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Beyond the Broadcast: Expert Insights on SGLT2 Inhibitors in Cardiometabolic Care

Announcer:
Welcome to CME on ReachMD. This activity, titled “Refining Strategies for Enhancing Cardiorenal Outcomes With SGLT2 Inhibitors: Optimizing the Cardiometabolic Care Mode” is provided by Medtelligence.

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Ms. Magwire:
When encountering patients with multiple cardiorenal comorbidities, healthcare providers across the care team spectrum are challenged to appropriately diagnose and initiate treatment amid evolving guideline recommendations. In addition, providers may be underutilizing SGLT2 inhibitors, an important class of therapy with many advantages for the treatment of atherosclerotic endpoints. Join us as we explore how best to use a multidisciplinary approach to treatment so that we can enhance cardiorenal outcomes in our patients.

This is CME on ReachMD, and I'm Melissa Magwire.

Dr. Miller:
And I'm Keith Miller.

Ms. Denicola:
And I'm Dawn Denicola.

Dr. Bullington:
And I'm Matthew Bullington.

Ms. Magwire:
So, Keith, let's start with you. Tell us about a typical patient that you might see, a cardiorenal metabolic patient, and about the approach that a cardiologist would take.

Dr. Miller:
Thanks, Melissa. Now, this is a great case, a 68-year-old male with a history of type 2 diabetes, hypertension, chronic kidney disease stage 3b, and heart failure with reduced ejection fraction, with an EF of 38%. And on this particular clinic day, he reports with worsening heart failure, a high hemoglobin A1c, and with a serum creatine of 1.8 mg/dL. And this encapsulates so many of our patients. They're not just a heart failure patient, but they're a heart failure patient with other comorbidities. So when I see a patient like this, of course, as a cardiologist, the first thing I'm thinking about is their congestive heart failure and what do I do to think about their risk. And something has changed. He's complaining of worsening heart failure, whether it's more fluid retention or shortness of breath or whatever. But it's an opportunity. It's a moment in time to kind of reexamine what's going on. What's changed? Is there a new rhythm problem or a coronary problem or a valve problem, something that we need to reassess? And it's also an opportunity to think about how we're treating the heart failure itself. So we try to correct the correctable factors that might have triggered a decompensation.

And then we direct our attention to guideline-directed medical therapy. And as you know, the guidelines for managing heart failure, and

especially heart failure with reduced ejection fraction, have been completely rewritten in the last several years. And there's nothing more important to that rewrite than the inclusion of SGLT2 inhibitors, which have become one of the 4 pillars of managing patients with heart failure with reduced ejection fraction. So we have to certainly acknowledge that there's a role for that therapy for this patient.

But we also have to look at the patient holistically, because he's not just a patient living with heart failure; he's a patient with diabetes, and he's a patient with chronic kidney disease. And we have to factor in how are we going to incorporate an SGLT2 inhibitor or a RAS inhibitor, or whatever the medication might be, into their regimen? And how does it affect their other chronic comorbidities?

And finally, trying to help the patient understand why we're bringing a new medication into the mix and why their cardiologist is suddenly talking to them about a drug that they've seen on TV and associated with treating diabetes. They're not used to their cardiologist treating their diabetes, so education is a really important part of that. And I think for them to hear it from their cardiologist, in addition to their primary care provider and other providers involved in their care, is really important.

Ms. Magwire:
I think you really highlighted the complexity of patients living with these comorbidities and how you need a really comprehensive approach as well as a really good communication strategy. So thank you.

Ms. Denicola:
So, Melissa, as a registered nurse and a certified diabetes education and care specialist, how would you go about treating this patient?

Ms. Magwire:
Yeah, to Dr. Miller's approach as well, it's comprehensive in its education. That's going to be the hallmark of that. It's really the most, probably, important thing when you get adherence or buy-in to the care plan. Often, these patients see multiple providers. They have multiple comorbidities. They're living with diabetes. They're living with heart disease. Not only do they have heart disease, but they also have heart failure. They may also have other comorbid conditions. And so they're typically seeing 4, 5, 6 practitioners and may be getting, unfortunately, different messages from each one of those practitioners. So really designing that care plan based on a foundation of education is key to that.

And explaining the role of SGLT2 inhibitors as well as their other guideline-directed medical therapies. We're asking them to take multiple medications, but they need to know why so that we have that adherence. And also lifestyle interventions, as you can't have one without the other, and they really go hand in hand. And then awareness of symptoms. How do we mitigate side effects, potentially? How do we know when the patient needs to call in and talk to their care provider?

But really making that team approach with that coordinated approach and that whole 360 view of cardio-kidney-metabolic and what it means to have all those comorbidities and empowering them with things that they can do to make their life a little bit easier and ensure that that care plan is actually successful.

Ms. Denicola:
I think that to touch on what you said, patient education and letting them know why they are on this slew, if you will, of medications, is really going to help them.

Ms. Magwire:
For those tuning in you're listening to CME on ReachMD. I'm Melissa Magwire, and here with me today are Keith Miller, Dawn Denicola, and Matthew Bullington. We're discussing how to enhance cardiorenal outcomes with SGLT2 inhibitors.

So, Matthew, I'm going to pick on you now. What are your thoughts from a pharmacist's perspective?

Dr. Bullington:
Sure, Melissa. From a pharmacy perspective, first off, I can clearly see where this patient would likely benefit from an SGLT2 inhibitor. We typically see a reduction in A1c from 0.4% to a little bit over 1%. Now, that's from the clinical trial data, so really, anecdotally, we can see even better than that. So this patient really would benefit from an SGLT2 inhibitor.

