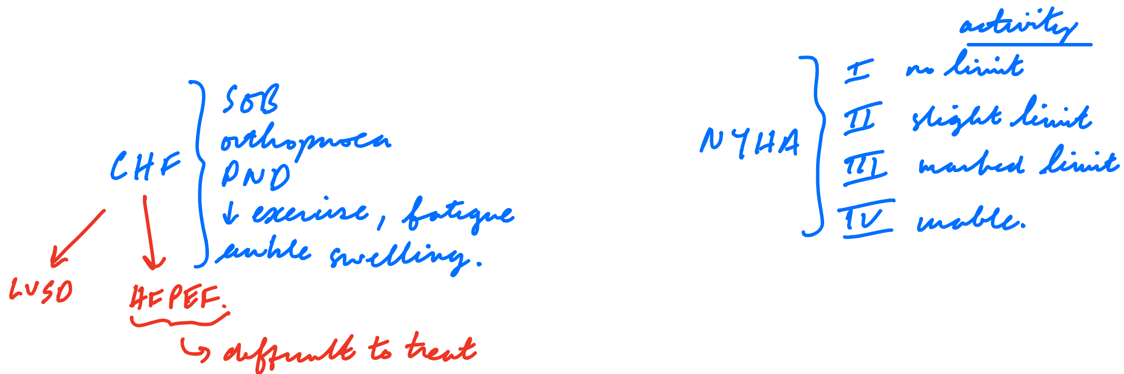
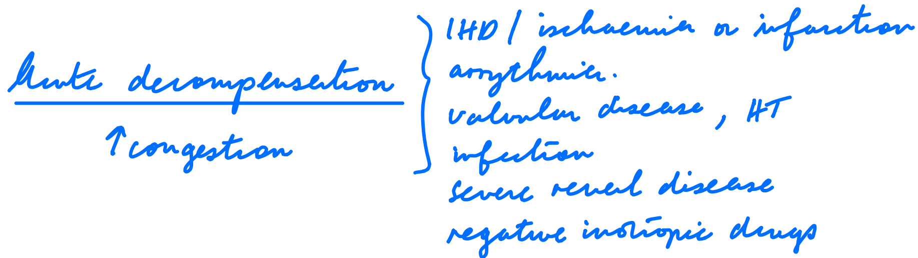
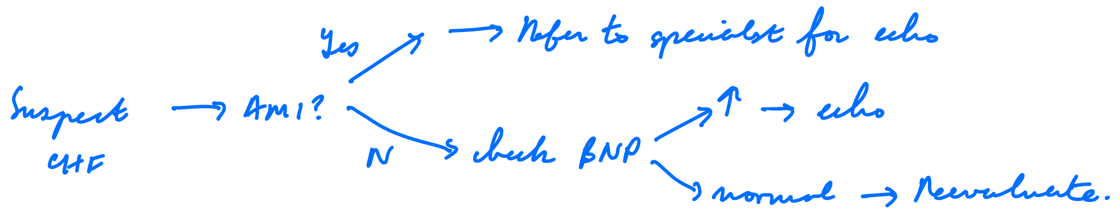
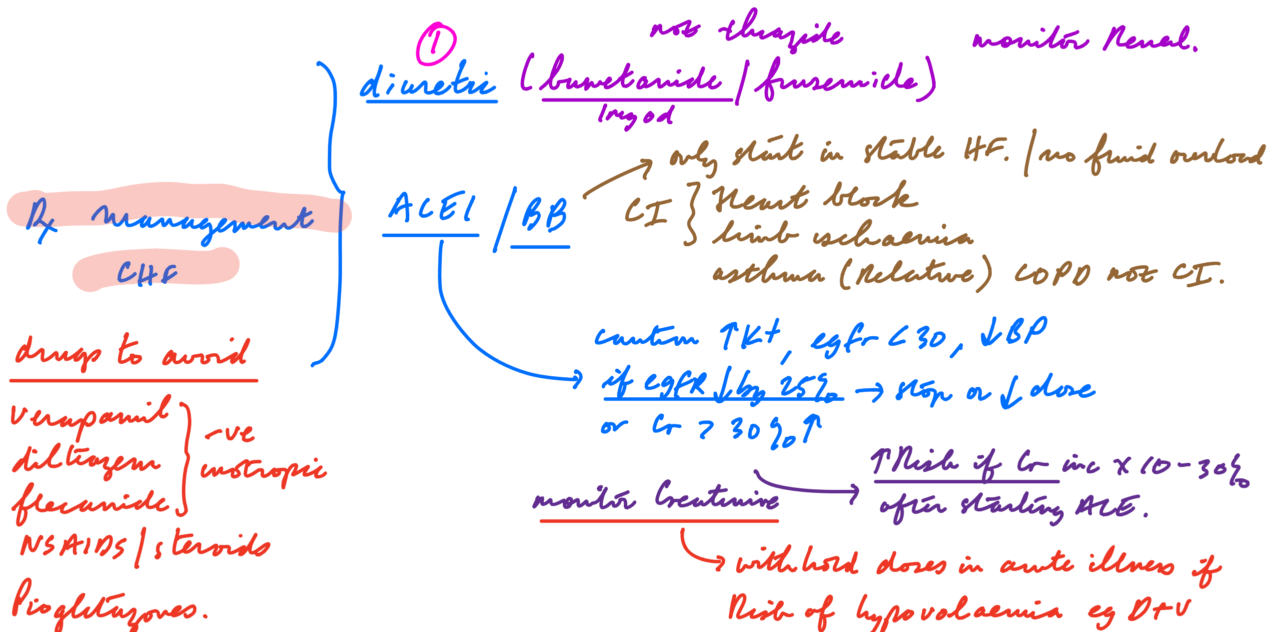
BMJL Managing heart failure









