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Cardiorenal Collaboration: Optimizing Multidisciplinary Care in the CvRM Patient

Announcer:
Welcome to CME on ReachMD. This activity, titled “Cardiorenal Collaboration: Optimizing Multidisciplinary Care in the CvRM Patient” is provided by Medtelligence.

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Dr. Townsend:
We know that SGLT-2 inhibitors are effective based on the outcomes of large clinical trials, such as EMPA-REG, but they do more than lower blood sugar and improve the A1C. Like statins, SGLT-2s offer many advantages for anyone who has a potential or an existing atherosclerotic event, and today we’ll explore the multidisciplinary approach to treatment so that we can improve the outcomes in our patients who have these cardiorenal comorbidities. This is CME on ReachMD and I'm Dr. Ray Townsend.

Ms. Magwire:
I'm Melissa Magwire.

Dr. Weber:
I'm Dr. Michael Weber.

Dr. Townsend:
I want to start off by just giving a brief definition of what we mean by a cardiorenal metabolic, or a cardio-kidney metabolic type of patient. And this is a group of conditions that includes type 2 diabetes, hypertension, hyperlipidemia, chronic kidney disease and trappings, like heart failure and acute MI. These conditions are linked by insulin resistance, systemic inflammation, and stuff like central obesity.

Michael, let's start with you. Can you share with us a little bit about the typical patient that you might see who would be classified as a cardiometabolic – cardiorenal metabolic type of patient?

Dr. Weber:
We see a lot of patients, particularly with an aging population, who have all the items you've already, mentioned. People who have high blood pressure, lipid abnormalities, diabetes, and who are at risk of having heart disease. And what we have to be aware of is that these are all interconnected. You said that insulin resistance is a big factor in this interconnection, and I agree with you.

One of the areas that perhaps doesn't get understood as much as possible is that heart disease is linked to all of this. it is very much part of kidney disease. In fact, most people who have kidney disease in the end are going to get into problems with heart disease unless we do something to prevent it. .

Dr. Townsend:
Mike, walk us a little bit through the approach that a cardiologist takes when confronted with a patient that has these kind of disorders.

Dr. Weber:
Well, the most important thing – and it's not just for the cardiologist, it's for everybody who sees a patient like this – is to think, does the patient have a heart problem? And we tend to think when we say that, do they have angina or are they at risk for having a heart attack? And yes, that is important. But at the same time, heart failure has to be mentioned because it's far more common than people think, and it's often overlooked. It's either not diagnosed at all or not taken as seriously as it should be.

Dr. Townsend:
And so, Melissa, From your standpoint as a diabetes educator and care specialist, what comes to your mind when you see a patient who's got a cardiac label on them, but also has those trappings, we call cardiorenal metabolic patient?

Ms. Magwire:
Understanding that this constellation of comorbidities and diagnoses are all interrelated, and no longer looking at that patient with that single scope of, I'm just looking at their cardiac issues, because it's so much more than that.

And really, pulling in that holistic view of all of these interrelated comorbidities, and making sure that we're looking at that totality of that and not just singly focused in on glycemic control or chest pain, but really looking at all of the other symptoms these patients might be having and making that connection.

Dr. Weber:
Getting the whole social background is also a critical part of this. But we can also fall back on tests,for measuring glucose control, for measuring kidney function. we also now have a very good test for heart failure. Looking at anti-proBNP.. And if the numbers are high, then we really have , I won't call it confirmation of heart failure, but a very strong suspicion of heart failure. And I believe that kidney outlines, Ray, recommend that we measure ProBNP just about every year in someone who's got chronic kidney disease.

Dr. Townsend:
It's a good point, Michael.

We see these kind of patients knowing that we have a problem with them being overweight, having blood sugar issues, often having lipid issues, frequently having a story that's consistent with breathlessness. Is it the anemia from CKD? Is it actually related to cardiac failure? And if it is cardiac failure, which of those? reduced ejection fraction, mid-line ejection fraction, and preserved ejection. And so, we pick out our guidelines and we look through them and we find that we have 127-page KDIGO guideline, we have 107-page ESC guideline, we've got diabetes care divided into a series of chapters, and so every January we're watching for the supplement to give us a little bit more understanding about what to do. But fortunately, in kidney disease, we turned the corner a few years ago from frequently negative clinical trials to the beginning of positive clinical trials that show both a reduction in the rate at which kidney failure is progressing, as well as an improvement in things like hospitalization for heart failure and other cardiovascular endpoints. So, our current evidence, especially with the SGLT-2s, really kind of motivated us. and now we're actually digging in and using the SGLT-2s clinically to improve patient care and improve outcomes, particularly in something that used to have a dismal outlook, like CKD progression in a diabetic with proteinuria.

