Les noves guies d'Insuficiència Cardíaca de la ESC-HFA 2016 a debat

Recomanacions en el Tractament Farmacològic de la Insuficiència Cardíaca Crònica

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Classes of recommendations	Definition	Suggested wording to use
Class I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	Is recommended/is indicated
Class II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.	
Class IIa	*Weight of evidence/opinion is in favour of usefulness/efficacy.*	Should be considered
Class IIb	*Usefulness/efficacy is less well established by evidence/opinion.*	May be considered
Class III	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.	Is not recommended

Level of evidence A	Data derived from multiple randomized clinical trials or meta-analyses.
Level of evidence B	Data derived from a single randomized clinical trial or large non-randomized studies.
Level of evidence C	Consensus of opinion of the experts and/or small studies, retrospective studies, registries.

Definicions d´Insuficiència cardíaca

(ESC Guidelines 2016)

Table 3.1 Definition of heart failure with preserved (HFpEF), mid-range (HFmrEF) and reduced ejection fraction (HFrEF)

Type of HF		HFrEF	HFmrEF	HFpEF
CRITERIA	1	Symptoms ± Signs[a]	Symptoms ± Signs[a]	Symptoms ± Signs[a]
	2	LVEF <40%	LVEF 40–49%	LVEF ≥50%
	3	–	1. Elevated levels of natriuretic peptides[b]; 2. At least one additional criterion: a. relevant structural heart disease (LVH and/or LAE), b. diastolic dysfunction (for details see Section 4.3.2).	1. Elevated levels of natriuretic peptides[b]; 2. At least one additional criterion: a. relevant structural heart disease (LVH and/or LAE), b. diastolic dysfunction (for details see Section 4.3.2).

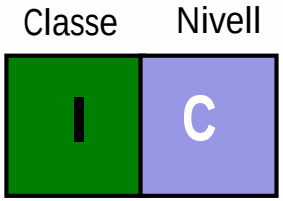
BNP = B-type natriuretic peptide; HF = heart failure; HFmrEF = heart failure with mid-range ejection fraction; HFpEF = heart failure with preserved ejection fraction; HFrEF = heart failure with reduced ejection fraction; LAE = left atrial enlargement; LVEF = left ventricular ejection fraction; LVH = left ventricular hypertrophy; NT-proBNP = N-terminal pro-B type natriuretic peptide.

[a]Signs may not be present in the early stages of HF (especially in HFpEF) and in patients treated with diuretics.

[b]BNP> 35 pg/ml and/or NT-proBNP>125 pg/mL.

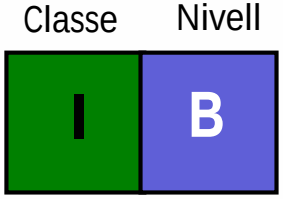
Ponikowski P, et al. Eur Heart J. 2016; 37(27): 2.129-2.200

Recomanacions pel tractament de pacients amb ICFEp i ICFErm



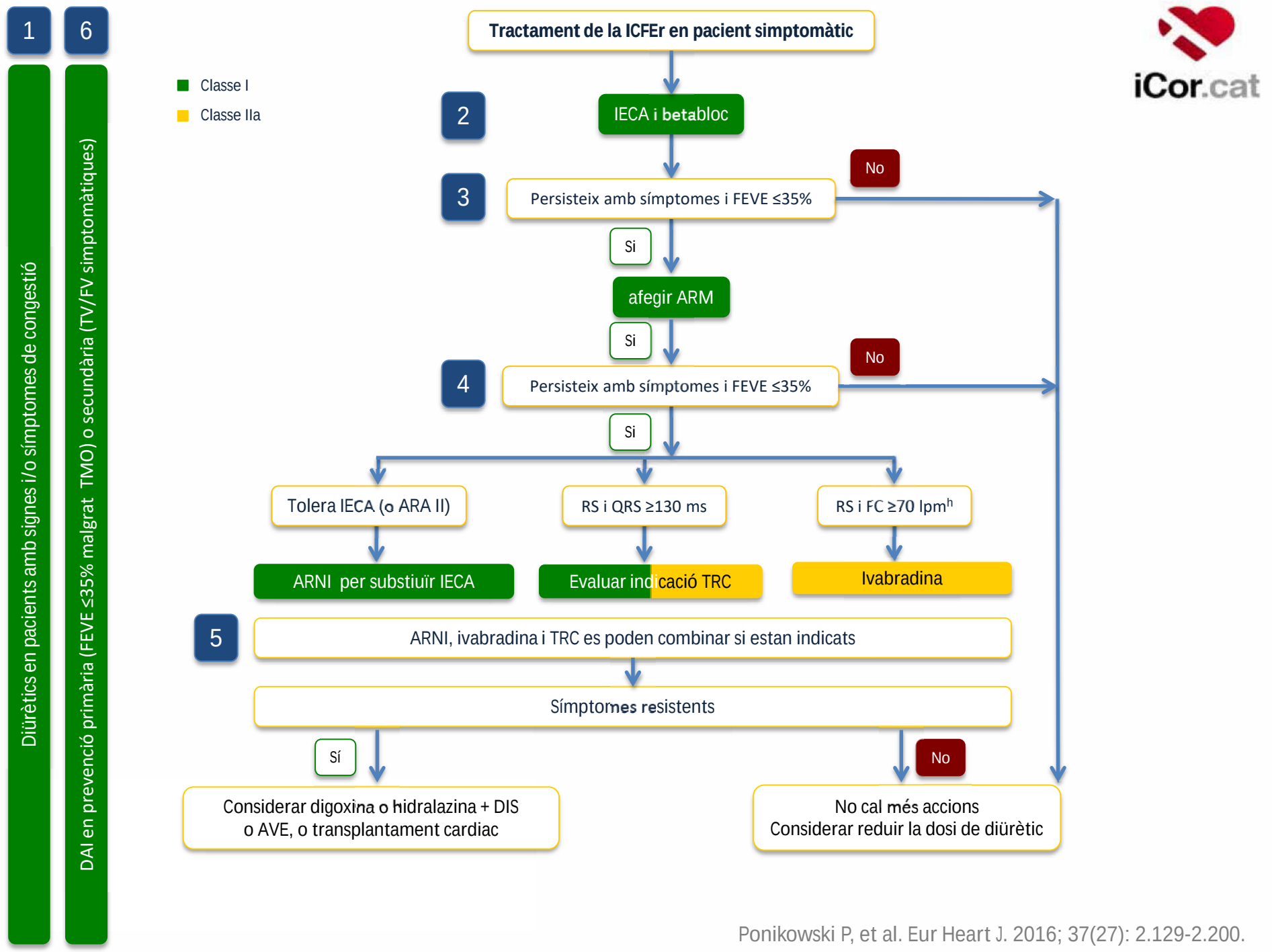
Guia IC ESC 2016

Es recomana avaluar la presencia de **comorbilitats** d'origen CV i no CV, amb la finalitats de tractar-les amb intervencions segures i efectives per a millorar els símptomes, la qualitat de vida i/o el pronòstic



Guia IC ESC 2016

Els **diüètics** es recomanen en pacients congestius amb la finalitat de millorar signes i símptomes.



