

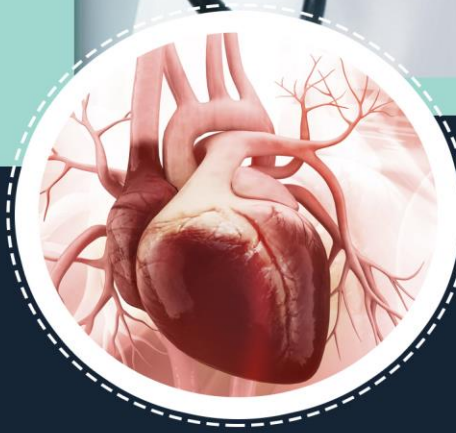


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FACULTY OF
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GUIDELINE UPDATE 2021 OF HEART FAILURE

HFmrEF

Class IIb

- An ACE-I may be considered for patients with HFmrEF to reduce the risk of HF hospitalization and death.
- An ARB may be considered for patients with HFmrEF to reduce the risk of HF hospitalization and death.
- A beta-blocker may be considered for patients with HFmrEF to reduce the risk of HF hospitalization and death.
- An MRA may be considered for patients with HFmrEF to reduce the risk of HF hospitalization and death.
- Sacubitril/valsartan may be considered for patients with HFmrEF to reduce the risk of HF hospitalization and death.

HFpEF

Class I

Screening for and treatment of etiologies, and CV and non CV comorbidities are recommended in patients with HFpEF (see relevant sections of this document)

Prevention and monitoring

class I

- To lower the risk of HF hospitalization and mortality, selfmanagement techniques are recommended.
- Programs that are either home-based or clinicbased improve outcomes and are suggested to lower the risk of HF hospitalization and mortality.

Class IIa

To avoid HF hospitalizations, influenza and pneumococcal immunizations should be explored.

In individuals with more severe illness, frailty, or comorbidities, a supervised, exercise-based cardiac rehabilitation program should be explored.

class IIb

Patients with HF may benefit from noninvasive HTM to minimize the incidence of recurrent CV and HF hospitalizations, as well as CV death.



Recommendations for management of patients with advanced HF

Class I

- Patients being considered for long-term MCS must have good compliance, appropriate capacity for device handling and psychosocial support.
- Patients with advanced HF who are unresponsive to medical/device therapy and do not have extreme contraindications should consider heart transplantation.

Class IIb

. In patients with inadequate cardiac output and signs of organ hypoperfusion, continuous inotropes and/or vasopressors may be explored as a bridge to MCS or heart transplantation.

Recommendations for management of patients after HF hospitalization.

Class I

- It is suggested that patients hospitalized for HF be thoroughly assessed before being discharged to rule out persisting indications of congestion and to optimize oral treatment.
- It is recommended that evidence-based oral medical treatment be administered before discharge.
- An early follow-up visit is recommended at 1-2 weeks after discharge to assess signs of congestion, drug tolerance, and start and/or up titrate evidence-based therapy.

Recommendations for management of patient's atrial fibrillation

Class IIa

Long-term treatment with an oral anticoagulant should be considered for stroke prevention in AF patients with a CHA₂DS₂-VASC score of 1 in men or 2 in women.



GUIDELINE UPDATE 2021 OF HEART FAILURE

Recommendations for management of patients with HF and CCS

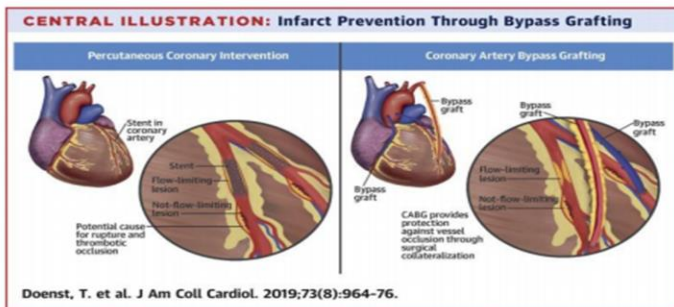
Class IIa

-CABG should be considered as the first-choice revascularization strategy, in patients suitable for surgery, especially if they have diabetes and for those with multi-vessel disease.

-In LVAD candidates needing coronary revascularization, CABG should be avoided, if possible.

Class IIb

Based on a Heart Team review of coronary anatomy, comorbidities, and surgical risk, PCI may be explored as an alternative to CABG. After careful consideration of the individual risk to benefit ratio, including coronary anatomy (i.e. proximal stenosis >90 percent of large vessels, stenosis of the left main or proximal LAD), comorbidities, life expectancy, and patient perspectives, coronary revascularization may be considered to improve outcomes in patients with HFrEF, CCS, and coronary anatomy suitable for revascularization.

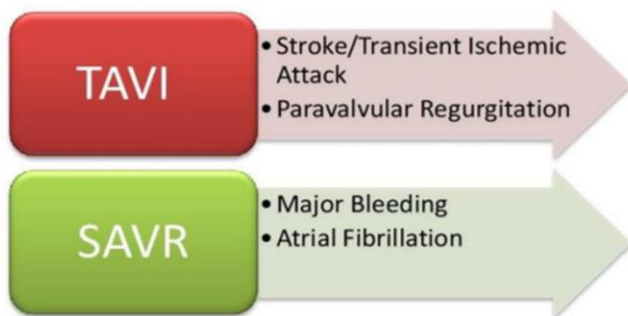


Recommendations for management of patients with HF and valvular heart disease

Class I

In patients with HF with severe high-gradient aortic stenosis, aortic valve intervention, such as TAVI or SAVR, is advised to minimize mortality and improve symptoms.

The Heart Team should choose between TAVI and SAVR based on the patient's preferences and characteristics, such as age, surgical risk, clinical, anatomical, and procedural elements, and assess the risks and benefits of each technique.



Class IIa

Percutaneous edge-to-edge mitral valve repair should be considered in carefully chosen patients with secondary mitral regurgitation who are highly symptomatic despite OMT and meet criteria to reduce HF hospitalizations but are not candidates for surgery or who do not require coronary revascularization.

Class IIb

In carefully selected patients with secondary mitral regurgitation who are highly symptomatic despite OMT and do not meet criteria for reducing HF hospitalization, percutaneous edge-to-edge mitral valve repair may be considered to improve symptoms.

These patients are not eligible for surgery and do not require coronary revascularization.

Recommendations for management of patients with HF and diabetes

Class I

-SGLT2 inhibitors (canagliflozin, dapagliflozin, empagliflozin, ertugliflozin, sotagliflozin) are recommended in patients with T2DM at risk of CV events to reduce hospitalizations for HF, major CV events, end-stage renal dysfunction, and CV death.

-SGLT2 inhibitors (dapagliflozin, empagliflozin, and sotagliflozin) are recommended in patients with T2DM and HFrEF to reduce hospitalizations for HF and CV death.

Class III

The DPP-4 inhibitor saxagliptin is not recommended in patients with HF.

