ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure 2012

The Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2012 of the European Society of Cardiology. Developed in collaboration with the Heart Failure Association (HFA) of the ESC

Authors/Task Force Members: John J.V. McMurray (Chairperson) (UK)*, Stamatis Adamopoulos (Greece), Stefan D. Anker (Germany), Angelo Auricchio (Switzerland), Michael Böhm (Germany), Kenneth Dickstein (Norway), Volkmar Falk (Switzerland), Gerasimos Filippatos (Greece), Cândida Fonseca (Portugal), Miguel Angel Gomez-Sanchez (Spain), Tiny Jaarsma (Sweden), Lars Køber (Denmark), Gregory Y.H. Lip (UK), Aldo Pietro Maggioni (Italy), Alexander Parkhomenko (Ukraine), Burkert M. Pieske (Austria), Bogdan A. Popescu (Romania), Per K. Rønnevik (Norway), Frans H. Rutten (The Netherlands), Juerg Schwitter (Switzerland), Petar Seferovic (Serbia), Janina Stepinska (Poland), Pedro T. Trindade (Switzerland), Adriaan A. Voors (The Netherlands), Faiez Zannad (France), Andreas Zeiher (Germany).

ESC Committee for Practice Guidelines (CPG): Jeroen J. Bax (CPG Chairperson) (The Netherlands), Helmut Baumgartner (Germany), Claudio Ceconi (Italy), Veronica Dean (France), Christi Deaton (UK), Robert Fagard (Belgium), Christian Funck-Brentano (France), David Hasdai (Israel), Arno Hoes (The Netherlands), Paulus Kirchhof (Germany/UK), Juhani Knuuti (Finland), Philippe Kolh (Belgium), Theresa McDonagh (UK), Cyril Moulin (France), Bogdan A. Popescu (Romania), Željko Reiner (Croatia), Udo Sechtem (Germany), Per Anton Sirnes (Norway), Michal Tendera (Poland), Adam Torbicki (Poland), Alec Vahanian (France), Stephan Windecker (Switzerland).

Document Reviewers: Theresa McDonagh (CPG Co-Review Coordinator) (UK), Udo Sechtem (CPG Co-Review Coordinator) (Germany), Luis Almenar Bonet (Spain), Panayiotis Avraamides (Cyprus), Hisham A. Ben Lamin (Libya), Michele Brignole (Italy), Antonio Coca (Spain), Peter Cowburn (UK), Henry Dargie (UK), Perry Elliott (UK), Frank Arnold Flachskampf (Sweden), Guido Francesco Guida (Italy), Suzanna Hardman (UK), Bernard Lung
The disclosure forms of the authors and reviewers are available on the ESC website www.escardio.org/guidelines
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Abbreviations and acronyms

ACE angiotensin-converting enzyme
ACHD adult congenital heart disease
AF atrial fibrillation
AF-CHF Atrial Fibrillation and Congestive Heart Failure
AHF acute heart failure
AIRE Acute Infarction Ramipril Efficacy
ARB angiotensin receptor blocker
ARR absolute risk reduction
ATLAS Assessment of Treatment with Lisinopril And Survival
AV atroventricular
AVP arginine vasopressin
BEAUTIFUL MorBidity-mortality EvAlUaTion of the I f inhibitor ivabradine in patients with coronary disease and left ventricUlar dysfunction
BEST Beta-Blocker Evaluation of Survival Trial
BivAD bi-ventricular assist device
BNP B-type natriuretic peptide
b.p.m. beats per minute
BTC bridge to candidacy
BTD bridge to decision
BTR bridge to recovery
BTT bridge to transplantation
CABG coronary artery bypass graft
CAD coronary artery disease
CARE-HF Cardiac Resynchronization in Heart Failure Study
CCB calcium-channel blocker
1. Preamble

Guidelines summarize and evaluate all available evidence at the time of the writing process, on a particular issue with the aim of assisting physicians in selecting the best management strategies for an individual patient, with a given condition, taking into account the impact on outcome, as well as the risk–benefit ratio of particular diagnostic or therapeutic means. Guidelines are no substitutes, but are complements, for textbooks and cover the European Society of Cardiology (ESC) Core Curriculum topics. Guidelines and recommendations should help physicians to make decisions in their daily practice. However, the final decisions concerning an individual patient must be made by the responsible physician(s).

A large number of Guidelines have been issued in recent years by the ESC as well as by other societies and organizations. Because of the impact on clinical practice, quality criteria for the development of guidelines have been established in order to make all decisions transparent to the user. The recommendations for formulating and issuing ESC Guidelines can be found on the ESC website (http://www.escardio.org/guidelines-surveys/esc-guidelines/about/Pages/rules-writing.aspx). ESC Guidelines represent the official position of the ESC on a given topic and are regularly updated.

Members of this Task Force were selected by the ESC to represent professionals involved with the medical care of patients with this pathology. Selected experts in the field undertook a comprehensive review of the published evidence for diagnosis, management, and/or prevention of a given condition according to ESC Committee for Practice Guidelines (CPG) policy. A critical evaluation of diagnostic and therapeutic procedures was performed including assessment of the risk–benefit ratio. Estimates of expected health outcomes for larger populations were included, where data exist. The level of evidence and the strength of recommendation of particular treatment options were weighed and graded according to pre-defined scales, as outlined in Tables A and B.

The experts of the writing and reviewing panels filled in declarations of interest forms of all relationships which might be perceived as real or potential sources of conflicts of interest. These forms were compiled into one file and can be found on the ESC website (http://www.escardio.org/guidelines). Any changes in declarations of interest that arise during the writing period must be notified to the ESC and updated. The Task Force received its entire financial support from the ESC without any involvement from the healthcare industry.

The ESC CPG supervises and coordinates the preparation of new Guidelines produced by Task Forces, expert groups, or consensus panels. The Committee is also responsible for the endorsement process of these Guidelines. The ESC Guidelines undergo extensive review by the CPG and external experts. After appropriate revisions, it is approved by all the experts involved in the Task

Table A  Classes of recommendations

<table>
<thead>
<tr>
<th>Classes of recommendations</th>
<th>Definition</th>
<th>Suggested wording to use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td>Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.</td>
<td>Is recommended/is indicated</td>
</tr>
<tr>
<td>Class II</td>
<td>Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.</td>
<td>Should be considered</td>
</tr>
<tr>
<td>Class IIa</td>
<td>Weight of evidence/opinion is in favour of usefulness/efficacy.</td>
<td>Should be considered</td>
</tr>
<tr>
<td>Class IIb</td>
<td>Usefulness/efficacy is less well established by evidence/opinion.</td>
<td>May be considered</td>
</tr>
<tr>
<td>Class III</td>
<td>Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.</td>
<td>Is not recommended</td>
</tr>
</tbody>
</table>

Table B  Levels of evidence

<table>
<thead>
<tr>
<th>Level of evidence A</th>
<th>Data derived from multiple randomized clinical trials or meta-analyses.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of evidence B</td>
<td>Data derived from a single randomized clinical trial or large non-randomized studies.</td>
</tr>
<tr>
<td>Level of evidence C</td>
<td>Consensus of opinion of the experts and/or small studies, retrospective studies, registries.</td>
</tr>
</tbody>
</table>
3. Definition and diagnosis

3.1 Definition of heart failure

Heart failure can be defined as an abnormality of cardiac structure or function leading to failure of the heart to deliver oxygen at a rate commensurate with the requirements of the metabolizing tissues, despite normal filling pressures (or only at the expense of increased filling pressures).1 For the purposes of these guidelines, HF is defined, clinically, as a syndrome in which patients have typical symptoms (e.g. breathlessness, ankle swelling, and fatigue) and signs (e.g. elevated jugular venous pressure, pulmonary crackles, and displaced apex beat) resulting from an abnormality of cardiac structure or function. The diagnosis of HF can be difficult (see Section 3.6). Many of the symptoms of HF are non-discriminating and, therefore, of limited diagnostic value.2–6 Many of the signs of HF result from sodium and water retention and resolve quickly with diuretic therapy, i.e. may be absent in patients receiving such treatment. Demonstration of an underlying cardiac cause is therefore central to the diagnosis of HF (see Section 3.6). This is usually myocardial disease causing systolic ventricular dysfunction. However, abnormalities of ventricular diastolic function or of the valves, pericardium, endocardium, heart rhythm, and conduction can also cause HF (and more than one abnormality can be present) (see Section 3.5). Identification of the underlying cardiac problem is also crucial for therapeutic reasons, as the precise pathology determines the specific treatment used (e.g. valve surgery for valvular disease, specific pharmacological therapy for LV systolic dysfunction, etc.).

3.2 Terminology related to left ventricular ejection fraction

The main terminology used to describe HF is historical and is based on measurement of LV ejection fraction (EF). Mathematically, EF is the stroke volume (which is the end-diastolic volume minus the end-systolic volume) divided by the end-diastolic volume. In patients with reduced contraction and emptying of the left ventricle (i.e. systolic dysfunction), stroke volume is maintained by an increase in end-diastolic volume (because the left ventricle dilates), i.e. the heart ejects a smaller fraction of a larger volume. The more severe the systolic dysfunction, the more the EF is reduced from normal and, generally, the greater the end-diastolic and end-systolic volumes.

The EF is considered important in HF, not only because of its prognostic importance (the lower the EF the poorer the survival) but also because most clinical trials selected patients based upon EF (usually measured using a radionuclide technique or echocardiography). The major trials in patients with HF and a reduced EF (HF-REF), or ‘systolic HF’, mainly enrolled patients with an EF ≤35%, and it is only in these patients that effective therapies have been demonstrated to date.

Other, more recent, trials enrolled patients with HF and an EF >40–45% and no other causal cardiac abnormality (such as valvular or pericardial disease). Some of these patients did not have an entirely normal EF (generally considered to be >50%)

2. Introduction

The aim of this document is to provide practical, evidence-based guidelines for the diagnosis and treatment of heart failure (HF). The principal changes from the 2008 guidelines1 relate to:

(i) an expansion of the indication for mineralocorticoid (aldosterone) receptor antagonists (MRAs);
(ii) a new indication for the sinus node inhibitor ivabradine;
(iii) an expanded indication for cardiac resynchronization therapy (CRT);
(iv) new information on the role of coronary revascularization in HF;
(v) recognition of the growing use of ventricular assist devices; and
(vi) the emergence of transcatheter valve interventions.

There are also changes to the structure and format of the guidelines. Therapeutic recommendations now state the treatment effect supported by the class and level of recommendation in tabular format; in the case of chronic heart failure due to left ventricular (LV) systolic dysfunction, the recommendations focus on mortality and morbidity outcomes. Detailed summaries of the key evidence supporting generally recommended treatments have been provided. Practical guidance is provided for the use of the more important disease-modifying drugs and diuretics. When possible, other relevant guidelines, consensus statements, and position papers have been cited to avoid unduly lengthy text. All tables should be read in conjunction with their accompanying text and not read in isolation.
Underlying cardiac abnormality is. Patients who have had HF for having asymptomatic LV systolic dysfunction (or whatever the never exhibited the typical signs or symptoms of HF is described as asymptomatic by treatment. In these guidelines, a patient who has served or reduced EF over preserved or reduced ‘systolic normal EF (see Section 4.1.1), hence the preference for stating pre-

may show abnormalities in patients with a preserved or even

and operator. Other, more sensitive measures of systolic function depend on the imaging technique employed, method of analysis,

is generally accepted as the likely cause of HF in these patients (hence the term ‘idiopathic HF’).7,8

It is important to note that EF values and normal ranges are dependent on the imaging technique employed, method of analysis, and operator. Other, more sensitive measures of systolic function may show abnormalities in patients with a preserved or even normal EF (see Section 4.1.1), hence the preference for stating preserved or reduced EF over preserved or reduced ‘systolic function’.5,10

HF = heart failure; HF-PEF = heart failure with ‘preserved’ ejection fraction; HF-REF = heart failure and a reduced ejection fraction; LA = left atrial; LV = left ventricular; LVEF = left ventricular ejection fraction.

*Signs may not be present in the early stages of HF (especially in HF-PEF) and in patients treated with diuretics (see Section 3.6).

but also did not have a major reduction in systolic function either. Because of this, the term HF with ‘preserved’ EF (HF-PEF) was created to describe these patients. Patients with an EF in the range 35–50% therefore represent a ‘grey area’ and most probably have primarily mild systolic dysfunction. The diagnosis of HF-PEF is more difficult than the diagnosis of HF-REF because it is largely one of exclusion, i.e. potential non-cardiac causes of the patient’s symptoms (such as anaemia or chronic lung disease) must first be discounted (Table 1).7,8 Usually these patients do not have a dilated heart and many have an increase in LV wall thickness and increased left atrial (LA) size. Most have evidence of diastolic dysfunction (see Section 4.1.2), which is generally accepted as the likely cause of HF in these patients (hence the term ‘idiopathic HF’).7,8

It is important to note, however, that symptom severity correlates poorly with ventricular function, and that although there is a clear relationship between severity of symptoms and survival, patients with mild symptoms may still have a relatively high absolute risk of hospitalization and death.11–13 Symptoms can also change rapidly; for example, a stable patient with mild symptoms can become suddenly breathless at rest with the onset of an arrhythmia, and an acutely unwell patient with pulmonary oedema and NYHA class IV symptoms may improve rapidly with the administration of a diuretic. Deterioration in symptoms indicates heightened risk of hospitalization and death, and is an indication to seek prompt medical attention and treatment. Obviously, improvement in symptoms (preferably to the point of the patient being to reduce morbidity, including hospital admissions, and mortality).

The Killip classification may be used to describe the severity of the patient’s condition in the acute setting after myocardial infarction.14

### Table I Diagnosis of heart failure

<table>
<thead>
<tr>
<th>The diagnosis of HF-REF requires three conditions to be satisfied:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Symptoms typical of HF</td>
</tr>
<tr>
<td>2. Signs typical of HF</td>
</tr>
<tr>
<td>3. Reduced LVEF</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>The diagnosis of HF-PEF requires four conditions to be satisfied:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Symptoms typical of HF</td>
</tr>
<tr>
<td>2. Signs typical of HF</td>
</tr>
<tr>
<td>3. Normal or only mildly reduced LVEF and LV not dilated</td>
</tr>
<tr>
<td>4. Relevant structural heart disease (LV hypertrophy/LA enlargement) and/or diastolic dysfunction (see Section 4.1.2)</td>
</tr>
</tbody>
</table>

HF = heart failure; HF-PEF = heart failure with ‘preserved’ ejection fraction; HF-REF = heart failure and a reduced ejection fraction; LA = left atrial; LV = left ventricular; LVEF = left ventricular ejection fraction.

*Signs may not be present in the early stages of HF (especially in HF-PEF) and in patients treated with diuretics (see Section 3.6).
### 3.5 Epidemiology, aetiology, pathophysiology, and natural history of heart failure

Approximately 1–2% of the adult population in developed countries has HF, with the prevalence rising to ≥10% among persons 70 years of age or older. There are many causes of HF, and these vary in different parts of the world (Web Table 3). At least half of patients with HF have a low EF (i.e. HF-REF). HF-REF is the best understood type of HF in terms of pathophysiology and treatment, and is the focus of these guidelines. Coronary artery disease (CAD) is the cause of approximately two-thirds of cases of systolic HF, although hypertension and diabetes are probable contributing factors in many cases. There are many other causes of systolic HF (Web Table 3), which include previous viral infection (recognized or unrecognized), alcohol abuse, chemotherapy (e.g. doxorubicin or trastuzumab), and ‘idiopathic’ dilated cardiomyopathy (although the cause is thought to be unknown, some of these cases may have a genetic basis).

HF-PEF seems to have a different epidemiological and aetiological profile from HF-REF. Patients with HF-PEF are older and more often female and obese than those with HF-REF. They are less likely to have coronary heart disease and more likely to have hypertension and atrial fibrillation (AF). Patients with HF-PEF have a better prognosis than those with HF-REF (see below).

In patients with LV systolic dysfunction, the maladaptive changes occurring in surviving myocytes and extracellular matrix after myocardial injury (e.g. myocardial infarction) lead to pathological ‘remodelling’ of the ventricle with dilatation and impaired contractility, one measure of which is a reduced EF. What characterizes untreated systolic dysfunction is progressive worsening of these changes over time, with increasing enlargement of the left ventricle and decline in EF, even though the patient may be symptomless initially. Two mechanisms are thought to account for this progression. The first is occurrence of further events leading to additional myocyte death (e.g. recurrent myocardial infarction). The other is the systemic responses induced by the decline in systolic function, particularly neurohumoral activation.

Two key neurohumoral systems activated in HF are the renin–angiotensin–aldosterone system and sympathetic nervous system. In addition to causing further myocardial injury, these systemic responses have detrimental effects on the blood vessels, kidneys, muscles, bone marrow, lungs, and liver, and create a pathophysiological ‘vicious cycle’, accounting for many of the clinical features of the HF syndrome, including myocardial electrical instability. Interruption of these two key processes is the basis of much of the effective treatment of HF.

Clinically, the aforementioned changes are associated with the development of symptoms and worsening of these over time, leading to diminished quality of life, declining functional capacity, episodes of frank decompensation leading to hospital admission (which is often recurrent and costly to health services), and premature death, usually due to pump failure or a ventricular arrhythmia. The limited cardiac reserve of such patients is also dependent on atrial contraction, synchronized contraction of the left ventricle, and a normal interaction between the right and left ventricles. Intercurrent events affecting any of these (e.g. the development of AF or conduction abnormalities, such as left bundle branch block [LBBB]) or imposing an additional haemodynamic load on the failing heart (e.g. anemia) can lead to acute decompensation.

Before 1990, the modern era of treatment, 60–70% of patients died within 5 years of diagnosis, and admission to hospital with worsening symptoms was frequent and recurrent, leading to an epidemic of hospitalization for HF in many countries. Effective treatment has improved both of these outcomes, with a relative reduction in hospitalization in recent years of 30–50% and smaller but significant decreases in mortality.

### 3.6 Diagnosis of heart failure

#### 3.6.1 Symptoms and signs

The diagnosis of HF can be difficult, especially in the early stages. Although symptoms bring patients to medical attention, many of the symptoms of HF (Table 4) are non-specific and do not, therefore, help discriminate between HF and other problems. Symptoms that are more specific (i.e. orthopnoea and paroxysmal nocturnal dyspnoea) are less common, especially in patients with milder symptoms, and are, therefore, insensitive.

Many of the signs of HF result from sodium and water retention, and are, therefore, also not specific. Peripheral oedema has other causes as well, and is particularly non-specific. Signs resulting from sodium and water retention (e.g. peripheral oedema) resolve quickly with diuretic therapy (i.e. may be absent in patients receiving such treatment, making it more difficult to assess patients already treated in this way). More specific signs, such as elevated jugular venous pressure and displacement of the apical impulse, are harder to detect and, therefore, less reproducible (i.e. agreement between different doctors examining the same patient may be poor).

Symptoms and signs may be particularly difficult to identify and interpret in obese individuals, in the elderly, and in patients with chronic lung disease.

The patient’s medical history is also important. HF is unusual in an individual with no relevant medical history (e.g. a potential cause of cardiac damage), whereas certain features, particularly previous myocardial infarction, greatly increase the likelihood of HF in a

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**Table 2** New York Heart Association functional classification based on severity of symptoms and physical activity

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td>No limitation of physical activity. Ordinary physical activity does not cause undue breathlessness, fatigue, or palpitations.</td>
</tr>
<tr>
<td>Class II</td>
<td>Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in undue breathlessness, fatigue, or palpitations.</td>
</tr>
<tr>
<td>Class III</td>
<td>Marked limitation of physical activity. Comfortable at rest, but less than ordinary physical activity results in undue breathlessness, fatigue, or palpitations.</td>
</tr>
<tr>
<td>Class IV</td>
<td>Unable to carry on any physical activity without discomfort. Symptoms at rest can be present. If any physical activity is undertaken, discomfort is increased.</td>
</tr>
</tbody>
</table>
3.6.2 General diagnostic tests in patients with suspected heart failure

In view of the difficulty in grading the evidence for diagnostic tests, all diagnostic recommendations have been given an arbitrary evidence level of C.

3.6.3 Essential initial investigations: echocardiogram, electrocardiogram, and laboratory tests

The echocardiogram and electrocardiogram (ECG) are the most useful tests in patients with suspected HF. The echocardiogram provides immediate information on chamber volumes, ventricular systolic and diastolic function, wall thickness, and valve function. This information is crucial in determining appropriate treatment (e.g. an ACE inhibitor and beta-blocker for systolic dysfunction or surgery for aortic stenosis). Echocardiography is discussed in detail later (see Section 4). The ECG shows the heart rhythm and electrical conduction, i.e. whether there is sinoatrial disease, atrioventricular (AV) block, or abnormal intraventricular conduction (see Table 5). These findings are also important for decisions about treatment (e.g. rate control and anticoagulation for AF, pacing for bradyarrhythmia, or CRT if the patient has LBBB) (see Section 9.2 on treatment). The ECG may also show evidence of LV hypertrophy or Q waves (indicating loss of viable myocardium), giving a possible clue to the aetiology of HF. HF is very unlikely (likelihood <2%) in patients presenting acutely and with a completely normal ECG. In patients with a non-acute presentation, a normal ECG has a somewhat lower negative predictive value (likelihood 10–14%).

The information provided by these two tests will permit an initial working diagnosis and treatment plan in the majority of patients. Routine biochemical and haematological investigations are also important, partly to determine whether renal–angiotensin–aldosterone blockade can be initiated safely (renal function and potassium) and to exclude anaemia (which can mimic or aggravate HF) and because they provide other, useful information (see Section 3.6.6).

Other tests are generally only required if the diagnosis remains unclear (e.g. if echocardiographic images are suboptimal or if an unusual cardiac cause, or a non-cardiac cause, of the patient’s condition is suspected) or if further evaluation of the underlying cause of the patient’s cardiac problem is indicated (e.g. perfusion imaging or angiography in suspected CAD or endomyocardial biopsy in certain infiltrating diseases of the myocardium). Special tests are discussed in more detail in Sections 4 and 5.

3.6.4 Natriuretic peptides

Because the signs and symptoms of HF are so non-specific, many patients with suspected HF referred for echocardiography are not found to have an important cardiac abnormality. Where the availability of echocardiography is limited, an alternative approach to diagnosis is to measure the blood concentration of a natriuretic peptide, a family of hormones secreted in increased amounts when the heart is diseased or the load on any chamber is increased (e.g. by AF, pulmonary embolism, and some non-cardiovascular conditions, including renal failure). Natriuretic peptide levels also increase with age, but may be reduced in obese patients. A normal natriuretic peptide level in an untreated patient virtually excludes significant cardiac disease, making an echocardiogram unnecessary (investigation for a non-cardiac cause of the patient’s problems is likely to be more productive in such patients). The use of natriuretic peptides as a ‘rule-out’ test in the diagnosis of HF is discussed in detail elsewhere.

