

This Expert Consensus Decision Pathway (ECDP) provides a practical framework for early recognition, structured diagnosis, evidence-based treatment, and longitudinal management of heart failure with preserved ejection fraction (HFpEF).

1

Recognize patients at risk

Suspect HFpEF in patients with dyspnea, exercise intolerance, or edema and preserved ejection fraction (EF $\geq$ 50%), particularly in the presence of common cardiometabolic comorbidities such as hypertension, obesity, diabetes, chronic kidney disease (CKD), or atrial fibrillation (AF).

2

Confirm the diagnosis using a structured approach

Apply a stepwise evaluation using clinical scoring tools (often H₂FPEF), echocardiography, and natriuretic peptides, recognizing important diagnostic limitations, especially in obesity. No single test is definitive; diagnosis requires integrating clinical, imaging, and laboratory data.

3

Exclude mimics before final diagnosis

Systematically rule out noncardiac causes (eg, pulmonary disease, anemia, CKD, obesity, frailty) and cardiac conditions (eg, valvular, pericardial, or infiltrative disease) that may explain symptoms before making a final diagnosis of HFpEF.

4

Initiate foundational therapy early

Start an sodium-glucose cotransporter-2 (SGLT2) inhibitor early and consider a nonsteroidal mineralocorticoid receptor antagonists (MRA) when appropriate, unless contraindicated, to reduce HF hospitalizations and improve symptoms, quality of life, and functional capacity. Early initiation, including during hospitalization, supports better long-term outcomes.

5

Relieve congestion and stabilize symptoms

Use loop diuretics to control volume overload and relieve symptoms, adjusting therapy based on clinical status while avoiding excessive diuresis, hypotension, or worsening kidney function.

6

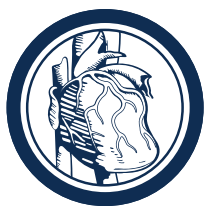
Personalize therapy based on phenotype

Tailor treatment to phenotype, sex-specific considerations, patient preferences, and comorbidity burden: add incretin-based therapy in obesity to improve weight and functional status; consider angiotensin receptor/neprilysin inhibitor (ARNI) in women or those with EF < 55-60%; and use an angiotensin II receptor blocker when ARNI is not feasible. Limit beta-blockers to specific indications.

7

Optimize comorbidities using a CKM framework

Aggressively manage hypertension (target ~120-129 mm Hg systolic), diabetes, CKD, and obesity using therapies with overlapping cardiovascular and metabolic benefit (eg, SGLT2 inhibitor, glucagon-like peptide-1 receptor agonists, MRA). Use the cardio-kidney metabolic framework to prioritize risk reduction, treatment selection, and longitudinal management, recognizing that increasing comorbidity burden is strongly linked to worse outcomes.



8

Manage AF and ischemic heart disease

Address AF with balanced rate control and consideration of rhythm control strategies, including ablation when symptomatic. Treat coronary artery disease with guideline-directed medical therapy and revascularization when appropriate, recognizing the high prevalence of both macro- and microvascular disease.

9

Incorporate nonpharmacologic and monitoring strategies

Promote structured exercise and long-term weight management to improve functional capacity and quality of life. Consider implantable pulmonary artery pressure monitoring in selected high-risk patients with persistent symptoms or recurrent hospitalizations.

10

Deliver longitudinal, team-based care

Implement a multidisciplinary model integrating cardiology, primary care, and specialty support, using electronic medical record-enabled tools to identify risk and guide therapy. Shift from episodic, reactive care toward proactive, continuous longitudinal management focused on early intervention and lifelong risk reduction.

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