PLACE 2026
PLATFORM OF LABORATORIES FOR ADVANCES IN CARDIAC EXPERIENCE

CONGRESSO
ROMA, 25 - 27 Giugno 2026

INSUFFICIENZA CARDIACA: HOT NEWS

Scompenso cardiaco a FE preservata: i nuovi "pilastri" della terapia medica

Giovanni Pulignano
PDTA Scompenso Cardiaco
UOC Cardiologia - Az.Osp. San Camillo- Forlanini, Rome

SISTEMA SANITARIO REGIONALE
AZIENDA OSPEDALIERA SAN CAMILLO FORLANINI

Il sottoscritto PULIGNANO GIOVANNI
in qualità di relatore

ai sensi dell’art. 76, comma 4 dell'Accordo Stato-Regioni del 2 febbraio 2017 e del paragrafo 4.5. del Manuale nazionale di accreditamento per l'erogazione di eventi ECM

dichiara
di aver avuto rapporti di finanziamento
Boheringher, Astra Zeneca, Pfizer, Novartis, Bayer, Menarini

- Lo scompenso cardiaco a frazione di eiezione preservata (HFpEF) è una delle sfide cliniche più significative e complesse nella cardiologia moderna.

- A differenza dello scompenso cardiaco a FE ridotta (HFrEF), per il quale da alcuni decenni sono disponibili terapie che riducono significativamente la mortalità e la morbilità, la gestione dell'HFpEF è stata a lungo un'area di incertezza terapeutica.

- La sua eterogeneità e la complessa fisiopatologia richiedono un approccio diagnostico e terapeutico che va oltre i paradigmi tradizionali.

HF reduced EF

HF preserved EF

Courtesy, D. Del Sindaco 2008

Heart Failure With Preserved Ejection Fraction

Treat Now by Treating Comorbidities

Sanjiv J. Shah, MD
Mihai Gheorghiade, MD

JAMA, July 23/30, 2008—Vol 300, No. 4

the care of these patients should be redirected toward screening and treatment of important comorbidities such as hypertension, CAD, atrial fibrillation, diabetes, and chronic kidney disease

Can Brain Natriuretic Peptide Be Used to Guide the Management of Patients With Heart Failure and a Preserved Ejection Fraction?

The Wrong Way to Identify New Treatments for a Nonexistent Disease

Milton Packer, MD

Left ventricular filling pressures in patients with HFPEF are elevated not because the left ventricle cannot fill, but because it is overfilled, most likely as a result of the interplay of numerous comorbid conditions that can affect the level and distribution of circulating blood volume and ventricular-vascular coupling.

Circ Heart Fail. 2011;4:538-540

ESC European Society of Cardiology
European Heart Journal (2019) **40**, 3277–3280
doi:10.1093/eurheartj/ehz756

ISSUE @ A GLANCE

Heart failure with preserved ejection fraction: towards an understanding of an enigma

Thomas F. Lüscher[1,2,3]

Do patients with suspected heart failure and preserved left ventricular systolic function suffer from "diastolic heart failure" or from misdiagnosis? A prospective descriptive study

Lynn Caruana, Mark C Petrie, Andrew P Davie, John J V McMurray

Conclusions For most patients with a diagnosis of heart failure but preserved left ventricular systolic function there is an alternative explanation for their symptoms—for example, obesity, lung disease, and myocardial ischaemia—and the diagnosis of diastolic heart failure is rarely needed. These alternative diagnoses should be rigorously sought and managed accordingly.

Developing Therapies for Heart Failure With Preserved Ejection Fraction

Considering its prevalence and outcomes, future projections, and lack of effective therapies, HFpEF represents the single largest unmet need in cardiovascular medicine.

Javed Butler, JACC: Heart Failure

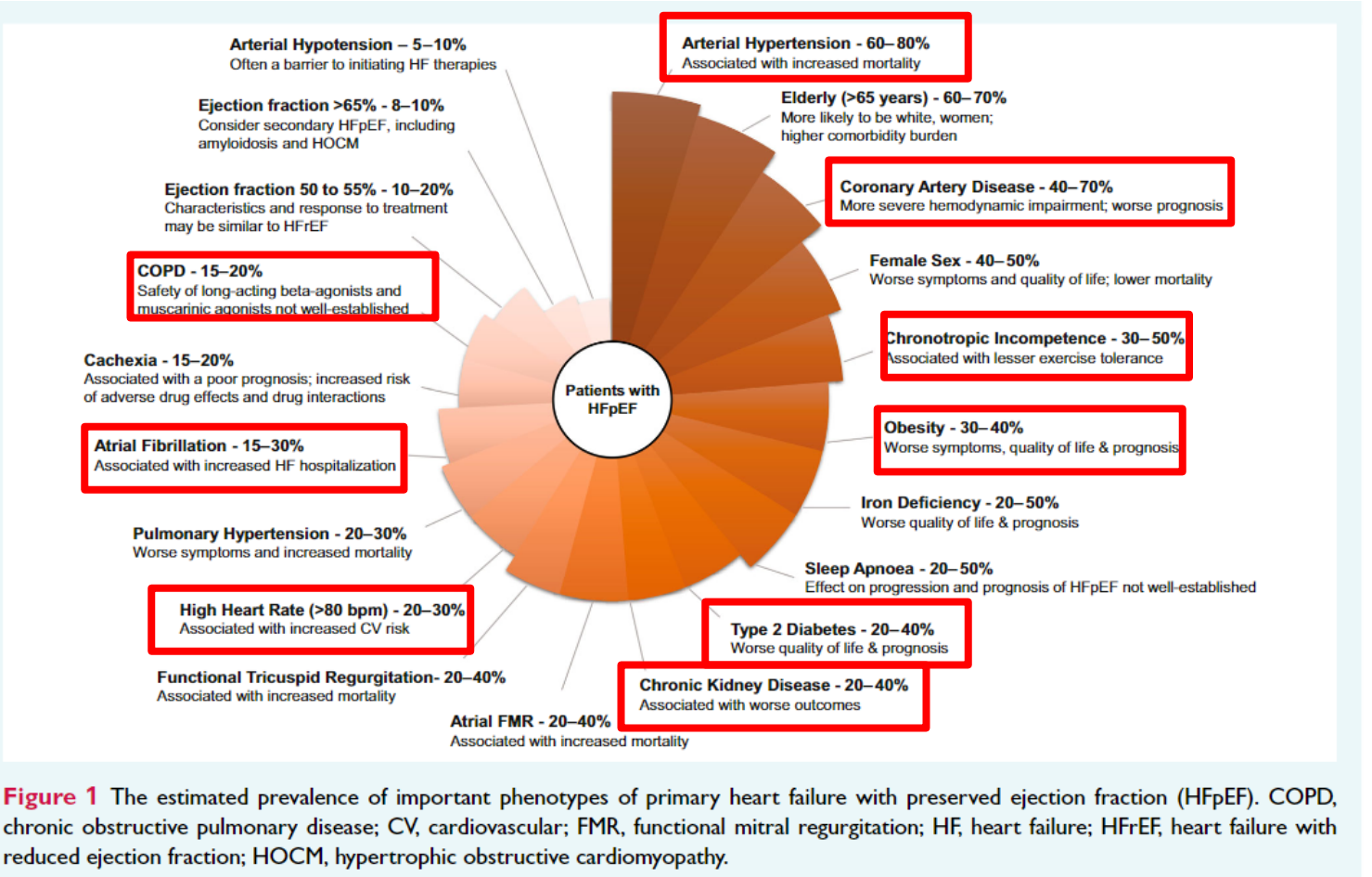
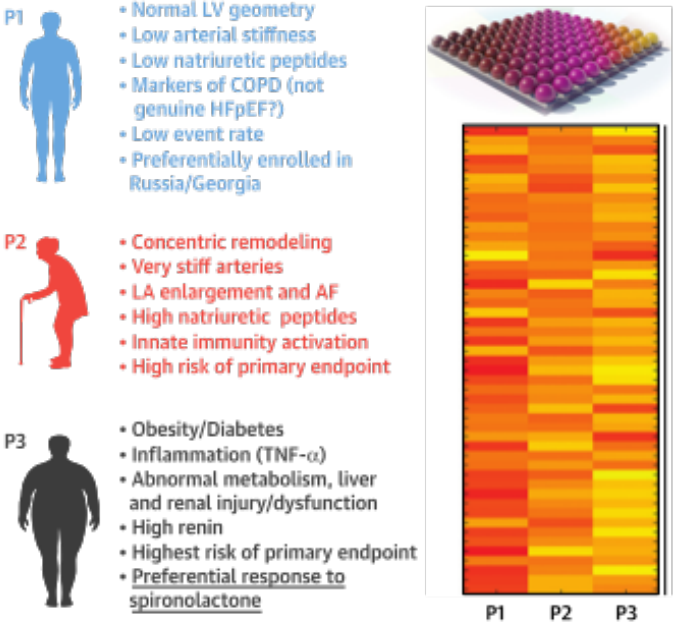


Figure 1 The estimated prevalence of important phenotypes of primary heart failure with preserved ejection fraction (HFpEF). COPD, chronic obstructive pulmonary disease; CV, cardiovascular; FMR, functional mitral regurgitation; HF, heart failure; HFrEF, heart failure with reduced ejection fraction; HOCM, hypertrophic obstructive cardiomyopathy.

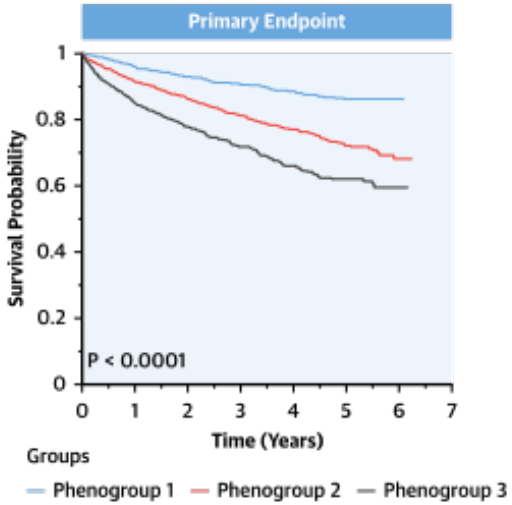
Anker S et al, European Journal of Heart Failure (2023) 25, 936–955

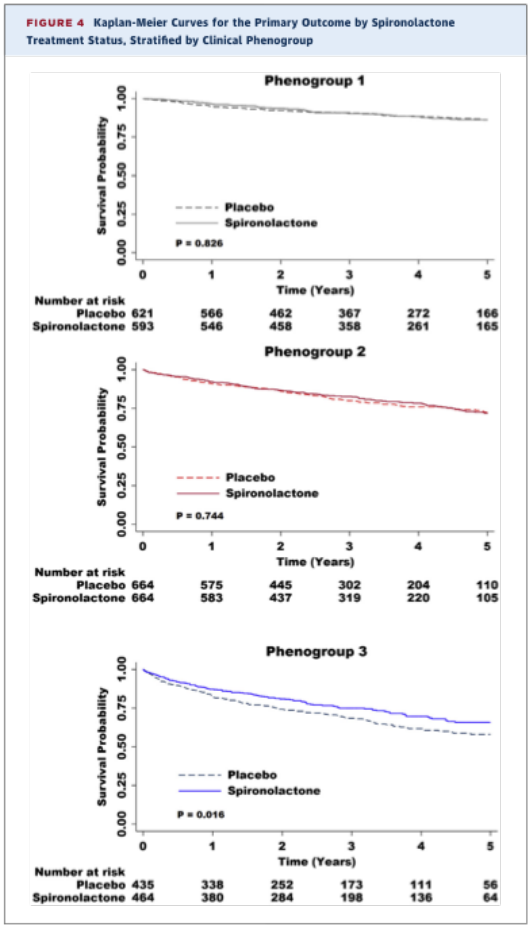
Clinical Phenogroups in HFpEF

Detailed Phenotypes, Prognosis, and Response to Spironolactone



Cluster analysis of 8 clinical variables in all participants in TOPCAT (n3,445)



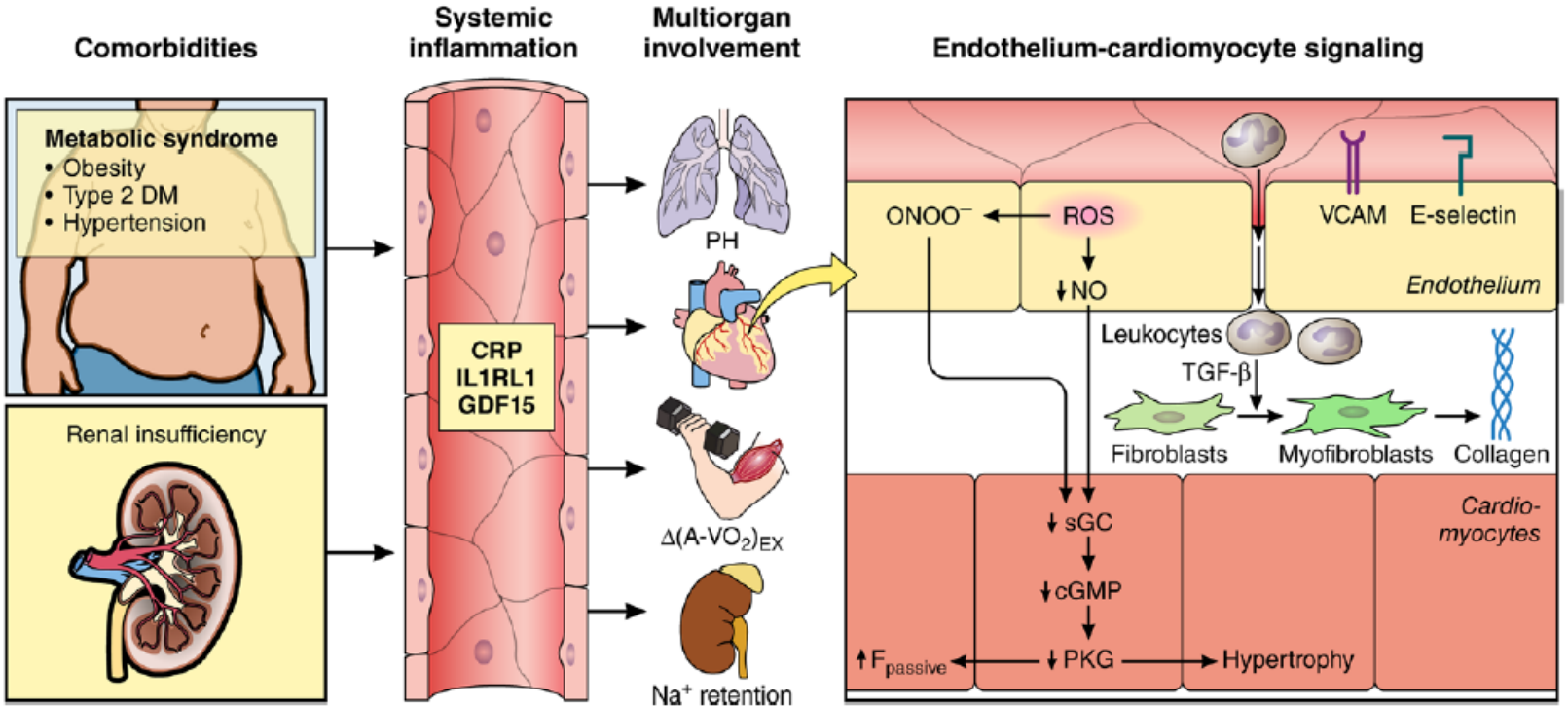


Cohen JB et al. J Am Coll Cardiol. 2020;8(3):172-84.

