The Canadian Cardiac
Chronicle

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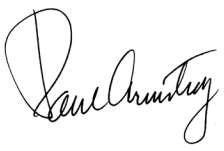
When the year 2020 concludes it will echo like none other in my lifetime. The vulnerability of our species to a virus has been a transformative invasion of every aspect of our lives. The havoc so wreaked is a cogent reminder of Lewis Thomas's admonition that we are indeed a "fragile species". Some of you have been especially affected: all of us have been indirectly affected by this incredible intrusion into our lives. A personal shout out to our dear colleague Michele Senni, Chief of Cardiology in Bergamo who contracted COVID-19 last spring while working on the front lines when that region of Italy was so profoundly affected. It is great and welcome news that he has recovered well and is now working with our CVC team to develop a significant manuscript from the rich VICTORIA database that he helped generate as a national leader in Italy. Well done Michele!

The intersection of COVID-19 with cardiovascular medicine has been enormous. One noteworthy nexus in this arena has been acute myocardial infarction. The number of patients presenting with known or suspect MI has dramatically declined. Moreover, those who do arrive in the ER are delayed in their presentation, presumably because of their concerns of contracting a dangerous infectious disease. Even after hospital arrival, their access to care is often delayed - especially in STEMI for primary PCI - because of uncertainty of their COVID status and the need for health care worker personal protection. We have contended that pharmacoinvasive strategy provides a valuable alternative reperfusion strategy.

Notwithstanding the challenges, we continue to randomize STEMI patients in STREAM-2 (the second **ST**rategic **R**eperfusion in patients **E**arly **A**fter **M**yocardial Infarction) as we explore the efficacy and safety of half-dose tenecteplase with Frans Van de Werf and key international colleagues. We learned only days ago of the tragic news that our good friend and colleague Tony Gershlick from the University of Leicester succumbed to COVID-19. We remember him as a key member of our original STREAM study and particularly his irrepressible good humor and creative energy that helped us change the delivery of STEMI care.

As we contemplate what has transpired across the spectrum of our lives in the past 9 months we appreciate another remarkable human characteristic, namely our ability to adapt to change. Our CVC team has been working productively from home and doing a great job to keep the research flame alive, as have so many of you. Clearly, we have learned that much can be accomplished from a social distance whether it be clinical research, routine patient care, scientific meetings, education or the functionality of an organization. Some of these learnings will persist in the post pandemic era and one challenge we will face is to discriminate which of these many new adaptations are worth preserving, what is their lasting value and how do we ascertain unseen short versus longer-term negative consequences? The holistic practice of medicine requires physical touch. The sheer joy of face-to-face meetings, the synergies that result in new ideas and purposeful energy, the spontaneous combustion emanating from informal hallway connections are missing from our personal and professional lives. As social creatures, we yearn for their restoration and the handshakes, hugs or pats on the shoulder that go with them.

As you hunker down for the most unusual of holiday seasons, I hope you take the needed time to restore your spirit and energy. Genuine cause for optimism, based on the remarkable progress in vaccine science, promises that in the months ahead we may be able to resume those elements of our lives that have the most meaning and lasting value. On behalf of all of us here at CVC, we send you our very best wishes for a Happy Christmas, Hanukkah or other celebration you will experience. We look forward to *personally engaging* with you in year 2021.



Paul W. Armstrong
CVC Founding Director

STREAM-2

Global enrollment continues to climb, with our local site remaining the enrollment leader! Even during the pandemic, our local team enrolls steadily in this trial designed to determine the efficacy and safety of early fibrinolytic treatment with half-dose tenecteplase and additional antiplatelet and antithrombin therapy in subjects with acute ST-elevation myocardial infarction.

We want to recognize the Principal Investigator, **Dr. Robert Welsh**, and Study Coordinator, **Suzanne Welsh**, for their dedicated work to ensure the success of the trial. As well, a special acknowledgement to our star sub-investigators, **Dr. Kevin Bainey** and **Dr. Janek Senaratne**, for continually keeping the STREAM-2 trial in mind when connecting with EMS teams and patients. Keep up the great work!

