**Disease Modifiers and Outcomes in Hypertrophic Cardiomyopathy With and Without Sarcomere Variants**

Christoffer R. Vissing, MD, PhD; Anna Axelsson Raja, MD, PhD; Victoria N. Parikh, MD; Adam S. Helms, MD; Jodie Ingles, PhD, MPH; Rachel Lampert, MD, Anjali T. Owens, MD; Joseph W. Rossano, MD, MS; Sara Saberi, MD; Dominic J. Abrams, MD; Christopher Semsarian, MBBS, PhD, MPH: John C. Stendahl, MD, PhD; James S. Ware, PhD, MRCP; Michelle Michels, MD, PhD, Erin Miller, MS, CGC; Thomas D. Ryan, MD, PhD; Sharlene M. Day, MD; Iacopo Olivotto, MD; Neal K. Lakdawala, MD; Henning Bundgaard, MD, PhD; Brian Lee Claggett, PhD; and Carolyn Y. Ho, MD.

Affiliations

Department of Medicine, Brigham and Women’s Hospital, Boston, Massachusetts, 02115 USA (B.L.C, N.K.L., C.Y.H.).

Center for Inherited Cardiovascular Disease, Division of Cardiovascular Medicine, Stanford University School of Medicine, Stanford, California, USA (V.N.P.).

Department of Internal Medicine, Division of Cardiovascular Medicine, University of Michigan, Ann Arbor (A.S.H., S.S.).

Centre for Population Genomics, Garvan Institute of Medical Research and University of New South Wales, Sydney, Australia (J.I.)

Center for Cardiovascular Genetics, Department of Cardiology, Boston Children’s Hospital & Harvard Medical School, Boston, MA (D.J.A).

Agnes Ginges Centre for Molecular Cardiology at Centenary Institute, University of Sydney, Australia (C.S.).

Department of Medicine, Section of Cardiovascular Medicine, Yale School of Medicine, New Haven, Connecticut, USA (R.L, J.C.S).

Department of Cardiology, Thoraxcenter, Erasmus Medical Center Rotterdam, the Netherlands (M.M.)

Division of Cardiology, University of Pennsylvania, Philadelphia, Pennsylvania, USA (A.T.O., S.M.D.).

Royal Brompton & Harefield Hospitals, Guy’s and St. Thomas’ NHS Foundation Trust, London, United Kingdom (J.S.W.).

Department of Pediatrics, University of Cincinnati College of Medicine, Cincinnati, OH; Division of Cardiology, The Heart Institute, Cincinnati Children’s Hospital Medical Center, Cincinnati, OH (E.M., T.D.R.).

Meyer Children Hospital, Department of Experimental and Clinical Medicine, University of Florence, Italy (I.O,).

Department of Cardiology, Rigshospitalet, Copenhagen University Hospital, Denmark (C.R.V., A.A.R., H.B.).

Department of Cardiology, Hvidovre Hospital, Copenhagen University Hospital, Denmark (C.R.V.).

**Running Title:** Sarcomeric and non-sarcomeric HCM

**Corresponding Authors:**

Carolyn Y. Ho, MD

Cardiovascular Division, Brigham and Women’s Hospital

75 Francis Street, Boston, MA 02115

Email : [cho@bwh.harvard.edu](mailto:cho@bwh.harvard.edu)

Tel : 617-732-5685

Fax : 617-264-5265

Christoffer R. Vissing, MD, PhD

Department of Cardiology, Rigshospitalet, Copenhagen University Hospital

Blegdamsvej 9, 2100, Copenhagen, Denmark

Email: [christoffer.rasmus.vissing.01@regionh](mailto:christoffer.rasmus.vissing.01@regionh).dk

Tel: +45 20 86 63 96 / +1 857-707-2233

**Word count**

Abstract: 333 words (Limit: 350 words)

Manuscript: 3411 words (Limit: 5000 words)

**ABSTRACT:**

***Background***: Rare sarcomere gene variants are a key cause of hypertrophic cardiomyopathy (HCM). Clinical differences based on genetic substrate have been identified but are underexplored, particularly regarding the impact and sequence of cardiovascular comorbidities and events.

***Methods***: We conducted a longitudinal cohort study of genotyped HCM patients in the Sarcomeric Human Cardiomyopathy Registry (SHaRe). Patients were classified as sarcomeric HCM (pathogenic/likely pathogenic sarcomere gene variant present) or non-sarcomeric HCM (genetically-elusive). The influence of genetic classification, comorbidities, and the sequence of cardiovascular events were assessed in time-varying Cox proportional hazards models.

***Results***: Among 6,120 patients (40% female, 87% probands, 50% sarcomeric HCM), with a median follow-up of 5.3 years, sarcomeric HCM (n=3,038) was associated with a younger age at diagnosis (median age 38.1 versus 54.3 years, p<0.001), higher burden and age-standardized incidences (ASI) of atrial fibrillation (ASI ratio 1.28 [CI 1.16-1.40]), LV systolic dysfunction (ASI ratio 1.31 [CI 1.15-1.48]) and ventricular arrhythmias (ASI ratio 1.37 [CI 1.17-1.52]). Conversely, non-sarcomeric HCM was associated with a higher prevalence of obesity, hypertension and LV obstruction, with an independent association between non-sarcomeric HCM and obstructive physiology after adjusting for age and sex (HR 1.43 [CI 1.21-1.69]).

All-cause mortality was similar between groups (10.4% vs. 9.4%); however, sarcomeric HCM was associated with younger age at death (mean 7.8 years earlier) and higher HCM-related mortality (HR 1.61 [CI 1.18-2.20]) due to sudden cardiac death or heart failure (OR 2.86 [CI 2.05-4.06], p<0.001).

