Sacubitril/Valsartan: for all patients?

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Topic(s):
Chronic Heart Failure: Pharmacotherapy

Citation:
Heart failure (HF) presents high morbimortality and high consumption of care resources conditioned by acute exacerbations. Therefore, it is defensible to approach these patients by differentiated teams in the treatment of HF with experience in the management of prognostic modifying factors, including immunomodulatory drugs. Sacubitril/valsartan (ARNI) was shown a significant reduction of cardiovascular events and mortality without worsening renal function or hyperkalaemia but higher proportions of patients with hypotension and angioedema.

The objective of this study is to characterize a population of patients oriented in consultation of HF and to evaluate limiting factors of the use of sacubitril/valsartan (ARNI).

A retrospective cohort study that included all patients observed at the IC consultation between January 2 and December 5, 2018. Clinical and analytical data were collected.

A total of 128 patients were observed, 82.8% males, mean age 64 years; 82% of patients had HF with reduced FE, FE intermediate 15% and FE preserved 3%. The mean value of LVEF was 30.4 ± 9.9%. The most frequent HF etiology was dilated cardiomyopathy (44.5%) followed by ischemic heart disease (43.8%). 38% of patients were in NYHA class II, 29% in NYHA III and 4% in NYHA IV.

Regarding pharmacological therapy, 93% of patients had ACEI/ARA (prior to ARNI), 95.3% beta-blocker (BB), 88.3% mineralocorticoid receptor antagonists (ARM) and 15.6% ivabradine. However, only 23% of the patients under ACEI/ARA, 25% of the patients under BB and 16% of the patients under MRA were at the recommended maximum dose of drugs.

Of the total of patients evaluated with LVEF =35% and symptomatic (n = 69), 35% were medicated with ARNI (n=24). It was possible to titrate ARNI to a higher dose than ACEI/ARA in 44% of patients and 45% maintained equipotent dose, with titration mean time up to the maximum tolerated dose of 48 days.

During follow-up 2 patients discontinued ARNI due to itch and 3 reduced dose (1 for symptomatic hypotension, 1 for worsening renal function, and 1 due to hyperkalemia). No patient had angioedema. After onset ARNI there was a significant increase in creatinine (p=0.031), however, only 5 patients had increase of more than 25% of the baseline value. No significant increase was observed in the plasma levels of potassium, only 2 patients presented hyperkalaemia, 1 of the cases requiring hospitalization.

With regard to the 45 patients who would have indicated, but did not initiate ARNI the main reasons were: 34% for economic failure, 27% for hemodynamic profile and 15% for severe chronic kidney disease.

In conclusion, there is also a low prevalence of ARNI use (35%) and one of the main reasons is its high cost. The majority of patients tolerated the drug and in 44% of cases it was possible to titrate to a dose higher than the dose of ACEI/ARA.