Chronic heart failure: core treatments for heart failure

Heart failure with reduced ejection fraction

Offer:

- an ACE inhibitor, and
- a beta-blocker, and
- an MRA, and
- an SGLT2 inhibitor

Use the person's medical history, clinical assessment results, frailty status, prognosis and preferences when deciding when and how to optimise medicine doses

If symptoms persist with maximum tolerated dose of each medicine, consider replacing the ACE inhibitor with an ARNI

Consider lower starting doses or smaller dose increments if the person has chronic kidney disease and an eGFR of 45 ml per minute per 1.73 m^2 or less

The specialist heart failure multidisciplinary team should consider liaising with a renal physician if the person has chronic kidney disease and an eGFR of less than 30 ml per minute per 1.73 m^2

Alternative options

(eGFR advice applies for both ARNIs and ARBs)

Replace the ACE inhibitor with an ARNI if the person has symptoms of intolerance to ACE inhibitors (other than angioedema)

For people with angioedema after taking an ACE inhibitor, or who have symptoms of intolerance to ARNIs, consider an ARB

In **all settings** and at **all stages** in the care pathway:

- ensure people with heart failure have **rehabilitation and education**
- give **diuretics**, at the lowest effective dose, if needed for **congestion and fluid retention**
- consider intravenous iron if the person has a haemoglobin level of less than 150 g per litre and is iron deficient
- consider an implantable cardioverter defibrillator (see NICE technology appraisal TA314 for full details)

Specialist assessment

If symptoms persist, seek specialist advice and consider:

Consider replacing the ACE inhibitor with hydralazine and nitrate if the person has symptoms of intolerance to ACE inhibitors, ARNIs and ARBs

Ivabradine, if sinus rhythm and heart rate of 75 beats per minute or more and ejection fraction is 35% or less (see NICE technology appraisal TA267 for full details)

Digoxin, for worsening or severe heart failure despite optimised treatment combinations

Cardiac resynchronisation therapy, if QRS interval of 120 or more and ejection fraction is 35% or less (see NICE technology appraisal TA314 for full details)

ACE: angiotensin-converting enzyme
ARB: angiotensin II receptor blocker
ARNI: angiotensin receptor–neprilysin inhibitor
MRA: mineralocorticoid receptor antagonist
SGLT2: sodium–glucose cotransporter 2 inhibitor

NICE National Institute for Health and Care Excellence

Chronic heart failure: core treatments for heart failure

Heart failure with mildly reduced ejection fraction

Consider:
- an ACE inhibitor, and
- a beta-blocker, and
- an MRA, and
- an SGLT2 inhibitor

For guidance on SGLT2 inhibitors, see NICE technology appraisal TA929 and NICE technology appraisal TA902

Use the person's medical history, clinical assessment results, frailty status, prognosis and preferences when deciding when and how to optimise medicine doses

Consider lower starting doses or smaller dose increments if the person has chronic kidney disease and an eGFR of 45 ml per minute per 1.73 m^2 or less

The specialist heart failure multidisciplinary team should consider liaising with a renal physician if the person has chronic kidney disease and an eGFR of less than 30 ml per minute per 1.73 m^2

Alternative options

(eGFR advice applies for ARBs)

Consider replacing the ACE inhibitor with an ARB if the person has symptoms of intolerance to ACE inhibitors

Heart failure with preserved ejection fraction

Consider:
- an MRA, and
- an SGLT2 inhibitor

For guidance on SGLT2 inhibitors, see NICE technology appraisal TA929 and NICE technology appraisal TA902

Use the person's medical history, clinical assessment results, frailty status, prognosis and preferences when deciding when and how to optimise medicine doses

Consider lower starting doses or smaller dose increments if the person has chronic kidney disease and an eGFR of 45 ml per minute per 1.73 m^2 or less

The specialist heart failure multidisciplinary team should consider liaising with a renal physician if the person has chronic kidney disease and an eGFR of less than 30 ml per minute per 1.73 m^2

In **all settings** and at **all stages** in each care pathway:
- ensure people with heart failure have **rehabilitation and education**
- give **diuretics**, at the lowest effective dose, if needed for **congestion and fluid retention**

ACE: angiotensin-converting enzyme
ARB: angiotensin II receptor blocker
ARNI: angiotensin receptor–neprilysin inhibitor
MRA: mineralocorticoid receptor antagonist
SGLT2: sodium–glucose cotransporter 2 inhibitor

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