ABSTRACTS
NVVC Najaarscongres
Donderdag 5 november
09.00 – 10.30 uur

SESSIE 1: Heart Failure

	Zaal: Athenezaal	Voorzitters: dr. Rosemarijn Jansen, Cardioloog St. Antonius Ziekenhuis Dr. Mira van der Naald, AIOS UMCU
1	09.00 - 09.10	**Healthcare Costs, Carbon Emissions and Workforce Implications of Device-Based Multisensory Monitoring in Heart Failure** *De heer Ugur Aslan, LUMC, Leiden*
2	09.11 - 09.21	**Prognostic Value of Plasma Mid-Regional Pro-Adrenomedullin Levels in Pulmonary Arterial Hypertension** *De heer Jop Schneijdenberg, Erasmus MC, Rotterdam*
3	09.22 - 09.32	**Prognostic Value of Low Serum Chloride Levels for 1-year Mortality and Rehospitalisation in Acute Heart Failure Patients** *De heer Kay van Erkel, Catharina Ziekenhuis, Eindhoven*
4	09.33 - 09.43	**Extensive evaluation of 55 non-genetic factors identifies increased BMI as a risk factor for myocarditis in desmoplakin cardiomyopathy** *De heer Arman Salavati, UMC Utrecht, Utrecht*
5	09.44 - 09.54	**Sodium-Glucose Cotransporter 2 Inhibitor Therapy and Heart Failure Outcomes in Systemic Right Ventricular Failure: Insights from the International ACHIEVE-SGLT2i Registry** *De heer Björn Westdorp, LUMC,Leiden*
6	09.55 - 10.05	**Diagnostic evaluation and recognition of HFpEF in routine clinical practice: A multicentre retrospective study** *Mevrouw Kirsten Buitenhuis, Erasmus MC, Rotterdam*
7	10.06 - 10.16	**Hypertrophic cardiomyopathy with the three Dutch founder variants in MYBPC3: a natural history** *De heer Eric Klaassen Barba, Erasmus MC, Rotterdam*
8	10.17 - 10.27	**Patient Preferences for the Organization of Hypertrophic Cardiomyopathy Care in the Netherlands: A Discrete Choice Experiment** *Mevrouw Raveena Mangal, Erasmus MC, Rotterdam*

Session 1: Heart Failure
Abstract 1

Healthcare Costs, Carbon Emissions and Workforce Implications of Device-Based Multisensory Monitoring in Heart Failure

Presenting author: U. Aslan
Department: Cardiology

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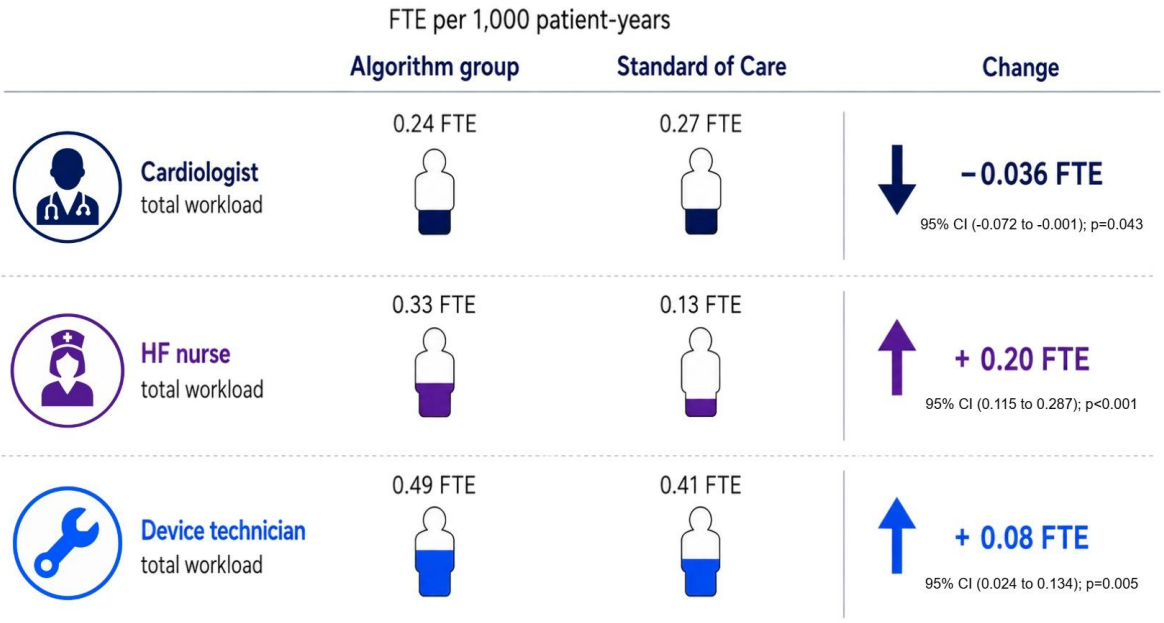
Purpose:
Multisensory monitoring using cardiac implantable electronic devices (CIEDs) may improve clinical outcomes in heart failure (HF), but its broader health system impact is uncertain. We evaluated HF-related healthcare costs, carbon emissions and outpatient workload of algorithm-guided monitoring compared with standard care.
Methods:
System-level analysis of a propensity score-matched cohort of 191 patient pairs with HF and a CIED, followed for 632 patient-years. Patients managed with HeartLogic or TriageHF within a structured care pathway were compared with standard care. Observed HF-related healthcare utilisation was translated into costs, carbon emissions and activity-based workload estimates for cardiologists, HF nurses and device technicians, using Dutch reference prices and published emission factors.
Results:
CIED-algorithm-guided HF monitoring reduced costs by €496 per patient-year (€860 vs €1,356; 95% CI, −€959 to −€107; p=0.009) and carbon emissions by 21.81 kg CO_2-equivalent (32.96 vs 54.76 kg; 95% CI, −45.82 to −2.14; p=0.029), mainly due to fewer hospitalisations and emergency department visits. Cardiologist was lower (rate ratio 0.869; p=0.043), whereas HF nurse and device technician were higher (rate ratios 2.534 and 1.190; both p=<0.005). Per 1,000 patients annually, this corresponded to 0.03 fewer cardiologist and 0.20 and 0.08 additional HF nurse and device technician full-time equivalents.
Conclusion:
Algorithm-guided CIED monitoring was associated with lower HF-related healthcare costs and carbon emissions while shifting outpatient care towards nurse-led remote management. These results warrant prospective multicentre confirmation to guide workforce planning and reimbursement.

