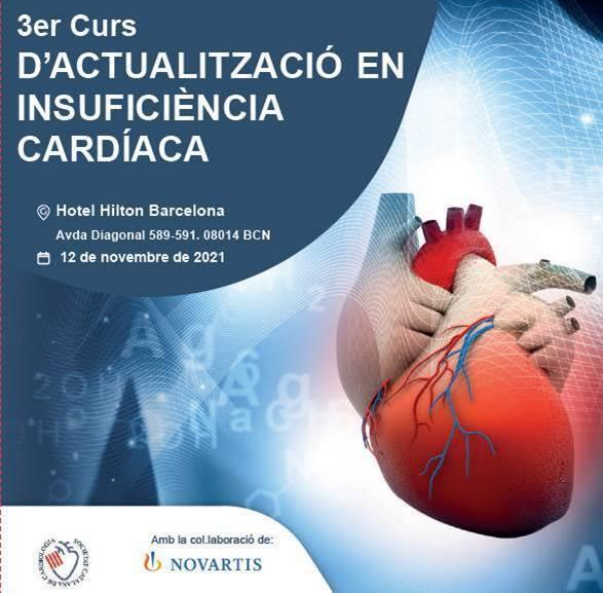
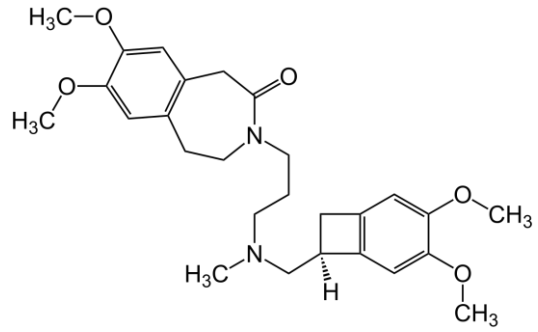




