



Response to the letter “All rise! Orthostatic Hypotension in Heart Failure”

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Response to the letter “All rise ! Orthostatic Hypotension in Heart Failure”

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We have read with interest the letter from Fudim and Soloveva (1) and we are pleased that they acknowledged the importance of low blood pressure management in the follow-up of patients with chronic heart failure with reduced ejection fraction (HFrEF).

The step-by-step evaluation we previously proposed for HFrEF patient with low blood pressure emphasizes the need to assess the link between a (low) blood pressure reading and signs and/or symptoms suggestive of hypotension rather than immediately change heart failure therapeutics (2). Only few tools are available to establish such a relationship. To that purpose, office orthostatic hypotension screening is highly available, simple, fast and remains crucial in routine practice, as it could explain many symptoms (p.e. falls) in frail populations. Fudim and al. offered us a very useful figure to put this into perspective (1).

However, office orthostatic hypotension screening can lack sensitivity. Additional evidence is probably needed on that topic, but in the meanwhile, we preferred suggesting in our algorithm a wider use of ambulatory blood pressure measurement (ABPM). ABPM remains only scarcely used and studied in HFREF until now (3-4), but can be useful as it provides a larger number of BP measurements in conditions that are more representative of daily life.

The overall goal of our low blood pressure management algorithm (2) is to protect most severe patients with low baseline blood pressure from a decrease/discontinuation of therapeutic classes that have demonstrated a benefit in morbidity and mortality. Old patients are at particular high risk of orthostatic hypotension, even if supine BP seems to be adequate, with sometimes severe consequences (p.e. falls). However, our algorithm also improve the probability of maintaining life-saving HFrEF medication in patients with an actual low blood pressure intolerance by first favoring the suppression of antihypertensive drugs not indicated in the HFREF and by modulating diuretic doses according to the level of congestion.

We agree with Fudim and Soloveva regarding the need to better understand the blood pressure profile of these hypotensive patients. Searching for office orthostatic hypotension and a more frequent use of ABPM should probably be part of the routine assessment of HFrEF patients. Whether implementing this BP assessment and using the low BP algorithm we proposed (2) can improve outcome through an optimized used of HF medication should be nonetheless formally evaluated.

References :

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