



This Concise Clinical Guidance (CCG) provides practical direction for identifying cardiac amyloidosis in routine practice, selecting the correct diagnostic tests in the correct order, initiating disease-modifying therapy at the appropriate time, and adjusting heart failure management to amyloid physiology to preserve function and quality of life.

1 Differentiate light chain amyloid cardiomyopathy (AL-CM) from transthyretin cardiomyopathy (ATTR-CM) early because management diverges immediately.

Determine amyloid type promptly, as AL-CM requires urgent hematologic evaluation, while ATTR-CM management centers on cardiology-led disease modification and subtype-specific counseling.

2 Maintain a low threshold to evaluate patients with heart failure with preserved ejection fraction (HFpEF) or characteristic "red flags."

Actively assess for amyloidosis in patients with presumed HFpEF particularly if associated with aortic stenosis, carpal tunnel syndrome, spinal stenosis, biceps tendon rupture, or neuropathy rather than attributing symptoms to age or comorbidities.

3 Order monoclonal protein testing before radionuclide scintigraphy every time.

Always screen for plasma cell disorders first; interpreting scintigraphy without this step risks misdiagnosing AL-CM as ATTR-CM and delaying life-saving therapy.

4 Pursue diagnosis early to preserve eligibility for disease-modifying therapy.

Initiate evaluation promptly, as available therapies slow progression but do not reverse disease and are most effective when started before advanced functional decline.

5 Initiate FDA-approved ATTR-CM therapy once diagnosis is confirmed.

Stabilizers (tafamidis, acoramidis) and silencers (vutrisiran) should be started without delay in appropriate patients to slow disease progression.

6 Tailor therapy choice to ATTR subtype and patient context.

Prefer silencer therapy in variant transthyretin amyloid cardiomyopathy (ATTRv-CM) with polyneuropathy when appropriate; otherwise, guide selection based on access, cost, payer requirements, and patient preference.

7 Avoid routine combination stabilizer-silencer therapy.

Prescribe monotherapy in accordance with current evidence and avoid combination treatment given lack of trial evidence of benefit of combination therapy.

8 Monitor response clinically rather than relying on formal treatment thresholds.

Use symptom trajectory, functional status, and clinical judgment to guide ongoing management, recognizing that standardized definitions of response or failure are lacking.

9 Adjust heart failure therapy to amyloid physiology.

Use beta-blockers and vasodilators cautiously due to reliance on heart rate to maintain cardiac output and inability to augment stroke volume in response to vasodilation in restrictive physiology; consider mineralocorticoid antagonists and SGLT2 inhibitors for relief of congestion, with careful diuretic titration.

10 Reassess therapy tolerance and patient goals over time.

Continuously balance symptom control, quality of life, and disease progression through shared decision-making as clinical status evolves.

Scan this QR code to access the full CCG for detailed figures and clinical nuance.

