



Beyond the textbook: patient voices and expert-led practical management for SGLT2 inhibitor implementation in heart failure

9–12 May 2026

Barcelona, Spain

April 2026 | SC-CRP-19363

Life forward



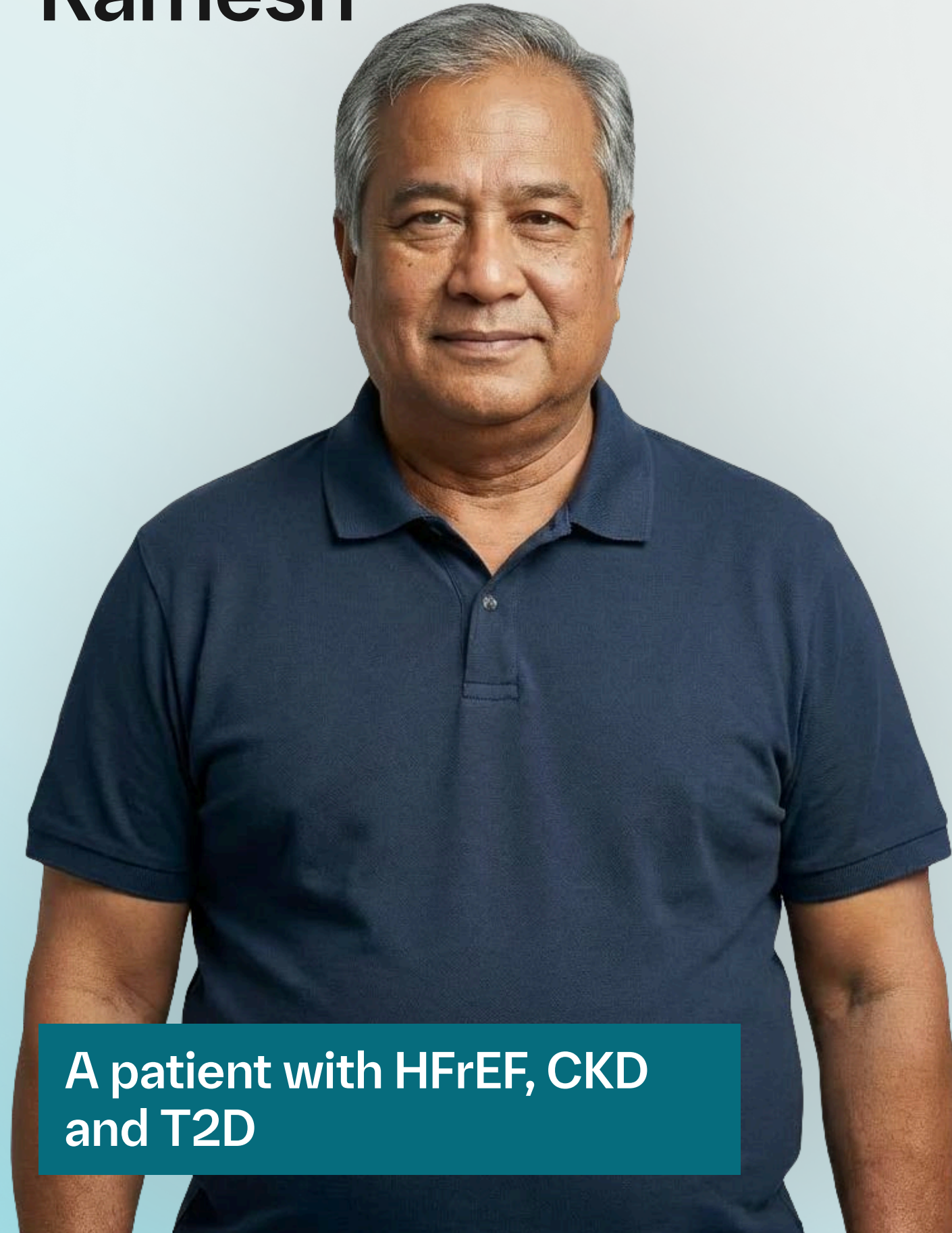
Meet your patients – select a journey to follow

