



ACTUALIZACIÓN DE LAS GUÍAS ESC 2026 EN INSUFICIENCIA CARDIACA

- La visión Vasco-Navarra -

7 de octubre. BIZKAIA ARETOA. BILBAO

Insuficiencia Cardíaca Descompensada y Avanzada

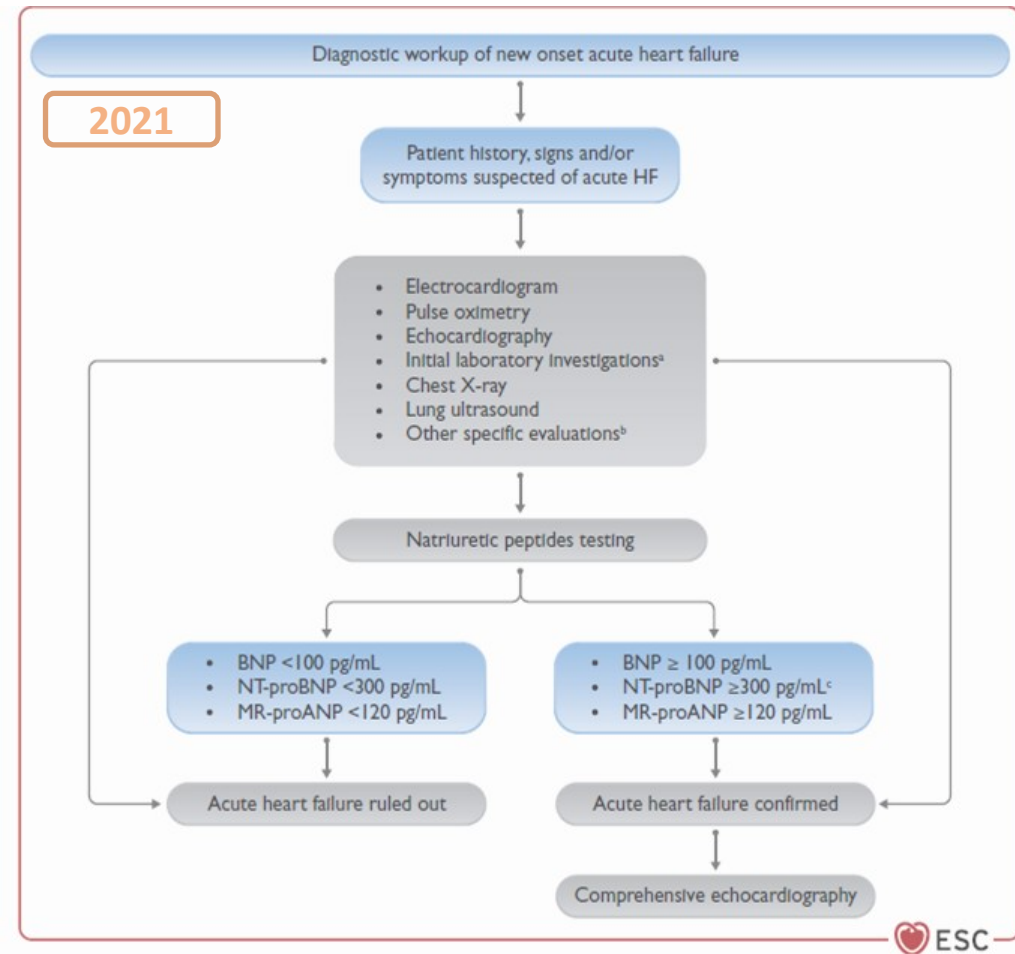
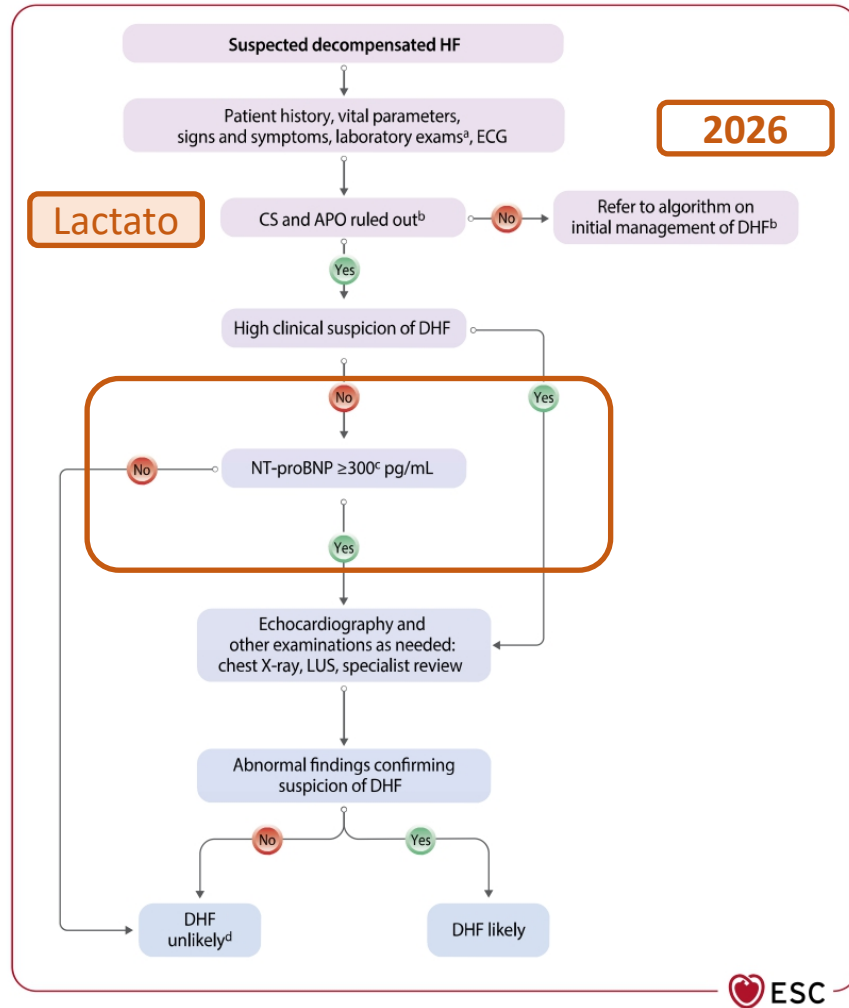