If you are interested in further information regarding this trial, please contact Clinical Trial Project Lead Courtney Gubbels at 1-800-707-9098 ext 2, or via email at courtney.gubbels@ualberta.ca.

Sponsored by Leuven Research & Development (LRD) at University of Leuven, Belgium, STREAM-2 is a Phase 4 trial on STrategic Reperfusion in elderly patients Early After Myocardial Infarction

ClinicalTrials.gov Identifier: NCT02777580

EMPACT-MI

The CVC is very excited to be working on this pragmatic, streamlined trial investigating the effect of empagliflozin on hospitalization for heart failure and mortality in patients with acute myocardial infarction. In Canada, we are pleased to have **Dr. Jay Udell** (Women's College Hospital) as a member of the Study Executive Committee, and **Dr. Shaun Goodman** (CVC Faculty) and **Dr. Shelley Zieroth** (St. Boniface Hospital) playing a key role as National Leaders.

EMPACT-MI is a global study with approximately 400 sites in 16 countries. In Canada, we have selected 26 sites who are currently working on ethics, budgets, and contracts.

The first Investigator Meeting was held virtually on November 4. It was a great opportunity to learn about the protocol and study drug. For those who were unable to attend the live event, a recording of the meeting will be available to sites soon. As well, there are additional (required) online modules that will soon be available for sites to complete their protocol training.

The trial's first patient is expected to be enrolled in early December. Patients will be followed for up to one year in this event-driven trial.

The NOL is expected the third week of December. Because timelines are tight, we are aiming to have the first site activated in Canada in December or early January 2021, with the first patient enrolled soon thereafter. We are excited to see who will be the first site activated in Canada!

For questions about EMPACT-MI, please contact Jodi Parrotta, Clinical Trials Project Lead/QA-Regulatory Compliance Lead at 1-800-707-9098, ext. 3 or via email at Jodi.Parrotta@ualberta.ca.

Sponsored by Boehringer Ingelheim and Eli Lilly, **EMPACT-MI** is a phase III, streamlined, multicentre, randomised, parallel group, double-blind, placebo-controlled, superiority trial to evaluate the effect of Empagliflozin on hospitalization for heart failure and mortality in patients with acute myocardial infarction.

ClinicalTrials.gov Identifier: NCT04509674

SODIUM-HF

Thank you to all of our sites for their continued dedication and creativity during these challenging times. **Recruitment has now ended for all sites – thank you to everyone for your efforts!**

Per the **DSMB-related correspondence** earlier this fall, please remember:

- All 18 month and 24 month visits should continue for all patients, as this follow-up is key to completing the study objectives.
- For sites participating in the optional long-term follow up substudy: efforts to enroll your patients should continue, and it is more important than ever to contact your patients ASAP.

We cannot have any LTFU patients in this trial! Every patient counts, so the expectation is for sites to search for all potentially LTFU patients until database lock. Thank you for your continued diligence in this regard.

For general study updates and news, follow us on Twitter (@sodiumhf).

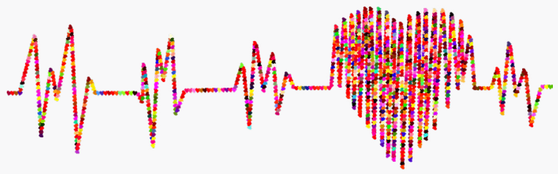
If you have questions about the SODIUM-HF trial, please contact the Clinical Trials Project Lead, Karin Kushniruk at karin.kushniruk@ualberta.ca.

SODIUM-HF

Funded by the Canadian Institute of Health Research (CIHR) and University Hospital Foundation, SODIUM-HF is a multicenter, randomized, open-label **S**tudy **O**f **DI**etary Intervention **U**nder 100 **M**MOL in **H**eart **F**ailure.

