

Liderando el conocimiento del mañana

Cardio Advanced Forum

Formación online en actualizaciones en Cardiología

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Actualización 2023 ESC GPC Insuficiencia Cardíaca (2021)

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2023 Focused Update of the 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

European Heart Journal, 2023;, ehad195, https://doi.org/10.1093/eurheartj/ehad195

Introduction



- Since the publication of the 2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure (HF) there have been several randomized controlled trials that should change patient management ahead of the next scheduled full guideline.
- The TF considered major RCTs and meta-analyses published between 31st March 2021 and 31st March 2023
 - Results leading to new or changed Class I/IIa recommendations were selected for inclusion in Recommendation Tables
 - > ≥75% of TF agreement to include a trial
 - > Trials that would have an impact upon recommendations in other ESC Guidelines under preparation were not been included to avoid discordance. (REVIVED-BCIS2)
- More than 75% of the TF had to agree for the COR/LOE to be ratified
 - Members with DOI on topics were asked to abstain from voting.
 - In assigning recommendations, as in the 2021 ESC Guidelines, the TF focused on the primary endpoints of trials.
- New recommendations are additive to, and changed recommendations substitute, those of the 2021
 Guideline

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RCTs considered: 31st March 2021-31st March 2023



Trial acronym	Trial
ADVOR	Acetazolamide in Decompensated Heart Failure with Volume Overload
CLOROTIC	Combination of Loop Diuretics with Hydrochlorothiazide in Acute Heart Failure
COACH	Comparison of Outcomes and Access to Care for Heart Failure
DAPA-CKD	Dapagliflozin And Prevention of Adverse outcomes in Chronic Kidney Disease
DELIVER	Dapagliflozin Evaluation to Improve the LIVEs of Patients with PReserved Ejection Fraction Heart Failure
EMPA-KIDNEY	EMPAgliflozin once daily to assess cardio-renal outcomes in patients with chronic KIDNEY disease
EMPEROR-Preserved	Empagliflozin Outcome Trial in Patients with Chronic Heart Failure with Preserved Ejection Fraction
EMPULSE	Empagliflozin in Patients Hospitalized with Acute Heart Failure Who Have Been Stabilized
FIDELIO-DKD	Finerenone in Reducing Kidney Failure and Disease Progression in Diabetic Kidney Disease
FIGARO-DKD	Finerenone in Reducing Cardiovascular Mortality and Morbidity in Diabetic Kidney Disease
IRONMAN	Effectiveness of Intravenous Iron Treatment versus Standard Care in Patients with Heart Failure and Iron Deficiency
PIVOTAL	Proactive IV Iron Therapy in Haemodialysis Patients
REVIVED-BCIS2	Revascularization for Ischemic Ventricular Dysfunction
STRONG-HF	Safety, Tolerability and Efficacy of Rapid Optimization, Helped by NT-proBNP Testing, of Heart Failure Therapies
TRANSFORM-HF	Torsemide Comparison with Furosemide for Management of Heart Failure
TRILUMINATE Pivotal	Clinical Trial to Evaluate Cardiovascular Outcomes in Patients Treated With the Tricuspid Valve Repair System Pivotal

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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

DESC

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

DESC

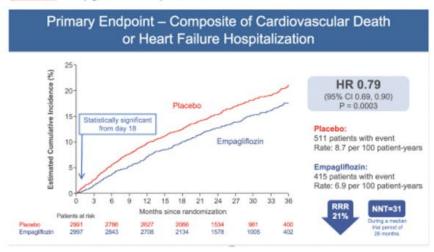
CHF: EMPEROR-Preserved and DELIVER SGLT2i Empagliflozin and Dapagliflozin HFpEF and HFmrEF



