Srdeční selhání – „State-of-the-art“

2026 ESC HF Guidelines

Jan Krejčí

Pohled do nedávné minulosti - 2016

European Heart Journal (2016) **37**, 2129–2200
doi:10.1093/eurheartj/ehw128

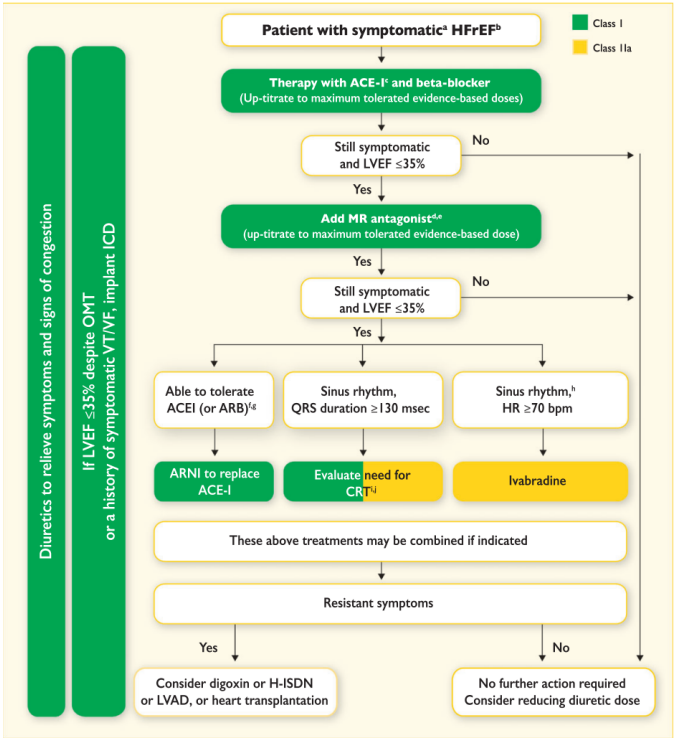
ESC GUIDELINES

2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure

The Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC)

Table 3.1 Definition of heart failure with preserved (HFpEF), mid-range (HFmrEF) and reduced ejection fraction (HFrEF)

Type of HF		HFrEF	HFmrEF	HFpEF
CRITERIA	1	Symptoms ± Signs[a]	Symptoms ± Signs[a]	Symptoms ± Signs[a]
	2	LVEF <40%	LVEF 40–49%	LVEF ≥50%
	3	–	1. Elevated levels of natriuretic peptides[b]; 2. At least one additional criterion: a. relevant structural heart disease (LVH and/or LAE), b. diastolic dysfunction (for details see Section 4.3.2).	1. Elevated levels of natriuretic peptides[b]; 2. At least one additional criterion: a. relevant structural heart disease (LVH and/or LAE), b. diastolic dysfunction (for details see Section 4.3.2).



Pohled do nedávné minulosti - 2021

ESC European Society of Cardiology
European Heart Journal (2021) **00**, 1–128
doi:10.1093/eurheartj/ehab368

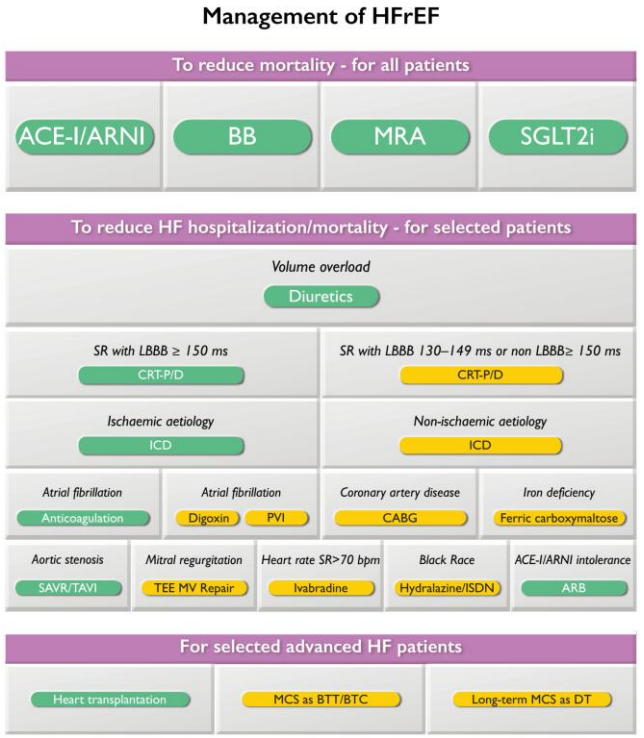
ESC GUIDELINES

2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure

Developed by the Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC)

Table 3 **Definition of heart failure with reduced ejection fraction, mildly reduced ejection fraction and preserved ejection fraction**

Type of HF		HFrEF	HFmrEF	HFpEF
CRITERIA	1	Symptoms ± Signs[a]	Symptoms ± Signs[a]	Symptoms ± Signs[a]
	2	LVEF ≤40%	LVEF 41–49%[b]	LVEF ≥50%
	3	–	–	Objective evidence of cardiac structural and/or functional abnormalities consistent with the presence of LV diastolic dysfunction/raised LV filling pressures, including raised natriuretic peptides[c]



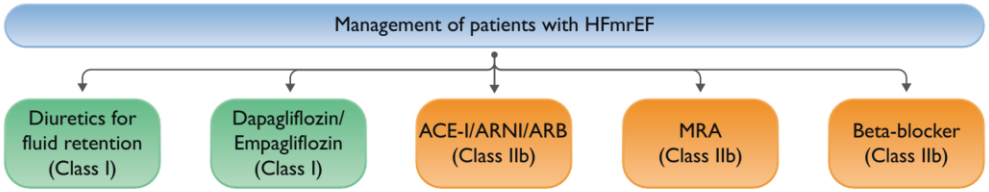
Pohled do nedávné minulosti - 2023

ESC European Society of Cardiology
European Journal of Heart Failure (2024) 26, 5–17
doi:10.1002/ejhf.3024

ESC GUIDELINES

2023 Focused Update of the 2021 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure

Developed by the task force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC)



Recommendation Table 1 — Recommendation for the treatment of patients with symptomatic heart failure with mildly reduced ejection fraction

Recommendation	Class[a]	Level[b]
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFmrEF to reduce the risk of HF hospitalization or CV death.[c] [6,8]	I	A

Recommendation Table 2 — Recommendation for the treatment of patients with symptomatic heart failure with preserved ejection fraction

Recommendation	Class[a]	Level[b]
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFpEF to reduce the risk of HF hospitalization or CV death.[c] [6,8]	I	A

…a teď máme úplně nová doporučení 2026

ESC European Society of Cardiology
European Heart Journal (2026) 00, 1–112
https://doi.org/10.1093/eurheartj/ehag100

ESC GUIDELINES

2026 ESC Guidelines for the management of heart failure

Developed by the task force for the management of heart failure of the European Society of Cardiology (ESC)

…a ta přinesla celou řadu revolučních změn…

Novinky z 2026 ESC HF Guidelines

Class of recommendation	Definition	Wording to use
I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	*"is recommended"* or *"is indicated"*
II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.	
IIa	Weight of evidence/opinion is in favour of usefulness/efficacy.	*"should be considered"*
IIb	Usefulness/efficacy is less well established by evidence/opinion.	*"may be considered"*
III	Evidence or general agreement that the given treatment or procedure is not useful/effective, and in some cases may be harmful.	*"is not recommended"*

Level of evidence	Definition
A	Conclusive evidence, usually from at least two adequately powered randomized controlled trials[a] free of major bias, with substantial evidence against the play of chance when combined in a meta-analysis (e.g., P <0.005 for superiority).[b]
B1	Suggestive evidence from at least one adequately powered randomized controlled trial free of major bias, or a meta-analysis of such randomized controlled trials, with some evidence against the play of chance (e.g., P <0.05 for superiority).[c]
B2	Limited evidence from at least two adequately powered non-randomized studies with careful control of major sources of bias and substantial evidence against the play of chance (e.g., P <0.005 for superiority),[b] or from a meta-analysis of small, underpowered randomized controlled trials with some evidence against the play of chance (e.g., P <0.05 for superiority).[c]
C	Preliminary evidence from non-randomized studies without careful control of major sources of bias, a single small, underpowered randomized controlled trial, or expert consensus.

