BNP Levels Predict Outcome in Pediatric Heart Failure Patients: Post-hoc Analysis of the Pediatric Carvedilol Trial

Running Title: BNP Predicts Pediatric Heart Failure Outcomes

Scott R Auerbach, MD*, Marc E Richmond, MD*, Jacqueline M Lamour, MD†, Elizabeth D Blume, MD‡, Linda J Addonizio, MD*, Robert E Shaddy, MD§, Lynn Mahony, MD‖, Elfriede Pahl, MD¶ and Daphne T Hsu, MD†. *Pediatric Cardiology, Columbia University, Morgan Stanley Children's Hosp of New York Presbyterian, New York, NY, United States, 10032; †Pediatric Cardiology, Albert Einstein College of Medicine, Children's Hospital at Montefiore, Bronx, NY, United States; ‡Pediatric Cardiology, Children's Hospital Boston, Boston, MA, United States; §Pediatric Cardiology, Children's Hospital of Philadelphia, Philadelphia, PA, United States; ‖Pediatric Cardiology, University of Texas Southwestern Medical Center, Dallas, TX, United States and ¶Pediatric Cardiology, Northwestern University Feinberg School of Medicine, Children's Memorial Hospital, Chicago, IL, United States.

Correspondence to:
Daphne Hsu, M.D
Professor of Pediatrics, Albert Einstein College of Medicine
Division Chief and Co-director of the Pediatric Heart Center at the Children’s Hospital at Montefiore
3415 Bainbridge Ave.
Bronx, New York 10467-2490
Phone: (718) 741-2315
FAX: (718) 920-4351
E-mail: dhsu@montefiore.org

Subject Codes: [11], [37], [41], [110], [118]
ABSTRACT

**Background:** The ability of serum B-type natriuretic peptide levels (BNP) to predict outcomes in children with heart failure (HF) has not been well demonstrated. This study was designed to determine if BNP levels predict outcomes in patients with moderate symptomatic HF.

**Methods and Results:** We investigated whether enrollment BNP levels for the Pediatric Carvedilol Trial were associated with baseline characteristics. Freedom from a composite endpoint of HF hospitalization, death, or transplantation at 9 months was compared using a threshold BNP level identified using receiver operating curve analysis. Median BNP level was 110 pg/ml (Interquartile range [IQR], 22.4 to 342.0 pg/ml) in 138 subjects. Median age was 3.4 years (IQR 1.1-11.0 years). Diagnoses were cardiomyopathy (60%) and congenital heart disease (40%); 73% had a systemic left ventricle (LV). BNP levels correlated moderately with LV ejection fraction (R=0.39, p<0.001), but did not differ by HF class, age, diagnosis, sex, ventricular morphology, or LV end-diastolic dimension Z-score (R=0.19). Outcome events included 25 HF hospitalizations, 4 deaths and 2 transplants. Sensitivity was 71% and specificity 63% for a BNP cutoff value of 140 pg/ml. BNP ≥ 140 pg/ml (Hazard Ratio [HR] 3.7, CI 1.62-8.4, p=0.002) and age > 2 yr (HR 4.45, CI 1.68-12.04, p=0.003) were independently associated with worse outcomes.

**Conclusions:** In children with moderately symptomatic HF, BNP ≥ 140 pg/ml and age > 2 yr identified subjects at higher risk for worse outcome. Further validation is needed to determine the BNP levels necessary to stratify risk in other pediatric cohorts.

**Key Words:** heart failure, pediatrics, natriuretic peptides, cardiomyopathy
ABBREVIATIONS

BNP = B Type Natriuretic Peptide
CHD = Congenital heart disease
HF = Heart Failure
HR = Hazard Ratio (HR)
IQR = Interquartile Range
lnBNP = Natural Log of BNP
LV = Left Ventricle
LVEDd = Left Ventricular End Diastolic Dimension in Diastole
LVEF = Left Ventricular Ejection Fraction
NYHA = New York Heart Association
Introduction