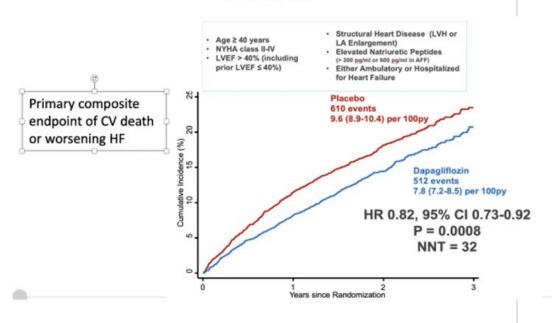
EMPEROR-Preserved

5988 patients with HF and LVEF>40% ± T2DM at baseline

LVEF>40%, NT-proBNP>300pg/ml or 900pm/ml in AF



DELIVER



Anker SD et al. NEJM 2021;385(16):1451-1461

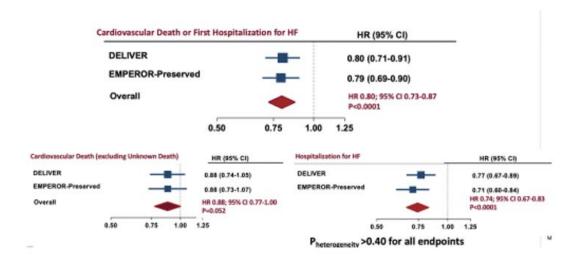
Solomon SD et al NEJM 2022;387:1089-1098

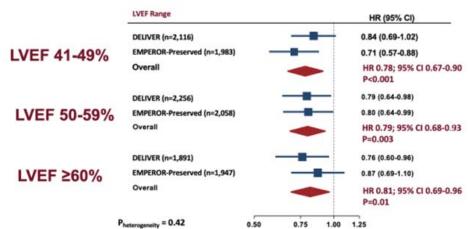
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DELIVER and EMPEROR-Preserved Meta-Analysis







Vadugunathan M et al, Lancet 2022;400(10354):757-767.

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Recommendation for the treatment of patients with symptomatic heart **©** ESC

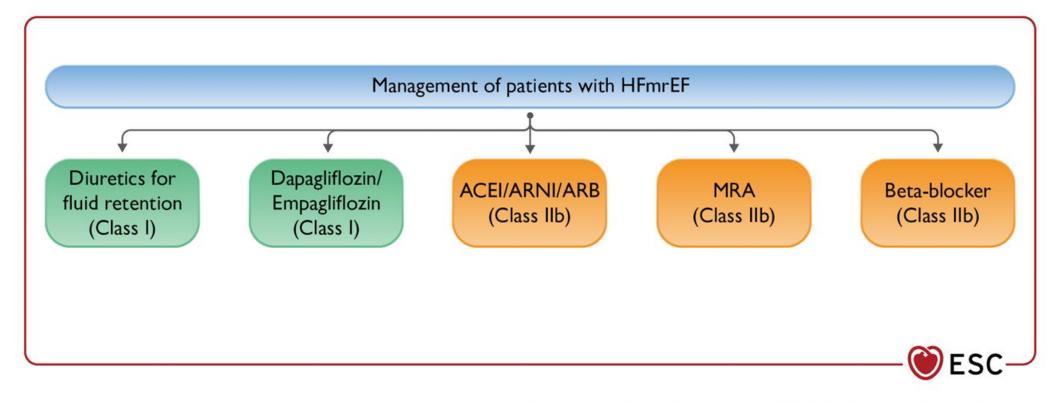


failure with mildly reduced ejection fraction

Recommendations	Class	Level
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFmrEF to reduce the risk of HF hospitalization or CV death.	Ĩ	Α

Figure 1. Management of patients with heart failure with mildly reduced **ESC** 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.

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2023 Focused update of the 2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure (European Heart Journal; 2023 - doi:10.1093/eurheartj/ehad195)

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Recommendation for the treatment of patients with symptomatic heart **ESC**