Susan



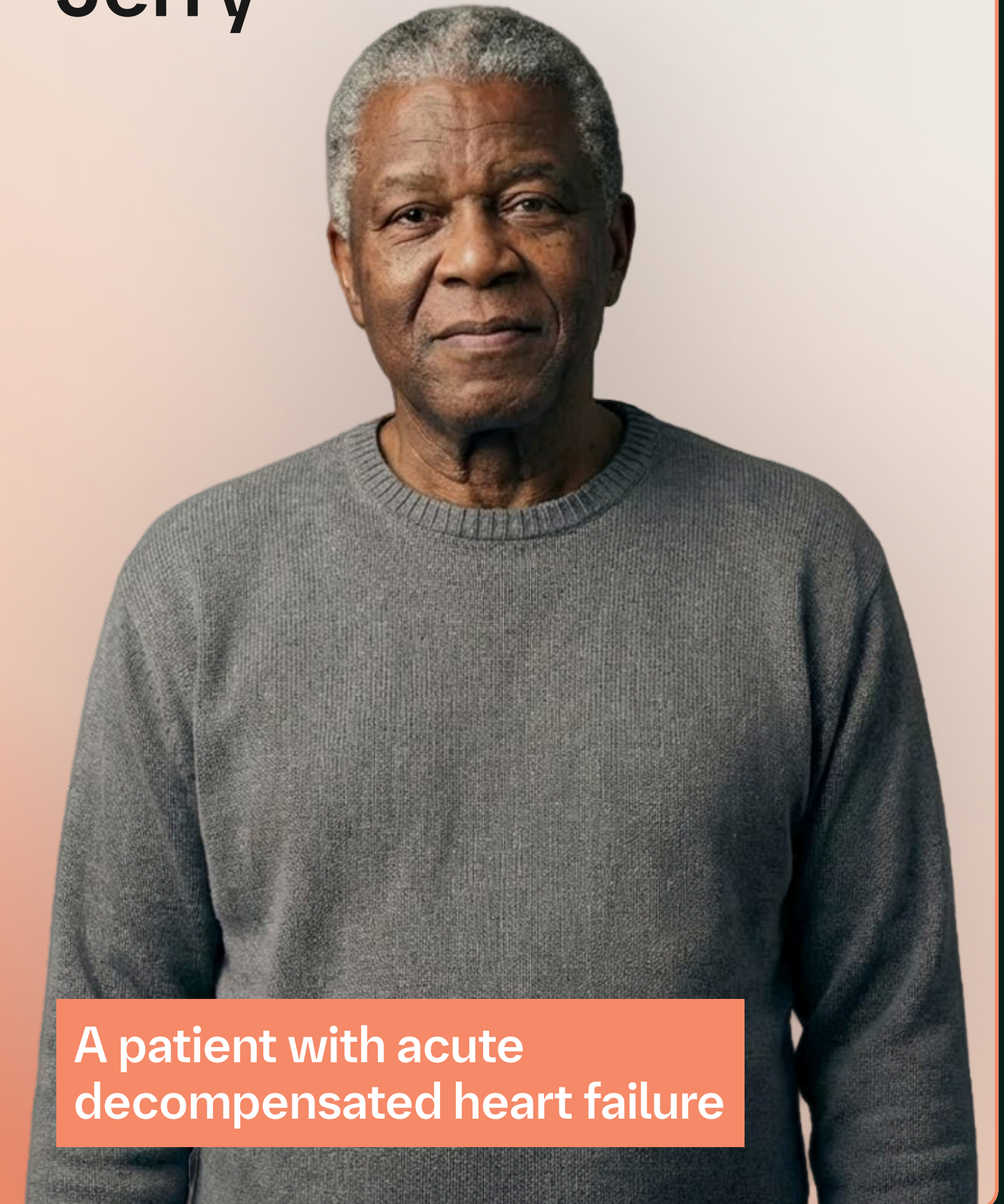
A patient with HFpEF

Ramesh



A patient with HFrEF, CKD
and T2D

Jerry



A patient with acute
decompensated heart failure

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Life forward

Meet Susan

A patient with HFpEF



“Over the past few months, I’ve been feeling much more tired. Even simple things like walking around the house leave me worn out...”

