HealthPathways Melbourne

Updates in Heart Failure management for GPs

19 August 2025

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

HealthPathways- Heart Failure

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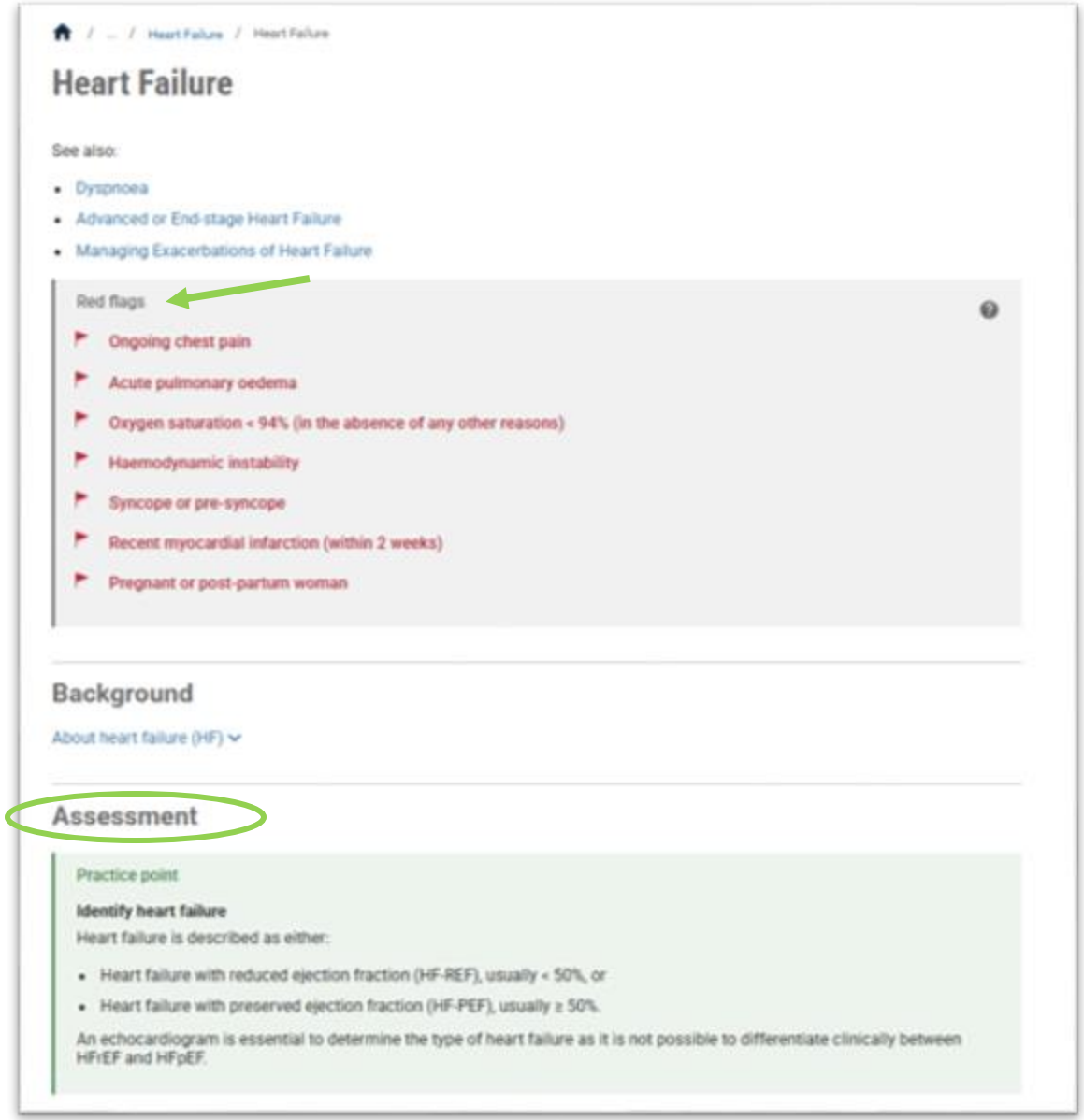


Heart Failure / Heart Failure

Heart Failure

See also:

- Dyspnoea
- Advanced or End-stage Heart Failure
- Managing Exacerbations of Heart Failure