Table 4 Symptoms and signs typical of heart failure

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Typical</td>
<td>More specific</td>
</tr>
<tr>
<td>Breathlessness</td>
<td>Elevated jugular venous pressure</td>
</tr>
<tr>
<td>Orthopnoea</td>
<td>Hepatogastic reflux</td>
</tr>
<tr>
<td>Paroxysmal nocturnal dyspnoea</td>
<td>Third heart sound (gallop rhythm)</td>
</tr>
<tr>
<td>Reduced exercise tolerance</td>
<td>Laterally displaced apical impulse</td>
</tr>
<tr>
<td>Fatigue, tiredness, increased time to recovery after exercise</td>
<td>Cardiac murmur</td>
</tr>
<tr>
<td>Ankle swelling</td>
<td>Less specific</td>
</tr>
<tr>
<td>Nocturnal cough</td>
<td>Peripheral oedema (ankle, sacral, scrotal)</td>
</tr>
<tr>
<td>Wheezing</td>
<td>Pulmonary crepitations</td>
</tr>
<tr>
<td>Weight gain (&gt;2 kg/week)</td>
<td>Reduced air entry and dullness to percussion at lung bases (pleural effusion)</td>
</tr>
<tr>
<td>Weight loss (in advanced heart failure)</td>
<td>Tachycardia</td>
</tr>
<tr>
<td>Bloated feeling</td>
<td>Irregular pulse</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Tachypnoea (&gt;16 breaths/min)</td>
</tr>
<tr>
<td>Confusion (especially in the elderly)</td>
<td>Hepatomegaly</td>
</tr>
<tr>
<td>Depression</td>
<td>Ascites</td>
</tr>
<tr>
<td>Palpitations</td>
<td>Tissue wasting (cachexia)</td>
</tr>
<tr>
<td>Syncope</td>
<td></td>
</tr>
</tbody>
</table>
two most commonly used natriuretic peptides, B-type natriuretic peptide (BNP) and N-terminal pro B-type natriuretic peptide (NT-proBNP). The exclusion threshold differs for patients presenting with acute onset or worsening of symptoms (e.g. to a hospital emergency department) and those presenting with a more gradual onset of symptoms.

For patients presenting with acute onset or worsening of symptoms, the optimal exclusion cut-off point is 300 pg/mL.
for NT-proBNP and 100 pg/mL for BNP. In one other study, mid-regional atrial (or A-type) natriuretic peptide (MR-proANP), at a cut-off point of 120 pmol/L, was shown to be non-inferior to these thresholds for BNP and NT-proBNP in the acute setting.51

For patients presenting in a non-acute way, the optimum exclusion cut-off point is 125 pg/mL for NT-proBNP and 35 pg/mL for BNP. The sensitivity and specificity of BNP and NT-proBNP for the diagnosis of HF are lower in non-acute patients. 43– 50

### 3.6.5 Chest X-ray

A chest X-ray is of limited use in the diagnostic work-up of patients with suspected HF. It is probably most useful in identifying an alternative, pulmonary explanation for a patient’s symptoms and signs. It may, however, show pulmonary venous congestion or oedema in a patient with HF. It is important to note that significant LV systolic dysfunction may be present without cardiomegaly on the chest X-ray.

### 3.6.6 Routine laboratory tests

In addition to standard biochemical [sodium, potassium, creatinine/estimated glomerular filtration rate (eGFR)] and haematological tests (haemoglobin, haematocrit, ferritin, leucocytes, and platelets), it is useful to measure thyroid-stimulating hormone (thyrotropin) as thyroid disease can mimic or aggravate HF (Table 6). Blood glucose is also worth measuring as undiagnosed diabetes is common in patients with HF. Liver enzymes may also be abnormal in HF (important if considering amiodarone or warfarin).

As well as a pre-treatment check, biochemical monitoring is important after the initiation of renin–angiotensin system blockers, while the dose is being up-titrated (see Section 7.2) and during longer term follow-up, especially if an intercurrent illness leading to sodium and water loss occurs (e.g. diarrhoea and vomiting) or another drug that affects sodium and water homeostasis or renal function is started or the dose altered (e.g. non-steroidal anti-inflammatory drugs (NSAIDs) or diuretics). Many

### Table 5 Most common abnormalities on the electrocardiogram in heart failure

<table>
<thead>
<tr>
<th>Abnormality</th>
<th>Causes</th>
<th>Clinical implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinus tachycardia</td>
<td>Decompensated HF, anaemia, fever, hyperthyroidism</td>
<td>Clinical assessment</td>
</tr>
<tr>
<td>Sinus bradycardia</td>
<td>Beta-blockade, digoxin, ivabradine, verapamil, diltiazem, Antiarrhythmics</td>
<td>Review drug therapy</td>
</tr>
<tr>
<td>Atrial tachycardia/Flutter/Flutarity</td>
<td>Hyperthyroidism, infection, mitral valve disease</td>
<td>Slow AV conduction, anticoagulation, pharmacological cardioversion, electrical cardioversion, catheter ablation</td>
</tr>
<tr>
<td>Ventricular arrhythmias</td>
<td>Ischaemia, infarction, cardiomyopathy, myocarditis, hypokalaemia, hypomagnesaemia, Digitalis overdose</td>
<td>Laboratory investigation</td>
</tr>
<tr>
<td>Myocardial ischaemia/Infarction</td>
<td>Coronary artery disease</td>
<td>Echocardiography, troponins, perfusion/viability studies, coronary angiography, electrophysiology testing, ICD</td>
</tr>
<tr>
<td>Q waves</td>
<td>Infarction, hypertrophic cardiomyopathy, LBBB, pre-excitation</td>
<td>Echocardiography, perfusion/viability studies, coronary angiography</td>
</tr>
<tr>
<td>LV hypertrophy</td>
<td>Hypertension, aortic valve disease, hypertrophic cardiomyopathy</td>
<td>Echocardiography/CMR</td>
</tr>
<tr>
<td>AV block</td>
<td>Infection, drug toxicity, myocarditis, sarcoidosis, genetic cardiomyopathy, Laminopathy, desminopathy, Lyme disease</td>
<td>Review drug therapy, evaluate for systemic disease; family history/ genetic testing indicated. Pacemaker or ICD may be indicated.</td>
</tr>
<tr>
<td>Low QRS voltage</td>
<td>Obesity, emphysema, pericardial effusion, amyloidosis</td>
<td>Echocardiography/CMR, chest X-ray, for amyloidosis consider further imaging (CMR, 99mTc-DPD scan) and endomyocardial biopsy</td>
</tr>
<tr>
<td>QRS duration ≥120 ms and LBBB morphology</td>
<td>Electrical and mechanical dysynchrony</td>
<td>Echocardiography</td>
</tr>
</tbody>
</table>

AV = atrioventricular; CMR = cardiac magnetic resonance; CRT-P = cardiac resynchronization therapy pacemaker; CRT-D = cardiac resynchronization therapy defibrillator; ECG = electrocardiogram; HF = heart failure; ICD = implantable cardioverter-defibrillator; LBBB = left bundle branch block; LV = left ventricular; 99mTc-DPD = technetium-99m 3,3-diphosphono-1,2-propanodicarboxylic acid.
<table>
<thead>
<tr>
<th>Abnormality</th>
<th>Causes</th>
<th>Clinical implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Renal/kidney impairment</td>
<td>Renal disease, Renal congestion, ACE inhibitor/ARB, MRA, Dehydration, NSAIDs and other nephrotoxic drugs</td>
<td>Calculate eGFR, Consider reducing ACE inhibitor/ARB or MRA dose or postpone dose up-titration, Check potassium and BUN, Consider reducing diuretic dose if dehydrated but if renal congestion, more diuresis may help, Review drug therapy</td>
</tr>
<tr>
<td>Anaemia (&lt;13 g/dL/8.0 mmol/L in men, &lt;12 g/dL/7.4 mmol/L in women)</td>
<td>Chronic HF, haemodilution, iron loss or poor utilization, renal failure, chronic disease, malignancy</td>
<td>Diagnostic work-up, Consider treatment</td>
</tr>
<tr>
<td>Hyponatraemia (&lt;135 mmol/L)</td>
<td>Chronic HF, haemodilution, AVP release, diuretics (especially thiazides) and other drugs</td>
<td>Consider water restriction, adjusting diuretic dosage, Ultrafiltration, vasopressin antagonist, Review drug therapy</td>
</tr>
<tr>
<td>Hypoalbuminaemia (&gt;150 mmol/L)</td>
<td>Water loss/inadequate water intake</td>
<td>Assess water intake, Diagnostic work-up</td>
</tr>
<tr>
<td>Hypokalaemia (&lt;3.5 mmol/L)</td>
<td>Diuretics, secondary hyperaldosteronism</td>
<td>Risk of arrhythmia, Consider ACE inhibitor/ARB, MRA, potassium supplements</td>
</tr>
<tr>
<td>Hyperkalaemia (&gt;5.5 mmol/L)</td>
<td>Renal failure, potassium supplement, renin–angiotensin–aldosterone system blockers</td>
<td>Stop potassium supplements/potassium sparing diuretics, Reduce dose of/stop ACE inhibitor/ARB/MRA, Assess renal function and urine pH, Risk of bradycardia and serious arrhythmias</td>
</tr>
<tr>
<td>Hyperglycaemia (&gt;6.5 mmol/L/117 mg/dL)</td>
<td>Diabetes, insulin resistance</td>
<td>Evaluate hydration, treat glucose intolerance</td>
</tr>
<tr>
<td>Hyperuricaemia (&gt;500 µmol/L/8.4 mg/dL)</td>
<td>Diuretic treatment, gout, malignancy</td>
<td>Allopurinol, Reduce diuretic dose</td>
</tr>
<tr>
<td>Albumin high (&gt;45 g/L)</td>
<td>Dehydration</td>
<td>Rehydrate</td>
</tr>
<tr>
<td>Albumin low (&lt;30 g/L)</td>
<td>Poor nutrition, renal loss</td>
<td>Diagnostic work-up</td>
</tr>
<tr>
<td>Transaminase increase</td>
<td>Liver dysfunction, Liver congestion, Drug toxicity</td>
<td>Diagnostic work-up, Liver congestion, Review drug therapy</td>
</tr>
<tr>
<td>Elevated troponins</td>
<td>Myocyte necrosis, Prolonged ischaemia, severe HF, myocarditis, sepsis, renal failure</td>
<td>Evaluate pattern of increase (mild increases common in severe HF), Perfusion/viability studies, Coronary angiography, Evaluation for revascularization</td>
</tr>
<tr>
<td>Elevated creatine kinase</td>
<td>Inherited and acquired myopathies (including myositis)</td>
<td>Consider genetic cardiomyopathy (laminopathy, desminopathy, dystrophinopathy), muscular dystrophies, Statin use</td>
</tr>
<tr>
<td>Abnormal thyroid tests</td>
<td>Hyper-/hypothyroidism, Amiodarone</td>
<td>Treat thyroid abnormality, Reconsider amiodarone use</td>
</tr>
<tr>
<td>Urine analysis</td>
<td>Proteinuria, glycosuria, bacteria</td>
<td>Diagnostic work-up, Rule out infection, diabetes</td>
</tr>
<tr>
<td>International normalized ratio &gt;3.5</td>
<td>Anticoagulant overdose, Liver congestion/disease, Drug interactions</td>
<td>Review anticoagulant dose, Assess liver function, Review drug therapy</td>
</tr>
<tr>
<td>CRP &gt;10 mg/L, neutrophilic leukocytosis</td>
<td>Infection, inflammation</td>
<td>Diagnostic work-up</td>
</tr>
</tbody>
</table>

ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; AVP = arginine vasopressin; BNP = B-type natriuretic peptide; BUN = blood urea nitrogen; CRP = C-reactive protein; eGFR = estimated glomerular filtration rate; HF = heart failure; MRA = mineralocorticoid receptor antagonist; NSAID = non-steroidal anti-inflammatory drug.
routine laboratory tests provide valuable prognostic information (see Section 6).

3.6.7 Algorithm for the diagnosis of heart failure
An algorithm for the diagnosis of HF or LV dysfunction is shown in Figure 1.

In patients presenting to hospital as an emergency with suspected HF and acute onset of symptoms, early echocardiography is recommended (and immediate echocardiography in shocked or severely haemodynamically compromised patients). If a natriuretic peptide is measured, a high exclusion cut-off point should be used.39–50 In patients presenting non-emergently in primary care, or to a hospital outpatient...
4. The role of cardiac imaging in the evaluation of patients with suspected or confirmed heart failure

Imaging plays a central role in the diagnosis of HF and in guiding treatment. Of the several imaging modalities available, echocardiography is the method of choice in patients with suspected HF for reasons of accuracy, availability (including portability), safety, and cost.\(^{27-34}\) It may be complemented by other modalities, chosen according to their ability to answer specific clinical questions and taking account of contraindications to, and risks of, specific tests (see Table 7).\(^{9,10,52-60}\) All imaging examinations, regardless of type, should be performed only by individuals competent and experienced in the specific technique.\(^{32}\)

4.1 Echocardiography

Echocardiography is a term used here to refer to all cardiac ultrasound imaging techniques, including two-dimensional/three-dimensional echocardiography, pulsed and continuous wave Doppler, colour flow Doppler, and tissue Doppler imaging (TDI).\(^{8,27-34,61-64}\) Echocardiography provides information about cardiac anatomy (e.g., volumes, geometry, mass) and function (e.g., LV function and wall motion, valvular function, right ventricular function, pulmonary artery pressure, pericardium).

4.1.1 Assessment of left ventricular systolic dysfunction

LVEF is not an index of contractility as it depends on volumes, preload, afterload, heart rate, and valvular function, and is not the same as stroke volume. Stroke volume may be maintained by LV dilation in a patient with HF-REF, whereas it may be reduced in patients with HF-PEF and concentric LV hypertrophy. EF may also be preserved (and stroke volume reduced) in patients with significant mitral regurgitation. Thus EF must be interpreted in its clinical context.

The recommended echocardiographic method for measurement of EF is the apical biplane method of discs (the modified Simpson’s rule).\(^{8,27-34,61}\) However, because this method relies on accurate tracing of the endocardial border, use of a contrast agent to better delineate the endocardial border is recommended when image quality is suboptimal (i.e., where <80% of the endocardial border is adequately visualized).\(^{61}\) The Teichholz and Quinones methods of calculating EF from linear dimensions may result in inaccuracies, particularly in patients with regional LV dysfunction; the same is true for another technique for assessing LV systolic function—fractional shortening. These and visual assessment of EF (‘eye-balling’) are not recommended.\(^{61}\) Three-dimensional echocardiography of adequate quality further improves the quantification of ventricular volumes and EF calculation.\(^{12}\) The LV wall motion score index may be an acceptable alternative to EF but is not widely used. Other indices of LV systolic function include AV plane systolic excursion, systolic tissue Doppler velocities, and measurements of deformation (strain and strain rate). Deformation imaging is more sensitive than EF in detecting minor changes in LV systolic function. However, issues of reproducibility and standardization currently limit the routine clinical use of deformation imaging. Stroke volume and cardiac output can also be calculated by measuring the velocity time integral at the LV outflow tract area.

The most common echocardiographic abnormalities seen in patients with HF and their clinical significance are presented in Table 8.

4.1.2 Assessment of left ventricular diastolic dysfunction

LV diastolic dysfunction is thought to be the underlying pathophysiological abnormality in patients with HF-PEF, and thus its identification is fundamental to the diagnosis of this type of HF (Table 9).\(^{7,8,27-34,63,64}\) The Doppler echocardiographic diastolic indices commonly measured in patients with HF are shown in Table 9. Of note, normal values for functional echocardiographic indices of LV diastolic dysfunction may also depend on age, heart rate, and body size.\(^{63,64}\) Importantly, no single echocardiographic parameter is sufficiently accurate and reproducible to be used in isolation to make a diagnosis of LV diastolic dysfunction. Therefore, a comprehensive echocardiographic examination incorporating all relevant two-dimensional and Doppler data is recommended.\(^{8,63,64}\) This should include the evaluation of both structural (LV hypertrophy, LA dilation) and functional abnormalities (Table 1). Tissue Doppler imaging-derived early diastolic myocardial velocities (e‘), measured at the mitral annulus, allow the assessment of myocardial relaxation. A normal e‘ (>8 cm/s septal, >10 cm/s lateral, or >9 cm/s average, measured using real-time pulsed TDI) is very unusual in a patient with HF. The E/e‘ ratio correlates with LV filling pressure.\(^{63,64}\) (Table 9).

Thus, echocardiographic evidence of LV diastolic dysfunction may consist of a reduced e‘ (e‘ average <9 cm/s) or an increased E/e‘ ratio (>15), or a combination of these parameters (Table 9). The presence of at least two abnormal measurements and/or AF increases the likelihood of the diagnosis.

4.2 Transoesophageal echocardiography

Transoesophageal echocardiography (TOE) is not needed in routine diagnostic assessment unless the transthoracic ultrasound window is inadequate (e.g., because of obesity, chronic lung disease, ventilated patients) and an alternative modality [e.g., cardiac magnetic resonance (CMR) imaging] is not available or applicable.

TOE is, however, valuable in patients with complex valvular disease (especially mitral disease and prosthetic valves), suspected endocarditis, and in selected patients with congenital heart disease.
Table 7  Possible applications of various imaging techniques in the diagnosis of HF

<table>
<thead>
<tr>
<th>Remodelling/dysfunction</th>
<th>Echo</th>
<th>CMR</th>
<th>Cath</th>
<th>SPECT</th>
<th>MDCT</th>
<th>PET</th>
</tr>
</thead>
<tbody>
<tr>
<td>LV:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remodelling/dysfunction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LV:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remodelling/dysfunction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RV:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remodelling/dysfunction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main advantages</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main disadvantages</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Selection of a test in daily practice should consider availability, local expertise, advantages/disadvantages, and, in the case of several questions to address, which test could best answer several of them.

ARVC = arrhythmogenic right ventricular cardiomyopathy; CAD = coronary artery disease; Cath = cardiac catheterization; CMP = cardiomyopathy; CMR = cardiac magnetic resonance; EDV = end-diastolic volume; EF = ejection fraction; ESV = end-systolic volume; HCM = hypertrophic cardiomyopathy; LV = left ventricular; MDCT = multidetector computed tomography; PET = positron emission tomography; RV = right ventricular; SPECT = single photon emission computed tomography.

*Stress (dobutamine) imaging.

†Fractional flow reserve or 'Doppler' flow reserve measurements.

‡Including measurements of aortic annulus for transcatheter aortic valve implantation.

§Endomyocardial biopsy.

Asynchronous myocardial scarring (ischaemia).

bFunctional analysis; Image quality limited if arrhythmia.

cEndomyocardial biopsy.

dHaemodynamic evaluation (constriction).

eDescribes disease activity by contrast-enhanced CMR.

fContrast-enhanced cardiac magnetic resonance imaging (black-blood and first-pass studies).

gArterial spin labelling.

hGood quality irrespective of patient habitus.

iExcellent attenuation correction.

jForeign metallic bodies in specific locations (e.g. in the eye) and electronic devices (some pacemakers are MR-compatible); relative contraindication: claustrophobia.
TOE is also used to check for thrombus in the left atrial appendage of patients with AF.

4.3 Stress echocardiography

Exercise or pharmacological stress echocardiography may be used to identify the presence and extent of inducible ischaemia and to determine whether non-contracting myocardium is viable (see Section 13). This technique may also be useful in evaluating patients with suspected severe aortic stenosis, reduced EF, and a low transvalvular gradient (see Section 13.3.1). Diastolic stress testing is an emerging procedure to identify HF-PEF in patients with HF symptoms during physical activity, normal EF, and inconclusive diastolic function parameters at rest.

4.4 Cardiac magnetic resonance

CMR is a non-invasive technique that provides most of the anatomical and functional information available from echocardiography, including evaluation of ischaemia and viability, as well as additional assessments. CMR is regarded as the gold standard with respect to accuracy and reproducibility of volumes, mass, and wall motion. Because CMR yields good image quality in most patients, it is the best alternative imaging modality in patients with non-diagnostic echocardiographic studies.

CMR is particularly valuable in identifying inflammatory and infiltrative conditions, and in predicting prognosis in patients with these (Table 7). CMR is also useful in the work-up of patients with suspected cardiomyopathy, arrhythmias, suspected cardiac tumours (or cardiac involvement by tumour), or pericardial diseases, and is the imaging method of choice in patients with complex congenital heart disease.

Limitations include lack of availability, inability to image patients with certain metallic implants (including many, but not all, cardiac devices), and cost. Also, the accuracy of functional analysis is limited in patients with atrial arrhythmias. Some patients cannot tolerate the procedure, often because of claustrophobia. Linear gadolinium chelates are contraindicated in individuals with a GFR < 30 mL/min/m² because they cause the rare condition known as nephrogenic systemic fibrosis.

Table 8 Common echocardiographic abnormalities in patients with heart failure

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Abnormality</th>
<th>Clinical implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parameters related to systolic function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LV ejection fraction</td>
<td>Reduced (&lt;50%)</td>
<td>LV global systolic dysfunction</td>
</tr>
<tr>
<td>LV fractional shortening</td>
<td>Reduced (&lt;25%)</td>
<td>LV radial systolic dysfunction</td>
</tr>
<tr>
<td>LV regional function</td>
<td>Hypokinesis, akinesis, dyskinesis</td>
<td>Myocardial infarction/ischaemia, Cardiomyopathy, myocarditis</td>
</tr>
<tr>
<td>LV end-diastolic size</td>
<td>Increased (diameter ≥60 mm, &gt;32 mm/m², volume &gt;97 mL/m²)</td>
<td>Volume overload HF likely</td>
</tr>
<tr>
<td>LV end-systolic size</td>
<td>Increased (diameter &gt;45 mm/ &gt;25 mm/m², volume &gt;43 mL/m²)</td>
<td>Volume overload HF likely</td>
</tr>
<tr>
<td>LV outflow tract velocity time integral</td>
<td>Reduced (&lt;15 cm)</td>
<td>Reduced LV stroke volume</td>
</tr>
<tr>
<td>Parameters related to diastolic function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LV diastolic dysfunction parameters</td>
<td>Abnormalities of the mitral inflow pattern, tissue velocities (e') or the E/e' ratio</td>
<td>Indicate LV diastolic dysfunction degree and suggest level of filling pressure</td>
</tr>
<tr>
<td>Left atrial volume index</td>
<td>Increased (volume &gt;34 mL/m²)</td>
<td>Increased LV filling pressure (past or present)</td>
</tr>
<tr>
<td>Mitral valve disease</td>
<td></td>
<td>Mitral valve disease</td>
</tr>
<tr>
<td>LV mass index</td>
<td>Increased: &gt;95 g/m² in women and &gt;115 g/m² in men</td>
<td>Hypertension, aortic stenosis, hypertrophic cardiomyopathy</td>
</tr>
<tr>
<td>Parameters related to valvular function</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valvular structure and function</td>
<td>Valvular stenosis or regurgitation (especially aortic stenosis and mitral regurgitation)</td>
<td>May be the cause of HF or a complicating factor or the result of HF (secondary mitral regurgitation) Assess dysfunction severity and haemodynamic consequences Consider surgery</td>
</tr>
<tr>
<td>Other parameters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RV function (e.g. TAPSE)</td>
<td>Reduced (TAPSE &lt;16 mm)</td>
<td>RV systolic dysfunction</td>
</tr>
<tr>
<td>Tricuspid regurgitation peak velocity</td>
<td>Increased (&gt;3.4 m/s)</td>
<td>Increased RV systolic pressure</td>
</tr>
<tr>
<td>Systolic pulmonary artery pressure</td>
<td>Increased (&gt;50 mmHg)</td>
<td>Pulmonary hypertension likely</td>
</tr>
<tr>
<td>Inferior vena cava</td>
<td>Dilated, with no respiratory collapse</td>
<td>Increased right atrial pressure</td>
</tr>
<tr>
<td>Pulmonary hypertension possible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pericardium</td>
<td>Effusion, haemopericardium, calcification</td>
<td>Consider tamponade, malignancy, systemic diseases, acute or chronic pericarditis, constrictive pericarditis</td>
</tr>
</tbody>
</table>

E/e' = ratio of the mitral inflow E wave to the tissue Doppler e' wave; HF = heart failure; LV = left ventricular; RV = right ventricular; TAPSE = tricuspid annular plane systolic excursion.
4.5 Single-photon emission computed tomography and radionuclide ventriculography

Single-photon emission computed tomography (SPECT) may be useful in assessing ischaemia and viability if CAD is suspected, and provides prognostic as well as diagnostic information (Table 7).\(^5^4\) Gated SPECT can also yield information on ventricular volumes and function, but exposes the patient to ionizing radiation.