Phenotype-Specific Treatment of Heart Failure With Preserved Ejection Fraction

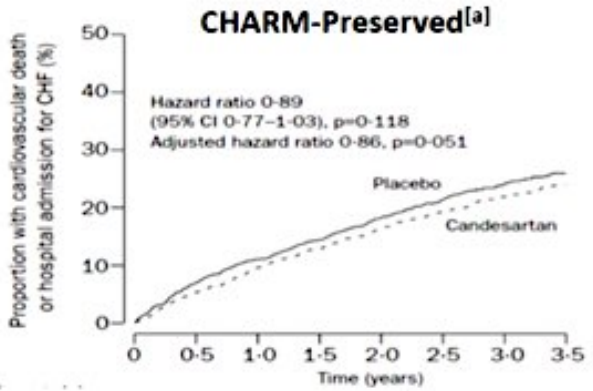
A Multiorgan Roadmap

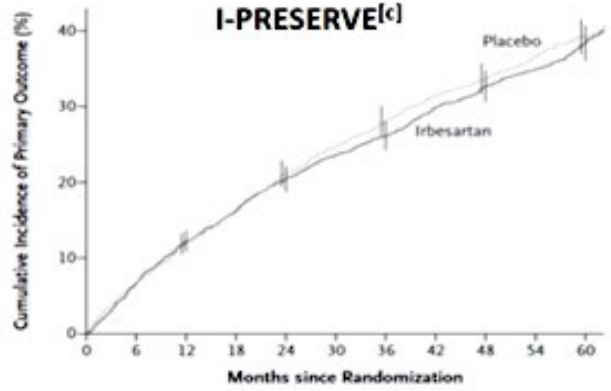
Systemic and myocardial signaling in HFPEF.

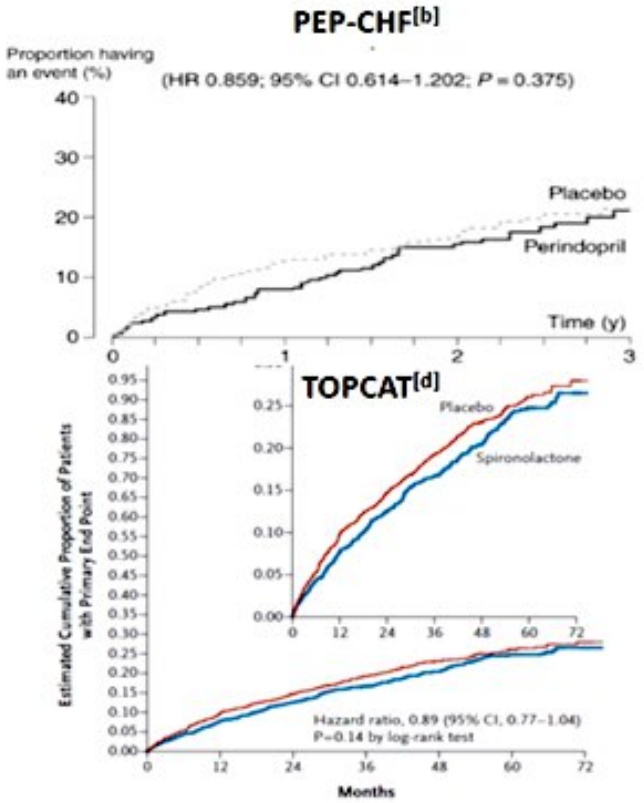


Shah SJ et al (2016). Circulation134(1):73–90

Terapia HFpEF: Perchè questi trial hanno “fallito” ?





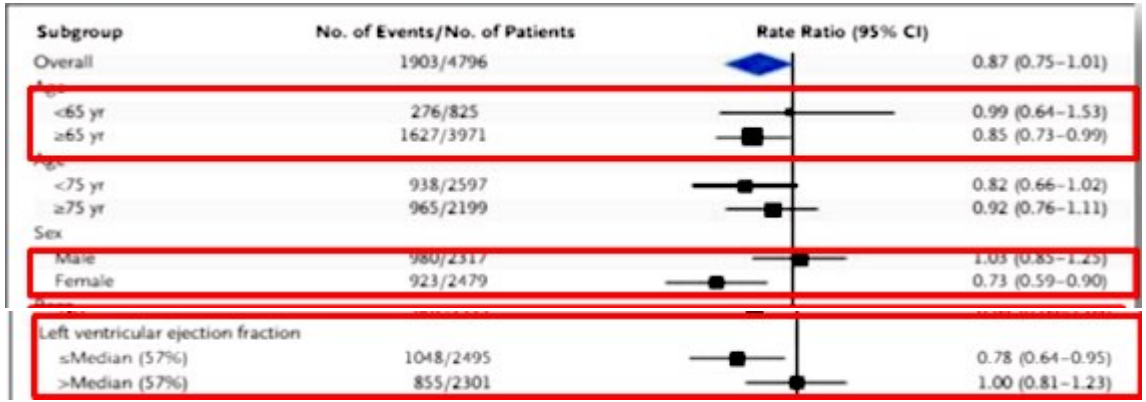


a. Yusuf S, et al. *Lancet*. 2003;363:777-781; b. Cleland JGF, et al. *Eur Heart J*. 2006;27:2338-2345; c. Massie BM, et al. *N Engl J Med*. 2008;359:2456-2367; d. Pitt B, et al. *N Engl J Med*. 2014;370:1383-1392.

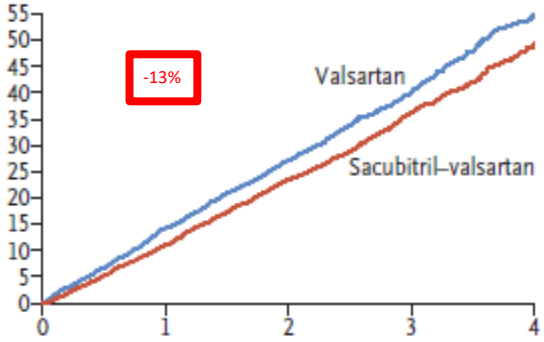
Angiotensin–Neprilysin Inhibition in Heart Failure with Preserved Ejection Fraction

Older (65-75 yrs) white woman with EF 45-57%?

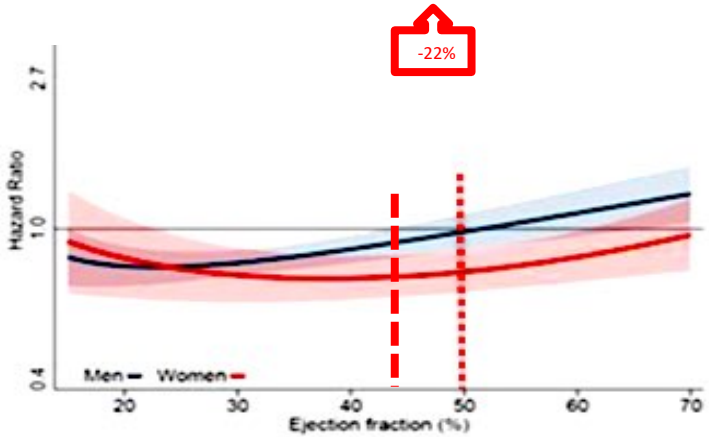
PARAGON-HF



Total Hospitalizations for Heart Failure and Death from Cardiovascular Causes



RR 0,87 [IC 95%, 0,75-1,01]; P=0,059

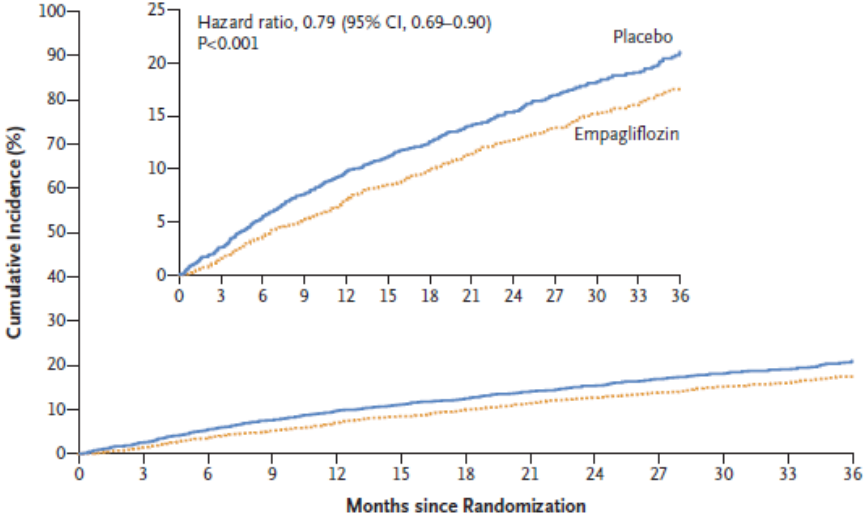


S.D. Solomon, J.J.V. McMurray, NEJM 2019, september

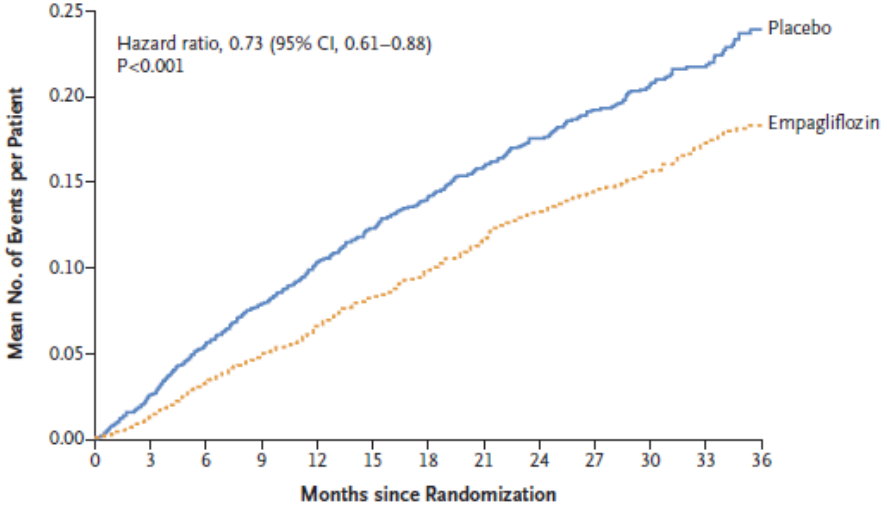
Empagliflozin in Heart Failure with a Preserved Ejection Fraction

EMPEROR-PRESERVED

Primary Outcome, a Composite of Cardiovascular Death or Hospitalization for Heart Failure

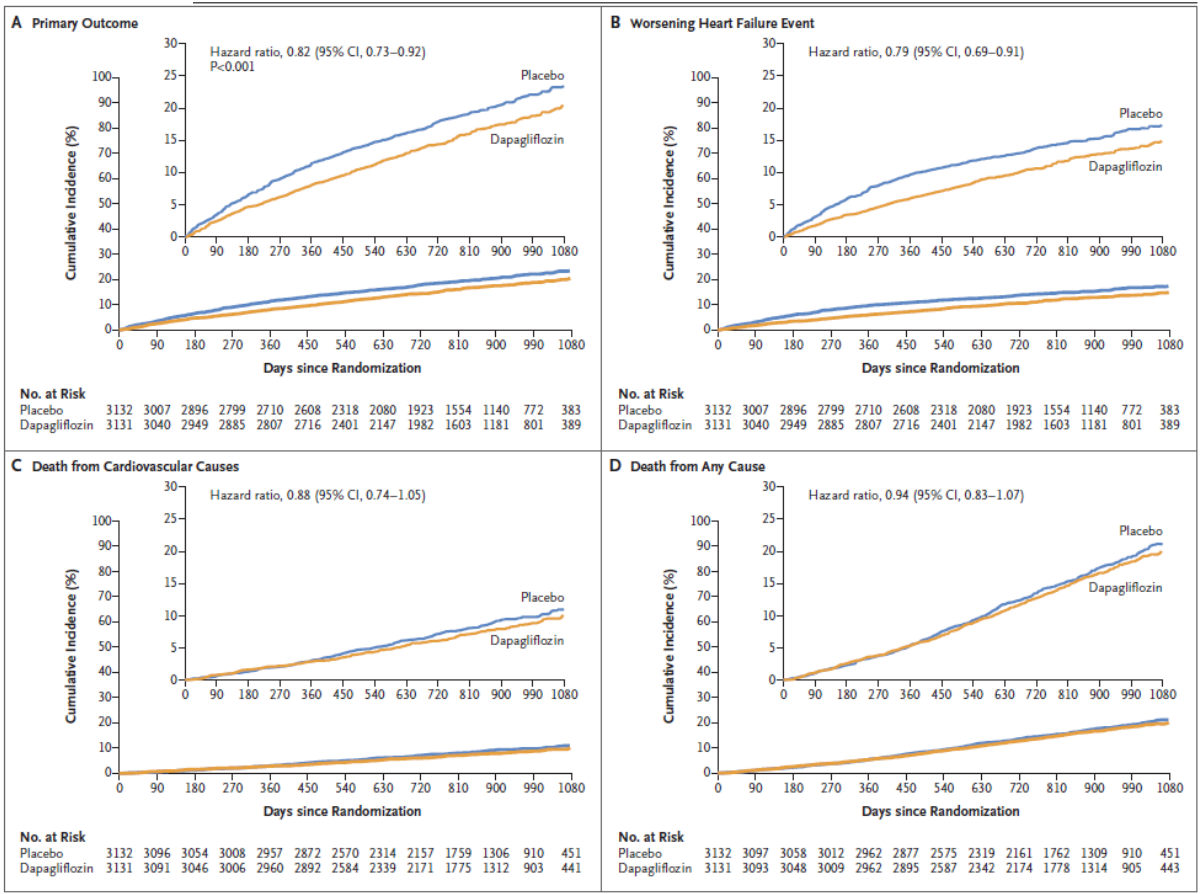


Hospitalizations for Heart Failure.



