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Diagnóstico rápido y preciso de la IC

José Manuel García Pinilla

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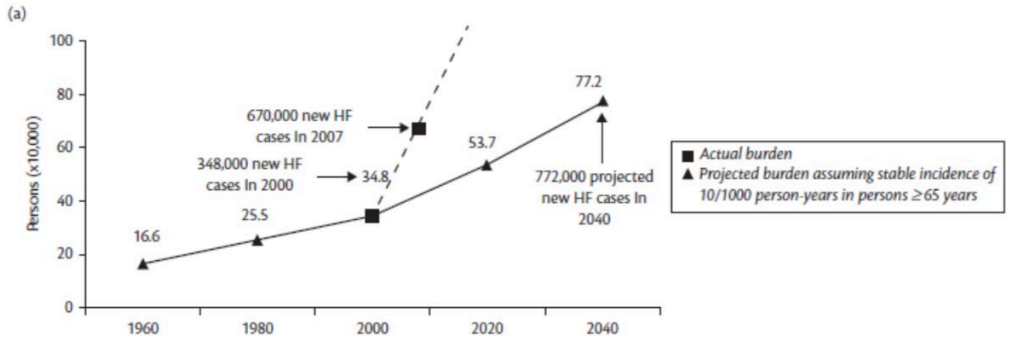
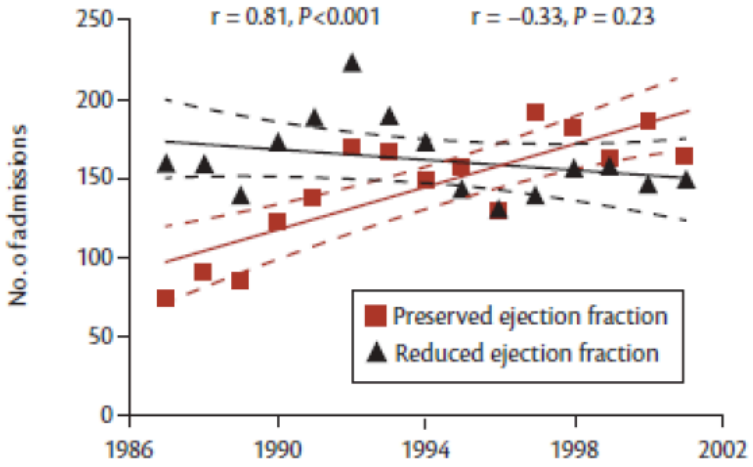
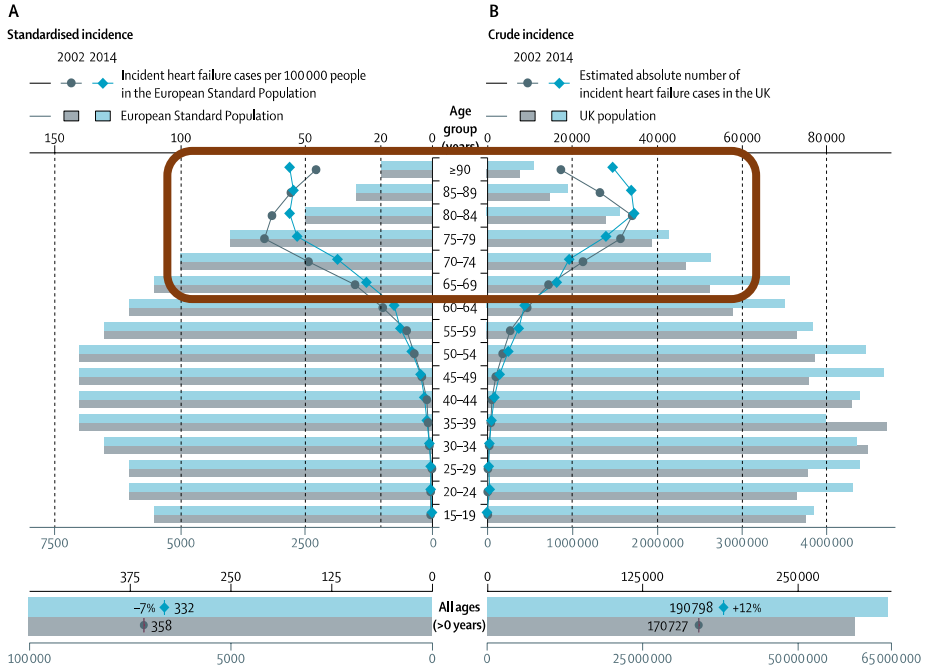
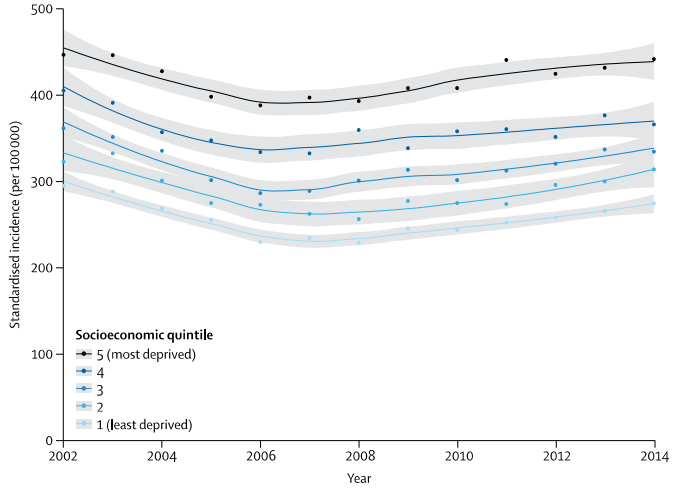
Una pandemia...