Temporal analysis identified atrial fibrillation as the strongest modifier of adverse outcomes, including increased risks of LV systolic dysfunction (HR 2.89 [CI 2.37-3.53]), ventricular arrhythmias (HR 3.17 [CI 2.40-4.20]), and mortality (HR 2.03 [CI 1.72-2.41]). Interaction analyses demonstrated that the impact of atrial fibrillation and LV systolic dysfunction on adverse outcomes was amplified in sarcomeric HCM, with effect ratios up to 1.97 for severe heart failure and 1.86 for mortality.

***Conclusions***: The genetic substrate of patients with HCM influenced clinical course and the impact of cardiovascular comorbidities on adverse outcomes. Obesity, hypertension, and LV obstruction were more prominent in non-sarcomeric HCM. Sarcomeric HCM was associated with greater risk of severe heart failure, arrhythmias, HCM-related mortality, and worse consequences from atrial fibrillation and LV systolic dysfunction with a higher incidence of subsequent ventricular arrhythmias, advanced heart failure, and death. These findings have implications for risk stratification and managing patients according to genotype and comorbidities.

***Keywords:*** hypertrophic cardiomyopathy, cardiovascular outcomes, heart failure, genetics

**CLINICAL PERSPECTIVE**

**What is new?**

* Hypertension, obesity, and obstructive physiology are more prevalent in non-sarcomeric HCM but are not associated with excess risk of advanced heart failure, sudden cardiac death, or mortality.
* Atrial fibrillation is strongly associated with subsequent development of advanced heart failure, ventricular arrhythmias, stroke, and death in all patients, and has a significantly greater burden for patients with sarcomeric HCM.
* The risk of HCM-related mortality is twice as high in patients with sarcomeric HCM compared to non-sarcomeric HCM

**What are the clinical implications?**

* Patients with sarcomeric HCM are at higher risk for disease-related adverse outcomes, including death, thus aggressive management of comorbidities and vigilant surveillance for cardiac arrhythmias and LV systolic dysfunction are appropriate.
* Integrating genetic testing results may improve clinical risk stratification, and may justify differentiated follow-up.

**Abbreviations**

HCM = Hypertrophic cardiomyopathy

ICD = implantable cardioverter defibrillator

LV = Left ventricle

NYHA = New York Heart Association

P/LP = Pathogenic or likely pathogenic

SCD = Sudden cardiac death

SHaRe = Sarcomeric Human Cardiomyopathy Registry

**INTRODUCTION**

Hypertrophic cardiomyopathy (HCM) is a complex cardiovascular disorder defined by left ventricular hypertrophy, not explained by an increased afterload or storage/infiltrative disorders. A considerable proportion of disease is caused by damaging variants in genes encoding sarcomere proteins, most frequently *MYH7*, *MYBPC3*, *TNNT2*, and *TNNI3*.1,2 Studies comparing the phenotype in patients with HCM carrying sarcomere variants (sarcomeric HCM) to those with non-sarcomeric HCM (where a genetic etiology remains elusive despite genetic testing), have identified a younger age at diagnosis of HCM, higher lifetime burden of adverse events, and less obstruction in patients with sarcomeric HCM3–5. However, it remains unclear whether the occurrence and temporal relationship of cardiovascular events in sarcomeric vs non-sarcomeric HCM differs, and whether there are different interaction between cardiac comorbidities and cardiovascular outcomes based on underlying genotype. Understanding the differences in disease progression, the influence of comorbidities, and drivers of adverse outcomes between sarcomeric and nonsarcomeric HCM is necessary to optimize the care of individual patients and their families.

This study aims to contrast the experience of patients with sarcomeric and non-sarcomeric HCM, with a particular focus on assessing the impact of comorbidities and characterizing longitudinal clinical course. By analyzing a large cohort of genotyped HCM patients, we seek to uncover patterns that may provide valuable insights into disease development, progression, and risk stratification, thus enabling more personalized clinical management of HCM.

**METHODS:**

***Study Design:***

This was a multicenter observational study using data from the Sarcomeric Human Cardiomyopathy Registry (SHaRe).SHaRe is a longitudinal database of patients with HCM who receive care at 12 international expert HCM centers. Collected data include cardiovascular events prior to first visit at a SHaRe site, demographics, clinical characteristics, cardiac imaging results, genetic testing results, cardiovascular comorbidities, and longitudinal, prospective capture of clinical features and outcomes as previously described.3 Institutional review board and ethics approval was obtained in accordance with local policies at each SHaRe site.

***Population:***

This study included SHaRe patients who had undergone genetic testing for sarcomere gene variants. Patients were stratified into two groups based on the presence (sarcomeric HCM) or absence (non-sarcomeric HCM) of pathogenic or likely pathogenic (P/LP) variants in 8 core sarcomere genes (*MYBPC3, MYH7, TNNT2, TNNI3, TPM1, MYL2, MYL3*, and *ACTC*).12 Patients with phenocopies of HCM (e.g., storage disorders), carrying sarcomere variants of uncertain significance, or with no genetic testing were excluded. Genetic variants were classified based on criteria of the American College of Medical Genetics and Genomics and Association for Molecular Pathology.6,7 Variants with conflicting classification were reviewed by the SHaRe variant curation committee and assigned a consensus SHaRe-based classification.

***Clinical Features:***

Features of interest were selected based on their clinical relevance and potential impact on morbidity and mortality. They were categorized into the following groups:

1. Cardiovascular comorbidities: Hypertension and obesity (body mass index > 30).
2. Cardiac remodeling and function: Left ventricular (LV) ejection fraction (EF), LV outflow gradient and maximal LV wall thickness.
3. Heart failure: New York Heart Association (NYHA) functional class III-IV, LV systolic dysfunction (LV EF <50%), cardiac transplantation or LV assist device implantation.
4. Arrhythmias: Unexplained syncope, atrial fibrillation, non-sustained ventricular tachycardia, cardiac arrest, and a composite ventricular arrhythmia outcome which included sudden cardiac death, aborted sudden cardiac death, sustained ventricular tachycardia and appropriate implantable cardioverter-defibrillator [ICD] therapy.
5. Stroke.
6. Mortality: All-cause and HCM-related mortality (defined as death due to sudden cardiac death [SCD], heart failure and stroke). Data on causes of death were evaluated from death certificates, autopsy reports (if available) and by review of available hospital records.

