

Therapy of Chronic Heart Failure

Yacoub Irshaid, MD, PhD, ABCP

Department of Pharmacology, Faculty of Medicine

Chronic Heart Failure

- Heart failure (HF) is a progressive clinical syndrome associated with **impairment of the ability of the ventricle to fill with or eject blood**.
- HF may be caused by an **abnormality in systolic function, diastolic function, or both**.
- The leading causes of HF are coronary artery disease and hypertension.

Chronic Heart Failure

- In heart failure with reduced ejection fraction (HFrEF) there is a decrease in cardiac output, **resulting in** activation of compensatory responses that attempt to maintain adequate cardiac output.

Chronic Heart Failure

- These responses include: activation of the sympathetic nervous system (SNS) and the renin–angiotensin–aldosterone system (RAAS), resulting in vasoconstriction, sodium and water retention, ventricular hypertrophy and remodeling.

Chronic Heart Failure

- Pharmacotherapy targeted at antagonizing the neurohormonal activation has slowed the progression of HFrEF and improved survival.
- Heart failure with preserved ejection fraction (HFpEF) is primarily due to diastolic dysfunction of the heart (or disturbances in relaxation).
- It may be treated differently from HFrEF.

Causes of Heart failure

Causes of systolic dysfunction (decreased contractility):

- 1) Reduction in muscle mass (myocardial infarction).
- 2) Dilated cardiomyopathies.
- 3) Ventricular hypertrophy.
- 4) Pressure overload (systemic or pulmonary hypertension, aortic or pulmonary valve stenosis).
- 5) Volume overload (valvular regurgitation, AV-shunts, high-output states).

Causes of Heart failure

Causes of diastolic dysfunction (restriction in ventricular filling):

- 1) Increased ventricular stiffness.
- 2) Ventricular hypertrophy (hypertrophic cardiomyopathy, others).
- 3) Infiltrative myocardial diseases (amyloidosis, sarcoidosis, endomyocardial fibrosis).
- 4) Myocardial ischemia and infarction.
- 5) Mitral or tricuspid valve stenosis.
- 6) Pericardial disease (pericarditis, pericardial tamponade).

Factors Precipitating/Exacerbating Heart Failure

- A. Cardiac events:** myocardial ischemia and infarction, atrial fibrillation, uncontrolled HTN.
- B. Noncardiac events:** pulmonary infections, pulmonary embolus, diabetes, worsening renal function, **hypothyroidism, and hyperthyroidism.**
- C. Nonadherence** with prescribed HF medications or with dietary recommendations, such as sodium intake and fluid restriction.

Factors Precipitating/Exacerbating Heart Failure

D. Drugs can precipitate or exacerbate HF by one or more of the following mechanisms:

- 1) Negative inotropic effects.**
- 2) Direct cardiotoxicity.**
- 3) Increased sodium and/or water retention.**

Factors Precipitating/Exacerbating Heart Failure

Negative Inotropic Effect:

- Antiarrhythmics (disopyramide, flecainide, propafenone).
- Beta-blockers (propranolol, metoprolol, carvedilol).
- Calcium channel blockers (verapamil, diltiazem).

Cardiotoxicity:

Doxorubicin, epirubicin, daunomycin, ethanol, cyclophosphamide, trastuzumab, bevacizumab, ifosfamide, lapatinib, sunitinib, imatinib, amphetamines, cocaine.

Factors Precipitating/Exacerbating Heart Failure

Sodium and Water Retention:

NSAIDs, COX₂-inhibitors, rosiglitazone and pioglitazone, glucocorticoids, androgens and estrogens, high dose salicylates, high sodium-containing drugs (ticarcillin disodium)

Factors Precipitating/Exacerbating Heart Failure

- Many of these precipitating factors are preventable.
- **Medication history** and **discontinuation of medications known to exacerbate HF** are **part of therapy**.

Ventricular Hypertrophy and Remodeling

- Left ventricular hypertrophy and remodeling are key elements in the pathogenesis of progressive myocardial failure.
- Ventricular remodeling is a broad term describing **changes in both myocardial cells and extracellular matrix** that **result in changes in the size, shape, structure, and function of the heart.**

Ventricular Hypertrophy and Remodeling

- These progressive changes result in a change in shape of the left ventricle from an ellipse to a sphere.
- The change in ventricular size and shape further depresses the mechanical performance of the heart, increases regurgitant flow through the mitral valve, and thus, sustains progression of remodeling.

Ventricular Hypertrophy and Remodeling

- Ventricular hypertrophy and remodeling can follow any condition that causes myocardial injury.
- The onset of the remodeling process precedes the development of HF symptoms.

