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## Investigating Cardiology Barriers to Implementing the 2020 ACC Expert Consensus Decision Pathway

Announcer:

You're listening to ReachMD, and this episode of Heart Matters is sponsored by Novo Nordisk. Here's your host, Dr. Matthew Sorrentino.

Dr. Sorrentino:

Welcome to Heart Matters on ReachMD. I'm Dr. Matthew Sorrentino, and here with me today to share his strategies for overcoming challenges in the implementation of the 2020 ACC Expert Consensus Decision Pathways on Novel Therapies for Cardiovascular Risk Reduction in Patients with Type 2 Diabetes is Dr. Sandeep R. Das. Dr. Das is a Professor of Medicine in the Cardiology Division at the University of Texas Southwestern Medical Center in Dallas, and Director of Acute Coronary Care at Parkland Health and Hospital system. Dr. Das serves as a health system quality officer for UT Southwestern and is a founding member of the Center for Innovation and Value at Parkland. Dr. Das represents the American College of Cardiology on the American Diabetes Association standards of care. And he co-chaired the 2018 and 2020 ACC Expert Consensus Decision Pathways on Novel Therapies for Cardiovascular Risk Reduction in Patients with Type 2 Diabetes. Dr. Das welcome to the program.

Dr. Das:

Thank you very much, Dr. Sorrentino. I very much appreciate the invitation.

Dr. Sorrentino:

To start us off Dr. Das, all of us are very excited about some of the new novel therapies that not only help our patients with diabetes but seem to have a cardiovascular benefit as well. What are some of the main updates coming from the 2020 Expert Consensus Decision Pathway?

Dr. Das:

Thanks for the question. So what really has happened since about 2008, the FDA has required large cardiovascular outcomes trials with every new diabetes drug introduced to the market. And since about 2016, we've had a string of very positive outcomes trials in the cardiovascular space in two broad drug classes.

The first is sodium-glucose cotransporter-2, or SGLT-2, inhibitors. And the second is glucagon-like peptide 1 receptor agonists or GLP1-RA. So, since 2016, we've had some really striking cardiovascular outcome benefits in these two drug classes. And that really prompted us to revisit the way clinicians should be taking care of patients with diabetes.

Dr. Sorrentino:

With these new, exciting classes of medications, I'm sure there's some barriers and challenges to using them. What are some of the challenges that cardiologists encounter when trying to implement these new ACC recommendations?

Dr. Das:

Yeah, so there definitely are challenges with uptake. I think the biggest challenge is almost a conceptual one, which is that people look at glucose-lowering medications as the province of the diabetes care provider. So much like we prescribe a statin to reduce the risk of heart attack, here, we might prescribe an SGLT-2 inhibitor to reduce the risk of heart failure or prescribe a GLP1-RA to reduce the risk of second heart attack. So thinking about it from an outcome-based perspective, rather than from a glucose-lowering perspective, I think is the first important paradigm shift.

And the second is related to that, which is really that for decades now diabetes care providers have been thinking metformin first-line,

and then cost-effective glucose-lowering, maybe sulfonylureas, maybe things like that. And really, this sort of upends that whole paradigm, because now we have drugs that improve heart outcomes. And so, I think that they sort of bumped the queue, they just jumped to the front of the line as drugs that we should consider quite early on in these patients rather than focusing on glucose-lowering.

Dr. Sorrentino:

I wonder if you can comment on cardiologists' reluctance to adopt specifically the SGLT-2s and the GLP1-RAs because they feel that they're adding therapy that their primary care physician or the endocrinologist should add, they feel like they're stepping on other people's practices? Or is this something that cardiologists should really embrace and say, 'This is our class of preventive medicines that we should be using?'

