Podcast Series: Heart Failure Podcast Series
Episode Title: **Practical Challenges and Opportunities: Implementing Evidence-Based Management of HFmrEF/HFpEF - The 2022 AHA/ACC/HFSA Guidelines and Beyond**

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00:00:04.900 --> 00:00:10.990
Anita Deswal: Hello, and welcome to the American Heart Association's Heart Failure Podcast Series.

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00:00:11.390 --> 00:00:22.720
Anita Deswal: This episode is titled, Practical Challenges and Opportunities, Implementing Evidence-Based Management of Heart Failure with Mildly Reduced or Preserved Ejection Fraction.

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00:00:22.820 --> 00:00:30.170
Anita Deswal: the 2022 AHA, ACC, and Heart Failure Society of America guidelines, and beyond.

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00:00:30.840 --> 00:00:35.410
Anita Deswal: This program has been created and directed by a volunteer planning committee.

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00:00:35.760 --> 00:00:40.799
Anita Deswal: Funding for this AHA educational program is provided by Bayer.

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00:00:41.570 --> 00:00:45.670
Anita Deswal: I'm Anita Deswal, and I'll be introducing today's discussion.

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00:00:46.270 --> 00:00:52.780
Anita Deswal: I am chair of cardiology at the University of Texas MD Anderson Cancer Center in Houston, Texas.

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00:00:53.700 --> 00:00:56.969
Anita Deswal: I'll next ask my colleagues to introduce themselves.

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00:00:59.740 --> 00:01:11.900
Anekwe Onwuanyi: Hi, thanks, Dr. Deswal. I'm Anekwe Onwuanyi, I'm a professor and chief of cardiology at Morehouse School of Medicine in Atlanta, Georgia.

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00:01:12.300 --> 00:01:13.919
Anekwe Onwuanyi: And thank you for having me on.

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00:01:17.810 --> 00:01:27.379
Orly Vardeny: Thank you for the opportunity. My name is Orly Vardeny, and I'm a pharmacist, I'm a professor of medicine at University of Minnesota in Minneapolis in Minnesota.

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00:01:29.140 --> 00:01:38.689
Amanda Vest: Great to be here. I'm Amanda Vest. I'm a heart failure cardiologist and section head of heart failure and transplant cardiology at Cleveland Clinic in Ohio.

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00:01:39.870 --> 00:01:42.900
Anita Deswal: Great, thank you. So, let's get started.

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00:01:43.160 --> 00:01:55.400
Anita Deswal: I'll start off with a patient case, just to, you know, put this into context, and I'm sure many of you will be familiar with this kind of scenario.

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00:01:55.490 --> 00:02:08.020
Anita Deswal: So we have a 69-year-old Black female with a long-standing history of hypertension, type 2 diabetes, chronic kidney disease, and obesity, who's now hospitalized for the first time with heart failure.

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00:02:08.520 --> 00:02:18.800
Anita Deswal: She has, a normal rhythm. Her blood pressure is controlled, at admission with a systolic in the 130s.

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00:02:19.020 --> 00:02:33.629
Anita Deswal: Her electrolytes are within normal limits, her EGFR is 50 mL per minute per 1.73 meters squared, and on the day of admission, her left ventricular rejection fraction is 52%.

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00:02:34.280 --> 00:02:39.329
Anita Deswal: A recent stress test didn't suggest a significant cardiac ischemia.

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00:02:40.050 --> 00:02:48.700
Anita Deswal: So, besides treating the patient with loop diuretics for volume overload, what other evidence-based therapies can we consider?

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00:02:49.300 --> 00:02:55.950
Anita Deswal: And when initiating these new medications, the patient has questions about how much they will cost.

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00:02:56.510 --> 00:03:09.529
Anita Deswal: Should we introduce all these medications during the hospitalization, or should we, you know, time them out? So these are all questions that come up, and we will be addressing as we go along in our discussion.

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00:03:10.530 --> 00:03:13.700
Anita Deswal: So, starting off with, Anekwe.

