



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

ECHO Session Date: 2-26-26

Presenter Credential: NP

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

Summary:

This is an older case of a 71-year-old Hispanic male with Medicare and a history of HFrEF who died in 2007 during his last hospitalization. While the exact immediate cause of death was not explicitly stated, the panel implied that he died from progressive end-stage heart failure, likely due to pump failure rather than a primary arrhythmic event. He had an ICD placed in 2005, but there was no indication that he had received shocks.

He was diagnosed with HFrEF in 2005 following an MI, was a NYHA Class III with an LVEF of 36%. His comorbidities included CAD, insulin-dependent diabetes, CVA, hypertension, hyperlipidemia, prior TB, a 20-pack-year smoking history, and a dual-chamber ICD/pacemaker. Vitals showed BP 120 mmHg, HR 58 bpm, weight 142 lbs, no JVD, but peripheral edema. He was on GDMT including carvedilol 25 mg BID, lisinopril 20 mg daily, spironolactone 50 mg daily (with weakness, SOB, and elevated potassium concerns), metformin 1000 mg BID (adherence issues due to taste and swallowing difficulty), and furosemide 20 mg daily (nocturia affecting sleep), along with insulin and warfarin. Labs showed creatinine 1.9 and potassium 4.8; echocardiogram revealed hypokinesis, and prior ischemic workup included heart catheterization after his 2005 MI.

The primary question for the ECHO panel: When should we prioritize combination therapy versus monotherapy in optimizing GDMT, considering medication complexity, adherence challenges, renal function?

If you were to have a similar case today, the panel suggests the following:

Initiate an SGLT2 Inhibitor (first approved by FDA in March 2013)

- Start empagliflozin (10–25 mg daily) or dapagliflozin.
- Consider 25 mg if additional glycemic control is needed (A1C 8.5).
- Monitor closely for hypoglycemia and consider down-titrating insulin.
- Continue metformin initially; reassess and potentially reduce pill burden if glycemic control improves.
- This was viewed as the highest-yield intervention for both heart failure and diabetes.

Consider Switching from Lisinopril to Entresto (Sacubitril/Valsartan)

- Guideline-directed option but not mandatory depending on clinical stability, affordability.
- If pursued, stop lisinopril, wait 72 hours, start low dose (24/26 mg twice daily)
- Use caution due to creatinine of 1.9, potassium 4.8 and borderline blood pressure (SBP 120)
- Emphasize shared decision-making, weighing mortality benefit vs. risk of “rocking the boat.”



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Evaluate for CRT (Cardiac Resynchronization Therapy)

- If QRS is prolonged (it was unknown), consider adding an LV lead for CRT in addition to existing ICD.
- Requires EKG review to assess QRS duration.

End-of-Life Planning for ICD

- In progressive heart failure, discuss ICD deactivation when appropriate.
- Avoid repeated shocks in end-stage disease.
- Incorporate hospice/palliative care when transitioning goals of care.

Social & Resource Support

- Ensure screening for all eligible assistance programs (even if Medicaid is denied).
- Explore food delivery programs, medical alert systems and in-home caregiver support
- Provide Spanish-language heart failure education materials (e.g., from the [American Heart Association](#)).