Dr. Das:

The short answer here is we have to own it. We need to own it. It's the right thing for patients. Every person taking care of a patient is involved in doing what they can to improve outcomes. And this is a significant part of it. So where the trouble comes, so among cardiologists that I've spoken with, it's near-universal, that they have no desire to get into managing blood glucose. But that said we've for many, many years sort of co-opted the use of drugs like statins, as I mentioned before, where we don't really think of them in terms of an endocrine effect, we think of them in terms of a cardiovascular effect. So here GLP1-RAs and SGLT-2 inhibitors, first of all, in the secondary prevention CVD context, so people with prior heart attack, stroke, or significant peripheral vascular disease those patients have a fairly significant benefit reduction in recurrent events on the order of 10 to 15 percent reduction, relative risk reduction with use of these new agents. And it looks like it stacks. So that's just a fantastic opportunity there to improve outcomes.

And then there have been some more recent trials that are even more provocative. So the SGLT-2 inhibitors specifically have kind of blown the doors off the heart failure world with a fairly massive reduction and combined that points of death or heart failure hospitalization in patients with depressed EF, out to about a 30 percent relative reduction. So these are drugs that are just massively beneficial to that subset of patients.

There's also been data and patients that don't have diabetes. So interestingly enough half of the time I prescribe these drugs, it's the patients that don't have diabetes. And so, I always have to start that conversation with the pharmacist might tell you this is a diabetes drug, but here's why I think that it's important for you to have it. Also, there's great data on kidney outcomes with SGLT-2 inhibitors. And now there's a real provocative result, there was a trial published recently in the New England Journal for a GLP1-RA that showed a pretty substantial weight loss effect from these drugs. And the drug that effectively reduces weight loss, while not having other serious concerns, really has been kind of the Grail of medicine for a while. Patients, it's very high on their list of things that they like. So having that as a "side effect" of the drug is fantastic. So there's just a lot of opportunities, I think here, to improve patient outcomes and improve things people care about. And so, cardiologists absolutely should be in this space.

Dr. Sorrentino:

For those just tuning in, you're listening to Heart Matters on ReachMD. I'm Dr. Matthew Sorrentino, and today, I've been speaking with Dr. Sandeep Das, who's sharing his perspective on implementing the 2020 ACC Expert Consensus Decision Pathway on Novel Therapies for Cardiovascular Risk Reduction in Patients with Type 2 Diabetes. And as Dr. Das just mentioned, even some patients without type 2 diabetes, these drugs might have a role in helping cardiovascular risk reduction.

You've mentioned some of these challenges in implementing these medications and these updates. What can we do? What are some strategies or resources that are available to help cardiologists understand these medications, understand the benefit, and have them begin using them in their practices?

Dr. Das:

So really, the Expert Consensus Decision Pathway was our way of trying to solve that issue. What we really wanted to do is go out there and synthesize the information from a dozen large, randomized trials, that frankly, a lot of busy clinicians just don't have the bandwidth to spend hours processing through. So, we sort of did the dirty work of arguing over them and figuring out the implications and how to integrate these into practice. And then we put that together in a relatively concise form so I guess it was admitting the self-interest that I was one of the co-chairs of the group, and encouraged people to pull that JACC, Journal of the American College of Cardiology, 2020 ACC Expert Consensus Decision Pathway for these drugs, and that would be a useful first step.

Dr. Sorrentino:

So, I have a lot of my colleagues who are still reluctant to use the SGLT-2 inhibitors or the GLP1 receptor agonists. I think there's some fear about making the glucose go too low or side effects that they're concerned about. When you have a reluctant colleague, what do you tell them about these different medications to get them more ready to buy in and try using them?

Dr. Das:

So this comes up all the time. And what I do is I start by referring to the fact that the SGLT-2 inhibitors have been tested in patients without diabetes. So, the drug class got a bit of a bad rep. Everybody was very worried about the concept of euglycemic diabetic ketoacidosis. And the concern that there could be significant glucose-related problems. But now we know that these drugs are extremely well-tolerated and safe, even in people without diabetes. So that should at least be reassuring that the drugs by themselves are not going to cause you a catastrophe.

Similarly, the GLP1-RA has just been tested in a large trial for weight loss in a large trial of obese patients without diabetes. And again, no safety signal for hypoglycemia. So I think that side effects are important. But hypoglycemia is not really the main one. So let me just take a second and try to concisely summarize what I say to people.

