Q: When should we consider SGLT-2 inhibitors in patients with acute decompensated heart failure?

A: Sodium-glucose cotransporter 2 (SGLT-2) inhibitors should be started as early as possible in patients hospitalized with acute decompensated heart failure who do not have clear contraindications to them, and continued after discharge (Figure 1). These medications are well tolerated, can aid in decongestion without worsening renal function, and have multiple cardiovascular benefits.

Introduced in 2012, SGLT-2 inhibitors were developed to treat type 2 diabetes by reducing reabsorption of glucose from the renal filtrate, but they have since been found to have multiple cardiovascular benefits beyond glucose-lowering, which may be attributed to their natriuretic and osmotic diuretic effects and other metabolic effects. Of note, they lower N-terminal pro-B-type natriuretic peptide levels, which may be a key determinant of improved clinical outcomes regardless of left ventricular ejection fraction.

**BENEFITS OF STARTING EARLY**

Acute decompensated heart failure is one of the leading reasons for hospital admissions worldwide and is associated with considerable morbidity and mortality. As outlined below and in Table 1, studies have suggested that patients hospitalized for acute decompensated heart failure could tolerate SGLT-2 inhibitors and derive cardiac benefit from them, especially when these drugs were started early. While most of the patients in these trials had reduced left ventricular ejection fraction, the benefits were consistent across all left-ventricular-ejection-fraction groups.

The **EMPA-RESPONSE-AHF trial** (Effects of Empagliflozin on Clinical Outcomes in Patients With Acute Decompensated Heart Failure), with 79 patients, found patients who were randomized to empagliflozin within 24 hours of admission had a significant reduction in the composite outcome of worsening heart failure, rehospitalization for heart failure, or death at 60 days compared with placebo.

The **EMPULSE trial** (Empagliflozin in Patients Hospitalized With Acute Heart Failure Who Have Been Stabilized) found that patients who were randomized to receive empagliflozin 10 mg daily within 5 days of admission had a significant reduction in the combined primary end point, ie, a hierarchical composite of death from any cause, number of heart failure events, and time to first heart failure event, or a 5-point or greater difference in change from baseline in the Kansas City Cardiomyopathy Questionnaire Total Symptom Score at 90 days compared with placebo.

The **DELIVER trial** (Dapagliflozin Evaluation to Improve the Lives of Patients With Preserved Ejection Fraction Heart Failure), in a prespecified analysis of 654 (10.4%) of the trial patients who were randomized to receive dapagliflozin or placebo while hospitalized for heart failure or within 30 days of hospital discharge, demonstrated a reduced risk of worsening heart failure or cardiovascular death. The investigators calculated that the number needed to treat with dapagliflozin to prevent 1 primary outcome event was 28 patient-years in recently hospitalized patients and 65 patient-years in patients not recently hospitalized.

The **SOLOIST-WHF trial** (Effect of Sotagliflozin on Cardiovascular Events in Patients With Type 2 Diabetes...
**Figure 1.** Proposed algorithm for initiating sodium-glucose cotransporter 2 inhibitors in acute decompensated heart failure.

1. **Patient hospitalized with acute decompen-sated heart failure**
   - Assess volume status, blood pressure, and renal function
   - **Hypotension (SBP < 90 mm Hg)**
   - **Acute kidney injury or eGFR < 20–25 mL/min/1.73 m²**
   - **NT-proBNP < 300 pg/mL**
   - **Dehydrating illness or clear contraindications**

   - **Yes**
     - Do not initiate SGLT-2 inhibitor
   - **No**
     - **On an SGLT-2 inhibitor before admission?**
       - **Yes**
         - Start an SGLT-2 inhibitor at heart failure study dose:
           - Empagliflozin 10–25 mg once daily
           - Dapagliflozin 10 mg once daily
           - Sotagliflozin 200–400 mg once daily
       - Follow up in clinic in 2–4 weeks with repeat renal function panel
       - **At baseline eGFR or < 30% reduction?**
         - **No**
           - Hold SGLT-2 inhibitor, assess alternative causes of worsening nephropathy, and treat if present
         - **Yes**
           - Continue or resume SGLT-2 inhibitor
       - **Yes**
         - Continue SGLT-2 inhibitor
   - **No**
     - On an SGLT-2 inhibitor before admission?
       - **Yes**
         - Continue SGLT-2 inhibitor
       - **No**
         - Hold SGLT-2 inhibitor, assess alternative causes of worsening nephropathy, and treat if present

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*Dapagliflozin: No dosage adjustment for eGFR ≥ 25 mL/min/1.73 m². Manufacturer labeling does not recommend initiation of therapy at eGFR < 25 mL/min/1.73 m². Sotagliflozin is not indicated for patients with eGFR < 25 mL/min/1.73 m². For heart failure, empagliflozin is not indicated for eGFR < 20 mL/min/1.73 m². For type 2 diabetes mellitus, empagliflozin is not indicated for eGFR < 30 mL/min/1.73 m².

1. Direct evidence on the effects of canagliflozin and ertugliflozin on heart failure outcomes is available only in patients with type 2 diabetes mellitus. It remains to be determined if they have similar effects in patients without type 2 diabetes.