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Conrad N, et al. Lancet 2018; 391: 572–80

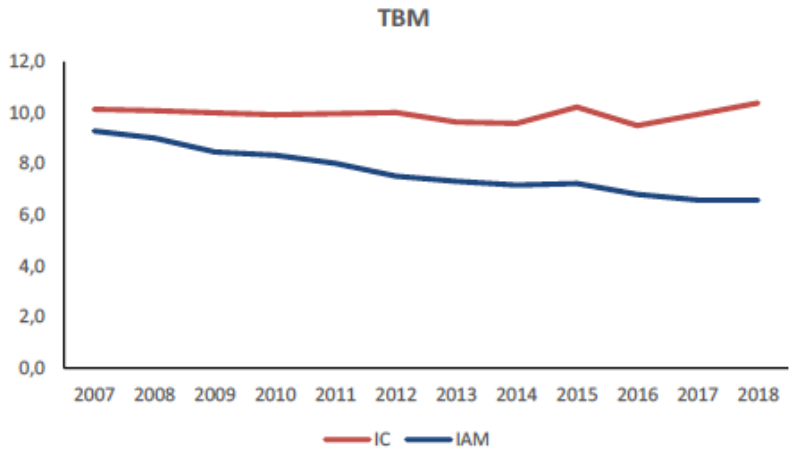

Figura 4.1. Distribución de la mortalidad ajustada a riesgo (RAMER) intrahospitalaria de la insuficiencia cardiaca por Comunidad Autónoma (2018)