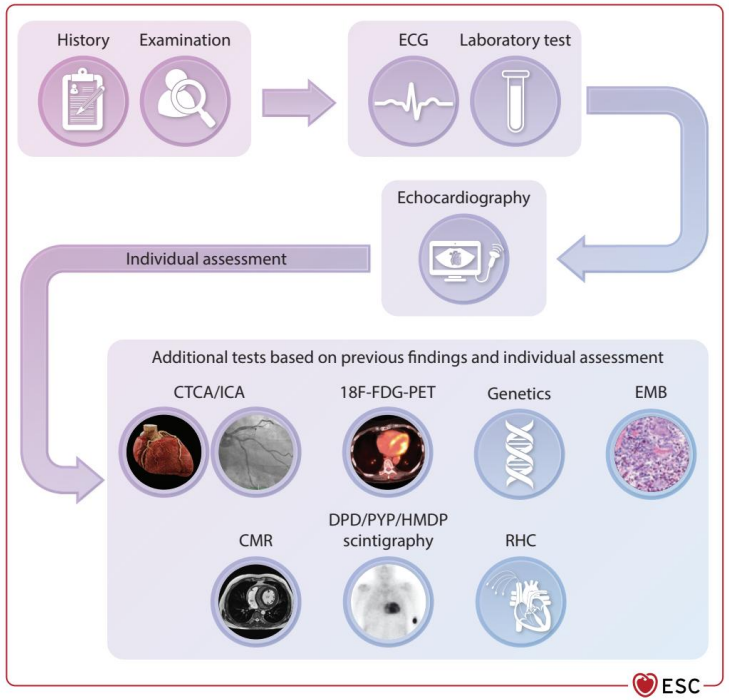
Novinky z 2026 ESC HF Guidelines

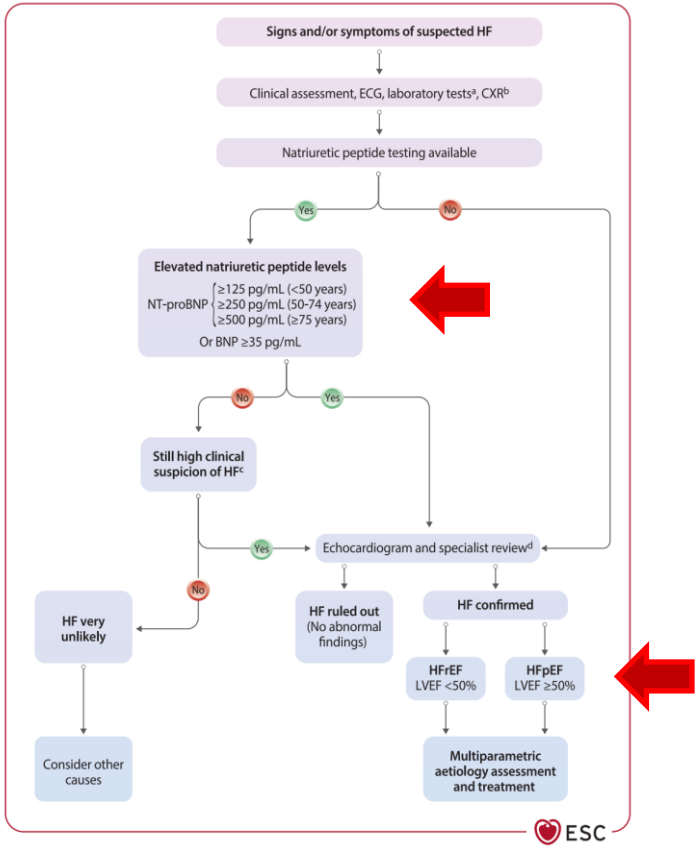
Class of recommendation	Definition	Wording to use
I	Evidence and/or general agreement that a given treatment or procedure is beneficial, useful, effective.	*"is recommended"* or *"is indicated"*
II	Conflicting evidence and/or a divergence of opinion about the usefulness/efficacy of the given treatment or procedure.	
IIa	We	
IIb	Use	
III	Evide or pr may	

- **Všechna doporučení byla překlasifikována („re-graded"), nejde tedy o down-grading nebo up-grading.**
- **např. LOE A mohla být změněna na B1 bez nových dat, podobně třída doporučení 1 mohla být změněna na 2A bez nových dat** (třída 1 by měla být dominantně podporována LOE A).

	omized controlled trials[a] hen combined
	controlled trial free of some evidence
	d studies with careful play of chance (e.g., P <0.005 for superiority),[b] or from a meta-analysis of small, underpowered randomized controlled trials with some evidence against the play of chance (e.g., P <0.05 for superiority).[c]
C	Preliminary evidence from non-randomized studies without careful control of major sources of bias, a single small, underpowered randomized controlled trial, or expert consensus.

Novinky z 2026 ESC HF Guidelines - diagnostika





I. INTERNÍ KARDIOANGIOLOGICKÁ KLINIKA FNUSA A LF MU

FAKULTNÍ NEMOCNICE U SV. ANNY V BRNĚ

Novinky z 2026 ESC HF Guidelines – nové dělení

Table 4 New concepts

New concepts
HFrEF has been expanded to include LVEF up to 50%
HFmrEF has been removed
HFpEF includes LVEF from 50% and above
Decompensated HF replaces acute HF
Stages of HF (A–D) ranging from risk factors to advanced HF have been adopted
New classifications for medical and interventional therapy have been introduced

HFrEF: characterized by LVEF <50% and symptoms and/or signs of HF.
HFpEF: characterized by LVEF ≥50% and symptoms and/or signs of HF and objective evidence of cardiac structural and/or functional abnormalities consistent with the presence of left ventricular (LV) diastolic dysfunction/raised LV filling pressures, supported by raised natriuretic peptides.

Novinky z 2026 ESC HF Guidelines

Table 4 New concepts

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HFrEF has been expanded to include LVEF up to 50%
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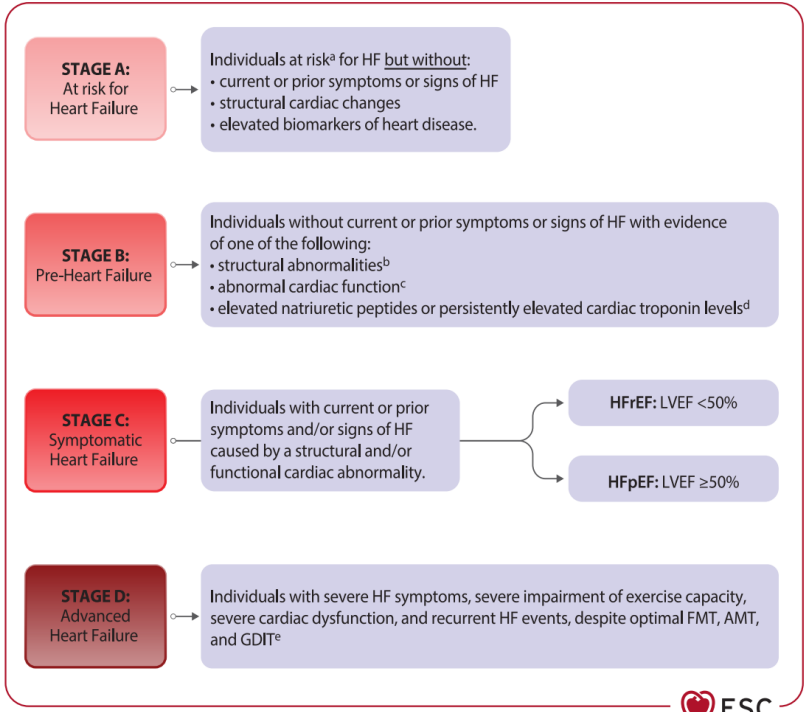
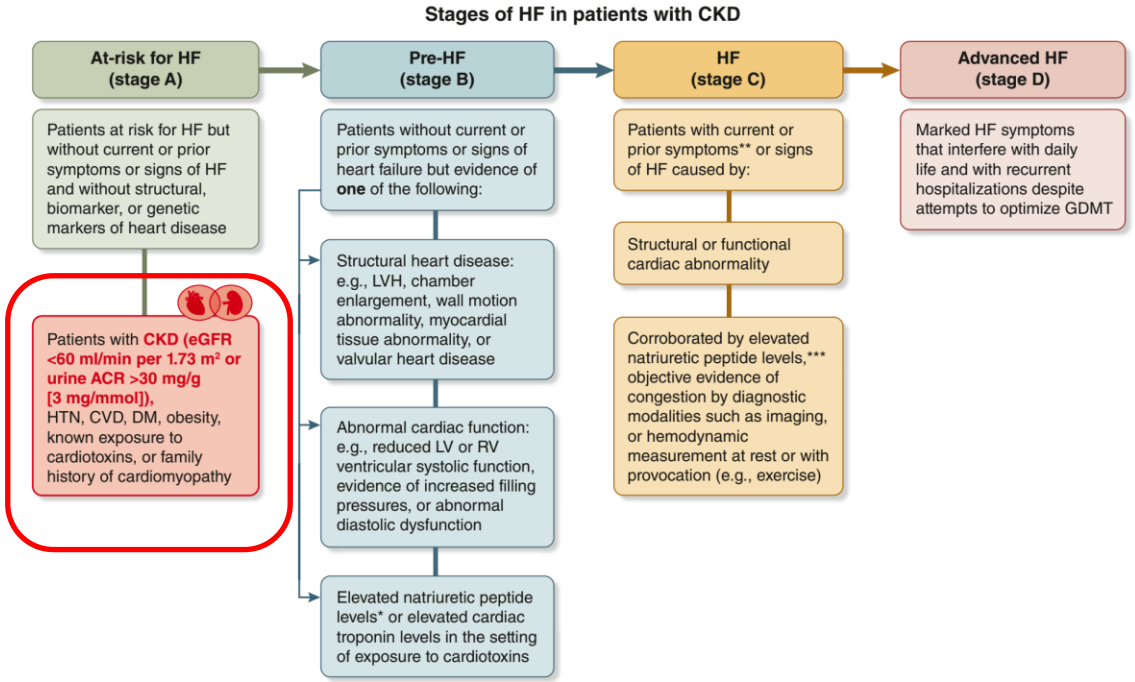


Větší důraz na prevenci srdečního selhání (stadia A a B)

Prevence a fokus na rizikové skupiny – zdůraznění role CKD

Kidney disease and heart failure: recent advances and current challenges: conclusions from a Kidney Disease: Improving Global Outcomes (KDIGO) Controversies Conference

- Asi 10% - 30% nemocných s CKD má srdeční selhání.
- Asi 30% - 60% pacientů s HF má CKD.



