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EDITORIAL



Highlights of Acta Cardiologica

This issue of Acta Cardiologica contains several and original articles dealing with risk stratification in heart failure (HF), the prevention of cardiovascular events by statins in myocardial infarction with non-obstructive coronary arteries, the impact of cardiac rehabilitation on left ventricular diastolic function after percutaneous coronary intervention, the role of advanced strain imaging in the assessment of atrial function and the risk of recurrence of atrial fibrillation (AF) after catheter ablation and the assessment of the importance of myocardial damage in the Behçet's disease.

HF with preserved ejection fraction (HFpEF) is a complex and heterogeneous syndrome characterised by multiple phenotypes, clinical presentations, and associated comorbidities (e.g. advanced age, hypertension, obesity, diabetes, dyslipidaemia, renal dysfunction, and AF) [1]. Until now, management of HFpEF has been limited to reduce symptoms and managing underlying conditions. The efficacy of sacubitril–valsartan in HFrEF ($r = \text{reduce}$) has been widely demonstrated, while its impact on HFpEF is controversial. Yuheng et al. in their analysis of four randomised studies using sacubitril–valsartan, found no net benefit (all-cause mortality, cardiovascular mortality, and the improvement in NYHA class) in favour of this treatment, with nevertheless a reduction in the number of hospitalisations compared with valsartan or individualised medical therapy [2].

Patients hospitalised for acute HF are at high risk for cardiovascular death and readmission. The acute HF index (AHFI) and Emergency Heart failure Mortality Risk Grade (EHMRG) have been recently developed to identify high-risk HF patients in the emergency department. These multivariable indexes comprise routinely collected clinical variables for evaluating the risk of morbidity and death for HF patients [3]. The combined use of the two risk models makes it possible to better stratify the risk of patients. Patients with high-risk AHFI and high-risk EHMRG groups had shorter survival times [4] (Figure 1).

MINOCA encompasses a heterogeneous group of conditions that include both atherosclerotic and non-atherosclerotic disease resulting in myocardial damage that is not due to obstructive coronary artery disease (CAD) [5]. As the pathophysiology is different, the role of medical treatment in the secondary prevention of MINOCA is less well standardised than in myocardial infarction secondary to an obstructive coronary lesion. In their meta-analysis, Masson et al. showed that in a population with MINOCA,

the use of statin therapy can be associated with a significant reduction of major cardiovascular events and mortality [6].

Diastolic dysfunction and CAD are intertwined. Exercise-based cardiac rehabilitation aimed to improve outcomes of patients with CAD. In their study, Bjelobrck et al. showed that following acute coronary syndrome treated with percutaneous coronary intervention, cardiac rehabilitation not only improved the overall prognosis but also reduced the degree of diastolic dysfunction [7].

Because of its recognised value, echocardiography has become established in guidelines for the management of AF and cardiomyopathies. In fact, echocardiography has a unique and important role in the assessment of cardiac structure and function, and risk stratification in these patients. Altogether, the reported meta-analysis of Anagnostopoulos et al. and the findings of Sunbul et al. underscored the additional prognostic value of strain imaging. The assessment of LA strain adds valuable information to conventional clinical risk scores and improves the prediction of the recurrence risk of AF after catheter ablation [8]. In Behçet's patients, left ventricular global longitudinal strain and LA conduit strain were significantly reduced compared to controls, and more so as

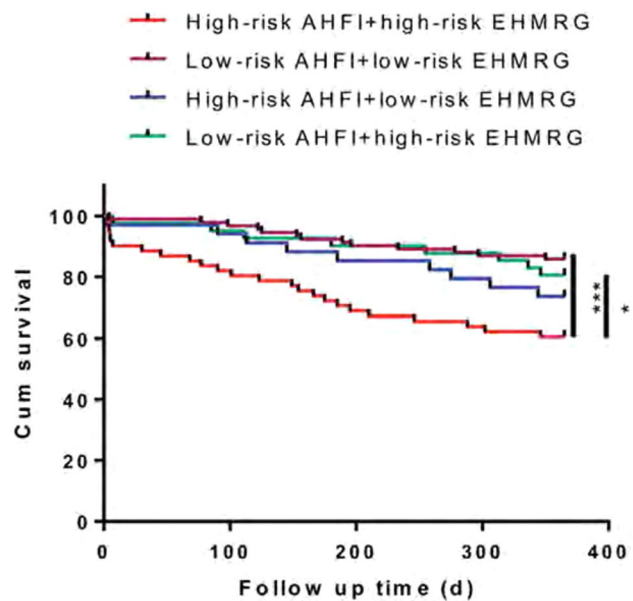


Figure 1. K–M curve for survival time in AHF patients with high/low AHFI/EHMRG. $p < 0.05$ and $p < 0.001$.

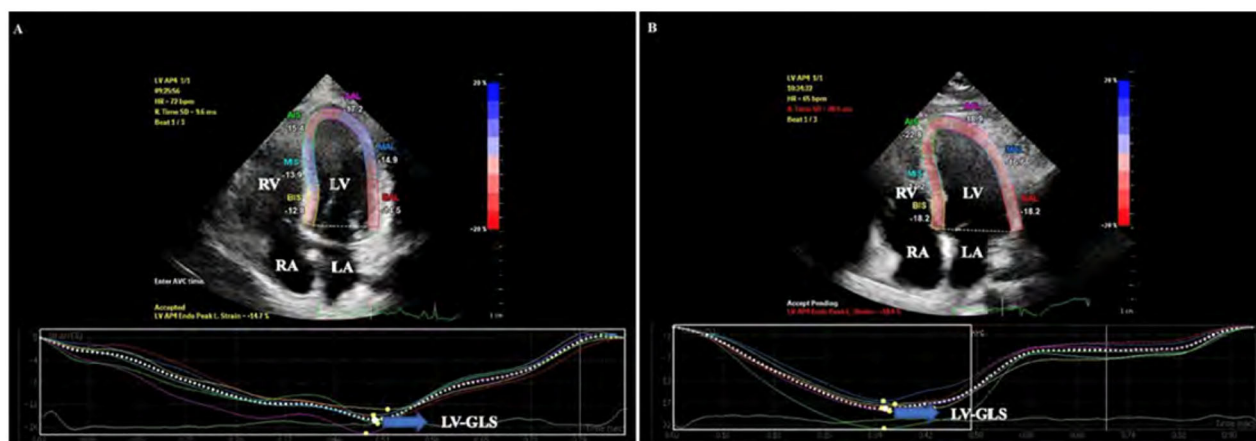


Figure 2. Left ventricular global longitudinal strain (LV-GLS) pattern in a patient with neuro-Behçet's disease (A) and control (B) (LV: left ventricular; RV: right ventricular; LA: left atrium; RA: right atrium).

there was neurological damage, suggesting a link between neurological manifestations and cardiac dysfunction (Figure 2) [9].

Disclosure statement

No potential conflict of interest was reported by the author(s).

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