A new prediction model for ventricular arrhythmias in arrhythmogenic right ventricular cardiomyopathy

Julia Cadrin-Tourigny¹,²†, Laurens P. Bosman³,⁴‡, Anna Nozza⁵, Weijia Wang¹, Rafik Tadros², Aditya Bhonsale¹, Mimount Bourfiss⁴, Annik Fortier⁵, Øyvind H. Lie⁶,⁷, Ardan M. Saguner⁸, Anneli Svensson⁹, Antoine Andorin², Crystal Tichnell¹, Britney Murray¹, Katja Zeppenfeld¹⁰, Maarten P. van den Berg¹¹, Folkert W. Asselbergs³,⁴,¹², Arthur A.M. Wilde¹³, Andrew D. Krahn¹⁴, Mario Talajic², Lena Rivard², Stephen Chelko¹, Stefan L. Zimmerman¹⁵, Ihab R. Kamil¹⁶, Jane E. Crosson¹, Daniel P. Judge¹, Sing-Chien Yap¹⁶, Jeroen F. van der Heijden⁴, Haririkhsna Tandri¹, Jan D.H. Jongbloed¹⁷, Marie-Claude Guertin⁵, J. Peter van Tintel⁸,¹⁸, Pyotr G. Platonov¹⁹, Firat Duru⁸, Kristina H. Haugaa⁶,⁷, Paul Khairy², Richard N.W. Hauer³,⁴, Arthur A.M. Wilde¹³, Andrew D. Krahn¹⁴, Mario Talajic², Lena Rivard², Stephen Chelko¹, Stefan L. Zimmerman¹⁵, Ihab R. Kamil¹⁶, Jane E. Crosson¹, Daniel P. Judge¹, Sing-Chien Yap¹⁶, Jeroen F. van der Heijden⁴, Haririkhsna Tandri¹, Jan D.H. Jongbloed¹⁷, Marie-Claude Guertin⁵, J. Peter van Tintel⁸,¹⁸, Pyotr G. Platonov¹⁹, Firat Duru⁸, Kristina H. Haugaa⁶,⁷, Paul Khairy², Richard N.W. Hauer³,⁴, Hugh Calkins¹, Anneline S.J.M. te Riele³,⁴‡, and Cynthia A. James¹*‡

¹Division of Cardiology, Department of Medicine, Johns Hopkins Hospital, Carnegie 568D, 600 N. Wolfe St, Baltimore, MD 21287, USA; ²Cardiovascular Genetics Center, Montreal Heart Institute, Universite de Montreal, 500 Belanger St, Montreal H1T 1C8, Canada; ³Cardiovascular Genetics Center, UMC Utrecht, Utrecht University, PO Box 19258, 3501 DG Utrecht, The Netherlands; ⁴Department of Cardiology, University Medical Center Utrecht, University of Utrecht, Heidelberglaan 100, 3584 CX Utrecht, The Netherlands; ⁵Montreal Health Innovations Coordinating Center, Universite de Montreal, 4100 Molson St, Suite 400, Montreal H1Y 3N1, Canada; ⁶Department of Cardiology, Center for Cardiological Innovation, Oslo University Hospital, Postboks 4950 Nydalen, 0424 Oslo, Norway; ⁷University of Oslo, Postboks 1171, Blindern 0318 Oslo, Norway; ⁸Department of Cardiology, University Heart Center Zurich, Ramistrasse 100, 8091 Zurich, Switzerland; ⁹Department of Cardiology, University Hospital Linkoping, S-581 85 Linkoping, Sweden; ¹⁰Department of Cardiology, Leiden University Medical Center, Albinusdreef 2, 2333 ZA Leiden, The Netherlands; ¹¹Department of Cardiology, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands; ¹²Faculty of Population Health Sciences, Institute of Cardiovascular Science, Institute of Health Informatics, University College London, 69-75 Chennis Mews, London, UK; ¹³Department of Clinical and Experimental Cardiology, Amsterdam UMC, University of Amsterdam, Heart Center, Meibergdreef 9, 1105 AZ, Amsterdam, The Netherlands; ¹⁴Division of Cardiology, Department of Medicine, University of British Columbia 211-1033 Davie Street, Vancouver, BC V6E 1M7, Canada; ¹⁵The Russell H. Morgan Department of Radiology and Radiological Science, Johns Hopkins Hospital, 600 N. Wolfe St, Baltimore, MD 21287, USA; ¹⁶Department of Cardiology, Thoraxcenter, Erasmus Medical Center, Dr. Molewaterplein 40, 3015 GD, Rotterdam, The Netherlands; ¹⁷Department of Genetics, University of Groningen, University Medical Center Groningen, Hanzeplein 1, 9713GZ Groningen, The Netherlands; ¹⁸Department of Clinical Genetics, Academic Medical Center, University of Amsterdam, Meibergdreef 9, 1100 DD Amsterdam, The Netherlands; and ¹⁹Department of Cardiology, Clinical Sciences, Lund University Hospital, 22185 Lund, Sweden