These features were compared between sarcomeric and non-sarcomeric HCM to determine differences in clinical course and overall prognosis. Additionally, the occurrence, timing, and sequence of these features were analyzed to better understand the natural history of HCM.

Our next objective was to evaluate whether adverse events occurred in a specific order and if timing differed by genetic status. To do this, we performed Cox proportional hazards modelling, including time-varying effects of key disease-course modifiers (obesity, hypertension, obstruction, atrial fibrillation, LV systolic dysfunction) on seven cardiovascular outcomes (atrial fibrillation, NYHA III/IV symptoms, LV systolic dysfunction, ventricular arrhythmias, stroke, cardiac transplantation, all-cause death). Analyses were adjusted for sex, corrected for multiple testing, and tested for interaction with genetic status.

***Statistical Analyses*:**

SHaRedata through June 2024 were analyzed. Continuous variables are presented as mean ± SD if normally distributed or as median (interquartile range, IQR) if deviating substantially from the normal distribution as evaluated by quantile-quantile plots. Categorical variables are presented as counts and percentages. Between group comparisons were evaluated statistically using Welch’s t-test, Wilcoxon rank sum test, Fisher’s exact test or Chi-square tests as appropriate.

Logistic regression was used to calculate odds ratios (OR) and 95% confidence intervals (CI) for comparing the clinical characteristics of patients with sarcomeric and non-sarcomeric HCM.

We computed the relative risk of cardiovascular comorbidities and adverse events in patients with non-sarcomeric and sarcomeric HCM. The incidence of cardiovascular outcomes during follow-up was compared using the Kaplan-Meier method or the cumulative incidence function. In addition, age-specific incidence rates were reported according to age quintiles (<30, 31-45, 46-55, 56-65 and >65 years of age). Age-specific incidence rates were calculated, and Cox proportional hazards models were used to estimate hazard ratios (HR) and 95% CI, adjusting for potential confounders. Age-standardized rates were computed, with the reference age set to correspond to the age-distribution of the combined cohort at the time of study inclusion. A standardized incidence ratio was calculated from the age-standardized rates to compare the relative risk of investigated outcomes.

We assessed the clinical course of HCM over time by examining the relative timing of developing LV obstruction, atrial fibrillation, NYHA class III-IV symptoms, LV systolic dysfunction, the composite VA outcome, stroke, cardiac transplantation, LV assist device implantation, and death. We used Cox proportional hazards modeling with age as the timescale with delayed entry (i.e., left-truncated at the time of the first SHaRe visit). Time-varying covariates (modifiers) included obesity, hypertension, LV obstruction, atrial fibrillation, onset of NYHA class III-IV symptoms, LV systolic dysfunction, and the composite ventricular arrhythmia outcome. We adjusted for sex and age at diagnosis with HCM and applied Bonferroni correction for multiple testing.

We also investigated potential interactions between these modifiers and genetic status (non-sarcomeric versus sarcomeric HCM) for all outcomes. If a significant interaction was found, we reported the combined effect of the modifier and genetic status on developing the outcome of interest.

A p-value of <0.05 was considered significant. Statistical analyses were conducted using R version 4.2.2 (R Foundation for statistical computing, Vienna, Austria), and the packages *tidyverse*, *broom*, *ggtext*, *scico*, *survival*, *survMiner*, *epiR*, *epitools*, *gt*, *gtsummary*, *patchwork* and *janitor*. Due to patient privacy concerns, the data that support the findings of this study are not publicly available. The code for statistical analysis and creating figures can be found online8.

**RESULTS:**

We evaluated 11,335 individuals with HCM and analyzed 6,120 children and adults (40% female, 87% probands) in whom genetic testing had been performed and either identified a P/LP sarcomere variant (sarcomeric HCM, n= 3,082) or no P/LP variant (non-sarcomeric HCM, n= 3,038. Median age of HCM diagnosis was 46.8 years (IQR: 30.7 to 59.0) and age at first visit to a SHaRe site was 51.1 years (IQR: 36.4 to 62.7). In 725 patients (12%), HCM had been diagnosed in childhood, while 152 (2%) were younger than 18 years. At first SHaRe visit, hypertension was prevalent in 32%, atrial fibrillation in 13%, previous stroke in 3.2%; and 2.0% had been resuscitated from cardiac arrest.

**Clinical Characteristics of Sarcomeric versus Non-sarcomeric HCM**

Clinical characteristics stratified by genetic subgroup are presented in **Table 1**. Patients with sarcomeric HCM were ~16 years younger at diagnosis (median age 38.1 versus 54.3 years, p<0.001), more likely to be diagnosed with HCM in childhood (OR 3.57 [CI, 2.98-4.29]), and had higher, but still low, European Society of Cardiology 5-year SCD risk scores (median 2.3% versus 1.8%, p <0.001). Patients with non-sarcomeric HCM were less likely to be female (OR 0.74 [CI, 0.67-0.82]) or self-reported as white (OR 0.78 [CI, 0.67-0.92]), but more likely to report advanced symptoms at baseline (NYHA functional class III-IV, OR 1.36 [CI, 1.16-1.65]).

