

XI Reunión. Estado del Arte en
INSUFICIENCIA CARDIACA

PRÁCTICA CLÍNICA Y MODELOS ORGANIZATIVOS

Sede: Hotel Meliá MaríaPita, A Coruña

A CORUÑA 27-28 SEPTIEMBRE 2024



XI Meeting. State of the Art in
HEART FAILURE

CLINICAL PRACTICE AND ORGANIZATIONAL MODELS

Venue: Hotel Meliá MaríaPita, A Coruña

#ACoruñaHF2024

A CORUÑA 27-28 SEPTEMBER 2024

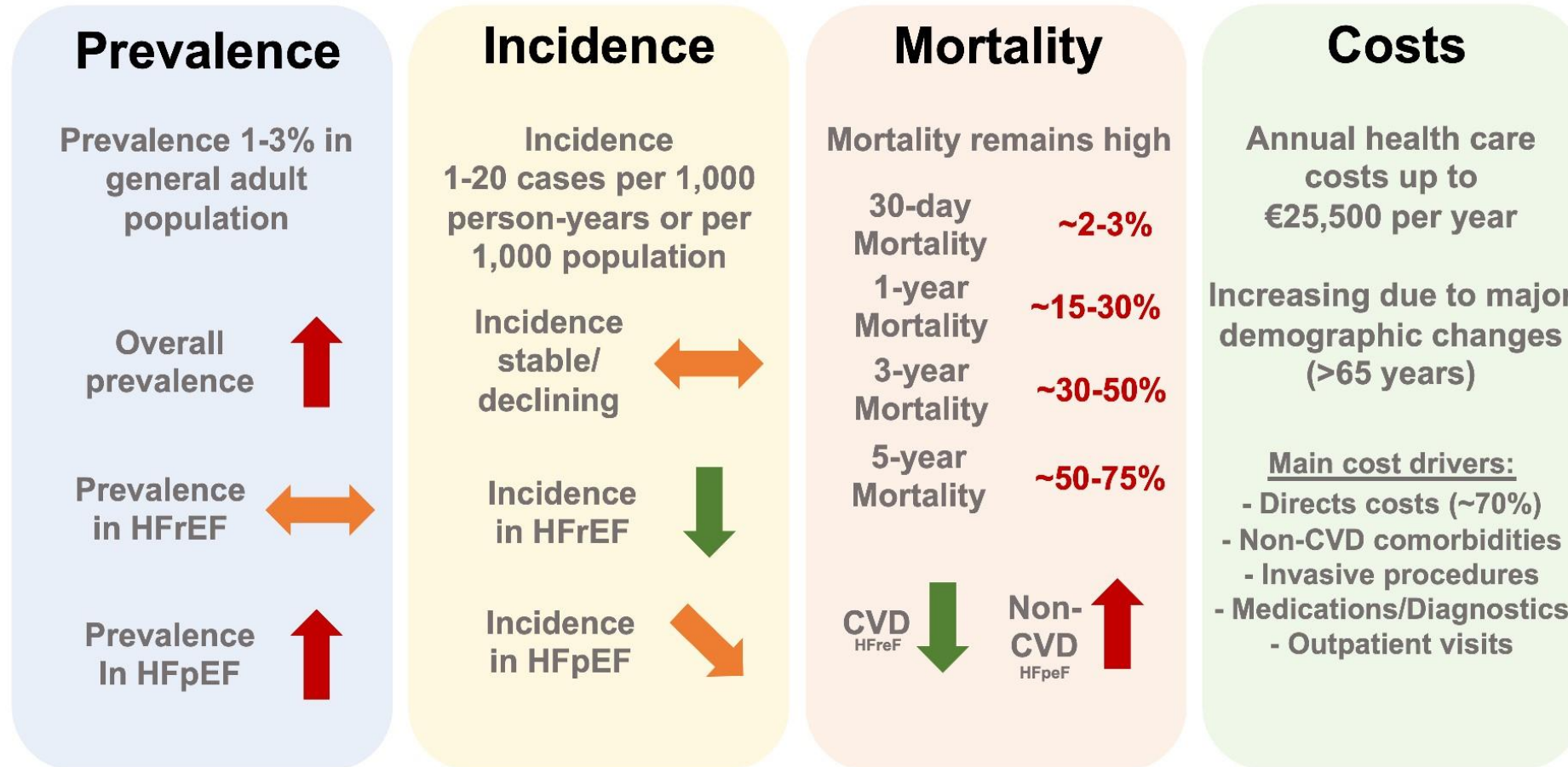
Overview of HF treatment in 2024. Key points

Visión global del tratamiento de la IC en 2024. Puntos clave



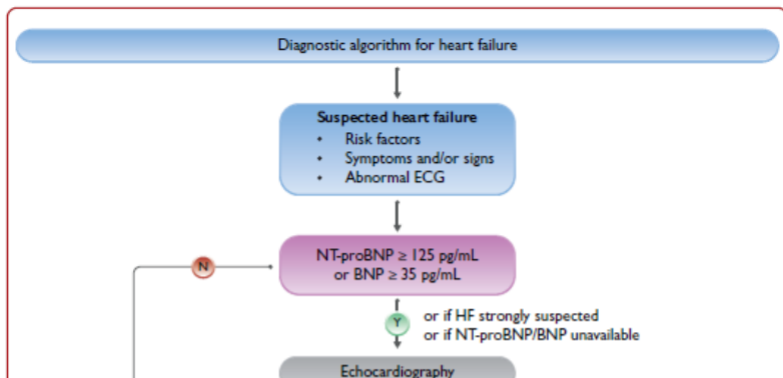
Sonia Mirabet Pérez MD, PhD
Hospital de Sant Pau. Barcelona