Kidney International (2026) **109,** 1095–1113;

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FAKULTNÍ NEMOCNICE U SV. ANNY V BRNĚ

2026 ESC HF Guidelines – prevence srdečního selhání

Recommendation Table 1 — Recommendations for prevention of heart failure (see *Evidence Tables 1–15*)

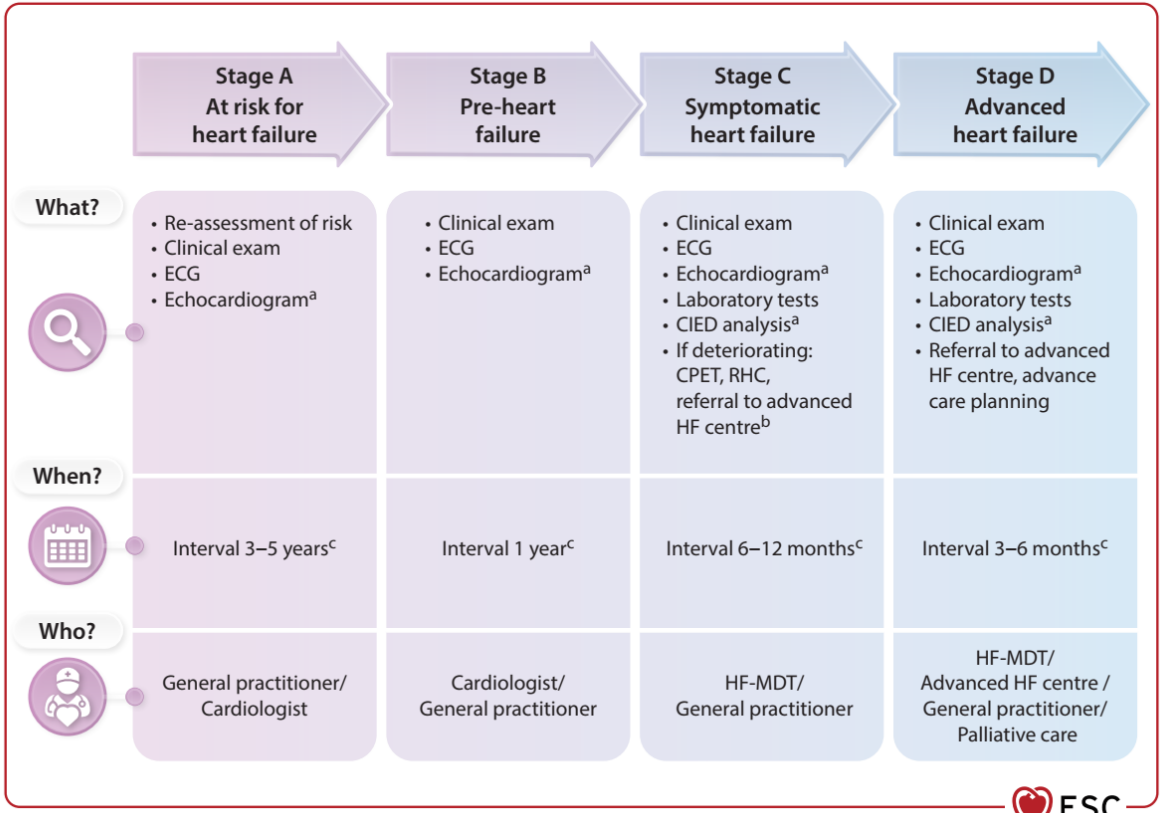
Recommendations	Class[a]	Level[b]
Strict blood pressure control (systolic blood pressure target <130 mmHg) is recommended in patients with hypertension or stage B HF to reduce the risk of HF.[63–69,102]	I	A
An SGLT2-I is recommended in patients with T2DM at risk of HF (multiple ASCVD risk factors or established ASCVD) to reduce the risk of HF and CV death.[103]	I	A
An SGLT2-I is recommended in patients with T2DM and CKD[c] to reduce the risk of HF or CV death.[104]	I	A
Finerenone is recommended in patients with T2DM and CKD[d] to reduce the risk of HF.[105–108]	I	A
Counselling on healthy lifestyle choices including maintaining a healthy weight, consuming a well-balanced diet, avoiding sedentary behaviour, abstaining from smoking and heavy alcohol consumption as well as counselling against the use of drugs such as cocaine, amphetamines, and anabolic steroids is recommended for all patients with stage A or B HF to reduce the risk of HF progression.[74,84,85,87,91,95–100,109–112]	I	C
Treatment with a statin should be considered in people at high risk of, or with established ASCVD, to reduce the risk of HF.[75]	IIa	A
A GLP-1 RA should be considered in patients with T2DM and at least one other additional CV risk factor to reduce the risk of HF or CV death.[71,113,114]	IIa	A

2026 ESC HF Guidelines – prevence srdečního selhání

Recommendation Table 2 — Recommendations for stage B heart failure and left ventricular dysfunction (see *Evidence Table 16*)

Recommendations	Class[a]	Level[b]
An ACE-I or ARB (if intolerant to ACE-I) is recommended in patients with stage B HF and LVEF ≤40% to reduce the risk of HFH and death.[135–138,144]	I	A
A beta-blocker is recommended in patients with stage B HF and LVEF <50% to reduce the risk of HFH or death.[35,139,140]	I	B1
Eplerenone is recommended in patients with LVEF ≤40% after myocardial infarction with signs of HF or diabetes to reduce the risk of HFH and death.[143]	I	B1

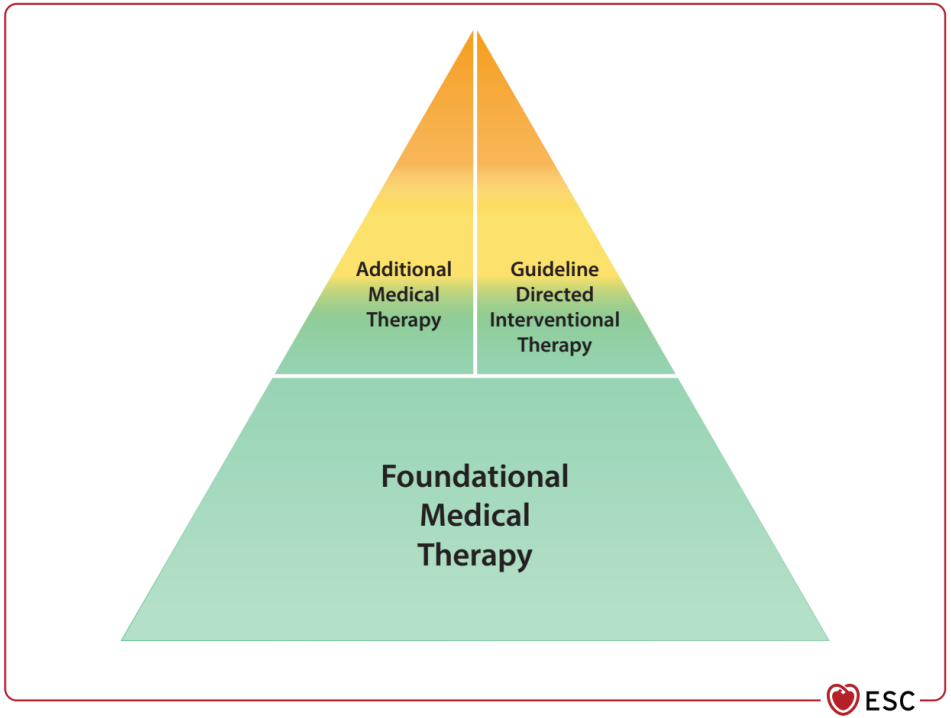
Novinky z 2026 ESC HF Guidelines – follow-up dle stadia