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00:03:13.960 --> 00:03:28.140
Anita Deswal: Do you want to take us through the 2022 main guideline recommendations for heart failure with mildly reduced and preserved EF? And then we can talk about what newer, therapies are available since then?

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00:03:30.930 --> 00:03:34.350
Anekwe Onwuanyi: Thank you, Anita. I'm happy to do so.

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00:03:34.530 --> 00:03:41.149
Anekwe Onwuanyi: So, the 2022 AHA, ACC, HFSA guideline.

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00:03:41.330 --> 00:03:45.559
Anekwe Onwuanyi: recommendation, for HFpEF, and HFmrEF…

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00:03:46.270 --> 00:03:49.510
Anekwe Onwuanyi: Mildly reduced EF heart failure phenotypes?

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00:03:50.570 --> 00:03:56.050
Anekwe Onwuanyi: To say the least, was scanty in terms of recommendations, as we are all aware of.

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00:03:56.300 --> 00:04:05.590
Anekwe Onwuanyi: And, and this is partly because of the difficulty and the challenge in discovery of proven therapies.

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00:04:07.110 --> 00:04:13.610
Anekwe Onwuanyi: At that time, in 2022, essentially, the guideline recommendation was

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00:04:13.750 --> 00:04:20.140
Anekwe Onwuanyi: essentially based on the use of SGLT2 inhibitors, which was a…

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00:04:20.320 --> 00:04:27.050
Anekwe Onwuanyi: plus 2A indication, for patients with these heart failure phenotypes.

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00:04:27.760 --> 00:04:32.459
Anekwe Onwuanyi: Obviously, since then, there's been…

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00:04:32.660 --> 00:04:37.970
Anekwe Onwuanyi: A real dramatic increase in terms of evidence shift.

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00:04:38.370 --> 00:04:39.929
Anekwe Onwuanyi: In this space.

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00:04:40.170 --> 00:04:47.079
Anekwe Onwuanyi: And, we'll be discussing some of those therapies in detail, but to kind of give you an…

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00:04:47.510 --> 00:04:50.700
Anekwe Onwuanyi: Kind of a high-level, mention here.

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00:04:51.830 --> 00:04:56.010
Anekwe Onwuanyi: Some critical clinical trials have shed some light into the

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00:04:56.190 --> 00:05:01.050
Anekwe Onwuanyi: Feasibility of additional therapy, the STEP HF trial.

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00:05:01.780 --> 00:05:05.349
Anekwe Onwuanyi: In patients with… with and without diabetes.

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00:05:05.850 --> 00:05:14.650
Anekwe Onwuanyi: Looking at utilization of, agents, that will…

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00:05:16.010 --> 00:05:20.950
Anekwe Onwuanyi: GLP-1 agonist in treating patients who are obese.

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00:05:21.270 --> 00:05:32.540
Anekwe Onwuanyi: Greater than, 30, in terms of their BMI, and also patients who have ejection fraction greater than 45%.

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00:05:33.220 --> 00:05:41.229
Anekwe Onwuanyi: GLP-1 agonist was shown to really be beneficial, reducing the heart failure events and also quality of life.

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00:05:42.480 --> 00:05:47.300
Anekwe Onwuanyi: improving the quality of life in these patients. Subsequent to that.

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00:05:47.350 --> 00:06:02.720
Anekwe Onwuanyi: Additional studies with the SUMMIT trial, looking at tirzepatide, which is a combination of both, GIP and GLP-1 agonists, also showed some benefit in this regard.

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00:06:02.880 --> 00:06:14.469
Anekwe Onwuanyi: So there's been some significant shift in evidence since 2022. As you'll be hearing more about this conversation, these therapies are now making their way

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00:06:14.660 --> 00:06:26.269
Anekwe Onwuanyi: Through, in terms of the process for guideline, emergence, so to speak, and, you'll be hearing more about them as we go forward.

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00:06:29.250 --> 00:06:29.900
Anita Deswal: So…

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00:06:30.180 --> 00:06:41.130
Anita Deswal: Thank you. Besides, GLP-1 and GIP agonists, anything else, that has come on the horizon? Orly, any thoughts?