Global Burden of Heart Failure



Savarese et al. Cardiovasc Res 2023

1. Diagnosis and patient assessment



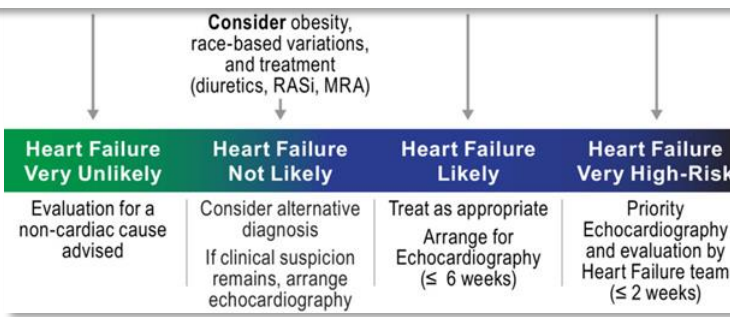
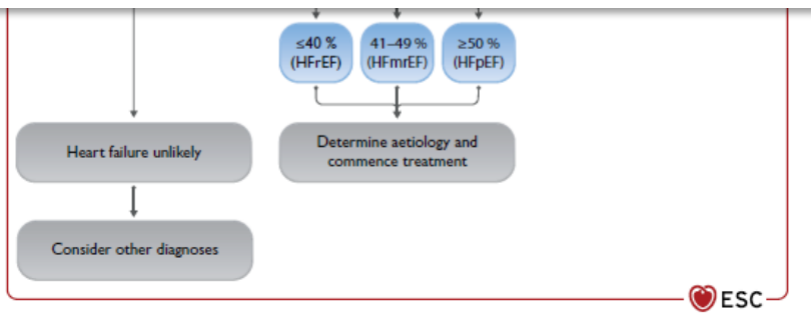
Practical algorithms for early diagnosis of heart failure and heart stress using NT-proBNP: A clinical consensus statement from the Heart Failure Association of the ESC

Suspected *de novo* Heart Failure as an **Outpatient**
(History, physical exam, ECG)



	Clinical Variable	Values	Points
H ₂	Heavy	Body mass index > 30 kg/m ²	2
	Hypertensive	2 or more antihypertensive medicines	1
F	Atrial Fibrillation	Paroxysmal or Persistent	3
P	Pulmonary Hypertension	Doppler Echocardiographic estimated Pulmonary Artery Systolic Pressure > 35 mmHg	1
E	Elder	Age > 60 years	1
F	Filling Pressure	Doppler Echocardiographic E/e' > 9	1
H₂FPEF score			Sum (0-9)

- Accurate diagnosis
- Appropriate characterization and classification of the patients
- Identification of the etiology of HF and proper management of these etiologies



Minor	TR velocity > 2.8 m/s (PASP > 35 mmHg)	Average E/e' 9-14 or GLS < 16%	LAVI 29-34 ml/m ² or LVMI > 115/95 g/m ² (m/w) or RWT > 0,42 or LV wall thickness ≥ 12 mm	NT-proBNP 125-220 pg/ml or BNP 35-80 pg/ml	NT-proBNP 365-660 pg/ml or BNP 105-240 pg/ml
Major Criteria: 2 points	≥ 5 points: HFpEF				
Minor Criteria: 1 point	2-4 points: Diastolic Stress Test or Invasive Haemodynamic Measurements				

McDonagh TA et al. Eur Heart J 2021
 Bayes-Genis T et al. Eur J Heart Fail 2023
 Reddy et al. Circulation 2018
 Pieske et al. Eur Heart J 2019

2. Initial Treatment

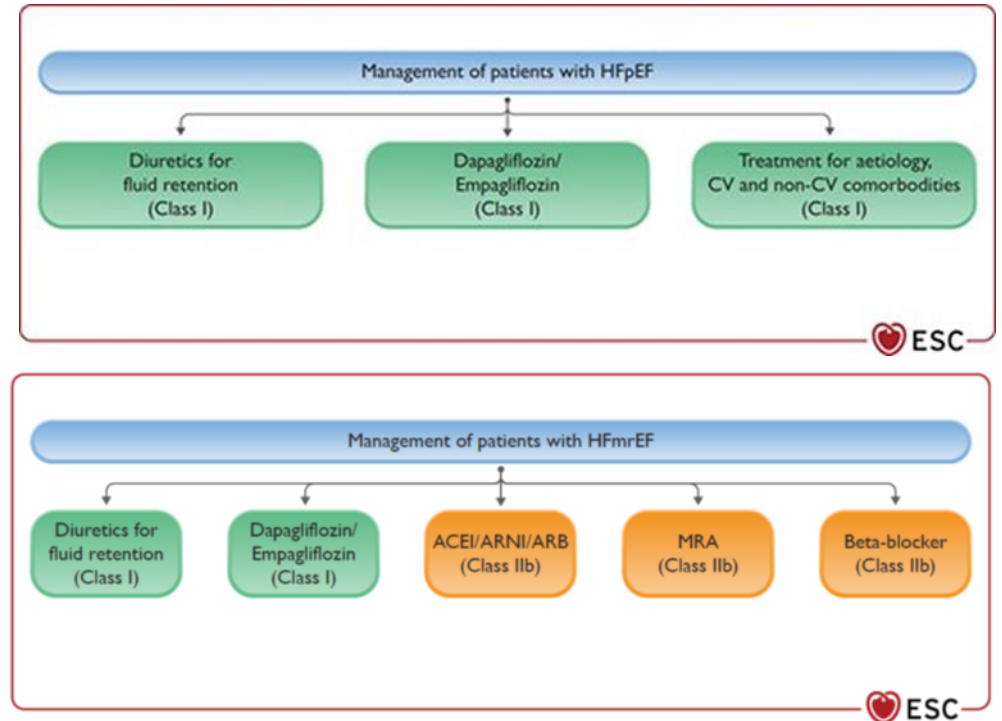
- Compliance with guidelines
- Education