4.6 Positron emission tomography imaging

Positron emission tomography (PET) [alone or with computed tomography (CT)] may be used to assess ischaemia and viability, but the flow tracers (N-13 ammonia or O-15 water) require an on-site cyclotron.\(^5^8,^6^0,^6^9\) Rubidium is an alternative tracer for ischaemia testing with PET, which can be produced locally at relatively low cost (Table 7).\(^6^3\) Lack of availability, radiation exposure, and cost are the main limitations.

4.7 Coronary angiography

Coronary angiography should be considered in patients with angina pectoris or a history of cardiac arrest if the patient is otherwise suitable for coronary revascularization. Angiography should also be considered in patients with evidence of reversible myocardial ischaemia on non-invasive testing, especially if the EF is reduced (because coronary artery bypass surgery may be beneficial) (Section 13). Non-invasive assessment of myocardial viability may also be carried out before angiography as some observational data show that coronary angiography may be of little, if any, benefit and may confer considerable risk, in the absence of significant viability. In cases where ischaemia information is lacking, fractional flow reserve gives information about the haemodynamic relevance of lesions.\(^7^0\)

Coronary angiography may be required, urgently, in selected patients with acute HF (AHF) (shock or acute pulmonary oedema), particularly those with an associated acute coronary syndrome (see Section 12.7.1 and revascularization guidelines\(^7^1\)). Coronary angiography may also be indicated in patients with valve disease when surgical correction is planned.

4.8 Cardiac computed tomography

The main use of CT in patients with HF is a non-invasive means to visualize the coronary anatomy.\(^5^9\) The risk vs. benefit of this procedure should be considered as discussed above, under coronary angiography (Section 4.7).

5. Other investigations

5.1 Cardiac catheterization and endomyocardial biopsy

In patients with suspected constrictive or restrictive cardiomyopathy, cardiac catheterization used in combination with other non-invasive imaging techniques may help to establish the correct diagnosis (see Table 7). In patients with suspected myocarditis and infiltrative diseases (e.g. amyloidosis, see Table 7), endomyocardial biopsy may be needed to confirm the diagnosis. The use of this procedure is described in detail in other guidelines.\(^7^2\)
5.2 Exercise testing
Exercise testing allows objective evaluation of exercise capacity and exertional symptoms, such as dyspnoea and fatigue. The 6-min walk test and a variety of treadmill and bicycle protocols are available. Gas exchange analysis helps differentiate between cardiac and respiratory causes of dyspnoea, shows whether the anaerobic threshold has been reached, and provides prognostic information (peak oxygen consumption is often measured as part of the assessment of candidates for heart transplantation). A normal exercise capacity in a patient not receiving treatment effectively excludes the diagnosis of symptomatic HF, although it must be remembered that there is a poor correlation between exercise capacity and resting haemodynamic measures, including EF.

5.3 Genetic testing
The emerging role of genetic testing in ‘idiopathic’ dilated and hypertrophic cardiomyopathy is described in detail elsewhere. Currently this is recommended in patients with dilated cardiomyopathy and AV block or a family history of premature unexpected sudden death, as a prophylactic implantable cardioverter-defibrillator (ICD) may be indicated.

5.4 Ambulatory electrocardiographic monitoring
Ambulatory ECG monitoring is valuable in the assessment of patients with symptoms suggestive of an arrhythmia or bradycardia (e.g. palpitations or syncope) and in monitoring ventricular rate control in patients with AF. It is useful for identifying the type, frequency, and duration of atrial and ventricular arrhythmias, silent episodes of ischaemia and bradycardia, and conduction disturbances, which may cause or exacerbate HF.

6. Prognosis
Many variables provide prognostic information (Web Table 10), although most of this can be obtained from readily available data such as age, aetiology, NYHA class, EF, key co-morbidities (renal dysfunction, diabetes, anaemia, hyperuricaemia), and plasma natriuretic peptide concentration. Clearly these variables change over time, as does prognosis. Assessment of prognosis is particularly important when counselling patients about devices and surgery (including transplantation) and in planning end-of-life care with patients, their family, and caregivers.

7. Pharmacological treatment of heart failure with reduced ejection fraction (systolic heart failure)

7.1 Objectives in the management of heart failure
The goals of treatment in patients with established HF are to relieve symptoms and signs (e.g. oedema), prevent hospital admission, and improve survival. Although the focus of clinical trials was previously mortality, it is now recognized that preventing HF hospitalization is important for patients and healthcare systems. Reductions in mortality and hospital admission rates both reflect the ability of effective treatments to slow or prevent progressive worsening of HF. This is often accompanied by reverse LV remodelling and a reduction in circulating natriuretic peptide concentrations.

The relief of symptoms, improvement in quality of life, and increase in functional capacity are also of the utmost importance to patients, but they have not been the primary outcome in most trials. This is in part because they are difficult to measure and partly because some treatments previously shown to improve these outcomes also decreased survival. However, effective pharmacological therapies and CRT improve these outcomes, as well as mortality and hospitalization.

Figure 2 shows a treatment strategy for the use of drugs (and devices) in patients with HF-REF; the recommendations for each treatment are summarized below. Three neurohumoral antagonists—an ACE inhibitor [or angiotensin receptor blocker (ARB)], a beta-blocker, and an MRA—are fundamentally important in modifying the course of systolic HF and should at least be considered in every patient. They are commonly used in conjunction with a diuretic given to relieve the symptoms and signs of congestion. The following text summarizes the evidence supporting the recommendations in this section, in Web Tables 11–13 and in Figure 2. The recommended doses of these disease-modifying medications are given in Table 14. The recommendations given in Section 7.4 summarize drugs that should be avoided in patients with HF-REF.

7.2 Treatments recommended in potentially all patients with systolic heart failure

7.2.1 Angiotensin-converting enzyme inhibitors and beta-blockers
The pivotal trials with beta-blockers were conducted in patients with continuing symptoms and a persistently low EF, despite treatment with an ACE inhibitor and, in most cases, a diuretic. Despite this, there is consensus that these treatments are complementary and that a beta-blocker and an ACE inhibitor should both be started as soon as possible after diagnosis of HF-REF. This is in part because ACE inhibitors have a modest effect on LV remodelling whereas beta-blockers often lead to a substantial improvement in EF. Furthermore, beta-blockers are anti-ischaemic, are probably more effective in reducing the risk of sudden cardiac death, and lead to a striking and early reduction in overall mortality.

Key evidence supporting the use of angiotensin-converting enzyme inhibitors
- Two key randomized controlled trials [Cooperative North Scandinavian Enalapril Survival Study (CONSENSUS) and Studies of Left Ventricular Dysfunction (SOLVD)-Treatment] assigned ~2800 patients with mild to severely symptomatic HF to placebo or enalapril. Most were also treated with a diuretic and digoxin, but <10% of patients in each trial were treated with a beta-blocker. In CONSENSUS, which enrolled patients...
Diuretics to relieve symptoms/signs of congestion

ACE inhibitor (or ARB if not tolerated) →
ADD a beta-blocker

Still NYHA class II-IV?
Yes
ADD a MR antagonist

Still NYHA class II-IV?
No
LVEF ≤ 35%?
Yes
Sinus rhythm and HR ≥ 70 beats/min?
Yes
ADD ivabradine

Consider CRT-P/CRT-D

Still NYHA class II-IV and LVEF ≤ 35%?
No
QRS duration ≥ 120 ms?
Yes
Consider ICD

Still NYHA class II-IV?
Yes
Consider digoxin and/or H-ISDN
If end stage, consider LVAD and/or transplantation

No further specific treatment
Continue in disease-management programme

ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; CRT-D = cardiac resynchronization therapy defibrillator; CRT-P = cardiac resynchronization therapy pacemaker; H-ISDN = hydralazine and isosorbide dinitrate; HR = heart rate; ICD = implantable cardioverter-defibrillator; LBBB = left bundle branch block; LVAD = left ventricular assist device; LVEF = left ventricular ejection fraction; MR antagonist = mineralocorticoid receptor antagonist; NYHA = New York Heart Association.

a Diuretics may be used as needed to relieve the signs and symptoms of congestion (see Section 7.5) but they have not been shown to reduce hospitalization or death.
b Should be titrated to evidence-based dose or maximum tolerated dose below the evidence-based dose.
c Asymptomatic patients with an LVEF ≤ 35% and a history of myocardial infarction should be considered for an ICD.
d If mineralocorticoid receptor antagonist not tolerated, an ARB may be added to an ACE inhibitor as an alternative.
e European Medicines Agency has approved ivabradine for use in patients with a heart rate ≥ 75 b.p.m. May also be considered in patients with a contraindication to a beta-blocker or beta-blocker intolerance.
f Not indicated in NYHA class IV.

Figure 2 Treatment options for patients with chronic symptomatic systolic heart failure (NYHA functional class II–IV).
Pharmacological treatments indicated in potentially all patients with symptomatic (NYHA functional class II–IV) systolic heart failure

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Classa</th>
<th>Levelb</th>
<th>Refc</th>
</tr>
</thead>
<tbody>
<tr>
<td>An ACE inhibitor is recommended, in addition to a beta-blocker, for all patients with an EF ≤40% to reduce the risk of HF hospitalization and the risk of premature death.</td>
<td>I</td>
<td>A</td>
<td>87–91</td>
</tr>
<tr>
<td>A beta-blocker is recommended, in addition to an ACE inhibitor (or ARB if ACE inhibitor not tolerated), for all patients with an EF ≤40% to reduce the risk of HF hospitalization and the risk of premature death.</td>
<td>I</td>
<td>A</td>
<td>92–98</td>
</tr>
<tr>
<td>An MRA is recommended for all patients with persisting symptoms (NYHA class II–IV) and an EF ≤35%, despite treatment with an ACE inhibitor (or an ARB if an ACE inhibitor is not tolerated) and a beta-blocker, to reduce the risk of HF hospitalization and the risk of premature death.</td>
<td>I</td>
<td>A</td>
<td>99, 100</td>
</tr>
</tbody>
</table>

ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; EF = ejection fraction; HF = heart failure; MRA = mineralocorticoid receptor antagonist; NYHA = New York Heart Association.

aClass of recommendation.

bLevel of evidence.

cReferences.

with severe HF, 53% of patients were treated with spironolactone.

- Both of these two RCTs showed that ACE inhibitor treatment reduced mortality (relative risk reduction [RRR] 27% in CONSENSUS and 16% in SOLVD-Treatment). In SOLVD-Treatment there was also an RRR of 26% in HF hospitalization. These benefits were additional to those gained with conventional treatment at that time (i.e. a diuretic, digoxin, and spironolactone).

- The absolute risk reduction (ARR) in mortality in patients with mild or moderate HF (SOLVD-Treatment) was 4.5%, equating to a number needed to treat (NNT) of 22 to postpone one death (over an average of 41 months). The equivalent figures for severe HF (CONSENSUS) were 14.6% for ARR and 7 for NNT (over an average of 6 months).

- These findings are supported by a meta-analysis of smaller, short-term, placebo-controlled randomized controlled trials (RCTs), which showed a clear reduction in mortality within only 3 months.69 These RCTs also showed that ACE inhibitors improve symptoms, exercise tolerance, quality of life, and exercise performance.

- In the Assessment of Treatment with Lisinopril And Survival (ATLAS) trial,90 3164 patients with mainly moderate to severe HF were randomized to low- or high-dose lisinopril. There was an RRR of 15% in the risk of death or HF hospitalization in the high-dose lisinopril group compared with the low-dose lisinopril group.

- Additional support for the use of ACE inhibitors comes from an RCT in patients with a low EF but no symptoms of HF (‘asymptomatic LV systolic dysfunction’) and three large (5966 patients in total) placebo-controlled, randomized, outcome trials in patients with HF, LV systolic dysfunction, or both after acute myocardial infarction.91 In the SOLVD-Prevention trial (which randomized 4228 patients with asymptomatic LV systolic dysfunction), there was a 20% RRR in death or HF hospitalization. In the myocardial infarction trials, which used captopril [Survival and Ventricular Enlargement (SAVE)], ramipril [Acute Infarction Ramipril Efficacy (AIRE)], and trandolapril [TRAndolapril Cardiac Evaluation (TRACE)], there was a 26% RRR in death and a 27% RRR in death or HF hospitalization.101

- ACE inhibitors occasionally cause worsening of renal function, hyperkalaemia, symptomatic hypotension, cough, and, rarely, angioedema. An ACE inhibitor should only be used in patients with adequate renal function (creatinine ≤221 μmol/L or ≤2.5 mg/dL or eGFR ≥30 mL/min/1.73 m²) and a normal serum potassium level (see Web Table 11).

Practical guidance on how to use ACE inhibitors is given in Web Table 11.102

Key evidence supporting the use of beta-blockers

- More RCTs have been undertaken with beta-blockers than with ACE inhibitors in patients with HF.

- Three key trials [Cardiac Insufficiency Bisoprolol Study II (CIBIS II), Carvedilol Prospective Randomized Cumulative Survival (COPERNICUS), and Metoprolol CR/XL Randomised Intervention Trial in Congestive Heart Failure (MERIT-HF)] randomized nearly 9000 patients with mild to severely symptomatic HF to placebo or a beta-blocker (bisoprolol, carvedilol, or metoprolol succinate CR/XL).72–96 More than 90% of the patients were on an ACE inhibitor or ARB.

- Each of these three trials showed that beta-blocker treatment reduced mortality (RRR ~34% in each trial) and HF hospitalization (RRR 28–36%) within ~1 year of starting treatment. There was also an also an improvement in self-reported patient well-being in COPERNICUS and MERIT-HF. These benefits were additional to those gained with conventional treatment, including an ACE inhibitor.

- The ARR in mortality (after 1 year of treatment) in patients with mild to moderate HF (CIBIS II and MERIT-HF combined) was 4.3%, equating to an NNT (for 1 year to postpone one death) of 23. The equivalent figures for severe HF (COPERNICUS) were ARR 7.1% and NNT 14.

- These findings are supported by another placebo-controlled RCT [Study of Effects of Nebivolol Intervention on Outcomes and Rehospitalization in Seniors With Heart Failure (SENIORS)] in 2128 elderly (≥70 years) patients, 36% of whom had an LVEF >35%. Treatment with nebivolol resulted in an RRR of 14% in the primary composite endpoint of death or cardiovascular hospitalization, but did not reduce mortality.97
The findings of these trials were also supported by an earlier programme of studies with carvedilol (US carvedilol studies), a meta-analysis of other small beta-blocker trials, and a placebo-controlled RCT in 1959 patients with an LVEF ≤0.40 after acute myocardial infarction in which the RRR in mortality with carvedilol was 23% during a mean follow-up of 1.3 years.98

One large RCT [Beta-Blocker Evaluation of Survival Trial (BEST)] with bucindolol, a beta-blocker with partial agonist properties, did not show a significant reduction in mortality, though its findings were generally consistent with the above studies.103

Another RCT [Carvedilol or Metoprolol European Trial (COMET)] showed that carvedilol increased survival compared with short-acting metoprolol tartrate (different from the long-acting succinate formulation used in MERIT-HF).104

Beta-blockers should usually be initiated in stable patients, and used only with caution in recently decompensated patients (and only initiated in hospital in these patients). Recently decompensated patients were, however, safely initiated on beta-blocker treatment in COPERNICUS.105

Continuation of beta-blocker treatment during an episode of decompensation has been shown in an RCT to be safe, although dose reduction may be necessary.106 Temporary discontinuation is advised in shocked or severely hypoperfused patients. Re-institution of treatment should be attempted before discharge.

Practical guidance on how to use beta-blockers is given in Web Table 12.102

7.2.2 Mineralocorticoid/aldosterone receptor antagonists

Spironolactone and eplerenone block receptors that bind aldosterone and other corticosteroids, and are best characterized as MRAs. Although patients in the Eplerenone in Mild Patients Hospitalization and Survival Study in Heart Failure (EMPHASIS-HF)100 were required to have additional features elevating risk (recent cardiovascular hospitalization or elevated natriuretic peptide concentration), the benefits of MRAs probably extend to all patients with systolic HF, particularly as the two RCTs in chronic HF are supported by an additional RCT in patients with acute myocardial infarction.99,100,107

Key evidence supporting the use of mineralocorticoid receptor antagonists

- The Randomized Aldactone Evaluation Study (RALES) trial99 was undertaken with the MRA spironolactone in patients with severe HF.
- In RALES, 1663 patients with an EF ≤35% and in NYHA functional class III (having been in class IV within the past 6 months) were randomized to placebo or spironolactone 25–50 mg once daily added to conventional treatment. At the time this trial was conducted, beta-blockers were not widely used to treat HF, and only 11% were treated with a beta-blocker.
- Treatment with spironolactone led to an RRR in death of 30% and an RRR in HF hospitalization of 35% within an average of 2 years of starting treatment. These benefits were additional to those gained with conventional treatment, including an ACE inhibitor.
- The ARR in mortality (after a mean of 2 years of treatment) in patients with severe HF was 11.4%, equating to an NNT (for 2 years to postpone one death) of 9.
- More recently the EMPHASIS-HF trial100 was undertaken in patients with systolic HF and mild symptoms.
- In EMPHASIS-HF, 2737 patients aged ≥55 years with NYHA functional class II symptoms and an EF ≤30% (≤35% if the QRS duration was >130 ms) were enrolled. Patients had to have either experienced a cardiovascular hospitalization within the previous 6 months or have an elevated plasma natriuretic peptide concentration and be treated with an ACE inhibitor, ARB, or both, and a beta-blocker.
- Treatment with eplerenone (up to 50 mg once daily) led to an RRR of 37% in cardiovascular death or HF hospitalization.

### Table 14 Evidence-based doses of disease-modifying drugs used in key randomized trials in heart failure (or after myocardial infarction)

<table>
<thead>
<tr>
<th>Category</th>
<th>ACE inhibitor</th>
<th>Beta-blocker</th>
<th>MRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose (mg)</td>
<td>Starting dose (mg)</td>
<td>Target dose (mg)</td>
<td></td>
</tr>
<tr>
<td>Captopril</td>
<td>6.25 t.i.d.</td>
<td>50 t.i.d.</td>
<td></td>
</tr>
<tr>
<td>Enalapril</td>
<td>2.5 b.i.d.</td>
<td>10–20 b.i.d.</td>
<td></td>
</tr>
<tr>
<td>Lisinopril</td>
<td>2.5–5.0 o.d.</td>
<td>20–35 o.d.</td>
<td></td>
</tr>
<tr>
<td>Ramipril</td>
<td>2.5 o.d.</td>
<td>5 b.i.d.</td>
<td></td>
</tr>
<tr>
<td>Trandolapril</td>
<td>0.5 o.d.</td>
<td>4 o.d.</td>
<td></td>
</tr>
<tr>
<td>Bisoprolol</td>
<td>1.25 o.d.</td>
<td>10 o.d.</td>
<td></td>
</tr>
<tr>
<td>Carvedilol</td>
<td>3.125 b.i.d.</td>
<td>25–50 b.i.d.</td>
<td></td>
</tr>
<tr>
<td>Metoprolol succinate (CR/XL)</td>
<td>12.5/25 o.d.</td>
<td>200 o.d.</td>
<td></td>
</tr>
<tr>
<td>Nebivolol</td>
<td>1.25 o.d.</td>
<td>10 o.d.</td>
<td></td>
</tr>
<tr>
<td>Candesartan</td>
<td>4 or 8 o.d.</td>
<td>32 o.d.</td>
<td></td>
</tr>
<tr>
<td>Valartan</td>
<td>40 b.i.d.</td>
<td>160 b.i.d.</td>
<td></td>
</tr>
<tr>
<td>Losartan</td>
<td>50 o.d.</td>
<td>150 o.d.</td>
<td></td>
</tr>
<tr>
<td>Eplerenone</td>
<td>25 o.d.</td>
<td>50 o.d.</td>
<td></td>
</tr>
<tr>
<td>Spironolactone</td>
<td>25 o.d.</td>
<td>25–50 o.d.</td>
<td></td>
</tr>
</tbody>
</table>

ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; b.i.d. = bis in die (twice daily); MRA = mineralocorticoid receptor antagonist; o.d. = omni die (once every day); t.i.d. = ter in die (three times daily).

Indicates an ACE inhibitor where the dosing target is derived from post-myocardial infarction trials.

Indicates drugs where a higher dose has been shown to reduce morbidity–mortality compared with a lower dose of the same drug, but there is no substantive placebo-controlled randomized controlled trial and the optimum dose is uncertain.

Indicates a treatment not shown to reduce cardiovascular or all-cause mortality in patients with heart failure or after acute myocardial infarction (or shown to be non-inferior to a treatment that does).
were obtained within an average of 21 months of starting treat-
ment and were additional to those gained with conventional
treatment, including an ACE inhibitor and beta-blocker.
- The ARR in the primary composite mortality–morbidity end-
point in patients with mild symptoms was 7.7%, equating to 
an NNT (for an average of 21 months to postpone one 
event) of 13. The ARR in mortality was 3%, equating to an 
NNT of 33.
- These findings are supported by another RCT [Eplerenone 
Post-Acute Myocardial Infarction Heart Failure Efficacy and Sur-
vival Study (EPHESUS)], which enrolled 6632 patients 3–14 
days after acute myocardial infarction with an EF ≤40% and 
HF or diabetes. Patients were randomized to placebo or 
eplerenone 25–50 mg once daily added to conventional treat-
ment including an ACE inhibitor/ARB (87%) and a beta-blocker 
(75%). Treatment with eplerenone led to an RRR in death of 
15%.
- Spironolactone and eplerenone can cause hyperkalaemia and 
worsening renal function, which were uncommon in the 
RCTs, but may occur more frequently in ordinary clinical prac-
tice, especially in the elderly. Both should only be used in 
patients with adequate renal function and a normal serum po-
tassium concentration; if either is used, serial monitoring of 
serum electrolytes and renal function is mandatory.

Other treatments with less-certain benefits in patients with symptomatic (NYHA class II–IV) systolic heart failure

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Classa</th>
<th>Levelb</th>
<th>Refc</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommended to reduce the risk of HF hospitalization and the risk of premature death in patients with an EF ≤40% and unable to tolerate an ACE inhibitor because of cough (patients should also receive a beta-blocker and an MRA).</td>
<td>I</td>
<td>A</td>
<td>108, 109</td>
</tr>
<tr>
<td>Recommended to reduce the risk of HF hospitalization in patients with an EF ≤40% and persisting symptoms (NYHA class II–IV) despite treatment with an ACE inhibitor and a beta-blocker who are unable to tolerate an MRA.</td>
<td>I</td>
<td>A</td>
<td>110, 111</td>
</tr>
<tr>
<td>Ivabradine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Should be considered to reduce the risk of HF hospitalization in patients in sinus rhythm with an EF ≤35%, a heart rate remaining ≥70 b.p.m., and persisting symptoms (NYHA class II–IV) despite treatment with an evidence-based dose of beta-blocker (or maximum tolerated dose below that), ACE inhibitor (or ARB), and an MRA (or ARB).</td>
<td>IIa</td>
<td>B</td>
<td>112</td>
</tr>
<tr>
<td>May be considered to reduce the risk of HF hospitalization in patients in sinus rhythm with an EF ≤35% and a heart rate ≥70 b.p.m. who are unable to tolerate a beta-blocker. Patients should also receive an ACE inhibitor (or ARB) and an MRA (or ARB).</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Digoxin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May be considered to reduce the risk of HF hospitalization in patients in sinus rhythm with an EF ≤45% who are unable to tolerate a beta-blocker (ivabradine is an alternative in patients with a heart rate ≥70 b.p.m.). Patients should also receive an ACE inhibitor (or ARB) and an MRA (or ARB).</td>
<td>IIb</td>
<td>B</td>
<td>113</td>
</tr>
<tr>
<td>May be considered to reduce the risk of HF hospitalization in patients with an EF ≤45% and persisting symptoms (NYHA class II–IV) despite treatment with a beta-blocker, ACE inhibitor (or ARB), and an MRA (or ARB).</td>
<td>IIb</td>
<td>B</td>
<td>113</td>
</tr>
<tr>
<td>H-ISDN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May be considered as an alternative to an ACE inhibitor or ARB, if neither is tolerated, to reduce the risk of HF hospitalization and risk of premature death in patients with an EF ≤45% and dilated LV (or EF ≤35%). Patients should also receive a beta-blocker and an MRA.</td>
<td>IIb</td>
<td>B</td>
<td>114, 115</td>
</tr>
<tr>
<td>May be considered to reduce the risk of HF hospitalization and risk of premature death in patients with an EF ≤45% and dilated LV (or EF ≤35%) and persisting symptoms (NYHA class II–IV) despite treatment with a beta-blocker, ACE inhibitor (or ARB), and an MRA (or ARB).</td>
<td>IIb</td>
<td>B</td>
<td>116</td>
</tr>
<tr>
<td>An n-3 PUFAf preparation may be considered to reduce the risk of death and the risk of cardiovascular hospitalization in patients treated with an ACE inhibitor (or ARB), beta-blocker, and an MRA (or ARB).</td>
<td>IIb</td>
<td>B</td>
<td>117</td>
</tr>
</tbody>
</table>

ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; CHARM-Added = Candesartan in Heart Failure: Assessment of Reduction in Mortality and Morbidity-Added; EF = ejection fraction; HF = heart failure; H-ISDN = hydralazine and isosorbide dinitrate; MRA = mineralocorticoid receptor antagonist; NYHA = New York Heart Association; PUFA = polyunsaturated fatty acid.