Dapagliflozin in Heart Failure with Mildly Reduced or Preserved Ejection Fraction

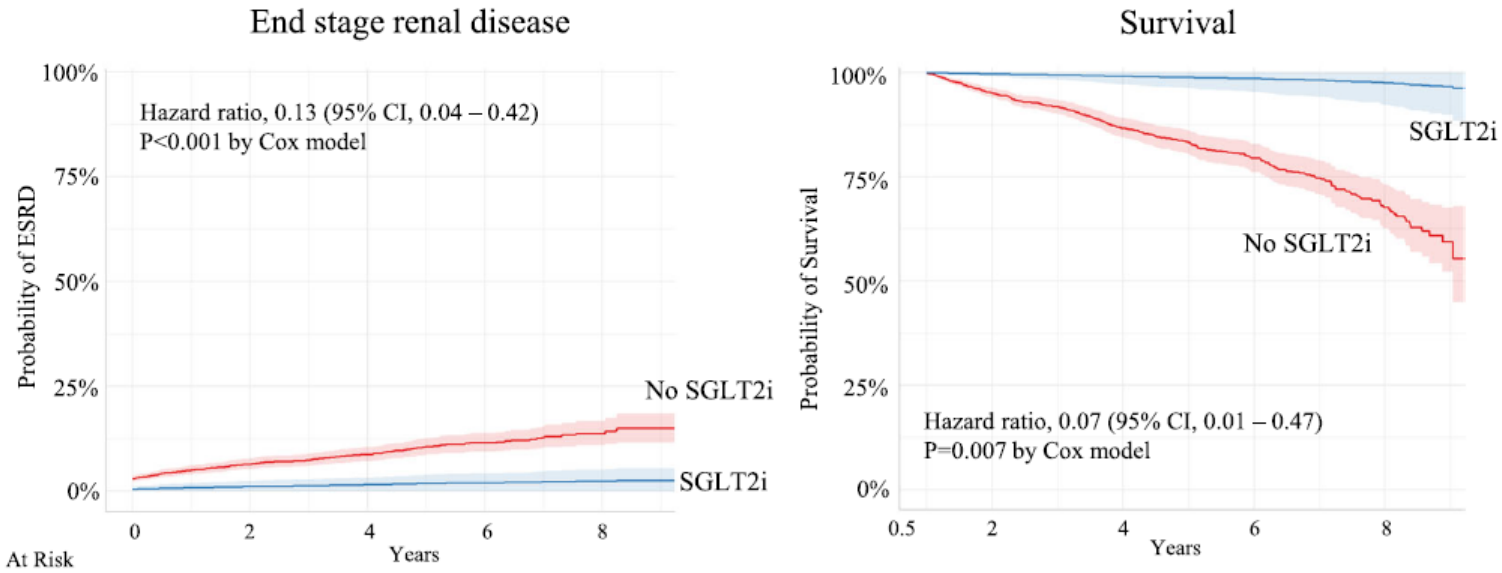
DELIVER



Solomon S. D. et al. *N Engl J Med. (2022); https://doi.org/10.1056/*NEJMoa2206286

Retrospective analysis of SGLT2 inhibitors in heart failure with preserved ejection fraction

Figure 3 Risk of end stage renal disease and all-cause mortality in heart failure with preserved ejection fraction patients prescribed SGLT2i after adjusting for age, sex, race, hypertension status, and diabetes status. Kaplan–Meier curves for mortality were also adjusted for chronic kidney disease status.



John S. Clemmer et al, ESC Heart Failure 2023; 10: 2010–2018

MRA non steroidei vs steroidei

- Blocco selettivo dell'attivazione patologica mediata da aldosterone e cortisolo
- Riduzione dell'infiammazione e della fibrosi a livello renale, cardiaco e vascolare

	Steroidal Aldosterone antagonists		**Finerenone**
			
Structural properties	Flat (steroidal)	Flat (steroidal)	Bulky (nonsteroidal)[1,5]
Potency to MR	High[4,10]	Moderate[1,4,10]	High[1,2,10]
Selectivity to MR	Low[4,10]	Moderate[4,10]	High[1,2,10]
Half-life	>20 hours*	4–6 hours*	2–3 hours#
Active metabolites	++	–	–
CNS penetration	Yes	Yes	No based on preclinical data[3]
Gynecomastia	Yes[4]	Less than spironolactone[4]	No signal in phase II studies[7-9]
Hyperkalaemia	Yes[4]	Yes[4]	Moderately increased*,[7-9]
Tissue distribution	Kidney > heart (at least 6-fold)[6,10]	Kidney > heart (~3-fold)[6,10]	Balanced kidney : heart (1:1)[6,10]

Based on preclinical data and ARTS phase II programme

FIDELITY Pooled Analysis

FIDELIO-DKD

GFR categories (ml/min per 1.73 m²) Description and range			Persistent albuminuria categories Description and range		
			A1	A2	A3
			Normal to mildly increased	Moderately increased	Severely increased
			<30 mg/g <3 mg/mmol	30–300 mg/g 3–30 mg/mmol	>300 mg/g >30 mg/mmol
G1	Normal or high	≥90			
G2	Mildly decreased	60–89			10%
G3a	Mildly to moderately decreased	45–59		4%	75%
G3b	Moderately to severely decreased	30–44		6%	
G4	Severely decreased	15–29			
G5	Kidney failure	<15			

+

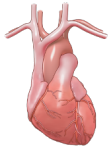
FIGARO-DKD

Persistent albuminuria categories Description and range		
A1	A2	A3
Normal to mildly increased	Moderately increased	Severely increased
<30 mg/g <3 mg/mmol	30–300 mg/g 3–30 mg/mmol	>300 mg/g >30 mg/mmol
		45%
	13%	
	15%	
	13%	

=

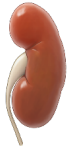
FIDELITY
(FIDELIO-DKD + FIGARO-DKD pooled)

Persistent albuminuria categories Description and range		
A1	A2	A3
Normal to mildly increased	Moderately increased	Severely increased
<30 mg/g <3 mg/mmol	30–300 mg/g 3–30 mg/mmol	>300 mg/g >30 mg/mmol



PRIMARY CV ENDPOINT

Time to CV death, non-fatal MI, non-fatal stroke or hospitalisation for HF



KEY SECONDARY KIDNEY ENDPOINT

Time to kidney failure (initiation of chronic dialysis for ≥90 days, kidney transplantation or sustained eGFR <15 ml/min/1.73 m²)**, sustained ≥57% decrease in eGFR from baseline, or renal death**

30≤UACR<300 mg/g and
25≤eGFR<90 mL/min/1.73m²

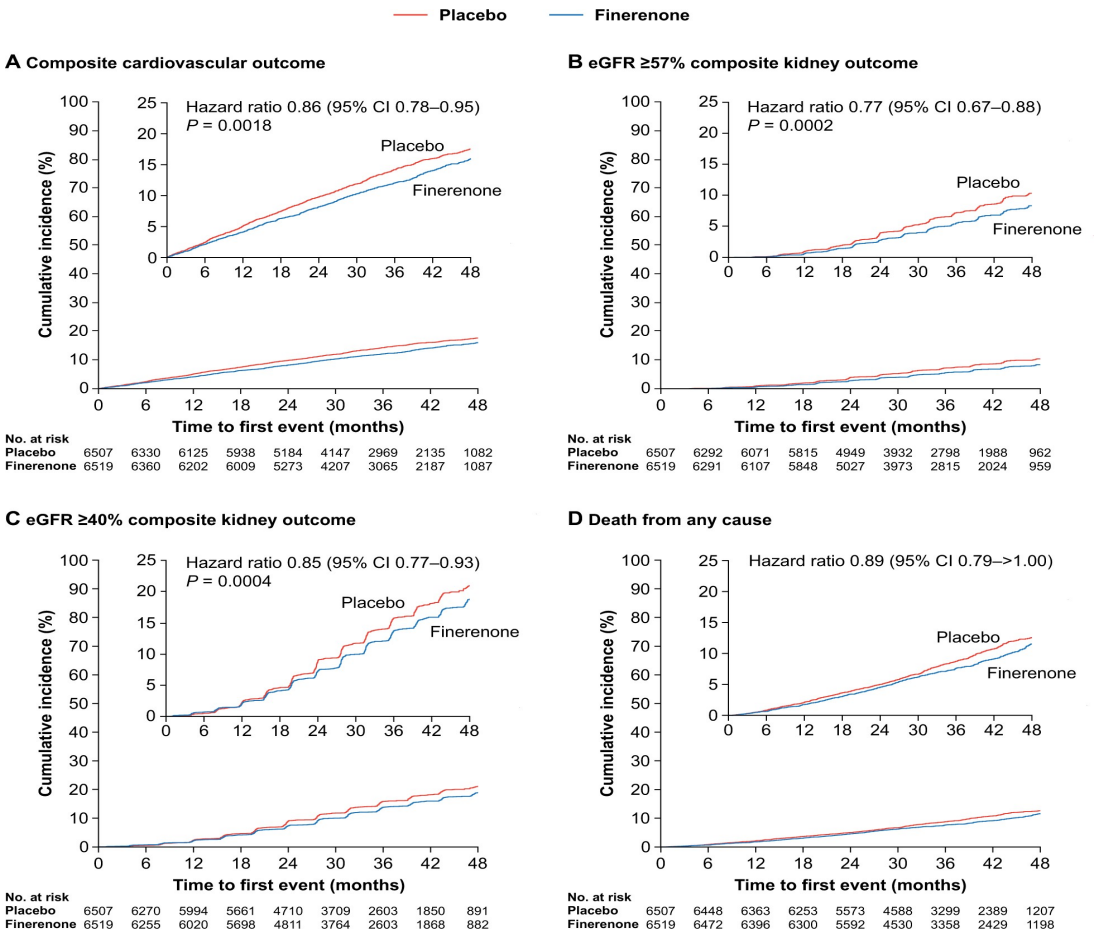
or

300≤UACR≤5000 mg/g and
eGFR≥25 mL/min/1.73m²

1. KDIGO. *Kidney Int* 2020;98:S1–S115; 2. Ruilope LM, *et al*. *Am J Nephrol* 2019;50:345–356; 3. Bakris GL, *et al*. *Am J Nephrol* 2019;50:333–344 4. Agarwal R et al. *Eur Heart J* 2021. DOI: 10.1093/eurheartj/ehab777/6433104

Cardiovascular and kidney outcomes with finerenone in patients with type 2 diabetes and chronic kidney disease: the FIDELITY pooled analysis

Il finerenone ha ridotto il rischio di esiti cardiovascolari e renali clinicamente importanti rispetto al placebo nell'intero spettro della malattia renale cronica nei pazienti con diabete di tipo 2.

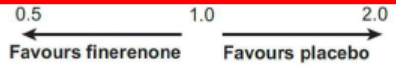


Agarwal R, *et al. Eur J Heart* 2022;43:474–484

Cardiovascular and kidney outcomes with finerenone in patients with type 2 diabetes and chronic kidney disease: the FIDELITY pooled analysis

FIDELITY (FIDELIO-DKD and FIGARO-DKD pooled analysis)

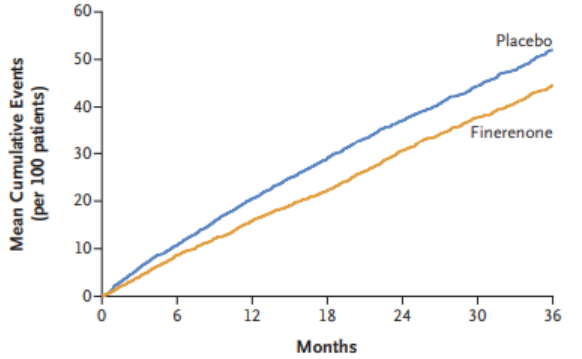
Outcome	Finerenone (n = 6519)		Placebo (n = 6507)		Hazard ratio (95% CI)	*P*-value[a]
	Number of patients with event (%)	Number of patients with event per 100 patient-years	Number of patients with event (%)	Number of patients with event per 100 patient-years		
Composite cardiovascular outcome[b]	825 (12.7)	4.34	939 (14.4)	5.01	0.86 (0.78–0.95)	0.0018
Death from cardiovascular causes	322 (4.9)	1.61	364 (5.6)	1.84	0.88 (0.76–1.02)	0.092
Non-fatal myocardial infarction	173 (2.7)	0.88	189 (2.9)	0.97	0.91 (0.74–1.12)	0.36
Non-fatal stroke	198 (3.0)	1.01	198 (3.0)	1.02	0.99 (0.82–1.21)	0.95
Hospitalization for heart failure	256 (3.9)	1.31	325 (5.0)	1.68	0.78 (0.66–0.92)	0.0030
eGFR ≥57% composite kidney outcome[c]	360 (5.5)	1.96	465 (7.1)	2.55	0.77 (0.67–0.88)	0.0002
Kidney failure	254 (3.9)	1.38	297 (4.6)	1.62	0.84 (0.71–0.99)	0.039
End-stage kidney disease[d]	151 (2.3)	0.76	188 (2.9)	0.96	0.80 (0.64–0.99)	0.040[e]
Sustained decrease in eGFR to <15 mL/min/1.73 m²	195 (3.0)	1.06	237 (3.6)	1.29	0.81 (0.67–0.98)	0.026[e]
Sustained ≥57% decrease in eGFR from baseline	257 (3.9)	1.40	361 (5.5)	4.03	0.70 (0.60–0.83)	< 0.0001
Renal death	2 (<0.1)	0.01	4 (<0.1)	0.02	0.53 (0.10–2.91)	0.46[e]
eGFR ≥40% composite kidney outcome[f]	854 (13.1)	4.81	995 (15.3)	5.64	0.85 (0.77–0.93)	0.0004
Sustained ≥40% decrease in eGFR from baseline	817 (12.5)	4.60	962 (14.8)	5.45	0.84 (0.76–0.92)	0.0002
Death from any cause	552 (8.5)	2.76	614 (9.4)	3.10	0.89 (0.79–>1.00[g])	0.051[e]
Hospitalization for any cause	2836 (43.5)	19.04	2926 (45.0)	19.91	0.96 (0.91–1.01)	0.087[e]