Amaia Martínez León
Cristina Goena Vives

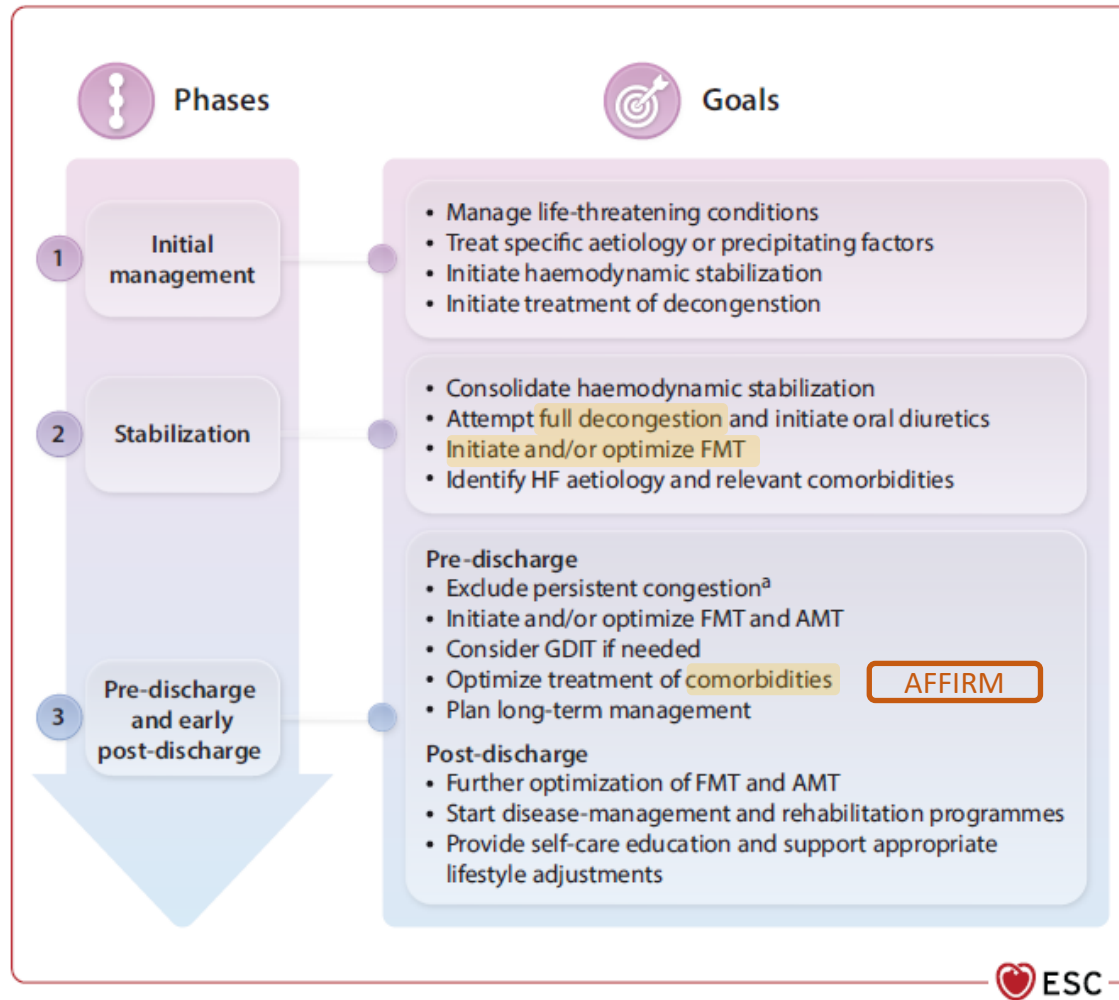
Insuficiencia Cardíaca Descompensada

- IC aguda → IC descompensada
- Inicio agudo/gradual de los síntomas/signos de IC
- De severidad suficiente para requerir atención médica urgente e inicio/intensificación de tratamiento
- Puede requerir ingreso hospitalario no planificado, visita a urgencias o atención ambulatoria no planificada requiriendo tratamiento para IC
- Empeoramiento IC preexistente o IC “de novo”
- Se asocia a alto riesgo de muerte (intra y extrahospitalaria)

