bpacnz PRIMARY CARE UPDATE SERIES

MANAGING HEART FAILURE IN PRIMARY CARE

The diagnosis of heart failure in primary care can be challenging as symptoms may be mild or progress slowly, can vary substantially, and routine clinical assessments lack specificity. In many regions there are lengthy wait times for echocardiograms, yet these definitive evaluations are essential to direct evidence-based treatment of heart failure, and may potentially identify underlying causes that can be addressed. Nevertheless, immediate pharmacological intervention is required to control symptoms and reduce the risk of hospitalisation/mortality, and as a result, treatment is generally initiated while awaiting confirmation of the full clinical picture.

Key practice points:

- Clinical suspicion of heart failure should be prompted by the patient's symptoms and signs in the context of their medical history and an ECG; brain natriuretic peptide (BNP) testing is recommended to support a diagnosis
  - Echocardiography is not required for a diagnosis of heart failure, but is key to guiding long-term management because the evidence bases for treating heart failure with a reduced ejection fraction (HFrEF) and heart failure with a preserved ejection fraction (HFpEF) differ substantially and this is the only assessment that distinguishes the two types
  - It is practical to proceed with the assumption that the patient has HFrEF until proven otherwise by an echocardiogram
- Once a clinical diagnosis of heart failure has been established, pharmacological treatment should be initiated immediately
  - Initiate assertive furosemide treatment if the patient has symptoms of congestion; long-term diuretic use is not recommended once symptoms are controlled
  - An angiotensin converting enzyme (ACE) inhibitor (or angiotensin II receptor blocker [ARB], if not tolerated) and a beta-blocker should also be initiated as soon as practically possible; start at a low lose, gradually titrate upwards to the maximum tolerated dose, and continue long-term to control symptoms and reduce the risk of hospitalisation and mortality
  - Spironolactone (or eplerenone) should be considered if patients remain symptomatic; in some patients with severe symptoms, spironolactone may be used concomitantly alongside the ACE inhibitor and beta-blocker straight away
- The combination treatment of the ARB valsartan and the neprilysin inhibitor sacubitril (brand name Entresto) can improve clinical outcomes in patients with symptomatic HFrEF despite optimal dosing of an ACE inhibitor and a beta-blocker
  - This medicine is available fully funded with Special Authority approval*
  - The patient's ACE inhibitor (or ARB) should be stopped before initiating Entresto
  - Three strengths are available, and monitoring blood pressure, renal function and serum potassium should take place when initiating and two weeks after up-titrating the dose
- If HFpEF is confirmed, a cardiologist should generally be involved to refine treatment, which largely focuses on careful control of fluid balance using diuretics at the lowest possible dose, in addition to managing associated co-morbidities

* Sacubitril/valsartan is available under Special Authority for patients who meet the following criteria:
  - Heart failure with New York Heart Association (NYHA) functional class II–IV symptoms; and
  - Documented left ventricular ejection fraction of ≤35%; and
  - Receiving concomitant optimal standard chronic heart failure treatments