

I'm not a robot!

Mechanism of adaptation

Activation of neurohormonal system

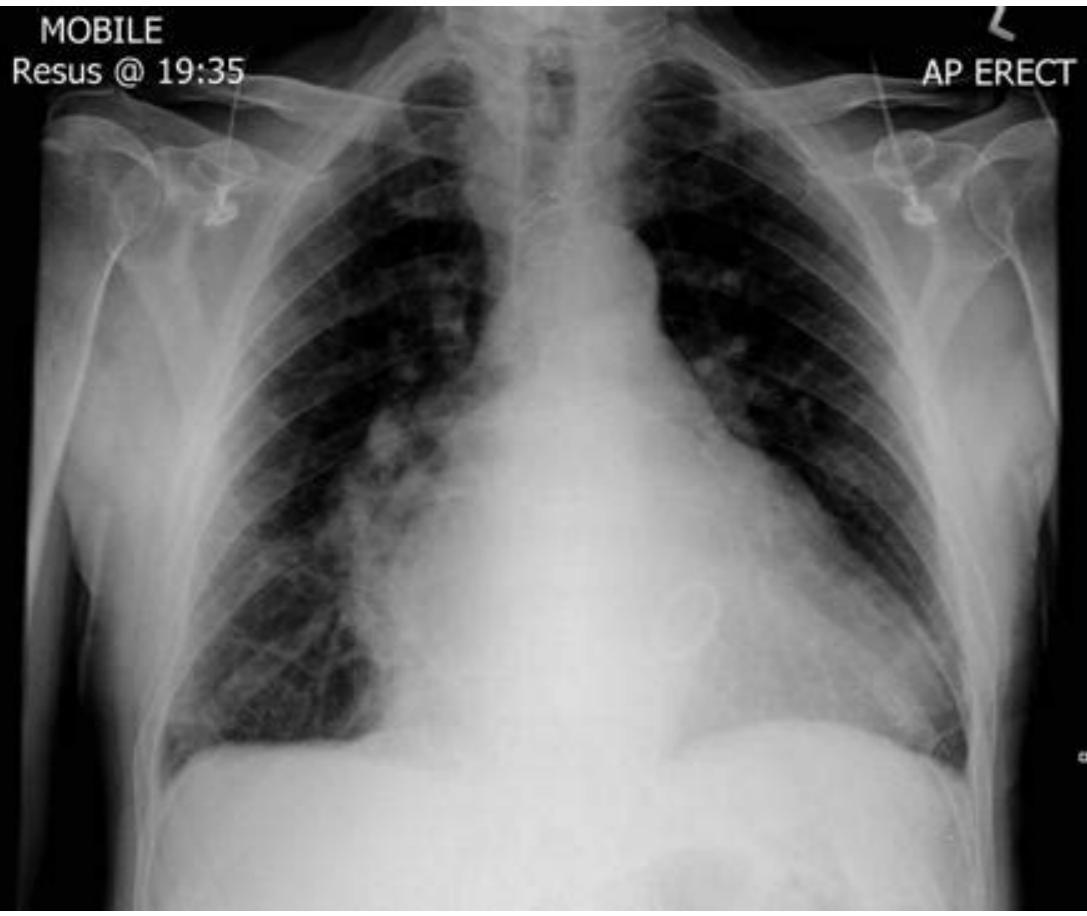
- SNS>NA>Incrs HR, Incrs contractility, VasoC
- Activation of RAAS
- ANP>VasoD, natriuresis, diuresis

Frank-starling mechanism (hemodynamic changes)

- Incrs EDV> Incrs EDP > muscle fibers stretch > Incrs cardiac chamber V > contract more forcibly
- However, incrs dilatation>incrs ventricular wall tension >incrs O₂ demand

Myocardial structural changes (cellular)

- Pressure overload>incrs fiber diameter>concentric hypertrophy (incrs wall thickness w/o incrs chamber size)
- Volume overload>incrs fiber length>eccentric hypertrophy>incrs heart size, incrs wall thickness



CLEVELAND CLINIC JOURNAL OF MEDICINE

Follow-up blood cultures:

When, how often?

Sternal dehiscence

after heart surgery

Aleukemic leukemia cutis

Subclinical hypothyroidism:

When to treat?

Heart failure guidelines:

What's new in the update?