Diagnóstico de Insuficiencia Cardíaca Descompensada



Manejo general



No interrumpir FMT siempre que sea posible



Presentación clínica y manejo específico

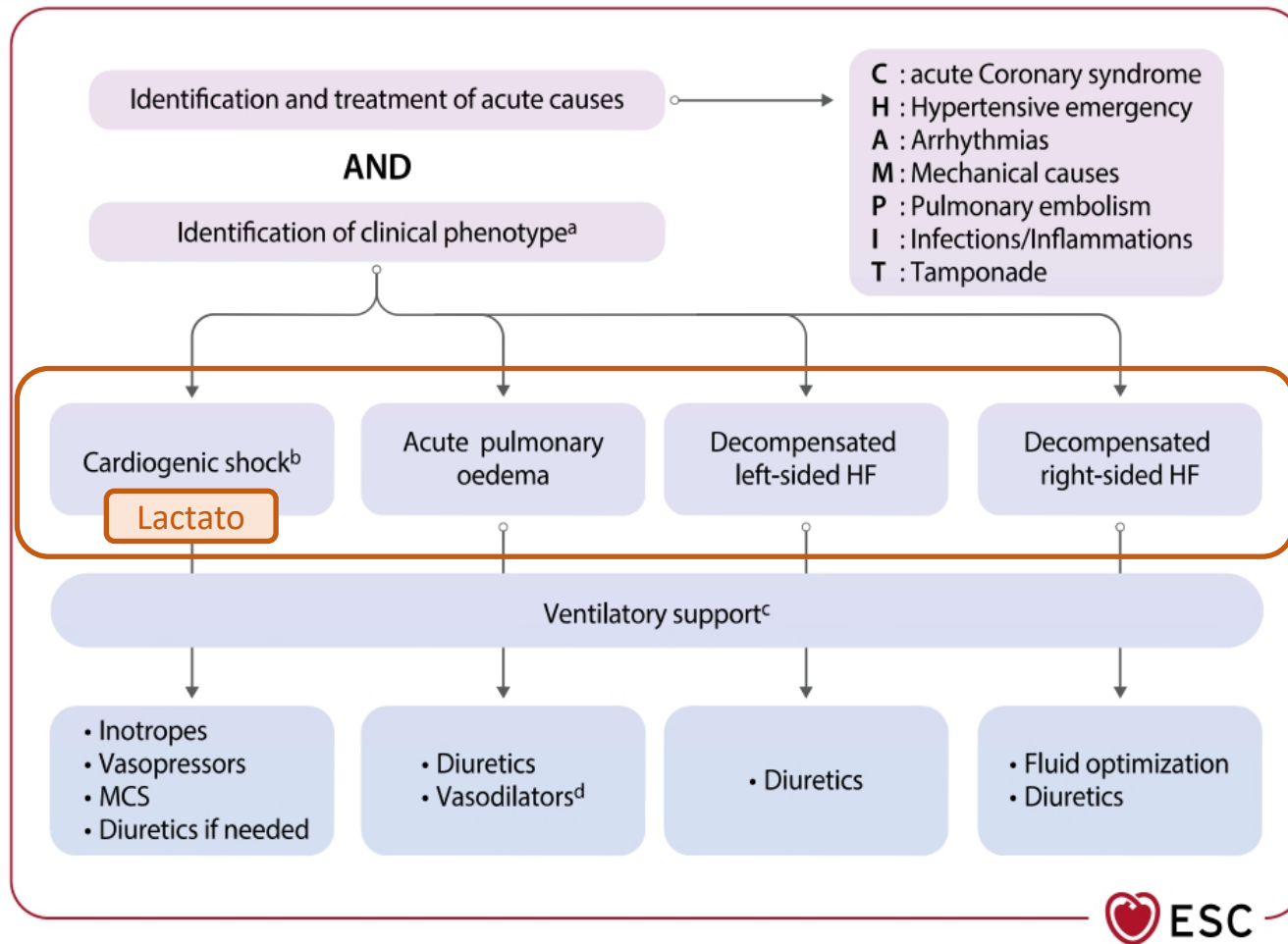


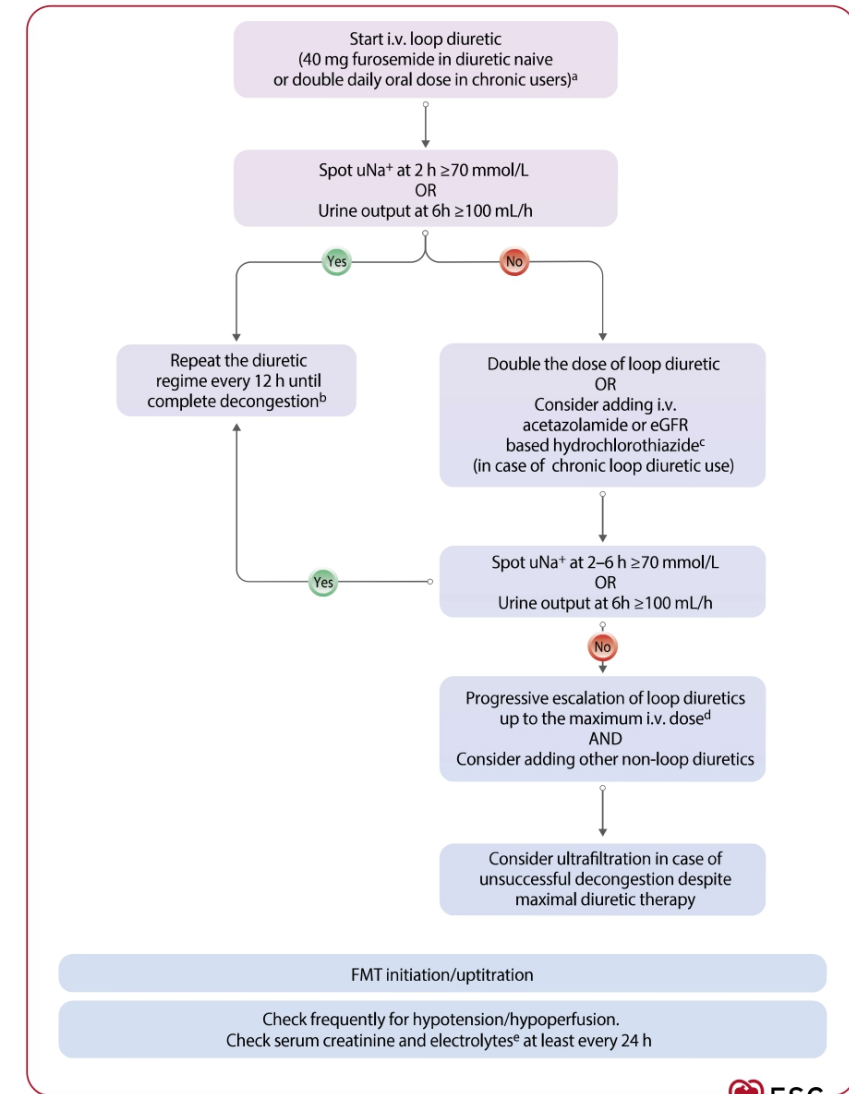
Table 13 SCAI classification for cardiogenic shock



STAGE A 'At risk'	A patient who is not currently experiencing signs or symptoms of CS but is at risk for development of CS.
STAGE B 'Beginning/pre-shock' cardiogenic shock	A patient who has clinical evidence of hemodynamic instability (including relative hypotension or tachycardia) without hypoperfusion.
STAGE C 'Classic' cardiogenic shock	A patient that manifests with hypoperfusion requiring intervention (inotrope, vasopressor, or mechanical support).
STAGE D 'Deteriorating'	A patient that is similar to stage C but deteriorating with failure to respond to initial interventions.
STAGE E 'Extremis'	A patient with refractory shock or cardiac arrest requiring multiple simultaneous acute interventions, including CPR.