Biomarkers are an increasingly important diagnostic tool in the management of the adult patient with heart failure (HF). B-type natriuretic peptide (BNP) is one such biomarker and is produced by ventricular myocytes in response to pressure and volume overload and wall tension.\(^1\)\(^-\)\(^2\) BNP is initially part of a 134 amino acid pre-proBNP, which undergoes processing, resulting in the 76 amino acid N-terminal proBNP (NT-proBNP) and the 32 amino acid molecule BNP\(^3\)\(^-\)\(^5\). In adult HF patients, serum BNP levels have been correlated with New York Heart Association (NYHA) Class, and are used to estimate the severity of disease and predict adverse outcomes.\(^6\)\(^-\)\(^8\) Recent recommendations for the use of biomarker testing in adults with HF indicate that BNP and NT pro-BNP levels are useful in the screening and risk stratification of selected patients.\(^6\)\(^,\)\(^9\)\(^,\)\(^10\) Studies in both children and adults with acquired or congenital heart disease (CHD) have shown elevated serum BNP levels in patients with increased ventricular wall stress and ventricular dysfunction.\(^11\)\(^-\)\(^14\) Limited data are available on the predictive value of BNP in pediatric patients with ventricular systolic dysfunction.\(^15\) Price et al. demonstrated that BNP levels predicted worse 90 day event free survival in a population of children with systolic left ventricular dysfunction, 58% of whom were asymptomatic. No studies have been performed to determine the ability of BNP levels to predict outcomes in children with symptomatic HF and ventricular dysfunction secondary to cardiomyopathy or CHD. It is unlikely that data from adults with HF can be routinely applied to children, as there may be age related differences in normative data and in the neurohormonal response to ventricular dysfunction from cardiomyopathy or congenital heart disease.
The purpose of this study was to determine if BNP levels in children with symptomatic HF correlate with the severity of HF and whether they can reliably predict adverse outcomes in children with symptomatic HF and ventricular dysfunction.

Methods

Study Design

This study is a post-hoc analysis of data from the Pediatric Carvedilol Trial. The details of this trial have been described previously.\textsuperscript{16,17} Briefly, the Pediatric Carvedilol Trial was a prospective, multicenter, randomized, double-blind, placebo-controlled, parallel design study, involving 26 centers, that evaluated the effect of carvedilol on clinical HF outcomes in symptomatic pediatric subjects with systolic dysfunction of the systemic ventricle.\textsuperscript{16} The overall results of the study failed to demonstrate a treatment benefit of carvedilol on a composite primary endpoint of HF outcomes including death, transplantation, heart failure hospitalization or worsened parental assessment or HF score. Specifically, there was no difference between the placebo and carvedilol treatment groups in the percentage of subjects who improved, worsened or were unchanged after 8 months. Data from the Pediatric Carvedilol Trial was collected with informed consent and this post-hoc analysis was approved by the institutional review board of Columbia University.

Subject Participation and Outcomes

Subjects included in the original study had the diagnosis of cardiomyopathy or congenital heart disease and systolic ventricular dysfunction. Systolic ventricular dysfunction was defined as an ejection fraction $\leq 40\%$ in subjects with systemic left ventricular dysfunction or qualitative
evidence of a dilated ventricle with moderate systemic ventricular systolic dysfunction in patients with a systemic right ventricle or single ventricle physiology. Other inclusion criteria included a Ross or NYHA HF class II to IV, age < 18 years old, and a history of a stable outpatient medication regimen for at least 1 month prior to enrollment. All subjects who had a serum BNP level measured at the time of enrollment were included in the current analysis. While the primary endpoint of the Pediatric Carvedilol Trial was assessed 8 months after enrollment, subjects who had not reached the composite endpoint continued to be followed for one more month, making the overall subject follow-up for this secondary analysis 9 months. Subjects actively listed for transplantation at time of entry into the Pediatric Carvedilol Trial or anticipated to undergo heart transplantation or corrective heart surgery during the study follow-up period, were excluded. Of the 178 subjects eligible for the Pediatric Carvedilol Trial, 15 were excluded for the following reasons: not stable with medications (7), ventricular function too good (5), low blood pressure (1), ventricular arrhythmia (1), and endocrine exclusion (1). Study endpoints included hospitalization for worsening HF, all-cause mortality, or transplantation. The endpoint of hospitalization for worsening HF was adjudicated blindly by the Pediatric Carvedilol Trial steering committee.

