

Guidelines Are Meant to Guide, But They Are Not Absolute

To the Editor:

Recently, Cholack et al¹ wrote about calcium channel blocker (CCB) use in heart failure with reduced ejection fraction (HFrEF) and concomitant atrial fibrillation. They reported CCB use in 7.3% of HFrEF/atrial fibrillation patients despite CCBs being “contraindicated” in most heart failure guidelines. Beyond the repeated contraindications comments in their paper, I believe several concerns about CCBs in heart failure should be noted.

Guidelines are only guidelines. The above, as others, do not/are not meant to apply to every clinically encountered scenario.

1. In some patients, heart failure is a consequence of rapid ventricular rates from atrial fibrillation (a tachycardia-induced cardiomyopathy—noted briefly only in their Limitations Section). Herein, ventricular rate reduction by whatever means necessary can reverse the cardiomyopathy/heart failure. In my >4 decades experience, most such patients require multiple concomitant atrioventricular (AV) nodal blockers, including CCBs, to achieve this goal. The high use of combined blockers in the authors’ patients (89.7% of the 7.3%) suggests that this could have been a factor. Unfortunately, the causes of heart failure in this report were not stated, nor were they correlated with CCB use. (Moreover, confusing in their report, their Table lists 89.7% of their CCB-using patients as taking multiple AV nodal blockers. Yet, the same table shows that 25 (86.2%) were taking a beta-blocker with their CCB and 20.7% were taking digoxin with their CCB. Because either of these combinations represents “multiple AV nodal blockers,” I am uncertain as to how the authors arrived at the number 89.7% overall.)
2. Hypertension was one predictor of CCB use. This is of relevance given the fact that the study patients’ average

age was >70 years. In older patients, CCBs are often necessary for antihypertensive efficacy, and hypertension control is an important component in heart failure therapy. Thus, while guideline contraindicated, herein, CCBs may be clinically necessary and not represent inappropriate usage.

3. Not considered in the heart failure guidelines is a report by Hansen et al,² in which 103 acute myocardial infarction patients with pulmonary congestion, an S3 gallop, or shock required treatment with a diuretic and an angiotensin-converting enzyme inhibitor and could not tolerate/were not given a beta-blocker. Verapamil vs placebo was added instead. The 3-month major cardiac event rate on placebo was 35%, verapamil, 14% ($P = .015$). Thus, verapamil (absent a beta-blocker) may be useful in heart failure when combined with renin-angiotensin inhibition—at least in post-myocardial infarction patients. Unfortunately, neither heart failure etiology nor coronary disease were listed in the Table of Cholack et al’s¹ paper.

Thus, guidelines should guide, but contraindications are not absolute, and require interpretation in each clinical scenario—a point not noted in the paper.

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