Transcript Details

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Engaging Patients With Heart Failure and Chronic Hyperkalemia: Shared Decision-Making to Support Guideline-Directed Medical Therapy

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Dr. Savarese:
Hello, I'm Dr. Gianluigi Savarese. Welcome to this Patient-Clinician Connection focused on shared decision-making in patients with heart failure who develop chronic or recurrent hyperkalemia.

As cardiologists, we frequently care for patients receiving guideline-directed medical therapy, including RAS inhibitors and mineral corticoid receptor antagonists. These therapies improve outcome and prolong survival, yet they can increase the risk of hyperkalemia. Too often, the development of hyperkalemia, or concern that it may occur, results in dose reductions or discontinuation of therapies with established cardiovascular and renal benefits.

Today, however, we have additional management options that might help maintain potassium control while supporting continued use of evidence-based therapies.

Through a clinical vignette, I will demonstrate how I engage patients in shared decision-making when discussing chronic hyperkalemia management, treatment goals, and the role oral potassium binders may play in supporting long-term care.

Let me introduce our patient, Robert, who is 59 years old. He has a diagnosis of heart failure with reduced ejection fraction, and he has an EF of 40%. He has CKD stage 3b with an eGFR of 40. He has hypertension, type 2 diabetes, ischemic heart disease, and he is a former smoker. He is currently on GDMT, namely sacubitril/valsartan 49/51 twice per day, bisoprolol 5 mg, spironolactone 25 mg, dapagliflozin 10 mg, and furosemide 40 mg once per day. His potassium values have been ranging between 5.6 and 5.9. He is symptomatic with a New York Heart Association functional class IIIA. He has a stable blood pressure around 100/60, a heart rate of around 65, and his renal function has been stable, although he has a history of hyperkalemic events with prior hospitalization.

Dr. Savarese:
Robert, your heart failure medications are helping protect your heart, reduce your risk of hospitalization, and they make you feel better. But your potassium levels have been running higher than we'd like. Before we discuss next steps, what concerns you most?

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Robert:
Well, I don't want to end up back in the hospital. I'm finally feeling better, and I'd like to stay that way.

Dr. Savarese:
Okay, so avoiding hospitalization and maintaining your current quality of life are your biggest priorities. Do I understand correctly?

Robert:
Yes, and I'd really like to stay on the medications that are helping my heart, if possible. They help me feel better.

Dr. Savarese:
That's very helpful to know. Keeping your heart failure controlled while safely managing your potassium will be an important goal as we make decisions together.

Dr. Savarese:
Notice that the conversation begins with patient's priorities rather than immediately discussing laboratory values or treatment options. Shared decision-making starts with understanding what matters most to the patient. In this case, avoiding hospitalization and maintaining effective heart failure therapy becomes key drivers of treatment discussion.

Dr. Savarese:
Robert, potassium is an important mineral that helps regulate heart rate and muscle function. The challenge is that some of the medications that help protect your heart and kidneys can also increase potassium levels. When potassium rises repeatedly, clinicians sometimes reduce or stop these therapies. The problem is that doing so may mean losing some of the benefits those medications provide.

Robert:
So the potassium itself is a problem, but stopping the heart medications can also be a problem.

Dr. Savarese:
Yes, exactly. Our goal is not simply to lower potassium; our goal is to manage potassium in a way that allows us to continue the therapies that help protect your heart and kidneys whenever possible.

Robert:
Yeah, that makes sense.

Dr. Savarese:
We now have strategies that may help us do both: maintain potassium control while supporting continuation of evidence-based treatments.

Dr. Savarese:
This exchange reframes the hyperkalemia management. Rather than focusing only on potassium reduction, the discussion emphasized preservation and optimization of guideline-directed therapy. This helps patients understand why management decisions extend beyond a single laboratory value.

Dr. Savarese:
One option we can discuss is an oral potassium binder. These medications work in the gastrointestinal tract to remove potassium from the body and help maintain potassium levels within a safer range.

Robert:
Would that mean I could stay on my heart medications?

Dr. Savarese:
That is often one of the reasons we consider these therapies. They might help support continuation or optimization of RAS inhibitors and MRA therapy while controlling potassium. There are different oral potassium binders available, and selecting one involves considering

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several patient-specific factors.

Robert:
What kind of factors?

Dr. Savarese:
We look at potassium level, kidney function, current medication, sodium intake, and fluid retention. You have mentioned occasional swelling in your legs, and I see some mild edema on examination. Because people with heart failure can be sensitive to changing fluid status, that becomes an important part of our discussion.

Robert:
So it's not just about the potassium number.

Dr. Savarese:
Yeah, that's correct. We want to choose an approach that fits your overall clinical situation, addresses any side effects that you are experiencing, and aligns with your treatment goal.

Dr. Savarese:
This discussion highlights an important aspect of shared decision-making. The conversation moves beyond efficacy alone and incorporates factors such as kidney disease, edema risk, volume status, sodium restrictions requirement, concomitant diuretic use, and the patient's goal regarding GDMT continuation.

Dr. Savarese:
Robert, based on your recurrent hyperkalemia, your goal of remaining on effective heart failure therapy, and your concern about future hospitalizations, I think it would be reasonable to discuss adding an oral potassium binder as part of your long-term management plan. We'll continue monitoring your potassium, kidney function, and fluid status closely and adjust our approach as needed.

Robert:
If adding another medication helps me stay on the treatments helping my heart, I'm open to that.

Dr. Savarese:
That's exactly the kind of discussion we want to have. There isn't a one-size-fits-all answer. The right decision is one that considers both the clinical evidence and what matters most to you.

Robert:
Okay. Thank you. I like being involved in the decision and that you're listening to what's important to me.

Dr. Savarese:
And that partnership is an important part of achieving the best possible outcome.

Dr. Savarese:
This exchange demonstrates how clinicians can integrate patient preferences into evidence-based care. The recommendation is anchored to the patient's stated goals, recurrent hyperkalemia history, and need to maintain GDMT. The patient becomes an active participant in selecting a management strategy rather than simply receiving instructions.

As cardiologists, our role extends beyond simply prescribing medications; we must help patients understand the relationship between hyperkalemia management and long-term cardiovascular outcomes.

Patients with heart failure and associated comorbidities often face recurrent hyperkalemia while receiving therapies that provide substantial clinical benefit. Through shared decision-making, we can help patients understand available options, evaluate individual risk factors, and select management strategies that align with their goals.

By incorporating patients' preferences, discussing the role of oral potassium binders, and focusing on the continuation and optimization

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of guideline-directed medical therapy whenever appropriate, we can support better outcomes and stronger patient engagement.

Thank you for joining this Patient-Clinician Connection on shared decision-making in chronic hyperkalemia management in heart failure. I hope I've given you a useful framework for partnering with patients to make informed treatment decisions that support both clinical goals and quality of life.

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