Keywords:
heart failure, remote monitoring, sustainability

Figure:
Algorithm-guided monitoring was associated with lower cardiologist workload and higher HF nurse and remote device monitoring workload, reflecting a shift toward remote and nurse-led care pathways. Workload is presented as FTE per 1000 patient-year. 1 FTE represents 1872 hours.
FTE: Full time equivalent; HF: Heart Failure



Session 1: Heart Failure
Abstract 2

Prognostic Value of Plasma Mid-Regional Pro-Adrenomedullin Levels in Pulmonary Arterial Hypertension.

Presenting author: J.W. Schneijdenberg
Department: Cardiology

J.W. Schneijdenberg (Erasmus MC, Rotterdam); A.E. van den Bosch (Erasmus MC, Rotterdam); J.Y. Vis (Erasmus MC, Rotterdam); K.A. Boomars (Erasmus MC, Rotterdam)

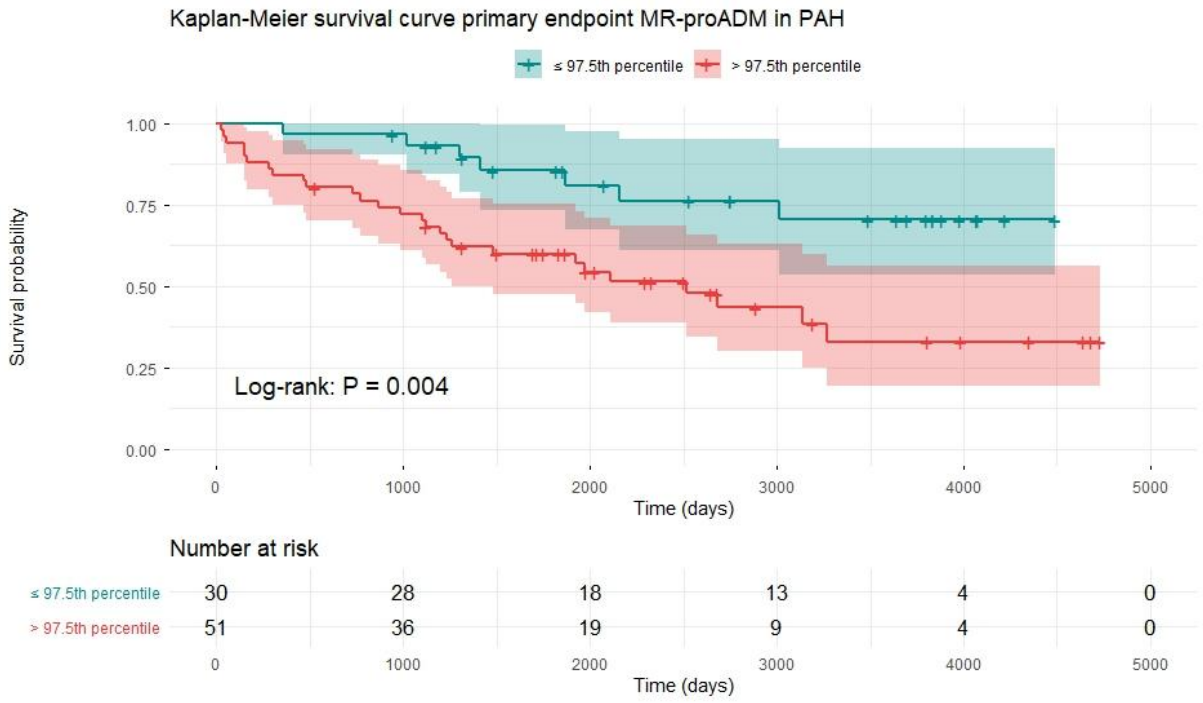
Purpose:
In pulmonary arterial hypertension (PAH), accurate risk stratification is vital for treatment planning and timely therapeutic escalation. Circulating biomarkers play an important role in risk assessment. Mid-regional pro-adrenomedullin (MR-proADM), a stable surrogate of adrenomedullin, has emerged as novel biomarker due to its vasoactive and vasodilatory properties. This study evaluates the prognostic value of MR-proADM for transplant-free survival in PAH patients.
Methods:
Blood samples were obtained from treatment-naïve PAH patients between September 2012 and July 2023. MR-proADM concentrations were measured in EDTA-plasma using an immunofluorescent assay (MR-proADM KRYPTOR, BRAHMS GmbH, Hennigsdorf). The primary endpoint was death or lung transplantation. Kaplan-Meier analysis and log-rank testing compared outcomes between patients with normal and elevated MR-proADM levels, defined as values above the 97.5th percentile in healthy controls (1). Associations between MR-proADM and the primary endpoint were investigated using Cox-proportional hazards models adjusted for age and NT-proBNP.
Results:
MR-proADM was measured in 81 PAH patients (age 57 [42 – 67] years; 75% female). During a follow-up of 5.1 [3.1 – 8.6] years, 34 patients reached the primary endpoint. Patients with elevated baseline MR-proADM showed a significantly higher risk of reaching the primary endpoint (Figure 1, P=0.004). MR-proADM was significantly associated with the primary endpoint (HR per 1 nmol/L increase 1.71, 95% CI 1.31-2.22; P<0.001), even after adjustment for age and NT-pro-BNP (HR per 1 nmol/L increase 1.61, 95% CI 1.12-2.32; P=0.011).
Conclusion:
Elevated baseline MR-proADM is associated with poorer transplant-free survival in PAH and adds prognostic information independent of age and NT-proBNP. MR-proADM may therefore improve risk stratification in PAH.

