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Released: 09/16/2024
Valid until: 09/15/2025
Time needed to complete: 52m

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Earlier is Better: Identifying and Diagnosing HF Early in Disease Progression

Announcer:
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Dr. McDonough:
Heart failure is a progressive disease. The earlier it's diagnosed and appropriately treated, the better the prognosis. Would you be able to identify a patient in the early stages? This is CME on ReachMD, and I'm Dr. Brian McDonough. Joining me to discuss the early diagnosis of heart failure is Dr. Barry Greenberg, Dr. Neil Skolnik, and Ms. Karina Brown, who is a registered nurse. Dr. Greenberg, Dr. Skolnik, Ms. Brown, welcome to the program.

Ms. Brown:
Thank you for having us.

Dr. Greenberg:
Nice to be here.

Dr. Skolnik:
It’s a pleasure to be here.

Dr. McDonough:
Now, the objective for today's discussion is to define a strategy to identify and diagnose patients with early heart failure using the updated criteria of the ACC/AHA stages. But before we do that, Dr. Skolnik, can you provide a brief overview of heart failure?

Dr. Skolnik:
Brian, it’s my pleasure. This is an incredibly important topic, because it affects 5 million people in the United States with over 500,000 new cases diagnosed per year. It is the leading cause of hospitalization in adults greater than or equal to 65 years of age, and half of those people are actually rehospitalized every 6 months. We know it's a progressive illness, and once symptoms develop and as they get worse, prognosis becomes worse, which is why our early diagnosis is important.

Dr. McDonough:
With that in mind, let's turn to you now, Dr. Greenberg, can you explain the updates to the most recent ACC/AHA stages of heart failure?

Dr. Greenberg:
The staging criteria that were put forth by the ACC/AHA are really helpful in understanding the progressive nature of the disease. And patients get classified as having stage A for heart failure if they've got cardiovascular risk factors. However, they don't have any evidence of structural abnormalities or signs or symptoms of heart failure. They move on to stage B when those risk factors give rise to structural abnormalities within the heart that could be a reduction in ejection fraction, left ventricular hypertrophy, left atrial enlargement,

or they can have evidence of elevated filling pressures, either on heart catheterization or with the use of natriuretic peptides, which are elevated. When patients then progress further and become symptomatic, they're then considered stage C. And then finally, for those patients who continue to advance to end-stage heart failure, they're considered stage D.

Dr. McDonough:
And why is it important to identify patients during the early stages of heart failure, Ms. Brown?

Ms. Brown:
It is important to identify so that we can have a holistic approach and patient-specific interventions as well as tailor their prognosis to their interventions.

Dr. McDonough:
Along similar lines, Dr. Greenberg, why is it important to determine heart failure etiology?

Dr. Greenberg:
Once you determine what the etiology is, there are some management issues that are quite different depending on the etiology. Think of somebody with coronary disease who you might want to think about revascularization in comparison to somebody whose heart failure is related to amyloid disease, which would have an entirely different set of tests and treatments that you would want to put into play. It's also important at that point to identify comorbid conditions, because they so much influence the management of the patients, and then finally recognizing what risk factors are present in the heart failure patients.

Dr. McDonough:
And Dr. Skolnik, what comorbidities and risk factors lead you to more closely monitor a patient for early heart failure?

Dr. Skolnik:
Brian, it's so important to recognize that people with diabetes, people with chronic kidney disease, obesity, hypertension, coronary disease, are all at risk for heart failure When we see people who say are 50 years of age or older and come in saying they're getting a little short of breath with exertion remember, short of breath on usual activities, fits stage C, symptomatic heart failure that Barry was just talking about. So we need to think about even in those people who are not highly symptomatic, if they're fatigued, if they're getting short of breath with walking, and particularly if they have any of these risk factors, to think about doing further testing for heart failure.

Dr. McDonough:
Dr. Greenberg, can you please review the sentinel symptoms of heart failure?

Dr. Greenberg:
Yeah, I think it's important right from the get-go to point out that there's no one single sign or symptom that's pathognomonic of heart failure. And you really need to integrate these together to give you a complete picture, and that can lead to a diagnosis that's very specific for heart failure. But the symptoms that patients develop are due either to congestion, and that's related to excess fluid congestion, think about shortness of breath, peripheral edema, abdominal bloating; or symptoms due to reduced cardiac output, that's the fatigue, the mental grogginess that some of our patients begin to experience.

Dr. McDonough:
Now, as a primary care physician, Dr. Skolnik, you're the first line of identification, so do you use any kind of paradigm to help you in identifying your early heart failure patients?

Dr. Skolnik:
Well, Brian, there is the Heart Failure Association of the European Society of Cardiology paradigm, FIND-HF, heart failure. That's fatigue, increased water accumulation, natriuretic peptide testing, dyspnea. But to be honest with you, I think that there are two different presentations. There's the presentation (of) that person who's coming in if they're short of breath, they have edema, you listen, they have rales. Then there's the more subtle presentation, which I think is what we're talking about when we talk about early detection of heart failure. And I really think that's that person who, as Barry alluded to, they might be fatigued. The New York Heart Association, stage II classification for stage II heart failure is shortness of breath, dyspnea on usual levels of exertion, meaning, from your office to the car, that's that person who doesn't have rales, they may have a little bit of edema. You need to think about heart failure, and you need to then test for it.

Dr. McDonough:
Ms. Brown, from a nursing perspective, do you have anything you'd like to add here?

Ms. Brown:

Yes. Just quickly, just making sure that we always are also looking at the other contributing factors, such as family history can be a strong indicator as well, as well as their lifestyle factors that can be exacerbating the symptoms.

Dr. McDonough:
So now that we've talked about the sentinel symptoms, let's shift over to diagnostic tools.

Dr. McDonough:
And Dr. Skolnik, what are the initial diagnostic tests that you would perform to confirm heart failure?

Dr. Skolnik:
Brian, this is why it's so easy. Send off an NT-proBNP. Easy. If it's elevated, follow that with an echocardiogram, and it's pretty much going to give you your diagnosis.

Dr. McDonough:
Coming back to you, Dr. Greenberg, any pearls about how to interpret the NT-proBNP and any other testing that you might do?

Dr. Greenberg:
Yeah, I do want to emphasize that the real mainstay of making the diagnosis is the history and physical exam. And after we do that, we go on and look at natriuretic peptides and other more sophisticated tests. The natriuretic peptides are interesting in that they do give you a very good indication whether or not there's an increase in stress on the wall of the left ventricle. But there are a variety of factors that can influence them. For instance, obesity tends to modulate the natriuretic peptide levels, so that they're somewhat lower in obese patients, and they may be elevated when patients have chronic kidney disease or atrial arrhythmias. So I think you need to really look at these levels in the context of what else is going on.

Dr. McDonough:
And that's a great way to round out our discussion on early diagnosis of heart failure. And I want to thank my guests, Dr. Barry Greenberg, Dr. Neil Skolnik, and Ms. Karina Brown. It was great speaking with all of you today.

Dr. Greenberg:
Thank you.

Ms. Brown:
Thank you.

Announcer:
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