Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/clinical-practice/cardiology/heart-failure-treatment-trends-insights-from-frame-hf-and-iris-hf/57080/

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Treatment Patterns and MRA Use in Patients with HFmrEF/HFpEF: Insights From FRAME-HF and IRIS HF

Announcer:
Welcome to DataPulse from ESC Heart Failure 2026 on ReachMD. This activity, titled "Treatment Patterns and MRA Use in Patients with HFmrEF/HFpEF: Insights From FRAME-HF and IRIS HF" is provided by **Medcon International**.

Dr. Ambrosy:
Hello from ESC Heart Failure here in Barcelona. I'm Dr. Andrew Ambrosy, and today I'm breaking down data that were presented this weekend from the FRAME-HF and IRIS-HF studies.

Let me start with FRAME-HF. Mineralocorticoid receptor antagonists, or MRAs, are a cornerstone of guideline-directed medical therapy for heart failure, but historically they have been underused, in part because of concerns about hyperkalemia. With the FDA approval of finerenone for HFmrEF and HFpEF in July of 2025 following the FINEARTS-HF trial, it's a timely moment to ask: where do we stand with MRA use in real-world practice?

FRAME-HF examined temporal trends in predominantly steroidal MRA use within a large, diverse community-based cohort of more than 82,000 adults with heart failure and known ejection fraction followed from 2014 through 2024. The cohort was racially and ethnically diverse, with roughly 40% nonwhite patients, and the LVEF distribution mirrored what we see in clinical practice: about 29% HFrEF, 13% HFmrEF, and 58% HFpEF.

The headline finding: overall MRA use rose from 23% in 2014 to 39% in 2024, while the proportion of patients ineligible for MRAs due to hyperkalemia, low eGFR, or kidney replacement therapy remained stable at around 15%. The greatest absolute gains were seen in HFrEF and HFmrEF, with more modest gains in HFpEF. Even so, MRAs remain substantially underutilized compared with other GDMT classes such as RAS inhibitors and beta-blockers.

The take-home message is that we've made real progress but there's a clear opportunity to do better, particularly in HFpEF, where the nonsteroidal MRA finerenone may now help close the gap.

Turning to IRIS-HF, this was a contemporary cross-sectional survey of 3,000 patients with HFmrEF or HFpEF managed in 51 ambulatory cardiology practices across Germany, drawing on records from 2022 through 2024. About one-third of patients had HFmrEF, and two-thirds had HFpEF.

As expected, the HFmrEF group looked clinically more like HFrEF: more men, more coronary artery disease, and a younger age of diagnosis; while disease severity judged by NYHA class, natriuretic peptides, and recent heart failure hospitalization was similar between the 2 groups.

Despite that similar severity, treatment patterns differed meaningfully. Use of steroidal MRAs, ARNI, and SGL2 inhibitors was consistently more frequent in HFmrEF than in HFpEF. And in multivariable analysis, predictors of SGLT2 inhibitor use included diabetic status, as reflected by hemoglobin A1c, younger age, and concomitant ARNI therapy.

Taken together, FRAME-HF and IRIS-HF tell a consistent story across 2 health systems on 2 continents. GDMT uptake is moving in the

right direction, but patients with preserved ejection fraction continue to receive less intensive therapy than their counterparts with reduced or mildly reduced ejection fraction, even when disease severity is comparable. Closing that implementation gap, especially with newer agents like nonsteroidal MRAs and SGL2 inhibitors, is where I think the next chapter of heart-failure care will be written.

From ESC Heart Failure 2026, I'm Dr. Andrew Ambrosy, and thank you for listening.

Announcer:
Thank you for listening to this DataPulse from ESC Heart Failure 2026 on ReachMD. This activity is provided by **Medcon International**. Thank you for listening.