Dr. Weber:
You know, Melissa, we know now that drugs like the SGLT-2s have a big part to play in treating heart failure, a big part to play in treating chronic kidney disease.

But as a diabetes specialist, where do they fit into the treatment of type 2 diabetes? Are they a first-line drug? A second-line drug? Can we be opportunistic with them?

Ms.. Magwire:
unfortunately, so many of our patients living with type 2 diabetes also have all of these other comorbidities. And so yes, when they were first brought to the market, it was for glycemic control. But we now know, to your point, we treat heart failure, we treat diabetic kidney disease, cardiovascular risk factor, and glycemic control. And it's having that understanding that this is multi functioning, multifactorial, maybe this patient may have an A1C or a glycemic level that's in control, but that's not why we're prescribing this SGLT-2 in this case. We are prescribing this SGLT-2 for this patient living with diabetes because of their diabetic kidney disease or because of their cardiovascular risk or heart failure. So, it's really ensuring that everyone on the team is understanding why you're using this drug category or this medication.

Dr. Weber:
Ray, when do you think SGLT-2 for someone with chronic kidney disease? Because we know it's recommended but there are other things we can do. We should be using blockers of the renin angiotensin system for renal protection and so forth. How do we fit in the

SGLT-2 into this sort of patient?

Dr. Townsend:
When SGLT-2s first started to enter into the marketplace and we looked at kidney disease progression, we kind of mandated that people had to be on a RAS-blocking drug. And you might expect that that would just set the stage for more side effect profiles, because one of the things – and I'm sure Melissa would agree with this – is a patient with CKD, hypertension, a tendency toward breathlessness, etcetera, they're on a raft of medications with a lot of potential side effects. But the SGLT-2s have been, at least from a patient standpoint, fairly well-tolerated even when added on to these complex regimens. And so, I think that when a RAS-blocking drug is present, or reasonably contraindicated because of something like a potassium of 4.9 or 5.0 or something like that that might lead someone to consider an alternative, the KDIGO and the ADA guidelines kind of slip in the SGLT-2s right after that raft of exercise and you know the other heart-healthy things that we do from a diet standpoint.

So, early on is what I would say is the answer to your question. And one of the things that the EMPA kidney study did is it pushed the envelope as far as it goes, I think, in this whole area because they enrolled patients, at least a subset, that had neither diabetes nor significant albuminuria. And I think that really opened the door to our thinking of where this kind of drug fits in managing a patient whose kidneys are not functioning normally.

Ms. Magwire:
Yeah. And I think it's kind of helped in some ways break down those silos, because gone are those days, at least in this arena, where oh, that's a cardiac drug, that's an endocrinology drug, that's a nephrology drug. To your point, unfortunately our patients living with type 2 diabetes have this whole satellite of all of these other comorbidities. It's really that coordinated approach and that realization that these are all interrelated and anyone on that care team can go ahead and take that ball and run with it and get these folks started on guideline directed medical therapy.

Dr. Weber:
Yeah. The problem is, Ray, that so many patients fall under the umbrella we're talking about, the cardio-kidney metabolic syndrome, particularly as we have an aging and somewhat obese population. We can't just say this is a job for the diabetes specialist or the kidney specialist or the heart specialist. It has to be treated in the primary care setting most of the time or much of the time. [14:45]

Dr. Townsend:
We now have three different SGLT-2s with solid information, data you can take to the bank. It's a good effect and it really puts SGLT-2s into the format of a pillar for the care of a diabetic or a nondiabetic with CKD, particularly if you can detect albuminuria on a dipstick in the office, urinalysis. So, I think that the consistency of the data, the importance of this for kidney disease progression because it is expensive and terrifying to achieve end-stage kidney disease and need a transplant or go on dialysis. And we have means now to at least delay the progression to that end point. And I think classifying it like a pillar, a foundationally important structural aspect of the care of this patient, is one way to get it at least through the barrier of, oh my god, I've got so many guidelines. How do I follow each one of them in this patient who's got every sort of metabolic derangement you can think of? And so, getting the idea that this is a central and useful thing, and both ADA and KDIGO have it very early in the care, particularly of a diabetic patient. I think that's part of the key.