*aClass of recommendation.

bLevel of evidence.

cReferences.

dIn the CHARM-Added trial, candesartan also reduced cardiovascular mortality.

eEuropean Medecines Agency has approved ivabradine for use in patients with a heart rate ≥75 b.p.m.

fPreparation studied in cited trial; the GISSI-HF trial had no EF limit.
• Spironolactone can also cause breast discomfort and enlargement in men (10% compared with 1% on placebo, in RALES); this side effect is infrequent with eplerenone.

Practical guidance on how to use MRAs is given in Web Table 13.102

7.2.3 Other treatments recommended in selected patients with systolic heart failure

This section describes other treatments that are valuable in patients with systolic HF. They have not, however, been shown clearly to reduce all-cause mortality or in the case of hydralazine and isosorbide dinitrate (H-ISDN), this has only been clearly shown in African-Americans. Most of these drugs have shown convincing benefits in terms of symptom reduction, HF hospitalization, or both, and are useful alternative or additional treatments in patients with HF.

7.2.4 Angiotensin receptor blockers

ARBs remain recommended as an alternative in patients intolerant of an ACE inhibitor.109,109 However, ARBs are no longer the first-choice recommendation in patients with HF and an EF ≤ 40% who remain symptomatic despite optimal treatment with an ACE inhibitor and beta-blocker. This is because in EMPHASIS-HF, eplerenone led to a larger reduction in morbidity–mortality than seen in the ARB ‘add-on’ trials discussed below, and because in both the Randomized Aldactone Evaluation Study (RALES) and EMPHASIS-HF, MRA treatment reduced all-cause mortality, whereas ARB ‘add-on’ treatment did not.

Key evidence

• Two key placebo-controlled RCTs [Valsartan Heart Failure Trial (Val-HeFT) and CHARM-Added] randomized ~7600 patients with mild to severely symptomatic HF to placebo or an ARB (valsartan and candesartan), added to an ACE inhibitor (in 93% of patients in Val-HeFT and all patients in CHARM-Added). In addition, 35% of patients in Val-HeFT and 55% in CHARM-Added were treated with a beta-blocker.

• Each of these two trials showed that ARB treatment reduced the risk of HF hospitalization (RRR 24% in Val-HeFT and 17% in CHARM-Added) but not all-cause hospitalization. There was a 16% RRR in the risk of cardiovascular death with candesartan in CHARM-Added. These benefits were additional to those gained with conventional treatment, including a diuretic, digoxin, an ACE inhibitor, and a beta-blocker (but few patients were taking an MRA).

• The ARR in the primary composite mortality– morbidity endpoint in patients with mild to moderate HF was 4.4%, equating to an NNT (for an average of 41 months to postpone one event) of 23 in CHARM-Added. The equivalent figures for Val-HeFT were ARR 3.3% and NNT 30 (over an average of 23 months).

• The CHARM trials and Val-HeFT also showed that ARBs improve symptoms and quality of life. Other trials showed that these agents improve exercise capacity.

• CHARM-Alternative was a placebo-controlled RCT with candesartan in 2028 patients with an LVEF ≤ 40%, intolerant of an ACE inhibitor. Treatment with candesartan resulted in an RRR of cardiovascular or HF hospitalization of 23% (ARR 7%, NNT 14, over 34 months of follow-up).108 Valsartan was also beneficial in the subset of patients in Val-HeFT not treated with an ACE inhibitor.109

• Another trial [Evaluation of Losartan In The Elderly (ELITE) II] failed to show that losartan 50 mg daily was as effective as captopril 50 mg three times daily. However, a subsequent RCT [Heart failure Endpoint evaluation of Angiotensin II Antagonist Losartan (HEAAL)] showed that 150 mg daily of losartan was superior to 50 mg daily, supporting the similar findings of the Assessment of Treatment with Lisinopril And Survival (ATLAS) trial with the ACE inhibitor lisinopril—see above. In HEAAL there was an RRR of 10% in death or HF hospitalization in the high-dose losartan group (P = 0.027) over a median follow-up of 4.7 years. The results from these two trials, ATLAS and HEAAL, indicate that more benefit is obtained from using higher doses of renin–angiotensin system blockers and underscore the importance of attaining, if possible, the target doses proven to be of benefit in the key RCTs.

Practical guidance on how to use an ARB is given in Web Table 11.

7.2.5 Ivabradine

Ivabradine is a drug that inhibits the I<sub>f</sub> channel in the sinus node. Its only known pharmacological effect is to slow the heart rate in patients in sinus rhythm (it does not slow the ventricular rate in AF).

Key evidence

• The Systolic Heart failure treatment with the I<sub>f</sub> inhibitor ivabradine Trial (SHIFT) enrolled 6588 patients in NYHA functional class II–IV, sinus rhythm with a rate of ≥ 70 b.p.m., and an EF ≤ 35%.112 Patients were also required to have had a HF hospitalization in the previous 12 months. They were randomized to ivabradine (up-titrated to a maximal dosage of 7.5 mg twice daily) or placebo, added to a diuretic (in 84%), digoxin (22%), an ACE inhibitor (79%), an ARB (14%), a beta-blocker (90%), and an MRA (60%). Only 26% of patients were, however, on full-dose beta-blocker. The median follow-up was 23 months. The RRR in the primary composite outcome of cardiovascular death or HF hospitalization was 18% (P < 0.0001); the reduction in cardiovascular death (or all-cause death) was not significant, but the RRR in HF hospitalization was 26%. The ARR in the primary composite mortality–morbidity endpoint was 4.2%, equating to an NNT (for an average of 23 months to postpone one event) of 24. Ivabradine also improved LV function and quality of life.
Five per cent of patients on ivabradine had symptomatic bradycardia compared with 1% of the placebo group (P < 0.0001). Visual side effects (phosphenes) were reported by 3% of patients on ivabradine and 1% on placebo (P < 0.0001).

Additional safety evidence for ivabradine comes from the MorBidity-mortality EvaLUaTion of the I2 inhibitor ivabradine in patients with coronary disease and left ventricular dysfunction (BEAUTIFUL) trial, an RCT in which 10 917 patients with coronary heart disease and an EF <40% were assigned to treatment with ivabradine 7.5 mg twice daily or placebo and followed for a median of 19 months. Although ivabradine did not reduce the primary outcome of cardiovascular death, myocardial infarction, or HF hospitalization, it was well tolerated.122

7.2.6 Digoxin and other digitalis glycosides

In patients with symptomatic HF and AF, digoxin may be used to slow a rapid ventricular rate, although other treatments are preferred (see Section 10.1).

Digoxin may also be used in patients in sinus rhythm with symptomatic HF and an LVEF ≤40% as recommended below, based on the evidence summarized below.113

Key evidence
- A single large morbidity–mortality RCT [Digitalis Investigation Group (DIG)] has been undertaken with digoxin in patients with symptomatic HF and a low EF.113
- In the DIG trial, 6800 patients with an EF ≤45% and in NYHA functional class II–IV were randomized to placebo or digoxin (0.25 mg once daily), added to a diuretic and an ACE inhibitor. This trial was performed before beta-blockers were widely used for HF.113
- Treatment with digoxin did not alter all-cause mortality but did lead to an RRR for hospital admission for worsening HF of 28% within an average of 3 years of starting treatment. The absolute ARR was 7.9%, equating to an NNT (for 3 years to postpone one patient admission) of 13.
- These findings are supported by a meta-analysis of smaller trials suggesting that digoxin can improve symptoms and prevent deterioration.123
- Digoxin can cause atrial and ventricular arrhythmias, particularly in the context of hypokalaemia, and serial monitoring of serum electrolytes and renal function is mandatory.
- The efficacy and safety of other digitalis glycosides such as digitoxin have not been studied properly in heart failure.

7.2.7 Combination of hydralazine and isosorbide dinitrate

In one relatively small RCT conducted exclusively in men (and before ACE inhibitor or beta-blockers were used to treat HF), this vasodilator combination led to a borderline reduction in mortality when compared with placebo.114–116 In a subsequent RCT, the addition of H-ISDN to conventional therapy (ACE inhibitor, beta-blocker, and MRA) reduced morbidity and mortality (and improved symptoms) in African-Americans with HF.116 The selected patient population studied, relatively small RCT size, and early termination (for mortality benefit) have left uncertainty about the real value of this combination therapy, especially in non-black patients.

Key evidence
- There are two placebo-controlled (V-HeFT-I and A-HeFT) RCTs and one active-controlled (V-HeFT-II) RCT with H-ISDN.114–116
- In V-HeFT-I, 642 men were randomized to placebo, prazosin, or H-ISDN added to a diuretic and digoxin.114 No patients were treated with a beta-blocker or an ACE inhibitor (and the use of MRAs was not documented). Mortality rates were not different in the placebo and prazosin groups. With H-ISDN, there was a trend to a reduction in all-cause mortality during the overall period of follow-up (mean 2.3 years): RRR 22%; ARR 5.3%; NNT 19. H-ISDN increased exercise capacity and LVEF compared with placebo.
- In A-HeFT, 1050 African-American men and women in NYHA class III or IV were randomized to placebo or H-ISDN, added to a diuretic (in 90%), digoxin (60%), an ACE inhibitor (70%), an ARB (17%), a beta-blocker (74%), and spironolactone (39%).116 The initial dose of treatment was 20 mg ISDN/37.5 mg hydralazine thrice daily, increasing to a target of 40 mg/75 mg thrice daily. The trial was discontinued prematurely, after a median follow-up of 10 months, because of a significant reduction in mortality (RRR 43%; ARR 4.0%; NNT 25). H-ISDN also reduced the risk of HF hospitalization (RRR 33%) and improved quality of life.
- In V-HeFT-II, 804 men, mainly in NYHA class II or III, were randomized to enalapril or H-ISDN, added to a diuretic and digoxin.115 No patients were treated with a beta-blocker. There was a trend in the H-ISDN group to an increase in all-cause mortality during the overall period of follow-up (mean 2.5 years): relative increase in risk was 28%.
- The most common adverse effects with H-ISDN in these trials were headache, dizziness/hypotension, and nausea. Arthralgia leading to discontinuation or reduction in dose of H-ISDN occurred in 5–10% of patients in V-HeFT I and II and a sustained increase in antinuclear antibody in 2–3% of patients (but lupus-like syndrome was rare).

7.2.8 Omega-3 polyunsaturated fatty acids

The small treatment effect of n-3 polyunsaturated fatty acids (PUFAs) in the Gruppo Italiano per lo Studio della Sopravvivenza nell’Infarto miocardico-heart failure (GISSI-HF) trial was only detected after covariate adjustment in the statistical analysis and there was no effect on HF hospitalization.117 The effect of n-3 PUFAs after myocardial infarction is uncertain.17

Key evidence
- In the GISSI-HF PUFA trial, 6975 patients with NYHA class II–IV symptoms and an EF ≤40% (or if >40%, HF hospitalization in the previous year) were randomized to placebo or 1 g daily of an n-3 PUFA preparation in addition to standard therapy includ-
ing an ACE inhibitor/ARB in 94%, beta-blocker in 65%, and spironolactone in 39%. The median follow-up was 3.9 years. n-3 PUFA treatment led to an RRR of 8% in the co-primary composite outcome of death or cardiovascular hospitalization in an adjusted analysis (adjusted \( P = 0.009 \)). There was no reduction in HF hospitalization, but there was a 10% RRR in cardiovascular mortality (adjusted \( P = 0.045 \)) and 7% RRR in cardiovascular hospitalization (adjusted \( P = 0.026 \)).

- These findings are supported by one post-myocardial infarction RCT (GISSI-Prevenzione) but not by another (OMEGA). In GISSI-Prevenzione, involving 11,324 patients enrolled after a recent (\( \leq 3 \) months) myocardial infarction, patients received placebo or 1 g daily of n-3 PUFA. n-3 PUFA treatment led to an RRR of 10% in the primary composite outcome of death, myocardial infarction, or stroke (largely driven by a reduction in cardiovascular death).

- OMEGA randomized 3851 patients 3–14 days after acute myocardial infarction to placebo or 1 g n-3 PUFA daily for 1 year. Outcomes did not differ between treatment groups.

- n-3 PUFA preparations differ in composition and the dose may be important.

- The main adverse effects of n-3 PUFAs reported in these trials were nausea and other minor gastrointestinal disturbances.

### 7.3 Treatments not recommended (unproven benefit)

#### 7.3.1 3-Hydroxy-3-methylglutaryl-coenzyme A reductase inhibitors (‘statins’)

Although there is a wealth of robust evidence supporting the value of statins in patients with atherosclerotic (arterial) disease, most trials excluded patients with HF (because it was uncertain that they would benefit). Two recent trials studied statin treatment specifically in patients with chronic HF and did not demonstrate convincing evidence of benefit (although there was little evidence of harm). Despite the evidence in other areas of cardiovascular medicine, the evidence does not therefore support the initiation of statins in most patients with chronic HF.

**Key evidence**

- The Controlled Rosuvastatin Multinational Trial in Heart Failure (CORONA) and GISSI-HF compared rosuvastatin with placebo in patients with symptomatic HF.

- CORONA enrolled 5011 older patients (\( \geq 60 \) years) with symptomatic HF (NYHA class II–IV) of ischaemic aetiology with an EF \( \leq 40\% \), felt by the investigator not to require cholesterol-lowering therapy. Rosuvastatin did not reduce the primary endpoint (cardiovascular death, myocardial infarction, or stroke) or all-cause mortality.

- The GISSI-HF statin trial enrolled 4574 patients with symptomatic HF (NYHA class II–IV) of ischaemic and non-ischaemic aetiology. Patients had an EF \( \leq 40\% \) (or if \( > 40\% \), HF hospitalization in the previous year) and were randomized to placebo or rosuvastatin 10 mg daily, in addition to standard therapy including an ACE inhibitor/ARB in 94%, beta-blocker in 63% and spironolactone in 40%. The median follow-up was 3.9 years. The co-primary endpoints of all-cause mortality and the composite of all-cause death or cardiovascular hospitalization were not reduced by rosuvastatin.

### 7.3.2 Renin inhibitors

One direct renin inhibitor (aliskiren) is currently being evaluated in two morbidity–mortality RCTs. It is not presently recommended as an alternative to an ACE inhibitor or ARB.

#### 7.3.3 Oral anticoagulants

Other than in patients with AF (both HF-REF and HF-PEF), there is no evidence that an oral anticoagulant reduces mortality–morbidity compared with placebo or aspirin (see Section 10.1).

### 7.4 Treatments not recommended (believed to cause harm)

**Treatments (or combinations of treatments) that may cause harm in patients with symptomatic (NYHA class II–IV) systolic heart failure**

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Class</th>
<th>Level</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thiazolidinediones (glitazones) should not be used as they cause worsening HF and increase the risk of HF hospitalization.</td>
<td>III</td>
<td>A</td>
<td>131–133</td>
</tr>
<tr>
<td>Most CCBs (with the exception of amlodipine and felodipine) should not be used as they have a negative inotropic effect and can cause worsening HF.</td>
<td>III</td>
<td>B</td>
<td>134</td>
</tr>
<tr>
<td>NSAIDs and COX-2 inhibitors should be avoided if possible as they may cause sodium and water retention, worsening renal function and worsening HF.</td>
<td>III</td>
<td>B</td>
<td>135, 136</td>
</tr>
</tbody>
</table>

The addition of an ARB (or renin inhibitor) to the combination of an ACE inhibitor AND a mineralocorticoid antagonist is NOT recommended because of the risk of renal dysfunction and hyperkalaemia.

ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; CCB = calcium-channel blocker; COX = cyclo-oxygenase; EF = ejection fraction; HF = heart failure; NSAID = non-steroidal anti-inflammatory drug; NYHA = New York Heart Association.

\(<\text{Class of recommendation.}>\)

\(<\text{Level of evidence.}>\)

\(<\text{References.}>\)
7.5 Diuretics

The effects of diuretics on mortality and morbidity have not been studied in patients with HF, unlike ACE inhibitors, beta-blockers, and MRAs (and other treatments). However, diuretics relieve dyspnoea and oedema and are recommended for this reason in patients with signs and symptoms of congestion, irrespective of EF.

Loop diuretics produce a more intense and shorter diuresis than thiazides, which cause a more gentle and prolonged diuresis. Thiazides may be less effective in patients with reduced kidney function. Loop diuretics are usually preferred to thiazides in HF-REF although they act synergistically and the combination may be used (usually on a temporary basis) to treat resistant oedema.

The aim of using diuretics is to achieve and maintain euvolaemia (the patient’s ‘dry weight’) with the lowest achievable dose. This means that the dose must be adjusted, particularly after restoration of dry body weight, to avoid the risk of dehydration leading to hypotension and renal dysfunction. This may reduce cardiac output in patients with HF-PEF and often needlessly prevents the use of (or achievement of the target dose of) other disease-modifying therapies such as ACE inhibitors (or ARBs) and MRAs in patients with HF-REF. Many patients can be trained to self-adjust their diuretic dose, based on monitoring of symptoms/signs of congestion and daily weight measurements.

Practical guidance on the use of diuretics is given in Web Table 15 and the doses of commonly used diuretics are shown in Table 16.

Use of potassium-sparing diuretics and potassium supplements

- If a potassium-losing diuretic is used with the combination of an ACE inhibitor and an MRA (or ARB), potassium replacement is usually not required.
- Serious hyperkalaemia may occur if potassium-sparing diuretics or supplements are taken in addition to the combination of an ACE inhibitor (or ARB) and MRA.
- The use of all three of an ACE inhibitor, MRA and ARB is not recommended.

8. Pharmacological treatment of heart failure with ‘preserved’ ejection fraction (diastolic heart failure)

No treatment has yet been shown, convincingly, to reduce morbidity and mortality in patients with HF-PEF. Diuretics are used to control sodium and water retention and relieve breathlessness and oedema as in HF-REF. Adequate treatment of hypertension and myocardial ischaemia is also considered to be important, as is control of the ventricular rate in patients with AF (see Section 11). Two very small studies (<30 patients each) have shown that the heart rate-limiting calcium-channel blocker (CCB) verapamil may improve exercise capacity and symptoms in these patients. Rate-limiting CCBs may also be useful for ventricular rate control in patients with AF and in the treatment of hypertension and myocardial ischaemia (which is not the case in patients with HF-REF where their negative inotropic action can be dangerous). Beta-blockers may also be used to control the ventricular rate in patients with HF-PEF and AF.

The drugs that should be avoided in HF-REF (see Section 7.4) should also be avoided in HF-PEF, with the exception of CCBs. The key mortality–morbidity trials to date are:

- The 3023-patient Candesartan in Heart Failure: Assessment of Reduction in Mortality and Morbidity (CHARM)-Preserved trial, which showed no reduction in the primary composite endpoint (cardiovascular death or HF hospitalization).
- The 850-patient Perindopril for Elderly People with Chronic Heart failure trial (PEP-CHF), which showed no reduction in the primary composite endpoint of death or HF hospitalization.
- The 4128 patient Irbesartan in heart failure with preserved systolic function trial (I-Preserve) which showed no reduction in the primary composite outcome of death or cardiovascular

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### Table 16: Doses of diuretics commonly used to treat heart failure (with and without a preserved ejection fraction, chronic and acute)

<table>
<thead>
<tr>
<th>Diuretics</th>
<th>Initial dose (mg)</th>
<th>Usual daily dose (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Loop diuretics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furosemide</td>
<td>20–40</td>
<td>40–240</td>
</tr>
<tr>
<td>Bumetanide</td>
<td>0.5–1.0</td>
<td>1–5</td>
</tr>
<tr>
<td>Torasemide</td>
<td>5–10</td>
<td>10–20</td>
</tr>
<tr>
<td><strong>Thiazides</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bendroflumethiazide</td>
<td>2.5</td>
<td>2.5–10</td>
</tr>
<tr>
<td>Hydrochlorothiazide</td>
<td>25</td>
<td>12.5–100</td>
</tr>
<tr>
<td>Metolazone</td>
<td>2.5</td>
<td>2.5–10</td>
</tr>
<tr>
<td>Indapamide</td>
<td>2.5</td>
<td>2.5–5</td>
</tr>
<tr>
<td><strong>Potassium-sparing diuretics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spironolactone/ eplerenone</td>
<td>12.5–25</td>
<td>50</td>
</tr>
<tr>
<td>Amlodipine</td>
<td>2.5</td>
<td>5</td>
</tr>
<tr>
<td>Triamterene</td>
<td>25</td>
<td>50</td>
</tr>
</tbody>
</table>

ACEi = angiotensin-converting enzyme inhibitor; ARB = angiotensin receptor blocker.

1. Oral or intravenous; dose might need to be adjusted according to volume status/weight; excessive doses may cause renal impairment and ototoxicity.
2. Do not use thiazides if estimated glomerular filtration rate <30 mL/min, except when prescribed synergistically with loop diuretics.
3. Indapamide is a non-thiazide sulfonamide.
4. A mineralocorticoid antagonist (MRA) i.e. spironolactone/eplerenone is always preferred. Amlodipine and triamterene should not be combined with an MRA.
hospitalization (specifically, HF, myocardial infarction, unstable angina, arrhythmia, or stroke).\textsuperscript{141}

9. Non-surgical device treatment of heart failure with reduced ejection fraction (systolic heart failure)

This section discusses the use of ICDs and CRT. While no new ICD RCT has completed since publication of the 2008 guidelines,\textsuperscript{1} there have been several important RCTs using CRT that have changed the recommendations (see below). Other technologies including a wearable defibrillator vest\textsuperscript{132} and implantable monitors (either ‘stand-alone’ or incorporated into other devices) are of research interest, but do not yet have enough evidence behind them to support guideline recommendations.

9.1 Implantable cardioverter-defibrillator

Approximately half of the deaths in patients with HF, especially in those with milder symptoms, occur suddenly and unexpectedly, and many, if not most, of these are related to ventricular arrhythmias (whereas others may be related to bradycardia and asystole). Prevention of sudden death is therefore an important goal in HF. While the key disease-modifying neurohumoral antagonists mentioned earlier reduce the risk of sudden death, they do not abort it. Specific antiarrhythmic drugs do not decrease this risk (and may even increase it).\textsuperscript{143} For this reason, ICDs have an important role to play in reducing the risk of death from ventricular arrhythmias.