**Figure 1** depicts the relative risk of cardiovascular co-morbidities and adverse events in patients with non-sarcomeric versus sarcomeric HCM. Overall, patients with non-sarcomeric HCM were more likely to have hypertension (RR 1.95 [CI 1.82-2.08]), obesity (RR 1.38 [CI 1.27-1.50]), obstructive physiology (gradient >30 mmHg; RR 1.47 [CI 1.39-1.55]) and to have undergone septal reduction therapy (RR 1.16 [CI 1.04-1.29]). Patients with sarcomeric HCM were more likely to experience ventricular arrhythmias (RR for non-sustained ventricular tachycardias 1.25 [CI 1.15-1.35] and RR for the composite ventricular arrhythmia outcome 1.97 [CI 1.65-2.36]), advanced heart failure (RR for LV systolic dysfunction 1.82 [CI 1.54-2.15] and RR for cardiac transplantation 3.20 [CI 2.11-4.83]) and HCM-related mortality (RR 2.78 [CI 2.02-3.82]).

**Incident events during longitudinal follow-up** Over a median follow-up of 5.3 years (IQR: 1.7 to 10.4), we evaluated the incidence of LV obstruction, atrial fibrillation, the composite ventricular arrhythmia outcome, and LV systolic dysfunction in patients without these outcomes at baseline. Patients with non-sarcomeric HCM had higher cumulative and age-specific incidences of LV obstruction (**supplementary figure 1**), with an adjusted hazard ratio (aHR) of 1.43 (CI: 1.21-1.69) for obstructive physiology (adjusted for age at HCM diagnosis, sex, obesity, presence of hypertension and being the family proband).

Patients with sarcomeric HCM had a higher incidence of atrial fibrillation, ventricular arrhythmias, and LV systolic dysfunction (**supplementary figures 2-3**). For atrial fibrillation the biggest relative differences in age-specific incidence were observed earlier in life (prior to age 45 years), and sarcomeric HCM was associated with an age-standardized incidence ratio of 1.28 (CI: 1.16 to 1.40, p<0.001) for developing atrial fibrillation. For the composite ventricular arrhythmia and the LV systolic dysfunction outcomes, the biggest relative difference in the age-specific incidences of the outcomes were observed in patients 65 years or older with an overall age-standardized incidence ratio of 1.37 (CI: 1.17 to 1.59, p <0.001) for ventricular arrhythmias (**supplementary figure 2**), and 1.31 (CI: 1.15 to 1.48, p =0.003) for LV systolic dysfunction in sarcomeric HCM (**supplementary figure 3**).

**Mortality in sarcomeric and non-sarcomeric HCM**

A total of 605 (9.9%) patients died during follow-up, with similar all-cause mortality in patients with sarcomeric and non-sarcomeric HCM (10.4% and 9.4% respectively). However, the mean age at death was 7.8 years lower (CI: 5.4 to 10.2, p <0.001) in sarcomeric HCM, resulting in a standardized incidence ratio 1.35 [CI: 1.21 to 1.51]) for all-cause mortality, or a hazard ratio of 1.52 (CI: 1.29 to 1.80, p <0.001) using age as the timescale, left-truncated at first SHaRe visit. **Table 2** summarizes causes of death. Patients with sarcomeric HCM were more likely to die from sudden cardiac death (20% versus 9% of deaths) and heart failure (25 versus 8% of deaths). Overall, patients with sarcomeric HCM had an odds ratio of 2.86 (CI: 2.05 to 4.06, p<0.001) of dying of either heart failure or sudden cardiac death. The cumulative incidence of HCM-related death (heart failure, stroke or SCD), from time of first SHaRe visit, and the age-specific incidence of HCM-related death is shown in **Figure 2**. Patients with sarcomeric HCM had a higher cumulative incidence of HCM-related death during follow-up (HR 1.61 [CI: 1.18 to 2.20, p <0.001], using follow-up as time-scale), and a significantly higher age-specific incidence after 45 years of age, with an overall standardized incidence ratio of 2.34 (CI: 1.98 to 2.75) for HCM-related death in patients with sarcomeric HCM.

**Temporal patterns of cardiovascular events**

Next, we investigated significant associations between potential disease modifiers (obesity, hypertension, LV obstruction, atrial fibrillation and LV systolic dysfunction) on the rate of subsequent outcomes, to identify exposure-outcome pairs (**Figure 3**), in the full cohort (n=6,120). Obesity was associated with a higher rate of atrial fibrillation (HR 1.66 [CI 1.43-1.92]) and NYHA class III-IV symptoms (HR 2.13 [CI 1.83-2.49]). Obstruction was associated with higher rates of incident atrial fibrillation (HR 1.75 [CI 1.51-2.03]) and NYHA class III-IV symptoms (2.16 [CI 1.85-2.53]). Atrial fibrillation was associated with the most subsequent events with higher downstream rates of developing incident heart failure outcomes (HR 2.22 for NYHA III-IV symptoms, HR 2.89 for LV systolic dysfunction, and 7.4 for cardiac transplantation), ventricular arrhythmias (HR 3.17 [CI: 2.40-4.2]), stroke (HR 1.94 [CI: 1.42-2.66]) and all-cause mortality (HR 2.03 [CI: 1.72-2.41]). Finally, LV systolic dysfunction was associated with a higher incidence of NYHA class III-IV symptoms (HR 2.48 [CI 1.94-3.18]), ventricular arrhythmias (HR 4.10 [CI 2.93-5.6]), cardiac transplantation (HR 34 [CI: 23-52]) and all-cause mortality (HR 3.97 [CI 3.26-4.8],).

Interaction analysis was performed to determine how genetic status modified the impact of modifier-outcome pairs. **Figure 4** shows the time-adjusted hazard ratios for modifier-outcome pairs, stratified by genotype, and using age as the time-scale left-truncated at the first visit at a SHaRe site. Effect ratios reflect the differential impact of the exposure in sarcomeric versus non-sarcomeric HCM. The largest interaction effects were found for atrial fibrillation. In sarcomeric relative to non-sarcomeric HCM, atrial fibrillation was associated with larger risk modification for the LV systolic dysfunction (effect ratio 1.89 [CI 1.35-2.66]), ventricular arrhythmias (effect ratio 1.88 [CI 1.21-2.92]), and death (effect ratio 1.86 [CI 1.46-2.37]) outcomes. LV systolic dysfunction conferred higher risk in sarcomeric HCM regarding developing NYHA class III-IV symptoms (effect ratio 1.97 [CI 1.15-3.36]) and death (effect ratio 1.80 [CI 1.23-2.64]).

