Les recommandations IC et Cardiomyopathies 2023

Emmanuelle Berthelot

CHU Bicêtre

2023 Focused Update of the 2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure

Updated the following sections:

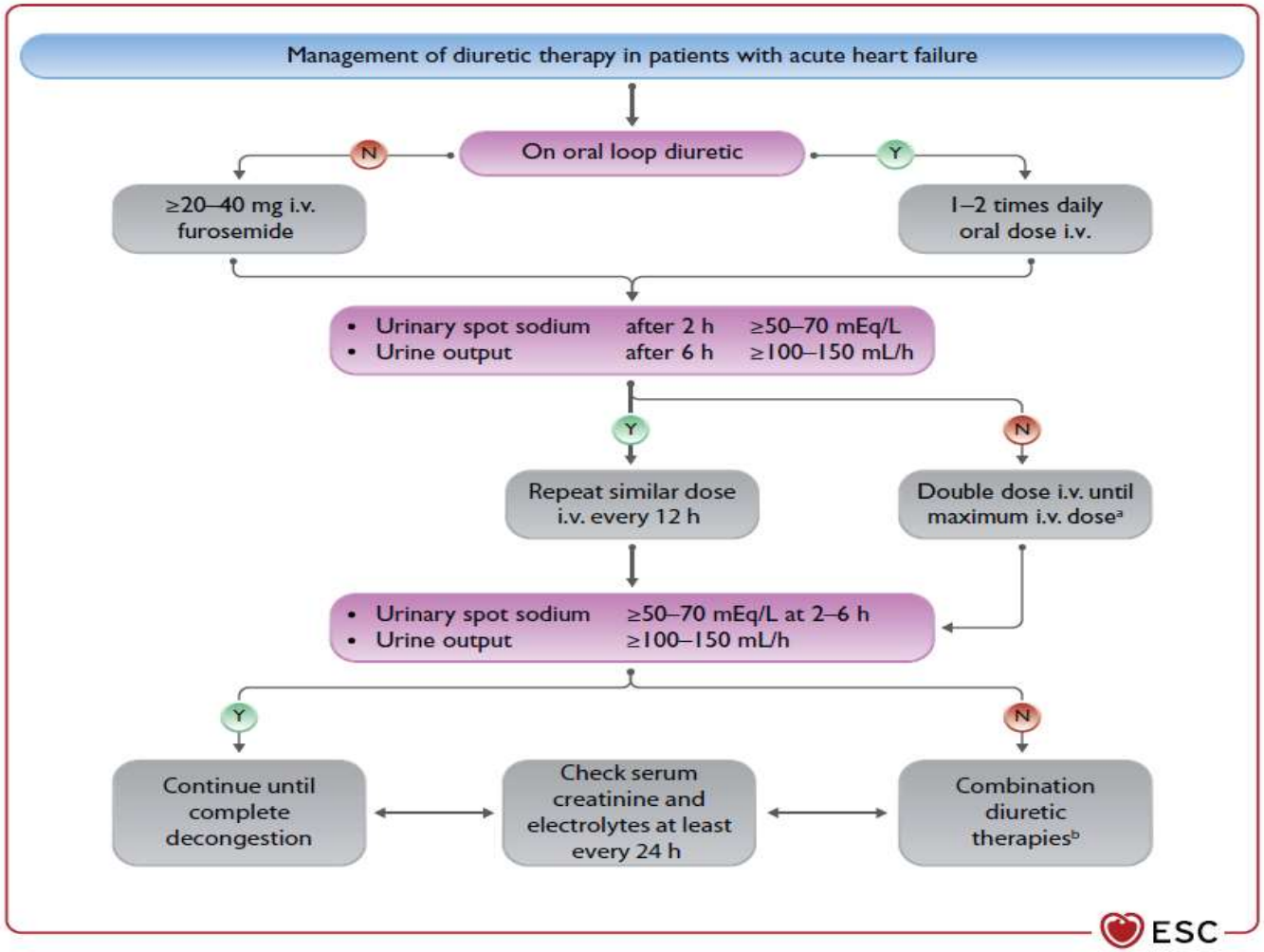
Chronic HF

- HF with mildly reduced ejection fraction (HFmrEF)
- HF with preserved ejection fraction (HFpEF)

Acute HF

Comorbidities and prevention of HF

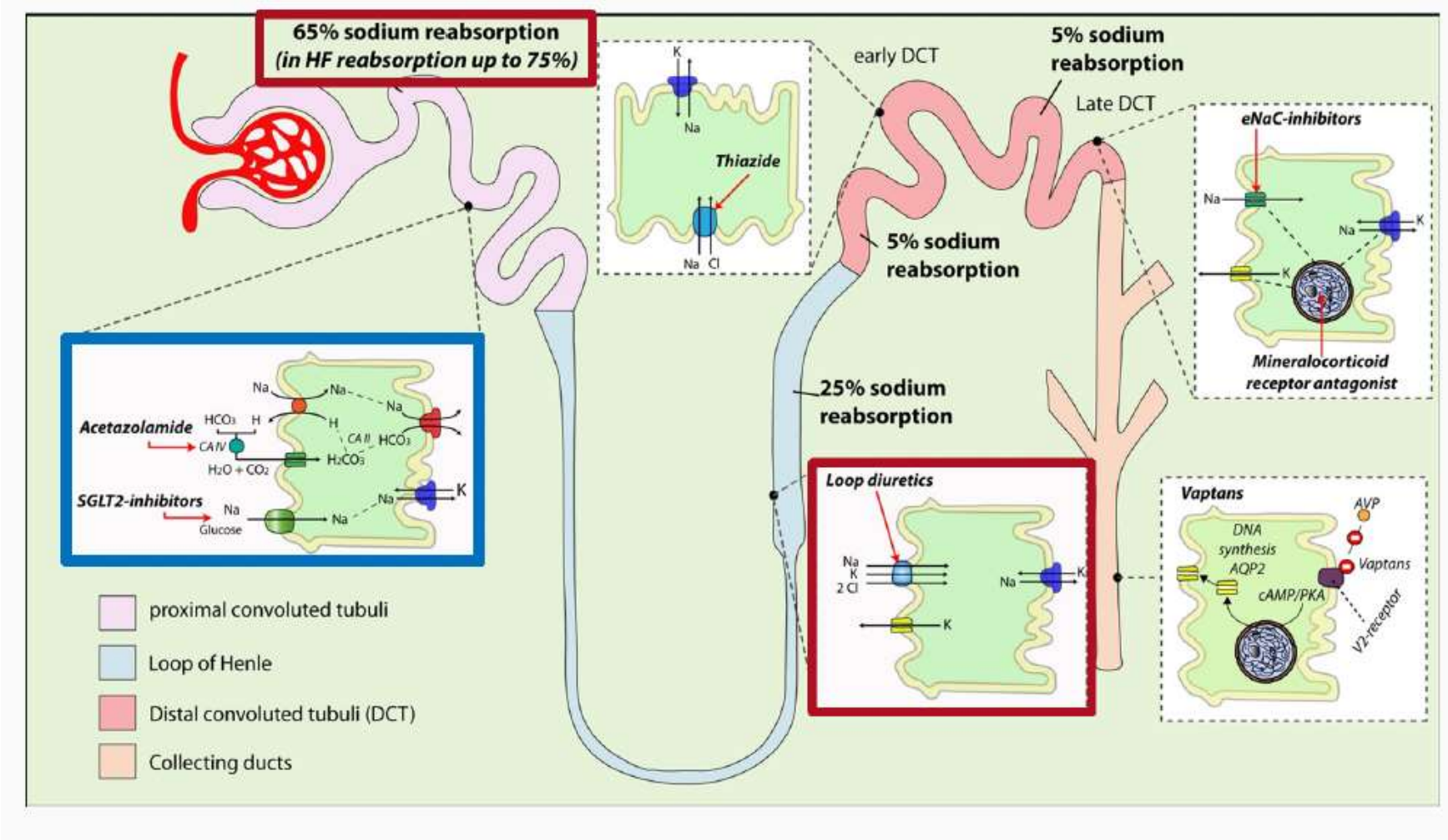
Comment utiliser les diurétiques dans l'insuffisance cardiaque aiguë ?



Dose maximale de furosémide IV : 400 à 600 mg, jusqu'à 1000 mg si IR sévère

McDonagh T, et al. Eur Heart J 2021;42(36):3599-3726

Réabsorption sodée au niveau du néphron et localisation de l'action des différents diurétiques



Acute heart failure

Acetazolamide in Acute Decompensated Heart Failure with Volume Overload

Wilfried Mullens, M.D., Ph.D., Jeroen Dauw, M.D., Pieter Martens, M.D., Ph.D., Frederik H. Verbrugge, M.D., Ph.D., F
Tartaglia, M.Sc., Fabien Chenot, M.D., Samer Moubayed, M.D., Riet Dierckx, M.D., Ph.D., Philippe Blouard, M.D., P
Group*

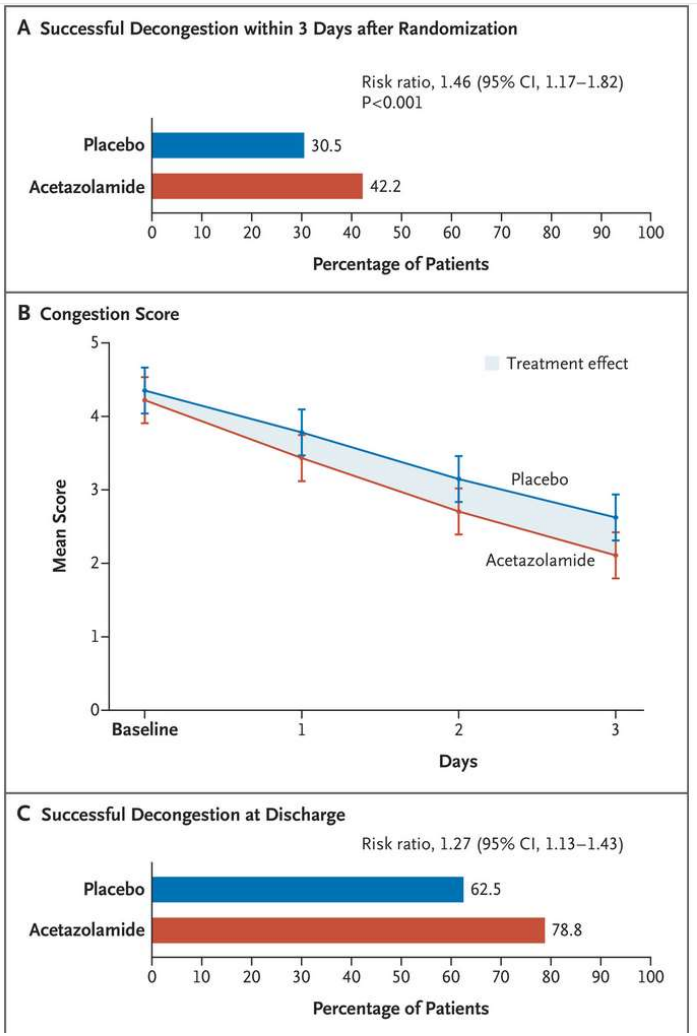
Abstract

BACKGROUND

Whether acetazolamide, a carbonic anhydrase inhibitor that reduces proximal tubular sodium reabsorption, can improve the efficiency of loop diuretics, potentially leading to more and faster decongestion in patients with acute decompensated heart failure with volume overload, is unclear.