Manejo de la descongestión

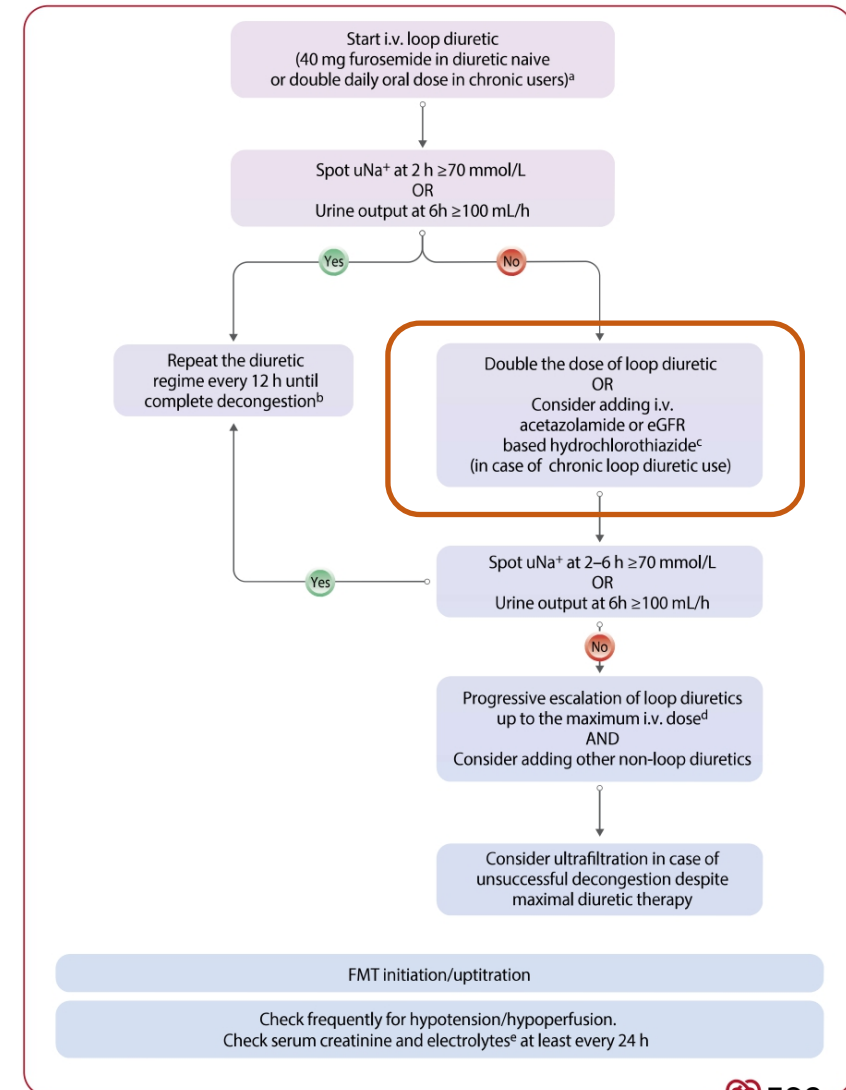
Diuretics		
Intravenous loop diuretics are recommended for all patients with DHF admitted with fluid overload to improve symptoms ^d .	I	A
The addition of short-term intravenous acetazolamide or oral hydrochlorothiazide should be considered in patients with fluid overload previously treated with loop diuretics, to reduce congestion. ^{510,511}	IIa	B1
Urinary Na ⁺ -guided diuretic therapy may be considered during the first days of treatment of patients with DHF to improve natriuresis and diuresis. ⁵⁰⁸	IIb	B1
SGLT2-I		
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. ^{492,522,525,541}	I	B1



Manejo de la descongestión

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ADVOR CLOROTIC



Manejo de la descongestión

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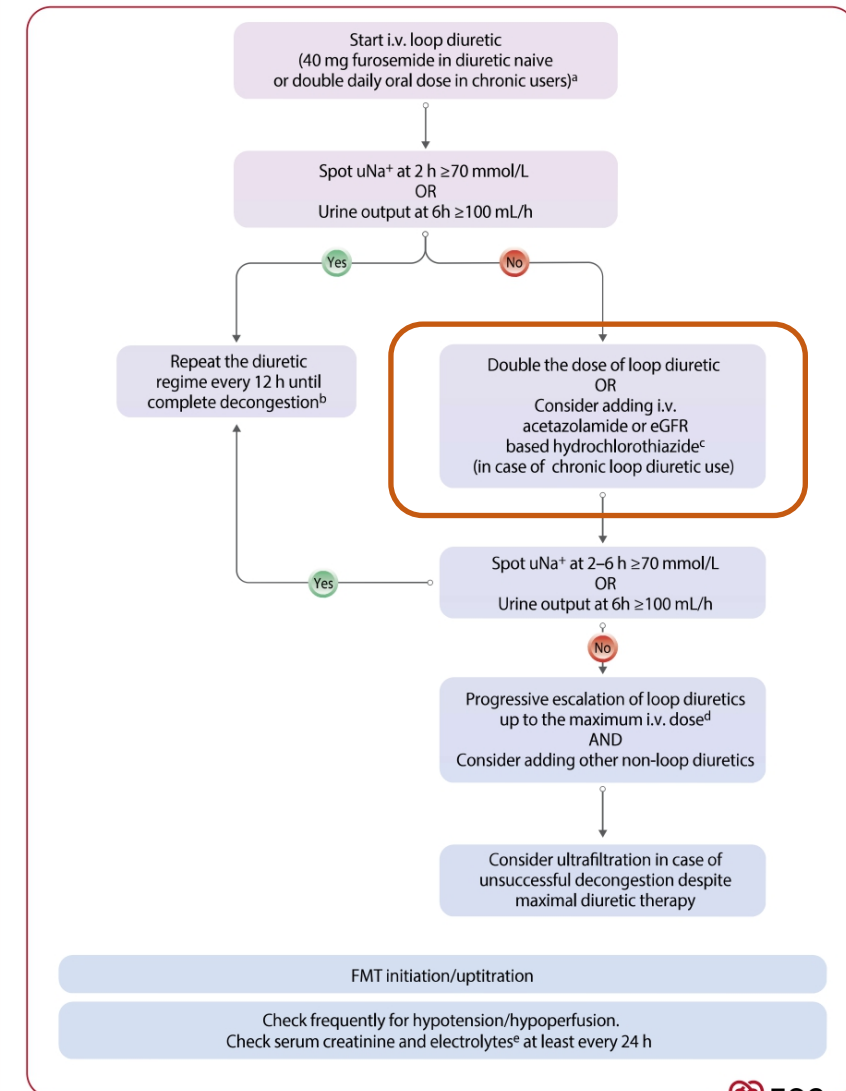
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SOCIEDAD
VASCO NAVARRA
DE CARDIOLOGÍA

Soporte mecánico circulatorio en shock cardiogénico

Recommendation Table 10 – Recommendations for the use of temporary mechanical circulatory support in patients with cardiogenic shock (see [Evidence Tables 68 and 69](#))

