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Level Up Your Skills: Tailoring Management of HF

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

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Dr. Skolnik:
You're listening to CME on ReachMD. This activity is titled, Level Up Your Skills: Tailoring Management of Heart Failure – A Panel Discussion. In this module, we examine a typical case that presents to primary care. How would your treatment strategy compare with the experts? Think about that as we discuss the case.

This is CME on ReachMD. I'm Dr. Neil Skolnik, and joining me to discuss tailoring management of heart failure in a panel discussion is Dr. Barry Greenberg, Dr. Trina Huynh, Jessica Lin, Dr. Melissa Mclenon, and Karina Brown. Thank you all for being here today.

In this program, we're going to use a case study to apply these guidelines for the diagnosis and management of a typical recently diagnosed patient with heart failure and comorbid obesity and diabetes. Karina, can you present a case that would encompass those key areas to help us address some key diagnostic and management issues?

Ms. Brown:
My pleasure. So we have a 66-year-old female with nonischemic DCM. She was recently diagnosed. Most recent injection fraction was 32%, heart rate is at 78 beats per minute. She is presenting with class III symptoms. Comorbidities is obesity with a BMI of 33%, type 2 diabetes. Her recent A1c was 8.2%. Her current medications are aspirin 81 daily, carvedilol 6.25 mg, and furosemide 40 mg twice daily, as well as losartan 50 mg. Her blood pressure is at 136/84 and her labs show her creatinine at 1.5. She's also euvolemic.

Dr. Skolnik:
What were the aspects of that allowed us to make the diagnosis originally, we'll assume that obviously she had an echo, her ejection fraction's 32%, at some point we had an NT-proBNP, perhaps initially when she came in with symptoms. And let's assume here that she had an evaluation for ischemia, because if there wasn't, then we would be doing it. But let's really move on now to treatment. We're going to focus on treatment, particularly the initial treatment selection and monitoring considerations. So Jess, what did you first consider when selecting initial therapy for this patient?

Dr. Lin:
Looking at the medication that the patient is already on, having beta blocker and ARB on board, I definitely would like to add an SGLT inhibitor, especially in light of her diabetes diagnosis. I think that would definitely be one to start with, as well as– spironolactone, one of the mineralocorticoid antagonists, given that her ejection fraction is less than 35% and her functional class is class III, so definitely would start with those with close lab monitoring.

Dr. Skolnik:
That sounds great. And Jess, I know some of our listeners are thinking, should they start both of those at once? Or –should they be

separated in time?

Dr. Lin:
Oh, I love that question. I'm always a fan of starting with one at a time, and closely monitoring side effects, potential renal impacts, especially because when I've seen patients started on too many medications too quickly, and there's a complication, whether that's low blood pressure or other side effects, they're just so quick to want to stop medication. I definitely start with one, make sure patients are tolerating it, blood pressure looks good, labs look good, before introducing a second agent.

Dr. Skolnik:
So helpful. Now, Dr. Huynh, what might a pharmacist consider at this point?

Dr. Huynh:
I think we would consider a couple things to try to get the patient to do some self-monitoring at home. First thing would be weights, if they're not getting daily weights, and we want the first thing in the morning dry weights. We encourage our patients to monitor their blood pressure one or two times a day, once in the morning and once at night, if they're able to. But the key thing I want them to know here is that, yes, we're monitoring blood pressure, we're writing down these values, but what we're really looking for is symptomatic hypotension. So if the patient is lightheaded and dizzy, that's when we would be concerned. I usually tell my patients, I titrate your medications to target dose as much as we can, and then once you get dizzy, we take one step back. So not necessarily targeting numbers per se.

The other thing to consider, if, you know, Jess were to start spironolactone is high-potassium diets. Patients who love avocado, tomatoes, potatoes, they might actually end up with laboratory values with high potassium. So investigating that later on and upfront will help you kind of combat that in the future as well.

Dr. Skolnik:
That's such helpful advice. And when you talk about weights, do you give a amount of weight gain as an indicator to a patient to call you? What would that be?

Dr. Huynh:
Yes. Good question. We usually use 3 pounds within one day or 5 pounds within five days or more. And this is stressing that this is their dry weight without eating or drinking anything first thing in the morning. Some patients tend to weigh themselves throughout the whole day and then report the weights, but that's inaccurate; we want the dry morning weights.

Dr. Skolnik:
Really helpful. Dr. Mclenon, any thoughts that you have?

Dr. Mclenon:
I think especially if it's a newly diagnosed heart failure, just educating the patient on heart failure in general so they understand how the medications are going to affect their heart failure and their symptoms. We have videos that we show patients, because a lot of times they do come back and they said, 'Well, I looked on the internet, and the internet says it could cause this, this and this and all the more toxic side effects,' and so they don't understand the benefit of the medication. So really taking time initially when you prescribe these new medications, to go over that with them and allow them to ask those questions.

Dr. Skolnik:
Dr. Greenberg, how might you adjust this patient's treatment plan at this point?

Dr. Greenberg:
We're making a big ask of this patient, because we're going to be doing a lot of things over the ensuing weeks after this patient first comes into the office. We're going to talk about increasing the dose of the beta blocker. We're going to be talking about switching from the ARB to an ARNI, which is the preferred RAS blocker for patients with heart failure and reduced ejection fraction. And then we're talking about adding two additional agents, which would give us the four foundational drugs for treating patients with heart failure. So I think that I'm just trying to put myself in the patient's shoes here. Boy, I would have a lot of questions. Why are you doing all of this? Do I need all of this? What am I going to do about side effects? So I think that aspect of how you do it, how you educate patients, is really critical if you're going to be successful.

Dr. Skolnik:
That's so important. Any other thoughts that other panelists have at this point?

Dr. Lin:
I've definitely had patients just ask, 'Why am I on all these medications, and you're adding more, increasing the doses when I feel fine?'

And I think that's where education is so important, that it's important to do that now and not wait till they're not fine.

Dr. Skolnik:
Well, this has been a great discussion. Really important information on heart failure. This has been CME on ReachMD. I'm Dr. Neil Skolnik, and we have had a great discussion on tailoring management of heart failure with Dr. Barry Greenberg, Dr. Trina Huynh, Jessica Lin, Dr. Melissa Mclenon, and Karina Brown. Thanks, everybody, for listening.

Announcer:
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