Ventricular Hypertrophy and Remodeling

- **The progression of the remodeling process leads to reductions in myocardial systolic and/or diastolic function, which results in further myocardial injury, perpetuating the remodeling process and the decline in left ventricular performance.**

Ventricular Hypertrophy and Remodeling

- **Angiotensin II, NE, endothelin, aldosterone, vasopressin, and numerous inflammatory cytokines**, play an important role in initiating the signal transduction cascade responsible for ventricular remodeling.
- These mediators are also toxic to other organs and provide evidence that HF is a systemic as well as a cardiac disorder.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6335102/>

Therapy of Chronic Heart Failure

Desired Outcomes:

- The goals of therapy in management of chronic HF are to:
 - 1) Improve the patient's quality of life
 - 2) Relieve or reduce symptoms
 - 3) Prevent or minimize hospitalizations
 - 4) Slow progression of the disease
 - 5) Prolong survival.

Therapy of Chronic Heart Failure

- The general principles used to guide the treatment of **HFrEF** are based on numerous large, randomized, double-blind, multicenter clinical trials.
- Until recently, **NO** such randomized trials had been performed in patients with **HFpEF**.
- The guidelines for the management of HFpEF are based primarily on studies in relatively small groups of patients and on clinical experience.

Therapy of Chronic Heart Failure

General Measures:

- **The complexity of the HF syndrome necessitates a comprehensive approach to management.**
- **This approach includes:**
 - 1) Accurate diagnosis.**
 - 2) Identification and treatment of risk factors.**
 - 3) Elimination or minimization of precipitating factors.**
 - 4) Appropriate pharmacologic and nonpharmacologic therapy.**
 - 5) Close monitoring and follow up.**

Therapy of Chronic Heart Failure

- **The first step in management of chronic HF is to determine the etiology and/or precipitating factors.**
- **Appropriate treatment of underlying disorders (hyperthyroidism, valvular heart disease, ..etc) may avoid the need for specific HF treatment.**
- **Revascularization or anti-ischemic therapy in patients with CHD may reduce HF symptoms.**
- **Drugs that aggravate HF should be discontinued if possible.**

Therapy of Chronic Heart Failure

- **Restriction of physical activity** reduces cardiac workload and is **recommended for all patients with acute congestive symptoms**, until patient's symptoms have stabilized and excess fluid is removed.
- **Exercise training may improve functional status & quality of life, and may reduce hospitalizations and death from cardiovascular causes.**

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- Restriction of dietary sodium and fluid intake is an important life-style intervention for both HFrEF and HFpEF, to allow use of lower and safer diuretic doses.
- In patients with **hyponatremia** (Na <130 mEq/L) or those with **persistent volume retention despite high diuretic doses and sodium restriction**, **daily fluid intake should be limited to 2 L/day from all sources.**

Therapy of Chronic Heart Failure

- You should be careful with sodium and fluid restriction in patients with HFpEF, because excessive restriction can lead to **hypotension**, **low-output state**, and/or **renal insufficiency**.

Therapy of Chronic Heart Failure

General Approach to Treatment:

- The ACC/AHA treatment guidelines are organized around the four identified stages of HF.
- Updated 2022: [Circulation. 2022;145:e895–e1032.](#)

New York Heart Association Functional Classification

Functional Stages:

A. Patients at Risk for HF

- Patients with cardiac disease but without limitations of physical activity.
- Ordinary physical activity does not cause undue fatigue, dyspnea, or palpitation.

New York Heart Association Functional Classification

Primary Prevention:

1. In patients with hypertension, blood pressure should be reduced.
2. In patients with type 2 diabetes and cardiovascular disease or at high risk of CVD, SGLT2i should be used **to prevent hospitalization for HF.**
3. Healthy life style habits: physical activity, normalization of body weight, healthy diet, and avoidance of smoking reduce future risk of HF

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- **Risk factors (HTN, dyslipidemia, diabetes, obesity, metabolic syndrome, smoking, and coronary artery disease) identification and treatment to prevent the development of structural heart disease and subsequent HF is important.**
- Risk factors act synergistically to develop both HFrEF and HFpEF.
- **ACE inhibitors (or ARBs) and statins** are recommended for HF **prevention** in patients with multiple cardiovascular risk factors.

New York Heart Association Functional Classification

B. Patients With Pre-HF:

- Patients with cardiac disease that results in slight limitations of physical activity.
- Ordinary physical activity results in fatigue, palpitation, dyspnea, or angina.
- These patients have structural heart disease (left ventricular hypertrophy, recent or old MI, valvular heart disease, or LVEF < 0.4), but do NOT have HF symptoms.

