Abstract: **P1662**

**Sacubitril/valsartan in chronic symptomatic heart failure: a real world experience of delivery and outcomes.**

**Authors:**
A Kearney\(^1\), L Hill\(^1\), J Davidson\(^1\), C Mc Clure\(^1\), L Dixon\(^1\), \(^1\)Royal Victoria Hospital - Belfast - United Kingdom of Great Britain & Northern Ireland,

**Topic(s):**
Chronic Heart Failure: Pharmacotherapy

**Citation:**

Introduction:

The PARADIGM-HF trial demonstrated a reduction in cardiovascular mortality and heart failure hospitalisation with sacubitril/valsartan compared to standard therapy in patients with chronic heart failure with reduced ejection fraction. Sacubitril/valsartan is recommended by NICE in patients with left ventricular ejection fraction \(\geq35\%\) and NYHA class II-IV symptoms who are established on ACE-inhibitors (ACE-I) or angiotensin II receptor blockers (ARB).

**Purpose:**

We report our clinical experience of sacubitril/valsartan use in a real world heart failure cohort.

**Methods:**

Eligible patients were identified from our electronic database and initiated on low dose sacubitril/valsartan. Patients were reviewed and uptitrated at 4 weekly intervals until the maximum tolerated dose was achieved. Data on New York Heart Association (NYHA) class, maximum tolerated dose, heart failure hospitalisation, mortality and discontinuation rates were collected and analysed on all patients who started sacubitril/valsartan between June 2016 and January 2018.

**Results:**

A total of 86 patients (mean age 65.3 ± 11.4 years) were commenced on sacubitril/valsartan. The mean length of follow-up was 11.4 months at the time of data collection. All patients were receiving stable doses of ACE-I or ARB prior to initiating sacubitril/valsartan with 94% and 85% established on beta-blockers and mineralocorticoid receptor antagonists respectively. 4 patients (4.7%) were admitted to hospital with decompensated heart failure and 4 patients (4.7%) died during the follow-up period of which 2 deaths occurred due to progressive heart failure, 1 due to myocardial infarction and 1 non-cardiovascular related death. 19 patients (22.1%) discontinued sacubitril/valsartan due to adverse side effects during the follow-up period. Reasons for discontinuation of therapy included symptomatic hypotension (n=5), deterioration in renal function (n=5), hyperkalaemia (n=3), gastrointestinal disturbance (n=3), rash (n=2) and cough (n=1). Of those who tolerated therapy 22 patients (32.8%) achieved and maintained titration to the maximum dose of 97/103mg twice daily whereas 24 patients (35.8%) tolerated the lowest dose of 24/26mg twice daily. 18 patients (26.9%) had an improvement in NYHA class compared to 1 patient (1.5%) who had a deterioration in NYHA class. 19 patients (28.4%) had a reduction in loop diuretic dose compared with 2 patients (3%) requiring higher loop diuretic dose.

**Conclusions:**
These results support the efficacy of sacubitril/valsartan in a well-treated real world heart failure cohort. A large proportion of patients did not achieve the maximum dose mainly because of symptomatic hypotension, deteriorating renal function and hyperkalaemia. This highlights the requirement for close monitoring of symptoms and renal function when initiating therapy and with dose titration. This can be achieved through a nurse-led heart failure clinic.