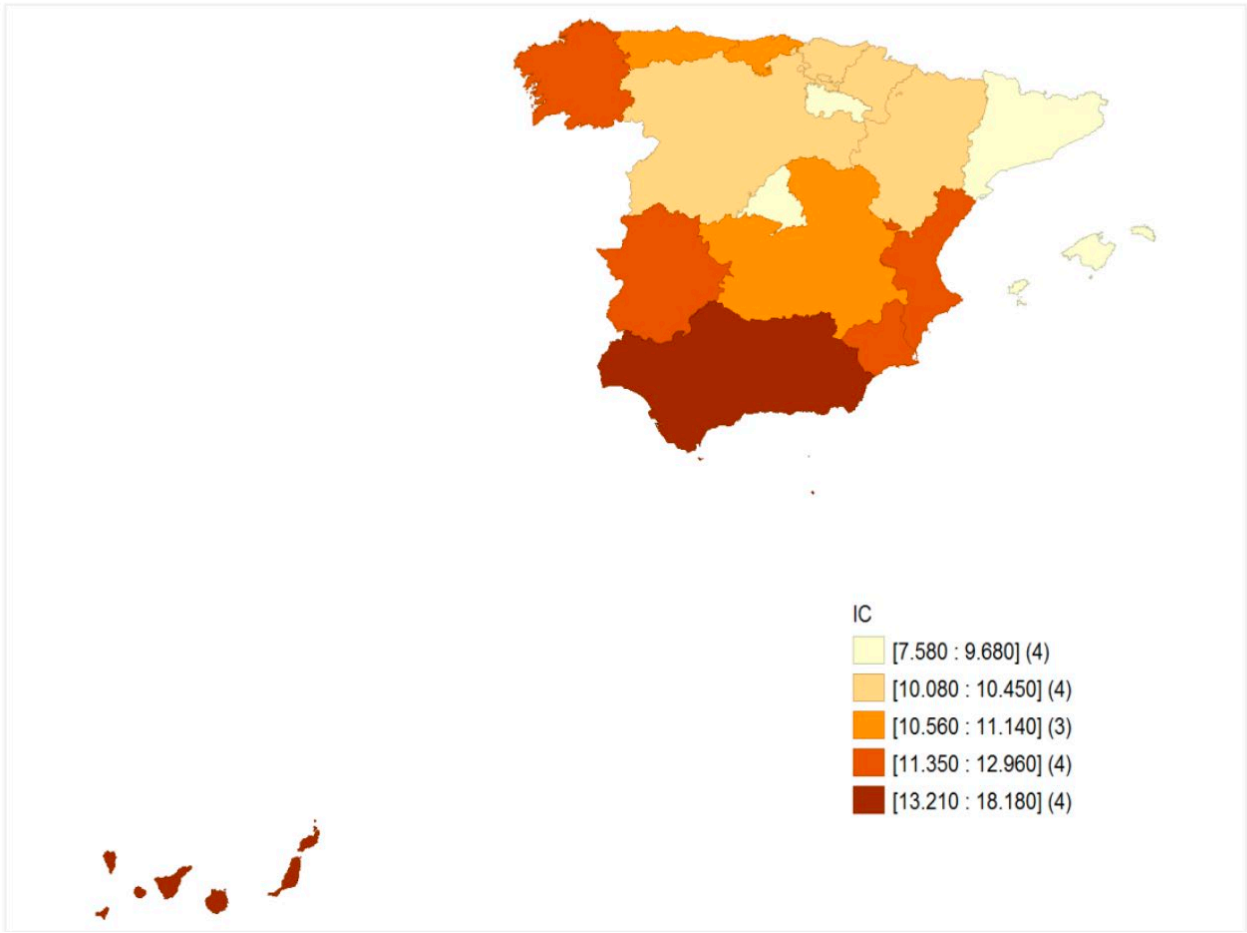

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Tabla 3. Factores clave en el diagnóstico rápido y preciso de la IC

	Factor clave	Resultado	Altamente prioritario
17.	Establecer vías de derivación a consultas de alta resolución de la IC y promover la valoración integral con AP, tras la valoración de la sospecha diagnóstica.	Adecuado y claramente necesario	✓
18.	Establecer como *gold standard* del diagnóstico la realización del ecocardiograma por parte del especialista en IC (cardiología o MI).	Adecuado y claramente necesario	
19.	Elaborar protocolos de solicitud de NT-proBNP en AP y urgencias.	Adecuado y claramente necesario	✓
20.	Promover el perfil de consultor referente, presencial o no presencial (cardiología o MI) para dar apoyo a AP en la sospecha diagnóstica de la IC.	Adecuado y claramente necesario	
21.	Planificar agendas para incorporar elementos telemáticos de consulta entre la AH y la AP.	Adecuado y claramente necesario	
22.	Establecer criterios y vías de derivación con las consultas de cardiología general y de MI.	Adecuado y claramente necesario	

REC CardioClinics. 2022;57(1):24–38

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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

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VOL. ■, NO. ■, 2022

PUBLISHED BY ELSEVIER

CLINICAL PRACTICE GUIDELINE: FULL TEXT

2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure

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Symptoms	Signs
Typical	**More specific**
Breathlessness	Elevated jugular venous pressure
Orthopnoea	Hepatojugular reflux
Paroxysmal nocturnal dyspnoea	Third heart sound (gallop rhythm)
Reduced exercise tolerance	Laterally displaced apical impulse
Fatigue, tiredness, increased time to recover after exercise	
Ankle swelling	
Less typical	**Less specific**
Nocturnal cough	Weight gain (>2 kg/week)
Wheezing	Weight loss (in advanced HF)
Bloated feeling	Tissue wasting (cachexia)
Loss of appetite	Cardiac murmur
Confusion (especially in the elderly)	Peripheral oedema (ankle, sacral, scrotal)
Depression	Pulmonary crepitations
Palpitation	Pleural effusion
Dizziness	Tachycardia
Syncope	Irregular pulse
Bendopnea[a]	Tachypnoea
	Cheyne-Stokes respiration
	Hepatomegaly
	Ascites
	Cold extremities
	Oliguria
	Narrow pulse pressure