Red flags

- Ongoing chest pain
- Acute pulmonary oedema
- Oxygen saturation < 94% (in the absence of any other reasons)
- Haemodynamic instability
- Syncope or pre-syncope
- Recent myocardial infarction (within 2 weeks)
- Pregnant or post-partum woman

Background

About heart failure (HF)

Assessment

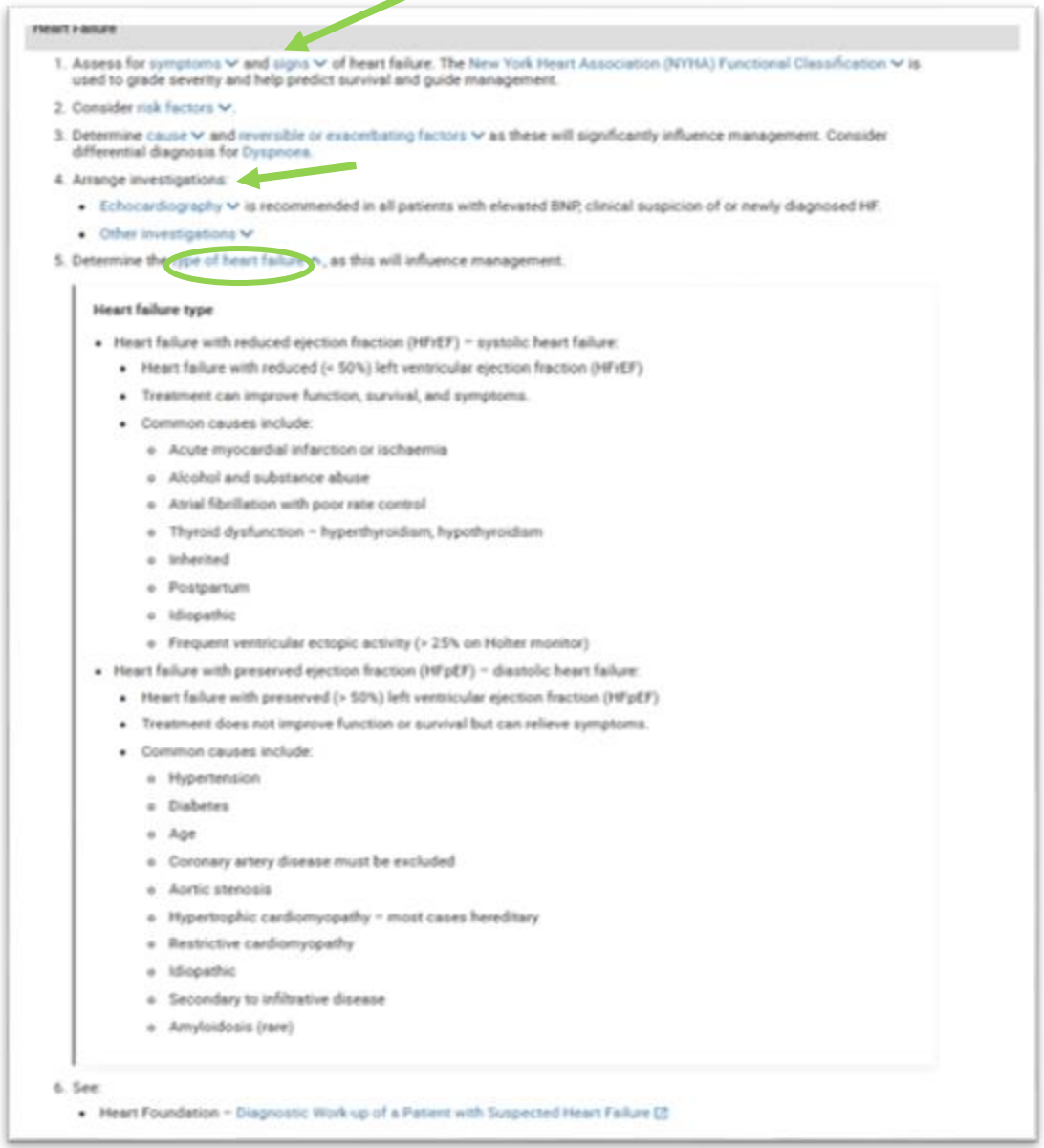
Practice point

Identify heart failure

Heart failure is described as either:

- Heart failure with reduced ejection fraction (HF-REF), usually < 50%, or
- Heart failure with preserved ejection fraction (HF-PEF), usually ≥ 50%.