**DISCUSSION:**

In this study, we systematically compared the clinical trajectories in two major subtypes of HCM: sarcomeric and non-sarcomeric HCM. Sarcomeric HCM was characterized by a more severe phenotype with a younger age at diagnosis, a higher burden of cardiac arrhythmias and severe heart failure symptoms, and an HCM-related mortality-rate twice that of non-sarcomeric HCM. Furthermore, the consequences of atrial fibrillation and LV systolic dysfunction were greater in sarcomeric HCM significantly greater risk of developing severe heart failure symptoms and dying.

**Patients with Non-sarcomeric HCM Have a Higher Burden of Cardiovascular Comorbidities**

As reported previously, we found that patients with non-sarcomeric HCM were more likely to have common cardiovascular comorbidities (hypertension and obesity) and obstructive physiology.3,9–11 Overall, the age-standardized incidence rate of having obstructive physiology was twice as high in non-sarcomeric HCM. Obesity was associated with an 80% higher rate of obstruction as seen previously,12 but had a larger effect in patients with non-sarcomeric HCM. LV obstruction has been linked with a higher risk of ventricular arrhythmias, stroke and death in HCM13. No significant associations between LV obstruction and these outcomes were identified here, after adjusting for age and sex, perhaps reflecting the high rate of septal reduction therapy in patients with LV obstruction in SHaRe.

Hypertension and specifically elevated diastolic blood pressure have been identified as an important comorbidity associated with non-sarcomeric HCM in Mendelian randomization analyses.14,15 Congruent with this, the prevalence of hypertension was almost twice as high in non-sarcomeric HCM. The consistency of these findings supports the hypothesis that hypertension and obesity may be in the causal pathway that leads to developing HCM.

**The Prevalence of and Consequences of Adverse Cardiovascular Outcomes, and HCM-Related Mortality are Higher in Sarcomeric HCM**

After performing age-specific analyses to account for the older age of non-sarcomeric HCM patients, patients with sarcomeric HCM had a higher prevalence of atrial and ventricular arrhythmias and LV systolic dysfunction. Overall, the age-standardized incidence rates were 28-37% higher in patients with sarcomeric HCM for each of these 3 outcomes. For atrial fibrillation, this finding was primarily due to atrial fibrillation emerging earlier in young patients with sarcomeric HCM, while the risk of ventricular arrhythmias seemed to persist into older age in patients with sarcomeric HCM. Moreover, the downstream impact of these events also appeared to be more consequential. For example, after atrial fibrillation developed, the rates of developing LV systolic dysfunction, ventricular arrhythmias or death were each ~2-fold higher in patients with sarcomeric than non-sarcomeric HCM.

Finally, patients with sarcomeric HCM had an HCM-related mortality rate double that of non-sarcomeric HCM. Age-specific analysis revealed that HCM-related mortality diverges in the two groups from age 45 years onwards. The largest relative difference in HCM-related mortality was in patients between the age of 46 and 55 years, where mortality was almost 4 times higher in patients with sarcomeric HCM. Previous studies have identified sarcomeric HCM to associate with higher all-cause mortality rates.3,5 However, prior studies did not investigate the difference in age-specific incidence of death or causes of death and may have been influenced by immortal time bias, leading to inflated effect estimates.

**Clinical Implications**

Findings from this study have implications for clinical practice and future research in HCM. Non-sarcomeric HCM was characterized by a higher burden of obesity, hypertension, and LV obstruction but less severe consequences of disease than patients with sarcomeric HCM. We hypothesize that hypertension and obesity may be in the causal pathway for developing non-sarcomeric HCM, reinforcing the importance of aggressive management and risk factor modification. On the other hand, patients with sarcomeric HCM appeared to be more susceptible to adverse outcomes intrinsic to their HCM (i.e. advanced heart failure, atrial and ventricular arrhythmias, HCM-related mortality) independent of non-HCM exposures. Atrial fibrillation was more prevalent, earlier in onset, and more consequential in sarcomeric HCM. Sudden cardiac death risk was higher and persisted to advanced age. As such, patients with sarcomeric HCM, may benefit from more intensive surveillance and management of ventricular and atrial arrhythmias and LV systolic dysfunction.16–18

Current risk stratification algorithms for sudden cardiac death in HCM do not account for genetic substrate.19–21 However, in this study, carrying a sarcomere variant was associated with a standardized incidence ratio of 1.3 for a composite ventricular arrhythmia outcome, and notably with the highest relative and absolute difference in older patients (>65 years); an age when risk is traditionally thought to be lower. These findings suggest that implementing information regarding genetic substrate into future SCD risk prediction models could improve model performance and better guide management decisions regarding primary prevention ICD.

**Limitations**

Several limitations should be acknowledged. First, our patients are followed at high-volume referral centers and predominantly self-identify as white. As such, findings may not be fully generalizable to a more ancestrally diverse patient population. Second, the study uses a pragmatic, partially retrospective observational design, and therefore, is subject to a potential selection, recall, and information bias. Third, although we attempted to control for potential confounders through statistical adjustments, there may be residual confounding that could impact the results of the study. Finally, we did not have comprehensive data on medical therapy and the potential impact of drugs on cardiovascular co-morbidities or occurrence of outcomes could not be evaluated.

**Conclusions**

Differences in clinical characteristics, trajectory, and susceptibility to adverse events exist between patients with sarcomeric and non-sarcomeric HCM.). Patients with sarcomeric HCM had a significantly greater burden of heart failure and cardiac arrhythmias, both of which were associated with more adverse outcomes, including death. These findings highlight the importance of genetic characterization in guiding risk stratification, surveillance, and management strategies. Continued research in this field will further refine our understanding of HCM pathophysiology and pave the way for more personalized approaches to patient care.

