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BRINGING CLINICIANS TOGETHER TO DISCUSS CURRENT DRUG THERAPY

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The following succinct analysis appeared in *Pharmacist's Letter*. Based on vol. 38. No. 5

HEART FAILURE

Big changes in guidelines will lead to debate about managing heart failure with reduced ejection fraction (HFrEF).

We're used to "triple therapy" for HFrEF...an ACEI or ARB, an evidence-based beta-blocker (carvedilol, etc), and an aldosterone antagonist (spironolactone, etc)...to reduce hospitalizations and death.

Now *Entresto* (sacubitril/valsartan) is preferred INSTEAD of an ACEI or ARB when possible...since it prevents hospitalization or CV death in about 1 in 21 patients versus an ACEI.

Guidelines also suggest "QUAD therapy"...adding an SGLT2 inhibitor (*Farxiga*, etc) to triple therapy, regardless of diabetes. This prevents hospitalization or CV death in about 1 in 20 patients.

But med adherence in clinical trials is much higher than in real-world patients. Plus *Entresto* or an SGLT2 inhibitor each costs about $600/month.

Consider whether this new guidance is practical for your patient.

Continue to focus on optimizing traditional triple therapy first...this can cost under $30/month. And less than 1% of patients with HFrEF are on triple therapy at target doses.

If patients still have heart failure symptoms, suggest switching from an ACEI or ARB to *Entresto*. But point out that *Entresto* is taken bid...and causes low BP in 1 in 21 patients.

Educate patients to wait at least 36 hours after stopping an ACEI if switching to *Entresto*...to reduce risk of angioedema.

If symptomatic patients are already on optimized triple therapy with *Entresto*...or also have type 2 diabetes...suggest adding an SGLT2 inhibitor. Benefits are likely a class effect.

But weigh SGLT2 inhibitor downsides...genitourinary infections, dehydration, etc. Consider lowering diuretic doses when starting due to risk of hypovolemia and acute kidney injury.

Expect prior auths or high co-pays with these costly Rxs. Review our *Guide for Helping Patients Afford Their Meds* for ways to assist...such as whittling duplicate or unneeded meds.

See our resource, *Improving Heart Failure Care*, for patient education tools, strategies to improve adherence, and more.

(For more on this topic, see Clinical Resource #380501 at PharmacistsLetter.com.)

Writing Committee Members, Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. J Am Coll Cardiol. 2022 Mar 24:S0735-1097(21)08395-9.

See LEADER NOTES for answers to discussion questions.

DISCUSSION QUESTIONS

OVERVIEW OF CURRENT THERAPY

1. **What are the new guidelines for management of heart failure?**

ANALYSIS OF NEW GUIDELINE

2. **What are the criteria for development or evaluation of practice guidelines?**

3. **Are the new ACC/AHA guidelines evidence based? Is evidence linked to recommendations with a strength of recommendation grading system?**

4. **Are the guidelines unbiased and representative of a wide range of clinicians?**

5. **Are the guidelines based on outcomes important to patients?**

See LEADER NOTES for answers to discussion questions.

6. **Are the interventions proposed in the guidelines feasible in all practice settings?**

7. **Has this guideline been prospectively validated?**

8. **What are the major guideline recommendations for pharmacological treatment of HFrEF, and what are considerations about these recommendations?**

9. **Are the guidelines expressed in terms we care about and can use?**

HOW SHOULD THE NEW FINDINGS CHANGE CURRENT THERAPY?

10. **Do the guidelines change your practice? How?**

See LEADER NOTES for answers to discussion questions.

APPLY THE NEW FINDINGS TO THE FOLLOWING CASE

JD is a 78-year-old African American male with a past medical history of HFrEF, type 2 diabetes, chronic kidney disease, hypertension, and obesity who presents for his 6-month follow-up visit. Over the past year, JD has been hospitalized 3 times for heart failure exacerbations. He is currently not reporting acute exacerbation symptoms.

A review of JD's medications shows he is currently on lisinopril 20 mg daily, metoprolol succinate 25 mg daily, and spironolactone 25mg daily for his HFrEF. He also uses furosemide when needed for leg swelling.

His BP is currently 136/84 mmHg, with a heart rate of 77. His left ventricular ejection fraction (LVEF) is currently 30%.

11. How could you optimize JD's medications for better HFrEF management?

JD is currently on the target dose of an ACEI and spironolactone. However, his beta-blocker is still at the starting dose. You recommend titrating it up every 1 to 2 weeks as tolerated toward the dose shown to be associated with benefit for HFrEF (e.g., 200 mg daily).

Three months later, JD has had yet another hospitalization for an acute exacerbation of heart failure. He reports that he has been adherent with his prescribed medications. His family expresses frustration at JD's frequent hospitalizations and asks what can be done to prevent future hospitalizations.

12. What medication adjustments do you now consider for JD? What considerations do you bring up to help JD and his family weigh treatment options?

You discuss the options with JD. He expresses interest in switching to *Entresto*, but wishes to hold off on the SGLT2 inhibitor for now due to the risks of side effects and the need to take a fourth medication. You recommend that he follow up within 6 weeks. You also reinforce self-care and lifestyle modifications such as daily weights, limiting excess salt, and increasing physical activity as tolerated. You also ensure JD is current with influenza and pneumonia vaccinations.

See LEADER NOTES for answers to discussion questions.

REFERENCES

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Additional Pharmacist's Letter Resources available at PharmacistsLetter.com

Improving Heart Failure Care. Pharmacist's Letter and Prescriber's Letter. May 2022.
Heart Failure Treatment at a Glance. Pharmacist's Letter and Prescriber's Letter. May 2022.
Target Doses of Meds for Systolic Heart Failure. Pharmacist's Letter and Prescriber's Letter. December 2017.
Loop Diuretic Use in Heart Failure. Pharmacist's Letter and Prescriber's Letter. February 2020.
Comparison of Commonly Used Diuretics. Pharmacist's Letter and Prescriber's Letter. May 2021.
Acute Heart Failure: FAQs. Pharmacist's Letter and Prescriber's Letter. September 2019.
Medications and Supplements With Adverse Effects in Heart Failure. Pharmacist's Letter and Prescriber's Letter. September 2016.
Diabetes Medications and Cardiovascular Impact. Pharmacist's Letter and Prescriber's Letter. October 2021.

See LEADER NOTES for answers to discussion questions.