CCF○HFrEF

The University of Zambia
School of Public Health ○ Family Medicine MMed Program

C/II-III Symptomatic

- ACE-I
- SGLT-2 inhibitor
- Beta blocker
- Furosemide
- *Spironolactone

D/IV Refractory

- Transplant
- Chronic inotropes
- MechanicalCirculatorySupport
- Experimental interventions
- Palliative care
- ICD deactivation

Inpatient Treatment

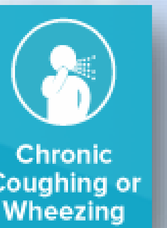
- ○ Diuresis
- ○ Monitor fluid intake & output
- ○ O_2 for saturations ≤ 90%
- ○ Continue home ACEI/BB
- ○ VTE prophylaxis with Klexane
- ○ FBC, RFTs, LFTs, ECG, CXR, POCUS

Diuresis

- ○ Should be ≥ chronic daily dose for overload
- ○ IV furosemide 40mg followed by 80mg in 1 hour if no response
- ○ Oral furosemide 20 - 80mg repeated every 6-8 hours increasing 20-40mg until desired response
- ○ If low blood pressure, consider Dopamine: 2-5mcg/kg/minute IV infusion

Prior to discharge

- ○ Start beta blocker
  Once hemodynamically stable
- ○ Start ACE-I before discharge
- ○ Start spironolactone if EF ≤ 35%
- ○ Lifestyle education
- ○ Schedule follow up within 1 week in OPD



MEDICATION	STARTING	TARGET	AFFECTS	NOTES
Enalapril	2.5mg bd	10mg bd	Mortality/QOL	All patients with HFrEF Alters natural history
Empagliflozin	10mg daily	-----	Mortality	If DM can use 25mg
Carvedilol	3.125mg bd	25mg bd	Mortality	Add when stable Improves clinical outcomes/NH
Furosemide	40mg daily	20-160mg/dose	Symptoms	Use as needed No mortality benefit
Spironolactone	12.5mg daily	25mg daily	Mortality	Class C/III-IV despite ACEI & BB *Only affects mortality if EF≤35%