**Baseline Assessment**

Subject characteristics obtained at enrollment included demographic information, NYHA HF class (generally applied in children ≥ 5 years of age) and Ross HF class (generally applied in children < 5 years of age). Venous samples for BNP level determination were drawn after the patient was in a sitting/supine position in a quiet room for 30 minutes. BNP levels were measured at the Mayo Medical Laboratories using the Beckman Coulter DXI 800 Immunoenzymatic Assay (Beckman Coulter Inc, Fullerton CA). This assay required whole blood
to be spun down to remove cells and then isolation of 0.4-1 ml of plasma, which was then immediately frozen. Blood samples were rejected if grossly hemolyzed. Echocardiograms were centrally interpreted. Ventricular morphology was defined by the core laboratory as either a systemic left ventricle (LV) or a systemic non-LV. All subjects with single ventricle physiology were classified as having a systemic non-LV. In subjects with a LV, ejection fraction and left ventricular end-diastolic dimension (LVEDd) were determined and LVEDd was normalized to body surface area using Z-scores. \(^{18}\) In subjects with a systemic non-LV, including all subjects with a single ventricle, LVEF and LVEDd were not measured.

**Statistical Analysis**

BNP levels at enrollment were compared by gender, race, diagnosis, subtype of systemic ventricle, HF class and age at enrollment. HF class and diagnosis were also compared against these characteristics in order to determine if there were differences between subjects based on HF class or diagnosis. For comparison, age at enrollment was divided into four groups, 0 to 2 years, 2 to 6 years, 6 to 12 years, and 12-18 years. Comparisons were also performed between those patients who were younger and older than 2 years. Continuous variables were expressed as mean (± SD) or median (Interquartile range [IQR]). Skewed data (BNP levels) were transformed logarithmically to produce a normal distribution for appropriate parametric testing. Univariate differences in continuous variables were analyzed with correlation and linear regression as appropriate. Univariate analysis of dichotomous variables was performed with the Pearson's \( \chi^2 \) test and the Mantel-Haenszel common odds ratio estimate. Univariate differences in dichotomous and continuous variables were assessed with the Mann-Whitney U test.

A composite endpoint that included hospitalization for worsening HF, all cause mortality and cardiac transplantation was used to assess the predictive value of the baseline BNP level. Before
performing survival analysis, a receiver operating characteristic curve was created to determine the BNP level that provided the best combination of sensitivity and specificity for predicting the composite endpoint. Survival analysis was performed with Kaplan-Meier and Cox proportional hazards modeling. The log-rank test was used to determine statistical significance between Kaplan-Meier survival curves. BNP level, age, diagnosis, HF class, gender, and type of systemic ventricle were all included in the hazard model. Analyses were performed in all subjects, regardless of treatment arm (placebo or carvedilol) since outcomes were previously shown to be no different among treatment groups. All statistical tests were 2-sided and significance was declared by an alpha value < 0.05. All statistical analyses were performed with SPSS software versions 15 and 16 (SPSS Inc., Chicago, IL).

Results

Baseline Assessment

Of the initial 161 subjects randomized, baseline serum BNP levels were available in 138. The most common reasons for a missing baseline BNP level were inability to draw blood or inadequate blood sample. Baseline characteristics for study subjects are shown in Table 1. In the 55 subjects with CHD, 36 (65%) had a systemic non-LV and 19 (35%) had a systemic LV. The majority of subjects were in HF class II at enrollment and only two subjects were HF class IV. Cardiac medications at the time of enrollment included angiotensin converting enzyme inhibitor or angiotensin receptor blocker (98%), digoxin (88%), loop diuretics (79%), aldosterone antagonists (33%), and antiarrhythmics (11%). There was no difference in the proportion of patients in HF class II vs. III/IV based on age group (p=0.31), gender (p=0.25), race (p=0.15), or diagnosis (p=0.47). Subjects with a systemic LV were less likely to be in HF class III-IV (Odds
Ratio [OR] 0.43; 95% CI 0.19-0.97). Subjects older than 2 years of age were less likely to have a systemic LV (OR 0.32; 95% CI 0.13-0.76) and less likely to have a diagnosis of cardiomyopathy (OR 0.26; 95% CI 0.12-0.56).

