CHF and Diabetes CME
November 11, 2020
Questions Asked and Answered

These questions were asked by meeting attendees during the CHF and Diabetes CME event on November 11, 2020.

Meeting Presenters

Donna M. Mancini, MD

Professor of Medicine, Cardiology
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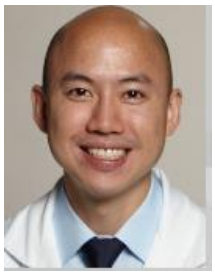

David W. Lam, MD

Assistant Professor of Medicine
Endocrinology, Diabetes and Bone Disease
Icahn School of Medicine at Mount Sinai

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Senior Vice President and Chief Nursing Executive
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CHF – Questions Asked and Answered

1. **How low do you allow blood pressure to go on these medications?**

   Donna Mancini, MD "I try to achieve highest tolerated doses of Goal Directed Medical Therapy as long as their systolic blood pressure is over 90 and they are asymptomatic. I also check orthostatic blood pressure.

2. **For a patient who is currently on an ARB and doing well, is it of benefit to change to Entresto, or should you switch only if they seem to be exhibiting signs of decline?**

   Donna Mancini, MD "This week, the AHA guidelines were changed and ARNI is recommended as first-line therapy. Clearly, Class III-IV HF patients should be switched."

3. **Are there any promising studies on stem cell treatments for HF for patients with EF less than 20?**

   Donna Mancini, MD "Unfortunately, no."

4. **What do you do for patients that complain of extra urination during the night?**

   Donna Mancini, MD "I generally recommend that they take their evening dose earlier."

5. Could you speak a bit more to "Renal Threshold dose"?

Donna Mancini, MD "I understood that if it takes a couple of hours after the dose you haven't gotten there. So what should you be shooting for and is monitoring CR part of finding the threshold? My recollection from long ago is that CR can be a bit confusing in HF given that both over diuresis AND under treated HF can bump CR. Generally, if the dose of the diuretic is efficacious, the patient should need to urinate in 20-30 min. If they report that the urge to urinate takes hours you are not at the optimal dose and you need to increase it. Monitoring creatinine is important but the process to identify an effective dose is independent of the creatinine."

6. When do we schedule with RFU with NP? Only when we can't make an appointment soon enough with HF MD?

Beth Oliver, DNP, RN "The goal is for patients to be seen in HF RFU within a week of being discharged from the hospital regardless if they have an appointment with their primary care provider. The RFU is a specialized clinic focused on heart failure care and measurements. The HF NP communicates closely with the patient's primary care provider and/or cardiologist – they can also determine at that point what the best long term plan of care is. The HF NP and MD work closely together – if the HF MD needs to see the patient they are available. The HF RFU visit should be considered an 'extension' of the inpatient stay."

Diabetes – Questions Asked and Answered

1. Which patients with type two diabetes should check their glucose at home?

David Lam, MD "There are two reasons for patients to check their blood sugar. The first is so that patients can be informed and know how their foods are affecting their body and their diabetes. It's a great patient education tool. In those cases, for patients who are engaged and want to improve, you can make dietary recommendations. It's not mandatory but, it's a great idea. It's also a good indicator, so you don't have to wait 3 months to know what your patients' A1C is. You can say to your patients, check your blood sugars 2-3 times a week, and if you notice they are persistently in the 200s give me a call and we can address the issue then. The second is for the patients on multiple-dose insulin regimens. The best evidence for self-monitored blood glucose testing having a benefit is for those using a multiple-dose insulin regimen. This is both from a safety perspective to prevent injection if they are hypoglycemic and also from a dose titration standpoint."

2. What is the role of sulfonylureas now that there are so many additional options with the secondary benefits on other co-morbidities?

David Lam, MD "The first is that they are cheap. For patients who are in the donut hole or who don't have a lot of options, sulfonylureas work. They don't have all of the added benefits but they lower the A1c. Would I prefer a patient be able to afford their medication, get their A1c lower but not have added benefits, or prescribe a medication they are never going to be able to afford or fill at the pharmacy? That's the role here - they are cheap and they work. Or another use case is if there are contraindications to other newer agents."

3. **On patients maxed out on metformin, SGLT2, and GLP whose diabetes is not controlled with A1c is 7-low 8s, what do you tend to add next?**

   David Lam, MD "This is where self-monitored blood glucose testing can play a role. You tell them, look you're on three agents, your blood sugars are still not reaching your goal but we need to find out why, where, and when. This is where more data can help and ask them to test their blood sugar. You might find out it's mostly post-dinner or post-breakfast that is the problem so you can then find a targeted agent. Maybe you order a sulfonylurea type agent, a metiglitinide that is similar to a sulfonylurea or even add a prandial dose of insulin. When you're maxed out on Metformin, SGLT2 and GLPs, and you really can't find a specific culprit, either start a TZD or low dose basal insulin."

