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Examining Heart Failure Management: How Can We Do Better?

Announcer:

Welcome to CME on ReachMD. This activity, entitled "Examining Heart Failure Management: How Can We Do Better?" is provided by Medtelligence and is supported by an independent educational grant from Vifor Pharma.

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Dr. Piña:

So, registry data has been showing us that we haven't been always implementing the clinical trials as we should and that our patients with heart failure are often not receiving the guideline-directed medical therapy. And we still believe in the guideline-directed medical therapy, and so what does that mean to your practice? What does that mean to your patients? So, welcome today to CME on ReachMD. I am thrilled to have my two friends today with me, Dr. Javed Butler and Dr. Giuseppe Rosano, and we're going to be having a conversation about guideline-directed medical therapy and trying to compare both the European guidelines and the US guidelines. So, Javed, I'm going to come to you first. You and I have a lot of discussions about how our own colleagues and our own institutions are still not doing the right thing with giving guideline-directed medical therapy, and that's your opinion and my opinion of our own place, but what do you know about registry data and data out there that may really refute what we're saying or actually confirm it?

Dr. Butler:

I mean, we have data for some of these therapies going more than a decade to two decades, and if you look at the registry data, there are really big opportunities there. So let's just review the data from CHAMP-HF registry – over 3,500 patients enrolled all across the United States, primary care sites, cardiology sites, specialists, generalists, academic sites. I mean, you just sort of look at a broad landscape of patients with heart failure reduced ejection fraction. And what we found, that the use of ACE inhibitor therapy was in the 70 percent range, use of beta blocker was in the, sort of the mid-60 range, and mineralocorticoid receptor antagonists was sort of in the mid-30 range. However, if you then look at triple therapy, i.e., the patients who received all three classes of drugs, it drops down to 22 percent. And if you actually raise the bar to what we should really be doing, which is not only provide triple therapy but triple therapy at the recommended doses – and remember, the registry excluded patients if you were not eligible for any particular therapy or there were relative contraindications. So, even with that caveat, if you look at triple therapy at recommended doses, there were only about 1 percent of the patients that met that criteria. So lots of opportunity – big gaps.

Dr. Piña:

So, Giuseppe, why is it so hard to do this? And what have your observations been in Europe?

Dr. Rosano:

More recently, there was another registry that – other registry data from the Swedish Heart Failure study that included 11,000 patients with heart failure, and that confirmed that there was 40 percent only of patients that were receiving the MRAs. So in part, it's related to inertia. On the other hand, there is a sort of limiting factor that is the baseline potassium, and, indeed, the BIOSTAT-CHF study clearly demonstrated that high baseline potassium – not necessarily hyperkalemia – but high range potassium levels was an independent predictor of low rate use or dosage of ACE inhibitors and ARB. So, I think that there are several reasons because of this inertia. Part is related to the decision itself, but in that case, the education and dissemination of guidelines is very important. And the other one is related to the possibility of up titrating with potassium being a limiting factor and with low blood pressure being the other limiting factor.

Dr. Piña:

So, Javed, how do you optimize drugs in your chronic patients that you see in clinic?

Dr. Butler:

Yeah, so, I mean, you know, it's sort of a team sport. A team sport has several members. You obviously need to engage the patient, so patient education is really, really important. So, they need to be a part of their own care and self-care, and there are some sort of simple things like low sodium diet – well, I shouldn't say simple things – but they're complicated, and we really need help. But relatively low-hanging fruits are low sodium, diet, exercise, smoking cessation. So these are things, sort of, that the patients can really help – adherence to medications – but we need also help from other team members like pharmacists so that they can go over the medication side effect profile, nutritionists that can talk about low-sodium diet or low-potassium diet or whatever you're recommending. From clinician perspective, treatment of comorbidities becomes very important – high blood pressure, diabetes, obesity, dyslipidemia, iron deficiency. So, we have to sort of think about these things, screen them, and optimally manage these things. And then comes the issue of sort of the stable medical therapy that we were talking about.

Dr. Piña:

Well, Giuseppe, you recently worked with some of your colleagues at the ESC on maybe a specific guideline for potassium that I think would be incredibly helpful to the clinicians. Do you want to tell us a little bit about that?

Dr. Rosano:

So, basically, this document gave a new place in therapy for the potassium binders as facilitators for the use of RAASi, but at the same time highlighted some important issues that are potassium supplementations and the use of non-cardiovascular drugs in the possible cause of hyperkalemia. And so whenever we feel – we see patients with hyperkalemia, we don't have to look just at the RAASi therapy, but also at all other medications that these patients are taking, because of the comorbidities, like NSAIDs, but also antibiotics, antifungal therapies, or nutraceuticals or supplements that may have an effect on potassium.

Dr. Piña:

So, to come back here to how do we do this, because I think our clinicians are always looking for – “Tell me how I can do this and do it better, making it easier to do the right thing” – I have always thought that if doing the right thing is the easiest thing to do, then it should be done. So, Javed, we've been talking about some of the chronic patients. Brand-new patient, acute heart failure patient – what are you going to do? How are you going to start all this? This is their first diagnosis.