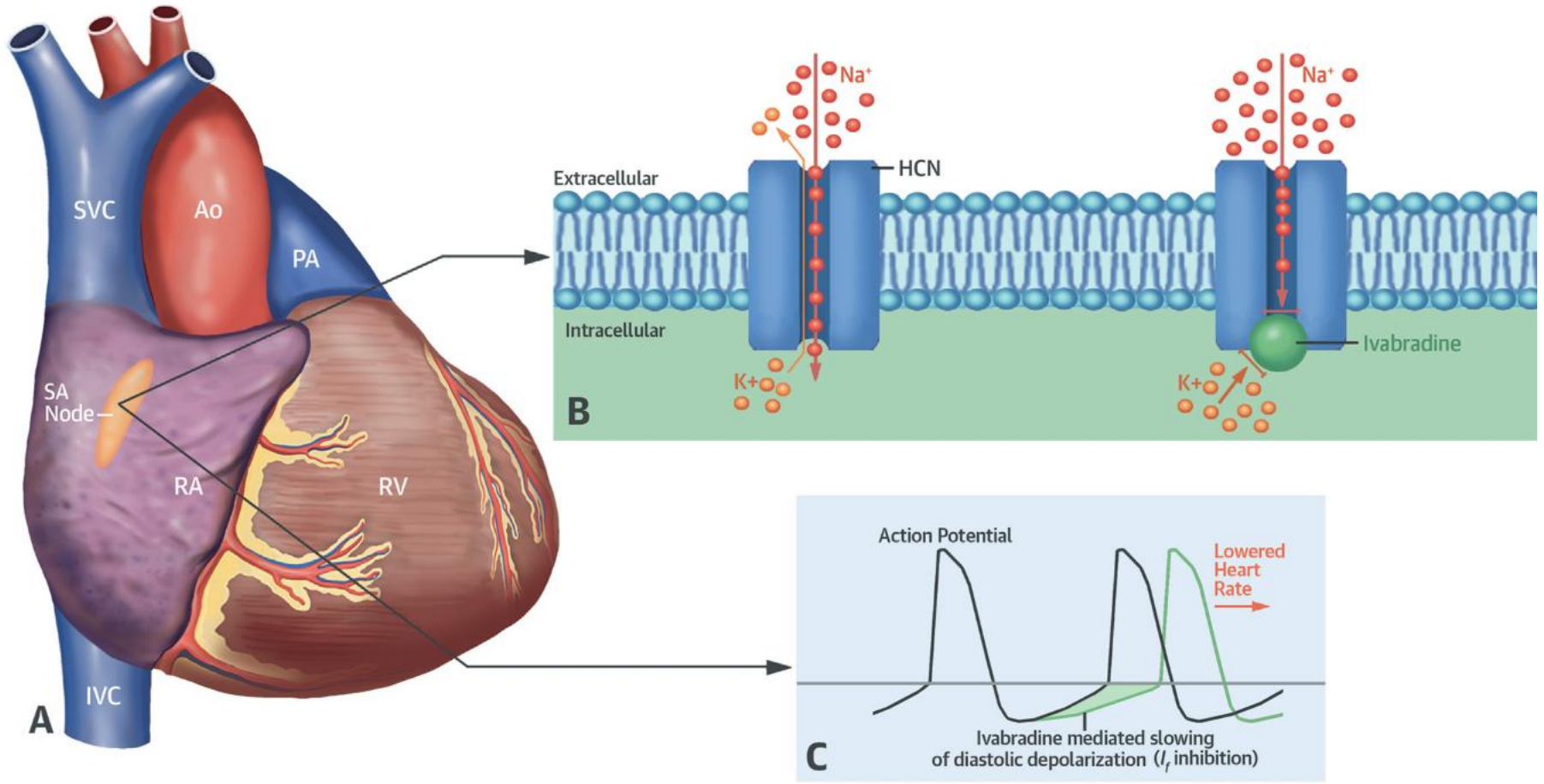
Papel de la Ivabradina

Santiago Cudini

Hospital de Figueres

12 de Noviembre de 2021

Mecanismo de acción de la Ivabradina



Koruth, J.S. et al. J Am Coll Cardiol. 2017:70(14):1777-84.

Evidencia del fármaco en IC

Ivabradine and outcomes in chronic heart failure (SHIFT): a randomised placebo-controlled study

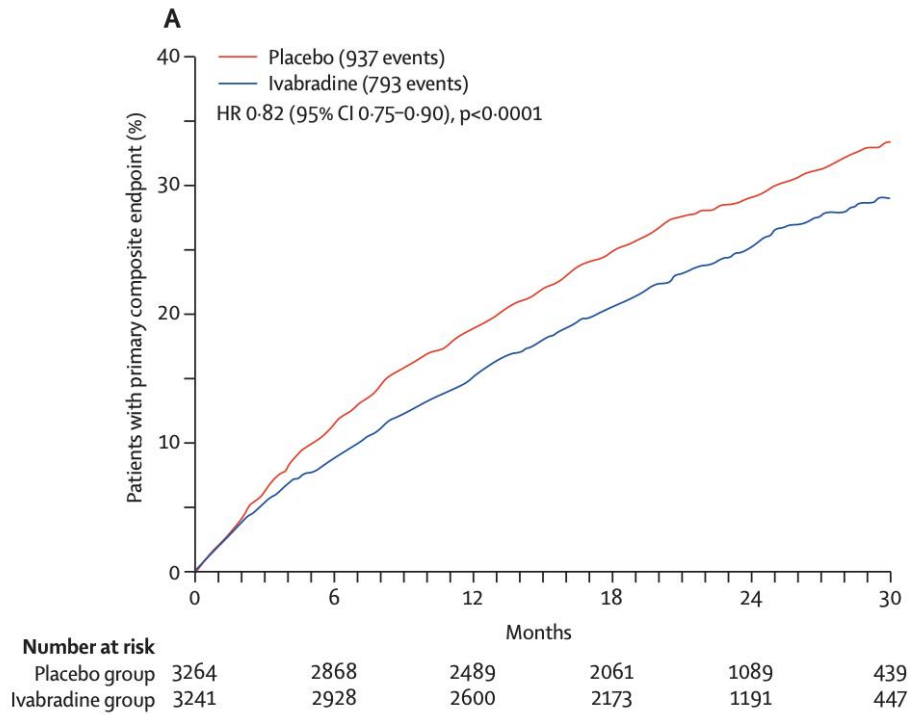
6558 Pacientes con IC sintomática FEVI < 35%

Ingreso en los últimos 12 meses

RS con FC >70lpm
TMO con BB a dosis máxima tolerada

Endpoint Combiinado

Mort CV y Reingreso



Karl Swedberg, et al. The Lancet 2010: DOI: 10.1016/S0140-6736(10)61198-1.

