

- 1) - gestione del politrauma in emergenza: valutazione primaria
- 2) - pneumotorace
- 3) - ischemia intestinale
- 4) - stato di male epilettico
- 5) - TVP
- 6) - IMA: diagnosi e trattamento
- 7) - dissezione aortica
- 8) - edema polmonare acuto
- 9) - patologia cerebrale tempo-dipendente
- 10) - embolia polmonare
- 11) - FA parossistica
- 12) - shock settico
- 13) - addome acuto
- 14) - trauma cranico in TAO/NAO
- 15) - occlusione intestinale
- 16) - trauma del bacino
- 17) - BAV
- 18) - polmonite da COVID
- 19) - shock anafilattico
- 20) - TPSV
- 21) - crisi asmatica acuta



- 1) - Blog
- 2) - Bluetooth
- 3) - CD (compact disc)
- 4) - Chiavetta Micro SD
- 5) - Cloud (nuvola)
- 6) - Condivisione dello schermo
- 7) - Desktop
- 8) - Download (scaricamento)
- 9) - Drone
- 10) - E-mail
- 11) - Excel
- 12) - Facebook
- 13) - File
- 14) - Hard disk, disco rigido o disco fisso
- 15) - Hashtag
- 16) - Link o hyperlink
- 17) - Motore di ricerca
- 18) - Mouse
- 19) - Navigare o surfare
- 20) - Newsletter
- 21) - Screenshot

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ESC

European Society
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ESC GUIDELINES

2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure

Developed by the Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC)

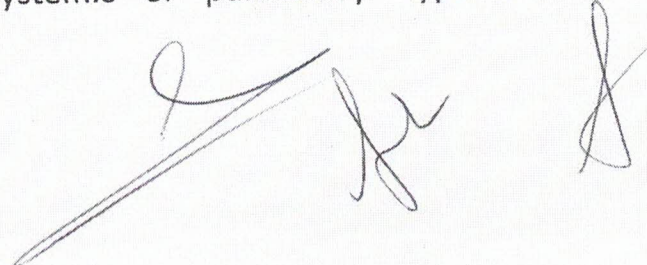
With the special contribution of the Heart Failure Association (HFA) of the ESC

- 1) The diagnosis of CHF requires the presence of symptoms and/or signs of HF and objective evidence of cardiac dysfunction (Figure 1). Typical symptoms include breathlessness, fatigue, and ankle swelling. Symptoms and signs lack sufficient accuracy to be used alone to make the diagnosis of HF.
- 2) Aortic valve surgery is recommended in patients with severe aortic regurgitation and HF symptoms regardless of LVEF. In case of high or prohibitive surgical risk, TAVI has been used to treat also aortic regurgitation.
- 3) Secondary mitral regurgitation (SMR) is mostly a disease of the left ventricle. It can also be caused by mitral annulus enlargement due to LA dilation. Moderate or severe SMR is associated with an extremely poor prognosis in patients with HF.
- 4) Arterial hypertension is a leading risk factor for the development of HF. Almost two-thirds of HF patients have a past history of hypertension. Clinical trials evaluating antihypertensive strategies and BP targets in patients with HF and hypertension have not been performed.
- 5) Treatment of HF is similar in patients with and without diabetes. Conversely, antidiabetic drugs differ in their effects in patients with HF and preference must be given to drugs that are both safe and reduce HF-related events.

