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EASTERN MELBOURNE
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Webinar Q & A

From hospital to home: coordinated heart failure care in general practice

Thursday 7 May 2026 – 6.30-8.00pm

About this webinar Q&A summary

This document collates questions raised by attendees during the *From hospital to home: coordinated heart failure care in general practice* webinar delivered on 7 May 2026, together with responses provided by the panel speakers during the live session, in the chat and after the webinar.

Disclaimer

This summary is intended as a practical reference to support ongoing learning and post-webinar reflection. It is provided for general educational purposes only; it does not constitute medical advice and should not replace individual clinical judgement. The content reflects information available at the time of the webinar and may have changed. Views expressed by speakers are their own and do not necessarily reflect those of Eastern Primary Health Network.

Webinar Q&A

1. **What lower limits for SBP, DBP, HR and postural BP drop is considered a trigger to pause up-titration or review by cardiac team? Should all four pillars be started simultaneously? Should up-titration be done simultaneously? In the 'ideal' patient, how many weeks should it take to have a patient on all four pillars and at ideal dose? What are the end-points we are titrating the medication against?**

   - In the STRONG-HF trial, medications were up-titrated if:
     - SBP > 95 mmHg
     - HR > 55 bpm
   - All four pillars should be started simultaneously, then incrementally up-titrated as tolerated according to clinical status as well (e.g. if BP is low, up-titrate one agent at a time with review. Reassess volume status and reduce loop diuretics if patient is well and euvolaemic/dry; if pulse is in the mid-50s, beta-blocker is typically maintained at current dose rather than up-titrated further).
   - In an ideal patient, this can be achieved within 2 weeks and definitely by 4 weeks
   - End-points for titration are maximum tolerated dose, or SBP <95, or HR <55
   - Postural BP drop: consider how long the patient is dizzy for (e.g. if they stand up, wait for 5-10 seconds then have no issues, current doses may be continued)

2. **Is it safe to reassure patients with bradycardia (e.g. HR ~40 bpm) and was 'slightly light-headed' intermittently for brief periods of time after starting Entresto®?**

   - Entresto® does not affect heart rate
   - ECG should be performed when HR <50bpm to ensure no evidence of high-degree block
   - If patient reports periods of light-headedness, Holter monitor should be used to exclude symptomatic pauses
   - If patient is well, they can be reassured if they are maintaining activities of daily living, and has stable BP and renal function
   - Light-headedness can be a common symptom in the first week post-initiation or at dose titration of Entresto®

3. **Is there a lower limit for diastolic BP?**

   - No clinically, low DBP is rarely a concern in isolation

4. **For spironolactone, is it better to dose daily or 3x a week (e.g. 25mg 2x weekly vs 12.5mg daily)?**

   - All major trials used daily dosing
   - Occasionally in practice, twice daily dosing may be trialled if unwanted effects (i.e. hyperkalaemia)

5. **Can most people tolerate maximum doses of all four pillars?**

   - ~80% of patients can tolerate maximum or target-dose therapy
   - Tolerance tends to be better when therapy is initiated early, while patients have a greater cardiac reserve, allowing higher doses and helping preserve function.

6. **How often should ECGs, EUC, BP and HR measurements be done during up-titration?**

   - Observations and blood tests: every 2 weeks, especially if recently out of hospital and up-

titrating rapidly
- ECG: ideally before initiating beta-blocker (to document rhythm rule out bradycardia or AVB), then at least annually, or sooner if there is rhythm irregularity or unexpected change

7. What ferritin and transferrin saturation thresholds justify IV iron?

- Ferritin < 100 µg/L ⟶ IV iron
- Ferritin 100–300 µg/L with TSAT < 20% ⟶ IV iron (functional iron deficiency)

8. Which ACEI is most effective for HF? Which cardio-selective beta-blocker?

- Enalapril is the only ACEI tested in RCTs; benefit considered a class effect
- Bisoprolol commonly preferred
- Nebivolol favoured in frailer patients or lower BP
- Metoprolol succinate often preferred when rate control is difficult (e.g. AF)
- Carvedilol rarely used due to twice-a-day dosing and alpha-blockade

9. How should iron deficiency be managed in HF? Is oral iron adequate?

- Oral iron is often poorly absorbed and poorly tolerated in HF
- IV iron should be considered when criteria are met

10. Do SGLT2 inhibitors cause an initial eGFR drop, and is this acceptable?

- A transient fall in eGFR (up to ~30%) is expected
- Long-term data show better renal outcomes
- Priority is decongestion and HF optimisation

11. When should renal physicians be involved?

- Consider referral when eGFR < 35
- Shared management preferred; avoid duplication of care where possible

12. Is fluid restriction still recommended?

- Routine long-term fluid restriction is not supported
- Reasonable in early post-discharge phase or after acute decompensation
- Should be relaxed after 6–12 months without admission

13. How often should heart failure medications be up-titrated – weekly or every two weeks?

- See above

14. How should patients discharged after a heart failure exacerbation with poorly controlled atrial fibrillation (AF) and high exertional heart rates be managed in the community?

- ECG initially to clarify rate and rhythm
- Ensure patient is anticoagulated
- Options for improved rate control include: increased dose of beta-blocker if tolerated, add digoxin and/or amiodarone if HR suboptimal, avoid verapamil and diltiazem as they are negative inotropes
- Target HR unclear in HF patients with AF; 60-70bpm at rest appears a reasonable target
- Refer to cardiologist for consideration of AF ablation or direct current reversion (DCR)

- Refer for a Home Medication Review to assess adherence and reconcile medication

15. For patients with HFpEF, which echocardiographic parameters best reflect improvement or treatment response over time?

- Decrease in left atrial pressures E/e' ratio
- Decrease in pulmonary pressure
- Decrease in LA volume
- Decrease in LV wall thickness

16. After starting an SGLT2 inhibitor, when should renal function be checked?

- Check baseline before starting treatment
- Repeat at 6 weeks
- If starting other agents or renal impairment, may warrant sooner if clinically indicated

17. How should peripheral oedema caused by calcium channel blockers be managed in patients with heart failure?

- Consider an alternate antihypertensive agent
- Consider ceasing or reducing the dose of calcium channel blocker and then adding alternate BP agent if needed
- Dihydropyridine calcium channel blockers commonly cause peripheral oedema from precapillary vasodilation and fluid redistribution, not true fluid overload; diuretics are usually ineffective and may increase dehydration, hypotension or renal risk in heart failure

18. Is inferior vena cava (IVC) ultrasound more useful than JVP assessment for assessing volume status in general practice?

- Volume status is best assessed by symptoms, weight, BP and renal function

19. How should heart failure be managed in patients with end-stage renal failure, particularly when fluid overload is present?

- Seek renal specialist opinion for end-stage renal disease, as some medications may need to be discontinued and patients can be resistant to diuresis (i.e. pre-dialysis CKD)
- In practice: diuretics such as furosemide can improve renal function if renally congested, but depends on case and comorbidities
- Refer for a Home Medication Review to assess adherence, check for heart failure exacerbating medications (e.g. over-the-counter NSAIDs) and reconcile medication

20. I often see physicians putting patients on furosemide and spironolactone due to fluid overload. Their eGFR plummets and this was immediately classified as acute kidney injury (AKI). This then led to the SGLT2 inhibitor being withheld. Is that warranted?

- No, SGLT2 inhibitor shouldn't be withheld; patient volume status should be re-assessed, and other contributory causes of AKI should be considered