ELIGIBILITY FOR DAPAGLIFLOZIN IN A REAL-LIFE HEART FAILURE CLINIC

C. Powell, K Kavanagh, J Morgan, N Stakelum Byrne, P Keelan, N Murphy. Our Lady of Lourdes Hospital, Drogheda, Co. Louth, Ireland

Introduction The rising prevalence of heart failure due to an aging population, higher post-myocardial infarction survival and the increasing burden of cardio-metabolic diseases, presents public health and economic challenges. Optimisation of heart failure therapy is essential in preventing the morbidity and mortality associated with this disease. The landmark DAPA-HF trial identified a 26% relative reduction in a composite primary outcome of worsening heart failure or death with use of dapagliflozin in patients with heart failure and reduced ejection fraction (HFrEF), irrespective of diabetic status. Although this class of drug is not yet incorporated into ESC guidelines, such a marked benefit may prompt consideration. The objective of this study is to determine the proportion of patients eligible for dapagliflozin at our site, based on inclusion and exclusion criteria of the DAPA-HF trial.

Methods A retrospective audit was conducted on all patients with HFrEF attending the outpatient heart failure clinic at University Hospital Galway between January and March 2020. Demographic and clinical data included age, gender, ejection fraction, NYHA class, comorbidities (in particular type 2 diabetes), aetiology of cardiomyopathy, history of admissions with decompensation within 12 months, history of ICD/CRT implantation, systolic blood pressure and pulse rate. Biochemical data included estimated glomerular filtration rate, NT-proBNP and potassium levels. Medication data included types and doses of GDMT, reasons (if documented) for not being on target dose, loop diuretic doses, and whether the patient was prescribed a SGLT2 inhibitor.

Results Data was collected on a total of 129 patients with a mean age of 71.3. 69% were male with a mean LVEF of 28.5%. Overall usage of RAS inhibitors and beta blockers was better than or comparable to existing large scale studies. However, a low proportion of patients on optimal dosing of these therapies was observed, consistent with existing data. A much larger proportion (45.7%) of our cohort were prescribed an ARNI than in either CHAMP-HF or CHECK-HF, likely a reflection of the approval of the drug occurring part-way through the studies. Regrettably our centre performed relatively poorly in both prescription and uptitration of MRAs. In terms of reasons underlying non-prescription or suboptimal dosing, with the exception of ACEI/ARBs no clearly documented or identifiable reason made up the largest proportion of each drug group. Of note only 6 patients (4.7%) were prescribed SGLT2 inhibitors; all of these patients were diabetic.

Conclusions Despite the strong body of evidence underpinning GDMT, gaps in prescribing habits still exist with specialist heart failure outpatient services. In particular issues around more widespread use of MRAs continue to undermine optimal therapy for heart failure. The low usage of SGLT2 inhibitors despite compelling evidence from the DAPA-HF trial is likely secondary to the lack of established guidelines on its use; we would expect this to be addressed in the next update to the ESC Guidelines.