HFrEF



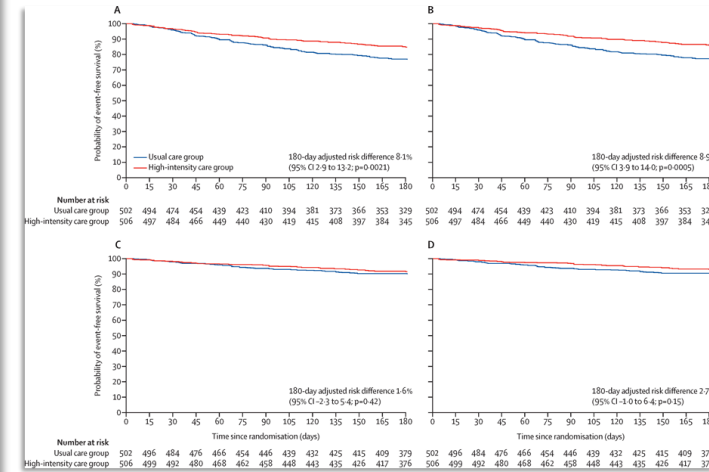
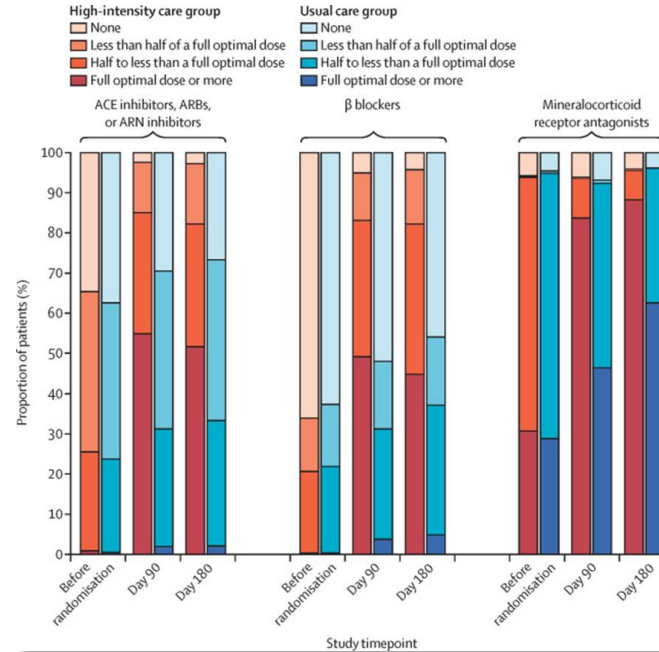
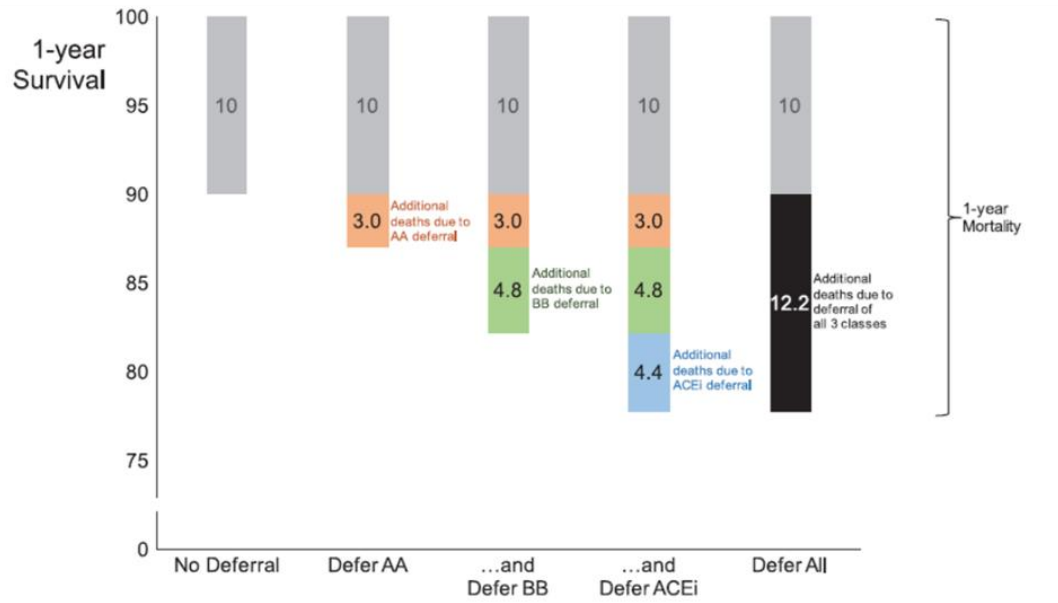
Timely initiation and up-titration of GDMT

HFmrEF HFpEF



Taylor R et al. Eur Heart J 2023
McDonagh TA et al. Eur Heart J 2023
McDonagh TA et al. Eur Heart J 2021

2. Initial Treatment HFrEF



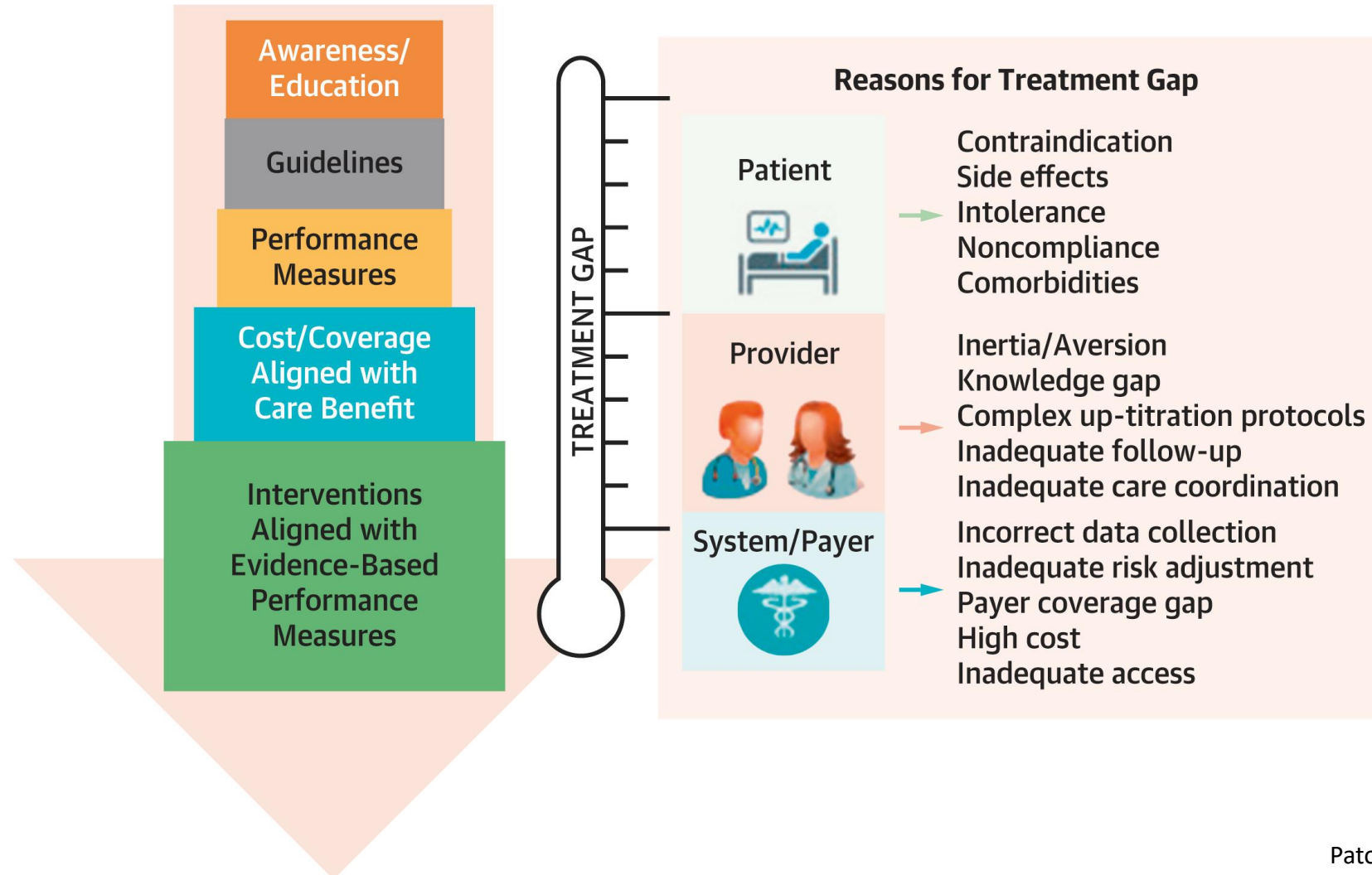
Absolute mortality arising from 1-year deferral of therapy