Managing malignant

pleural effusion

Breast augmentation:

Clinical considerations

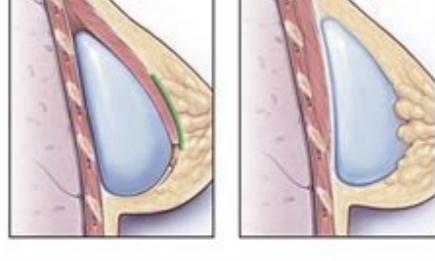


Table 4. Operating Characteristics of Prognostic Criteria for Predicting Death Within 6 Months After Hospital Discharge Among Patients With Chronic Disease

Criterion	Sensitivity, %*	Specificity, %†	Positive Likelihood Ratio‡	Negative Likelihood Ratio§
Broad inclusion	41.7	66.7	1.25	.874
Intermediate inclusion	16.2	90.1	1.63	.931
Narrow inclusion	1.4	99.5	2.88	.991
6-mo prognosis				
<=50%	22.1	91.4	2.57	.867
<=10%	2.4	99.4	4.33	.981
Actually discharged to hospice care	6.4	99.4	10.43	.942

*Sensitivity indicates the probability that a patient who died within 6 months met the criterion.

†Specificity indicates the probability that a patient who did not die within 6 months did not meet the criterion.

‡Positive likelihood ratio indicates the likelihood that a patient who died within 6 months met the criterion, divided by the likelihood that a patient who survived more than 6 months did not meet the criterion and reflects the degree to which the criterion identifies patients who will die within 6 months.

§Negative likelihood ratio indicates the likelihood that a patient who died within 6 months did not meet the criterion, divided by the likelihood that a patient who survived more than 6 months did not meet the criterion and reflects the degree to which it fails to identify patients who will die within 6 months.

||Estimated by the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments multivariate model.

Congestion at rest (WET)

Low perfusion at rest (COLD)	NO	NO	YES
	A	B	
Heart failure "light"	YES	L	C

Evidence for Congestion

Orthopnea

JVD

Edema

Ascites

Rales (rarely)

Valsalva square wave

Abd-jugular reflex

Evidence for low perfusion

Narrow pulse pressure

Cool extremities

May be sleepy, obtunded

Suspect from ACEI hypotension and low NA

One Cause of worsening renal fn

Heart failure guidelines canada. Heart failure guidelines 2021. Heart failure guidelines nz. Heart failure guidelines 2022 summary. Heart failure guidelines 2022 pdf. Heart failure guidelines pdf. Heart failure guidelines 2021 ppt. Heart failure guidelines australia.

Guidelines version available to download Previous version available to download. 2016 EHJ (2016) 37 (27):2129-2200 - 2016 doi.org/10.1093/euheartj/ehw383 2017 doi.org/10.1093/euheartj/ehw158 2016 2016 Editorial ESC Guidelines on Heart Failure 2016 2016 Addenda Web Tables - EHJ doi:10.1093/euheartj/ehw128 2012 EHJ 2012;33:1787-1847. 2012 Corrigendum FT. 2012 Eur Heart J 2012 EHJ doi:10.1093/euheartj/ehs104 Significant gaps exist despite evolving evidence and treatment strategies in patients with HF. Table 33 provides selected, common issues that should be addressed in future clinical research. Table 33 Evidence Gaps and Future Research Directions AF indicates atrial fibrillation; ARNI, angiotensin receptor-neprilysin inhibitor; ATTR, transthyretin amyloidosis; BP, blood pressure; CKD, chronic kidney disease; COVID-19, coronavirus disease 2019; eGFR, estimated glomerular filtration rate; CDMT, guideline-directed medical therapy; HF, heart failure; HFmEF, heart failure with improved ejection fraction; HFmrEF, heart failure with mildly reduced ejection fraction; HFrEF, heart failure with preserved ejection fraction; LV, left ventricular; MCS, mechanical circulatory support; MRA, mineralocorticoid receptor antagonist; PUFA, polyunsaturated fatty acid; QOL, quality of life; RV, right ventricular; SGLT1i, sodium-glucose cotransporter-1 inhibitors; SGLT2i, sodium-glucose cotransporter-2 inhibitors; TAVI, transcatheter aortic valve implantation; and VHD, valvular heart disease. Presidents and Staff American College of Cardiology/American Heart Association Thomas S.D. Getchius, Director, Guideline Strategy and Operations; Abdul R. Abdullah, MD, Director, Guideline Science and Methodology; American Heart Association Donald M. Lloyd-Jones, MD, ScM, FAHA, President Nancy Brown, Chief Executive Officer; Mariell Jessup, MD, FAHA, Chief Science and Medical Officer; Radhika Rajgopal Singh, PhD, Senior Vice President, Office of Science and Medicine; Paul St. Laurent, DNP, RN, Senior Science and Medicine Advisor, Office of Science, Medicine and HealthyJody Hundley, Production and Operations Manager, Scientific Publications, Office of Science Operations. REFERENCES SPREMBLE1. Graham R, Mancher M, Miller Wolman D, Greenfield S, Steinberg E, editors. Committee on Standards for Developing Trustworthy Clinical Practice Guidelines, Institute of Medicine (U.S.). Clinical practice guidelines we can trust. Washington (DC): National Academies Press; 2011.2. Eden J, Levit L, Berg A, Morton S, editors. 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