9.1.1 Secondary prevention of sudden cardiac death

Key evidence

ICDs reduce mortality in survivors of cardiac arrest and in patients with sustained symptomatic ventricular arrhythmias. Consequently, an ICD is recommended in such patients, irrespective of EF, with good functional status, a life expectancy of >1 year, and where the intent is to increase survival.\textsuperscript{144–147}

9.1.2 Primary prevention of sudden cardiac death

Key evidence

- The Sudden Cardiac Death in Heart Failure Trial (SCD-HeFT) enrolled 2521 patients with non-ischaemic dilated cardiomyopathy or ischaemic HF, no prior symptomatic ventricular arrhythmia, and an EF \( \leq 35\% \) who were in NYHA functional class II or III. These patients were randomized to placebo, amiodarone, or an ICD, in addition to conventional treatment including an ACE inhibitor or ARB (96%) and a beta-blocker (69%); MRA use was not reported.\textsuperscript{149}
- ICD treatment led to an ARR in death of 23% (\( P = 0.007 \)) over a median follow-up of 45.5 months. This benefit was additional to that gained with conventional treatment, including an ACE inhibitor and a beta-blocker. Amiodarone did not reduce mortality.
- The ARR in mortality with an ICD was 6.9%, equating to an NNT (for 45.5 months to postpone one death) of 14.
- Additional support for the use of ICDs comes from the Multi-center Automatic Defibrillator Implantation Trial II (MADIT-II),\textsuperscript{148} an RCT in which patients with a prior myocardial infarction and an EF \( \leq 30\% \) (59% of which were in NYHA class II or III) were assigned to receive either conventional treatment or conventional treatment plus an ICD. Use of an ICD led to a 31% RRR in mortality. Two other RCTs showed no benefit in patients treated with an ICD early (<40 days) after myocardial infarction.\textsuperscript{150,151} This is why ICD use in patients with coronary heart disease receives level of evidence A, but only in patients >40 days after acute myocardial infarction.
- There is less evidence in patients with non-ischaemic HF, with one moderate sized trial [Defibrillators in Non-ischemic Cardiomyopathy Treatment Evaluation (DEFINITE), \( n = 458 \)] showing only a non-significant trend to a reduction in mortality; hence the evidence level of B.\textsuperscript{152}
- ICD implantation should be considered only after a sufficient period of optimization of medical therapy (at least 3 months) and only if the EF remains persistently low.

Recommendations for the use of implanted cardioverter defibrillators in patients with heart failure

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Class\textsuperscript{a}</th>
<th>Level\textsuperscript{b}</th>
<th>Ref\textsuperscript{c}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary prevention</td>
<td>I</td>
<td>A</td>
<td>144–147</td>
</tr>
<tr>
<td>An ICD is recommended in a patient with a ventricular arrhythmia causing haemodynamic instability, who is expected to survive for &gt;1 year with good functional status, to reduce the risk of sudden death.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary prevention</td>
<td>I</td>
<td>A</td>
<td>148, 149</td>
</tr>
<tr>
<td>An ICD is recommended in a patient with symptomatic HF (NYHA class II–III) and an EF ( \leq 35% ) despite ( \geq 3 ) months of treatment with optimal pharmacological therapy, who is expected to survive for &gt;1 year with good functional status, to reduce the risk of sudden death.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) Ischaemic aetiology and &gt;40 days after acute myocardial infarction</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) Non-ischaemic aetiology</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HF = heart failure; ICD = implantable cardioverter defibrillator; NYHA = New York Heart Association.

\textsuperscript{a}Class of recommendation.

\textsuperscript{b}Level of evidence.

\textsuperscript{c}References.
ICD therapy is not indicated in patients in NYHA class IV with severe, drug-refractory, symptoms who are not candidates for CRT, a ventricular assist device, or cardiac transplantation (because such patients have a very limited life expectancy and are more likely to die from pump failure).

Patients should be counselled as to the purpose of an ICD and the complications related to its use (predominantly inappropriate shocks).  

If HF deteriorates, deactivation of a patient’s ICD may be considered after appropriate discussion with the patient and caregiver(s).

9.2 Cardiac resynchronization therapy

Two large RCTs have shown that CRT is of benefit in patients with mild (NYHA class II) symptoms as well as in those who are more severely symptomatic. There is little doubt that patients expected to survive with good functional status for >1 year should receive CRT if they are in sinus rhythm, their LVEF is low (<30%), QRS duration is markedly prolonged (>150 ms), and an ECG shows a left bundle branch morphology, irrespective of symptom severity. There is less consensus about patients with right bundle branch block or interventricular conduction delay (based on subgroup analyses) and those in AF (because most trials excluded these patients and because a high ventricular rate will prevent resynchronization). Another area of debate is what to do in an HF-REF patient without an indication for CRT who needs a conventional pacemaker. The possibility that patients with a QRS duration of 120 ms may have ‘mechanical dyssynchrony’ (detectable by imaging) and might benefit from CRT is another area of research interest but remains to be proven.

Recommendations for the use of CRT where the evidence is strong—patients in sinus rhythm with NYHA functional class III and ambulatory class IV heart failure and a persistently reduced ejection fraction, despite optimal pharmacological therapy

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Class</th>
<th>Level</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LBBB QRS morphology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRT-P/CRT-D is recommended in patients in sinus rhythm with a QRS duration of ≥120 ms, LBBB QRS morphology, and an EF ≤35%, who are expected to survive with good functional status for &gt;1 year, to reduce the risk of HF hospitalization and the risk of premature death.</td>
<td>I</td>
<td>A</td>
<td>156, 157</td>
</tr>
<tr>
<td><strong>Non-LBBB QRS morphology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRT-P/CRT-D should be considered in patients in sinus rhythm with a QRS duration of ≥150 ms, irrespective of QRS morphology, and an EF ≤35%, who are expected to survive with good functional status for &gt;1 year, to reduce the risk of HF hospitalization and the risk of premature death.</td>
<td>IIa</td>
<td>A</td>
<td>156, 157</td>
</tr>
</tbody>
</table>

CRT-D = cardiac resynchronization therapy defibrillator; CRT-P = cardiac resynchronization therapy pacemaker; EF = ejection fraction; HF = heart failure; LBBB = left bundle branch block; NYHA = New York Heart Association.

Class of recommendation.

Level of evidence.

References.

Recommendations for the use of CRT where the evidence is strong—patients in sinus rhythm with NYHA functional class II heart failure and a persistently reduced ejection fraction, despite optimal pharmacological therapy

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Class</th>
<th>Level</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LBBB QRS morphology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRT, preferably CRT-D is recommended in patients in sinus rhythm with a QRS duration of ≥130 ms, LBBB QRS morphology, and an EF ≤30%, who are expected to survive for &gt;1 year with good functional status, to reduce the risk of HF hospitalization and the risk of premature death.</td>
<td>I</td>
<td>A</td>
<td>154, 155</td>
</tr>
<tr>
<td><strong>Non-LBBB QRS morphology</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRT, preferably CRT-D should be considered in patients in sinus rhythm with a QRS duration of ≥150 ms, irrespective of QRS morphology, and an EF ≤30%, who are expected to survive for &gt;1 year with good functional status, to reduce the risk of HF hospitalization and the risk of premature death.</td>
<td>IIa</td>
<td>A</td>
<td>154, 155</td>
</tr>
</tbody>
</table>

CRT-D = cardiac resynchronization therapy defibrillator; EF = ejection fraction; HF = heart failure; LBBB = left bundle branch block; NYHA = New York Heart Association.

Class of recommendation.

Level of evidence.

References.
9.2.1 Recommendations for cardiac resynchronization therapy where the evidence is certain

Key evidence supporting the use of cardiac resynchronization therapy

Moderate to severely symptomatic heart failure

- Two key placebo-controlled RCTs [Comparison of Medical Therapy, Pacing, and Defibrillation in Heart Failure (COMPANION) and Cardiac Resynchronization in Heart Failure Study (CARE-HF)] randomized 2333 patients with moderate to severely symptomatic HF (NYHA class III or IV) to either optimal medical therapy or optimal medical therapy plus CRT. Patients in COMPANION were required to be in sinus rhythm, to have an EF ≤ 35% and a QRS duration of at least 120 ms, and a HF hospitalization or equivalent in the preceding year. Patients in CARE-HF were required to be in sinus rhythm and to have an EF ≤ 35%, a QRS duration ≥ 120 ms (if the QRS duration was 120–149 ms other echocardiographic criteria for dys synchrony had to be met), and an LV end-diastolic dimension of at least 30 mm (indexed to height).

- Each of these two trials showed that CRT reduced the risk of death from any cause and hospital admission for worsening HF [RRR in death of 24% with a CRT-pacemaker (CRT-P) and of 36% with CRT-defibrillator (CRT-D) in COMPANION and of 36% with CRT-P in CARE-HF]. In CARE-HF, the RRR in HF hospitalization with CRT-P was 52%. These benefits were additional to those gained with conventional treatment, including a diuretic, digoxin, an ACE inhibitor, a beta-blocker, and an MRA.

- The ARR with CRT-D in the composite outcome of cardiovascular death or cardiovascular hospitalization in COMPANION was 8.6%, equating to an NNT (over a median duration of follow-up of ~16 months) to postpone one event of 12. The corresponding figures for CRT-P in CARE-HF (over a mean follow-up of 29 months) were an ARR of 16.6% and an NNT of 6.

- These trials also showed that CRT improves symptoms, quality of life, and ventricular function. Other trials showed that these agents improve exercise capacity.

- Because these severely symptomatic patients have much to gain and because there was no subgroup of patients that clearly did not benefit from CRT, individuals in NYHA functional class III and IV have been given the broadest indication for CRT.

Mild to moderately symptomatic HF

- Two key placebo-controlled RCTs randomized 3618 patients with mild (MADIT-CRT, 15% NYHA class I and 85% NYHA class II) to moderately [Resynchronization/Defibrillation for Ambulatory Heart Failure Trial (RAFT), 80% NYHA class II and 20% NYHA class III] symptomatic HF to either optimal medical therapy plus an ICD or optimal medical therapy plus a CRT-D. Patients in MADIT-CRT were required to have an EF ≤ 30%, a QRS duration ≥ 130 ms, and to be in sinus rhythm. Patients in RAFT were required to have an EF ≤ 30% and a QRS duration ≥ 120 ms (13% of enrolled patients had AF with a well-controlled ventricular rate).

- Each of these two trials showed that CRT reduced the risk of the primary composite endpoint of death or HF hospitalization (HF event in MADIT-CRT) (RRR of 34% in MADIT-CRT and 25% in RAFT). There was a 25% reduction in all-cause mortality in RAFT (P = 0.003), but mortality was not reduced in MADIT-CRT. These benefits were additional to those gained with conventional treatment, including a diuretic, digoxin, an ACE inhibitor, a beta-blocker, an MRA, and an ICD.

- The ARR in the primary composite mortality–morbidity endpoint in MADIT-CRT was 8.1%, equating to an NNT (for an average of 2.4 years to postpone one event) of 12. The equivalent figures for RAFT were ARR 7.1% and NNT 14 (over an average of 40 months).

- These trials also showed that CRT improves symptoms, quality of life, and ventricular function. Other trials showed that these agents improve exercise capacity.

- Both MADIT-CRT and RAFT showed a significant treatment-by-subgroup interaction whereby QRS duration modified the treatment effect (CRT appeared more effective in patients with a QRS ≥ 150 ms) and patients with LBBB also seemed to obtain more benefit than those with right bundle branch block or an interven tricular conduction defect (these groups overlap considerably, as patients with LBBB are more likely to have a QRS duration ≥ 150 ms). These findings are supported by echocardiographic analyses. For these reasons, in patients with milder symptoms, CRT is recommended only in those with either a QRS duration ≥ 150 ms or ≥ 130 ms plus an LBBB pattern.

9.2.2 Recommendations for cardiac resynchronization therapy where the evidence is uncertain

Two commonly encountered clinical situations where there is little robust evidence for (or against) CRT are AF and when a patient with a reduced EF has an indication for conventional pacing and no other indication for CRT.

Atrial fibrillation

One small, single-blind study [Multisite Stimulation in Cardiomyopathies (MUSTIC)] included 59 HF-REF patients with persistent/permanent AF (without AV nodal ablation) may benefit from CRT are selected patients with LBBB and a paced QRS duration ≥ 200 ms. The study had a crossover design (3 months conventional pacing vs. 3 months CRT). There was a high drop-out rate (42%) and there was no difference in the primary endpoint of 6-min walk distance. The key large RCTs of CRT all excluded patients in AF, with the exception of RAFT. RAFT included 229 patients with permanent AF or flutter either with a controlled ventricular rate (≤ 60 b.p.m. at rest and ≤ 90 b.p.m. during a 6-min walk test) or with planned AV junction ablation. Further analysis did not show a significant interaction between baseline rhythm and treatment effect, but this subgroup represented only a small proportion of the overall population. Other data suggesting that patients with AF (without AV nodal ablation) may benefit from CRT are limited by being observational in nature.

Patients with an indication for conventional pacing

All the major RCTs of CRT, with the exception of RAFT, excluded patients with a conventional indication for pacing. RAFT included...
135 patients with a paced QRS duration $\geq$ 200 ms, a subgroup too small for meaningful analysis. Conventional right ventricular pacing, however, alters the normal sequence of cardiac activation in a similar way to LBBB, and experimental and observational data suggest that this may lead to deterioration in LV systolic function.164,165 It is on this basis that CRT is recommended as an alternative to conventional right ventricular pacing in patients with HF-REF who have a standard indication for pacing or who require a generator change or revision of a conventional pacemaker.

10. Arrhythmias, bradycardia, and atrioventricular block in patients with heart failure with reduced ejection fraction and heart failure with preserved ejection fraction

The management of arrhythmias is discussed in other ESC guidelines,143,166 and this section focuses only on aspects that are particularly relevant to patients with HF.

10.1 Atrial fibrillation

AF is the most common arrhythmia in HF; it increases the risk of thrombo-embolic complications (particularly stroke) and may lead to worsening of symptoms. Whether AF is an independent predictor of mortality is less certain, as is whether it can cause systolic HF (‘tachycardiomypathy’).

AF should be classified and managed according to the current AF guidelines (i.e. first episode, paroxysmal, persistent, longstanding persistent, or permanent), recognizing the uncertainty about the actual duration of the episode and about previous undetected episodes.166

The following issues need to be considered in patients with HF and AF, especially a first episode of AF or paroxysmal AF:

- Identification of correctable causes (e.g. hyperthyroidism, electrolyte disorders, uncontrolled hypertension, mitral valve disease).
- Identification of potential precipitating factors (e.g. recent surgery, chest infection or exacerbation of chronic pulmonary disease/asthma, acute myocardial ischaemia, alcohol binge) as this may determine whether a rhythm-control strategy is preferred to a rate-control strategy.
- Assessment for thromboembolism prophylaxis.

10.1.1 Rate control

An approach to controlling the ventricular rate in patients with HF and AF is shown in Figure 3. Recommendations for stepwise use of individual treatments in patients with HF-REF are given below.

For rate control in patients with HF-REF, a beta-blocker is preferred over digoxin as the latter does not provide rate control during exercise.167 Furthermore, beta-blockers have favourable effects on mortality and morbidity in systolic HF per se (see above). The combination of digoxin and a beta-blocker is more effective than a beta-blocker alone in controlling the ventricular rate at rest.168

In patients with HF-PEF, rate-limiting CCBs (verapamil and diltiazem) are an effective alternative to a beta-blocker (but their use is not recommended in patients with HF-REF as their negative inotropic action may further depresses LV systolic function).134,167
The combination of digoxin and a rate-limiting CCB is more effective than a CCB alone in controlling the ventricular rate at rest.169 Assessment of control of the ventricular rate on exertion requires either ambulatory ECG monitoring or measurement of the rate during moderate exercise. The optimum ventricular rate in patients with HF and AF is uncertain because the one RCT comparing strict with lenient rate control included very few patients with HF.170 In the Atrial Fibrillation and Congestive Heart Failure (AF-CHF) study (which showed similar outcomes for a rate-control compared with a rhythm-control strategy) the target rate was <80 b.p.m. at rest and <110 b.p.m. during a 6-min walk test.171

In extreme cases, AV node ablation and pacing may be required; in this situation in patients with systolic HF, CRT may be considered instead of conventional pacing (see Section 9.2).164

10.1.2 Rhythm control

In patients with chronic HF, a rhythm-control strategy (including pharmacological or electrical cardioversion) has not been demonstrated to be superior to a rate-control strategy in reducing
mortality or morbidity. This strategy is probably best reserved for patients with a reversible secondary cause of AF (e.g. hyperthyroidism) or an obvious precipitant (e.g. recent pneumonia) and in patients who cannot tolerate AF after optimization of rate control and HF therapy. Amiodarone is the only antiarrhythmic that should be used in patients with systolic HF. The role of catheter ablation as a rhythm control strategy in HF is at present uncertain.

In patients with AHF, emergency cardioversion may be required to correct profound haemodynamic instability (see Section 12.2).

10.1.3 Thrombo-embolism prophylaxis

Thrombo-embolism prophylaxis in patients with HF and AF should be based on the Cardiac failure, Hypertension, Age ≥75 (Doubled), Diabetes, Stroke (Doubled)-Vascular disease, Age 65–74 and Sex category (Female) (CHA2DS2-VASc) score (see Table 17), in keeping with the 2010 ESC AF guidelines. A substantial proportion of patients with HF will have a score ≥3, indicating that careful consideration should be given before prescribing an oral anticoagulant and that regular review is needed (and correctable risk factors addressed) if an oral anticoagulant is given.

Some new anticoagulant drugs such as the oral direct thrombin inhibitors and oral factor Xa inhibitors are contraindicated in severe renal impairment (creatinine clearance <30 mL/min). This is clearly a concern in many patients with HF and, if these drugs are used, serial monitoring of renal function is required. There is no known way to reverse the anticoagulant action of these new drugs.

10.2 Ventricular arrhythmias

Ventricular arrhythmias are frequent in HF patients, particularly in those with a dilated left ventricle and reduced EF. Ambulatory ECG recording detects premature ventricular complexes in virtually all HF patients, and episodes of asymptomatic, non-sustained ventricular tachycardia are common. Historical studies have suggested that ‘complex ventricular arrhythmias’ (frequent premature ventricular complexes and non-sustained ventricular
tachycardia) are associated with a poor outcome in HF. Certain recommendations from the American College of Cardiology/American Heart Association/ESC guidelines on the management of ventricular arrhythmias and sudden death, which may be particularly relevant to patients with HF, are summarized below. The role of catheter ablation in patients with HF other than as an adjunct in the treatment of refractory ventricular arrhythmias is uncertain. The reader is also referred to the section on ICDs (Section 9.1).

10.3 Symptomatic bradycardia and atrioventricular block

Although the indications for pacing in patients with HF are similar to those in other patients, as described in the ESC guidelines on pacing, there are issues specific to HF, including:

- Before implanting a conventional pacemaker in a patient with HF-REF, consider whether there is an indication for an ICD, CRT-P, or CRT-D (see Sections 9.1 and 9.2).
- Because right ventricular pacing may induce dyssynchrony and worsen symptoms, CRT should be considered instead of conventional pacing in patients with HF-REF (see Section 9.2).

### Table 17 Assessment of stroke risk in patients with atrial fibrillation

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Class</th>
<th>Level</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrical cardioversion or pharmacological cardioversion with amiodarone may be considered in patients with persisting symptoms and/or signs of HF despite optimum pharmacological treatment and adequate control of the ventricular rate, to improve clinical/symptomatic status.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Amiodarone may be considered prior to (and following) successful electrical cardioversion to maintain sinus rhythm.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Dronedarone is not recommended because of an increased risk of hospital admissions for cardiovascular causes and an increased risk of premature death.</td>
<td>III</td>
<td>A</td>
<td>176, 177</td>
</tr>
<tr>
<td>Class I antiarrhythmic agents are not recommended because of an increased risk of premature death.</td>
<td>III</td>
<td>A</td>
<td>178</td>
</tr>
</tbody>
</table>

AF = atrial fibrillation; EF = ejection fraction; HF = heart failure; LV = left ventricular; NYHA = New York Heart Association.

*Class of recommendation.
†Level of evidence.
‡References.

### Table 18 Assessment of bleeding risk in patients with atrial fibrillation

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Class</th>
<th>Level</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension (systolic blood pressure &gt;160 mmHg)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal renal and liver function (1 point each)</td>
<td>1 or 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding tendency or predisposition</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labile international normalized ratio (if on warfarin)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elderly (e.g. age &gt; 65 years)</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs (e.g. concomitant aspirin, NSAID) or alcohol (1 point each)</td>
<td>1 or 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum score</td>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A HAS-BLED score ≥3 suggests that caution is warranted when prescribing oral anticoagulation and regular review is recommended.
### Recommendations for the prevention of thromboembolism in patients with symptomatic HF (NYHA functional class II–IV) and paroxysmal or persistent/permanent AF

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Classa</th>
<th>Levelb</th>
<th>Refc</th>
</tr>
</thead>
<tbody>
<tr>
<td>The CHA2DS2-VASc and HAS-BLED scores (Tables 17 and 18) are recommended to determine the likely risk–benefit (thrombo-embolism prevention vs. risk of bleeding) of oral anticoagulation.</td>
<td>I</td>
<td>B</td>
<td>179, 180</td>
</tr>
<tr>
<td>An oral anticoagulant is recommended for all patients with paroxysmal or persistent/permanent AF and a CHA2DS2-VASc score $\geq 1$, without contraindications, and irrespective of whether a rate- or rhythm-management strategy is used (including after successful cardioversion).</td>
<td>I</td>
<td>A</td>
<td>184</td>
</tr>
<tr>
<td>In patients with AF of $\geq 48$ h duration, or when the known duration of AF is unknown, an oral anticoagulant is recommended at a therapeutic dose for $\geq 3$ weeks prior to electrical or pharmacological cardioversion.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Intravenous heparin or LMWH is recommended for patients who have not been treated with an anticoagulant and require urgent electrical or pharmacological cardioversion.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Alternative to i.v. heparin or LMWH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A TOE-guided strategy may be considered for patients who have not been treated with an anticoagulant and require urgent electrical or pharmacological cardioversion.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Combination of an oral anticoagulant and an antiplatelet agent is not recommended in patients with chronic ($&gt;12$ months after an acute event) coronary or other arterial disease, because of a high risk of serious bleeding. Single therapy with an oral anticoagulant is preferred after 12 months.</td>
<td>III</td>
<td>A</td>
<td>185</td>
</tr>
</tbody>
</table>

**AF** = atrial fibrillation; **CHA2DS2-VASc** = Claudicatio, Hypertension, Age $\geq 75$ (Doubled), Diabetes, Stroke (Doubled), Vascular disease, Age 65–74 and Sex category (Female); **EF** = ejection fraction; **HAS-BLED** = Hypertension, Abnormal renal/liver function (1 point each), Stroke, Bleeding history or predisposition, Labile international normalized ratio, Elderly ($>65$), Drugs/alcohol concomitantly (1 point each); **HF** = heart failure; **i.v.** = intravenous; **LMWH** = low molecular weight heparin; **LV** = left ventricular; **NYHA** = New York Heart Association; **TOE** = transoesophageal echocardiography.

*aClass of recommendation.

*bLevel of evidence.

*cReferences.