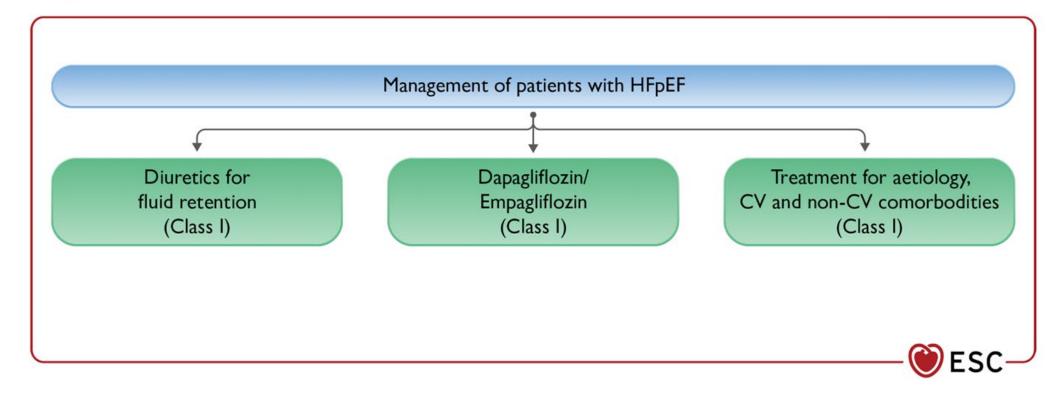


failure with preserved ejection fraction

Recommendations	Class	Level
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFpEF to reduce the risk of HF hospitalization or CV death.	1	Α

Figure 2. Management of patients with heart failure with preserved ejection fraction





CV, cardiovascular; HFpEF, heart failure with preserved ejection fraction.

DESC

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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

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Recommendations for pre-discharge and early post-discharge follow-up of patients hospitalized for acute heart failure ESC 2021 HF Guidelines



Recommendations	Class	Level
It is recommended that patients hospitalized for HF be carefully evaluated to exclude persistent signs of congestion before discharge and to optimize oral treatment	Ī	С
It is recommended that evidence-based oral medical treatment be administered before discharge.	1	С
An early follow-up visit is recommended at 1-2 weeks after discharge to assess signs of congestion, drug tolerance and start and/or uptitrate evidence-based therapy.	1	С
Ferric carboxymaltose should be considered for iron deficiency, defined as serum ferritin <100 ng/mL or serum ferritin 100–299 ng/mL with TSAT <20%, to improve symptoms and reduce rehospitalizations.	lla	В

HR = heart failure; TSAT = transferrin saturation.

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Pre-discharge management: STRONG-HF

Patients

- 1078 patients hospitalized for acute HF
- Not already on full doses of GRMT
- Haemodynamically stable
- NT-proBNP >2500 pg/mL at screening, >10% decrease screening to randomization

Randomization

High-intensity care (HIC) vs usual care (UC)

High intensity care

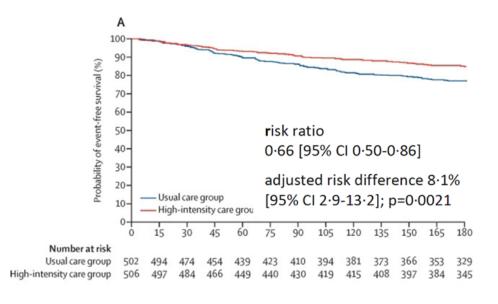
 Early (2 days before discharge) and rapid intensification of oral HF treatment with ACE-I/ARB/ARNI, beta-blockers and MRA

Mebazaa A et al Lancet. 2022 Dec 3;400(10367):1938-1952.

Results

Full doses of oral therapies. HIC vs UC

- ACEi/ARB/ARNI 55% vs. 2%,
- beta-blockers 49% vs. 4%
- MRA 84% vs. 46%



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



Recommendations	Class	Level
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	*	В
first 6 weeks following a HF hospitalization is recommended to reduce the risk of HF rehospitalization or death.		

DESC



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

- > T2 diabetes and CKD
- > Iron deficiency

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2023 Focused update of the 2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure (European Heart Journal; 2023 – doi:10.1093/eurheartj/ehad195)

DESC

ESC 2021 HF guidelines - Diabetes



Recommendations	Class	Level
SGLT2 inhibitors (canagliflozin, dapagliflozin, empagliflozin, ertugliflozin,	1, 1, .	
sotagliflozin) are recommended in patients with T2DM at risk of CV		^
events to reduce hospitalizations for HF, major CV events, end-stage		Α
renal dysfunction, and CV death.		
SGLT2 inhibitors (dapagliflozin, empagliflozin, and sotagliflozin) are		
recommended in patients with T2DM and HFrEF to reduce	1	Α
hospitalizations for HF and CV death.		