↑ Risk ↑K^+.

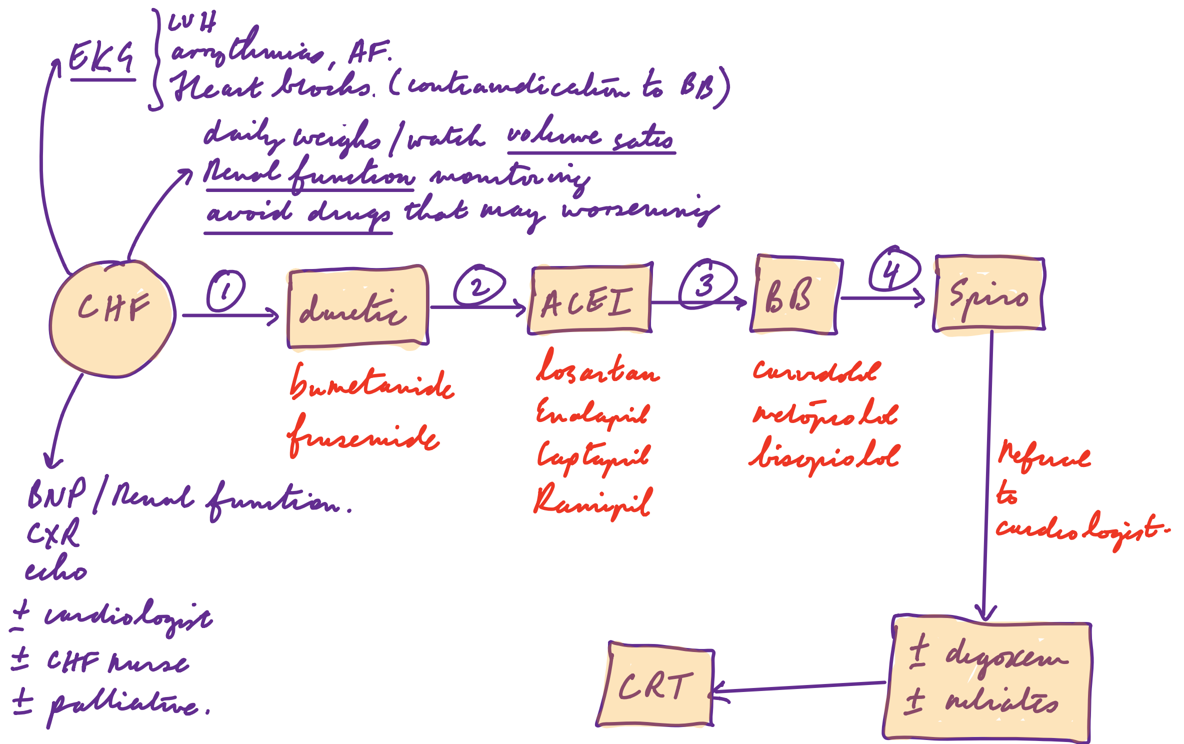
Aldosterone agonists (spironolactone)