The distributions of baseline BNP levels, before and after logarithmic transformation, are shown in Figure 1, along with baseline median BNP and mean lnBNP levels, respectively. Median BNP levels did not differ by HF class (p=0.96), age group (p=0.21), diagnosis (p=0.53), sex (p=0.18), or ventricular morphology (p=0.95). In the 101 patients who had a systemic LV, lnBNP correlated moderately with LVEF (r=0.39; p<0.001) but not with LVEDd Z-score (r=0.19, p=0.054).

**BNP and Outcomes**

Outcome events occurred in 31 subjects and included 25 HF hospitalizations, 4 deaths and 2 transplants. Of the 25 subjects meeting the endpoint of hospitalization for worsening heart failure, 7 eventually died. 12 other subjects meeting the endpoint of hospitalization eventually underwent transplantation during the study period, with a median time to transplantation of 3 months (IQR 1.3-6.8) after enrollment. The median length of follow-up per subject was 7.7 months (IQR 7.2-8.2). The median time to composite outcome was 2.6 months (IQR 1.6-5.0). Median BNP was higher in subjects who reached the composite endpoint than for those who did not (308 pg/ml [IQR 122-672] vs 76 pg/ml [IQR 20-267], respectively, p=0.001). Analysis using a receiver operating characteristic curve showed that a BNP cutoff value of 140 pg/ml offered the best combination of sensitivity and specificity for the composite endpoint (Figure 2). Comparison of baseline characteristics between the subjects with BNP < 140 pg/ml and those with BNP ≥ 140 pg/ml showed significant differences only in LVEDd Z-score and LVEF in the
101 patients with a systemic LV (Table 1). Kaplan Meier survival analysis demonstrated significantly lower event free survival from the composite endpoint of freedom from heart failure hospitalization, transplantation or death for subjects with an enrollment BNP level of ≥ 140 pg/ml (Figure 3). Kaplan Meier survival analysis was repeated using a more restrictive composite endpoint of freedom from death or transplantation, which continued to show a statistically significant lower freedom from death or transplantation for subjects with a BNP level of ≥ 140 pg/ml (Figure 4).

After controlling for age, gender, HF class, diagnosis, and ventricular morphology, Cox proportional hazards modeling showed that a BNP level of ≥ 140 pg/ml and an age > 2 years each independently increased the likelihood of heart failure hospitalization, transplantation or death (Hazard Ratio (HR) 3.69, CI 1.61-8.44, p=0.002 and HR 4.45, CI 1.65-12.04, p=0.003, respectively (Table 2)).

Discussion

This post-hoc analysis of data from the Pediatric Carvedilol Trial demonstrates that serum BNP levels in children with moderately symptomatic HF are higher than normal values reported in children. The median BNP in children with HF was 110 pg/ml compared to 20-40 pg/ml reported in normal children. BNP levels did not differ by gender, diagnosis or subtype of systemic ventricle. There was a moderate correlation between lnBNP level and LVEF but no significant correlation between lnBNP levels and LV dimension. It is interesting, however, that a BNP level of ≥140 pg/ml was associated with a higher LVEDd Z-score and lower EF, which is consistent with the data that BNP levels increase with increasing wall stress. This is the first
prospective, multicenter study showing BNP to be predictive of clinical outcomes in a cohort of children with symptomatic HF.

BNP levels were not different among HF classes in this study. Previous studies have shown a correlation between higher BNP levels and worsening HF classes and measures of functional status.\(^6,^{13,19}\) These studies included subjects with HF classes I to IV, while in the current study, 72% of the subjects had HF class II and 27% had HF Class III or IV, with only two subjects with class IV. This suggests that BNP levels are not sensitive enough to distinguish between HF Class II and III in children.

