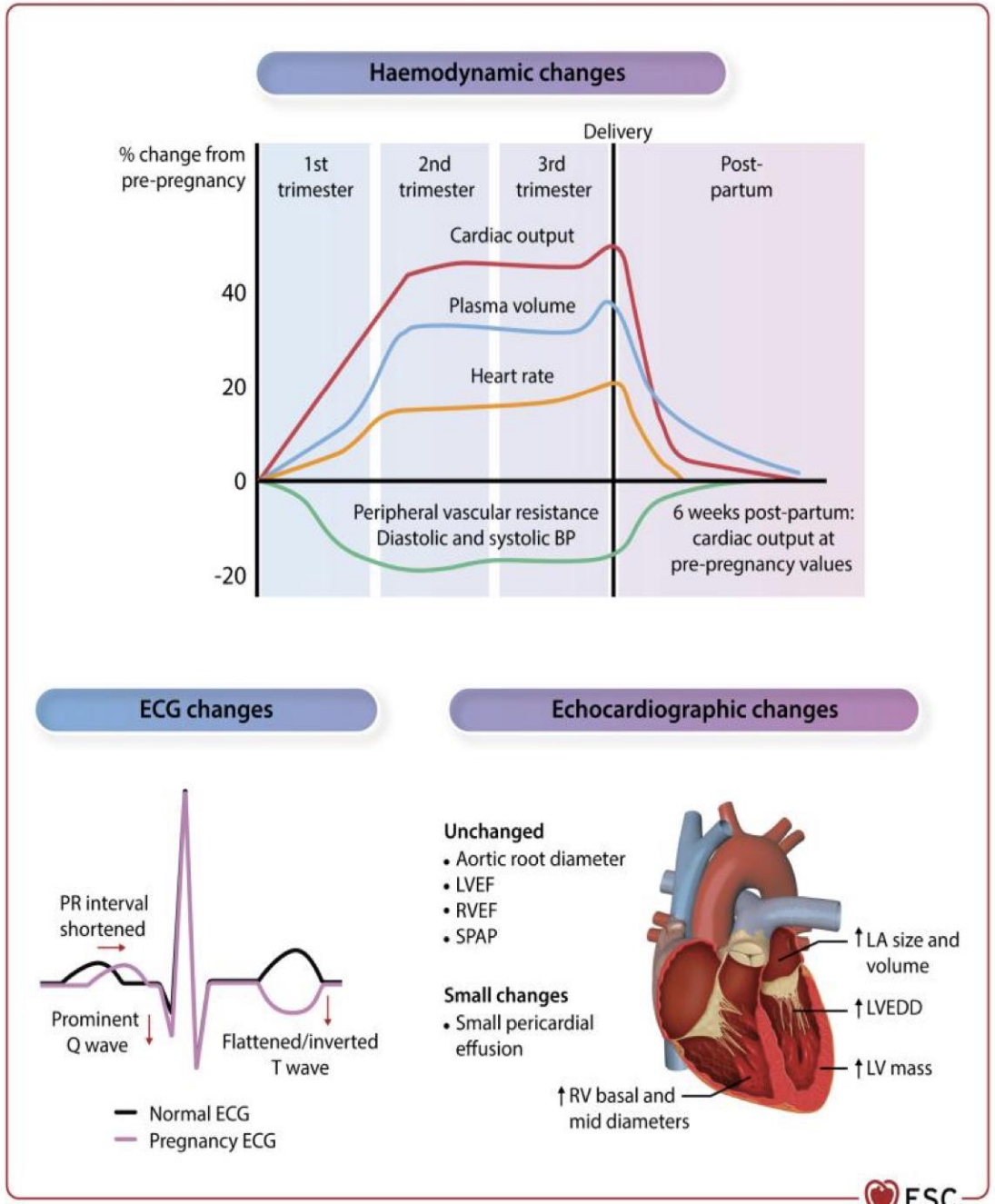
- Breastfeeding and lactation
- Contraception
- Maternal cardiac follow-up

Long term

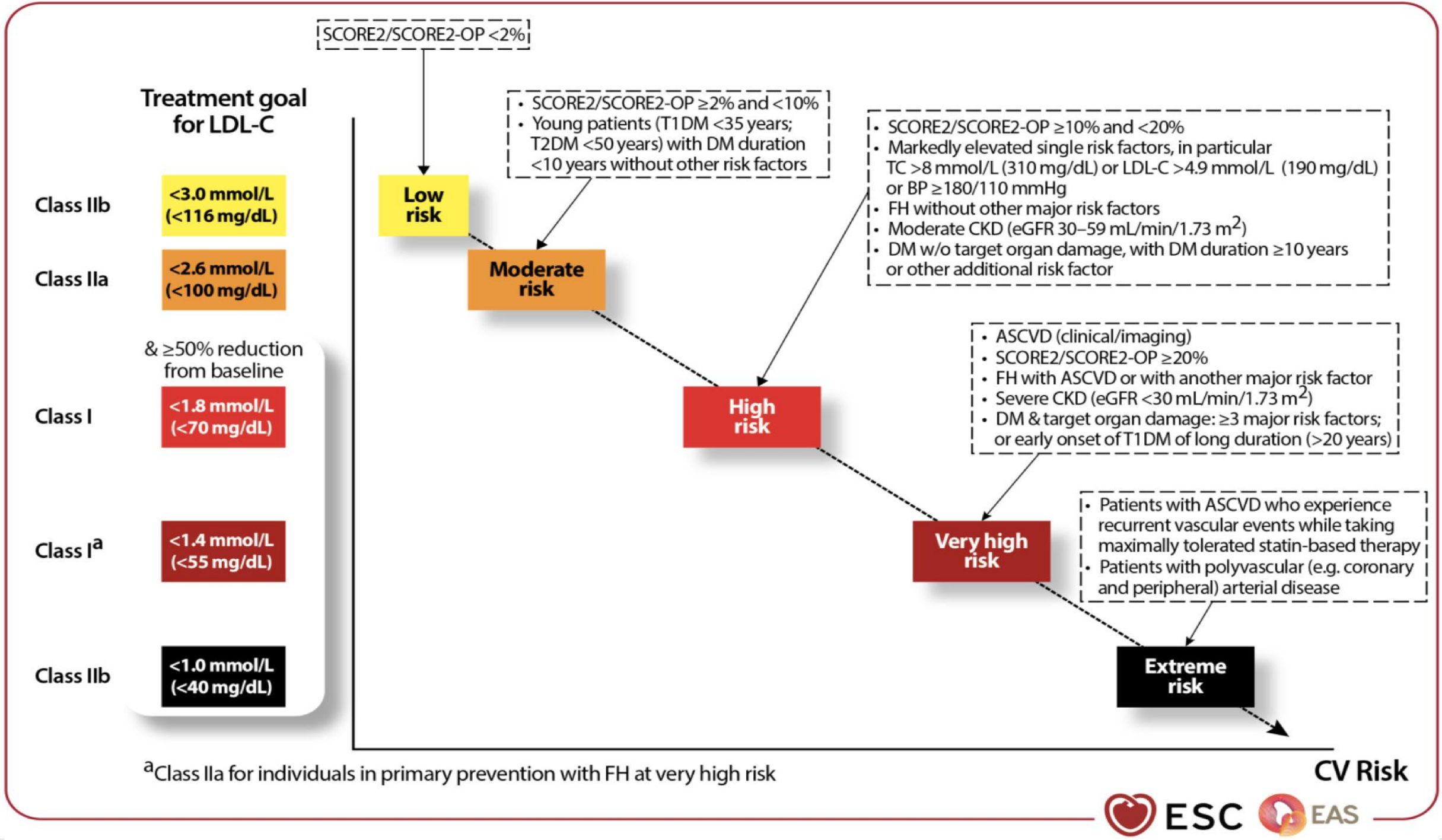
- Identify adverse pregnancy outcome
- Women's Heart Clinic
- Cardiovascular risk factor screening

ESC

Physiology of haemodynamic changes and changes in electrocardiogram and echocardiography during and post pregnancy



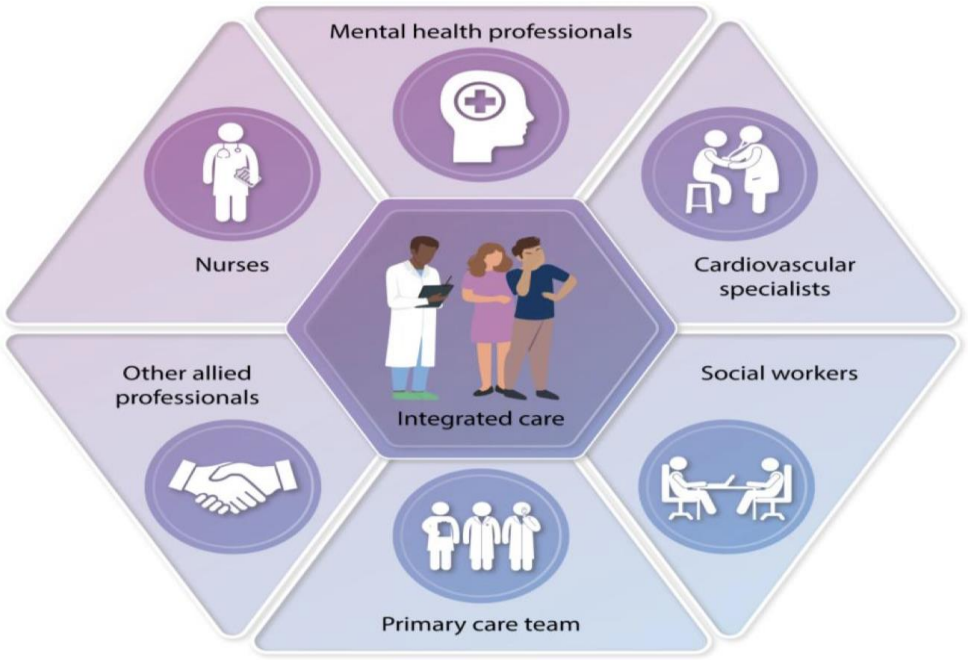
2025 Focused Update of the 2019 ESC/EAS Guidelines for the management of dyslipidaemias

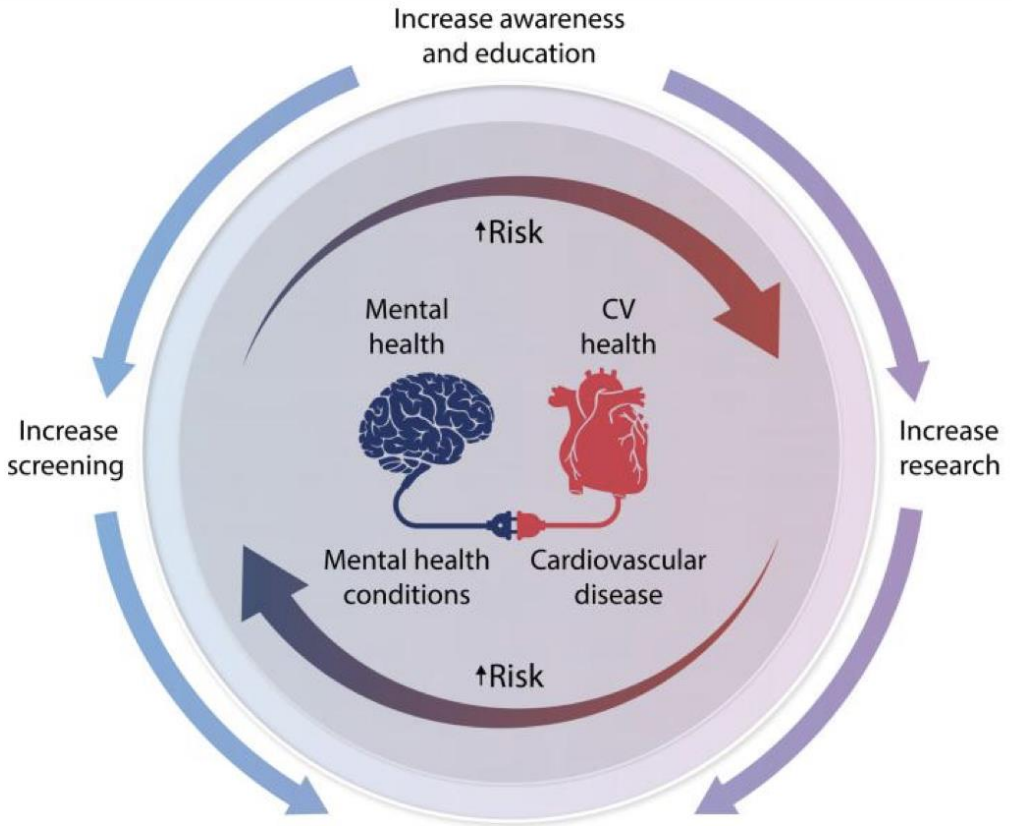

SCORE2/SCORE2-OP <2%
Treatment goal for LDL-C
Class IIb
<3.0 mmol/L (<116 mg/dL)
Class IIa
<2.6 mmol/L (<100 mg/dL)
& ≥50% reduction from baseline
Class I
<1.8 mmol/L (<70 mg/dL)
Class I[a]
<1.4 mmol/L (<55 mg/dL)
Class IIb
<1.0 mmol/L (<40 mg/dL)
Low risk
• SCORE2/SCORE2-OP ≥2% and <10%
• Young patients (T1DM <35 years; T2DM <50 years) with DM duration <10 years without other risk factors
Moderate risk
• SCORE2/SCORE2-OP ≥10% and <20%
• Markedly elevated single risk factors, in particular TC >8 mmol/L (310 mg/dL) or LDL-C >4.9 mmol/L (190 mg/dL) or BP ≥180/110 mmHg
• FH without other major risk factors
• Moderate CKD (eGFR 30–59 mL/min/1.73 m2)
• DM w/o target organ damage, with DM duration ≥10 years or other additional risk factor
High risk
• ASCVD (clinical/imaging)
• SCORE2/SCORE2-OP ≥20%
• FH with ASCVD or with another major risk factor
• Severe CKD (eGFR <30 mL/min/1.73 m2)
• DM & target organ damage: ≥3 major risk factors; or early onset of T1DM of long duration (>20 years)
Very high risk
• Patients with ASCVD who experience recurrent vascular events while taking maximally tolerated statin-based therapy
• Patients with polyvascular (e.g. coronary and peripheral) arterial disease
Extreme risk
CV Risk
[a]Class IIa for individuals in primary prevention with FH at very high risk
ESC
EAS

2025 ESC Clinical Consensus Statement on mental health and cardiovascular disease

SECTION SUMMARY POINTS

1. Mental health and mental health conditions interact with CV health and CVD in a multidirectional way.
2. The coexistence of CVD and mental health conditions can create a mutual interaction that worsens both mental and CV health, leading to poorer outcomes.
3. Routine CV clinical practice lacks integrated, systematic and appropriate screening, evaluation, communication, and management of mental health.
4. There is limited evidence on the best ways to communicate, promote, maintain, and improve mental health and resilience in people with CVD and their family members.
5. The evidence base to guide practice in relation to the screening and management of mental health conditions in people with CVD is limited.