For those of you just tuning in, you're listening to CME on ReachMD. I'm Dr. Ray Townsend, and with me here today are Dr. Mike Weber and Melissa Magwire. We've discussed the role of SGLT-2 inhibitors and the multidisciplinary approach to improve outcomes for patients with cardiorenal or cardio-kidney metabolic abnormalities.

So, I'll go back to you, Melissa. what would you say from the diabetes education and care specialty about what's important in your mind to get this message across to our primary care colleagues?

Ms. Magwire:
So, really laying that foundation for that multidisciplinary team approach and care-coordinated approach, I think, is really the caveat for having successful patient outcomes.

Dr. Townsend:
Terrific. Thank you for that. So, Michael, you have any further thoughts on this particular issue?

Dr. Weber:
So, the pillars you talked about are so important, mentally or even physically on – on a electronic health record, check the box. Is this patient getting an SGLT-2 agent? Because that covers all of these areas. Is the patient getting proper treatment for their lipid disorder? Is their blood pressure under control and should I be adding to the RAS blocker? What is the kidney function? Are there other things I should be doing more aggressively to preserve kidney function, as you've already described? So, we need to be thinking about these

drugs. We haven't mentioned the drugs like the mineralocorticoid receptor antagonists, drugs like spironolactone, which nobody likes too much. But eplerenone, and now an even newer version called finerenone, which is approved for people just like the ones we're talking about. These are the pillars that we have to think about each time and make sure we're not shortchanging our patient by not giving them a medication that's going to improve their prognosis.

Dr. Weber:
Great. Melissa, any further thoughts on this?

Ms. Magwire:
Yeah. I mean, I think just as we've kind of discussed over the last couple of minutes, this is a really complex, multifaceted disease state, and it really needs to be looked at in a holistic manner with that coordinated team-based approach, so that we can check those boxes off or ensure that our patients are getting guideline-directed medical therapy and being set up for the best possible outcomes.

Dr. Townsend:
And I just want to echo something Michael said. And that is that you know when you – when you're doing this kind of care, one of the things nephrologists especially keep in mind is that when we add an SGLT-2 to a patient with CKD, it's not to improve their A1C at this point. There's lots of other people looking at that per se. And the other merciful thing in all this is that when you look at the actual recommendations, like from the Americ – European Society of Cardiology, you can use these down GFR's of 20, and so that is such a relief because we were so straightjacketed before with having to have GFRs above 45, say, to do things like, renal innervation, for example. So, the good news is that the GFR down to 20 is recommended. I mean, some of the trials, yes, they use 25 and 30 is the bottom line, but the safety of the class has been down to 20 now. And so that plus, don't worry about if the A1C doesn't come pl meting downward. This has benefits over and above glucose control. let me start with you, Dr. Weber. Do you have a final take-home message for our audience here?

Dr. Weber:
I think we've made a very strong point, Ray, that we can no longer think in silos. We have to ass e that when we have someone with diabetes who's overweight, got high blood pressure, we are almost certainly going to be seeing a good likelihood of chronic kidney disease, and we should be very suspicious that heart failure and other cardiovascular problems are lurking in the wings. And we have to learn to integrate all of these conditions into a standard approach,

Dr. Townsend:
Great. How about you, Melissa?

Ms. Magwire:
I think because of the fact that we've said over and over again how interrelated these conditions are, and we're all touching these patients in our practice for one reason or the other, is that, go ahead and take the lead. And make sure that we've got these folks not only supported with the education that they need and the lifestyle and – and behavior modification, but that guideline-directed medical therapy,

Dr. Townsend:
And I'll just chime in with one or two final thoughts here to take home. One of which is that when you use these meds, they have a bit of a diuretic effect, so always pay attention to the vol e status because people will lose a little bit of fluid and salt, which is a good thing. And after about a year or so, you really begin to see the benefits for the value of SGLT2's when it comes to kidney function preservation.

So, I want to thank our audience for listening in. And thank you, Dr. Michael Weber and Melissa Magwire, for joining me and sharing your insights.

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