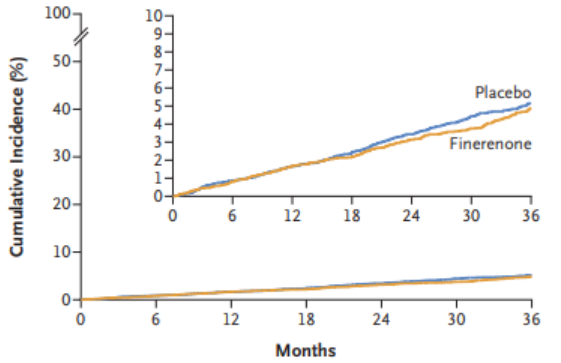
Finerenone in Heart Failure with Mildly Reduced or Preserved Ejection Fraction

FINEARTS-HF

A Total Worsening Heart Failure Events and Death from Cardiovascular Causes



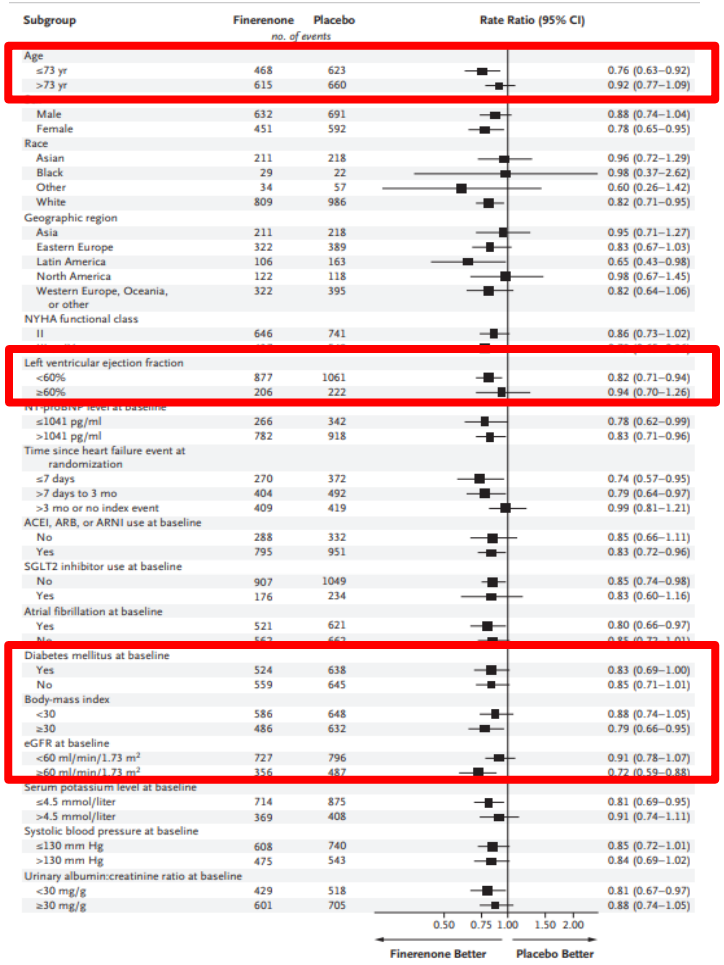
C Death from Cardiovascular Causes



Finerenone 10-20/ 20- 40 vs placebo (se GFR ><60 ml/min)

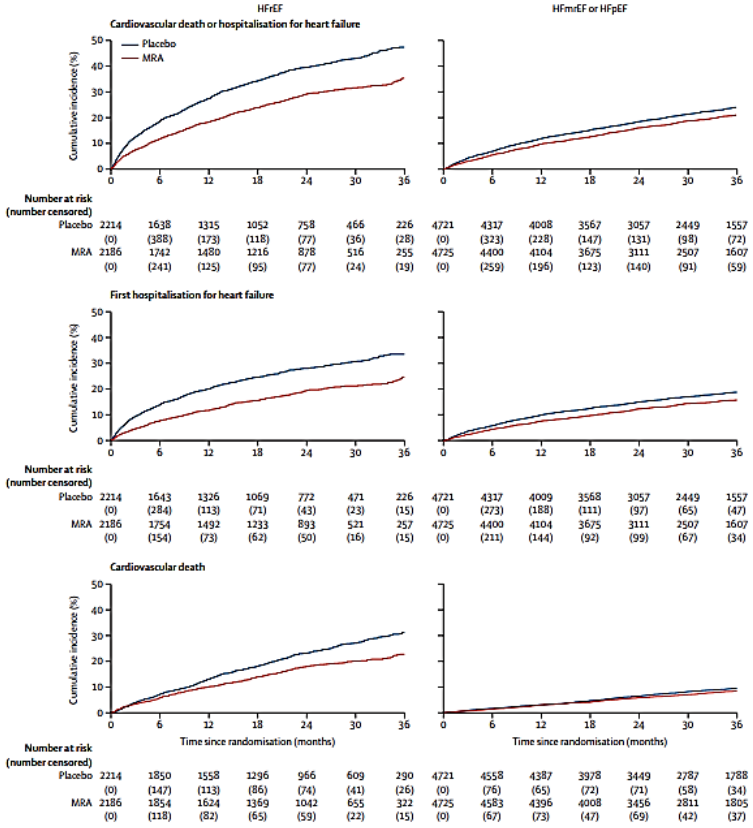
Nei pazienti con HF FE lievemente ridotta o preservata, il finerenone ha determinato una riduzione dell'end-point primario (eventi WHF totali e decessi per cause CV) rispetto al placebo

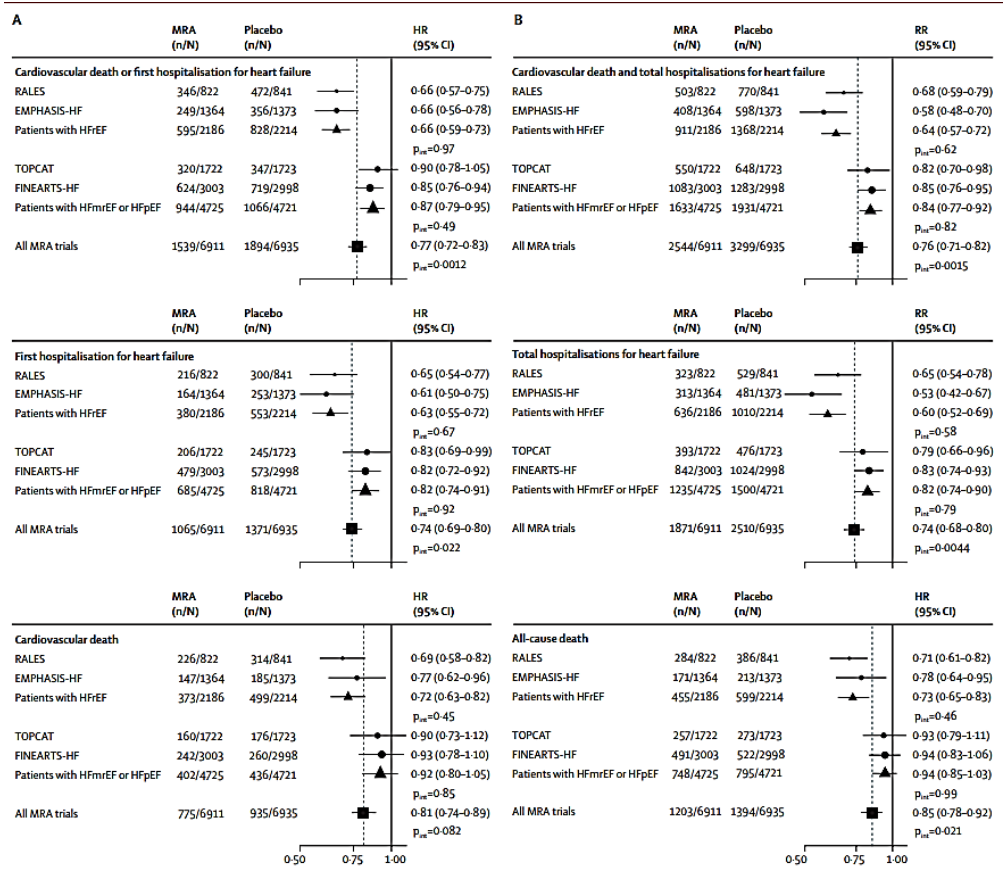
- Riduzione del 16% (RR 0.84, IC95% 0.74-0.95, p=0.007)
- Eventi HF totali ridotti del 18% (RR 0.82, p=0.006)
- Ospedalizzazioni HF ridotte del 14% (HR 0.86, p=0.02)



Mineralocorticoid receptor antagonists in heart failure: an individual patient level meta-analysis

RALES, EMPHASIS-HF, TOPCAT FINEARTS-HF

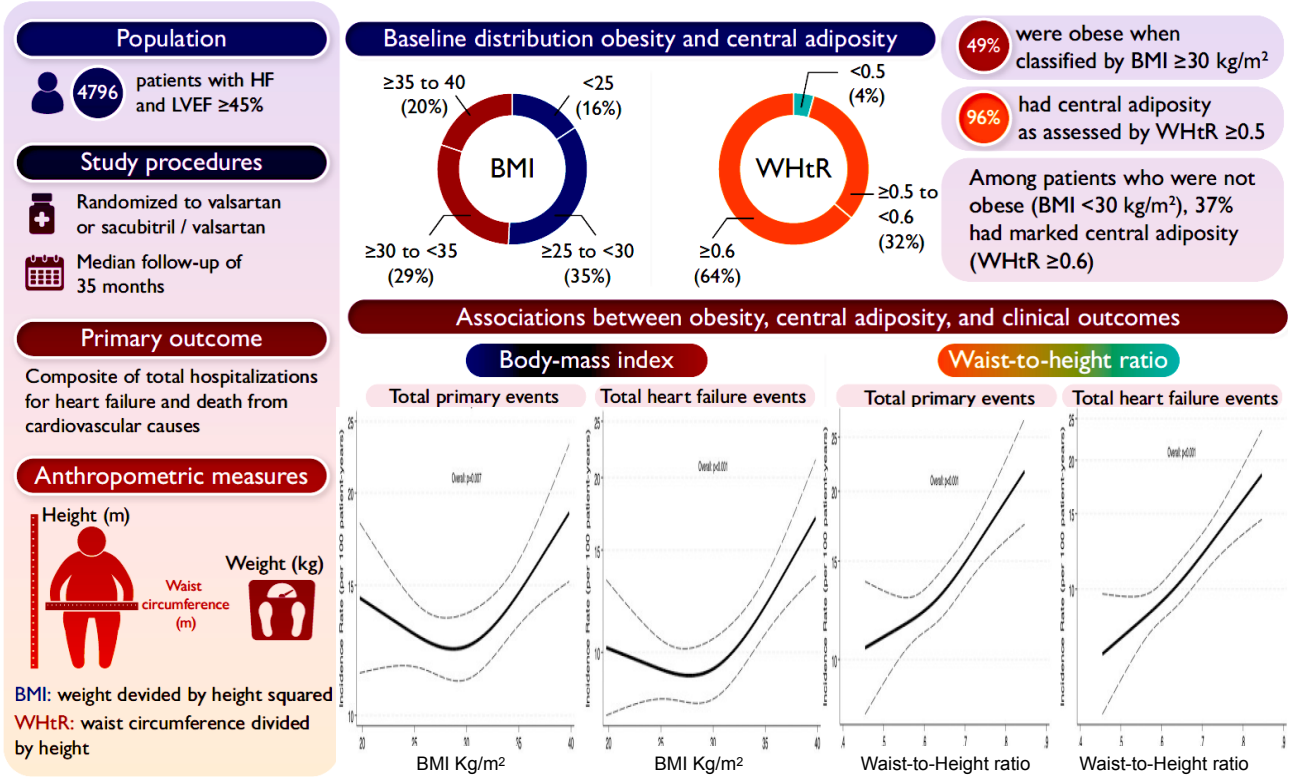




Jhund, P., Lancet 2024; 404: 1119–31

Near-universal prevalence of central adiposity in HFpEF:

the PARAGON-HF trial



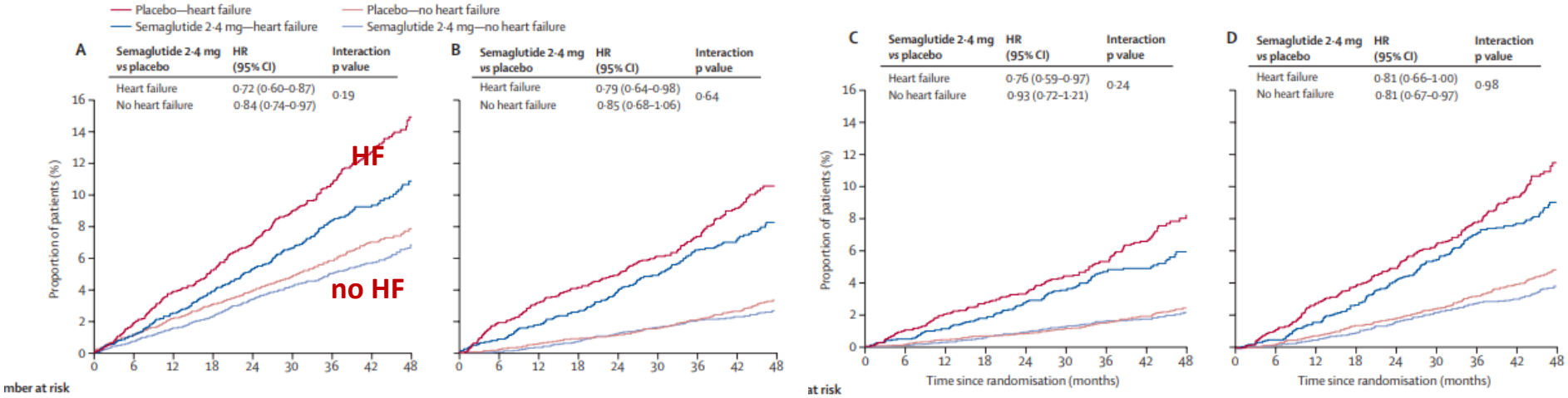
In **PARAGON-HF**, in contrast with BMI,
nearly every patient with HFpEF had central adiposity (as assessed by WHtR),
and the risks of adverse HF events were more robustly related to WHtR

Peikert A et al. **Eur Heart J** 2025; 46, 2372–2390

Semaglutide and cardiovascular outcomes in patients with obesity and prevalent heart failure: a prespecified analysis of the SELECT trial

- Age ≥45 years
- BMI ≥27 kg/m2
- Prior MI or Stroke or PAD with claudication and ankle-brachial index <0.85 prior revascularization, or amputation

MACE (A), heart failure composite (B), cardiovascular death (C), and all-cause death (D)



