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From Episode to Empowerment

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Jennifer Carlquist

Welcome to this educational activity from GLC. I'm Jen Carlquist, and here with me today is Brian Rose. We're going to discuss the importance of patient education and shared decision-making in PSVT, or paroxysmal supraventricular tachycardia.

Brian, how do you explain PSVT to patients and what their treatment options are?

Brian Rose, PA-C:

Thank you, Jennifer. PSVT is a very common complaint we see in the clinic, whether patients are being referred from their primary care provider or from the emergency room or following a recent hospitalization. These patients can range anywhere from teenage years all the way up to 65-plus. We see this quite often more commonly in female patients as opposed to males, so quite a very common complaint that I see in the clinic.

Explaining what PSVT actually is is key. I often will talk to them about rhythm problems in general, and that if they've ever watched TV, they definitely have heard about atrial fibrillation and all the commercials that exist with it. I explain to them that SVT is a blanket term that encompasses a couple different heart rhythm issues, to include AVNRT, atrial tachycardia, AVRT, just to name a few. Specifically, I try and understand the frequency of their symptoms, how many times they've had to seek care for their symptoms, because that really allows us to make a tailored approach of how to treat them.

Explaining the full plethora of treatment options to include AV nodal blocking agents taken as pill-in-the-pocket or on a daily basis versus intranasal etipamil all the way to antiarrhythmics and referral for ablation are covered usually during that first visit. I like to focus not only on long-term maintenance and trying to bridge that patient to EP evaluation and ablation, if desired, but also how to abort these acute symptoms, and that is where etipamil has really come to the forefront.

As we know, vagal maneuvers, based on the data provided, are effective in less than 10% of patients. We still cover this because it allows patients to try something noninvasive to abort their symptoms. But I do warn them that usually this is not very effective. Again, we can use AV nodal blocking agents as pill-in-the-pocket, or etipamil, which is an intranasal calcium channel blocker, has really become a key player for these patients to abort their acute symptoms.

Jen, do you do the same in your practice?

Jennifer Carlquist, PA-C:

I love, Brian, what you do, and I do do something similar where I meet the patient where they are, and definitely, I structure an action plan. Something break glass, something in an emergency. And I also really understand from their viewpoint that there's a lot of fear surrounding this disease process. And so I like to kind of take the fear out by letting them know that we're going to put them in the driver's seat by giving them some of the tools that you talked about.

And I'm particularly interested, Brian, in hearing more about how, according to this label, how we should be using etripamil.

Brian Rose, PA-C:

So it's important to know that etripamil is used for outpatients at this point in time, consistent with its label. So these are hemodynamically stable patients with known PSVT. It is an intranasal delivery. A dose of 70 mg is administered as 2 nasal sprays, 1 spray into each nostril, and each nasal spray device delivers 2 sprays. So 2 sprays together equals 70 mg of etripamil.

It is important that the patient not snort this, not try and get it up into their sinus cavity like they would an inhaled or intranasal allergy medication, for example, that this is absorbed through the nasal mucosa.

The interesting thing and very convenient thing about etripamil is we know a lot of times in patients with PSVT is they require repeat dosing, so should symptoms persist for 10 minutes after administration of the initial etripamil spray, patients can actually take a second dose of 70 mg administered as 2 nasal sprays, again, 1 spray into each nostril. So we don't want to exceed 140 mg in a 24-hour period.

If patients are still symptomatic beyond that, they will need to seek emergency-level care.

Jennifer Carlquist, PA-C:

Brian, I think it's an exciting time, really, in the treatment of this disease state because when I first started in EP, we didn't have these kind of tools. And what's exciting is that they now can get in the driver's seat of managing their symptoms and potentially head off an expensive ER visit with these new options, and it helps allay their fears as well to know that they have some control, whereas before, they had to go to the ER and get a scary medicine called adenosine.

So our time is up, but I really hope that tonight we gave you something to think about. And thanks for listening.

Announcer:

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