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Bridging the Gap – How Do We Implement New Guidelines for HFrEF into Clinical Practice?

Dr. Bozkurt:
Hello, my name is Biykem Bozkurt. I'm from Baylor College of Medicine. And today I will be discussing, bridging the gap; how do we implement new guidelines for heart failure with reduced EF, into clinical practice?

In the universal definition of heart failure and 2022 ACC, AHA, HFSA guidelines, heart failure stages have been revised. The new terminologies include, at-risk for heart failure for stage A. Defined as patients at risk for heart failure but without current or prior symptoms or signs of heart failure and without structural or biomarkers of heart disease. Pre-heart failure for former stage B, which is defined as patients without current or prior symptoms or signs of heart failure, but with evidence of either structural heart disease, abnormal cardiac function or elevated natriuretic peptide levels or elevated cardiac troponin, especially in the setting of exposure to cardiotoxins. Heart failure for stage C, for patients with current or prior symptoms and or signs of heart failure caused by structural or functional cardiac abnormality. And advanced heart failure for former stage D, for patients with severe symptoms and/or signs of heart failure at rest with recurrent hospitalizations, despite GDMT.

There are also specific recommendations for all stages of heart failure in the new guidelines. In patients at risk for heart failure or stage A, we have Class one recommendations with SGLT2 inhibitors for patients with type 2 diabetes and cardiovascular risk to reduce future heart failure events. Optimal control of blood pressure in patients with hypertension; optimal management of cardiovascular disease in patients at risk for heart failure; genetic screening and counseling in patients and families with genetic or inherited cardiomyopathies; multidisciplinary evaluation for patients with exposure to cardiotoxic agents are Class one recommendations. Additionally, in patients with LV systolic dysfunction, ACE inhibitors, ARBs or beta blockers are indicated even in the absence of symptoms. Additionally, we have a Class 2A recommendation for natriuretic peptide based screening, which can be useful to prevent development of LV dysfunction or new onset of heart failure in patients at risk for heart failure.

In patients with symptomatic heart failure, treatment of heart failure would reduce EF, now includes the core foundational quadruple therapy of SGLT2 inhibitors, beta blockers, mineralocorticoid receptor antagonists and RAS inhibition with ARNI NYHA Class II to III or ACE inhibitor ARB therapy in NYHA Class II to IV heart failure patients as step one. After optimization of these therapies if patients remain symptomatic, hydralazine nitrates are indicated in African American or Black patients and device therapies such as ICD and CRT are to be considered. The sequencing of these agents comes as a frequent question. We did not specify which medication to be initiated first, but stated that step one medications, the quadruple step one medications, may be started simultaneously, at initial low doses. And subsequently, these medications can be up-titrated. Alternatively, these medications may be started sequentially with sequence guided by clinical or other factors, without the need to achieve the target dosing before initiation of the next medication. Of course, the permutations of how to start these medications can differ from patient to patient. This can depend on the specific etiology of the heart failure, the hemodynamic characterization of the patients as well as the phenotypes and comorbidities of the patients.

In the universal definition, we also focus on the terminologies for clinical trajectories and emphasize to use persistent heart failure rather than stable heart failure, for those patients with symptoms, though they may not be showing active signs of worsening. Heart failure in remission rather than recovered heart failure for those patients with resolution of symptoms or signs of heart failure, or with resolution of previous structural or functional heart disease after a phase of symptomatic heart failure. We also emphasize that worsening heart

failure patients need special attention, with consideration of additional therapies. Once GDMTs optimize, other additional therapies such as Ivabradine can be considered in symptomatic heart failure patients with reduced EF, with heart rate greater than 70, despite maximally tolerated beta blockers. Vericiguat has a Class 2B indication in symptomatic heart failure patients with reduced EF, recent hospitalization or with requirement of IV diuretics or with evidence of elevated natriuretic peptide levels. Similarly, Digoxin has a Class 2B recommendation in patients with symptomatic heart failure with reduced EF.

In clinical practice, sequence is usually individualized according to phenotypes and etiologies; for example, for a patient early post myocardial infarction or a patient with active ischemia. Or in patients with tachycardia, obviously beta blockers would be prioritized. For a patient with advanced CKD, SGLT2 inhibitors may be prioritized, followed up by ARNI. For a patient with significant congestion, NYHA Class III symptoms with recurrent hospitalizations after diuretics, SGLT2 inhibitors, ARNI, MRA may be prioritized followed by beta blockade and consideration of Vericiguat. For a patient with NYHA Class IV heart failure ACE inhibitors, SGLT2 inhibitors, mineralocorticoid receptor antagonist may be used, but ARNI probably would not be indicated, especially with the evidence of the results of the live HF trial.

In the new guidelines, CRT indications have not changed compared to the former guidelines. Patients with left bundle branch block with QRS over 150 milliseconds have Class 1 indication, patients with left bundle branch block with QRS over 120 but less than 150 milliseconds, a Class 2A. Patients with non-left bundle branch block with QRS over 150 milliseconds, a Class 2A and a non-left bundle branch block morphology with QRS between 120 and 150 milliseconds, a Class 2B indication for CRT.

Additionally, surgical revascularization is indicated among select patients with suitable coronary anatomy and ischemic cardiomyopathy. Transcatheter edge to edge mitral valve repair is indicated among patients with secondary MR, suitable anatomy and PA pressures and specifications after optimization of GDMT. Wireless monitoring of PA pressure by implanted hemodynamic monitoring, has a Class 2B recommendation. In patients hospitalized with heart failure, GDMT should be initiated and optimized as soon as possible. Initiation of GDMT is a Class one indication during hospitalization after clinical stability's achieved. We emphasize the congestion and continuation and optimization of GDMT. And very importantly, we emphasize that GDMT should not be routinely discontinued in patients experiencing mild decrease in renal function or an asymptomatic reduction of systolic blood pressure during heart failure hospitalization. If truly necessary to discontinue, we recommend GDMT to be resumed as soon as possible.

In summary, the new strategies and classification for stages of heart failure provide us important steps to enhance timely diagnosis and treatment of heart failure. There are specific recommendations for patients at risk for heart failure, pre-heart failure to prevent heart failure as well as in patients with heart failure and advanced heart failure across all stages. These new guidelines highlight new recommendations in heart failure practice. We're hoping that these new guidelines will be helpful to clinicians for implementation and delivery of care and improve patient outcomes. Thank you for your attention.