Implementation and testing of consensus-based guidance

ACTIVE principles

Psycho-Cardio team

Stepped care approach

Improved management and better outcomes


HOT LINES

What’s new in DAPT

AQUATIC TRIAL

ORIGINAL ARTICLE

Aspirin in Patients with Chronic Coronary Syndrome Receiving Oral Anticoagulation

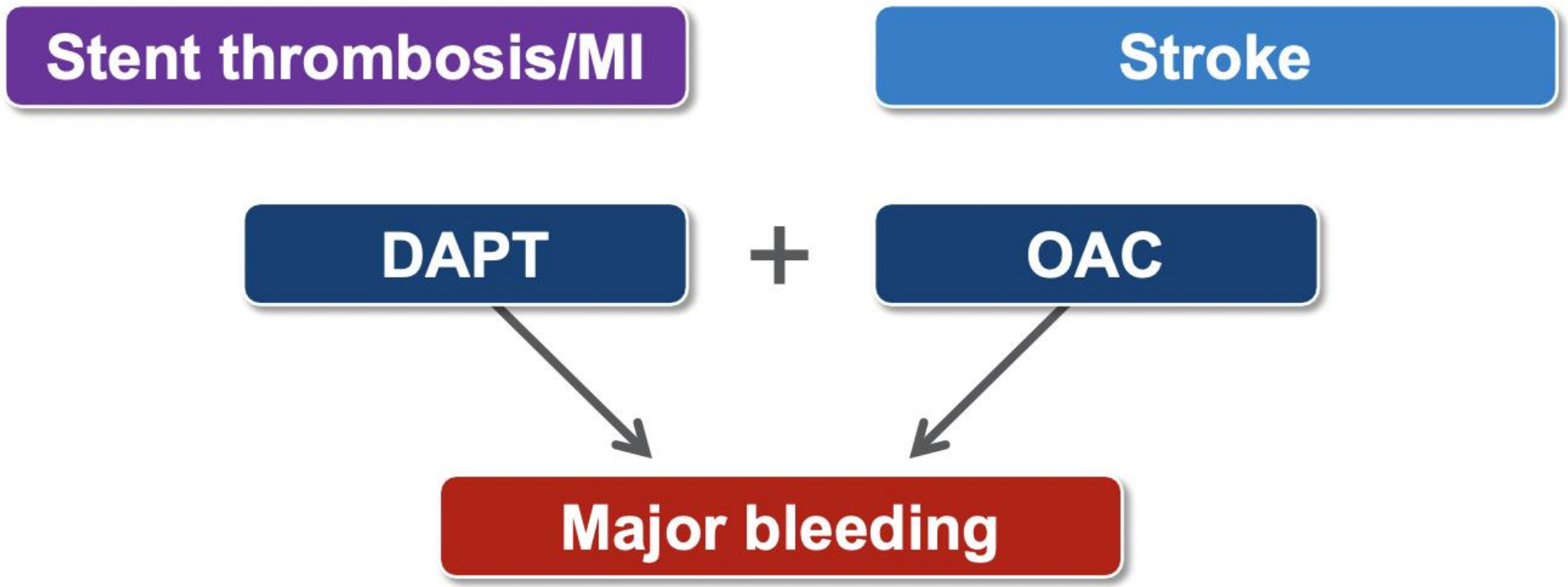
G. Lemesle,[1-4] R. Didier,[5-7] P.G. Steg,[4,8-10] T. Simon,[4,9,11-13] G. Montalescot,[11,14-16] N. Danchin,[4,17] C. Bauters,[1,3,18] D. Blanchard,[19] C. Bouleti,[20,21] D. Angoulvant,[22-24] S. Andrieu,[25] G. Vanzetto,[26] M. Kerneis,[14] V. Decalf,[27] E. Puymirat,[8,19,28] D. Mottier,[6,7,29,30] A. Diallo,[12,16,31-33] E. Vicaut,[12,16,31-33] M. Gilard,[5-7] and G. Cayla,[16,34,35] for the AQUATIC Trial Investigators*

AQUATIC

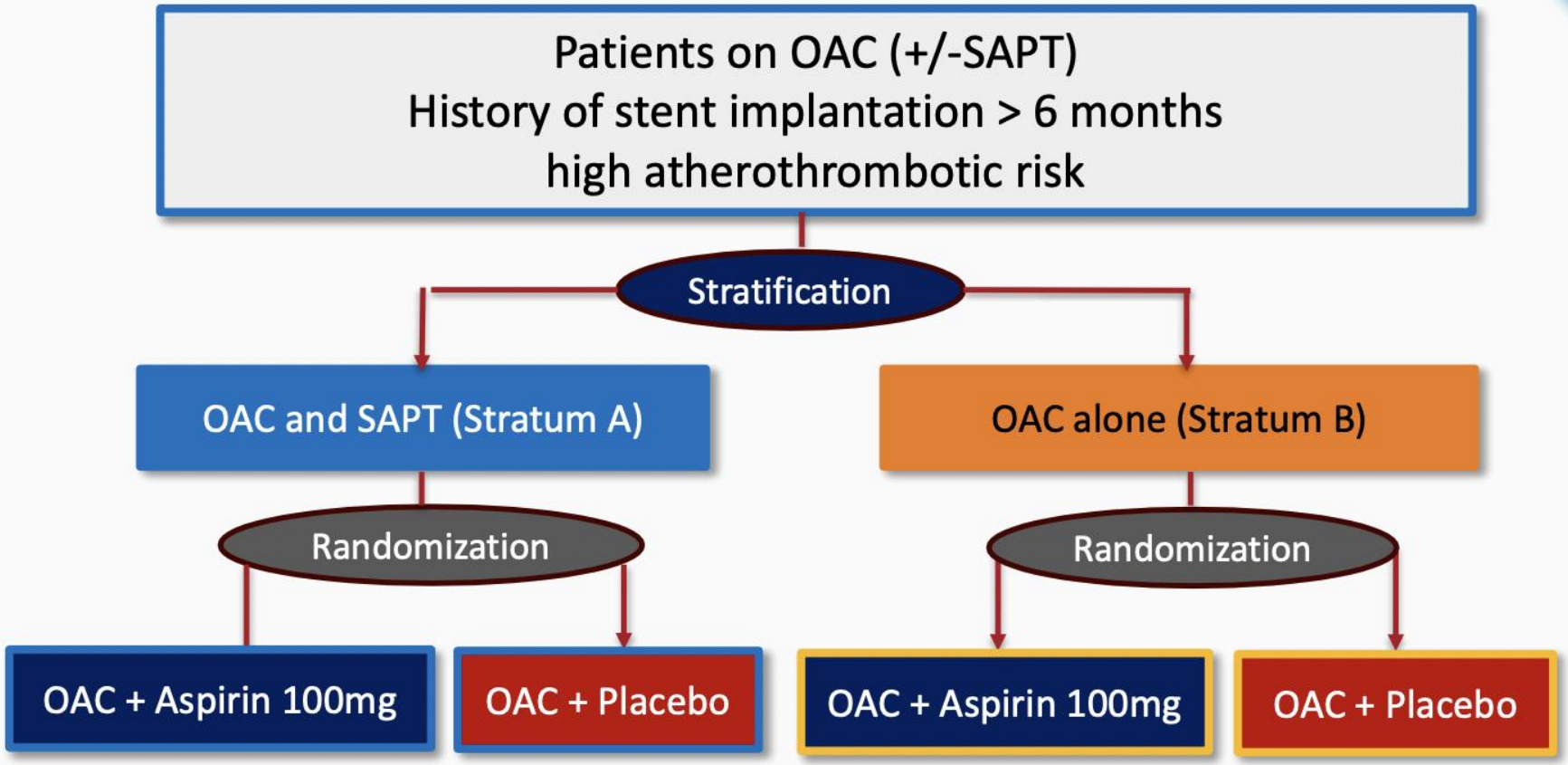
Assessment of **Q**uitting versus **U**sing **A**spirin **T**herapy **I**n patients with stabilized **C**oronary artery disease after stenting who require long-term oral anticoagulation

Investigator-driven, randomized, double-blind, placebo-controlled, multicenter trial

The problem: you cannot simultaneously prevent all three!



AQUATIC design



Primary outcome: CV death, MI, stroke, systemic embolism, any coronary revascularization, acute limb ischemia
Key secondary safety outcome: Major bleeding events (ISTH classification)

AQUATIC DESIGN

Main Inclusion criteria

Long term OAC treatment + Stent

and

High risk of atherothrombotic events:

PCI for **ACS**

or

Any of these criteria

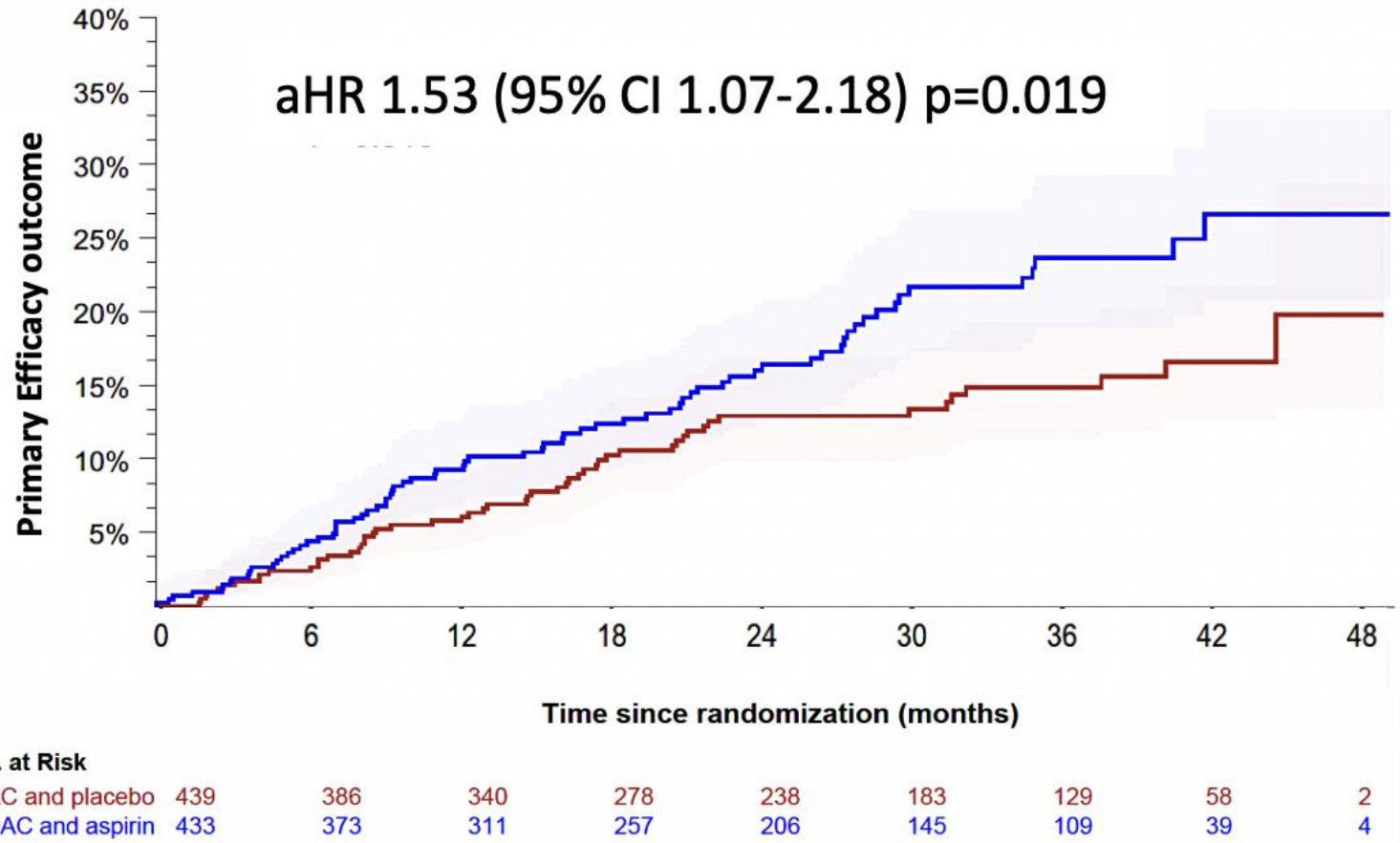
- Diabetes
- Chronic kidney disease
- Peripheral artery disease
- Multivessel coronary disease
- Complex PCI (Left main, CTO, 3 lesions…)
- History of stent thrombosis