Ponikowski P, et al. Eur Heart J. 2016; 37(27): 2.129-2.200.

DIÜRÈTICS

Classe	Nivell
I	B

Guia IC ESC 2016

Es recomanen per a millorar els símptomes i la capacitat d'exercici en pacients amb signes i/o símptomes de congestió

Classe	Nivell
IIa	B

Guia IC ESC 2016

S'haurien de considerar per a reduïr el risc d'hospitalització per IC en pacients amb signes i/o símptomes de congestió

Tractament de la ICFEr en pacient simptomàtic

IECA i betabloc

Classe	Nivell
I	A

Guia IC ESC 2016

IECA afegit a betabloc en pacients simptomàtics amb ICFEr

IECA			
Estudi	**Fàrmac**	**Símptomes**	**Resultatats (RRR)**
CONSENSUS N Engl J Med. 1987; 316(23): 1.429-1.435	Enalapril	Severs	Mortalitat 27%
SOLVD N Engl J Med. 1991; 325(5): 293-302	Enalapril	Lleus-moderats	Mortalitat 16% Hospitalització 26%
SOLVD Prevention Trial N Engl J Med. 1992; 327(10): 685-691	Captopril	Assimptomàtics post-IM	Mortalitat/ hospitalització IC 20%
SAVE Pfeffer MA, et al. N Engl J Med. 1992 Sep 3; 327(10): 669-677	Captopril		Mortalitat 26%
AIRE Lancet. 1993; 342(8.875): 821-828	Ramipril		Mortalitat/ hospitalització IC 27%
TRACE Køber L, et al. N Engl J Med. 1995; 333(25): 1.670-1.676	Trandolapril		

Tractament de la ICFEr en pacient simptomàtic

IECA i betabloc

Classe	Nivell
I	A

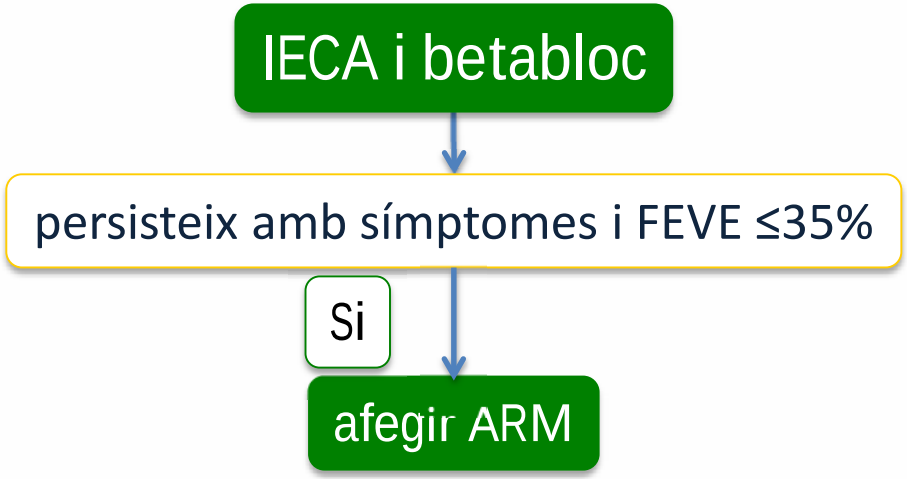
Guia IC ESC 2016

Betabloc afegit a IECA en pacients simptomàtics amb ICFEr

BETABLOCS			
Estudi	**Fàrmac**	**Símptomes**	**Resultats** (RRR – al primer any)
CIBIS II Lancet. 1999; 353(9.146): 9-13	Bisoprolol	Lleus- moderats	Mortalitat 34%
MERIT-HF Lancet. 1999; 353(9.169):2.001-2.007	Metoprolol CR/XL		
COPERNICUS Packer M, et al. Circulation. 2002; 106(17): 2.194-2.199	Carvedilol	Severs	Hospitalització IC 28-36%

>90% pacients prenien IECA o ARA II.

Tractament de la ICFEr en pacient simptomàtic



Classe	Nivell
I	A

Guia IC ESC 2016

ARM en pacients simptomàtics amb ICFEr en tractament amb IECA i betablocs

En cas d'ingrés hospitalari els darrers 6 mesos o nivells de PNs elevats (BNP>250 pg/ml or NTproBNP> 500 pg/ml en homes i 750 pg/ml en dones).

Tractament de la ICFEr en pacient simptomàtic

IECA i betabloc

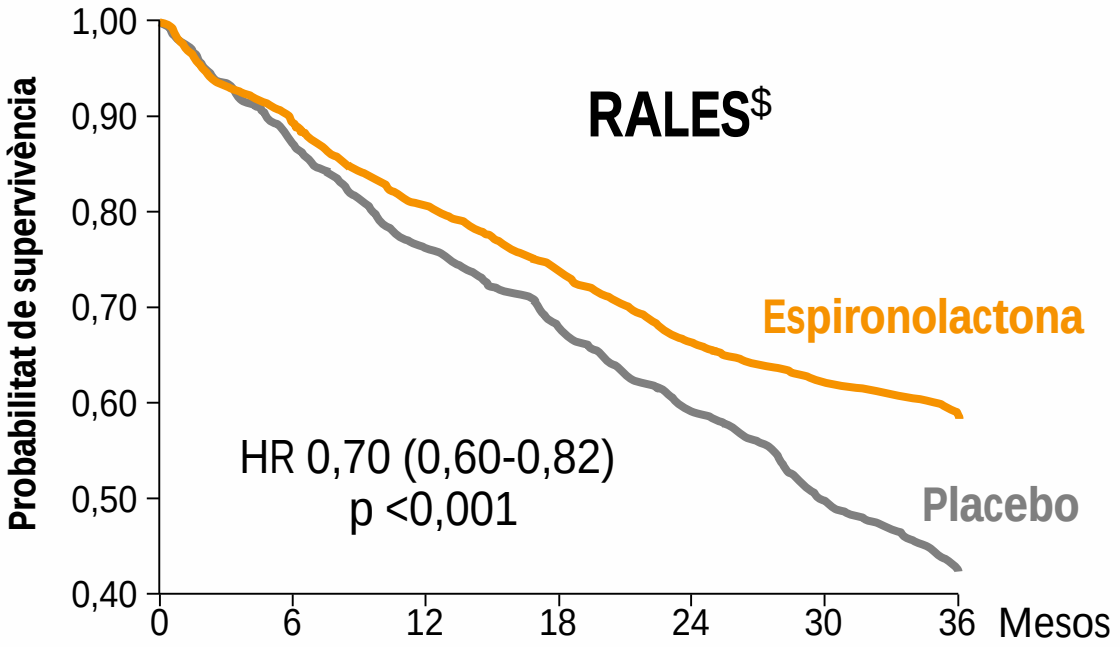
↓

persisteix amb símptomes i FEVE ≤35%

Si

↓

afegir ARM



Adaptada de Pitt B, et al. N Engl J Med. 1999; 341: 709-717.