**ACKNOWLEDGEMENTS:**

The authors are grateful for the dedicated work of the site data managers. The authors express deep appreciation to the patients and families who live with HCM and partner with us in research.

**FUNDING SOURCES:**

SHaRe receives unrestricted research support from Bristol Myers Squib, Pfizer, and Cytokinetics. CSem is the recipient of a National Health and Medical Research Council (NHMRC) Practitioner Fellowship (#1154992). JSW is supported by the Sir Jules Thorn Charitable Trust [21JTA], Medical Research Council (UK), British Heart Foundation [RE/18/4/34215], the National Institute for Health and Care Research (NIHR) Imperial College Biomedical Research Centre, and the NIHR Royal Brompton Cardiovascular Biomedical Research Unit. CRV was supported by grants from The Research Foundations at Rigshospitalet and Knud Højgaards Fond

**CONFLICT OF INTEREST AND DISCLOSURES:**

CRV, JCS, TDR and CSEM declare no relevant disclosures or competing interests.

CYH is a consultant for and/or receives research funding from Bristol Myers Squib, Pfizer, Cytokinetics, Tenaya, Biomarin, viz.AI and Lexicon. HB receives lecture fees from Amgen, MSD, Sanofi, BMS and Pfizer. VNP receives research funding from BioMarin and consults for Nuevocor and Viz.ai. ASH consults for and/or receives research funding from Tenaya Therapeutics and Lexeo. NKL is a consultant for Bristol Myers Squibb, Pfizer, Cytokinetics, Tenaya and Sarepta and receives research funding from Pfizer. SS isa consultant for Bristol Myers Squibb and Cytokinetics. MM is a consultant for Bristol Myers Squibb and Cytokinetics. JSW has consulted for MyoKardia (now Bristol Myers Squibb), Foresite Labs, and Pfizer. DJA is a consultant for Dinaqor. IO is a consultant for Bristol Myers Squibb, Cytokinetics, Tenaya, Lexeo, Edgewise, Rocket Pharma.

**References**

1. Ho CY, Charron P, Richard P, Girolami F, Van Spaendonck-Zwarts KY, Pinto Y. Genetic advances in sarcomeric cardiomyopathies: state of the art. *Cardiovasc. Res.* 2015;105:397–408.

2. Biddinger KJ, Jurgens SJ, Maamari D, Gaziano L, Choi SH, Morrill VN, Halford JL, Khera AV, Lubitz SA, Ellinor PT, et al. Rare and Common Genetic Variation Underlying the Risk of Hypertrophic Cardiomyopathy in a National Biobank. *JAMA Cardiol.* 2022;7:715–722.

3. Ho Carolyn Y., Day Sharlene M., Ashley Euan A., Michels Michelle, Pereira Alexandre C., Jacoby Daniel, Cirino Allison L., Fox Jonathan C., Lakdawala Neal K., Ware James S., et al. Genotype and Lifetime Burden of Disease in Hypertrophic Cardiomyopathy. *Circulation*. 2018;138:1387–1398.

4. Li Q, Gruner C, Chan RH, Care M, Siminovitch K, Williams L, Woo A, Rakowski H. Genotype-positive status in patients with hypertrophic cardiomyopathy is associated with higher rates of heart failure events. *Circ. Cardiovasc. Genet.* 2014;7:416–422.

5. Curran L, de Marvao A, Inglese P, McGurk KA, Schiratti P-R, Clement A, Zheng SL, Li S, Pua CJ, Shah M, et al. Genotype-Phenotype Taxonomy of Hypertrophic Cardiomyopathy. *Circ. Genomic Precis. Med.* 0:e004200.

6. Richards S, Aziz N, Bale S, Bick D, Das S, Gastier-Foster J, Grody WW, Hegde M, Lyon E, Spector E, et al. Standards and guidelines for the interpretation of sequence variants: a joint consensus recommendation of the American College of Medical Genetics and Genomics and the Association for Molecular Pathology. *Genet. Med.* 2015;17:405–423.

7. Hershberger RE, Givertz MM, Ho CY, Judge DP, Kantor PF, McBride KL, Morales A, Taylor MRG, Vatta M, Ware SM. Genetic evaluation of cardiomyopathy: a clinical practice resource of the American College of Medical Genetics and Genomics (ACMG). *Genet. Med.* 2018;20:899–909.

8. Vissing CR. Comparing Clinical Course of Hypertrophic Cardiomyopathy in Sarcomere Variant Carriers and Non-Carriers [Internet]. 2023;Available from: https://github.com/christoffervi/sarc\_nonsarc

9. Lopes LR, Syrris P, Guttmann OP, O’Mahony C, Tang HC, Dalageorgou C, Jenkins S, Hubank M, Monserrat L, McKenna WJ, et al. Novel genotype-phenotype associations demonstrated by high-throughput sequencing in patients with hypertrophic cardiomyopathy. *Heart Br. Card. Soc.* 2015;101:294–301.

10. Lopes LR, Rahman MS, Elliott PM. A systematic review and meta-analysis of genotype-phenotype associations in patients with hypertrophic cardiomyopathy caused by sarcomeric protein mutations. *Heart Br. Card. Soc.* 2013;99:1800–1811.

11. Curran L, Marvao A de, Inglese P, McGurk KA, Schiratti P-R, Clement A, Zheng SL, Li S, Pua CJ, Shah M, et al. A genotype-phenotype taxonomy of hypertrophic cardiomyopathy [Internet]. 2023 [cited 2023 Jun 20];2023.03.11.23285908. Available from: https://www.medrxiv.org/content/10.1101/2023.03.11.23285908v2

12. Fumagalli C, Maurizi N, Day SM, Ashley EA, Michels M, Colan SD, Jacoby D, Marchionni N, Vincent-Tompkins J, Ho CY, et al. Association of Obesity With Adverse Long-term Outcomes in Hypertrophic Cardiomyopathy. *JAMA Cardiol.* 2020;5:65–72.