New York Heart Association Functional Classification

Preventing the Syndrome of Clinical HF in Patients With Pre-HF:

- 1. In patients with LVEF \leq 40%, ACEIs should be used to prevent symptomatic HF and reduce mortality.**
- 2. In patients with a history of MI or ACS, statins should be used to prevent symptomatic HF and adverse cardiovascular events.**
- 3. In patients with a recent MI and LVEF \leq 40% who are intolerant to ACEIs, ARB should be used to prevent symptomatic HF and reduce mortality.**

New York Heart Association Functional Classification

- 4. In patients with a history of MI or ACS and LVEF \leq 40%, evidence-based beta blocker should be used to reduce mortality.**
- 5. In patients who are at least 40 days post MI and LVEF \leq 30% and NYHA class 1 symptoms while receiving Guideline-directed medical therapy (GDMT) and have reasonable expectation of meaningful survival for $>$ 1 year, an Implantable cardioverter-defibrillator (ICD) is recommended for primary prevention of sudden cardiac death to reduce total mortality.**

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- 6. In patients with LVEF \leq 50%, thiazolidindiones and nonhydropyridine calcium channel blockers should not be used.**

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C. Stage C HF

- Patients with cardiac disease that results in marked limitation of physical activity. Although patients are comfortable at rest, **less than ordinary activity will lead to symptoms.**
- Patients with structural heart disease and previous or current symptoms are classified as Stage C and can have HFrEF or HFpEF.

New York Heart Association Functional Classification

Nonpharmacological Interventions:

Patients with HF should:

1. Receive care from multidisciplinary teams to facilitate the implementation of GDMT, address potential barriers to self-care, reduce the risk of subsequent rehospitalization for HF, and improve survival.
2. Receive education and support to facilitate HF self care.

New York Heart Association Functional Classification

- 3. Receive vaccination for respiratory illness to reduce mortality.**
 - 4. Be screened for depression and other risk factors for poor self care.**
 - 5. Avoid excessive sodium intake to reduce congestive symptoms.**
- Participatio in exercise training or regular physical activity is recommended to improve functional status.**

New York Heart Association Functional Classification

Diuretic Therapy:

1. In patients with fluid retention, loop diuretics are recommended to relieve congestion, improve symptoms and prevent worsening heart failure.
2. In patients who do not respond to moderate-high dose, add metolazone.

New York Heart Association Functional Classification

Pharmacological Treatment for HFrEF:

- 1. In patients with HFrEF and NYHA class II-III symptoms, the use of ARNi (angiotensin receptor/neprilysin inhibitor) is recommended to reduce morbidity and mortality.**
- 2. In such patients, when the use of ARNi is not, the use of ACEIs is beneficial to reduce morbidity and mortality.**

New York Heart Association Functional Classification

- 3. If the patient is intolerant (cough or angioedema) to ACE inhibitors, ARBs are alternatives.**
- 4. In patients with chronic HFrEF and NYHA class II-III symptoms who tolerate ACEIs or ARBs, replacement by an ARNi is recommended to further reduce morbidity and mortality.**
- 5. ARNi should not be administered in any patient with a history of angioedema.**

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- 6. ARNi should not be coadministered with ACEIs or within the last 36 hours of the last dose of ACEIs.**
- 7. In patients with previous or current symptoms of chronic HFrEF, use of one of the three beta blockers (Bisoprolol, carvedilol, and sustained release metoprolol) is recommended to reduce mortality and hospitalization.**

New York Heart Association Functional Classification

- 8. In patients with symptomatic chronic heart failure, SGLT2i is recommended to reduce hospitalization and reduce mortality irrespective of the presence of type 2 diabetes.**

New York Heart Association Functional Classification

- 9. In patients with, eGFR is > than 30 mL/min and serum potassium < 5 mEq/L an MRA (spironolactone or eplerenone) is recommended to reduce morbidity and mortality.**
 - Careful monitoring of potassium and renal function is recommended.**
 - In patients when serum potassium can not maintained < 5.5 mEq/L, MRA should be discontinued to avoid life-threatening hyperkalemia.**

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Hydralazine and Isosorbide dinitrate:

- 1. For African-American patients with NYHA class III-IV HFrEF who receive optimal therapy, the combination hydralazine and isosorbide dinitrate is recommended to improve symptoms and reduce morbidity and mortality. (may have low NO).**
- 2. In patients who can not receive ACEIs, ARNi or ARB, hydralazine and isosorbide dinitrate is recommended to reduce morbidity and mortality.**

