

Sleep-disordered breathing is common in HF and particularly in HFrEF. A range of presentations exemplified by obstructive sleep apnea, central sleep apnea, and its extreme form of Cheyne-Stokes breathing are noted. Frequent periods of hypoxia and repeated micro- and macro-arousals trigger adrenergic surges, which can worsen hypertension and impair systolic and diastolic function. A high index of suspicion is required, especially in patients with difficult-to-control hypertension or with predominant symptoms of fatigue despite reverse remodeling in response to optimal medical therapy. Worsening of right heart function with improvement of left ventricular function noted on medical therapy should immediately trigger a search for underlying sleep-disordered breathing or pulmonary complications such as occult embolism or pulmonary hypertension. Treatment with nocturnal positive airway pressure improves oxygenation, LVEF, and 6-minute walk distance. However, no conclusive data exist to support this therapy as a disease-modifying approach with reduction in mortality.

Anemia is common in heart failure patients, reduces functional status and quality of life, and is associated with increased proclivity for hospital admissions and mortality. Anemia in heart failure is more common in the elderly, in those with advanced stages of HFrEF, in the presence of renal insufficiency, and in women and African Americans. The mechanisms include iron deficiency, dysregulation of iron metabolism, and occult gastrointestinal bleeding. Intravenous iron using either iron sucrose or carboxymaltose (Ferric Carboxymaltose Assessment in Patients with Iron Deficiency and Chronic Heart Failure [FAIR-HF] trial) has been shown to correct anemia and improve functional capacity. Erythropoiesis-regulating agents such as erythropoietin analogues have been studied with disappointing results. The Reduction of Events by Darbepoetin Alfa in Heart Failure (RED-HF) trial evaluated 2278 mild-to-moderate anemia patients with HFrEF and demonstrated that treatment with darbepoetin alfa did not improve clinical outcomes in patients with systolic heart failure.

Depression is common in HFrEF, with a reported prevalence of one in five patients, and is associated with a poor quality of life, limited functional status, and increased risk of morbidity and mortality in this population. Antidepressants may improve depression, promote vascular health, and decrease systemic inflammation in HFrEF. However, the largest randomized study of depression in HFrEF, the Sertraline Against Depression and Heart Disease in Chronic Heart Failure (SADHART-CHF) trial, showed that sertraline was safe, but did not provide greater reduction in depression or improve cardiovascular status among patients with heart failure and depression compared with nurse-driven multidisciplinary management.

Atrial arrhythmias, especially atrial fibrillation, are common and serve as a harbinger of worse prognosis in patients with heart failure. When rate control is inadequate or symptoms persist, pursuing a rhythm control strategy is reasonable. Rhythm control may be achieved via pharmacotherapy or by percutaneous or surgical techniques, and referral to practitioners or centers experienced in these modalities is recommended. Antiarrhythmic drug therapy should be restricted to amiodarone and dofetilide, both of which have been shown to be safe and effective but do not alter the natural history of the underlying disease. The Antiarrhythmic Trial with Dronedarone in Moderate-to-Severe Congestive Heart Failure Evaluating Morbidity Decrease (ANDROMEDA) studied the effects of the novel antiarrhythmic agent dronedarone and found an increased mortality due to worsening heart failure. Catheter ablation and pulmonary vein isolation appear to be safe and effective in this high-risk cohort and compare favorably with the more established practice of atrioventricular node ablation and biventricular pacing.

CARDIAC RESYNCHRONIZATION THERAPY

Nonsynchronous contraction between the walls of the left ventricle (intraventricular) or between the ventricular chambers (interventricular) impairs systolic function, decreases mechanical efficiency of contraction, and adversely affects ventricular filling. Mechanical

dyssynchrony results in an increase in wall stress and worsens functional mitral regurgitation. The single most important association of extent of dyssynchrony is a widened QRS interval on the surface electrocardiogram, particularly in the presence of a left bundle branch block pattern. With placement of a pacing lead via the coronary sinus to the lateral wall of the ventricle, cardiac resynchronization therapy (CRT) enables a more synchronous ventricular contraction by aligning the timing of activation of the opposing walls. Early studies showed improved exercise capacity, reduction in symptoms, and evidence of reverse remodeling. The Cardiac Resynchronization in Heart Failure Study (CARE-HF) trial was the first study to demonstrate a reduction in all-cause mortality with CRT placement in patients with HFrEF on optimal therapy with continued moderate-to-severe residual symptoms of NYHA class III or IV heart failure. More recent clinical trials have demonstrated disease-modifying properties of CRT in even minimally symptomatic patients with HFrEF, including the Resynchronization–Defibrillation for Ambulatory Heart Failure Trial (RAFT) and Multicenter Automatic Defibrillator Implantation Trial with Cardiac Resynchronization Therapy (MADIT-CRT), both of which sought to use CRT in combination with an implantable defibrillator. Most benefit in mildly symptomatic HFrEF patients accrues from applying this therapy in those with a QRS width of >149 ms and a left bundle branch block pattern. Attempts to further optimize risk stratification and expand indications for CRT using modalities other than electrocardiography have proven disappointing. In particular, echocardiographically derived measures of dyssynchrony vary tremendously, and narrow QRS dyssynchrony has not proven to be a good target for treatment. Uncertainty surrounds the benefits of CRT in those with ADHF, a predominant right bundle branch block pattern, atrial fibrillation, and evidence of scar in the lateral wall, which is the precise location where the CRT lead is positioned.

SUDDEN CARDIAC DEATH PREVENTION IN HEART FAILURE

SCD due to ventricular arrhythmias is the mode of death in approximately half of patients with heart failure and is particularly proportionally prevalent in HFrEF patients with early stages of the disease. Patients who survive an episode of SCD are considered to be at very high risk and qualify for placement of an implantable cardioverter-defibrillator (ICD). Although primary prevention is challenging, the degree of residual left ventricular dysfunction despite optimal medical therapy ($\leq 35\%$) to allow for adequate remodeling and the underlying etiology (post-myocardial infarction or ischemic cardiomyopathy) are the two single most important risk markers for stratification of need and benefit. Currently, patients with NYHA class II or III symptoms of heart failure and an LVEF $< 35\%$, irrespective of etiology of heart failure, are appropriate candidates for ICD prophylactic therapy. In patients with a myocardial infarction and optimal medical therapy with residual LVEF $\leq 30\%$ (even when asymptomatic), placement of an ICD is appropriate. In patients with a terminal illness and a predicted life span of less than 6 months or in those with NYHA class IV symptoms who are refractory to medications and who are not candidates for transplant, the risks of multiple ICD shocks must be carefully weighed against the survival benefits. If a patient meets the QRS criteria for CRT, combined CRT with ICD is often employed ([Table 280-3](#)).

SURGICAL THERAPY IN HEART FAILURE

Coronary artery bypass grafting (CABG) is considered in patients with ischemic cardiomyopathy with multivessel coronary artery disease. The recognition that hibernating myocardium, defined as myocardial tissue with abnormal function but maintained cellular function, could recover after revascularization led to the notion that revascularization with CABG would be useful in those with living myocardium. Revascularization is most robustly supported in individuals with ongoing angina and left ventricular failure. Revascularizing those with left ventricular failure in the absence of angina remains controversial. The Surgical Treatment for Ischemic Heart Failure (STICH) trial enrolled 1212 patients with an ejection fraction of 35% or less and coronary artery disease amenable to CABG and randomly assigned them to