Keywords:
Mid-regional pro-adrenomedullin, Pulmonary arterial hypertension, Biomarker

Figure:
Figure 1: Kaplan-Meier curves of transplant-free survival in PAH patients with normal or elevated MR-proADM levels. Elevated MR-proADM was defined as >0.64 nmol/L based on the 97.5th percentile in healthy controls (1). MR-proADM: mid-regional pro-adrenomedullin; PAH: pulmonary arterial hypertension.

Reference:

(1) Smith JG, Newton-Cheh C, Hedblad B, Struck J, Morgenthaler NG, Bergmann A, Wang TJ, Melander O. Distribution and correlates of midregional proadrenomedullin in the general population. Clin Chem. 2009 Aug;55(8):1593-5. doi: 10.1373/clinchem.2009.126482. Epub 2009 Jun 18. PMID: 19541860.



Session 1: Heart Failure
Abstract 3

Prognostic Value of Low Serum Chloride Levels for 1-year Mortality and Rehospitalisation in Acute Heart Failure Patients

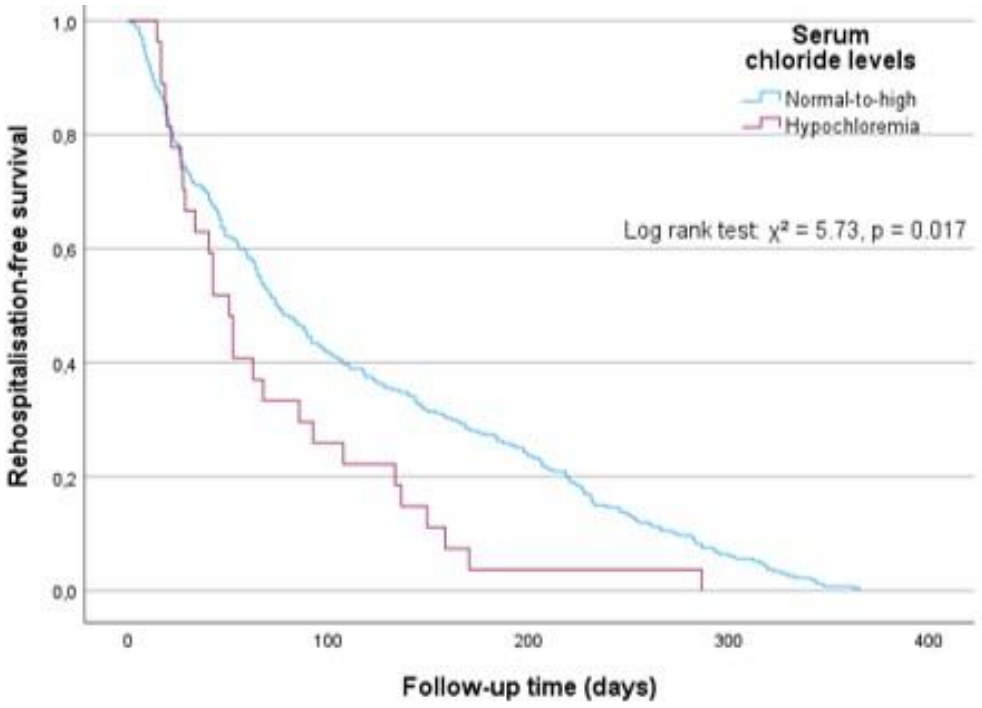
Presenting author: K. J. van Erkel
Department: Heart center

K. J. van Erkel (Catharina Ziekenhuis, Eindhoven); M. G. Rurup (Catharina Ziekenhuis, Eindhoven); K. Smulders (Catharina Ziekenhuis, Eindhoven); R. Tio (Catharina Ziekenhuis, Eindhoven); S. H. B. van Dijk (Catharina Ziekenhuis, Eindhoven); M. A. Soliman-Hamad (Catharina Ziekenhuis, Eindhoven)

