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Addressing Unmet Needs in ATTR-CM Care: Key Considerations for Optimal Management

Announcer:
You're listening to *Heart Matters* on ReachMD. On this episode, we'll hear from Dr. Michelle Kittleson, who's the Director of Postgraduate Education in Heart Failure and Transplantation and Professor of Medicine at the Cedars-Sinai Smidt Heart Institute in Los Angeles. She'll be discussing challenges and unmet needs in transthyretin cardiac amyloidosis, or ATTR-CM. Let's hear from Dr. Kittleson now.

Dr. Kittleson:
There are so many unmet needs or unanswered questions in the care of patients with ATTR cardiac amyloidosis. One is the underrecognition of this condition, and this can be exacerbated by disparities in healthcare in that we know that 3.4 percent of Black Americans are carriers of the V142I variant for TTR. Now, this does not mean that 3.4 percent of Black Americans will all develop TTR cardiac amyloidosis, but it means if an older Black patient sees you in clinic with dyspnea, edema, a relatively preserved ejection fraction, and increased wall thickness, think about cardiac amyloidosis to avoid underdiagnosis.

The second unmet need is our inability to truly understand how to manage asymptomatic gene carriers—that is, they've received a V142I variant flag on direct-to-consumer genetic testing or through cascade screening of a family member who's affected. Typically, you will not see TTR cardiac amyloidosis until a patient is in their sixth or seventh decade of life. But earlier, younger, how do you screen and manage these patients? Should preventive therapies be offered? There's no evidence for that at present. And then finally, when you've been diagnosed from another place, like a surgeon sent your carpal tunnel or spinal stenosis specimen and there is no cardiac involvement at present, is there a role for prophylactic preventive therapy? And what's the appropriate screening interval?

We have tafamidis and acoramidis, two TTR stabilizers. Both were shown in clinical trials to reduce the risk of death and heart failure hospitalization when compared to placebo. We do not know how they work head to head. We do not know how to measure response or lack of response to therapy, and even if we could, how that information should be incorporated into clinical practice. We look forward to ongoing trials to help us answer these important questions.

When it comes to TTR cardiac amyloidosis, I think it's important to have an optimistic outlook. Number one: we know that there are effective diagnostic strategies. Number two: there are effective therapies, and the earlier they are started, the better the patient will do. We know that in the most recent clinical trials, the survival of treated patients approaches that of their standard age-related mortality in the absence of cardiac amyloidosis, so through good recognition, proper testing and appropriate management, we can allow our patients great outlook for ATTR cardiac amyloidosis.

Announcer:
That was Dr. Michelle Kittleson discussing unmet needs in transthyretin cardiac amyloidosis care. To access this and other episodes in our series, visit *Heart Matters* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!