In this study of children with class II and III HF on a standard oral anticongestive regimen, 22% reached the composite endpoint of hospitalization for worsening HF, all cause mortality or transplantation within 9 months. A BNP level $\geq$ 140 pg/ml in this cohort was predictive of adverse outcomes. While these data are consistent with previous studies showing that BNP levels can predict adverse outcomes in both children and adults with HF, further validation is needed to determine the BNP level necessary to stratify risk in other specific and/or broader cohorts.\(^{15,19}\)

In a cohort of mostly asymptomatic older children, all of whom had a diagnosis of dilated cardiomyopathy with anatomically normal hearts, Price et al. reported a positive association of a BNP level of 300 pg/ml with a 90-day composite outcome of HF-related hospitalization, HF related death, or listing for transplantation.\(^{15}\) Our study population was very different in that all subjects were symptomatic and 40% of the subjects had a diagnosis of CHD, 27% with a non-LV systemic ventricle. This heterogeneity of ventricular morphology and homogeneity of symptoms may be the reason for the lower sensitivity and specificity for the ability of BNP levels to predict outcomes by receiver operating characteristic curve analysis when compared to a population of children with mostly asymptomatic ventricular dysfunction and anatomically normal hearts.
The threshold level of BNP associated with adverse outcome in the children with HF in this study is lower than what has been previously reported in adults. Healthy children have been shown to have lower baseline BNP levels than healthy adults, but no study has directly compared BNP levels in children and adults with comparable HF symptoms or severity. An important difference between the pediatric and adult HF populations is that a significant proportion of children have symptomatic HF due to failed palliation of CHD. Children with CHD have been found to have lower BNP levels than children with similar EF, end diastolic pressures, and functional status with a diagnosis of DCM. In particular, children with single ventricle physiology who have undergone Fontan palliation have also been noted to have lower than expected BNP levels relative to their ventricular function and functional status, which has been postulated to be secondary to reduced preload and limited preload reserve. Another possible explanation for the lower threshold BNP level in children is that this study had a longer follow-up period after measurement of the baseline BNP level when compared to prior studies. A higher BNP threshold level may be more accurate for predicting short-term outcomes, while a lower threshold BNP level may predict adverse outcomes with longer follow-up.

Although the purpose of this analysis was to evaluate the ability of BNP levels to predict clinical outcomes, it was also interesting to find that subjects who were > 2 years of age were over four times more likely to experience the composite endpoint in multivariate analysis. It seems reasonable to speculate that a larger proportion of subjects with CHD with ventricular dysfunction may also contribute to the increased risk of poor outcome in the older subjects. However, the Cox proportional hazards model controlled for diagnosis and ventricular morphology and still found age to be an independent predictor of outcomes in this cohort. This finding is consistent with a recent study of predictors of clinical outcome in subjects with dilated
cardiomyopathy, in which patients ≥ 6 years had a higher risk of adverse outcomes. The differences in diagnosis and ventricular morphology may explain the lower age cut off in our study.

Our findings suggest that BNP levels in stable pediatric outpatients with mild-to-moderately symptomatic HF can be used to identify children at risk for hospitalization for worsening HF, death, or transplantation. The major strength of this multicenter study is that it represents the largest cohort of subjects studied to date to determine the ability of BNP levels to predict the risk of adverse events in children with symptomatic HF. The data were obtained prospectively during a randomized placebo controlled trial and the endpoints for worsening HF were adjudicated by an endpoint steering committee. There are, however, several limitations of this study. The heterogeneous subject population may have introduced variability in the values of BNP levels that limited the sensitivity and specificity analysis. The numbers of subjects were insufficient to allow for analyses to determine if the BNP level can predict the composite outcome in subgroups of children with congenital heart disease and different ventricular morphologies and numbers of ventricles. Also, the study did not include determination of NT-proBNP levels, which have also been shown to be predictive of outcome in heart failure patients.

In conclusion, our findings suggest that BNP levels of ≥ 140 pg/ml in stable pediatric outpatients with mild-to-moderately symptomatic HF can be used to identify children at risk for hospitalization for worsening HF, death, or transplantation. Further studies are needed to validate the cutoff BNP level of 140 pg/ml in other specific and/or broader cohorts. BNP levels should be included in the risk stratification of children with HF, and higher BNP levels should warrant increased surveillance and management for worsening HF in this population. This knowledge
may be used in the future to tailor medical treatment to individual patients and to determine the optimal timing of transplantation. Whether escalating treatment regimens in patients with elevated BNP levels leads to improved outcomes requires further investigation.
Acknowledgements:

Roger Vaughan, PhD and Jimmy Duong MSc, from the Department of Biostatistics, Mailman School of Public Health, provided statistical support.