### Recommendations for the management of ventricular arrhythmias in heart failure

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Classa</th>
<th>Levelb</th>
<th>Refc</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is recommended that potential aggravating/precipitating factors (e.g. electrolyte disorders, use of proarrhythmic drugs, myocardial ischaemia) should be sought and corrected in patients with ventricular arrhythmias.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>It is recommended that treatment with an ACE inhibitor (or ARB), beta-blocker, and MRA should be optimized in patients with ventricular arrhythmias.</td>
<td>I</td>
<td>A</td>
<td>87–100</td>
</tr>
<tr>
<td>It is recommended that coronary revascularization is considered in patients with ventricular arrhythmias and coronary artery disease (see Section 13.2).</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>It is recommended that an ICD is implanted in a patient with symptomatic or sustained ventricular arrhythmia (ventricular tachycardia or ventricular fibrillation), reasonable functional status, and in whom a goal of treatment is to improve survival.</td>
<td>I</td>
<td>A</td>
<td>144–149</td>
</tr>
<tr>
<td>Amiodarone is recommended in patients with an ICD, who continue to have symptomatic ventricular arrhythmias or recurrent shocks despite optimal treatment and device re-programming.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Catheter ablation is recommended in patients with an ICD who continue to have ventricular arrhythmias causing recurrent shocks not preventable by optimal treatment device re-programming and amiodarone.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Amiodarone may be considered as a treatment to prevent recurrence of sustained symptomatic ventricular arrhythmias in otherwise optimally treated patients in whom an ICD is not considered appropriate.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Routine use of amiodarone is not recommended in patients with non-sustained ventricular arrhythmias because of lack of benefit and potential drug toxicity.</td>
<td>III</td>
<td>A</td>
<td>172, 173</td>
</tr>
<tr>
<td>Other antiarrhythmic drugs (particularly class IC agents and dronedarone) should not be used in patients with systolic HF because of safety concerns (worsening HF, proarrhythmia, and death).</td>
<td>III</td>
<td>A</td>
<td>176, 178</td>
</tr>
</tbody>
</table>

**ACE** = angiotensin-converting enzyme; **ARB** = angiotensin receptor blocker; **HF** = heart failure; **ICD** = implantable cardioverter-defibrillator; **MRA** = mineralocorticoid receptor antagonist.

*aClass of recommendation.

*bLevel of evidence.

*cReferences.
Physiological pacing to maintain an adequate chronotropic response and maintain atrial—ventricular coordination with a DDD system is preferable to VVI pacing in patients with both HF-REF and HF-PEF. Pacing solely in order to permit initiation or titration of beta-blocker therapy in the absence of a conventional indication is not recommended.

11. Importance and management of other co-morbidity in heart failure with reduced ejection fraction and heart failure with preserved ejection fraction

11.1 Heart failure and co-morbidities

Co-morbidities are important in patients with HF for four main reasons. First, co-morbidities may affect the use of treatments for HF (e.g. it may not be possible to use renin—angiotensin system inhibitors in ischaemic patients with renal dysfunction) (see Section 7.2). Secondly, the drugs used to treat co-morbidities may cause worsening of HF (e.g. NSAIDs given for arthritis) (see Section 7.4). Thirdly, the drugs used to treat HF and those used to treat co-morbidities may also interact with one another [e.g. beta-blockers and beta-agonists for chronic obstructive pulmonary disease (COPD) and asthma] and reduce patient adherence. Lastly, most co-morbidities are associated with worse clinical status and are predictors of poor prognosis in HF (e.g. diabetes). This has led to some co-morbidities themselves becoming targets for treatment (e.g. anaemia). Management of co-morbidities is a key component of the holistic care of patients with HF (see Section 14).

11.2 Anaemia

Anaemia (defined as a haemoglobin concentration <13 g/dL in men and <12 g/dL in women) is common in HF, particularly in hospitalized patients. It is more frequent in women, the elderly, and in patients with renal impairment. Anaemia is associated with more symptoms, worse functional status, greater risk of HF hospitalization, and reduced survival. A standard diagnostic work-up should be undertaken in anaemic patients. Correctable causes should be treated in the usual way, although no ‘definite’ aetiology is identified in many patients. Correction of iron deficiency using i.v. iron has been specifically studied in patients with HF (see Section 11.14). The value of erythropoietin-stimulating agents as a treatment for anaemia of unknown aetiology is unknown but is currently being tested in a large mortality-morbidity RCT.

11.3 Angina

Beta-blockers are effective agents for angina as well as an essential treatment for systolic HF. Certain other effective antianginal drugs have been studied in large numbers of patients with systolic HF and shown to be safe (e.g. amlodipine, ivabradine, and nitrates) and ranolazine is uncertain, while other drugs, specifically dilatazum and verapamil, are thought to be unsafe in patients with HF-REF (although they may be used in HF-PEF). Percutaneous and surgical revascularization are alternative approaches to the treatment of angina (see Section 13). Coronary artery bypass graft surgery may reduce morbidity and mortality in patients with HF-REF.

11.4 Asthma: see chronic obstructive pulmonary disease

See Section 11.7.

11.5 Cachexia

A generalized process, wasting all body compartments [i.e. lean tissue (skeletal muscle), fat tissue (energy reserves), and bone tissue (osteoporosis)], may occur in 10–15% of patients with HF, especially those with HF-REF. This serious complication is associated with worse symptoms and functional capacity, more frequent hospitalization, and decreased survival. Cachexia is specifically defined as involuntary non-oedematous weight loss ≥6% of total body weight within the previous 6–12 months. The causes are uncertain, but may include poor nutrition, malabsorption, impaired calorie and protein balance, hormone resistance, pro-inflammatory immune activation, neurohormonal derangements, and reduced anabolic drive. Potential treatments include appetite stimulants, exercise training, and anabolic agents (insulin, anabolic steroids) in combination with the application of nutritional supplements, although none is of proven benefit and their safety is unknown.

11.6 Cancer

Certain chemotherapeutic agents can cause (or aggravate) LV systolic dysfunction and HF. The best recognized of these are the anthracyclines (e.g. doxorubicin) and trastuzumab. Dexrazoxane may confer some cardioprotection in patients receiving anthracyclines. Pre- and post-evaluation of EF is essential in patients receiving cardiotoxic chemotherapy, as detailed elsewhere. Patients developing LV systolic dysfunction should not receive further chemotherapy and should receive standard treatment for HF-REF. Mediastinal irradiation can also lead to a variety of long-term cardiac complications, although the less frequent use of high-dose, wide-field radiotherapy has led to a decline in these problems.

11.7 Chronic obstructive pulmonary disease

COPD and asthma may cause diagnostic difficulties, especially in HF-PEF. These conditions are associated with worse functional status and a worse prognosis. Beta-blockers are contraindicated in asthma but not in COPD, although a selective beta-1 adrenoceptor antagonist (i.e. bisoprolol, metoprolol succinate, or nebivolol) is preferred. Oral corticosteroids cause sodium and water retention, potentially leading to worsening of HF, but this is not believed to be a problem with inhaled corticosteroids. COPD is an independent predictor of worse outcomes in HF.
11.8 Depression
Depression is common and is associated with worse clinical status and a poor prognosis in HF. It may also contribute to poor adherence and social isolation. A high index of suspicion is needed to make the diagnosis, especially in the elderly. Routine screening using a validated questionnaire is good practice. Psychosocial intervention and pharmacological treatment are helpful. Selective serotonin reuptake inhibitors are thought to be safe, whereas tricyclic antidepressants are not because they may cause hypotension, worsening HF, and arrhythmias. 196

11.9 Diabetes
Dysglycaemia and diabetes are very common in HF, and diabetes is associated with poorer functional status and worse prognosis.
Diabetes may be prevented by treatment with ARBs and possibly ACE inhibitors. Beta-blockers are not contraindicated in diabetes and are as effective in improving outcome in diabetic patients as in non-diabetic individuals, although different beta-blockers may have different effects on glycaemic indices. Thiazolidinediones (glitazones) cause sodium and water retention and increased risk of worsening HF and hospitalization, and should be avoided (see recommendations, Section 7.4). Metformin is not recommended in patients with severe renal or hepatic impairment because of the risk of lactic acidosis, but is widely (and apparently safely) used in other patients with HF. The safety of newer anti-diabetic drugs in HF is unknown.

11.10 Erectile dysfunction
Erectile dysfunction should be treated in the usual way; phosphodiesterase V inhibitors are not contraindicated other than in patients taking nitrates. Indeed short-term studies have shown that these agents have favourable haemodynamic and other effects in patients with HF-REF. There are, however, reports of phosphodiesterase V inhibitors causing worsening LV outflow tract obstruction in patients with hypertrophic cardiomyopathy, which may be a concern in some patients with HF-PEF.

11.12 Gout
Hyperuricaemia and gout are common in HF and may be caused or aggravated by diuretic treatment. Hyperuricaemia is associated with a worse prognosis in HF-REF. Xanthine oxidase inhibitors (allopurinol, oxyipurinol) may be used to prevent gout, although their safety in HF-REF is uncertain. Gout attacks are better treated by colchicine than with NSAIDs (although colchicine should not be used in patients with very severe renal dysfunction and may cause diarrhoea). Intra-articular corticosteroids are an alternative for monarticular gout, but systemic corticosteroids cause sodium and water retention.

11.13 Hyperlipidaemia
Elevated low-density lipoprotein cholesterol is uncommon in HF-REF; patients with advanced HF-REF often have low concentrations of low-density lipoprotein, which is associated with a worse prognosis. Rosuvastatin did not reduce the primary composite mortality–morbidity endpoints in two large RCTs in HF.

11.14 Hypertension
Hypertension is associated with an increased risk of developing HF; antihypertensive therapy markedly reduces the incidence of HF (with an exception of alpha-adrenoceptor blockers, which are less effective than other antihypertensives in preventing HF). Negatively inotropic CCBs (i.e. diltiazem and verapamil) should not be used to treat hypertension in patients with HF-REF (but are believed to be safe in HF-PEF), and moxonidine should also be avoided in patients with HF-REF as it increased mortality in patients in one RCT. If blood pressure is not controlled with an ACE inhibitor (or ARB), a beta-blocker, MRA, and diuretic, hydralazine and amlodipine (or felodipine), are additional

### Recommendations for the treatment of hypertension in patients with symptomatic HF (NYHA functional class II–IV) and LV systolic dysfunction

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Class</th>
<th>Level</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One or more of an ACE inhibitor (or ARB), beta-blocker, and MRA is recommended as first-, second-, and third-line therapy, respectively, because of their associated benefits (reducing the risk of HF hospitalization and reducing the risk of premature death).</td>
<td>I</td>
<td>A</td>
<td>87, 108–111</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A thiazide diuretic (or if the patient is treated with a thiazide diuretic, switching to a loop diuretic) is recommended when hypertension persists despite treatment with a combination of as many as possible of an ACE inhibitor (or ARB), beta-blocker, and MRA.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amlodipine is recommended when hypertension persists despite treatment with a combination of as many as possible of an ACE inhibitor (or ARB), beta-blocker, MRA, and diuretic.</td>
<td>I</td>
<td>A</td>
<td>188, 189</td>
</tr>
<tr>
<td>Hydralazine is recommended when hypertension persists despite treatment with a combination of as many as possible of an ACE inhibitor (or ARB), beta-blocker, MRA, and diuretic.</td>
<td>I</td>
<td>A</td>
<td>114–116</td>
</tr>
<tr>
<td>Felodipine should be considered when hypertension persists despite treatment with a combination of as many as possible of an ACE inhibitor (or ARB), beta-blocker, MRA, and diuretic.</td>
<td>IIa</td>
<td>B</td>
<td>204</td>
</tr>
<tr>
<td>Moxonidine is NOT recommended because of safety concerns (increased mortality).</td>
<td>III</td>
<td>B</td>
<td>203</td>
</tr>
<tr>
<td>Alpha-adrenoceptor antagonists are NOT recommended because of safety concerns (neurohumoral activation, fluid retention, worsening HF).</td>
<td>III</td>
<td>A</td>
<td>202, 206, 207</td>
</tr>
</tbody>
</table>

ACE = angiotensin-converting enzyme; ARB = angiotensin receptor blocker; HF = heart failure; LV = left ventricular; LVEF = left ventricular ejection fraction; MRA = mineralocorticoid receptor antagonist; NYHA = New York Heart Association.

*Class of recommendation.

1Level of evidence.

References.
11.14 Iron deficiency
Iron deficiency may contribute to muscle dysfunction in HF and causes anaemia. In a single RCT, 459 patients with NYHA class II or III systolic HF, a haemoglobin concentration between 9.5 and 13.5 g/dL, and iron deficiency (see below) were randomized 2:1 to i.v. ferric carboxymaltose or saline. In this trial, iron deficiency was diagnosed when serum ferritin was <100 μg/L or when the ferritin concentration was between 100 and 299 μg/L and transferrin saturation was <20%. Over 6 months of treatment, iron therapy improved self-reported patient global assessment and NYHA class (as well as 6-min walk distance and health-related quality of life) and may be considered as a treatment for these patients. The effect of treating iron deficiency in HF-P EF and the long-term safety of iron therapy in HF is unknown.

11.15 Kidney dysfunction and cardiorenal syndrome
The GFR is reduced in most patients with HF, especially if advanced, and renal function is a powerful independent predictor of prognosis in HF. Renin–angiotensin–aldosterone blockers (ACE inhibitors, renin inhibitors, ARBs, and MRAs) frequently cause a fall in GFR, although any reduction is usually small and should not lead to treatment discontinuation unless marked (see Web Table 11). Conversely, an immediate and large fall in GFR should raise the suspicion of renal artery stenosis. Sodium and water depletion (due to the excessive diuresis or fluid loss due to vomiting or diarrhoea) and hypotension are well recognized causes of renal dysfunction, but less well known is that volume overload, right heart failure, and renal venous congestion may also cause renal dysfunction. Other causes of kidney dysfunction are prostatic obstruction and nephrotoxic drugs such as NSAIDs and certain antibiotics (e.g. trimethoprim and gentamicin), all of which should be considered (and corrected or avoided) in HF patients with worsening renal function. Thiazide diuretics may be less effective in patients with a very low eGFR, and certain renally excreted drugs (e.g. digoxin, insulin, and low molecular weight heparin) may accumulate in patients with renal impairment. Sometimes the term ‘cardiorenal syndrome’ is used to describe concurrent heart and renal failure (and ‘cardiorenal–anaemia syndrome’ if there is concomitant anaemia).

Chronic or acute renal dysfunction is a particular problem in patients with AHF, and is discussed further in that section (see Section 12).

11.16 Obesity
Obesity is a risk factor for HF and complicates its diagnosis because it causes dyspnoea, effort intolerance, and ankle swelling, and may result in poor-quality echocardiographic images. Obese individuals also have reduced natriuretic peptide levels. Obesity is more common in HF-P EF than in HF-REF, although it is possible that misdiagnosis may explain at least some of this difference in prevalence. Obesity should be managed as recommended in other guidelines.

11.17 Prostatic obstruction
Alpha-adrenoceptor blockers cause hypotension, and sodium and water retention, and may not be safe in systolic HF (see Section 11.13). Sleep aponoa is of concern in patients with HF because it leads to intermittent hypoxaemia, hypercapnia, and sympathetic excitation. Obstructive sleep apnoea also causes recurrent episodes of negative intrathoracic pressure and increases in LV afterload. It is more common in patients who are obese and whose sleeping partners report that the patient snores or exhibits daytime somnolence (the patient may not be aware of these). However, not all patients with obstructive sleep apnoea are obese. The prevalence of central sleep apnoea (including Cheyne–Stokes respiration) in HF is uncertain and may have declined since the widespread use of beta-blockers and CRT. Screening for and the diagnosis and treatment of sleep apnoea is discussed in detail elsewhere. Diagnosis currently requires overnight polysomnography. Nocturnal oxygen supplementation, continuous positive airway pressure, bi-level positive airway pressure, and adaptive servo-ventilation may be used to treat nocturnal hypoxaemia.

12. Acute heart failure
Acute heart failure (AHF) is the term used to describe the rapid onset of, or change in, symptoms and signs of HF. It is a life-threatening condition that requires immediate medical attention and usually leads to urgent admission to hospital. In most cases, AHF arises as a result of deterioration in patients with a previous diagnosis of HF (either HF-REF or HF-P EF), and all of the aspects of chronic management described in these guidelines apply fully to these patients. AHF may also be the first presentation of HF (‘de novo’ AHF). AHF may be caused by an abnormality of any aspect of cardiac function (Web Table 3). In patients with pre-existing HF there is often a clear precipitant or trigger (e.g. an arrhythmia or discontinuation of diuretic therapy in a patient with HF-REF and volume overload or severe hypertension in patients with HF-P EF) (Table 19). The
12.1 Initial assessment and monitoring of patients

Three parallel assessments must be made during the initial evaluation of the patient, aided by the investigations listed in Figure 4.

(i) Does the patient have HF or is there an alternative cause for their symptoms and signs (e.g. chronic lung disease, anaemia, kidney failure, or pulmonary embolism)?

(ii) If the patient does have HF, is there a precipitant and does it require immediate treatment or correction (e.g. an arrhythmia or acute coronary syndrome)?

(iii) Is the patient’s condition immediately life-threatening because of hypoxaemia or hypotension leading to underperfusion of the vital organs (heart, kidneys, and brain)?

12.2 Treatment of acute heart failure

Often treatment must be administered in parallel with the diagnostic work-up (see treatment algorithm, Figure 5). Although not ‘evidence based’ in the same way as treatments for chronic HF, the key drugs are oxygen, diuretics, and vasodilators. Opiates and inotropes are used more selectively, and mechanical support of the circulation is required only rarely. Non-invasive ventilation is used commonly in many centres, but invasive ventilation is required in only a minority of patients.

Systolic blood pressure, heart rhythm and rate, saturation of peripheral oxygen (SpO₂) using a pulse oximeter, and urine output should be monitored on a regular and frequent basis until the patient is stabilized (see also Sections 12.3 and 12.4).

12.2.1 Pharmacological therapy

12.2.1.1 Acute management

**Oxygen**

Oxygen may be given to treat hypoxaemia (SpO₂ < 90%), which is associated with an increased risk of short-term mortality. Oxygen should not be used routinely in non-hypoxaemic patients as it causes vasoconstriction and a reduction in cardiac output.²²⁴

**Diuretics**

Most patients with dyspnoea caused by pulmonary oedema obtain rapid symptomatic relief from administration of an i.v. diuretic, as a result of both an immediate venodilator action and subsequent removal of fluid. The optimum dose and route of administration (bolus or continuous infusion) are uncertain. A recent, small, prospective RCT compared 12-hourly bolus injection with continuous infusion and low-dose (equal to pre-existing oral dose) with high-dose (× 2.5 times previous oral dose) using a 2 × 2 factorial design.²¹³ There was no difference between either of the treatment comparisons for the co-primary endpoints (patient global assessment of symptoms and change in serum creatinine). Compared with the low-dose strategy, the high-dose strategy was, however, associated with greater improvement in a number of secondary outcomes (including dyspnoea) but at the expense of more transient worsening of renal function.

In patients with resistant peripheral oedema (and ascites), a combination of a loop and a thiazide (e.g. bendroflumethiazide)
or thiazide-like diuretic (metolazone) may be needed to achieve an adequate diuresis (see Web Table 15). This potent combination is usually only needed for a few days and requires careful monitoring to avoid hypokalaemia, renal dysfunction, and hypovolaemia.

Opiates
Opiates such as morphine may be useful in some patients with acute pulmonary oedema as they reduce anxiety and relieve distress associated with dyspnoea. Opiates are also thought to be venodilators, reducing preload, and may also reduce sympathetic drive. Conversely, opiates induce nausea (necessitating the concomitant administration of an antiemetic, one of which, cyclizine, has vasoconstrictor activity) and depress respiratory drive, potentially increasing the need for invasive ventilation.

Vasodilators
Although vasodilators such as nitroglycerine (Table 20) reduce preload and afterload and increase stroke volume, there is no robust evidence that they relieve dyspnoea or improve other clinical outcomes. Vasodilators are probably most useful in patients with hypertension and should be avoided in patients with a systolic blood pressure <110 mmHg. Excessive falls in blood pressure should also be avoided because hypotension is associated with higher mortality in patients with AHF. Vasodilators should be used with caution in patients with significant mitral or aortic stenosis.

---

**Table 20** Intravenous vasodilators used to treat acute heart failure

<table>
<thead>
<tr>
<th>Vasodilator</th>
<th>Dosing</th>
<th>Main side effects</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitroglycerine</td>
<td>Start with 10–20 µg/min, increase up to 200 µg/min</td>
<td>Hypotension, headache</td>
<td>Tolerance on continuous use</td>
</tr>
<tr>
<td>Isosorbide dinitrate</td>
<td>Start with 1 mg/h, increase up to 10 mg/h</td>
<td>Hypotension, headache</td>
<td>Tolerance on continuous use</td>
</tr>
<tr>
<td>Nitroprusside</td>
<td>Start with 0.3 µg/kg/min and increase up to 5 µg/kg/min</td>
<td>Hypotension, isocyanate toxicity</td>
<td>Light sensitive</td>
</tr>
<tr>
<td>Nesiritide</td>
<td>Bolus 2 µg/kg + infusion 0.01 µg/kg/min</td>
<td>Hypotension</td>
<td></td>
</tr>
</tbody>
</table>

*Not available in many European Society of Cardiology countries.*
Nesiritide
Nesiritide—a human BNP that acts mainly as a vasodilator—was recently shown to reduce dyspnoea by a small but statistically significant amount when added to conventional treatment (mainly diuretic).228

Inotropes
Use of an inotropic such as dobutamine (Table 21) should usually be reserved for patients with such severe reduction in cardiac output that vital organ perfusion is compromised. Such patients are almost always hypotensive (‘shocked’). Inotropes cause sinus tachycardia and may induce myocardial ischaemia and arrhythmias. There is long-standing concern that they may increase mortality. There is pharmacological rationale to use levosimendan (or a phosphodiesterase III inhibitor such as milrinone) if it is felt necessary to counteract the effect of a beta-blocker.

Vaspressors
Drugs with prominent peripheral arterial vasoconstrictor action such as norepinephrine (Table 21) are sometimes given to severely ill patients with marked hypotension. These agents are given to raise blood pressure and redistribute cardiac output from the extremities to the vital organs. However, this is at the expense of an increase in LV afterload, and these agents have adverse effects similar to those of inotropes (and the most commonly used of these agents, norepinephrine and epinephrine, have inotropic activity). Their use should be restricted to patients with persistent hypoperfusion despite adequate cardiac filling pressures.

Dopamine
In large doses (>5 μg/kg/min) dopamine has inotropic and vasoconstrictor activity. At lower doses (<3 μg/kg/min) dopamine may have a selective renal arterial vasodilator activity and promote natriuresis, although this is uncertain. Dopamine may cause hypoaemia.229 Arterial oxygen saturation should be monitored, and supplemental oxygen administrated as required.

Other pharmacological therapy
Thrombo-embolism prophylaxis with heparin or another anticoagulant should be used, unless contraindicated or unnecessary (because of existing treatment with oral anticoagulants).214–216
tolvaptan (a vasopressin V2-receptor antagonist) may be used to treat patients with resistant hyponatraemia (thirst and dehydration are recognized adverse effects).230

12.2.1.2 After stabilization
Angiotensin-converting enzyme inhibitor/angiotensin receptor blocker
In patients with reduced EF not already receiving an ACE inhibitor (or ARB), this treatment should be started as soon as possible, blood pressure and renal function permitting (see recommendations in Section 7.2.1 and Web Table 11). The dose should be up-titrated as far as possible before discharge, and a plan made to complete dose up-titration after discharge.

Beta-blocker
In patients with reduced EF not already receiving a beta-blocker, this treatment should be started as soon as possible after stabilization, blood pressure and heart rate permitting (see recommendations in Section 7.1 and Web Table 12). The dose should be up-titrated as far as possible before discharge, and a plan made to complete dose up-titration after discharge. It has been shown that beta-blocker treatment may be continued in many patients during an episode of decompensation and started safely before discharge after an episode of decompensation.

Mineralocorticoid (aldosterone) receptor antagonist
In patients with reduced EF not already receiving an MRA, this treatment should be started as soon as possible, renal function and potassium permitting (see recommendations in Section 7.2 and Web Table 13). As the dose of MRA used to treat HF has a minimal effect on blood pressure, even relatively hypotensive patients may be started on this therapy during admission. The dose should be up-titrated as far as possible before discharge, and a plan made to complete dose up-titration after discharge.

Digoxin
In patients with reduced EF, digoxin may be used to control the ventricular rate in AF, especially if it has not been possible to up-titrinate the dose of beta-blocker. Digoxin may also provide symptom benefit and reduce the risk of HF hospitalization in patients with severe systolic HF (see recommendations in Section 7.2.6).