Eur Heart J 2021; 00:1-128

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Table 5 **Causes of heart failure, common modes of presentation and specific investigations**

Cause	Examples of presentations	Specific investigations
CAD	Myocardial infarction	Invasive coronary angiography
	Angina or "angina-equivalent"	CT coronary angiography
	Arrhythmias	Imaging stress tests (echo, nuclear, CMR)
Hypertension	Heart failure with preserved systolic function	24 h ambulatory BP
	Malignant hypertension/acute pulmonary oedema	Plasma metanephrines, renal artery imaging
		Renin and aldosterone
Valve disease	Primary valve disease e.g., aortic stenosis	Echo – transoesophageal/stress
	Secondary valve disease, e.g. functional regurgitation	
	Congenital valve disease	
Arrhythmias	Atrial tachyarrhythmias	Ambulatory ECG recording
	Ventricular arrhythmias	Electrophysiology study, if indicated
CMPs	All	CMR, genetic testing
	Dilated	
	Hypertrophic	
	Restrictive	Right and left heart catheterization
	ARVC	
	Peripartum	
	Takotsubo syndrome	CMR, angiography
	Toxins: alcohol, cocaine, iron, copper	Trace elements, toxicology, LFTs, GGT
Congenital heart disease	Congenitally corrected/repaired transposition of great arteries	CMR
	Shunt lesions	
	Repaired tetralogy of Fallot	
	Ebstein's anomaly	
Infective	Viral myocarditis	CMR, EMB
	Chagas disease	
	HIV	Serology
	Lyme disease	
Drug-induced	Anthracyclines	
	Trastuzumab	
	VEGF inhibitors	
	Immune checkpoint inhibitors	
	Proteasome inhibitors	
	RAF+MEK inhibitors	
Infiltrative	Amyloid	Serum electrophoresis and serum free light chains, Bence Jones protein, Bone scintigraphy, CMR, CT-PET, EMB
	Sarcoidosis	Serum ACE, CMR, FDG-PET, chest CT, EMB
	Neoplastic	CMR, EMB
Storage disorders	Haemochromatosis	Iron studies, genetics, CMR (T2* imaging), EMB
	Fabry disease	α-galactosidase A, genetics, CMR (T1 mapping)
	Glycogen storage diseases	
Endomyocardial disease	Radiotherapy	CMR
	Endomyocardial fibrosis/eosinophilia	EMB
	Carcinoid	24 h urine 5-HIAA
Pericardial disease	Calcification	Chest CT, CMR, Right and Left heart catheterisation
	Infiltrative	
Metabolic	Endocrine disease	TFTs, plasma metanephrines, renin and aldosterone, cortisol
	Nutritional disease (thiamine, vitamin B1 and selenium deficiencies)	Specific plasma nutrients
	Autoimmune disease	ANA, ANCA, rheumatology review
Neuromuscular disease	Friedreich's ataxia	Nerve conduction studies, electromyogram, genetics
	Muscular dystrophy	CK, electromyogram, genetics

