Arrhythmias

 It is essential to recognize and correct precipitating factors for arrhythmias, improve cardiac function and reduce neuro-endocrine activation with beta-blockade, ACE inhibition, and possibly, aldosterone receptor antagonists (Class of recommendation I, level of evidence C).

Ventricular arrhythmias

- In patients with ventricular arrhythmias, the use of anti-arrhythmic agents is only justified in patients with severe, symptomatic, sustained ventricular tachycardias and where amiodarone should be the preferred agent (Class of recommendation IIa, level of evidence B). 87,89
- ICD implantation is indicated in patients with heart failure and with life threatening ventricular arrhythmias (i.e. ventricular fibrillation or sustained ventricular tachycardia) and in selected patients at high risk of sudden death (Class of recommendation I, level of evidence A). 95,96,110-112

Atrial fibrillation

- For persistent (non-self-terminating) atrial fibrillation, electrical cardioversion could be considered, although its success rate may depend on the duration of atrial fibrillation and left atrial size (Class of recommendation IIa, level of evidence B).
- In patients with atrial fibrillation and heart failure and/ or depressed left ventricular function, the use of antiarrhythmic therapy to maintain sinus rhythm should be restricted to amiodarone (Class of recommendation I, level of evidence C) and, if available, to dofetilide (Class of recommendation IIa, level of evidence B).
- In asymptomatic patients beta-blockade, digitalis glycosides or the combination may be considered for control of ventricular rate (Class of recommendation I, level of evidence B). In symptomatic patients with systolic dysfunction digitalis glycosides are the first choice (Class of recommendation IIa, level of evidence C). In PLVEF, verapamil can be considered (Class of recommendation IIa, level of evidence C).
- Anti-coagulation in persistent atrial fibrillation with warfarin should always be considered unless contraindicated (Class of recommendation I, level of evidence C).
- Management of acute atrial fibrillation is not depending on previous heart failure or not. Treatment strategy is depending on symptoms and haemodynamic stability. For options see. 106

Symptomatic systolic left ventricular dysfunction and concomitant angina or hypertension

Specific recommendations in addition to general treatment for heart failure because of systolic left ventricular dysfunction. If angina is present

Table 20 Recommended components of care and following programmes (class level of evidence C)

- Use a multi-disciplinary team approach
- Vigilant follow-up, first follow-up within 10 days of discharge
- Discharge planning
- Increased access to health care
- Optimizing medical therapy with guidelines
- Early attention to signs and symptoms (e.g. telemonitoring)
- Flexible diuretic regimen
- · Intense education and counselling
- Inpatient and outpatient (home-based)
- · Attention to behavioural strategies
- Address barriers to compliance
- Early attention to signs and symptoms (e.g. telemonitoring)
- · Flexible diuretic regimen
- (1) optimize existing therapy, e.g. beta-blockade
- (2) add long-acting nitrates
- (3) if not successful, add amlodipine or felodipine
- (4) consider coronary revascularization.

If hypertension is present

- optimize the dose of ACE-inhibitors, beta-blocking agents, and diuretics.⁴⁰
- add spironolactone or ARBs if not present already
- if not successful, try second generation dihydropyridine derivatives.

Care and follow-up

See also Table 20.

- An organized system of specialist heart failure care improves symptoms and reduces hospitalizations (Class of recommendation I, level of evidence A) and mortality (Class of recommendation IIa, level of evidence B) of patients with heart failure.^{71,114–118}
- It is likely that the optimal model will depend on local circumstances and resources and whether the model is designed for specific sub-groups of patients (e.g. severity of heart failure, age, co-morbidity, and left ventricular systolic dysfunction) or the whole heart failure population (Class of recommendation I, level of evidence C). 119-122

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