ClinicalTrials.gov Identifier: NCT02012179

AEGIS-II



As we all continue to navigate our way through the unique challenges of conducting research during the pandemic, the CVC team wants to acknowledge your outstanding dedication to AEGIS-II.

Your teams have continued to excel at quality data entry, and our "data clean" metrics are fantastic. You have worked hard to restart following the COVID-19 enrollment hold, and we now have more than two thirds of our Canadian sites re-activated for enrollment. You are diligently screening to ensure that your teams enroll the right patients for this study, which is always extremely important - even more so at this time. Thank you!

Please continue to complete your training modules within DrugDev Spark in a timely manner. If there are any site personnel no longer actively working on AEGIS-II, please let us know. We can remove their systems access, which will ensure training modules are no longer being assigned to them and remaining outstanding for long periods of time.

A reminder to please continue to record all major and minor deviations from the protocol on the PD tracker and submit these to the CVC at the start of each month. If a patient has missed a visit, is contemplating IP discontinuation or consent withdrawal, please contact the CVC immediately.

We continue to conduct monitoring visits remotely at this time. We appreciate your patience and flexibility with this process.

AEGIS-II is a large, international, multicentre Phase 3 trial of infusing an intravenous formulation of apolipoprotein A-I (CSL112) to reduce cardiovascular events in acute coronary syndrome patients. CSL112, an intravenous formulation of apoA-I, enhances cholesterol efflux capacity, and therefore, has the potential to reduce plaque burden, stabilize plaque lesions at risk of rupture, and decrease the high rate of early recurrent events.

If you are interested in further information regarding this trial, please contact Clinical Trial Project Lead, Lyndsey Garritty at 1-800-707-9098, or via email at lyndsey.garritty@ualberta.ca.

Sponsored by CSL Behring LLC, this is a Phase 3, Multicentre, Double-blind, Randomized, Placebo-controlled, Parallel-group Study to Investigate the Efficacy and Safety of CSL112 in Subjects with Acute Coronary Syndrome.

ClinicalTrials.gov Identifier: NCT03473223

HEART-FID

As we continue on this path of conducting research during a pandemic, we are sorting out our way and once again drawing closer to our enrollment goals. If your site is not yet open for screening and enrolling, we hope to see your site active early in the New Year. For those sites active and enrolling even with the continuous operational challenges, we want to commend you for your effort! We appreciate your dedication to this important trial.

Data Entry Tip

Determining what date to enter for the date of drug discontinuation can be unclear. Please see below for clarification on how to enter this appropriately:

1. Permanent Drug Discontinuation - The date of drug discontinuation is the date the decision was made to permanently discontinue study drug.
2. Drug Discontinuation at Death - The date of drug discontinuation is the date of the last dose.

Please continue to enter your visit details as soon as you can after a visit is completed. Remember to continue to check frequently for queries that might have been posted on your data.

Keep up the great work with your data entry!

Sub-Study

All five participating Canadian sites have been activated on the sub-study. Congratulations to your teams for reaching this milestone. We look forward to the first Canadian sub-study participant being randomized!

Scheduling of Dosing Visits

A reminder of the changes to scheduling dosing visits due to the pandemic:

- Reschedule a visit up to 90 days from the missed visit
- There must be at least 90 days between dosing cycles
- Only 21 days between dosing visit 1 & 2
- If unable to schedule in these timelines, complete visit via phone

If you are interested in learning more about this trial, please contact Clinical Trial Project Lead Courtney Gubbels at 1-800-707-9098 ext 2, or via email at courtney.gubbels@ualberta.ca.