13. Maron MS, Olivotto I, Betocchi S, Casey SA, Lesser JR, Losi MA, Cecchi F, Maron BJ. Effect of Left Ventricular Outflow Tract Obstruction on Clinical Outcome in Hypertrophic Cardiomyopathy. *N. Engl. J. Med.* 2003;348:295–303.

14. Harper AR, Goel A, Grace C, Thomson KL, Petersen SE, Xu X, Waring A, Ormondroyd E, Kramer CM, Ho CY, et al. Common genetic variants and modifiable risk factors underpin hypertrophic cardiomyopathy susceptibility and expressivity. *Nat. Genet.* 2021;53:135–142.

15. de Marvao A, Dawes TJW, Shi W, Durighel G, Rueckert D, Cook SA, O’Regan DP. Precursors of Hypertensive Heart Phenotype Develop in Healthy Adults: A High-Resolution 3D MRI Study. *JACC Cardiovasc. Imaging*. 2015;8:1260–1269.

16. Marstrand P, Han L, Day SM, Olivotto I, Ashley EA, Michels M, Pereira AC, Wittekind SG, Helms A, Saberi S, et al. Hypertrophic Cardiomyopathy With Left Ventricular Systolic Dysfunction: Insights From the SHaRe Registry. *Circulation*. 2020;141:1371–1383.

17. Alaiwi SA, Roston TM, Marstrand P, Claggett BL, Parikh VN, Helms AS, Ingles J, Lampert R, Lakdawala NK, Michels M, et al. Left Ventricular Systolic Dysfunction in Patients Diagnosed With Hypertrophic Cardiomyopathy During Childhood: Insights From the SHaRe Registry (Sarcomeric Human Cardiomyopathy). *Circulation*. 2023;

18. Siontis KC, Geske JB, Ong K, Nishimura RA, Ommen SR, Gersh BJ. Atrial fibrillation in hypertrophic cardiomyopathy: prevalence, clinical correlations, and mortality in a large high-risk population. *J. Am. Heart Assoc.* 2014;3:e001002.

19. O’Mahony C, Jichi F, Pavlou M, Monserrat L, Anastasakis A, Rapezzi C, Biagini E, Gimeno JR, Limongelli G, McKenna WJ, et al. A novel clinical risk prediction model for sudden cardiac death in hypertrophic cardiomyopathy (HCM Risk-SCD). *Eur. Heart J.* 2014;35:2010–2020.

20. O’Mahony C, Akhtar MM, Anastasiou Z, Guttmann OP, Vriesendorp PA, Michels M, Magrì D, Autore C, Fernández A, Ochoa JP, et al. Effectiveness of the 2014 European Society of Cardiology guideline on sudden cardiac death in hypertrophic cardiomyopathy: a systematic review and meta-analysis. *Heart Br. Card. Soc.* 2019;105:623–631.

21. O’Mahony C, Jichi F, Ommen SR, Christiaans I, Arbustini E, Garcia-Pavia P, Cecchi F, Olivotto I, Kitaoka H, Gotsman I, et al. An International External Validation Study of the 2014 European Society of Cardiology Guideline on Sudden Cardiac Death Prevention in Hypertrophic Cardiomyopathy (Evidence from HCM). *Circulation*. 2017;CIRCULATIONAHA.117.030437.

**Table 1:** Clinical characteristics of the cohort at first SHaRe visit.

| Characteristic | SARCOMERIC HCM N= 3,082 | NON-SARCOMERIC HCM  N = 3,038 | p-value |
| --- | --- | --- | --- |
| **Demographic information** |  |  |  |
| Female | 1,328 (43%) | 1,092 (36%) | <0.001 |
| Age at HCM diagnosis (years) | 38.1 [22.6, 51.0] | 54.3 [42.5, 63.7] | <0.001 |
| Age at first visit to a SHaRe site | 44 [29, 56] | 58 [46, 67] | <0.001 |
| Family proband, n (%) | 2,449 (79%) | 2,886 (95%) | <0.001 |
| HCM diagnosed in childhood (18 years) | 550 (18%) | 175 (6%) | <0.001 |
| **Race** |  |  | <0.001 |
| White | 2,665 (86%) | 2,462 (81%) |  |
| Black | 93 (3.0%) | 161 (5.3%) |  |
| Asian | 101 (3.3%) | 115 (3.8%) |  |
| Native Hawaiian or Other Pacific Islander | 8 (0.3%) | 3 (<0.1%) |  |
| More than One | 4 (0.1%) | 5 (0.2%) |  |
| American Indian or Alaska Native | 3 (<0.1%) | 4 (0.1%) |  |
| Other or Not Reported | 208 (6.7%) | 288 (9.5%) |  |
| **Clinical findings** |  |  |  |
| Systolic blood pressure, mmHg | 120 [110, 131] | 130 [119, 140] | <0.001 |
| Diastolic blood pressure, mmHg | 71 [65, 80] | 76 [70, 82] | <0.001 |
| Body mass index | 26.3 [23.1, 30.1] | 27.8 [24.8, 31.9] | <0.001 |
| Body surface area, m2 | 1.92 [1.73, 2.11] | 1.99 [1.81, 2.17] | <0.001 |
| **Echocardiography findings** |  |  |  |
| Maximal LV wall thickness, mm | 18.0 [14.0, 22.0] | 17.0 [14.0, 20.0] | <0.001 |
| LV ejection fraction, % | 63.6 ± 10.3 | 65.3 ± 9.2 | <0.001 |
| Obstructive physiology (gradient >30 mmHg [resting or provoked]) | 706 (23%) | 1,208 (40%) | <0.001 |
| Left atrial diameter, mm | 40.3 ± 10.5 | 41.0 ± 9.5 | 0.002 |
| **Co-morbidities and medical history** |  |  |  |
| Hypertension | 628 (20%) | 1,345 (44%) | <0.001 |
| Atrial fibrillation | 393 (13%) | 400 (13%) | 0.6 |
| Syncope | 312 (10%) | 273 (9.0%) | 0.13 |
| Stroke | 85 (2.8%) | 116 (3.8%) | 0.020 |
| Family history of sudden cardiac death | 396 (13%) | 156 (5.1%) | <0.001 |
| Resuscitated cardiac arrest | 87 (2.8%) | 48 (1.6%) | <0.001 |
| New York Heart Association class III-IV | 202 (6.6%) | 264 (8.7%) | 0.002 |
| LV systolic dysfunction (LV ejection fraction<50%) | 112 (3.6%) | 51 (1.7%) | <0.001 |
| Severe LV systolic dysfunction (LV ejection fraction<35%) | 5 (0.8%) | 8 (0.3%) | 0.003 |
| **ESC SCD risk** |  |  | <0.001 |
| High (>6% per 5 years) | 179 (9.6%) | 83 (4.3%) |  |
| Moderate (4-6% per 5 years) | 245 (13%) | 151 (7.8%) |  |
| Low (<4% per 5 years) | 1,435 (77%) | 1,701 (88%) |  |
| Unknown | 1,223 | 1,103 |  |
| 5- year risk score | 2.30 (1.50, 3.80) | 1.80 (1.30, 2.70) | <0.001 |
| n (%); Median [Q1, Q3]; Mean ± SD **Abbreviations:** ESC = European Society of Cardiology; HCM = hypertrophic cardiomyopathy; LV = left ventricle; SCD = sudden cardiac death | | | |
|  | | | |