Tractament de la ICFEr en pacient simptomàtic

IECA i betabloc

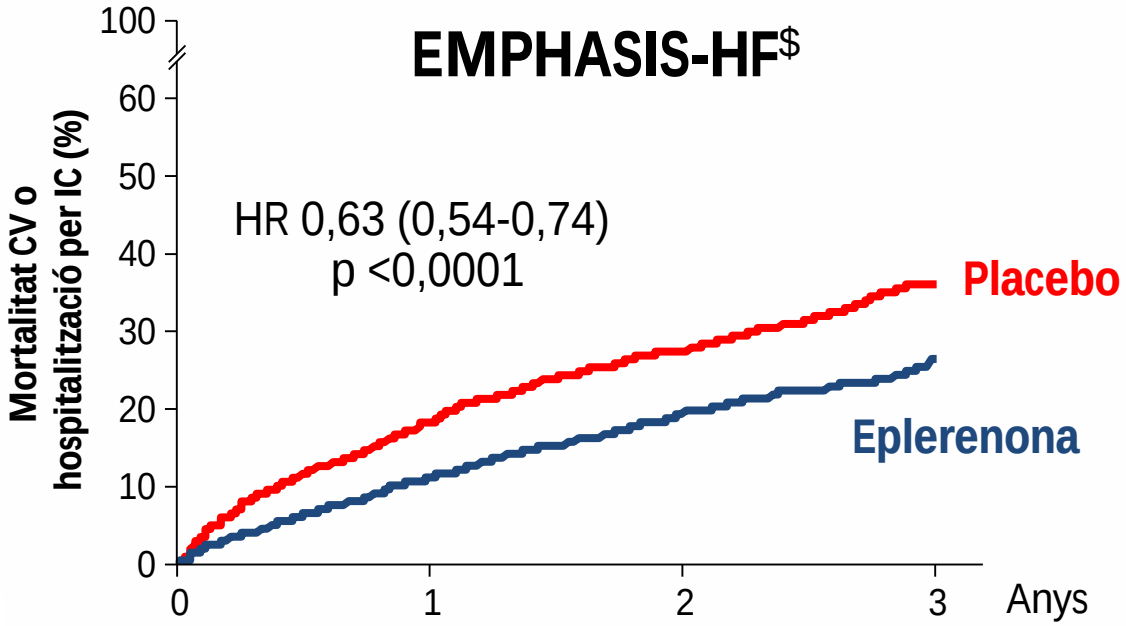
↓

persisteix amb símptomes i FEVE ≤35%

Si

↓

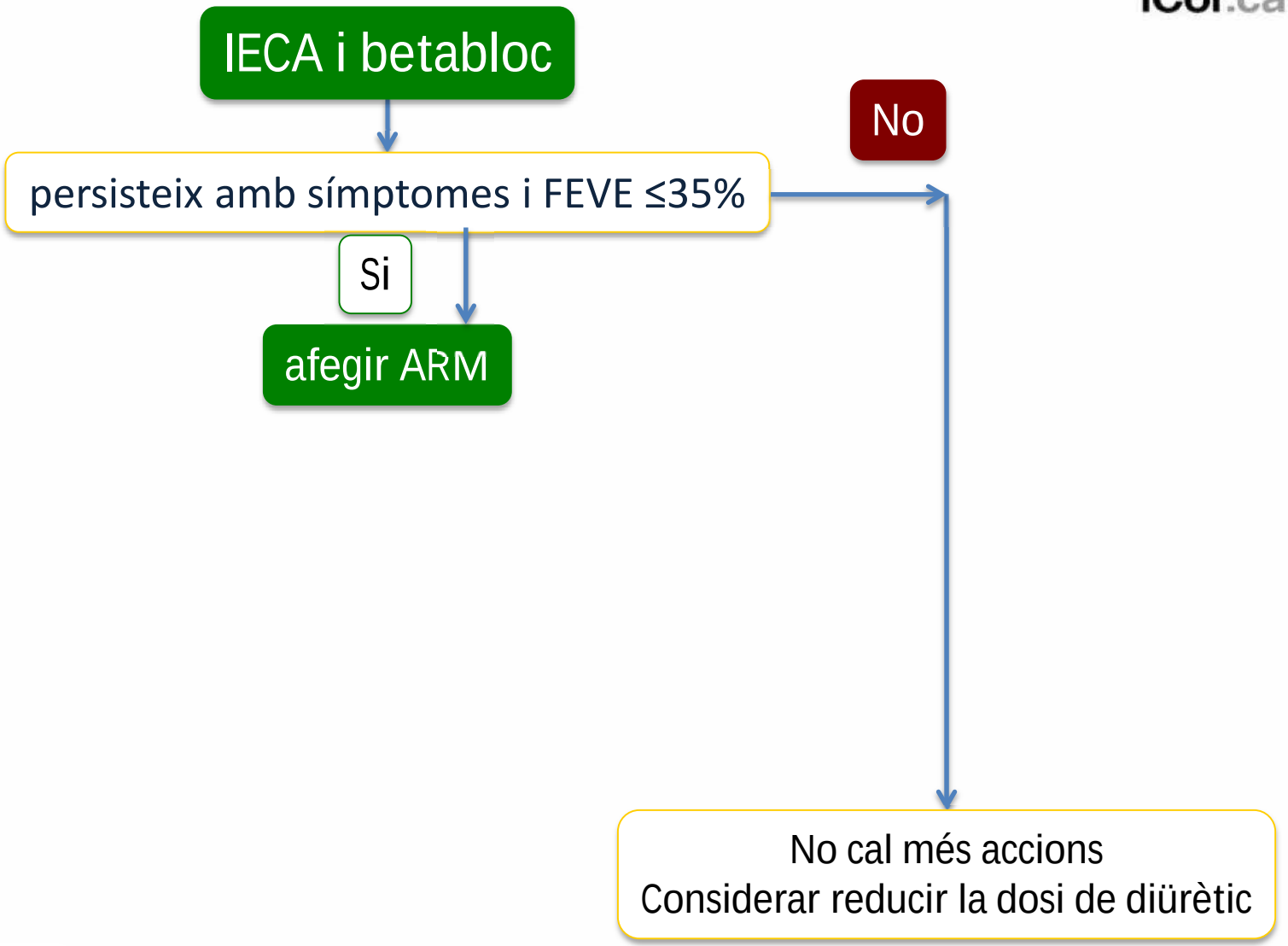
afegir ARM



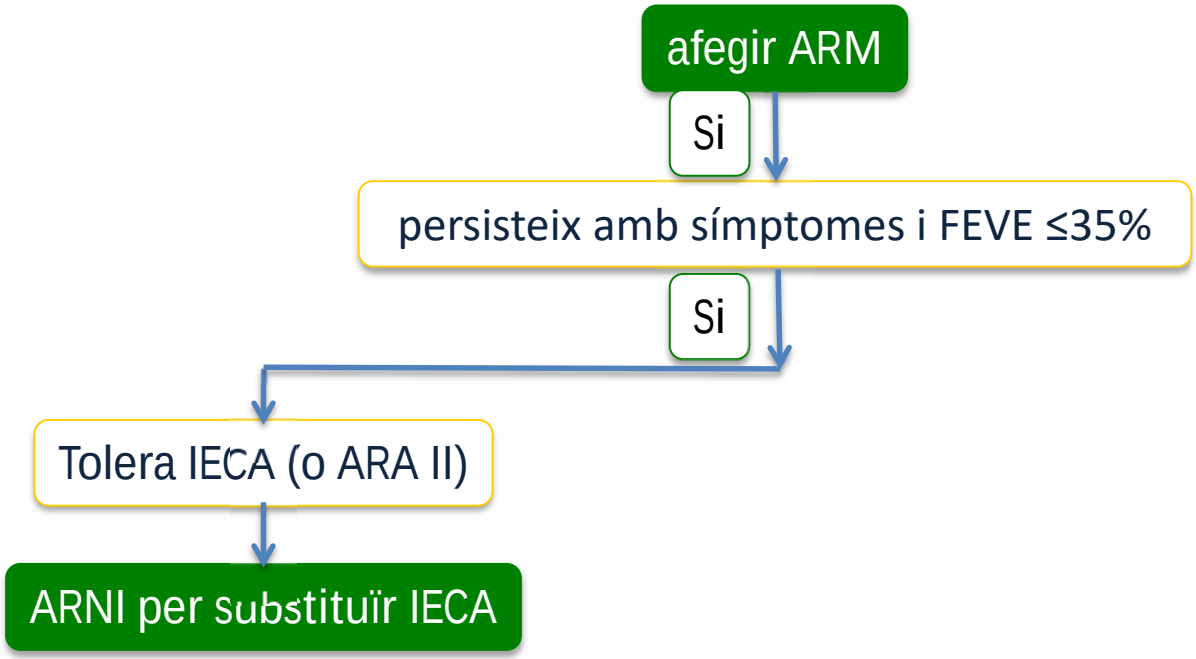
Adaptada de Zannad F, et al. N Engl J Med. 2011; 364: 11-21.

3

Tractament de la ICFEr en pacient simptomàtic



Tractament de la ICFEr en pacient simptomàtic



Classe	Nivell
I	B

Guia IC ESC 2016

