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Released: 06/10/2022
Valid until: 06/10/2023
Time needed to complete: 15 minutes

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# How Do I Optimize GDMT with New Therapies in My Patients Following a Worsening HF Event?

**Announcer:**
Welcome to CME on ReachMD. This activity, entitled “How Do I Optimize GDMT with New Therapies in My Patients Following a Worsening Heart Failure Event?” is provided by Medtelligence.

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[CHAPTER 1]

**Dr. Piña:**
Welcome to the New Therapies in Worsening Heart Failure Educational Series. In this first chapter, we'll set the stage for the series in its entirety.

This is CME on ReachMD, and I'm Dr. Ileana Piña.

**Dr. Hernandez:**
I'm Adrian Hernandez, a cardiologist at Duke.

**Dr. Piña:**
Okay, Adrian, let's get started. First, give us a brief overview of the clinical characteristics and challenges of this worsening heart failure that we keep talking about. Then tell our audience about the new therapies that are now included in the guidelines as part of the guideline-directed medical treatment [GDMT].

**Dr. Hernandez:**
Over the years, we've been really interested in trying to categorize heart failure based on their different clinical scenarios, phenotypes, and actually prognosis. And so traditionally, we've often thought about heart failure as really 2 conditions, HFrEF, or heart failure with reduced ejection fraction, and heart failure with preserved ejection fraction.

But now we're really trying to focus on different subcategories of heart failure. And so, one important category of heart failure are those who have chronic heart failure with reduced ejection fraction but have a worsening heart failure event. And so that means patients who have worsening decompensation or heart failure hospitalization or IV diuretic use, for example, or perhaps even worsening heart failure based on their prognosis with elevated natriuretic peptide levels.

And if you look at this population, they're very high risk. It’s almost 20% of those patients who developed worsening heart failure within a year and a half of being diagnosed initially. And those who have a worsening heart failure event, their mortality rate is high. Their rehospitalization rate is high. So about 23%, 25% will unfortunately die after a worsening heart failure event. And then those patients are also very high risk for coming back again with worsening heart failure or rehospitalization. So, about half of those patients will get re-hospitalized, unfortunately.

So, this is a very high-risk population. It has unmet needs in terms of their medical care. And so now we have new evidence about how

to treat them. One example of that, in terms of focus of this population, is with the VICTORIA trial and the use of vericiguat. And so that did show improvement in outcomes, and that is now reflected in the guidelines as a class 2b recommendation.

**Dr. Piña:**
Yeah, and I think we've been, you know, for a long time, realizing that by the time we make a decision to put somebody in the hospital because they're decompensated, it's almost as if they already are on a different trajectory. And by putting them in the hospital, their trajectories get worse. And it's always been a concern when those patients go home, what's going to happen to them? And I think in the VICTORIA trial, we saw the very, very high event rate.

So, Adrian, if you're going to wrap this up for us, what would you say our one key takeaway is from this chapter that we're recording?

**Dr. Hernandez:**
When someone has worsening heart failure, a hospitalization, and requires escalation of therapy more urgently, we should actually treat that as a new event and trying to change our trajectory in terms of their health outcomes. And now we have evidence to do so.

**Dr. Piña:**
Thank you, Adrian.

In Chapter 2, we'll be discussing the new AHA, ACC, and Heart Failure Society Guidelines and the Heart Failure Classification. Stay tuned.

[CHAPTER 2]

**Dr. Piña:**
Welcome back. In the first chapter, we covered some of the challenges with worsening heart failure and novel therapies that can help manage your patients. In Chapter 2, we'll be discussing updates in the new AHA [American Heart Association], ACC [American College of Cardiology], and Heart Failure Society heart failure guidelines.

So, Adrian, can you give us a brief overview of the changes in the new guidelines? We'd also like to hear your opinion on how a new therapy like vericiguat would fit into that guideline-directed medical therapy.

**Dr. Hernandez:**
Sure, so it's really exciting times in heart failure where we have greater evidence in terms of how to manage heart failure and improve outcomes. And some of the top things that came out of these guidelines was the importance of the so-called Fab Four, a quad four therapy for patients with heart failure with reduced ejection fraction. We now have great evidence in terms of the use of SGLT2 inhibitors across a range of heart failure. And so, we also now have new recommendations for heart failure with preserved ejection fraction, emphasizing MRAs [mineralocorticoid receptor antagonists], SGLT2 [sodium-glucose cotransporter-2] inhibitors, and ARNI [angiotensin receptor-neprilysin inhibitor] therapy.

Another thing is that we're also attentive to other areas in terms of new cardiomyopathies that had not been fully recognized in the guidelines such as amyloid heart disease. So, there are a lot here in the guidelines that we should be considering across the range of heart failure.