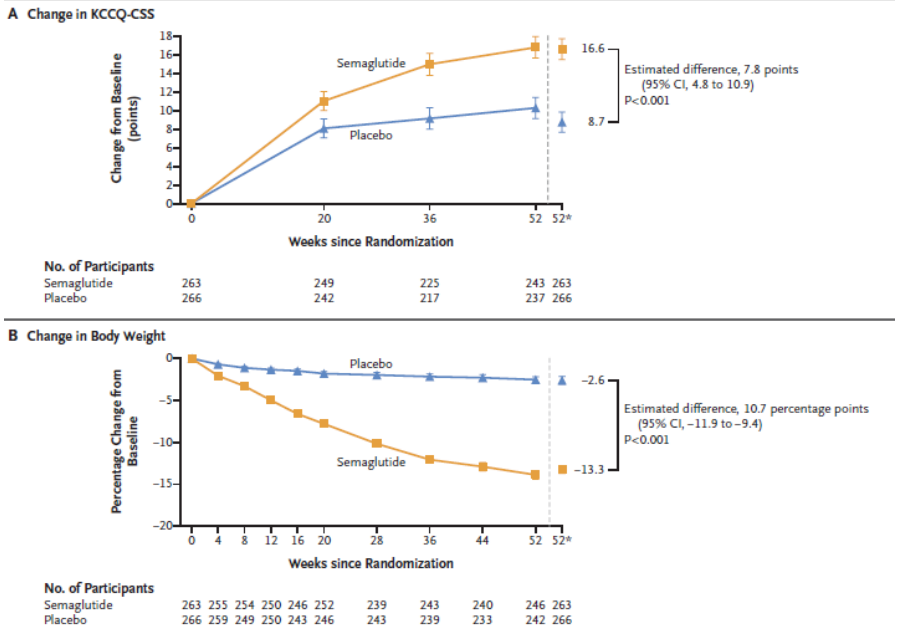
In patients with atherosclerotic cardiovascular disease and overweight or obesity, treatment with semaglutide 2·4 mg reduced MACE and composite heart failure endpoints compared with placebo in those with and without clinical heart failure, regardless of heart failure subtype

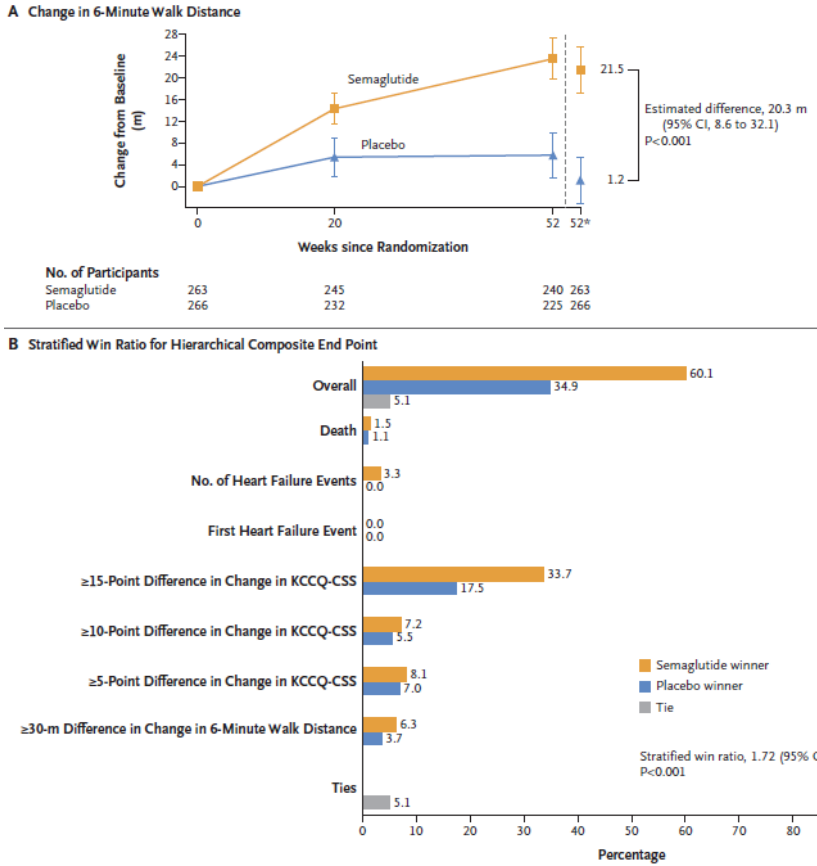
Deanfiled J et al. Lancet 2024; 404: 773–86

Semaglutide in Patients with Heart Failure with Preserved Ejection Fraction and Obesity

STEP-HFpEF

STEP-HFpEF: n=529; LVEF≥45%; NYHA II-IV; elevated NP; **BMI>30 kg/m2,** Semaglutide (up to 2.4 mg)



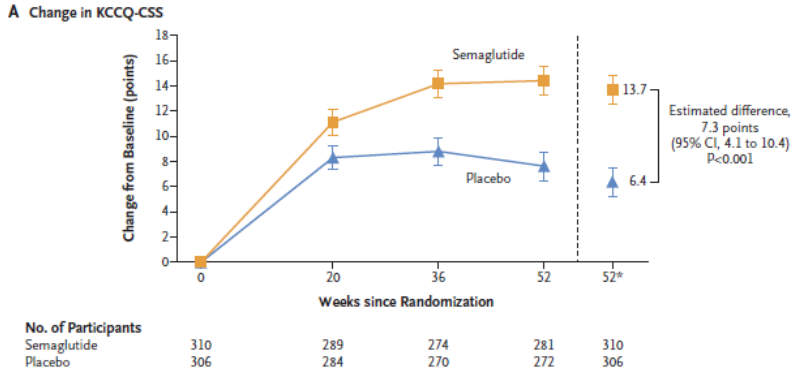


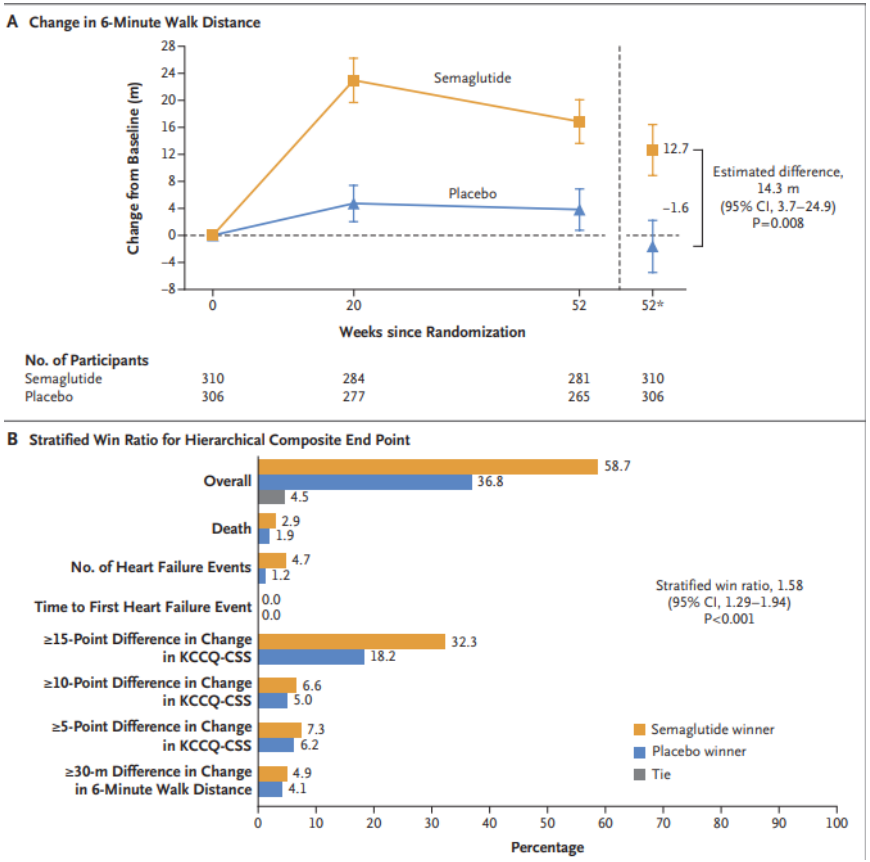
In patients with heart failure with preserved ejection fraction and obesity, treatment with semaglutide (2.4 mg) led to larger reductions in symptoms and physical limitations, greater improvements in exercise function, and greater weight loss than placebo

Kosiborod et al. N Engl J Med 2023;389:1069-84.

Semaglutide in Patients with Obesity-Related Heart Failure and Type 2 Diabetes

STEP-HFpEF – DM





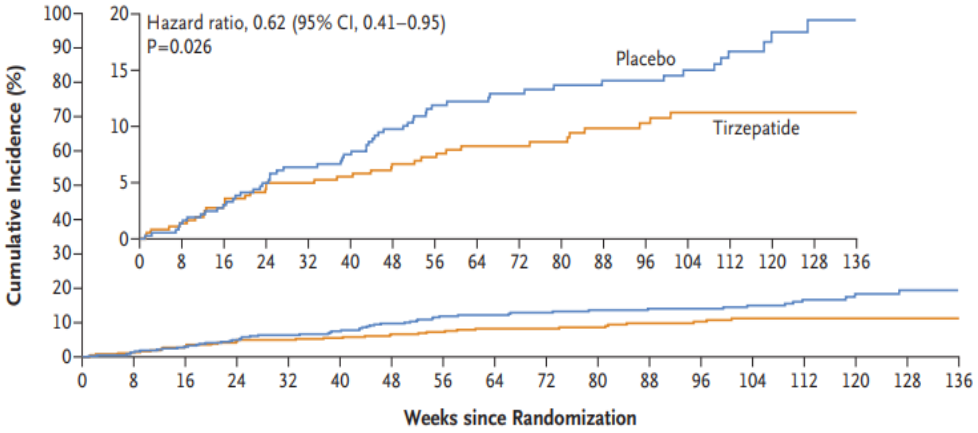
Kosiborod et al. N Engl J Med 2024;390:1394-407.

Tirzepatide for Heart Failure with Preserved Ejection Fraction and Obesity

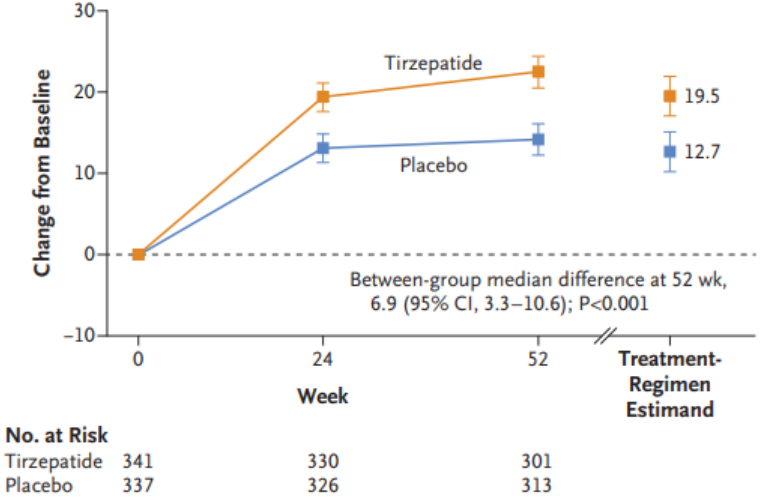
SUMMIT Trials

731 patients with HF, EF at least 50%, BMI at least 30 to receive tirzepatide (up to 15 mg subcutaneously once per week) or placebo

Death from Cardiovascular Causes or a Worsening Heart-Failure Event.



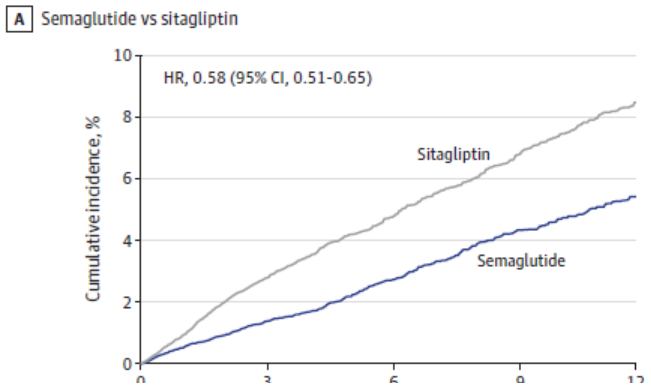
Change in Kansas City Cardiomyopathy Questionnaire Clinical Summary Score (KCCQ-CSS).

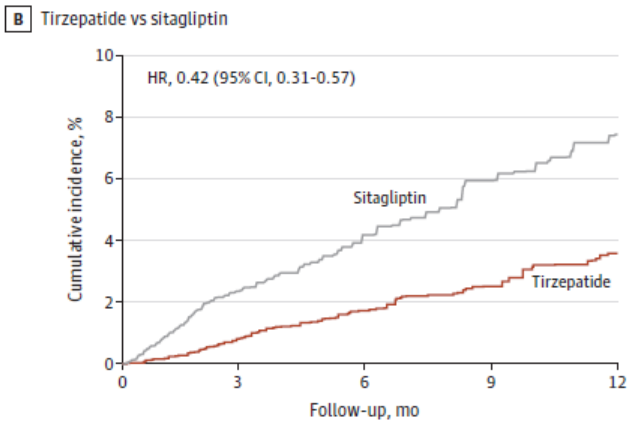


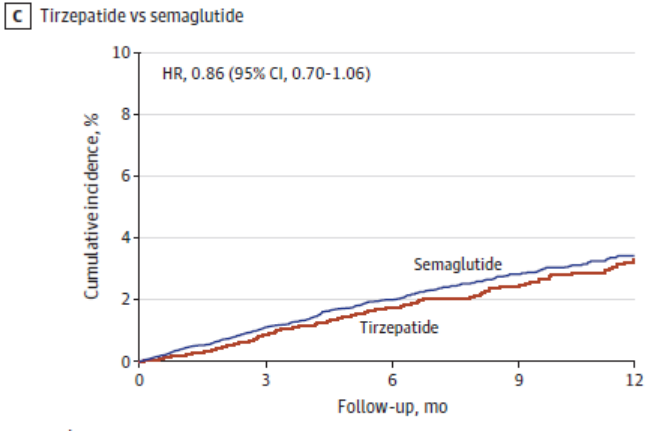
Treatment with tirzepatide led to a lower risk of a composite of death from cardiovascular causes or worsening heart failure than placebo and improved health status in patients with heart failure with preserved ejection fraction and obesity.

