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

ECHO Session Date: 12/18/25

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

Summary: This case involves an 82-year-old male with longstanding HFrEF (EF 30%, NYHA class I) due to ischemic cardiomyopathy following multiple MIs, most recently in 2005, who is followed in rural Challis and remains functionally active but reports persistent fatigue over the past year despite being otherwise asymptomatic. He is on partial GDMT including metoprolol succinate 25 mg daily, lisinopril 10 mg daily (transitioned back from Entresto due to hypotension and dizziness), and dapagliflozin 10 mg daily, but is not on an MRA for unclear reasons and has had unexplained down-titration of both beta blocker and ARNI doses over time. Comorbidities include CAD, CKD stage 3, DM2, COPD, depression, and hypothyroidism with elevated TSH and normal T4.

Q#1: Should an MRA be initiated to slow disease progression given the patient's stable renal function and potassium levels, and how should GDMT be optimized (including consideration of ARNI versus ACE inhibitor) in the setting of reduced ejection fraction and prior hypotension while preserving quality of life?

Q#2: Can the patient's persistent fatigue be attributed primarily to heart failure, or is it more likely related to other contributing factors such as medication changes, depression, thyroid dysfunction, or age?

Thank you for your dedication to this patient!

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:

Geriatric Framework & Goals of Care

- Balance benefits versus harms of therapies in frail and elderly patients.
- Prioritize quality of life, functional status, and patient goals alongside guideline recommendations.
- Recognize competing mortality risks, with heart failure–related events often outweighing ischemic events once heart failure is established.

Heart Failure Assessment, Prognosis, and Management

- Reassess heart failure classification, questioning whether reported NYHA Class I status aligns with symptoms such as sleeping most of the day (recognizing that NYHA is effort-based and that depression or sleep disorders can mimic heart failure symptoms).
- Clarify heart failure stage by assessing symptom burden, response to medical therapy, functional decline, and overall disease trajectory, rather than relying on ejection fraction alone, to determine whether features of advanced (Stage D) heart failure are present.
- Consider objective functional assessment (e.g., treadmill testing or CPET) when reported activity tolerance may overestimate true capacity, ensuring testing remains optional and patient dependent.
- Check BNP or NT-proBNP levels to help determine whether fatigue is driven by heart failure severity and for prognostication, while interpreting results cautiously in older adults, as levels may be chronically elevated even when heart failure is stable.

- Use GDMT cautiously in octogenarians, acknowledging limited trial data in this age group while focusing on individualized dosing and tolerance (for more information, see Chris Longenecker's Managing Heart Failure for Special Populations (Rural, Geriatric, SUD) session).
- Use shared decision-making when considering device therapy (AICD) in frail or elderly patients, including discussion of:
    - Limited evidence in patients ≥80 years
    - Approximately 20% risk of inappropriate shocks
- Monitor home blood pressures closely, particularly episodes of very low systolic readings (e.g., 80s), when adjusting therapy.

Fatigue, Mood, Sleep, and Functional Contributors

- Do not assume fatigue is due to heart failure alone, particularly when patients report the ability to engage in activities such as pickleball; clarify what the activity entails (e.g., standing versus sustained exertion).
- Screen for sleep apnea, particularly central sleep apnea, given heart failure and daytime somnolence; referral for an in-lab sleep study is preferred over home testing.
- Evaluate depression and social isolation as likely contributors to excessive daytime sleep.
- Review medications that may contribute to fatigue, including:
    - Trazodone, which may worsen daytime somnolence
    - Beta blockers, acknowledging that dose reduction rarely resolves fatigue but may be trialed with agreement to resume if no benefit is seen
- Assess nutrition, including the possibility of inadequate caloric or protein intake in patients living alone.
- Optimize antidepressant management when fatigue and depression coexist.
- Recommend counseling, highlighting the availability of telehealth options.
- Encourage social engagement through community activities, senior centers, faith-based involvement (if applicable), or other opportunities to reduce isolation.

Lipid Management & Cardiovascular Prevention

- Continue statin therapy for ischemic cardiomyopathy as secondary prevention.
- Consider switching from simvastatin to more commonly used agents (e.g., rosuvastatin or atorvastatin) due to:
    - Drug–drug interaction risk
    - Increased concern for rhabdomyolysis in older adults
- Acknowledge the limited mortality benefit of statins in heart failure overall, while reinforcing guideline support for statin use in ischemic heart failure specifically.