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Cracking the Code of Obstruction: Unmet Needs in oHCM

Announcer:
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Dr. Nassif:
Welcome everybody. I'm Michael Nassif and I'm pleased to present this CE by ReachMD.

And today we are going to take a deep dive into the underlying disease burden of obstructive hypertrophic cardiomyopathy. And one of the important reasons we talk about obstructive hypertrophic cardiomyopathy and hypertrophic cardiomyopathy in general is it is the most common genetic heart disease. And where we used to think it was fairly rare, it turns out with modern genetics, increased awareness, and better imaging and screening it's not all that uncommon. We think estimates are much closer to 1 in 200 people who are affected with obstructive HCM.

And part of the reason obstructive HCM is at the forefront is it's not only an incredibly burdensome disease, but it tends to affect people in the prime of their lives. It commonly affects people in their 30s, 40s, and 50s. And where we think about the hallmark symptom being dyspnea on exertion, patients also commonly have fatigue. They also have chest pain, both atypical at rest and with exertion, frequently have palpitations, and some of the more concerning symptoms are presyncope and syncope with that exertion.

We estimate 80% of patients with obstructive hypertrophic cardiomyopathy have limitations when doing vigorous physical activity. We estimate that 60% of patients are limited from participating in even moderate activity, and 1/2 of patients with obstructive HCM we estimate cannot even walk up a flight of stairs without having significant discomfort.

And I do think HCM is particularly important to have a really good history along with your physical exam. Unlike some other conditions, most patients with HCM, it is genetic, and they've had sarcomere gene mutation since birth, and these symptoms have been very slowly coming on over years or decades. So often patients will minimize their symptoms. Often patients will normalize their symptoms. They'll think they're short of breath, but it's because they're older and in their 50s and a little bit overweight and a little bit deconditioned. But I like to, 1. ask any family member or spouse that's with them if they've seen the patient slowing down. I also like to ask the patients to try to compare themselves to others; if they're out walking, do they set the pace or does somebody else set the pace.

Also we do a lot of functional testing, not necessarily to exclude or include anyone for additional aggressive therapies but just to show the patient where their VO_2 max or their METs or their exercise capacity would be into similar-aged sex and weight patients.

And so when we look at our current guidelines, first-line therapy is beta blockers, diltiazem, and verapamil. But I think it's worth noting in

spite of beta blockers, in particular, being the first-line guideline-directed therapy for decades, the level of evidence is actually quite weak behind these.

But I do think people don't realize how often symptoms persist.

It is also worth noting that up until the past couple of years, we got myosin inhibitors. However, our first true targeted therapy to address the underlying fundamental issue, which in this case is sarcomere gene mutations, has been these myosin inhibitors.

And so our key takeaways and the reason this is an important subject to talk about is this is a very burdensome disease. We now have therapies we're going to discuss in subsequent episodes that are very efficient at rapidly and sustainably dramatically improving these symptoms and alleviating these burdensome diseases. And HCM not only is much more common than we previously thought but I think a lot of the symptomatology and the symptom burdens have been kind of underappreciated. And I think there is a significant residual burden even after patients are on first-line current guideline-directed medical therapy, specifically beta blockers. In subsequent episodes we'll show you some of the evidence to that effect.

And that's all of our time for this episode. Thank you so much for joining.

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