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

ECHO Session Date: 11/20/25 **Presenter Credential**: PA-C

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

Summary:
An 83-year-old man with newly diagnosed HFrEF (EF 25–30%, NYHA III) and significant cardiac history—including prior LAD PCI, cardiac arrest with dual-chamber pacemaker placement, PSVT/NSVT, chronic diastolic HF, and frequent PVCs—presents with questions regarding further evaluation of nonischemic cardiomyopathy, ICD candidacy, and timing of palliative care. His comorbidities include CKD IV, DM2, prior CVA, carotid disease, hypoxemic respiratory failure requiring continuous O_2, and OSA. He is on guideline-directed therapy with metoprolol, lisinopril recently restarted by nephrology, dapagliflozin, and high-dose furosemide, but cannot tolerate an MRA due to kidney disease. Recent labs show creatinine 3.23 and K^+ 4.2. He has good adherence, strong family support, lives independently, and prioritizes avoiding hospitalization and maintaining independence for travel.

Questions:

- What further work up should I consider to diagnosis cause of HFrEF? When to consider ICD? When to consider palliative care consult?
- Diuretic considerations given CKD IV-- what loop diuretic is best, frequency of lab monitoring? How strict to be about fluid and salt restrictions?

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:

Evaluate causes of newly reduced EF

- Check the RV pacing burden; high pacing can cause pacemaker-induced cardiomyopathy.
- Obtain PVC (premature ventricular contraction) burden via external patch monitoring if pacemaker data is insufficient.
- Consider pacing-related or ectopy-related cardiomyopathy as likely contributors given a previously normal EF.

Device therapy considerations

- If high RV pacing burden with new LV dysfunction, consider upgrading to cardiac resynchronization therapy (CRT).
- Discuss ICD vs. CRT-P alone based on:
  - prior cardiac arrest
  - arrhythmia risk
  - comorbidities (advanced CKD)
  - patient goals of care and code status
- For patients prioritizing quality over quantity of life, CRT without ICD may be more appropriate.

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Medication & kidney function

- A creatinine rise from 3.2 to 3.78 after starting lisinopril is less than 30%; continuing the ACE inhibitor is reasonable with renal-cardiology collaboration.
- Monitor potassium closely; evaluate safety of continuing RAAS in advanced CKD.

Diuretics & Congestion Management

- In advanced CKD, loop diuretics are primary therapy:
    - Either torsemide or furosemide are acceptable; choice should be based on absorption variability and patient response.
    - New research: **New research: Potential advantages of torsemide in patients with heart failure: more than just a 'water pill'?**

- For refractory congestion, metolazone can still potentiate loop diuretics even in CKD; give 30 minutes before the loop diuretic for best effect.
- Reducing diuretic dose may allow better tolerance and optimization of core GDMT.

Diet, sodium, and fluid guidance

- Evidence supporting strict salt or fluid restriction in HF is weak.
- Recommend general healthy dietary patterns, but avoid overly strict restriction—especially in older adults prioritizing quality of life.
- Fluid restriction is not routinely recommended unless kidney-driven (e.g., approaching dialysis).

Goals of care & palliative support

- As the patient was previously listed as DNR but received CPR, there is an urgent need to clarify code status.
- Recommend palliative care consultation to support goals-of-care discussions, family involvement, ICD decision-making, and travel planning and safety.

Travel counseling

- Air travel is not advised for patients at NYHA Class IV or with severe HF due to hypoxia and lack of access to timely care.
- For driving trips:
    - Consider safety risks due to possible arrhythmia during long drives
    - Plan routes with access to medical care; avoid remote overnight locations
    - Recommend traveling with family support