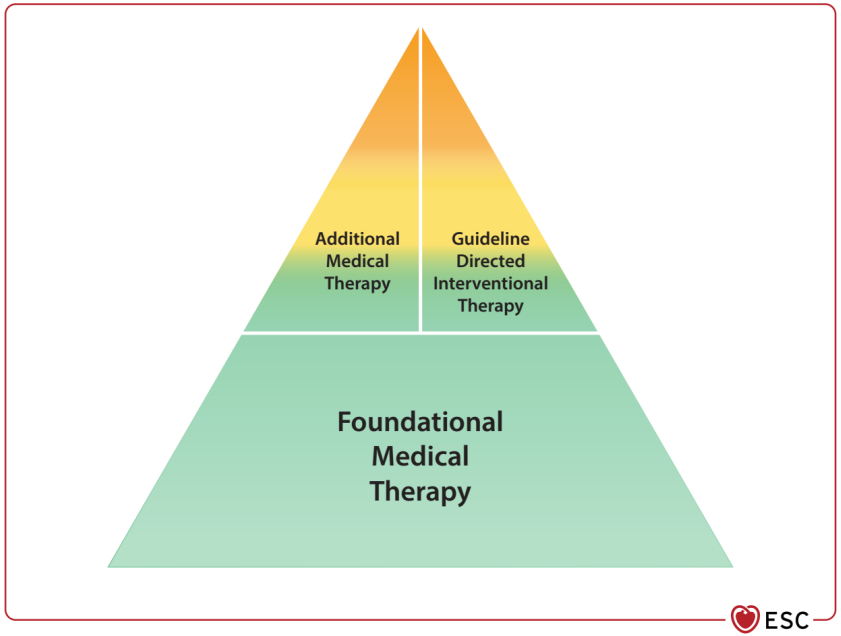
2026 ESC HF Guidelines - léčba srdečního selhání

Table 4 New concepts

New concepts
HFrEF has been expanded to include LVEF up to 50%
HFmrEF has been removed
HFpEF includes LVEF from 50% and above
Decompensated HF replaces acute HF
Stages of HF (A–D) ranging from risk factors to advanced HF have been adopted
New classifications for medical and interventional therapy have been introduced



2026 ESC HF Guidelines - léčba srdečního selhání



FMT

Recommendation with class I for the broad HF population with the endpoint(s) HFH and/or death

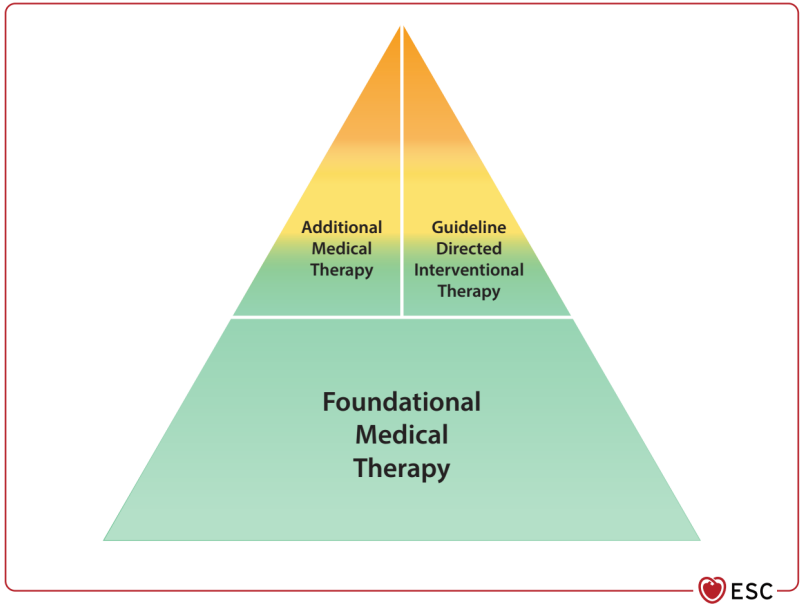
AMT

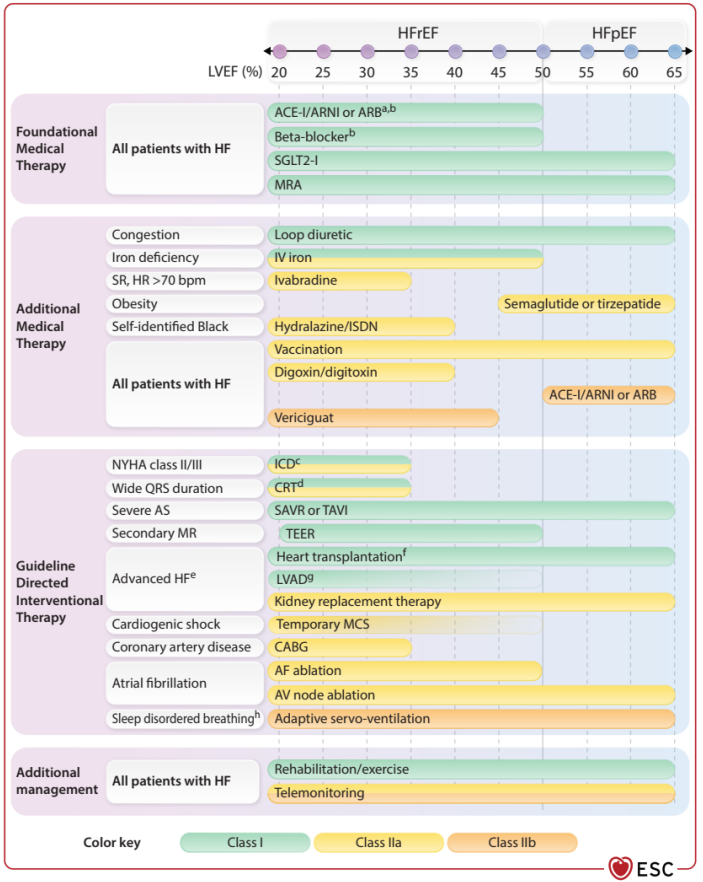
Recommendations with class IIa/IIb OR class I where the endpoint is QoL or symptoms

GDIT

Recommendations for all non pharmacological interventional therapies.

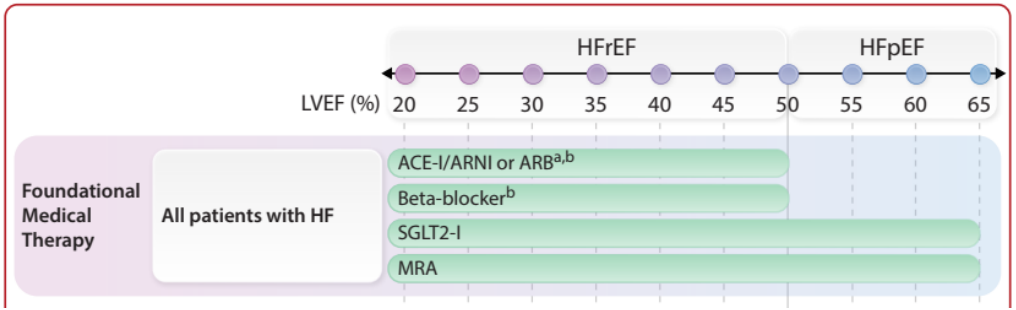
2026 ESC HF Guidelines - léčba srdečního selhání „v kostce“





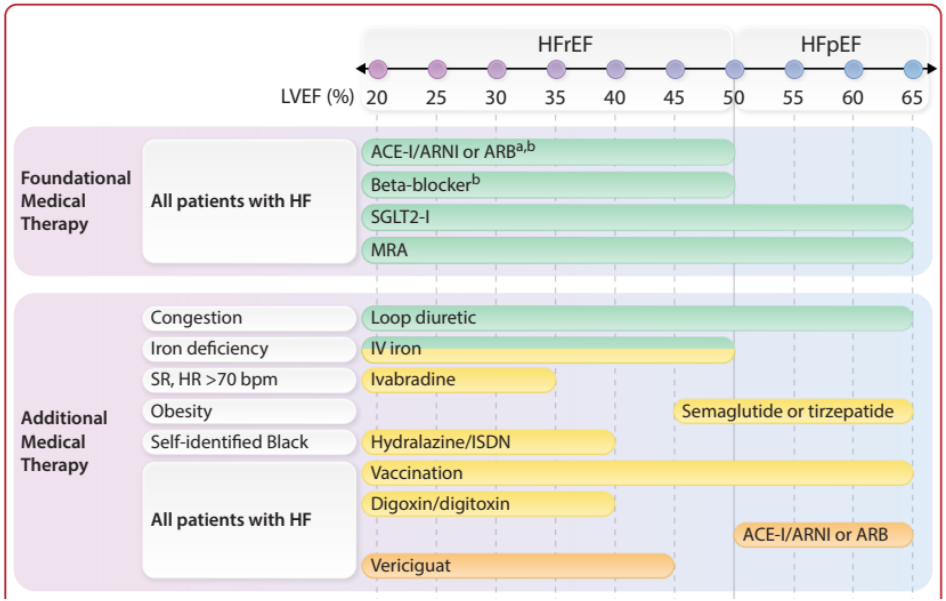
I. INTERNÍ KARDIOANGIOLOGICKÁ KLINIKA FNUSA A LF MU

