**THE MANAGEMENT OF PATIENTS WITH ADVANCED HEART FAILURE**

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Advanced heart failure patients are pretty heterogeneous with varying clinical presentations. It is growing in magnitude and represents a major public health problem. Left ventricular assist device (LVAD) support is an accepted treatment of patients with end-stage heart failure. The increased applicability and excellent results with LVADs have revolutionized the treatment options available for these patients. Success with LVADs as bridge-to-transplant therapy has led to their successful use as an alternate to a transplant (ie, as destination therapy [DT]). The REMATCH trial showed a 48% reduction in all-cause mortality in patients receiving LVAD therapy versus OMM (P = 0.001). One-year survival was 52% in the LVAD group and 25% in the OMM group, whereas 2-year survival was 23% and 8%, respectively. Currently destination therapy is indicated in patients who 1. have chronic end-stage heart failure (New York Heart Association Class IV symptoms for at least 90 days with a life expectancy of less than 2 years); 2. are not candidates for heart transplantation, and 3. meet all of the following conditions: a. the patient's Class IV heart failure symptoms have failed to respond to optimal medical management, including dietary salt restriction, diuretics, digitalis, beta-blockers and ACE inhibitors (if tolerated) for at least 60 of the last 90 days, b. the patient has a left ventricular ejection fraction (LVEF) less than 25%, and c. the patient has a continued need for intravenous inotropic therapy owing to symptomatic hypotension, decreasing renal function or worsening pulmonary congestion. Despite evidence based medical and pharmacologic advances the management of heart failure remains challenging, especially in the ambulatory setting. There is an urgent need to develop strategies to reduce hospitalizations and re-admission rates for heart failure in general. Advanced heart failure carries a high burden of symptoms, suffering, and death. Palliative care can complement traditional care to improve symptom amelioration, patient-caregiver communication, emotional support, and medical decision making. Palliative therapies is, however, still underused in the treatment of advanced HF. Planning for adverse events and the end of life, can be integrated into HF care early in illness.

Discussions that acknowledge the uncertainty of HF course and length of life and incorporate patient and family goals and values facilitates this planning. Clear processes for weighing potential benefits and burdens of interventions and therapies should accompany decision-making.