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Understanding the New Heart Failure Guidelines – What's New for HFrEF?

Dr. Bozkurt:
Hello, my name is Biykem Bozkurt. I'm from Baylor College of Medicine. And today, I will be discussing understanding the new heart failure guidelines. What's new for heart failure with reduced ejection fraction.

We have strong evidence that treatment with ARNi and SGLT2 inhibitors are very beneficial in patients with heart failure with reduced EF. As shown, in the PARADIGM trial, treatment with ARNi and also in the DAPA-HF and EMPEROR-Reduced trials, treatment with SGLT2 inhibitors is associated with significant reductions in cardiovascular death and heart failure hospitalizations.

These have resulted in incorporation of SGLT2 inhibitors and ARNi in recommendations for treatment of symptomatic heart failure with reduced EF. In the new 2022 ACC/AHA/HFSA heart failure guidelines, the first step is initiation of core foundational quadruple therapy with SGLT2 inhibitors, beta blockers, mineralocorticoid receptor antagonists, and RAAS inhibition with ARNi in NYHA class II to III or ACE inhibitors or ARB in NYHA class II to IV heart failure patients. After optimization of these therapies, if patients remain symptomatic, hydralazine nitrates are indicated in African American or Black patients, and device therapies such as ICD and CRT are to be considered.

Once GDMT is optimized, other additional therapies such as ivabradine has a class 2a indication in symptomatic heart failure patients with reduced EF, with heart rate greater than 70, despite maximally tolerated beta blockers. Vericiguat has a class 2b indication in symptomatic heart failure patients with reduced EF, recent heart failure hospitalization, or requirement of IV diuretics, or with elevated natriuretic peptide levels. Similarly, digoxin has a class 2b recommendation for symptomatic heart failure patients with reduced EF. Polyunsaturated fatty acids and potassium binders in patients with hyperkalemia while taking RAAS inhibition also have class 2b indications.

Additionally, surgical revascularization is indicated among select patients with suitable coronary anatomy and ischemic cardiomyopathy. Transcatheter edge-to-edge mitral valve repair can be considered among patients with secondary MR, suitable anatomy, PA pressures and ventricular size specifications after optimization of guideline-directed medical therapy. Wireless monitoring of PA pressures by implanted hemodynamic monitoring has a class 2b recommendation.

In the continuum of treatment of patients with heart failure with reduced EF, we also address treatment of patients with heart failure with mildly reduced EF. In these patients, with positive results of the EMPEROR-Reserved trial, which included patients with ejection fraction over 40%, SGLT2 inhibitors have class 2a indications. ACE inhibitors, ARBs, ARNi, MRA, and beta blockers have class 2b recommendations.

In heart failure with improved ejection fraction after treatment, GDMT is recommended to be continued to prevent relapse of heart failure and LV dysfunction, even in patients who may become asymptomatic. In patients hospitalized with heart failure, initiation of GDMT is a class 1 indication during hospitalization after clinical stability is achieved. We emphasize the congestion and continuation and optimization of GDMT, and very importantly, GDMT not to be routinely discontinued in patients experiencing mild decrease of renal function or asymptomatic reduction of blood pressure during heart failure hospitalization. If truly necessary to discontinue, GDMT to be reinitiated and further optimized as soon as possible.

We also have specific recommendations for comorbidities including class 1 recommendations for optimal treatment of hypertension in patients with heart failure and hypertension, SGLT2 inhibitors in patients with diabetes, and class 2a recommendations for IV iron replacement therapy in patients with iron deficiency, atrial fibrillation ablation in patients with heart failure, and symptoms attributable to atrial fibrillation. In summary, in the new guidelines, core foundational quadruple therapy with SGLT2 inhibition, beta blockers, MRA, and RAAS inhibition with ARNi, ACE inhibitors or ARBs are recommended as the first step in patients with heart failure with reduced EF. Additional therapies with ivabradine, vericiguat, digoxin, can be considered subsequently if patients remain symptomatic. In patients with heart failure with milder reduced EF, SGLT2 inhibitors have a class 2a, and other agents, including beta blockers, ARNi, ACE inhibitors, ARB, and MRAs have class 2b indications. And in patients whose ejection fraction improves after treatment, GDMT should be continued to prevent relapse. Thank you for your attention. And look forward to your participation in other sessions.