Received 2 August 2018; revised 21 November 2018; editorial decision 31 January 2019; accepted 1 March 2019; online publish-ahead-of-print 27 March 2019

See page 1859 for the editorial comment on this article (doi: 10.1093/eurheartj/ehz195)

Aim

Arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVC) is characterized by ventricular arrhythmias (VAs) and sudden cardiac death (SCD). We aimed to develop a model for individualized prediction of incident VA/SCD in ARVC patients.

Methods and results

Five hundred and twenty-eight patients with a definite diagnosis and no history of sustained VAs/SCD at baseline, aged 38.2 ± 15.5 years, 44.7% male, were enrolled from five registries in North America and Europe. Over 4.83 (interquartile range 2.44–9.33) years of follow-up, 146 (27.7%) experienced sustained VA, defined as SCD, aborted SCD, sustained ventricular tachycardia, or appropriate implantable cardioverter-defibrillator (ICD) therapy. A

* Corresponding author. Tel: +1 413 287 5985, Fax: +1 410 502 9148, Email: cjames7@jhmi.edu
† The first two authors share the co-first authorship.
‡ The last two authors share the co-last authorship.

© The Author(s) 2019. Published by Oxford University Press on behalf of the European Society of Cardiology.

This is an Open Access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (http://creativecommons.org/licenses/by-nc/4.0/), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited. For commercial re-use, please contact journals.permissions@oup.com
Introduction

Arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVC) is an inherited cardiomyopathy characterized by progressive fibro-fatty replacement of the myocardium which predisposes patients to ventricular arrhythmias (VAs) and sudden cardiac death (SCD). Once the diagnosis is established, a primary goal of management is prevention of SCD, for which implantable cardioverter-defibrillators (ICDs) are a common consideration. There is agreement that most ARVC patients with a prior history of sustained VA or resuscitated sudden cardiac arrest (SCA) benefit from secondary prevention ICDs. However, for the primary prevention population, there is no established risk stratification scheme.

Over the past two decades, multiple attempts have been made to identify factors associated with VA in this clinically challenging population. While these studies have significantly contributed to our understanding of clinical, demographic, and behavioural factors associated with arrhythmic risk, the relatively small patient populations provided insufficient statistical power to assess the independent predictive value of potentially correlated risk factors.

To overcome this important limitation, we assembled a large cohort of patients with ARVC from five registries (Johns Hopkins, Dutch, Nordic, Swiss, and Canadian) without a history of sustained VAs at baseline. Our aim was (i) to develop a model for individualized prediction of incident sustained VA in patients with ARVC using readily available clinical variables; and (ii) to compare this new model to a current consensus-based ICD placement algorithm.

Methods

Study design
We conducted an observational, retrospective, longitudinal cohort study in accordance with the Transparent Reporting of a Multivariable Prediction Model for Individual Prognosis or Diagnosis (TRIPOD) statement.