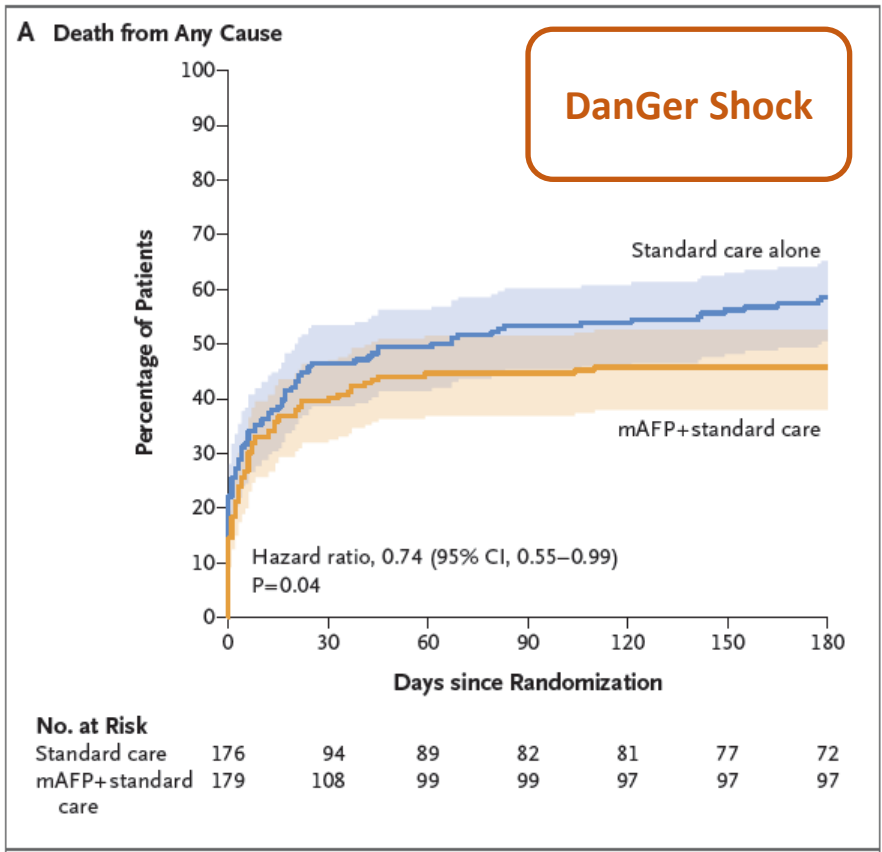
Recommendations	Class ^a	Level ^b
A multidisciplinary Shock Team is recommended in potential candidates for temporary MCS to guide the device selection (modality and type) based on patient and HF characteristics. ^{564,565}	I	C



Especialista en cuidados
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especialista en IC, cirugía cardíaca y
cardiología intervencionista en un
centro con experiencia en IC
avanzada

Cardiogenic shock caused by acute MI		
Temporary MCS with a microaxial flow pump should be considered in selected patients with cardiogenic shock caused by ST-elevation MI with left ventricular systolic dysfunction and no risk of hypoxic brain injury ^f in order to reduce the risk of death. ^{546,549,550}	IIa	B1
Temporary MCS is not recommended in unselected patients with cardiogenic shock caused by acute MI, due to risk of harm. ^{546,552,553}	III	B1
IABP is not recommended in unselected patients with cardiogenic shock, due to the lack of effect. ^{557,560}	III	B1
MI-related mechanical complications		
Temporary MCS ^d should be considered in patients with mechanical complications related to MI ^e as a bridge to definitive treatment.	IIa	C

Soporte mecánico circulatorio en shock cardiogénico



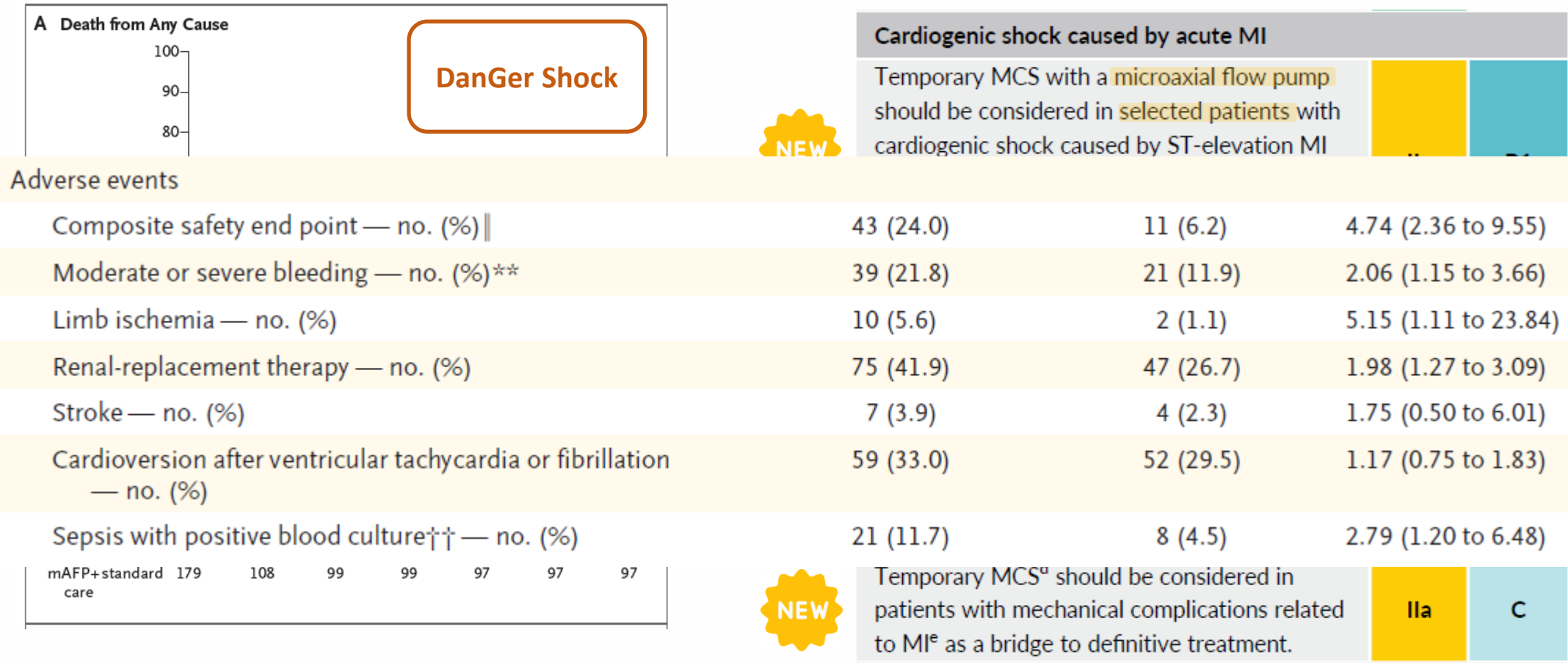
Moller JE. *N Engl J Med* 2024;390:1382–93.