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SGLT2 inhibitors trials



New

T2DM at high risk of CVD

DECLARE-TIMI 58

CANVAS

VERTIS CV

EMPA-REG

Heart Failure

DAPA-HF

EMPEROR-REDUCED

EMPEROR-PRESERVED

DELIVER

SOLOIST-WHF

Chronic kidney disease

CREDENCE

SCORED

DAPA-CKD

New

EMPA-KIDNEY

→ (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*

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13 trials 90413 patients



→ @ 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*

Cardiovascular death or hospitalisation for heart failure*

Events/participants Mean baseline eGFR, mL/min per 1.73m²

RR (95% CI)

Results

SGLT2 inhibitor Placebo

		302.2	· idees		
Diabetes					
High atherosclerotic				,	
cardiovascular risk trials	80	1490/24563	1232/18005	-	0.80 (0.74-0.86)
Stable heart failure trials†	61	923/5046	1154/5037	-	0.77 (0.71-0.84)
Chronic kidney disease trials	45	643/10474	847/10457	-	0.74 (0.66-0.82)
Subtotal: diabetes	67	3056/40691	3233/34113	\$	0.77 (0.73-0.81)
No diabetes					
Stable heart failure trials†	64	710/5316	890/5322	- 	0.78 (0.70-0.86)
Chronic kidney disease trials	40	50/2476	53/2491	-	0.95 (0.65-1.40)
Subtotal: no diabetes	56	/60///92	943//813	<>>	0-/9 (0-/2-0-8/)
Total: overall	65	3816/48483	4176/41926	\$	0.77 (0.74-0.81)
Heterogeneity by diabetes sta	atus: p=0.67				

Lancet. 2022 Nov 19;400(10365):1788-1801

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Recommendations for the prevention of heart failure in patients with type 2 diabetes and chronic kidney disease



Recommendations	Class	Level
In patients with type 2 diabetes and CKD, SGLT2 inhibitors (dapagliflozin or empagliflozin) are recommended to reduce the risk of HF hospitalization or CV	1	Α
death.		

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Finerenone trials

Effect of Finerenone on Chronic Kidney Disease Outcomes in Type 2 Diabetes

George L. Bakris, M.D., Rajiv Agarwal, M.D., Stefan D. Anker, M.D., Ph.D., Bertram Pitt, M.D., Luis M. Ruilope, M.D., Peter Rossing, M.D., Peter Kolkhof, Ph.D. Christina Nowack, M.D., Patrick Schloemer, Ph.D., Amer Joseph, M.B., B.S., and Gerasimos Filippatos, M.D., for the FIDELIO-DKD Investigators*

No. 5734 patients
Primary endpoint: composite of kidney
failure, sustained ↓ eGFR ≥40% or death
from renal causes.

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*

No. 7437 patients

Primary endpoint: composite of CV death, nonfatal MI, non-fatal stroke, or HF hospitalization

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FASTTRACK CLINICAL RESEARCH

Diabetes and metabolic disorders

Cardiovascular and kidney outcomes with finerenone in patients with type 2 diabetes and chronic kidney disease: the FIDELITY pooled analysis