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Hear from Susan

 Play video



See topics



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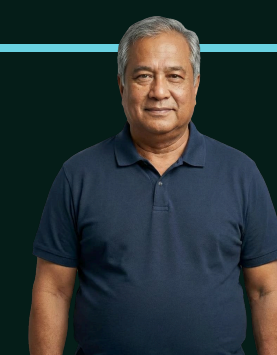
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A patient with HFpEF



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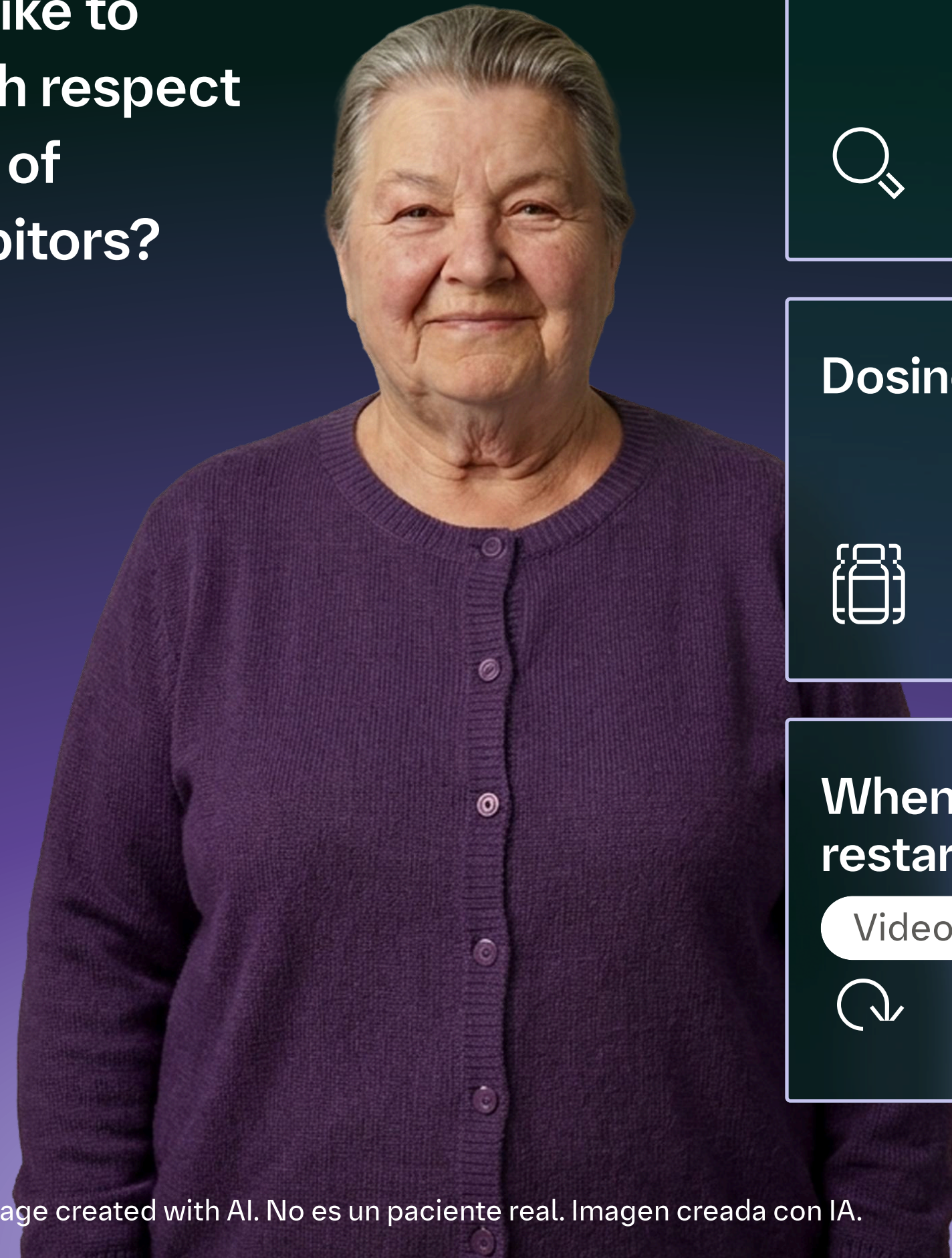