Study population
The study population was drawn from five ARVC registries encompassing 14 academic centres (Supplementary material online, Table S1) in six countries. Each registry is itself a longitudinal cohort study. From each registry, we included all patients who (i) were diagnosed with definite ARVC by the current 2010 Task Force Criteria (TFC) and (ii) had not experienced spontaneous sustained VA or SCA at diagnosis. The study conforms to the Helsinki declaration and was approved by local ethics and/or institutional review boards.

Study outcomes
The primary study outcome was the first sustained VA following diagnosis by the TFC. Sustained VA was defined as a composite of the occurrence of SCD, SCA, spontaneous sustained ventricular tachycardia (VT) (VT lasting ≥30 s at ≥100 b.p.m. or with haemodynamic compromise requiring cardioversion), ventricular fibrillation/flutter (VF), or appropriate ICD intervention. The first episode of a rapid sustained VA (defined as SCD, SCA, VF, or VT >250 b.p.m.), heart transplantation, cardiovascular mortality, and all-cause mortality were also recorded.

Predictors
Potential predictors were pre-specified based on clinical experience and current literature on arrhythmic risk stratification in ARVC including: (i) a recent systematic review and meta-analysis and (ii) the International Task Force Consensus (ITFC) Statement for Treatment of ARVD/C and a recent analysis of the performance of its risk stratification algorithm. Variables considered were sex, age, recent (<6 months) cardiac syncope, non-sustained VT (NSVT), number of premature ventricular complexes (PVCs) on 24-h Holter monitoring, extent of T-wave inversion (TWI) on anterior and inferior leads, right ventricular ejection fraction (RVEF), and left ventricular ejection fraction (LVEF). Each predictor variable was determined at the time of diagnosis, defined as 1 year before to 1 year after the date of diagnosis by TFC but always prior to occurrence of the primary outcome. Definitions of predictor variables are provided in Supplementary material online, Table S2. In Supplementary material online, Table S3, we describe the rationale for selecting each predictor, as well as the rationale for excluding other variables.

Data collection
Data were collected independently by each registry according to standard operating procedures (Supplementary material online, Table S4). Outcomes were adjudicated at each centre via review of electrocardiogram (ECG) tracings, ICD interrogation tracings, as well as medical and death records. ECGs were interpreted through an ECG core laboratory.
by two cardiologists–electrophysiologists (J.C.T. and R.T.) blinded to the rest of the data and outcomes. Genetic variants were adjudicated according to the American College of Medical Genetics and Genomics guidelines by consensus of specialists in cardiac genetics (B.M., J.D.H.J., J.P.v.T., and C.A.J.).

Statistical analysis
Analyses were performed using SAS software version 9.4 (SAS Institute, Cary, NC, USA) and RStudio version 1.1.414 (Boston, MA, USA). Categorical variables were summarized as frequencies (%) and compared using the χ² or the Fisher’s exact tests, as appropriate. Continuous variables were presented as mean ± standard deviation or median [interquartile range (IQR)], and compared using the independent sample t-test or the Mann–Whitney U test. Follow-up duration was calculated from the date of diagnosis to the date of reaching the endpoint or censoring, which was defined as death from any other cause, heart transplantation, or the most recent follow-up visit at which the endpoint could be ascertained. The overall probability of survival free from sustained VA was estimated using the Kaplan–Meier method.

Missing data
Potential bias from missing data was evaluated by comparing characteristics of patients with one or more missing predictor variables to patients with complete data. Missing quantitative values for RVEF and LVEF were imputed manually when qualitative assessment was present (as detailed in Supplementary material online, Table S4). Other missing data were assumed to be missing at random and imputed using multiple imputation with chained equations. The multiple imputation model included all pre-specified predictors as well as proband status, QRS duration, right ventricular volume, ICD carrier status, together with the outcome, and a cumulative baseline hazard estimation. A total of 25 imputed datasets were generated, and the final inference estimations were combined using Rubin’s rules. A complete case analysis and an analysis without manual imputation of RVEF and LVEF were conducted as sensitivity analyses.

