

Supplementary material

Gorczyca-Głowacka I, Mastalerz-Migas A, Lelonek M. Real-life implementation of guidelines for heart management. Kardiol Pol. 2023.

Please note that the journal is not responsible for the scientific accuracy or functionality of any supplementary material submitted by the authors. Any queries (except missing content) should be directed to the corresponding author of the article.

Table S1. Comparison of respondents' workplace and HFrEF management among cardiologists and non-cardiologists.

	All n = 117	Cardiologists n = 64	Non- cardiologists n = 53	P-value	Cramer's V
Localization of the workplace					
Provincial center	34 (29)	21 (32.8)	13 (24.5)	0.0005	0.3884
Urban center	36 (30.8)	12 (18.8)	24 (45.3)		
County center	16 (13.7)	6 (9.4)	10 (18.9)		
Academic center	31 (26.5)	25 (39)	6 (11.3)		
Workplace					
General practice	39 (33.3)	0 (0.0)	39 (73.6)	<0.0001	0.7973
Outpatient specialist care	17 (14.5)	15 (23.4)	2 (3.8)		
Hospital	23 (19.7)	15 (23.4)	8 (15.1)		
Hospital and outpatient specialist care	38 (32.5)	34 (53.2)	4 (7.5)		
Selection of the most significant clinical feature of SGLT2i					
Easy dosing	26 (22.3)	18 (28.2)	8 (15.1)	0.2761	0.1818
Pleiotropic action	55 (47)	28 (43.8)	27 (50.9)		
Therapy safety	19 (16.2)	8 (12.5)	11 (20.8)		
Quick clinical effect	17 (14.5)	10 (15.5)	7 (13.2)		
Choice of SGLT2i					
More often dapagliflozin	56 (47.9)	32 (50)	24 (45.3)	0.0006	0.3848
More often empagliflozin	46 (39.3)	31 (48.4)	15 (28.3)		
SglT2i rarely used	8 (6.8)	1 (1.6)	7 (13.2)		
No experience with SGLT2i	7 (6)	0 (0.0)	7 (13.2)		
Providing information about the possible presence of sugar in the urine during SGLT2i therapy					
Yes	99 (84.6)	59 (92.2)	40 (75.4)	0.0584	0.2526
No	11 (9.4)	2 (3.1)	9 (17)		
Considering the information to be of little importance	3 (2.6)	1 (1.6)	2 (3.8)		
Handing over the relevant leaflets	4 (3.4)	2 (3.1)	2 (3.8)		
Providing information on the possible need to reduce the doses of hypoglycaemic drugs when using SGLT2i to patients treated for diabetes mellitus					
Yes	90 (76.9)	55 (85.9)	35 (66.1)	0.0201	0.2899
No	12 (10.2)	4 (6.3)	8 (15.1)		
Handing over the relevant leaflets	10 (8.5)	5 (7.8)	5 (9.4)		
No experience in using SGLT2i	5 (4.4)	0 (0.0)	5 (9.4)		

Management of patients with HFrEF and atrial fibrillation					
Frequent use of digitalis	10 (8.5)	3 (4.7)	7 (13.2)	0.0282	0.2787
Selecting heart rate control strategy	50 (42.7)	25 (39.1)	25 (47.2)		
Referral to an ablation center	22 (18.8)	10 (15.6)	12 (22.6)		
Referral for cardioversion, and if unsuccessful, to an ablation center	35 (29.9)	26 (40.6)	9 (17)		
Management of patients with HFrEF in sinus rhythm					
Checking heart rate on the ECG	75 (64.1)	49 (76.6)	26 (49)	<0.0001	0.5812
Frequent use of ivabradine	13 (11.1)	13 (20.3)	0 (0.0)		
Rare use of ivabradine	23 (19.7)	2 (3.1)	19 (35.7)		
No referral for an ECG in a stable clinical phase	6 (5.1)	0 (0.0)	6 (11.3)		
Education in the field of heart failure					
Yes	98 (83.8)	60 (93.7)	38 (71.7)	0.0005	0.3893
No	12 (10.3)	0 (0.0)	12 (22.6)		
Education through appropriate Internet portals	6 (5.1)	4 (6.3)	2 (3.8)		
Educator-led education	1 (0.8)	0 (0.0)	1 (1.9)		
Opinion on the use of vericiguat					
A conclusion that the therapy will be applicable due to the residual risk in heart failure	19 (16.2)	19 (12.2)	0 (0.0)	<0.0001	0.6231
A conclusion that the drug will most often be prescribed in a hospital setting before patient's discharge	17 (14.5)	15 (23.4)	2 (3.8)		
No patients who are potential candidates for this therapy	14 (12)	11 (17.2)	3 (5.7)		
Unfamiliar with therapy	67 (57.3)	19 (12.2)	48 (90.6)		

Abbreviations: ACEi, angiotensin-converting enzyme inhibitor; ARNi, angiotensin receptor-neprilysin inhibitor; HFrEF, heart failure with reduced ejection fraction; SGLT2i, sodium-glucose cotransporter 2 inhibitors