From my perspective, I would definitely want to check the comprehensive medication review, so I would take a look at all of the medicines that the patient is currently taking, incorporate any possible drug-to-drug interactions, or in the case of the SGLT2 inhibitors, they have a fairly clean drug-to-drug interaction profile, so I'm more looking at other medications that might enhance some of the effects of an SGLT2, just to ensure that we don't overcorrect.

Next, I look at affordability, because we can have these great tools, but if we can't get them in the hands of the patients, it's not going to do anything. So we have several avenues that we can look at if a patient says, "I'm having trouble affording this medication."

And finally, I take a look at side effects and treatment and prevention of those side effects. With the SGLT2 inhibitors, we do worry about UTIs and yeast infections. And for patients, although it's a major annoyance, the treatment for those can be fairly simple and straightforward. If they know that going in, that if you have this problem we can take care of it pretty easily, I think that would set them at ease and make them relax.

And finally, as far as preventing those side effects, dehydration can be an issue. So when we're explaining to a patient you need to drink lots of water, sometimes we need to really hone in on what lots of water means, because lots of water can mean different things to different people. So I want you to drink 8 to 12 glasses of water every day, or 64 to 96 ounces of water every day, and maybe even use a marked container so that you know exactly how much you drink during the day.

Ms. Magwire:
Sure. Great points.

So how about you, Dawn. What comes to mind as an advanced practice practitioner when you think about treating this type of patient that Dr. Miller outlined?

Ms. Denicola:
This patient we see all day, every day, right? And really doing an assessment to complement the physician, kind of taking a deeper dive into their history: when were they diagnosed with diabetes, what type of treatments have they been on, and assessing their understanding of how that's progressed. Their heart failure, whether it's been because of CKD, diabetes, or ischemic, as well as their diabetes. Is the heart failure worsening? What are the precipitants of that? Have they had recent hospitalizations? Frequent visits for IV or subcutaneous Lasix also? And evaluating GDMT. What are they on? Which of the 4 pillars are they already on? Is there a reason why we've not started them? Is it blood pressure? Is it the CKD that's keeping us from adding those on?

And talking to them about how this can affect the disease process. Most of these patients have family members that have all these same things, and so they speak about their history of their family. So I think talking to them about how this could change things for them and improve their care compared to the history of their family.

Their role in the SGLT2 – you were talking about prevention – can be a balance if they have CKD, when you talk about drinking the water, so helping them understand symptoms and when they need to talk to us. And other lifestyle modifications such as activity and exercise to the best of their tolerance.

Ongoing adjustments to medications, letting them know the plan. When are we going to see them again? When do we need to get lab work? When do they need to notify us of issues and really just investing in that patient.

Social determinants become really important at this point. If we have all the best medications, all the best ideas about their diagnoses, but we don't take into account the environment that they live in, I think we're really missing the point. So we have to talk about affordability as well as can you get to the pharmacy and those kinds of things.

Ms. Magwire:
Yeah, so what I'm hearing you saying is that it takes a team, but also making sure that that patient is part of that team.

Ms. Denicola:
Yep, absolutely.

Ms. Magwire:
But then also maybe kind of broadening the lanes that we practice in, and to your point, maybe not so siloed anymore, and looking at it as a whole cardiometabolic constellation and sort of that continuum of care across the board. So exactly.

So let's offer our listeners one final takeaway message. And Keith, I'm going to start with you. What do you think our audience should remember most from our discussion today?

Dr. Miller:
Well, for me, I think the big paradigm shift in the last several years taking care of these patients has been to really look at the patient as a whole and think a little bit more carefully and in a little more detail about their diabetes, and not just that they are someone living with diabetes but how it's being managed and how that relates to their heart failure care.

And we didn't talk about this a lot, but I think the importance of team-based care is a really big deal. In our practice, we rely really a lot on pharmacists and advanced practice providers to help us sort of execute on these plans. We kind of make an initial plan in the room, but we often rely on our APPs and our pharmacists to help us execute that plan in follow-up visits.

Ms. Magwire:
Yeah. So, Dawn, how about you?

Ms. Denicola:
For me, it's that investing in the patient with the time. Talking to them, education, looking at social determinants and precipitants of issues that they've had in the past, and helping them to understand how the addition of these medications, the SGLT2 inhibitors and others, are going to help with the progression of disease.

Ms. Magwire:
Great. And, Matthew, finally?

Dr. Bullington:
Yeah, as Dr. Miller addressed, we have to start looking at these patients as a whole patient, and we're seeing some of the silos break down between cardiology and endocrinology. So a cardiologist may be prescribing an SGLT2 inhibitor in a patient that is taking glimepiride or insulin, so we need to be aware of the possibility of hypoglycemia with those two products. But if that same patient, instead of insulin and sulfonylurea, is taking a GLP-1 or metformin, we don't have to be so worried about hypoglycemia. So that education is important, I think, for all of us and for the patient as well.

Ms. Magwire:
Yep. Great. Again, you guys had a lot of really good insights, but I think what I'm hearing from you is that it's communication, education, and teamwork, coordination. So I think you guys really kind of wrapped that up nicely.

So our time is up, and I want to thank our audience for listening. And thank you to my colleagues for joining me and sharing their insights. It was a pleasure learning from all of you.

Dr. Miller:
Thank you very much. And goodbye.

Ms. Denicola:
Thanks for having me.

Dr. Bullington:
Thank you for having me.

Announcer:
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