Sacubitril/valsartan per substituïr l'IECA en pacients ambulatoris amb símptomes (NYHA≥ II) i ICFEr malgrat TMO amb IECA, betablocs i ARM

Amb nivells elevats de PNs (BNP ≥ 150 pg/mL o NT-proBNP ≥ 600 pg/mL, o en cas d'ingrés per IC els darrers 12 mesos BNP ≥ 100 pg/mL o NT-proBNP ≥ 400 pg/mL

Tractament de la ICFEr en pacient simptomàtic

afegir ARM

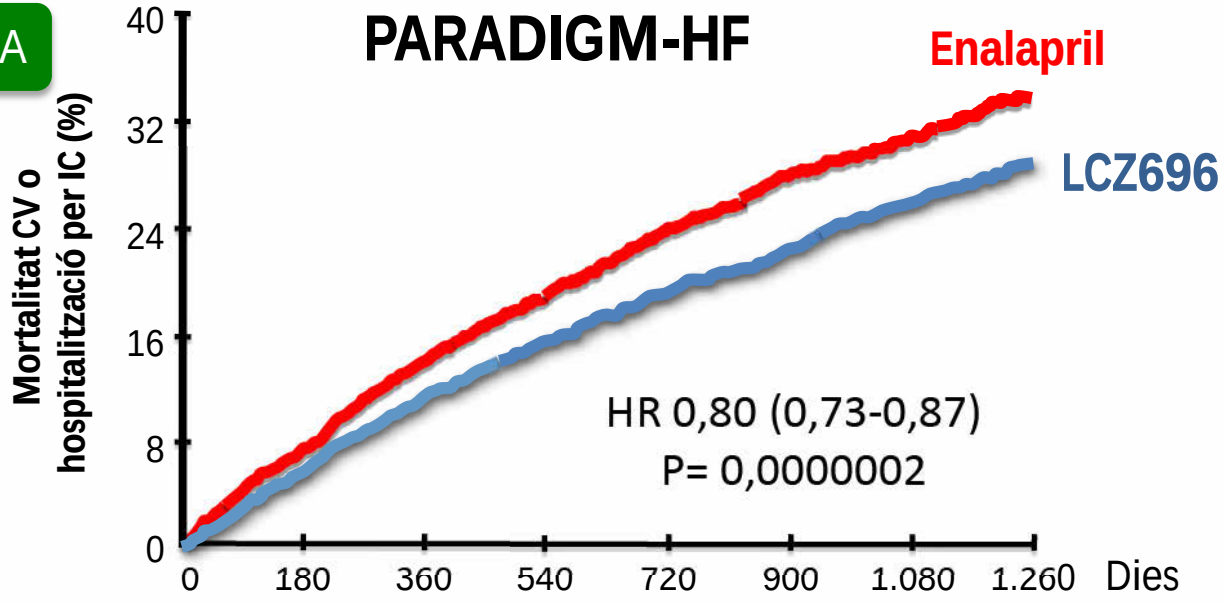
Si

persisteix amb símptomes i FEVE ≤35%

Si

Tolera IECA (o ARA II)