METHODS

In this multicenter, parallel-group, double-blind, randomized, placebo-controlled trial, we assigned



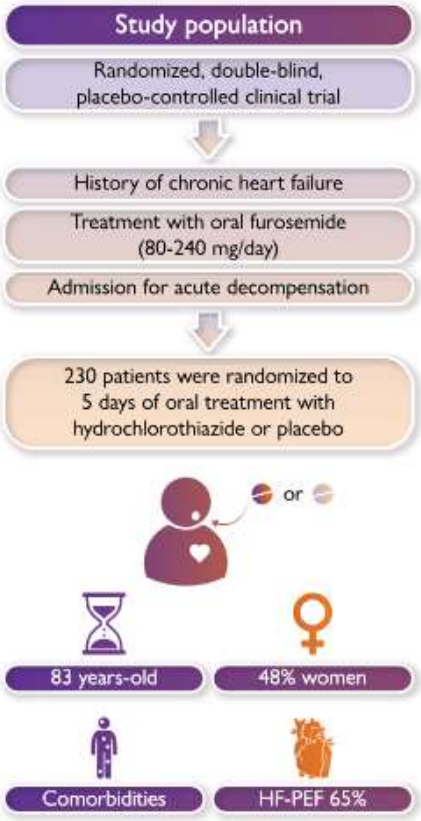
Acute heart failure

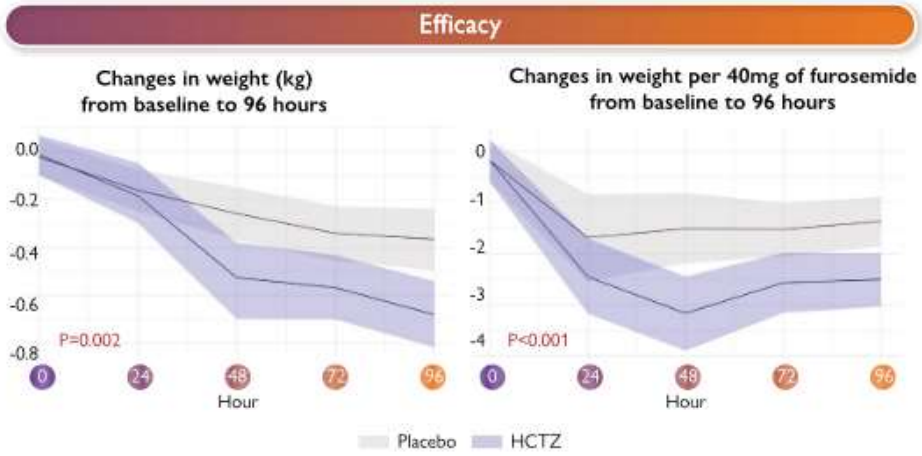
ESC European Society of Cardiology
European Heart Journal (2023) **44**, 411–421
https://doi.org/10.1093/eurheartj/ehac689

CLINICAL RESEARCH
Heart failure and cardiomyopathies

Combining loop with thiazide diuretics for decompensated heart failure: the CLOROTIC trial

Joan Carles Trullàs [1,2]*, José Luis Morales-Rull[3], Jesús Casado[4], Margarita Carrera-Izquierdo[5], Marta Sánchez-Marteles[6], Alicia Conde-





Safety	Placebo	HCTZ	p-value
All-cause mortality at 90 days	19 (16.4%)	23 (20.2%)	0.566
All-cause rehospitalizations at 90 days	40 (34.5%)	43 (37.7%)	0.709
Impaired renal function (serum creatinine and eGFR)	20 (17.2%)	53 (46.5%)	<0.001
Hyponatraemia (Na+ ≤ 130 mmol/L) - (Na+ ≤ 125 mmol/L)	6 (5.2%)–2 (1.7%)	10 (8.8%)–3 (2.6%)	0.416–0.682
Hypokalaemia (K+ ≤ 3.0 mmol/L) - (K+ ≤ 2.5 mmol/L)	18 (16.1%)–0 (0.0%)	43 (40.6%)–2 (1.8%)	<0.001–0.245
Serious adverse events	27 (23.3%)	26 (22.8%)	0.93

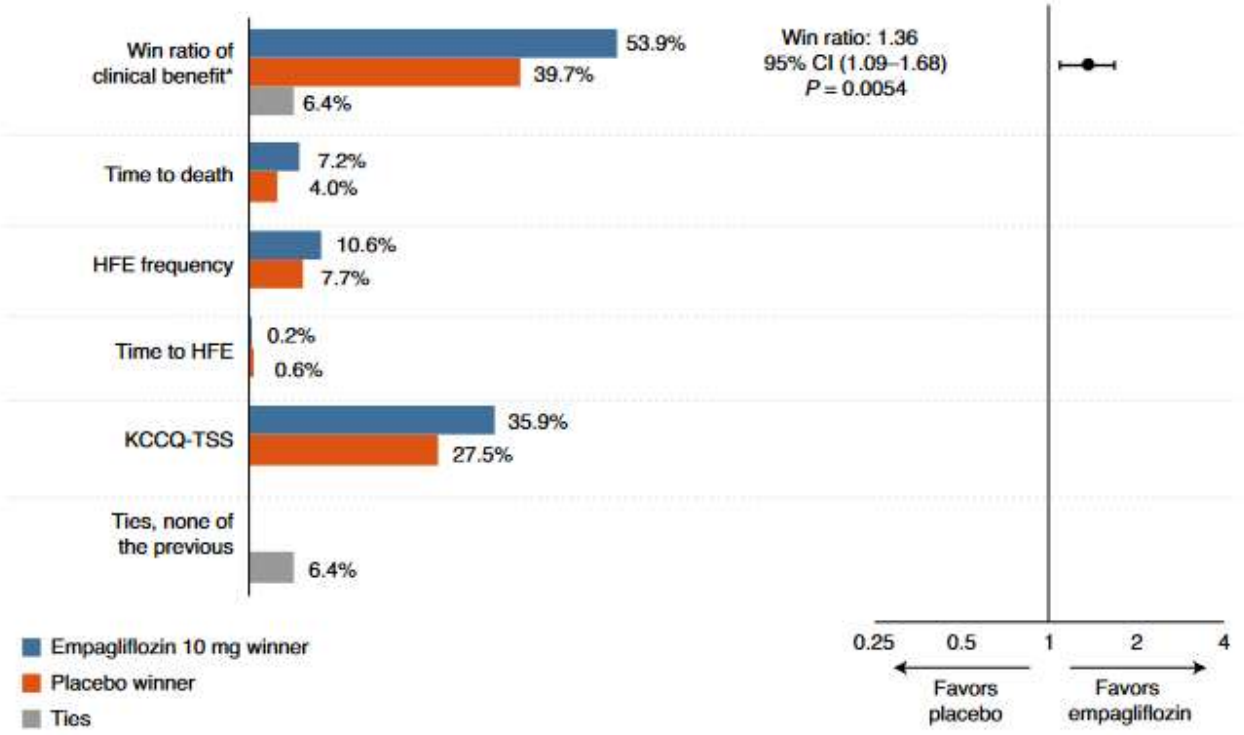
Acute heart failure

ARTICLES
https://doi.org/10.1038/s41591-021-01659-1
nature medicine
Check for updates

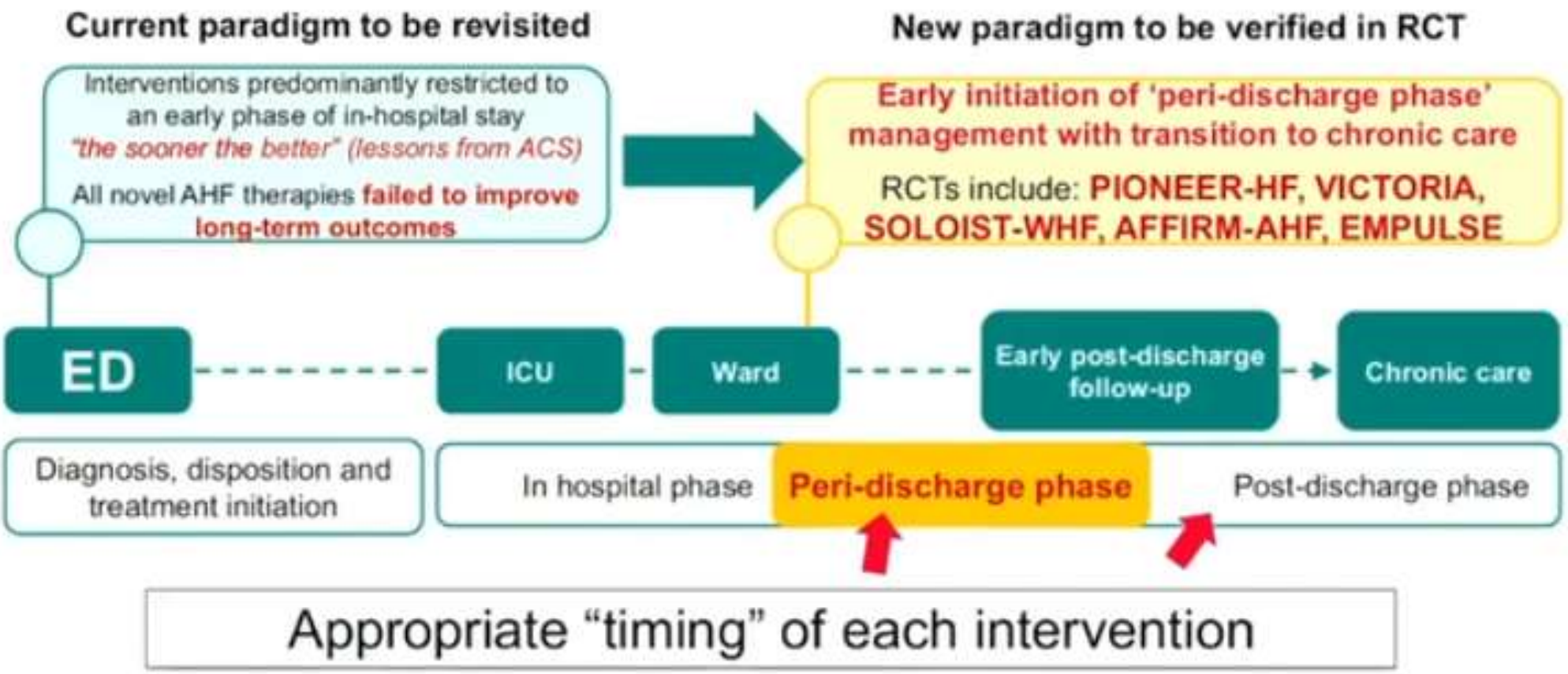
OPEN

The SGLT2 inhibitor empagliflozin in patients hospitalized for acute heart failure: a multinational randomized trial

The sodium–glucose cotransporter 2 inhibitor empagliflozin reduces the risk of cardiovascular death or heart failure hospitalization in patients with chronic heart failure, but whether empagliflozin also improves clinical outcomes when initiated in patients who are hospitalized for acute heart failure is unknown. In this double-blind trial (EMPULSE; NCT04157751), 530 patients with a primary diagnosis of acute de novo or decompensated chronic heart failure regardless of left ventricular ejection fraction were randomly assigned to receive empagliflozin 10 mg once daily or placebo.



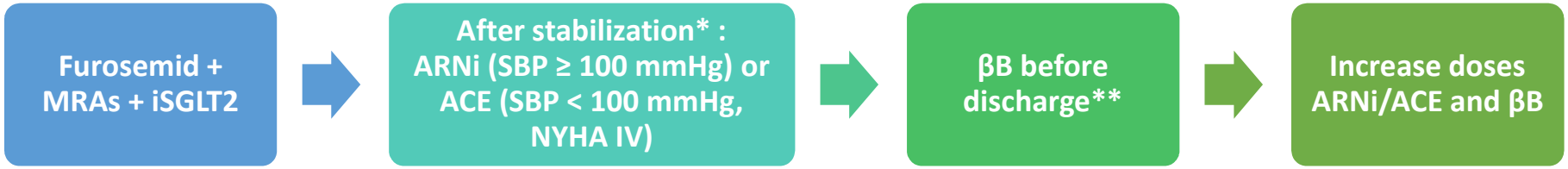
Acute heart failure



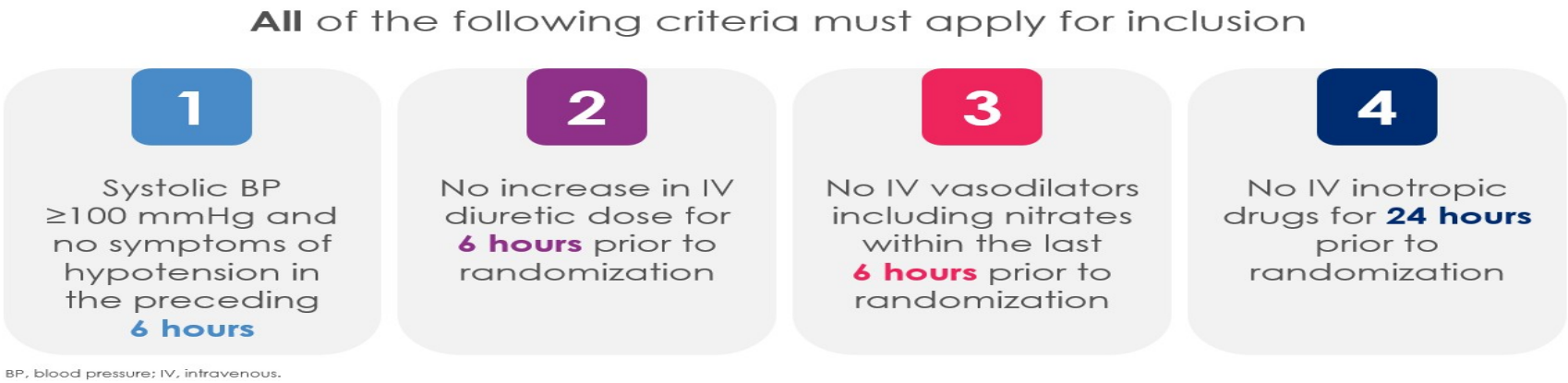
EJH 2022

Comment introduire les différentes classes pharmacologiques essentielles chez un patient présentant une ICFEr hospitalisé pour décompensation ?

