Brigham and Women's Hospital
Founding Member, Mass General Brigham

TREATMENT OF HEART FAILURE IN 2025

Anju Nohria, MD, MSc
Associate Physician
Cardiovascular Division, Department of Internal Medicine
Brigham and Women's Hospital
Associate Professor of Medicine
Harvard Medical School

Anju Nohria, MD, MSc

Harvard Medical School
Medicine Residency @ Yale New Haven Hospital
Cardiovascular Medicine Fellowship @BWH
Heart Failure and Transplantation Fellowship @BWH
Associate Professor of Medicine@ HMS
Director, Cardio-Oncology Program @ DFCI/BWH

- Clinical focus: Heart Failure and Cardio-Oncology
- Research focus: Cardio-Oncology

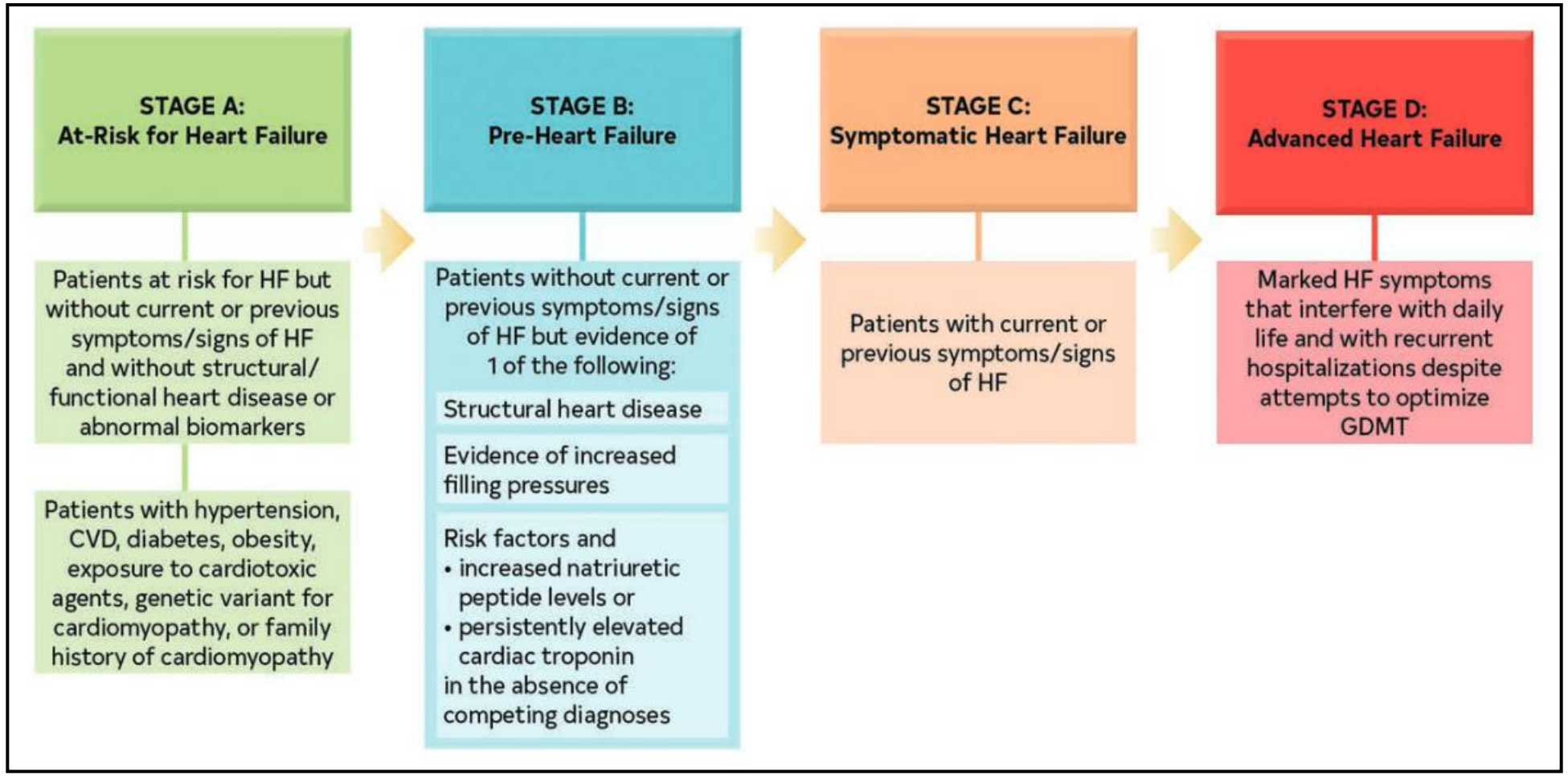
DISCLOSURES

- Research Support: Bristol Myers Squibb
- Consulting Fees: AstraZeneca and Takeda Oncology

OBJECTIVES

- Focus on out-patient management of HF
- Updates from the 2022 HF guidelines
  - Novel therapies for HF w/ reduced ejection fraction (HFrEF)
- Novel therapies for HF w/ preserved ejection fraction (HFpEF)

Stages of Heart Failure



Heidenreich et al. Circulation 2022;145:e876-894.

Stage A HF: Primary Prevention of HF

- SBP < 130/80 mm Hg

- Age > 40, ≥ 1 CV RF
- BNP ≥ 50 pg/ml

- PREVENT- HF score

COR	LOE	Recommendations
1	A	1. In patients with hypertension, blood pressure should be controlled in accordance with GDMT for hypertension to prevent symptomatic HF.[46,111–118]
1	A	2. In patients with type 2 diabetes and either established cardiovascular disease or at high cardiovascular risk, SGLT2i should be used to prevent hospitalizations for HF.[119–121]
1	B-NR	3. In the general population, healthy lifestyle habits such as regular physical activity, maintaining normal weight, healthy dietary patterns, and avoiding smoking are helpful to reduce future risk of HF.[122–130]
2a	B-R	4. For patients at risk of developing HF, natriuretic peptide biomarker–based screening followed by team-based care, including a cardiovascular specialist optimizing GDMT, can be useful to prevent the development of LV dysfunction (systolic or diastolic) or new-onset HF.[131,132]
2a	B-NR	5. In the general population, validated multivariable risk scores can be useful to estimate subsequent risk of incident HF.[133–135]

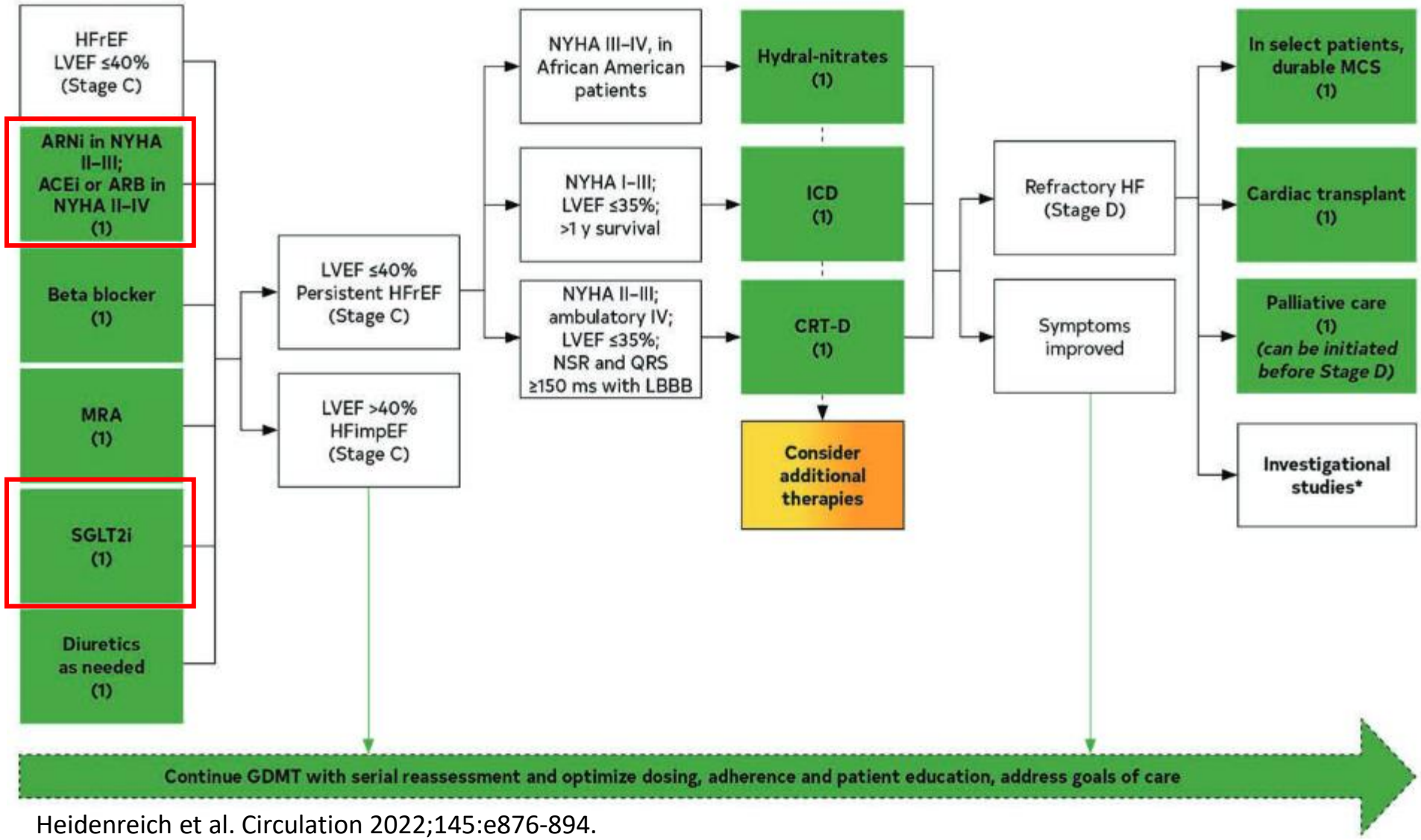
Heidenreich et al. Circulation 2022;145:e876-894.
https://professional.heart.org/en/guidelines-and-statements/prevent-calculator

Stage B HF: Preventing Symptomatic HF in Pre-HF

- ACEi + BB for LVEF ≤ 40%
- ARB for ACEi intolerant pts
- Statins for post-MI or ACS pts
- ICD for NYHA Class I pts w/ LVEF ≤ 30%, 40 days after MI
- *Non-dihydropyridine CCB and thiozolidinediones should be avoided in LVEF < 50%*

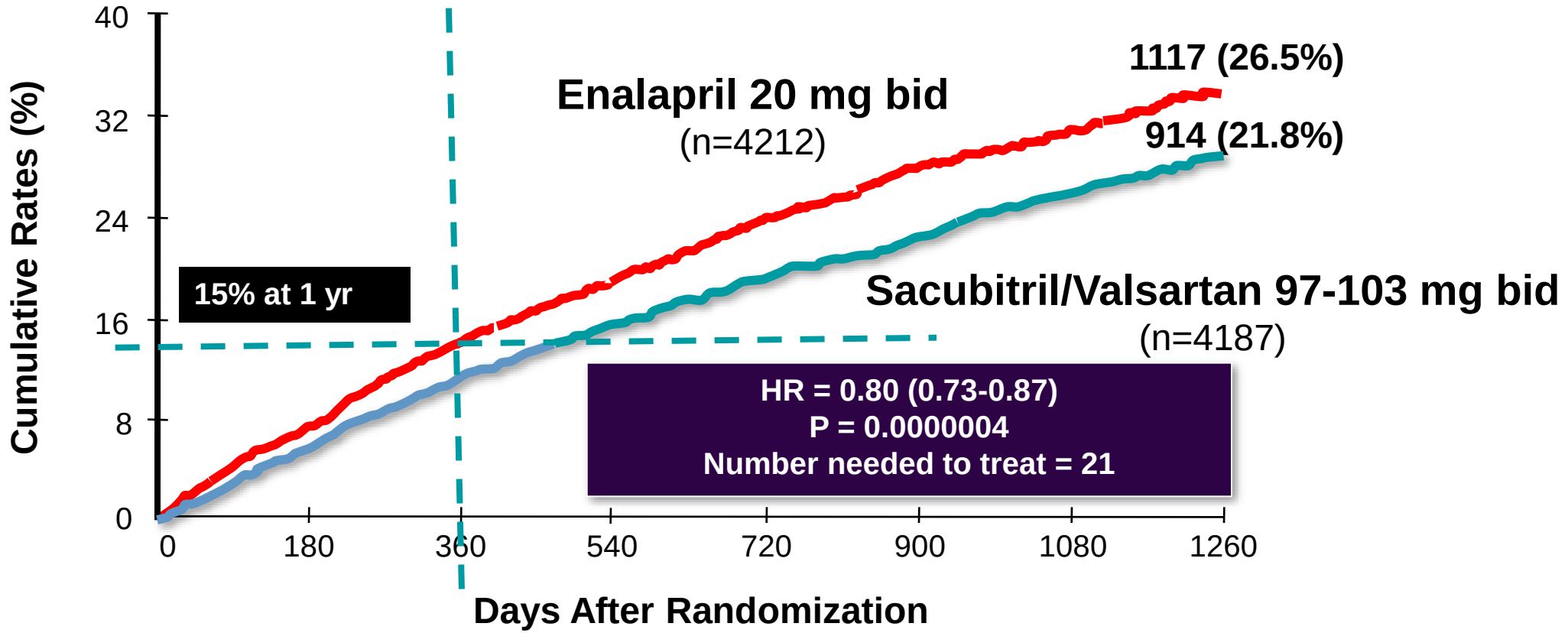
Heidenreich et al. Circulation 2022;145:e876-894.

Stage C HF: Symptomatic HF



Heidenreich et al. Circulation 2022;145:e876-894.

PARADIGM-HF: Primary Endpoint CV Death or HF Hospitalization



Major Side Effects: Hypotension, hyperkalemia, angioedema, renal dysfunction

McMurray JJ et al. N Engl J Med 2014;371:993-1004.

