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From Guidelines to Practice: Key Updates From 2021 HFSA

Announcer:
Welcome to CME on ReachMD. This episode is part of the Global Heart Failure Academy and is brought to you by Medtelligence.

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Dr. Piña:
Rapid initiation and up-titration of guideline-directed medical therapy, or as we call it, GDMT, is critical to achieve optimal patient outcomes. This is especially important in patients who have multiple comorbidities and in pivotal situations where we want to avoid stopping or lowering the dose of any of the 4 critical medicines that these patients must receive.

This is CME on ReachMD, and I'm Dr. Ileana Piña. I'm joined by my colleagues, Dr. Javed Butler, and Dr. Giuseppe Rosano. Welcome. We'll be recapping the data and the views of the 3 of us, along with Dr. Gregg Fonarow, presented at a symposium held in conjunction with the HFSA, or the Heart Failure Society of America's 2021 annual scientific meeting. Dr. Butler and Dr. Rosano, welcome.

Dr. Butler:
Absolutely great to be here.

Dr. Rosano:
Thank you for having me. It's a pleasure to be here.

Dr. Piña:
Great. So, Rosano, let's get with it. Let's go and let's start with your first session from our symposium.

Dr. Rosano:
Yeah, my presentation dealt with the new guidelines from the ESC/HFA that were just being released in the ESC Congress at the end of August and how does it impact the guideline-directed medical therapy. The key new points that have been highlighted were to start together foundation therapy, personalize therapy, and profiling patients according to comorbidity and phenotype, especially phenotype patients according to blood pressure, heart rate, presence or not of atrial fibrillation, and renal function in order to favor selective and tailored up-titration of foundation therapy and, when appropriate, start with other medications that have a Class 2 recommendation.

Dr. Piña:
That was a lot of work. Javed, do you want to comment on the guidelines, since we haven't seen the American guidelines yet?

Dr. Butler:
Yeah, so you know the guidelines as you might have expected, that quadruple therapy is now recommended as foundational therapy, and what Dr. Rosano was talking, it's sort of really important because while it's very comprehensive, looking at multiple comorbidities and the combination of those comorbidities given different profiles, the solutions are actually very common sense practical things that we can do. And this really does not necessarily require specialty care or going to some centers. I mean, any clinicians – any doctor, nurse,

primary care physician – these are just practical management tips that we can implement and achieve optimum medical therapy, or at least a whole lot better than what we are doing today by using those techniques.

Dr. Piña:
Yeah, which we will hear from you as well. So now your session, Javed. Tell us sort of the summary of all the good points that you made.

Dr. Butler:
Yeah, so my presentation was focused primarily on looking at the real-world evidence of where these guideline-directed therapies are in terms of their utilization. And the message was a little bit sober. So, one, there are huge gaps in where we need to be, what we should be treating our patients with, and what we actually are. And it's not only the provision of care – sort of, yes, no, whether somebody's on therapy or not – it's a combination of therapy, whether somebody is on triple or quadruple therapy, and then the doses – whether somebody is on optimal dose or not. So that was a problem. The second issue that we discussed and discovered is that if you look at the temporal trends, there are some improvements in beta-blocker use, but otherwise, for RAAS [renin-angiotensin-aldosterone system] inhibitor [RAASi] use and MRA use, we are really seeing no improvement over the past decade. So that's another issue. The third thing that we tried to discuss last night, that a lot of our sort of reflex reasons for which we think that patients are not given optimal medical therapy are just not true when you look at the data objectively. So things like, you know, the clinical trial patient population was a very different profile, and my patients have blood pressure which are lower or creatinine which is higher. But when you objectively look at the data on the real-world practice patient, that just is not borne out. So I think there is a lot more in terms of inertia and what we can do today. So those are the points that I discussed.

Dr. Piña:
So, Javed, the argument of should we start them all together, should we start them in pieces – what would you say about that?

Dr. Butler:
Yeah, so, you know, there were a couple of things that Dr. Fonarow mentioned in his presentation that I was very, very impressed with. So, one, he said that just because you're giving two medications doesn't mean you don't need to give the third and the fourth, because the benefits were fully additive and incremental. So that was one issue. The second point that he mentioned that really struck a chord with me was the rapidity with which you get the benefit. I mean, you're talking about these therapies that have benefits that accrue, both symptomatic and clinical, within weeks. So this whole issue of waiting for months on end, we really put our patients at risk. So that brings us to this question about the sequencing issue. We need to remember that sequencing is a historical, not a biologic, construct. It just so happened in the 1980s, we just, you know, adjusted ACE inhibitors and then beta-blockers, and then we moved on. But there's no biologic rationale for that. So depending on whatever the patient comorbidity burden is, and, you know, somebody has high potassium, low creatinine, high blood pressure, whatever, you can then use that, but just get all the medications onboard. You know, if you take some time to up-titrate the doses, which are very important, that's okay, but at least cover all the major adverse pathophysiologic pathways as soon as possible. And when we say, you know, don't give sequential therapy, give simultaneous therapy, we don't mean to give 4 medications at 12:00, right at the same time on the same day. What we basically mean is with 2-, 3-, 4-day interval, maybe a weekly interval – but in 3 to 4 weeks, let's get all the therapies onboard for the patient.

