

## University of Groningen

### Correction to

Tromp, Jasper; Bamadhaj, Sahiddah; Cleland, John G. F.; Angermann, Christiane E.; Dahlstrom, Ulf; Ouwerkerk, Wouter; Tay, Wan Ting; Dickstein, Kenneth; Ertl, Georg; Hassanein, Mahmoud

*Published in:*  
The Lancet Global Health

**IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.**

*Document Version*  
Publisher's PDF, also known as Version of record

*Publication date:*  
2020

[Link to publication in University of Groningen/UMCG research database](#)

*Citation for published version (APA):*

Tromp, J., Bamadhaj, S., Cleland, J. G. F., Angermann, C. E., Dahlstrom, U., Ouwerkerk, W., Tay, W. T., Dickstein, K., Ertl, G., Hassanein, M., Perrone, S., Ghadanfar, M., Schweizer, A., Obergfell, A., Lam, C. S. P., Filippatos, G., & Collins, S. P. (2020). Correction to: Post-discharge prognosis of patients admitted to hospital for heart failure by world region, and national level of income and income disparity (REPORT-HF): a cohort study. *The Lancet Global Health*, 8(8), e1001.

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## Correction to: Post-discharge prognosis of patients admitted to hospital for heart failure by world region, and national level of income and income disparity (REPORT-HF): a cohort study

The international registry to assess medical practice with longitudinal observation for treatment of heart failure (REPORT-HF) cohort was designed to assess international variations in clinical practice patterns and outcomes for patients with acute heart failure. We reported<sup>1</sup> on differences in 1-year all-cause mortality according to geographic region, country income classification, and country level income inequality (Gini index). We identified an error in the dataset, which affected some of the estimates presented in our 2020 Article.<sup>1</sup>

As a result of a coding error, patients with left ventricular ejection fraction (LVEF) of more than 50% were classified as having heart failure with preserved ejection fraction (HFpEF) rather than an LVEF of at least 50%. Furthermore, we were able to include patients with heart failure with semi-quantitative moderate or severe reduced ejection fraction as HFrfEF, those with heart failure with mild reduced ejection fraction as HFmrEF, and those with heart failure with normal ejection fraction as HFpEF. This classification allowed us to categorise some of the patients previously labelled as missing into LVEF groups on the basis of their semi-quantitative patients. This increased the sample size of HFrfEF from 7600 to 8669, increased the sample size for HFpEF from 4505 to 5057, and decreased the sample size for HFmrEF from 3009 to 2814. The HFmrEF group showed a net decrease

due to the change in definition of HFpEF from LVEF of more than 50% to LVEF of at least 50%. This decrease and coding error led to changes in tables 1–3, and in the appendix, for some of the variables reported. The overall distribution of the LVEF categories in the entire cohort and between geographical and income regions remained similar, heart failure cause was corrected in table 2.

After correct classification and adding patients based on semi-quantitative values, the primary conclusion that patients with acute heart failure from low income countries had worse mortality (hazard ratio [HR] 1.58; 95% CI 1.41–1.77) remained. Regional differences in outcome remained similar, where patients from southeast Asia (2.04, 1.74–2.38), central and south America (1.70, 1.48–1.95), and eastern Mediterranean and Africa (1.77, 1.53–2.04) had the worst 1-year all-cause mortality. The interaction between Gini coefficient and income class remained significant in multivariable analyses ( $p_{\text{interaction}} < 0.001$ ). Patients with HFmrEF (0.83, 0.74–0.92) and HFpEF (0.67, 0.61–0.74) still had better 1-year mortality rates than patients with HFrfEF. The interaction between heart failure status (HFrfEF vs HFpEF) and country income level remained significant ( $p_{\text{interaction}} < 0.001$ ), as previously reported.

The updated Article and online material with tracked changes showing the effects of correctly classifying the misclassified patients and adding patients based on their semi-quantitative measurements are added to this letter as an appendix.

We declare no competing interests. GF and SPC contributed equally.

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- 1 Tromp J, Bamadhaj S, Cleland JGF, et al. Post-discharge prognosis of patients admitted to hospital for heart failure by world region, and national level of income and income disparity (REPORT-HF): a cohort study. *Lancet Glob Health* 2020; **8**: e411–22.

See Online for appendix