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00:06:42.770 --> 00:06:55.179
Orly Vardeny: Yeah, so another, medication that has gained evidence in recent years is the nonsteroidal

Melocorticoid receptor antagonist, finerenone.

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00:06:55.490 --> 00:07:03.730
Orly Vardeny: So, finerenone has a slightly different pharmacoid profile compared to steroidal MRAs.

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00:07:04.080 --> 00:07:11.799
Orly Vardeny: With its binding to the receptor differently, and having, equal activity.

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00:07:12.030 --> 00:07:15.299
Orly Vardeny: Both in the kidney and in the heart.

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00:07:15.470 --> 00:07:23.110
Orly Vardeny: On the receptors, so that, suggest potential Benefits with respect to

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00:07:23.330 --> 00:07:28.490
Orly Vardeny: Prevention of the progression of kidney disease, in addition to cardiac protection.

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00:07:28.800 --> 00:07:35.969
Orly Vardeny: The non-steroidal mineral corticoid receptor antagonist finerenone was studied in patients with mildly reduced or preserved ejection fraction, and found to reduce the composite of cardiovascular death.

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00:07:36.390 --> 00:07:39.669
Orly Vardeny: And…

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00:07:40.000 --> 00:07:47.009
Orly Vardeny: And worsening heart failure events, which were comprised of heart failure hospitalizations.

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00:07:47.260 --> 00:07:49.450
Orly Vardeny: or worsening heart failure visits. This was reduced by 16% among those randomized to finerenone compared to placebo.

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00:07:49.800 --> 00:07:58.770
Orly Vardeny: This medication was started, in a multitude of care settings, including inpatient.

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00:07:58.890 --> 00:08:02.120
Orly Vardeny: Patients that were recently discharged.

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00:08:02.420 --> 00:08:05.169
Orly Vardeny: And then patients who were in the ambulatory setting.

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00:08:07.390 --> 00:08:08.280
Anita Deswal: Perfect.

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00:08:08.280 --> 00:08:33.180

Anita Deswal: And I think we've now, you know, take SGLT2 inhibitors for granted. It's interesting if we look back at the 2022 guideline. At that time, we only had one trial, and that's why it was a Class 2A recommendation. And I think, you know, as we move forward, we've gotten other trials, and it would clearly make a Class 1 recommendation if we were probably rewriting the guidelines, but

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00:08:33.179 --> 00:08:40.549
Anita Deswal: the SGLT2 inhibitors are another pillar of therapy for these patients with HFpEF and mildly reduced EF.

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00:08:40.870 --> 00:08:47.609
Anita Deswal: So, having these three new therapies, or, you know, stronger evidence for at least one of them.

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00:08:47.670 --> 00:08:56.129
Anita Deswal: I think that question always comes up, how do we go about starting them, and then what do we need to do as we follow these patients? So…

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00:08:56.160 --> 00:09:13.249
Anita Deswal: Amanda, you know, a lot of excitement on the incretin-based therapies. How do you see them in this patient? Is that something we consider after she's gone out, you know, to treat the obesity and HFpEF, or should we start it while she's in the hospital?

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00:09:13.640 --> 00:09:37.999
Amanda Vest: Oh, that's such a great question. So, you know, I think some of the pieces that you've touched on there are about the time to benefit, and what are the endpoints that we're trying to achieve for the patient. So, we happen to know that this patient, has had a hospitalization recently, and I think top of our mind should be preventing another recurrent hospitalization. She's had symptomatic heart failure, and we don't want that to worsen again.

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00:09:38.000 --> 00:10:02.960
Amanda Vest: So I would have thought in that situation, especially if you're bringing in new medications, there would be more of a case for getting her onto the SGLT2 inhibitor if she's not already, and probably onto finerenone, if that's a new medicine for her, because of those very short time to benefits that we've seen from the studies that Ollie was describing there, with really all of those agents, whether we're talking to Paglifer.