Purpose:
Heart failure (HF) is a growing global health concern, with acute decompensated heart failure (AHF) being the leading cause of hospitalisation in older patients. Despite decongestive therapy, mortality and rehospitalization remain high, underscoring the need for improved risk stratification. Chloride plays a key role in fluid homeostasis, and hypochloremia may impair renal function and induce diuretic resistance, potentially worsening outcomes. This study investigates whether low chloride levels in hospitalised AHF patients are associated with increased 1-year mortality and rehospitalization.
Methods:
This retrospective observational study included 1391 AHF patients admitted to the Catharina Hospital Eindhoven between 2017 and 2022. Patients were classified as hypochloremic (<96 mM) or non hypochloremic based on chloride levels at admission. Kaplan Meier and Cox regression analyses assessed associations with 1 year mortality and rehospitalisation, adjusting for relevant covariates. A Fine Gray model accounted for mortality as a competing event in the time-to-rehospitalization analysis.
Results:
Of all patients, 10.0% (n=139) presented with hypochloremia. Hypochloremia was independently associated with higher 1 year mortality (HR 1.768, 95% CI 1.818-2.646, p=0.006) and increased rehospitalisation risk in both Cox regression (HR 1.738, 95% CI 1.109-2.726, p=0.016) and competing risk analysis (SHR 1.731, 95% CI 1.241-2.436, p=0.001). Rehospitalised patients with hypochloremia were readmitted significantly earlier (p=0.017).
Conclusion:
Hypochloremia at admission is independently associated with increased 1 year mortality and rehospitalisation in AHF patients. As an inexpensive, routinely measured parameter, serum chloride may be a useful biomarker for rehospitalization and mortality risk stratification. Prospective studies should evaluate whether chloride guided treatment strategies can improve outcomes.

Keywords:
Hypochloremia, Heart failure, Rehospitalisation

Figure:
Kaplan-Meier curve of time to rehospitalisation among patients rehospitalised within one year following an admission for acute heart failure, stratified by serum chloride levels at admission. Patients with hypochloremia were rehospitalised significantly earlier than those with normal-to-high chloride levels (log-rank test: $\chi^2 = 5.73$, $p = 0.017$).



Session 1: Heart Failure
Abstract 4

Extensive evaluation of 55 non-genetic factors identifies increased BMI as a risk factor for myocarditis in desmoplakin cardiomyopathy

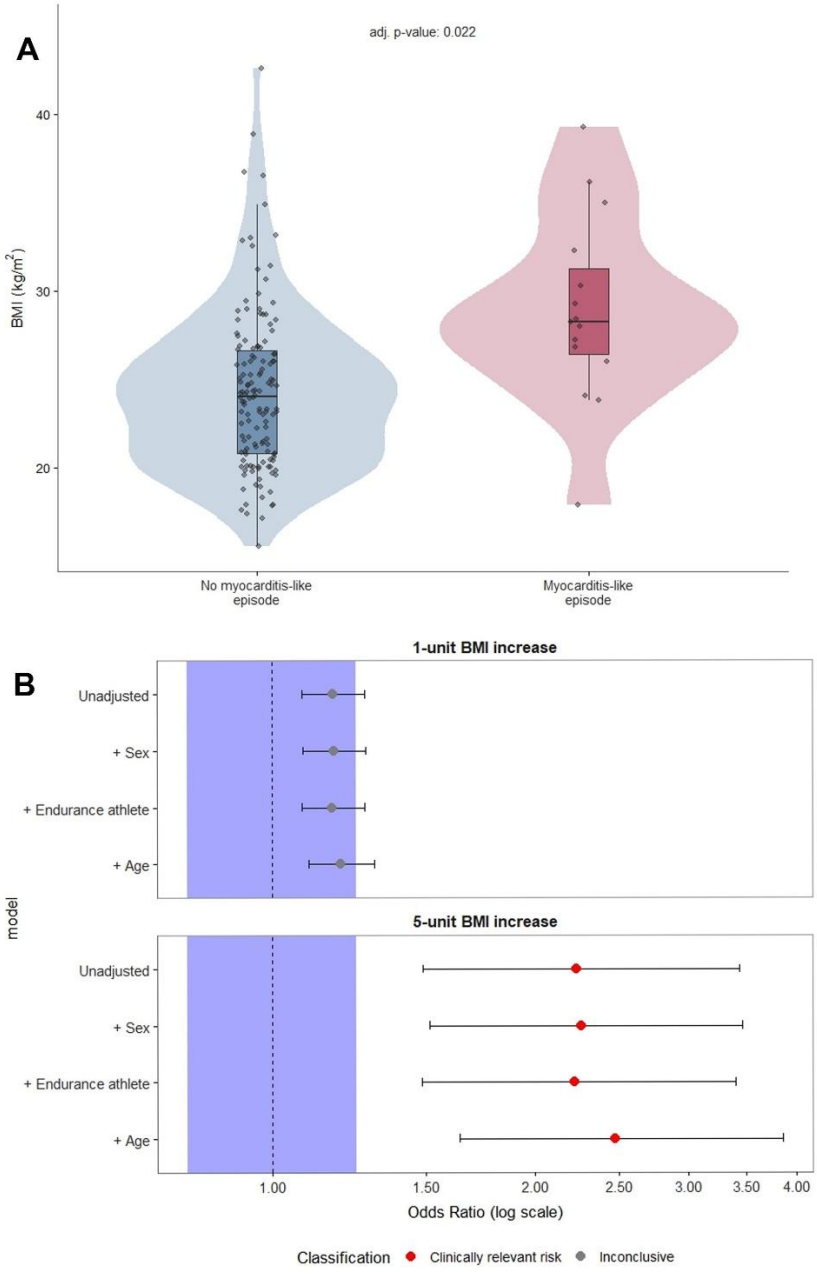
Presenting author: A. Salavati
Department: Cardiology