- eGFR = estimated glomerular filtration rate; NT-proBNP = N-terminal pro-B-type natriuretic peptide; SBP = systolic blood pressure; SGLT-2 = sodium-glucose cotransporter 2
BADWAN AND COLLEAGUES

Post Worsening Heart Failure), in a prespecified analysis based on timing of the first dose of the SGLT-1/2 inhibitor sotagliflozin, found the degree of benefit in the primary end point (the total number of deaths from cardiovascular causes and hospitalizations and urgent visits for heart failure) was similar regardless of whether the drug was started during the admission (48.8% of the overall group) or within 3 days after discharge. Similarly, a post hoc analysis of this trial demonstrated that starting sotagliflozin before discharge in patients with type 2 diabetes hospitalized for acute decompensated heart failure significantly decreased cardiovascular deaths and heart failure events through 30 and 90 days after discharge. However, no trials to date have directly compared SGLT-2 inhibitors with combined SGLT-1/2 inhibitors.

Another advantage of starting these medications while the patient is in the hospital is the opportunity to address medication reconciliation and potential barriers to adherence, which we usually do on discharge.

SGLT-2 INHIBITORS HELP REMOVE FLUID

Congestion is thought to be the primary reason patients are hospitalized with acute decompensated heart failure. Excreting more sodium early during decongestive...
SGLT-2 INHIBITORS IN ACUTE HEART FAILURE

therapy is strongly associated with better postdischarge outcomes, and sodium excretion is a better prognostic indicator than urine output, net fluid balance, or weight change.14

A concern about starting SGLT-2 inhibitors as an add-on therapy (in addition to loop diuretics) is the potential for excessively rapid intravascular volume removal and renal injury. Nevertheless, empagliflozin was shown to achieve decongestion without worsening renal function in patients with type 2 diabetes hospitalized for acute decompensated heart failure.15 This might be explained by the natriuresis and osmotic diuresis caused by SGLT-2 inhibition, leading to reduced plasma volume and, subsequently, reduced preload.2 Furthermore, SGLT-2 inhibitors may act synergistically with loop diuretics for decongestion and have other beneficial metabolic effects.16

The 2023 DAPA-RESIST trial (Dapagliflozin Versus Thiazide Diuretic in Patients With Heart Failure and Diuretic Resistance)16 showed that dapagliflozin 10 mg daily was as effective as metolazone 5 to 10 mg daily in alleviating congestion in patients with acute decompensated heart failure with resistance to loop diuretics. Although patients in the dapagliflozin group received a higher total amount of furosemide, they encountered fewer biochemical disturbances than those in the metolazone group.

■ PATIENTS ALREADY ON SGLT-2 INHIBITORS

Although SGLT-2 inhibitors lowered blood pressure only slightly by themselves in large heart failure clinical trials, it is important to consider volume status, especially in those receiving other heart failure agents such as angiotensin receptor-neprilysin inhibitors and loop diuretics, which can increase the risk of orthostasis and falling after the patient goes home. Nevertheless, unless patients have a clear contraindication such as severe hypotension (systolic blood pressure < 90 mm Hg), shock, acute kidney injury, estimated glomerular filtration rate (eGFR) less than 20 or 25 mL/min/1.73 m² (depending on the specific agent), or diabetic ketoacidosis (including euglycemic ketoacidosis), those who are already receiving SGLT-2 inhibitors and are admitted with acute decompensated heart failure would benefit from continuing this therapy.3,7–9,12

Of note, evidence of the beneficial effects of canagliflozin and ertugliflozin on heart failure outcomes is available only in patients with type 2 diabetes, and there is even less evidence currently for outcomes with bexagliflozin. It remains to be determined if these drugs have similar effects in patients without type 2 diabetes.

■ PATIENTS WITH RENAL DYSFUNCTION

While SGLT-2 inhibitors have been shown to slow the progression of chronic kidney disease, they generally are not indicated for patients whose eGFR is less than 20 or 25 mL/min/1.73 m² (depending on the particular SGLT-2 inhibitor). A reason for caution in this situation is that SGLT-2 inhibitors cause a temporary drop in eGFR and persistent reductions in plasma volume. However, this initial nadir in eGFR early after starting SGLT-2 inhibitors partially reverses over the subsequent 6 to 8 weeks. Further, continuation is associated with improved renal and cardiovascular outcomes, and new studies suggest that SGLT-2 inhibitors should not be discontinued unless the eGFR decreases by more than 30%.17

■ DIABETIC KETOACIDOSIS AND INFECTIONS

SGLT-2 inhibitors are not approved for patients with type 1 diabetes, since their use may promote hypoglycemia in patients without sufficient insulin secretagogue activity, a situation also posing a risk for euglycemic diabetic ketoacidosis.18 Also, prescribers have been cautioned about genital mycotic infections and the rare severe complication of Fournier gangrene in patients at high risk (eg, older men and those with diabetes, alcohol use disorder, obesity, or immunocompromising conditions).

Fortunately, none of the previously mentioned trials found a higher risk of these complications in patients started on SGLT-2 inhibitors during admissions for acute decompensated heart failure.

■ THE BOTTOM LINE

In patients with acute decompensated heart failure without clear contraindications to these agents, an SGLT-2 inhibitor should be started as early as possible or continued if the patient is already receiving one. As an adjuvant therapy for decongestion, they have been shown to be well tolerated and can aid in decongestion without worsening renal function. Their use early during hospitalization and their continuation after discharge may translate into long-term clinical benefits.

■ DISCLOSURES

Dr. Tang has disclosed consulting for Boston Scientific, CardiaTec Biosciences, Cardiol Therapeutics, Genomics, Intellia Therapeutics, Kiniksa Pharmaceuticals, preCARDIA, Relypsa, Renovacor, Sequana Medical, WhiteSwell, and Zehna Therapeutics; board examination writing/approval committee for American Board of Internal Medicine; and editorialship/authorship for SpringerNature. The other authors report no relevant financial relationships which, in the context of their contributions, could be perceived as a potential conflict of interest.
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