New York Heart Association Functional Classification

Ivabradine:

- **For patient with symptomatic (NYHA class II-III) stable chronic HFrEF ($\leq 35\%$) who are receiving GDMT, including beta blocker at maximum tolerated dose, and who are in sinus rhythm with a heart rate of ≥ 70 bpm at rest, ivabradine can be beneficial to reduce heart failure hospitalization and cardiovascular death.**

New York Heart Association Functional Classification

Digoxin:

- In patients with symptomatic HFrEF despite GDMT (or who are unable to tolerate GDMT), digoxin may be considered to decrease hospitalization for HF.

Vericigaut:

- In selected high risk patients with HFrEF and recent worsening of HF already on GDMT an oral soluble guanylate cyclase stimulator may be considered to decrease HF hospitalization and cardiovascular death.

Therapy of Chronic Heart Failure

- **Nonpharmacologic therapy with devices such as an implantable cardioverter-defibrillator (ICD) or cardiac resynchronization therapy (CRT) with a biventricular pacemaker is also indicated in certain patients with HFrEF in Stage C.**

New York Heart Association Functional Classification

D. Stage D (Advanced) HF:

- Patients with cardiac disease that results in an inability to carry on physical activity without discomfort.
- Symptoms of congestive heart failure are present even at rest.
- With any physical activity, increased discomfort is experienced.

New York Heart Association Functional Classification

Recommendation:

- In patients with advanced heart failure, when consistent with patient's goal of care, **timely referral for HF speciality care is recommended** to:
 1. review HF management
 2. **assess suitability for advanced HF therapies** (left ventricular assist device [LVAD], cardiac transplantation, palliative care and palliative inotropes).
- *Those of you who are interested in the advanced therapies can go to the reference.*

New York Heart Association Functional Classification

- **For patients with advanced heart failure and hyponatremia, the benefit of fluid restriction to reduce congestion symptoms is uncertain.**

Therapy of Chronic Heart Failure

Heart Failure with Preserved Ejection Fraction:

- Less evidence-based information on the treatment of HFpEF is available.
- Guidelines recommend treating co-morbid conditions by controlling HR and BP, **alleviating causes of myocardial ischemia**, **reducing volume**, and **restoring and maintaining sinus rhythm** in patients with atrial fibrillation.

Treatment Approach of HFpEF

Symptom-targeted treatment	Rationale	Agent
Decrease pulmonary venous pressure	Reduce left ventricular volume	Diuretics, nitrates, salt restriction
Reduce myocardial oxygen demand	Reduce heart rate, control blood pressure	B-blockers, (verapamil, diltiazem), (ACEIs, ARB), other calcium channel blockers
Maintain atrial contraction	Restore sinus rhythm	Cardioversion of atrial fibrillation
Improve exercise tolerance		Use positive inotropic agents with caution

Disease-targeted treatment		
Prevent or treat myocardial ischemia		B-blockers, nitrates, (verapamil, diltiazem)
Prevent or regress ventricular hypertrophy		Antihypertensive therapy
Mechanism-targeted treatment		
Modify myocardial and extramyocardial mechanisms		Possibly (ACEIs, ARB), diuretics, spironolactone
Modify intracellular and extracellular mechanisms		Possibly (ACEIs, ARB), diuretics

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Calcium channel blockers:

- In patients with atrial fibrillation who are intolerant to or have NOT responded to a β -blocker; **diltiazem or verapamil** may be considered.
- A nondihydropyridine or dihydropyridine calcium channel blocker can be considered for angina and hypertension.

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- With a few exceptions, many of the drugs used to treat HFrEF are the same as those for treatment of HFpEF.
 - The rationale for their use, and the dosing regimen may be different.
1. β -blockers are recommended for the treatment of both HFrEF and HFpEF.
 - a) In HFpEF, β -blockers are used to decrease HR, prolong diastole, and modify hemodynamic response to exercise.
 - b) In HFrEF, β -blockers are used in the long term to improve the inotropic state and modify LV remodeling.

Therapy of Chronic Heart Failure

2. Diuretics also are used in the treatment of both HFrEF and HFpEF.
 - The doses of diuretics used to treat HFpEF are much smaller than those used to treat HFrEF.
3. Antagonists of the RAAS are useful in lowering BP and reducing LVH.
4. Some drugs, are used to treat either HFrEF or HFpEF:
 - Calcium channel blockers (diltiazem, amlodipine, and verapamil) may be useful in the treatment of HFpEF.
 - They have little utility in the treatment of HFrEF and should be avoided.