Main Exclusion criteria

Recent coronary or bleeding event
Haemorrhagic disease
Stroke within 1 month
Any history of haemorrhagic stroke
Contraindication to aspirin or OAC
Severe renal or hepatic insufficiency
Severe uncontrolled heart failure

Primary efficacy outcome

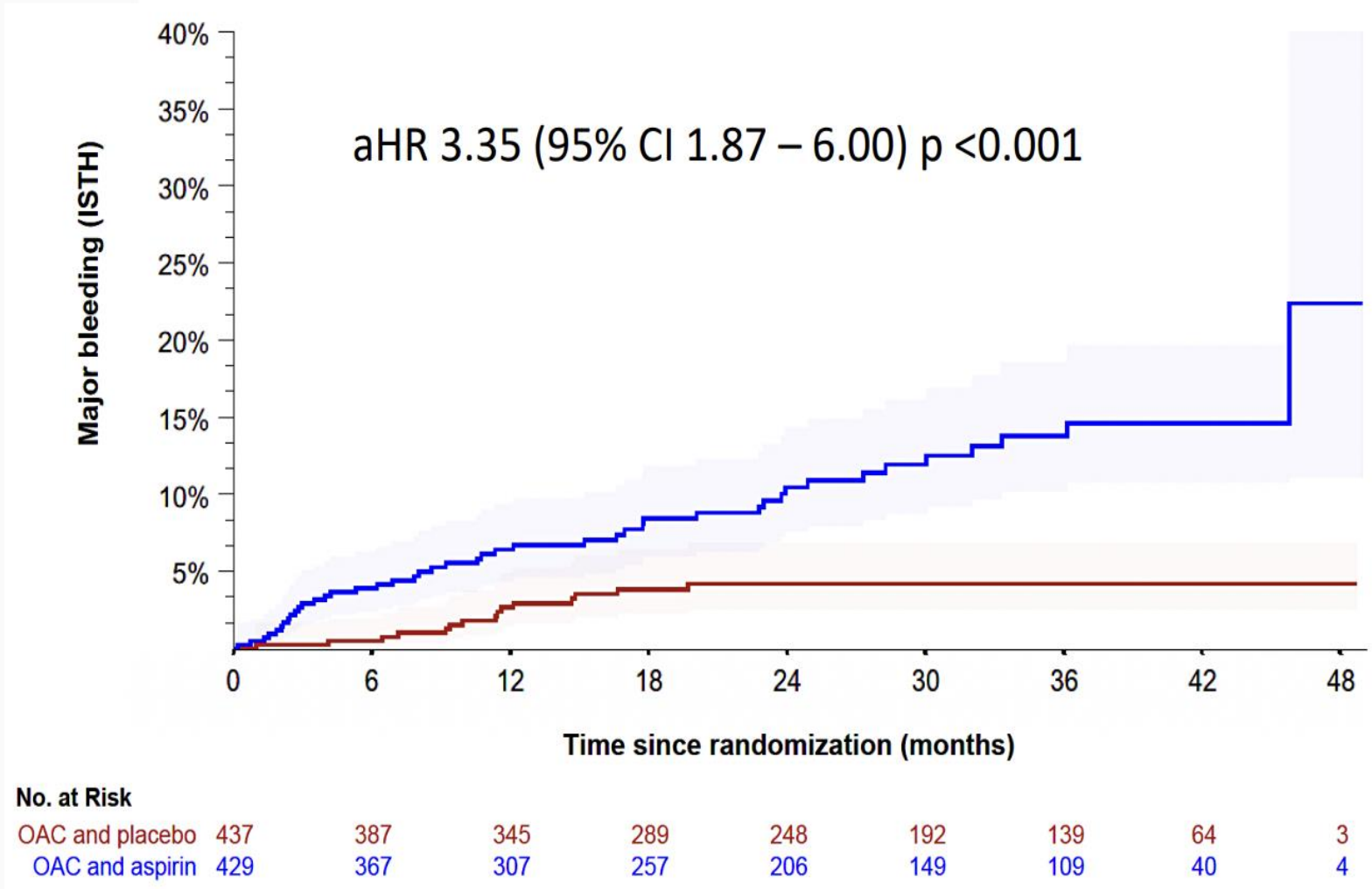
CV death, MI, stroke, systemic embolism, any coronary revascularization and acute limb ischemia



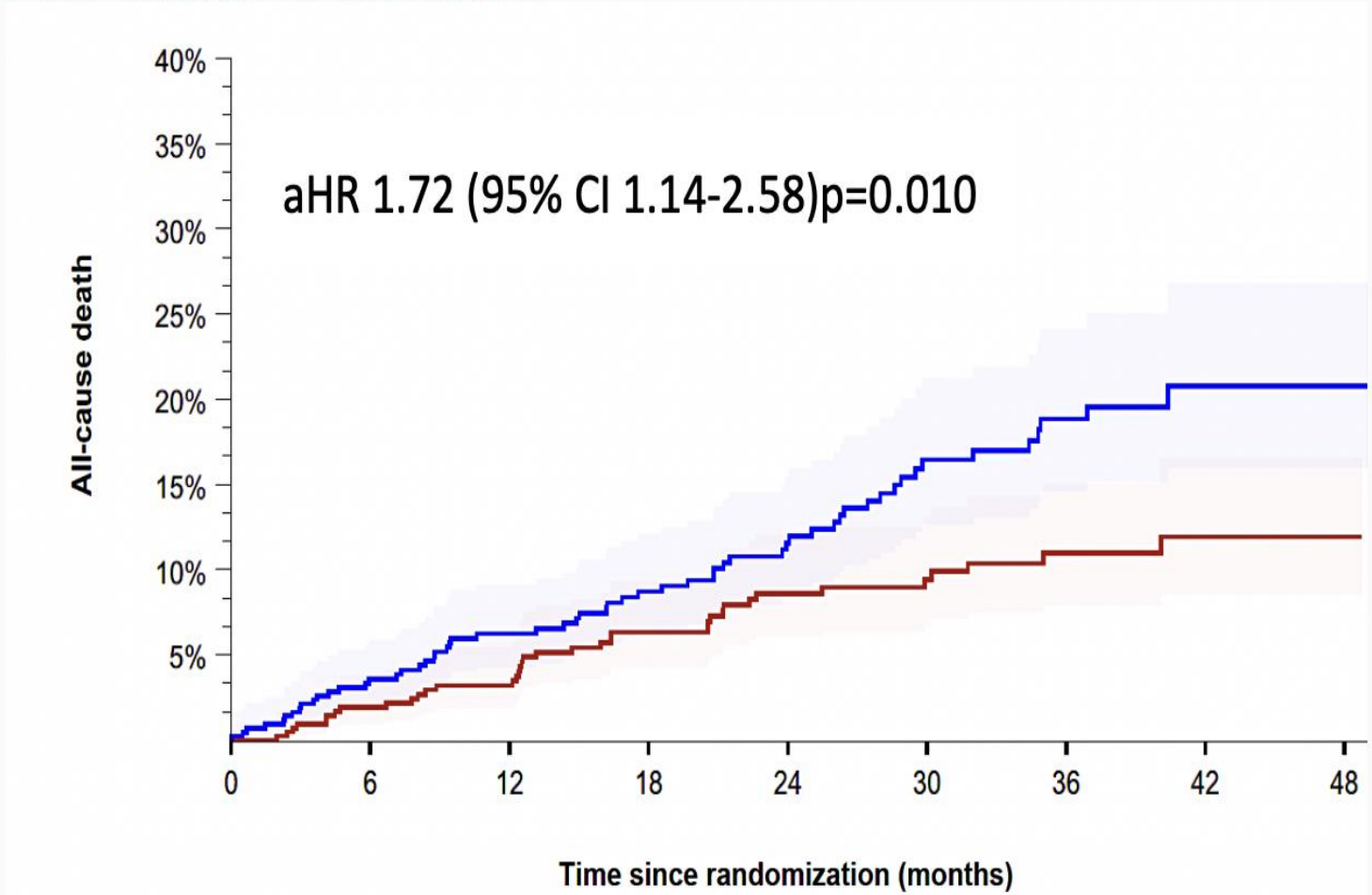
OAC + Aspirin

OAC + Placebo

Secondary safety outcome: ISTH major bleeding



All cause death



No. at Risk									
OAC and placebo	439	389	352	297	256	197	142	64	3
OAC and aspirin	433	382	327	277	225	163	120	43	4

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Aspirin in Patients with Chronic Coronary Syndrome Receiving Oral Anticoagulation

G. Lemesle,[1-4] R. Didier,[5-7] P.G. Steg,[4,8-10] T. Simon,[4,9,11-13] G. Montalescot,[11,14-16] N. Danchin,[4,17] C. Bauters,[1,3,18] D. Blanchard,[19] C. Bouleti,[20,21] D. Angoulvant,[22-24] S. Andrieu,[25] G. Vanzetto,[26] M. Kerneis,[14] V. Decalf,[27] E. Puymirat,[8,19,28] D. Mottier,[6,7,29,30] A. Diallo,[12,16,31-33] E. Vicaut,[12,16,31-33] M. Gilard,[5-7] and G. Cayla,[16,34,35] for the AQUATIC Trial Investigators*

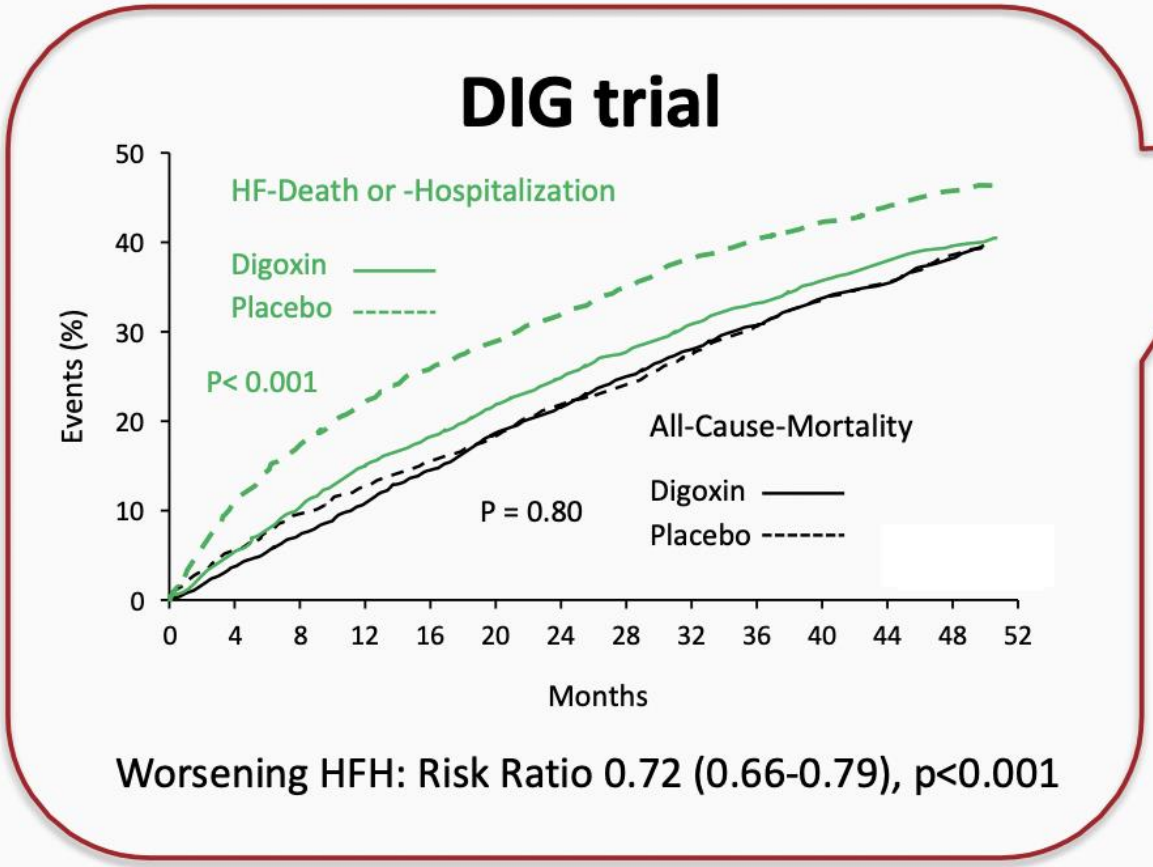
Stented patients on OAC should not receive long term aspirin even if they are at high atherothrombotic risk

What’s new in heart failure

DIGIT-HF: Digitoxin in Patients with Heart Failure and Reduced Ejection Fraction

Udo Bavendiek, MD
Department of Cardiology and Angiology, Hannover Medical School, Hannover, Germany