Packer M eta l. N Engl J Med 2025;392:427-37. DOI: 10.1056/NEJMoa2410027

Semaglutide and Tirzepatide in Patients With Heart Failure With Preserved Ejection Fraction



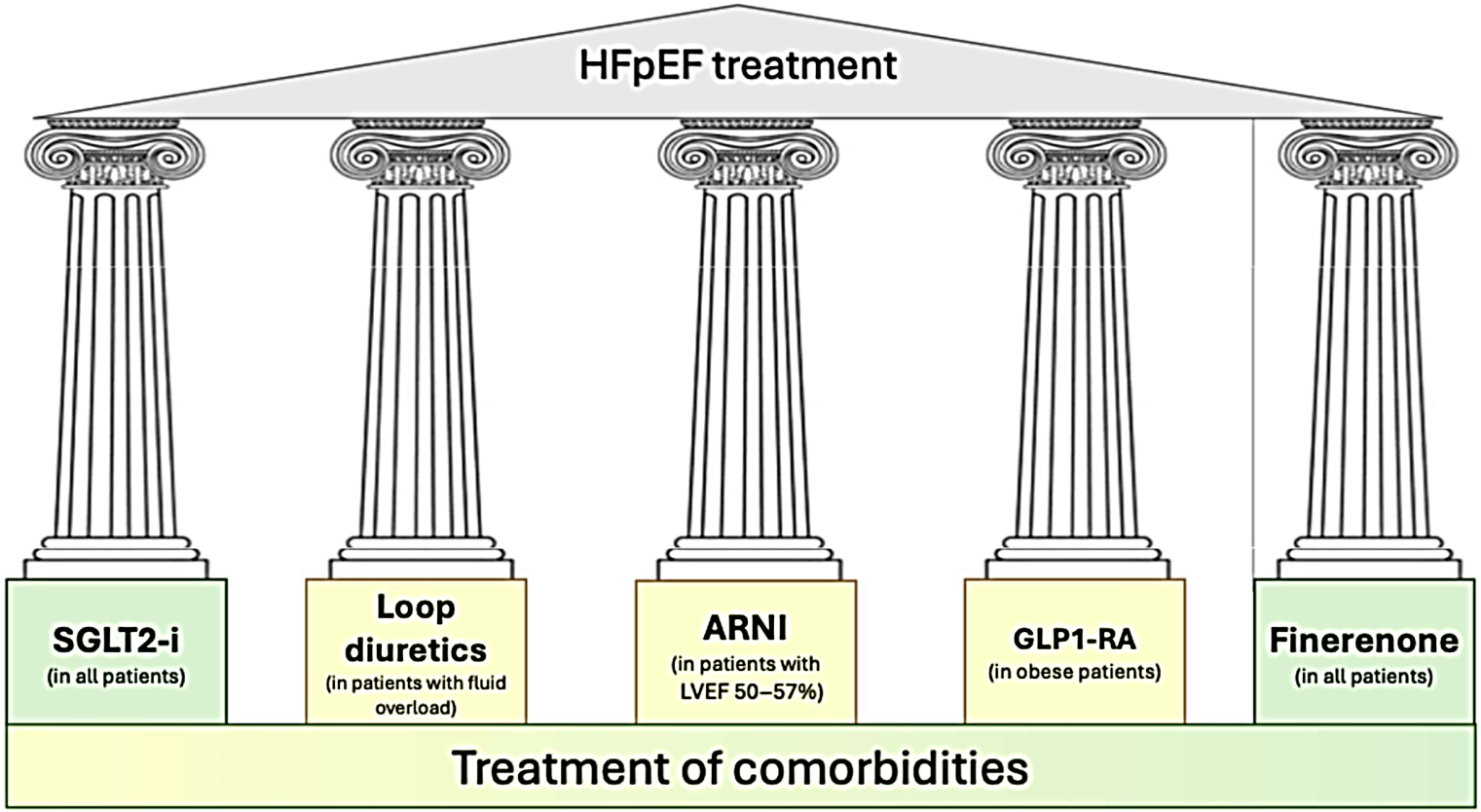




Clinical Practice
3US claims data sources:Medicare Parts A, B, and D (2018 through 2020), Optum Clinformatics Data Mart (2018 through November 2024), andMerativeMarketScan (2018 through2022).
STEP-HFpEF DM and SUMMIT CRITERIA

In patients with cardiometabolic HFpEF, semaglutide and tirzepatide showed **more than 40% risk reduction** for the composite of hospitalization for heart failure or all-cause mortality compared with a placebo proxy.
Tirzepatide showed no meaningful benefit over semaglutide.

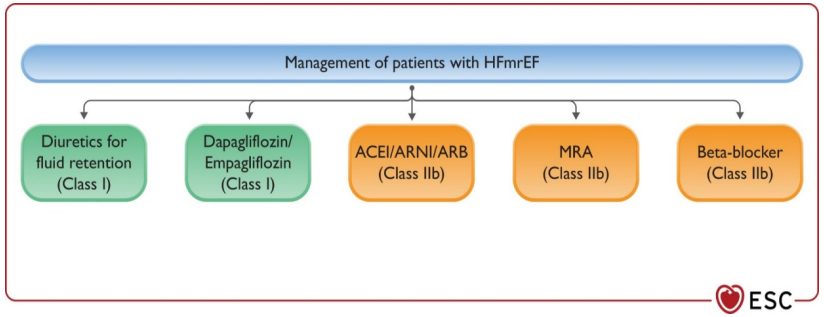
Kruger et al. JAMA. doi:10.1001/jama.2025.14092 Published online August 31, 2025.


HFpEF treatment
SGLT2-i
(in all patients)
Loop diuretics
(in patients with fluid overload)
ARNI
(in patients with LVEF 50–57%)
GLP1-RA
(in obese patients)
Finerenone
(in all patients)
Treatment of comorbidities

Management of patients with heart failure with mildly reduced ejection fraction.

Recommendation Table 1 — Recommendation for the treatment of patients with symptomatic heart failure with mildly reduced ejection fraction

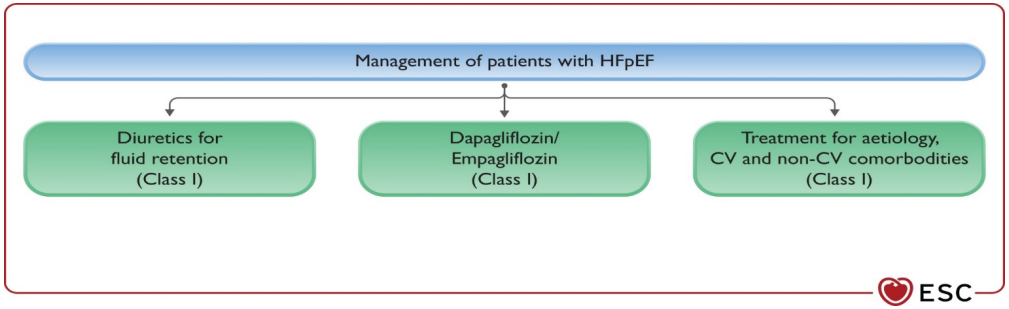
Recommendation	Class[a]	Level[b]
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFmrEF to reduce the risk of HF hospitalization or CV death.[c 6,8]	I	A



Management of patients with heart failure with preserved ejection fraction.

Recommendation Table 2 — Recommendation for the treatment of patients with symptomatic heart failure with preserved ejection fraction

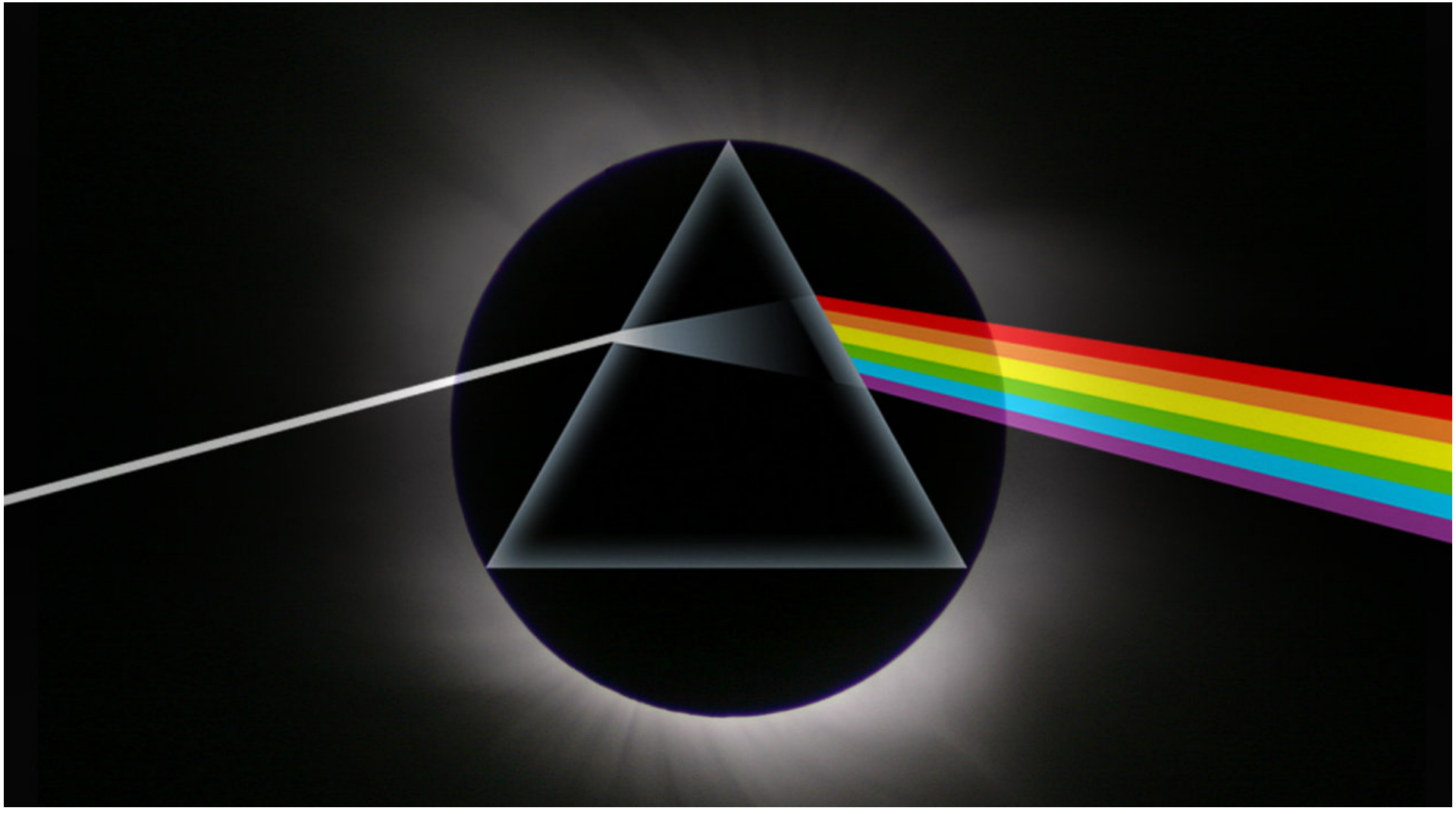
Recommendation	Class[a]	Level[b]
An SGLT2 inhibitor (dapagliflozin or empagliflozin) is recommended in patients with HFpEF to reduce the risk of HF hospitalization or CV death.[c 6,8]	I	A



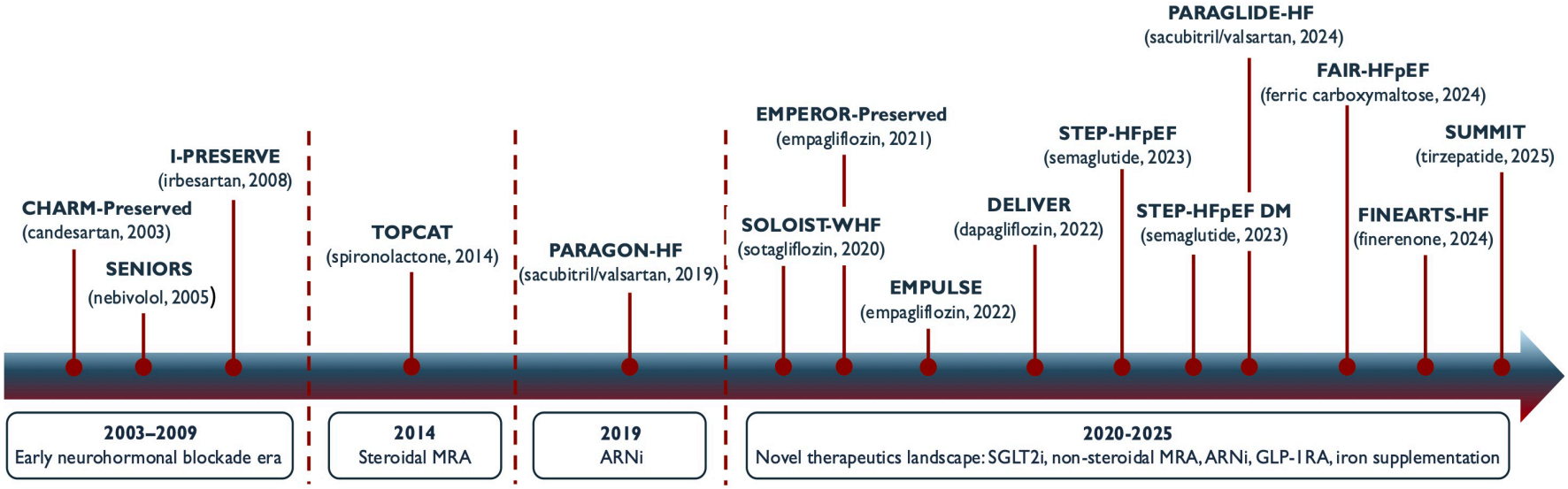
Recommendations	Class[a]	Level[b]
In patients with T2DM and CKD,[c] SGLT2 inhibitors are recommended to reduce the risk of HF hospitalization or CV death.[35]	I	A
In patients with T2DM and CKD,[c] finerenone is recommended to reduce the risk of HF hospitalization.[10,11,34,40]	I	A

Conclusioni

- L’HFpEF rappresenta circa il 50% dei casi di scompenso cardiaco, con elevata mortalità e morbilità.
- L'HFpEF è una sindrome clinica eterogenea, influenzata nel suo sviluppo e progressione da numerose comorbilità.
- La disfunzione del ventricolo sinistro può essere una manifestazione di varie combinazioni di condizioni cardiache, vascolari, metaboliche, polmonari, renali e legate all’invecchiamento.
- Pertanto, oltre al trattamento con Diuretici, SGLT2i, Finerenone (e GLP1-RA negli obesi), il metodo più efficace per migliorare la prognosi può essere una terapia su misura per il profilo clinico di ciascun paziente.
- Un approccio basato su algoritmi per identificare i fenotipi HFpEF più comuni e identificare la strategia di trattamento deve tenere conto della complessità delle molteplici comorbilità .