4. **Do you prescribe oral semaglutide to patients when they do not want to use injectable medication? Should PCPs refer to endocrinology to start oral semaglutide?**

   David Lam, MD "I definitely have. I don't think it requires a referral to a specialist to start. The other thing is if they are against injectables and not currently on a SGLT2 inhibitor, you could consider adding that."

5. **Do you prefer one SGLT2 inhibitor or GLP1 over the others?**

   David Lam, MD "I don't have a preferred SGLT2 inhibitor or GLP-1. I will often go with the insurance formulary. Even if you get prior authorization for a non-formulary agent, sometimes it comes at a higher tier and higher cost for the patient. If it is a high-risk patient, let's say they're high risk for readmission or they've already had a lot of hospital admissions, I might try to make a case with their insurance company based on the existing clinical trial evidence."

6. **Do you have any suggestions regarding patient education for GLP-1 agonist administration for patients? Do you find they need an in-person demonstration? Are there admin videos available?**

   David Lam, MD "If I'm starting the medication in the office, I will almost always demonstrate it to the patient. I think it helps decrease the fear of the injection. The same is true with insulin—it helps to have a demonstration. If an in-office demonstration isn't possible, the manufacturers have videos on their websites for how to inject their specific medications. So, let's say you're prescribing Liraglutide—the video is right on the Liraglutide website and they're generally pretty good. Your assessment of the patients' dexterity is important because the attachment of the needle can sometimes be a little bit tricky. So, the need for in-person demonstration is patient dependent."

7. **How would you adjust medication for a CHF patient if adding an SGLT2 inhibitor?**

   Donna Mancini, MD "The addition of the SGLT2 inhibitor may increase diuresis. After adding it, you may have to decrease the diuretics. But generally, with the addition, I don't do anything."

   David Lam, MD "One other point is we are going to see patients coming out of the hospital from a heart failure admission on an SGLT2 inhibitor. I think it is important as outpatient providers for us to recognize that this might be a new agent that is being started on the inpatient side. Also, the diabetes regimen established on the inpatient side incorporated that SGLT2 inhibitor."

8. **As an endocrinologist do you have any concerns about numerous cardiologists, nephrologists prescribing SGLT2 inhibitors?**

David Lam, MD “There is a little bit of concern based on it being a new medication for some prescribers and there is a degree of education that needs to occur. Educational opportunities like this conference, that are talking about SGLT2 inhibitors, serve to inform the prescribers. I think it is critical to do this so that providers can inform patients on the mechanisms of these drugs and the potential risks.”

9. **What is your lowest GFR for Metformin use?**

David Lam, MD “I think it's not just the absolute number, but it's the stability. I've got patients who have GFRs of 40 or 35 but have been rock-solid stable and have compelling reasons to be on Metformin. If there's a good reason to have them on metformin as opposed to any of the other agents that we've talked about, I'll do it. And, of course, tons of patient counseling and a very transparent conversation about the risk. It has to be prescribed for the right patient that's going to be very aware of their medical conditions and potential increased risk for lactic acidosis.”

10. **Where does Rybelsus fit in your experience?**

David Lam, MD “Rybeslus is oral semaglutide to use once daily. The nice thing is that it's not an injection. It’s for a patient that you can't, despite counseling, get on an injection. I don't think it has the same robust cardiovascular outcomes trial data. So, I think it's going to be for those patients that you can't get on an injection, you have a compelling reason why they should be on this class of medication, let's say, obesity, high ASCVD risk and you just can't get them on an injection or SGLT2 inhibitor. For me, it's been patient cost that has also been a limiting factor.”

11. **What is your take on the use of TZDs for patients that do not have any contraindications to it—some have argued that it may have cardiovascular benefit as well?**

David Lam, MD “If there are no contraindications for a TZD, and there is a reason why they can't be on SGLT2s or GLP1s and so forth, I will use it. Especially with my extremely insulin resistant patients. I find that it helps with insulin sensitivity. In general, I tend to use it in lower doses and I am very careful in its use.”

12. **Is Metformin contraindicated with liver disease?**

David Lam, MD “It depends on the liver disease and it depends on their level of hepatic dysfunction. For a patient who has non-alcoholic fatty liver disease with no cirrhosis, I would consider using it, but it really depends on the extent of the liver disease.”

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