Consider Nuances to Optimize Acute and Chronic Heart Failure Treatment

You'll see new focus on fine-tuning diuresis and discharge meds in acute heart failure...due to guidance from the Am College of Cardiology.

Continue to start IV furosemide at 1 to 2.5 times the TOTAL DAILY oral home dose. Divide the total IV dose in half and schedule BID...even if your patient takes a loop diuretic once daily at home.

But this is a wide range. Choose your starting point based on the patient's adherence, BP, renal function...and symptom severity.

Keep in mind, monitoring urine output after the first dose is key to ensure you've hit the "diuretic threshold." In general, double the IV dose if urine output is less than 500 mL in 4 to 6 hours.

New guidance notes you can increase to as much as 500 mg/day of IV furosemide. But consider adding other meds when you hit the "ceiling" and aren't getting more diuresis...which is usually before the max.

For more on when to add thiazides or vasodilators...or switch to continuous loop infusions...see our chart, Acute Heart Failure: FAQs.

As congestion resolves, step down to oral diuretics...and use this transition as a cue to tune up discharge meds.

Continue to ensure heart failure patients with reduced ejection fraction (HFrEF) are on an ACEI or ARB...an evidence-based beta-blocker (carvedilol, etc)...and an aldosterone antagonist.

Then try to step up toward target doses before discharge.

Recent data suggest sacubitril/valsartan (Entresto) can be started during a HFrEF admission. But this can be tricky in the real world.

Before switching an ACEI or ARB to Entresto, ensure patients can afford it. Entresto costs about $510/month...and may require a prior auth or high co-pay. Nonadherence outweighs any benefit of switching.

Also consider hypotension risk. Don't start Entresto with unstable BP...systolic BP below 100 mmHg...or if you're still increasing diuretics.

Generally start most hospitalized patients on the lowest Entresto dose...instead of basing it on the previous ACEI or ARB dose. And allow a 36-hour washout if switching from an ACEI...due to risk of angioedema.

Order postdischarge lab monitoring if doses or meds are adjusted. And include med titration plans for the patient's primary care prescriber.

Key References:
- JACC Heart Fail 2019;7(1):1-12
- Pharmacotherapy 2018;38(4):406-16

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