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00:10:02.960 --> 00:10:27.950
Amanda Vest: and empagliflozin and finerenone, all of them falling within 30 days. So I would usually prioritize getting on the non-steroidal MRA and SGLT2 inhibitor, and then thinking, as a next step about our patient's obesity and how a GLP-1 agonist or GIP GLP-1 agonist may be of help to them. I think it's also important as well, because we don't just start a

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00:10:27.950 --> 00:10:52.549
Amanda Vest: If we're doing a metabolic heart failure type protocol, and we are looking to bring in the GLP-1 agonist into the patient's treatment, it really should be done as part of a multi-strategy intervention, hopefully with a dietitian, ideally with an exercise physiologist as well, and ideally, as I'm fortunate to in my program.

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00:10:52.550 --> 00:11:17.499
Amanda Vest: with a pharmacist with expertise in this area who can share in some of the follow-up and troubleshooting as one goes along. And it's a bit hard to bring all of that in as one is actively discharging from hospital and recovering. So, I think that's the way in which I would sequence, and then whether or not the patient should be started on a GLP-1 agonist depends on a whole host of things, including how functionally limited is she when she gets back to her baseline.

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00:11:17.500 --> 00:11:35.799
Amanda Vest: what is the body mass index? Or, you know, more importantly, how much visceral adiposity, that really dysfunctional and metabolically problematic adipose tissue does the patient have? And also, you know, cost is going to be a consideration, too.

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00:11:36.750 --> 00:11:37.700
Anita Deswal: Perfect.

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00:11:37.970 --> 00:11:52.319
Anita Deswal: And, you know, the trials all make it seem so easy, but as many of us know, getting patients onto the incretin-based therapies and then actually up-titrating them is not all that simple.

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00:11:52.320 --> 00:12:06.810
Anita Deswal: This patient also has diabetes, so depending on what other medications they're on, if they're on insulin or, you know, sulfonylureus, we don't use those, we don't see it as often now, but it's possible.

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00:12:06.810 --> 00:12:18.360
Anita Deswal: And then, how do we titrate the diabetes meds off, or down, so that the patient doesn't get hypoglycemic? But also to consider these meds

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00:12:18.360 --> 00:12:28.170
Anita Deswal: If the patient is not diabetic, because as all of you mentioned, the trials looked not just at patients with diabetes, but also those without diabetes, and

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00:12:28.170 --> 00:12:40.699
Anita Deswal: the benefit appeared to be irrespective of glycemic control. So, again, Amanda, one question, follow-up question. How do you do this at your institution as far as

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00:12:40.700 --> 00:12:51.430
Anita Deswal: hydrating these patients. Do you do everything done in a cardiology clinic with the dietitian and the pharmacist, or do you refer or work with your endocrinology colleagues?

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00:12:51.990 --> 00:13:16.970
Amanda Vest: Yeah, great question. So, we have a written protocol, and we, have the physician at the beginning speak to the patient, you know, using, of course, weight-neutral language. Sometimes it's difficult to even broach this topic for patients who've had stigmatized, experiences around their weight within their medical care. But getting, some of the information across about what the benefits may be, really explaining some of these

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00:13:16.970 --> 00:13:41.950

Amanda Vest: risks that are important as well, and acknowledging some of the logistics and potential costs. If a patient's interested in exploring in the direction of a GLP-1, then in our protocol, we have a couple of dietitians who work with our team, so we preferentially refer to them, and also trying to get patients in with the exercise physiologist, which of course isn't necessarily covered as part of a routine

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00:13:41.950 --> 00:13:46.700
Amanda Vest: healthcare benefit in the way it is for cardiac rehab with HFrEF.

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00:13:46.740 --> 00:14:11.289
Amanda Vest: And then as we go forward, really indebted to often our pharmacy technicians actually helping with the parals and getting the medication, we then are very careful to see the patients every four weeks. Now, that can be over video telehealth, or occasionally a phone call, but when we're up titrating, we really do like to connect with these patients every four weeks, and it's often a back and forth between the physician

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00:14:11.290 --> 00:14:36.039
Amanda Vest: and the pharmacist who's on the metabolic heart failure team. And that way, we can just be confident that we're troubleshooting the patient who isn't eating enough. That happens an awful lot, that people under-eat, especially their protein, and we have to remind them their protein goals. Patients who aren't drinking enough, and may need us even to walk back on their diuretics. For some patients, there may be concerns, about,

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00:14:36.040 --> 00:14:59.560
Amanda Vest: lack of change in weight, and we may have to remind them that the changes that were seen in trials occurred over a year, and we're only looking to lose one to two pounds a week. And really, we try and focus on helping patients think about the functionality they want to gain, their ability to expand their exercise capacity, rather than getting ultra-focused on what the scales say.