Sponsored by American Regent, HEART-FID is a Randomized, Double-Blind, Placebo-Controlled Study to Investigate the Efficacy and Safety of Injectafer® (Ferric Carboxymaltose) as Treatment for Heart Failure With Iron Deficiency

ClinicalTrials.gov Identifier: NCT03037931

MOIST Study

Congratulations to Dr. Ian Paterson and his team for beginning enrollment into the Multi-Organ Imaging with Serial Testing in COVID-19 infected patients (MOIST) study!

Patients with COVID-19 infection are at significant risk of deterioration from pulmonary and extra-pulmonary causes; the long-term consequences of these abnormalities are unknown. Systemic inflammation is considered a central feature of disease pathogenesis. However, the respective extent and time-course of multi-organ involvement (heart, lungs, brain, and liver) have not yet been evaluated. Furthermore, their respective and combined impact on patient morbidity and mortality has not been assessed.

Using novel MRI pulse sequences, the MOIST Study aims to assess the presence, extent, and time course of inflammation in the heart, lungs, brain, and liver of participants with new or recent COVID-19 infection.

If you are interested in learning more about the MOIST Study, please contact the Clinical Trial Project Lead, Karin Kushniruk, at 1-800-707-9098, ext. 7 or karin.kushniruk@ualberta.ca.

Sponsored by Canadian Institute of Health Research, the MOIST Study will assess the presence, extent and time course of inflammation in the heart, lungs, brain and liver of participants with new or recent COVID-19 infection.

ClinicalTrials.gov Identifier: NCT04525404

MAP-AHF

The MRI Assessment of Pulmonary Edema in Acute Heart Failure study is a single-centre project taking place at the University of Alberta Hospital / Mazankowski Alberta Heart Institute in collaboration with the Peter S. Allen MR Research Centre.

Study recruitment is currently on hold due to the COVID-19 pandemic, but we look forward to seeing it resume in the near future.

Cardiogenic pulmonary edema is a cardinal sign of acute heart failure, and is a cause of the primary heart failure symptom, shortness of breath, which is most commonly treated with diuretic therapy. While increased lung water is typically reported descriptively (i.e., auscultation and/or chest x-ray), these measures are not sufficiently sensitive to exclude pulmonary congestion.

Further research is needed to a) determine changes in Lung Water Density (i.e., quantification of pulmonary edema on MRI) over the course of hospitalization and standard treatment of acute heart failure, and b) explore whether Lung Water Density is predictive of long-term outcomes in the acute heart failure population.

If you are interested in further information about the MAP-AHF study, please contact the Clinical Trial Project Lead, Karin Kushniruk, at 1-800-707- 9098, ext. 7 or karin.kushniruk@ualberta.ca.

MAP - AHF

Sponsored by: Canadian Institutes of Health Research MAP-AHF will examine the changes in lung water density over the course of treatment in patients hospitalized for acute heart failure, and will explore whether changes in lung water levels can predict long term outcomes.

ClinicalTrials.gov Identifier: NCT03999138

FEAST-HF

Enrollment has been progressing well, and we wish to thank our participating sites for their continued dedication and creativity during these unprecedented times.

Got Fiber?

Recent attention focused on the role of the gut microbiome in human disease, including its significant role in the pathogenesis of heart failure. Several small studies have shown an interplay between the microbiome and heart failure, and that dietary interventions such as the addition of dietary fiber can modulate the gut microbiome. This trial will explore if modification of the microbiome can mitigate the symptoms of patients with heart failure, and whether new avenues for treatment and future research for patients with heart failure will be revealed.

If you are interested in further information about the FEAST-HF trial, please contact the Clinical Trial Project Lead, Karin Kushniruk, at 1-800-707- 9098, ext. 7 or karin.kushniruk@ualberta.ca.