ARNI per substituïr IECA



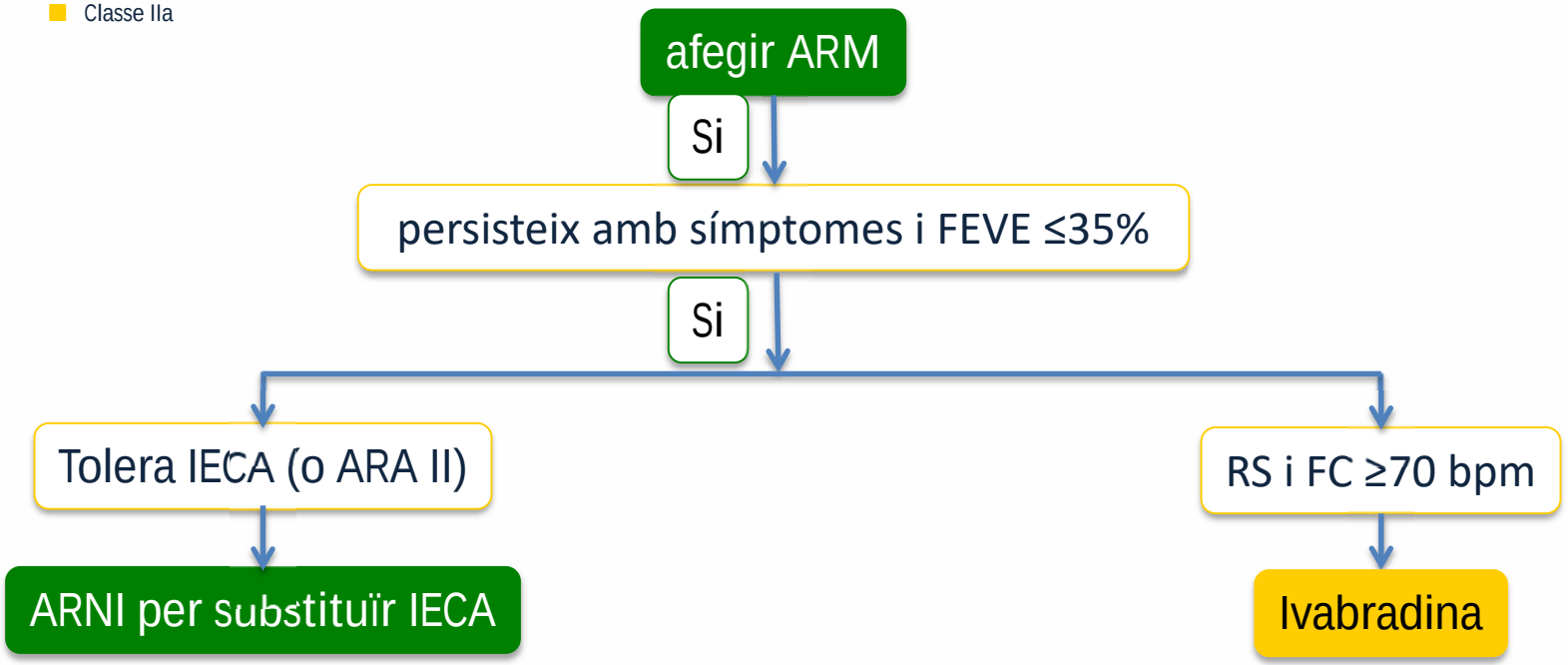
McMurray JJ, et al. N Engl J Med. 2014; 371: 993-1.004.

Recommendations	Class [a]	Level [b]
Potential aggravating/precipitating factors (e.g. low serum potassium/ magnesium, ongoing ischaemia) should be sought and corrected in patients with ventricular arrhythmias.	IIa	C
Treatment with beta-blocker, MRA and sacubitril/valsartan reduces the risk of sudden death and is recommended for patients with HFrEF and ventricular arrhythmias (as for other patients)(see Section 7).	I	A
Implantation of an ICD or CRT-D device is recommended for selected patients with HFrEF (see Section 8).	I	A
Several strategies should be considered to reduce recurrent symptomatic arrhythmias in patients with an ICD (or in those who are not eligible for ICD), including attention to risk factors and optimal pharmacological treatment of HF, amiodarone, catheter ablation and CRT.	IIa	C
Routine use of antiarrhythmic agents is not recommended in patients with HF and asymptomatic ventricular arrhythmias because of safety concerns (worsening HF, proarrhythmia, and death).	III	A

Recomanacions en el maneig de les taquiarrítmies ventriculars a la IC

Tractament de la ICFEr en pacient simptomàtic

Classe I
Classe IIa



Classe	Nivell
IIa	B

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Ivabradina en pacients amb símptomes i FEVE ≤35% en RS amb FC en repos ≥70 bpm malgrat betablocs, IECA (o ARA II) i ARM (o ARA II)

Tractament de la ICFEr en pacient simptomàtic

- Classe I
- Classe IIa

afegir ARM

Si

persisteix amb símptomes i FEVE ≤35%

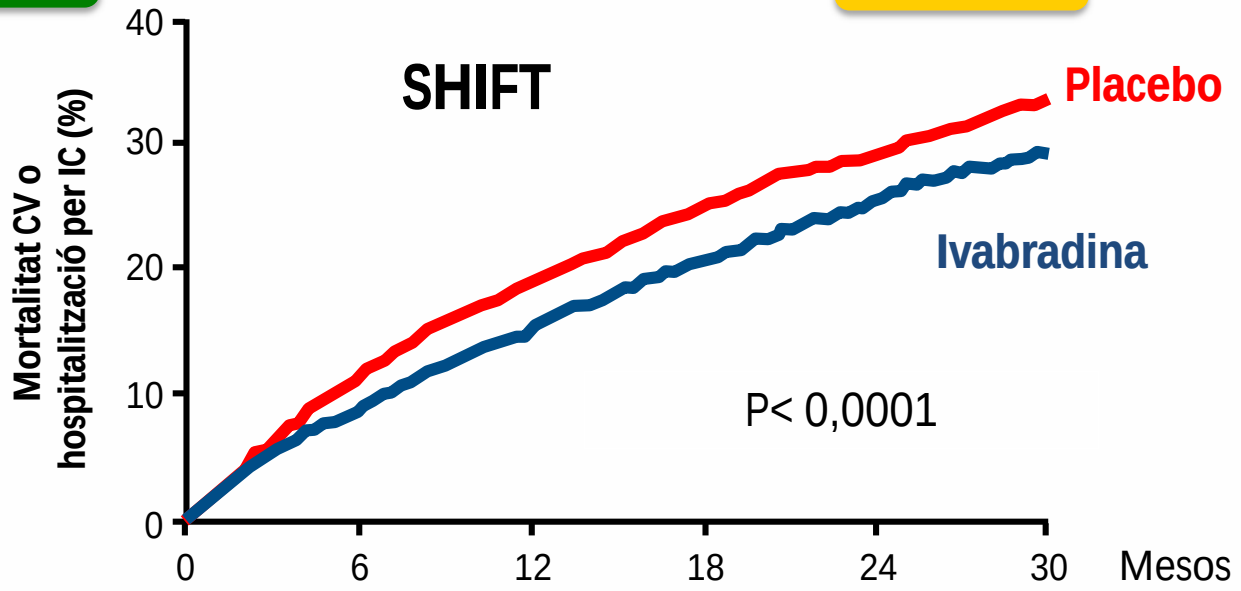
Si

Tolera IECA (o ARA II)

