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Pharmacist's Letter
Hospital

Help Troubleshoot Med Regimens for HFrEF

Your skills will be needed to help fine-tune discharge meds for patients with heart failure with reduced ejection fraction (HFrEF).

Optimized meds reduce the risk of mortality and hospitalization. A hospital admission can be a key opportunity to improve HFrEF regimens.

But fewer than 1 in 6 patients get guideline-recommended “quad therapy” with an ACEI, ARB, or sacubitril/valsartan (*Entresto*)...an evidence-based beta-blocker (carvedilol, etc)...an aldosterone antagonist...plus an SGLT2 inhibitor (dapagliflozin, etc).

It’s partly due to concerns about comorbidities or med side effects.

Low blood pressure. Don’t automatically back off of HFrEF meds for patients with asymptomatic hypotension, such as SBP 90 to 100 mm Hg.

But with symptomatic low BP, weigh options to improve tolerability.

For example, consider stopping BP-lowering meds that don’t improve HFrEF outcomes...such as amlodipine or thiazides. And suggest cautiously stepping down loop diuretic doses for patients who are euvolemic.

If this isn’t enough, suggest reducing the dose of HFrEF meds that lower BP most...an ACEI, ARB, sacubitril/valsartan, or a beta-blocker.

Chronic kidney disease (CKD). Don’t routinely avoid HFrEF meds just because of the potential for transient bumps in serum creatinine (ACEI or ARB, SGLT2 inhibitor, etc) or risk for hyperkalemia (ACEI or ARB, etc).

Encourage collaboration with the nephrologist...especially when eGFR is below 30 mL/min/1.73 m^2 or potassium is above 5 mEq/L.

Reinforce starting with a LOW dose (lisinopril 2.5 mg daily, etc)...and titrating to typical target doses if labs and BP are stable.

Keep in mind, SGLT2 inhibitors improve HFrEF and CKD outcomes even without diabetes...and may be started down to an eGFR of 20 mL/min/1.73 m^2.

Emphasize close monitoring of electrolytes and kidney function...especially when adding or titrating meds. For example, recommend labs at baseline...at 1 to 2 weeks later...and at least quarterly.

If SCr bumps up over 50%, generally suggest holding SGLT2 inhibitors and halving doses of other meds...except beta-blockers. Recommend holding meds that raise potassium for levels above 5.5 mEq/L.

Suggest re-titrating meds in 2 to 4 weeks once labs improve.

COPD or asthma. Don’t shy away from using a SELECTIVE beta-blocker that improves outcomes with HFrEF...metoprolol succinate or bisoprolol.

Advise starting with a low dose and titrating up.

But lean away from carvedilol in COPD...it’s NONcardioselective and there’s not much evidence of safety in these cases.

Recommend avoiding nonselective beta-blockers entirely in asthma...there’s evidence bronchospasm or exacerbations can occur.

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Get our resource, *Improving Heart Failure Care*, for guidance about target doses of meds, tackling affordability, and more.

Key References:

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