Diuretic effects of MRAs and SGTL2i participate to decongestion induced by furosemid



* Meets stabilization critera :



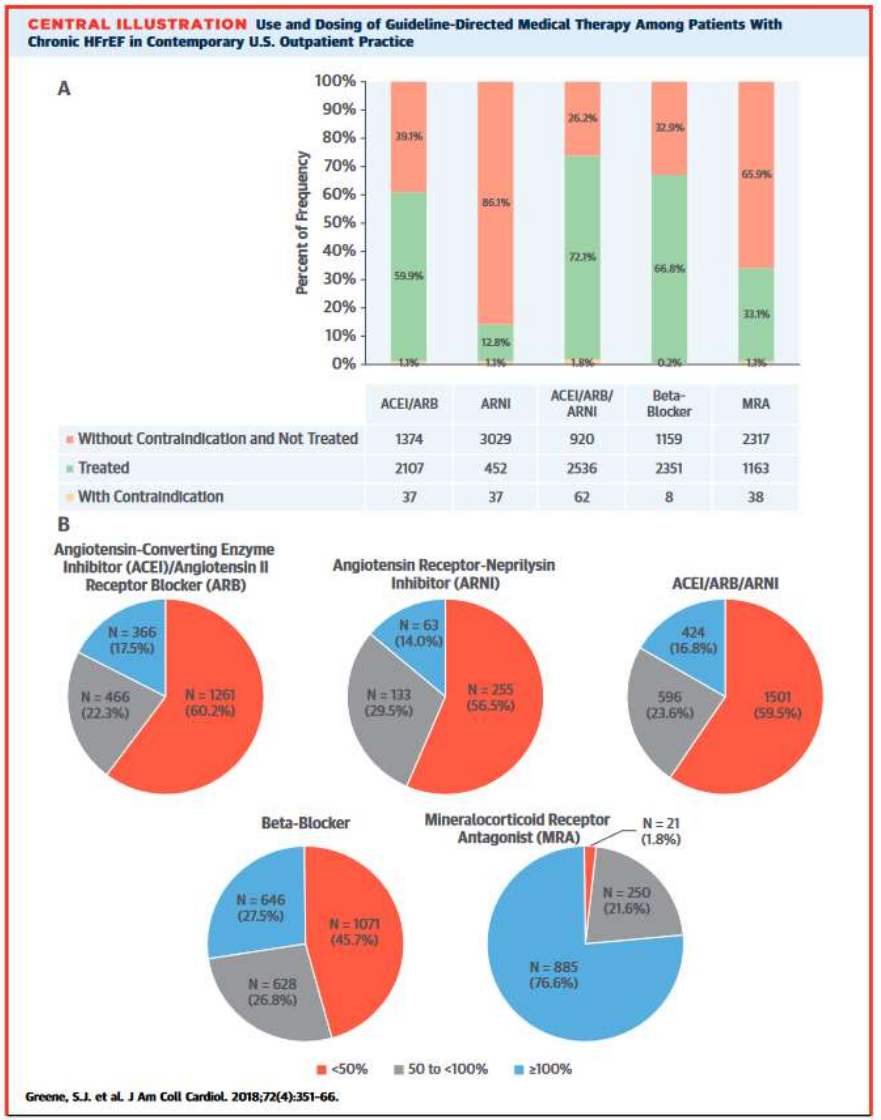
** Introduce early βB if arhythmic events

Starting all 4 classes in a short-time period (≤ 1 week) is feasible during hospitalization

Tromp J, et al. Eur J Heart Fail 2021;23(5):826-834

Management strategies

Multiple real-life registries show significant **gaps in the optimal use and dosing of GDMT**, both in outpatients and in patients hospitalized for heart failure[1–11]

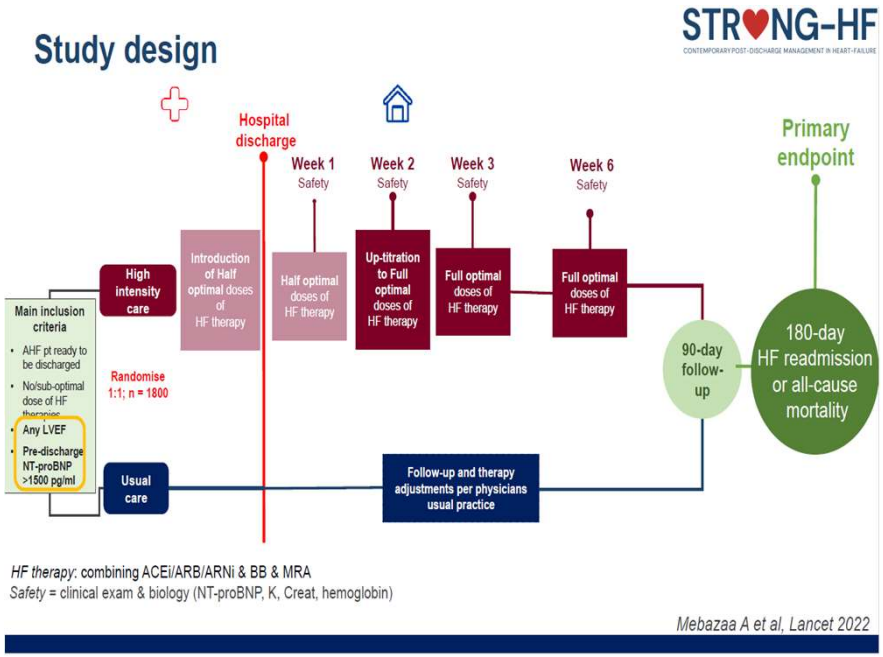


CHAMP registry J Am Coll Cardiol 2018;72:351–66

Management strategies

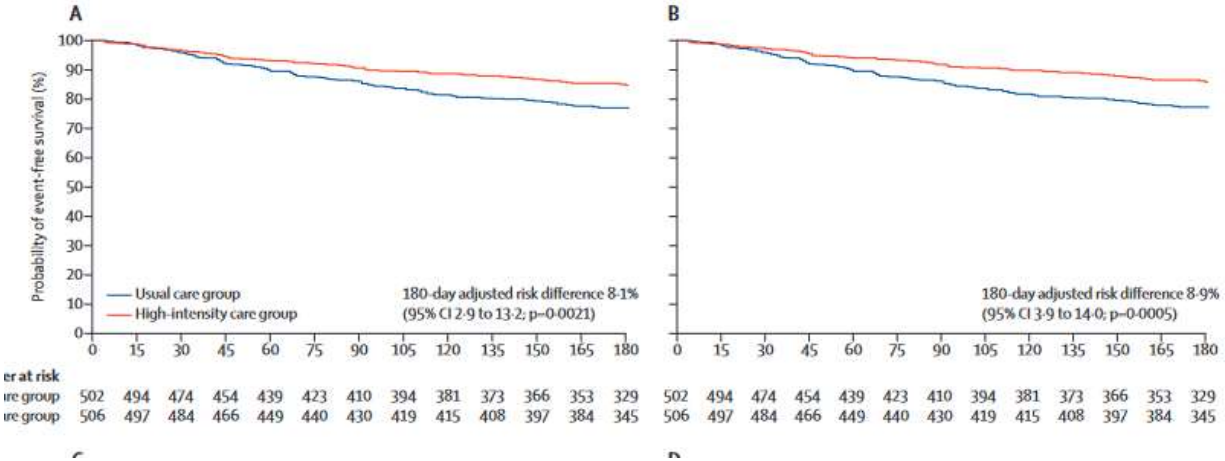
Safety, tolerability, and efficacy of up-titration of guideline-directed medical therapies for acute heart failure (STRONG-HF): a multinational, open-label, randomised, trial

Alexandre Mebazaa, Beth Davison, Ovidiu Chioncel, Alain Cohen-Solal, Rafael Diaz, Gerasimos Filippatos, Marco Metra, Piotr Ponikowski, Karen Sliwa, Adriaan A Voors, Christopher Edwards, Maria Novosadova, Koji Takagi, Albertino Damasceno, Hadiza Saidu, Etienne Gayat, Peter S Pang, Jelena Celutkiene, Gad Cotter

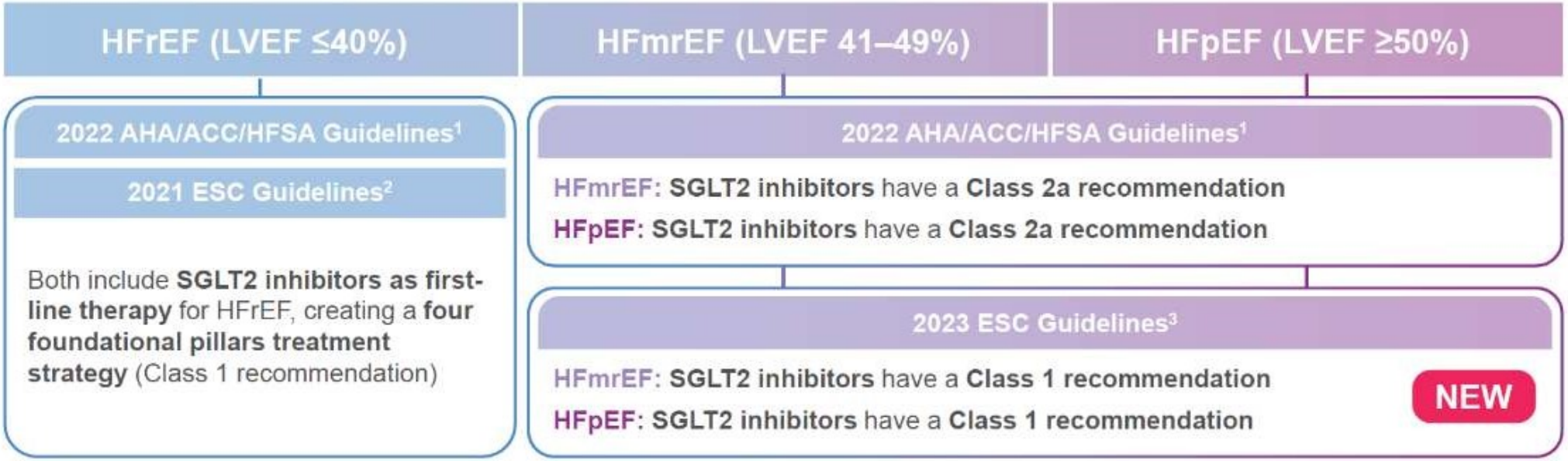


Recommendation Table 3 — Recommendation for pre-discharge and early post-discharge follow-up of patients hospitalized for acute heart failure

Recommendation	Class[a]	Level[b]
An intensive strategy of initiation and rapid up-titration of evidence-based treatment before discharge and during frequent and careful follow-up visits in the first 6 weeks following a HF hospitalization is recommended to reduce the risk of HF rehospitalization or death.[c,d,e] 16	I	B



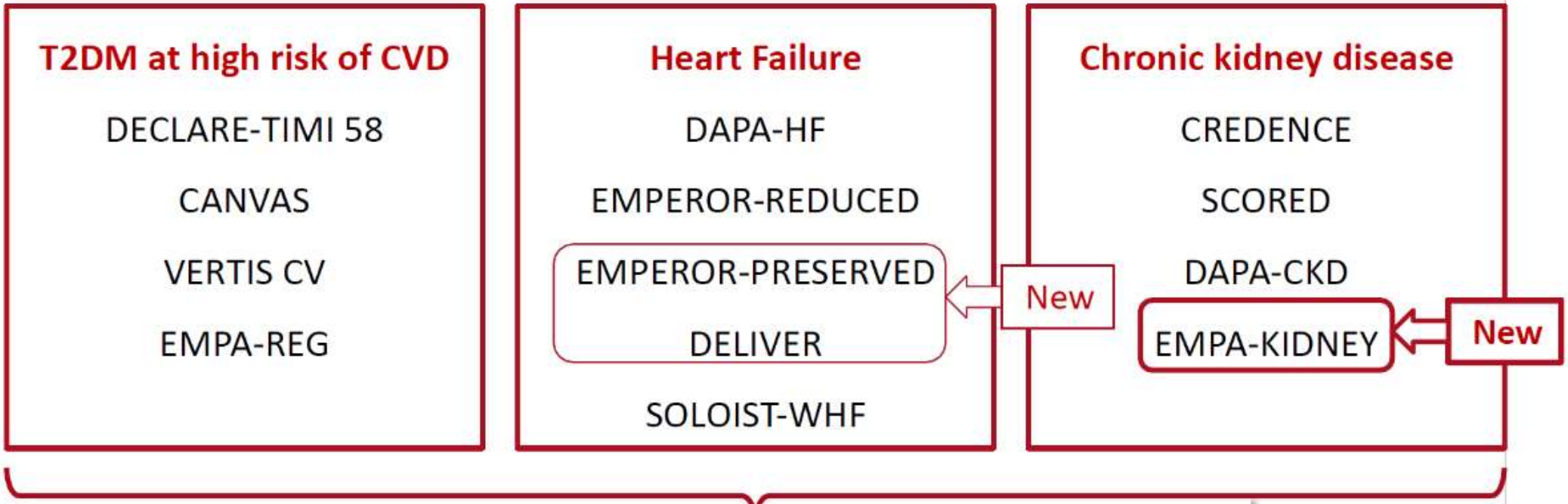
International guidelines support the use of SGLT2 inhibitors for patients with heart failure regardless of LVEF, including in the hospital setting



ACC, American College of Cardiology; AHA, American Heart Association; ESC, European Society of Cardiology; HFmrEF, heart failure with mildly reduced ejection fraction; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HFSA, Heart Failure Society of America; LVEF, left ventricular ejection fraction; SGLT2, sodium-glucose co-transporter-2.