Guideline Update

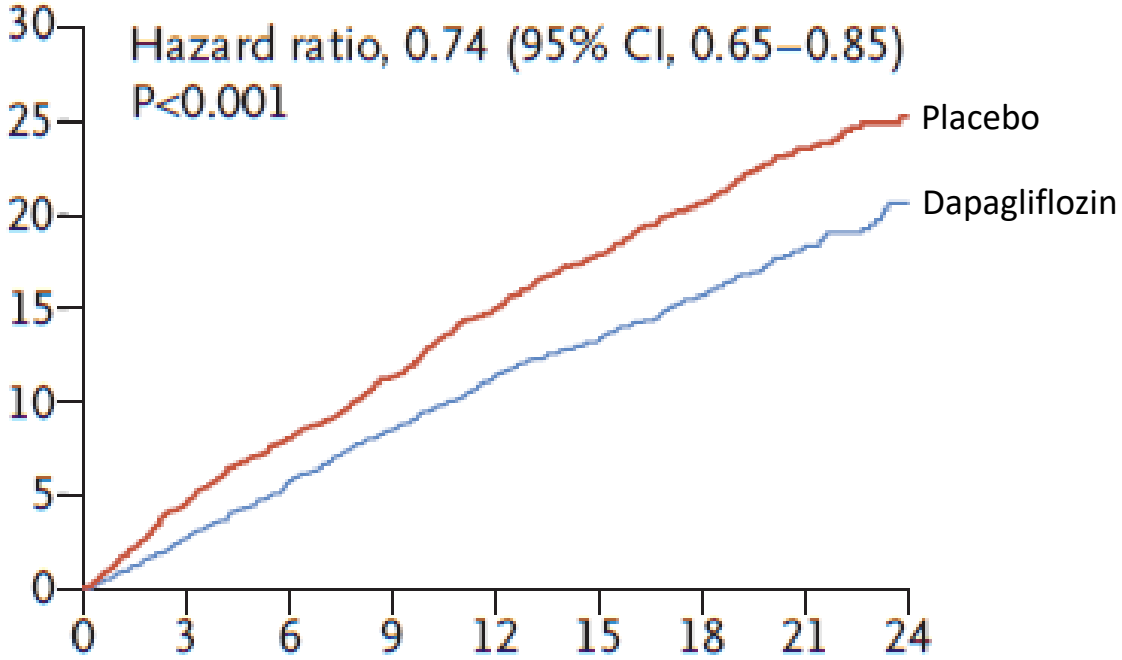
2016 ACC/AHA/HFSA Focused Update on New Pharmacological Therapy for Heart Failure: An Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure

COR	LOE	Recommendations
I	B-R	ACEi OR ARB OR ARNI in conjunction with beta-blockers + MRA (where appropriate) is recommended for patients with chronic HFrEF to reduce morbidity and mortality.
I	B-R	In patients with chronic, symptomatic HFrEF NYHA class II or III who tolerate and ACE inhibitor or ARB, replacement by an ARNI is recommended to further reduce morbidity and mortality
III	B-R	ARNI should NOT be administered concomitantly with ACEi or within 36 hours of last ACEi dose
III	C=EO	ARNI should NOT be administered to patients with a history of angioedema

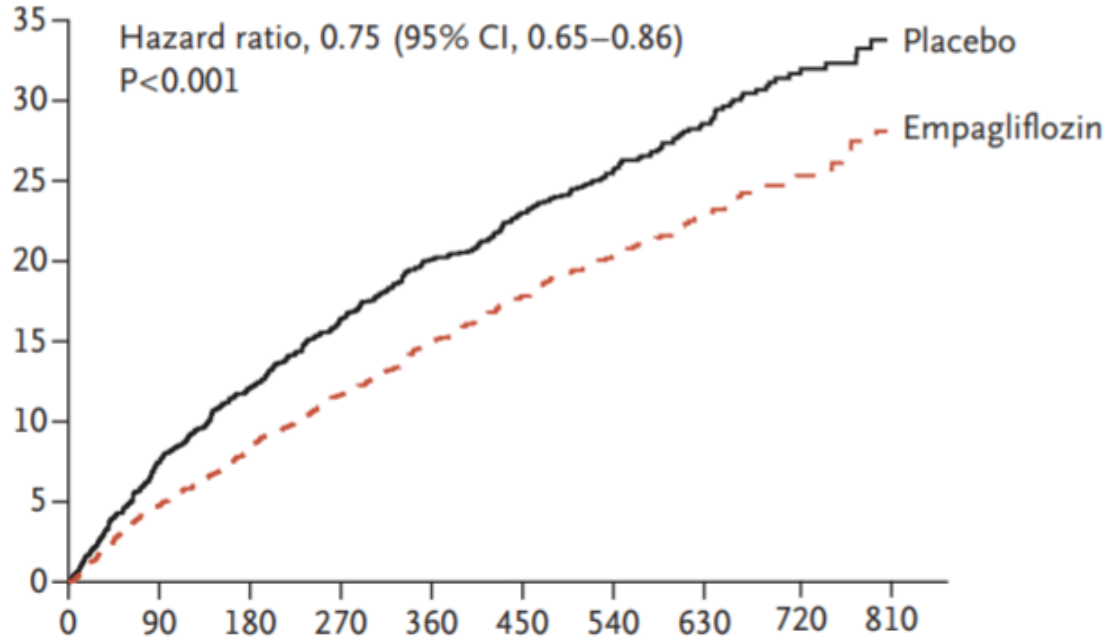
Yancy, et al. Circulation 2017;136:e137-161

SGLT-2i for Symptomatic HFrEF

DAPA-HF:
CV Death, HF Hosp. or ED visit for HF



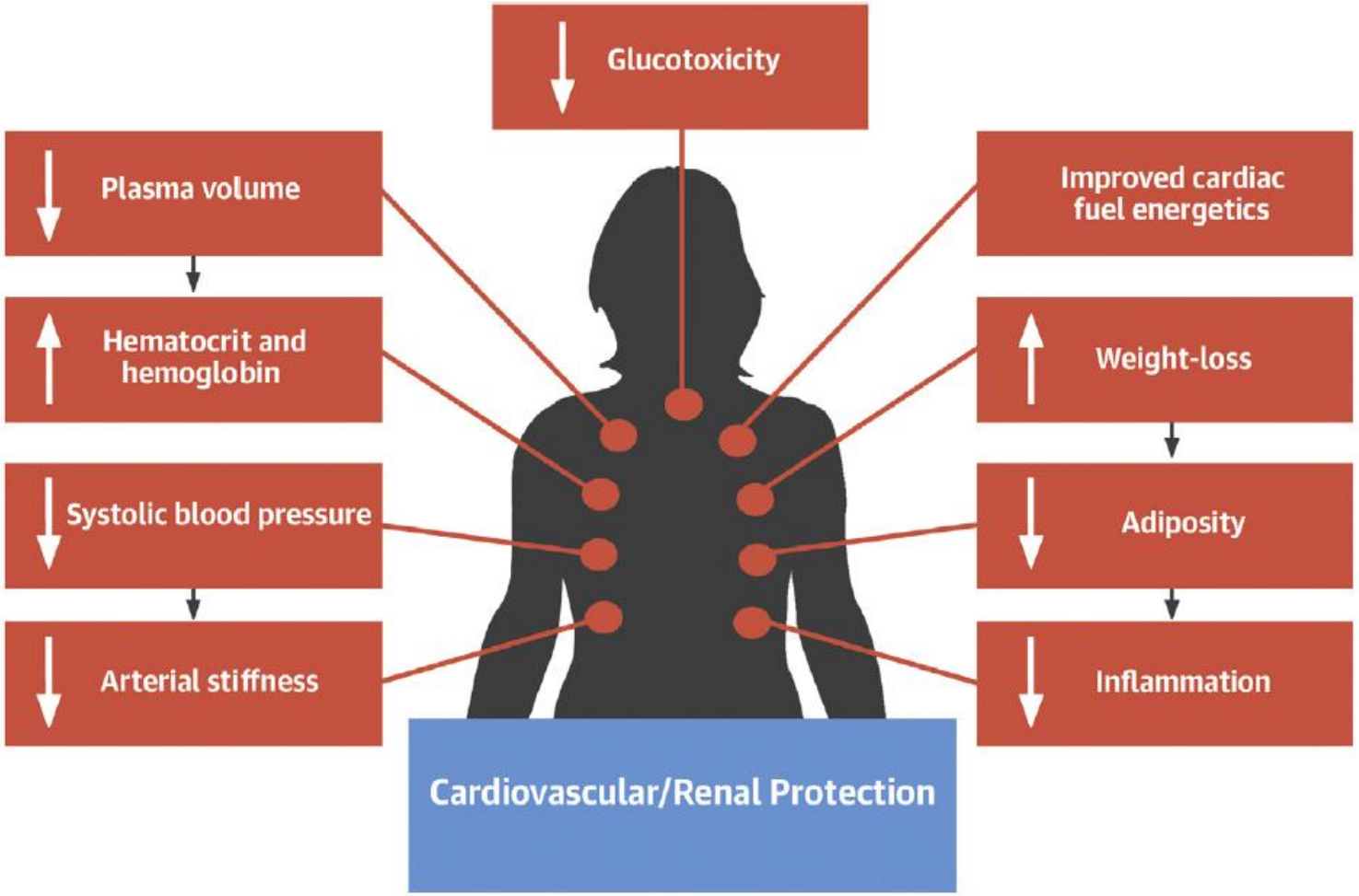
EMPEROROR-REDUCED HF:
CV Death or HF Hospitalization



- Decrease progression of CKD
- Benefits are independent of DM

McMurray et al. NEJM 2019;381(21):1995; Packer et al. NEJM 2020;383(15):1413-24. .

Potential Mechanisms for Cardiorenal Benefits of SGLT2i



Zelniker et al. JACC 2020;75(4):422

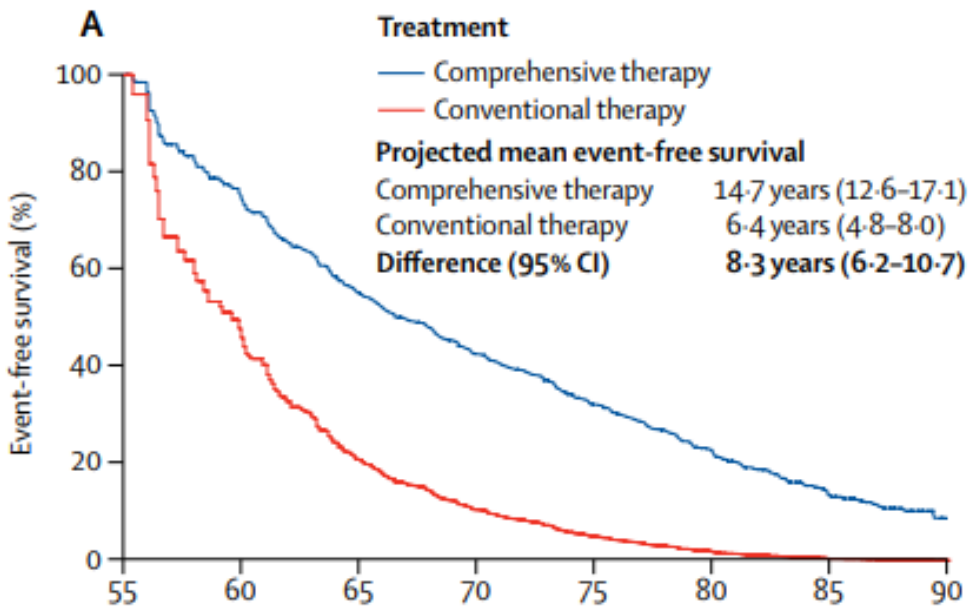
Guideline Update

COR	LOE	Recommendation
1	A	1. In patients with symptomatic chronic HFrEF, SGLT2i are recommended to reduce hospitalization for HF and cardiovascular mortality, irrespective of the presence of type 2 diabetes.[31,32]

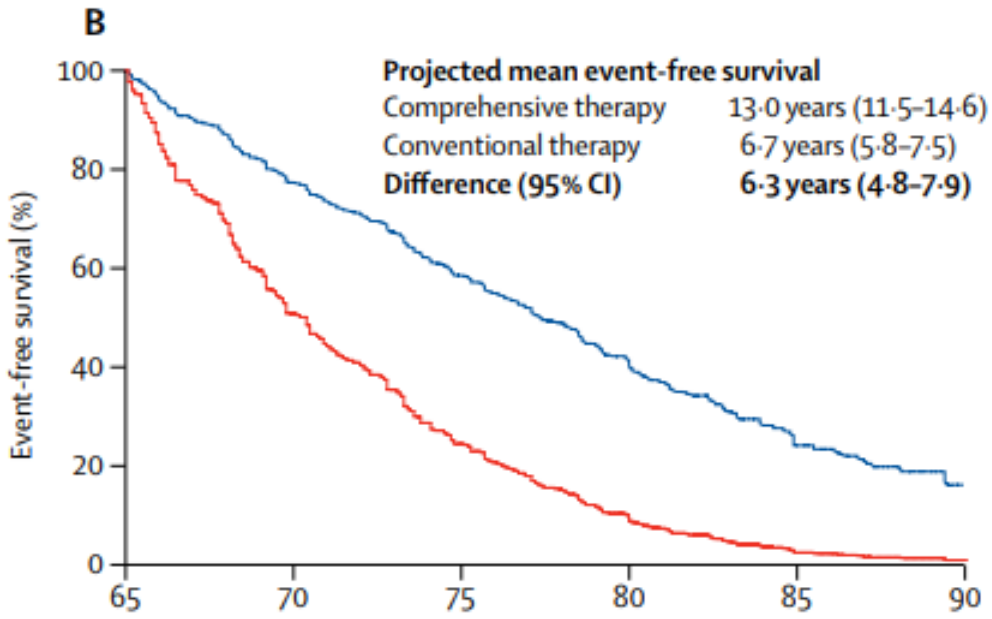
Heidenreich et al. Circulation 2022;145:e876-894.

Estimation of Lifetime Benefit of Comprehensive vs. Conventional HFrEF Therapy

Age ≥ 55 years



Age ≥ 65 years



Conventional: ACEi/ARB + beta-blocker
Comprehensive: ARNI + B-blocker + MRA + SGLT-2i

Vaduganathan et al. Lancet 2020;396:121-28.

Question 1.

A 65 y.o. male w/ chronic HFrEF presents for a follow up visit after HF hospitalization. He reports dyspnea with 1 flight of stairs, 2 pillow orthopnea and mild lower extremity edema. His medications include sacubitril-valsartan 24-26 mg twice daily, spironolactone 25 mg daily, metoprolol succinate 25 mg daily and torsemide 80 mg daily. His exam reveals HR 85 bpm, BP 100/70 mm Hg, no JVD but mild HJR, clear lungs, RRR, systolic murmur c/w mitral regurgitation, and trace LE edema. Labs reveal Na 135 mEq/L, K 4.2 mEq/L, BUN 40 mg/dL, Cr 1.8 mg/dL, eGFR 41 ml/min/1.73m2, NT-proBNP 1500 pg/mL.

What is the next best step in his management?

A. Increase sacubitril-valsartan to 49-51 mg twice daily
B. Add empagliflozin 10 mg daily
C. Increase metoprolol succinate to 50 mg daily
D. Increases torsemide to 80 mg twice daily

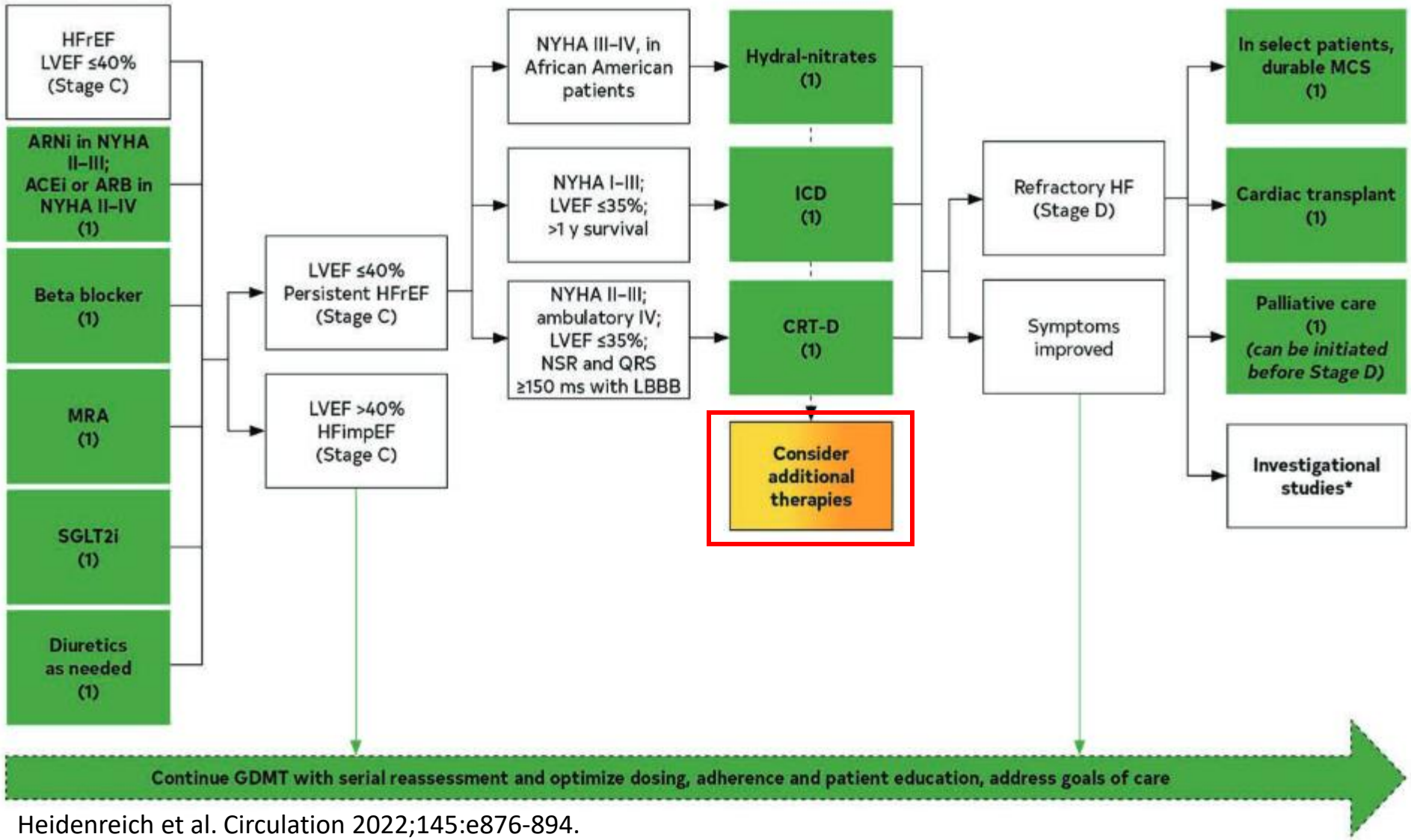
TRANSFORM-HF: Torsemide vs. Furosemide

N=2859, HF hospitalization, LVEF < 40% or ↑ Natriuretic peptides

Variable	Torsemide (n = 1431) No. (%)	Torsemide (n = 1431) Events per 100 patient-years	Furosemide (n = 1428) No. (%)	Furosemide (n = 1428) Events per 100 patient-year	Risk reduction (95% CI)[a]	HR (95% CI)[b]	*P* value[b]
Primary outcome							
All-cause mortality	373 (26.1)	17.0	374 (26.2)	17.0	0.12 (−2.85 to 3.14)	1.02 (0.89 to 1.18)	.76
Secondary outcomes							
All-cause mortality or all-cause hospitalization (over 12 mo)	677 (47.3)	99.2	704 (49.3)	107.6	1.99 (−1.79 to 5.56)	0.92 (0.83 to 1.02)	
Total hospitalizations (over 12 mo)	940	106.3	987	111.9		RR, 0.94 (0.84 to 1.07)	
All-cause mortality or all-cause hospitalization (over 30 d)	149 (10.4)	147.2	157 (11.0)	157.5	0.58 (−1.80 to 2.75)	0.94 (0.75 to 1.18)	

Mentz et al. JAMA 2023;329 (3):214-223.

