MyCardioAdvocate™

HFrEF Heart Failure

Heart Failure with Reduced Ejection Fraction (HFrEF)

Too little, too late — when we have the tools to save lives but fail to use them.

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Why This Matters

Heart failure with reduced ejection fraction (HFrEF, EF ≤40%) is the most deadly form of heart failure. Your left ventricle has become weakened, unable to pump blood forward effectively. It's a progressive disease: the heart keeps trying harder, fluid backs up into your lungs and legs, you become breathless and exhausted, and without optimal treatment, you die.

But here's the hope: We have FOUR pillar medications proven to extend life, reduce hospitalizations, and improve quality of life. Yet many patients are on none of them. Many are on one or two. Doses are often suboptimal. And critical gaps remain around when to use statins in HFrEF—especially in non-ischemic disease.

Why HFrEF Flies Under the Radar

HFrEF is dismissed as 'terminal' or 'untreatable' when it's neither. Symptoms can be confused with other things—shortness of breath could be asthma, fatigue could be depression. Many patients are never referred to a cardiologist; primary care doctors manage it alone without guideline-directed medical therapy (GDMT) expertise. Doses are started low and never titrated upward because patients are 'stable.' And the role of statins in HFrEF remains confused: do they help if my heart isn't from a heart attack?

- Lack of GDMT optimization is the #1 preventable cause of HFrEF hospitalizations.
- Patients often stop therapy because of side effects (hypotension, hyperkalemia) rather than staying on optimal doses with careful monitoring.
- Non-ischemic HFrEF is treated differently from ischemic, yet many don't know which type they have.

What Changed in 2026: HFrEF & Statin Guidelines

2026 ATP IIIb Updates:

- **HFrEF WITHOUT documented ASCVD:** Statins now COR 3: No Benefit (upgraded from COR 2b). No clear mortality benefit from lipid-lowering therapy alone in non-ischemic HFrEF. However, if you have preserved or low LDL, don't stop; focus on GDMT.
- **HFrEF WITH ischemic cardiomyopathy (prior MI, CAD):** Moderate-intensity statin recommended (COR 2b). Secondary prevention principles apply.
- **The FOUR PILLARS of HFrEF therapy (non-negotiable):**
  - 1. ACE inhibitor (or ARB if ACE intolerant) or ARNI (angiotensin receptor-neprilysin inhibitor, preferred)
  - 2. Beta-blocker (metoprolol succinate, carvedilol, bisoprolol)
  - 3. Mineralocorticoid receptor antagonist (MRA: spironolactone, eplerenone)
  - 4. SGLT2 inhibitor (empagliflozin, dapagliflozin)
- **ARNI priority:** Sacubitril/valsartan (Entresto) is superior to ACE-I/ARB alone and is now preferred first-line unless contraindicated.

MyCardioAdvocate™ Checklist: HFrEF & Optimal Care

1. Am I on all FOUR pillars of GDMT?

Ask your cardiologist for a clear list: Am I on an ARNI (or ACE/ARB)? A beta-blocker? An MRA? An SGLT2 inhibitor? If you're missing any, that's your starting conversation.

2. Is ARNI being used instead of ACE inhibitor or ARB?

Sacubitril/valsartan (Entresto) is the preferred first-line for HFrEF. If you're on a simple ACE-I or ARB, ask: 'Have we considered switching to an ARNI? What are the reasons not to?'

3. Is dose optimization happening, not just drug initiation?

Starting a drug at a low dose is not enough. Each pillar medicine needs to be titrated to target dose (or maximum tolerated dose) to work effectively. Ask your cardiologist about your target doses and when you'll increase.

4. Do I need a statin, and for what reason?

If you have HFrEF from a prior heart attack or coronary artery disease, you should be on a statin for secondary prevention. If your HFrEF is NOT from ischemia (e.g., viral, cardiomyopathy), a statin may not help—focus on the four pillars instead. Ask your cardiologist: 'Is my heart disease from blocked arteries, or is it from something else?'

5. Am I a candidate for device therapy (CRT, ICD) and cardiac rehabilitation?

If your EF is ≤35%, you may benefit from an implantable cardioverter-defibrillator (ICD) to prevent sudden cardiac death. If your EF is ≤35% AND you have a wide QRS duration (≥120 ms), cardiac resynchronization therapy (CRT) may be lifesaving. Cardiac rehabilitation reduces mortality. Ask your cardiologist about these options.

6. Are side effects (hypotension, hyperkalemia, cough) being managed proactively?

Many patients lower doses or stop GDMT because of side effects. Don't. Potassium-elevating drugs need lab monitoring (K, creatinine) every 1–2 weeks during titration. Cough from ACE-I? Switch to ARNI. Hypotension? Check if other medications can be adjusted. Work with your team to find optimal dosing that you can tolerate.

CPR Opportunity: Statin Therapy in Borderline Ischemic HFrEF

The Gray Zone: You have HFrEF with no documented MI or significant CAD, but borderline findings: mildly elevated troponin, prior ECG changes, family history of early CAD. 2026 guidelines say 'COR 3: No Benefit' for statins in non-ischemic HFrEF. But is your disease truly non-ischemic, or is it borderline?

> **Shared Decision-Making Frame:** If diagnostic uncertainty exists (e.g., no coronary angiography done, or angiography showed minor lesions), discuss with your cardiologist whether statin therapy for secondary prevention is reasonable. A cardiac catheterization may clarify etiology. In borderline cases, the harm from a statin is minimal; the benefit in ischemic disease is proven.

Key Takeaways

- HFrEF is treatable and survivable with optimal GDMT. Four pillars: ARNI, beta-blocker, MRA, SGLT2i.
- Dose optimization is as important as drug selection. Low doses don't save lives.
- Statins help if you have ischemic HFrEF; they don't if your disease is non-ischemic.

- Device therapy and cardiac rehab are life-extending. Ask if you're a candidate.
- Side effects don't mean stop—they mean adjust and monitor.

Next Steps & Related Content

- Schedule a cardiology visit. Bring a list of current medications, recent EF, and last echocardiogram results.
- Ask: 'What are my target doses for each pillar medication? When will we increase them?'
- Review: MyCardioAdvocate™ After a Heart Attack, HFpEF, Statins, Risk Calculators.

Disclaimer: *This brief is for educational purposes only. It does not replace personalized medical advice. Discuss all treatment decisions with your cardiologist. References: 2026 ATP IIIb, 2022 AHA/ACC/HFSA HFrEF guideline, landmark trials (PARADIGM-HF, DAPA-HF, EMPEROR-Reduced, SGLT2i in HFrEF meta-analyses).*