1. Heidenreich PA *et al. J Am Coll Cardiol.* 2022;79:e263; 2. McDonagh T *et al. Eur Heart J.* 2021;42:3599; 3. McDonagh T *et al. Eur Heart J.* 2023: doi.org/10.1093/eurheartj/ehad195.

SGLT2 inhibitors trials



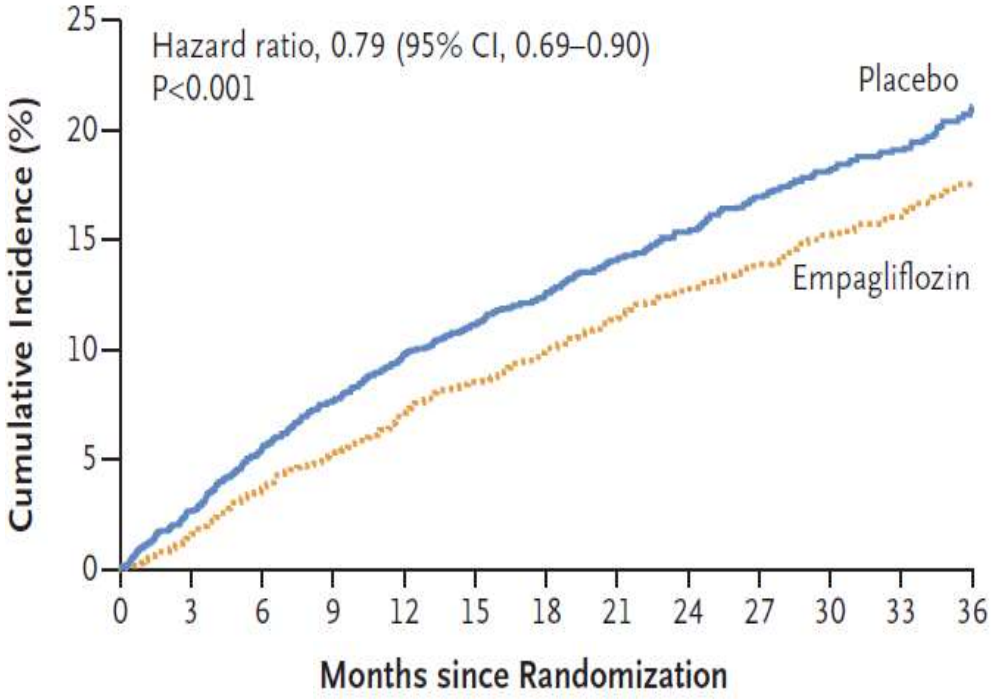
Impact of diabetes on the effects of sodium glucose co-transporter-2 inhibitors on kidney outcomes: collaborative meta-analysis of large placebo-controlled trials

The Nuffield Department of Population Health Renal Studies Group and the SGLT2 inhibitor Meta-Analysis Cardio-Renal Trialists' Consortium**

13 trials 90413 patients

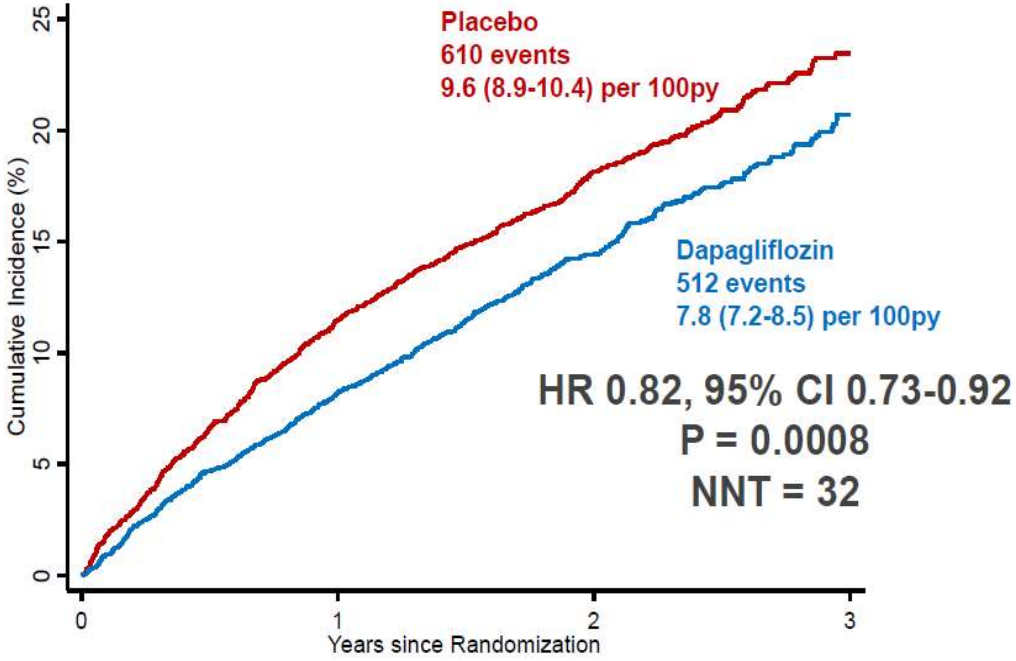
Effets des iSGLT2 dans l'ICFEp

Etude EMPEROR-Preserved
Décès cxvx ou hospitalisations pour IC



Anker SD, et al. N Engl J Med 2021;385(16):1451-1461

Etude DELIVER
Décès cxvx ou aggravation IC



Solomon SD, et al. N Engl J Med 2022;387:1089-1098

IC et comorbidités : diabète, insuffisance rénale, carence martiale

Principales comorbidités dans les essais sur l'ICFEp

	PARAGON-HF	EMPEROR-Preserved	DELIVER-HF
Age	73 ans	72 ans	72 ans
Sexe féminin	52 %	45 %	44 %
HTA	96 %	90 %	89 %
Diabète	43 %	49 %	45 %
Obésité	49 %	36 %	
FA	32 %	51 %	42 %
Insuffisance rénale	47 %	50 %	49 %

Les comorbidités sont à l'origine de la majorité des décès au cours de l'ICFEp en dehors des cardiomyopathies restrictives

Solomon SD, et al. Circ Heart Fail 2018;11(7):e004962

Chronic HF : HFmREF

Recommendation Table 1 — Recommendation for the treatment of patients with symptomatic heart failure with mildly reduced ejection fraction

Recommendation	Class[a]	Level[b]
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFmrEF to reduce the risk of HF hospitalization or CV death.[c 6,8]	I	A

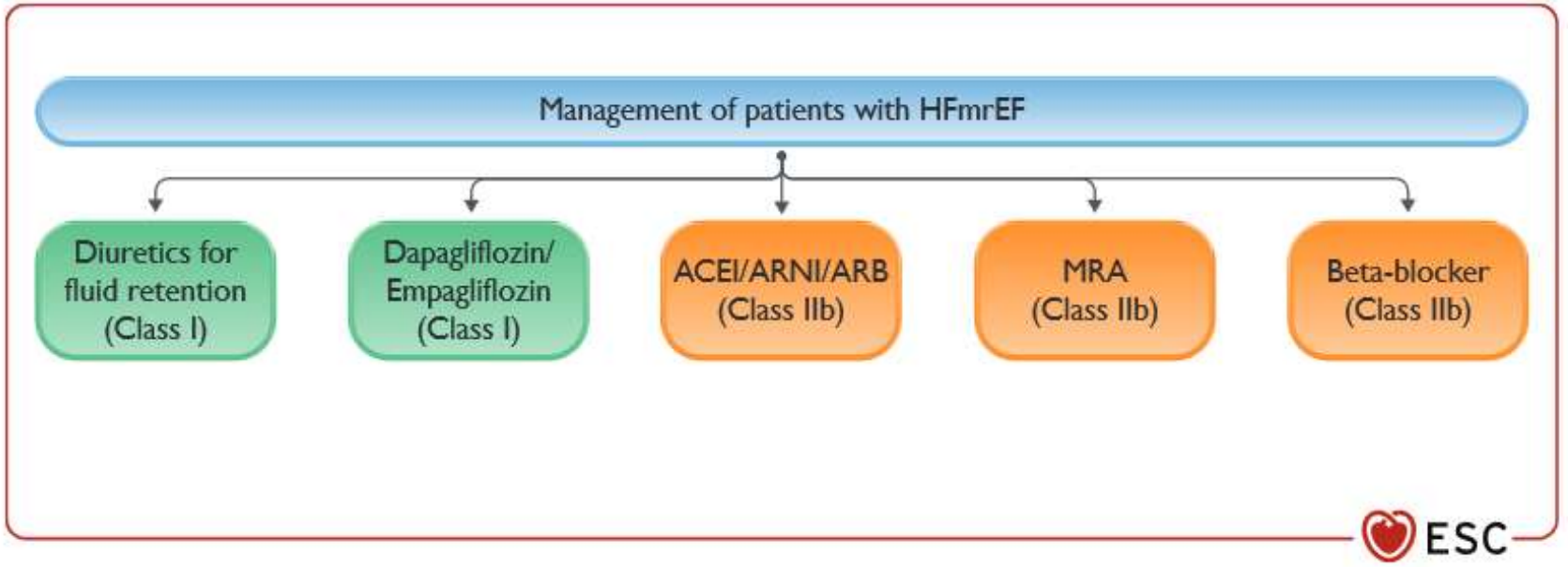


Figure 1 Management of patients with heart failure with mildly reduced ejection fraction. ACE-I, angiotensin-converting enzyme inhibitor; ARB, angiotensin receptor blocker; ARNI, angiotensin receptor–neprilysin inhibitor; HFmrEF, heart failure with mildly reduced ejection fraction; MRA, mineralocorticoid receptor antagonist.

Chronic HF : HFpEF

Recommendation Table 2 — Recommendation for the treatment of patients with symptomatic heart failure with preserved ejection fraction

Recommendation	Class[a]	Level[b]
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFpEF to reduce the risk of HF hospitalization or CV death.[c 6,8]	I	A

CV, cardiovascular; HF, heart failure; HFpEF, heart failure with preserved ejection fraction; SGLT2, sodium–glucose co-transporter 2.