12.2.2 Non-pharmacological/non-device therapy
It is common to restrict sodium intake to <2 g/day and fluid intake to <1.5–2.0 L/day, especially (the latter in hyponatraemic

| Table 21 | Drugs used to treat acute heart failure that are positive inotropes or vasopressors or both |

<table>
<thead>
<tr>
<th>Drug</th>
<th>Bolus</th>
<th>Infusion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dobutamine</td>
<td>No</td>
<td>2–20 μg/kg/min (β+)</td>
</tr>
<tr>
<td>Dopamine</td>
<td>No</td>
<td>&lt;3 μg/kg/min; renal effect (β+)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3–5 μg/kg/min; inotropic (β+)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;5 μg/kg/min; (β+), vasopressor (α+)</td>
</tr>
<tr>
<td>Milrinone</td>
<td>25–75 μg/kg over 10–20 min</td>
<td>0.375–0.75 μg/kg/min</td>
</tr>
<tr>
<td>Enoximone</td>
<td>0.5–1.0 mg/kg over 5–10 min</td>
<td>5–20 μg/kg/min</td>
</tr>
<tr>
<td>Levosimendan</td>
<td>12 µg/kg over 10 min (optional)³</td>
<td>0.1 µg/kg/min, which can be decreased to 0.05 or increased to 0.2 µg/kg/min</td>
</tr>
<tr>
<td>Norepinephrine</td>
<td>No</td>
<td>0.2–1.0 µg/kg/min</td>
</tr>
<tr>
<td>Epinephrine</td>
<td>Bolus: 1 mg can be given i.v. during resuscitation, repeated every 3–5 min</td>
<td>0.05–0.5 µg/kg/min</td>
</tr>
</tbody>
</table>

²Also a vasodilator.
³Bolus not recommended in hypotensive patients (systolic blood pressure <90 mmHg).
α = alpha adrenoceptor; β = beta adrenoceptor; δ = dopamine receptor.
**Recommendations for the treatment of patients with acute heart failure**

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Class</th>
<th>Level</th>
<th>Ref</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients with pulmonary congestion/oedema without shock</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An i.v. loop diuretic is recommended to improve breathlessness and relieve congestion. Symptoms, urine output, renal function, and electrolytes should be monitored regularly during use of i.v. diuretic.</td>
<td>I</td>
<td>B</td>
<td>213</td>
</tr>
<tr>
<td>High-flow oxygen is recommended in patients with a capillary oxygen saturation &lt;90% or PaO₂ &lt;60 mmHg (8.0 kPa) to correct hypoxaemia.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Thrombo-embolism prophylaxis (e.g. with LMWH) is recommended in patients not already anticoagulated and with no contraindication to anticoagulation, to reduce the risk of deep venous thrombosis and pulmonary embolism.</td>
<td>I</td>
<td>A</td>
<td>214–216</td>
</tr>
<tr>
<td>Non-invasive ventilation (e.g. CPAP) should be considered in dyspnoeic patients with pulmonary oedema and a respiratory rate &gt;20 breaths/min to improve breathlessness and reduce hypercapnia and acidosis. Non-invasive ventilation can reduce blood pressure and should not generally be used in patients with a systolic blood pressure &lt;85 mmHg (and blood pressure should be monitored regularly when this treatment is used).</td>
<td>IIa</td>
<td>B</td>
<td>217</td>
</tr>
<tr>
<td>Inotropic agents are NOT recommended unless the patient is hypotensive (systolic blood pressure &lt;85 mmHg), who do not have severe mitral or aortic stenosis, to reduce pulmonary capillary wedge pressure and systemic vascular resistance. Caution is recommended in patients with acute myocardial infarction. Nitroprusside may also relieve dyspnoea and congestion. Symptoms and blood pressure should be monitored frequently during administration of i.v. diuretics.</td>
<td>IIb</td>
<td>B</td>
<td>218, 219</td>
</tr>
<tr>
<td>A vasopressor (e.g. dopamine or norepinephrine) may be considered in patients who have cardiogenic shock, despite treatment with an inotrope, to increase blood pressure and vital organ perfusion. The ECG should be monitored as these agents can cause arrhythmias and myocardial ischaemia.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>An i.v. infusion of sodium nitroprusside may be considered in patients with pulmonary congestion/oedema and a systolic blood pressure &gt;110 mmHg, who do not have severe mitral or aortic stenosis, to reduce pulmonary capillary wedge pressure and systemic vascular resistance.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>An i.v. infusion of levosimendan (or a phosphodiesterase inhibitor) may be considered to reverse the effect of beta-blockade if beta-blockade is thought to be contributing to hypoperfusion. The ECG should be monitored continuously because inotropic agents can cause arrhythmias and myocardial ischaemia, and, as these agents are also vasodilators, blood pressure should be monitored carefully.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>A vasopressor (e.g. dopamine or norepinephrine) may be considered in patients who have cardiogenic shock, despite treatment with an inotrope, to increase blood pressure and vital organ perfusion. The ECG should be monitored as these agents can cause arrhythmias and myocardial ischaemia. Intra-arterial blood pressure measurement should be considered.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Short-term mechanical circulatory support may be considered (as a ‘bridge to decision’) in patients deteriorating rapidly before a full diagnostic and clinical evaluation can be made.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td><strong>Patients with hypotension, hypoperfusion or shock</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electrical cardioversion is recommended if an atrial or ventricular arrhythmia is thought to be contributing to the patient's haemodynamic compromise in order to restore sinus rhythm and improve the patient's clinical condition.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>An i.v. infusion of an inotrope (e.g. dobutamine) should be considered in patients with hypotension (systolic blood pressure &lt;85 mmHg) and/or hypoperfusion to increase cardiac output, increase blood pressure, and improve peripheral perfusion. The ECG should be monitored continuously because inotropic agents can cause arrhythmias and myocardial ischaemia.</td>
<td>IIa</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Short-term mechanical circulatory support should be considered (as a ‘bridge to recovery’) in patients remaining severely hypoperfused despite inotropic therapy and with a potentially reversible cause (e.g. viral myocarditis) or a potentially surgically correctable cause (e.g. acute interventricular septal rupture).</td>
<td>IIa</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>An i.v. infusion of levosimendan (or a phosphodiesterase inhibitor) may be considered to reverse the effect of beta-blockade if beta-blockade is thought to be contributing to hypoperfusion. The ECG should be monitored continuously because inotropic agents can cause arrhythmias and myocardial ischaemia, and, as these agents are also vasodilators, blood pressure should be monitored carefully.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>A vasopressor (e.g. dopamine or norepinephrine) may be considered in patients who have cardiogenic shock, despite treatment with an inotrope, to increase blood pressure and vital organ perfusion. The ECG should be monitored as these agents can cause arrhythmias and myocardial ischaemia. Intra-arterial blood pressure measurement should be considered.</td>
<td>IIb</td>
<td>C</td>
<td>–</td>
</tr>
</tbody>
</table>

**Patients with an ACS**

Immediate primary PCI (or CABG in selected cases) is recommended if there is an ST elevation or a new LBBB ACS in order to reduce the extent of myocyte necrosis and reduce the risk of premature death. | I | A | 221 |

Alternative to PCI or CABG:

Intravenous thrombolytic therapy is recommended, if PCI/CABG cannot be performed, if there is ST-segment elevation or new LBBB, to reduce the extent of myocyte necrosis and reduce the risk of premature death. | I | A | 222 |

Early PCI (or CABG in selected patients) is recommended if there is non-ST elevation ACS in order to reduce the risk of recurrent ACS. Urgent revascularization is recommended if the patient is haemodynamically unstable. | I | A | 221 |

Eplerenone is recommended to reduce the risk of death and subsequent cardiovascular hospitalization in patients with an EF ≤40%. | I | B | 107 |
### Recommendations for the treatment of patients with acute heart failure (Cont.)

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Classa</th>
<th>Levelb</th>
<th>Refc</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients with an ACS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>An ACE inhibitor (or ARB) is recommended in patients with an EF ≤40%, after stabilization, to reduce the risk of death, recurrent myocardial infarction, and hospitalization for HF.</td>
<td>I</td>
<td>A</td>
<td>101</td>
</tr>
<tr>
<td>A beta-blocker is recommended in patients with an EF ≤40%, after stabilization, to reduce the risk of death and recurrent myocardial infarction.</td>
<td>I</td>
<td>B</td>
<td>223</td>
</tr>
<tr>
<td>An i.v. opiate (along with an antiemetic) should be considered in patients with ischaemic chest pain to relieve this symptom (and improve breathlessness). Alertness and ventilatory effort should be monitored frequently after administration because opiates can depress respiration.</td>
<td>IIa</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td><strong>Patients with AF and a rapid ventricular rate</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients should be fully anticoagulated (e.g. with i.v. heparin), if not already anticoagulated and with no contraindication to anticoagulation, as soon as AF is detected to reduce the risk of systemic arterial embolism and stroke.</td>
<td>I</td>
<td>A</td>
<td>184</td>
</tr>
<tr>
<td>Electrical cardioversion is recommended in patients haemodynamically compromised by AF and in whom urgent restoration of sinus rhythm is required to improve the patient’s clinical condition rapidly.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Electrical cardioversion or pharmacological cardioversion with amiodarone should be considered in patients when a decision is made to restore sinus rhythm non-urgently (‘rhythm control’ strategy). This strategy should only be employed in patients with a first episode of AF of &lt;48 h duration (or in patients with no evidence of left atrial appendage thrombus on TOE).</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Intravenous administration of a cardiac glycoside should be considered for rapid control of the ventricular rate.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
<tr>
<td>Dronedarone is not recommended because of safety concerns (increased risk of hospital admission for cardiovascular causes and an increased risk of premature death), particularly in patients with an EF ≤40%.</td>
<td>III</td>
<td>A</td>
<td>176</td>
</tr>
<tr>
<td>Class I antiarrhythmic agents are not recommended because of safety concerns (increased risk of premature death), particularly in patients with LV systolic dysfunction.</td>
<td>III</td>
<td>A</td>
<td>178</td>
</tr>
<tr>
<td><strong>Patients with severe bradycardia or heart block</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pacing is recommended in patients haemodynamically compromised by severe bradycardia or heart block to improve the patient’s clinical condition.</td>
<td>I</td>
<td>C</td>
<td>–</td>
</tr>
</tbody>
</table>

ACE = angiotensin-converting enzyme; ACS = acute coronary syndrome; AF = atrial fibrillation; ARB = angiotensin receptor blocker; CABG = coronary artery bypass graft; CPAP = continuous positive airway pressure; ECG = electrocardiogram; EF = ejection fraction; HF = heart failure; i.v. = intravenous; LBBB = left bundle branch block; LMWH = low molecular weight heparin; LV = left ventricular; PaO2 = partial pressure of oxygen; PCI = percutaneous coronary intervention; TOE = transoesophageal echocardiography.

aClass of recommendation.  
bLevel of evidence.  
cReferences.

patients) during the initial management of an acute episode of HF associated with volume overload, although there is no firm evidence to support this practice.

#### 12.2.2.1 Ventilation

**Non-invasive ventilation**

Continuous positive airway pressure (CPAP) and non-invasive positive pressure ventilation (NIPPV) relieve dyspnoea and improve certain physiological measures (e.g. oxygen saturation) in patients with acute pulmonary oedema. However, a recent large RCT showed that neither type of non-invasive ventilation reduced mortality or the rate of endotracheal intubation when compared with standard therapy, including nitrates (in 90% of patients) and opiates (in 51% of patients). This result is in contrast to the findings of meta-analyses of earlier, smaller studies.

Non-invasive ventilation may be used as adjunctive therapy to relieve symptoms in patients with pulmonary oedema and severe respiratory distress or who fail to improve with pharmacological therapy. Contraindications include hypotension, vomiting, possible pneumothorax, and depressed consciousness.

**Endotracheal intubation and invasive ventilation**

The primary indication for endotracheal intubation and invasive ventilation is respiratory failure leading to hypoxaemia, hypercapnia, and acidosis. Physical exhaustion, diminished consciousness, and inability to maintain or protect the airway are other reasons to consider intubation and ventilation.

#### 12.2.2.2 Mechanical circulatory support

**Intra-aortic balloon pump**

The conventional indications for an intra-aortic balloon pump (IABP) are to support the circulation before surgical correction of specific acute mechanical problems (e.g. interventricular septal rupture and acute mitral regurgitation), during severe acute myocarditis and in selected patients with acute myocardial ischaemia or infarction before, during, and after percutaneous or surgical revascularization. There is no good evidence that an IABP is of benefit in other causes of cardiogenic shock. More recently, balloon pumps (and other types of short-term, temporary circulatory support) have been used to bridge patients until implantation of a ventricular assist device or heart transplantation (see Section 13.5).
Acute pulmonary oedema/congestion

| Inappropriate boli of loop diuretic
| **Yes**
| **No**
| **Check systolic blood pressure**
| **SBP <85 mmHg**
| **SBP 85–110 mmHg**
| **SBP >110 mmHg**
| **Add non-vasoconstrictor inotrope**
| **No additional therapy until response assessed**
| **Consider vasodilator (e.g. NTG)**
| **Adequate response to treatment**
| **Yes**
| **No**
| **Re-evaluation of patient’s clinical status**
| **SBP <85 mmHg**
| **SpO2 <90%**
| **Urine output <20 mL/h**
| **Yes**
| **No**
| **Yes**
| **Yes**

- Stop vasodilator
- Stop beta-blocker if hypoperfused
- Consider non-vasoconstrictor inotrope or vasoconstractor
- Consider right-heart catheterization
- Consider mechanical circulatory support
- Oxygen
- Consider NIV
- Consider ETT and invasive ventilation
- Bladder catheterization to confirm
- Increase dose of diuretic or use combination of diuretics
- Consider low-dose dopamine
- Consider right-heart catheterization
- Consider ultrafiltration

**Figure 5** Algorithm for management of acute pulmonary oedema/congestion.

CRP = continuous positive airway pressure; ETT = endotracheal tube; i.v. = intravenous; NPPV = non-invasive positive pressure ventilation; NIV = non-invasive ventilation; NTG = nitroglycerine; PaO2 = partial pressure of oxygen; SBP = systolic blood pressure; SpO2 = saturation of peripheral oxygen.

1. In patients’ already taking diuretic, 2.5 times existing oral dose recommended. Repeat as needed.
2. “Pulse oximeter” oxygen saturation <90% or SpO2 <85 mmHg (<8.0 kPa).
3. Usually start with 40-60% oxygen, titrating to SpO2 >90%. Caution required in patients at risk of CO2 retention.
4. For example, 4-8 mg of morphine plus 10 mg of metoclopramide; observe for respiratory depression. Repeat as needed.
5. Cold skin, low pulse volume, poor urine output, confusion, myocardial ischaemia.
6. For example, start an i.v. infusion of dobutamine 2.5 µg/kg/min, doubling dose every 15 min according to response or tolerability (dose titration usually limited by excessive tachycardia, arrhythmias, or ischaemia). A dose >100 µg/min is rarely needed.
7. A dose of >100 µg/min is rarely needed.
8. An adequate response includes reduction in dyspnoea and adequate diuresis (>100 mL/h urine production in first 2 h), accompanied by an increase in oxygen saturation (if hypoxic) and usually reduction in heart and respiratory rate (which should occur in 1-2 h). Peripheral blood flow may also increase as indicated by a reduction in skin vasoconstriction, an increase in skin temperature, and improvement in skin colour. There may also be a decrease in lung crackles.
9. Once the patient is comfortable and a stable diuresis has been established, withdrawal of i.v. therapy can be considered (with substitution of oral diuretic treatment).
10. As for symptoms related to HF (dyspnoea, orthopnoea, paroxysmal nocturnal dyspnoea), associated co-morbidity (e.g. chest pain due to myocardial ischaemia), and treatment-related adverse effects (e.g. symptomatic hypotension). Assess for signs of peripheral and pulmonary congestion/oedema, heart rate and rhythm, blood pressure, peripheral perfusion, respiratory rate, and respiratory effort. An ECG (rhythm/aemia and infarction) and blood chemistry/haematology (sodium, electrolyte disturbances, kidney failure) should also be examined. Pulse oximetry (or arterial blood gas measurements) should be checked and echocardiography performed (if not already carried out).
11. Less than 100 mL/h over 1–2 h is an inadequate initial response to i.v. diuretic (confirm is inadequate by catheterizing bladder).
12. In patients with persistently low blood pressure/shock, consider alternative diagnoses (e.g. pulmonary embolism), acute mechanical problems, and severe valvular disease (particularly aortic stenosis). Pulmonary artery catheterization may identify patients with an inadequate left ventricular filling pressure (and characterize the patient’s haemodynamic pattern, enabling more precise tailoring of vasoactive therapy).
13. Do not use dobutamine as a sole agent in patients with end-stage heart failure.
14. An intra-aortic balloon pump or other mechanical circulatory support should be considered in patients without contraindications.
15. In patients where mechanical circulatory support is not available or contraindicated, then consider right heart catheterization.
16. Consider endotracheal intubation and invasive ventilation if worsening hypoxaemia, failing respiratory effort, increasing confusion, etc.
17. If no response to doubling of dose of diuretic despite adequate left ventricular filling pressure (either inferred or measured directly) start i.v. infusion of dopamine 2.5 µg/kg/min.
18. Higher doses are not recommended to enhance diuresis.
Ventricular assist devices
Ventricular assist devices and other forms of mechanical circulatory support (MCS) may be used as a ‘bridge to decision’ or longer term in selected patients (see Section 13.5).

12.2.2.3 Ultrafiltration
Venovenous isolated ultrafiltration is sometimes used to remove fluid in patients with HF, although is usually reserved for those unresponsive or resistant to diuretics.

12.3 Invasive monitoring
12.3.1 Intra-arterial line
Insertion of an intra-arterial line should only be considered in patients with persistent HF and a low systolic blood pressure despite treatment.

12.3.2 Pulmonary artery catheterization
Right heart catheterization does not have a general role in the management of AHF, but may help in the treatment of a minority of selected patients with acute (and chronic) HF. Pulmonary artery catheterization should only be considered in patients: (i) who are refractory to pharmacological treatment; (ii) who are persistently hypotensive; (iii) in whom LV filling pressure is uncertain; or (iv) who are being considered for cardiac surgery. A primary concern is to ensure that hypotension (and worsening renal function) is not due to inadequate LV filling pressure, in which case diuretic and vasodilator therapy should be reduced (and volume replacement may be required). Conversely, a high LV filling pressure and/or systemic vascular resistance may suggest an alternative pharmacological strategy (e.g. inotropic or vasodilator therapy), depending on blood pressure. Measurement of pulmonary vascular resistance (and its reversibility) is a routine part of the surgical work-up before cardiac transplantation.

12.4 Monitoring after stabilization
Heart rate, rhythm, blood pressure, and oxygen saturation should be monitored continuously for at least the first 24 h of admission, and frequently thereafter. Symptoms relevant to HF (e.g. dyspnoea) and related to the adverse effects of treatments used (e.g. dizziness) should be assessed at least daily. Fluid intake and output, weight, and the jugular venous pressure and extent of pulmonary and peripheral oedema (and ascites if present) should be measured daily to evaluate the correction of volume overload. Blood urea nitrogen, creatinine, potassium, and sodium should be monitored daily during i.v. therapy and when renin–angiotensin–aldosterone system antagonists are being initiated or if the dose of any of these drugs is changed.

12.5 Other in-patient assessments
After initial treatment of the acute episode, every patient should be assessed for possible causes of HF (if the HF is new) and precipitants of worsening (if the HF has previously been diagnosed). The focus is detection of reversible or treatable causes (Table 19).

12.6 Readiness for discharge
Before discharge is contemplated, the acute episode of HF should have resolved and, in particular, congestion should be absent and a stable oral diuretic regimen established for at least 48 h. Long-term disease-modifying therapy (including a beta-blocker) should be optimized as much as possible and appropriate education provided to the patient and family/caregivers. Pre- and post-discharge management should follow the standards of care laid out by the Heart Failure Association. The goals of treatment during the different stages of management of patients with HF are summarized in Table 22.

### Table 22: Goals of treatment in acute heart failure

<table>
<thead>
<tr>
<th>Immediate (ED/ICU/CCU)</th>
<th>Intermediate (in hospital)</th>
<th>Pre-discharge and long-term management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Treat symptoms</td>
<td>• Stabilize patient and optimize treatment strategy</td>
<td>• Plan follow-up strategy</td>
</tr>
<tr>
<td>• Restore oxygenation</td>
<td>• Initiate and up-titrante disease-modifying pharmacological therapy</td>
<td>• Enrol in disease management programme, educate, and initiate appropriate lifestyle adjustments</td>
</tr>
<tr>
<td>• Improve haemodynamics and organ perfusion</td>
<td>• Consider device therapy in appropriate patients</td>
<td>• Plan to up-titrante optimize dose of disease-modifying drugs</td>
</tr>
<tr>
<td>• Limit cardiac and renal damage</td>
<td>• Identify aetiology and relevant co-morbidities</td>
<td>• Ensure assessed for appropriate device therapy</td>
</tr>
<tr>
<td>• Prevent thrombo-embolism</td>
<td>• Identify aetiology and relevant co-morbidities</td>
<td>• Prevent early readmission</td>
</tr>
<tr>
<td>• Minimize ICU length of stay</td>
<td>• Identify aetiology and relevant co-morbidities</td>
<td>• Improve symptoms, quality of life, and survival</td>
</tr>
</tbody>
</table>

CCU = coronary care unit; ED = emergency department; ICU = intensive care unit.

12.7 Special patient populations
12.7.1 Patients with a concomitant acute coronary syndrome
Patients with a concomitant acute coronary syndrome should be assessed and treated according to the current acute coronary syndrome guidelines. They should undergo coronary angiography and revascularization as appropriate. This should be undertaken as an urgent procedure in patients with haemodynamic instability and as an emergency procedure in those in cardiogenic shock. If haemodynamic instability persists despite optimal medical treatment, an IABP should be inserted before coronary angiography and revascularization. Persistent haemodynamic instability may also be caused by mechanical complications of infarction (e.g. mitral valve papillary muscle rupture), which may be identified using echocardiography and may require urgent corrective surgery.
12.7.2 Isolated right ventricular failure

New-onset isolated right ventricular failure may occur secondarily to an acute coronary syndrome (and is managed as described above) and following massive pulmonary embolism (see pulmonary embolism guidelines237). In both situations, diuretics and vasodilators should be used cautiously or avoided so as not to reduce right ventricular filling.

Progressive isolated right ventricular failure may occur in patients with pulmonary hypertension. Type V phosphodiesterase inhibitors, endothelin antagonists, and prostaclin analogues may help by decreasing pulmonary arterial resistance (see guidelines240).

12.7.3 Acute heart failure with ‘cardiorenal syndrome’

Acute worsening HF, or its treatment, or both may cause acute worsening of renal function (the so-called ‘type 1 cardiorenal syndrome’) in up to one-third of patients, and is associated with worse survival and prolonged hospitalization.209 An acute renal-cardiac syndrome (the so-called ‘type 3 cardiorenal syndrome’), characterized by worsening cardiac function secondary to volume overload resulting from acute kidney injury, may also occur, but is less common. The main management issues with these patients are that renal dysfunction may limit the use of renin–angiotensin–aldosterone system blockers and that progressive uraemia and volume overload may necessitate renal replacement therapy. Often these patients are best cared for jointly with a nephrologist.

12.7.4 Perioperative acute heart failure

AHF may occur in patients before (e.g. because of pre-operative infarction), during (‘failure to wean’), and after (mechanical complications and pericardial tamponade must be excluded) cardiac surgery. The specialized management of this group of patients is described in detail elsewhere241 and may involve use of mechanical support, including extracorporeal membrane oxygenation (ECMO).