Model development and validation
The association between the pre-specified predictors and the primary outcome was assessed using Cox regression. Proportional-hazard assumptions were verified as well as linearity of the association for continuous predictors. The final model was fitted using stepwise backward selection based on Akaike’s Information Criterion. The discriminative performance of the model was measured using Harrell’s C-statistic.

The model was validated using 200 bootstrap samples. The degree of optimism was estimated by the average calibration slope of the bootstrap samples. Agreement between predicted and observed outcomes was evaluated graphically using calibration plots that incorporated grouped Kaplan–Meier estimates and the continuous hazard regression function. Calibration analyses were repeated for patient subgroups including genotype and ICD status.

Model presentation
For an individual patient, the risk of sustained VA was calculated using the following equation:

\[ P(\text{VA at time } t) = 1 - S_0(t) \exp(\text{LP}) \]

where \(S_0(t)\) is the baseline survival probability at time \(t\) (i.e. at 5 years), and LP (linear predictor) is the sum of the products of the predictors and associated coefficients for a given patient.

Clinical utility
To assess the implications of our model in clinical practice, we compared performance of our model to that of the consensus-based algorithm for ICD placement published in the ITFC Statement for Treatment of ARVC. First, we explored the clinical impact of potential thresholds for ICD implantation by evaluating the proportions of appropriate and inappropriate treatment at each of these thresholds. Second, we performed a decision curve analysis to evaluate the clinical benefit of our model. In this analysis, the clinical benefit was assessed by the ‘net benefit’; a weighted measure of the balance between appropriate and inappropriate ICD implantations. A value of 0 indicates no benefit, while higher values indicate greater benefit.

Results
Study population
The study population consisted of 528 patients with definite ARVC and no history of sustained VA or SCA at time of diagnosis. Almost half (\(n = 236, 44.7\%\)) of the population was male with an average age at diagnosis of 38.2 ± 15.5 years. Proband counts were presented as mean ± standard deviation or median [interquartile range (IQR)], and compared using the independent sample t-test or the Mann–Whitney U test. Follow-up duration was calculated from the date of diagnosis to the date of reaching the endpoint or censoring, which was defined as death from any other cause, heart transplantation, or the most recent follow-up visit at which the endpoint could be ascertained. The overall probability of survival free from sustained VA was estimated using the Kaplan–Meier method.

Outcomes
During a median follow-up of 4.83 years (IQR 2.44–9.33 years), 146 (27.7%) patients experienced the composite outcome, with a corresponding annual event rate of 5.6% [95% confidence interval (CI) 4.7–6.6].

Figure 1 shows the cumulative survival free from first sustained VA. As shown in the figure, events occurred throughout follow-up, with a cumulative event-free survival at 5 years of 73.6% (95% CI 69.4–78.0%). The most common first sustained VA was appropriate ICD therapy (\(n = 102, 70.0\%\)), followed by spontaneous sustained VT (\(n = 35, 23.9\%\)), SCA (\(n = 6, 4.1\%\)), and SCD (\(n = 3, 2.0\%\)).

Rapid sustained VAs (VT with cycle length <240 ms, SCA, or SCD) were experienced by 53 (10.0%) patients during follow-up at an annual event rate of 1.7% (95% CI 1.3–2.2). At last follow-up, 18 (3.4%) patients had died and 14 (2.7%) had undergone heart transplantation.

Model development
Table 1 shows baseline characteristics of patients with and without sustained VA during follow-up. Table 2 summarizes development of the risk prediction model. As shown in these tables, each pre-specified predictor had a significant \((P < 0.05)\) univariable linear or
log-linear relationship with the primary outcome. All predictors were, therefore, fitted into a multivariable model, after which step-wise backward selection was performed leading to the removal of LVEF from the final model. As a sensitivity analysis, we repeated this process (i) for patients with complete data and (ii) without manual imputation for RVEF. As can be appreciated from Supplementary material online, Table S6, this resulted in inclusion of the same predictor variables (i.e. excluding LVEF) with only small changes to the coefficients in the resulting model.

