MyCardioAdvocate™

HFpEF Heart Failure

Heart Failure with Preserved Ejection Fraction (HFpEF)

When your doctor says "your heart is pumping fine"—but you can't catch your breath.

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Why This Matters

Heart failure with preserved ejection fraction (HFpEF, EF ≥50%) is the majority of heart failure cases, yet it remains the orphan stepchild of cardiology. Your heart pumps normally on the surface, but it's stiff—it can't relax and fill properly. Blood backs up into your lungs, you're breathless and exhausted, and most therapies that work for HFrEF don't work for you.

The transformation started in 2022 with SGLT2 inhibitors (EMPEROR-Preserved, DELIVER). In 2025, STEP-HFpEF showed that GLP-1 receptor agonists have dramatic benefits in obese HFpEF patients. Yet many HFpEF patients still receive no disease-specific therapy, no weight loss program, and are told to 'live with it.'

Why HFpEF Flies Under the Radar

HFpEF is a diagnosis of exclusion and requires careful workup (BNP/NT-proBNP, echocardiography, sometimes invasive hemodynamics). Many doctors miss it, attributing breathlessness to asthma, obesity, or deconditioning. Unlike HFrEF, there's no single 'magic bullet' therapy. Management is multimodal: SGLT2i, GLP-1 RA (if obese), treating comorbidities (atrial fibrillation, hypertension, sleep apnea), and aggressive weight loss.

- HFpEF and obesity/metabolic disease are intertwined; most HFpEF patients are overweight or obese.
- Atrial fibrillation drives HFpEF progression; rate control and rhythm control are critical.
- Sleep apnea is overlooked as a HFpEF driver.
- Diagnosis requires a high index of suspicion and often specialist referral.

What Changed in 2026: HFpEF & Emerging Therapies

2026 Updates:

- **HFpEF is NOT directly addressed in 2026 ATP IIIb lipid guidelines**—a notable gap. SGLT2 inhibitors and GLP-1 agonists are not lipid drugs; they work through other mechanisms (glucose, weight loss, endothelial function).
- **SGLT2 inhibitors (empagliflozin, dapagliflozin):** Now cornerstone therapy for HFpEF. EMPEROR-Preserved and DELIVER trials show 21–25% reduction in HF hospitalization and cardiovascular death.
- **GLP-1 receptor agonists (tirzepatide, semaglutide, liraglutide):** STEP-HFpEF (2025) showed tirzepatide 21% body weight loss in obese HFpEF patients with dramatic symptom improvement. Not yet standard of care, but transformative.
- **Diuretics + rate/rhythm control + weight loss:** Remain foundational. Aggressive AFib management and sleep apnea treatment are essential.

MyCardioAdvocate™ Checklist: HFpEF & Your Management

1. Is your HFpEF diagnosis confirmed with proper workup?

You should have had an echocardiogram showing EF ≥50%, elevated BNP or NT-proBNP, and imaging evidence of diastolic dysfunction or elevated filling pressures. Don't assume you have HFpEF without confirmatory testing.

2. Are you on an SGLT2 inhibitor (empagliflozin or dapagliflozin)?

SGLT2i is now first-line disease-modifying therapy for HFpEF regardless of diabetes status. If not on one, ask your cardiologist why.

3. Is obesity being addressed with lifestyle change and GLP-1 RA if appropriate?

If you have HFpEF and BMI >27 (or waist circumference >40 inches for men, >35 for women), weight loss is therapeutic. GLP-1 RA (tirzepatide, semaglutide) now has evidence for HFpEF and can achieve 20% body weight reduction. Discuss with your cardiologist and primary care doctor.

4. Are comorbidities being actively managed (AFib, hypertension, sleep apnea, metabolic disease)?

Each comorbidity worsens HFpEF and requires specific treatment. Do you have AFib? Is rate controlled to <100 bpm? Do you have sleep apnea? Are you on CPAP? Is your blood pressure on target? These matter as much as SGLT2i.

5. Are you enrolled in exercise and cardiac rehabilitation?

Exercise intolerance is characteristic of HFpEF, but supervised cardiac rehabilitation improves symptoms and exercise capacity. Ask your doctor for referral.

CPR Opportunity: GLP-1 RA for HFpEF with Obesity

The Gray Zone: STEP-HFpEF (2025) showed dramatic benefit of tirzepatide in obese HFpEF patients—21% body weight loss, symptom improvement, reduced hospitalizations. Yet GLP-1 RA is not yet standard of care for HFpEF in most practices. Access is limited by insurance, supply, cost. When should you push for it?

> **Shared Decision-Making Frame:** If you have HFpEF with obesity (BMI >27) and are not responding adequately to SGLT2i, diuretics, and comorbidity management, GLP-1 RA is now reasonable to discuss. Benefits: weight loss, improved symptoms, reduced hospitalization. Risks: GI side effects, cost, access. Work with your cardiology and primary care team to determine if it's right for you.

On the Horizon: HFpEF

- **Tirzepatide (dual GLP-1/GIP agonist):** Greater weight loss and metabolic benefit than semaglutide; ongoing trials in HFpEF.
- **Better phenotyping of HFpEF:** Recognizing HFpEF-metabolic (obesity-driven), HFpEF-hypertensive, HFpEF-post-MI (pseudonormal filling), and HFpEF-restrictive. Each may respond differently to therapy.
- **Newer agents:** Soluble guanylate cyclase stimulators, natriuretic peptide analogs, and direct myosin activators in late-stage development.

Key Takeaways

- HFpEF is real, common, and increasingly treatable with SGLT2i and GLP-1 RA.
- Obesity and metabolic disease drive HFpEF. Weight loss is therapeutic.
- Comorbidities (AFib, HTN, sleep apnea) are as important as specific HF drugs.
- SGLT2i is first-line for all HFpEF. GLP-1 RA is emerging therapy if obese.
- Exercise rehabilitation and lifestyle modification are foundational.

Next Steps & Related Content

- If you have dyspnea and preserved EF, ask for BNP/NT-proBNP and advanced echo to confirm HFpEF diagnosis.
- Ask your cardiologist: 'Am I on SGLT2 inhibitor? If not, why?'
- Schedule weight loss assessment and sleep apnea screening.
- Review: MyCardioAdvocate™ Obesity & Weight Management, Metabolic Syndrome, AFib.