No. = 13026 patients; Median FU= 3 ys



Outcome	Finerenone (n = 6519)		Placebo (n = 6507)		H	azard ratio (95% CI)	P-value ^a	
	Number of patients with event (%)	Number of patients with event per 100 patient-years	Number of patients with event (%)	Number of patients with event per 100 patient-years)			
Composite cardiovascular outcome ^b	825 (12.7)	4.34	939 (14.4)	5.01	⊷	0.86 (0.78-0.95)	0.0018	
Death from cardiovascular causes	322 (4.9)	1.61	364 (5.6)	1.84	⊢•	0.88 (0.76–1.02)	0.092	
Non-fatal myocardial infarction	173 (2.7)	0.88	189 (2.9)	0.97	-	0.91 (0.74–1.12)	0.36	
Non-fatal stroke	198 (3.0)	1.01	198 (3.0)	1.02	-	0.99 (0.82–1.21)	0.95	
Hospitalization for heart failure	256 (3.9)	1.31	325 (5.0)	1.68	——	0.78 (0.66-0.92)	0.0030	
eGFR ≥57% composite kidney outcome ^c	360 (5.5)	1.96	465 (7.1)	2.55		0.77 (0.67-0.88)	0.0002	
Kidney failure	254 (3.9)	1.38	297 (4.6)	1.62		0.84 (0.71-0.99)	0.039	
End-stage kidney disease ^d	151 (2.3)	0.76	188 (2.9)	0.96		0.80 (0.64-0.99)	0.040°	
Sustained decrease in eGFR to <15 mL/min/1.73 m ²	195 (3.0)	1.06	237 (3.6)	1.29	⊷	0.81 (0.67-0.98)	0.026*	
Sustained ≥57% decrease in eGFR from baseline	257 (3.9)	1.40	361 (5.5)	4.03	⊷	0.70 (0.60-0.83)	< 0.0001	
Renal death	2 (<0.1)	0.01	4 (<0.1)	0.02		0.53 (0.10-2.91)	0.46°	
eGFR ≥40% composite kidney outcome¹	854 (13.1)	4.81	995 (15.3)	5.64	⊢	0.85 (0.77-0.93)	0.0004	
Sustained ≥40% decrease in eGFR from baseline	817 (12.5)	4.60	962 (14.8)	5.45	⊢	0.84 (0.76-0.92)	0.0002	
Death from any cause	552 (8.5)	2.76	614 (9.4)	3.10		0.89 (0.79->1.00) 0.051°	
Hospitalization for any cause	2836 (43.5)	19.04	2926 (45.0)	19.91	ю	0.96 (0.91–1.01)	0.087°	
					0.5 1.	0 2.0		
					avours finerenone	Favours placebo		

Recommendations for the prevention of heart failure in patients with type 2 diabetes and chronic kidney disease



Recommendations	Class	Level
In patients with type 2 diabetes and CKD, SGLT2 inhibitors (dapagliflozin or empagliflozin) are recommended to reduce the risk of HF hospitalization or CV death.	1	Α
In patients with type 2 diabetes and CKD, finerenone is recommended to reduce the risk of HF hospitalization.	Ĩ	Α

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Recommendations for anaemia and iron deficiency in patients with heart failure ESC 2021 HF Guidelines

symptomatic HF patients recently hospitalized for HF and with LVEF <50% and iron

deficiency, defined as serum ferritin <100 ng/mL or serum ferritin 100–299 ng/mL with



Recommendations It is recommended that all patients with HF be periodically screened for anaemia and iron deficiency with a full blood count, serum ferritin concentration, and TSAT. Intravenous iron supplementation with ferric carboxymaltose should be considered in symptomatic patients with LVEF <45% and iron deficiency, defined as serum ferritin <100 ng/mL or serum ferritin 100–299 ng/mL with TSAT <20%, to alleviate HF symptoms, improve exercise capacity and QOL. Intravenous iron supplementation with ferric carboxymaltose should be considered in

HF = heart failure; LVEF = left ventricular ejection fraction; QOL= quality of life; TSAT = transferrin saturation.

TSAT <20%, to reduce the risk of HF hospitalization.

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Intravenous iron in patients with heart failure and iron deficiency: an updated meta-analysis

Fraser J. Graham¹*©, Pierpaolo Pellicori², Paul R. Kalra^{3,4,5}, Ian Ford¹, Dario Bruzzese⁶, and John G.F. Cleland²

European Journal of Heart Failure (2023)

doi:10.1002/ejhf.2810

A Random Effects: Composite of recurrent hospitalisation for heart failure or cardiovascular death

Study	Rate Ratio tudy logRR SE Weight IV, Random, 95%					1		Rat IV, Ran	-	atio n, 95% CI		
Anker IPD 2018 Ponikowski 2020 Kalra 2022	-0.6340 -0.2360 -0.1980	0.1240	16.1% 39.7% 44.2%	0.53 [0.33; 0.79 [0.62; 0.82 [0.66;	1.01]			- 4				
Total (95% CI) Heterogeneity: Tau Test for overall effe				0.75 [0.61; (P = 0.26); t ² =	26%	0.1	0.2 Fav	0.5	1	2 Favours So	5 C/Placeb	10