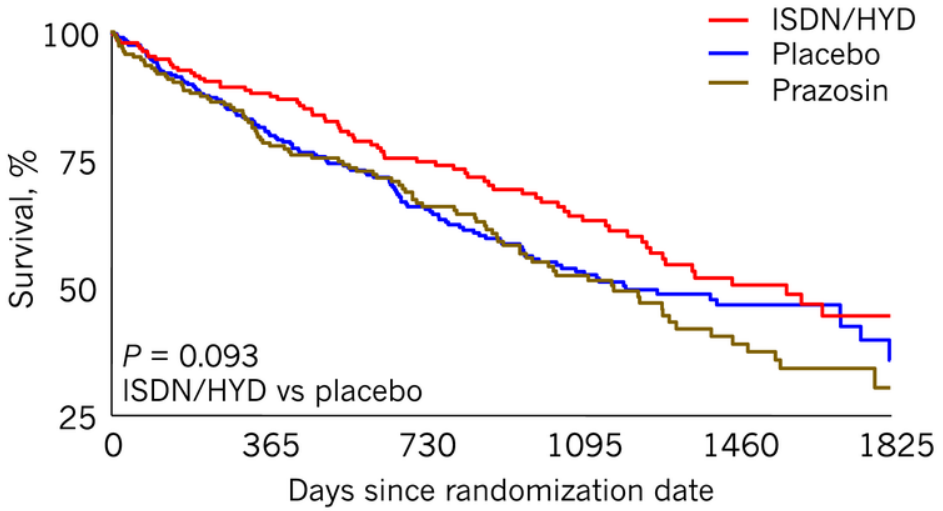
Stage C HF: Symptomatic HF



Heidenreich et al. Circulation 2022;145:e876-894.

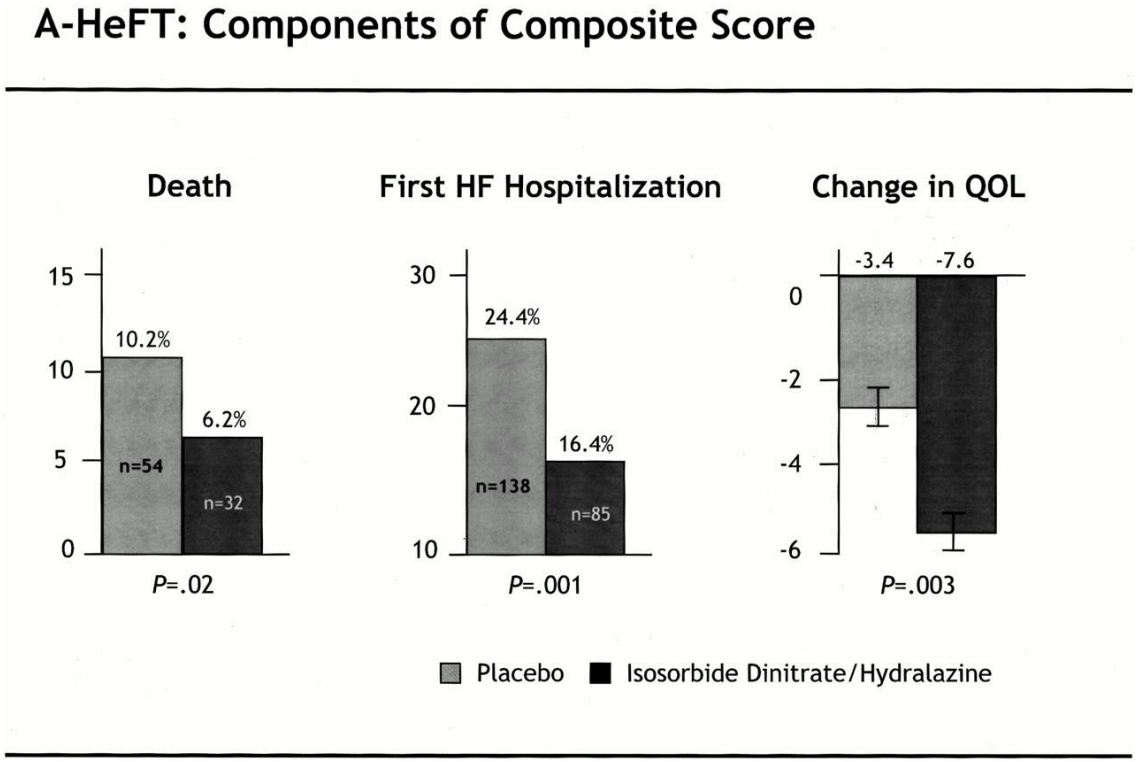
Hydralazine/Isordil in HFrEF

V-HEFT 1: EF < 45%, NYHA II-IV HF



ISDN/HYD,	n = 186	148	109	71	37	16
Placebo,	n = 276	202	135	84	41	10
Prazosin,	n = 183	135	94	58	27	7

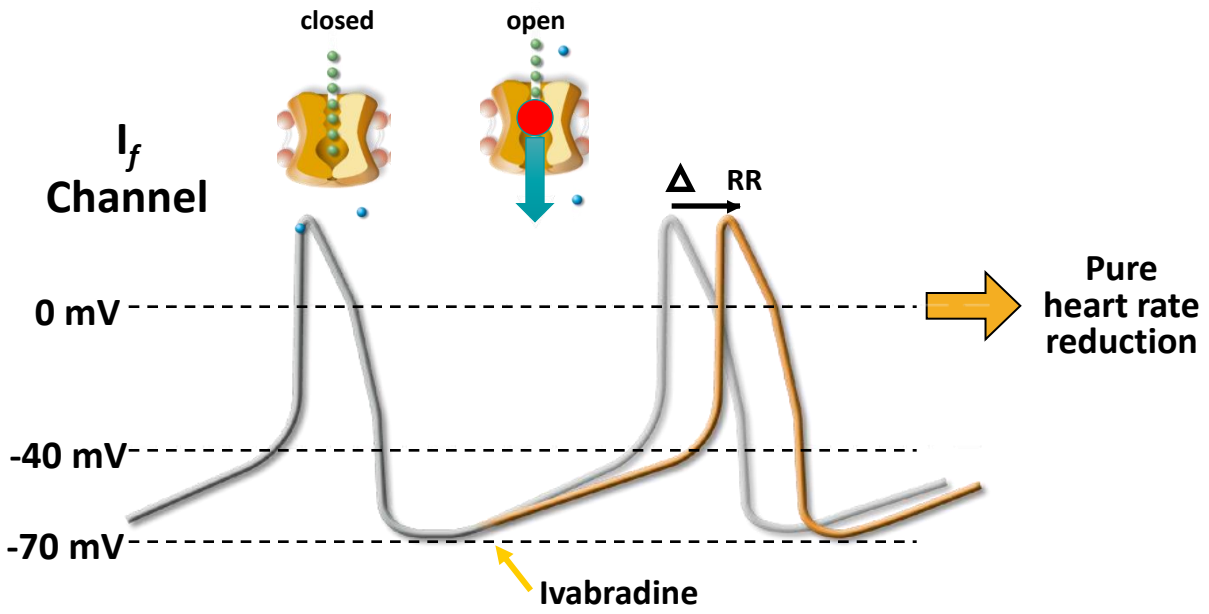
A-HEFT: Black pts, HFrEF, NYHA III-IV



- Consider in CKD, where RAASi and SGLT-2i contraindicated
- Consider in Black pts

Cohn et al. NEJM 1986;314:1547; Taylor etal NEJM 2004;351:2049.

Ivabradine: A selective I_f Inhibitor



I_f inhibition reduces the diastolic depolarization slope, thereby lowering heart rate
No effect on myocardial contractility or relaxation
Use-dependent block = low risk of bradycardia

Thollon et al. Br J Pharmacol. 1994;112:37-42.

SHIFT Trial: Effect of Ivabradine on Outcomes

Endpoints	HR	95% CI	p value
Primary composite endpoint (CV death or hospitalization for worsening HF)	0.82	[0.75,0.90]	p<0.0001
All-cause mortality	0.90	[0.80,1.02]	p=0.092
Death from HF	0.74	[0.58,0.94]	p=0.014
All-cause hospital admission	0.89	[0.82,0.96]	p=0.003
Any CV hospital admission	0.85	[0.78,0.92]	p=0.0002
CV death/hospitalization for HF or non-fatal MI	0.82	[0.74,0.89]	p<0.0001

Swedberg K, et al. Lancet. 2010;376(9744):875-885

Guideline Update

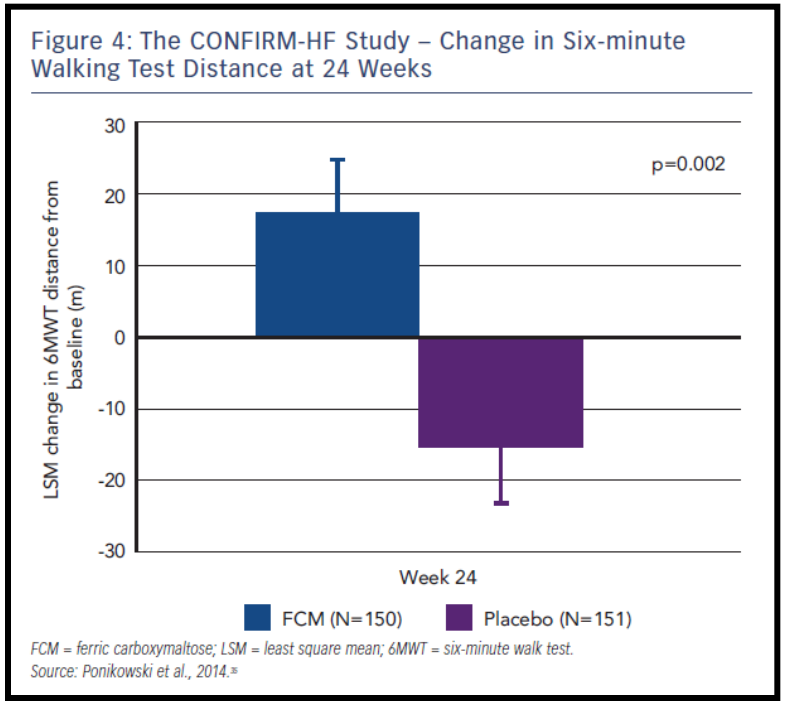
COR	LOR	
IIa Moderate	**B-R**	**Ivabradine may be beneficial to reduce HF hospitalization for patients with symptomatic stable chronic HFrEF who are receiving GDMT, including a beta blocker at maximum tolerated dose, and who are in sinus rhythm with a heart rate of ≥ 70 bpm at rest.**

Yancy, et al. Circulation 2017;136:e137-161

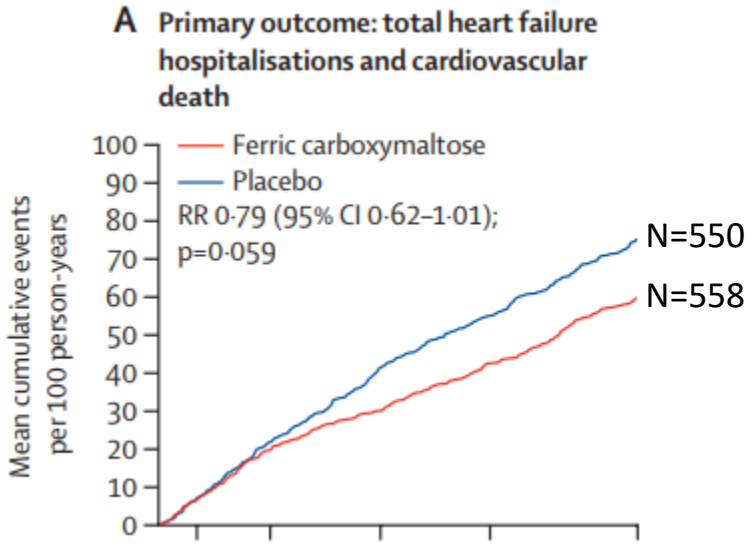
Treatment of Iron Deficiency in HFrEF

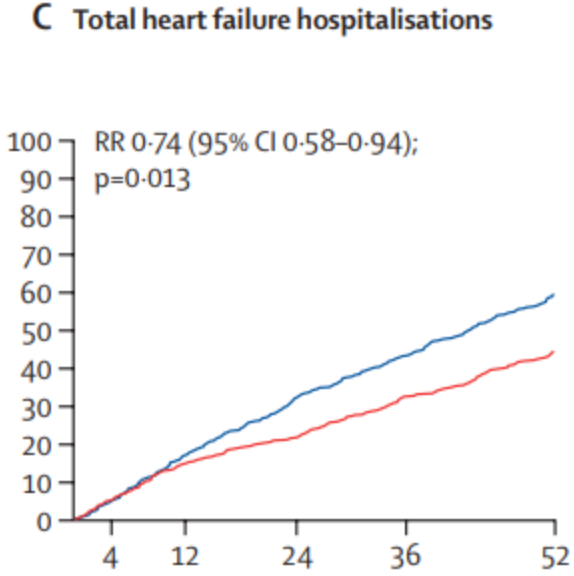
- NYHA II-IV HFrEF, ferritin < 100 ng/ml *OR* ferritin 100-300 ng/ml + transferrin saturation < 20%