2026 ESC HF Guidelines - léčba srdečního selhání (FMT)



Recommendations	Class[a]	Level[b]
All patients with HF, independent of LVEF		
An SGLT2-I (dapagliflozin or empagliflozin) is recommended in patients with symptomatic HF independent of LVEF to reduce the risk of HFH or CV death.[241–245,326]	I	A
An MRA (sMRA for HFrEF and sMRA/nsMRA for HFpEF) is recommended in patients with symptomatic HF independent of LVEF to reduce the risk of HFH or CV death.[c 43,254–257]	I	A
Dynamic individualized dosing of loop diuretics according to volume status is recommended in patients with HF and signs and/or symptoms of congestion to alleviate HF symptoms, improve exercise capacity, and reduce the risk of HFH.[d 327–329]	I	A
Uptitration of FMT at least every 1–2 weeks in patients with HF, guided by symptoms, vital signs, and laboratory findings, to achieve optimal target doses shown to be efficacious in RCTs is recommended to reduce the risk of HFH or death.[274,311]	I	C
Continuation of FMT at the highest tolerated doses is recommended in all patients with HF, including those who become asymptomatic or with LVEF improvement, in order to reduce the risk of HFH and death.[321]	I	C

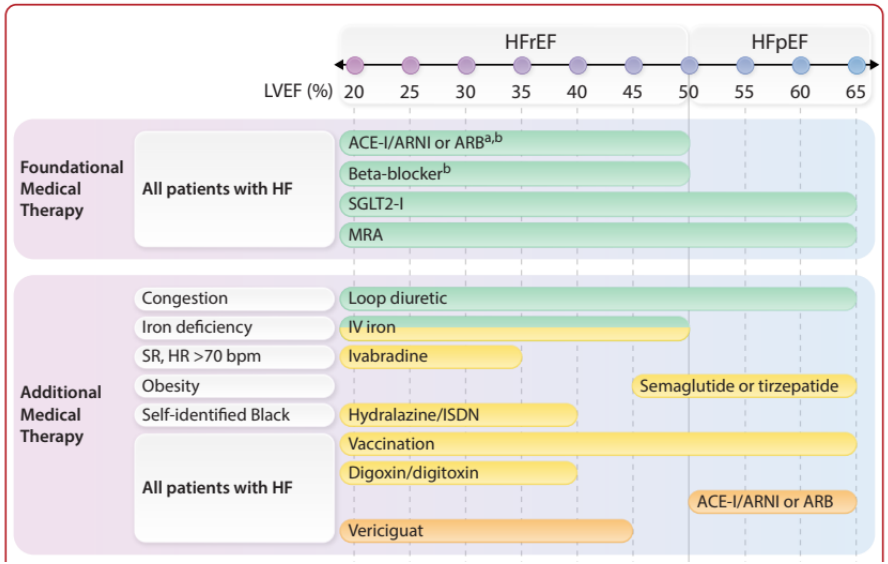
2026 ESC HF Guidelines - AMT - léčba srdečního selhání u obesity

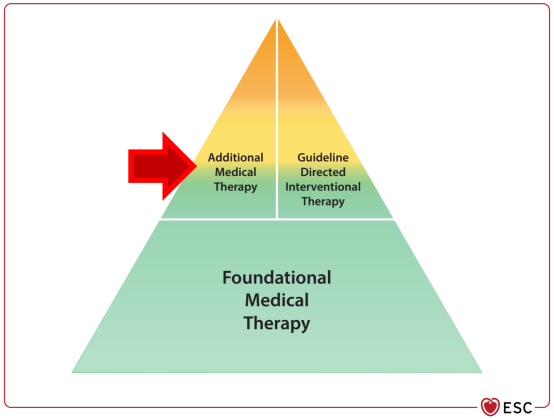


Recommendation Table 18 — Recommendations for obesity in patients with heart failure (see *Evidence Tables 85 and 86*)

Recommendations	Class[a]	Level[b]
Semaglutide or tirzepatide should be considered for patients with symptomatic HF, LVEF ≥45%, and BMI ≥30 kg/m^2, regardless of diabetes status, to reduce body weight, and improve exercise capacity and QoL.[315–317,819,820,825]	IIa	B1
Bariatric surgery may be considered in obese patients with HF and a BMI ≥35 kg/m^2 to reduce body weight when repetitive and structured lifestyle changes combined with weight-reducing medications do not result in maintained weight loss.[823,824]	IIb	C

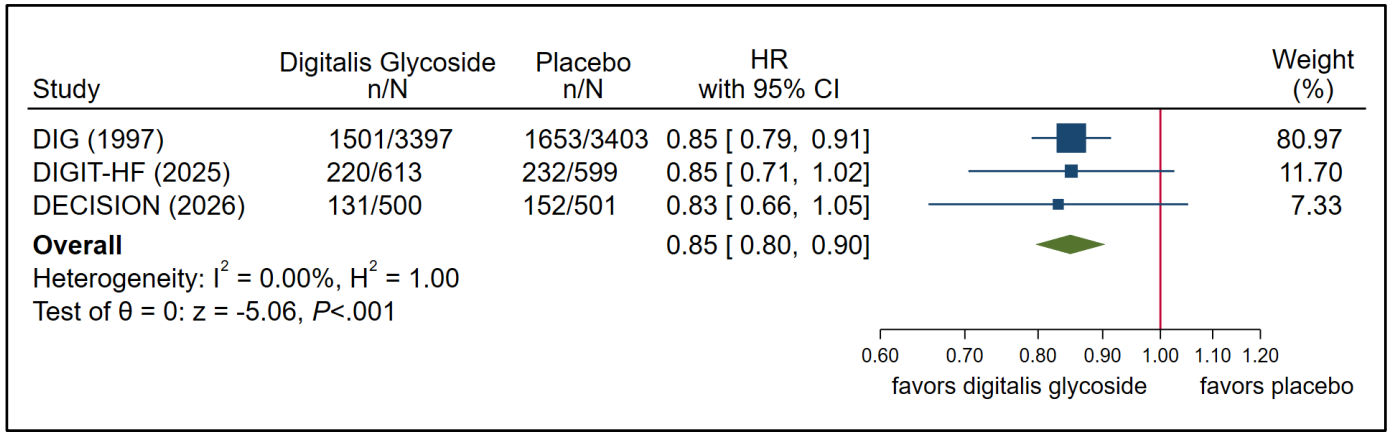
2026 ESC HF Guidelines - léčba srdečního selhání (AMT)





Recommendations in 2021 version	Class[a]	Level[b]	Recommendations in 2026 version	Class[a]	Level[b]
Digoxin may be considered in patients with symptomatic HFrEF in sinus rhythm despite treatment with an ACE-I (or ARNI), a beta-blocker and an MRA, to reduce the risk of hospitalization (both all-cause and HF hospitalizations).	IIb	B	A cardiac glycoside (digoxin or digitoxin) should be considered in patients with symptomatic HFrEF with LVEF ≤40%, despite optimal FMT, to reduce the risk of HFH.	IIa	B1

2026 ESC HF Guidelines - srdeční glykosidy



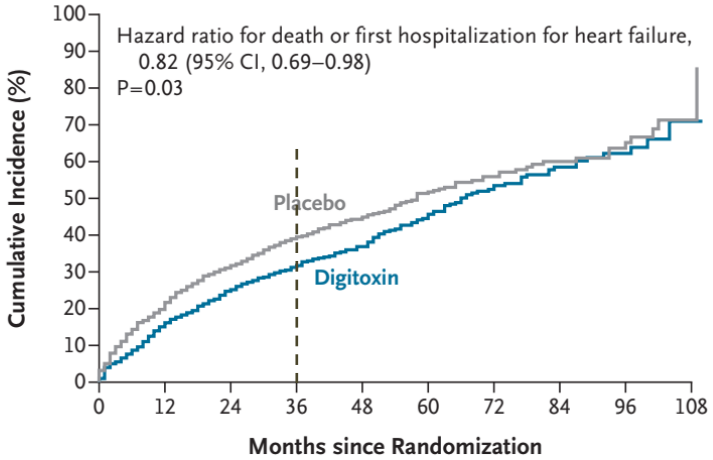
Recommendations	Class	Level
HFrEF		
A cardiac glycoside (digoxin or digitoxin) should be considered in patients with symptomatic HFrEF with LVEF ≤40%, despite optimal FMT, to reduce the risk of HFH.	IIa	B1

Damman K et al. JAMA. 2026 Jun 16;335(23):2029-2037

Srdeční glykosidy…studie DIGIT-HF

Digitoxin in Patients with Heart Failure and Reduced Ejection Fraction

A Death from Any Cause or First Hospitalization for Heart Failure



No. at Risk

Placebo	599	421	309	234	184	126	78	47	24	4
Digitoxin	613	460	346	276	208	144	92	55	25	3

in our trial.[15] Despite the higher burden of heart failure symptoms and the better implementation of therapy in our trial, the absolute reduction in the risk of death from any cause or first hospitalization for worsening heart failure — and thus the number of patients who would need to be treated to avoid one primary-outcome event — seems to be similar to that in the PARADIGM-HF and DAPA-HF trials and EMPEROR-Reduced