A. Salavati (University Medical Center Utrecht, Utrecht); J.A.C. Straatsma (University Medical Center Utrecht, Utrecht), N. Pronk (University Medical Center Utrecht, Utrecht), R. Gharehbeiklou (University Medical Center Utrecht, Utrecht), A.C. Houweling (Amsterdam University Medical Center, Amsterdam), A.S. Amin (Amsterdam University Medical Center, Amsterdam), M. van den Boogaard (Amsterdam University Medical Center, Amsterdam), J.A.J. Verdonschot (Maastricht University Medical Center+, Maastricht), N.J. Beelen (Maastricht University Medical Center+, Maastricht), J.M.A. Verhagen (Erasmus MC University Medical Center Rotterdam, Rotterdam), S.C. Yap (Erasmus MC University Medical Center Rotterdam, Rotterdam), I. Christiaans (University Medical Center Groningen, Groningen), M.G.P.J. Cox (University Medical Center Groningen, Groningen), P. Van der Harst (University Medical Center Groningen, Groningen), J.P. van Tintelen (University Medical Center Utrecht, Utrecht), J. van Setten (University Medical Center Utrecht, Utrecht), A.S.J.M. te Riele (University Medical Center Utrecht, Utrecht)

Purpose:
Desmoplakin (DSP) cardiomyopathy carries a relatively high risk of heart failure (HF), sustained ventricular arrhythmia (VA) and myocarditis. However, disease severity varies highly and remains largely unexplained beyond two known risk factors (i.e. female sex and endurance athlete status). This study aimed to identify novel non-genetic factors for disease severity in DSP cardiomyopathy.
Methods:
We included adult DSP (likely) pathogenic (LP/P) variant carriers from five tertiary hospitals in the Netherlands who completed a structured telephone interview on 55 lifestyle, environmental and female-specific non-genetic factors. Associations between non-genetic factors and HF, sustained VA and myocarditis were studied through Firth's penalized logistic regression corrected for sex, age or endurance athlete status. P-values were Bonferroni corrected on the number of principal components explaining 90% of variance.
Results:
A total of 153 DSP LP/P variant carriers (proband: n=51 (33.3%); female: n=94 (61.4%); age 44.1 yrs [29.2-56.0]) were included. Individuals with myocarditis (n=15, 9.8%) had a significantly higher BMI than individuals without myocarditis (28.3 kg/m2 [26.4-31.3] vs. 24.0 kg/m2 [20.8-26.6]; p=0.022). A 5-unit increase in BMI was associated with a 2.2-2.5 fold increase in myocarditis across adjusted regression models (all p=0.001), see Figure. The Youden-optimal cutoff for BMI and myocarditis was 26.8 kg/m2 (sensitivity: 0.73, specificity: 0.78). None of the other non-genetic factors were associated with any of the primary endpoints.
Conclusion:
Increased BMI is a potential novel risk factor for myocarditis in DSP cardiomyopathy. Future research should validate these findings and investigate whether BMI-lowering interventions prevent myocarditis episodes in DSP LP/P variant carriers.

Keywords:
Desmoplakin cardiomyopathy, Arrhythmogenic right ventricular cardiomyopathy, Myocarditis

Figure:
Figure – Panel A: violin plot depicting association between body mass index (BMI) and occurrence of myocarditis. Panel B: forest plot with equivalence bounds at odds ratio 0.80-1.25 for results from Firth's penalized logistic regression for body mass index (BMI) and myocarditis across unadjusted models and adjusted models for either sex, endurance athlete status or age for 1kg/m2 and 5 kg/m2 unit BMI increases.



ABSTRACTS
NVVC Najaarscongres
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Session 1: Heart Failure
Abstract 5

Sodium-Glucose Cotransporter 2 Inhibitor Therapy and Heart Failure Outcomes in Systemic Right Ventricular Failure: Insights from the International ACHIEVE-SGLT2i Registry

Presenting author: B.N. Westdorp
Department: Hartziekten

B.N. Westdorp; B.N. Westdorp (Leiden University Medical Center, Leiden); A.M. Tebbens (Leiden University Medical Center, Leiden); R.M.L. Neijenhuis (Leiden University Medical Center, Leiden); R. Mazurek (Mount Sinai Fuster Heart Hospital, New York, New York); G. Torres-Viera (Nemours Childrens Health, Wilmington, Delaware); A.M. Cedars (Johns Hopkins University, Baltimore, Maryland); A.N. Zaidi (Mount Sinai Fuster Heart Hospital, New York, New York); S.T. MacDonald (University Hospital of Wales, Cardiff); N.L. Walker (Golden Jubilee University National Hospital, Glasgow); F. Zemrak (Barts Health NHS Trust, London); M. Klincheva (Zan Mitrev Clinic, Skopje); H.B. van der Zwaan (University Medical Center Utrecht, Utrecht); L. Bosch (University Medical Center Utrecht, Utrecht); B.J. Bouma (Amsterdam University Medical Center, Amsterdam); P. Kiès (Leiden University Medical Center, Leiden); N.C. Weber (Amsterdam University Medical Center, Amsterdam); J.W. Jukema (Leiden University Medical Center, Leiden); M.R.M. Jongbloed (Leiden University Medical Center, Leiden); G.R. Veldtman (Helen DeVos Children's Hospital, Grand Rapids, Michigan); E.L. Fu (Leiden University Medical Center, Leiden); A.D. Egorova (Leiden University Medical Center, Leiden)