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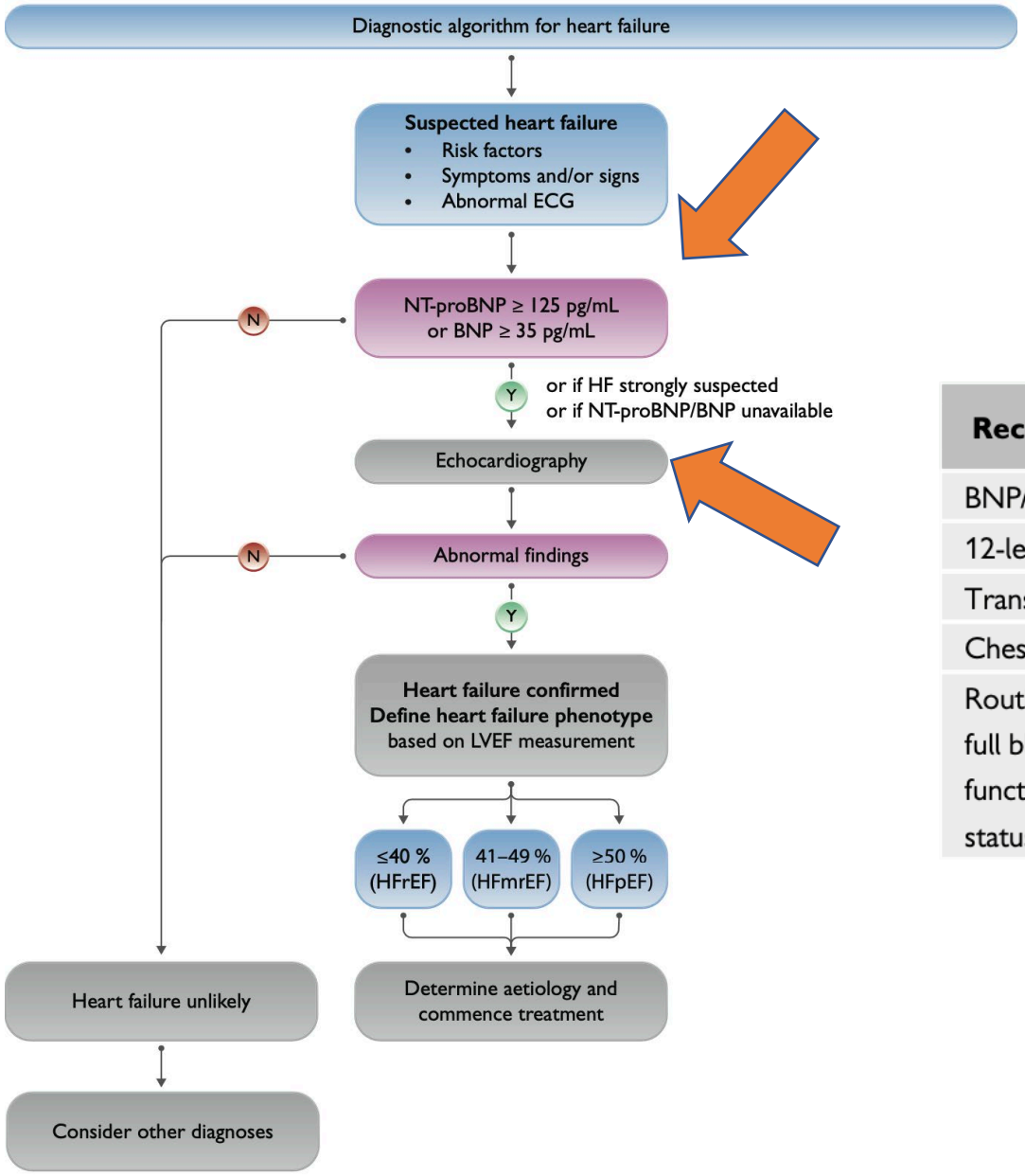

Recommendations	Class[a]	Level[b]
BNP/NT-proBNP[c]	I	B
12-lead ECG	I	C
Transthoracic echocardiography	I	C
Chest radiography (X-ray)	I	C
Routine blood tests for comorbidities, including full blood count, urea and electrolytes, thyroid function, fasting glucose and HbA1c, lipids, iron status (TSAT and ferritin)	I	C