¿Qué característica tenía la población sustituta en SHIFT?

	Ivabradine group (n=3241)	Placebo group (n=3264)
NYHA class		
Class II	1585 (49%)	1584 (49%)
Class III	1605 (50%)	1618 (50%)
Class IV	50 (2%)	61 (2%)
Treatment at randomisation		
β blocker	2897 (89%)	2923 (90%)
ICD	92 (3%)	115 (4%)

IECA/ARAII
BB
ARM

Reasons for failure to reach target dose*†		
Hypotension	933 (44%)	952 (45%)
Fatigue	676 (32%)	670 (32%)
Dyspnoea	284 (14%)	302 (14%)
Dizziness	267 (13%)	245 (12%)
Bradycardia	134 (6%)	125 (6%)
Other	199 (9%)	219 (10%)
Patients not receiving β blocker	344 (11%)	341 (10%)
Reasons for non-prescription of β blocker		
Chronic obstructive pulmonary disease	126 (37%)	109 (32%)
Hypotension	59 (17%)	68 (20%)
Asthma	35 (10%)	39 (11%)
Cardiac decompensation	23 (7%)	31 (9%)
Dizziness or bradycardia	24 (7%)	17 (5%)
Fatigue	17 (5%)	20 (6%)
Raynaud or peripheral arterial disease	16 (5%)	20 (6%)
Other	44 (13%)	37 (11%)

Karl Swedberg, et al. The Lancet 2010: DOI: 10.1016/S0140-6736(10)61198-1.

ESC
European Society of Cardiology
European Heart Journal (2021) **42**, 3599–3726
doi:10.1093/eurheartj/ehab368

2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure

I_f-channel inhibitor		
Ivabradine should be considered in symptomatic patients with LVEF ≤35%, in SR and a resting heart rate ≥70 b.p.m. despite treatment with an evidence-based dose of beta-blocker (or maximum tolerated dose below that), ACE-I/(or ARNI), and an MRA, to reduce the risk of HF hospitalization and CV death.[139]	IIa	B
Ivabradine should be considered in symptomatic patients with LVEF ≤35%, in SR and a resting heart rate ≥70 b.p.m. who are unable to tolerate or have contraindications for a beta-blocker to reduce the risk of HF hospitalization and CV death. Patients should also receive an ACE-I (or ARNI) and an MRA.[140]	IIa	C

IC sintomática
FEVI < 35%
RS con FC >70lpm

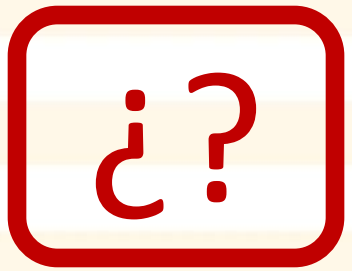
Con BB a dosis máxima tolerada o sin BB con menor evidencia
MAS IECA (¿ARNI?) y ARM

