Among patients with heart failure, neurohormonal blockade with angiotensin-converting enzyme inhibitors, β-adrenergic receptor blockers (BB), and aldosterone antagonists has been shown to improve mortality and hospitalization rates. Combination therapy with these drugs can reduce mortality more than monotherapy alone. Dosing is also important. Improvement in left ventricular function and survival are dose-dependent effects for BB. Most heart failure trials used relatively high doses of BB and angiotensin-converting enzyme inhibitors. Studies have found that many patients with heart failure are treated with dosages of BB and angiotensin-converting enzyme inhibitors below those used in clinical trials.

Unfortunately, all of these drug classes can cause hypotension. In our clinic, we regularly encounter patients with heart failure who have low normal blood pressure. We try to administer ≥2 classes of drugs, usually BB and angiotensin-converting enzyme inhibitors. Some patients, however, can only tolerate a single drug.

Among patients with heart failure who have low blood pressure, which agent should we initiate first? Should we increase 1 agent to target dose before beginning the other? Also, which drug should we decrease if a patient develops hypotension on a multidrug regimen?

Disclosures
None.

References

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