Purpose:
Sodium-Glucose Cotransporter 2 Inhibitor (SGLT2i) therapy is an established pillar in the management of left ventricular heart failure. Evidence on its clinical impact in adult congenital heart disease patients with a systemic right ventricle is limited.
Methods:
Adult congenital heart disease patients from nine centers initiating SGLT2i therapy were enrolled in the ACHIEVE-SGLT2i registry (NCT06932081); data from those with a systemic right ventricle and heart failure were analyzed. The primary outcome was the change in heart failure events; longitudinal NT-proBNP levels, echocardiographic parameters, and safety were assessed.
Results:
A total of 104 patients with a systemic right ventricle were included (mean age 47 years, 37% female); 61% transposition of the great arteries (TGA) after atrial switch and 39% congenitally corrected TGA. Median follow-up was 398 days [IQR 190-719]. Comparing 12 months post- and pre-initiation periods, heart failure event rates reduced by 74% (IRR 0.26, 95% CI 0.08 to 0.93, p = 0.038). NT-proBNP levels decreased by 22% (95% CI 5% to 35%, p = 0.013) within 100 days, with apparent stabilization afterwards. A 2.4-fold higher odds of improved systolic right ventricular function was observed after initiation (OR 2.39, 95% CI 0.93 to 6.15, p = 0.07), although non-significant. Ten patients (10%) reported side effects; 7 (7%) discontinued therapy.

Conclusion:
SGLT2i therapy appears safe and well tolerated. Initiation was associated with lower heart failure event rates and reduced NT-proBNP levels within the first 100 days. These findings support a role for SGLT2i in this population and warrant further evaluation of its effectiveness.

Keywords:
Sodium-Glucose Cotransporter 2 Inhibitors, adult congenital heart disease, heart failure

ABSTRACTS
NVVC Najaarscongres
Donderdag 5 november
09.00 – 10.30 uur

Session 1: Heart Failure
Abstract 6

Diagnostic evaluation and recognition of HFpEF in routine clinical practice: A multicentre retrospective study

Presenting author: K. Buitenhuis
Department: Cardiology

K. Buitenhuis (Erasmus MC, Rotterdam); S. Sanders-van Wijk (Zuyderland Medisch Centrum, Sittard/Heerlen); S. Koudstaal (Groene Hart Ziekenhuis, Gouda); A. Schut (WCN, Utrecht); N. Ourahou (Amphia Ziekenhuis, Breda); T. van den Berg (Zuyderland Medisch Centrum, Sittard/Heerlen); M. Varwijk (Zuyderland Medisch Centrum, Sittard/Heerlen); J.J. Brugts (Erasmus MC, Rotterdam); J. Schaap (Amphia Ziekenhuis, Breda)

Purpose:
Heart failure (HF) with preserved ejection fraction (HFpEF) accounts for approximately half of all heart failure cases worldwide, with a prevalence that continues to increase. However, HFpEF often remains unrecognised in clinical practice, reflecting its heterogeneous presentation and the challenges of establishing a definitive diagnosis. To support clinicians in estimating the likelihood of HFpEF, several diagnostic likelihood scores, such as H2FpEF, have been proposed. However, little is known about the availability of diagnostic parameters and the use of these tools in routine clinical practice. This retrospective study aimed to evaluate the prevalence of a probable HFpEF diagnosis according to the H2FpEF-score in patients with a primary referral to the outpatient cardiology clinic for HF-like symptoms.
Methods:
We conducted a retrospective cohort study, in 306 patients with HF-like symptoms (e.g. dyspnoea, oedema, and/or fatigue) without a prior history of heart failure, referred for a first evaluation to the outpatient clinic from three Dutch general hospitals during February 2024 until August 2025. In none of these hospitals a HFpEF likelihood score is part of routine clinical care. We recorded the cardiologists (differential) diagnosis at 2-6 months after referral and used a H2FpEF-score ≥6 as the reference standard for HFpEF. For the analysis, only patients with an available echocardiogram were included (n=280, 81.5%).
Results:
Among patients with preserved left ventricle ejection fraction (≥50%) and no severe valvular disease (n=179, 58.5%), the cohort showed a high prevalence of HFpEF risk factors: age >60 years (n=163, 91.1%) female sex (n=104, 58.1%) and BMI >30 kg/m2 (n=57, 37.7%). NT-proBNP was elevated (>125 pg/mL) in 69.3% (n=125). In 78.2% (n=140) of cases, an H2FpEF score could be calculated, of whom 51 (36.4%) had a score ≥5 and 28 (20%) had a score ≥6, representing a moderate (≥84%) and high (≥91%) probability of HFpEF, respectively. HFpEF was included in the differential diagnosis in 24.6%. Sensitivity and specificity of the physician's clinical (differential) diagnosis of HFpEF were 53.6% and 87.5% respectively.

Conclusion:
These real-world findings demonstrate that HFpEF is under-recognised in symptomatic patients despite a high likelihood of the condition according to the H2FpEF-score. The observed gap between likelihood-based assessment and clinical diagnosis support the rationale for the implementation of H2FpEF-likelihood scores in routine clinical practice and the prospective evaluation of the impact thereof in the identification of patients with HFpEF.