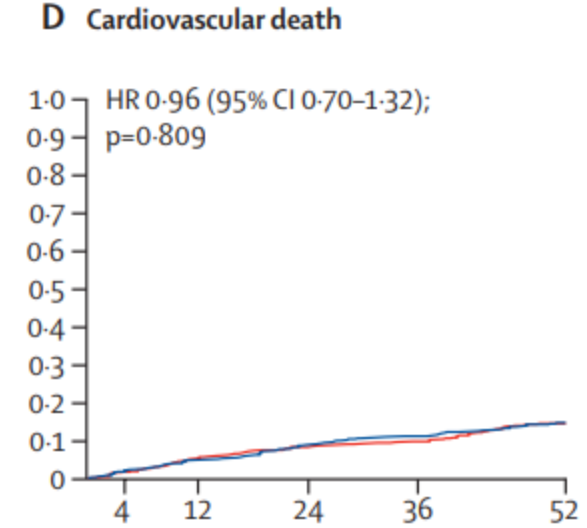
CONFIRM-HF



AFFIRM-AHF







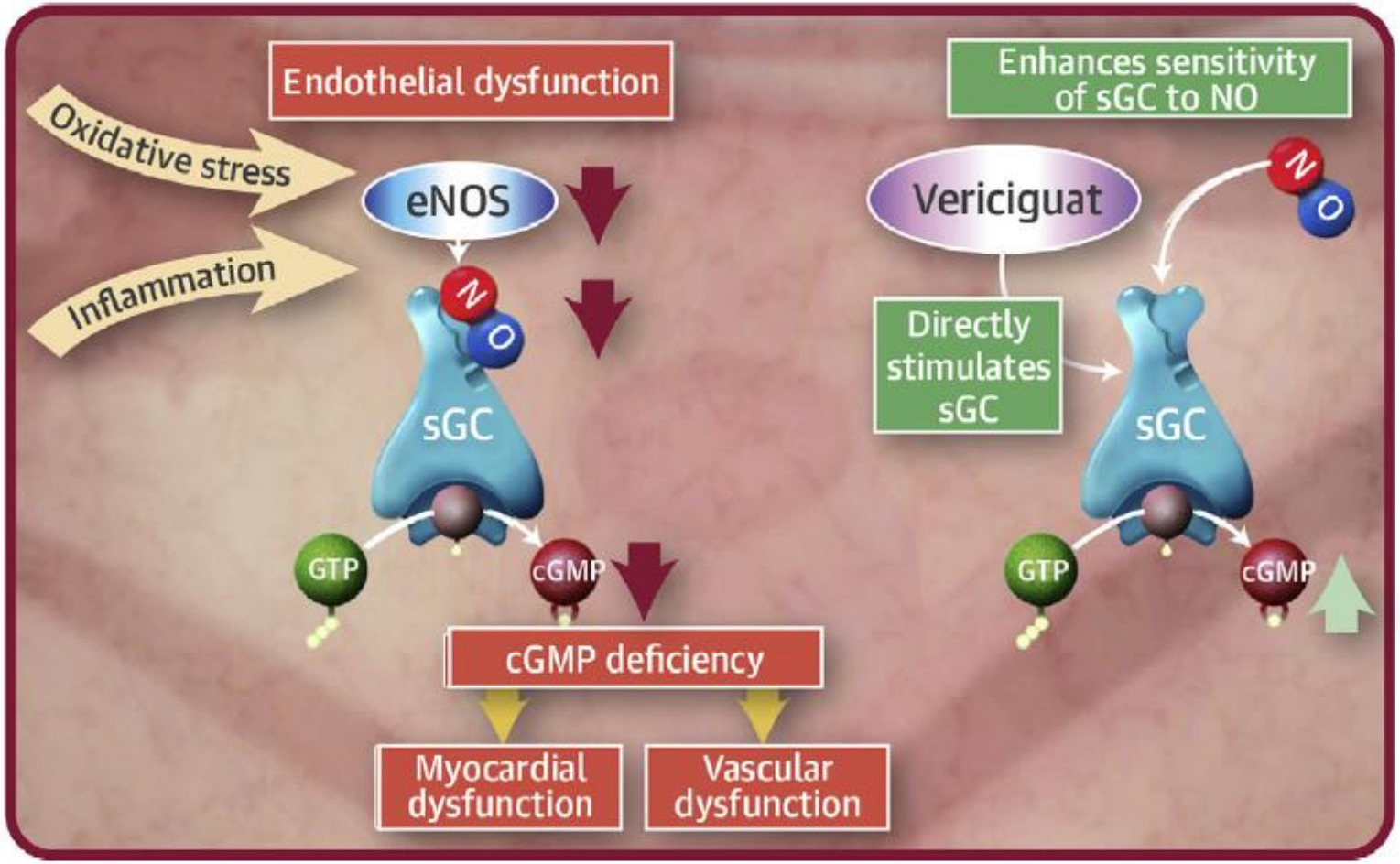
Ponikowski et al. Eur Heart J 2015;36(11):657; Ponikowski et al. Lancet 2020;396(10266):1895.

Guideline Update

Recommendations for Anemia		
COR	**LOE**	**Recommendations**
IIb	**B-R**	**In patients with NYHA class II and III HF and iron deficiency (ferritin <100 ng/mL or 100 to 300 ng/mL if transferrin saturation is <20%), intravenous iron replacement might be reasonable to improve functional status and QoL(173, 174).**
See Online Data Supplement D.		
III: No Benefit	**B-R**	**In patients with HF and anemia, erythropoietin-stimulating agents should not be used to improve morbidity and mortality (176).**
See Online Data Supplement D.		

Yancy, et al. Circulation 2017;136:e137-161

Vericiguat: Mechanism of Action



Armstrong, P.W. et al. J Am Coll Cardiol HF. 2018;6(2):96-104.

VICTORIA: Individual Endpoints

Outcome	Vericiguat (N=2526)		Placebo (N=2524)		Hazard Ratio (95% CI)†	P Value‡
	no. (%)	*events/100 patient-yr*	*no. (%)*	*events/100 patient-yr*		
Primary composite outcome and components						
Death from cardiovascular causes or first hospitalization for heart failure	897 (35.5)	33.6	972 (38.5)	37.8	0.90 (0.82–0.98)	0.02
Death from cardiovascular causes§	206 (8.2)		225 (8.9)			
Hospitalization for heart failure	691 (27.4)		747 (29.6)			
Secondary outcomes						
Death from cardiovascular causes	414 (16.4)	12.9	441 (17.5)	13.9	0.93 (0.81–1.06)	
Hospitalization for heart failure	691 (27.4)	25.9	747 (29.6)	29.1	0.90 (0.81–1.00)	
Total hospitalizations for heart failure¶	1223	38.3	1336	42.4	0.91 (0.84–0.99)	0.02
Secondary composite outcome and components						
Death from any cause or first hospitalization for heart failure	957 (37.9)	35.9	1032 (40.9)	40.1	0.90 (0.83–0.98)	0.02
Death from any cause§	266 (10.5)		285 (11.3)			
Hospitalization for heart failure	691 (27.4)		747 (29.6)			
Death from any cause	512 (20.3)	16.0	534 (21.2)	16.9	0.95 (0.84–1.07)	0.38

Armstrong et al. N Engl J Med 2020;382(20):1883-93

Question 2.

A 70 y.o. female with a history of HTN, hyperlipidemia, type II DM, CAD, paroxysmal afib and ischemic cardiomyopathy (EF 30%) presents with NYHA Class III symptoms of HF. After optimizing her volume status, she remains dyspneic while walking around the house. Her vital signs are notable for HR 80 bpm, BP 118/80 mm Hg. Her exam shows JVP 11 cm of water, mild bibasilar crackles, irregularly, irregular rhythm, + MR, + TR, and chronic 1+ bilateral edema. Her laboratory values are notable for Na 136 mEq/L, K 4.8 mEq/L, BUN 50 mg/dL, creatinine 2.4 mg/dL, eGFR 18 ml/min/1.73m2, NT-proBNP 2500 pg/mL. Her medications include apixaban 5 mg twice daily, atorvastatin 80 mg daily, carvedilol 6.25 mg twice daily, hydralazine 100 mg three times daily, isosorbide mononitrate 60 mg daily, insulin, torsemide 160 mg twice daily and multivitamin.

What is the next best step to improve her symptoms?

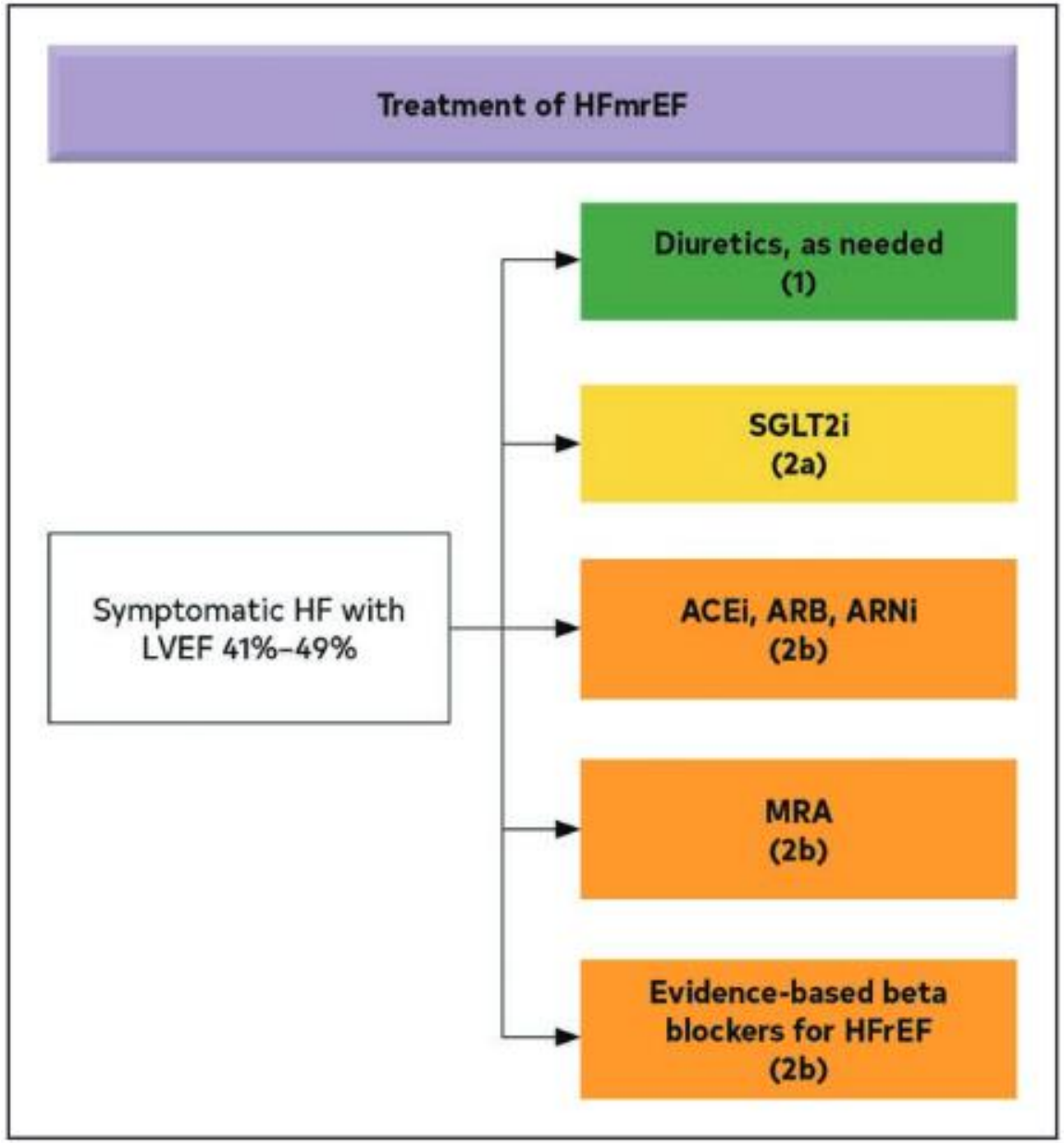
A. Add empagliflozin 10 mg daily
B. Add ivabradine 5 mg twice daily
C. Add vericiguat 10 mg daily
D. Add Entresto 24-26 mg twice daily

Who To Refer for Advanced Heart Failure Evaluation (C2D population)?

- Persistent NYHA III/IV symptoms despite maximal medical therapy
- Escalating diuretic requirements (furosemide > 160 mg/d ± thiazides)
- Objective limitation in exercise capacity
  - 6 min walk < 300 m or peak VO2 < 12-14 ml/kg/min or < 50% predicted
- ≥ 2 HF hospitalizations in past yr or HF hospitalization requiring ICU care
- Repeated ICD shocks for ventricular arrhythmias
- Intolerance of previously tolerated GDMT due to hypotension or worsening Cr
- Need for IV inotropes during admission or at home
- RV failure, progressive kidney and liver failure
- Progressive hyponatremia
- Cardiac cachexia

Dunlay et al. JAMA Cardiol. 2025;10(4):391-398.

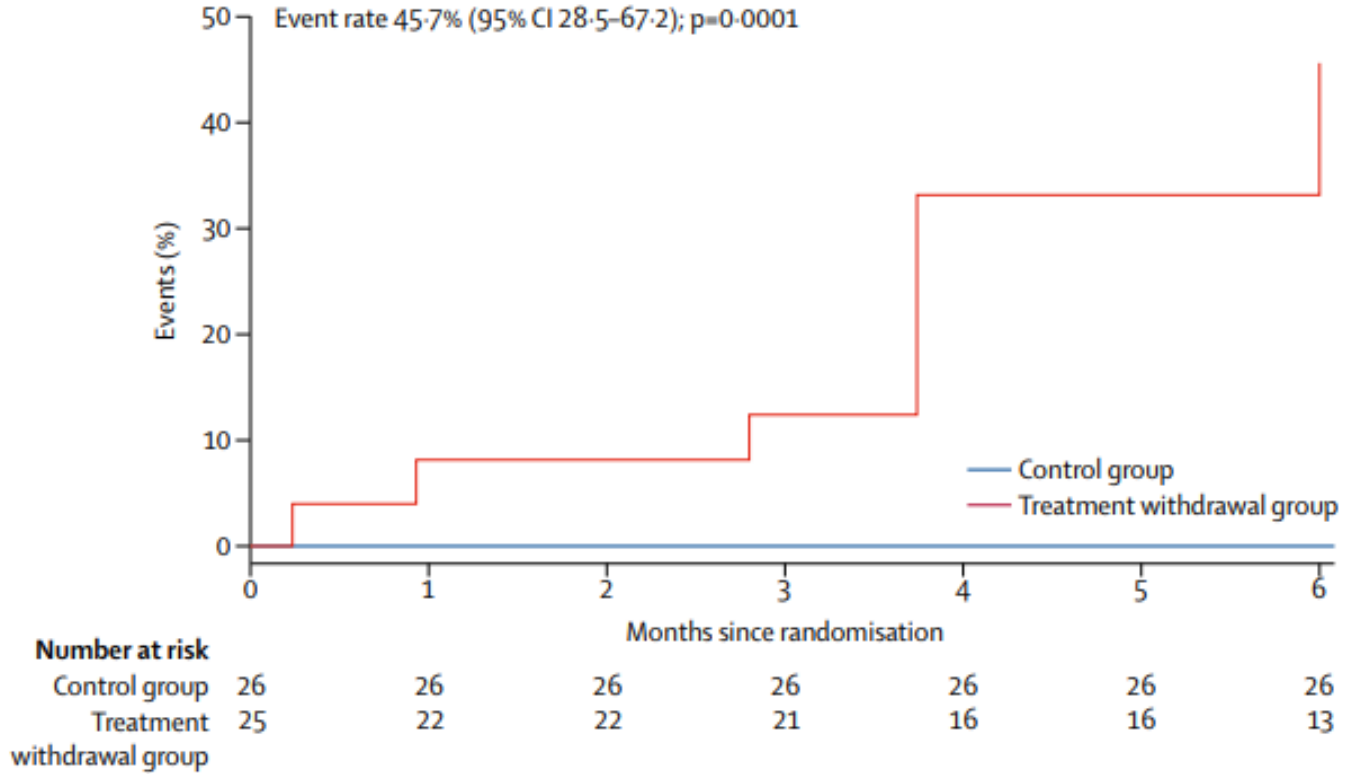
HF with Mid-Range LVEF (41-49%)



Heidenreich et al. Circulation 2022;145:e876-894

Rationale for Continued GDMT after LV Recovery: TRED-HF

- 51 pts w/ prior HFrEF on GDMT who had recovered: EF > 50%, nl LVEDVi, no sxs, BNP < 250
  - Open label study of GDMT withdrawal
- End-pt: recurrent LVEF < 50%, ↑ LVEDVi, BNP > 400, HF sxs



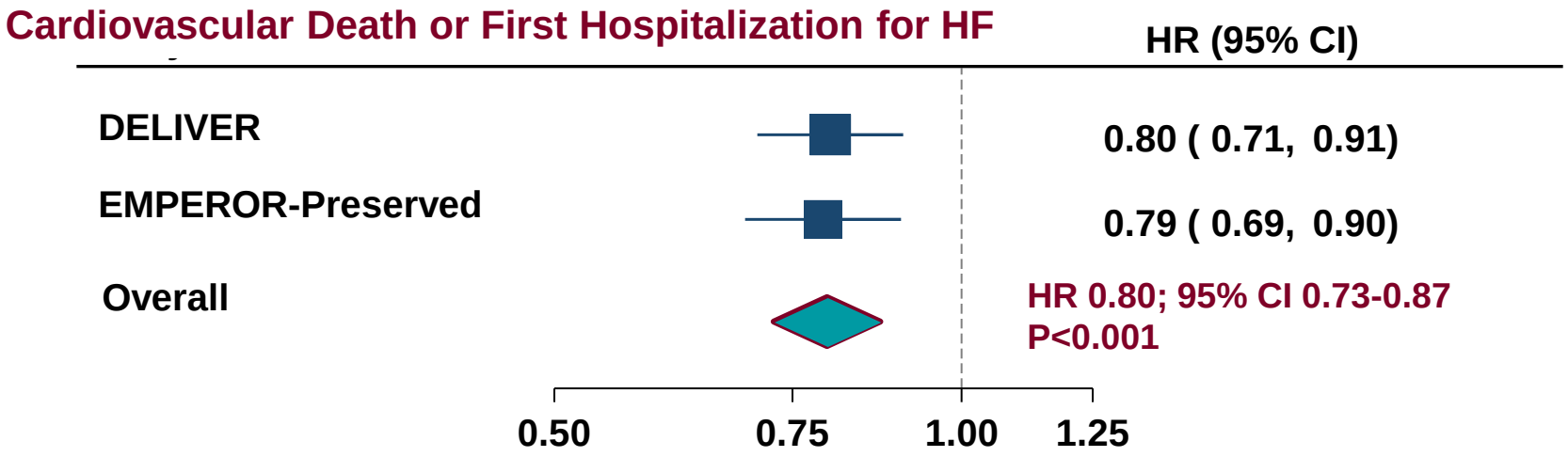
Halliday et al. Lancet 2019;393:61-73.