The following formula allows for the calculation of the 5-year risk of sustained VA:

\[
P(\text{VA at 5 years}) = 1 - 0.801 \exp(LP)
\]

where \(LP = 0.488\times\text{sex} - 0.022\times\text{age} + 0.657\times\text{history of recent cardiac syncope} + 0.811\times\text{history of NSVT} + 0.170\times\ln(24\text{ h PVC count}) + 0.113\times\text{Sum of anterior and inferior leads with TWI} - 0.025\times\text{RVEF}.

Supplementary material online, Table S7 provides the probability of survival \(S_0(t)\) at 1, 2, 3, and 4 years to facilitate calculating risk for shorter time durations.

Supplementary material online, Table S8 illustrates the use of this risk calculator in 3 patients from our cohort. An online application to calculate risk for an individual patient is available at: www.arvcrisk.com.

Model validation

The optimism-corrected C-statistic of the predictive model was 0.77 (95% CI 0.73–0.81). Internal validation with bootstrapping revealed a calibration slope of 0.93 (95% CI 0.92–0.95), reflecting a small degree of over-optimism. Figure 2 presents a graphical representation of calibration, showing good overall agreement between the predicted and observed 5-year risk. Calibration plots showing similarly good agreement for shorter follow-up durations can be found in Supplementary material online.
material online, Figure S1. Additional calibration plots for patients stratified by ICD carrier status and genotype are presented in Supplementary material online, Figure S2. As can be appreciated from this figure, predicted and observed 5-year risk remained concordant in these patient subgroups.

**Clinical utility**

To assess the implications of our model in clinical practice, we explored the impact of potential 5-year VA risk thresholds for ICD implantation in our model vs. the ITFC consensus algorithm (i.e., ICD implantation in those with an ITFC Class I/IIa indication). As can be appreciated from the two last columns of Supplementary material online, Table S9, applying the ITFC algorithm would have resulted in treating 355 (67.2%) patients and protecting 131 (89.9%) of those who subsequently developed VA. In comparison, to provide the same level of protection (89.9%), our model would result in the implantation of 282 (53.4%) ICDs, thereby reducing the total number of ICD implants by 20.6% [(355–282)/355] (P < 0.001).

**Table 2** Ventricular arrhythmia risk prediction model

<table>
<thead>
<tr>
<th></th>
<th>Univariable model</th>
<th>Multivariable (final model)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>HR (95% CI)</td>
<td>P-value</td>
</tr>
<tr>
<td>Male sex</td>
<td>1.74 (1.26–2.42)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Age (per year increase)</td>
<td>0.98 (0.97–0.99)</td>
<td>0.001</td>
</tr>
<tr>
<td>Recent cardiac syncope</td>
<td>2.57 (1.66–3.97)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Prior NSVT</td>
<td>3.15 (2.12–4.68)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>24 h PVC count (ln)*</td>
<td>1.32 (1.17–1.48)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Leads with TWI anterior + inferior</td>
<td>1.20 (1.12–1.29)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>RVEF (per % decrease)</td>
<td>1.05 (1.03–1.06)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>LVEF (per % decrease)</td>
<td>1.02 (1.01–1.04)</td>
<td>0.011</td>
</tr>
</tbody>
</table>

LVEF, left ventricular ejection fraction; NSVT, non-sustained ventricular tachycardia; PVC, premature ventricular complex; RVEF, right ventricular ejection fraction; TWI, T-wave inversion.

*PVC count had a log-linear relationship.
We subsequently compared the clinical performance of our model to the ITFC algorithm using decision curve analysis. As shown in Figure 4, our proposed model was associated with the highest net benefit within the entire range of potential treatment thresholds for ICD placement. This suggests superiority in clinical practice regardless of implantation threshold.