An echocardiogram is essential to determine the type of heart failure as it is not possible to differentiate clinically between HFrEF and HFpEF.



1. Assess for symptoms and signs of heart failure. The New York Heart Association (NYHA) Functional Classification is used to grade severity and help predict survival and guide management.
2. Consider risk factors.
3. Determine cause and reversible or exacerbating factors as these will significantly influence management. Consider differential diagnosis for Dyspnoea.
4. Arrange investigations:
   - Echocardiography is recommended in all patients with elevated BNP, clinical suspicion of or newly diagnosed HF.
   - Other investigations
5. Determine the type of heart failure, as this will influence management.

Heart failure type

- Heart failure with reduced ejection fraction (HFrEF) – systolic heart failure:
  - Heart failure with reduced (< 50%) left ventricular ejection fraction (HFrEF)
  - Treatment can improve function, survival, and symptoms.
  - Common causes include:
    - Acute myocardial infarction or ischaemia
    - Alcohol and substance abuse
    - Atrial fibrillation with poor rate control
    - Thyroid dysfunction – hyperthyroidism, hypothyroidism
    - Inherited
    - Postpartum
    - Idiopathic
    - Frequent ventricular ectopic activity (> 25% on Holter monitor)
- Heart failure with preserved ejection fraction (HFpEF) – diastolic heart failure:
  - Heart failure with preserved (> 50%) left ventricular ejection fraction (HFpEF)
  - Treatment does not improve function or survival but can relieve symptoms.
  - Common causes include:
    - Hypertension
    - Diabetes
    - Age
    - Coronary artery disease must be excluded
    - Aortic stenosis
    - Hypertrophic cardiomyopathy – most cases hereditary
    - Restrictive cardiomyopathy
    - Idiopathic
    - Secondary to infiltrative disease
    - Amyloidosis (rare)

6. See:
   - Heart Foundation – Diagnostic Work-up of a Patient with Suspected Heart Failure

HealthPathways- Heart Failure

Management

Manage according to heart failure stage and type. Consider Nurse-led self-management support:

Prevention of heart failure

Initial heart failure management

1. If red flags in a patient with suspected heart failure, or new heart failure that has not responded to initial and escalated treatment with diuretic therapy, arrange acute cardiology referral or admission for management.
2. Refer for non-acute cardiology assessment if:
   - known heart failure with symptoms unresponsive to medical management e.g., symptoms at rest, or on minimal exertion.
   - new onset heart failure with reduced ejection fraction < 50% (HF-rEF) and structural or valvular heart disease.
   - new onset heart failure with preserved ejection fraction (HF-pEF) that has failed maximum tolerated diuretic treatment.
3. Consider a cardiology assessment for all patients newly diagnosed with heart failure. These patients may be suitable for advanced treatments, unless they have multiple co-morbidities. The specialist will also manage any heart failure with co-existent or causative valvular disease.
4. If possible, withdraw any medications which can contribute to the heart failure.
5. In the majority of patients with symptomatic heart failure, start a diuretic to reduce fluid overload and review regularly. Aim to establish a goal (dry) weight.
6. Consider starting all hypertensive patients on an ACE inhibitor (ACEI)
7. If unable to tolerate an ACE inhibitor (ACEIs), consider starting an angiotensin 2 receptor antagonists (A2RAs/ARBs). A2RAs/ARBs improve survival in heart failure with reduced ejection fraction.
8. Then manage according to heart failure type:

   Heart failure with reduced ejection fraction (HFrEF) EF < 50% (systolic heart failure)

   Heart failure with preserved ejection fraction (HFpEF) EF > 50% (diastolic heart failure)

See NICE – Chronic Heart Failure: Management.

Ongoing management

Exacerbation management

Management following discharge

ACE inhibitors (ACEI)

- Helps with LV re-modelling.
- Improves morbidity and mortality.
- Start at low dose. Refer to table.
- It is important to titrate to highest tolerated dose over 2 to 3 weeks.

