

Review of the ACC/AHA Heart Failure Stages

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I. HOW TO USE

When to Use

Use in adults with risk factors for heart failure, abnormal cardiac biomarkers, abnormal cardiac imaging, or known/suspected heart failure to classify disease stage and guide stage-specific prevention or treatment.

Pearls / Pitfalls

- ACC/AHA stage reflects disease progression; NYHA class reflects current symptom severity.
- Stage A patients have HF risk factors but no symptoms, structural heart disease, or abnormal cardiac biomarkers.
- Stage B patients have no HF symptoms but have structural heart disease, abnormal cardiac function, increased filling pressures, or elevated cardiac biomarkers.
- Stage C includes patients with current or prior symptoms of heart failure.
- Stage D includes advanced HF with persistent severe symptoms despite GDMT and need for specialized HF care.
- If categories overlap, assign the highest stage supported by objective evidence.
- Borderline BNP, NT-proBNP, or troponin values should be interpreted using assay-specific reference ranges and clinical context.

Why to Use

The ACC/AHA staging system provides a longitudinal framework for heart failure progression, from risk factors to advanced disease. It helps identify patients before symptoms develop, supports prevention, and links dis-

Abstract

The ACC/AHA Heart Failure Stages categorize patients based on risk and disease progression, from preclinical risk to advanced heart failure. The system links each stage to guideline-directed management, emphasizing prevention, early intervention, and escalation of therapy.

ease stage to guideline-directed management. It complements, but does not replace, NYHA functional classification.

II. NEXT STEPS

Advice

Use the ACC/AHA stage to guide prevention, treatment intensity, and need for specialty referral. Consider NYHA class, LVEF phenotype, comorbidities, patient goals, and access to therapies when applying stage-based recommendations.

Management

Stage A (at risk for heart failure): Patients at high risk of developing HF because of the presence of conditions that are strongly associated with the development of HF. Such patients have no identified structural or functional, or biomarker abnormalities	Treat risk factors to prevent heart failure. Optimize blood pressure, diabetes, ASCVD, obesity, lifestyle factors, and exposure to cardiotoxic therapies. In patients with type 2 diabetes and established cardiovascular disease or high cardiovascular risk, consider SGLT2 inhibitor therapy to reduce HF hospitalization risk. Consider genetic counseling or surveillance when there is a family history or known genetic risk of cardiomyopathy.
Stage B (pre-heart failure): Patients who have developed structural heart disease that is strongly associated with the development of HF but who have never	Confirm the finding that defines Stage B, such as reduced LVEF, structural heart disease, increased filling pressures, or abnormal cardiac biomarkers. In patients with reduced LVEF, initiate disease-modifying therapy to prevent symptomatic HF, including ACEi/ARB/ARNi, evidence-based beta blocker therapy, and SGLT2 inhibitor therapy when appropriate. Treat prior MI/ACS and ASCVD aggressively, including statin therapy when indicated. Consider ICD therapy in eligible patients with persistently reduced

shown signs or symptoms of HF.	LVEF despite GDMT and expected survival >1 year.
Stage C: Patients who have current or prior symptoms of HF associated with underlying structural heart disease.	Classify by LVEF phenotype and optimize GDMT. For HFrEF, prioritize foundational disease-modifying therapy with ARNi/ACEi/ARB, evidence-based beta blocker, mineralocorticoid receptor antagonist, and SGLT2 inhibitor, as tolerated. Use diuretics for fluid retention and symptom relief. Consider add-on therapies, device therapy, revascularization, or HF specialty referral based on LVEF, rhythm, QRS duration, ischemic heart disease, symptoms, comorbidities, and patient goals.
Stage D: Patients with advanced structural heart disease and marked symptoms of HF at rest despite maximal medical therapy and who require specialized interventions.	Refer for HF specialty care when symptoms persist despite GDMT, particularly with recurrent hospitalizations, escalating diuretic needs, hypotension, worsening renal function, intolerance of GDMT, inotrope requirement, or poor functional status. Evaluate appropriate patients for advanced therapies such as LVAD or transplant, and incorporate shared decision-making, palliative care, and patient goals.
	Management section is based on and adapted from 2022 ACC/AHA Heart Failure Guidelines. Reference: https://pubmed.ncbi.nlm.nih.gov/35363499/ Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation. 2022;145(18):e895-e1032.

