ACE INHIBITORS

Improve symptoms and prognosis in all grades of heart failure. All patients with LVSD should be treated with an ACE-I regardless of symptoms

- Begin at lowest dose and uptitrate.
Target doses of ACE-I: ramipril 5mg twice daily (or 10mg once daily), lisinopril 30-35mg once daily or enalapril 10-20mg twice daily.

- U&E must be checked at one week following initiation and each up-titration to assess renal function

- If renal function deteriorating (decrease in GFR of >30%.), consider stopping ACE-I and seek specialist advice.

- If Serum potassium level is > 5.5 and < 6.0 reduce the ACE-I dose by 50% and re check in a week, if the serum potassium level is >6.0 stop ACE-I and seek specialist advice

- If ACE-I not tolerated due to persistent dry cough, substitute with an angiotensin receptor blocker (ARB) licensed for use in heart failure (see below).

ANGIOTENSIN II RECEPTOR BLOCKERS

- For patients intolerant of ACE-I due to side-effects, most commonly cough.

- As add on therapy in patients with ongoing symptoms in spite of ACE-I and beta-blocker, and intolerant of mineralocorticoid receptor antagonists (under specialist guidance only).

- Begin at lowest dose and slowly uptitrate to target dose.

- Target doses of AIIRB's: Candesartan 32mg, Valsartan 160mg twice daily (post-MI heart failure only).

- If on montherapy use the same monitoring as per ACE-I. If on dual therapy (i.e. ACE-I and AIIRB) then use the same monitoring as per mineralocorticoid receptor antagonist.

(Extracted from NHSGG&C Guidelines for *The Investigation and Management of Left Ventricular Systolic Dysfunction (LVSD))*