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00:15:00.690 --> 00:15:05.620
Anita Deswal: Perfect, thanks. Were you going to say something, Anekwe? You had a comment?

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00:15:06.310 --> 00:15:21.230
Anekwe Onwuanyi: Yeah, no, I completely agree with Amanda, and I just also wanted to really underscore, in terms of side effects of some of the medications that we use, that the SGLT2 inhibitors have such an

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00:15:21.530 --> 00:15:36.789
Anekwe Onwuanyi: favorable profile, side effect profile, that, you know, in terms of maintenance, that's some medication that has to be started early and on board, and in that, situation.

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00:15:37.020 --> 00:15:44.639
Anekwe Onwuanyi: You are, you don't have too much to worry about in terms of monitoring the patient on therapy.

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00:15:45.520 --> 00:15:55.690
Anekwe Onwuanyi: I also wanted to get some sense of, in communities that are a little bit more challenged, that many times we do have to make some

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00:15:55.970 --> 00:16:14.359
Anekwe Onwuanyi: difficult choices about… about the things that, we can focus on, and the things that can bring us immediate, return while we build on those other, ancillary and supportive, service. So, I wanted, anyone who…

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00:16:14.930 --> 00:16:18.659
Anekwe Onwuanyi: Comments, as to how do we…

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00:16:19.230 --> 00:16:30.629
Anekwe Onwuanyi: in an environment where there is scarcity, so to speak, how do we approach this? In my center, there's quite a bit of negotiation to really

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00:16:30.790 --> 00:16:35.749
Anekwe Onwuanyi: Figure out what the patient can take and afford at the time of care.

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00:16:36.550 --> 00:16:43.340
Anita Deswal: Yeah, that's a great segue, and I think cost and access is really a major issue.

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00:16:43.370 --> 00:17:02.779
Anita Deswal: just before we get to the cost and access, because that's a whole conversation, I would want to, you know, we talked about, sort of, the three pillars here, the SGLT2, if there's obesity, discussed the incretin-based therapies, and then the MRAs, especially with the evidence for non-steroidals.

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00:17:02.870 --> 00:17:18.960
Anita Deswal: what monitoring is needed for the non-steroidal MRAs, or in some cases, maybe steroidal, if the patient can't afford non-steroidal, even though the evidence is not as great, for the HFpEF/ mildly reduced EF with the steroidal MRAs.

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00:17:18.960 --> 00:17:28.310
Anita Deswal: So, Orly, any thoughts on what monitoring is required or should be mandated for these patients once they start MRAs and they're discharged?

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00:17:28.310 --> 00:17:37.480
Orly Vardeny: Sure. I think top of mind, anytime we start a monocorticoid receptor antagonist, whether it is steroidal or non-steroidal, is potassium.

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00:17:37.810 --> 00:17:48.639
Orly Vardeny: And I think potassium changes, are often the reason that clinicians are hesitant to initiate MRA’s, and if they see a change.

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00:17:48.950 --> 00:17:59.850
Orly Vardeny: the patients are taken off MRAs more quickly than probably is necessary. Having said that, it is important to monitor

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00:17:59.980 --> 00:18:06.709
Orly Vardeny: At baseline, so we know what the beginning, potassium is, knowing that it's going to increase

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00:18:06.840 --> 00:18:14.240
Orly Vardeny: By an average of 0.2 to 0.3, depending on whether it's steroidal or non-steroidal MRA.

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00:18:14.330 --> 00:18:29.409
Orly Vardeny: The steroidal MRAs are monitored more quickly in the trials, about… within about a week to two weeks of initiation or dose titration, whereas the nonsteroidal MRAs in the trials were monitored 4 weeks after initiation.

