# key points

SELECTED BY

**Dr Peter Saul**
GP, Wrexham and associate GP Dean for North Wales

**NICE has updated its guideline on heart failure.** The principal changes from the 2003 guideline include more directive advice on how to improve the quality and timeliness of diagnosis. There is greater encouragement to use beta-blockers, more emphasis on rehabilitation, and better access to specialist advice – particularly at the time of diagnosis, admission to hospital, and where symptoms do not respond to first-line therapy with diuretics, ACE inhibitors and beta blockers.

**A full history should be taken and clinical examination** carried out. Patients with a past history of MI, or those with a high plasma BNP, should be referred to be seen within two weeks for echocardiography and specialist opinion. The specialist should determine: whether heart failure is present; its likely aetiology; precipitating factors; type of cardiac dysfunction; correctable causes; relevant comorbidity, and prognosis. Those with no history of MI but an elevated plasma BNP should be referred to be seen within six weeks for such assessment.

**For patients with systolic heart failure, ACE inhibitors** and beta-blockers are still recommended as first-line therapies. Angiotensin receptor blockers (ARBs) should be considered only if ACE inhibitors are not tolerated. If the patient is still symptomatic despite such therapy, a more specialist assessment is advised, with consideration of the addition of either an ARB (such as candesartan), aldosterone antagonist, or a combination of a nitrate and hydralazine.

**Older adults, and patients with peripheral vascular** disease, erectile dysfunction, diabetes mellitus, interstitial pulmonary disease and COPD without reversibility are specifically mentioned as those who should be considered for beta-blocker therapy. A start low, go slow approach is recommended, with clinical review after each titration.

**A subset of patients with symptoms despite ACE** inhibitors and beta-blockers, and with a broad QRS complex on the ECG, should be considered for cardiac resynchronisation therapy. An implantable defibrillator should be considered for those patients at high risk of sudden death.

**Monitoring should include a clinical assessment,** medication review, and a check of renal function as a minimum. Such a review should take place at least six monthly but may have to be much more frequent if there is a change in drug prescription or clinical status.

**A new recommendation is that patients with stable heart** failure should be offered a supervised group exercise-based rehabilitation programme designed for such patients. This should include a psychological and educational component, and could be incorporated within an existing cardiac rehabilitation programme.