NHS Rotherham

Rotherham PCT– Heart Failure Prescribing Guidelines

Overview

The Patient has a diagnosis of heart failure and should be taking;

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Diuretics

- Loop diuretics are the mainstay of heart failure symptom control, although there is no evidence that they have a mortality benefit.
- Furosemide or bumetanide are the drugs of choice. It is rarely necessary to use more than furosemide 80mg daily or bumetanide 2mg daily although there is no recommendation as to the optimum dose.
- The dose should be increased gradually to control symptoms

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ACE Inhibitor

- **The patient should be receiving either Ramipril or Lisinopril ***

* Alternative ACE inhibitors may be occasionally used

- An Angiotensin Receptor Antagonist/Sartan (AR2A) can be used instead of an ACE inhibitor. Candesartan is the only Angiotensin Receptor Antagonist/Sartan (AR2A) licensed for use in heart failure.
- A combination of Hydralazine and Isosorbide dinitrate can be used where use of an ACE inhibitors or Angiotensin Receptor Antagonist/Sartan (AR2A) is contraindicated.

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Beta-Blockers

- **The patient should be receiving Bisoprolol or (Nebivolol if over 70).**

- Occasionally Carvedilol may be used.
- Patients receiving beta-blockers prior to developing heart failure may be left on their original beta blocker

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Essential Risk Reduction

Antiplatelets

- All patients should be taking Aspirin 75mg daily unless contraindicated
- Ensure BP is controlled before initiating aspirin.
- Patients may be taking aspirin + clopidogrel for 12 months post an MI without ST-elevation after which time the clopidogrel should be stopped (See the South Yorkshire clopidogrel guidelines for further details)

Hypertension Management

- Once patients have been stabilise on an ACE-inhibitor + a beta-blocker, ensure BP is controlled. (140/90mmHg, 140/80mmHg if diabetic)
- A thiazide diuretic (Bendroflumethiazide) will act synergistically with the loop diuretics resulting in an excessive diuresis and should be avoided.
- Verapamil, diltiazem and short acting-dihydropyridines such as nifedipine can cause deterioration and should be avoided.
- Doxazosin should also be avoided in heart failure.
- If further anti-hypertensive medication is necessary **amlodipine** would be the most suitable additional agent.

Cholesterol Management

- Treat as secondary prevention and commence simvastatin 40mg daily
- Aim to reduce total cholesterol by 25% or to below 5mmol/l (LDL < 3 mmol\l) which ever is greater

Vaccination

- Pneumococcal + Annual influenza vaccination recommended

Advanced management, following specialist advice

Spironolactone

- For patients with NYHA III heart failure (Marked limitation of symptoms by activity) unless contraindicated by the presence of renal impairment or high potassium.

Digoxin

- Should be considered for patients in sinus rhythm who remain symptomatic after optimum therapy.