STRONG-HF (intensive treatment strategy of rapid up-titration)

- Feasible and safe
- Improves QOL and reduces symptoms
- Reduces the risk of 180-day all-cause death or heart failure readmission compared with usual care

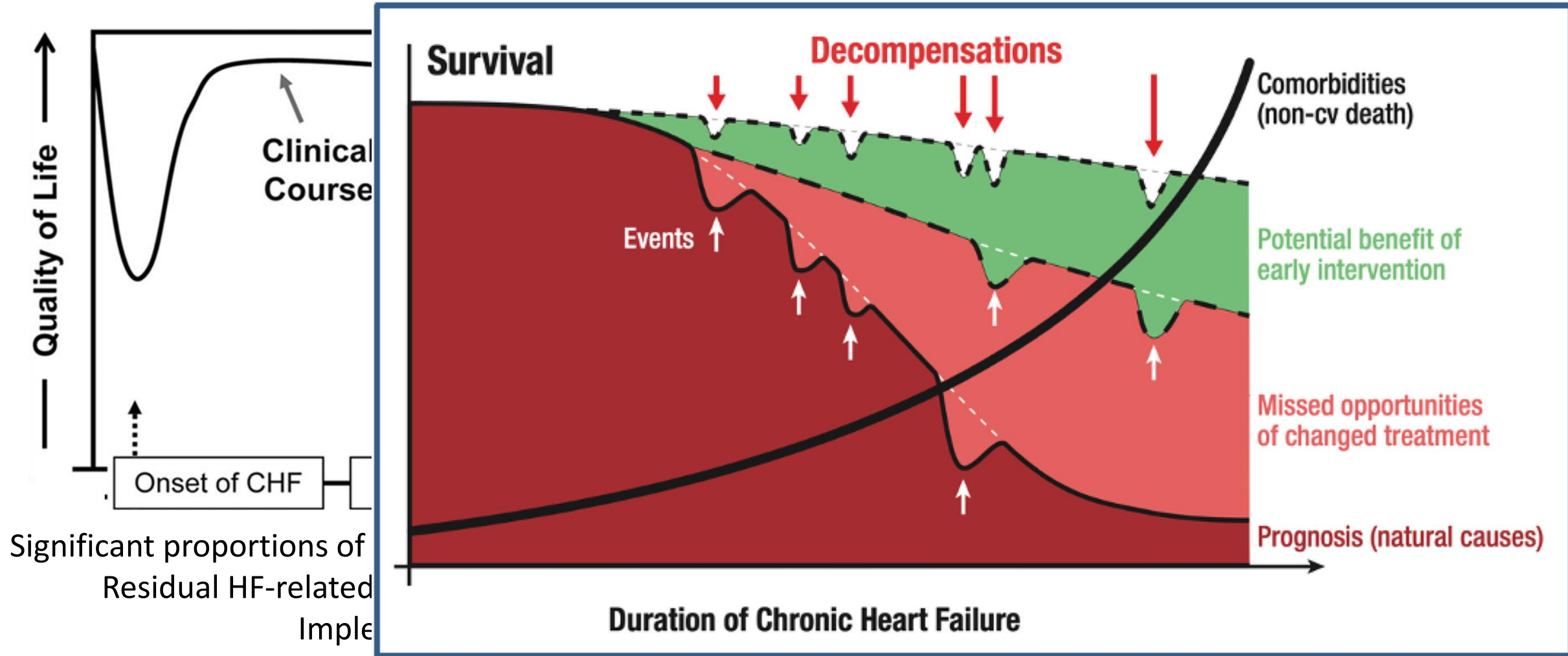
Zaman et al. Eur J Heart Fail 2017
Mebazaa et al. Lancet 2022