[a]Class of recommendation

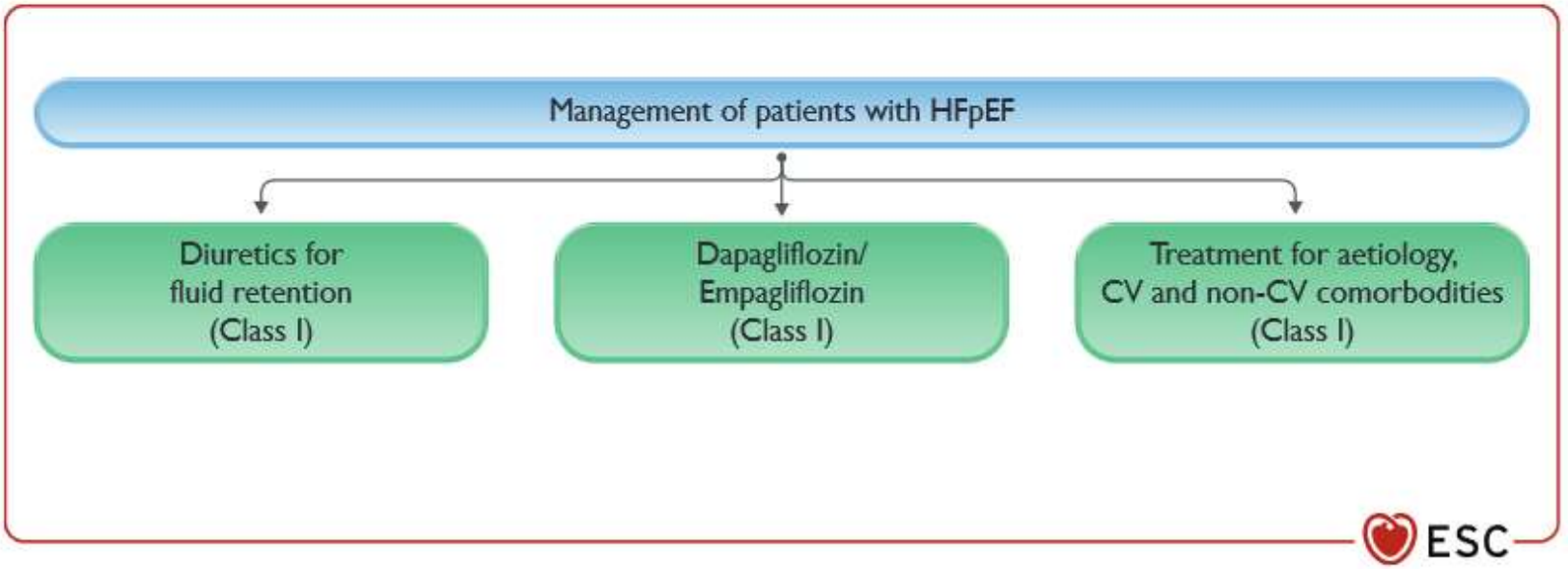


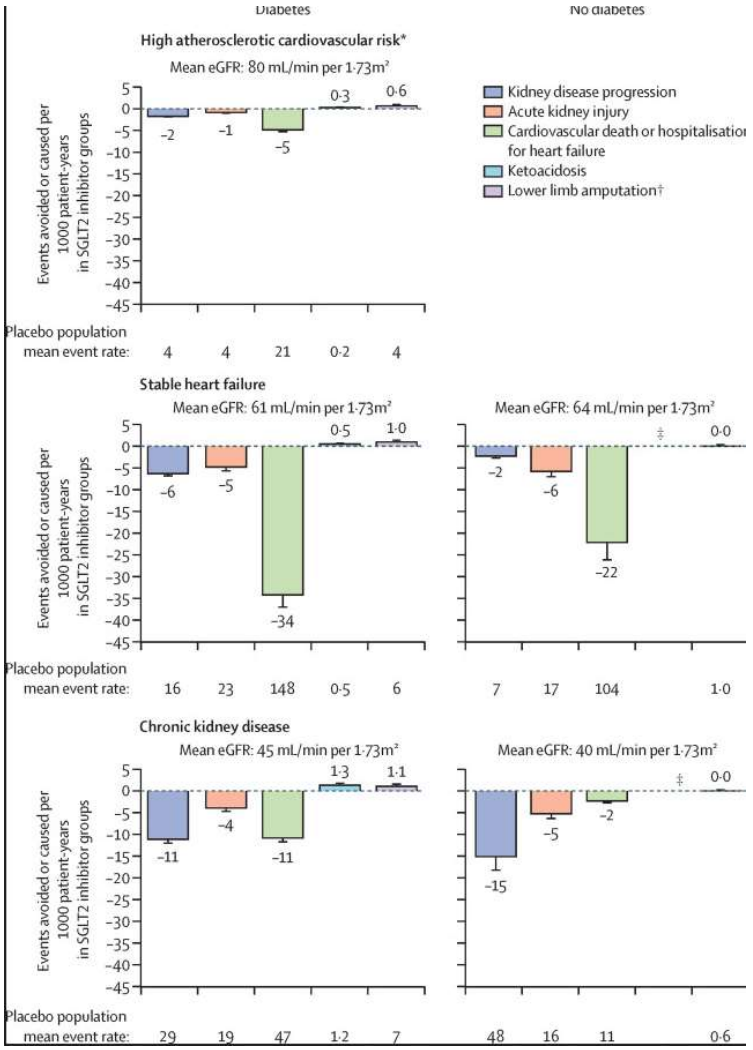
Figure 2 Management of patients with heart failure with preserved ejection fraction. CV, cardiovascular; HFpEF, heart failure with preserved ejection fraction.

Comorbidities : Diabetes and HF

5.1. Chronic kidney disease and type 2 diabetes mellitus

The 2021 ESC HF Guidelines gave recommendations for the prevention of HF in patients with diabetes. This update provides new recommendations for prevention of HF in patients with chronic kidney disease (CKD) and T2DM.[5,7,10,11,34,35]

Previous trials have shown the effects of ARB in preventing HF events in patients with diabetic nephropathy.[36,37] Both the Kidney Disease: Improving Global Outcomes (KDIGO) and the 2022 American Diabetes Association Standards of Medical Care in Diabetes and KDIGO recommendations indicate treatment with an ACE-I or ARB for patients with CKD, diabetes, and hypertension or albuminuria.[38,39]



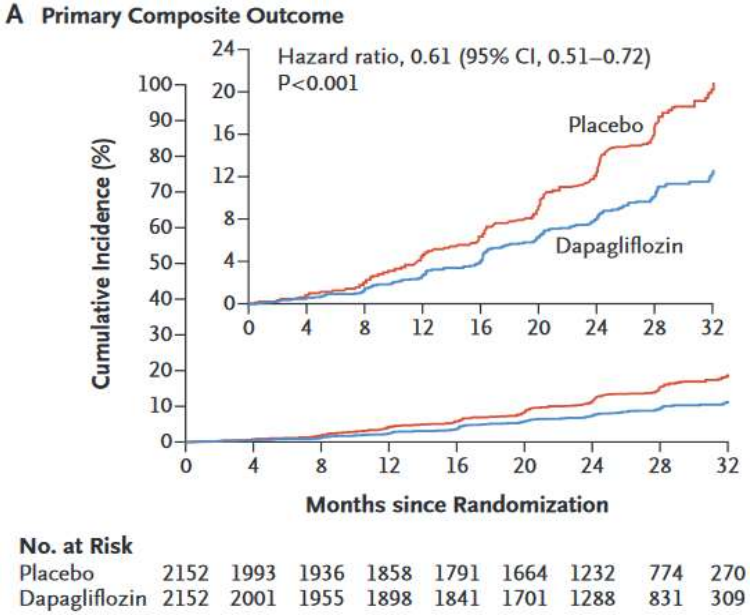
Nuffield et al. Lancet 2022;400:1788–801.

Les iSGLT2 au cours des maladies rénales chroniques

Progression de la maladie rénale ou décès cardiovasculaires

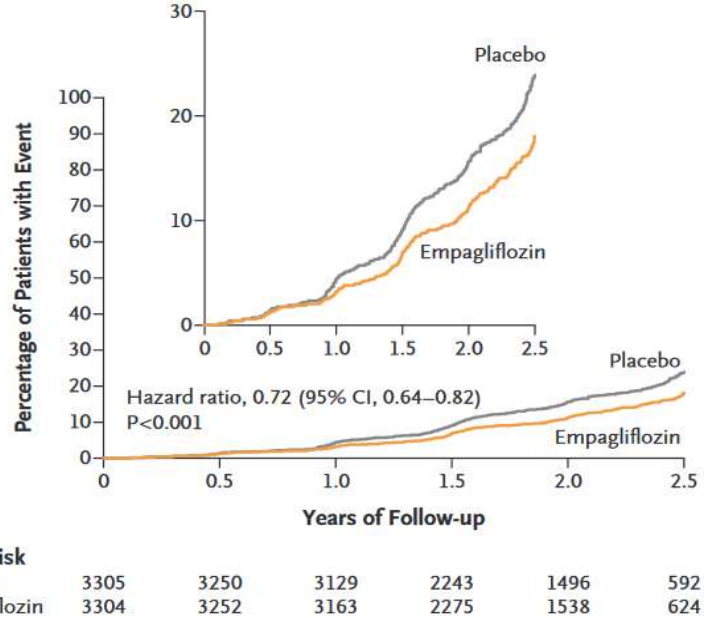
DAPA-CKD (46% diabétiques)

Déclin de la fonction rénale (↓ ≥ 50 % DFG), maladie rénale terminale, décès de causes rénales ou cardiovasculaires



EMPA-KIDNEY (67% diabétiques)

Progression maladie rénale (↓ ≥ 40 % DFG, DFG < 10 mL/min), décès de causes rénales ou cardiovasculaires



Chez les patients atteints de MRC, diabétiques ou non, la dapagliflozine et l'empagliflozine à 10 mg améliorent le pronostic rénal et cardiovasculaire

Heerspink HJL, et al. N Enl J Med 2020;383(15):1436-1446

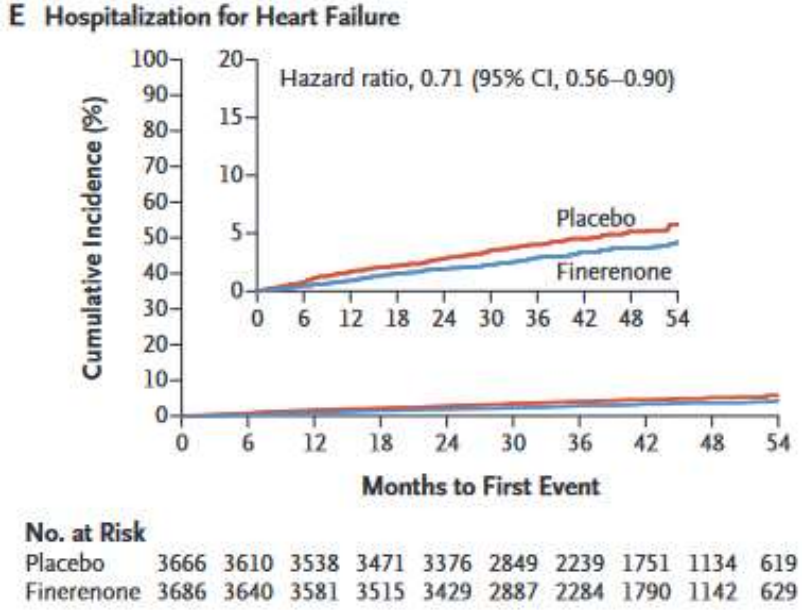
EMPA-KIDNEY Collaborative Group, et al. N Engl J Med 2023;388(2):117-127

Comorbidities : Diab and CKD

ORIGINAL ARTICLE

Cardiovascular Events with Finerenone in Kidney Disease and Type 2 Diabetes

B. Pitt, G. Filippatos, R. Agarwal, S.D. Anker, G.L. Bakris, P. Rossing, A. Joseph, P. Kolkhof, C. Nowack, P. Schloemer, and L.M. Ruilope, for the FIGARO-DKD Investigators*



Recommendation Table 4 — Recommendations for the prevention of heart failure in patients with type 2 diabetes mellitus and chronic kidney disease

Recommendations	Class[a]	Level[b]
In patients with T2DM and CKD,[c] SGLT2 inhibitors are recommended to reduce the risk of HF hospitalization or CV death.[35]	I	A
In patients with T2DM and CKD,[c] finerenone is recommended to reduce the risk of HF hospitalization.[10,11,34,40]	I	A

ESC 2023 : Traitement de la carence martiale chez les patients avec ICFEr ou mr (FE < 50 %)

Recommendations	Class[a]	Level[b]
Intravenous iron supplementation is recommended in symptomatic patients with HFrEF and HFmrEF, and iron deficiency, to alleviate HF symptoms and improve quality of life.[c] 12,41,47–49	I	A
Intravenous iron supplementation with ferric carboxymaltose or ferric derisomaltose should be considered in symptomatic patients with HFrEF and HFmrEF, and iron deficiency, to reduce the risk of HF hospitalization.[c] 12,41,43–46	IIa	A

McDonagh TA, et al. Eur Heart J 2023;44(37):3627-3639

Comorbidities : iron deficiency

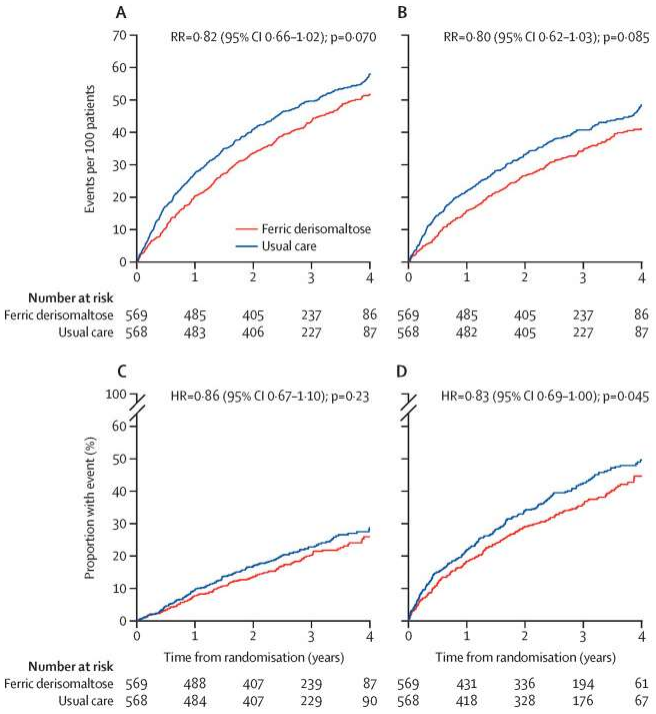
Intravenous ferric derisomaltose in patients with heart failure and iron deficiency in the UK (IRONMAN): an investigator-initiated, prospective, randomised, open-label, blinded-endpoint trial

*Paul R Kalra, John G F Cleland, Mark C Petrie, Elizabeth A Thomson, Philip A Kalra, Iain B Squire, Fozia Z Ahmed, Abdallah Al-Mohammad, Peter J Cowburn, Paul W X Foley, Fraser J Graham, Alan G Japp, Rebecca E Lane, Ninian N Lang, Andrew J Ludman, Iain C Macdougall, Pierpaolo Pellicori, Robin Ray, Michele Robertson, Alison Seed, Ian Ford, for the IRONMAN Study Group**

Summary

Background For patients with heart failure, reduced left ventricular ejection fraction and iron deficiency, intravenous ferric carboxymaltose administration improves quality of life and exercise capacity in the short-term and reduces hospital admissions for heart failure up to 1 year. We aimed to evaluate the longer-term effects of intravenous ferric derisomaltose on cardiovascular events in patients with heart failure.

