



Rethinking Heart Failure: Myths and Reality

MYTH: Patients with a normal left ventricular ejection fraction (LVEF) cannot have heart failure.

REALITY:

Patients can have a normal LVEF and also have heart failure. Patients with HFpEF have an LVEF $\geq 50\%$.¹



NORMAL ejection fraction (EF) range and overlapping comorbidity symptoms **can delay diagnosis**^{2,3}

Diagnosing HFpEF should include a combination of evaluation of clinical symptoms and diagnostic tests, such as imaging tests and measuring natriuretic peptide levels (BNP or NT-proBNP) levels.¹

MYTH: Heart failure with reduced ejection fraction (HFrEF) is the most common type of heart failure.

REALITY:

HFpEF is the most common type of heart failure, making up more than half of all heart failure cases in the US.⁴

Relative prevalence^{4,*}



MYTH: HFpEF is not as severe as other types of heart failure.

REALITY:

Patients with HFpEF and HFrEF have similarly high rates of hospitalization, readmissions, and mortality. The risk of death increases with each subsequent hospitalization.⁸⁻¹¹

	Length in Hospital ^{8,§}	In-hospital Mortality ^{8,§}	5-Year Readmission ^{9,¶}	5-Year Mortality ^{9,¶}
HFrEF	6.8 days	5.1%	82%	75%
HFpEF	7 days	4.3%	84%	76%

Among Medicare beneficiaries ≥ 65 years of age

In patients with HFpEF:



21% readmitted within 30 days of hospital discharge^{10,||}



80% readmitted within 1 year of hospitalization (among Medicare beneficiaries ≥ 65 years of age)^{9,¶}



In patients with heart failure, in-hospital initiation of guideline-directed medical therapy (GDMT) is associated with greater long-term adherence and prescription persistence.²

MYTH: Patients with HFpEF are treated just as aggressively with GDMT as patients with HFrEF.

REALITY:

There is a higher percentage of patients with HFpEF not taking any GDMT compared with patients with HFrEF¹³

There is a lower percentage of patients with HFpEF taking multiple classes of GDMT compared with patients with HFrEF¹³

	No GDMT	Only 1 GDMT	≥ 2 GDMTs
HFrEF	3%	17%	80%
HFpEF	12%	39%	49%

GDMT for HFrEF includes diuretics, SGLT2i, ARNi, ARB, ACEi, MRA, and BB. GDMT for HFpEF includes diuretics, SGLT2i, ARNi, ARB, and MRA. Utilization data from January 2024 to December 2024.

KEY TAKEAWAYS:

- **HFpEF is the most common type of heart failure** and is associated with high rates of hospitalization, readmissions, and mortality^{4,8-11}
- **Patients with HFpEF have lower utilization of GDMT** as compared with HFrEF¹³
- **These outcomes underscore the need to optimize GDMT utilization and enhance overall disease management**²

ACEi, angiotensin-converting enzyme inhibitor; AHRQ, Agency for Healthcare Research and Quality; ARB, angiotensin receptor blocker; ARNi, angiotensin receptor-neprilysin inhibitor; BB, beta blocker; BNP, B-type natriuretic peptide; HFmrEF, heart failure with mildly reduced ejection fraction; ICD-9-CM, International Classification of Diseases, Ninth Revision, Clinical Modification; ICD-10, International Classification of Diseases, Tenth Revision; MRA, mineralocorticoid receptor antagonist; NT-proBNP, N-terminal pro-B-type natriuretic peptide; SGLT2i, sodium-glucose cotransporter-2 inhibitor.

*The publication defined HFrEF as EF $<40\%$, HFmrEF as EF 40–49%, and HFpEF as EF $\geq 50\%$.
†A single community surveillance study with predominantly White race/ethnicity of 2762 Olmsted County, Minnesota, residents diagnosed with heart failure during outpatient visits or hospital discharges, according to ICD-9-CM code 428, between 2000 and 2010. HFpEF was defined as an EF $\geq 50\%$ and HFrEF as an EF $<50\%$.
‡Analysis of 8468 patients with heart failure with LVEF ≥ 50 in I-PRESERVE and TOPCAT registries.
§Study of 5,046,879 hospitalizations of patients ≥ 18 years of age in the AHRQ's Nationwide Inpatient Sample files from 2003–2012 hospitalized with acute heart failure.
¶Longitudinal study of 39,982 patients ≥ 65 years of age in the Get With The Guidelines®–Heart Failure registry, linked with US Centers for Medicare & Medicaid Services claims data from January 1, 2005, through December 30, 2009.
||Retrospective study of 60,514 adults ≥ 18 years in the Nationwide Readmission Database who were hospitalized for acute or chronic HFpEF according to an ICD-10 diagnosis code of I5031 or acute on chronic HFpEF.¹⁰

References: 1. Heidenreich PA, et al. *J Am Coll Cardiol*. 2022;79(17):e263–e421. 2. Kittleson MM, et al. *J Am Coll Cardiol*. 2023;81(18):1835–1878. 3. Savarese G, et al. *Nat Rev Cardiol*. 2022;19(2):100–116. 4. Racine M, et al. CardioVascular Resource Group. CVrg Market Strategies Heart Failure 3Q 2024. 5. Jasinska-Piadlo A, et al. *Heart*. 2023;109(11):874–883. 6. Gerber Y, et al. *JAMA Intern Med*. 2015;175(6):996–1004. 7. Tromp J, et al. *J Am Coll Cardiol*. 2019;74(5):601–612. 8. Goyal P, et al. *Am J Med*. 2016;129(6):635.e15–635.e6.35E26. 9. Shah KS, et al. *J Am Coll Cardiol*. 2017;70(20):2476–2486. 10. Jha AK, et al. *World J Cardiol*. 2022;14(9):473–482. 11. Lindmark K, et al. *ESC Heart Fail*. 2021;8(3):2144–2153. 12. Writing Committee; Hollenberg SM, et al. *J Am Coll Cardiol*. 2024;84(13):1241–1267. 13. Data on file. Bayer.