2. Initial Treatment HFrEF



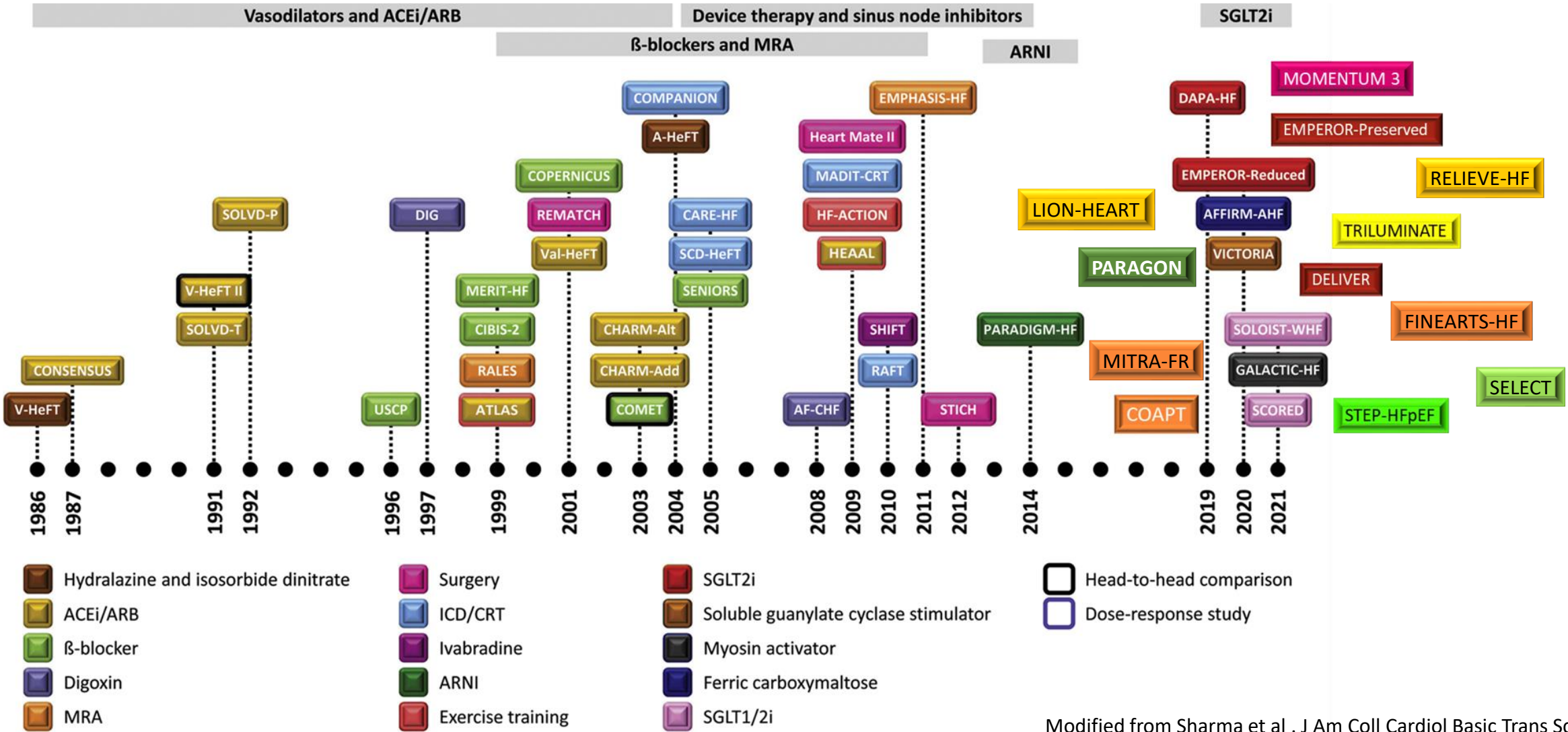
Patolia et al. J Am Coll Cardiol 2023

3. Therapy Optimization



Allen et al. Circulation 2012
Abdin et al. ESC Heart Fail 2021

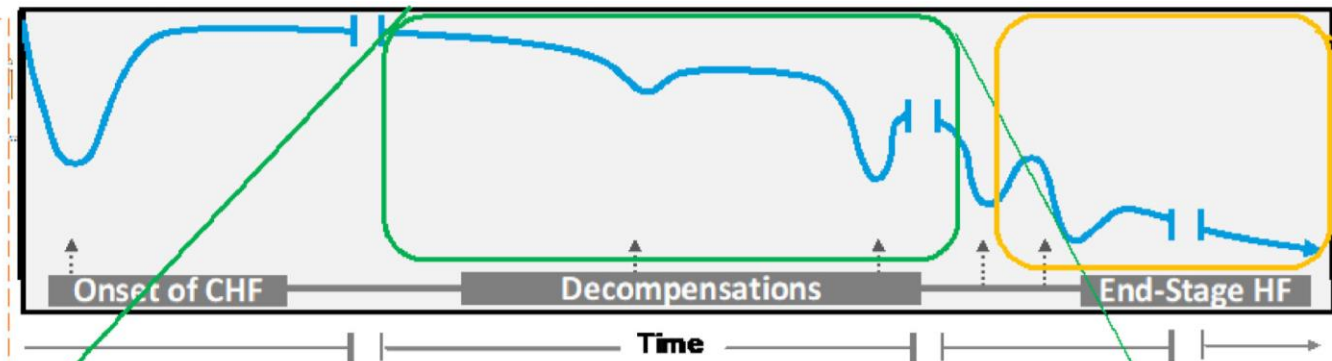
3. Therapy Optimization



Modified from Sharma et al. J Am Coll Cardiol Basic Trans Science. 2022

3. Therapy Optimization

An interdisciplinary team that consists of a general cardiologist, HF cardiologist, interventional cardiologist, structural cardiologist, multimodality imaging cardiologist, electrophysiologist, and cardiothoracic surgeon is crucial for the successful implantation and delivery of device-based therapies in heart failure



Palliative Care
Heart Transplantation

LVAD (HM3)
 -NYHA IV
 -LVEF ≤ 25%
 -inotrope dependent or Cardiac Index (CI) < 2.2 L/min/m²
 -Failing to respond to GDMT for at least 45 out of the last 60 days

Implantable cardioverter-defibrillator (ICD)
 -NYHA I-III
 -LVEF ≤ 35%
 -Projected survival > 1 year
COR*: 1

Cardiac resynchronization therapy (CRT-D)
 -NYHA II-III; ambulatory IV
 -LVEF ≤ 35%
 -Normal sinus
 -QRS ≥ 150 msec with a LBBB
COR*: 1

COR*: 1 (inotrope dependent)
COR*: 2a (Select NYHA IV patients)