ARB/Neprilysin Inhibitor (Valsartan/Sacubitril)

- The natriuretic peptides ANP and BNP cause vasodilation, natriuresis, and diuresis.
- In addition, they inhibit renin secretion, aldosterone production and attenuate ventricular hypertrophy and fibrosis.
- Neprilysin is a zinc-dependent metalloprotease that breaks down the natriuretic peptides ANP & BNP, in addition to bradykinin and other peptides.

ARB/Neprilysin Inhibitor (Valsartan/Sacubitril)

- **Valsartan/Sacubitril** can be used for the treatment of patients with HFrEF.
- **Sacubitril** is prodrug, which inhibits the action of neprilysin, leading to vasodilation, increased glomerular filtration, natriuresis, and diuresis.
- The combination reduces mortality and hospitalizations in patients with HFrEF.

ARB/Neprilysin Inhibitor (Valsartan/Sacubitril)

Adverse Effects:

- Hypotension, dizziness, hyperkalemia, worsening of renal function, and cough – most common.
- Angioedema.

Drug interactions:

1. Should NOT be used concurrently with ACE inhibitors or ARBs. ACEIs should be discontinued 36 hours prior to initiating sacubitril/valsartan.
2. Should be avoided with **aliskiren** (direct renin inhibitor).

ARB/Neprilysin Inhibitor (Valsartan/Sacubitril)

Contraindications:

- 1. Patients with history of angioedema**
- 2. Pregnancy**
- 3. Hyperkalemia**
- 4. Renal artery stenosis**
- 5. Severe hepatic impairment**
- 6. Renal dysfunction**
- 7. Diabetic patients taking aliskiren due to an increased risk of hypotension, hyperkalemia, and renal impairment.**

Ivabradine

- Ivabradine blocks the I_f current in the SA node that is responsible for controlling the heart rate.
- By blocking this current, ivabradine **slows the spontaneous depolarization of the sinus node** resulting in a dose-dependent slowing of the heart rate.
- Ivabradine's effects are specific to the I_f current and it does not affect myocardial contractility, or AV conduction.

Ivabradine

- Used for patients with HFrEF in sinus rhythm with a heart rate ≥ 70 beats/min that are receiving maximally tolerated treatment with β -blockers or have contraindications to β -blockers.
- Ivabradine is extensively metabolized by intestinal and hepatic CYP3A4.
- Co-administration with CYP3A4 inhibitors (itraconazole, macrolide antibiotics, HIV protease inhibitors, verapamil, diltiazem, grapefruit juice) **is contraindicated because of the large increase in exposure and potential for bradycardia.**

Ivabradine

- Use with CYP3A inducers (St. John's wort, rifampin, phenytoin) should be avoided.
- Because QT interval prolongation can be increased by slower heart rates, ivabradine should be used cautiously, if at all, with other agents known to prolong the QT interval.

Adverse Effects:

1. Bradycardia in ~ 10% of patients.
2. Effects on vision primarily manifesting as phosphenes (transient brightness in portions of the visual field).
3. Atrial fibrillation.

sGC stimulators - Vericiguat

- **Nitric oxide (NO) is generated from L-arginine by the action of nitric oxide synthase (NOS), which in turn stimulates soluble guanylate cyclase (sGC) to generate cGMP.**
- **cGMP mediates vascular smooth muscle relaxation leading to vasodilation and subsequent reduction of blood pressure.**
- **In the heart, natriuretic peptides lead to the activation of the NO-sGC-cGMP pathway.**

Vericiguat

- **Subsequent production of cGMP leads to activation of protein kinases that phosphorylate target proteins.**
- **This results in cardioprotective actions, such as natriuresis, improved diastolic relaxation, improved coronary blood flow and reduced smooth muscle proliferation, hypertrophy, inflammation, and fibrosis.**

Vericiguat

- However, in patients with heart failure, disruption of the NO-sGC-cGMP signalling pathway is seen, as a result of hypoperfusion that results in a state of oxidative stress and inflammation in the heart.
- **sGC stimulators activate sGC independent of NO by binding to a non-heme site in sGC.**
- They have been in use for pulmonary arterial hypertension (riociguat).

