Prescribing and Deprescribing for Heart Failure

By Christine Kilgore

Optimizing heart failure therapies, including the newer angiotensin-receptor nephrisin inhibitors (ARNIs), is critically important for older residents who have symptomatic heart failure with a reduced ejection fraction (HFrEF), said Meenakshi Patel, MD, FACP, CMD, at the Annual Conference of AMDA – The Society for Post-Acute and Long-Term Care Medicine.

“We need to make sure residents are on the appropriate medications, and right now that includes angiotensin-converting enzyme inhibitors [ACEIs], angiotensin II receptor blockers [ARBs], or ARNiS, along with beta blockers and aldosterone receptor antagonists,” said Dr. Patel, a practicing geriatrician at Valley Medical Primary Care in Centerville, OH, and assistant professor of geriatrics at Wright State University Boonshoft School of Medicine in Dayton. She emphasized, “We don’t need to walk away from ARNiS when patients have kidney disease.”

ARNiS target both the renin-angiotension-aldosterone system and the natriuretic peptide system, and should not be used with an ACEI. The American College of Cardiology/American Heart Association/American Society of Pharmacists guideline update published in 2016 recommends switching appropriate patients who are stable on ACEIs/ ARBiS to ARNI therapy (Circulation 2016;134:e282–e293).

Sacubitril/valsartan, the first-in-class ARNI, was approved by the Food and Drug Administration in 2015 for the treatment of chronic HFREF (NYHA class II–IV) after the PARADIGM-HF (Prospective Comparison of ARNi with ACEI to Determine Impact on Global Mortality and Morbidity in Heart Failure) trial showed that patients taking the combination drug had a 20% greater reduction in cardiovascular mortality — from both sudden cardiac death and worsening heart failure — compared with patients taking the ACEI enalapril (Eur Heart J 2015;36:1990–1970).

The benefits of the new agent were seen across all age groups, with a favorable benefit-risk profile in all age groups (Eur Heart J 2015;36:2576–2584).

With over 8,000 patients aged 18 to 96, the PARADIGM trial was the largest mortality-morbidity trial ever conducted in patients with HFREF. Dr. Patel noted that in the mortality and morbidity reductions, the trial showed “reductions in hospitalizations by about 44%, which is huge for us,” she said. “And [sacubitril/valsartan] did not have a negative impact on renal function compared to tril/valsartan.”

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Another new heart failure medication, ivabradine, reduces the heart rate and may be beneficial in reducing heart failure hospitalizations, cardiovascular death, and death from heart failure when it is added to beta-blockade. Like the ARNiS, it is addressed in the 2016 ACC/AHA/HFSA guidelines.

“I haven’t used this agent much in my facility, but it’s an option that we have and something we should start looking at [for some patients],” Dr. Patel said. “The higher the heart rate, the higher the risk of cardiovascular mortality and heart failure hospitalizations.”

In other key messages, Dr. Patel emphasized the importance of strict attention to weight and congestion. “Congestion or volume overload precedes hospitalization often by days,” she said, giving facilities valuable opportunities to prevent hospitalizations with daily weights, preferably using the same scale and taken at the same time (first thing in the morning before breakfast and with an empty bladder, if possible).

Regarding the diagnosis of heart failure, “the echocardiogram is the single most important test we can do for heart failure,” Dr. Patel emphasized. “It is vitally important [for determining ejection fraction] and knowing what type of heart failure [HF with reduced EF versus preserved EF] we’re dealing with. And it’s often missed.”

Heart failure with preserved ejection fraction is also common in the senior population, particularly in women, and is treated primarily with fluid management and diuretics. “Stay tuned — there are a couple of trials with newer agents that are looking at heart failure with preserved ejection fraction,” Dr. Patel said. “For the moment, however, [symptom control] is all we have.”

In another presentation, Luke D. Kim, MD, CMD, assistant professor of medicine at the Cleveland Clinic Lerner College of Medicine, said that optimizing clinical care in hospital-discharged skilled nursing facility patients with heart failure can improve outcomes. The Cleveland Clinic instituted a “connected care” program in 2011–2014 in which patients at seven SNFs in the area were visited four to five times a week by hospital-employed physicians and advanced practice professionals, and greater attention was paid to goals-of-care discussions and medication reconciliation. There was a monthly outcome review, and the providers were evaluated by outcomes rather than productivity.

In comparing the intervention SNFs to other SNFs (usual care), Dr. Kim and his coinvestigators found that absolute reductions in hospital readmission ranged from 4.6% for patients at low risk of admission to 9.1% for patients at high risk (J Hosp Med 2017;12:238–244).

Dr. Kim said he is anticipating the publication of the results from another randomized trial conducted in the Denver metro area, the SNF Connect Trial, in which usual care was compared with a heart failure disease management program. The program has seven components covering clinical care — such as daily weights, symptoms, and activity assessment, ejection fraction documentation, and daily surveillance — and discharge measures. Rehospitalizations, emergency visits, and mortality are being assessed.

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ICD Deactivation

Discussions about deactivating an implantable cardioverter defibrillator (ICD) should take place early and more often, urged Meenakshi Patel, MD, FACP, CMD. “Fewer than 45% [of ICDs] are deactivated even after a do-not-resuscitate (DNR) order is in place, and 8% get shocked within minutes of death,” she said. “This should be a proactive action, not an omission.”

ICD deactivation is an important element of goals of care discussions and advanced care planning, and it’s important to discuss it before palliation becomes the focus.

Advanced heart failure (stage D) is something “we all deal with,” Dr. Patel said. “We initially treat these patients pretty aggressively and try to get them in optimized physical condition, but there comes a time when we need to focus on palliation.”

Aliens

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