key points

SELECTED BY
Dr Peter Saul
GP, Wrexham and Associate GP Dean for North Wales

The typical presentation of heart failure in primary care is insidious, with progressive breathlessness on exertion, ankle swelling, orthopnoea or paroxysmal nocturnal dyspnoea. Not all patients will have all these symptoms, and in many patients there may be other causes.

If a GP suspects heart failure, then the key blood test is B-type natriuretic peptide (BNP). If the BNP is normal then heart failure is unlikely and other diagnoses should be considered. If it is raised, or if there is a past history of myocardial infarction, the patient requires further assessment, which must include echocardiography and a specialist assessment. The underlying cardiac abnormality should be identified. An ECG is often very useful and if it is completely normal it makes heart failure less likely.

Both the NICE and the ESC guidance emphasise the importance of lifestyle management (regular appropriate exercise, avoiding excessive salt and alcohol consumption). ACE inhibitors (or angiotensin receptor blockers) and beta-blockers licensed for heart failure (carvedilol, bisoprolol, nebivolol) remain the mainstay of treatment in addition to as small a dose of diuretic as possible to control any fluid retention. Aldosterone antagonism is recommended by the 2012 ESC guidance for all patients who remain symptomatic despite an ACE inhibitor and beta-blocker. If the rhythm is sinus but the heart rate is $\geq$ 75 beats per minute, therapy needs to be optimised, perhaps by increasing the beta-blocker dose, if possible, or by the addition of ivabradine.

For patients with heart failure, no significant valve disease, and normal systolic function (previously termed diastolic heart failure) the treatment options remain disappointing. Symptomatic relief can be obtained by judicious use of diuretics, ACE inhibitors, and perhaps beta-blockers if the heart rate is fast. Treatment of comorbidities such as hypertension, obesity, diabetes and atrial fibrillation is also vital.

All patients with heart failure require monitoring. This should include: clinical assessment of functional capacity, fluid status, cardiac rhythm and rate, cognitive status and nutritional status; a review of medication, and serum urea, electrolytes, creatinine and estimated glomerular filtration rate.

The high-risk period for any patient is after discharge from hospital, and good communication between the patient, carers, and all healthcare professionals is essential. Discharge should only occur once the patient has stabilised, with the primary care team aware of the management plan, and with clear instructions to the patient and family about how to access advice.