Target doses of ACE inhibitors in heart failure

Medication	Starting dose	Target maintenance dose
Captopril	6.25 mg three times daily	25 mg three times daily
Enalapril	2.5 mg daily	20 mg twice daily
Fosinopril	5 to 10 mg daily	20 mg daily*
Lisinopril	2.5 mg daily	30 mg daily
Perindopril arginine	2.5 mg daily	10 mg daily*
Quinapril	5 mg daily	20 to 40 mg daily
Ramipril	2.5 mg daily	10 mg daily
Trandolapril	1 mg daily	4 mg daily

* No evidence but class effect

- See weekly while titrating and monitor blood pressure, potassium, and creatinine. 25 to 30% rise in creatinine is acceptable.
- If estimated glomerular filtration rate (eGFR) drop is > 30%, consider renal artery stenosis.
- Be cautious if eGFR is < 30.
- Night-time dosing reduces daytime hypotension.
- Risk of first dose hypotension is increased if systolic blood pressure < 90 mmHg.
- Adjust dose for renal impairment and in the elderly.
- Contraindications:
  - Potassium > 5.5 mmol/L
  - Creatinine > 250 micromoles/L
  - Symptomatic hypotension
  - Systolic blood pressure < 80 mm Hg
  - Angioedema
  - Pregnancy

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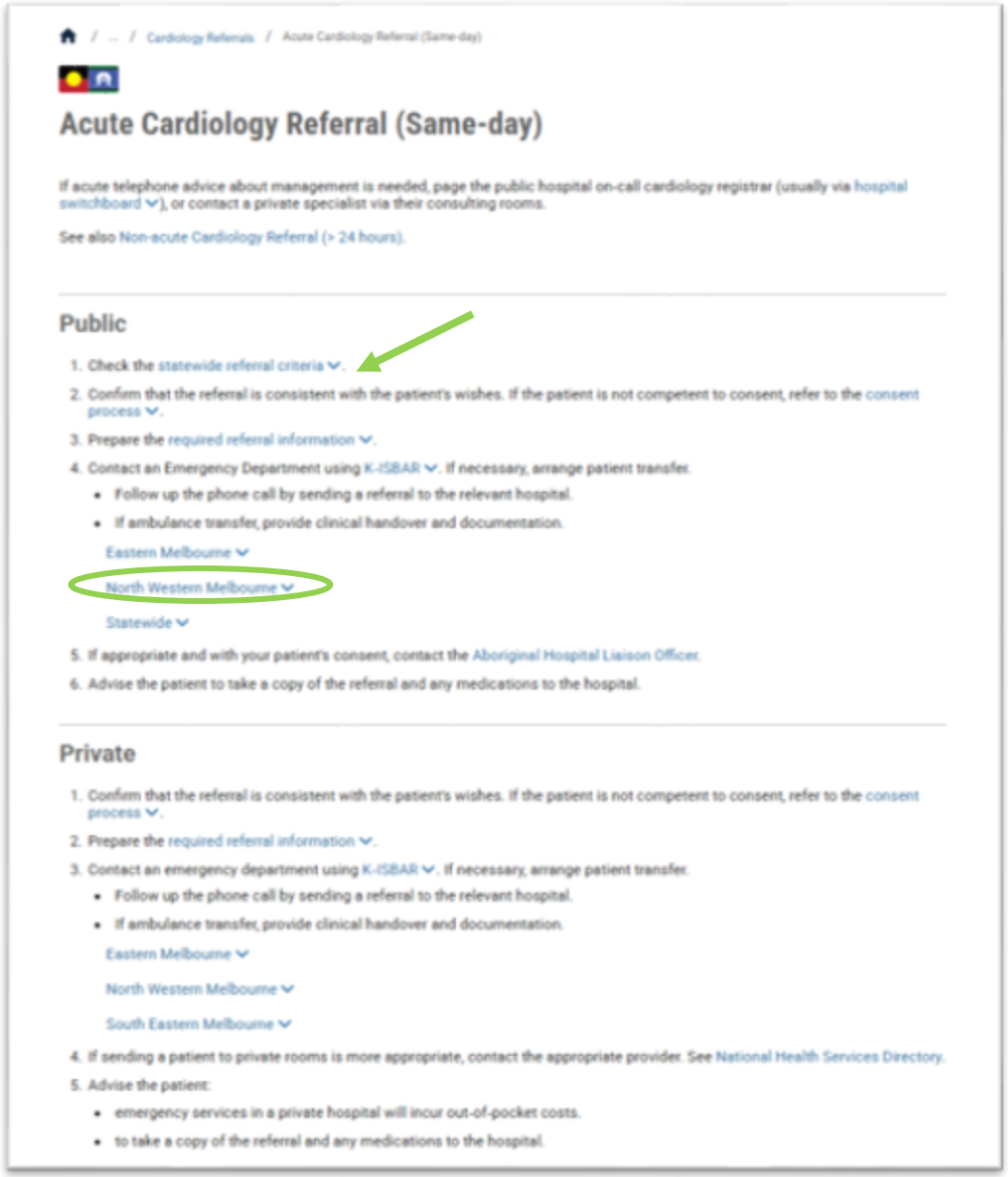