NEW

NEW

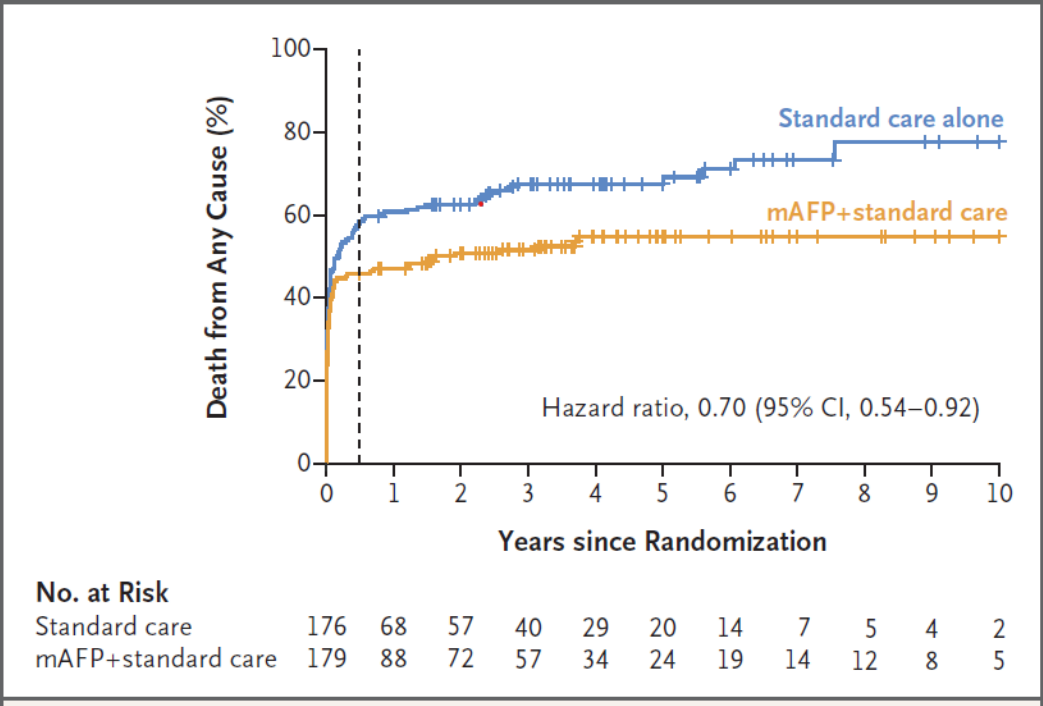
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Soporte mecánico circulatorio en shock cardiogénico



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Soporte mecánico circulatorio en shock cardiogénico



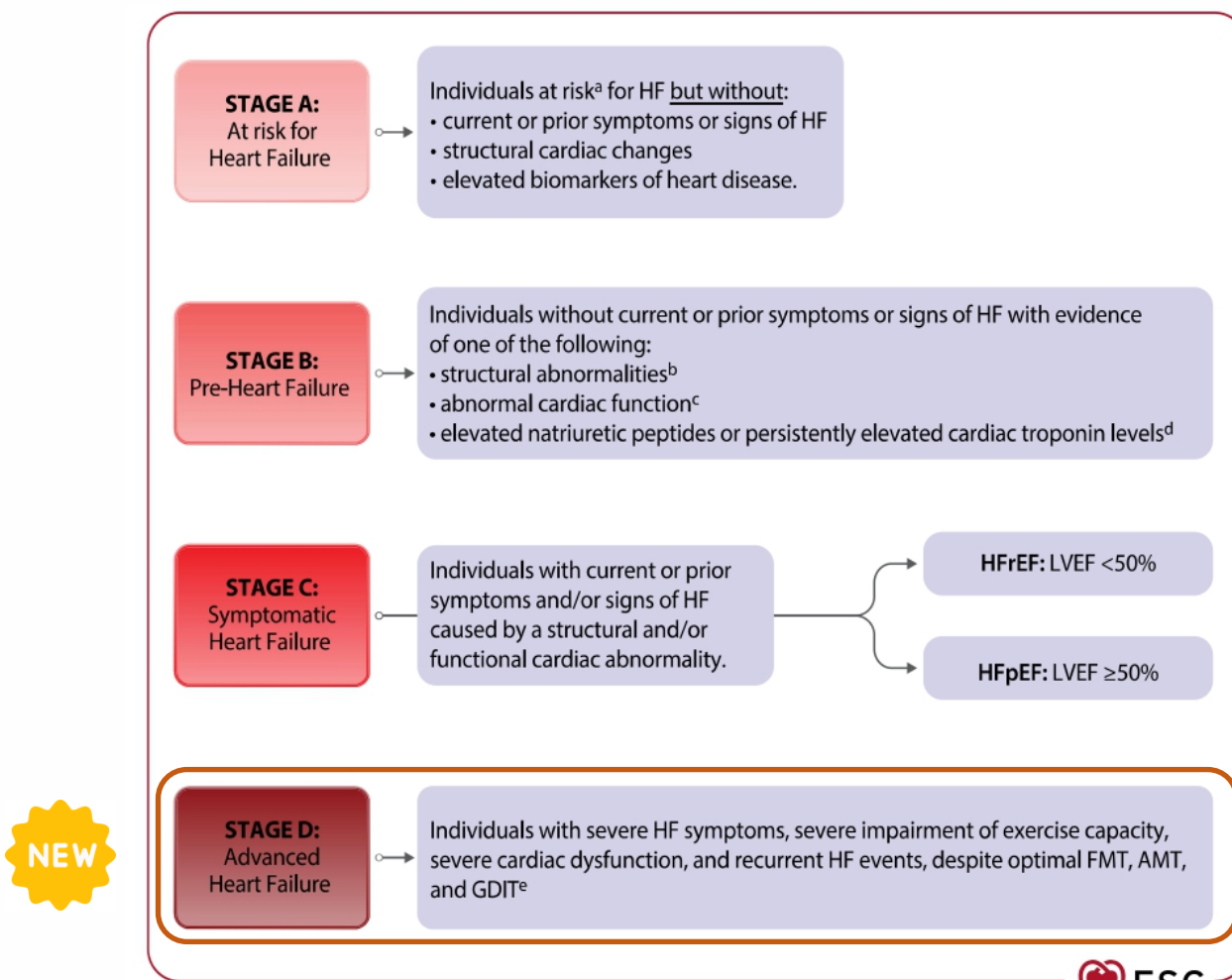
Moller JE. N Engl J Med 2025;393: 1037–8.