Vericiguat

- It has significant benefits in **reducing hospitalizations** in **patients with HFrEF** that are at high risk of cardiovascular events.
- No benefit of these drugs in patients with HFpEF.
- Vericiguat did NOT show any mortality benefit.
- Adverse effects: **low blood pressure and anemia.**
- It is contraindicated in patients with concomitant use of other soluble guanylate cyclase (sGC) stimulators and **during pregnancy.**

Sodium-glucose co-transporter 2 inhibitors (SGLT2i) in HF

Dapagliflozin and Empagliflozin:

- Unless contraindicated, SGLT2 inhibitors should be initiated early **as part of the foundational therapy** in all patients with HF.
- The sodium-glucose co-transporter 2 (SGLT2) inhibitors have been shown to reduce risks of clinical events in patients with heart failure (HF), with early and sustained benefits **regardless of ejection fraction, diabetic status, and care setting.**

Sodium-glucose co-transporter 2 inhibitors (SGLT2i) in HF

- **Association of ARNi, β -blockers, MRA, and SGLT2 inhibitors was the best combination for reducing all-cause death and the composite outcome of cardiovascular death or hospitalization for HF, and serious adverse renal outcomes in patients with a broad spectrum of severity of HFrEF.**

Sodium-glucose co-transporter 2 inhibitors (SGLT2i) in HF

Contraindications:

- 1. Type 1 DM or history of ketoacidosis**
- 2. Hypotension (systolic BP < 100 mmHg)**
- 3. Severe kidney disease (eGFR < 20-25 mL/min/1.73 m²)**
- 4. Pregnancy, risk of pregnancy, breast feeding.**
- 5. Caution in patients with a history of recurrent genital or urinary tract infections.**

Sodium-glucose co-transporter 2 inhibitors (SGLT2i) in HF

Monitoring:

- 1. Check renal function when starting therapy and after 1-2 weeks**
- 2. Blood glucose**
- 3. Observe for acute illness or major surgery. It is recommend to withhold SGLT2 inhibitors in case of prolonged fasting or 3 days before major surgery.**

Sodium-glucose co-transporter 2 inhibitors (SGLT2i) in HF

Patient/caregiver counselling:

- 1. Ensure adequate daily genital hygiene**
- 2. Watch for symptoms of volume depletion, urogenital infection, and diabetic ketoacidosis**
- 3. Avoid dehydration, low carbohydrate (ketogenic) diet, and excessive alcohol consumption**

Diuretics

- **Diuretic therapy and sodium restriction, are recommended in all patients with fluid retention.**
- **Once fluid overload has been resolved, many patients require chronic diuretic therapy to maintain normal blood volume.**

Benefits:

- 1. Reduction of symptoms associated with fluid retention**
- 2. Improvement of exercise tolerance and quality of life**
- 3. Reduction of hospitalizations from HF.**
- 4. Reduction of pulmonary and peripheral edema through reduction of preload.**

Diuretics

- **Diuretics do NOT prolong survival or alter disease progression.**
- **Over-diuresis leads to reduction in cardiac output, and renal hypoperfusion.**
- **Hypotension or worsening renal function (increased creatinine) may be indicative of volume depletion and necessitate a reduction in the diuretic dose.**
- **Diuretic therapy is usually initiated at low doses in the outpatient setting, with dosage adjustments based on symptom assessment and daily body weight.**

Diuretics

- **Over-diuresis may produce hypotension with ACE inhibitor or β -blocker therapy.**
- **In patients with HFpEF, diuretic treatment should be initiated at low doses in order to avoid hypotension and fatigue.**
- **Hypotension can be a significant problem in the treatment of HFpEF because a **small change in volume causes a large change in filling pressure and cardiac output.****

Diuretics

- **After the acute treatment of HFpEF has been completed, long-term treatment should include small - moderate oral doses of diuretics (furosemide 20-40 mg/day, chlorthalidone 25-100 mg, or hydrochlorothiazide 12.5-25 mg/day).**

Thiazide diuretics:

- **Thiazide or the thiazide-like diuretics (metolazone, indapamide) can be used in combination with loop diuretics to promote a very effective diuresis.**

Diuretics

- **Thiazide diuretics may be preferred in patients with mild fluid retention and elevated BP because of their more persistent antihypertensive effects compared with loop diuretics.**

Loop Diuretics:

- **Loop diuretics are usually necessary to restore and maintain euvolemia in HF.**
- **Probenecid or organic by-products of uremia can inhibit delivery of loop diuretics to their site of action and decrease effectiveness.**

Diuretics

- **Loop diuretics induce a prostaglandin-mediated increase in renal blood flow, which contributes to their natriuretic effect.**
- **Coadministration of NSAIDs, including COX-2 inhibitors, blocks the prostaglandin-mediated effect and can diminish diuretic efficacy.**
- **Unlike thiazides, loop diuretics maintain their effectiveness in the presence of impaired renal function, although higher doses are necessary to obtain adequate delivery of the drug to the site of action.**

ACE Inhibitors

- ACE inhibitors are key component of therapy of patients with HFrEF.
- They decrease the production of angiotensin II and aldosterone.
- This decrease in angiotensin II and aldosterone attenuates ventricular remodeling, myocardial fibrosis, myocyte apoptosis, cardiac hypertrophy, norepinephrine release, vasoconstriction, and sodium and water retention.
- Bradykinin is increased by ACE inhibitors along with the release of vasodilatory prostaglandins and histamine.