Sources of Funding:

This publication was made possible by Grant Number UL1 RR024156 from the National Center for Research Resources, a component of the National Institutes of Health (NIH), and NIH Roadmap for Medical Research. Its contents are solely the responsibility of the authors and do not necessarily represent the official view of the National Center for Research Resources or the NIH. Information on the National Center for Research Resources is available at the National Center for Research Resources Website. Information on Re-engineering the Clinical Research Enterprise can be obtained from the NIH Roadmap website.

Disclosures:

None.
References


<table>
<thead>
<tr>
<th>Characteristics</th>
<th>All Subjects (N=138)</th>
<th>BNP &lt; 140 pg/ml (N=74)</th>
<th>BNP &gt; 140 pg/ml (N=64)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex N (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>69 (50)</td>
<td>40 (54)</td>
<td>29 (46)</td>
</tr>
<tr>
<td>Male</td>
<td>69 (50)</td>
<td>34 (46)</td>
<td>35 (54)</td>
</tr>
<tr>
<td>Ethnicity N (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>33 (24)</td>
<td>14 (19)</td>
<td>19 (30)</td>
</tr>
<tr>
<td>Asian</td>
<td>3 (2.2)</td>
<td>2 (3)</td>
<td>1 (2)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>69 (50)</td>
<td>38 (51)</td>
<td>31 (48)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>27 (20)</td>
<td>17 (23)</td>
<td>10 (16)</td>
</tr>
<tr>
<td>Other</td>
<td>6 (4.3)</td>
<td>3 (4)</td>
<td>3 (5)</td>
</tr>
<tr>
<td>Diagnosis N (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>83 (60)</td>
<td>46 (62)</td>
<td>37 (58)</td>
</tr>
<tr>
<td>Congenital Heart Disease</td>
<td>55 (40)</td>
<td>28 (38)</td>
<td>27 (42)</td>
</tr>
<tr>
<td>Ventricular Morphology N (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systemic Non-Left Ventricle</td>
<td>37 (27)</td>
<td>20 (27)</td>
<td>17 (26)</td>
</tr>
<tr>
<td>Systemic Left Ventricle</td>
<td>101 (73)</td>
<td>54 (73)</td>
<td>47 (73)</td>
</tr>
<tr>
<td>Median Age, IQR</td>
<td>3.4 (1.1-10.8)</td>
<td>3.1 (0.8-12.9)</td>
<td>3.5 (1.4-10.1)</td>
</tr>
<tr>
<td>0 to 2 yrs, N (%)</td>
<td>55 (40)</td>
<td>32 (43)</td>
<td>23 (36)</td>
</tr>
<tr>
<td>2 to 6 yrs, N (%)</td>
<td>25 (18)</td>
<td>9 (12)</td>
<td>16 (25)</td>
</tr>
<tr>
<td>5 to 12 yrs, N (%)</td>
<td>27 (20)</td>
<td>14 (19)</td>
<td>13 (20)</td>
</tr>
<tr>
<td>12-18 yrs, N (%)</td>
<td>31 (22)</td>
<td>19 (26)</td>
<td>12 (19)</td>
</tr>
<tr>
<td>Age &gt; 2 yrs, N (%)</td>
<td>83 (60)</td>
<td>42 (57)</td>
<td>41 (64)</td>
</tr>
<tr>
<td>Ross or NYHA HF Class N (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Class II</td>
<td>100 (72)</td>
<td>55 (74)</td>
<td>45 (70)</td>
</tr>
<tr>
<td>Class III-IV</td>
<td>38 (28)</td>
<td>19 (26)</td>
<td>19 (30)</td>
</tr>
<tr>
<td>Study Arm N (%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placebo</td>
<td>44 (32)</td>
<td>28 (38)</td>
<td>16 (25)</td>
</tr>
<tr>
<td>Low Dose</td>
<td>47 (34)</td>
<td>23 (31)</td>
<td>24 (38)</td>
</tr>
<tr>
<td>High Dose</td>
<td>47 (34)</td>
<td>23 (31)</td>
<td>24 (38)</td>
</tr>
<tr>
<td>Mean LVEDd Z Score ±SD N=102</td>
<td>6.6 ± 3.5</td>
<td>5.5 ± 2.8</td>
<td>7.8 ± 3.8*</td>
</tr>
<tr>
<td>Mean LVEF (%) ±SD N=106</td>
<td>26.5 ± 7.9</td>
<td>29.4 ± 7.4</td>
<td>23.2 ± 7.3*</td>
</tr>
</tbody>
</table>

