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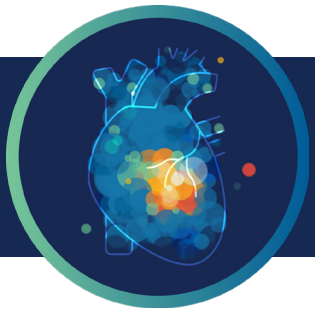
EXPERT INSIGHTS: Q&A WITH DR. HANY RAGY



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Access the full publication:
Beta-Blockers after Myocardial Infarction and Preserved Ejection Fraction

How would you summarize the findings of this trial to a patient in your clinic that had an acute myocardial infarction 3 months ago, was treated with coronary stenting, discharged with an echocardiogram confirming preserved left ventricular systolic function, and had b een prescribed bisoprolol 5 mg once daily as part of their cocktail of secondary preventative medications?

I would tell the patient that there is new data that suggests their beta blocker pill may not be very necessary, and that if they would like to take less pills, that may be the first to stop. I would explain that this is because they are deemed low risk and have good cardiac function. I would explain that neither continuing nor stopping beta blockers will harm their heart.

Will this trial change your overall clinical practice when treating "low risk" acute heart attack patients with preserved left ventricular systolic function?

I was mainly prescribing beta blockers in patients post large anterior myocardial infarctions or with other indications including symptomatic tachycardia. The results of the REDUCE-AMI trial will have little impact on my own practice.

What are your thoughts on prospective registry-based clinical trials? Do they have a place in generating real world evidence compared to the robust validation characteristic of a well conducted placebo-controlled randomized controlled clinical trial?

Registry-based trials like the thrombus aspiration trials for instance, have a place in generating real world evidence, I accept that.

This was an open-label study with no placebo control, significant crossover rate (14% in the no beta blocker arm), and hard clinical endpoints were not independently adjudicated by a clinical events committee. Is there anything you would change to ensure a more scientifically robust study design?

This would make me ask - in patients without contraindications to beta blocker therapy, what is the harm seen from prescribing beta blockers after an acute heart attack? Probably little or no harm is likely to happen. This is not comparable, for example, to proving you do not need aspirin as an antiplatelet agent and therefore preventing gastric bleeds. In general, this is a well performed trial that essentially will have little clinical impact.

Beta blockers are but a single component of the current secondary prevention armamentarium we have at our disposal to protect patients from recurrent adverse cardiovascular events. What are you most excited about in terms of future therapies in this arena, which are currently in clinical development, and why?

I am excited about achieving maximal lipid-modifying therapy post myocardial infarction using the new drugs early on, like PCSK9 inhibitors. I believe the early data from the PACMAN-AMI trial (doi:10.1001/jama.2022.5218) and other studies like it are very promising, and worthy of future research.