L'essai **DIG (DIG Investigation Group, 1997)** a montré une réduction des hospitalisations pour aggravation de l'IC, **mais un effet neutre sur la mortalité globale, et un signal de risque à des concentrations élevées de digoxine.**



Bavendiek U, Bauersachs J, ESC Textbook of Heart Failure 2023
Adapted from DIG Invesigators NEJM 1997, 336:525

Potential benefit particularly if
- LVEF <25%
- NYHA III/IV
- Digoxin 0.5-0.9 ng/ml

Digoxin > 1.0 ng/ml
- association with worse outcomes

Digitoxin
- more stable serum concentrations even if worsening renal function
- no clinical trials of appropiate size

Rathore SS et al., JAMA 2003, 289:871
Belz GG, Eur J Clin Invest 2001, 31(2):10
Gheorghiade M et al. , EJHF 2013, 15:551

With funding from the:
Federal Ministry

Digitoxin présente des **avantages pharmacocinétiques** : élimination hépatique complémentaire (entérohépatique), moins dépendante de la fonction rénale, ainsi qu'une stabilité de concentration plus élevée

Study design and recruitment

DIGIT-HF

investigator-initiated, multicentre, randomized, double-blind, placebo-controlled, event-driven phase IV trial investigating wether digitoxin improves outcomes in patients with heart failure and reduced ejection fraction

Main inclusion criteria
- Chronic HF
- NYHA II and LVEF ≤30%
  or
  NYHA III-IV and LVEF ≤40%
- Evidence based HF therapy
  ≥ 6 months

Main exclusion criteria
- Amiodarone
- Heart rate < 60 b.p.m
  (except CRT-in place)
- Recent (< 2 month)
  procedure potentially
  improving LVEF/HF

Randomization of 1240 patients (05/2015 – 09/2023, LPLV 29.11.2024,
55 sites: Germany 89%, Austria 3%, Serbia 8%)

Intention to treat population: n= 1212 (at least one dose of IMP)

R 1:1

N = 613 Digitoxin + SOC

Starting: 0.07 mg PO OD (DTX target serum concentration 8-18 ng/ml) at 6 weeks post randomization: DTX serum concentration and DTX dose titration (0.05, 0.07, or 0.1 mg PO OD)

N = 599 Placebo + SOC

Follow-Up every 6 month after randomization

Sample size calculation based on estimation
- at initial trial design: n=2190
- after trial extension 2019: n=1653

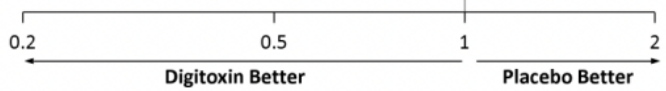
With funding from the:
Federal Ministry

Prespecified Subgroups for Primary Outcome II

Treatment effect of digitoxin appeared to be consistent

DIGIT-HF

Group	Digitoxin	Placebo	Hazard Ratio (95% CI)
	no. of patients with events/total no. (pct)		
All patients	242 / 613 (39.5)	264 / 599 (44.1)	0.82 (0.69 - 0.98)
ICD therapy			
Yes	179 / 415 (43.1)	162 / 364 (44.5)	0.94 (0.75 - 1.16)
No	63 / 198 (31.8)	101 / 234 (43.2)	0.57 (0.41 - 0.80)
CRT therapy			
Yes	84 / 162 (51.9)	65 / 144 (45.1)	1.03 (0.73 - 1.45)
No	158 / 451 (35)	198 / 453 (43.7)	0.72 (0.58 - 0.90)
MRA			
Yes	166 / 466 (35.6)	189 / 458 (41.3)	0.82 (0.67 - 1.02)
No	76 / 147 (51.7)	75 / 141 (53.2)	0.97 (0.68 - 1.38)
ARNi			
Yes	81 / 248 (32.7)	83 / 231 (35.9)	0.80 (0.58 - 1.11)
No	161 / 365 (44.1)	181 / 368 (49.2)	0.84 (0.67 - 1.05)
SGLT2i*			
Yes	24 / 121 (19.8)	32 / 113 (28.3)	0.70 (0.40 - 1.23)
No	32 / 98 (32.7)	36 / 96 (37.5)	0.59 (0.34 - 1.04)
Triple therapy			
Yes	159 / 436 (36.5)	178 / 422 (42.2)	0.81 (0.65 - 1.01)
No	83 / 177 (46.9)	86 / 177 (48.6)	0.89 (0.64 - 1.23)
Quadruple therapy*			
Yes	20 / 101 (19.8)	28 / 99 (28.3)	0.77 (0.41 - 1.42)
No	36 / 118 (30.5)	40 / 110 (36.4)	0.64 (0.39 - 1.07)



ARNI

SGLT2i

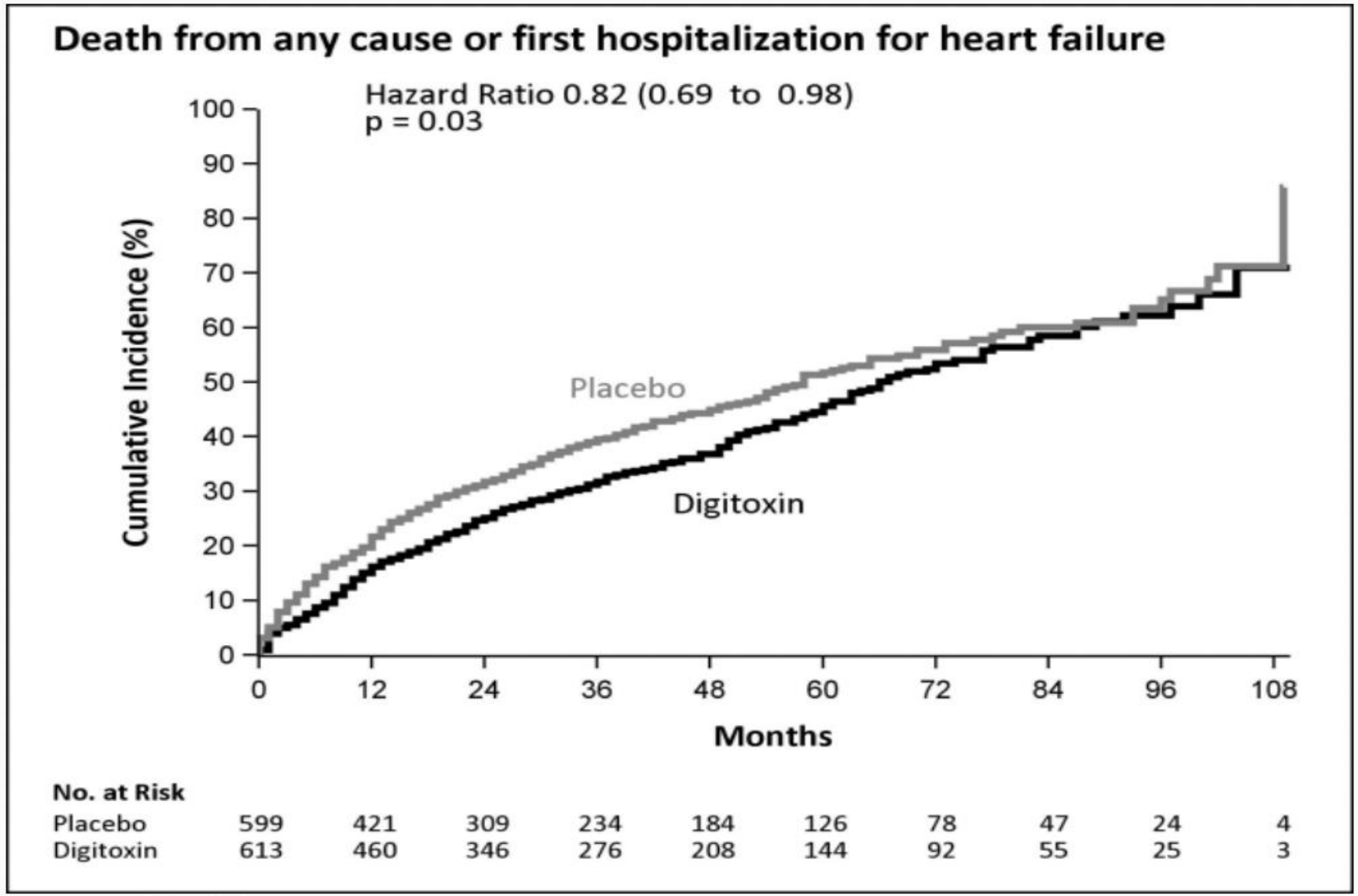
Triple therapy

Quadruple therapy

With funding from the:

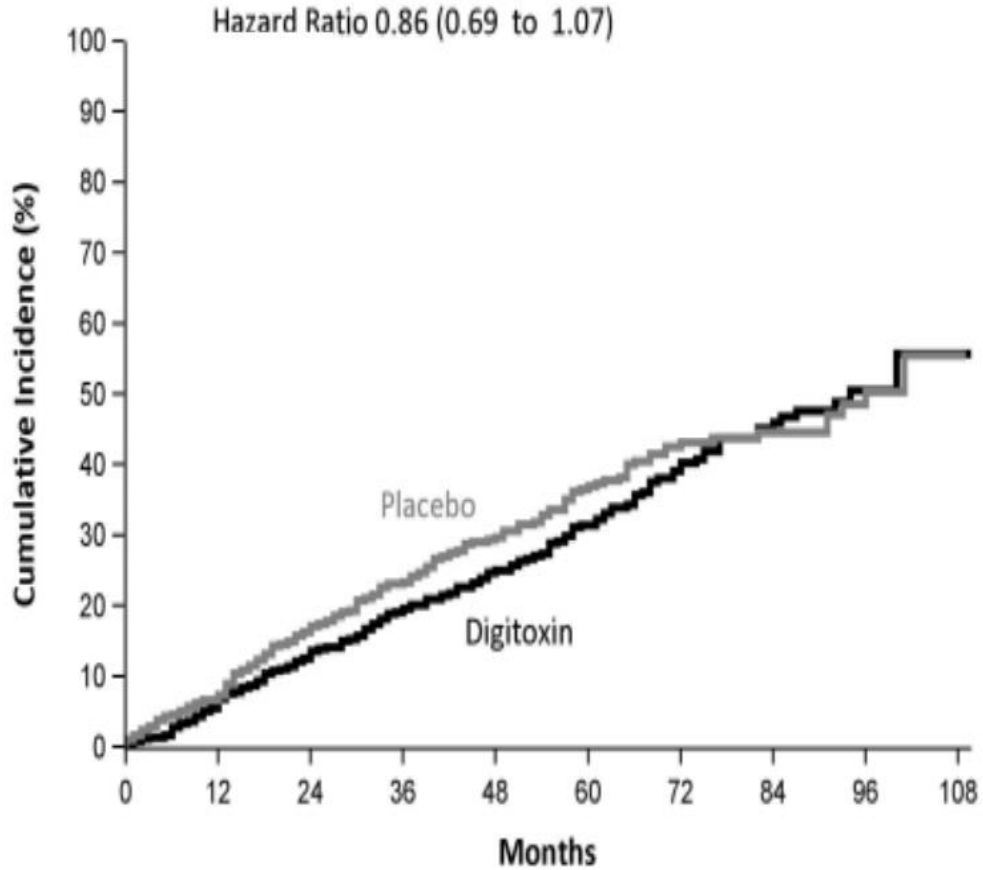
Federal Ministry of Research, Technology and Space

Death from any cause or first hospitalization for heart failure



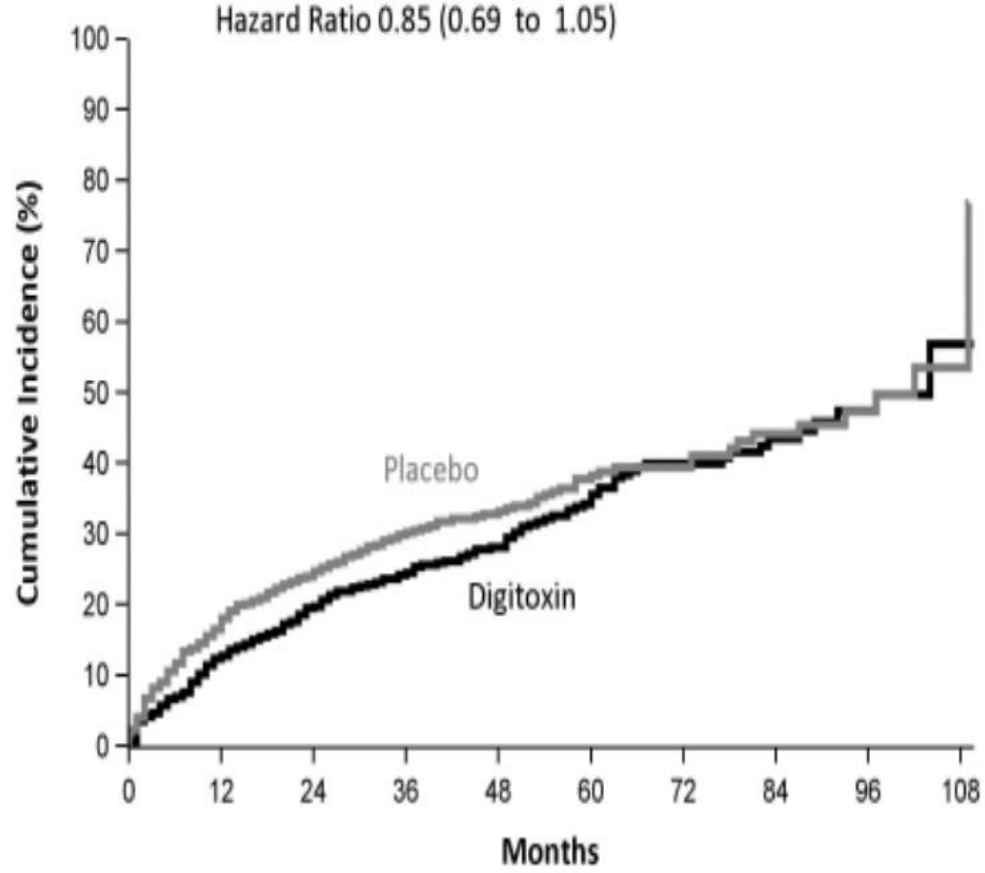
No. at Risk										
Placebo	599	421	309	234	184	126	78	47	24	4
Digitoxin	613	460	346	276	208	144	92	55	25	3

Death from any cause *



No. at Risk										
Placebo	599	485	370	291	229	162	103	60	29	4
Digitoxin	613	507	398	317	239	172	113	70	28	4

First hospitalization for heart failure



No. at Risk										
Placebo	599	421	309	234	184	126	78	47	24	4
Digitoxin	613	460	346	276	208	144	92	55	25	3

*<0.001 for noninferiority (hazard ratio margin 1.303)

With funding from the:

Conclusion

DIGIT-HF

- Digitoxin reduced the risk of a composite of all-cause death and hospital admission for worsening heart failure among patients with HFrEF receiving a well-implemented guideline-recommended medical therapy.
- These findings appeared to be consistent among all pre-specified subgroups, including patients treated with ARNI and SGLT2-inhibitors.
- Treatment with digitoxin appeared to be safe in contradiction to previous nonrandomized studies or post-hoc analysis claiming harmful effects of cardiac glycosides in heart failure with and without atrial fibrillation.
- These data support the use of digitoxin in patients with heart failure and reduced ejection fraction.

