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Choosing the Right Therapy for Patients With PSVT

Announcer:

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Brian Rose

Welcome to this educational activity from GLC. I'm Brian Rose, and I'm pleased to be here with Jennifer Carlquist. In this episode, we will discuss current therapies for PSVT, or paroxysmal supraventricular tachycardia.

Jennifer Carlquist, PA-C:

So, Brian, I'm excited to talk about this topic because this is a disease process that affects many and causes a lot of fear. And so, what I like to do when I see a patient is I like to run through the options. And I do set up the conversation pretty early that most likely they are heading for a curative approach of an ablation, and I will get them in the queue to see electrophysiology early on in their diagnosis because sometimes that can take a while. And then in the meantime, I'll go ahead and tread water if they have episodes in between, and I'll use things like beta-blockers. I'll use things like calcium channel blockers. And if I'm happening to see them in the hospital and they have the PSVT episode there, a lot of times, we'll reach for things like adenosine, or we might even try diltiazem or verapamil to see if we can go ahead and abort their episode.

Sometimes we'll also, in the hospital, start them on antiarrhythmics, but that's usually going to be done in consultation with electrophysiology because there's a lot of side effects that can come with these medications, and there's a lot of other secondary decisions that have to be made behind the scenes if they have structural heart disease or coronary artery disease.

But I know there's a new treatment out, Brian, that is also kind of a safety net, and I would love to hear your thoughts on it.

Brian Rose, PA-C:

Yes, absolutely. Etipamil is an intranasal calcium channel blocker that was recently approved by the FDA for use in symptomatic PSVT outpatients. Specifically, I want to talk about their RAPID phase 3 clinical trial. So this looked at patients that had adjudicated PSVT, and what that means is these were patients that were actually found to have PSVT and were able to self-treat themselves. And what they found was the average conversion time after a dose of intranasal etipamil was about 17.2 minutes. And again, those patients could repeat after 10 minutes of the initial dose if they were still symptomatic.

Similarly, the NODE trial looked at the percentage of patients that actually did convert with utilization of etipamil, and what they found there was that within 60 minutes of administration of etipamil, about 70.5% of patients would convert to sinus rhythm.

Jennifer Carlquist, PA-C:

That's exciting and impressive. And to be honest, I'm excited, as a practitioner, to now have this as a tool in my tool belt because, for so long, patients really did not feel like they were in the driver's seat of their disease process, and they didn't feel like they had control over their symptoms. And I think that's oftentimes really scary for them. This is an easy option that works faster than the other drugs, and it also has very few side effects. And it's portable, and I think it can a lot of times abort an ER visit for a patient, like you said, a 75% conversion rate to sinus that saves them an ER bill as well, and potentially being exposed while they're at the ER to other infectious diseases in the waiting room. So this is a win-win, I think, for patients. It's a win-win for providers.

And I'd like to kind of know, Brian, how you go about deciding therapy for patients with PSVT.

Brian Rose, PA-C:

That's an excellent question. So a lot of times it depends on where you're meeting the patient at. If this is an ER consultation, for example, where the patient is treatment naive, or they might have just been treated with adenosine and converted, we're making sure that they're on that initial AV nodal blocking agent. And I'm also discussing with them about utilization of etipamil. We're reviewing whether or not they desire ablation and making sure that they have a prompt referral to EP services.

If a patient is having recurrent PSVT despite AV nodal agents, so that's when we're talking about addition of antiarrhythmic therapy, and I'm really sitting down saying, hey, you've been in the emergency room 2 or 3 times over this period of time, maybe the last year, this is really a good time for us to really take pause and send you to EP to really talk about the possibility of ablation.

And then a lot of times we're talking about utilization of medication even after ablation because, even though the high rate of success with PSVT ablation is very lucrative for patients, when they hear 90-plus percent success rate, there is a possibility of recurrence. So having medications to take on an as-needed basis if they were to have recurrent disease is very attractive.

Jennifer Carlquist, PA-C:

Agreed. I really think the shared decision-making with the patients here is key. Giving them the tools they need to set them up to win and having those talks early about what do you do when you get in these crisis situations, because I think a lot of patients kind of freeze up, and they just go into panic mode. So giving them an algorithm, a stepwise approach to follow, and arming them with the tools.

And I do know, like what you were saying, Brian, is that patients will get to a point where they'll decide enough is enough. I want the ablation, and it's always a great moment when that happens because they're making the decision, and it empowers them, again, to just feel in control of their care.

Brian Rose, PA-C:

That was a wonderful discussion on choosing the right therapy for patients with PSVT. Thank you for joining us. Our time is up and thank you for listening.

Announcer:

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