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Released: 09/16/2024
Valid until: 09/15/2025
Time needed to complete: 52m

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A Practical Guide to Prescribing in HF

Announcer:
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Dr. Skolnik:
The AHA/ACA guidelines for managing heart failure were updated in 2022. Do you feel confident in prescribing the four foundational guideline-directed medical therapies, as well as two newly approved agents?

This is CME on ReachMD. I'm Dr. Neil Skolnik, and joining me to discuss prescribing in heart failure is Dr. Barry Greenberg, Dr. Trina Huynh, PharmD, and Dr. Melissa Mclenon, DNP. Thank you all for being here today.

Dr. Huynh:
Thank you.

Dr. Mclenon:
Thank you.

Dr. Greenberg:
Thank you. Pleasure to be with you.

Dr. Skolnik:
Now, if we look at the 2022 guidelines, Dr. Greenberg, what are the key global takeaways?

Dr. Greenberg:
So there are really four foundational drugs for patients with heart failure with reduced ejection fraction. And these were added with class I recommendations, the highest you can get based on really convincing evidence from clinical trials that they improve outcomes in patients with heart failure and reduced ejection fraction.

So the four classes of drugs are the renin angiotensin system inhibitors, that includes the ARNIs, the ACE inhibitors, and the angiotensin receptor blockers. There are the MRAs, or mineralocorticoid receptor antagonists. Drugs we see in that class are spironolactone and eplerenone. Beta blockers, but only three of the available beta blockers are guideline recommended, that is sustained release metoprolol, carvedilol, and bisoprolol. And then finally, the new kid on the block are the SGLT inhibitors, a series of drugs that were initially developed for diabetes, and now found to have a favorable effect in patients with heart failure.

Dr. Skolnik:
Now, the 2022 guidelines identified the four foundational guideline-directed medical therapies, or GDMT, as Dr. Greenberg went over, as the classes of medicines for patients with HFrEF. What's the process for determining which agent in each class is most appropriate for a specific patient? Let's start with– Dr. Huynh, how can you explain how you decide an optimal treatment approach for a specific

patient?

Dr. Huynh:
Yes. First off, I think it's very important to be honest and upfront with the patient that they're going to be, and our goal is, to get them on all four GDMT medications. I find it very helpful for them to lay that foundation and then we will have a shared decision on which ones to start and titrate. And depending on which drug class and which one to start is very dependent on the patient's factors and laboratory values. So for examples, with the renin angiotensin system, the RAS inhibition those are blood pressure-lowering agents. We have to monitor potassiums, but they all, across the board, do the same similar effects, with the ARNI being the first-line option. So I would always try to get my patients on an ARNI as much as possible. With the MRAs are – or the spironolactone and eplerenone drug class, again, if a patient tells me they have a very high-potassium diet, I might not start that immediately. So considering that as a factor too when you start these medications.

The beta blockers, we have a little bit more leeway in terms of which one to start. We know that carvedilol you have to take with food, because it does have the hypotension effects if you don't take with food. Metoprolol may have more of a blood pressure-lowering agent, same with bisoprolol, because they're more selective beta blockers. So those are certain things we can consider.

With the SGLT inhibitors, we know that, across the board, they're very similar mechanism actions, so I don't necessarily warn them about the different side effects, more so what is dictated by their insurance at this point, because they are very expensive medications.

Dr. Skolnik:
Really good points. Thanks so much. Dr. Greenberg, your thoughts?

Dr. Greenberg:
The one thing I would mention is that for the SGLT inhibitors, for the patients I'm putting on sotagliflozin, I do remind them that this acts, not only in the kidney but in the bowel, to block reabsorption of glucose, so that diarrhea may be a side effect in this patient population.

Dr. Skolnik:
So since the publication of the 2022 ACC/AHA guidelines, a few other agents have become FDA approved for heart failure, and since they were approved after the guidelines came out, they're obviously not included in the guidelines. Dr. Huynh, when and for whom would ivabradine be an appropriate treatment?

Dr. Huynh:
So ivabradine is a specific funny channel inhibitor so that it lowers the heart rate and it's more selective toward the cardiac pacemaker currents. It really targets the heart rate more than lowering blood pressure. With the starting dose of 2.5 or 5 mg twice a day, the patient should be taking this with food. I would consider this medication, ivabradine, specifically for patients who are already on the four GDMT medications and they're still symptomatic and their normal resting heart rate is greater than 70 beats per minute. This one medication is actually a 3A4 substrate, so there is some drug interactions to consider for your patients. And if a patient is not in normal sinus rhythm, it's also not recommended as well for use.

Dr. Skolnik:
That's helpful. Dr. Greenberg, your thoughts?

Dr. Greenberg:
Yeah, just to elaborate a little bit about what the guidelines say, they recognize ivabradine as being a useful drug in this patient population. It's just not at the level as the four foundational drugs. But once you get patients on those four foundational drugs and they remain symptomatic and they're in sinus rhythm with a heart rate greater than 70, there's a recommendation in the guidelines for considering ivabradine.

Dr. Skolnik:
Dr. Huynh, when and for whom would vericiguat be an appropriate treatment?

Dr. Huynh:
Yeah. So vericiguat is the first oral soluble guanylate cyclase simulator approved for reduced ejection fraction heart failure. It's indicated for patients with symptomatic chronic heart failure with ejection fraction less than 45%. And the benefit is to reduce the risk of cardiovascular death and heart failure-related hospitalization following a recent worsening event. And how do we define a worsening event? It's hospitalization for heart failure or need of IV diuretics in the outpatient setting. I will consider adding this to lower combined risk of death for cardiovascular causes, or first hospitalization related to heart failure. Statistically significantly, it reduces risk for all-cause mortality, or first hospitalization-related to heart failure. There's no benefit seen in trials for the – NT-proBNP levels grossly elevated. But when I think about our patients, and when I put this in therapy, is if they are on four GDMT already, the heart rate is

controlled, and they are still coming back into the hospital time and time again.

Dr. Skolnik:
So I think we are closing now, really the way we began this segment, which is with an orientation toward patients and their needs, and how to integrate that with guideline-directed medical care. This really has been a great discussion. Let me thank each of you in turn. Dr. Greenberg, thank you.

Dr. Greenberg:
It's been a pleasure.

Dr. Skolnik:
Dr. Mclenon.

Dr. Mclenon:
Thank you. Thank you for this opportunity.

Dr. Skolnik:
And Dr. Huynh.

Dr. Huynh:
Thank you. Thank you for having me.

Dr. Skolnik:
For ReachMD, it's been a pleasure. I'm Dr. Neil Skolnik.

Announcer:
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