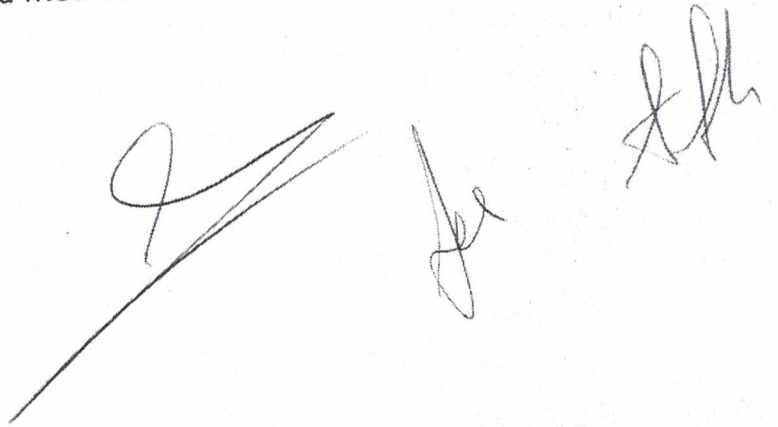
- 6) Obesity is a risk factor for hypertension and CAD and is also associated with an increased risk of HF. There is possibly a stronger association with HFpEF. Obesity may be a major cause of HFpEF and obese HFpEF patients display several pathophysiologic mechanisms that differ from non obese patients with HFpEF.
- 7) Iron deficiency and anaemia are common in patients with HF, being independently associated with reduced exercise capacity, recurrent HF hospitalizations, and high CV and all-cause mortality. According to the World Health Organization criteria, anaemia is defined as a haemoglobin concentration <12 g/dL in women and <13 g/dL in men.
- 8) Kidney dysfunction is a major independent determinant of increased mortality and morbidity in HF. However, there are settings in which changes in serum creatinine are not associated with worse outcomes.
- 9) Electrolyte disturbances are frequent in patients with HF and may often be iatrogenic. Serum potassium levels have a U-shaped relation with mortality with the lowest risk of death within a relatively narrow range of 4 to 5 mmol/L.
- 10) Hyperkalaemia is defined as serum potassium >5 mmol/L and can be classified as mild (>5.0 to 6.0 mmol/L) moderate (5.5 to 6.0 mmol/L), or severe (>6.0 mmol/L). It is associated with an increased risk of hospitalization and death.
- 11) Severe hyponatraemia may cause neurologic symptoms (seizures, obtundation, delirium) due to cerebral oedema and may require immediate treatment with hypertonic saline with serum sodium increases by 12 mmol/L per hour, though less than 8 mmol/L in 24 h as a more rapid correction increases the risk of myelinolysis.
- 12)) In addition to oral anticoagulation, a strategy of rhythm control including catheter ablation should be considered in patients whose symptoms and/or cardiac dysfunction are associated with AF.
- 13) Four major clinical presentations of acute HF may occur: ADHF, acute pulmonary oedema, RV failure, and cardiogenic shock. Treatment of acute HF

is based on diuretics for congestion, inotropes, and short-term MCS for peripheral hypoperfusion.

- 14) The diagnosis of HFpEF requires objective evidence of cardiac structural, or functional abnormalities as well as elevated plasma NP concentrations consistent with the presence of LV diastolic dysfunction and raised LV filling pressures. A diastolic stress test is recommended when these markers are equivocal.
- 15) Patients hospitalized for HF should be carefully evaluated to exclude persistent signs of congestion. Oral treatment should be optimized before discharge.
- 16) The management of adult congenital heart disease (ACHD) has been reviewed in detail in a recent ESC guideline. HF is a common problem affecting 20-50% of the ACHD population, and an important cause of death.
- 17) Hospitalization for at least 48 h may be useful for patients with acute myocarditis and HF, especially when troponins are elevated and when cardiac dysfunction, and/or arrhythmias are present at initial presentation.
- 18) Atrial disease, also termed atrial failure or myopathy, can be defined as a complex of subclinical structural, electrophysiological, and functional changes that affect the atria with the potential to produce clinical consequences.
- 19) Cardiomyopathies (CMPs) can be either inherited (genetic/familial) and/or acquired. They can also be accelerated by disease modifiers...The current pharmacological treatment of HF in DCM, HCM, or AC patients does not differ from general HF management, except for peculiar aspects reported in Tables 26-27.
- 20) HF occurs in patients with cancer as a result of the interaction among anticancer therapy, cancer itself, and patients' CV background (risk factors and coexisting CV disease). Several anticancer therapies may cause HF directly, through their cardiotoxic effects, or, indirectly, through other mechanisms, such as myocarditis, ischaemia, systemic or pulmonary hypertension, arrhythmias or valve disease.

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21) Heart transplantation remains the gold standard for the treatment of advanced HF in the absence of contraindications. Post-transplant 1- year survival is around 90% with a median survival of 12.5 years.

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