CRITICAL ACTIONS

N/A

III. EVIDENCE

Evidence Appraisal

Original/Primary
<https://www.ncbi.nlm.nih.gov/pubmed/11738322>
 Hunt SA, Baker DW, Chin MH, Cinquegrani MP, Feldman AM, Francis GS, Ganiats TG, Goldstein S, Gregoratos G, Jessup ML, Noble RJ, Packer M, Silver MA, Stevenson LW, Gibbons RJ, Antman EM, Alpert JS, Faxon DP, Fuster V, Jacobs AK, Hiratzka LF, Russell RO, Smith SC Jr; American College of Cardiology/American Heart Association. ACC/AHA guidelines for the evaluation and management of chronic heart failure in the adult: executive summary. A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to revise the 1995 Guidelines for the Evaluation and Management of Heart Failure). J Am Coll Cardiol. 2001 Dec;38(7):2101-13.

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 Heidenreich PA, Bozkurt B, Aguilar D, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. Circulation. 2022;145(18):e895-e1032.

The ACC/AHA Heart Failure Staging System is a guideline-endorsed, expert-consensus framework for classifying patients by heart failure risk and disease progression. It was introduced in the ACC/AHA heart failure guidelines and updated in the 2022 AHA/ACC/HFSA guideline to emphasize prevention, pre-HF identification, cardiac biomarkers, and stage-specific guideline-directed therapy.

This tool is not a quantitative risk score and does not provide

sensitivity, specificity, calibration, AUC, or an individualized probability of HF hospitalization or mortality. Its clinical value is in organizing care, identifying patients earlier in the HF continuum, and prompting appropriate prevention, GDMT, and specialty referral. Applicability depends on accurate clinical assessment, imaging, biomarker interpretation, and access to recommended therapies.

Formula

Selection of appropriate criteria.

Stage A (at risk for heart failure) is defined as a patient without symptoms, structural heart disease, or cardiac biomarkers suggesting cardiac injury or stress but who has chronic condition(s) that put them at increased risk. These conditions include HTN, DM, atherosclerotic CVD, metabolic syndrome and obesity, exposure to cardiotoxic drugs, carries a genetic variant for cardiomyopathy, or has a positive family history of cardiomyopathy.

Stage B (pre-heart failure) is defined as evidence of one of the following AND no symptoms or signs of heart failure.

1. Structural heart disease includes:
 - Reduced left or right ventricular systolic function (ie reduced ejection fraction or reduced strain)
 - Ventricular hypertrophy
 - Chamber enlargement
 - Wall motion abnormalities
 - Valvular heart disease
2. Evidence of increased filling pressures can be confirmed with invasive hemodynamic measurements or noninvasive imaging such as echocardiography.
3. Patients with risk factors AND either
 - a. Increased BNP OR
 - b. Persistently elevated cardiac troponin

Stage C (symptomatic heart failure) is defined as structural heart disease with current or previous symptoms of heart failure.

Stage D (advanced heart failure) is defined as marked symptoms of heart failure that interfere with daily life and lead to recurrent hospitalizations, despite goal directed medical therapy (GDMT).

Facts & Figures

- ACC/AHA stages progress from Stage A to Stage D and are not considered reversible.
- NYHA class and ACC/AHA stage measure different concepts: symptom burden versus disease progression.
- Stage B includes asymptomatic patients with structural heart disease, abnormal cardiac function, increased filling pressures, or abnormal cardiac biomarkers.
- GDMT can reduce morbidity and mortality in patients with symptomatic HFrEF.

- Access to imaging, biomarkers, genetic counseling, devices, LVAD, transplant, and multidisciplinary HF care may affect implementation.

Literature

Original/Primary

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