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00:18:29.910 --> 00:18:47.629
Orly Vardeny: At the end of the day, what we want to do is personalize it to the patient risk. If we feel like the patient may be at higher risk for hyperkalemia due to other comorbidities, such as chronic kidney disease, like our patient here, we may want to check a little bit sooner.

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00:18:47.930 --> 00:18:52.230
Orly Vardeny: Than… than the 4 weeks, and,

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00:18:52.480 --> 00:18:58.789
Orly Vardeny: After, checking and knowing that the potassium has raised, we want to be…

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00:18:59.300 --> 00:19:19.290
Orly Vardeny: cautious about discontinuing too quickly. If the potassium is above 5.0, that's still okay and reasonable to maintain a patient on an MRA, and we really don't want to think about reducing or discontinuing until the potassium gets closer to 5.5.

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00:19:20.560 --> 00:19:45.460
Anita Deswal: Yeah, and sometimes it's actually great that if patients are requiring potassium in the hospital, you start them on an MRA, and, you know, that goes away, and patients, you can sort of say, we're going to trade medicines and not really add another one, but this may have two… kill two birds with one stone in some ways. Treat the heart failure and the potassium. So, thank you for that, and going back

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00:19:45.460 --> 00:19:49.719
Anita Deswal: now, I think, to the really important question of access.

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00:19:49.720 --> 00:19:57.319
Anita Deswal: Orly, this is your specialty, and I would really ask for your expertise here.

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00:19:57.420 --> 00:20:11.559
Anita Deswal: How do we talk to our patients about what to add on, and what it's going to cost, and how do we work with our pharmacists and other team members to try to, you know, get these medicines to our patients?

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00:20:12.640 --> 00:20:15.180
Orly Vardeny: I think the access issue is…

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00:20:15.700 --> 00:20:29.350
Orly Vardeny: So crucial, because every… every patient is going to have a different story with respect to what they are able to afford, what is covered by insurance, whether they have insurance.

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00:20:29.780 --> 00:20:33.669
Orly Vardeny: And it's important to discover that.

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00:20:33.740 --> 00:20:51.439
Orly Vardeny: prior to hospital discharge. So, with our patient that's hospitalized, we have a little bit of time to do some homework to figure out what type of insurance she may have. If she doesn't have insurance, what are other options that are available? Because even if she does have insurance, some things may not be covered.

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00:20:51.730 --> 00:20:56.480
Orly Vardeny: Some things may require prior authorization, which may take a day or two, or three.

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00:20:56.640 --> 00:21:07.250
Orly Vardeny: So getting involved, getting the pharmacy, pharmacist involved early in the process to help streamline some of those processes would be really important.

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00:21:07.460 --> 00:21:11.300
Orly Vardeny: If a patient does not have insurance or any

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00:21:11.470 --> 00:21:14.550
Orly Vardeny: Help in terms of coverage.

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00:21:14.590 --> 00:21:33.879
Orly Vardeny: There are a couple of options available. There, for some patients, may qualify for patient assistance programs for the branded medications. This is a process, with… that involves a lot of paperwork and covers the patient for about a year at a time.

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00:21:34.430 --> 00:21:38.499
Orly Vardeny: Other than that, or if a patient doesn't qualify, there are…

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00:21:38.630 --> 00:21:51.450
Orly Vardeny: prescription drug cards that are available through, things like GoodRx that provide discounted prices for, mainly branded name medications.

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00:21:51.720 --> 00:21:54.840
Orly Vardeny: And then, there are other…

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00:21:55.040 --> 00:22:01.030
Orly Vardeny: Specialty clinics that have… are able to procure

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00:22:01.510 --> 00:22:21.339

Orly Vardeny: medications for a much reduced price. Patients need to be eligible for those clinics, but that is another way medications can be offered, either reduced cost or free of charge. So, lots of different, lots of things to unpack there, but it is very much patient-to-patient dependent.

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00:22:22.450 --> 00:22:38.230
Anita Deswal: Perfect. Thanks for, you know, introducing some of the options that we should always think outside the regular box of just writing the prescription and hoping it's going to be covered. This is something really to, I think, go ahead and on.

