

All four pillars of GDMT should be started together, not sequentially, and up-titrated rapidly. Suspect HF from breathlessness, fatigue or fluid overload; confirm with NT-proBNP/BNP and echocardiography; classify by ejection fraction to guide therapy.

RECOGNISING & CONFIRMING HF

- Breathlessness, fatigue, reduced exercise tolerance, or fluid overload (peripheral oedema, raised JVP, weight gain) — ask about orthopnoea and paroxysmal nocturnal dyspnoea
- Risk factors: ischaemic heart disease, hypertension, diabetes, valvular disease, atrial fibrillation, or prior cardiotoxic chemotherapy
- NT-proBNP <125pg/mL or BNP <35pg/mL in the non-acute outpatient setting makes HF unlikely; higher levels warrant echocardiography. NT-proBNP is now MBS-rebatable for non-hospital HF exclusion — confirm at mbsonline.gov.au
- Echocardiography confirms the diagnosis and measures ejection fraction (EF) to classify: HFrEF (EF≤40%), HFmrEF (EF41–49%), HFpEF (EF≥50%)
- Baseline work-up: FBC and iron studies, renal function and electrolytes, LFTs, TSH, glucose/HbA1c, lipids, and ECG

FOUNDATION THERAPY

- Loop diuretics relieve congestion and are titrated to euvolaemia — they treat symptoms but aren't one of the four pillars themselves
- IV iron is now more strongly recommended if iron-deficient (ferritin<100microg/L or transferrin saturation<20%), even without anaemia
- Lifestyle: individualised fluid intake (typically 1.5–2L/day) and reduced salt, influenza/pneumococcal vaccination, and exercise as tolerated

SAFETY

- Don't start an MRA if potassium >5.0mmol/L or eGFR<30 without specialist input; recheck U&E 1–2 weeks after starting or up-titrating
- An ARNI needs a 36-hour washout from an ACE inhibitor before starting, to reduce angioedema risk
- SGLT2 inhibitors can cause euglycaemic ketoacidosis — counsel on sick-day pausing and on ketone-related symptoms

THE FOUR PILLARS OF GDMT

Start together — not sequentially — and up-titrate rapidly, per the iCARDIO Alliance 2025 guidelines.

- 1 ARNI/ACEi/ARB:** an ARNI (sacubitril/valsartan) is preferred where accessible; an ACE inhibitor or ARB if an ARNI isn't suitable
- 2 Beta-blocker:** bisoprolol, carvedilol, metoprolol XR or nebivolol — start low and up-titrate as tolerated
- 3 MRA:** spironolactone or eplerenone — monitor potassium and renal function after starting and with dose changes
- 4 SGLT2 inhibitor:** dapagliflozin or empagliflozin — PBS-listed across all EF ranges, including HFpEF

FINERENONE: TGA YES, PBS NOT YET

TGA-approved for HFmrEF/HFpEF (LVEF≥40%) based on FINEARTS-HF, but as at mid-2026 finerenone is PBS-listed only for chronic kidney disease in type 2 diabetes — not yet for heart failure. Confirm current PBS status at pbs.gov.au before assuming subsidised access; spironolactone remains the PBS-funded MRA option for HFpEF in the meantime.

RED FLAGS / REFER

- New diagnosis of HFrEF → cardiology referral for confirmation and GDMT initiation/optimisation
- NYHA III–IV despite optimised four-pillar therapy → consider device therapy (ICD/CRT) or advanced HF referral
- Diagnostic uncertainty, or HFmrEF with atypical features → echocardiography review and cardiology opinion