Heart Failure — Practical Care & Monitoring

Phenotype, sick-day rules and referral triggers

CLINICAL PATHWAY

Phenotype shapes treatment and funding. All three ejection-fraction groups now benefit from an SGLT2 inhibitor, but ARNI/MRA evidence is strongest in HFrEF. Self-monitoring and sick-day rules are what keep patients out of hospital.

HFrEF vs HFmrEF vs HFpEF

- **HFrEF (EF≤40%):** the four pillars all apply with strong trial evidence — the most extensively studied phenotype
- **HFmrEF (EF41–49%):** SGLT2 inhibitors strongly supported; ARNI, MRA and beta-blocker are reasonable but with less robust evidence than HFrEF; finerenone is emerging (TGA-approved, not yet PBS-funded for HF — see CV-02A)
- **HFpEF (EF≥50%):** an SGLT2 inhibitor is now PBS-funded and a cornerstone of treatment; finerenone is emerging with the same funding caveat; GLP-1 receptor agonists (e.g. semaglutide) are increasingly used where obesity coexists, per STEP-HFpEF/SUMMIT evidence; diuretics treat congestion

NYHA CLASS & BIOMARKERS

- **NYHA I:** no symptoms with ordinary activity
- **NYHA II:** mild symptoms with ordinary activity; comfortable at rest
- **NYHA III:** marked limitation — symptoms with less-than-ordinary activity
- **NYHA IV:** symptoms at rest, or with any activity
- NT-proBNP <125pg/mL or BNP <35pg/mL (non-acute outpatient setting) makes HF unlikely; higher levels warrant echocardiography

SICK DAY RULES

- Daily weight, same scale and time of day — a gain of 2kg or more over 2–3 days needs prompt medical contact
- Watch for worsening breathlessness, orthopnoea, or increasing ankle/leg swelling
- If dehydrated (vomiting, diarrhoea, fever, reduced intake): temporarily hold the ACEi/ARB/ARNI, MRA and SGLT2 inhibitor, but continue the beta-blocker unless bradycardic or hypotensive
- Resume held medicines once well, and seek medical advice if unsure when to restart

REFERRAL & PRACTICAL CARE

- New diagnosis of HFrEF — for confirmation and GDMT initiation/optimisation
- NYHA III–IV symptoms despite optimised four-pillar therapy
- EF≤35% on maximised GDMT for more than 3 months — consider ICD/CRT
- Suspected advanced HF or recurrent decompensation admissions — consider transplant/mechanical support referral
- Between visits: annual influenza/pneumococcal vaccination, HF nurse or cardiac rehabilitation referral where available, and coordinate care under a chronic disease management plan (confirm item numbers at mbsonline.gov.au)

■ SAFETY

- A weight gain of 2kg or more over 2–3 days needs same-day medical contact, not the next routine review
- Continue the beta-blocker during intercurrent illness unless the patient is bradycardic or hypotensive — stopping it abruptly can precipitate decompensation
- Don't ignore a new murmur, resting tachycardia or hypotension in a known HF patient — reassess promptly

■ RED FLAGS / REFER

- New diagnosis of HFrEF → cardiology referral for confirmation and GDMT initiation
- NYHA III–IV despite optimised therapy, or EF≤35% on maximised GDMT for >3 months → consider device therapy (ICD/CRT)
- Suspected advanced HF or recurrent decompensation admissions → transplant/mechanical support referral