

# Heart failure hospitalization more than doubles in IBD flares

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Heart failure hospitalisation more than doubles during inflammatory bowel disease (IBD) flares, according to a study of more than 5 million Danish people. The research was presented today at the Heart Failure Congress 2014, held 17-20 May, in Athens, Greece. The Congress is the main annual meeting of the Heart Failure Association of the European Society of Cardiology.

Dr Søren L. Kristensen, lead author, said: "Previous studies have shown an association between [chronic inflammatory diseases](#) (psoriasis, rheumatoid arthritis, [systemic lupus erythematosus](#), celiac disease and IBD) and an increased incidence of venous- and arterial thrombotic disease (primarily heart attack and stroke). Researchers suggest the link is at least in part caused by inflammatory prothrombotic effects."

He added: "However not many studies have investigated whether the risk of [heart failure](#) is elevated in patients with these [inflammatory diseases](#), and none at all in patients with IBD. In the present study we aimed to clarify whether IBD patients had an [increased risk](#) of heart failure, and secondly whether this risk was correlated to periods of activity or 'flares' in the IBD."

The researchers used a nationwide cohort of 5 436 647 Danish citizens aged 18 years and above with no history of IBD or heart failure. In this study IBD was defined as Crohn's disease and ulcerative colitis. During 1997 to 2011, IBD developed in 23 681 patients, of whom 553 were hospitalised with heart failure during follow-up. Rates of hospitalisation

for heart failure were compared between the IBD group and the remaining Danish population, adjusted for age and sex differences.

In patients with new-onset IBD, disease activity (flare, persistent activity, remission) was monitored continuously throughout the study and determined by hospitalisations and prescriptions of glucocorticoids. Flares were defined as a prescription or hospitalisation following a quiescent period. Persistent activity was defined as repeated prescriptions or hospitalisations.

Dr Kristensen said: "We found that patients with new-onset IBD had a 37% increased risk of hospitalisation for heart failure during a mean follow-up of 6.4 years compared to the healthy population. But the risk more than doubled during periods of IBD activity."

He added: "When IBD patients had flares their risk of hospitalisation for heart failure was 2.5 times greater, and it was 2.7 times greater during persistent activity. There was no increased risk during the quiescent stages of IBD. Our findings suggest that efficient IBD treatment aimed at reducing the length and number of disease activity episodes might lower the risk of heart failure."

Dr Kristensen continued: "We found an increased risk of hospitalisation for heart failure in IBD patients of all ages, not just older patients. Gastroenterologists and other health professionals need to be aware of the increased risk of cardiovascular diseases, including heart failure, in their daily handling of patients with IBD. It's also important that they don't neglect younger patients, who are also at cardiovascular risk."

IBD is known to have effects in the body beyond the intestine including anaemia, and musculoskeletal, dermatologic, hepatic and ocular complications. Dr Kristensen said: "Our results indicate that heart failure may need to be added to this list, and hence be considered when

assessing these patients. Detecting heart failure early is crucial to halting its progression and improving prognosis."

Biological anti-inflammatory treatments offer the possibility of longer term remission to patients with IBD. Dr Kristensen said: "It will be interesting to see if these medications, which are increasingly used in IBD, lead to a reduction in the risk of heart failure and other cardiovascular diseases. We will investigate this question in a future observational study of all IBD patients in Denmark who are taking biological treatments."

He continued: "We cannot rule out the possibility that glucocorticoids used to manage IBD contribute to the risk of heart failure."

Dr Kristensen concluded: "There have been calls for patients hospitalised with IBD flares to receive thromboprophylaxis but such a general strategy needs more clinical validation. What is required is cardiovascular risk assessment of these [patients](#), especially during IBD flares, so that heart failure and other cardiovascular complications can be detected early and treated appropriately."

**More information:** Please see the details of the session here: [spo.escardio.org/SessionDetail ... d=13641#.U2tDpP1XKC4](https://spo.escardio.org/SessionDetail...d=13641#.U2tDpP1XKC4)

Provided by European Society of Cardiology

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