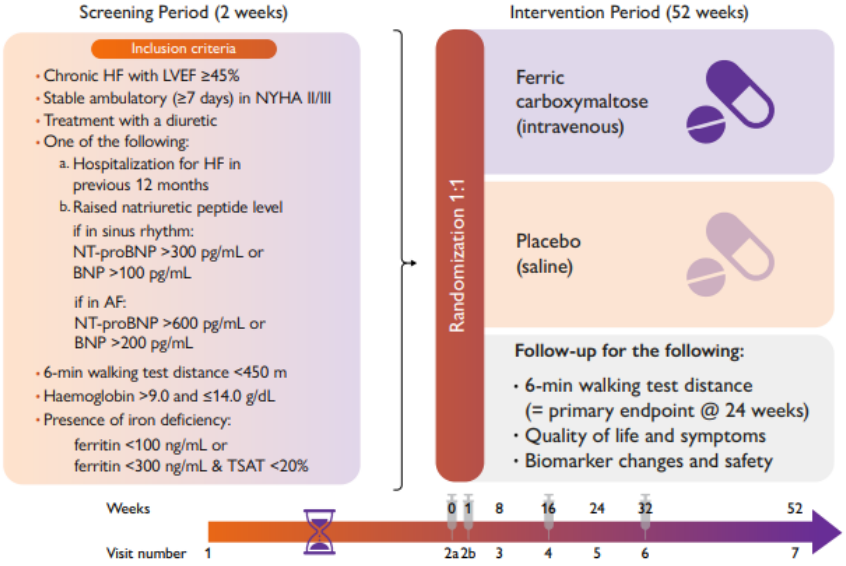
HFpEF Tharapy: Unmet needs and future directions

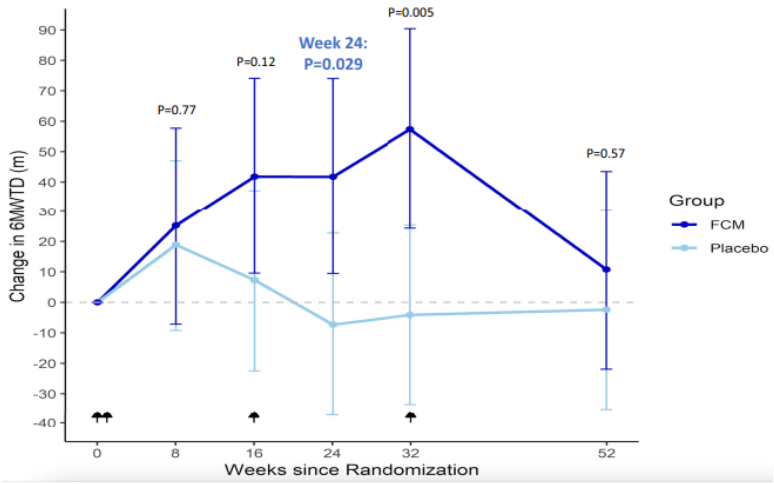


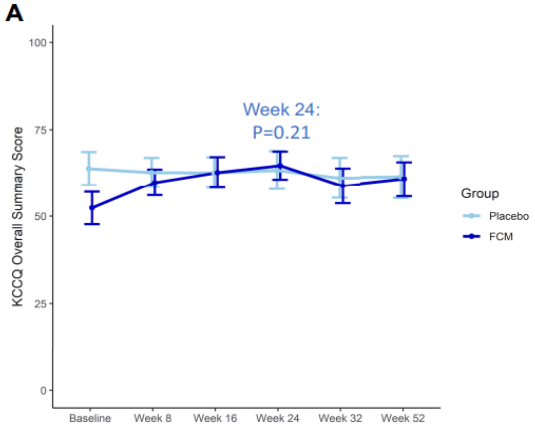
Future directions

REDEFINE-HF – finerenone in hospitalised HFpEF/HFmrEF
CONFIRMATION-HF – finerenone + dapagliflozin
BalanceD-HF –balcinrenone + dapagliflozin
SPIRIT-HF –spironolactone vs placebo in HFpEF/HFmrEF
SPIRRIT-HFpEF – registry-based RCT of spironolactone / eplerenone in HFpEF/HFmrEF

Ferric carboxymaltose and exercise capacity in heart failure with preserved ejection fraction and iron deficiency: the FAIR-HFpEF trial

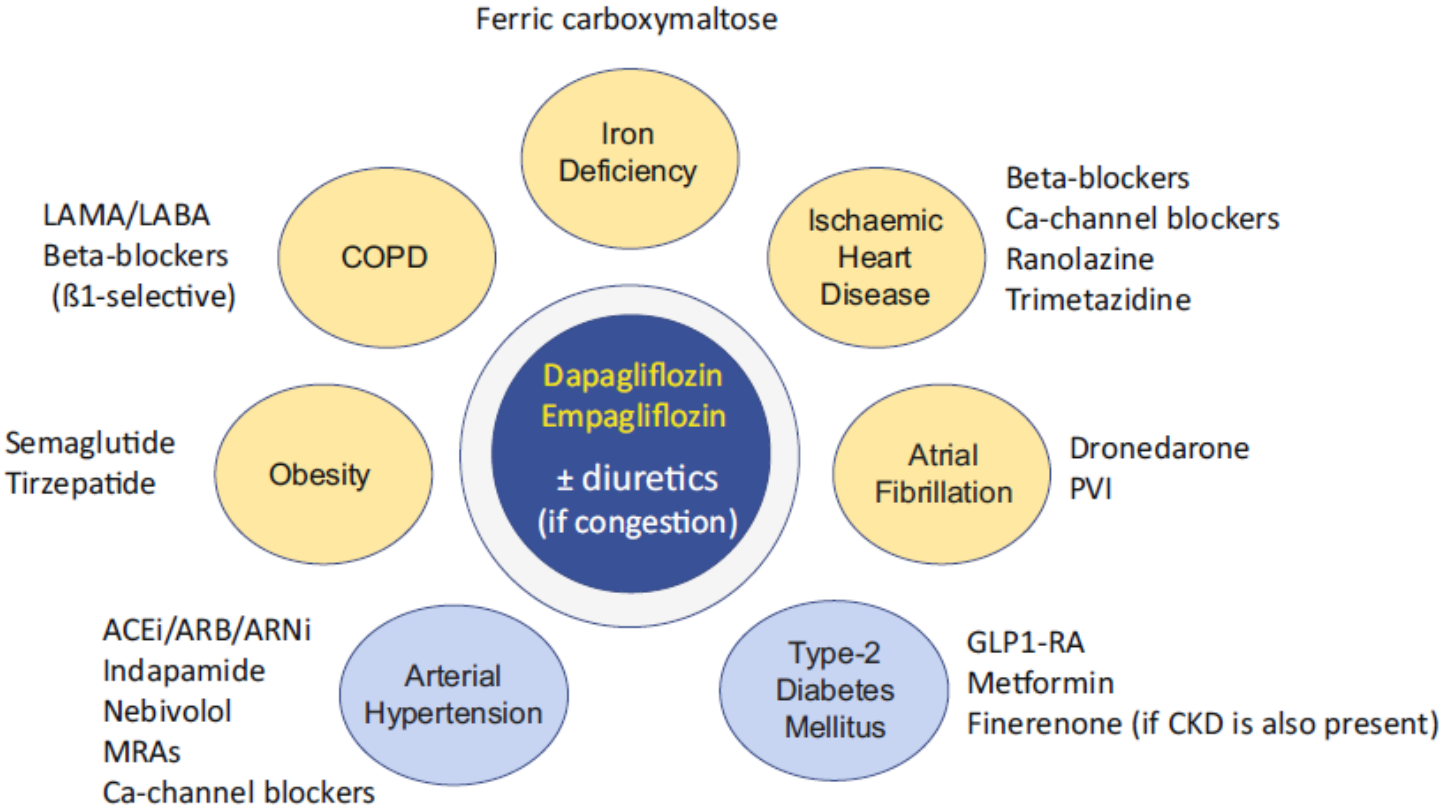






Stephan von Haehling , et al. European Heart Journal (2024) 45, 3789–3800

Verso una terapia “di precisione” nel HFpEF?

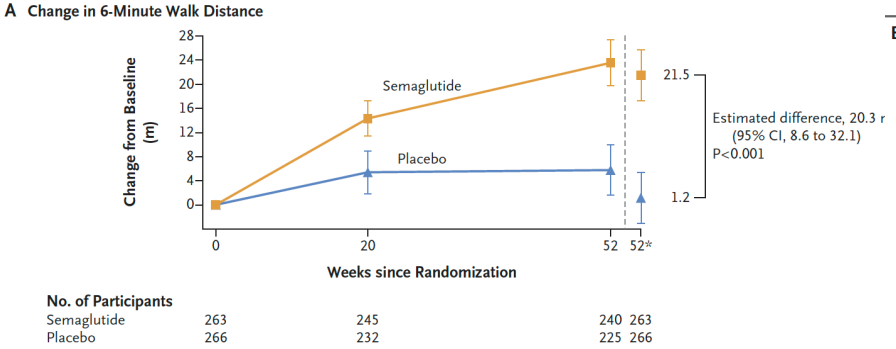


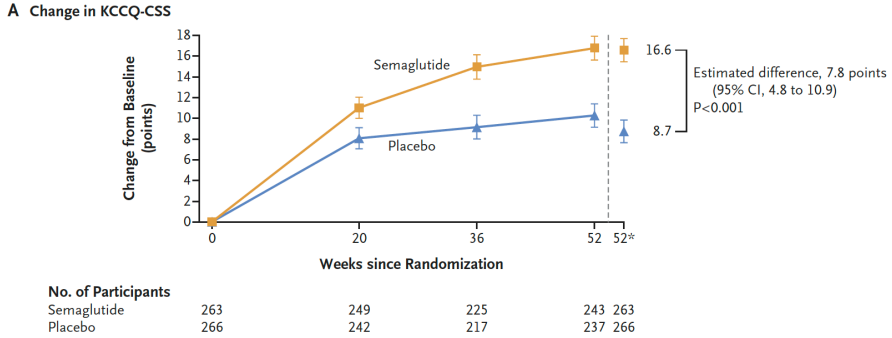
Anker S et al, European Journal of Heart Failure (2023) 25, 936–955

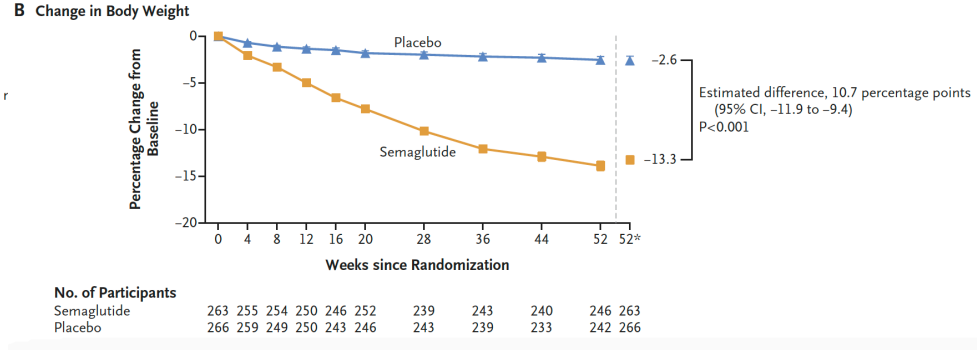
Semaglutide in Patients with Heart Failure with Preserved Ejection Fraction and Obesity

HFpEF and obesity: target therapy

STEP-HFpEF: n=529; LVEF≥45%;
NYHA II-IV; elevated NP; **BMI>30 kg/m2**
Semaglutide (up to 2.4 mg)



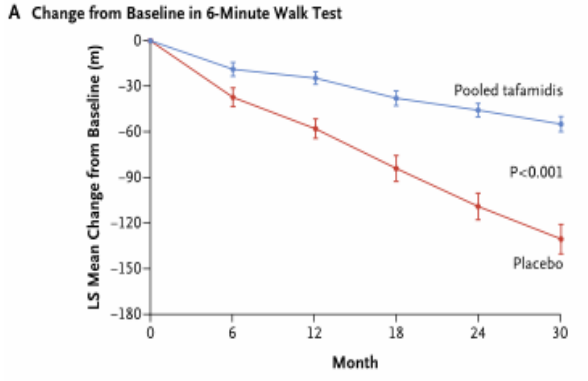


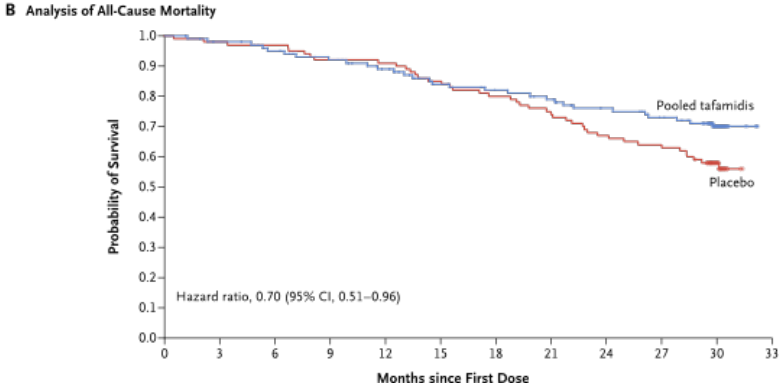


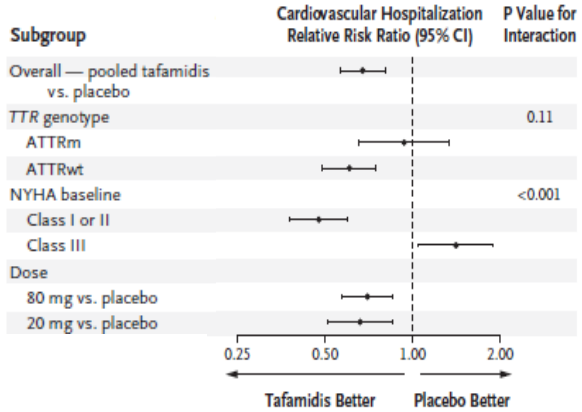
N Engl J Med 2023;389:1069-84.

