Practice Point

Heart Failure: Classification, Diagnosis and Management

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1. Classification and Staging

The ejection fraction categories have been recently reduced from three to two. HFrEF now covers any LVEF below 50%, and HFpEF begins at 50%. The mildly reduced band of 41 to 49% has gone, absorbed into HFrEF on the reasoning that those patients share the pathophysiology of reduced ejection fraction and respond to the same drugs. HFmrEF in a discharge summary is now superseded terminology.

Stage A is risk factors with no cardiac abnormality. Stage B is pre-heart-failure, meaning structural or functional abnormality or raised biomarkers without symptoms. Stage C is symptomatic disease. Stage D is advanced disease. Treatment never moves a patient back a stage. NYHA class is the separate measure, grading current function within Stage C or D, and it shifts week to week.

2. Diagnosis

Measure BNP or NT-proBNP in anyone with unexplained dyspnoea (Class 1). It rules the diagnosis in and out.

- Rule out. Ambulatory, BNP under 35 or NT-proBNP under 125 pg/mL. Decompensated, BNP under 100 or NT-proBNP under 300 pg/mL.
- Rule in, NT-proBNP by age. Above 450 pg/mL under 50 years. Above 900 from 50 to 74. Above 1800 from 75. A broad grey zone sits in between where judgement decides.
- Falsely low. Obesity, flash pulmonary oedema, mitral stenosis, constrictive pericarditis, acute mitral regurgitation, tamponade.
- Falsely high. Atrial fibrillation, renal failure, advancing age, pulmonary embolism, sepsis, acute coronary syndrome.

Baseline work-up: ECG, echocardiography, renal function and electrolytes, full blood count, ferritin and transferrin saturation, thyroid function, and assessment for ischaemia. A predischarge level predicts readmission, and patients whose levels fail to fall on treatment do worse.

3. Foundational Medical Therapy

Treatment is now sorted into three tiers. Foundational medical therapy holds a Class I recommendation for the general heart failure population. Additional medical therapy covers symptom relief and defined subsets. Guideline-directed interventional therapy covers devices and procedures.

Four drug classes make up the foundational tier: an ACE inhibitor, ARNI or ARB, a beta-blocker, a mineralocorticoid receptor antagonist, and an SGLT2 inhibitor. Diuretics relieve congestion and do nothing for survival, which keeps them outside this tier.

The MRA carries the notable change. It now holds a Class I recommendation in chronic heart failure at any ejection fraction, so it applies across the whole spectrum, where it previously stopped at 40%.

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Class	Agents	Status and cautions
ACE-I / ARNI or ARB	ARNI preferred. ACEi or ARB	Class I in HFrEF. Class IIb in HFpEF.
Beta-blocker	Bisoprolol, carvedilol, metoprolol succinate	Class I in HFrEF.
MRA	Spironolactone, eplerenone, finerenone	Class I in chronic HF at any LVEF. Potassium above 5.0 mEq/L needs caution.
SGLT2 inhibitor	Dapagliflozin, empagliflozin	Class I across the LVEF spectrum. Avoid below eGFR 20.

4. Reaching Optimal Doses

Optimal foundational therapy means the highest tolerated dose of each of the four classes. No optimal sequence exists, so all four should reach target or maximally tolerated doses inside three months. Risk of readmission and death peaks in the six weeks after an event, and STRONG-HF showed that starting all four before discharge and up-titrating over four to six weeks lowers both. Prefer low doses of everything over target doses of one or two.

- Review every two weeks. Check creatinine, potassium, blood pressure including a postural reading, and heart rate.
- A creatinine rise up to 20% above baseline is expected and is no reason to stop. Above 2.5 mg/dL, reduce or hold.
- When a dose is not tolerated, halve it instead of abandoning the class.

5. Additional Medical Therapy

- Loop diuretic. Class I for congestion at any ejection fraction. Symptom control, with no survival benefit.
- Semaglutide or tirzepatide (IIa). For preserved ejection fraction with obesity. SUMMIT reported a 38% reduction in cardiovascular death or worsening heart failure with tirzepatide, and STEP-HFpEF improved symptoms and exercise capacity with semaglutide.
- IV iron (IIa). Ferritin below 100 µg/L, or 100 to 300 with transferrin saturation under 20%.
- Ivabradine (IIa). Sinus rhythm, LVEF 35% or below, heart rate above 70 bpm on a maximally tolerated beta-blocker. Roughly 3% report phosphenes.
- Digoxin or digitoxin (IIa). Upgraded in 2026. DIGIT-HF found digitoxin cut death or first heart failure hospitalisation by 18% in advanced HFrEF already on contemporary therapy. Narrow window of 0.5 to 0.9 ng/mL.
- Hydralazine with isosorbide dinitrate (IIa). Patients self-identified as Black, already on optimal therapy. Data alongside an ARNI are insufficient.
- Vaccination (IIa). Influenza, pneumococcal and COVID-19 vaccination across the spectrum.
- Vericiguat (IIb). After a recent worsening event on top of foundational therapy. No benefit in the highest NT-proBNP quartile, above 5314 pg/mL.

6. Heart Failure with Preserved Ejection Fraction

The preserved group is where 2026 moves furthest. An MRA is Class I here as anywhere else, which is a genuine break from the 2022 ESC and 2022 ACC/AHA positions that put MRAs at IIb in this group. SGLT2 inhibitors hold Class I on EMPEROR-Preserved and DELIVER. Semaglutide or tirzepatide reaches IIa where obesity is present, the first time an anti-obesity agent has entered a heart failure guideline on outcome grounds.

ACE inhibitors, ARNI and ARBs stay at IIb in preserved ejection fraction. Treat hypertension to target, manage atrial fibrillation, and use loop diuretics for congestion. Absorbing the old mildly reduced band into HFrEF means patients between 41 and 49% now receive full foundational therapy, where the three-category system gave them weaker recommendations.

7. Guideline-Directed Interventional Therapy

Optimise drugs and reassess ejection fraction first. Among patients with LVEF at or below 35% started on sacubitril-valsartan, 61% had climbed above 35% by twelve months and no longer met the ICD threshold.

- ICD and CRT (Class I). LVEF 35% or below on optimal foundational therapy, NYHA II or III, with expected meaningful survival beyond a year. CRT requires a wide QRS, with the strongest evidence at 150 ms or more with left bundle branch block.
- TEER (Class I). Upgraded in 2026 for secondary mitral regurgitation. COAPT five-year data showed 57.3% all-cause mortality against 67.2% with medical therapy

alone.

- Valve intervention (Class I). SAVR or TAVI for severe aortic stenosis, at any ejection fraction.
- Advanced heart failure. Transplantation and durable mechanical circulatory support, the latter upgraded in 2026. Temporary MCS, kidney replacement therapy and CABG sit at IIa.
- Atrial fibrillation (IIa). AF ablation, or AV node ablation with pacing where rate control fails.