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Heart Failure Consensus Report: A Review of ADA Recommendations

Dr. Buse:
As the prevalence of diabetes continues to rise, we may also see an increase in rates of heart failure, and that's why the American Diabetes Association has released a new consensus statement for physicians about screening and diagnosing heart failure in patients with diabetes and prediabetes. These updated guidelines will be the focus of our conversation today.

Welcome to *Diabetes Discourse* on ReachMD. I'm Dr. John Buse. And joining us to explore these new recommendations is Dr. Rodica Pop-Busui. She's the Larry D. Soderquist Professor of Diabetes and Vice-Chair for Clinical Research in the Department of Internal Medicine and also the Director of Clinical Research, Mentoring & Development of the Caswell Diabetes Institute at the University of Michigan.

Dr. Pop-Busui, thanks so much for joining me today.

Dr. Pop-Busui:
Thank you very much, Dr. Buse. It is truly a pleasure to be here today.

Dr. Buse:
Wonderful. So, to start, could you give us some background about why the American Diabetes Association decided to pursue this initiative?

Dr. Pop-Busui:
Absolutely. In fact, this entire project had started several years ago preceding the pandemic at our 2018 Annual Scientific Session of the American Diabetes Association when we had as part of the cardiovascular interest group a very large session in which the attendants, which was composed of endocrinologists and many practitioners taking care of people with diabetes, had raised their questions on how to diagnose particularly people who are at risk or in earlier stages of heart failure. It was emerging, of course, so with all these exciting information on the benefits of some of our newer agents on preventing heart failure hospitalization, and it was an overall consensus in that large audience of more than 4,000 people that have asked for guidance, not from cardiologists because they were not cardiologists, but for the people who are managing diabetes on a daily basis how they can identify such patients and what would be the best approach to manage them to prevent later stages of heart failure.

Dr. Buse:
Wonderful. So, with that as background, what is the approach that's being suggested in this new guidance with regards to history, physical exam, labs, imaging for screening for heart failure?

Dr. Pop-Busui:
Right. And thank you so much for this question. I think that this consensus that had analyzed the largest bodies of evidence with respect to risk factors and way to diagnose as early as possible, people had unveiled actually, the very high value of biomarker screening that can identify patients in earlier stages of heart failure, such as stage A and B with the overall understanding that if clinicians can proactively identify these patients, they can either implement strategies that have been shown to be extremely beneficial in preventing later stage of disease and also try to avoid other type of steps or interventions that may in fact place higher risk on these patients.

We have been quite fortunate to work side by side with several of our colleagues, part of the American College of Cardiology and had access to several of these large cohorts, either clinical trials or observational cohorts, in which biomarker screening has been implemented, particularly to identify, potential, of predicting later risk, and thus, we were able to confidently reach this conclusion regarding timing and also threshold that would be easily implemented in clinical care and some of the most sensitive and specific

biomarkers that can be used.

Based on that, the consensus actually created a stepwise approach, that incorporates, several risk factors, biomarker screening, and then based on that additional step that would include, other type of imaging, including echocardiography when needed and the key points of clinical examinations that can further guide management.

Dr. Buse:
Wonderful. So, with that in mind, let's sort of dive into the actual recommendations. As I read it, should all or most patients with type 2 diabetes or diabetes in general have a natriuretic peptide or high-sensitivity cardiac troponin measured annually? And what kind of impact do you think that would have on the identification of heart failure?

Dr. Pop-Busui:
So that is what we have recommended indeed. I think that in a way we are pretty good, in implementing biomarker testing in clinical care, and I can give you an example. We implemented the A1c many years ago. That has been shown to be such an important biomarker to guide clinical care delivery. In a way, with the very high availability of these markers that high sensitivity and specificity that is not something that is complicated to do in clinical care. Definitely having once-a-year, NT-proBNP testing has been shown also to be cost-effective at least from these larger cohorts that have been analyzed and including in our consensus, and I believe that it's even more relevant today when indeed there are available medications that have a very strong track record in preventing the progression from these earlier stages to later stages like C and D that leads to this hospitalization and death.

Dr. Buse:
Well, thank you. For those just tuning in, you're listening to *Diabetes Discourse* on ReachMD. I'm Dr. John Buse, and today I'm speaking with Dr. Rodica Pop-Busui about the ADA consensus report for heart failure screening, diagnosis and management in diabetic and prediabetic patients.

So, let's get back to the ADA report. Can you tell us why the latest recommendations focus on using SGLT2 inhibitors and GLP-1 receptor agonists as well as metformin, ACE inhibitors, ARBs for stage A or sort of screening presymptomatic heart failure and downregulate the use of DPP-4 inhibitors, sulfonylureas and thiazolidinediones, that are, you know, frankly more often used and often less expensive?