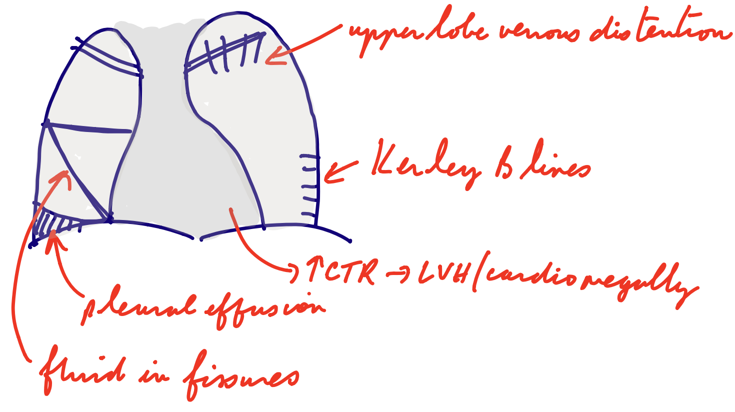
Refractory
- ARNI: sacubitril/valsartan.
- Ivabradine (sinus node inhibitor)
- digoxin, hydralazine / nitrates

Device therapy
- cardiac resynchronisation therapy (CRT) pacing.
- I defibrillator

Lifestyle
- smoking cessation
- ↓ EtOH
- ↓ salt intake
- ↑ physical activity
- weight management.
- influenza & pneumococcal vaccination.
- depression management.

End of life care
- palliative care
- Referral to heart failure nurse
- advance care planning.

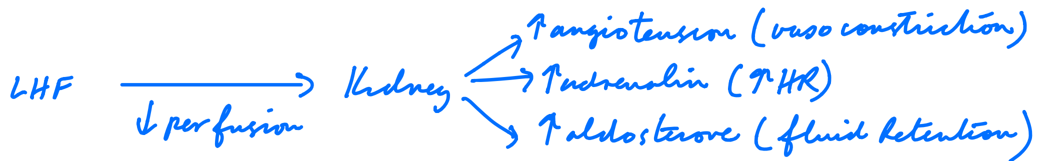

EKG
LVH
arrythmias, AF.
Heart blocks. (contraindication to BB)
daily weighs / watch volume satis
Renal function monitoring
avoid drugs that may worsening
CHF
1
diuretic
2
ACEI
3
BB
4
Spiro
bumetanide
frusemide
losartan
Enalapril
Captopril
Ramipril
carvedolol
metoprolol
bisoprolol
Referral
to
cardiologist.
BNP / Renal function.
CXR
echo
± cardiologist
± CHF nurse
± palliative.
± digoxin
± nitrates
CRT

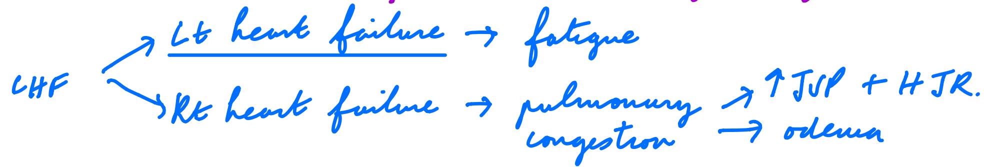

upper lobe venous distention
Kerley B lines
↑CTR → LVH / cardiomegally
pleural effusion
fluid in fissures