Jerry

A patient with acute decompensated heart failure



Which aspect of Susan's management would you like to explore with respect to initiation of SGLT2 inhibitors?



HFpEF diagnosis



Guideline implementation for HFpEF



Elderly patients



Dosing



Urinary tract infections/ genital tract infections

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Hypotension



When to stop, pause and restart treatment

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Collaborating with Primary Care



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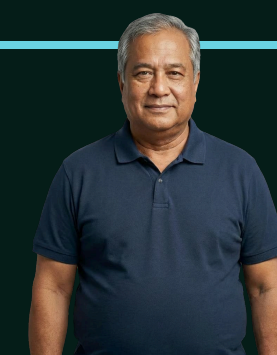
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A patient with HFpEF



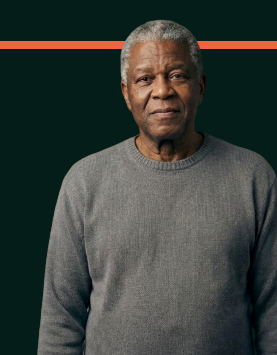
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What tools could you use to help determine if Susan has HFpEF?



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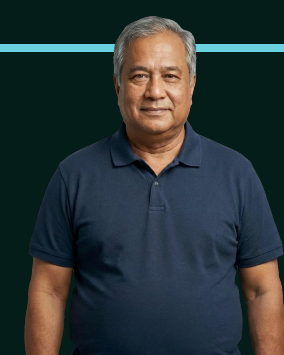
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In early HFpEF, non-specific and widely prevalent symptoms make heart failure difficult to diagnose



Studies document that 76% of patients with unrecognised heart failure have HFpEF



HFpEF is often under-recognised or diagnosed late, delaying optimised heart failure management

HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; RHF, right heart failure
van Riet EES et al. *Eur J Heart Fail* 2014;16:772



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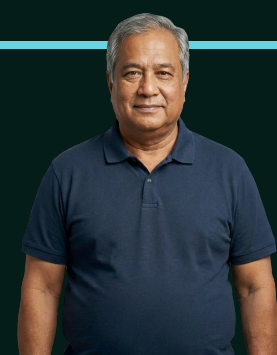
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Score-based algorithms assign patients with a likelihood of having HFpEF

Score-based algorithms are based on a combination of clinical, laboratory and imaging characteristics

H ₂ FPEF score ¹	HFA-PEFF diagnostic algorithm ²	HFpEF-ABA score ^{3,4}
<ul style="list-style-type: none">• Six clinical and echocardiographic characteristics• Discrimination of HFpEF from non-cardiac causes of dyspnoea• Determines the need for further diagnostic testing	<ul style="list-style-type: none">• Proposes a four-step diagnostic approach from clinical assessment to specialised tests• Helps to establish specific causes or alternative explanations	<ul style="list-style-type: none">• HFpEF scoring system is based on age, BMI and history of AF• Probability of HFpEF generated on a scale of 0–100• May be particularly beneficial in less specialised centres and in settings where dyspnoea is evaluated first