<p>Medical therapy Ivabradine Vericiguat Hydralazine + ISDN Ferric carboxymaltose Digoxine AF Ablation</p>	<p>Transcatheter edge-to-edge mitral valve repair (M-TEER) -NYHA II-Ambulatory IV -LVEF 20-50% -Moderate-severe (grade 3+) or severe (grade 4+) secondary MR -LVESD ≤ 7cm -Excludes RHF and/or severe PHTN (RVSP > 70 mmHg)</p>	<p>AVR (TAVI or SAVR) -NYHA I-IV -Asymptomatic patients with severe AS and LVEF < 50% -Severe high-gradient AS with symptoms (independent of LVEF) -Symptomatic patients with low-flow, low gradient severe AS with reduced LVEF -Symptomatic patients with low-flow, low gradient with normal LVEF if AS is the most likely cause of symptoms</p>	<p>Transcatheter tricuspid valve replacement system OR transcatheter edge-to-edge mitral valve repair (T-TEER) -NYHA I-IV -Signs/symptoms of TR or prior hospitalization for HF - Severe TR</p>	<p>Remote Hemodynamic Monitoring (CardioMEMs) -NYHA II-III -Independent of LVEF - Hospitalized for HF in the previous year and/or have elevated natriuretic peptides</p>	<p>Baroreflex activation therapy (BAT) -Persistent symptoms with NYHA III or II (with a recent history of Class III) -LVEF ≤ 35% - NT-proBNP <1600 pg/ml -Excludes patients with a guideline indication for CRT</p>	<p>Cardiac Contractility Modulation (CCM) -NYHA III -LVEF 25-45% -QRS duration < 130 ms -Contraindicated with permanent atrial fibrillation</p>
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COR*: 2a

COR**: 1

COR*: Not Provided

COR*: 2b

COR*: Not Provided

COR*: Not Provided

Modified from Estep JD et al. J Cardiac Fail. 2024

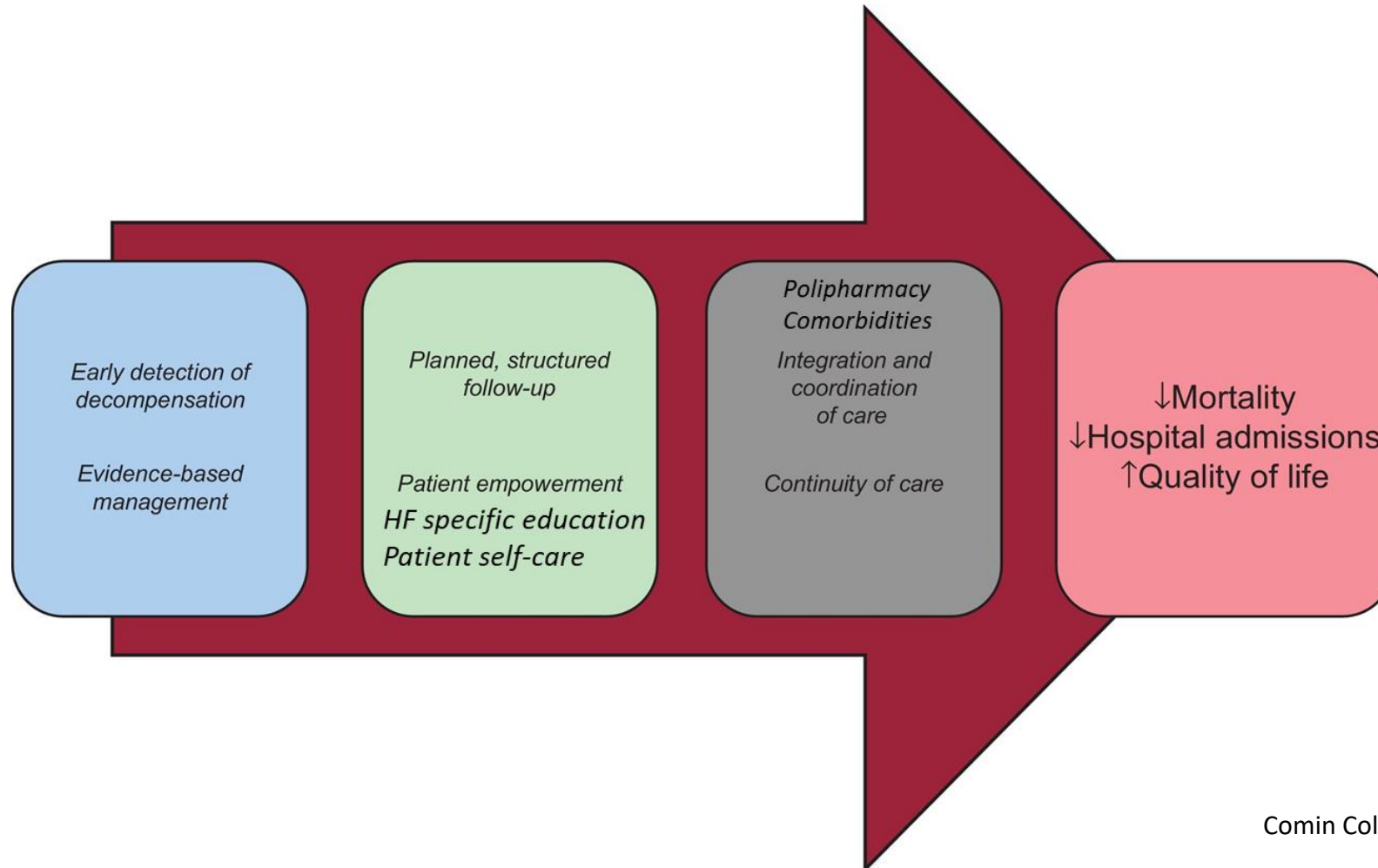
3. Therapy Optimization

- Regular follow-up
- Early referral and collaboration between primary and expert centers with HF specialists
- Dedicated studies: clinical, hemodynamic, imaging and structural phenotyping
- Careful and well-documented multidisciplinary decision-making
- Patient empowerment : extremely important allowing shared decision-making process
- Coordinated follow-up process