B Random Effects: First hospitalisation for heart failure or cardiovascular death

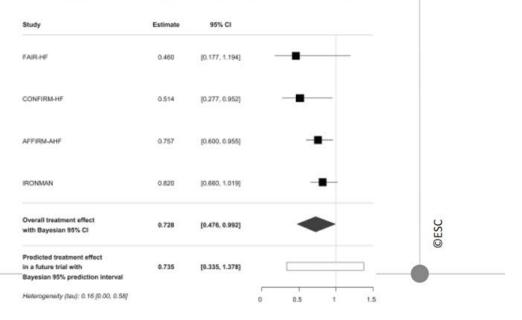
		V Iron	SoC/PI	acebo		Odds Ratio			Od	ds Ra	atio		
Study	Events	Total	Events	Total	Weight	MH, Random, 95% C	1		MH, Ran	ndom	, 95% CI		
Toblli 2007	0	20	5	20	1.1%	0.07 [0.00; 1.34]				\perp	-0		
Okonko 2008	2	24	1	11	1.5%	0.91 [0.07; 11.23]	•			•			\rightarrow
Van Veldhuisen 2017	11	88	8	86	8.4%	1.39 [0.53; 3.65]			_	-		-	
Anker IPD 2018	32	504	44	335	20.6%	0.45 [0.28; 0.72]		1.0	-				
Yeo 2018	5	24	5	25	4.5%	1.05 [0.26; 4.22]			1200				
Dhoot 2020	0	35	0	35	0.0%								
Ponikowski 2020	181	558	209	550	31.7%	0.78 [0.61; 1.00]			-	H			
Martens 2021	0	0	0	0	0.0%	Participation (Carried to							
Kalra 2022	198	569	231	568	32.1%	0.78 [0.61; 0.99]			-	-			
Total (95% CI)		1822		1630	100.0%	0.72 [0.53; 0.99]			-				
Heterogeneity: Tau ² = 0	0.0653; Ch	$i^2 = 8.9$	7, df = 6 (F	= 0.18	B): 12 = 33%			1			- 1	1	
Test for overall effect: Z	= -2.02 (P = 0.04	1)		***************************************		0.1	0.2	0.5	1	2	5	10
								Far	ours IV Iro	n F	avours So	C/Placebo	3

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Stefan D. Anker¹*, Muhammad Shahzeb Khan², Javed Butler^{3,4}, Stephan von Haehling⁵, Ewa A. Jankowska⁶, Piotr Ponikowski⁶, and Tim Friede⁷

Total HF hospitalization or CV death



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Recommendations for the management of iron deficiency in patients with heart failure



Recommendations	Class	Level
Intravenous iron supplementation is recommended in symptomatic patients with HFrEF and HFmrEF and iron deficiency, to alleviate HF symptoms and improve quality of life.	1	Α
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.	lla	Α

J.J.G

iSGLT-2 en ICFEmr e ICFEp

Inicio GDMT precoz y rápido pre alta

iSGLT-2 y finerenona en DM y ERC

Hierro i.v. En ICFEr e ICFEmr

Recommendations	Class	Level
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFmrEF to reduce the risk of HF hospitalization or CV death.	I	Α
Recommendations	Class	Level
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFpEF to reduce the risk of HF hospitalization or CV death.	ı	Α
Recommendations	Class	Level
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.	I	В
Recommendations	Class	Level
In patients with type 2 diabetes and CKD, SGLT2 inhibitors (dapagliflozin or empagliflozin) are recommended to reduce the risk of HF hospitalization or CV death.	1	Α
In patients with type 2 diabetes and CKD, finerenone is recommended to reduce the risk of HF hospitalization.	1	Α
Recommendations	Class	Level
Intravenous iron supplementation is recommended in symptomatic patients with HFrEF and HFmrEF and iron deficiency, to alleviate HF symptoms and improve quality of life.	1	Α
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.	lla	Α



Muchas Gracias

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