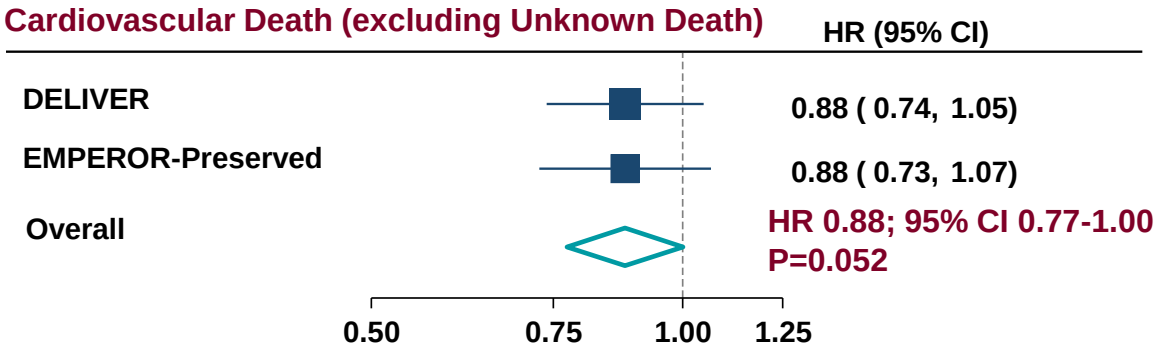
Guideline Update for HFpEF

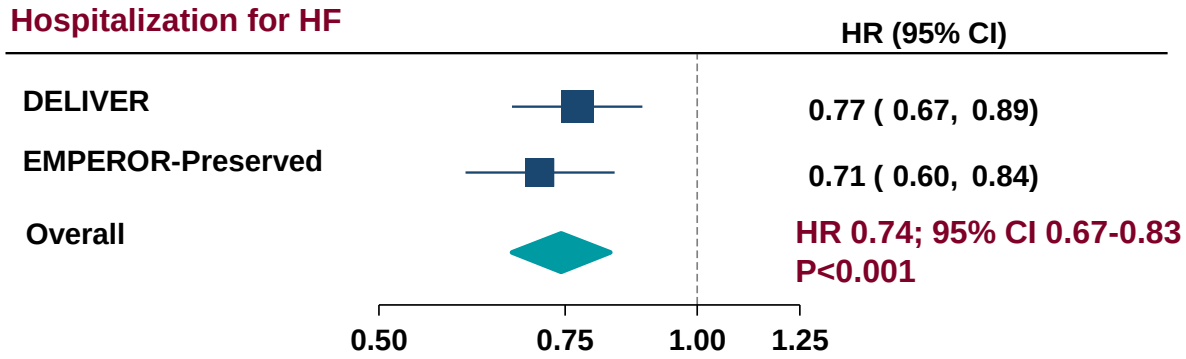
COR	LOE	Recommendations
1	C-LD	1. Patients with HFpEF and hypertension should have medication titrated to attain blood pressure targets in accordance with published clinical practice guidelines to prevent morbidity.[44–46]
2a	C-EO	2. In patients with HFpEF, management of AF can be useful to improve symptoms.
2a	B-R	1. In patients with HFpEF, SGLT2i can be beneficial in decreasing HF hospitalizations and cardiovascular mortality.[33]
2b	B-R	2. In selected patients with HFpEF, MRAs may be considered to decrease hospitalizations, particularly among patients with LVEF on the lower end of this spectrum.[38,42,43]
2b	B-R	3. In selected patients with HFpEF, ARNi may be considered to decrease hospitalizations, particularly among patients with LVEF on the lower end of this spectrum.[35,40]
3: No Benefit	B-R	4. In patients with HFpEF, routine use of nitrates or phosphodiesterase-5 inhibitors to increase activity or quality of life is ineffective.[49,50]

Heidenreich et al. Circulation 2022;145:e876-894

DELIVER and EMPEROR-Preserved Meta-Analysis:



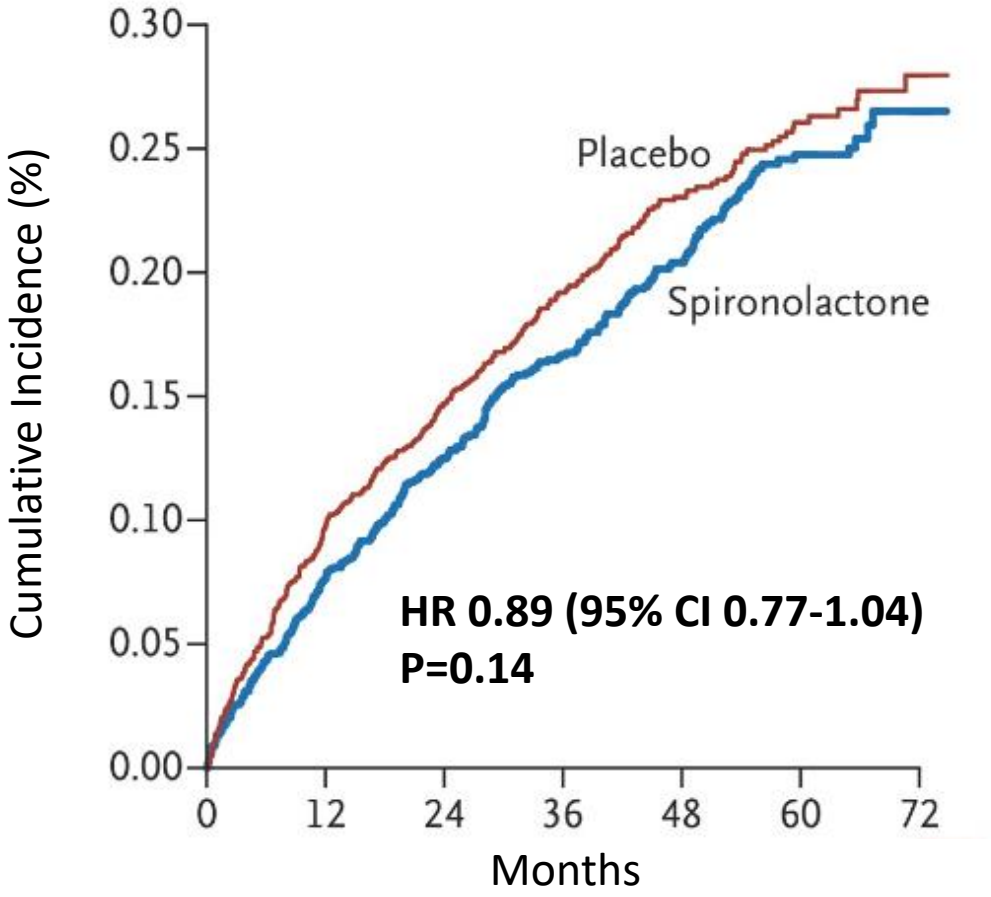


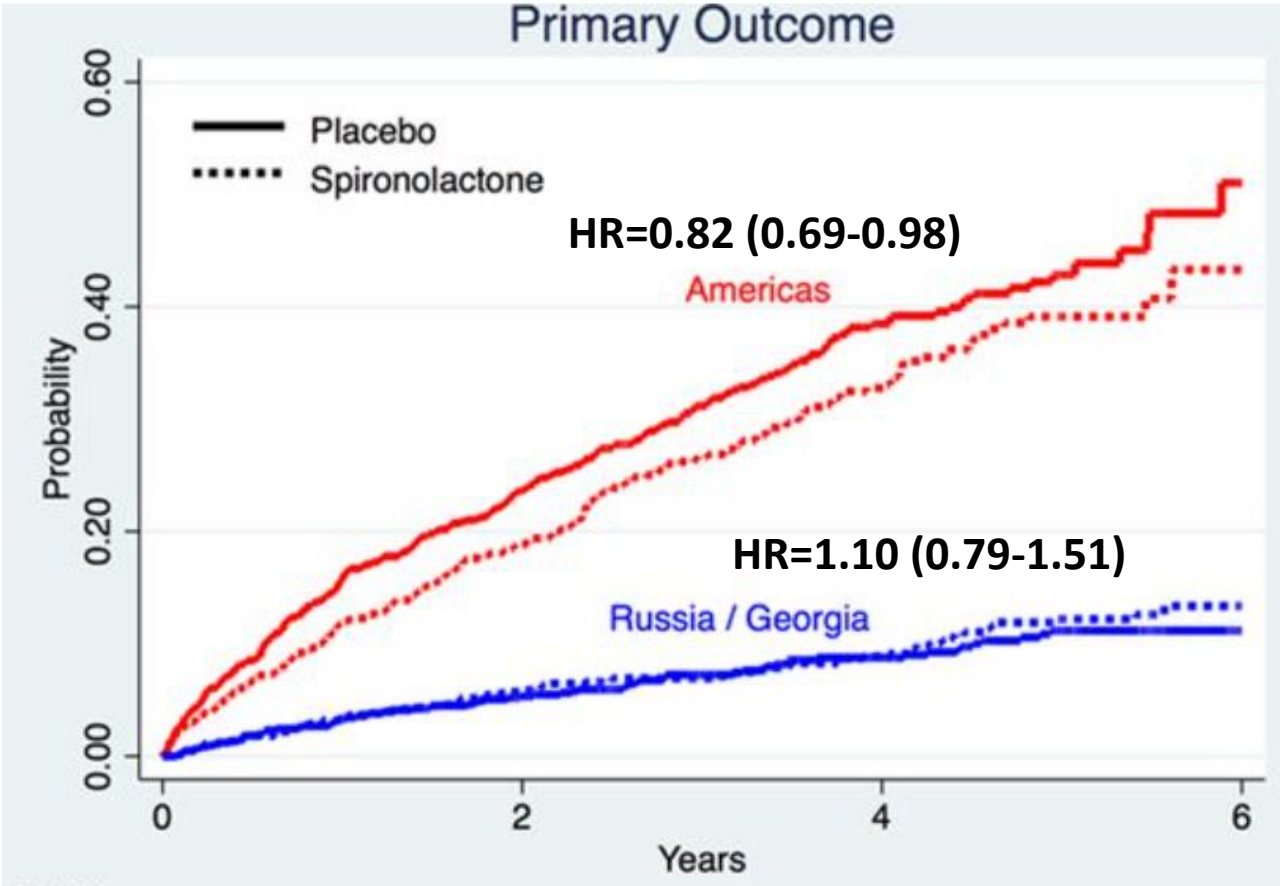


Vaduganathan M, et al. Lancet 2022

$P_{heterogeneity}$ >0.10 for all endpoints

TOPCAT: Spironolactone in HFpEF
1° Endpt: CV mortality, Aborted CV death, or HF Hosp.



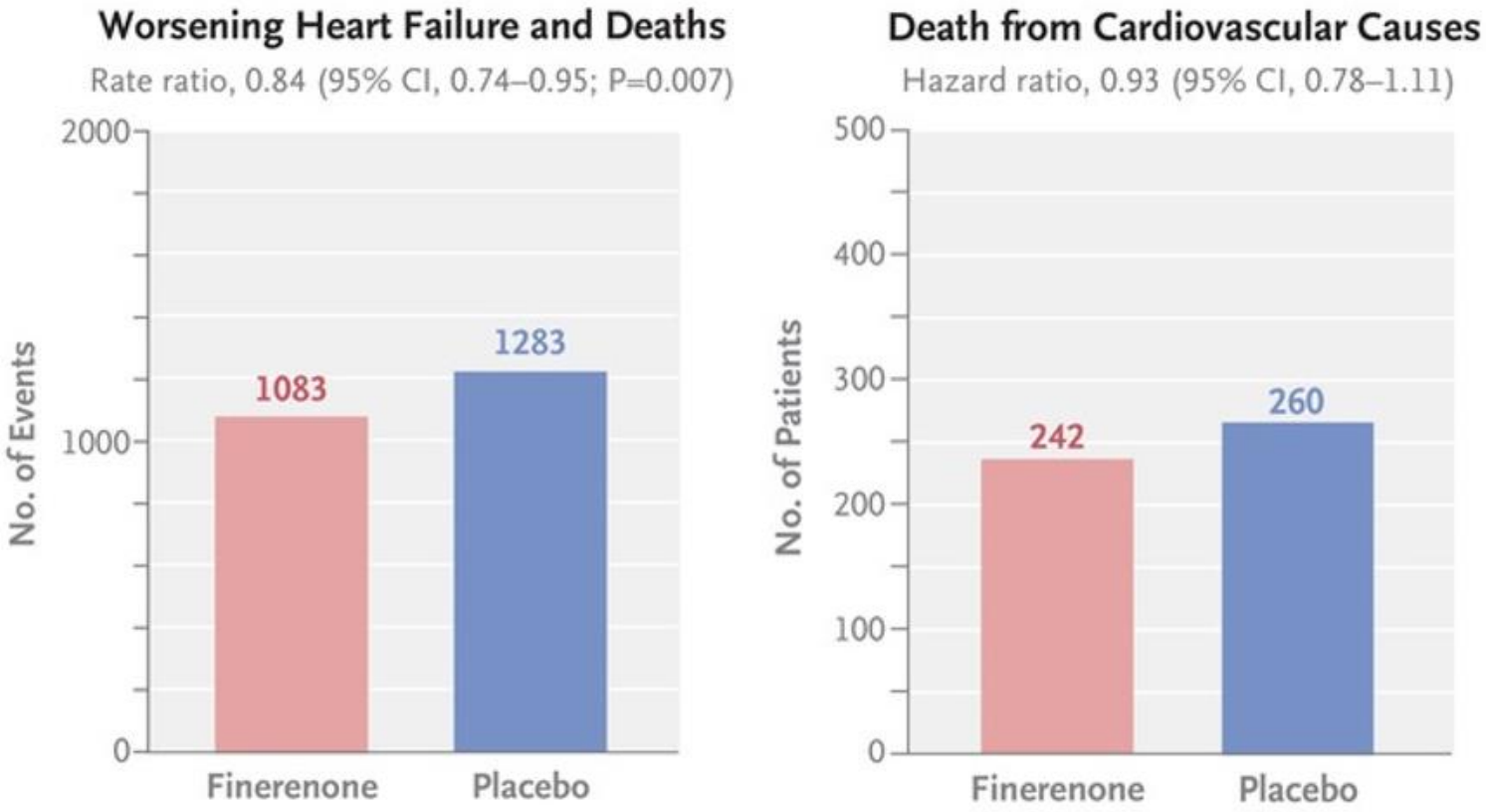


Pitt et al. NEJM 2014; 370:1383-1392; Pfeffer et al. Circulation 2015;131:34-42.

