Complete Summary

GUIDELINE TITLE

Management of asymptomatic patients with reduced left ventricular ejection fraction: HFSA 2006 comprehensive heart failure practice guideline.

BIBLIOGRAPHIC SOURCE(S)

Heart Failure Society of America. Management of asymptomatic patients with reduced left ventricular ejection fraction. J Card Fail 2006 Feb;12(1):e26-8. [23 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Heart Failure Society of America. Heart Failure Society of America (HFSA) practice guidelines. HFSA guidelines for management of patients with heart failure caused by left ventricular systolic dysfunction--pharmacological approaches. J Card Fail 1999 Dec;5(4):357-82.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Asymptomatic left ventricular dysfunction (ALVD)

GUIDELINE CATEGORY

Management
Treatment

CLINICAL SPECIALTY

Cardiology
Family Practice
Internal Medicine

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide recommendations for the management of patients with asymptomatic left ventricular dysfunction (ALVD)

TARGET POPULATION

Patients with asymptomatic left ventricular dysfunction (ALVD)

INTERVENTIONS AND PRACTICES CONSIDERED

1. Encourage regular exercise, smoking cessation, and alcohol abstinence
2. Aggressive blood pressure control, if hypertension is present
3. Angiotensin-converting enzyme (ACE) inhibitor
4. Angiotensin receptor blockers (ARBs)
5. Beta-blocker therapy

MAJOR OUTCOMES CONSIDERED

Heart failure rates

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Databases searched included Medline and Cochrane. In addition, the guideline developers polled experts in specific areas for data.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Level A: Randomized, Controlled, Clinical Trials
May be assigned based on results of a single trial

Level B: Cohort and Case-Control Studies
Post hoc, subgroup analysis, and meta-analysis
Prospective observational studies or registries

Level C: Expert Opinion
Observational studies – epidemiologic findings
Safety reporting from large-scale use in practice

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Heart Failure Society of America (HFSA) Guideline Committee sought resolution of difficult cases through consensus building. Written documents were essential to this process, because they provided the opportunity for feedback from all members of the group. On occasion, consensus of Committee opinion was sufficient to override positive or negative results of almost any form or prior evidence.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

"Is recommended": Part of routine care
Exceptions to therapy should be minimized.

"Should be considered": Majority of patients should receive the intervention.
Some discretion in application to individual patients should be allowed.

"May be considered": Individualization of therapy is indicated

"Is not recommended": Therapeutic intervention should not be used

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The process of moving from ideas of recommendations to a final document includes many stages of evaluation and approval. Every section, once written, had a lead reviewer and 2 additional reviewers. After a rewrite, each section was assigned to another review team, which led to a version reviewed by the Committee as a whole and then the Heart Failure Society of America (HFSA) Executive Council, representing 1 more level of expertise and experience. Out of this process emerged the final document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The strength of evidence (A, B, C) and strength of recommendations are defined at the end of the "Major Recommendations" field.

- It is recommended that all patients with asymptomatic left ventricular dysfunction (ALVD) exercise regularly according to a physician-directed prescription to avoid general deconditioning; to improve weight, blood pressure, and diabetes control; and to reduce cardiovascular risk. (Strength of Evidence = C)
- Smoking cessation is recommended in all patients including those with ALVD. (Strength of Evidence = B)
- It is recommended that alcohol consumption be discouraged in patients with ALVD. Abstinence is recommended if there is a current habit or previous history of excessive alcohol intake. (Strength of Evidence = C)
- It is recommended that all patients with ALVD with hypertension have aggressive blood pressure control. (Strength of Evidence = B)
- Angiotensin-converting enzyme (ACE) inhibitor therapy is recommended for asymptomatic patients with reduced left ventricular ejection fraction (LVEF) (<40%). (Strength of Evidence = A)
- Angiotensin receptor blockers (ARBs) are recommended for asymptomatic patients with reduced LVEF who are intolerant of ACE inhibitors from cough or angioedema. (Strength of Evidence = C)

  Routine use of the combination of ACE inhibitors and ARBs for prevention of heart failure is not recommended in this population. (Strength of Evidence = C)

- It is recommended that beta-blocker therapy be administered to asymptomatic patients with reduced LVEF. (After myocardial infarction [MI], Strength of Evidence = B; non post-MI, Strength of Evidence = C)

Definitions:

Strength of Evidence

Level A: Randomized, Controlled, Clinical Trials
May be assigned based on results of a single trial

Level B: Cohort and Case-Control Studies
Post hoc, subgroup analysis, and meta-analysis
Prospective observational studies or registries

Level C: Expert Opinion
Observational studies – epidemiologic findings
Safety reporting from large-scale use in practice

Strength of Recommendations

"Is recommended": Part of routine care
Exceptions to therapy should be minimized.