Sponsored by University Hospital Foundation and Weston Family Microbiome Initiative, FEAST-HF trial will explore the potential beneficial effects of dietary fiber supplementation, compared with placebo, in patients with Heart Failure

ClinicalTrials.gov Identifier: NCT03409926

Monitoring Tips

On behalf of the CVC monitoring team, I would like to extend a sincere THANKS to all CVC HEART-FID and AEGIS-II sites who have worked diligently to adapt to the constraints imposed on us during this pandemic. In March of this year, we suspended onsite monitoring visits, and transitioned to performing our regular periodic monitoring visits by phone. At that time, we could not imagine that more than a handful of these "Phone PMVs" would need to be done. However, in the intervening eight months, all our sites have had at least one phone visit, and many sites have had two or more.

Finding an efficient, effective way to monitor "virtually" is not without its challenges, as preserving participant confidentiality is of the utmost concern. Since April, our CRAs have been reviewing (de-identified) source document worksheets received through email or the CVC SharePoint secure platform. While this has been a tremendous help, going forward, we will be asking each site to assess their and their institutions policies as they relate to finding creative, secure ways to allow CRAs access to more robust participant information, especially for the assessment of safety and efficacy reporting. Following are some avenues for each site to explore to allow increased access to information for your CVC CRA.

Direct Remote Access to EMR

Some sites allow CRAs to access the patient's electronic medical record (EMR) while on site performing monitoring visits, but will not allow the CRAs to access the EMR remotely. For those sites, we ask that you explore with your institution if it would be possible to allow the CRA their usual access from a remote (off-site) location. Some institutions are considering this option now that on-site monitoring has been on hold for so long.

Indirect Access to EMR

Many of our Canadian sites allow "over-the-shoulder" access to the EMR while monitors are on site when direct access is not available. For these sites, we ask that you explore the potential of using an available video option (e.g., FaceTime, Google Meet, WebEx, Zoom, etc.) to provide your CRA "over the shoulder access" remotely for pre-selected participants during your Phone PMV. We have found some institutions are open to this idea if we use the media format of their choice, which CVC will welcome. The one concern we have heard from our sites for this option is the potential amount of study coordinator time that would be required for them to "show" the EMR in real time during the phone call. The CVC is very committed to respecting how much time we ask for during these Phone PMVs and we would work closely with each site to establish priorities for items to be reviewed this way, and limit the time allocated for this task during the call.

Printing an "Encounters List" from the EMR and Allowing the CRA to View it Remotely

If institutions are not agreeable to allowing CRAs to view the actual EMR remotely via one of the media formats noted above, it may be permissible to run an encounters list from the EMR and "show" this document to your CRA via a video meeting. This "encounters list" could then remain in your participant's source document/ research chart to show your site's due diligence in ensuring full SAE/CE reporting. The same method could be used to "show" your CRA printed medical records (e.g., discharge summary) that would be required to close an action item/ query or confirm that all SAEs/CEs were reported correctly.

We appreciate ANY ideas from our sites for ways to work together to ensure we "get the job done" to the best of our ability, and we sincerely hope that sometime in the new year we will be able to get back out to your site in person.

Please keep your designated Project Lead updated on the status of your site as it relates to COVID-19, and stay safe!

Dr. Justin Ezekowitz - Fellow of the Canadian Academy of Health Sciences

The CVC is proud to recognize that Dr. Justin Ezekowitz has been elected as a Fellow of the Canadian Academy of Health Sciences (CAHS).

Election to the CAHS Fellowship is considered one of the highest honours for individuals in the Canadian health sciences community. Fellows have demonstrated, through their careers and lives, that they are committed to their field of expertise in many ways.

The following is Dr. Ezekowitz's profile from the CAHS Fellowship announcement:

Dr. Ezekowitz has demonstrated a clear passion and commitment to advance academic health sciences. His research and clinical focus is on the care of patients with heart failure (a major cause of morbidity and mortality in North America). He is internationally recognized for conducting high quality clinical research on heart failure involving interdisciplinary research teams that include the full spectrum of scientists from discovery-based through population health-based researchers. He works closely with NGOs, specialty societies, and health systems in Alberta, in Canada, and elsewhere to optimize the care and outcomes for heart failure patients in Canada and internationally.