What’s new in cardiac arrhythymias?

The ALONE AF randomized trial

JAMA

Kim D, Joung B, et al, for the ALONE-AF Investigators

Long-Term Anticoagulation Discontinuation After Catheter Ablation for Atrial Fibrillation

The ALONE-AF Randomized Clinical Trial

Published online August 31, 2025

ESC (European Society of Cardiology) Congress

Available at jama.com

JAMA Network

Scan to read the article

Background: Current guidelines (long-term OAC after AF ablation)

Recommendations	Class	Level
Continuation of oral anticoagulation is recommended for at least 2 months after AF ablation in all patients, irrespective of rhythm outcome or CHA_2DS_2-VA score, to reduce the risk of peri-procedural ischaemic stroke and thromboembolism.	IC	C
Continuation of oral anticoagulation is recommended after AF ablation according to the patient's CHA_2DS_2-VA score, and not the perceived success of the ablation procedure, to prevent ischaemic stroke and thromboembolism.	IC	C

2024 ESC Guidelines. EHJ 2024

COR	LOE	Recommendation
1	B-NR	In patients who have undergone catheter ablation of AF, oral anticoagulation should be continued for at least 3 months after the procedure with a longer duration determined by underlying risk.
1	B-NR	In patients who have undergone catheter ablation of AF, continuation of longer-term oral anticoagulation should be dictated according to the patients' stroke risk (eg, CHA_2DS_2-VASc score ≥2).

2023 AHA Guidelines. Circ 2023

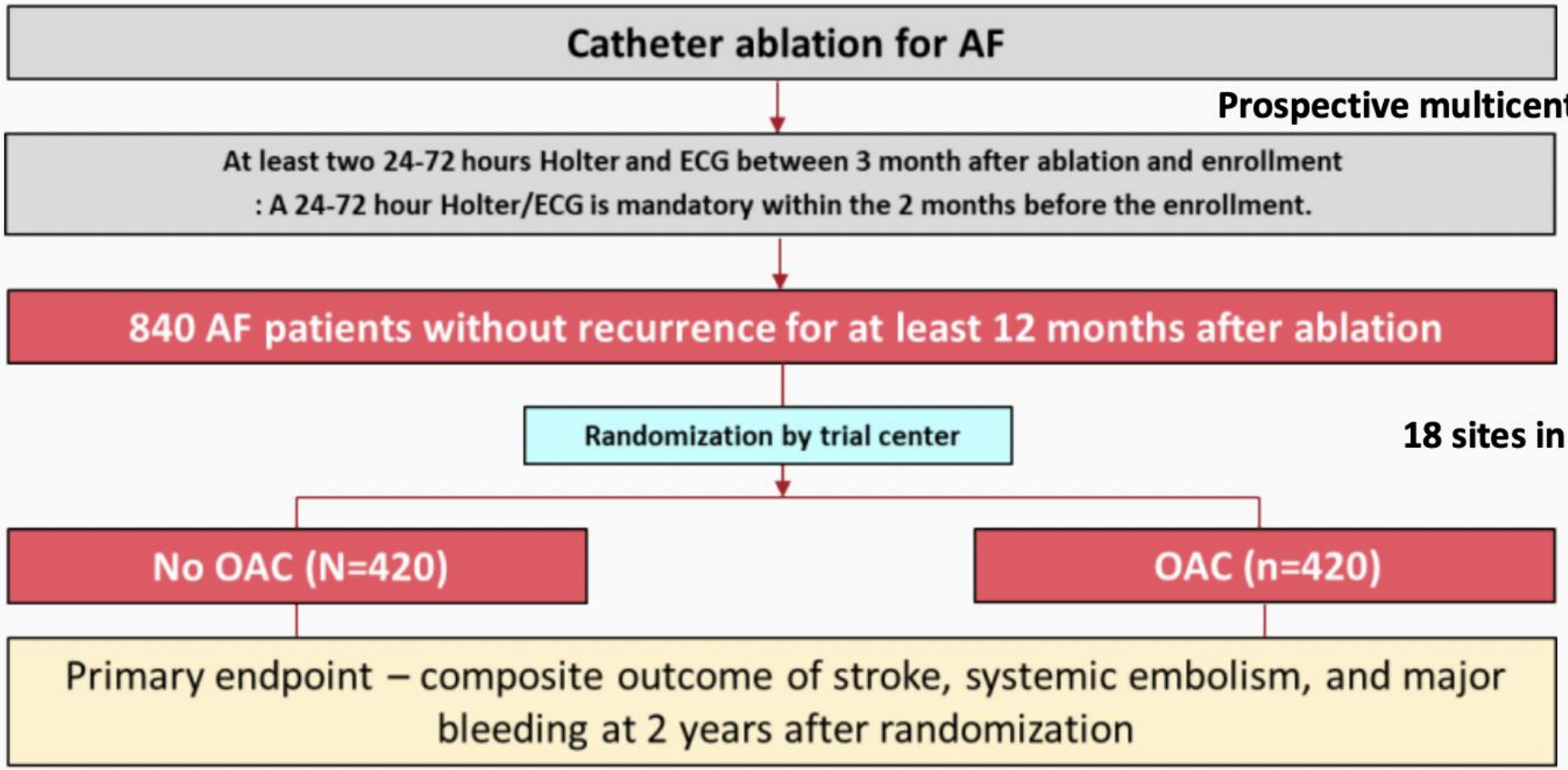
Objective

- To compare the primary composite outcome (including stroke, systemic embolism, and major bleeding) of therapy with and without direct oral anticoagulant (DOAC) in patients without documented atrial arrhythmia recurrence following AF ablation.

- The primary hypothesis was that discontinuing DOAC therapy would decrease the risk of net primary outcomes compared to continued DOAC therapy in patients without apparent atrial arrhythmia recurrence for at least 12 months post-AF ablation.

ALONE Trial Design

Anticoagu**L**ation **ONE** year after ablation of atrial fibrillation in patients with **A**trial **F**ibrillation



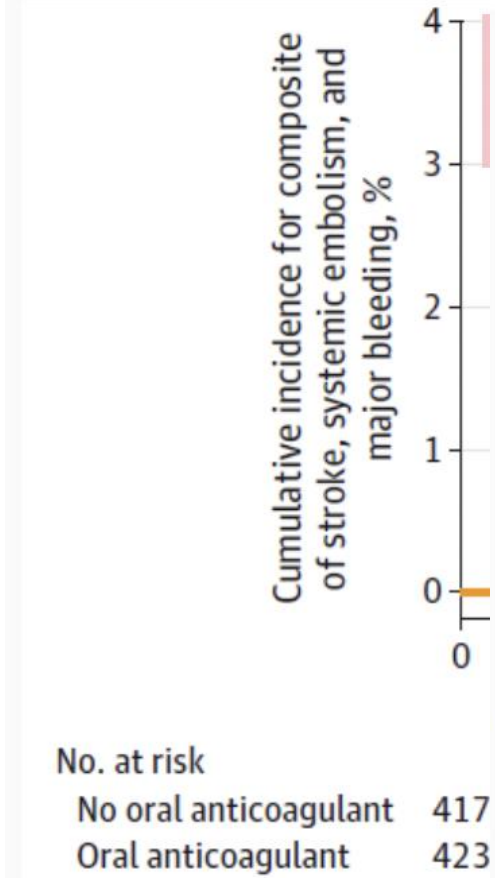
Enrollment criteria

Inclusion criteria

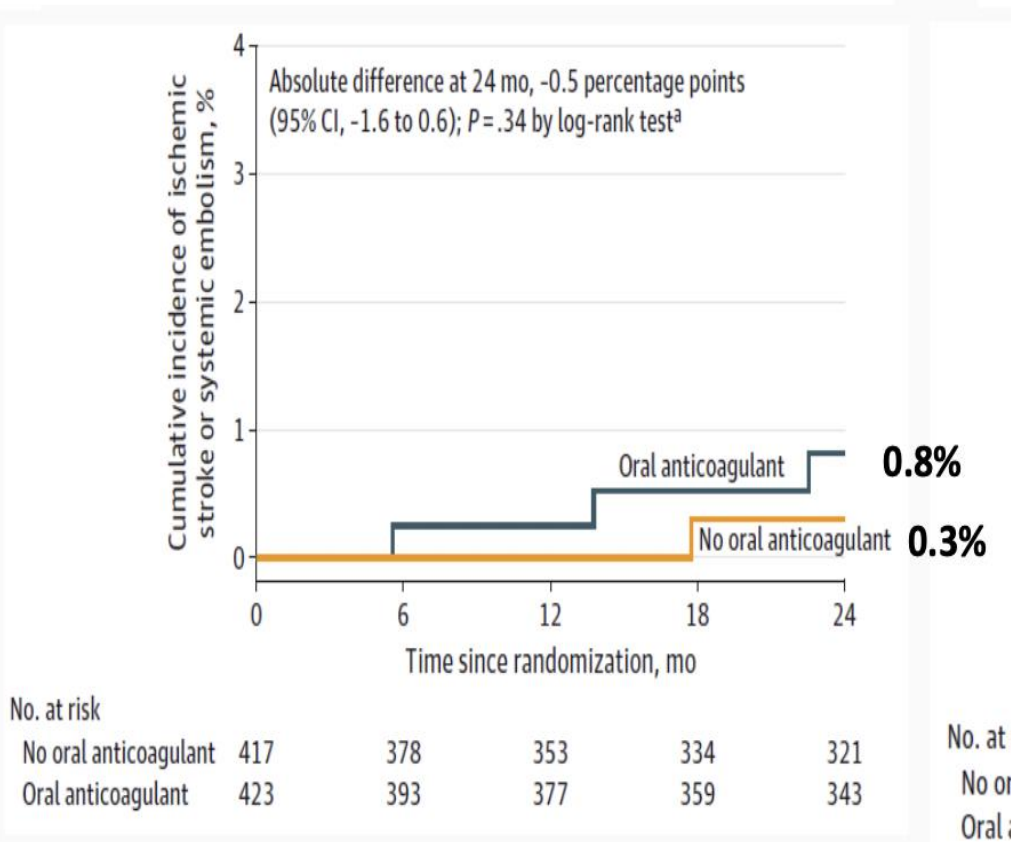
1. Age between 19 and 80 years
2. CHA_2DS_2-VASc score ≥ 1 (male) or ≥ 2 (female)
3. No recurrence of atrial arrhythmia at least 12 months after their first-time catheter ablation of atrial fibrillation, defined as an absence of ≥30 seconds of atrial fibrillation, atrial flutter, or atrial tachycardia in at least two 24–72 hour Holter and electrocardiogram recordings conducted beyond 3 months after the ablation and before enrollment (with at least one 24–72 hour Holter and electrocardiogram recording mandatory within the 2 months preceding enrollment)