Lancet 2022; 400: 2199–209
Published Online November 5, 2022
https://doi.org/10.1016/S0140-6736(22)02083-9



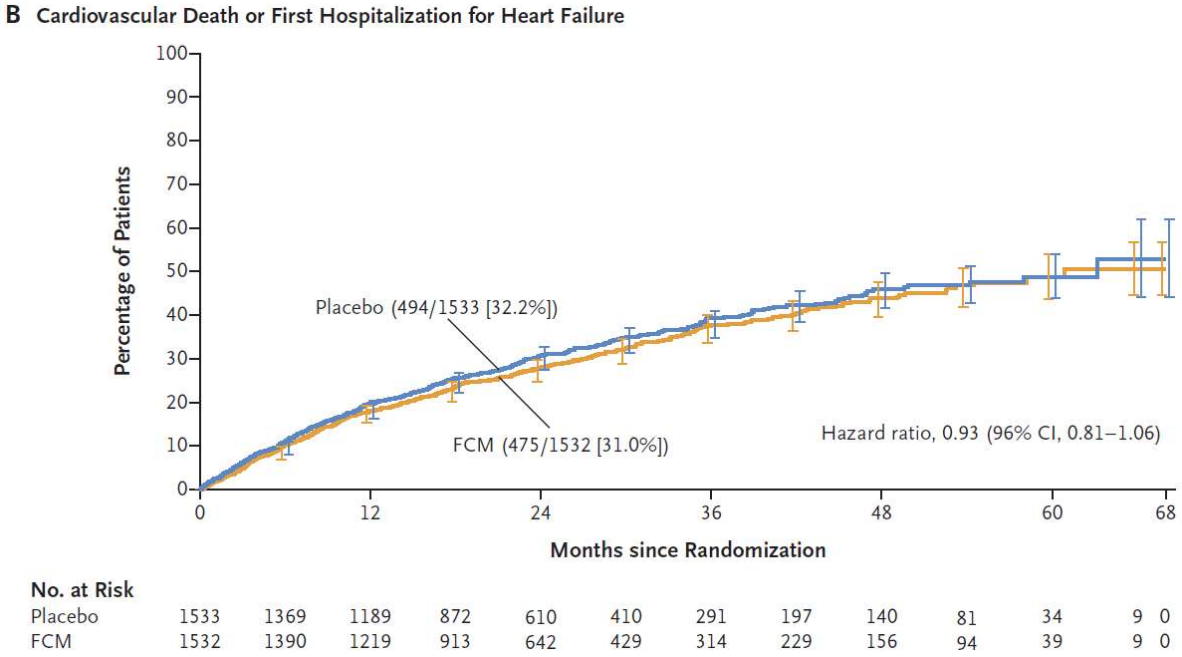
Recommendation Table 5 — Recommendations for the management of iron deficiency in patients with heart failure

Recommendations	Class[a]	Level[b]
Intravenous iron supplementation is recommended in symptomatic patients with HFrEF and HFmrEF, and iron deficiency, to alleviate HF symptoms and improve quality of life.[c] 12,41,47–49	I	A
Intravenous iron supplementation with ferric carboxymaltose or ferric derisomaltose should be considered in symptomatic patients with HFrEF and HFmrEF, and iron deficiency, to reduce the risk of HF hospitalization.[c] 12,41,43–46	IIa	A

HF, heart failure; HFmrEF, heart failure with mildly reduced ejection fraction; HFrEF, heart failure with reduced ejection fraction.
[a]Class of recommendation.
[b]Level of evidence.
[c]Most of the evidence refers to patients with left ventricular ejection fraction ≤45%.

Etude HEART-FID : effets du carboxymaltose ferrique IV sur les hospitalisations pour insuffisance cardiaque et les décès cardiovasculaires chez les patients avec ICFEr chronique (FE≤ 40 %) carencés en fer

Etude randomisée, en double aveugle, de 3065 pts traités par fer carboxymaltose tous les 6 mois si nécessaire, vs placebo, suivis 12 mois



La correction de la carence martiale par voie IV n'a diminué ni l'incidence des hospitalisations pour insuffisance cardiaque, ni celle des décès cardio-vasculaires dans l'ICFEr chronique stable

Mentz RJ, et al. N Engl J Med 2023;August 26th. https://doi.org/10.1056/NEJMoa2304968

Méta-analyse des données individuelles des patients traités par fer carboxymaltose IV pour une carence martiale au cours ICFEr et mr dans les essais CONFIRM-HF, AFFIRM-AHF, HEART-FID sur les hospitalisations et la mortalité

4501 pts, suivi : 52 semaines

	RR	IC 50 %	P
Critères primaires			
Hospitalisations cxvx et décès cxvx	0,86	0,75-0,98	0,029
Hospitalisations pour IC et décèx cxvx	0,87	0,75-1,01	0,076
Critères secondaires			
Hospitalisations cxvx	0,83	0,73-0,96	0,009
Hospitalisations pour IC	0,84	0,71-0,98	0,025
Décès cxvx	0,97	0,80-1,17	0,72

La correction de la carence martiale dans l'ICFEr et mr par du fer carboxymaltose semble diminuer le risque d'hospitalisation cxvx et pour IC mais pas la mortalité cxvx, avec des effets d'autant plus marqués que le CST (< 15 %) et l'hémoglobine sont bas.

Ponikowski P, et al. Eur Heart J August 2023. https://doi.org/10.1093/eurheartj/ehad586

ESC European Society of Cardiology

European Heart Journal (2023) **44**, 3503–3626
https://doi.org/10.1093/eurheartj/ehad194

ESC GUIDELINES

2023 ESC Guidelines for the management of cardiomyopathies

Developed by the task force on the management of cardiomyopathies of the European Society of Cardiology (ESC)

Authors/Task Force Members: Elena Arbelo *†, (Chairperson) (Spain), Alexandros Protonotarios ‡, (Task Force Co-ordinator) (United Kingdom), Juan R. Gimeno ‡, (Task Force Co-ordinator) (Spain), Eloisa Arbustini (Italy), Roberto Barriales-Villa (Spain), Cristina Basso (Italy), Connie R. Bezzina (Netherlands), Elena Biagini (Italy), Nico A. Blom[1] (Netherlands),

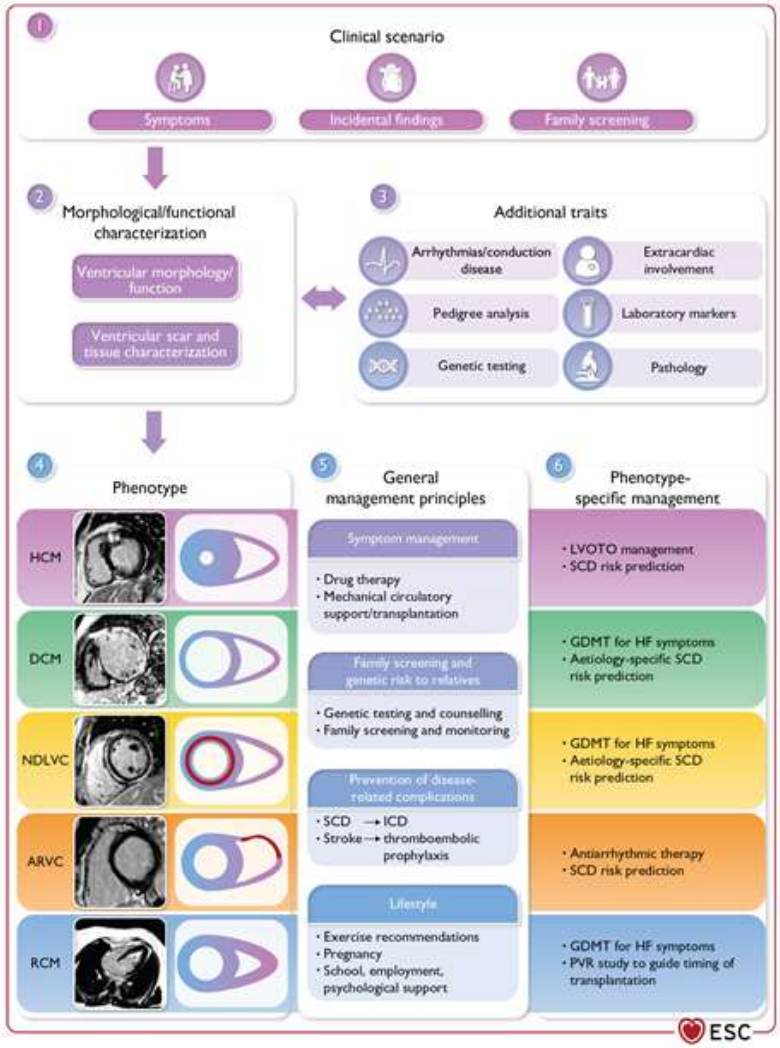
Definitions

A **cardiomyopathy** is defined as '*a myocardial disorder in which the heart muscle is structurally and functionally abnormal, in the absence of coronary artery disease (CAD), hypertension, valvular disease, and congenital heart disease (CHD) sufficient to cause the observed myocardial abnormality*'.

