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New Universal Definition Reframes Heart Failure Beyond Ejection Fraction

Ryan Quigley:

Welcome to *AudioAbstracts* on ReachMD. I'm Ryan Quigley, and today, I'll be reviewing the 2026 Second Universal Definition of Heart Failure.

Heart failure has long been organized around stages, ejection fraction thresholds, and broad categories of cause. But the field has changed since the first universal definition was published in 2021. New therapies now span wider ranges of ejection fraction; earlier intervention has become more important; and clinicians increasingly recognize that heart failure can improve without truly disappearing.

Published in *Circulation*, this new international consensus from the American Heart Association, American College of Cardiology, European Society of Cardiology, and World Heart Federation updates the framework around those shifts. It's important to note that this isn't a treatment guideline. Instead, it aims to give clinicians and researchers more clinically useful language for defining heart failure.

Perhaps the biggest change is how the document approaches left ventricular ejection fraction. Previous definitions relied on fixed numerical cutoffs to separate heart failure with reduced, mildly reduced, and preserved ejection fraction. The new consensus moves away from those fixed, one-size-fits-all thresholds because ejection fraction varies by imaging method and patient characteristics, and treatment benefits don't necessarily stop at an arbitrary numerical boundary.

Instead, it proposes three clinically actionable groups — heart failure with reduced, preserved, and improved ejection fraction — whose boundaries can flex rather than being anchored to one universal number. This allows clinicians to consider and account for differences in left ventricular ejection fraction that may be caused by factors like age, sex, and ethnicity.

The consensus also emphasizes that heart failure itself is diagnosed through an accumulation of clinical features rather than any single test. Natriuretic peptides can strengthen diagnostic certainty, but normal levels don't exclude heart failure with preserved ejection fraction.

A second major update is the emphasis on trajectory. Heart failure is presented as a dynamic syndrome that can move through improvement, remission, and, much less commonly, recovery. Improvement in ejection fraction alone doesn't mean the disease has resolved.

That distinction has direct clinical implications. Patients whose ejection fraction improves can retain structural abnormalities, biomarker elevations, symptoms, and a risk of recurrent ventricular dysfunction. The consensus therefore supports continued guideline-directed therapy and longitudinal surveillance. It also discourages the term "stable heart failure," because residual risks of worsening symptoms, hospitalization, and sudden cardiac death remain.

Additionally, the consensus sharpens the distinction between worsening and decompensated heart failure. Worsening heart failure describes progressive deterioration in a patient with established disease. Decompensated heart failure is defined more specifically by the need to intensify treatment or provide rescue therapy. That distinction could help standardize how these clinically important events are described across practice and research.

Another notable change is a new universal classification of heart failure by cause. Rather than relying on the familiar split between ischemic and nonischemic disease, the framework includes specific pathogenic groups such as hypertensive, valvular, arrhythmia-related, infiltrative, inflammatory, toxic, heritable, metabolic, pregnancy-related, and pulmonary or right-sided disease. The goal is to encourage clinicians to ask not simply whether a patient has heart failure, but what's driving it, particularly because identifying the cause could open the door to targeted therapy.

Taken together, the update shifts heart failure classification away from fixed snapshots and toward a more dynamic model. Ejection fraction still matters, but so do cause, trajectory, clinical context, and persistent disease biology.

For clinicians, that may be the most useful message from this new definition: a better ejection fraction isn't necessarily recovery, a normal biomarker doesn't always rule out disease, and identifying the underlying cause may matter as much as assigning the phenotype.

This has been an *AudioAbstract*, and I'm Ryan Quigley. To access this and other episodes in our series, visit ReachMD dot com, where you can Be Part of the Knowledge. Thanks for listening!

Reference:

Walsh MN, Kober L, Sliwa K, et al; on behalf of the Joint AHA/ACC/ESC/WHF Task Force for the Universal Definition of Heart Failure. AHA/ACC/ESC/WHF expert consensus document: second universal definition of heart failure (2026). *Circulation*. 2026;154. doi:10.1161/CIR.0000000000001455