key points

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Heart failure affects nearly one million people in the UK. Half of these patients have normal, or near normal, left ventricular ejection fraction and are classified as heart failure with preserved ejection fraction (HFpEF).

Newer imaging techniques have confirmed that systolic function in HFpEF patients is not completely normal, with reduced long axis function and extensive but subtle changes on exercise. Patients are likely to be older women with a history of hypertension. Other cardiovascular risk factors, such as diabetes mellitus, atrial fibrillation and coronary artery disease are prevalent in the HFpEF population.

Clinical symptoms and signs in HFpEF are often nonspecific although the primary symptoms are breathlessness, fatigue and fluid retention. Fluid overload can result in weight gain, peripheral oedema, or swelling of the ankles and legs, as well as abdominal congestion.

Depression is common in heart failure, with a prevalence of 20-40%. Patients with heart failure and depression have been found to have increased morbidity and mortality with impaired quality of life when compared with heart failure patients without depression. Identifying and treating depression is important in these patients.

There is still no single diagnostic test for HFpEF and the cornerstone in the assessment remains a thorough medical history and physical examination. The duration and extent of the symptoms are relevant and it is useful to classify patients according to the NYHA functional assessment. Rapid weight gain is suggestive of fluid overload, whereas anorexia, weight loss and early satiety suggest cardiac cachexia that is associated with an adverse prognosis.

Physical examination should include the patient's BMI and weight, heart rate and rhythm, lying and standing blood pressure and auscultation to rule out valvular disease and pulmonary congestion. Estimating the jugular venous pressure and the presence of peripheral oedema allows assessment of the patient's volume status.

Patients with heart failure should be referred to heart failure nurses and have follow-up with local cardiology services as these have both been shown to reduce mortality. Breathlessness and fluid overload should be managed with diuretics, heart rate controlled and myocardial ischaemia and hypertension treated. Loop diuretics and thiazides are effective for the rapid relief of symptoms and may improve quality of life, although they do not reduce morbidity or mortality. There is some evidence that thiazide diuretics may reduce morbidity and mortality in older hypertensive patients.