



## ECHO Idaho: Managing Heart Failure in Primary Care CASE RECOMMENDATION FORM

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**ECHO Session Date:** 9/18/2025

**Presenter Credential:** MD

Thank you for presenting your patient at ECHO Idaho –Managing Heart Failure in Primary Care session.

### Summary:

An 89-year-old woman with Medicare, residing in assisted living and supported by her daughter, presents with HFmrEF (EF 35%), NYHA Class III symptoms, and a history of valvular heart disease (mechanical AVR/MVR in 1980), chronic atrial fibrillation, rheumatic heart disease, CVA, TIAs, carotid stenosis, hypothyroidism, HTN, HLD, and prior GI bleed. Diagnosed with HF in 2017, she was last hospitalized in January 2025. She has hypotension (BP 91/54), JVD, edema, and weight gain above baseline despite low-dose torsemide (10–20mg daily), which has limited effect due to assisted living constraints on medication adjustment. Current GDMT includes low-dose Toprol XL for rate control; ACEI/ARB/ARNI, MRA, and SGLT2i are not used due to prior hypotension or never being started. Echocardiogram shows worsening function since 2020 with reduced EF, elevated filling pressures, severe atrial enlargement, RV dysfunction, significant tricuspid regurgitation, elevated RVSP, and worsening prosthetic valve gradients. Labs are stable with creatinine 0.91 and potassium 3.9. The care team's primary questions are how to manage GDMT in the setting of hypotension (which medications to prioritize or discontinue) and how best to optimize fluid removal given limited response to loop diuretic titration. The patient is cognitively intact, wishes to avoid rehospitalization, prioritize comfort, and live to her 90th birthday.

### Question:

When a patient has hypotension, which medications should be decreased or eliminated first and which are more important to keep going? Also how is it best to remove excess fluid when taking a low dose of loop diuretic daily and have already tried increasing that dose without much improvement?

After review of the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

### RECOMMENDATIONS:

#### Congestion & Diuretic Management

- Prioritize congestion control as main driver of quality of life
- Torsemide titration: increase dose up to 40 mg daily and reassess in ~5 days
- If inadequate response:
  - Add 2.5mg metolazone once daily (typically for 3 days)
  - Ideally give metolazone 30 minutes before the torsemide (loop diuretic), but same-time dosing is acceptable for adherence
- Encourage the patient to lie down after diuretic dosing to boost the effect by improving blood flow to the kidneys
- Consider subcutaneous furosemide kit (Furosix; no generic) for at-home diuresis if patient refuses hospitalization; tolerated well in patients with low BP



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### **Monitoring & Safety**

- For patients on chronic diuretics and potassium supplements, obtain baseline labs and recheck CMP/BMP about a week after intensifying diuresis. Potassium is usually stable, but supplementation may be increased short term. A mild, temporary rise in creatinine is common—especially with cardiorenal syndrome—and often returns to baseline once fluid status improves.

### **Guideline-Directed Medical Therapy (GDMT)**

- Spironolactone (MRA): If the patient's blood pressure is in the 90s/50s but they have no symptoms of hypotension or orthostasis, it may still be reasonable to try
- SGLT2 inhibitor: could also be considered, since it has minimal impact on blood pressure and provides benefits beyond diuresis, even if the fluid effect is modest

### **Additional Medicine Considerations:**

- Digoxin: Consider for symptom relief in HFrEF and AFib/valvular disease, though used selectively.

### **Nutrition & Lifestyle**

- Sodium restriction is important; difficult in assisted living settings.
- Encourage patient/family to advocate with facility dietitian for lower-sodium meals.
- Suggest keeping low-sodium, ready-to-eat foods (fruit, yogurt, hummus, vegetables) in a mini-fridge.
- Support small, realistic dietary changes while respecting quality-of-life preferences.

### **Goals of Care & Support**

- Patient's priorities: avoid hospitalization, focus on comfort, maintain function, and live to 90th birthday.
- Regularly revisit goals of care discussions with the patient and her daughter.
- Consider palliative or hospice referral to support ongoing care and communication.
- Ensure coordination among primary care, cardiology, assisted living staff, and family.