ABA, age, BMI and history of AF; AF, atrial fibrillation; HFA-PEFF, Heart Failure Association Pre-test assessment, Echocardiography and natriuretic peptide, Functional testing, Final etiology; HFpEF, heart failure with preserved ejection fraction
1. Reddy YNV et al. *Circulation* 2018;138:861; 2. Pieske B et al. *Eur Heart J* 2019;40:3297; 3. Reddy YNV et al. *Nat Med* 2024;30:2258; 4. Pandey A & Zieroth S. *Nat Med* 2024;30:2127



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The H₂FPEF score: an evidence-based approach to help identify HFpEF

H₂FPEF score is a **weighted** score integrating six predictive variables to create a composite score

	Clinical variable	Values	Points
H ₂	Heavy	BMI >30 kg/m ²	2
	Hypertensive	≥2 antihypertensive medicines	1
F	Atrial Fibrillation	Paroxysmal or persistent	3
P	Pulmonary hypertension	Doppler echocardiogram estimated pulmonary artery systolic pressure >35 mmHg	1
E	Elder	Age >60 years	1
F	Filling pressure	Doppler echocardiographic E/e' >9	1
H₂FPEF score			Sum (0-9)
Total points			0 1 2 3 4 5 6 7 8 9
Probability of HFpEF			0.2 0.3 0.4 0.5 0.6 0.7 0.8 0.9 0.95

	Susan	Points
H ₂	BMI 33 kg/m ²	2
	Lisinopril chlorthalidone	1
F	Atrial fibrillation not seen on ECG	0
P	Pulmonary artery systolic pressure <35 mmHg	0
E	Age 78 years	1
F	E/e'=16	1
Total points		5
Probability of HFpEF		~83%



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 BMI, body mass index; ECG, electrocardiogram; E/e', ratio between early mitral inflow velocity and mitral annular early diastolic velocity; HFpEF, heart failure with preserved ejection fraction
 Reddy YNV et al. *Circulation* 2018;138:861



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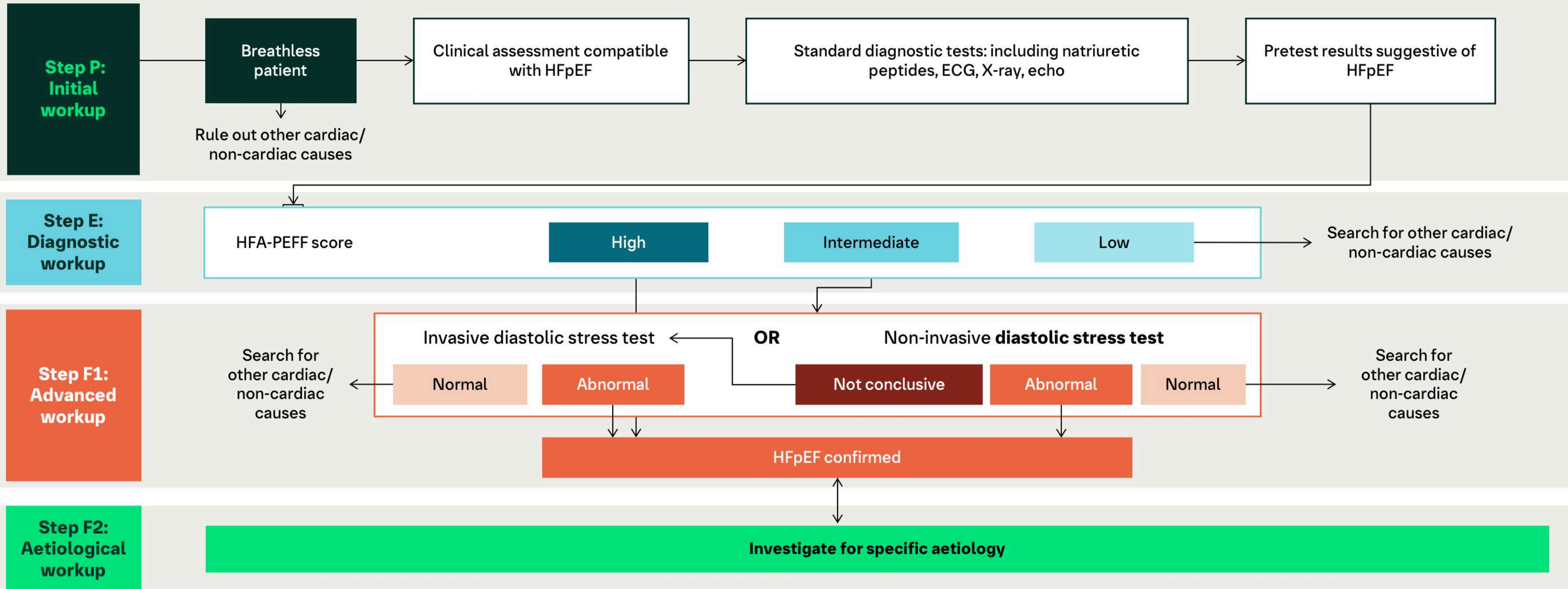
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The HFA-PEFF diagnostic algorithm: a consensus recommendation from the HFA-ESC