Dr. Pop-Busui:
Yes, and, of course, this is an area of continued debate whether it's in our consensus, whether it's in our the ADA/EASD guidelines.

In general, when we want to make sure that we deliver the best of care, ideally, we shouldn't have to worry about the cost. We should just have to make sure that we give people what they really need based on their specific characteristic and their specific phenotype. But there are clear evidence that some of the DPP-4 inhibitors may increase the risk of heart failure, and sometimes in clinical practice, if one agent may not be covered by a specific plan, some may just interchange them, and that's put people at harm. The TZDs have clear, track record and evidence of increased risk of, of heart failure, and I think that the sulfonylurea, sulfonylurea data is more or less mixed, but their potential of causing hypoglycemia, weight gain, have been, some of our main, considerations when, discussing about a patient population in which both weight gain and hypoglycemia could enhance the risk for more severe complications.

Dr. Buse:
That's actually very clear. So let's talk a bit about stage B heart failure. This is sort of the early symptomatic heart failure. Here again the consensus report really focuses on using SGLT2 inhibitors specifically, and, avoiding those other agents. I take it that's related to the known benefits of SGLT2 inhibitors in heart failure. Is that right?

Dr. Pop-Busui:
Correct. And in fact, I think that we have even—and this was actually an absolute consensus among all of the members of the writing group, that have all a pretty high level of expertise, that in fact, in this patient population, SGLT2 inhibitors should be an expected element of care, and I really like this wording because indeed this agent should be an expected element of care when one takes into account, the very large body of evidence and their benefits.

Dr. Buse:
Outstanding. So another interesting aspect of the consensus report is that it has a significant focus on targeting social determinants of health. What can you tell us about that and the rationale around that language?

Dr. Pop-Busui:
Thank you so much for asking this question. As it has been emerging for other areas in diabetes care in general, the role of the social

determinants of health, is actually very high in not only inducing or actually ensuring adherence to and engagement in daily care but also in increasing the risk of developing these various complications and increasing the burden of disease among our patients and I think that the jury is not completely clear whether this is—which one is the egg and which one is the chicken here, but definitely trying to understand how our patients are affected by their home environment, their overall social security feeling, their food security, the housing, are extremely important, and also trying to understand the level of support that they may have from the community, because that can also be critical on how a certain therapy is not only implemented but how that patient population will adhere, how are they even willing to communicate concerns, or understanding the benefit of a certain medication. So, basically, targeting this aspect, can have a dramatic impact on adherence to treatment, understanding treatment, as well as longer term benefits or preventing, serious complications.

Dr. Buse:
Yeah, I agree. Those are very important considerations. We could talk for hours about this topic, but before we close, could you maybe address the sort of more advanced stage C and stage D heart failure, what the recommendations are there, very top level?

Dr. Pop-Busui:
Right. Absolutely. And what we wanted to highlight here, it's the role of the team approach here, because definitely in stage C and D, the cardiology involvement, it's critical, and majority of these patients will have a cardiologist hopefully on their team. But it's not just that. I think this continues communication between the primary provider for diabetes care with a cardiologist, with a nurse dietitian incorporating additional lifestyle modifications and interventions, the social support, how to target optimally exactly the social determinants of health and making sure that providers are aware of these guidelines directed therapies that besides the SGLT2 inhibitors or other agents to treat hyperglycemia or other agents definitely not to be included. There are a variety of other, guidelines-directed agents, including, the RAS blockade, the diuretics, the MRAs, as well as the ARNi, that are now available.

It is still puzzling to many of us that when we look at statistics in this country whether it's for heart failure, whether it's for, let's say, just diabetes with enhanced risk factors, a relatively low number of patients are treated according to these guidelines or have access perhaps to all of these medications that would benefit and have been shown to have a track record of benefit, and that is why we have made it as simple as possible through the algorithm that highlights the multidisciplinary team as well as the various interventions that would be most applicable to each of these stages, and made them available for providers, there to implement in their care.

Dr. Buse:
Well, thank you. With those final thoughts in mind, I want to thank my guest, Dr. Rodica Pop-Busui, for sharing insights on the updated ADA consensus report. Rodica, it was great speaking with you today, and thank you so much for your service as President for Science & Medicine in the American Diabetes Association.

Dr. Pop-Busui:
Thank you so much, John. It is truly my pleasure, and obviously, I am following in your step as well.

Dr. Buse:
For ReachMD, I'm Dr. John Buse. To access this episode and others from our series, visit ReachMD.com/DiabetesDiscourse where you can be Part of the Knowledge. Thanks for listening.