VALLEY MEDICAL GROUP
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Clinical Champion Update

Date: 6/1/21 Subject: Congestive Heart Failure

Quick HF med update

Although management of heart failure includes many other vital processes (diagnosis and management of cause(s) of heart failure and associated conditions, preventative care, education/support for patient self-management, monitoring, cardiac rehab, device therapy, cardiac transplantation, palliative/hospice care), the greatest changes over the past 5-6 years have been in pharmacologic therapy. What was once a complex topic, is now even more so. Most of this change has occurred around treatment of HFrEF
(heart failure with reduced ejection fraction, ie less than 45%), but research is ongoing as to how these and other meds might also impact HFpEF.

As primary care practitioners, we need to be aware of, and work to facilitate, appropriate medical therapy for our heart failure patients.

Briefly,

1) At the time of initial presentation/diagnosis of HFrEF, medical therapy is "three-pronged".
    a) Loop diuretic (furosemide and others) with immediate effect on symptoms
    b) ARNI (angiotension receptor-neprolysin inhibitor, ie Entresto = sacubitril/valsartan) should
    be started if it is affordable (Medical Letter listings at $500-$600/mo) and
        If it is tolerated (no history of angioedema, no recent increase in diuretic, starting
        SBP > 100, avoid in frail elders)-----NOW also approved for HFpEF
        Stop any prior ACEI x 36hr, then start 40/51mg bid and increase to 97/103 after 2-4wks
        OR if new to ACEI/ARB or GFR < 30, start at 24/26mg bid.
        Monitor SBP (goal >90), K (goal < 5.5), creat (goal <3), GFR (goal >25)
    c) Evidence-based beta blocker (bisoprolol, carvedilol, metoprolol succinate (see old guideline).
2) Secondary therapy, as long as GFR > 30, consists of adding
    a) Mineralocorticoid receptor antagonist (spironolactone, eplerenone) AND
    b) SGLT-2 inhibitor (dapagliflozin, empagliflozin, canagliflozin, etc).

The same cautions re: hypotension, volume depletion, renal function and hyperkalemia apply.

As usual, consider hydralazine + nitrate as 1st line for African-Americans, and may be added to above if hypertension persists.

Ivabradine, a selective sinus node inhibitor, can be added if resting HR >70 despite maximum dose beta blocker.

There is new drug therapy available for certain amyloid cardiomyopathies.

Still not clear how sGC stimulator vericiguat (Verquvo), which increases cGMP, resulting in vasodilation and smooth muscle relaxation, may fit into this algorithm.

UpToDate has algorithms/pathways to assist with decision making re: starting/adjusting HF therapy.

Look for updated HF guidelines later this month!

Sincerely,
Pat Iverson
CHF Clinical Champion