Salah H . JACC Heart Fail 2023
Mullens et al. Eur J Heart Fail 2024

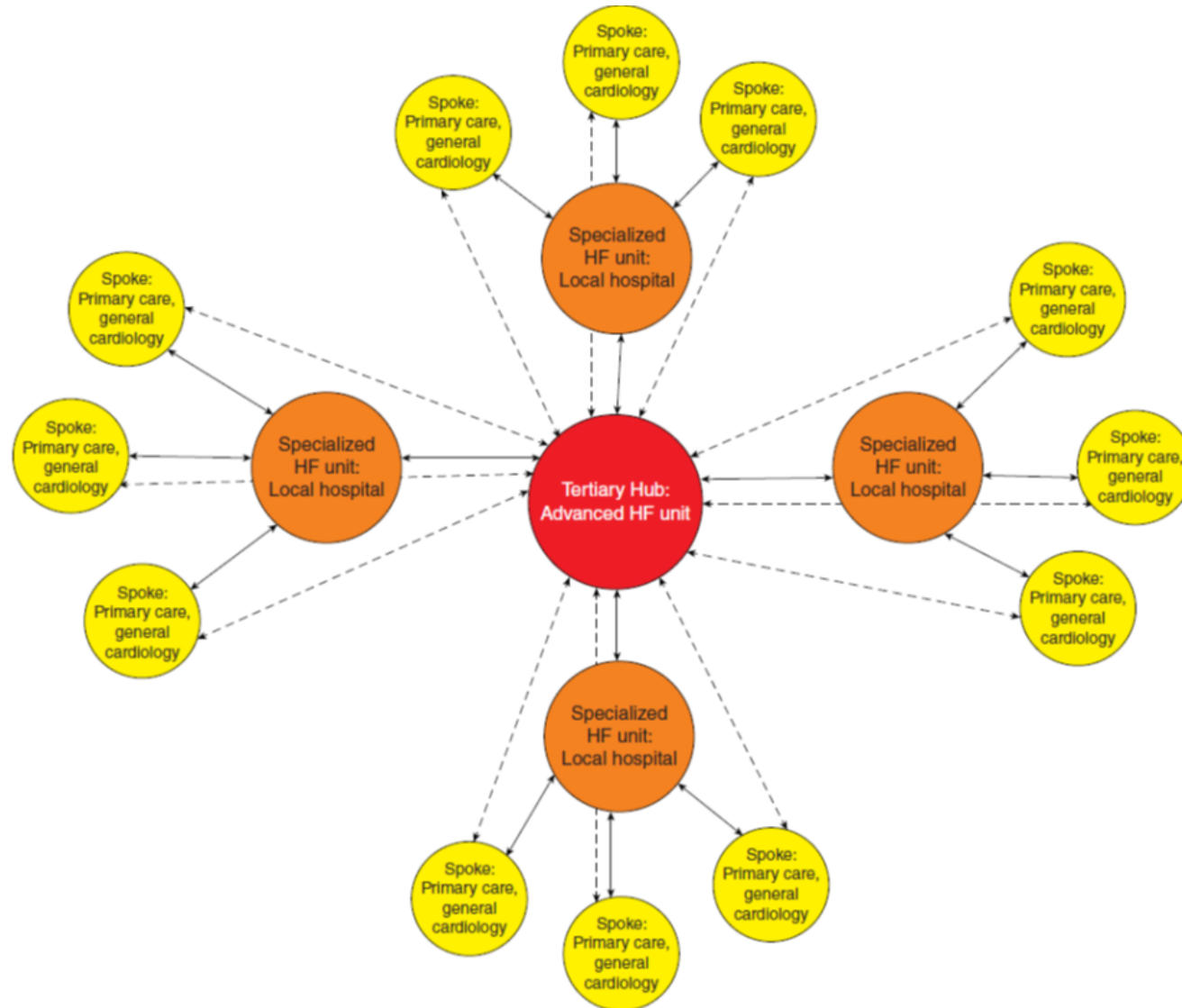
4. Heart Failure Units and Multidisciplinary Teams

- Systematize the diagnosis, treatment and clinical follow-up of HF patients
- Provides integrated and coordinated care of HF patients throughout the process



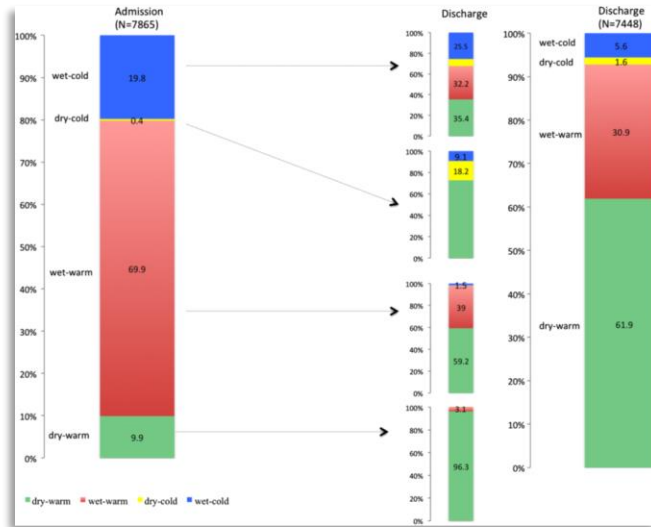
Comin Colet. Rev Esp Cardiol 2016

4. Heart Failure Units and Multidisciplinary Teams



Crespo-Leiro et al. Eur J Heart Failure 2018

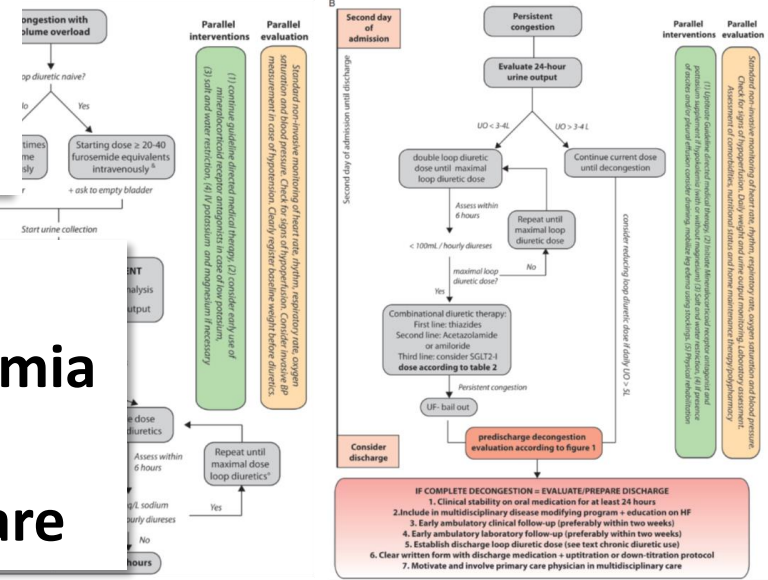
5. Decompensation



Chioncel et al. Eur J Heart Fail 2019

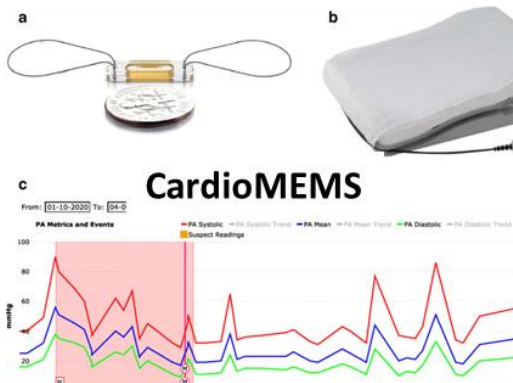
The use of diuretics in heart failure with congestion — a position statement from the Heart Failure Association of the European Society of Cardiology