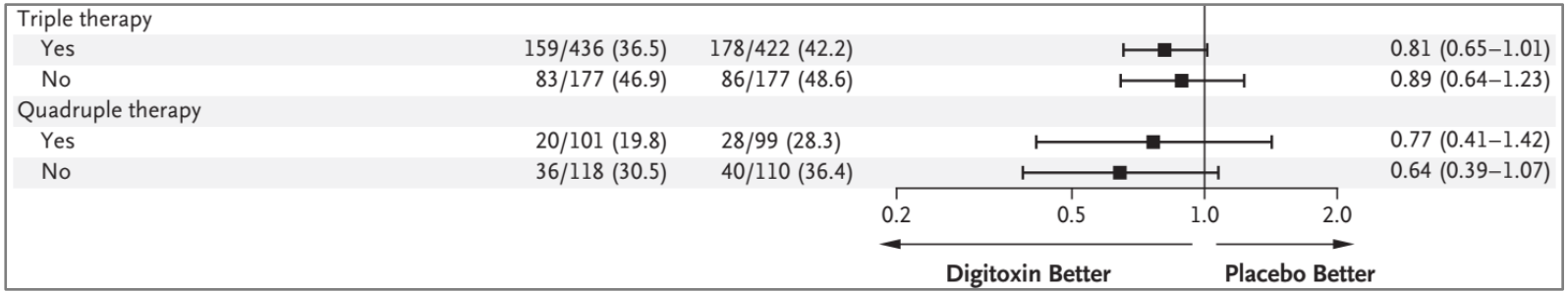
N Engl J Med 2025;393:1155-65.

MUNI MED

FAKULTNÍ NEMOCNICE U SV. ANNY V BRNĚ

Srdeční glykosidy…studie DIGIT-HF

Outcome	Digitoxin (N=613)		Placebo (N=599)		Hazard or Rate Ratio (95% CI)*
	no. (%)†	*events/100 patient-yr*	*no. (%)†*	*events/100 patient-yr*	
Primary outcome and components					
Death from any cause or first hospitalization for heart failure	242 (39.5)	12.8	264 (44.1)	15.7	0.82 (0.69 to 0.98)‡
Death from any cause	167 (27.2)	7.8	177 (29.5)	8.9	0.86 (0.69 to 1.07)§
First hospitalization for heart failure¶	172 (28.1)	9.1	182 (30.4)	10.8	0.85 (0.69 to 1.05)



N Engl J Med 2025;393:1155-65.

Srdeční glykosidy…studie DECISION

ESC European Heart Journal (2026) 00, 1–9
https://doi.org/10.1093/eurheartj/ehag385

Blinded withdrawal of randomized treatment with low-dose digoxin or placebo in heart failure: the DECISION trial

NYHA-class at EoS (%)				.769
II	535 (91.1%)	264 (91.7%)	271 (90.6%)	
III	52 (8.86%)	24 (8.33%)	28 (9.36%)	

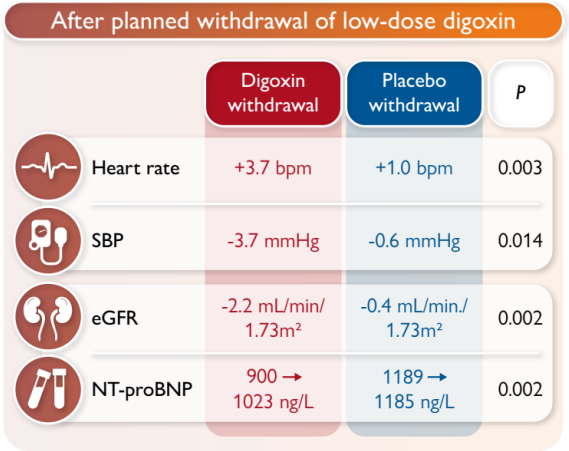
Results During the pre-withdrawal phase (100 days), incidence rates of cardiovascular (CV) death or worsening HF events were 5.7 vs 6.5 events per 100 patient-years in the digoxin vs placebo group; rate ratio (RR) 0.88; 95% confidence interval (CI) [0.24–3.10]. Following withdrawal, the incidence rate increased markedly in patients withdrawn from digoxin but not placebo (42.8 vs 5.9 events per 100 patient-years; time period-by-treatment interaction, *P* = .036). Fourteen events (12 hospitalizations and 2 urgent HF visits) occurred in the digoxin withdrawal arm vs two (one HF hospitalization and one CV death) in the placebo withdrawal arm (RR 7.37, 95% CI 1.56–34.88; *P* = .012). Withdrawal of digoxin was accompanied by an increase in heart rate (*P* = .003), reduction in systolic blood pressure (*P* = .014), and rise in NT-proBNP (*P* = .002).

Srdeční glykosidy…studie DECISION

ESC European Heart Journal (2026) 00, 1–9
https://doi.org/10.1093/eurheartj/ehag385

FASTTRACK – CLINICAL RESEARCH
Heart failure and cardiomyopathies

Blinded withdrawal of randomized treatment with low-dose digoxin or placebo in heart failure: the DECISION trial



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Novinky z 2026 ESC HF Guidelines – dekompenzované srdeční selhání

Table 4 New concepts

New concepts
HFrEF has been expanded to include LVEF up to 50%
HFmrEF has been removed
HFpEF includes LVEF from 50% and above
Decompensated HF replaces acute HF
Stages of HF (A–D) ranging from risk factors to advanced HF have been adopted
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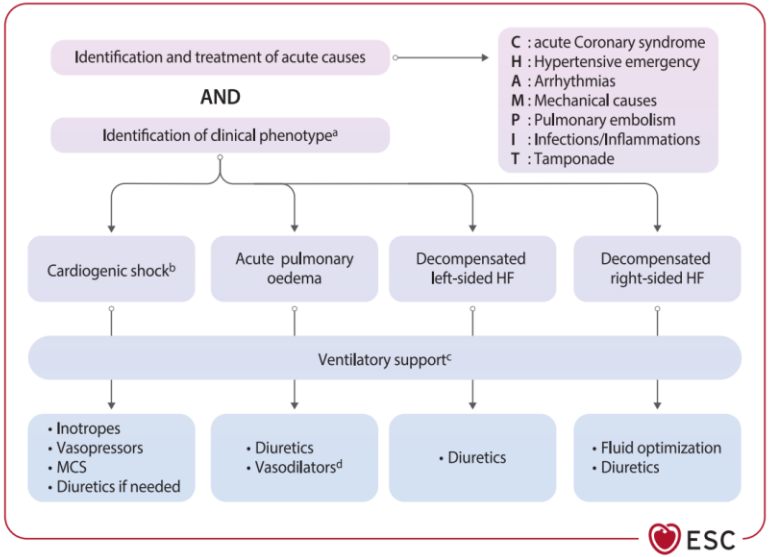


2026 ESC HF Guidelines – dekompenzované srdeční selhání

Decompensated heart failure—*Section 7*		
Urinary Na^+-guided diuretic therapy may be considered during the first days of treatment of patients with DHF to improve natriuresis and diuresis.	IIb	B1
In-hospital initiation of SGLT2-I is recommended in patients with DHF after initial stabilization to improve QoL and congestion symptoms and reduce the risk of HFH.	I	B1
A multidisciplinary Shock Team is recommended in potential candidates for temporary MCS to guide the device selection (modality and type) based on patient and HF characteristics.	I	C
Temporary MCS with a microaxial flow pump should be considered in selected patients with cardiogenic shock caused by ST-elevation MI with LV systolic dysfunction and no risk of hypoxic brain injury in order to reduce the risk of death.	IIa	B1
Temporary MCS should be considered in patients with mechanical complications related to MI as a bridge to definitive treatment.	IIa	C

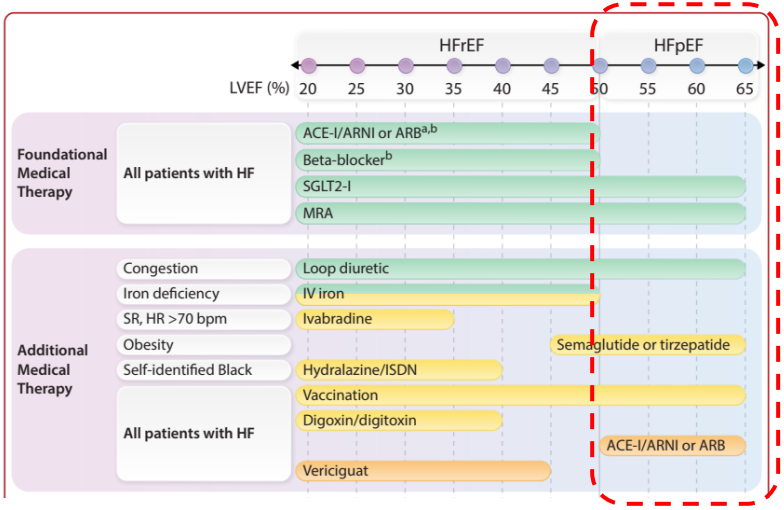
Recommendations in 2021 version	Class[a]	Level[b]	Recommendations in 2026 version	Class[a]	Level[b]
Continuous inotropes and/or vasopressors may be considered in patients with low cardiac output and evidence of organ hypoperfusion as bridge to MCS or heart transplantation.	IIb	C	Continuous inotropes should be considered in patients with advanced HFrEF, low cardiac output, and evidence of hypoperfusion or end-organ dysfunction, as BTD, BTT, or as bridge to durable MCS, to increase cardiac output and improve symptoms.	IIa	C