Keywords:
HFpEF, Diagnosis, Risk scores

Session 1: Heart Failure
Abstract 7

Hypertrophic cardiomyopathy with the three Dutch founder variants in MYBPC3: a natural history

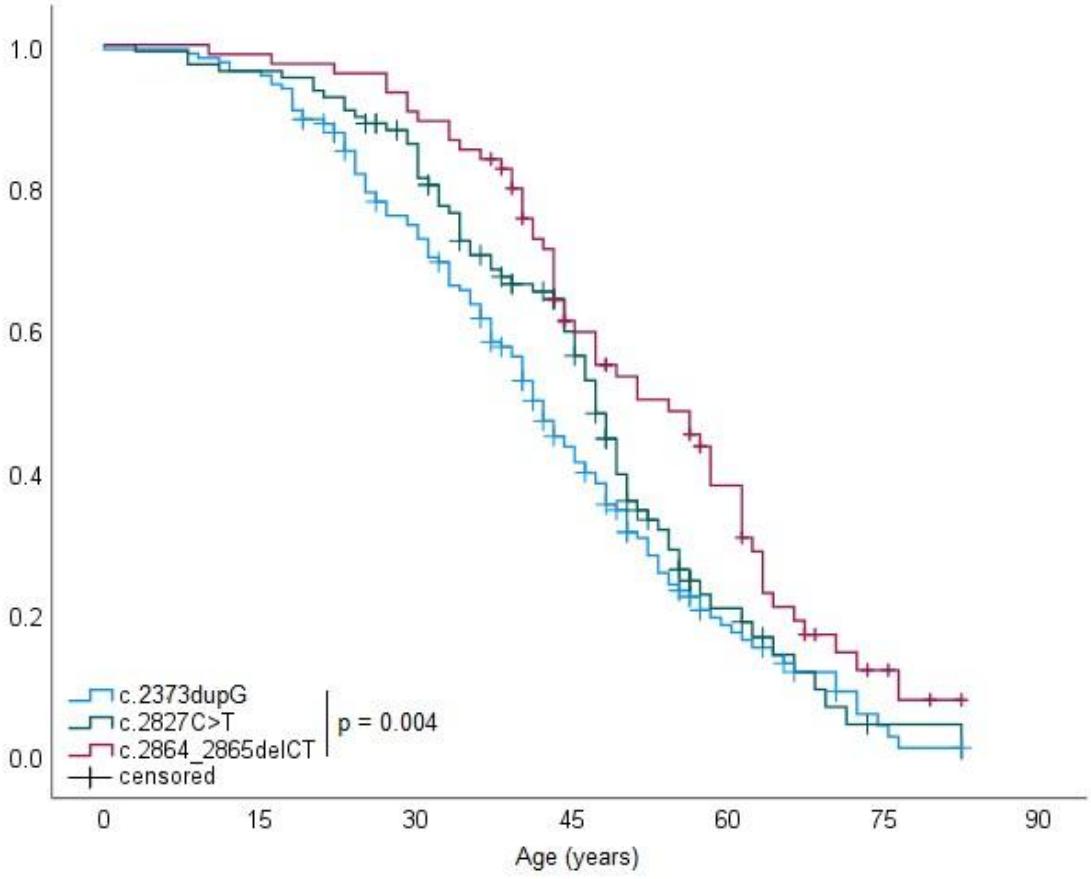
Presenting author: E. Klaassen Barba
Department: Cardiology

S.A.C. Schoonvelde (Erasmus MC); S.A.C. Schoonvelde (Erasmus MC, Rotterdam); E. Klaassen Barba (Erasmus MC, Rotterdam); PP. Zwetsloot (Erasmus MC, Rotterdam); A.F.L. Schinkel (Erasmus MC, Rotterdam); M.A. van Slegtenhorst (Erasmus MC, Rotterdam); J.M.A. Verhagen (Erasmus MC, Rotterdam); A. Hirsch (Erasmus MC, Rotterdam); R.A. de Boer (Erasmus MC, Rotterdam); M. Michels (Erasmus MC, Rotterdam)

Purpose:
Hypertrophic cardiomyopathy (HCM) is a common inherited cardiac disease with variable presentations. Three Dutch founder truncating MYBPC3 variants (c.2373dupG, c.2827C>T, and c.2864_2865delCT) account for most genotype-positive HCM in the Netherlands. Understanding their natural history may help guide management.
Methods:
In this retrospective study conducted at a tertiary referral center, carriers of one of these variants were included. HCM was diagnosed if wall thickness ≥13 mm; other carriers were classified as genotype-positive/phenotype-negative (G+/P-). Baseline and longitudinal echocardiographic data and clinical outcomes were used to construct a composite variable for clinical progression. Binary logistic regression assessed associations between variables of interest and clinical progression.
Results:
We identified 271 HCM patients (mean age 41±16 years, 63% male) and 84 G+/P- individuals (mean age 38±20 years, 35% male), over a median 10-year follow-up. Baseline characteristics were similar across the three MYBPC3 founder variants, except for older age at diagnosis in c.2864_2865delCT carriers (47 vs 38 and 41 years; $p<0.002$), as confirmed by penetrance analysis. All-cause mortality, heart transplantation and septal reduction therapy rates were similar among variants. Clinical progression occurred in 130 patient (48%), more often in females (57% vs 43%, $p=0.03$) and was associated with baseline LVOT obstruction (OR 3.4, 95% CI 1.7–6.7, $p<0.001$). Among G+/P− individuals, 8% developed overt HCM, with no variant-specific differences.
Conclusion:
The three Dutch MYBPC3 founder variants show comparable long-term disease courses, though c.2864_2865delCT is associated with later diagnosis. Baseline LVOT obstruction is strongly associated with clinical progression, and progression from G+/P− to overt HCM is uncommon.