Exclusion criteria

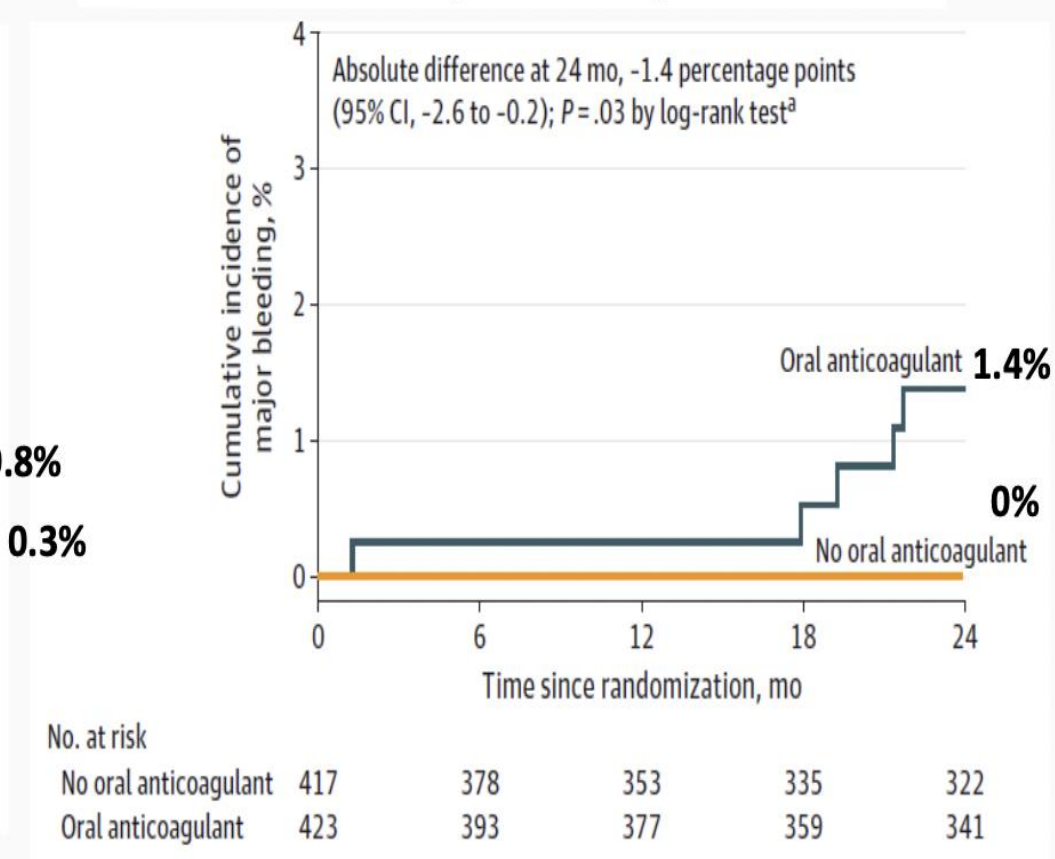
1. Significant liver or renal disease
2. Requiring anticoagulation due to surgery with a mechanical prosthetic valve, moderate-to-severe mitral stenosis, or deep vein thrombosis
3. Significant structural heart disease (moderate-to-severe mitral regurgitation, severe valvular regurgitation or stenosis, DCMP, or HCMP)
4. Active malignancy
5. Pregnancy or breast-feeding
6. Life expectancy < 1 year
7. Refuse or enable to understand the written informed consent



Ischemic stroke or systemic embolism



Major bleeding



Conclusion

- **In this ALONE-AF involving AF patients without AF recurrence following catheter ablation,**
- discontinuing OAC was associated with a lower risk of the composite outcome (stroke, systemic embolism, or major bleeding) versus continued OAC.
- The result appeared to be primarily driven by lower incidence of major bleeding events.
- The incidence of ischemic events appeared to be similar in the trial groups.

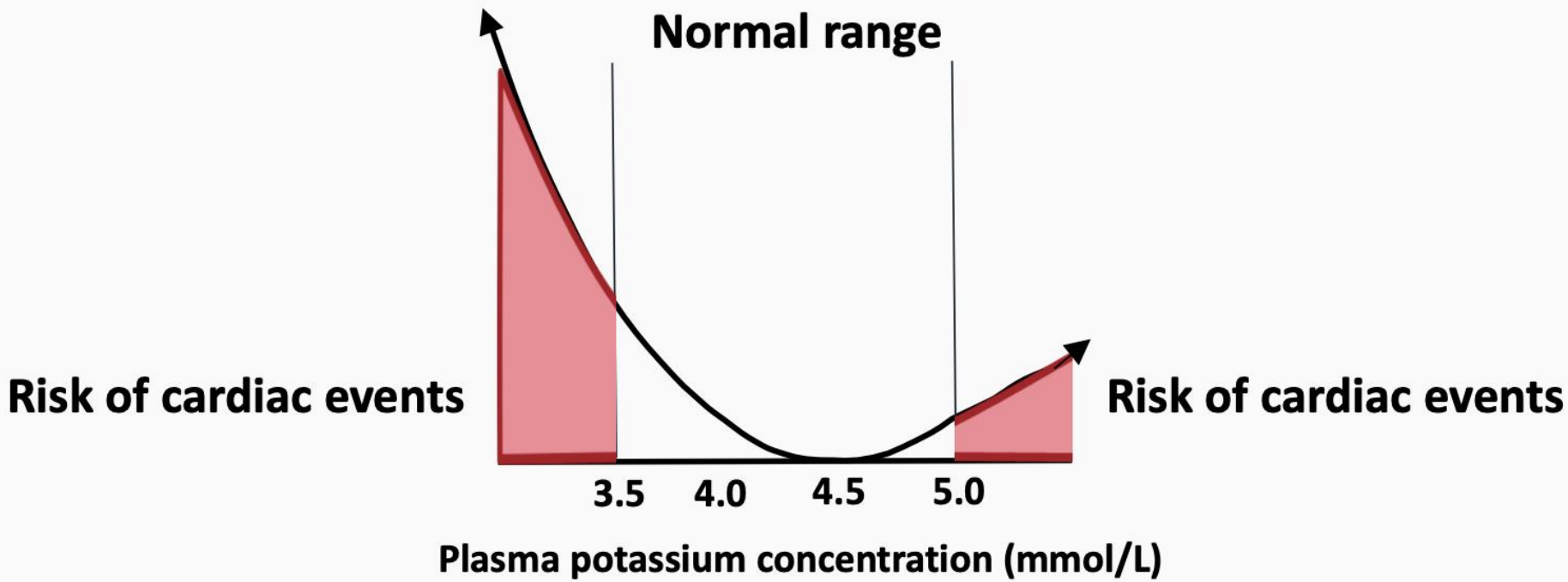
POTCAST

A randomized controlled trial of arrhythmia prevention using targeted plasma potassium levels in ICD Patients

