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Letter to the Editor

# Beta-blocker therapy in cocaine-associated heart failure: Attempting to mitigate the risk

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*Dear Editor,*

I appreciated reading Lopez and colleagues' recent original research [1]. Aside from the considerations provided by Barison and colleagues, therein lies the legal risk of the potential drug-drug interaction between cocaine and beta-blockers [2]. If clinicians are uncomfortable using beta-blockers in patients who actively use cocaine, a subset of patients with heart failure with reduced ejection fraction (HFrEF) may be candidates for using only a combination of an ACE-I, plus an aldosterone receptor antagonist (ARA), such as spironolactone. In the RALES study, patients receiving an ACE-I, who had NYHA Class III-IV HF symptoms, and an EF ≤ 35% were randomly assigned spironolactone 25 mg daily or placebo. Compared to placebo plus an ACE-I, the combination of an ARA plus an ACE-I significantly reduced the primary endpoint - risk of death from all causes (NNT = 9); only approximately 10% of patients in the study received a beta-blocker, and the primary outcome was significantly less with the combination of an ARA plus ACE-I [3].

Therefore, clinicians may consider the combination of an ACE-I plus an ARA in HFrEF patients who actively use cocaine, in place of a beta-blocker. This recommendation should be considered only in select patients (i.e. NYHA Class III-IV HF symptoms and an EF ≤ 35%) [3]. Although robust studies are needed to corroborate the potential benefits of using an ARA plus an ACE-I, without a beta blocker in patients with HFrEF who use cocaine, this may be a reasonable option in scenarios where clinicians are uncomfortable initiating a beta-blocker, for fear of exacerbating adverse cardiovascular outcomes.

## Conflict of interest statement

The author reports no conflicts of interest related to this correspondence. No funding was involved in the preparation of this scholarship.

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