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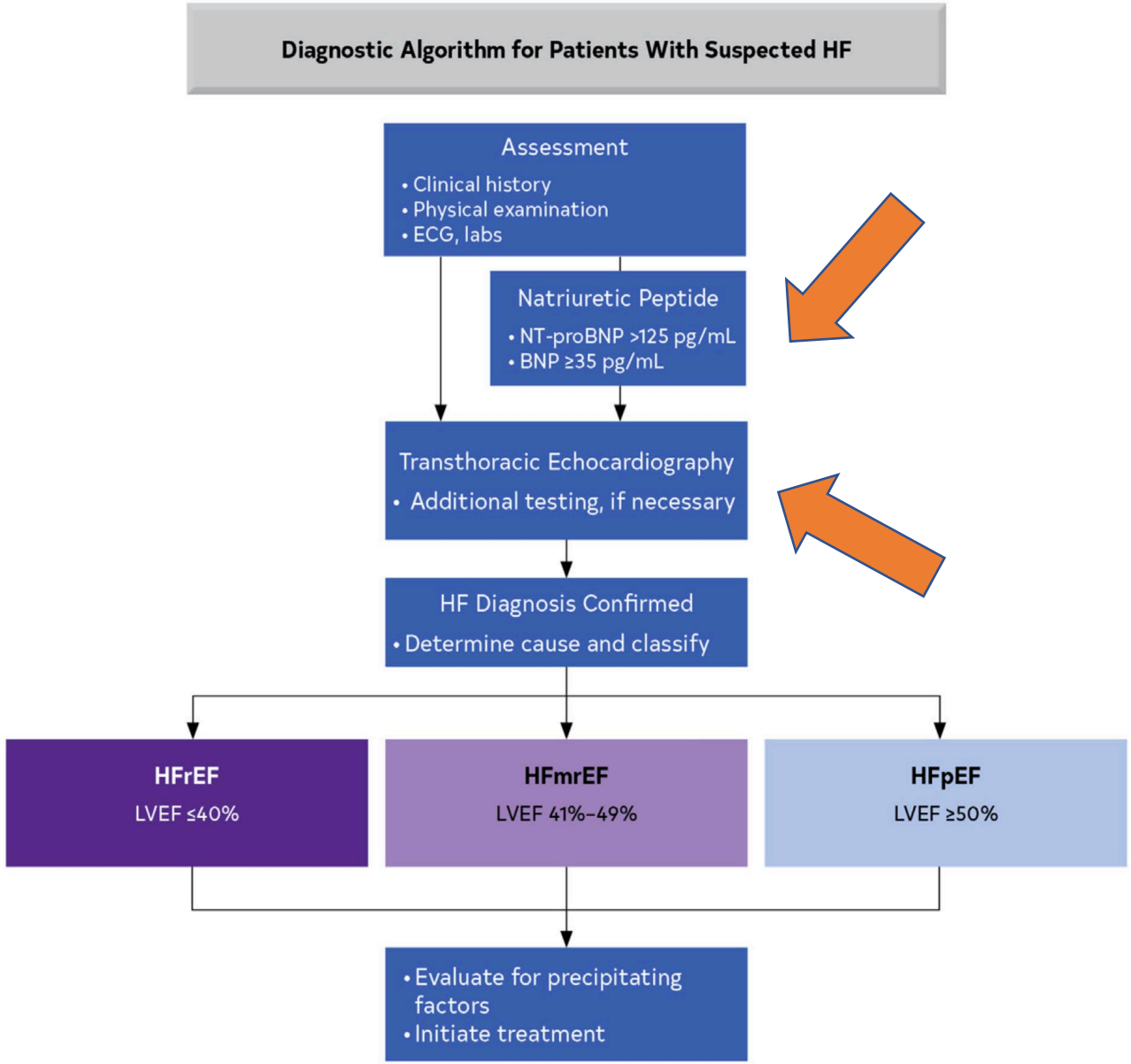

Heidenreich et al. 2022 AHA/ACC/HFSA Heart Failure Guideline. JACC 2022

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Table 7 Causes of elevated concentrations of natriuretic peptides[86-88]

Cardiac	Heart failure ACS Pulmonary embolism Myocarditis Left ventricular hypertrophy Hypertrophic or restrictive cardiomyopathy Valvular heart disease Congenital heart disease Atrial and ventricular tachyarrhythmias Heart contusion Cardioversion, ICD shock Surgical procedures involving the heart Pulmonary hypertension
Non-cardiac	Advanced age Ischaemic stroke Subarachnoid haemorrhage Renal dysfunction Liver dysfunction (mainly liver cirrhosis with ascites) Paraneoplastic syndrome COPD Severe infections (including pneumonia and sepsis) Severe burns Anaemia Severe metabolic and hormone abnormalities (e.g. thyrotoxicosis, diabetic ketosis)