2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

Figure 1

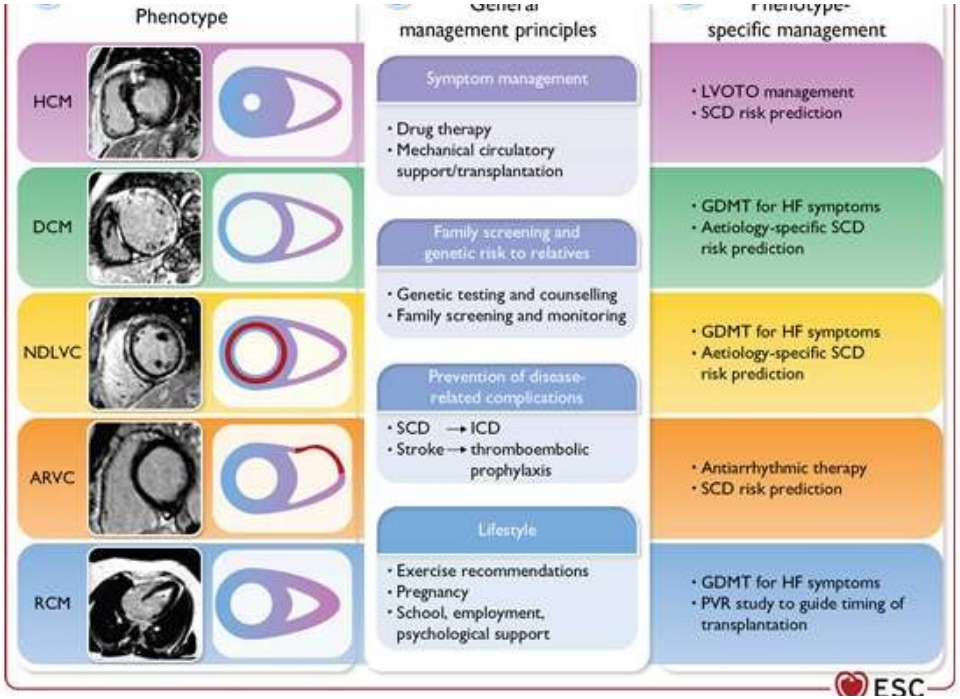
Central illustration. Key aspects in the evaluation and management of cardiomyopathies



2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

Morphological and functional traits used to describe cardiomyopathy phenotypes

Morphological traits
Ventricular hypertrophy: left and/or right
Ventricular dilatation: left and/or right
Non-ischaemic ventricular scar and other myocardial tissue characterization features on cardiac magnetic resonance
Functional traits
Ventricular systolic dysfunction (global, regional)
Ventricular diastolic dysfunction (restrictive physiology)



Key epidemiological metrics in adults and children for the different cardiomyopathy phenotypes

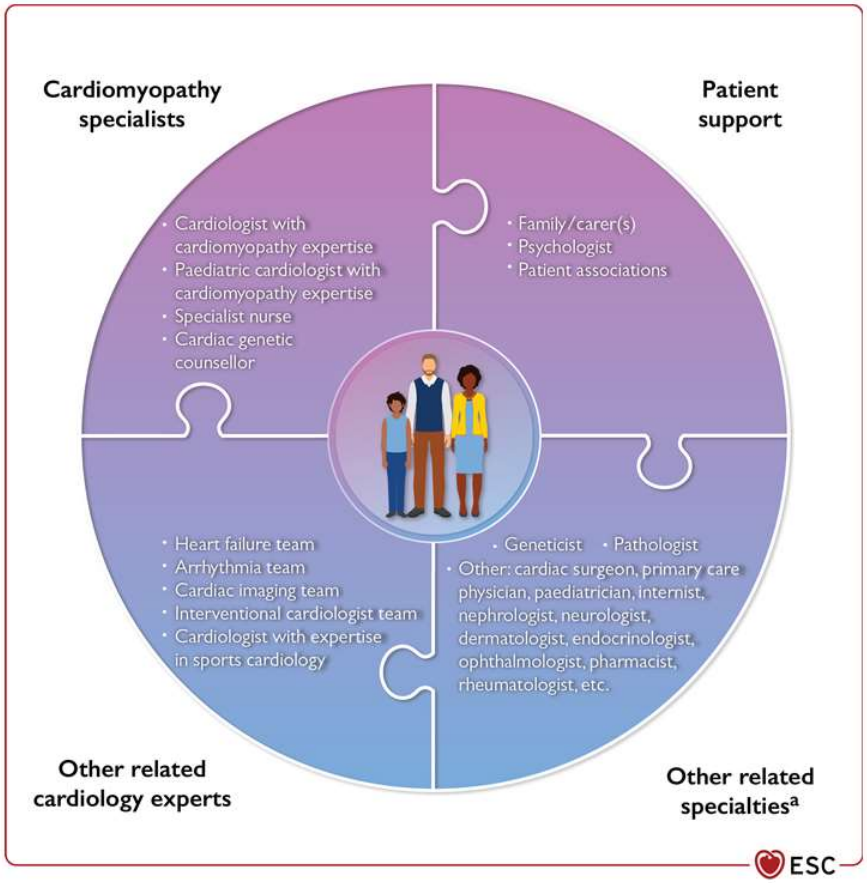
Cardiomyopathy phenotype	Adults	Children
HCM	Prevalence: 0.2%	Childhood incidence: 0.002–0.005% Childhood prevalence: 0.029%
DCM	Prevalence: 0.036–0.400%	Childhood incidence: 0.003–0.006% Childhood prevalence: 0.026% Infantile incidence: 0.038–0.046%
NDLVC	To be determined	To be determined
ARVC	Prevalence: 0.078%	Very rare in infancy and early childhood; to be determined in older children and adolescents
RCM	Rare	Childhood incidence: 0.0003%

Special populations

- Alcoholic cardiomyopathy
- Cancer therapy-induced cardiomyopathy
- Péripartum cardiomyopathy
- Acute myocarditis
- Anderson Fabry disease in LVH and HCM
- Amyloidosis in severe aortic cardiomyopathy, HFpEF
- Left ventricular hypertrabeculation (left ventricular non-compaction)
- Takotsubo syndrome

2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

Multidisciplinary care of cardiomyopathies



Recommendations	Class	Level
It is recommended that all patients with cardiomyopathy and their relatives have access to **multidisciplinary teams** with expertise in the diagnosis and management of cardiomyopathies.	I	C
Timely and adequate preparation for **transition of care from paediatric to adult services**, including joint consultations, is recommended in all adolescents with cardiomyopathy.	I	C

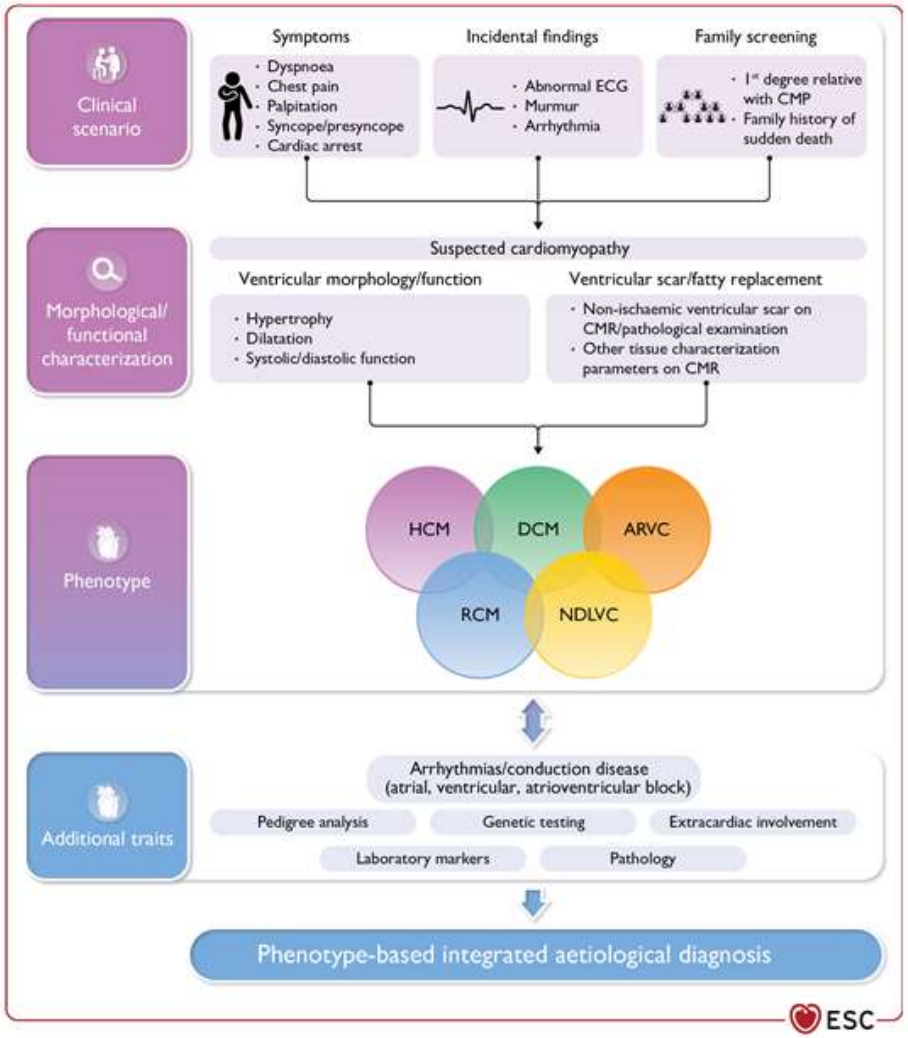
A shared and coordinated care approach between cardiomyopathy specialists and general adult and paediatric cardiology centres is strongly recommended

2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

Figure 2

Clinical diagnostic workflow of cardiomyopathy

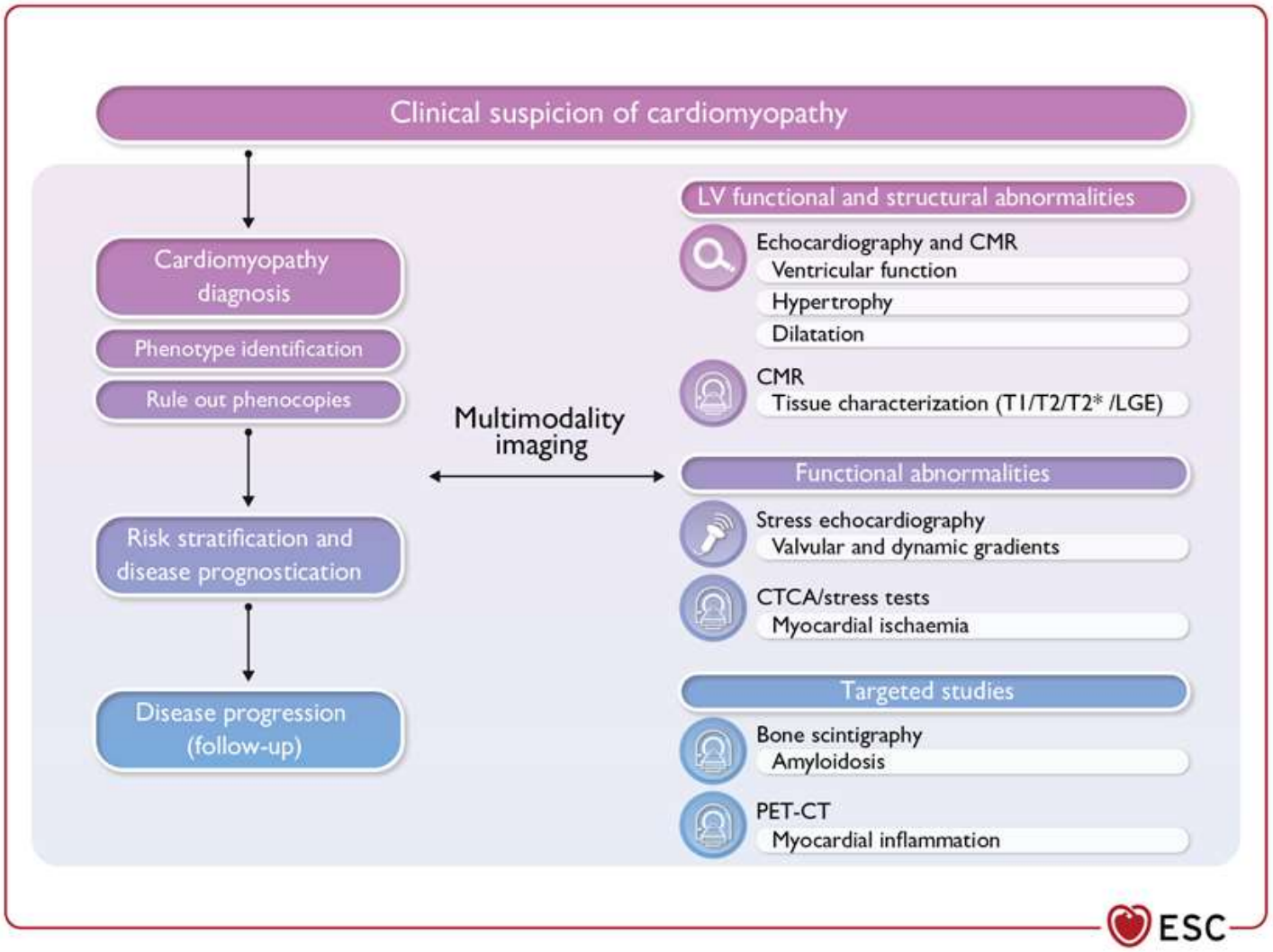
Recommendations	Class	Level
It is recommended that all patients with suspected or established cardiomyopathy undergo **systematic evaluation using a multiparametric approach** that includes clinical evaluation, pedigree analysis, ECG, Holter monitoring, laboratory tests, and multimodality imaging.	I	C
It is recommended that all patients with suspected cardiomyopathy undergo evaluation of **family history and that a three- to four-generation family tree** is created to aid in diagnosis, provide clues to underlying aetiology, determine inheritance pattern, and identify at-risk relatives.	I	C