Congratulations to Dr. Ezekowitz on this well-deserved accomplishment.

Canadian Cardiovascular Research Collaboratory

The **Canadian Cardiovascular Research Collaboratory** (C^3) is a virtual clinical research network established in 2018 by the CVC and the Richard Lewar Centre of Excellence (University of Toronto). C^3 is comprised of ~50 cardiovascular (CV) disease researchers affiliated with university-based research centres across Canada. It aims to blend collaboration and clinical laboratory to provide novel opportunities for CV researchers to identify and study important unanswered questions. C^3 facilitated several successful peer-reviewed grants for COVID-19-related studies and other CV studies in 2020.

To read more about C^3, please see our publication in the Canadian Journal of Cardiology.

Feature Publications

Congratulations to **Drs. Paul Armstrong and Justin Ezekowitz, along with their fellow coauthors**, on the publication of their article **Effect of Vericiguat vs Placebo on Quality of Life in Patients With Heart Failure and Preserved Ejection Fraction: The VITALITY-HFpEF Randomized Clinical Trial** in JAMA.

Patients with, versus without, heart failure with preserved ejection fraction (HFpEF) are at higher risk for hospitalization, mortality, and reduced quality of life as a result of functional limitations.

This clinical trial sought to evaluate the safety and efficacy of vericiguat, an oral soluble guanylate cyclase stimulator, on the physical limitation score (PLS) of the Kansas City Cardiomyopathy Questionnaire (KCCQ).

The authors concluded that despite vericiguat's efficacy in HFrEF patients, among those with HFpEF and recent decompensation, treatment with vericiguat did not improve the primary outcome of KCCQ PLS or the secondary endpoint of the 6-minute walking distance test.

They also noted that their findings might signal that nitric oxide may not be a key operative factor in the progression of HFpEF.

Feature Publications

Congratulations to **Dr. Justin Ezekowitz** and his coauthors on the publication of their article, N-Terminal Pro-B-Type Natriuretic Peptide and Clinical Outcomes: Vericiguat Heart Failure With Reduced Ejection Fraction Study, published in JACC: Heart Failure. We asked Dr. Ezekowitz a few questions to better understand this study and its importance.

1. What were the important study findings? What are the key takeaways from this research?

Patients in the VICTORIA trial treated with vericiguat had a reduction in the primary composite outcomes of cardiovascular death or heart failure hospitalization. NT-proBNP at randomization was related to both the rate of clinical events and the treatment efficacy of vericiguat. When examined further, patients with an NT-proBNP value less than 8000 pg/ml had greater benefit, and those with an NT-proBNP value less than 4000 pg/ml had an even further benefit related to CVD or HF hospitalization.

2. What inspired you and the other authors to conduct this study?

When the VICTORIA trial was completed, we noted an interaction of NT-proBNP and the clinical outcomes of the trial. We wanted to understand this better and use more advanced techniques to explore this further.

3. What are the real-world implications of these research findings?

Clinicians should be aware that the overall VICTORIA trial results should be the reason to consider vericiguat in the appropriate patient. However, there are certain patients that may have enhanced benefit - those with a lower NT-proBNP less than 8000 pg/ml, and especially those with an NT-proBNP less than 4000 pg/ml.

4. What should future research on this topic focus on?

Vericiguat has a unique place in the treatment plans for a patient. Future research should help us to better understand how vericiguat is used in practice, whether or not NT-proBNP is a good predictor in other populations, and if other biomarkers (especially those biomarkers in the similar natriuretic pathway) are useful in predicting clinical outcomes for patients with heart failure.

Dr. Ana Savu

Check out this recent publication, Cardiac Stress Testing After Coronary Revascularization, in the American Journal of Cardiology by **Drs. Ana Savu, Robert Welsh, Kevin Bainey, Shaun Goodman**, and **Padma Kaul** from CVC, along with their fellow coauthors.