| **Table 2:** All-cause and cause-specific mortality in sarcomeric and non-sarcomeric hypertrophic cardiomyopathy | | | |
| --- | --- | --- | --- |
| **CHARACTERISTIC** | **Sarcomeric HCM**, N = 3,082 | **Non-sarcomeric HCM**, N = 3,038 | **P-VALUE** |
| All-cause mortality | 320 (10%) | 285 (9.4%) | 0.20 |
| Non-cardiovascular death |  |  | <0.001 |
| *Malignancy* | 8 (2.5%) | 15 (5.3%) |  |
| *Non-cardiovascular death* | 124 (39%) | 185 (65%) |  |
| *Not Recorded* | 26 (8.1%) | 18 (6.3%) |  |
| Cardiovascular death |  |  | <0.001 |
| *Heart failure* | 79 (25%) | 24 (8.4%) |  |
| *Sudden cardiac death* | 63 (20%) | 26 (9.1%) |  |
| *Stroke* | 5 (1.6%) | 9 (3.2%) |  |
| *Other cardiovascular death* | 15 (4.7%) | 8 (2.8%) |  |
|  |  |  |  |

**Figure 1:**

**Et billede, der indeholder tekst, skærmbillede, nummer/tal

Automatisk genereret beskrivelseLegend:** Relative risk of the occurrence of 15 cardiovascular features (y-axis) in patients with sarcomeric versus non-sarcomeric hypertrophic cardiomyopathy (HCM). The relative risk ratio is given on the x-axis and the filled dots denote the point-estimate of the relative risk while the error-bars give the confidence intervals. On the right the overall prevalence of each feature is given separately for each group. **Abbreviations***:* *HCM* = hypertrophic cardiomyopathy, *ICD* = implantable cardioverter defibrillator, *LVSD* = left ventricular systolic dysfunction, *NSVT* = non-sustained ventricular tachycardia, *NYHA* = New York Heart Association functional class, *SRT* = septal reduction therapy, *VA* = ventricular arrhythmia.

**Figure 2**

Et billede, der indeholder tekst, skærmbillede, diagram, linje/række

Automatisk genereret beskrivelse

**Legend:** Incidence of hypertrophic cardiomyopathy (HCM) related mortality (sudden cardiovascular death, heart failure related death, and death due to stroke) in patients with sarcomeric (pink) versus non-sarcomeric (blue) HCM. Panel **A.** Cumulative incidence since first SHaRe evaluation, including numbers at risk by year. Panel **B.** Age-specific incidence (ASI) rates, including total person-years at risk in each age-group. The standardized incidence ratio (SIR) has been added for each age-group at the bottom of the plot.

**Figure 3:**

****

**Legend:** Heatmap showing the time-adjusted hazard ratios of being diagnosed with one of 8 cardiovascular outcomes (x-axis) predicated on of the presence of one of the 6 pre-defined disease-modifiers (exposures, y-axis). Hazard ratios larger than 1 are shown with Bonferroni corrected 95% confidence intervals if Bonferroni corrected p <0.05. Colors indicate the level of statistical significance. Hazard ratios are adjusted for sex and if a significant interaction was observed stratified analysis was performed. **Abbreviations***:* *LVSD* = left ventricular systolic dysfunction, *NYHA* = New York Heart Association functional class, *VA* = ventricular arrhythmia.

**Figure 4:**

****

**Legend**: Forest plot showing the time-adjusted hazard ratios for the combined effect of each individual modifier (exposure) and genetic status on the hazard of the outcomes (written in cursive). All hazard ratios are adjusted for sex and computed using age as the timescale with left-truncation at the first visit at a SHaRe site. Only exposure-outcome pairs in which the exposure was associated with a higher rate of the outcome and in which a significant interaction was found are included. The effect ratio of the interaction are given in text along with the p for interaction on the right hand side of the plot. **Abbreviations***:* *LVSD* = left ventricular systolic dysfunction, *NYHA* = New York Heart Association functional class, *VA* = ventricular arrhythmia.