Keywords:
Hypetrophic cardiomyopathy, Cardiogenetics, Natural history

Figure:
Kaplan-Meier penetrance curves illustrating the cumulative incidence of hypertrophic cardiomyopathy diagnosis among individuals carrying one of the three Dutch founder variants of the cardiac myosin-binding protein C gene (MYBPC3).



Session 1: Heart Failure
Abstract 8

Patient Preferences for the Organization of Hypertrophic Cardiomyopathy Care in the Netherlands: A Discrete Choice Experiment

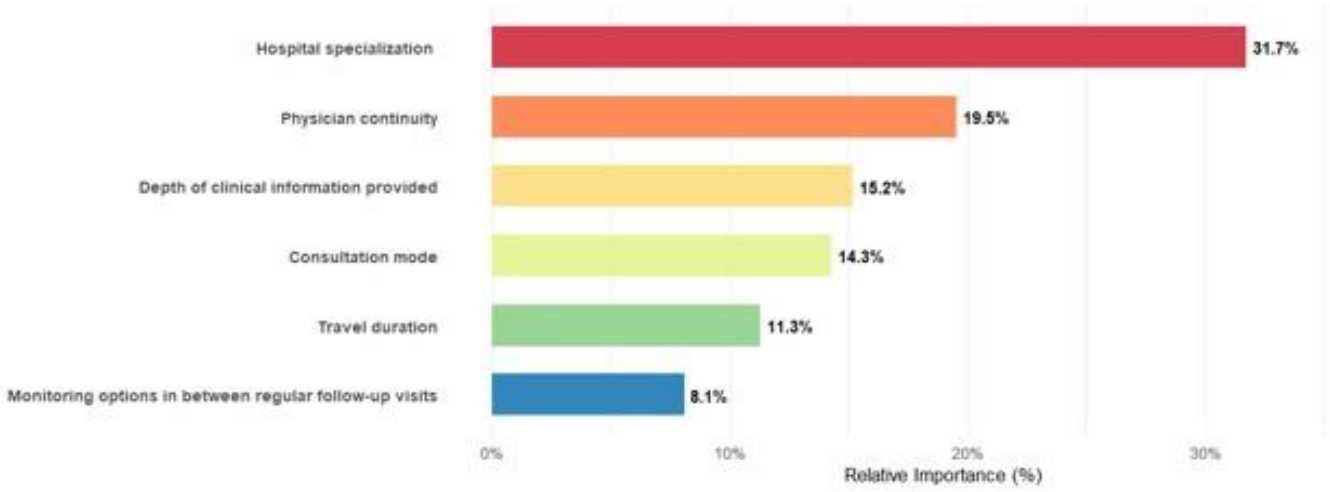
Presenting author: R.A. Mangal
Department: Cardiology

I. Wiethoff (Care and Public Health Research Institute, Maastricht); I. Wiethoff (Care and Public Health Research Institute, Maastricht); R.A. Mangal (Erasmus MC, Rotterdam); S.A.C. Schoonvelde (Erasmus MC, Rotterdam); S.M.A.A. Evers (Care and Public Health Research Institute, Maastricht and Trimbos Institute, Utrecht); N. Kairies-Schwarz (Institute for Health Services Research and Health Economics & Centre for Health and Society, Düsseldorf and German Diabetes Center, Düsseldorf); M. Michels (Erasmus MC, Rotterdam); M. Hiligsmann (Care and Public Health Research Institute, Maastricht).

Purpose:
Hypertrophic cardiomyopathy (HCM) is characterized by extensive clinical and genetic heterogeneity that requires regular cardiac evaluation for both patients and genotype-positive, phenotype-negative (G+/P-) individuals. Understanding patient preferences may enhance the organization of care for HCM patients and their families.
Methods:
A discrete choice experiment was performed to elicit the preferences of HCM patients and G+/P- individuals (≥18 years) across the Netherlands. Six attributes were selected based on the literature and semi-structured interviews (n=8): hospital specialization, travel duration, consultation mode, physician continuity, depth of clinical information provided and monitoring options in between regular check-ups. Choice tasks were based on a D-efficient design with three blocks of eleven tasks each. Trade-offs between attributes and their relative importance were analyzed using latent class analyses and random parameter mixed logit models.
Results:
The study enrolled 198 participants (63 years (SD±12); 40% female), including 24 (12.1%) G+/P- individuals and 174 (87.9%) HCM patients. Conditional relative attribute importance showed that hospital specialization was the most important (31.7%), followed by physician continuity (19.5%) and depth of information received (15.2%). Furthermore, in-person consultations were preferred (mean β=0.40) over remote consultations (negative mean β). The latent class model identified two preference groups. One group (29.8%) valued hospital specialization the most while the other group (70.2%) placed greater importance on different attributes.
Conclusion:
HCM patients and G+/P- individuals prioritized hospital specialization and in-person consultations. Intensified collaboration between HCM centers of expertise and general hospitals through a hub-and-spoke model could accommodate these patient preferences and improve HCM care in the Netherlands.

Keywords:
discrete choice experiment, hypertrophic cardiomyopathy, routine care

Figure:


Hospital specialization
31.7%
Physician continuity
19.5%
Depth of clinical information provided
15.2%
Consultation mode
14.3%
Travel duration
11.3%
Monitoring options in between regular follow-up visits
8.1%
0%
10%
20%
30%
Relative Importance (%)