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Insuficiencia Cardíaca Avanzada



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Definición y criterios de alto riesgo

Table 14 Criteria for definition of advanced heart failure

All the following criteria must be present despite FMT, AMT, and GDIT:

1. Severe and persistent symptoms of HF (NYHA class III or IV).
2. Severe cardiac dysfunction defined by at least one of the following:
 - LVEF $\leq 30\%$
 - Isolated RV failure (e.g. ARVC)
 - Non-operable severe valve abnormalities
 - Non-operable severe congenital abnormalities
 - Persistently high (or increasing) BNP or NT-proBNP values and severe LV diastolic dysfunction or structural abnormalities (i.e. HFpEF,^a hypertrophic or restrictive cardiomyopathies).
3. Episodes of pulmonary or systemic congestion requiring high-dose i.v. diuretics (or diuretic combinations) or malignant arrhythmias causing ≥ 2 unplanned visits or hospitalizations in the last 12 months, or ≥ 1 episode of low output requiring inotropes or vasoactive drugs.
4. Severe impairment of exercise capacity with inability to exercise, or low 6-min walk test distance (<300 m), or $pVO_2 < 12-14$ mL/kg/min,^b or $<50\%$ predicted value, estimated to be of cardiac origin.

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Table 15 Criteria for high risk of advanced heart failure

Rule of three criteria (at least 1):

- HFH (≥ 2 or ≥ 1 requiring inotropes within the last year)
- Diuretic resistance
- Intolerance to neurohormonal drugs with onset of cardiorenal syndrome

I NEED HELP criteria (at least 1):

- Inotropes
- NYHA class III/IV or persistently high natriuretic peptides
- End-organ dysfunction (liver, kidney)
- EF $< 20\%$ or poor RV function
- Defibrillator shocks
- HFH > 1
- Escalating diuretics
- Low blood pressure, high heart rate
- Prognostic medication intolerance or the need to downtitrate

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Manejo y tratamiento

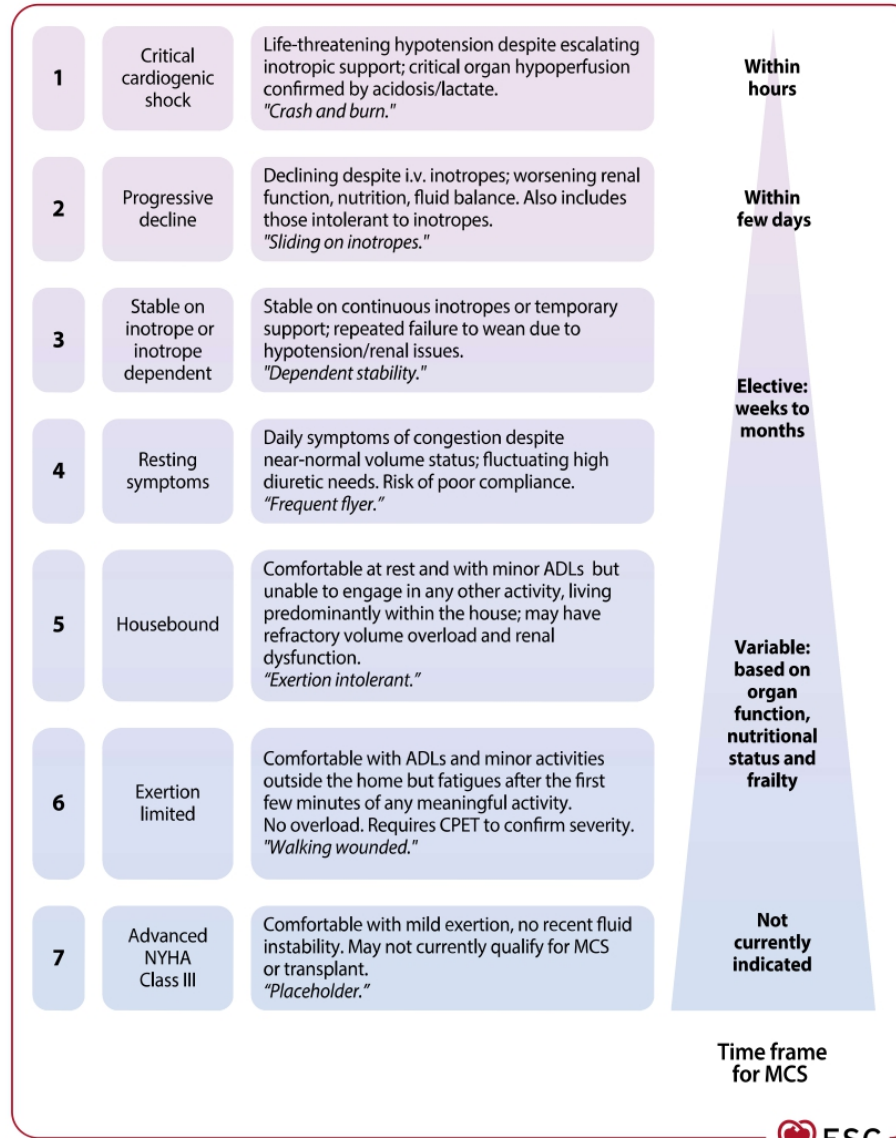
Recommendation Table 11 – Recommendations for diagnosis and evaluation of advanced heart failure (see [Evidence Tables 70 and 71](#))

Recommendations	Class ^a	Level ^b
NEW Early consultation with an advanced HF centre ^c is recommended in patients with advanced HF or at risk of advanced HF, who are motivated and do not have absolute contraindications for heart transplantation or durable MCS ^d , in order to evaluate candidacy. ^e 573,591	I	A