"Should be considered": Majority of patients should receive the intervention.
Some discretion in application to individual patients should be allowed.

"May be considered": Individualization of therapy is indicated

"Is not recommended": Therapeutic intervention should not be used

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations").

The recommendations are supported by randomized controlled clinical trials, cohort and case-control studies, and expert opinion.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Prevention of, or reduction of progressive ventricular remodeling
- Decreased risk of developing heart failure

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

It must be recognized that the evidence supporting recommendations is based largely on population responses that may not always apply to individuals within the population. Therefore, data may support overall benefit of 1 treatment over another but cannot exclude that some individuals within the population may respond better to the other treatment. Thus guidelines can best serve as evidence-based recommendations for management, not as mandates for management in every patient. Furthermore, it must be recognized that trial data on which recommendations are based have often been carried out with background therapy not comparable to therapy in current use. Therefore, physician decisions regarding the management of individual patients may not always precisely match the recommendations. A knowledgeable physician who integrates the guidelines with pharmacologic and physiologic insight and knowledge of the individual being treated should provide the best patient management.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Pocket Guide/Reference Cards
Slide Presentation

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Heart Failure Society of America. Management of asymptomatic patients with reduced left ventricular ejection fraction. J Card Fail 2006 Feb;12(1):e26-8. [23 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999 (revised 2006 Feb)

GUIDELINE DEVELOPER(S)

Heart Failure Society of America, Inc - Disease Specific Society

SOURCE(S) OF FUNDING

Heart Failure Society of America, Inc

GUIDELINE COMMITTEE

Comprehensive Heart Failure Practice Guideline Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Kirkwood F. Adams, Jr, MD (*Co-Chair*); JoAnn Lindenfeld, MD (*Co-Chair*); J. Malcolm O. Arnold, MD; David W. Baker, MD; Denise H. Barnard, MD; Kenneth Lee Baughman, MD; John P. Boehmer, MD; Prakash Deedwania, MD; Sandra B. Dunbar, RN, DSN; Uri Elkayam, MD; Mihai Gheorghiade, MD; Jonathan G. Howlett, MD; Marvin A. Konstam, MD; Marvin W. Kronenberg, MD; Barry M. Massie, MD; Mandeep R. Mehra, MD; Alan B. Miller, MD; Debra K. Moser, RN, DNSc; J. Herbert Patterson, PharmD; Richard J. Rodeheffer, MD; Jonathan Sackner-Bernstein, MD; Marc A. Silver, MD; Randall C. Starling, MD, MPH; Lynne Warner Stevenson, MD; Lynne E. Wagoner, MD

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Committee members and reviewers from the Executive Council received no direct financial support from the Heart Failure Society of America (HFSA) or any other

source for the development of the guideline. Administrative support was provided by the Heart Failure Society of America staff, and the writing of the document was performed on a volunteer basis by the Committee. Financial relationships that might represent conflicts of interest were collected for all members of the Guideline Committee and of the Executive Council, who were asked to disclose potential conflicts and recuse themselves from discussions when necessary. Current relationships are shown in Table 1.5 of the "Development and Implementation" companion document (see the "Availability of Companion Documents" field).

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GUIDELINE AVAILABILITY

Electronic copies: Available from the Heart Failure Society of America, Inc. Web site.

Print copies: Available from the Heart Failure Society of America, Inc., Court International - Suite 240 S, 2550 University Avenue West, Saint Paul, Minnesota 55114; Phone: (651) 642-1633

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Heart Failure Society of America. Executive summary: HFSA 2006 comprehensive heart failure practice guideline. J Card Fail 2006 Feb;12(1):10-38.
- Heart Failure Society of America. Development and implementation of a comprehensive heart failure practice guideline. J Card Fail 2006 Feb;12(1):e3-9.
- Heart Failure Society of America. Conceptualization and working definition of heart failure. J Card Fail 2006 Feb;12(1):e10-11.

  Electronic copies: Available from the Heart Failure Society of America, Inc. Web site.

- PowerPoint slides. HFSA 2006 comprehensive heart failure guideline.

  Electronic copies: Available from the Heart Failure Society of America, Inc. Web site.

The following is also available:

- Heart Failure Society of America. Pocket guide. HFSA 2006 comprehensive heart failure practice guideline.

Electronic copies: Not available at this time.

Print copies: Available from the Heart Failure Society of America, Inc., Court International - Suite 240 South, 2550 University Avenue West, Saint Paul, Minnesota 55114; Phone: (651) 642-1633

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on July 31, 2006. The information was verified by the guideline developer on August 10, 2006.

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