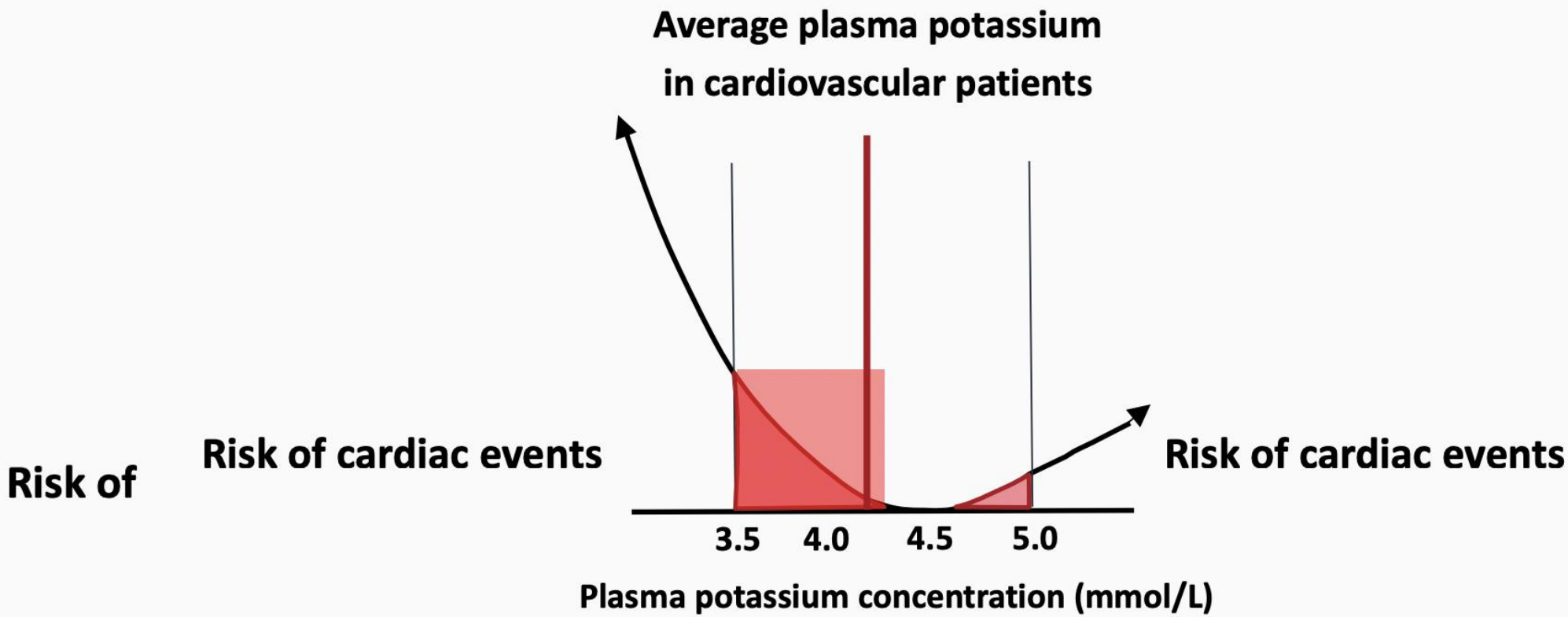
Christian Jons

The Heart Centre, Rigshospitalet, Copenhagen, Denmark

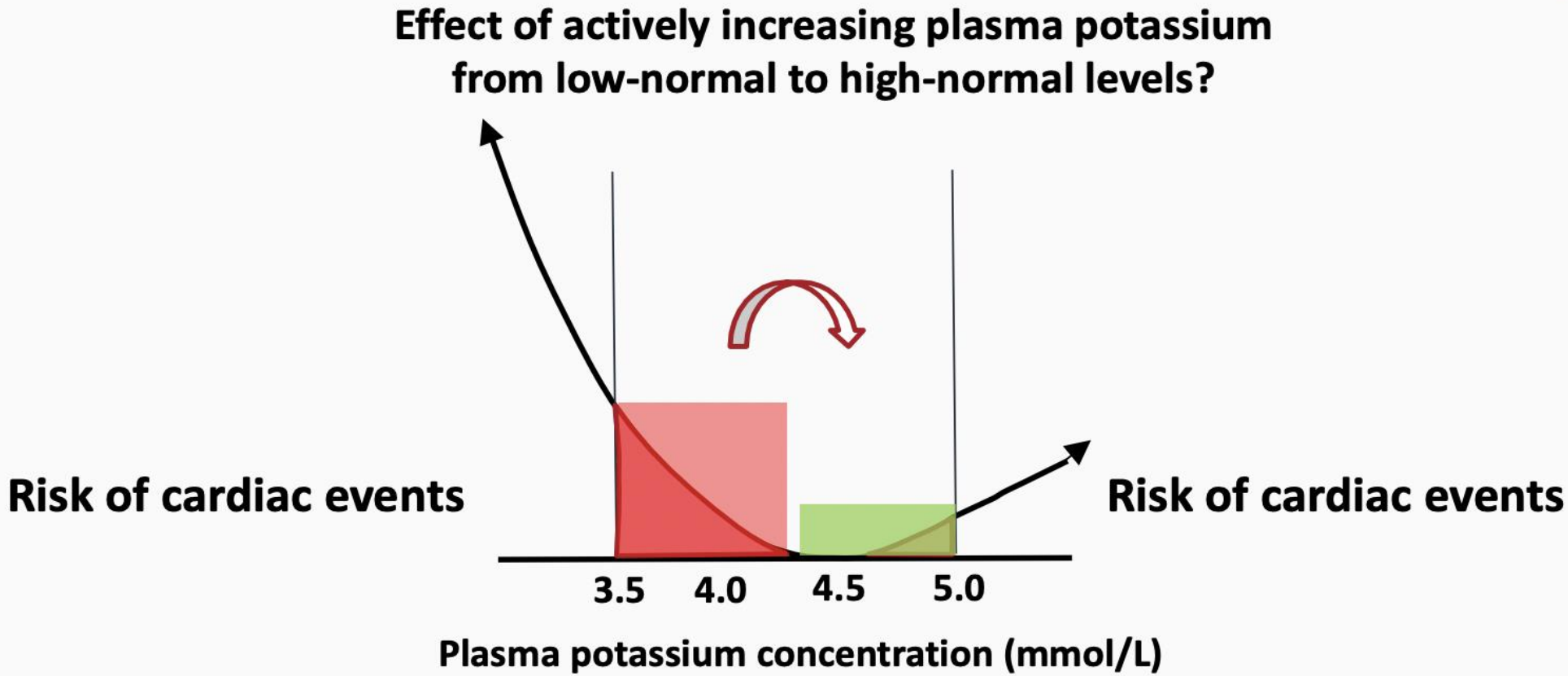
Background – The U-shaped risk



Backgr Background – The U-shaped risk



Background – The U-shaped risk



Study design

Inclusion criteria

- Plasma potassium ≤4.3 mmol/l
- Age ≥18 years
- ICD or CRT-D implanted

Exclusion criteria

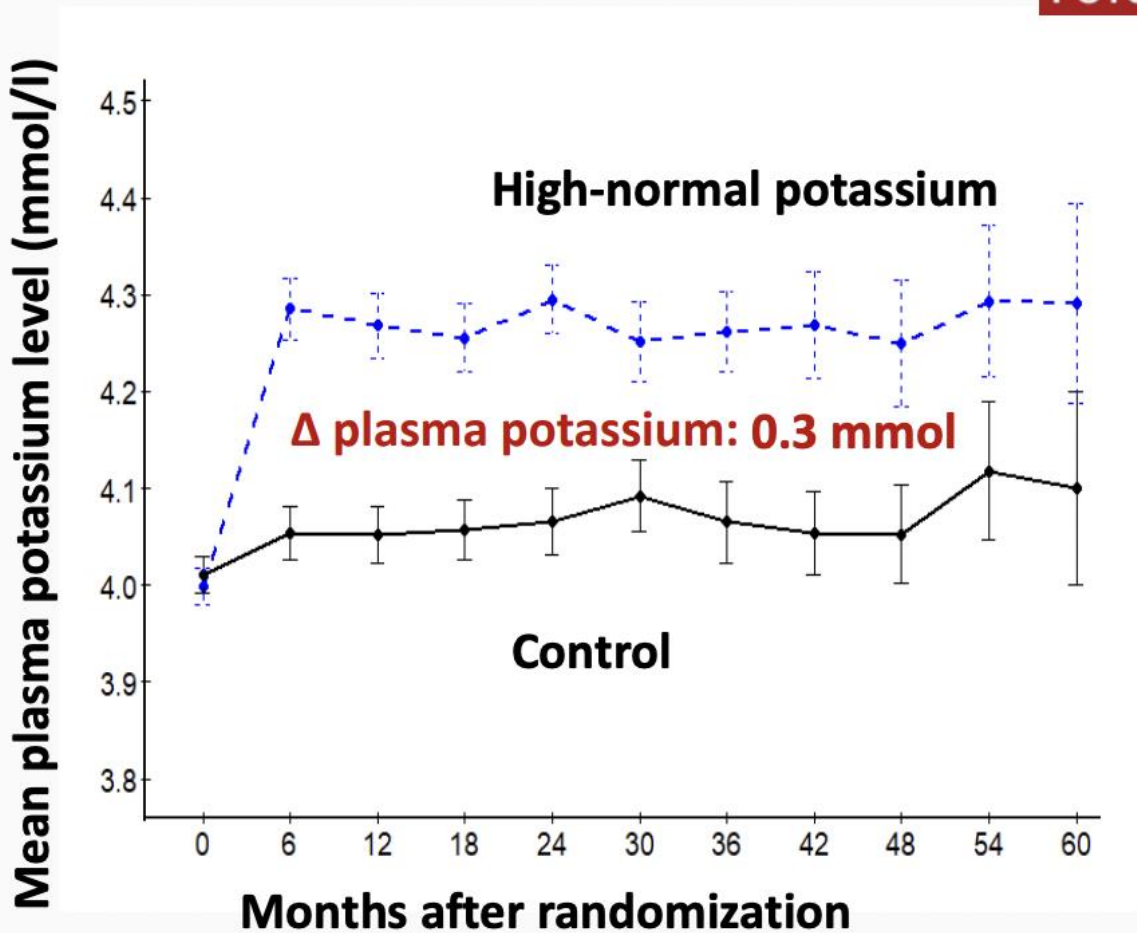
- Renal function: eGFR <30 ml/min/1.73m²
- Pregnancy
- Lack of ability to understand and sign consent

Plasma potassium uptitration

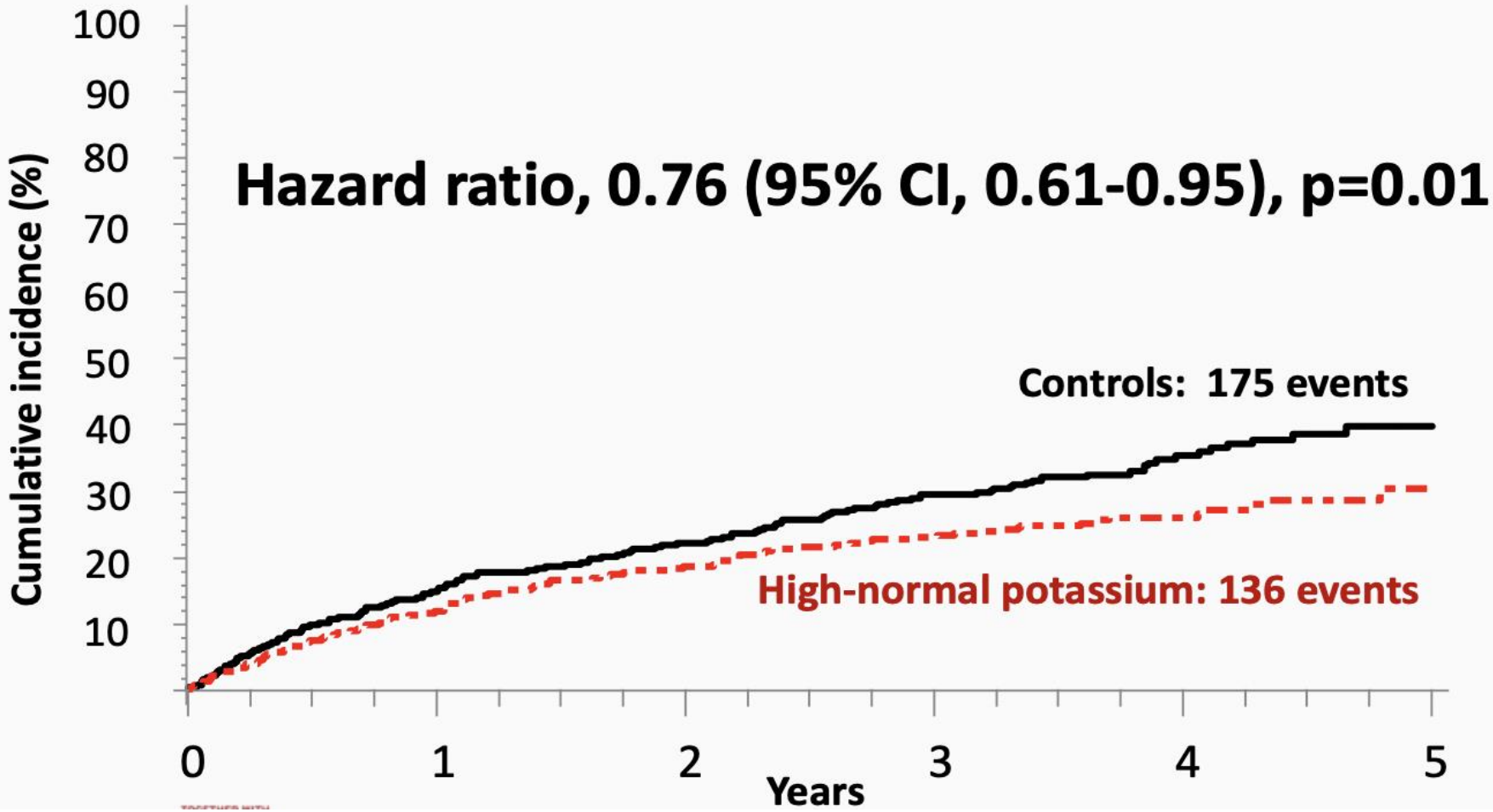
- Potassium-rich diet guidance
- Mineralocorticoid receptor antagonists
- Potassium supplements
- Potassium-losing diuretics reduced or stopped