Recommendation Table 12 – Recommendations for medical management of advanced heart failure (see [Evidence Tables 72 and 73](#))

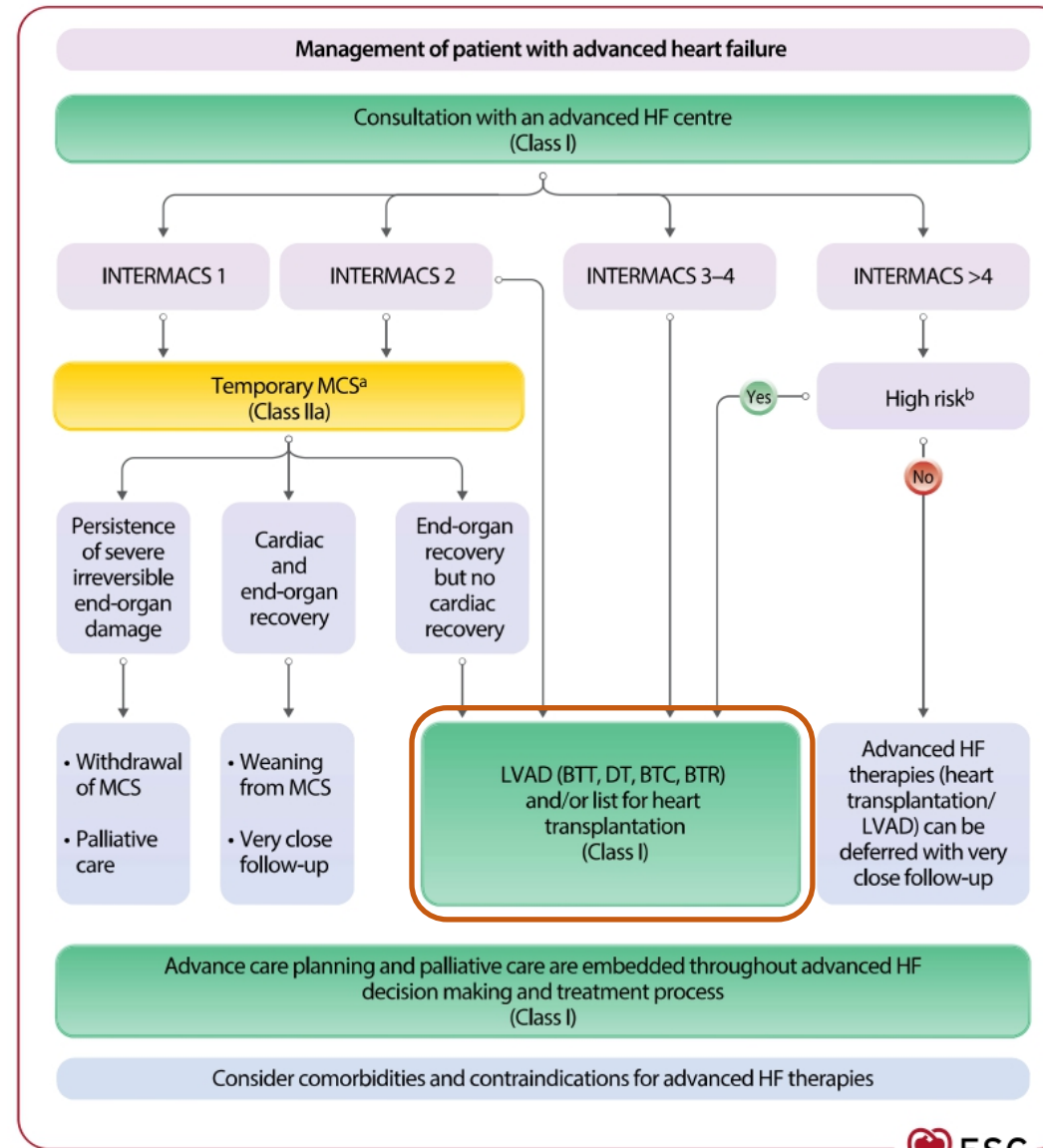
Recommendations	Class ^a	Level ^b
NEW Down-titration or discontinuation of beta-blockers or ivabradine should be considered in selected patients with advanced HFrEF and evidence of organ hypoperfusion, despite initial treatment, to increase cardiac output and improve symptoms.	Ila	C
Continuous inotropes 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. 598,599	Ila	C

Manejo y tratamiento



Manejo y tratamiento

El trasplante cardiaco sigue siendo el Gold standard



Manejo y tratamiento

Table 16 Indications and contraindications for implantation of a left ventricular assist device

Indications ^a
HF with severely reduced LVEF and one of the following:
• INTERMACS 1–2 with neurological and other end-organ recovery but no cardiac recovery on temporary MCS
OR
• INTERMACS 2–4
OR
• Severe symptoms and signs (NYHA class III/IV; INTERMACS >4) despite optimal FMT and GDIT, and at least one of the following:
◦ Unable to exercise due to HF or, if able to perform CPET, with $pVO_2 < 12\text{--}14 \text{ mL/kg/min}$ and/or $< 50\%$ predicted value.
◦ End-organ dysfunction (worsening kidney and/or hepatic function, group 2 pulmonary hypertension, cardiac cachexia) due to reduced perfusion as indicated by cardiac index $\leq 2 \text{ L/min/m}^2$ despite euvolaemic or therapy-resistant hypervolaemic status.
◦ Repeated HFH within the previous 12 months without an obvious precipitating cause.

Contraindications

Absolute:

- Severe right ventricular dysfunction despite euvolaemic status
- Severe irreversible end-organ (kidney and/or liver) disease
- Severe irreversible neurological disease
- Severe pulmonary disease
- Contraindication to long-term oral anticoagulation
- Medical non-adherence and/or other psychosocial limitations
- Insufficient social supports to achieve compliant care in the outpatient setting
- Psychological instability that jeopardizes proper follow-up and intensive therapeutic regime after implantation

Relative:

- Obesity or malnutrition
- Musculoskeletal disease that impairs rehabilitation
- Malignancy (depending on type and prognosis)
- Severe peripheral arterial disease
- Systemic infection
- Alcohol or substance abuse within the past 6 months, or active smoking
- Impaired cognitive function
- Frailty



ESKERRIK ASKO!



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