Cardiology Referrals / Acute Cardiology Referral (Same-day)

Acute Cardiology Referral (Same-day)

If acute telephone advice about management is needed, page the public hospital on-call cardiology registrar (usually via hospital switchboard), or contact a private specialist via their consulting rooms.

See also Non-acute Cardiology Referral (> 24 hours).

Public

1. Check the statewide referral criteria.
2. Confirm that the referral is consistent with the patient's wishes. If the patient is not competent to consent, refer to the consent process.
3. Prepare the required referral information.
4. Contact an Emergency Department using K-ISBAR. If necessary, arrange patient transfer.
   - Follow up the phone call by sending a referral to the relevant hospital.
   - If ambulance transfer, provide clinical handover and documentation.

   Eastern Melbourne

   North Western Melbourne

   Statewide
5. If appropriate and with your patient's consent, contact the Aboriginal Hospital Liaison Officer.
6. Advise the patient to take a copy of the referral and any medications to the hospital.

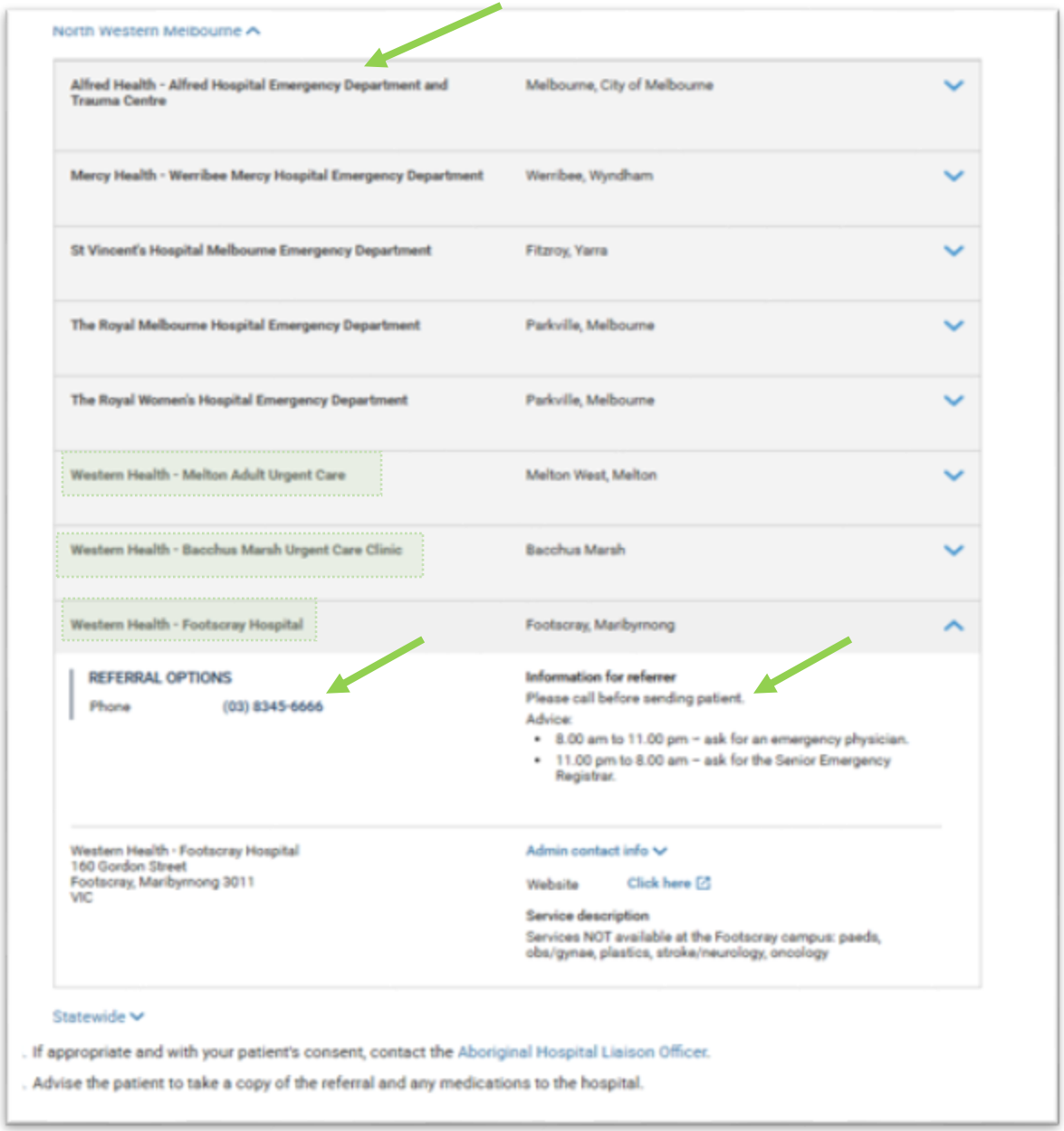
Private

1. Confirm that the referral is consistent with the patient's wishes. If the patient is not competent to consent, refer to the consent process.
2. Prepare the required referral information.
3. Contact an emergency department using K-ISBAR. If necessary, arrange patient transfer.
   - Follow up the phone call by sending a referral to the relevant hospital.
   - If ambulance transfer, provide clinical handover and documentation.

   Eastern Melbourne

   North Western Melbourne

   South Eastern Melbourne
4. If sending a patient to private rooms is more appropriate, contact the appropriate provider. See National Health Services Directory.
5. Advise the patient:
   - emergency services in a private hospital will incur out-of-pocket costs.