The NEW ENGLAND JOURNAL of MEDICINE

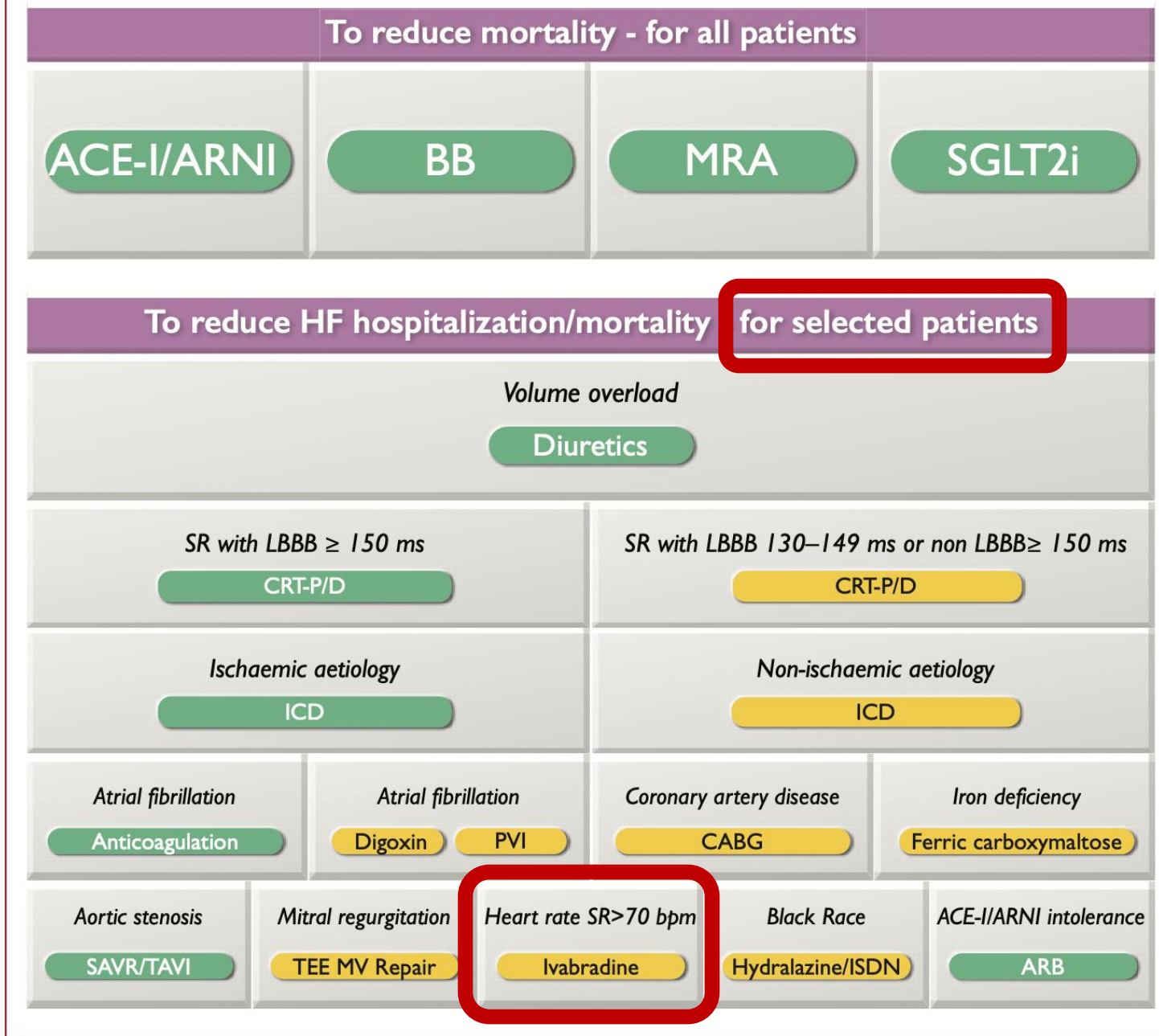
ESTABLISHED IN 1812 SEPTEMBER 11, 2014 VOL. 371 NO. 11

Angiotensin–Neprilysin Inhibition versus Enalapril in Heart Failure

Characteristic	LCZ696 (N=4187)	Enalapril (N=4212)
Treatments at randomization — no. (%)		
Diuretic	3363 (80.3)	3375 (80.1)
Digitalis	1223 (29.2)	1316 (31.2)
Beta-blocker	3899 (93.1)	3912 (92.9)
Mineralocorticoid antagonist	2271 (54.2)	2400 (57.0)
Implantable cardioverter–defibrillator	623 (14.9)	620 (14.7)
Cardiac resynchronization therapy	292 (7.0)	282 (6.7)



Management of HFrEF



Conclusión

- Debemos iniciar e intentar titular hasta dosis máximas los BB antes de comenzar Ivabradina.
- Esta recomendada para un grupo seleccionado de pacientes.
- Existe un GAP en la evidencia debido a como ha ido evolucionando el TM en IC.

Muchas gracias.