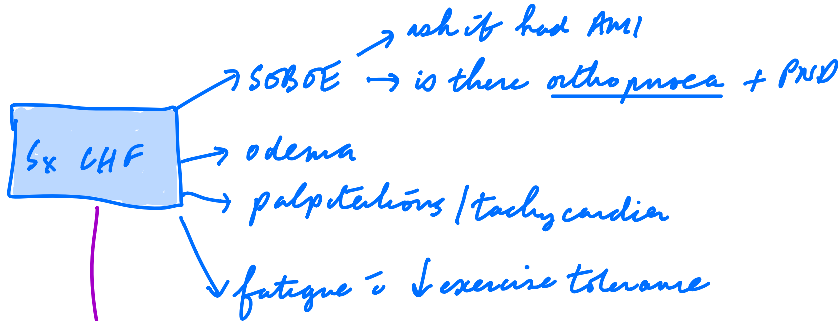
Diagnosing Heart failure

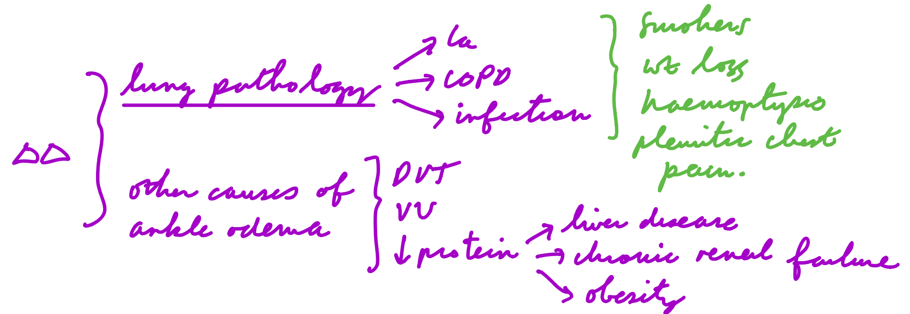
↑BNP → echocardiogram } aortic stenosis and cor pulmonale can ↑ BNP.