2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

Figure 6

Multimodality imaging process in cardiomyopathies



2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

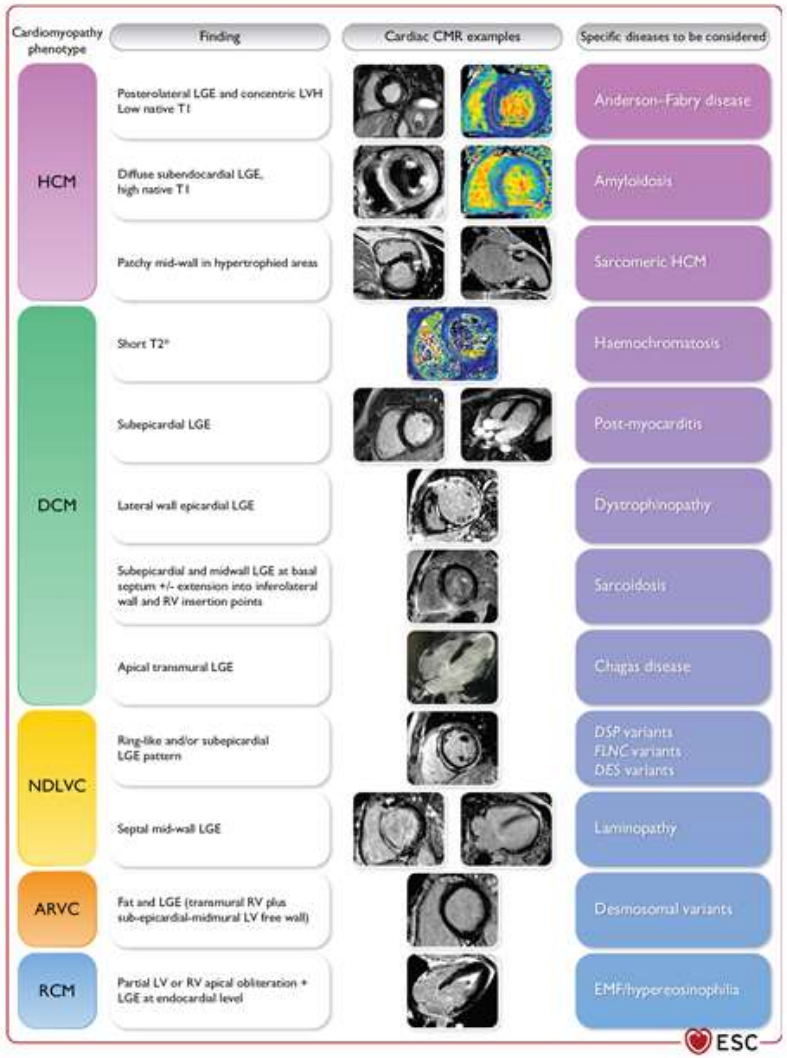
Recommendations for cardiac magnetic resonance indication in patients with cardiomyopathy

Recommendations	Class	Level
Contrast-enhanced CMR is recommended in patients with cardiomyopathy at initial evaluation.	I	B
Contrast-enhanced CMR should be considered in patients with cardiomyopathy during follow-up to monitor disease progression and aid risk stratification and management.	IIa	C
Contrast-enhanced CMR should be considered for the serial follow-up and assessment of therapeutic response in patients with cardiac amyloidosis, Anderson–Fabry disease, sarcoidosis, inflammatory cardiomyopathies, and haemochromatosis with cardiac involvement.	IIa	C
In families with cardiomyopathy in which a disease-causing variant has been identified, contrast-enhanced CMR should be considered in genotype-positive/phenotype-negative family members to aid diagnosis and detect early disease.	IIa	B
In cases of familial cardiomyopathy without a genetic diagnosis, contrast-enhanced CMR may be considered in phenotype-negative family members to aid diagnosis and detect early disease.	IIb	C

2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

Figure 7

Examples of cardiac magnetic resonance imaging tissue characterization features that should raise the suspicion of specific aetiologies, grouped according to cardiomyopathy phenotype



2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

Recommendations for genetic counselling and testing in cardiomyopathies (1)

Recommendations	Class	Level
Genetic counselling		
Genetic counselling, provided by an appropriately trained healthcare professional and including genetic education to inform decision-making and psychosocial support, is recommended for families with an inherited or suspected inherited cardiomyopathy, regardless of whether genetic testing is being considered.	I	B
It is recommended that genetic testing for cardiomyopathy is performed with access to a multidisciplinary team, including those with expertise in genetic testing methodology, sequence variant interpretation, and clinical application of genetic testing, typically in a specialized cardiomyopathy service or in a network model with access to equivalent expertise.	I	B
Pre- and post-test genetic counselling is recommended in all individuals undergoing genetic testing for cardiomyopathy.	I	B

2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

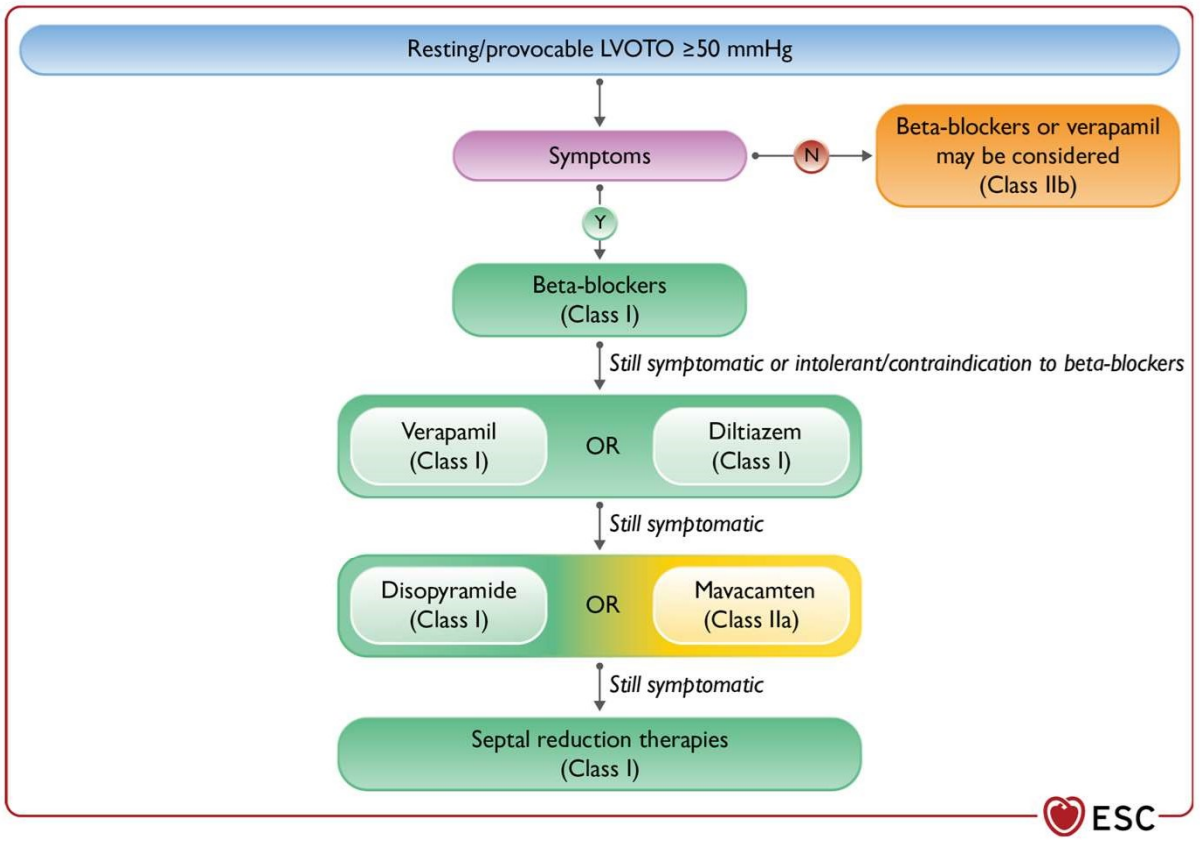
Examples of inheritance patterns that should raise the suspicion of specific genetic aetiologies, grouped according to cardiomyopathy phenotype (1)

Cardiomyopathy phenotype		AD	AR	X-linked	Matrilineal
HCM	Sarcomeric	X			
	Anderson–Fabry			X	
	Danon			X	
	TTR amyloidosis	X			
	RASopathy	X	(X)		
	Friedreich ataxia		X		
	Mitochondrial				
	Mitochondrial DNA				X
	Nuclear DNA	X	X	X	

2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

Traitement des cardiomyopathies obstructives

Flowchart on the management of left ventricular outflow tract obstruction



Place des inhibiteurs de la myosine

- En association aux bêtabloquants ou aux ICA^{++} : IIa, A
- En cas de CI ou d'intolérance aux bêtabloquants, aux ICA^{++}, au disopyramide : IIa, B

2023 ESC Guidelines for the management of cardiomyopathies
(European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad 194)

Effet de la diminution du gradient de pression intraventriculaire gauche au cours des CMH obstructives sous macavamten

Etude EXPLORER-HCM (429 pts)

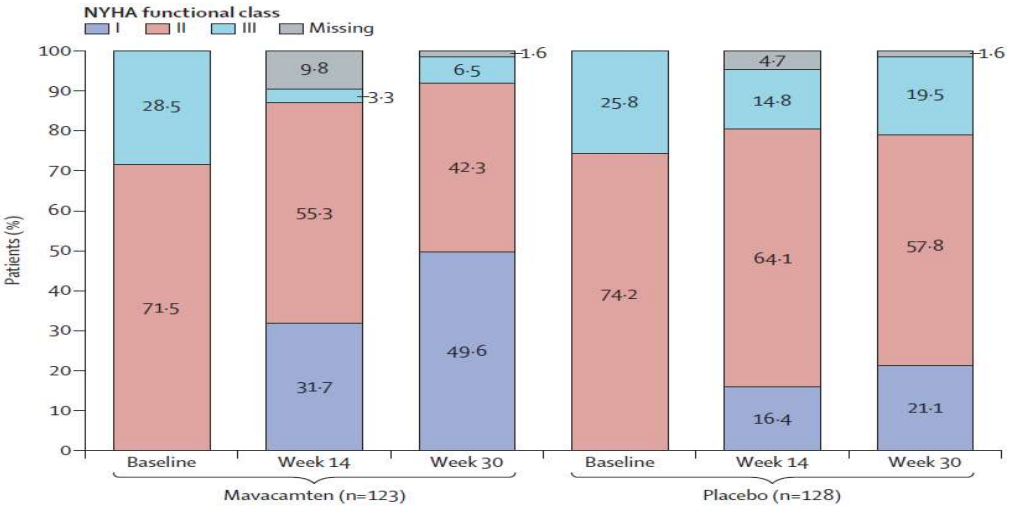
Etude VALOR-HCM (112 pts)

Diminution moyenne du gradient intra VG en post-exercice

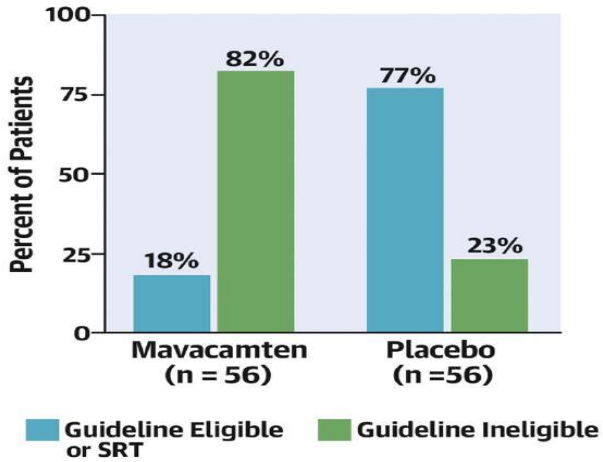
- 36 mmHg (p< 0,0001 vs placebo)

- 37,2 mmHg

Effets sur les symptômes (NYHA)



Patients qui nécessitent ou restent selon les recommandations éligibles à un traitement de réduction septale



+ amélioration du pic VO_2 et KCCQ-CSS

Olivotto I, et al. Lancet 2020;396:759-69

Desai MY, et al. J Am Coll Cardiol 2022;80(2):95-108

Actualités dans l'insuffisance cardiaque en 2023 : messages clefs

- IC aiguë : multiplier les sites d'action sur le néphron en cas de résistance au furosémide
- ICFEr : mettre en route les 4 classes thérapeutiques qui diminuent la mortalité, ARNi/IEC, βB, ARM, iSGLT2, le plus rapidement possible en augmentant les posologies aux doses maxima-tolérées en 6 semaines
- ICFEmr : même traitement que ICFEr
- ICFEp : iSGLT2 + diurétique de l'anse ± ARM et traitement étiologique
- Co-morbidités :
  - Diabète : iSGLT2, finérénone
  - Carence martiale : fer IV à visée symptomatique
- Individualisation des cardiomyopathies ventriculaires gauches non dilatées
- Cardiomyopathies hypertrophiques obstructives : intérêt des inhibiteurs de la myosine