[00:00:00.12] - Dr. Gibson
Dimitry Abramov, Mike Gibson, we're talking about HFpEF. You know, Dimitry, I think a lot of people think this is an echo diagnosis, but there's a lot of signs and symptoms that people miss or confuse with things like COPD. So first of all, set the stage, talk to us, you know, how many people out there have HFpEF? We all are familiar with HFrEF, but when I talk with primary care docs and internists, they're not as familiar with So highlight some of the prevalence incidence numbers for us.

[00:00:34.00] - Dr. Abramov
Absolutely. Thank you very much for having me on today. So we all know heart failure is very, very prevalent in the community. Millions of people, at least 6, 7 million Americans, if not more, have heart failure. I would say the current data suggests that at least half, if not more than half of them, have heart failure with preserved ejection fraction. And what's concerning about the demographics is unlike heart failure with reduced ejection fraction, where the incidence and prevalence is generally stable or decreasing over time. Because of comorbidity burden in the community, aging population, both the incidence and really the prevalence of heart failure with preserved ejection fraction has really been increasing. Well, like you mentioned, you know, people have not heard potentially as much about it outside of cardiology, the heart failure community, partly because historically treatments have been more limited. But now, as incredibly effective treatments have been coming out over the last 5 or 10 years, I think there's an increase increased focus to try to identify patients, diagnose them early, identify their risk factors to try to manage and prevent some of the really high morbidity and mortality that's associated with heart failure with preserved ejection fraction.

[00:01:43.03] - Dr. Gibson
You know, I think people always think of HFrEF as the syndrome with high morbidity and mortality. Talk to us about the long-term outcomes though with HFpEF.

[00:01:53.21] - Dr. Abramov
Yeah, very, very similar if not worse. Comorbidities have more of a role in patients with heart failure and preserved ejection fraction, but the morbidity and mortality is similar in many ways if not higher. These patients are hospitalized at extremely high rates. Length of stay is high, readmission rates are high, morbidity and mortality rates after hospitalizations with readmission and mortality are very, very high from both cardiovascular and non-cardiovascular causes. So it's really imperative to try to identify these patients as early as possible.

[00:02:26.05] - Dr. Gibson
Now we have a diabesity epidemic out there. A lot of people with CKM, cardio-kidney metabolic disease, that has a high incidence of HFpEF as well, right?

[00:02:38.14] - Dr. Abramov
Absolutely, yeah. Thanks for bringing that up. I mean, I think it's really, really important. I mean, there's been many ways to think about how we diagnose heart failure with preserved ejection fraction. You know, kind of historically, there's universal definition of heart failure criteria. So signs and symptoms, you know, echo or other imaging findings, evidence of elevated filling pressures by BNP or other ways. There have been score criteria, H2F, PEF, and other scores that are available. But I think increasingly the field is moving towards appreciating the overlap between heart failure, preserved ejection fraction, and the CKM syndrome. So if you look at cohorts of patients outside in the community with heart failure, The vast majority of them have at least one CKM risk factor. So whether it be obesity, kidney disease, diabetes, other comorbidities. So 70, 80, 90% of patients with heart failure have at least one, if not multiple CKM risk factors. Probably among hospitalized patients, the prevalence of those risk factors is even more. So there's a very, very big overlap between cardiometabolic risk factors and heart failure reserve ejection fraction. And so that's really important to consider because if we think about how to identify these patients early, one approach is to use some of the prior diagnostic algorithms, risk scores, criteria.

[00:03:59.00] - Dr. Abramov
The other approach is to think about CKM risk factors. And when patients start developing kidney disease or diabetes or obesity, we need to be mindful that heart failure is gonna be very, very common

overlap in those patients. And the reason that's important, right, is because treatments are increasingly available with increasing overlap between what's approved for the management of heart failure, preserved ejection fraction, as well as the management of CKM early stages and late stages. And so we're talking about primarily SGLT2 inhibitors, nonsteroidal MRAs, we're talking about GLP-1s, other therapies that potentially may be available. So the sooner we put— we integrate this patient's symptoms, dyspnea, other things with their cardiometabolic risk, consider the heart failure diagnosis part of that and begin treatment even before heart failure develops in these people. Because again, GLP-1s, nonsteroidal MRAs, SGLT2s, those medications are approved for many conditions that are causal or pre-causal pathways to both more advanced CKM syndrome but also heart failure. So the sooner these conditions are diagnosed, particularly kidney health, the faster we're able to identify patients, treat them, and prevent disease progression of both comorbidities, but also heart failure itself. So critically important, I think.

[00:05:25.02] - Dr. Gibson
So highly prevalent disease, often going unrecognized, often confused with COPD, other things that cause shortness of breath. Think about it, recognize it early. We now have some new medicines that have come along that can be helpful. That was not true in the past, but as he mentioned, you know, the SGLT-2s and some of the other newer MRAs, we have some choices. Dimitry, thanks for joining us today.