Heart Failure

Introduction

SIGN defines Heart Failure (HF) as a clinical syndrome of symptoms (e.g. breathlessness, fatigue, ankle swelling) and signs (e.g. oedema, crepitations) resulting from structural and/or functional abnormalities which lead to reduced cardiac output or high filling pressures at rest, or with exertional stress[1]. Survival rates after HF diagnosis have shown a modest improvement in recent years. The five-year survival rate is approximately 50%, although the most recent figures that could be found related to 2012[2].

NICE estimates that, on average, a GP will look after 30 patients in their practice with HF and consider HF as a potential new diagnosis for a patient about ten times per year[3].

The number of people living with HF in the UK is set to double by 2040[2]. An ageing population and improved rates of survival after acute coronary syndrome are part of this picture. Currently, 80% of patients with HF are diagnosed during acute hospital admissions[2]. Studies indicate that, in 40% of these patients, symptoms were present in the months prior to admission that might have been identified in primary care[2].

With many advances in treatment in recent years, early detection and management by primary care could lead to significantly improved outcomes for patients. The aims of treatment are to reduce mortality, relieve symptoms, improve exercise tolerance, and reduce the incidence of acute exacerbations.

It is estimated that there are 400,000 patients in the UK living with undiagnosed HF. Public health campaigns, as well as increased use of NT-proBNP blood testing, and early referral for echocardiography with specialist review, aim to reduce this. Approximately 40% of these cases will be due to HF with preserved ejection fraction (HF**p**EF) where ischaemic heart disease is not implicated at all. A significant percentage may be caused by age-related valvular heart disease with a wide range of other conditions causing HF such as cardiomyopathy, myocarditis and toxic damage[2].

Editor's note: Structured feedback from our pilot groups showed that the availability of NT-proBNP varied across NHS boards in Scotland: some allow access to this test for primary care clinicians and others do not. Members may wish to speak to laboratory staff to see if this test is available to them and to consult with medical leaders for their thoughts on this variation.

Module aims:

- how to diagnose HF in primary care
- improve understanding of the staging of HF
- when to refer to secondary care
- increase knowledge of the pharmacological management of HF
- promote awareness of non-drug treatment of HF
- consider the management of patients in the palliative/end-stage of HF