   - to take a copy of the referral and any medications to the hospital.



North Western Melbourne

Alfred Health - Alfred Hospital Emergency Department and Trauma Centre	Melbourne, City of Melbourne
Mercy Health - Werribee Mercy Hospital Emergency Department	Werribee, Wyndham
St Vincent's Hospital Melbourne Emergency Department	Fitzroy, Yarra
The Royal Melbourne Hospital Emergency Department	Parkville, Melbourne
The Royal Women's Hospital Emergency Department	Parkville, Melbourne
Western Health - Melton Adult Urgent Care	Melton West, Melton
Western Health - Bacchus Marsh Urgent Care Clinic	Bacchus Marsh
Western Health - Footscray Hospital	Footscray, Maribyrnong

REFERRAL OPTIONS

Phone (03) 8345-6666

Information for referrer

Please call before sending patient.

Advice:

- 8.00 am to 11.00 pm – ask for an emergency physician.
- 11.00 pm to 8.00 am – ask for the Senior Emergency Registrar.

Western Health - Footscray Hospital
160 Gordon Street
Footscray, Maribyrnong 3011
VIC

Admin contact info

Website Click here

Service description

Services NOT available at the Footscray campus: paeds, obs/gynae, plastics, stroke/neurology, oncology

Statewide

. If appropriate and with your patient's consent, contact the Aboriginal Hospital Liaison Officer.

. Advise the patient to take a copy of the referral and any medications to the hospital.

Relevant and Related Pathways

Relevant pathways

Heart Failure

Advanced or End-stage Heart Failure

Managing Exacerbations of Heart Failure

Acute Chest Pain

Related pathways

Atrial Fibrillation (AF)

Cardiac and Heart Failure Rehabilitation

Dyspnoea

Monitoring of Cardiac Drugs

Cardiovascular Disease (CVD) Risk Assessment

Funny Turns

Chronic Condition Management Items

Health Assessments

Cardiology Investigation Referrals

Acute Cardiology Referral (Same-day)

Non-acute Cardiology Referral (> 24 hours)

Cardiac and Heart Failure Rehabilitation

Echocardiography (Echo)