2026 ESC HF Guidelines - léčba HFpEF

All patients with HF, independent of LVEF		
An SGLT2-I (dapagliflozin or empagliflozin) is recommended in patients with symptomatic HF independent of LVEF to reduce the risk of HFH or CV death.[241–245,326]	I	A
An MRA (sMRA for HFrEF and sMRA/nsMRA for HFpEF) is recommended in patients with symptomatic HF independent of LVEF to reduce the risk of HFH or CV death.[c 43,254–257]	I	A
Dynamic individualized dosing of loop diuretics according to volume status is recommended in patients with HF and signs and/or symptoms of congestion to alleviate HF symptoms, improve exercise capacity, and reduce the risk of HFH.[d 327–329]	I	A
HFpEF		
ACE-I/ARB/ARNI may be considered in patients with symptomatic HFpEF to reduce the risk of HFH.[39,40,42,319,332–337]	IIb	C

Recommendation Table 18 — Recommendations for obesity in patients with heart failure (see *Evidence Tables 85 and 86*)

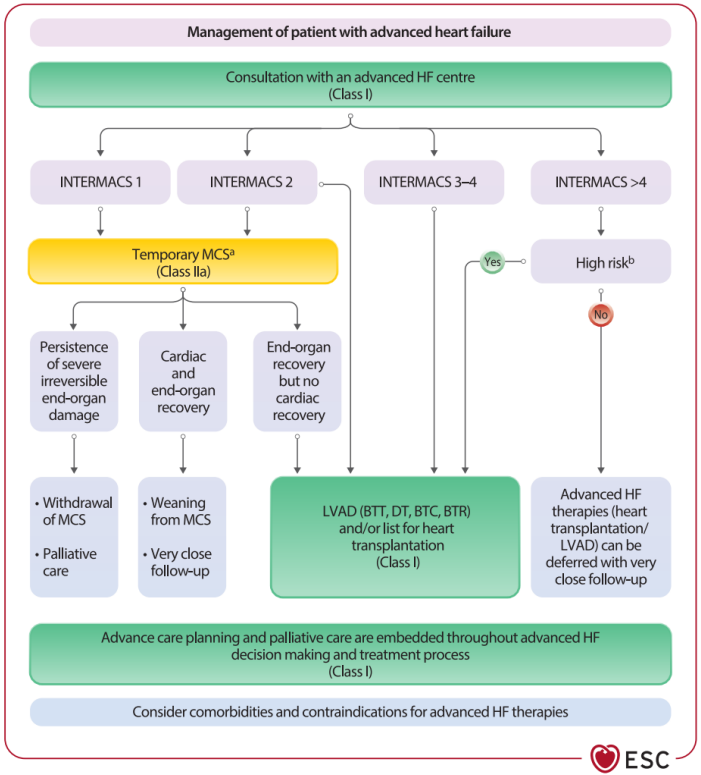
Recommendations	Class[a]	Level[b]
Semaglutide or tirzepatide should be considered for patients with symptomatic HF, LVEF ≥45%, and BMI ≥30 kg/m^2, regardless of diabetes status, to reduce body weight, and improve exercise capacity and QoL.[315–317,819,820,825]	IIa	B1



I. INTERNÍ KARDIOANGIOLOGICKÁ KLINIKA FNUSA A LF MU

FAKULTNÍ NEMOCNICE U SV. ANNY V BRNĚ

2026 ESC HF Guidelines – pokročilé srdeční selhání



Recommendations in 2021 version	Class[a]	Level[b]	Recommendations in 2026 version	Class[a]	Level[b]
Long-term MCS should be considered in patients with advanced HFrEF despite optimal medical and device therapy, not eligible for heart transplantation or other surgical options, and without severe right ventricular dysfunction, to reduce the risk of death and improve symptoms.	IIa	A	Durable MCS (LVAD) is recommended in selected patients with advanced HFrEF, despite FMT and GDIT, as BTT, BTC, BTR, or as destination therapy to improve symptoms and reduce the risk of death.	I	C
Long-term MCS should be considered in patients with advanced HFrEF refractory to optimal medical and device therapy as a bridge to cardiac transplantation in order to improve symptoms, reduce the risk of HF hospitalization and the risk of premature death.	IIa	B			

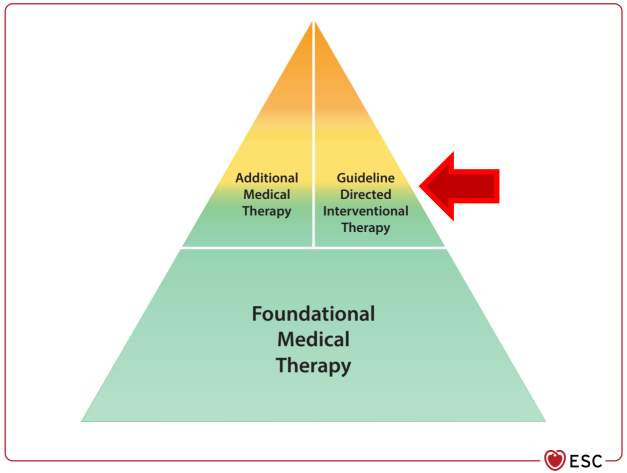
Recommendation	Class[a]	Level[b]
Heart transplantation is recommended in selected[c] patients with advanced HF refractory to FMT and GDIT, and without contraindications, to improve QoL and survival.[622,626]	I	C

Remote haemodynamic monitoring of PA pressure should be considered in symptomatic patients with HF, NYHA class III and an HFH in the past 12 months in order to reduce the risk of HFH.	IIa	B1

I. INTERNÍ KARDIOANGIOLOGICKÁ KLINIKA FNUSA A LF MU

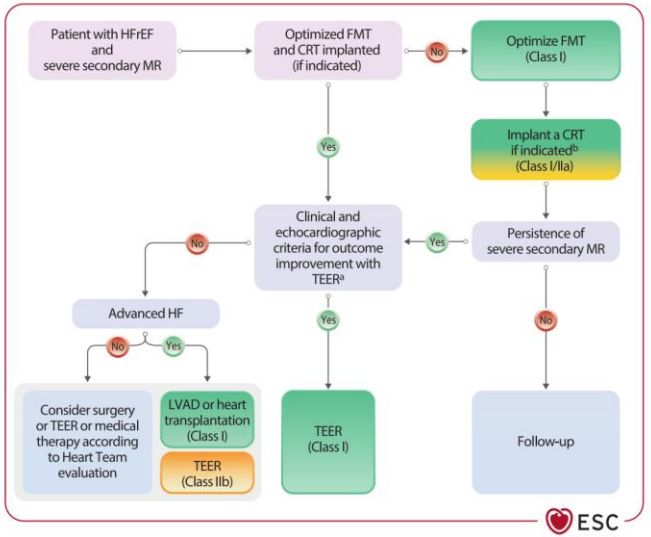
FAKULTNÍ NEMOCNICE U SV. ANNY V BRNĚ

2026 ESC HF Guidelines – intervenční léčba (GDIT)

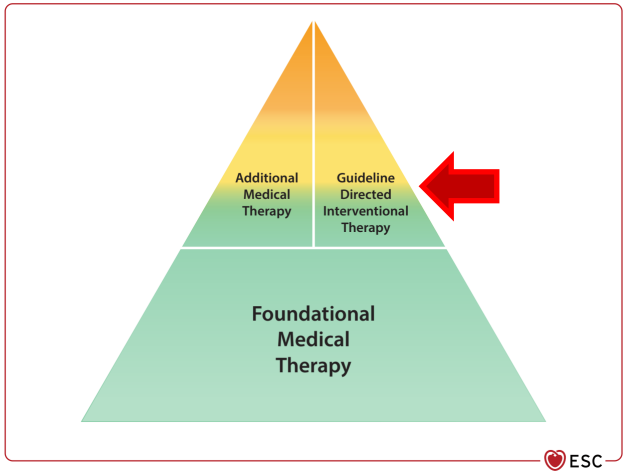


Recommendation Table 17 — Recommendations for valvular heart disease in patients with heart failure (see *Evidence Tables 83 and 84*)

Recommendations	Class[a]	Level[b]
Aortic stenosis		
Aortic valve intervention, SAVR or TAVI, is recommended in patients with severe aortic stenosis and HF[c] to improve symptoms and reduce the risk of death.[758–765]	I	B1
Secondary mitral regurgitation		
Mitral transcatheter edge-to-edge repair is recommended in haemodynamically stable, symptomatic patients with HFrEF and persistent severe secondary mitral regurgitation despite optimized FMT and CRT if indicated, who fulfil specific clinical and echocardiographic criteria,[d] in order to reduce the risk of HFH and improve QoL.[750–753]	I	B1