So for SGLT-2 inhibitors, what they do is they provide sort of a ceiling to your serum glucose, by making you pee out the excess. So, you get this concept of you euglycemic DKA, which is people can get diabetic ketoacidosis, but their glucose is not very, very high, their serum glucose, because they're urinating it all out. So it's not any different than regular garden variety DKA, and it's the same kind of thing that can cause it. But it's just that you can't be fooled by normal serum glucose. So that's that piece of it.

The complication that actually happens in practice, is there's an increased risk of your urogenital yeast infections. So, in some patients who have a predisposition to getting those, that may be challenging to implement.

And the other thing is, is they haven't been tested in people with end-stage renal disease. So that's another group where you have to be a little bit cautious about extrapolating data.

For the GLP1-RAs, the biggest thing about these drugs is they slow gastric emptying. So what they can do is they can cause some loss of appetite. And if people eat big meals, they can actually cause straight-up nausea. So the real instruction there is to tell people to be careful, you know, eat smaller meals adjust the dose gradually over time. And you may want to think very carefully if you had a patient that has a history of diabetic gastroparesis, or a history bariatric surgery, that those might be less appropriate patients for GLP1-RAs.

Dr. Sorrentino:

Have you found reluctance among cardiologists using agents that are oral agents versus ones that are injectable agents?

Dr. Das:

It's interesting. So in the diabetes, they're giving a lot of patients insulin, and there's no concern over, 'Oh, well, it's just prohibitively difficult to teach people how to take insulin.' That's not an issue, right? So the diabetes clinics and providers are well set up to do that.

In cardiology, we'd give some PCSK9s, or give some injectable drugs. But really, there is exactly what you said, which is a sort of barrier, almost a logistic barrier, to giving these drugs that have to be injected. Now, these are sub q injections, they're given via a pen, just like the diabetes drugs. They're really easy. So, I think it's a bit more of a psychological issue than it is an actual issue. The teaching is very, very simple. But that said, it is an issue. There's, one oral agent, I don't know if we're gonna see another big trial, but at least on the one trial, the results were quite similar in the GLP1 space to the injectable agents. So, we may see a push to sort of a proof of concept that you can get these agents orally. So, we may see a push to that, but I don't know that necessarily, we need that so much. I think that we can tell our patients that this is a drug that reduces your risk of heart attack, reduces your risk of stroke, it's gonna be a little bit of a needle stick once a week or once a day. But I think patients are pretty interested in getting better and avoiding bad outcomes. So, I think that we can engage them to be our allies in this fight.

Dr. Sorrentino:

To round out our discussion, do you have any final words of wisdom from the Expert Consensus Decision Pathway that you would really like our audience to know about?

Dr. Das:

Thanks for asking that. it's been a super fun discussion. I think that coming from an academic setting, there's really a lot of opportunities to leverage didactics. we have formal talks, probably an hour a day of some sort. And so there's a lot of opportunity to work that in and educate that way. We also interact a lot with trainees and so that by precepting and training clinics, etcetera, there is an opportunity to sort of encourage younger people to use that. For the busy practicing clinician, it's a little bit different because you're usually by yourself, and you're usually just working really hard on being efficient and getting through a large number of patients, although you're equally committed to trying to provide high-quality care. So, I think in that context, especially something like the Expert Consensus Pathway it can be super helpful because it can sort of distill and systematize your thinking in a way that's a little more easily grasped than perhaps the full complex guidelines. In terms of guidelines, the ADA standards of care, have done a fantastic job of updating their guideline very rapidly in response to emerging data.

Dr. Sorrentino:

Those are some great points to end on. And I want to thank you, Dr. Das, for providing your insights on the 2020 ACC Expert Consensus Decision Pathway. It was great speaking with you today.

Dr. Das:

Thanks very much. Dr. Sorrentino, I greatly appreciate the invitation. That's been fantastic.

Announcer:

This program was sponsored by Novo Nordisk. To revisit any part of this discussion and to access other episodes in this series, visit [ReachMD.com/HeartMatters](https://ReachMD.com/HeartMatters), where you can Be Part of the Knowledge. Thank you for listening.