- Detect congestion
- Determination of euvoalaemia
- Goals of therapy
- Stepped pharmacologic care



Mullens et al. Eur J Heart Fail 2019

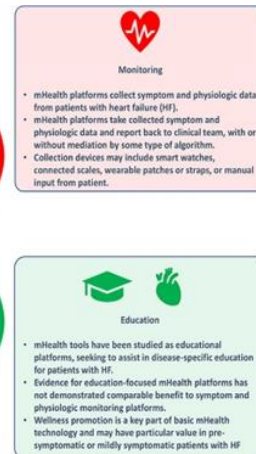
Prevention and early recognition of acute decompensation



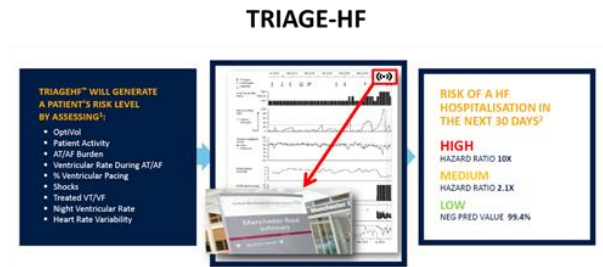
Abraham-W et al. Lancet 2011
Lindelfend J et al. Lancet 2021
Brugts et al. Lancet 2023



Haywood et al. J Card Fail 2023

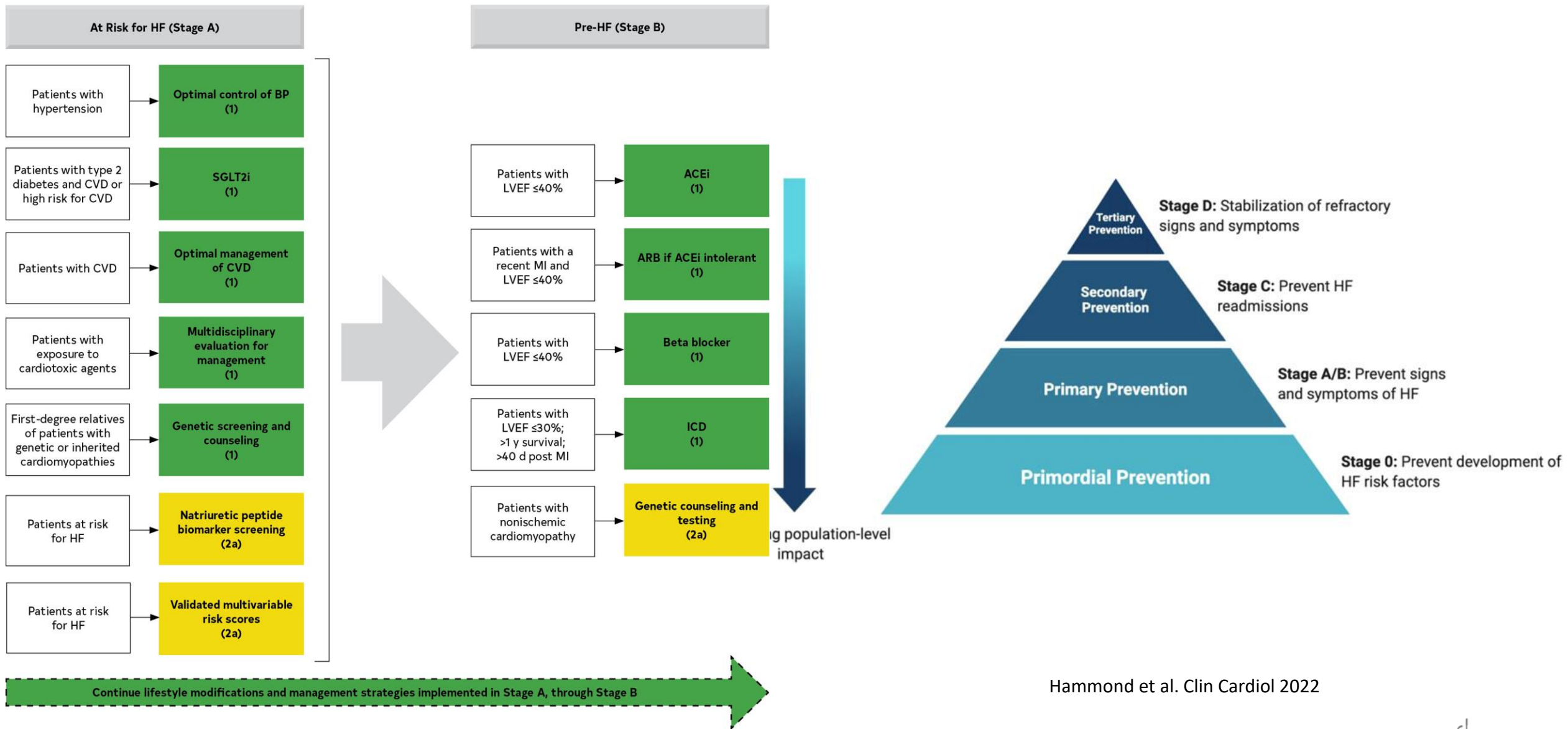


Lopez Azor et al. Card Fail Rev 2022



Virani et al. ESC Heart Fail 2018

6. Stages A and B : prevention



Hammond et al. Clin Cardiol 2022

Overview of HF treatment in 2024. Key points

- Accurate and timely diagnosis
- Initial treatment : compliance with guidelines
- Therapy optimization: Implement additional treatment, device therapy and advanced heart failure therapies
- Heart Failure Units , Multidisciplinary teams and Coordination
- Decompensation: prevention, early recognition and management
- Prevention