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SCIENTIFIC EDITORIAL

Practical management of heart failure with preserved ejection fraction. A modest proposal

Prise en charge des patients en insuffisance cardiaque à fraction d'éjection préservée : une proposition pratique

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While the management of patients with cardiac insufficiency with systolic dysfunction is well established [1], that of cardiac insufficiency with preserved ejection fraction is not based on any evidence. This is why – even though this pathology is present in more than 50% of patients with heart failure in clinical practice – only a minimal proportion of the latest European guidelines was devoted to this topic (one-quarter of a page within the 61 pages of recommendations and five of 270 references [1]). It also notably demonstrates the limits of the recommendations as well as the difficulty in writing the present paper, with its own limitations (it is a personal opinion and is therefore debatable).

The treatment philosophy for cardiac insufficiency with preserved systolic function is completely different from that of cardiac insufficiency with altered systolic function: with the latter, you want to block hormonal activation (RAS, sympathetic system); with the former you need to treat/address the causes of rigidity in the arteries and cardiac muscle (e.g. arterial hypertension), treat all comorbidities that could aggravate the symptoms of cardiac insufficiency, such as anaemia and renal insufficiency, and avoid the causes of acute cardiac decompensation (e.g. hypertensive crisis, infections, sodium overload, tachycardic episodes). Finally the treatment consists of maintaining the patient in euolemia (emphasizing the importance of therapeutic education, diuretic treatment as a base if needed, avoiding dehydration, etc.), as outlined in Fig. 1.

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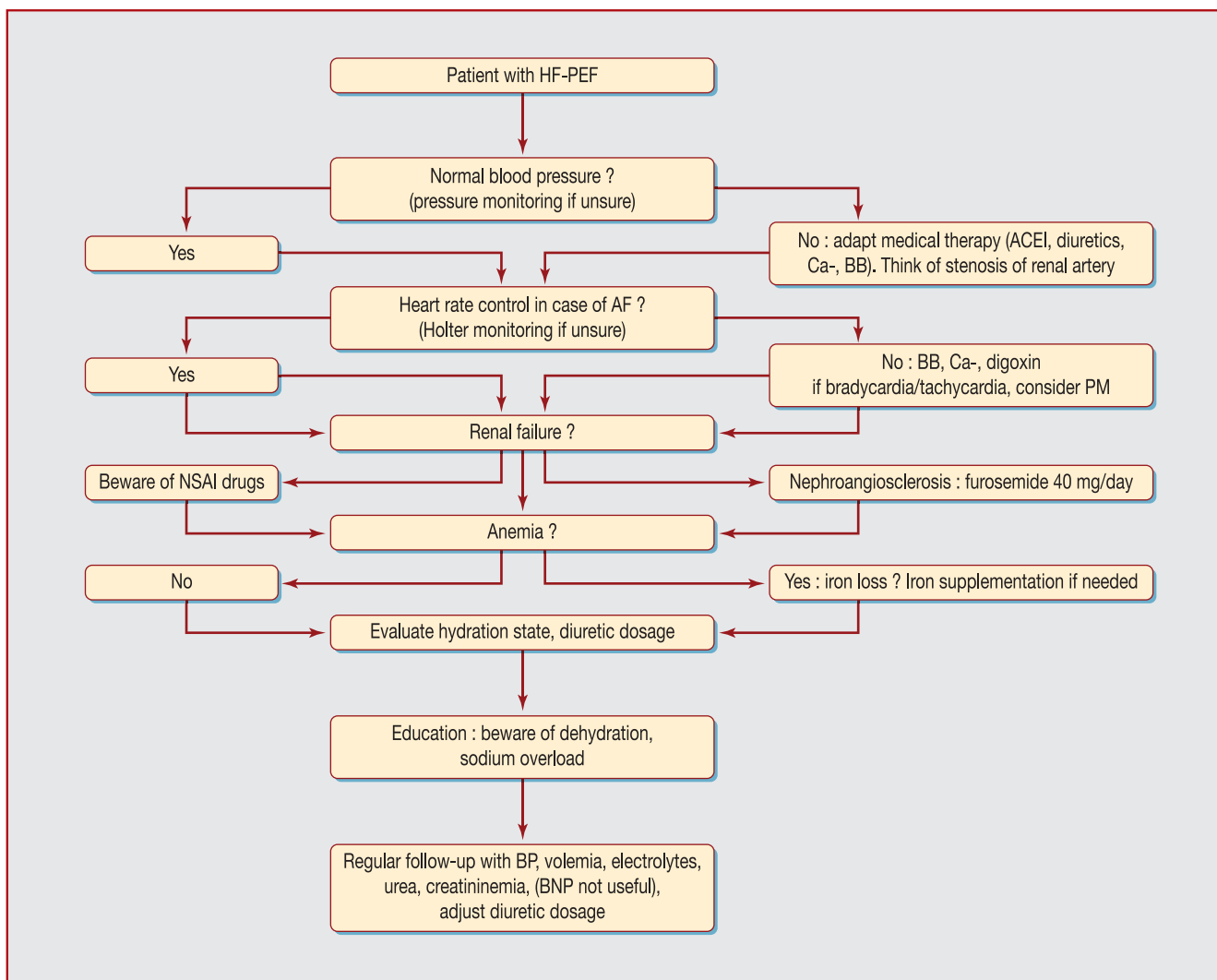


Figure 1. Proposed scheme for optimizing therapy in a patient with heart failure and preserved ejection fraction. ACEI: angiotensin converting enzyme inhibitor; AF: atrial fibrillation; BB: beta-blocker; BNP: brain natriuretic peptide; BP: blood pressure; Ca: calcium antagonist; HF-PEF: heart failure with preserved ejection fraction; NSAID: non-steroidal anti-inflammatory agent; PM: pacemaker.

In the absence of a curative treatment for cardiac insufficiency with preserved systolic function, it makes sense to try to prevent its occurrence. However, in order to do so it is important to understand the causes of or factors responsible for this condition. This type of cardiac insufficiency is notably observed in hypertensive patients, diabetic patients, the elderly and in patients with renal insufficiency [2–4]. We are able to treat diabetes and arterial hypertension and to slow the progression to cardiac insufficiency while it is still secondary to arterial hypertension and diabetes [5]. The correct management of these pathologies before cardiac insufficiency occurs is therefore fundamental, although it is equally important after cardiac insufficiency appears in order to limit its progression or allow for a possible recovery (e.g. regression of cardiac muscle hypertrophy after stabilising blood pressure) [6].

The causal role played by arterial hypertension is fundamental: it is a factor in increasing arterial rigidity, cardiac hypertrophy and renal insufficiency. Treating

arterial hypertension, even in the elderly, allows us to limit the appearance of cardiac insufficiency. The Hypertension in the Very Elderly Trial (HYVET) study, for example, demonstrated that the treatment of systolic arterial hypertension of more than 160 mmHg in patients over 80 years of age reduces the risk of cardiac insufficiency by 60% [7].

Even after the development of cardiac insufficiency, the treatment of arterial hypertension remains of utmost importance. This treatment is often challenging to put in place and its effects are difficult to evaluate due to the variability of blood pressure levels seen in such patients: the rigidity of their arteries, the reduction in sensitivity of baroreceptors, and systolic left ventricular function beyond the normal range allow rapid variations in blood pressure depending on both the position (orthostatic hypotension is frequent) and the effort being exerted (it is prudent to measure ambulatory arterial pressure in these patients to check that blood pressure is well controlled). The possibility of stenosis of the renal arteries should be considered

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