Commentary Article

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Treatment on Heart Failure

Liam Back*

Department of manager at Asda distribution, North warwickshire and Hinckley college,Australia

***Corresponding author:** Liam Back, Department of manager at Asda distribution, N orth warwickshire a nd Hinckley college,Australia, Email: liam.back@health.nsw.gov.au

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Commentary

Heart failure is a syndrome that may result from many cardiac and systemic disorders. Some of these disorders, at least initially, do not involve the heart, and the term heart failure may be confusing. Even in high-output states, however, the patient may present with the classic findings of exertional dyspnea and edema that resolve if the underlying disorder is eliminated. If they persist, these conditions may impair myocardial performance secondarily as a result of chronic volume overload or direct deleterious effects on the myocardium. Other conditions, including mechanical abnormalities, disorders of rate and rhythm, and pulmonary abnormalities, do not primarily affect myocardial function but are frequent causes of heart failure.

Heart failure is unlike some illnesses in palliative care because some treatments for heart failure have both quality of life benefits and disease-modifying effects. This finding contrasts with many types of disease-modifying cancer treatments that may have deleterious effects on quality of life. For example, two of the cornerstones of treatment for heart failure, described in the most recent ACC/AHA guidelines, as well as in recent review articles, are the use of ACE inhibitors or angiotensin receptor blockers and β-blockers. Both types of medications have been shown to improve survival and to decrease repeated hospitalizations. Because they have documented effects on quality of life, these medications should be continued in palliative care.

Two other medications for heart failure, diuretics and digoxin, also have clear effects on quality of life. Furosemide is the main diuretic for the use in patients with heart failure who have fluid overload. Its effects can be potentiated by spironolactone, which, when added to a loop diuretic such as furosemide, has been shown to lessen both mortality and symptoms and also to reduce hospitalizations in the setting of heart failure. Although digoxin has no documented effect on mortality, it has been shown to have symptomatic benefits in terms of decreased dyspnea and decreased hospitalizations. Therefore, these medications should be continued as well. Intravenous inotropic medications represent a dilemma for many patients, families, and health care providers. Although these medications have been shown to result in excess mortality in randomized trials, they have also been shown to decrease hospitalizations and the symptoms among patients recommended for use as a "bridge" to cardiac transplantation and as a palliative measure in patients with end-stage heart failure whose symptoms are refractory to other treatments. In the setting of hospice and palliative care, the use of intravenous inotropes can be confusing. In terms of philosophy of care, is this "aggressive" or "palliative"? In terms of resources, do we have the resources among our nurses or physicians to administer these safely in the home or nursing home setting? In view of capitated reimbursement, are we able to afford this medication? Although there are no clear guidelines at this time for the use of these medications in the palliative care or hospice context, case studies of patients who have benefited from using them have been published. More and more individual programs and physicians will face this dilemma as increasing numbers of patients with heart failure elect hospice care.