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00:22:38.230 --> 00:22:52.220
Anita Deswal: at… before discharge, if possible, and then I think when the patient returns, these will be challenges, again, to be addressed if they don't get the medication. So, I think that that really is a key point.

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00:22:52.240 --> 00:23:11.870
Anita Deswal: And then… so, thinking if we've got our patient on their way to at least starting some of these medicines in-house, and then maybe think… especially maybe the non-steroidal MRA and the SGLT2 inhibitor, and then monitoring them as they go out.

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00:23:11.870 --> 00:23:31.740
Anita Deswal: thinking of the incretin-based therapies, the GLP-1 or the GLP-1 GIP agonists, at, you know, once they re-present to follow up. Annekwa, any other thoughts on… are there other things we need to think about besides just these three pillars across for most patients?

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00:23:45.290 --> 00:24:02.049
Anekwe Onwuanyi: … thanks so much. I think, for… I will… if you don't mind, I will go back just a third to just clarify something that I should have clarified, well, in terms of the conversation, that when we talk about,

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00:24:03.390 --> 00:24:19.090
Anekwe Onwuanyi: Heart failure with mildly reduced ejection fraction. We are talking about patients with ejection fraction of 41% to 49%. I don't think I defined that initially, and then, of course, HFpEF above 50%.

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00:24:19.670 --> 00:24:38.489
Anekwe Onwuanyi: So, I do think there are other things to consider in terms of the management of these patients in addition to the therapeutics that we've just mentioned. It is important to also address comorbid issues that the patients are having.

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00:24:38.590 --> 00:24:44.929
Anekwe Onwuanyi: And also, because those play a kind of a direct role, in terms of

141
00:24:45.080 --> 00:24:51.739
Anekwe Onwuanyi: Whether they continue to stay on track in terms of readmissions.

142
00:24:52.270 --> 00:25:02.250
Anekwe Onwuanyi: and whether they continue to stay on track in terms of improvement in their functional capacity. So things of… such as managing the blood pressure effectively.

143
00:25:02.280 --> 00:25:15.990
Anekwe Onwuanyi: You know, making sure that, their diabetes is under control. Some of these drugs have some beneficial effects in that setting. It's… these are really important, for… for…

144
00:25:15.990 --> 00:25:22.720
Anekwe Onwuanyi: managing these patients. And also, to the point Amanda made very well, creating that comprehensive management

145
00:25:22.820 --> 00:25:36.909
Anekwe Onwuanyi: strategy for patients who are obese, is also critical. So I think all of those things are important. And then we should also, you know, make sure that if we can, in our programs.

146
00:25:36.910 --> 00:25:45.249
Anekwe Onwuanyi: to see if we can go upstream to really meet these patients before they come downstream with, you know, decompensated heart failure. So that's…

147
00:25:45.350 --> 00:25:47.049
Anekwe Onwuanyi: All of those are important.

148
00:25:47.720 --> 00:25:57.790
Anita Deswal: Yeah, thank you, thanks for bringing that up about the prevention aspect. You know, we often just see our patients when they come in with heart failure, but

149
00:25:57.820 --> 00:26:00.340
Anita Deswal: We could probably,

150
00:26:00.360 --> 00:26:16.580
Anita Deswal: treat a larger number of patients if we had them upstream when they have the uncontrolled hypertension going on for a long time, which is one of… really, the big driver of HFpEF for mildly reduced EF heart failure. So…

151
00:26:16.580 --> 00:26:32.189
Anita Deswal: That could be a whole different conversation by itself, but definitely when we see our patients for that prevention aspect, they… these drivers are still the same, and probably need to be worked on even at that time.

152
00:26:32.190 --> 00:26:49.750
Anita Deswal: And one of… just one of the other things, I think, before, we wrap up, is, Orly, I would love your thoughts on this, is when patients get, monitoring, and we, you know, you talked about potassium, but there's always the creatinine that comes with it.

153
00:26:49.910 --> 00:27:06.439
Anita Deswal: And, of course, some of these agents, we are going to see uptick in creatinine, but we necessarily don't want to pull back on therapies with just a little increase in creatinine. Any thoughts there? And I'd love to hear any other thoughts from other folks, too.