ARNI per substituïr IECA

RS i FC ≥70 bpm

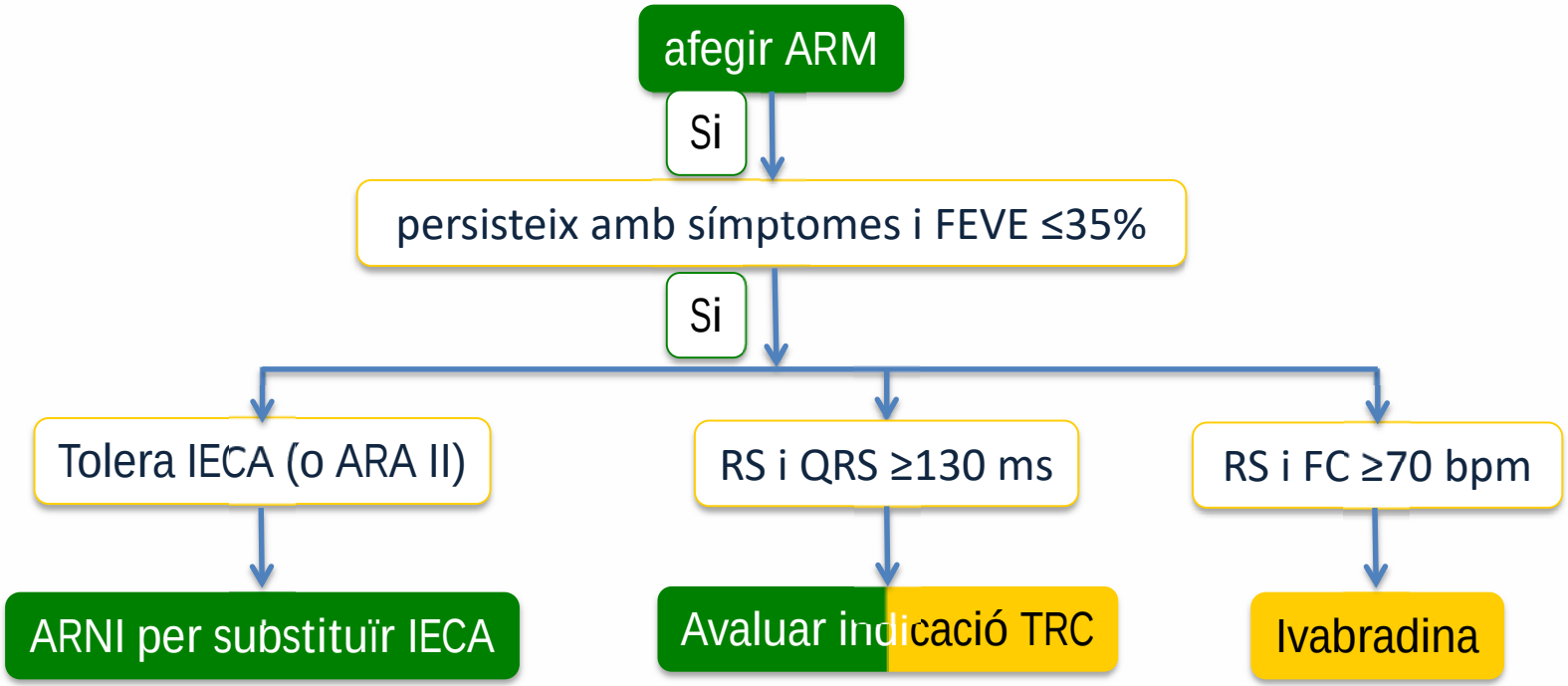
Ivabradina



Swedberg K, et al. Lancet. 2010; 376: 875-885.

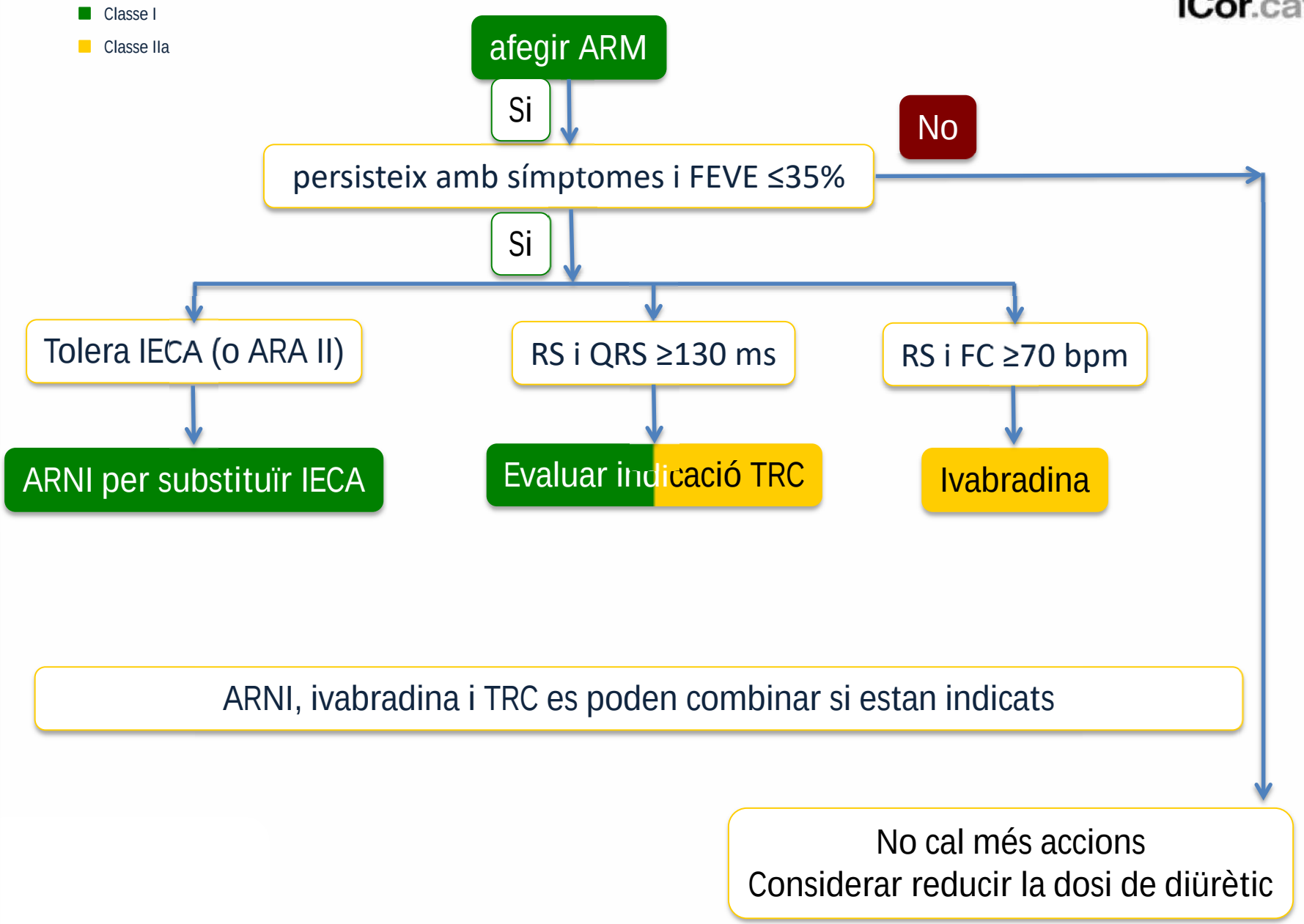
Tractament de la ICFEr en pacient simptomàtic