**Discussion**

**Main findings**

We developed and internally validated the first prediction model to generate individualized risk estimates for sustained VA in patients with ARVC. This model accurately distinguished patients who had incident sustained VA during follow-up from those who did not using seven non-invasive parameters that are readily available to the clinician. Predicted and observed risks were concordant both in the overall population and in key patient subgroups. In addition, the model compared favourably to a clinically available treatment algorithm, suggesting greater utility in everyday clinical practice.

**Prior studies**

This work builds upon numerous efforts in the ARVC community directed towards optimization of arrhythmic risk stratification. Indeed, selection of pre-specified predictors was based on a meta-analysis that included 45 studies examining the association of clinical and demographic characteristics with VAs. Despite this wealth of data, a lack of systematically analysed results complicates their translation to clinical care. Interpretation of the results of prior studies has been significantly hampered by limited sample sizes and heterogeneous study populations. In addition, none of the prior studies were designed to derive a prediction model that can be applied to clinical care. The 2015 ITFC Statement for Treatment of ARVC was a major step forward in consolidating the literature and proposing an
with a crude estimate of risk. Opportunities for improvement were based on expert opinion and provided only risk strata without a pre-existing history of sustained VA (5.6% per year). While our study quantifies the high rate of VA events in ARVC patients, it is important to recognize that ARVC is a progressive condition. Thus, patients should be periodically re-assessed with caution to patients of other ethnic background or genotypes.

The need for accurate ventricular arrhythmia risk prediction in arrhythmogenic right ventricular dysplasia/cardiomyopathy

Our study quantifies the high rate of VA events in ARVC patients without a pre-existing history of sustained VA (5.6% per year). While this event rate is significantly higher than for other types of non-ischaemic cardiomyopathies, it is comparable to previous studies in primary prevention ARVC populations, which reported annual event rates of 2–10%. Faced with this high event rate, many clinicians would agree that the majority of patients with definite ARVC benefit from ICD placement. However, ICD placement has significant drawbacks in this usually young and active population, including a considerable risk of complications and inappropriate interventions. Appropriate patient selection is thus of paramount importance.

Clinical utility

The greatest clinical utility of our model lies in the accurate individualized quantification of arrhythmic risk (Take home figure). By treating VA risk as a continuum instead of dividing patients into high-, intermediate-, and low-risk strata, we provide prognostic information that can aid clinical decision-making for prophylactic ICD placement. Importantly in this high-risk population, our model can help the clinician identify those who would fare well without an ICD. Of note, our study does not aim to prescribe ICD placement for a given patient. Instead, we seek to provide the clinician and patient with the necessary data to facilitate well-informed shared clinical decision-making.

While the acceptable risk threshold is undefined, our model performed better than the current consensus-based algorithm at any risk threshold. Importantly, our model results in a 20.6% reduction of ICD placement compared to the ITFC consensus algorithm, while protecting as many patients with VA events. Therefore, we believe that the model has the potential to set the standard for everyday clinical decision-making for primary prevention ICDs in patients with ARVC. To facilitate this, we have made our model available online as a ‘risk calculator’ on www.arvcrisk.com. Such a tool has had considerable clinical utility for arrhythmic risk prediction in hypertrophic cardiomyopathy. It is important to recognize that ARVC is a progressive condition. Thus, patients should be periodically re-stratified with right ventricular function assessment, ECG, and heart rhythm monitoring every 1–2 years as suggested in a recent expert consensus document. We provided risk estimates to facilitate shorter-term prediction and calibration plots establishing concordance between predicted and observed events over these shorter timeframes (Supplementary material online, Table S7 and Figure S1).