12.7.5 Peripartum cardiomyopathy

A high index of suspicion is needed to avoid late diagnosis of this serious condition, the management of which is described in detail in a Heart Failure Association statement and elsewhere.242,243

12.7.6 Adult congenital heart disease

Patients with adult congenital heart disease (ACHD) are a very heterogeneous patient population. The diagnosis and management of HF in these patients can be very complex, and close collaboration with a tertiary referral centre is mandatory.

Patients with ACHD may present with HF due to a reduced systemic LVEF, reduced systemic right ventricular EF, or isolated subpulmonary right ventricular failure (see Section 12.7.2). Patients with univentricular hearts, either unoperated or palliated by a Fontan procedure, are particularly difficult to evaluate and treat. CMR and cardiopulmonary exercise testing are especially valuable in their assessment, but the acquisition and interpretation of data require special expertise.66,244

There is a lack of multicentre RCTs to guide the treatment of HF in patients with ACHD. There are, however, a number of general empirical principles of management: (i) residual (post-repair) or new haemodynamic lesions should always be sought first; (ii) the value of ACE inhibitors, ARBs, and beta-blockers in ACHD is controversial and these drugs may even be harmful in certain patients, e.g. those with a Fontan circulation (see ESC guidelines245); (iii) pulmonary arterial vasodilators may be useful in certain patients with pulmonary hypertension (see ESC guidelines246); (iv) the role of CRT is unknown; and (v) heart transplantation is an option but may be precluded by factors such as complex cardiovascular anatomy, and renal and hepatic dysfunction.

13. Coronary revascularization and surgery, including valve surgery, ventricular assist devices, and transplantation

13.1 Coronary revascularization

Surgical (and percutaneous) coronary revascularization is indicated for the relief of angina pectoris in patients with either HF-REF or HF-PEF, and surgical coronary revascularization is indicated for ‘prognostic’ reasons in other patients with severe CAD, particularly those with three-vessel disease or left-main stenosis. The detailed indications for coronary revascularization are covered elsewhere.71

This section focuses on recent developments relevant to HF. The Surgical Treatment for Ischemic Heart Failure (STICH) trial addressed the broader role of surgical revascularization in patients with HF-REF and less severe CAD.191 Patients with an EF ≤35% and CAD who were suitable for surgery were randomized to coronary artery bypass graft (CABG) plus medical therapy or medical therapy alone. The patients enrolled were young (average age 60 years), predominantly male (88%), and were in NYHA class I (11%), II (52%), or III (34%). Their Canadian Cardiovascular Society angina class was 0 in 36%, I in 16%, II in 43%, III in 4%, and IV in 1%. Most patients had two-vessel (31%) or three-vessel (60%) CAD, and 68% had a severe proximal left anterior descending stenosis; very few (2%) had a left-main stenosis. The primary outcome (all-cause death) was not reduced by CABG. CABG did, however, reduce the secondary outcomes of cardiovascular death (RRR 19%) and death from any cause or cardiovascular hospitalization (RRR 26%). This trial may therefore extend the indication for CABG to ‘STICH-like’ patients with two-vessel CAD, including a left anterior descending stenosis, who are otherwise suitable for surgery and expected to survive >1 year with good functional status.

The benefit–risk balance for CABG in patients without angina/ ischaemia or without viable myocardium remains uncertain. Patients with >10% of dysfunctional but viable LV myocardium may be more likely to benefit from myocardial revascularization (and those with ≤10% less likely to benefit) although this approach to patient selection for revascularization is unproven. Several non-invasive techniques can be used to assess myocardial viability (Table 7). Nuclear imaging has a high sensitivity, whereas techniques evaluating contractile reserve have lower sensitivity but higher specificity. CMR is excellent for assessing the transmural extent of scar, but is not better at detecting viability or predicting recovery of wall motion.

The choice between percutaneous coronary intervention and CABG should be made by the Heart Team, including a HF specialist, and be based on the extent of CAD, expected completeness of
revascularization, associated valvular disease, and the presence of co-morbidities.

13.2 Ventricular reconstruction

The value of surgical ventricular reconstruction during which scar tissue is removed from the LV wall, with the aim of restoring a more physiological LV volume and shape, is uncertain and was not shown to be of benefit in STICH.\textsuperscript{246} This technique is not recommended for routine use and is discussed further in the revascularization guidelines.\textsuperscript{71} External containment devices are not recommended.

13.3 Valvular surgery

Valvular heart disease may cause or aggravate HF. This section briefly addresses problems particularly relevant to HF, and the reader is referred to the recent ESC/European Association for Cardio-Thoracic Surgery guidelines on valvular disease for more information.\textsuperscript{247}

13.3.1 Aortic stenosis

The main concern in patients with LV systolic dysfunction is the entity of ‘low-flow, low-gradient’ aortic stenosis (valve area <1 cm\(^2\), EF <40\%, mean gradient <40 mmHg) because some may have severe aortic stenosis and others ‘pseudo-aortic stenosis’ (i.e. where the low flow across the aortic valve is not caused by a severe fixed obstruction but by low stroke volume). In such individuals, low-dose dobutamine stress echocardiography may help differentiate between these two types of patient and provide information about contractile reserve which is of prognostic importance. In patients with severe aortic stenosis and a low EF, individuals with contractile reserve have a lower operative mortality and better long-term prognosis.

If the mean gradient is >40 mmHg, there is theoretically no lower EF limit for aortic valve replacement in symptomatic patients with severe aortic stenosis. However, substantial recovery of LV function is only likely when the reduced EF is caused by excessive afterload and is not due to scar.

Medical treatment should be optimized, although vasodilators (ACE inhibitors, ARBs, renin inhibitors, CCBs, hydralazine, and nitrates) may cause substantial hypotension in patients with severe aortic stenosis and should only be used with great caution. Optimization of treatment should not delay surgical decision-making. In patients not medically fit for surgery (e.g. because of severe pulmonary disease), transcatheter aortic valve replacement should be considered.\textsuperscript{248,249}

13.3.2 Aortic regurgitation

Aortic valve repair or replacement is recommended in all symptomatic patients and in asymptomatic patients with severe aortic regurgitation and an EF <50\%, who are otherwise fit for surgery. Surgery should also be considered in patients with severe aortic regurgitation and an LV end-diastolic diameter >70 mm or end-systolic diameter >50 mm (or >25 mm/m\(^2\) body surface area if small stature).\textsuperscript{31} Surgery is indicated to reduce the risk of death, and HF and LV function usually improve after aortic valve repair.

It is important not to confuse mild to moderate aortic incompetence secondary to LV dilatation with LV dilatation and systolic dysfunction due to primary severe aortic regurgitation.

13.3.3 Mitral regurgitation

Assessment of mitral regurgitation is complex, particularly in patients with systolic dysfunction (and assessment of systolic function is complicated in the presence of mitral regurgitation—see Section 4.1). Differentiating between primary and secondary mitral regurgitation is crucial (see below).

The decision to recommend surgery should take account of symptoms, age, concurrent AF, reduced LV systolic function, pulmonary hypertension, and the suitability of the valve for repair, which are the most important predictors of post-operative outcome.

Primary (organic) mitral regurgitation

In primary mitral regurgitation due to flail leaflets, an LV end-systolic diameter ≥40 mm is associated with increased mortality whether the patient is treated medically or surgically. When the EF is <30\%, a durable surgical repair may improve symptoms,
although its effect on survival is unknown. In this situation, the decision to operate should take account of response to medical therapy, co-morbidity, and the likelihood that the valve can be repaired (rather than replaced).

Secondary mitral regurgitation
This occurs because LV enlargement and remodelling lead to reduced leaflet closing. Effective medical therapy leading to reverse remodelling of the LV may reduce functional mitral regurgitation, and every effort should be made to optimize medical treatment in these patients.

Ischaemic mitral regurgitation is a particular type of secondary mitral regurgitation that may be more suitable for surgical repair. As it is often a dynamic condition, stress testing is important in its evaluation. An exercise-induced increase of effective regurgitant orifice (≥13 mm²) is associated with a worse prognosis. Combined valve and coronary surgery should be considered in symptomatic patients with LV systolic dysfunction, coronary arteries suitable for revascularization, and evidence of viability. Predictors of late failure of valve repair include large interpapillary muscle distance, severe posterior mitral leaflet tethering, and marked LV dilatation (LV end-diastolic diameter >65 mm). In these patients, mitral valve replacement, rather than repair, may be advisable. In the presence of AF, atrial ablation and left atrial appendage closure may be considered at the time of mitral valve surgery.

The role of isolated mitral valve surgery in patients with severe functional mitral regurgitation and severe LV systolic dysfunction who cannot be revascularized or have non-ischaemic cardiomyopathy is questionable, and in most patients conventional medical and device therapy are preferred. In selected cases, repair may be considered in order to avoid or postpone transplantation.

In patients with an indication for valve repair but judged inoperable or at unacceptably high surgical risk, percutaneous edge-to-edge repair may be considered in order to improve symptoms.250

### 13.4 Heart transplantation

Heart transplantation is an accepted treatment for end-stage HF.251,252 Although controlled trials have never been conducted, there is consensus that transplantation—provided that proper selection criteria are applied—significantly increases survival, exercise capacity, quality of life, and return to work compared with conventional treatment.

Apart from the shortage of donor hearts, the main challenges in transplantation are the consequences of the limited effectiveness and complications of immunosuppressive therapy in the long term (i.e. antibody-mediated rejection, infection, hypertension, renal failure, malignancy, and coronary artery vasculopathy). The indications for and contraindications to heart transplantation are summarized in Table 23.

### 13.5 Mechanical circulatory support

MCS is an umbrella term describing a number of different technologies used to provide both short- and longer term assistance in patients with either chronic HF or AHF. A variety of terms have been used to describe the use of these technologies (Table 24).251,253 The most experience is with MCS in end-stage HF = heart failure.
HF, initially as bridge to transplantation (BTT), but more recently as destination therapy (DT).

13.5.1 End-stage heart failure

For selected patients with end-stage HF, transplantation remains the gold-standard treatment, with good long-term survival. However, because of the increasing numbers of patients with end-stage HF, limited organ donation, and technological advances, MCS with an LV assist device (LVAD) or bi-ventricular assist device (BiVAD) is increasingly seen as an alternative for some of these individuals. Initially MCS was used as a short-term BTT treatment (Table 24), but is now being used long-term, as so-called 'destination therapy (DT)', in patients not eligible for transplantation. Ventricular assist devices may ultimately become a more general alternative to transplantation, as current 2- to 3-year survival rates in carefully selected patients receiving the latest continuous flow devices are much better than with medical therapy only.254,255 Patients receiving these devices also have a post-transplant survival rate similar to those not requiring bridging. However, despite technological improvements, bleeding, thromboembolism (both of which can cause stroke), infection, and device failure remain significant problems; these issues, plus the high cost of devices and implantation, have limited their wider use. It is recommended that such devices are only implanted and managed at tertiary heart failure centres with appropriately trained, specialist HF physicians and surgeons. Ideally these centres should also undertake transplantation.

In some patients, LV reverse remodelling and functional improvement during MCS permit removal of the ventricular assist devices ('bridge-to-recovery, BTR'). This outcome may occur in some patients with non-ischaemic cardiomyopathy, but is more likely in patients with an acute fulminant, but reversible, cause of HF such as acute myocarditis.256 Another concept is using MCS to permit recovery of end-organ dysfunction, so-called 'bridge to candidacy (BTC)', which may allow ineligible patients to become eligible for transplantation. The difficult decision to withdraw MCS may need to be made if the patient does not become eligible and DT is not possible.

Table 25 Patients potentially eligible for implantation of a ventricular assist device

<table>
<thead>
<tr>
<th>Patients with &gt;2 months of severe symptoms despite optimal medical and device therapy and more than one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• LVEF &lt;25% and, if measured, peak VO₂ &lt; 12 mL/kg/min</td>
</tr>
<tr>
<td>• ≥3 HF hospitalizations in previous 12 months without an obvious precipitating cause</td>
</tr>
<tr>
<td>• Dependence on inotropic therapy</td>
</tr>
<tr>
<td>• Progressive end-organ dysfunction (worsening renal and/or hepatic function) due to reduced perfusion and not to inadequate ventricular filling pressure (PCWP ≥20 mm Hg and SBP ≤80–90 mmHg or CI ≤2 L/min/m²)</td>
</tr>
<tr>
<td>• Deteriorating right ventricular function</td>
</tr>
</tbody>
</table>

Cl = cardiac index; HF = heart failure; i.v. = intravenous; LVEF = left ventricular ejection fraction; PCWP = pulmonary capillary wedge pressure; SBP = systolic blood pressure.

Typically, patients with end-stage HF considered for MCS are on continuous inotropic support (Table 25).211,253,257 Evaluation of right ventricular function is crucial as post-operative right ventricular failure greatly increases perioperative mortality and reduces survival to, and after, transplantation. Consequently, BiVAD, rather than LVAD, support should be considered for BTT in patients with biventricular failure or at high risk of developing right ventricular failure after LVAD implantation. Referral before right ventricular failure develops is preferable. Indeed, earlier ventricular assist device implantation in less severely ill patients (e.g. with an EF <25%, peak oxygen consumption <12 mL/kg/min, and only requiring intermittent inotropic support), and before right ventricular or multiorgan failure develops, leads to better surgical outcomes.

Patients with active infection, severe renal, pulmonary, or hepatic dysfunction, or uncertain neurological status after cardiac arrest or due to cardiogenic shock are not usually candidates for BTT or DT, but may be candidates for BTC.

13.5.2 Acute heart failure

In addition to ventricular assist devices, other forms of short-term, temporary MCS may be used in selected patients with AHF, including intra-aortic balloon counterpulsation, other percutaneous cardiac support, and ECMO. In addition to the uses described
above, MCS, particularly ECMO, can be used as a ‘bridge to decision (BTD)’ in patients with acute and rapidly deteriorating HF where full evaluation has not been possible and in whom death will occur without MCS. However, the difficult decision to withdraw MCS may need to be made if the patient is not eligible for conventional corrective surgery or longer term MCS.

14. Holistic management, including exercise training and multidisciplinary management programmes, patient monitoring, and palliative care

Non-pharmacological non-device/surgical interventions used in the management of HF (both HF-REF and HF-PEF) are summarized in Tables 26 and 27, and detailed practical recommendations on their use have been published by the Heart Failure Association. There is no evidence that most of these improve mortality or morbidity, and some long-cherished approaches may not be beneficial, e.g. advice to restrict sodium intake and self-management counselling. For this reason, these interventions have not been given a recommendation with an evidence level. The exceptions are implementation of care in a multidisciplinary framework and exercise training, both of which are discussed further below.

14.1 Exercise training

Several systematic reviews and meta-analyses of small studies have shown that physical conditioning by exercise training improves exercise tolerance, health-related quality of life, and HF hospitalization rates in patients with HF. Recently, a single large RCT [Heart Failure: A Controlled Trial Investigating Outcomes of Exercise Training (HF-ACTION)] investigated the effects of exercise training in 2331 relatively young (mean age 59 years) medically stable patients with mild to moderately severe symptoms (NYHA class II 63% and class III 35%) and an EF ≤ 35%. The intervention comprised 36 supervised sessions in the initial 3 months followed by home-based training. The median follow-up was 30 months. In an adjusted analysis, exercise training led to an 11% reduction in the primary composite outcome of all-cause mortality or all-cause hospitalization (unadjusted \( P = 0.13 \); adjusted \( P = 0.03 \)). There was also a 15% RRR in a secondary composite outcome of cardiovascular death or HF hospitalization (unadjusted \( P = 0.06 \); adjusted \( P = 0.03 \)). There was no reduction in mortality, and no safety concerns were raised. Adherence to exercise declined substantially after the period of supervised training. Collectively, the evidence suggests that physical training is beneficial in HF, although typical elderly patients were not enrolled in many studies and the optimum exercise ‘prescription’ is uncertain. Furthermore, the single large trial showed a borderline treatment effect that was only obtained with a very intensive intervention that may not be practical to deliver in every centre.

**Table 26** Characteristics and components of management programmes for patients with heart failure with reduced ejection fraction and heart failure with preserved ejection fraction

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should employ a multidisciplinary approach (cardiologists, primary care physicians, nurses, pharmacists, etc.)</td>
<td>Optimized medical and device management</td>
</tr>
<tr>
<td>Should target high-risk, symptomatic patients</td>
<td>Adequate patient education, with special emphasis on adherence and self-care</td>
</tr>
<tr>
<td>Should include competent and professionally educated staff</td>
<td>Patient involvement in symptom monitoring and flexible diuretic use</td>
</tr>
<tr>
<td></td>
<td>Follow-up after discharge (regular clinic and/or home-based visits; possibly telephone support or remote monitoring)</td>
</tr>
<tr>
<td></td>
<td>Increased access to healthcare (through in-person follow-up and by telephone contact; possibly through remote monitoring)</td>
</tr>
<tr>
<td></td>
<td>Facilitated access to care during episodes of decompensation</td>
</tr>
<tr>
<td></td>
<td>Assessment of (and appropriate intervention in response to) an unexplained increase in weight, nutritional status, functional status, quality of life, and laboratory findings</td>
</tr>
<tr>
<td></td>
<td>Access to advanced treatment options</td>
</tr>
<tr>
<td></td>
<td>Provision of psychosocial support to patients and family and/or caregivers</td>
</tr>
</tbody>
</table>
discussed in more detail in a recent Heart Failure Association consensus paper.263

### 14.2 Organization of care and multidisciplinary management programmes

The goal of management of HF is to provide a ‘seamless’ system of care, embracing both the community and hospital, to ensure that the management of every patient is optimal, from the beginning to the end of their healthcare journey. The standards of care that patients with HF should expect have been published by the Heart Failure Association.236 To achieve this goal, other services, such as cardiac rehabilitation and palliative care, must be integrated into the overall provision for patients with HF. Fundamental to the delivery of this complete package of care are multidisciplinary management programmes designed to improve outcomes through structured follow-up with patient education, optimization of medical treatment, psychosocial support, and improved access to care.264 Key to the success of these programmes is coordination of care along the continuum of HF and throughout the chain-of-care delivered by the various services within the healthcare system. This
necessitates close collaboration between HF practitioners (cardiologists and HF nurses) and experts in allied health professions, including pharmacists, dieticians, physiotherapists, psychologists, primary care providers, and social workers. Although the content and structure of HF management programmes may vary in different countries and healthcare settings, the components shown in Tables 26 and 27 are recommended.

14.3 Serial natriuretic peptide measurement
High natriuretic peptide concentrations are associated with a poor prognosis, and a fall in peptide levels correlates with a better prognosis. However, several RCTs that evaluated natriuretic peptide-guided treatment (intensifying treatment in order to lower peptide levels) have given conflicting results. It is uncertain whether outcome is better using this approach than by simply optimizing treatment (combinations and doses of drugs, devices) according to guidelines.

14.4 Remote monitoring (using an implanted device)
Management adapted in response to monitoring thoracic impedance (as an indirect measure of intrathoracic fluid) has not been shown to improve outcomes. Treatment adjusted in response to pulmonary artery pressure measured using an implanted monitor did reduce hospital admission for HF in one RCT, but the general applicability of this approach is uncertain and a guideline recommendation is not yet possible.

14.5 Remote monitoring (no implanted device)
The optimum approach to non-invasive remote monitoring is uncertain, and RCTs performed to date have given inconsistent results and do not yet support a guideline recommendation.

14.6 Structured telephone support
Although a meta-analysis of RCTs suggests that structured telephone support in addition to conventional care may reduce the risk of hospitalization in patients with HF, few individual RCTs showed this benefit, and the evidence is not robust enough to support a guideline recommendation.

14.7 Palliative/supportive/end-of-life care
HF has an unpredictable disease trajectory and it is often difficult to identify a specific time point to consider palliative care. Features that should trigger consideration of palliative care are listed in Tables 28 and 29. At this point in a patient’s disease trajectory, the focus should be on improvement in quality of life, control of symptoms, early detection, and treatment of episodes of deterioration, and on pursuing a holistic approach to patient care, encompassing physical, psychological, social, and spiritual well-being. Liaison between the specialist palliative care service and the HF team and/or the primary care physician, using a shared-care approach, is required in order to address and coordinate the patients’ care optimally. Palliative care has been discussed in detail in a position paper from the Heart Failure Association.

15. Gaps in evidence
Clinicians responsible for managing patients with HF must frequently make treatment decisions without adequate evidence or a consensus of expert opinion. The following is a shortlist of selected, common issues that deserve to be addressed in future clinical research.

15.1 Diagnosis
The diagnosis of HF-PEF remains a particular challenge, and the optimum approach incorporating symptoms, signs, imaging, biomarkers, and other investigations is uncertain.

15.2 Co-morbidity
The long-term safety and efficacy of many treatments for co-morbidities are unknown, but are of great interest and importance.

<table>
<thead>
<tr>
<th>Table 28 Patients in whom palliative care should be considered</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Frequent admission to hospital or other serious episodes of</td>
</tr>
<tr>
<td>• Heart transplantation and mechanical circulatory support ruled out</td>
</tr>
<tr>
<td>• Chronic poor quality of life with NYHA class IV symptoms</td>
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<tr>
<td>• Cardiac cachexia/low serum albumin</td>
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<tr>
<td>• Dependence in most activities of daily living</td>
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<td>• Clinically judged to be close to the end of life</td>
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NYHA = New York Heart Association.

<table>
<thead>
<tr>
<th>Table 29 Key components of palliative care service</th>
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<tbody>
<tr>
<td>• Frequent assessment of patient’s physical, psychological, and spiritual needs</td>
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<tr>
<td>• Focus on complete symptom relief from both HF and other co-morbidities</td>
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<tr>
<td>• Advanced care planning, taking account of preferences for place of death and resuscitation (which may include deactivating ICD)</td>
</tr>
</tbody>
</table>

HF = heart failure; ICD = implantable cardioverter-defibrillator.
15.3 Non-pharmacological, non-interventional therapy
Salt restriction—is it effective and safe?
Cardiac cachexia—is there an effective and safe treatment?

15.4 Pharmacological therapy
Digoxin—efficacy and safety in modern era of pharmacological and device therapy?
Hydralazine and ISDN—efficacy and safety in non-black patients?
Renin inhibition—is it an effective and safe alternative to/ addition to ACE inhibition?
New oral anticoagulants—efficacy and safety compared with aspirin in patients in sinus rhythm?
Clopidogrel and other novel antiplatelet agents—efficacy and safety compared with aspirin in patients in sinus rhythm?
Dual nephrilysin/angiotensin receptor inhibitors—efficacy and safety compared with an ACE inhibitor?

15.5 Devices
CRT—the efficacy and safety of CRT remains unknown in certain groups of patients.

• patients with a normal QRS duration but echocardiographic dyssynchrony?
• patients with RBBB and LVCD?
• patients in AF?
LVAD—the long-term efficacy and safety of LVADs as an alternative to heart transplantation or medical therapy remains uncertain
Remote monitoring—the long-term efficacy and safety of the various remote monitoring strategies available remain uncertain

15.6 Acute heart failure
The treatment of acute heart failure remains largely opinion-based with little good evidence to guide therapy.

Intravenous nitrates—efficacy and safety still uncertain.
Levosimendan—efficacy and safety still uncertain.
Omecamtiv mecarbil—is it effective and safe?
Ultrafiltration—efficacy and safety unknown.

15.7 End-of-life care
What is the optimum palliative care package?
When should palliative care be started?

The CME text ‘European Guidelines on cardiovascular disease prevention in clinical practice (version 2012)’ is accredited by the European Board for Accreditation in Cardiology (EBAC). EBAC works according to the quality standards of the European Accreditation Council for Continuing Medical Education (EACCME), which is an institution of the European Union of Medical Specialists (UEMS). In compliance with EBAC/EACCME guidelines, all authors participating in this programme have disclosed potential conflicts of interest that might cause a bias in the article. The Organizing Committee is responsible for ensuring that all potential conflicts of interest relevant to the programme are declared to the participants prior to the CME activities.

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References


