Dr Charles Nelson
MBBS, MPhil, FRACP, FCSANZ, Echocardiology Fellowship
Cardiologist, Certified CTCA Specialist
Provider No. 049244LX
ABN: 20 163 285 255

Heartmed Cardiology Services

Newsletter Autumn (May) 2024: Heart Failure

Welcome to the inaugural edition of the Heartmed Newsletter, designed specifically for General Practitioners. This issue is devoted to new and/or lesser known facts about Heart Failure (HF) relevant to General Practitioners.

- Classical diagnostic symptoms aside, as HF progresses, patients frequently develop lightheadedness, or fatigue at rest or with minimal exertion that limits exercise capacity
- The absence of physical findings does not exclude HF
- Common manifestations of advanced HF include exercise intolerance, unintentional weight loss, refractory volume overload, recurrent ventricular arrhythmias, as well as hypotension and signs of inadequate perfusion (eg, low pulse pressure).
- Even 1 symptom or sign of HF is sufficient to indicate investigation with echocardiogram +/- NT pro BNP
- A distance of ≤300 m on 6 minute Hall Walk has been associated with increased risk of death
- It is now more important than ever to diagnose HFPEF. Doing so is relatively simple for severely decompensated patients. However, not so easy for mildly decompensated patients. Especially for these latter patients, Diastolic stress echocardiogram and NT proBNP are useful. A "positive" diastolic stress echocardiogram may be reported as "elevated filling pressures with exercise". Performance of a diastolic stress echocardiogram is similar to performance of a standard exercise stress echocardiogram, however, the former tends to be performed only by cardiologists with a special interest in echocardiography.
- HF mortality increases with each HF hospitalization
- In HFPEF, SGLT2 inhibitors, e.g. Empagliflozin 10 mg mane and spironolactone up to 50 mg mane reduce hospitalisations and improve quality of life
- Iron infusion improves quality of life in heart failure patients whose ferritin is less than 100 ng/mL or whose ferritin is less than 300 ng/mL and iron saturation is less than 20%. These parameters differ from those used to diagnose conventional iron deficiency.
- Triggers for HF patient referral to a Cardiologist include:
  - New-onset HF (regardless of EF) for evaluation of etiology, guideline-directed evaluation and management of recommended therapies
  - Chronic HF with high-risk features
    - Persistent NYHA functional class III to IV symptoms or profound fatigue
    - Systolic blood pressure ≤90 mmHg or symptomatic hypotension
    - Creatinine ≥ 160 umol/L or BUN ≥ 3801 umol/L
  - Onset of atrial fibrillation
  - Inability to tolerate optimally dosed beta blockers, ACEI/ARB/ARNI, and/or aldosterone antagonists
  - Evaluation for potential ischemic etiology
  - Suspected myocarditis
  - Established or suspected specific cardiomyopathies, eg, hypertrophic cardiomyopathy, arrhythmogenic right ventricular dysplasia, Chagas disease, restrictive cardiomyopathy, cardiac sarcoidosis, amyloid, aortic stenosis
  - Valvular heart disease with or without HF symptoms

Wahroonga Specialist Centre, Suite 3, 176 Fox Valley Road, Wahroonga NSW 2076
T 9487 6377 **F** 9487 6577 info@heartmed.com.au www.heartmed.com.au