Dr. Piña:
And it's a great place for patient education. Giuseppe, your second talk was all about a patient that you presented and strategies to use in a complex patient that had a lot of other comorbidities. You want to go over that with us?

Dr. Rosano:
My other presentation focused on a patient with heart failure with reduced ejection fraction, with an ICD [International Classification of Diseases] hyperkalemia and CKD [chronic kidney disease] and focused mostly on how we can implement especially RAASi therapy that was under-dosed in a patient that's, say, a borderline EGFR for initiation or for discontinuation of some of the RAASi therapy. And I discussed how the potassium binders and the SGLT2 inhibitors can facilitate the implementation of RAASi therapy, especially in hyperkalemia, favoring also the stabilization of CKD. And I also discussed the ways to improve adherence. For example, with what we have here in the UK that is the blister pack, the role of pharmacies and heart failure nurses, as Javed said, in order to make calls, reminders, and we have nurses that see patients at home regularly and check their medications.

Dr. Piña:
So, you know, the word "enabling" is not a word that we have used commonly in heart failure therapy. And yet, our chemotherapy oncology colleagues do this all the time. They give the patients these drugs that really make them sick and then they provide for them antiemetics so that they can take the chemotherapy that could potentially save their lives. So that "enabling" word is a new word for us, and I noted that in the European guidelines, it was in there. Are you enabling the use of these drugs by giving potassium binders? We

now have two of them that seem to have really a good safety profile and a good effectiveness.

Dr. Butler:
So, you know, conceptually speaking, when you say to a patient take your one medication at 10 in the morning, and the other at 3 in the afternoon so that your blood pressure doesn't go down all at the same time, that is enablement, right? When you ask the patient to cut down their dose of diuretics so that they have a little bit more volume, a little bit more blood pressure, so that they can tolerate their ARNI therapy, that is enablement. So the concept is with us. Now what is different is that we are using certain medications to enable other medications, and I think that concept, in the cardiology practice, is taking a little bit of time for people to grasp at, but as you mentioned, in oncology it is done all the time to enable therapies. And also, I don't want to make light of side effects. Of course we have to do everything to minimize the side effect profile for the patient, but also realize that stopping medical therapy and their primary disease getting worse is a worse bargain than trying to enable and manage their side effect profile.

Our cancer colleagues – when somebody has cancer, they don't worry about, you know, 2 drugs, 3 drugs, side effect profile. They give everything to save patients' lives and then manage the side effect profile. And I think we should develop some of those attributes as well.

Dr. Piña:
Now the final session was mine, and what I did is I reviewed managing common comorbidities. I don't know too many heart failure patients that have heart failure and nothing else. And we have counted, for example, the number of drugs that the patients leave the hospital with, and it comes to about 13. I don't know how anyone can take 13 drugs in one day. So we try very hard to manage the comorbidities, because I think we need to. This could be partnering, for example, with a primary care. Even Medicare recognizes that the patients, when they are in the hospital or being treated for heart failure, probably have at least 4 or 5 different comorbidities, which includes things like diabetes, hypertension, including obesity, which may make it very difficult to follow some of the recommendations that we have, for example, about activity. And the comorbidities should not be an interruption. And, hey, now we've got the SGLT2 inhibitors that can address, especially in those diabetic patients, where you may be able to decrease some of their other diabetic and hypoglycemic drugs. So comorbidities must be addressed. They must be detected. And things like iron, iron deficiency, anemia, these are all like little buttons that we need to totally button in the patient. Is the patient a candidate for a CRT [cardiac resynchronization therapy] or an ICD [implantable cardioverter defibrillator]? These are still heart failure therapies. So there are a lot of things to be considered, and I like to talk about the precision medicine and the totality of the care of the patient, where you do address, acknowledge, and tell the patients, "I realize that this is going on, but we're going to work with you to get this done. I want you to take your medications."

Unfortunately, we are out of time. I'd like to thank our audience for listening and joining us today, and I want to thank Dr. Butler and Dr. Rosano for sharing all their valuable insights and knowledge, as well as Dr. Fonarow for his terrific presentation at the symposium. It was great speaking with you today. Have a great day.

Dr. Butler:
Absolutely a delight. Thank you very much. Great discussion.

Dr. Rosano:
Thank you, Ileana, for having me. Thanks a lot.

Announcer:
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