Limitations and future directions

Our study population was drawn from academic centres across Northern Europe and North America. Consistent with this, patients were predominantly Caucasian and pathogenic variants were primarily identified in PKP2. Results should consequently be extrapolated with caution to patients of other ethnic background or genotypes. Our ascertainment from tertiary care settings may have created a referral bias that could lead to overestimation of VA risk in a community-derived population. These limitations highlight the importance of external validation studies that include patients from community settings and with a diversity of ethnic backgrounds and genotypes. As in similar studies, we used a surrogate composite endpoint that included appropriate ICD therapy to infer risk of SCD. While most clinicians agree that ICD-treated VA represents a severe event, ICD therapies are an imperfect substitute for SCD. To address these limitations, we stratified the population by prophylactic algorithm for ICD placement. Nevertheless, the ITFC recommendations were based on expert opinion and provided only risk strata with a crude estimate of risk. Opportunities for improvement were subsequently raised. Therefore, to the present day, there is no uniformly accepted risk stratification algorithm for ARVC.

Model development and validation

In order to be widely applicable, a risk stratification algorithm should be derived from a broad population, simple, and easy to use. As such, we assembled the largest cohort to date of ARVC patients from multinational transatlantic registries, and measured seven easily available clinical parameters. Our model showed good discrimination between those with vs. without sustained VA (as indicated by the C-statistic), and good agreement between observed and predicted sustained VA risk (as determined by the calibration plots). In addition, sensitivity analyses revealed that the relationships between predictors and outcome were comparable in key patient subgroups.

Figure 4 Decision curve analysis comparing the clinical utility of our model (red dotted line) to the International Task Force Consensus Statement algorithm (blue dotted line). The clinical utility of both treatment strategies is compared by plotting the net benefit (y axis) for a range of potential implantable cardioverter-defibrillator placement thresholds based on the 5-year risk of VA (x axis). Our model showed the highest net benefit for all potential thresholds (ranging from 2.5% to 27.5%). This indicates that our model would result in the highest weighted balance of appropriate vs. inappropriate implantable cardioverter-defibrillator placements, regardless of the clinically preferred risk threshold. ICD, implantable cardioverter-defibrillator; ITFC, International Task Force Consensus Statement.

Take home figure

The greatest clinical utility of our model lies in the accurate individualized quantification of arrhythmic risk. By treating VA risk as a continuum instead of dividing patients into high-, intermediate-, and low-risk strata, we provide prognostic information that can aid clinical decision-making for prophylactic ICD placement. Importantly in this high-risk population, our model can help the clinician identify those who would fare well without an ICD. Of note, our study does not aim to prescribe ICD placement for a given patient. Instead, we seek to provide the clinician and patient with the necessary data to facilitate well-informed shared clinical decision-making.

While the acceptable risk threshold is undefined, our model performed better than the current consensus-based algorithm at any risk threshold. Importantly, our model results in a 20.6% reduction of ICD placement compared to the ITFC consensus algorithm, while protecting as many patients with VA events. Therefore, we believe that the model has the potential to set the standard for everyday clinical decision-making for primary prevention ICDs in patients with ARVC. To facilitate this, we have made our model available online as a ‘risk calculator’ on www.arvcrisk.com. Such a tool has had considerable clinical utility for arrhythmic risk prediction in hypertrophic cardiomyopathy. It is important to recognize that ARVC is a progressive condition. Thus, patients should be periodically re-stratified with right ventricular function assessment, ECG, and heart rhythm monitoring every 1–2 years as suggested in a recent expert consensus document. We provided risk estimates to facilitate shorter-term prediction and calibration plots establishing concordance between predicted and observed events over these shorter timeframes (Supplementary material online, Table S7 and Figure S1).