Tafamidis Treatment for Patients with Transthyretin Amyloid Cardiomyopathy

ATTR-ACT







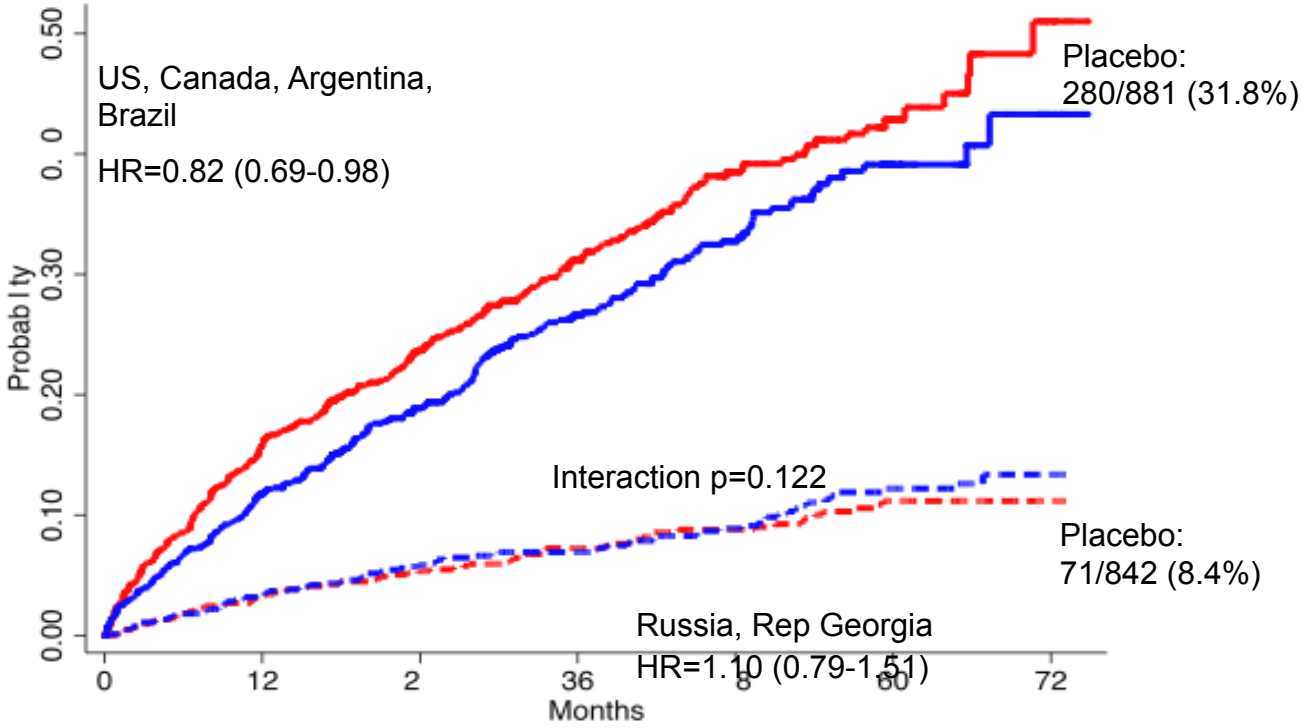
ATTR-ACT: the «three first times» trial

- **The first time a medical treatment has been shown to reduce mortality and morbidity in TTR-related CA**
- **The first time a medical treatment has been shown to reduce mortality and HF hospitalisation in HFpEF.**
- **The first time a HF drug is effective on a hard endpoint by acting centrally (on the myocardium), rather than peripherally or by neurohormonal modulation (ACE-inhibitors, ARBs, Sacubitril, beta-blockers, diuretics, Ivabradine).**

Maurer MS et al, NEJM 2018

Spironolactone for Heart Failure with Preserved Ejection Fraction

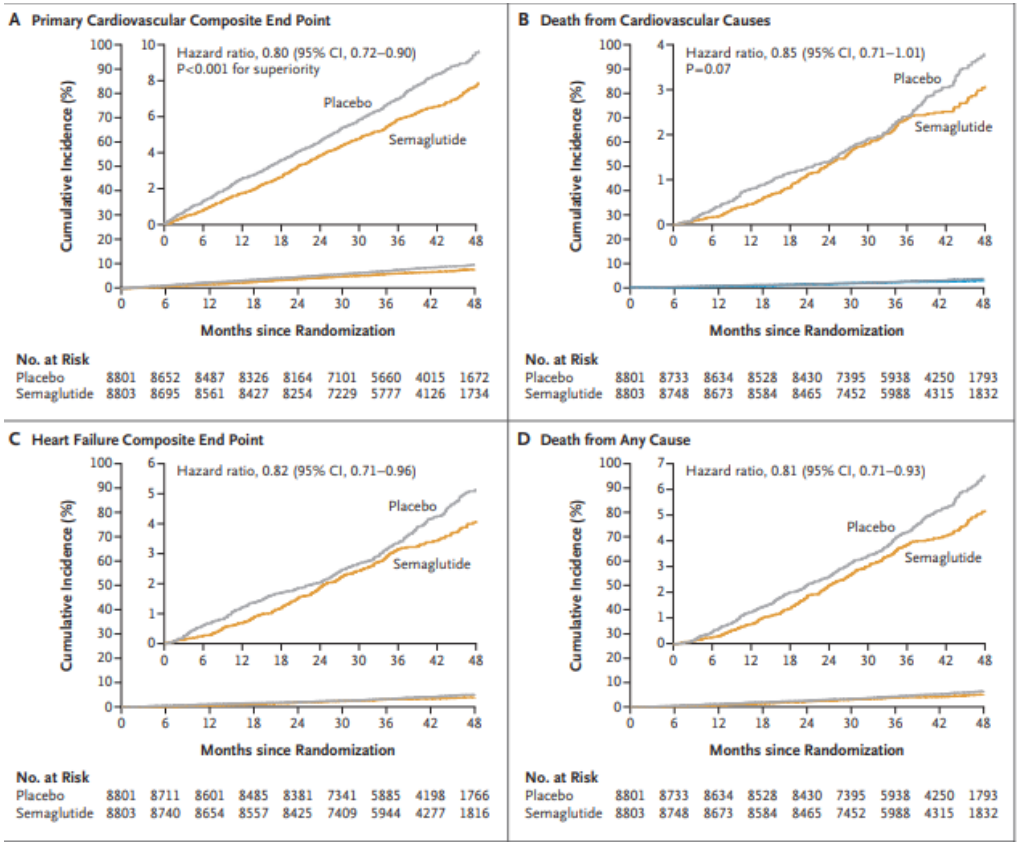
Exploratory (post-hoc):Placebo vs. Spiro by region



Pitt et al. N Engl J Med 2014;370:1383-92

Semaglutide and Cardiovascular Outcomes in Obesity without Diabetes

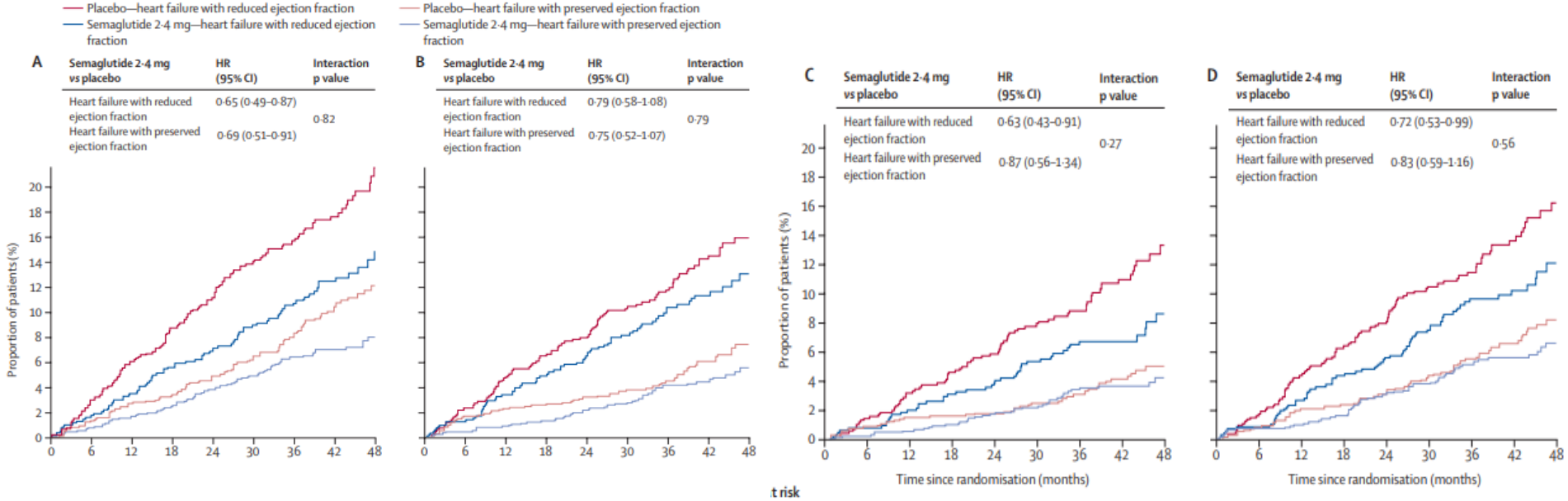
SELECT



In patients with preexisting cardiovascular disease and overweight or obesity but **without diabetes,** weekly subcutaneous semaglutide at a dose of 2.4 mg was superior
to placebo in reducing the incidence of death from cardiovascular causes, nonfatal myocardial infarction, or nonfatal stroke at a mean follow-up of 39.8 months.

Semaglutide and cardiovascular outcomes in patients with obesity and prevalent heart failure: a prespecified analysis of the SELECT trial

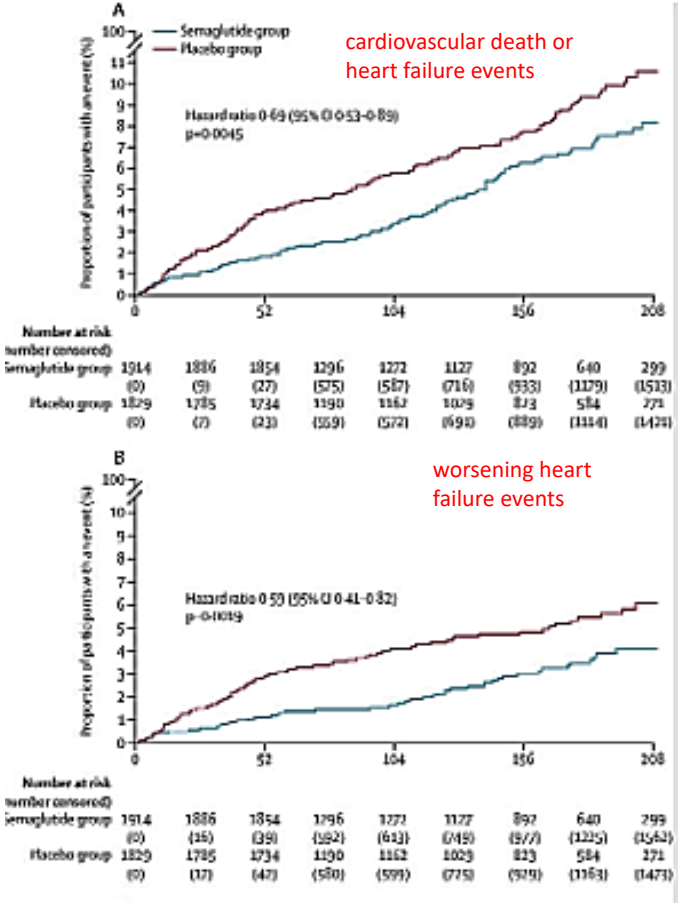
risk of MACE (A), heart failure composite (B), cardiovascular death (C), and all-cause death (D)

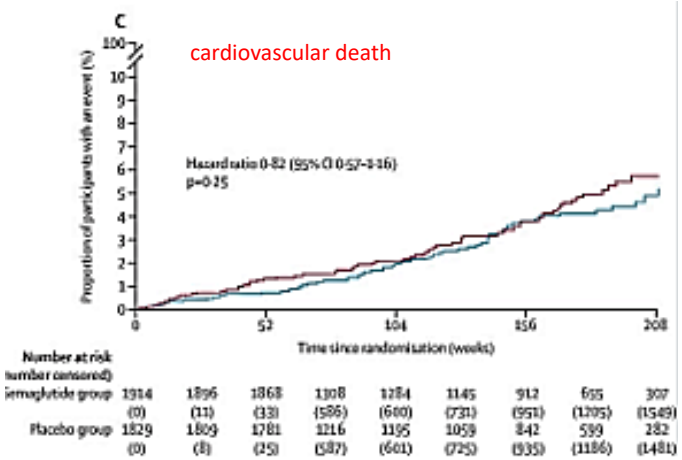


In patients with atherosclerotic cardiovascular disease and overweight or obesity, treatment with semaglutide 2·4 mg reduced MACE and composite heart failure endpoints compared with placebo in those with and without clinical heart failure, regardless of heart failure subtype

Deanfiled J et al. Lancet 2024; 404: 773–86

Semaglutide versus placebo in patients with heart failure and mildly reduced or preserved ejection fraction: a pooled analysis of the SELECT, FLOW, STEP-HFpEF, and STEP-HFpEF DM randomised trials





In patients with HFpEF, semaglutide reduced the risk of the combined endpoint of cardiovascular death or worsening heart failure events, and worsening heart failure events alone, whereas its effect on cardiovascular death alone was not significant.

JACC: Heart Failure

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http://dx.doi.org/10.1016/j.jchf.2013.10.006

MINI FOCUS ISSUE: HEART FAILURE WITH PRESERVED EJECTION FRACTION State-of-the-Art Papers

CME

Developing Therapies for Heart Failure With Preserved Ejection Fraction

Current State and Future Directions

Javed Butler, MD, MPH,[1] Gregg C. Fonarow, MD,[2] Michael R. Zile, MD,[3] Carolyn S. Lam, MD,[4] Lothar Roessig, MD,[5] Erik B. Schelbert, MD, MS,[6] Sanjiv J. Shah, MD,[7] Ali Ahmed, MD,[8] Robert O. Bonow, MD,[7] John G. F. Cleland, MD,[9] Robert J. Cody, MD, MBA,[10] Ovidiu Chioncel, MD, PHD,[11] Sean P. Collins, MD,[12] Preston Dunnmon, MD,[13] Gerasimos Filippatos, MD,[14] Martin P. Lefkowitz, MD,[15] Catherine N. Marti, MD,[1] John J. McMurray, MD,[16] Frank Misselwitz, MD,[5] Savina Nodari, MD,[17] Christopher O'Connor, MD,[18] Marc A. Pfeffer, MD,[19] Burkert Pieske, MD,[20] Bertram Pitt, MD,[21] Giuseppe Rosano, MD,[22] Hani N. Sabbah, PHD,[23] Michele Senni, MD,[24] Scott D. Solomon, MD,[19] Norman Stockbridge, MD, PHD,[13] John R. Teerlink, MD,[25] Vasiliki V. Georgiopoulou, MD,[1] Mihai Gheorghiade, MD[7]

Considering its prevalence and outcomes, future projections, and lack of effective therapies, HFpEF represents the single largest unmet need in cardiovascular medicine.