- Classe I
- Classe IIa



ARNI, ivabradina i TRC es poden combinar si estan indicats

Tractament de la ICFEr en pacient simptomàtic



Tractament de la ICFEr en pacient simptomàtic

ARNI , ivabradina i TRC es poden combinar si estan indicats

Símptomes resistents

Si

Considerar digoxina o hidralazina + DIS o AVE, o transplantament cardíac

No

No cal més accions
Considerar reduir la dosi de diürètic

Recomanacions per el tractament de les co-morbilitats en IC

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Recommendations	Class [a]	Level [b]
Iron deficiency		
Intravenous FCM should be considered in symptomatic patients with HFrEF and iron deficiency (serum ferritin <100 µg/L, or ferritin between 100–299 µg/L and transferrin saturation <20%) in order to alleviate HF symptoms, and improve exercise capacity and quality of life.	IIa	A
Diabetes		
Metformin should be considered as a first-line treatment of glycaemic control in patients with diabetes and HF, unless contra-indicated.	IIa	C

Tractaments NO recomanats en co-morbilitats en IC

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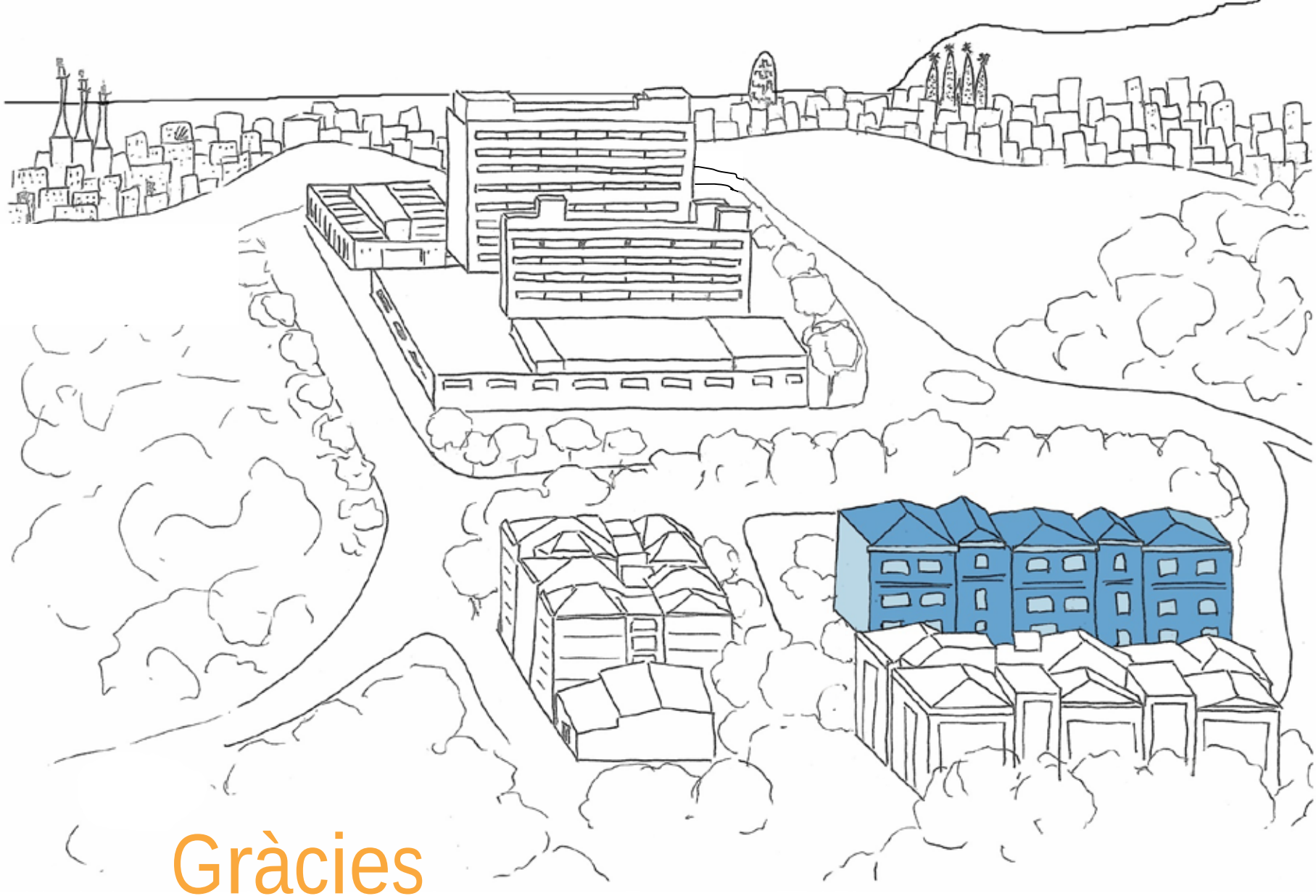
Recommendations	Class [a]	Level [b]	Ref [c]
Sleep apnoea			
Adaptive servo-ventilation is not recommended in patients with HFrEF and a predominant central sleep apnoea because of an increased all-cause and cardiovascular mortality.	III	B	473
Diabetes			
Thiazolidinediones (glitazones) are not recommended in patients with HF, as they increase the risk of HF worsening and HF hospitalization.	III	A	209, 210
Arthritis			
NSAIDs or COX-2 inhibitors are not recommended in patients with HF, as they increase the risk of HF worsening and HF hospitalization.	III	B	211–213