Dr. Butler:

Yeah, so just make sure that you screen for etiology of heart failure. That becomes very important. A lot of time, we, we miss these things. So, what is going on for these patients? Whether it's coronary artery disease thyroid disease, valvular disease, iron overload, all of those things need to be sort of thought about and are screened for. Patient education, especially in the beginning, becomes very important, and then make a plan of rapidly giving effective therapy for these patients. Because it's not only giving the

recommended therapy, but the quicker we give the recommended therapy the better it is because these patients are at a higher risk not only of progressive heart failure, but also of sudden cardiac death.

Dr. Piña:

You know, and this is where the team approach comes in, because if you can get the team engaged very early and then the patient sees the team as his or her entire care team where all these points – cause look at all the different points that we've been talking about. We've talked about diet, we've talked about the different drugs, we've talked about measuring potassium, and now I can add exercise. How often is exercise being recommended in this population where we know, cause we've tested it, that it is safe, that there are no excess events, and that if the patients can show up and can adhere, you may be able to decrease heart failure hospitalizations. Something that we looked at in HF-ACTION, the NHLBI trial, was we started thinking about anemia. And this is way back when we were just going through the records of the patients coming in. And we noticed that there was a significantly lower hemoglobin than what we would expect, and so we looked – a substudy, obviously a post hoc, to look at hemoglobin and what the impact of hemoglobin was. But now we know a lot more about this, and as a matter of fact, our new updated guidelines from 2017 actually have a whole section dedicated to anemia. Giuseppe, tell us a little bit about how Europe has really been the hub of a lot of this work about iron deficiency.

Dr. Rosano:

Yes. First of all, let me say that the exercise, regular exercise is extremely important, as you demonstrated, in patients with heart failure, and also cardiac rehabilitation is very important, especially for patients coming out of an acute event. And in these patients, it's always important, as in any patient with the heart failure and reduced ejection fraction, to look out – look not just for anemia, but for iron deficiency, because iron deficiency can precede by often some years the occurrence of anemia. And it's not just anemia, but it's iron deficiency that has a significant effect on exercise capacity because of both the effect of iron not just on the oxygen transport, but also as a metabolic agent increasing the production of iron, which is phosphate. And there's clear evidence now that iron supplement, IV iron supplementation is extremely important in improving exercise capacity in patients with heart failure. This is very constant, and this is extremely effective in – especially in those patients, the more difficult patients, patients with comorbidities that – ideally patients are weak. Where often we think that their weakness is something related to heart failure, but indeed is in large part related to the iron deficiency. And the ESC guidelines recommend testing for this serum ferritin in patients with heart failure and defines iron deficiency not just as a serum ferritin below 100 microgram per liter, but also the ferritin between 100 and 299 micrograms – that is also – say that with a transferrin, a transferrin saturation less than 20 percent. And I understand that similar recommendations have been given by our colleagues in Australia. So, it is important to screen for iron deficiency even in those patients without anemia, and if that is detected, iron deficiency, iron supplementation, especially IV iron, because we know that the oral iron supplementation has no effect on exercise capacity. So IV iron is extremely effective in improving exercise capacity but also quality of life.

Dr. Piña:

Javed, how do you interpret the recommendations that were made in the US guidelines in 2017?

Dr. Butler:

Yeah, so the guidelines were actually pretty clear, but you have to put them into clinical practice, right? So, one – there's a recommendation to check iron panel in new onset of heart failure evaluation in appropriate cases, but their sort of thought process is a little bit different, that is, to rule out hemochromatosis. But nevertheless, sort of, iron is really important right at the beginning when you make the diagnosis of heart failure, but then there's a very clear recommendation that patients on optimal medical therapy who have persistent symptoms and exercise intolerance, that these patients benefit from IV iron replacement. Well, in order to implement their therapy, you need to check whether they're iron deficient or not, and remember that this is regardless whether you're anemic or not. If you have iron deficiency, there is not one but multiple trials have shown improvement in functional capacity, so there's a class recommendation that in patients with persistent exercise intolerance, symptomatic heart failure on optimal medical therapy, that these patients need to be replaced with IV iron.

Dr. Piña:

Well, that's all the time that we have today. I hope that our colleagues take a look at every single one of your heart failure patients. Even though they may appear, quote, unquote, "stable," stability is an illusion. Look at the guidelines. Follow the guidelines. Do your best to get those doses up. Keep up titrating it. Every visit you should be thinking about what could I do today with this patient to get closer to that guideline-directed medical therapy. That may include potassium binders, it may include IV iron, it may include a lot more education about meals, about food, about diet, and potassium content.

So, I want to thank my two friends and guests, Drs. Giuseppe Rosano and Javed Butler for their time and their expertise in this wonderful program. Thank you.

Dr. Rosano:

Thank you.

Dr. Butler:

Thank you.

Announcer:

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