ECG, electrocardiogram; echo, echocardiography; HFA-ESC, Heart Failure Association of the European Society for Cardiology; HFA-PEFF, Heart Failure Association Pre-test assessment, Echocardiography and natriuretic peptide, Functional testing, Final etiology; HFpEF, heart failure with preserved ejection fraction
 Pieske B et al. *Eur Heart J* 2019;40:3297
 Figure adapted from: Pieske B et al. 2019



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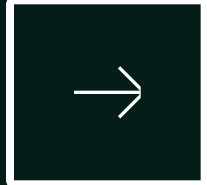
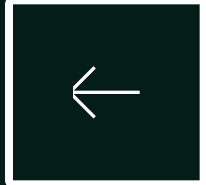
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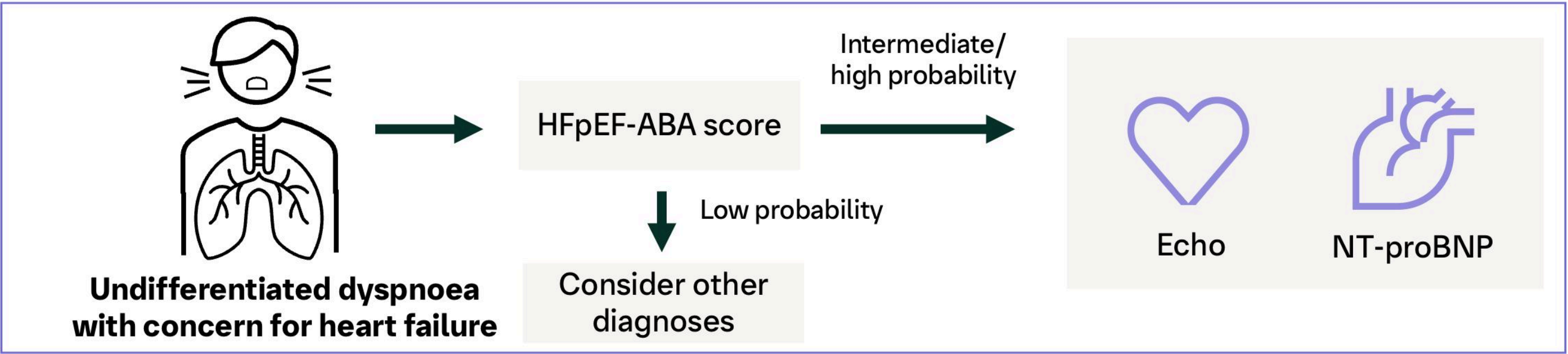
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The HFpEF-ABA score is a simplified screening tool for HFpEF