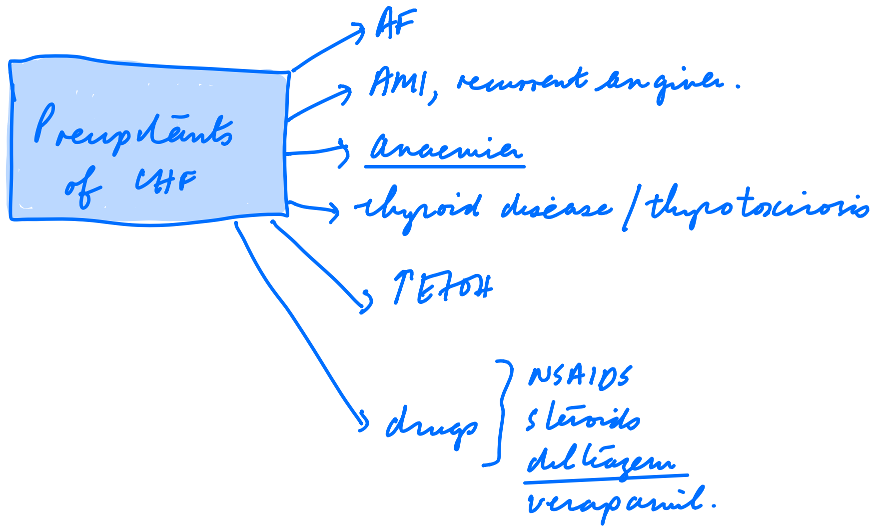
* normal EKG makes CHF unlikely

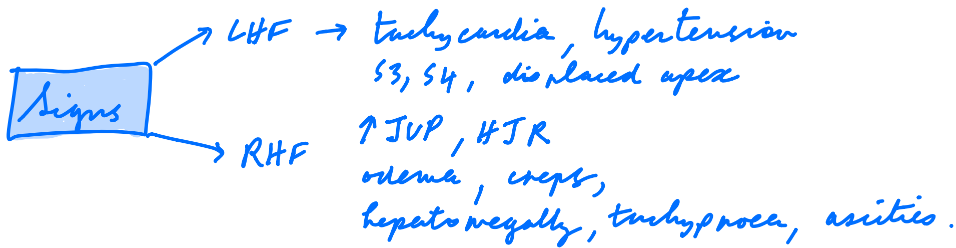


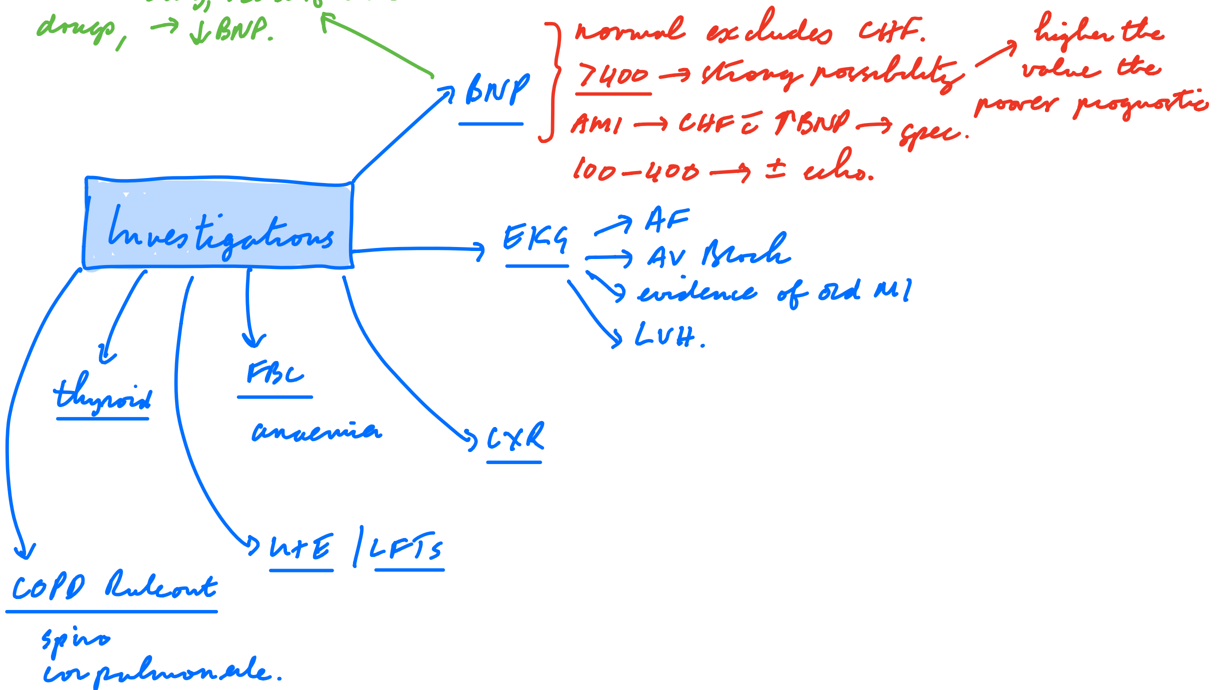


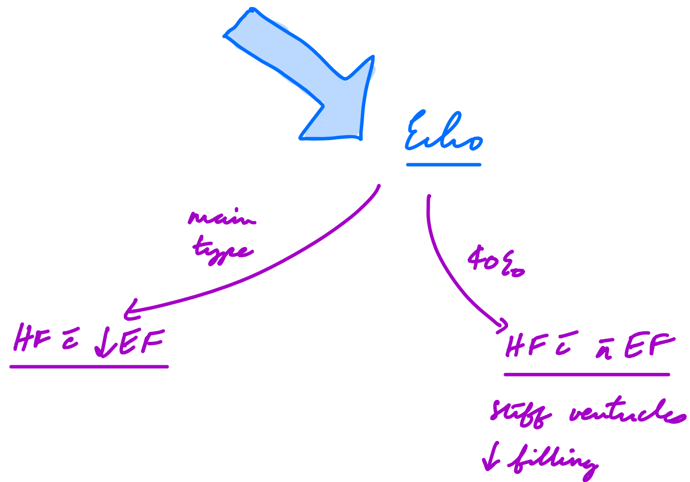





Precipitants of CHF
AF
AMI, recurrent angina.
anaemia
thyroid disease / thyrotoxicosis
↑EtOH
drugs
NSAIDS
steroids
diltiazem
verapamil.


Signs
LHF → tachycardia, hypertension
S3, S4, displaced apex
RHF
↑JVP, HJR
oedema, creps,
hepatomegaly, tachypnoea, ascites.


Investigations
obesity, heart failure
drugs, → ↓BNP.
BNP
normal excludes CHF.
>400 → strong possibility
higher the value the power prognostic
AMI → CHF c̄ ↑BNP → spec.
100–400 → ± echo.
EKG
AF
AV block
evidence of old MI
LVH.
thyroid
FBC
anaemia
CXR
U+E / LFTs
COPD Ruleout
spiro
cor pulmonale.



1. Only start Rx CHF **after** echo.
   - eg ACEI, BB etc.
   - can use diuretics for symptom control while awaiting echo.
2. if suspect CHF in someone post AMI → Urgent Referral for echo. (no need for BNP)
3. **normal EKG** makes diagnosis of CHF unlikely