Gràcies

Diürètics en pacients amb signes i/o símptomes de congestió

DAI

DAI

Classe I Nivell A

Guia IC ESC 2016

Prevenció secundària en pacient recuperat d'una arrítmia ventricular (TV/FV) que causa inestabilitat hemodinàmica

Classe I Nivell A

Guia IC ESC 2016

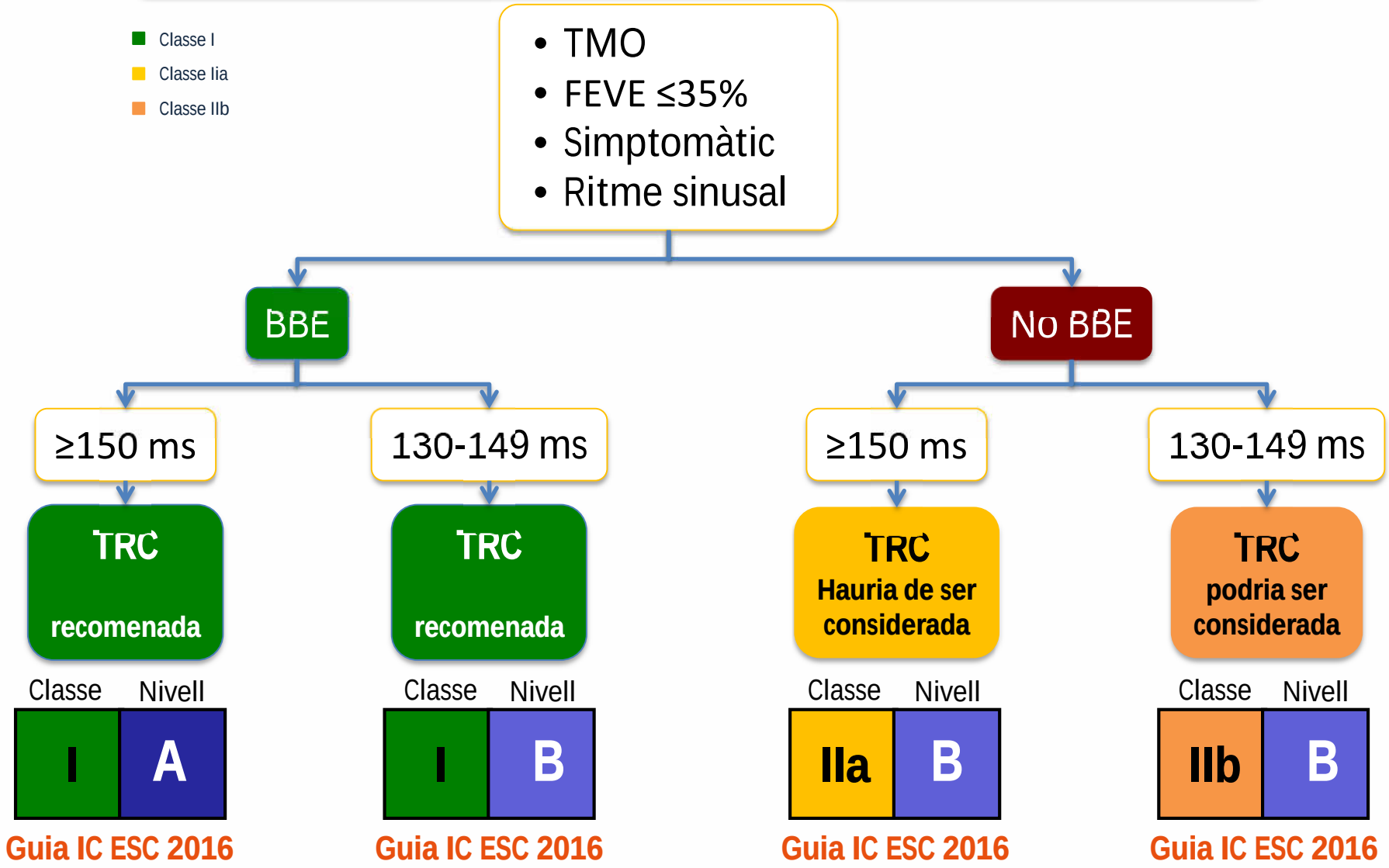
Prevenció primària en pacients amb cardiopatia isquèmica, símptomes de IC (CF II-III de la NYHA) i FEVE ≤35% malgrat ≥3 mesos de TMO

Classe I Nivell B

Guia IC ESC 2016

Prevenció primària en pacients amb miocardiopatia dilatada, símptomes de IC (CF II-III de la NYHA) i FEVE ≤35% malgrat ≥3 mesos de TMO

Terapia de resincronització cardíaca en pacients amb IC crònica



Otros fármacos recomendados en pacientes seleccionados con HFrEF y NYHA II-IV

Recommendations	Class [a]	Level [b]
Diuretics		
Diuretics are recommended in order to improve symptoms and exercise capacity in patients with signs and/or symptoms of congestion.	I	B
Diuretics should be considered to reduce the risk of HF hospitalization in patients with signs and/or symptoms of congestion.	IIa	B
Angiotensin receptor neprilysin inhibitor		
Sacubitril/valsartan is recommended as a replacement for an ACE-I to further reduce the risk of HF hospitalization and death in ambulatory patients with HFrEF who remain symptomatic despite optimal treatment with an ACE-I, a beta-blocker and an MRA[d]	I	B
I*f*-channel inhibitor		
Ivabradine should be considered to reduce the risk of HF hospitalization and cardiovascular death in symptomatic patients with LVEF ≤35%, in sinus rhythm and a resting heart rate ≥70 bpm despite treatment with an evidence-based dose of beta-blocker (or maximum tolerated dose below that), ACE-I (or ARB), and an MRA (or ARB).	IIa	B
Ivabradine should be considered to reduce the risk of HF hospitalization and cardiovascular death in symptomatic patients with LVEF ≤35%, in sinus rhythm and a resting heart rate ≥70 bpm who are unable to tolerate or have contra-indications for a beta-blocker. Patients should also receive an ACE-I (or ARB) and an MRA (or ARB).	IIa	C
ARB		
An ARB is recommended to reduce the risk of HF hospitalization and cardiovascular death in symptomatic patients unable to tolerate an ACE-I (patients should also receive a beta-blocker and an MRA).	I	B
An ARB may be considered to reduce the risk of HF hospitalization and death in patients who are symptomatic despite treatment with a beta-blocker who are unable to tolerate an MRA.	IIb	C