ACE Inhibitors

- **The most common cause of HFrEF is ischemic heart disease, which results in loss of myocytes, followed by ventricular dilation and remodeling.**
- **Captopril, ramipril, and trandolapril all benefit post-MI patients whether therapy is initiated early or late after the infarct.**

ACE Inhibitors

- **ACE inhibitors may have favorable effects on concomitant disorders (HTN, previous MI).**
- **ACE inhibitors lower glomerular capillary pressure, decrease proteinuria, and may halt progressive glomerular injury and loss of renal function in experimental chronic renal failure (CRF).**

ACE Inhibitors

- However, these patients **should be monitored carefully for the development of worsening renal function and/or hyperkalemia**.
- ACE inhibitors improve survival by 20 - 30% compared with placebo.

Angiotensin II Receptor Blockers

- Angiotensin II can be formed in a number of tissues, including the heart, through non-ACE-dependent pathways (chymase, cathepsin, and kallikrein).
- By blocking the angiotensin II receptor subtype, AT1, ARBs **attenuate the effects of angiotensin II on ventricular remodeling, regardless of the site of origin of the hormone.**
- These agents do **NOT** affect bradykinin, which is linked to ACEIs-induced cough and angioedema.

Angiotensin II Receptor Blockers

- **ARBs include candesartan, losartan, or valsartan which can reduce mortality and hospitalizations and improve symptoms.**
- **ARBs are indicated in patients who are unable to tolerate cough produced by ACE inhibitors.**
- **The role of ARBs in the treatment of HFpEF is less clear.**

β -Blockers

- β -blockers reduce morbidity and mortality in patients with HFrEF.
- They should be used **in all stable patients** with HF and a reduced left ventricular EF in the absence of contraindications or a clear history of β -blocker intolerance.
- Patients should receive a β -blocker when their symptoms are mild or well-controlled with diuretic and ACE inhibitor therapy.
- They are also recommended for asymptomatic patients with a reduced left ventricular EF to decrease the risk of progression to HF.

β -Blockers

- Three β -blockers have been shown to significantly reduce mortality compared with placebo: **carvedilol, metoprolol succinate (CR/XL), and bisoprolol**.
- They have been shown to decrease ventricular mass, reverse the sphericity of the ventricle, and reduce systolic and diastolic volumes.
- These effects are collectively called reverse remodeling, which means return of the heart toward more normal size, shape, and function.

β -Blockers

- Initiating a β -blocker first may be of benefit for patients with evidence of excessive SNS activity (tachycardia), and for patients whose renal function or potassium concentrations preclude starting an ACE inhibitor (or ARB) at that time.
- However, the risk for decompensation during β -blocker initiation may be greater in the absence of preexisting ACE inhibitor therapy, and careful monitoring is essential.

β -Blockers

- **β -Blockers favorable effects include: antiarrhythmic effects, attenuating or reversing ventricular remodeling, decreasing myocyte death from catecholamine-induced necrosis or apoptosis, preventing fetal gene expression, improving left ventricular systolic function, decreasing HR and ventricular wall stress thereby reducing myocardial oxygen demand, and inhibiting plasma renin release.**
- **β -blockers should NOT be started in patients on IV inotropic support.**

β -Blockers

- They should be started in very low doses with slow upward dose titration (not < 2 weeks), and close monitoring to minimize acute decompensation.
- **Dose up-titration is a long and gradual process.**
- Response to therapy may be delayed and HF symptoms may actually worsen during the initiation period.

β -Blockers

- In patients with **HFpEF**, β -blockers may help to lower and maintain low pulmonary venous pressure by decreasing HR and increasing the duration of diastole.
- **Tachycardia is poorly tolerated in patients with HFpEF because** rapid HRs cause an increase in myocardial oxygen demand and a decrease in coronary perfusion time, **which can promote ischemia even in the absence of epicardial CAD.**

β -Blockers

- A rapid rate reduces diastolic filling time.
- However, excessive bradycardia can result in a fall of cardiac output despite an increase in LV filling.

