



LETTER TO THE EDITOR

Beta-blockers in acute coronary syndrome patients: The concept of 'gradient of benefit'



Betabloqueadores no doente pós SCA: o conceito de gradiente de benefício

We read with interest the article by Velásquez-Rodríguez et al. published in the April 2021 issue of the *Journal*,¹ which analyzes the impact of beta-blocker (BB) therapy in post-acute coronary syndrome (ACS) patients. In this important study, the population consisted of ST-elevation myocardial infarction (STEMI) patients divided into two groups according to left ventricular ejection fraction (LVEF): $\leq 40\%$ vs. $>40\%$. The impact of BB therapy in the $\leq 40\%$ population is well known, and current guideline-directed medical therapy (GDMT) includes it as the first-line treatment to reduce heart rate.² The real challenge is to understand the impact of BB therapy in currently treated post-ACS patients with LVEF $>40\%$, since the main studies were performed in the pre-revascularisation era and the role of BB therapy in patients treated according to contemporary practice has been questioned.³ Our team has previously published a study investigating the therapeutic impact on in-hospital mortality in currently treated post-ACS patients (n=9429) stratified according to LVEF, adding a third group – patients with mid-range LVEF, between 40 and 50% (n=1926, 20%).⁴ Regarding the group with low LVEF, our results support the conclusions achieved by Velásquez-Rodríguez et al., with BB therapy

having an impact in reducing in-hospital mortality. However, in the intermediate LVEF group, BB therapy also had an impact on in-hospital mortality. In patients with LVEF $>50\%$ there was no benefit from BB therapy (Figure 1).⁴ Similar findings were also seen in the Japanese CHART-2 study.⁵

In the study by Velásquez-Rodríguez et al., application of other forms of GDMT was lower than expected in the no-BB group (69.3% were on angiotensin-converting enzyme inhibitors). However, in our study, all GDMTs were used very frequently, and although other forms of ACS were included, coronary angiography was performed in $>90\%$ of the overall population.⁶ Only 6.2% of the population analyzed by Velásquez-Rodríguez et al. had atrial fibrillation, while in our study atrial fibrillation was diagnosed in less than 10% of the overall population, and thus its deleterious effects on BB efficacy may not have had a significant impact in either study.⁴ Neither study analyzed BB dosages, but a previous study by Ibrahim et al. assessed dosing and concluded that a higher dosage was only modestly beneficial in improving prognosis.⁷ A previous individual patient data meta-analysis by Cleland et al. including 11 trials also reinforced our conclusions, showing that BB therapy improved LVEF for patients in sinus rhythm and with LVEF $<40\%$, and that for patients in the 40-50% range it appeared more likely to help than to harm.⁸

In conclusion, it seems that as LVEF begins to fall, the margin for therapeutic benefit increases (Figure 1). The ideal cut-off for each GDMT is difficult to attain, but according to both these recent results, BB therapy may in fact start to be beneficial sooner than other GDMTs,⁴ at least

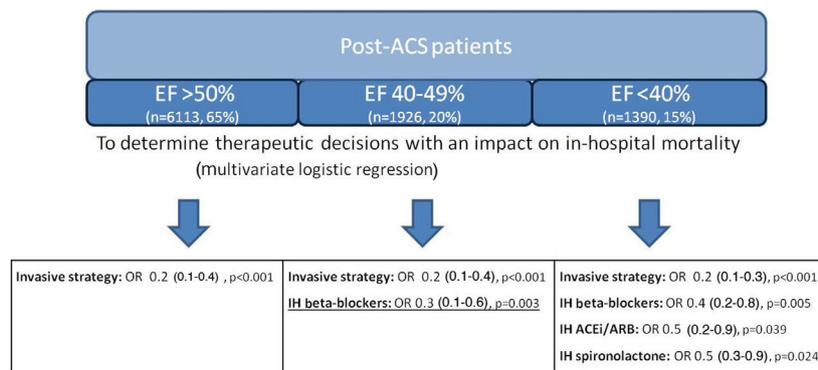


Figure 1 Gradient of benefit for post-acute coronary syndrome patients. ACEi: angiotensin converting enzyme inhibitors; ACS: acute coronary syndrome; ARB: angiotensin receptor blockers; EF: ejection fraction; IH: in-hospital.

for patients in sinus rhythm. This is a burning question that should be answered through future randomized controlled trials such as the ongoing REBOOT trial (ClinicalTrials.gov identifier: NCT03596385).

Conflicts of interest

The authors have no conflicts of interest to declare.

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Fernando Montenegro Sá^{a,*}, João Morais^b

^a *Hospital Pedro Hispano – ULS Matosinhos, Matosinhos, Portugal*

^b *Centro Hospitalar de Leiria, Leiria, Portugal*

*Corresponding author.

E-mail address: fernandosa@ulsm.min-saude.pt (F.M. Sá).