FINEARTS: Finerenone in HFpEF
1° Endpt: CV death and worsening HF events

- N=6001 pts
- Age ≥ 40 yrs, LVEF≥ 40%, structural heart dz, NYHA II-IV HF, ↑NPs
- RCT: 1:1 Finerenone 20 or 40 mg daily vs. placebo
- Median f/u: 32 mths

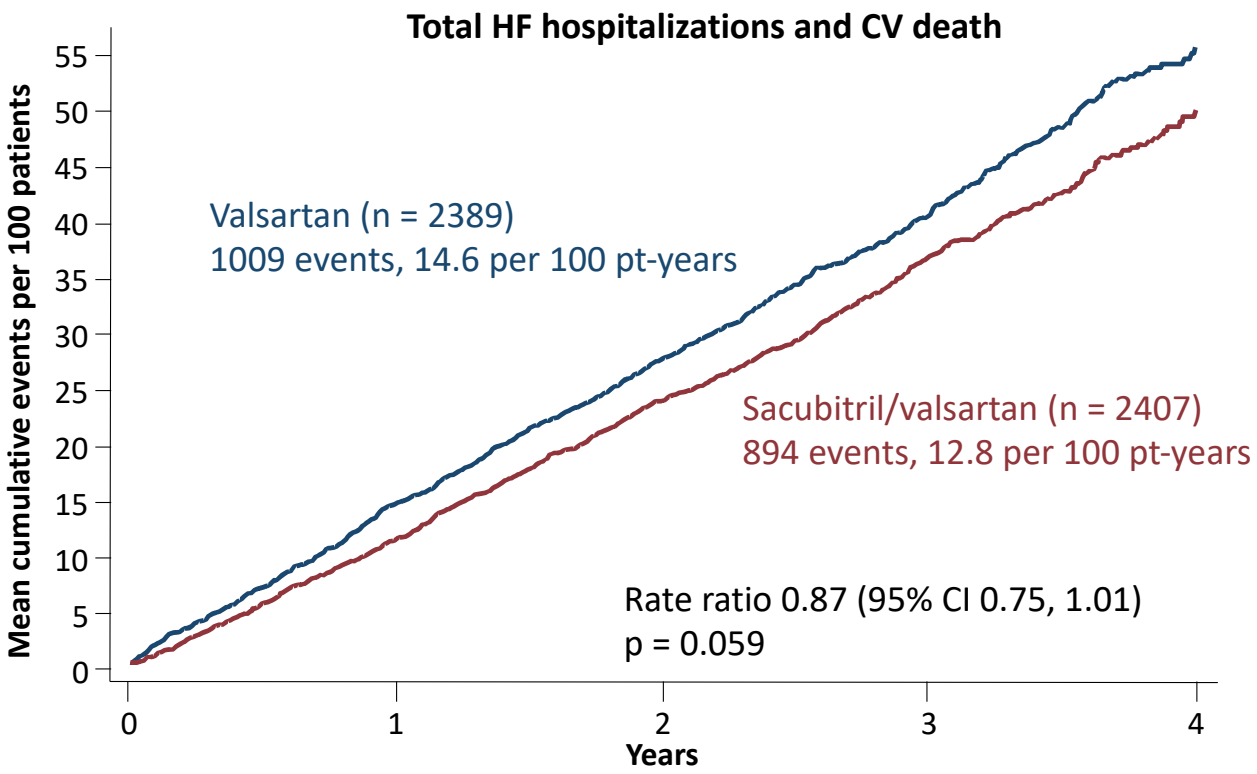
- ↑ hyperkalemia



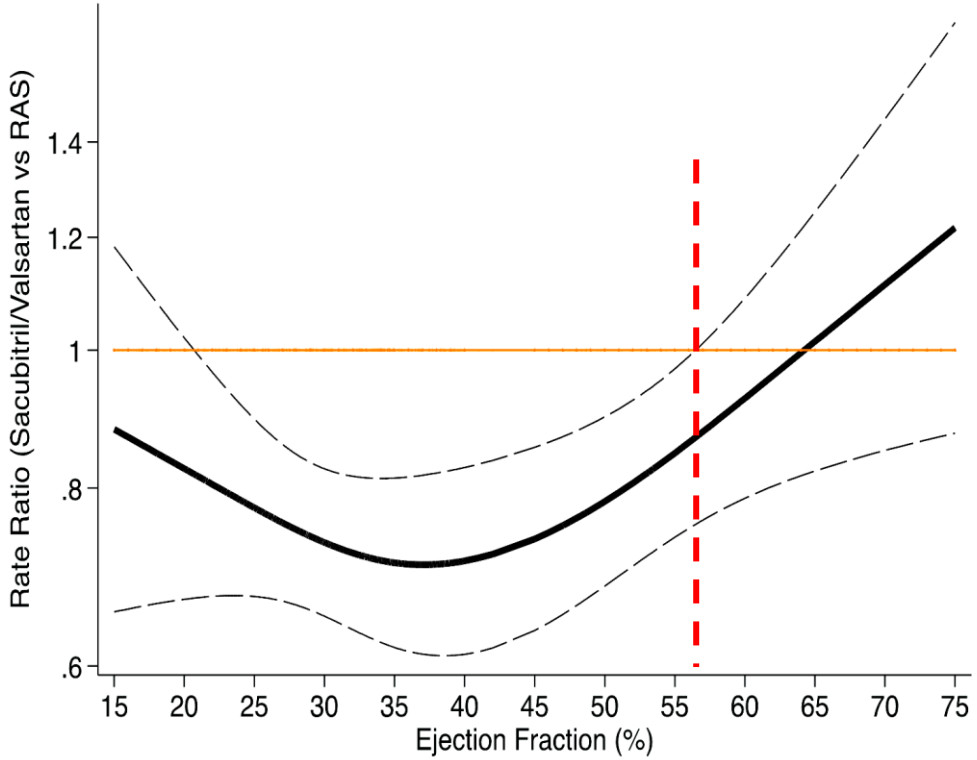
Solomon et al. NEJM 2024;391:1475-85.

ARNI in HF with HFmrEF or HFpEF

PARAGON-HF Primary Results



PARADIGM-HF/PARAGON-HF Pooled

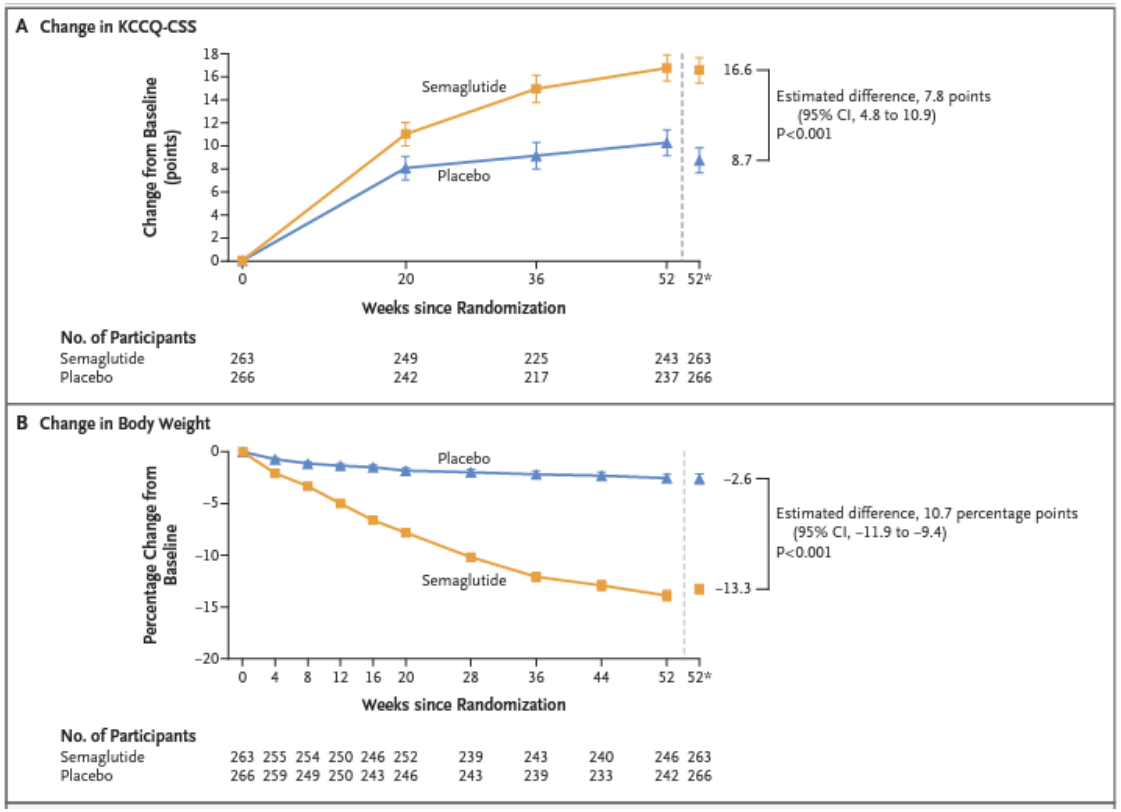


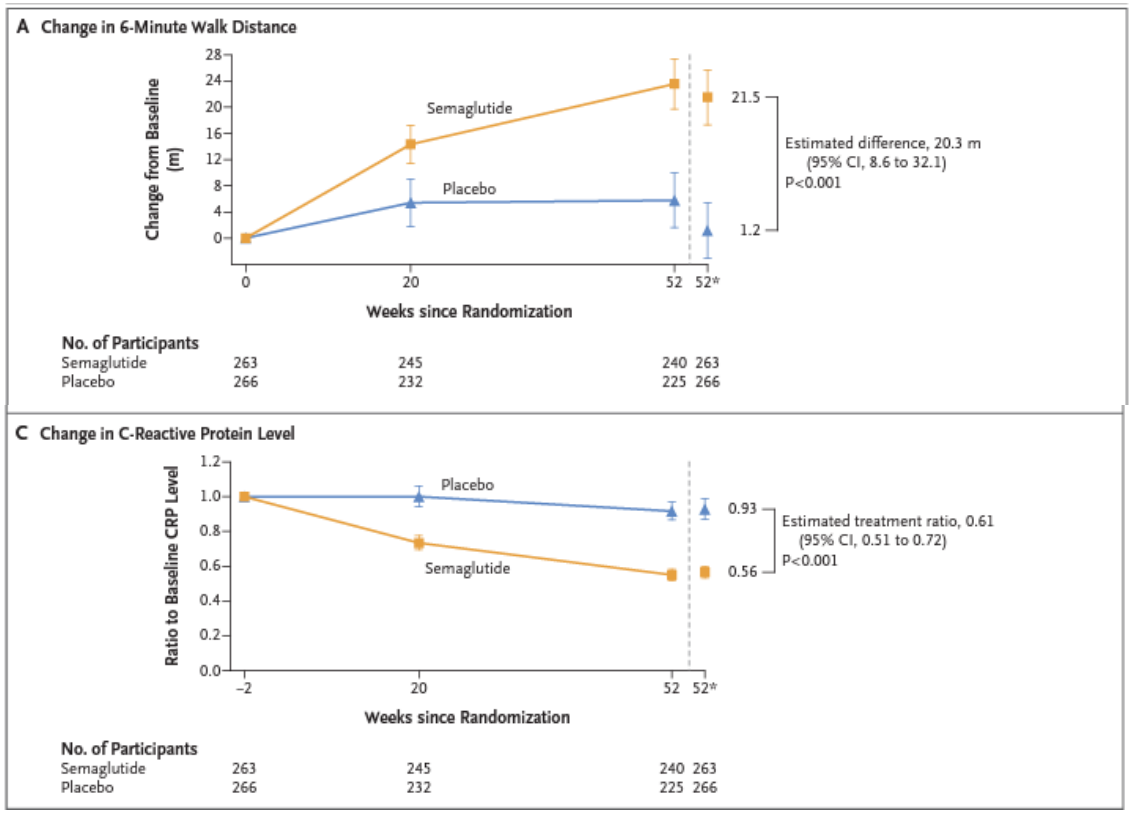
Feb 2021 US FDA approval for sacubitril/valsartan in expanded population, emphasizing benefits in EF 'below normal'

Solomon SD, et al. N Engl J Med 2019; Solomon SD, Circulation 2020

GLP-1 agonists in HFpEF: STEP-HFpEF

N=529 pts, symptomatic HFpEF (EF ≥ 45%), BMI ≥ 30
RTC: Semaglutide 2.4 mg weekly vs. placebo X 52 weeks

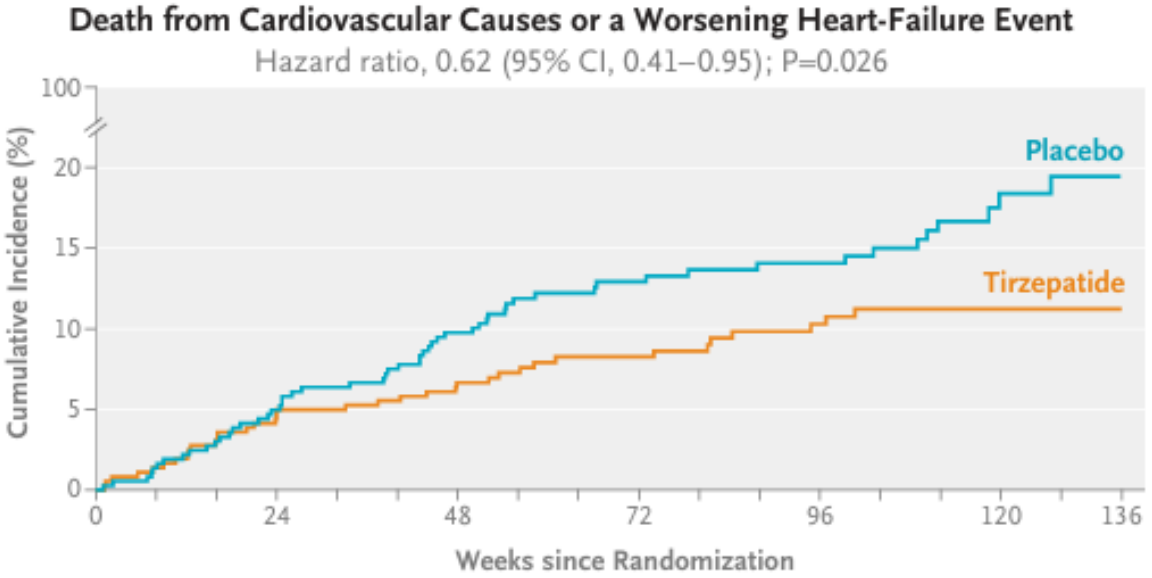




Kosiborod et al. N Engl J Med 2023;389:1069-84.