Uptitration duration, mean 85 days

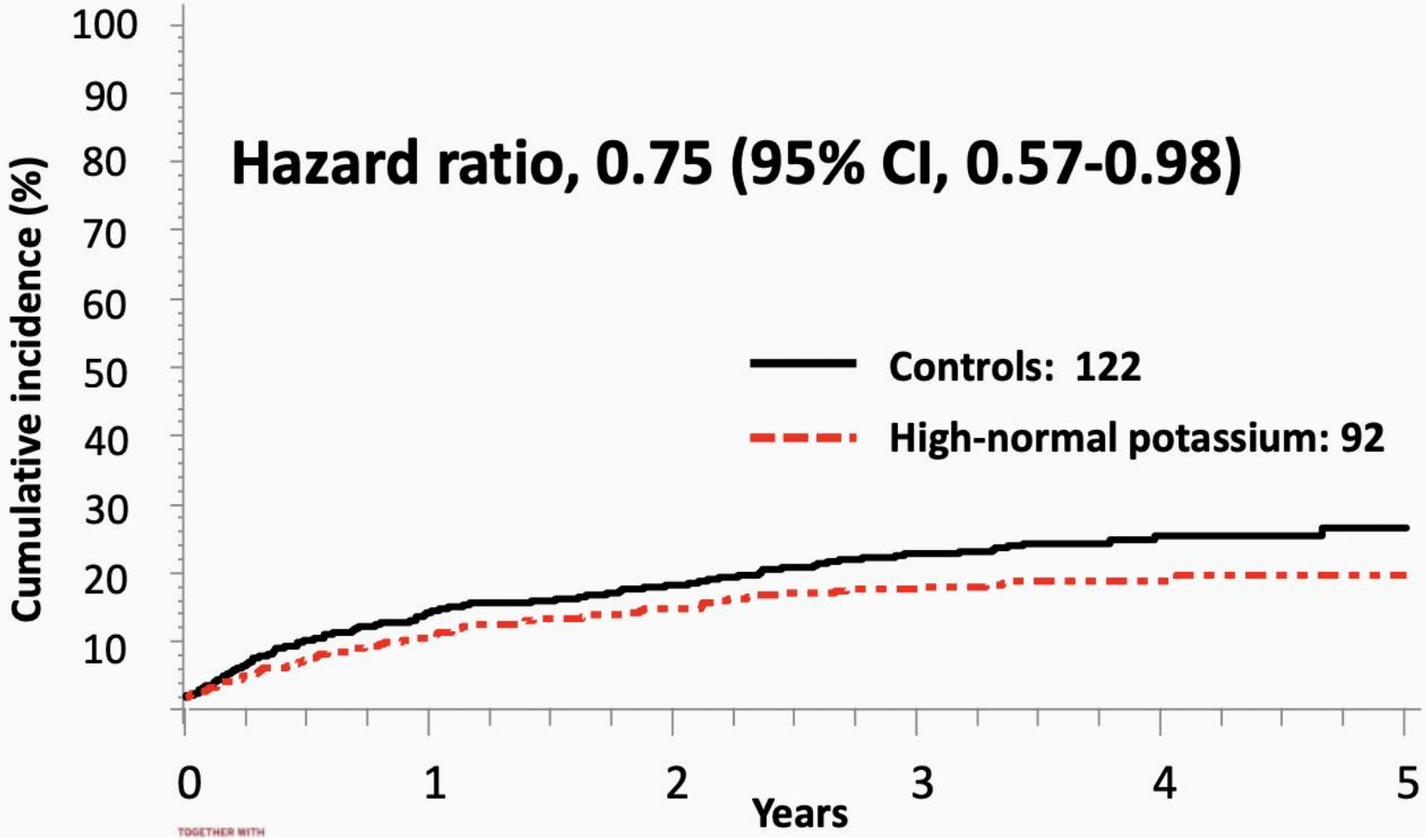
Plasma potassium increase ~ 0.3 mmol/L



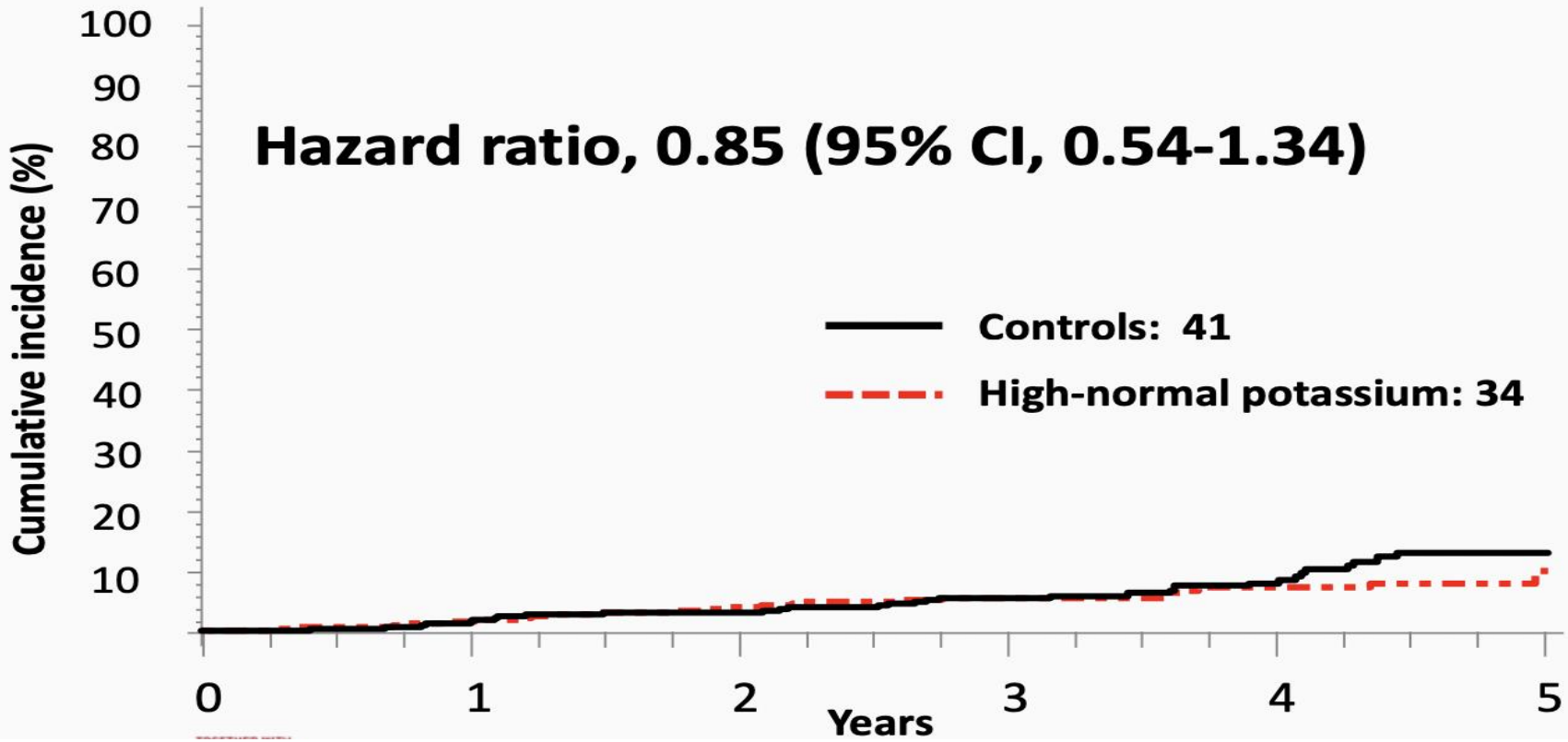
Composite end point



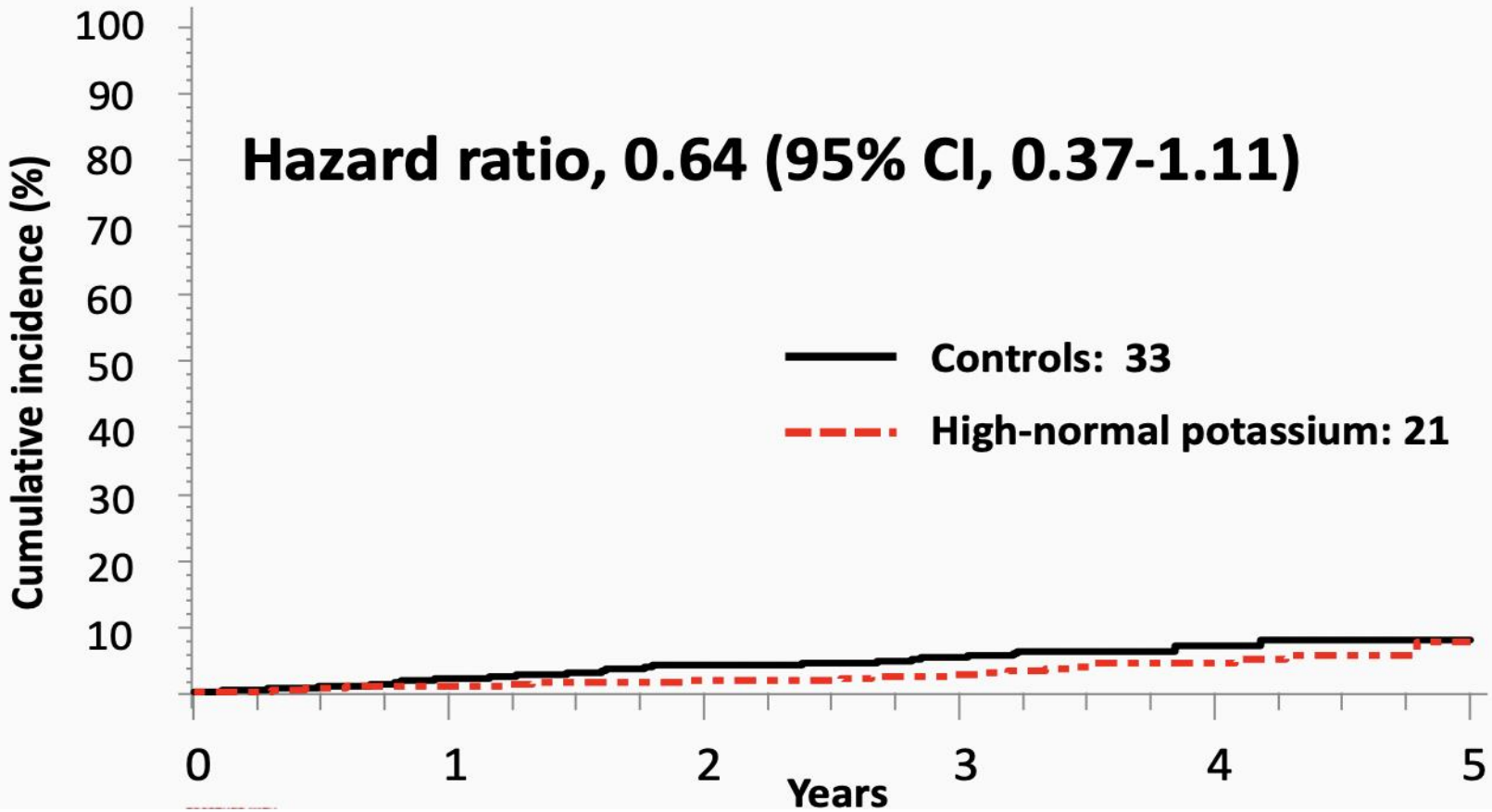
Appropriate ICD therapy or ECG-documented sustained VT



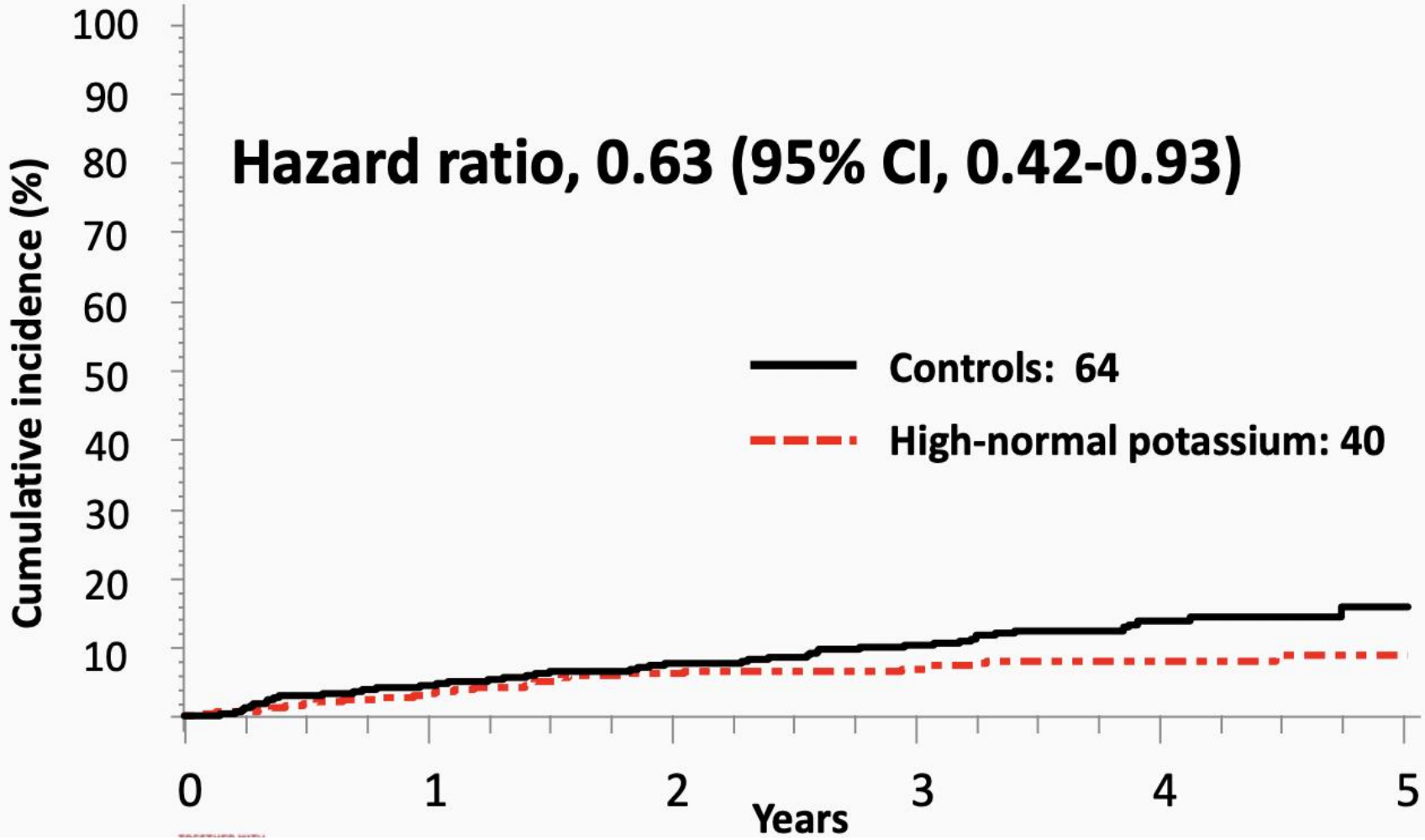
Death (All causes)



Heart failure hospitalization



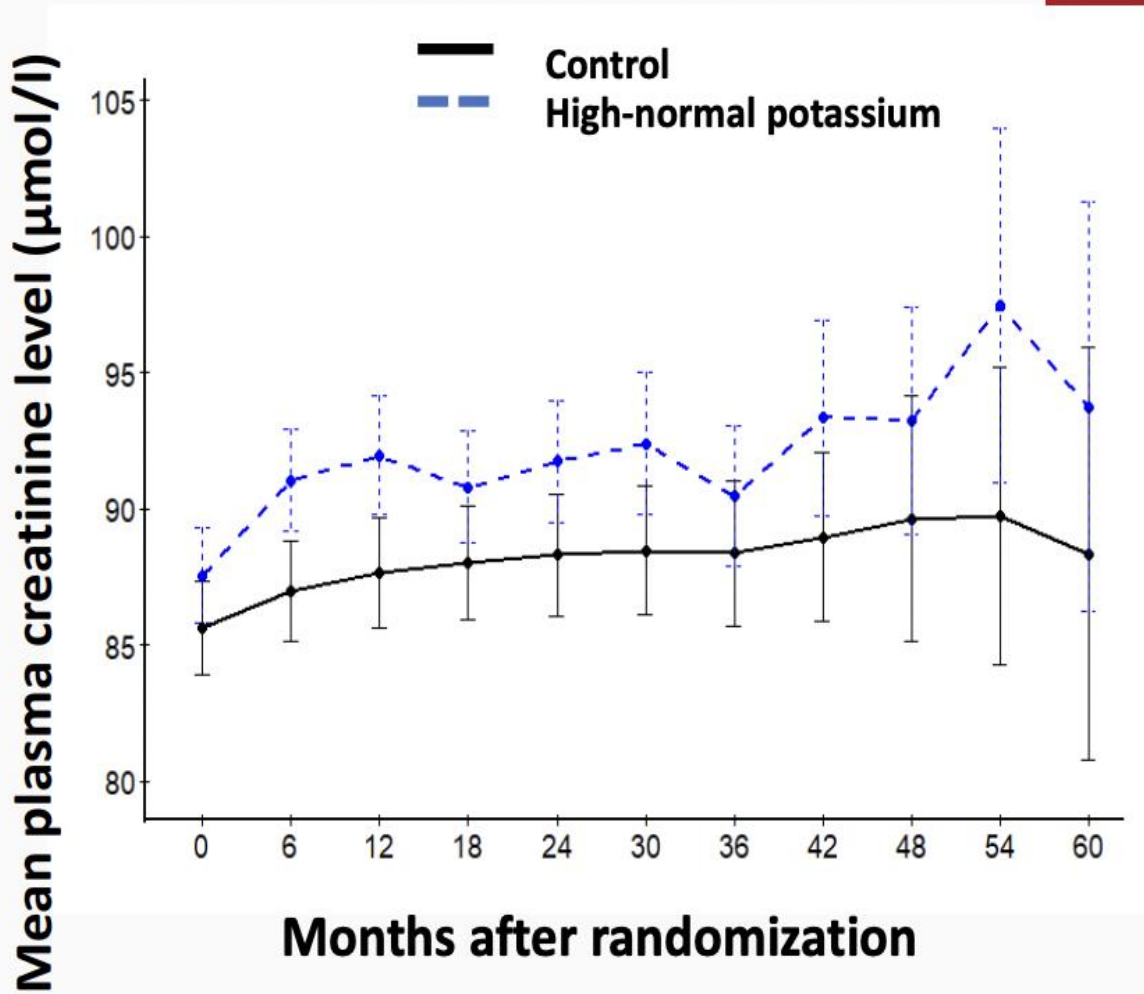
Arrhythmia hospitalization



Safety end points – Hospitalization for hypokalemia, hyperkalemia or renal failure

- No deaths related to intervention
- Plasma creatinine increased ~ 4 µmol/l in the high-normal potassium group
- High-normal potassium group:
  17 hospitalizations in 17 patients
- Control group:
  12 hospitalizations in 10 patients

HR, 1.75 (95% CI, 0.80 to 3.82), p=0.16



Conclusions

- The intervention increased plasma potassium levels by ~0.3 mmol/l - which was maintained for the duration of the trial
- The primary composite endpoint was reduced by 24% - mainly driven by ventricular arrhythmia
- No significant differences were seen in hospitalizations for renal failure and eletrolyte disturbances between the two groups

Conclusion : ESC 2025 ?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