154
00:27:06.860 --> 00:27:21.939
Orly Vardeny: That is such an important point, because a lot of these therapies are active in the kidneys and affect kidney hemodynamics, and so what we will see is an initial dip in EGFR for many of the therapies, including SGLT2 inhibitors.

155
00:27:22.070 --> 00:27:27.269
Orly Vardeny: Including, steroidal and non-steroidal MRAs, or, including finerenone.

156
00:27:27.490 --> 00:27:33.699
Orly Vardeny: Including sacubitril-valsartan, ACE inhibitors, ARBs, and there have been

157
00:27:33.940 --> 00:27:43.279
Orly Vardeny: several analyses of looking exactly at that topic, which is, if a patient does experience

158
00:27:43.530 --> 00:27:54.130
Orly Vardeny: worsening of renal function to a certain extent, 20%, and maybe up to about 30% reduction in EGFR.

159
00:27:54.330 --> 00:28:00.579
Orly Vardeny: Do they still benefit from therapy? And the answer's yes. In fact, patients with chronic kidney disease

160
00:28:00.830 --> 00:28:10.859
Orly Vardeny: have an even enhanced magnitude in terms of absolute risk reduction from these therapies, so we absolutely do not want to pull back.

161
00:28:11.180 --> 00:28:21.360
Orly Vardeny: It's a different story if we see a doubling in serum creatinine, or really a 50% reduction in EGFR, but that 20 up to 30% reduction

162
00:28:21.580 --> 00:28:28.440
Orly Vardeny: should be expected and becomes the new baseline. And that we should discontinue therapies when we see that.

163
00:28:29.350 --> 00:28:32.600

Anita Deswal: Perfect, thank you. And Amanda, any thoughts?

164
00:28:33.550 --> 00:28:58.080
Amanda Vest: Yes, well, listening to this wonderful conversation, it just reminds me that to well manage a patient with heart failure with mildly preserved EF these days, one needs to really be an expert in cardio-kidney-metabolic disease. So, the CKM syndrome, as the AHA has coined the term. And in some ways, I feel as though our patient who's just had symptoms and landed in hospital, who would have

165
00:28:58.080 --> 00:29:22.650
Amanda Vest: stage 4 CKM, because they have a diagnosis of heart failure, is a patient who may benefit a lot, and in whom it may be easier to start some of these medicines in terms of convincing the patient, because she felt unwell. You know, if we take this a couple steps back, as was just mentioned in terms of prevention, if we are working with a patient in a cardiology clinic who perhaps has a lower stage of CKM,

166
00:29:22.650 --> 00:29:47.630
Amanda Vest: Then there may be several of these medicines still indicated, because they have the same benefits, and over a long time could even prevent them from getting to this situation Our Lady was in. But it is a bit harder to start talking about three classes of meds when we have a patient who's not symptomatic and doesn't exactly have a disease that they're feeling and experiencing at this time. So, we should acknowledge that sometimes in the

167
00:29:47.630 --> 00:30:04.720
Amanda Vest: cardiology clinic, it can be difficult to get patients both doing the non-pharmacological work with their dietary approaches and physical activity, but also taking on these meds, especially if they feel well and don't quite understand how their metabolic and cardiorenal health will benefit.

168
00:30:05.680 --> 00:30:20.629
Anita Deswal: Yeah, thank you. That's, you know, a really great point, and this whole, concept of CKM. It's nice, because it's helping us think about the whole patient, rather than just being cardiology-focused, too.

169
00:30:20.630 --> 00:30:38.360
Anita Deswal: But, great points there. And, I, I think we need to wrap up, but, really appreciate this conversation and, all your insights on how we can, get our patients with HFPEF and mildly reduced EF heart failure treated.

170
00:30:38.360 --> 00:30:55.800
Anita Deswal: So, thank you, and thank you everyone for joining our conversation. Just a reminder that this episode is part of the AHA's Heart Failure Podcast Series. More episodes can be found at learn.heart.org, and thank you again.