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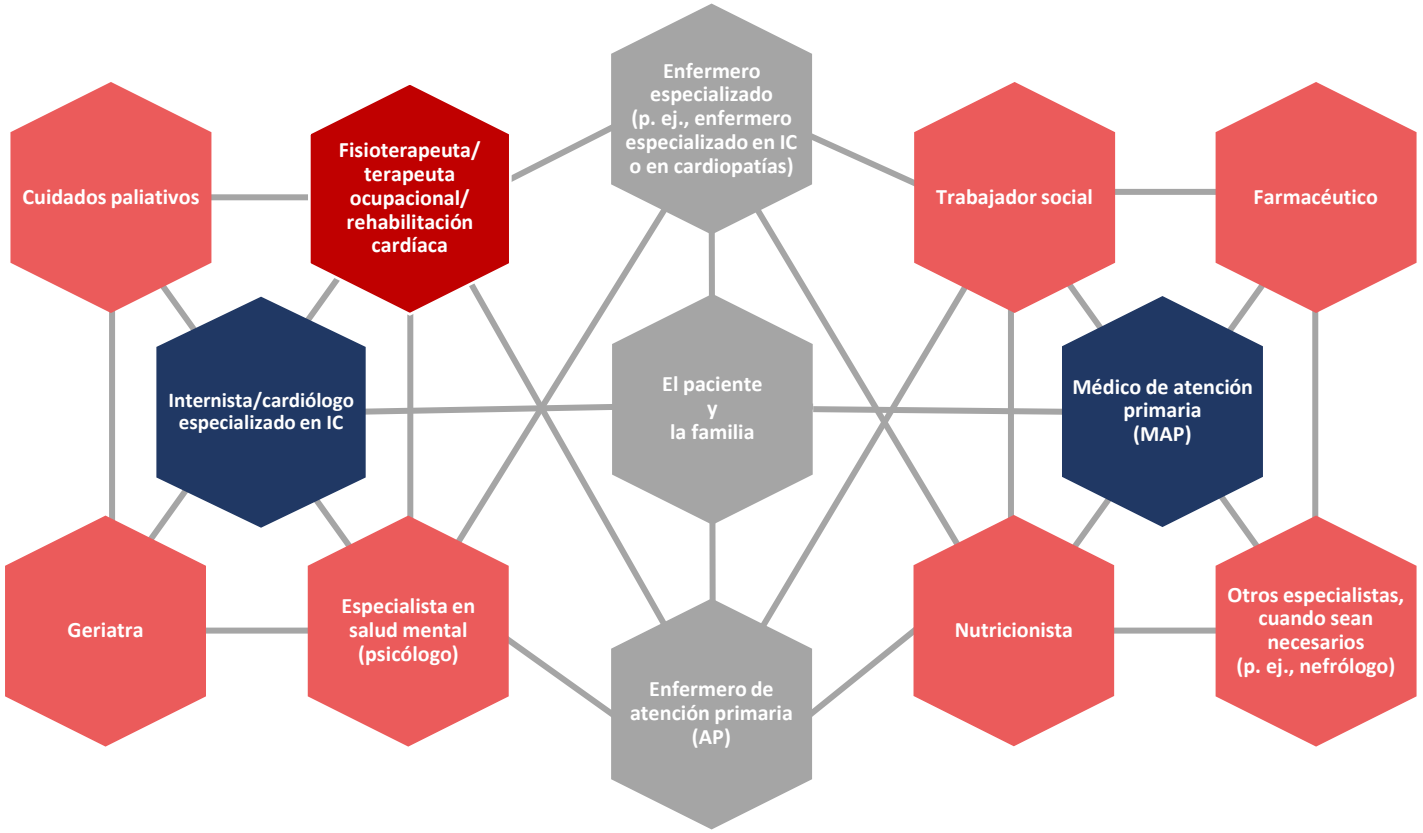
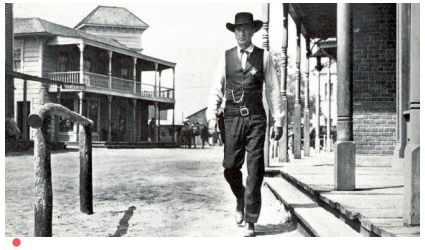
Manejo multidisciplinar: unidades de ICC





COR	LOE	RECOMMENDATIONS
1	B-R	1. In patients with high-risk HF, particularly those with recurrent hospitalizations for HFrEF, referral to multidisciplinary HF disease management programs is recommended to reduce the risk of hospitalization (1-4).
1	B-NR	2. In patients hospitalized with worsening HF, patient-centered discharge instructions with a clear plan for transitional care should be provided before hospital discharge (5,6).
2a	B-NR	3. In patients hospitalized with worsening HF, participation in systems that allow benchmarking to performance measures is reasonable to increase use of evidence-based therapy, and to improve quality of care (7-10).
2a	B-NR	4. In patients being discharged after hospitalization for worsening HF, an early follow-up, generally within 7 days of hospital discharge, is reasonable to optimize care and reduce rehospitalization (11,12).

Heidenreich et al. 2022 AHA/ACC/HFSA Heart Failure Guideline. JACC 2022

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Conclusiones

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Gracias

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