

- CHF ranks number one for hospitalizations
- CHF patients with end-stage disease have symptom burden profiles similar to cancer patients
- The median survival is 2 years after admission to hospital (CMS patients)
- Inotropes
 - 6-month prognosis once inotrope dependent
 - Do not prolong life
 - Can improve symptoms
- Seattle Heart Failure Model requires lots of variables, but is useful
- Poor prognosis
 - Recurrent hospitalizations
 - BP is decreased and patient not able to take medication for the CHF as a result
 - Worsening renal function
 - EF- is not a reliable indicator of prognosis in older patients.
 - Focus on frailty, functional status, renal status and BP when determining prognosis

General predictors of shorter prognosis

- Cardiac hospitalization (triples 1-year mortality; nearly 1 in 10 die within 30 days of admission)
- Intolerance to neurohormonal therapy (i.e. beta-blockers or ACE-inhibitors) is associated with high 4-month mortality
- Elevated BUN (defined by upper limit of normal) and/or creatinine ≥ 1.4 mg/dl (120 μ mol/l).
- Systolic blood pressure < 100 mm Hg and/or pulse > 100 bpm (each doubles 1-year mortality)
- Decreased left ventricular ejection fraction (linearly correlated with survival at LVEF $\leq 45\%$)
- Ventricular dysrhythmias, treatment resistant
- Anemia (each 1 g/dl reduction in hemoglobin is associated with a 16% increase in mortality)
- Hyponatremia (serum sodium ≤ 135 -137 mEq/l)
- Cachexia or reduced functional capacity
- Orthopnea
- PAD in the geriatric population
- Co-morbidities: diabetes, depression, COPD, cirrhosis, cerebrovascular disease, and cancer
- Patients who are hospitalized for advanced HF/decompensated HF have a high mortality rate
 - 2-22% die in the hospital
 - 11% die within 30 days
 - 33% die within one year