

renal insufficiency, and in women and African Americans. The mechanisms include iron deficiency, dysregulation of iron metabolism, and occult gastrointestinal bleeding. Intravenous iron using either iron sucrose or carboxymaltose (Ferric Carboxymaltose Assessment in Patients with Iron Deficiency and Chronic Heart Failure [FAIR-HF] trial) has been shown to correct anemia and improve functional capacity. Another trial, CONFIRM-HF, enrolled similar patients with iron deficiency (ferritin <100 ng/mL or 100–300 ng/mL if transferrin saturation <20%) and demonstrated that use of ferric carboxymaltose in a simplified high-dose schedule resulted in improvement in functional capacity, symptoms, and QOL. Oral iron supplementation does not appear to be effective in treating iron deficiency in HF. Erythropoiesis-regulating agents such as erythropoietin analogues have been studied with disappointing results. The Reduction of Events by Darbepoetin Alfa in Heart Failure (RED-HF) trial demonstrated that treatment with darbepoetin alfa did not improve clinical outcomes in patients with systolic HF and may increase risk of stroke.

Depression is common in HFrEF, with a reported prevalence of one in five patients, and is associated with a poor QOL, limited functional status, and increased risk of morbidity and mortality in this population. However, the largest randomized study of depression in HFrEF, the Sertraline Against Depression and Heart Disease in Chronic Heart Failure (SADHART-CHF) trial, showed that although sertraline was safe, it did not provide greater reduction in depression or improve cardiovascular status among patients with HF and depression compared with nurse-driven multidisciplinary management.

Atrial arrhythmias, especially atrial fibrillation, are common and serve as a harbinger of worse prognosis in patients with HF. When rate control is inadequate or symptoms persist, pursuing a rhythm control strategy is reasonable. Rhythm control may be achieved via pharmacotherapy or by percutaneous or surgical techniques, and referral to practitioners or centers experienced in these modalities is recommended. Antiarrhythmic drug therapy should be restricted to amiodarone and dofetilide, both of which have been shown to be safe and effective but do not alter the natural history of the