SUMMIT: GLP-1 and GIP Agonist in HFpEF

- N=732 pts
- Age ≥ 40 yrs, BMI ≥ 30, NYHA II-IV HF, LVEF ≥ 50%, ↑ NPs, LAE or ↑PCWP @ rest or exercise, ≥ 30 HF hosp. w/in 1 yr or eGFR < 70.
- RCT: 1:1 tirzepatide up to 15 mg SC weekly vs. placebo x 52 weeks
- Median f/u = 104 weeks



- Discontinuation due to GI side effects:
  - 6.3% vs 1.4%

- Wt loss: 13.9% vs 2.2%
- Change in KCCQ: 19.5 vs 12.7
- Change in 6 min walk distance: 26 vs 10.1 m
- Change in CRP: 38.8% vs 5.9%

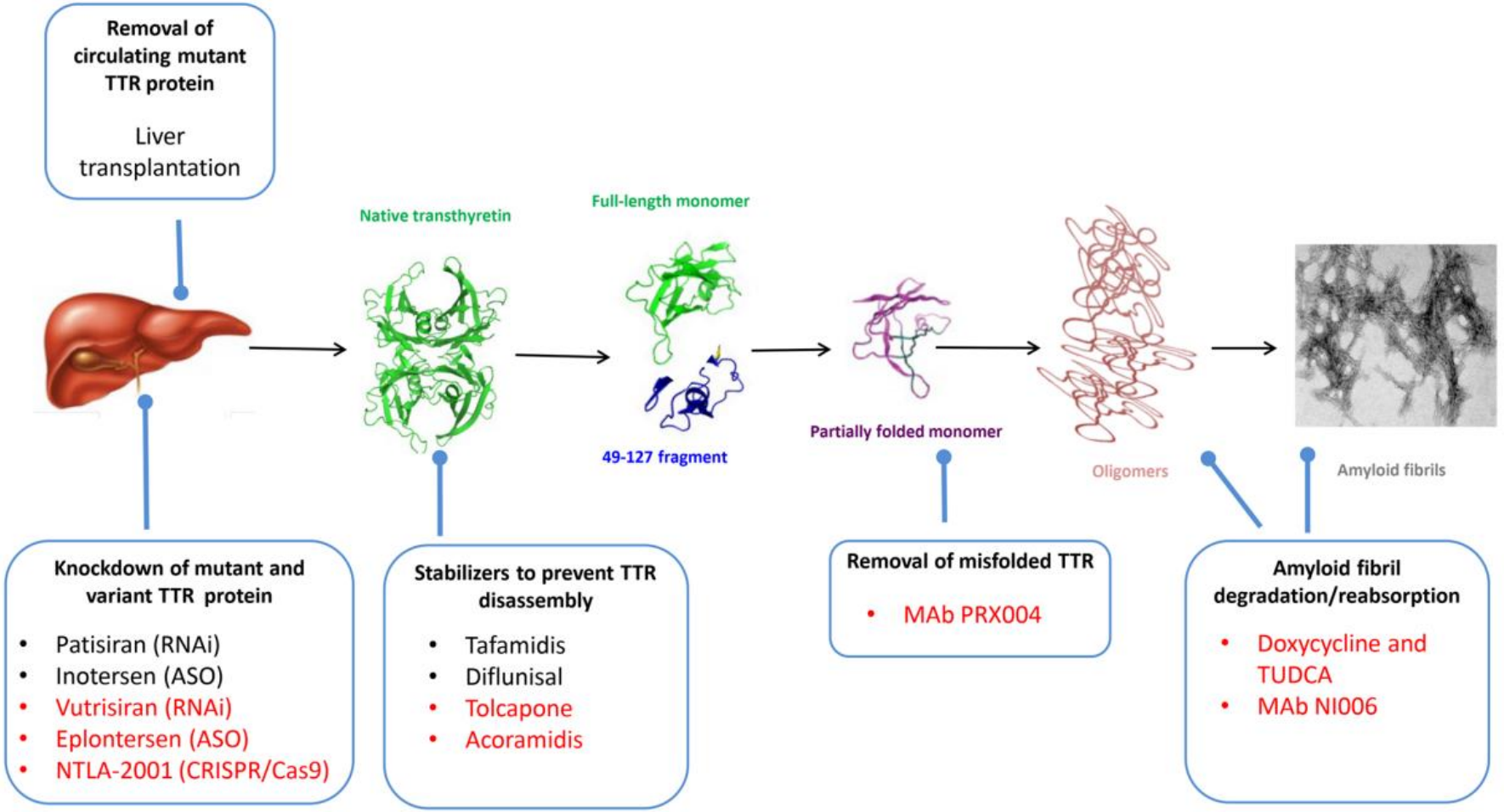
Packer et al. NEJM 2025;392:427-32.

Question 3.

Which of the following therapies has not been shown to reduce HF hospitalizations in HFpEF?

A. Empagliflozin
B. Sacubitril-Valsartan
C. Finerenone
D. Semiglutide
E. Tirzepatide
F. B and D

Therapies for ATTR Amyloidosis



Obici et al. Neurotherapeutics 2021;18:2286-2302.

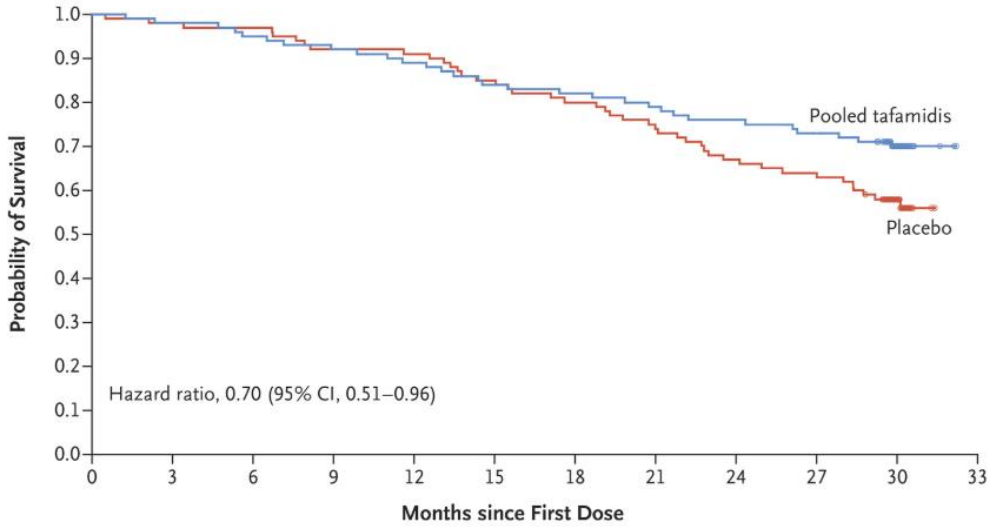
Stabilizers for TTR Cardiac Amyloid

- N=441, ATTR amyloid (wt or mutant), NYHA I-III
- RCT: 2:1:2 tafamadis 80 mg vs 20 mg qd vs placebo

A Primary Analysis, with Finkelstein–Schoenfeld Method

	No. of Patients	P Value from Finkelstein–Schoenfeld Method	Win Ratio (95% CI)	Patients Alive at Mo 30 *no. (%)*	Average Cardiovascular-Related Hospitalizations during 30 Mo among Those Alive at Mo 30 *per patient per yr*
Pooled Tafamidis	264	<0.001	1.70 (1.26–2.29)	186 (70.5)	0.30
Placebo	177			101 (57.1)	0.46

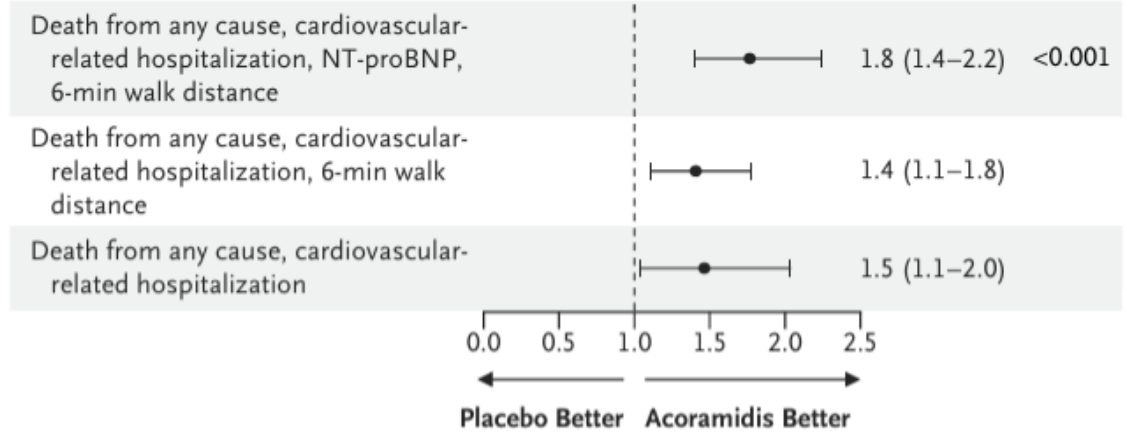
B Analysis of All-Cause Mortality



Maurer et al. NEJM 2018;379(11):1007-16

- N=632, ATTR amyloid (wt or mutant), NYHA I-III
- RTC: 2:1 acoramidis 800 mg bid vs placebo

Primary Efficacy Analysis and Prespecified Secondary Analyses



Gillmore et al. NEJM 2024;390:132-42.

Helios-B: Vutrisiran (RNAi) for ATTR Amyloidosis

RCT: 1:1 Vutrisiran 25 mg q 12 weeks vs placebo x 36 mths

654 adults

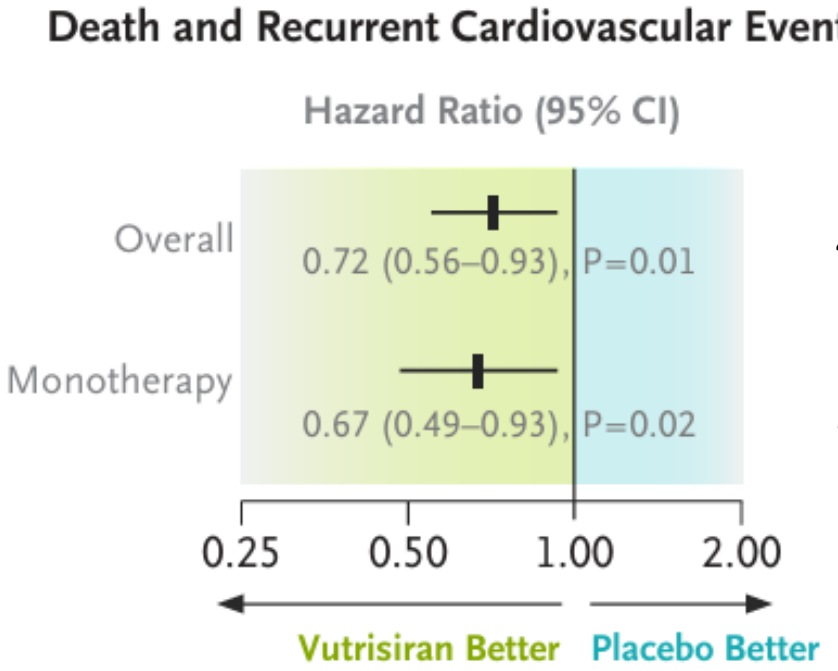
Median age, 77 years

Men: 93%; Women: 7%

Presence of TTR amyloid deposits in a tissue-biopsy specimen or fulfillment of scintigraphy-based diagnostic criteria for ATTR amyloidosis with cardiomyopathy

Cardiac involvement as assessed with transtho-racic echocardiography

Clinical history of heart failure



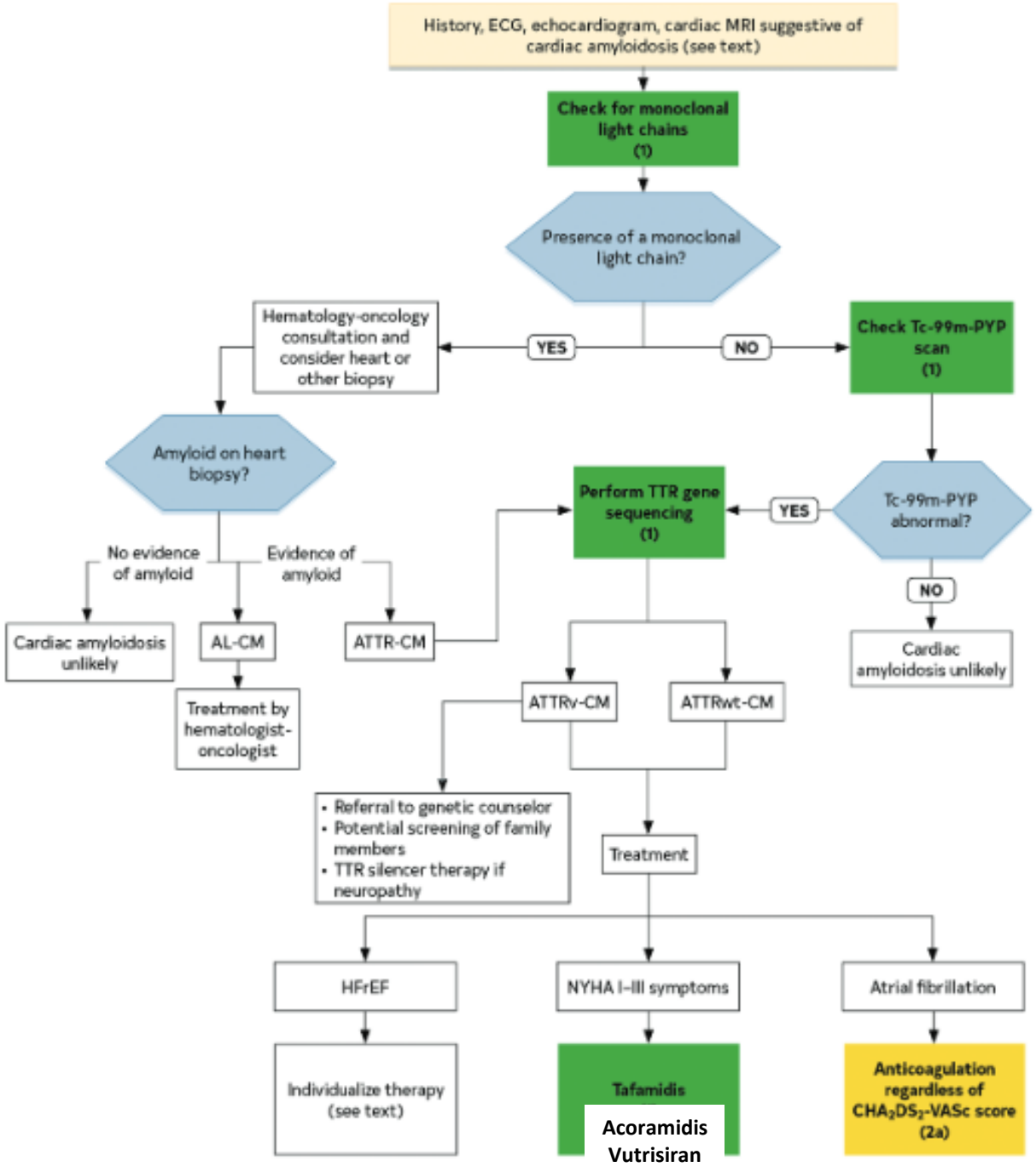
40% on tafamadis @ baseline

20% started tafamadis during trial

Fontana et al. NEJM 2025;392:33-44.

Diagnostic and Management Algorithm for Cardiac Amyloidosis

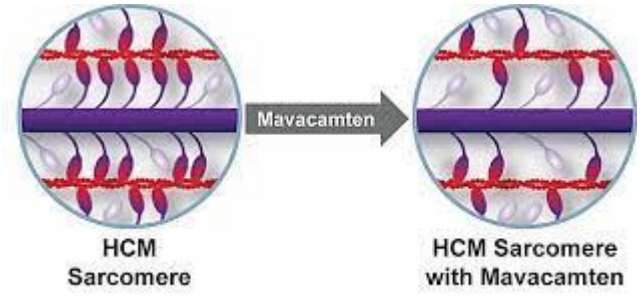
- Biceps tendon rupture
- Bilateral carpal tunnel syndrome
- Lumbar spinal stenosis
- Peripheral neuropathy
- LVH on echo
- Biatrial enlargement
- Low QRS voltage on ECG despite LVH



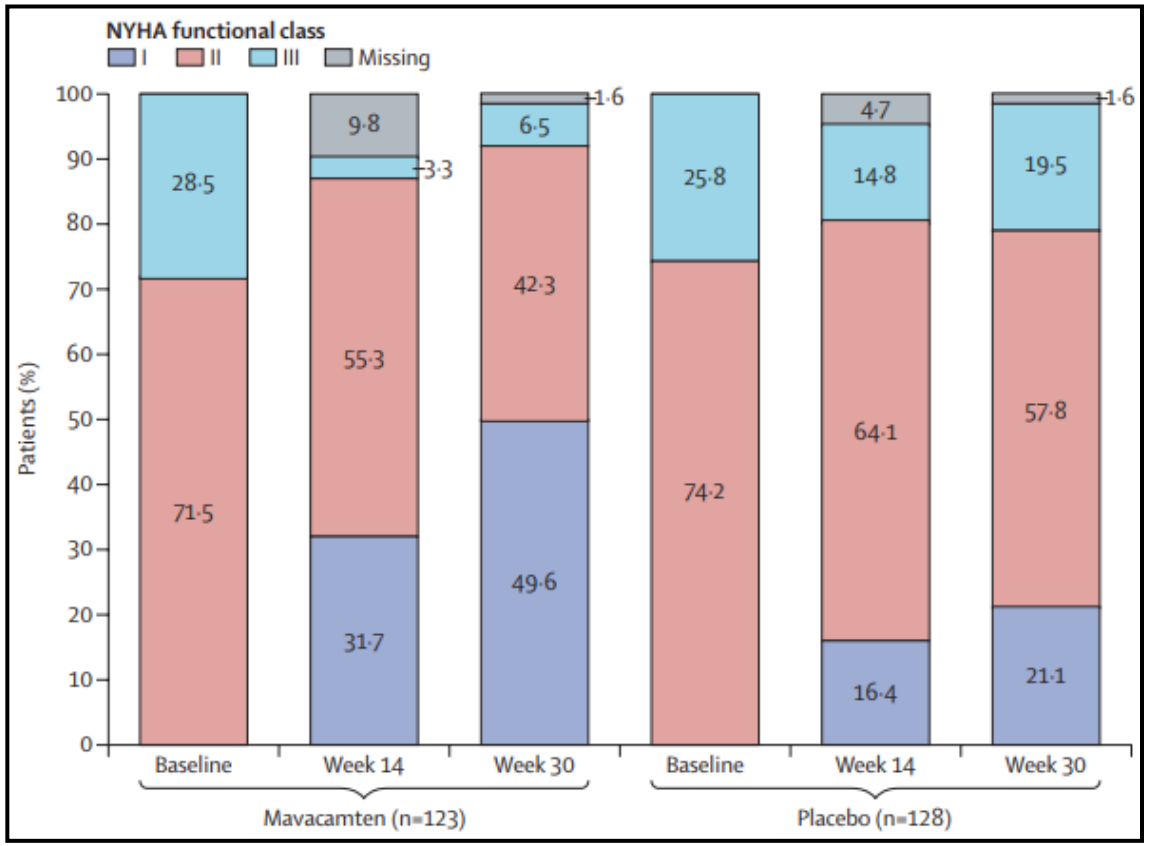
Heidenreich et al. Circulation 2022; 145;e876-894.