2026 ESC HF Guidelines – intervenční léčba (GDIT)



Rate control		
Beta-blockers are recommended in stable patients with HFrEF and AF as first-line therapy for short- and long-term rate control.[663,665]	I	C
Digoxin should be considered in stable patients with HFrEF and AF when the ventricular rate remains high despite beta-blockers, or when beta-blockers are contraindicated/not tolerated, in order to obtain short- and long-term rate control.[665–667]	IIa	C
Atrioventricular node ablation combined with CRT should be considered in patients with severely symptomatic permanent AF and poor rate control despite medical therapy and at least one HFH to reduce symptoms, physical limitations, recurrent HFH, and death.[672,673]	IIa	B1
Intravenous amiodarone or digoxin may be considered in haemodynamically unstable patients with HFrEF and AF to stabilize the patient and achieve acute control of heart rate.[668–671]	IIb	C
Cardioversion		
Urgent cardioversion is recommended in the setting of DHF in patients presenting with rapid ventricular rates and haemodynamic instability to restore sinus rhythm.[669,671,692,695]	I	C
Atrial fibrillation catheter ablation		
Catheter ablation for AF should be considered in selected[e] patients with symptomatic AF and HFrEF to improve QoL and reduce the risk of HFH or death.[674–676,678,681,682,684,696]	IIa	C

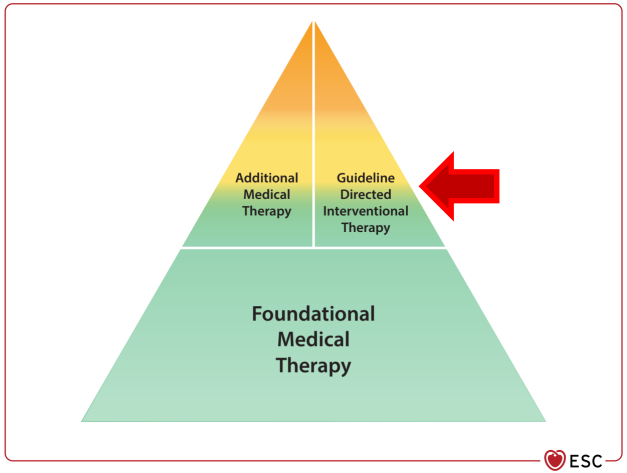
Recommendation Table 16 — Recommendations for revascularization in chronic coronary syndrome in patients with heart failure (see *Evidence Table 82*)

Recommendations	Class[a]	Level[b]
Revascularization for symptom improvement (HFpEF and HFrEF)		
Coronary revascularization is recommended in patients with HF, obstructive CAD, and persistent angina, despite FMT for HF and antianginal drugs, to relieve symptoms.[734,735]	I	C
Revascularization for outcome improvement (HFrEF)		
If revascularization is planned after assessment by a Heart Team, CABG should be considered as the preferred revascularization strategy, in patients with LVEF ≤35% and multivessel CAD suitable for surgery, to improve long-term survival.[180]	IIa	B1

I. INTERNÍ KARDIOANGIOLOGICKÁ KLINIKA FNUSA A LF MU

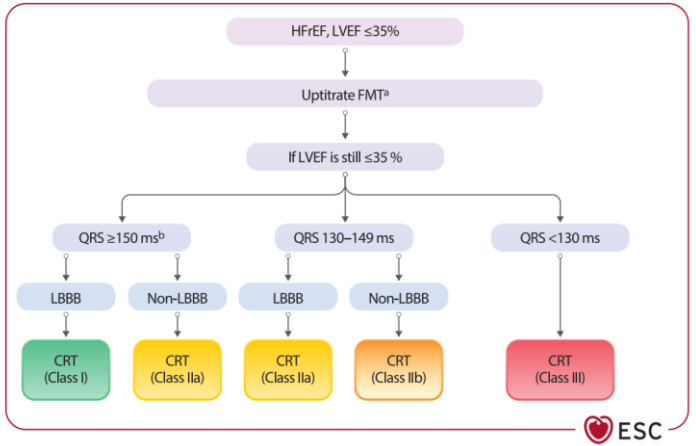
FAKULTNÍ NEMOCNICE U SV. ANNY V BRNĚ

2026 ESC HF Guidelines – intervenční léčba (GDIT)



Recommendation Table 6 — Recommendations for implantable cardioverter-defibrillator implantation (see *Evidence Tables 42–48*)

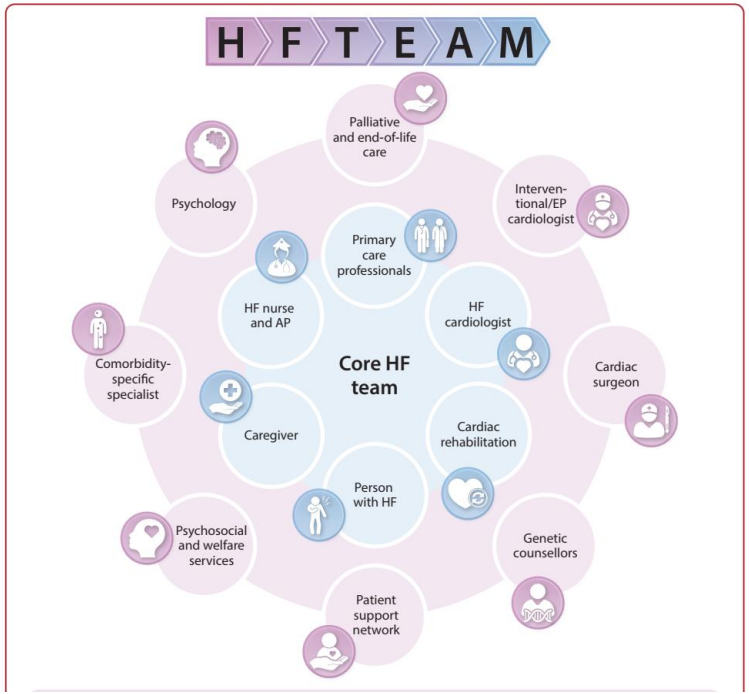
Recommendations	Class[a]	Level[b]
An ICD is recommended in patients who have recovered from a ventricular arrhythmia causing haemodynamic instability (secondary prevention), and who are expected to survive for >1 year with good functional status, in the absence of reversible causes, or unless the ventricular arrhythmia has occurred <48 h after an MI, to reduce the risk of sudden death and all-cause death.[346]	I	A
An ICD is recommended in patients with symptomatic HFrEF (NYHA class II/III) of an ischaemic aetiology (unless they have had an MI in the prior 40 days), and an LVEF ≤35% despite ≥3 months of optimal FMT, provided they are expected to survive longer than 1 year with good functional status, to reduce the risk of sudden death and all-cause death.[340,342,373,374]	I	B1
An ICD should be considered in patients with symptomatic HFrEF (NYHA class II/III) of a non-ischaemic aetiology, and an LVEF ≤35% despite ≥3 months of optimal FMT, provided they are expected to survive longer than 1 year with good functional status, to reduce the risk of sudden death and all-cause death.[340,341,344,375]	IIa	B1
Prior to generator replacement for CIEDs, a shared decision-making process between the patient and a cardiologist experienced in CIEDs and HF should be considered to ensure that the balance between risks and benefits still favour a CIED.[376–380]	IIa	C



2026 ESC HF Guidelines – ATTR-CM

Recommendations in 2021 version	Class[a]	Level[b]	Recommendations in 2026 version	Class[a]	Level[b]
Tafamidis is recommended in patients with genetic testing proven hTTR-CA and NYHA class I or II symptoms to reduce symptoms, CV hospitalization and mortality.	I	B	Treatment with a TTR silencer (vutrisiran) or stabilizer (tafamidis or acoramidis) for patients with variant or wild-type transthyretin cardiac amyloidosis and NYHA class I–III is recommended to reduce progression of symptoms and the risk of CV hospitalization and all-cause death.	I	A
Tafamidis is recommended in patients with wtTTR-CA and NYHA class I or II symptoms to reduce symptoms, CV hospitalization and mortality.	I	B			

2026 ESC HF Guidelines – krok správným směrem?



Heart Failure	Overarching principles of a HF management programme: • Patient-centred • Multidisciplinary • Delivered by competent professionals • Contributes to research, audit and implementation of evidence • Advocacy to improve access to care
Treatments	Access to HF treatments and interventions Treatment goals: • Prevention of disease progression • Symptom control Management of comorbidities Management of psychological distress
Education	Individualized education for the person with HF and caregiver to support self-care and recognize change in symptoms Professional education for HF specialists and non-specialists to support competence in HF care
Assessment	Identification of HF aetiology Ongoing clinical assessment and investigations appropriate to the patient and stage of HF Assessment of social determinants of health that impact access to care and adherence Frailty assessment
Monitoring	Coordinated care Monitoring strategies to facilitate: • Optimization of HF therapies • Recognition of disease progression • Early supported discharge • Opportunities for advanced care planning, advanced HF referral and palliative care

ESC

Děkuji za pozornost!