射血分率保留的心臟衰竭治療

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While the CHARM study has firstly proposed the term “preserved” to recruit patients with LVEF of >40% in 2003, numerous clinical trials have then investigated the pharmacological therapy in patients with HFpEF in the past 2 decades. Given the enrolled criteria were quite different between each other, the guidelines nowadays have suggested a universal definition for HFpEF, which includes a LVEF of ≥50%, associated symptoms and signs, elevated natriuretic peptides, and structural heart abnormalities or diastolic dysfunction. In contrast, subjects with symptoms and/or signs of HF, and a mildly reduced LVEF of 41–49% are considered to have HFmrEF.

Nowadays, there could be only one RCT performed exclusively in patients with HFmrEF that PEP-CHF study has enrolled subjects with LV wall motion index of 1.4–1.6, which is about LVEF 40%~50%. Otherwise, the associated data can only be assembled from subgroup analysis of trials in HFpEF. Although, there is no sufficient data supporting the disease-modifying medications in HFmrEF, a similar approach to HFrEF is generally suggested.

The diagnosis of HFpEF remains challenging, involving cardiac and extracardiac mechanisms. For subjects with a very high LVEF, a prompt survey for underline pathology, such as hypertrophic cardiomyopathy is indicated. To date, none of the large RCTs has been conducted specifically in patients with HFpEF but encompass a wide range of LVEF of more than 40% or 45%. These include CHARM-Preserved, DIG-Preserved, PEP-CHF, I-PRESERVE, J-DHF, TOPCAT, PARAGON-HF, and EMPEROR-preserved. As the disease-modifying therapies for HFpEF are limited, treatment should be pointed at reducing symptoms of congestion with diuretics and treating the underlying comorbidities. For patients with a prior reduced LVEF of ≤40% presents LVEF ≥50%, HF with improved LVEF rather than HFpEF should be considered. Continued treatment for HFrEF is recommended in these patients.