



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

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**ECHO Session Date:** 10/16/25

**Presenter Credential:** MD

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

### Summary:

A 67-year-old male with Medicare and a history of ischemic cardiomyopathy and chronic combined systolic and diastolic heart failure (LVEF 36–38%) presents for heart failure management. Comorbidities include prior anterior STEMI with LAD stents, ventricular tachycardia (status post ICD implantation), coronary artery disease, hypertension, type 2 diabetes (A1c 8.1%), abdominal aortic aneurysm (3.5 cm), hyperlipidemia, obesity, and former smoking. He is NYHA class II with mild lower extremity edema, BP 104/61 mmHg, HR 66 bpm, and creatinine 1.1, potassium 5.3. Current GDMT includes metoprolol ER 100 mg daily, Entresto 97/103 mg BID, spironolactone 25 mg daily, and Farxiga 10 mg daily; no loop diuretic due to minimal edema. Additional meds include amiodarone, aspirin, ezetimibe, atorvastatin, metformin, and Ozempic. Recent echo (Apr 2025) shows stable EF 36%. The provider seeks guidance on ICD placement criteria if one were not already indicated for prior VT, assuming no VT history. The patient recently relocated to Idaho, has not discussed advance directives, and aims to maintain maximum function and quality of life.

### Questions:

If ICD were not already in place for VT hx (and assuming no known hx VT), what criteria would you use to place ICD?

**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:**

#### 1. ICD Placement

- Use LVEF  $\leq 35\%$  as the general threshold for primary prevention ICD placement.
- Assess at least 6–12 weeks post-MI and after optimization of GDMT before making the decision.
- Engage in shared decision-making to ensure the patient understands the risks, benefits, and goals of care.
- Patients with ischemic cardiomyopathy have a higher arrhythmic risk, so ICD placement may be favored when borderline.

#### 2. Potassium Management

- Current potassium of 5.3 mmol/L is acceptable if stable; slightly elevated potassium may even be protective against ventricular tachycardia.
- Continue to monitor trends; if levels rise, review spironolactone dose (consider reduction or switch to finerenone for less hyperkalemia risk).
- Avoid potassium binders unless guided by cardiology/nephrology.
- Maintain vigilance with concurrent use of sacubitril/valsartan (Entresto) and MRA, which can increase potassium.

#### 3. GDMT and Medication Optimization

- Continue high-dose sacubitril/valsartan (Entresto) and SGLT2 inhibitor (dapagliflozin (Farxiga))—commendable adherence to guideline-directed therapy.
- Push GDMT to target doses while balancing safety (renal function, potassium, BP).



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- Insurance coverage for Entresto is improving and generics are likely to become more widely available in the near future since the patent expired in July 2025 and the FDA has approved a generic version.

### 4. Lipid Management

- Continue atorvastatin 80 mg + ezetimibe; current LDL 35 is excellent.
- While statins don't reduce mortality in established heart failure ([per CORONA trial](#)), they still reduce they still reduce cardiovascular hospitalizations—appropriate for this patient with extensive coronary artery disease.

### 5. Sleep and Comorbidities

- Evaluate for sleep apnea.

### 6. Lifestyle & Nutrition

- Encourage gradual lifestyle modifications toward a plant-forward diet rich in fiber, whole grains, legumes, fruits, and fatty fish.
- Address metabolic syndrome and weight management through small, sustainable changes (e.g., fewer restaurant meals, balanced breakfasts).
- Reinforce cardiac rehab referral—indicated for both post-MI and heart failure management if not yet completed.