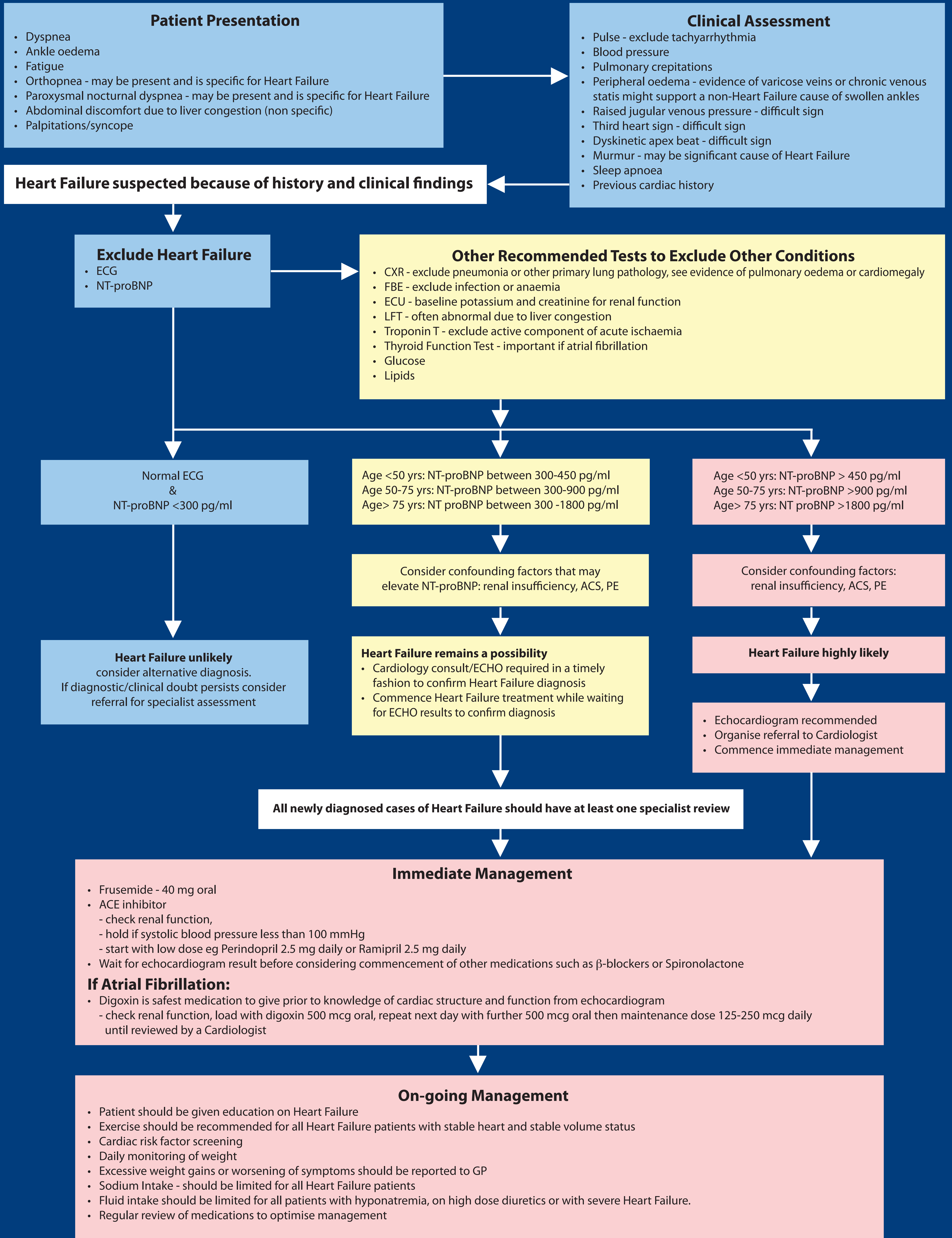




Heart Failure Clinical Presentation Pathway



Patient Presentation

- Dyspnea
- Ankle oedema
- Fatigue
- Orthopnea - may be present and is specific for Heart Failure
- Paroxysmal nocturnal dyspnea - may be present and is specific for Heart Failure
- Abdominal discomfort due to liver congestion (non specific)
- Palpitations/syncope

Clinical Assessment

- Pulse - exclude tachyarrhythmia
- Blood pressure
- Pulmonary crepitations
- Peripheral oedema - evidence of varicose veins or chronic venous stasis might support a non-Heart Failure cause of swollen ankles
- Raised jugular venous pressure - difficult sign
- Third heart sign - difficult sign
- Dyskinetic apex beat - difficult sign
- Murmur - may be significant cause of Heart Failure
- Sleep apnoea
- Previous cardiac history

Heart Failure suspected because of history and clinical findings

Exclude Heart Failure

- ECG
- NT-proBNP

Other Recommended Tests to Exclude Other Conditions

- CXR - exclude pneumonia or other primary lung pathology, see evidence of pulmonary oedema or cardiomegaly
- FBE - exclude infection or anaemia
- ECU - baseline potassium and creatinine for renal function
- LFT - often abnormal due to liver congestion
- Troponin T - exclude active component of acute ischaemia
- Thyroid Function Test - important if atrial fibrillation
- Glucose
- Lipids

Normal ECG & NT-proBNP <300 pg/ml

Heart Failure unlikely
consider alternative diagnosis.
If diagnostic/clinical doubt persists consider referral for specialist assessment

Age <50 yrs: NT-proBNP between 300-450 pg/ml
Age 50-75 yrs: NT-proBNP between 300-900 pg/ml
Age > 75 yrs: NT proBNP between 300 -1800 pg/ml

Consider confounding factors that may elevate NT-proBNP: renal insufficiency, ACS, PE

Heart Failure remains a possibility
• Cardiology consult/ECHO required in a timely fashion to confirm Heart Failure diagnosis
• Commence Heart Failure treatment while waiting for ECHO results to confirm diagnosis

Age <50 yrs: NT-proBNP > 450 pg/ml
Age 50-75 yrs: NT-proBNP >900 pg/ml
Age > 75 yrs: NT proBNP >1800 pg/ml

Consider confounding factors: renal insufficiency, ACS, PE

Heart Failure highly likely

- Echocardiogram recommended
- Organise referral to Cardiologist
- Commence immediate management

All newly diagnosed cases of Heart Failure should have at least one specialist review

Immediate Management

- Frusemide - 40 mg oral
- ACE inhibitor
- check renal function,
- hold if systolic blood pressure less than 100 mmHg
- start with low dose eg Perindopril 2.5 mg daily or Ramipril 2.5 mg daily
- Wait for echocardiogram result before considering commencement of other medications such as β-blockers or Spironolactone

If Atrial Fibrillation:

- Digoxin is safest medication to give prior to knowledge of cardiac structure and function from echocardiogram
- check renal function, load with digoxin 500 mcg oral, repeat next day with further 500 mcg oral then maintenance dose 125-250 mcg daily until reviewed by a Cardiologist

On-going Management

- Patient should be given education on Heart Failure
- Exercise should be recommended for all Heart Failure patients with stable heart and stable volume status
- Cardiac risk factor screening
- Daily monitoring of weight
- Excessive weight gains or worsening of symptoms should be reported to GP
- Sodium Intake - should be limited for all Heart Failure patients
- Fluid intake should be limited for all patients with hyponatremia, on high dose diuretics or with severe Heart Failure.
- Regular review of medications to optimise management