Lipid Disorders Specialist Referral

HIP – Health Independence Program

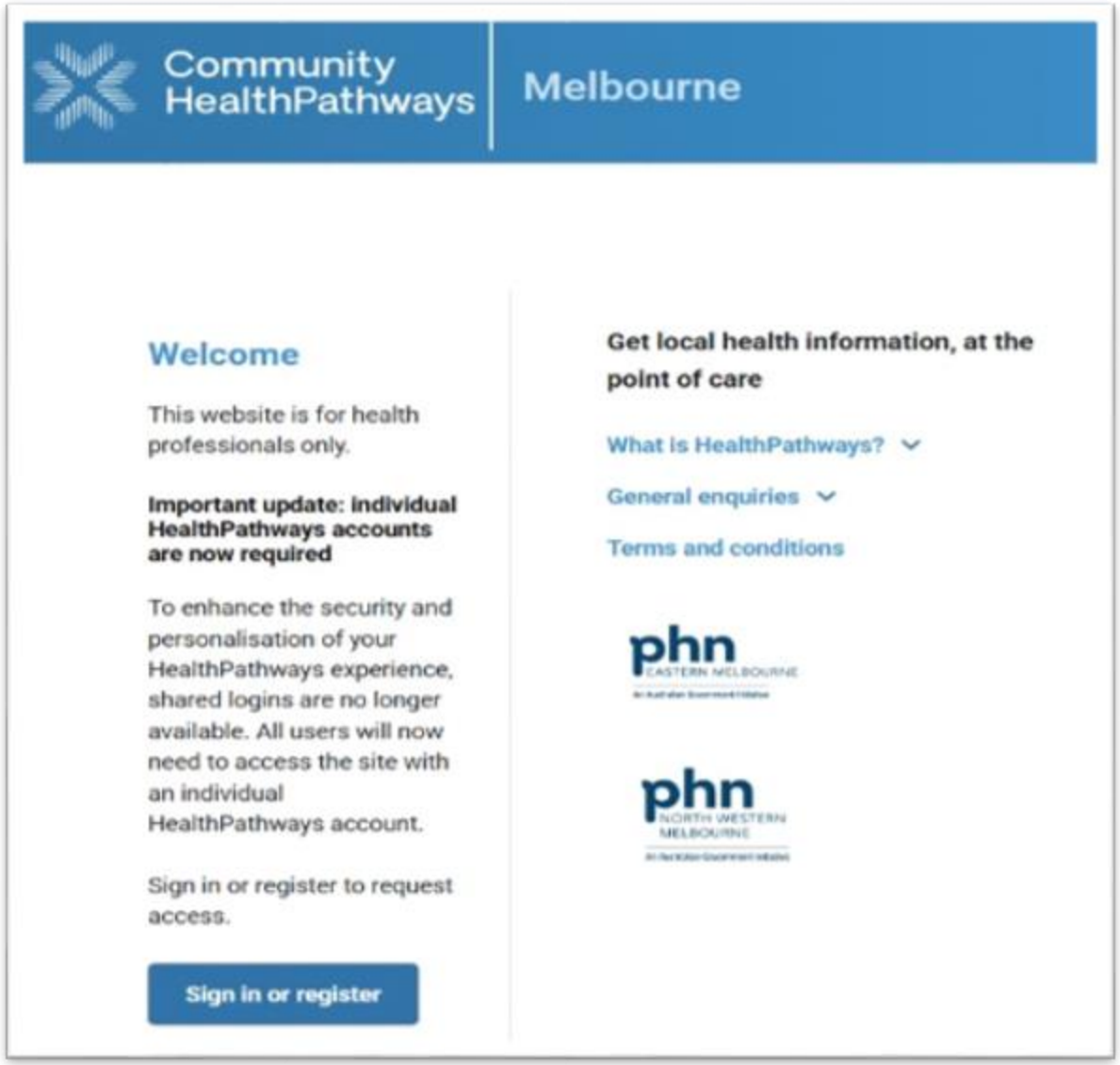
Statewide Referral Criteria for Specialist Clinics

CPD Hours for HealthPathways Use

Accessing HealthPathways

Please click on the **Sign in or register** button to create your individual account or scan the QR code below.

If you have any questions, please email the team info@healthpathwaysmelbourne.org.au



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