Limitations and future directions

Our study population was drawn from academic centres across Northern Europe and North America. Consistent with this, patients were predominantly Caucasian and pathogenic variants were primarily identified in PKP2. Results should consequently be extrapolated with caution to patients of other ethnic background or genotypes. Our ascertainment from tertiary care settings may have created a referral bias that could lead to overestimation of VA risk in a community-derived population. These limitations highlight the importance of external validation studies that include patients from community settings and with a diversity of ethnic backgrounds and genotypes. As in similar studies, we used a surrogate composite endpoint that included appropriate ICD therapy to infer risk of SCD. While most clinicians agree that ICD-treated VA represents a severe event, ICD therapies are an imperfect substitute for SCD. To address these limitations, we stratified the population by prophylactic
ICD placement and demonstrated the model performed similarly well (Supplementary material online, Figure S2). There is certainly room for further iterations of the model by including other predictors. One of them is inducibility on programmed ventricular stimulation (PVS). The characteristics of the 214 (40.7%) patients who underwent PVS in our cohort with regards to the presence or absence of inducibility is presented in Supplementary material online, Table S10.

**Conclusion**

Based on the largest cohort to date of ARVC patients with no sustained VA history at diagnosis, we present a new prediction model to generate individualized estimates of the risk of incident VA. This model, based on readily available clinical parameters, performs better than the current consensus guideline and has the potential to set the standard for prophylactic ICD placement in ARVC.

**Supplementary material**

Supplementary material is available at European Heart Journal online.

**Acknowledgements**

The authors thank Rob Roudijk, MD and Freyja van Lint, MD for data collection. They thank the ARVC patients and families who made this work possible.

**Funding**

This work was supported by the Canadian Heart Rhythm Society George Mines Traveling Fellowship to J.C.-T.; the Montreal Heart Institute Foundation ‘Bal du Coeur’ bursary to J.C.-T.; by a grant from the Fondation Leducq’ [grant number 16 CVD 02] to H.C.; the Dutch Heart Foundation [grant numbers 2015T058 to A.S.J.M.t.R.; CVON2015-12 eDETECT, 2012-10 PREDICT, CVON PREDICT Young Talent Program to A.S.J.M.t.R.]; the Netherlands Organisation for Scientific Research [O04.11.586 to CAJ]; the Netherlands Heart Institute [project 06901]; the Swiss National Science Foundation [320030_160327]; the UMC Utrecht 2017 Alexandre Suerman Stipend to M.B.; and the UMC Utrecht Fellowship Clinical Research Talent to A.S.J.M.t.R. This project has received support from the European Union’s Horizon 2020 research and innovation program under the ERA-NET Co-fund action no. 680969 (ERA-CVD DETECTIN-HF). The Johns Hopkins ARVD Program is supported by the Dr Francis P. Chiaromonte Private Foundation, the Leyla Erkan Family Fund for ARVD Research, the Dr Satish, Rupal, and Robin Shah ARVD Fund at Johns Hopkins, the Bogle Foundation, the Healing Hearts Foundation, the Campanella family, the Patrick J. Harrison Family, the Peter French Memorial Foundation, and the Wilmerding Endowments. The Zurich ARVC Program is supported by grants from the Georg und Bertha Schwzyer-Winiker Foundation, the Baugarten Foundation, and the Swiss Heart Foundation. The Johns Hopkins ARVD Program and the Zurich ARVC Program are also supported by a joint grant from the Leonie-Wild Foundation, Drs R.T. and M.T. are supported by the Marvin and Philippa Carsley Chair of Medicine. F.W.A. is supported by UCL Hospitals NIHR Biomedical Research Centre.

**Conflict of interest:** H.C. is a consultant for Medtronic Inc. and St. Jude Medical/Abbott. H.C. receives research support from Boston Scientific Corp. C.T. and C.A.J. receive salary support from this grant. C.A.J. has received funding for an invited lecture from Abbott. H.T. receives research support from Abbott. A.A.M.W. received a personal fee from Audentes 2017. A.M.S. received lecture honoraria from Boston Scientific Corp. S.L.Z. receives salary support as an advisor to Siemens Healthcare. D.P.J. is a consultant for Pfizer, GSK, and Blade Therapeutics, and receives research support from NIH, Eidos Therapeutics, and Array Biopharma. The rest of the authors have no conflicts of interest.
References