EXPLORER-HF: Mavacamten for Hypertrophic Obstructive Cardiomyopathy

Inhibitor of cardiac myosin: reduces # of cross-bridges between actin and myosin



- N=251 pts, HCM, LVOT gradient > 50 mmHg, NYHA II-III
- **1° Endpoint**: ≥ 1.5 ml/kg/min ↑ in peak VO2 + ≥ 1 NYHA Class ↓ in sxs *OR* ≥ 3 ml/kg/min ↑ in peak VO2 w/ stable sxs
- **37% vs. 17%, p=0.0005**



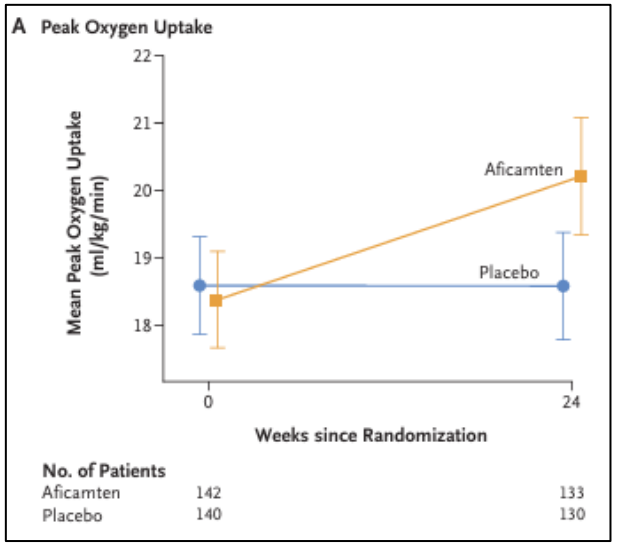
Olivotto et al. Lancet 2020;396:759-69.

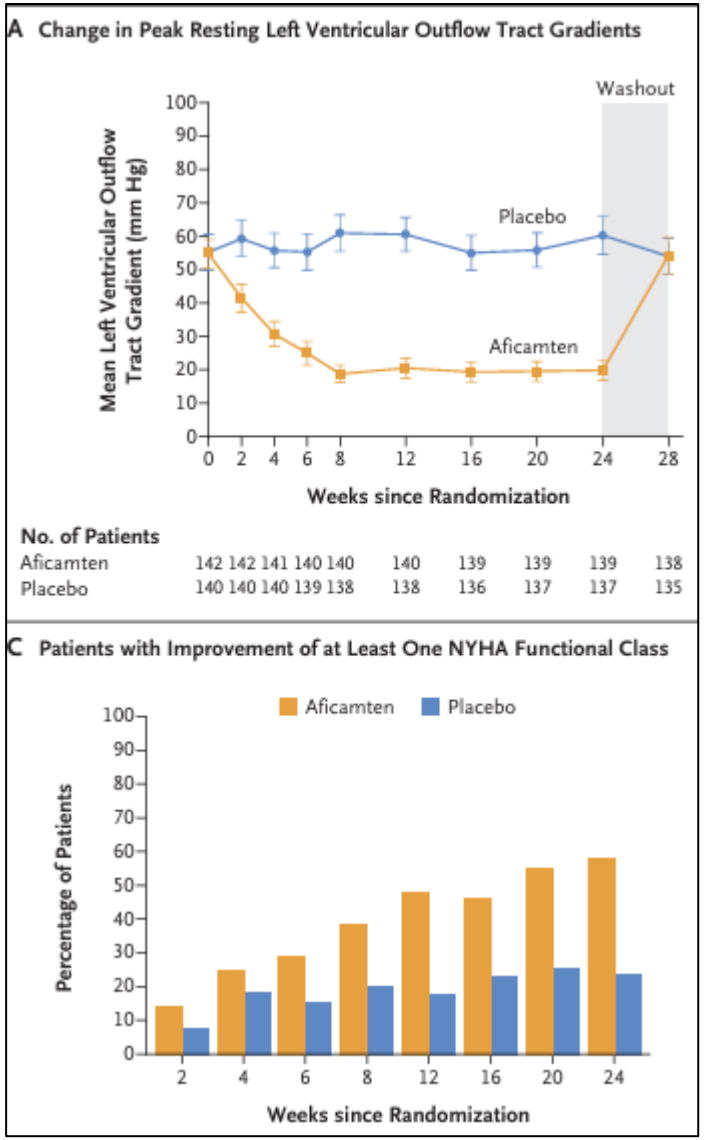
SEQUOIA-HCM: Aficamten for Obstructive HCM

- N=282 pts
- EF ≥ 60%,
- LVOT gradient ≥ 30 mm Hg @ rest or ≥ 50 mm Hg w/ Valsalva
- NYHA II-III HF

- RCT: 1:1 aficamten 20-50 mg daily vs placebo

- 1° Endpt: change in peak VO2

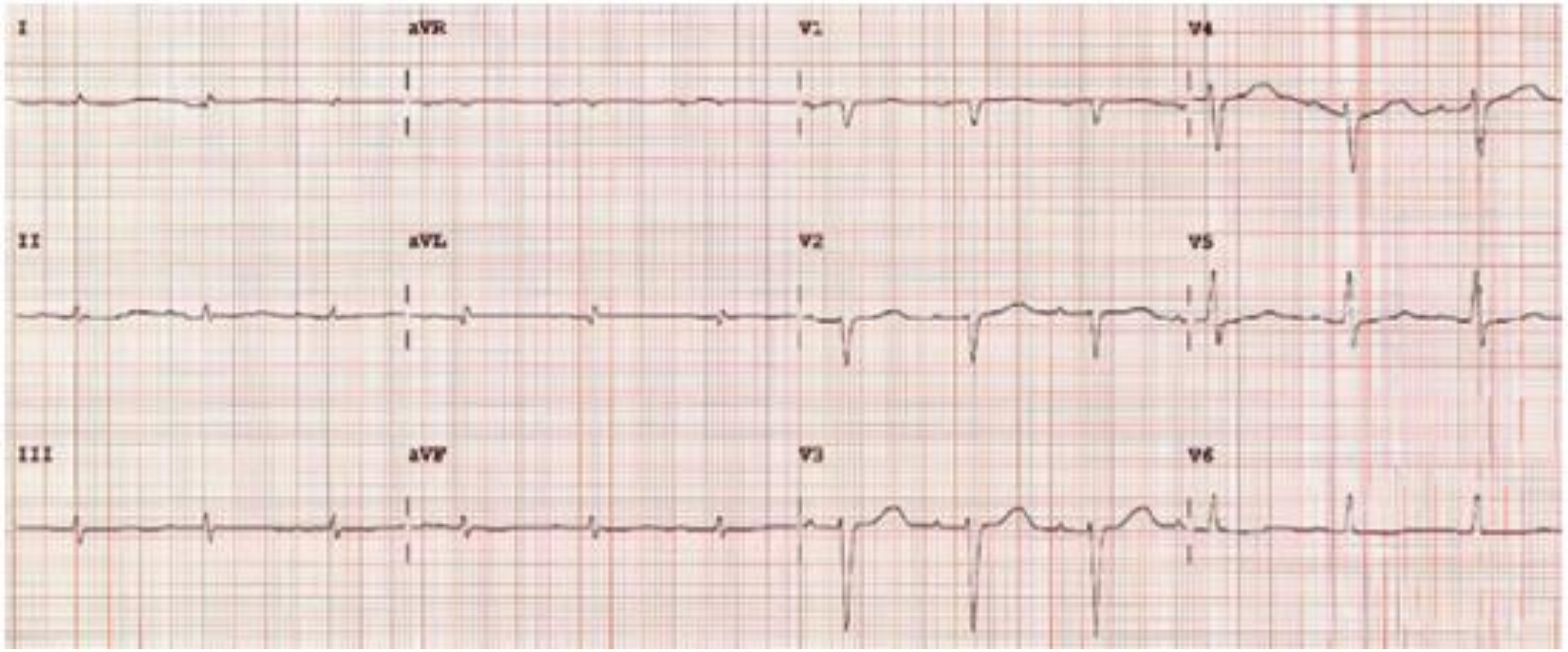




Maron et al. NEJM 2024;390:1849-61.

Question 4.

A 55 y.o. Black man presents with progressive shortness of breath and fatigue for the past 3 months. On review of systems, he reports numbness and tingling in both his feet > hands and pain in his feet that has limited his walking. He denies any CV risk factors and states that his father died of heart failure at the age of 60 years. His exam is unremarkable except for mild JVD. His labs are also within normal limits except for an elevated NT-proBNP of 1280 pg/mL. His echo shows LVEF of 50-55% and concentric LVH with a wall thickness of 13 mm. His EKG is shown below:



Question 4 contd.

What is the next best diagnostic test?

A. Serum and urine protein electrophoresis
B. Right and left heart catheterization
C. Genetic testing for non-ischemic cardiomyopathy
D. Technetium 99-m pyrophosphate scan

Take Home Messages

For Stage A HF:

- ✓Target BP < 130/80 mm Hg
- ✓For diabetics w/ CV risk, consider SGLT2 inhibitors to reduce risk of incident HF
- ✓Consider BNP for risk stratification and aggressive RF management in pts with CV risk factors

For Stage C HF w/ reduced EF:

- ✓Use ARNi over ACEi/ARB to reduce morbidity/mortality in NYHA II-III pts
- ✓Use SGLT2i to reduce mortality and HF hospitalizations, even in patients w/o DM
- ✓Maximize GDMT as tolerated to improve sxs and mortality
- ✓Add ivabradine to reduce HF hospitalizations if SR w/ HR ≥ 70 bpm, despite max beta-blockade
- ✓Consider IV iron if iron deficient to reduce symptoms and HF hospitalizations
- ✓Consider vericiguat to reduce HF hospitalizations, esp. in sicker pts with eGFR 15-30

Take Home Messages

For HF w/ preserved EF

- ✓Consider SGLT-2i to reduce HF hospitalizations
- ✓Consider ARNI/MRAs to reduce HF hospitalizations in pts with EF < 55%
- ✓Promote diet, exercise, and weight loss to improve outcomes
- ✓GLP-1 agonists and GLP-1/GIP agonists help reduce HF hospitalizations and improve QOL
- ✓Remember HFpEF is a heterogeneous syndrome and consider specific therapies for certain diagnoses
- ✓Look for clues of TTR amyloidosis and consider tafamadis, acoramidis or vutrisiran to reduce mortality and HF hospitalizations if present
- ✓Consider mavacamten/aficamten in symptomatic patients with hypertrophic obstructive cardiomyopathy to improve exercise capacity and symptoms

REFERENCES

1. Heidenreich et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: Executive Summary: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation 2022;145:e876-894.
2. Solomon et al. Dapagliflozin in Heart Failure with Mildly Reduced or Preserved Ejection Fraction. N Engl J Med 2022;387(12):1089-1098.
3. Solomon SD et al. Finerenone in Heart Failure with Mildly Reduced or Preserved Ejection Fraction. N Engl J Med. 2024 Oct 24;391(16):1475-1485.
4. Kosiborod MN et al. Semaglutide in Patients with Heart Failure with Preserved Ejection Fraction and Obesity. N Engl J Med. 2023 Sep 21;389(12):1069-1084.
5. Packer M et al. Tirzepatide for Heart Failure with Preserved Ejection Fraction and Obesity. N Engl J Med. 2025 Jan 30;392(5):427-437.
6. Maurer et al. Tafamidis Treatment for Patients with Transthyretin Amyloid Cardiomyopathy. N Engl J Med. 2018 Sep 13;379(11):1007-1016.
7. Gillmore JD et al. Efficacy and Safety of Acoramidis in Transthyretin Amyloid Cardiomyopathy. N Engl J Med. 2024 Jan 11;390(2):132-142.
8. Fontana M et al. Vutrisiran in Patients with Transthyretin Amyloidosis with Cardiomyopathy. N Engl J Med. 2025 Jan 2;392(1):33-44.
9. Olivoto et al. Mavacamten for treatment of symptomatic obstructive hypertrophic cardiomyopathy (EXPLORER-HCM): a randomised, double-blind, placebo-controlled, phase 3 trial. Lancet 2020;396:759-69.
10. Maron MS et al. Aficamten for Symptomatic Obstructive Hypertrophic Cardiomyopathy. N Engl J Med. 2024 May 30;390(20):1849-1861.

Answer 1.

Correct Answer: B

All patients with HFrEF should be on a 4-drug regimen to reduce the risk of HF hospitalization and death. These include ARNI/ACEi/ARB + b-blocker + MRA + SGLT-2i. This patient is already on the first 3 drugs, albeit at low doses. The guidelines recommend that you add a SGLT-2i before trying to maximize the doses of the other drugs. While you could give more torsemide, he is very mildly volume overloaded and the increase may result in worsening renal dysfunction. SGLT-2i also has a mild diuretic effect and therefore this may result in some diuresis while preserving renal function in the long run.

Answer 2.

Correct Answer: C

This patient is in NYHA Class III HF despite being on a good medical regimen. She cannot tolerate RAAS inhibition due to her renal function. She is therefore on hydralazine and isordil per the guidelines. She cannot take SGLT-2i since they are currently contraindicated in patients with eGFR < 25 ml/min/1.73 m^2. She cannot take ivabradine since she is in afib. Therefore, the only viable choice for her would be to add vericiguat which is safe to use in patients with eGFR 15-30 ml/min/1.73 m^2. Furthermore, she has adequate BP room to tolerate additional vasodilation.

Answer 3.

Correct Answer: E

SGLT-2i, finerenone, and tirzepatide have all been shown to reduce HF hospitalizations, but not mortality, in RCTs of patients with HFpEF.
Trials of candesartan, sacubitril-valsartan, and spironolactone suggested a trend towards improvement but did not significantly reduce HF hospitalizations in patients with HFpEF.
STEP-HFpEF evaluated changes in quality of life, 6 min walk distance and biomarkers but did not evaluate hard-endpoints such as HF hospitalizations or mortality in patients with HFpEF. Therefore, it is not known whether semiglutide reduces HF hospitalizations in patients with HFpEF.

Answer 4.

Correct answer: A

This patient's history (HF sxs and peripheral neuropathy) and test findings (LVH with decreased voltage on EKG) are concerning for cardiac amyloidosis. His race and family history raise the concern for mutant ATTR amyloidosis. V122I is a common pathogenic TTR mutation that is found in 3-4% of individuals of African ancestry in the US and is associated with cardiomyopathy and heart failure. The algorithm suggested by the guidelines recommends checking serum light chains as the first step in patients with a suspicion for cardiac amyloidosis. If this is negative, one would proceed with a technetium 99-m pyrophosphate scan which if positive can be diagnostic of ATTR amyloidosis.