And importantly, regarding the range of heart failure, we now really consider the full range of heart failure. As we mentioned in our last chapter, that classically, we considered heart failure with reduced ejection fraction and preserved ejection fraction and left out the middle ground, so-called the mid-range ejection fraction, as well as those patients who have recovery of their LV [left ventricular] function. And so now we have guidelines that also concentrate across the spectrum of ejection fraction. And so, it's not just around HFrEF with the so-called Fab Four of our RAAS inhibition with ARNIs, ACE [angiotensin-converting enzyme], or ARBs [angiotensin receptor blockers], beta-blockers, MRAs, and SGLT inhibitors, but we also now have additional recommendations regarding those patients who have worsening heart failure such as those who have a hospitalization and then would have an indication or recommendation regarding vericiguat.

And regarding those so-called patients with mid-REF that have not been recognized before, there are new recommendations of using SGLT2 inhibitors as well as considerations for ARNI, ACE inhibitors, ARBs, and MRAs. The SGLT2 inhibitors in this guideline have a 2a recommendation with RAAS inhibition having a 2b recommendation.

And then that conundrum of patients who have a recovery ejection fraction or improved ejection fraction, the recommendation is to continue guideline-directed medical therapy because we don't necessarily know what will happen if we stop. So, there's a lot here. And so, I certainly encourage people to take a deeper dive in those top 10 recommendations.

**Dr. Piña:**

Yeah, Adrian, and I think it's been really eye opening, even to me, how complex the patients can be and how many other little things like iron deficiency that we need to pay attention to. Does the patient have a sleep disorder? So, there are all these other areas that clinicians need to at least look at. And I really do recommend reading at least the executive summary of the guidelines; that can be very helpful.

Well, this has been great. Now before we wrap up, Adrian, can you provide us with one key takeaway from this chapter?

**Dr. Hernandez:**
Make sure to treat every patient that has heart failure. Every patient deserves a chance.

**Dr. Piña:**
That's great, thank you.

In Chapter 3, we'll look at a patient case and discuss when to use the novel therapies when worsening heart failure occurs despite maximum GDMT. Stay tuned.

[CHAPTER 3]

**Dr. Piña:**
Welcome. For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Ileana Pina and here with me today is Dr. Adrian Hernandez. We are discussing the use of novel therapies in worsening heart failure.

In Chapter 2, we walked through some of the changes in the heart failure classification and how a novel therapy like vericiguat can be incorporated into optimized therapy.

Now in Chapter 3, we will focus on a patient case to demonstrate the use of the novel therapies when worsening heart failure occurs despite maximum GDMT. Let's get started, Adrian.

We discussed some of the characteristics of that worsening heart failure, the challenges in managing guideline-directed medical therapy in these patients, and updates to the guidelines regarding heart failure classification, which you really explained extremely well. In a clinical setting, when would you incorporate the use of a novel therapy like vericiguat? And as a follow-up to that, what does the future have in store for us in terms of clinical trials? You and I are both clinical trialists.

**Dr. Hernandez:**
Yeah, so, Ileana, unfortunately, we still see these cases come in of patients who have been on great medical therapy but for whatever reason have worsening heart failure. And so just recently on rounds I saw a patient who's a 73-year-old gentleman with ischemic cardiomyopathy, an EF [ejection fraction] of 25%. And so, I thought, you know, well, what can we do? What can we add to this patient's regimen? He's actually been hospitalized twice in the past year. And last time, we thought we were really good. We were set. He was on the quad four therapy; he was on sacubitril/valsartan, a beta-blocker, an SGLT2 inhibitor, and an MRA. So, I thought at that time that we're home free for him.

But when he came in this time, clearly with worsening heart failure, we had to look for something else. And so, considering his condition, what can we add next, especially when he had maximal therapy already, in terms of dosing? And so vericiguat becomes very clear. Something that can be used to try to prevent him from having worsening heart failure and he's in the hospital and it's a time to act. And so that's what we started on the way out.

**Dr. Piña:**
And did you see any changes in blood pressure or renal function after you started the drug?

**Dr. Hernandez:**

No. And so this was something very easy to use. So, we don't have to worry, in this case, very much in terms of blood pressure. His blood pressures were actually 110s and 120s. He was on a nitrate, which is important. And we don't have to do very much in terms of other lab monitoring beyond what we do routinely for heart failure. And so, we'll see how things work. So far, so good. We need to see how he does over the next 6 months.

**Dr. Piña:**
At least another option in our little kit of options. And I know that I am personally very interested in looking at the women in the VICTORIA trial as well as racial differences, because we always talk about these subgroups and who may benefit more than another. So, I find this very fascinating.

So, this has been great. But before we wrap up, Adrian, can you one more time provide us with a key takeaway from this chapter,

especially from the patient you just presented?

**Dr. Hernandez:**
Right. When someone comes in the hospital, that's a time to act. That worsening heart failure, they will come back again if we don't do something.

**Dr. Piña:**
It's a golden opportunity to get the patients on the right drugs.

Unfortunately, that's all the time we have today. So, I want to thank our audience for listening in and thank you, Dr. Adrian Hernandez, for joining me and sharing all your valuable insights. It was great speaking with you today. Thank you and goodbye.

**Announcer:**
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