BETA-BLOCKERS

Improve symptoms and prognosis in all grades of heart failure.

All patients with LVSD, regardless of symptoms, should be started on beta-blocker therapy **as soon as their condition is stable** i.e. free from decompensated heart failure (unless contraindicated by a history of asthma or heart block).

Beta-blocker treatment should be prescribed under the guidance of a health professional experienced in the management of heart failure.

Diltiazem or verapamil must be discontinued.

Uptitrate slowly at intervals of not less than two weeks to target (or maximally tolerated) dose (carvedilol 25mg twice daily, (50 mgs twice daily if >85kgs), bisoprolol 10mg, nebivolol 10mg).

Nebivolol is restricted to use only in those>70 who are intolerant of both carvedilol and bisoprolol, and only on the advice of an expert.

Do not increase dose if heart rate ≤50bpm or systolic
blood pressure ≤90mmHg.

Patients stabilised on another b-blocker (for e.g. CHD or hypertension), consider substituting if clinically appropriate and patient’s heart failure condition is stable

e.g. if atenolol: total daily dose ≤0mg switch to 2.5mg bisoprolol once daily or 12.5mg carvedilol twice daily; if total daily dose >50 mg switch to 5mg bisoprolol once daily or 25mg carvedilol twice daily.

(extracted from NHSGG&C Guideline for ‘The Investigation & Management of LVSD’)

http://library.nhsggc.org.uk/mediaAssets/My%20HSD/LVSD%20guideline.pdf