* p ≤ 0.001 as compared to BNP < 140 pg/ml
<table>
<thead>
<tr>
<th></th>
<th>HR (95% CI)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>BNP ≥ 140 pg/ml</td>
<td>3.69 (1.61-8.44)</td>
<td>0.002</td>
</tr>
<tr>
<td>Age &gt; 2 years</td>
<td>4.45 (1.65-12.04)</td>
<td>0.003</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>3.02 (0.75-12.12)</td>
<td>0.12</td>
</tr>
<tr>
<td>HF Class III-IV</td>
<td>1.35 (0.62-2.97)</td>
<td>0.45</td>
</tr>
<tr>
<td>Male Sex</td>
<td>1.02 (0.49-2.14)</td>
<td>0.95</td>
</tr>
<tr>
<td>Systemic LV</td>
<td>0.29 (0.07-1.23)</td>
<td>0.09</td>
</tr>
</tbody>
</table>
Figure Legends

Figure 1. Baseline BNP distribution before (left) and after (right) logarithmic transformation. Baseline BNP levels were significantly skewed rightward, necessitating logarithmic transformation prior to performing parametric testing. Logarithmic transformation resulted in a normal distribution.

Figure 2. Receiver operating characteristic curve for BNP levels. This receiver operating characteristic curve demonstrates that a BNP level of 140 pg/ml results in a sensitivity of 71% and specificity of 63% to predict the composite outcome of hospitalization for worsening HF, death, or transplantation. The area under the curve was 0.71 (95% CI 0.60-0.81).

Figure 3. Kaplan-Meier survival curve showing freedom from the composite endpoint. Survival analysis of time to hospitalization for worsening HF, death, or transplant showed significantly worse event free survival in subjects with a BNP ≥ 140 pg/ml. Event free survival at 6 and 9 months was 90% and 78%, respectively, for a BNP level < 140 pg/ml and 68% and 50%, respectively, for a BNP level of ≥ 140 pg/ml.

Figure 4. Kaplan-Meier survival curve showing freedom from death or transplantation only. Survival analysis was repeated using a composite endpoint of time to death or transplantation and showed significantly worse event free survival in subjects with a BNP ≥ 140 pg/ml. Event free survival at 6 and 9 months was 92% and 78%, respectively, for a BNP level < 140 pg/ml and 76% and 57%, respectively, for a BNP level of ≥ 140 pg/ml.
Baseline BNP Level Distribution

Median BNP 110 pg/ml
Interquartile Range 22-342 pg/ml

Baseline InBNP Distribution

Mean InBNP 4.5 +/- 1.7
BNP Levels Predict Outcome in Pediatric Heart Failure Patients: Post-hoc Analysis of the Pediatric Carvedilol Trial
Scott R. Auerbach, Marc E. Richmond, Jacqueline M. Lamour, Elizabeth D. Blume, Linda J. Addonizio, Robert E. Shaddy, Lynn Mahony, Elfriede Pahl and Daphne T. Hsu

*Circ Heart Fail.* published online June 23, 2010;
*Circulation: Heart Failure* is published by the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231
Copyright © 2010 American Heart Association, Inc. All rights reserved.
Print ISSN: 1941-3289. Online ISSN: 1941-3297

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://circheartfailure.ahajournals.org/content/early/2010/06/23/CIRCHEARTFAILURE.109.906875

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in *Circulation: Heart Failure* can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to *Circulation: Heart Failure* is online at:
http://circheartfailure.ahajournals.org//subscriptions/