Aldosterone Antagonists

- Spironolactone and eplerenone inhibit sodium reabsorption and potassium excretion, thus, they have potassium-sparing effects (and protons).
- Aldosterone antagonists inhibit cardiac extracellular matrix and collagen deposition, thereby attenuating cardiac fibrosis and ventricular remodeling.
- They attenuate the systemic pro-inflammatory state, atherogenesis, and oxidative stress caused by aldosterone.

Aldosterone Antagonists

- **Spironolactone reduces mortality by 30% and eplerenone by 15% in HFrEF.**
- **The most common adverse effects of spironolactone are gynecomastia and hyperkalemia, while that of eplerenone is hyperkalemia.**
- **There are NO clear guidelines on aldosterone antagonist use for patients with HFpEF.**

Aldosterone Antagonists

Factors contributing to the high incidence of Hyperkalemia with aldosterone antagonists:

- 1) The initiation of aldosterone antagonists in patients with impaired renal function or high serum K^+ .
- 2) The failure to decrease or stop potassium supplements when starting aldosterone antagonists.
- 3) Diabetes mellitus
(<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9036284/>).
- 4) High potassium intake with food.
- 5) Concomitant use of ACE inhibitors /ARBs and NSAIDs.

Aldosterone Antagonists

Strategies for reducing the risk for hyperkalemia with aldosterone antagonists:

1. Avoid starting aldosterone antagonists in patients with any of the following:
 - a) Serum creatinine concentration >2.0 mg/dL in women or >2.5 mg/dL in men or a CrCL <30 mL/min.
 - b) Recent worsening of renal function.
 - c) Serum K^+ >5 mEq/L.
 - d) History of severe hyperkalemia.

Aldosterone Antagonists

- 2. Start with low doses (12.5 mg/day for spironolactone and 25 mg/day for eplerenone) especially in the elderly, patients with diabetes, or a CrCL <50 mL/min.**
- 3. Decrease or discontinue potassium supplements when starting an aldosterone antagonist.**
- 4. Avoid concomitant use of NSAIDs (COX-1 or COX-2 inhibitors).**
- 5. Avoid concomitant use of high-dose ACE inhibitors or ARBs.**

Aldosterone Antagonists

6. Monitor serum K^+ and renal function within 3 days and 1 week after the initiation or dose titration of an aldosterone antagonist or any other medication that could affect potassium.
7. Thereafter, K^+ and renal function should be monitored monthly for the first 3 months, and then every 3 months.
8. If K^+ exceeds 5.5 mg/dL at any point during therapy, discontinue any potassium supplementation or, in the absence of potassium supplements, reduce or stop aldosterone antagonist therapy.

Aldosterone Antagonists

9. Counsel patients to:

- a) Limit intake of high potassium-containing foods and **salt substitutes**.**
- b) Avoid the use of over-the-counter NSAIDs.**
- c) Temporarily discontinue aldosterone antagonist therapy if diuretic therapy is interrupted.**

Nitrates and Hydralazine

- **Nitrates and hydralazine are combined in the treatment of HFrEF because of their complementary hemodynamic actions.**
- **Nitrates cause venodilation and decrease preload.**
- **Hydralazine is a direct-acting arterial vasodilator causing a decrease in afterload.**

Nitrates and Hydralazine

- Hydralazine and ISDN reduce all-cause mortality.
- By serving as a nitric oxide donor, nitrates increase nitric oxide bioavailability.
- Nitric oxide attenuates myocardial remodeling by reducing cardiac myocyte hypertrophy, cardiac dilation and mortality.
- Thus it may play a protective role in HF.

Nitrates and Hydralazine

- Hydralazine reduces oxidative stress.
- The combination requires frequent dosing three times daily.
- In the absence of another indication for nitrate therapy (angina), nitrates provide limited benefits to patients with HFpEF.

Digoxin

- It has a positive inotropic effect on the heart.
- It improves cardiac function, quality of life, exercise tolerance, and HF symptoms in patients with HFrEF (decreases morbidity)
- **No apparent benefit of digoxin on hospitalizations or mortality.**
- **It is not a first line agent in HF.**
- It helps control of ventricular response in patients with HFrEF and supraventricular arrhythmias, although β -blockers are generally more effective, especially during exercise.
- **There is NO established role for digoxin in HFpEF when patients are in normal sinus rhythm, but may be of benefit in patients with concomitant HFpEF and atrial fibrillation.**