

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/medical-industry-feature/guideline-directed-medical-therapy-for-the-management-of-heart-failure/14559/>

ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Guideline Directed Medical Therapy for the Management of Heart Failure

Announcer:

You're listening to ReachMD. This medical industry feature is titled "Guideline Directed Medical Therapy for the Management of Heart Failure." Here is your guest, Dr. Stephen Greene."

Dr. Greene:

Welcome everyone, and thank you for listening today to the fifth podcast in our heart failure series. My name is Dr. Stephen Greene, and I am an Advanced Heart Failure Specialist at Duke Heart Transplant Clinic and a Cardiologist at Duke Cardiology Clinic in Durham, North Carolina.

Last time, you heard my colleague Dr. Pam Kushner discuss how heart failure is diagnosed. Today, we will discuss the 2022 American Heart Association, American College of Cardiology, and Heart Failure Society of America joint guideline for the management of heart failure.

This podcast is supported by and made on behalf of Boehringer Ingelheim Pharmaceuticals, Inc. and Lilly USA, LLC. Content discussed during this podcast has been reviewed for consistency with FDA guidelines and is not approved for continuing medical education credit.

The 2022 guideline provides recommendations for medical therapy based on contemporary evidence for the treatment of patients with heart failure.

For patients in stage A, meaning they are at risk for developing heart failure, specific recommendations are outlined to prevent progression to pre-heart failure, or stage B.

In patients with hypertension, for example, blood pressure should be controlled to prevent symptomatic heart failure. By contrast, in patients with type 2 diabetes and established cardiovascular disease or at high risk for cardiovascular disease, sodium glucose cotransporter-2, or SGLT2, inhibitors should be used to prevent hospitalizations for heart failure. In patients with cardiovascular disease, their condition should be optimally managed. In patients with exposure to cardiotoxic agents, multidisciplinary evaluation for management should be performed, and those with a first-degree relative with genetic cardiomyopathies should receive genetic screening and counseling. Finally, in patients at risk for developing heart failure, natriuretic peptide biomarker-based screening followed by team-based care can be useful to prevent the development of left ventricular dysfunction or new onset of heart failure. Validated multivariate risk scores can be useful in this population to estimate subsequent risk of heart failure.

For patients in stage B, or pre-heart failure, recommendations are given to prevent the syndrome of clinical heart failure.

For patients with a left ventricular ejection fraction less than or equal to 40%, an angiotensin-converting enzyme (ACE) inhibitor or a beta blocker should be administered to prevent symptomatic heart failure. In patients with a recent myocardial infarction *and* a left ventricular ejection fraction of less than or equal to 40%, an angiotensin- receptor blocker should be given if the person is intolerant to ACE inhibitors. An implantable cardioverter-defibrillator is recommended for primary prevention of sudden cardiac death in patients who have reached at least 40 days after their myocardial infarction with a left ventricular ejection fraction of less than or equal to 30% and who have New York Heart Association class I symptoms and a reasonable expectation of survival for more than 1 year. Finally, in patients with nonischemic cardiomyopathy, genetic counseling and testing is recommended.

In general, lifestyle modifications—including regular exercise, healthy dietary patterns, and avoiding smoking— along with management

strategies are helpful to reduce the risk of heart failure in patients at stage A or stage B.

Let's now quickly review the 2 major types of heart failure:

Heart failure with preserved ejection fraction is caused by endothelial dysfunction, arterial stiffening, and left ventricular abnormalities where the heart muscle is stiff and thickened, resulting in less blood than normal filling the left ventricle, so less blood is available to be pumped out.

In heart failure with reduced ejection fraction, the heart fills normally, but there is loss of systolic cardiac function because the heart muscle is weakened. This results in less blood being pumped out of the left ventricle. Heart failure with reduced ejection fraction accounts for approximately 50% of all heart failure cases.

The 2022 guideline-directed medical therapy for patients with heart failure with preserved ejection fraction mirrors what is recommended for heart failure in general. That is, the use of diuretics to reduce congestion and improve symptoms; identification and treatment of specific causes such as amyloidosis; and management of contributing comorbidities such as hypertension, coronary artery disease, and atrial fibrillation.

Additional medication recommendations for patients with heart failure with preserved ejection fraction include SGLT2 inhibitors, angiotensin receptor–neprilysin inhibitors, mineralocorticoid receptor antagonists, and angiotensin-receptor blockers.

The guideline-directed medical therapy for patients with heart failure with *reduced* ejection fraction strongly emphasizes treatment with multiple medications demonstrated to improve clinical outcomes, as tolerated. This includes 4 classes of medication: angiotensin receptor–neprilysin inhibitors, beta blockers, mineralocorticoid receptor antagonists, and SGLT2 inhibitors.

Close adherence to each of these guidelines outlined will truly improve the outcomes for patients with this debilitating disease.

Thank you all for joining me today.

To conclude, the 2022 American Heart Association, American College of Cardiology, and Heart Failure Society of America joint guideline for the management of heart failure is a patient centered. It presents an evidence-based approach to treating patients with heart failure. This guideline is instrumental in effectively treating patients with heart failure and should be followed more closely to improve quality of care and align with patients' well-being.

I hope you'll join my colleague Dr. Pam Kushner for the next and final chapter in our heart failure podcast series, as she discusses the cardio-renal-metabolic continuum and comorbidities associated with heart failure.

Announcer:

This program is part of a 6-part series supported by and created on behalf of Boehringer Ingelheim Pharmaceuticals, Inc. and Lilly USA, LLC. If you missed any part of this discussion and would like to access the other episodes in this series, visit reach-m-d-dot-com-slash-industry-feature. This is ReachMD. Be part of the knowledge.