The Appropriate Use Criteria considers cardiac stress testing (CST) to be rarely appropriate within two years after percutaneous coronary intervention (PCI) and within five years after coronary artery bypass grafting (CABG), unless prompted by symptoms or other changes in clinical status.

Although there is knowledge of the patterns of CST after PCI, little is known regarding the use and yield of CST after CABG. To address these gaps, the authors of this population-based study sought to determine patterns of CST after revascularization of both PCI and CABG in Alberta, Canada. Specifically, they aimed to ascertain the frequency and timing of CST within two years of PCI and CABG, as well as downstream coronary angiography and revascularization that occurred as a consequence of stress testing.

The authors concluded that approximately one-half of patients undergo CST between 60 days and two years of coronary revascularization in Alberta. Rates of CST are similar after CABG and PCI. Presence of comorbidities is associated with less likelihood of CST, while urban residence and greater neighborhood median household income are associated with a greater likelihood of CST. Further research is needed to better inform the selection of patients most likely to benefit from CST after revascularization.

The Canadian Cardiac Chronicle

Feature Publications

Dr. Nariman Sepehrvand and his coauthors recently published their article, Change of Health-Related Quality of Life Over Time and its Association with Patient Outcomes in Patients with Heart Failure, in the J Am Heart Association. We asked Dr. Sepehrvand a few questions to better understand this study and its importance.

1. What were the important study findings? What are the key takeaways from this research?

Using the Alberta HEART cohort, we investigated the change of health-related quality of life (HRQoL) and its correlation with outcomes in patients across the risk spectrum of heart failure (HF). There have not been enough studies comparing quality of life and its change over time between heart failure patients with preserved (HFpEF) versus reduced ejection fraction (HFrEF). We showed that patients with HFpEF had numerically lower quality of life, as assessed by the Kansas City Cardiomyopathy Questionnaire (KCCQ), compared to patients with HFrEF. After adjustment for confounders, a decrease in KCCQ over time was associated with adverse clinical outcomes. The relationship between the change in HRQoL and clinical outcomes was stronger in patients with HFpEF than in those with HFrEF.

2. What inspired you and the other authors to conduct this study?

Improving HRQoL is important for patients with HF and as an endpoint in HF trials. Reviewing the Alberta HEART study, we were surprised by the wealth of HRQoL data reported from patients in different disease trajectories - from those at risk of HF to patients with HFpEF or HFrEF - especially in a study for which this was not the primary focus. Therefore, we thought there are plenty of important questions that we would be able to answer by leveraging the data from the Alberta HEART cohort.

3. What are the real-world implications of these research findings?

The study revealed variability in HRQoL, its change over time, and correlation with clinical outcomes between different HF subtypes. So far, the HRQoL measures were used merely to assess quality of life in individual patients; the relationship between HRQoL and quality of care for patients with HF has been unclear. Given the observed variability and prognostication in different patient trajectories, it seems that we might be able to use these measures to quantify the quality of HF care in the healthcare systems.

4. What should future research on this topic focus on?

This study suggested the potential of HRQoL measures to quantify the quality of care in the HF setting, but such a concept needs to be tested in future, preferably prospective, studies.

CVC Holiday Closure

The CVC offices will be closed from December 25, 2020 to January 1, 2021

Should any urgent issues arise, we ask that you call the designated helpline for your study.

The CVC's main voicemail will be checked daily throughout the closure to address any important study-related issues, and staff email will be checked intermittently.

Any urgent requests can be sent to tracy.temple@ualberta.ca, or call 780-952-2140.

About the Chronicle

This newsletter is published periodically as a service to Canadian investigational sites. The purpose is to provide information of interest to individuals involved in cardiovascular clinical trials managed by the Canadian VIGOUR Centre, University of Alberta in Edmonton, Alberta, Canada.

What did you think of this Chronicle edition?
Send us an email: thecvc@ualberta.ca

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