HFpEF scoring system is based on ABA

Implementation of the HFpEF-ABA score to screen for patients with HFpEF



ABA, age, BMI and history of AF; Echo, echocardiogram; HFpEF, heart failure with preserved ejection fraction; NT-proBNP, N-terminal pro-B-type natriuretic peptide
Pandey A & Zieroth S. *Nat Med* 2024;30:2127
Figure adapted from: Pandey A & Zieroth S. 2024



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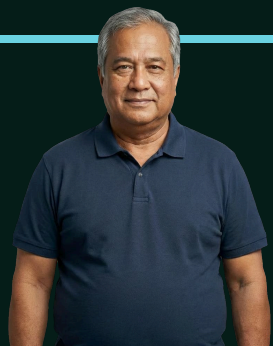
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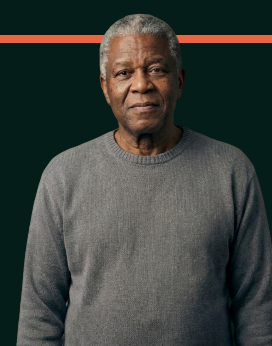
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What treatment(s) would be suitable for this patient?



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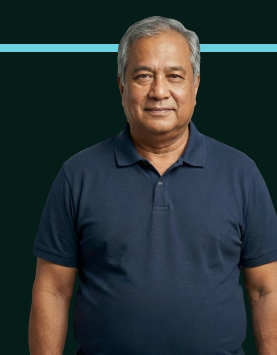
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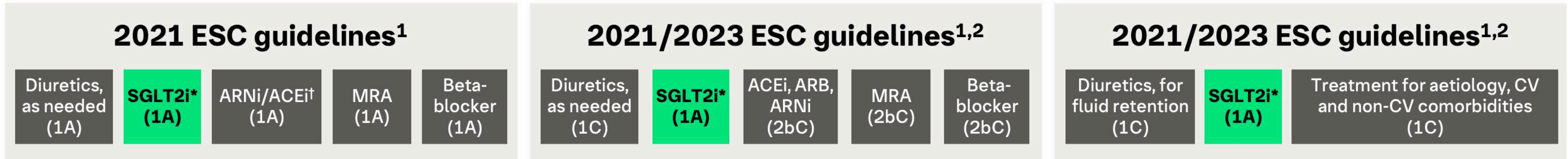
A patient with acute decompensated heart failure



SGLT2 inhibitors are foundational disease-modifying treatments in heart failure, recommended across the LVEF spectrum^{1,2}



SGLT2 inhibitors are the only treatment with a class IA recommendation to reduce heart failure hospitalisation and cardiovascular death across the LVEF spectrum,^{1,2} and are the only foundational therapy with a class IA recommendation for HFpEF in Europe²



The parentheses refer to the class of recommendation and level of evidence in the guidelines. Classes of recommendations: **class 1**, is recommended or is indicated; **class 2a**, should be considered; **class 2b**, may be considered; **class 3**, is not recommended. Levels of evidence: **A**, data derived from multiple randomised clinical trials or meta-analyses; **B**, data derived from a single randomised clinical trial or large non-randomized studies; **C**, consensus of opinion of the experts and/or small studies, retrospective studies, registries²
 *Dapagliflozin or empagliflozin; †ARB is recommended in those unable to tolerate an ACEi or ARNi
 ACEi, angiotensin-converting enzyme inhibitor; ARB, angiotensin II receptor blocker; ARNi, angiotensin receptor–neprilysin inhibitor; CV, cardiovascular; ESC, European Society of Cardiology; HFmrEF, heart failure with mildly reduced ejection fraction; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; LVEF, left ventricular ejection fraction; MRA, mineralocorticoid receptor antagonist;
 SGLT2i, sodium-glucose co-transporter-2 inhibitor
 1. McDonagh TA et al. *Eur Heart J* 2021;42:3599; 2. McDonagh TA et al. *Eur Heart J* 2023;44:3627



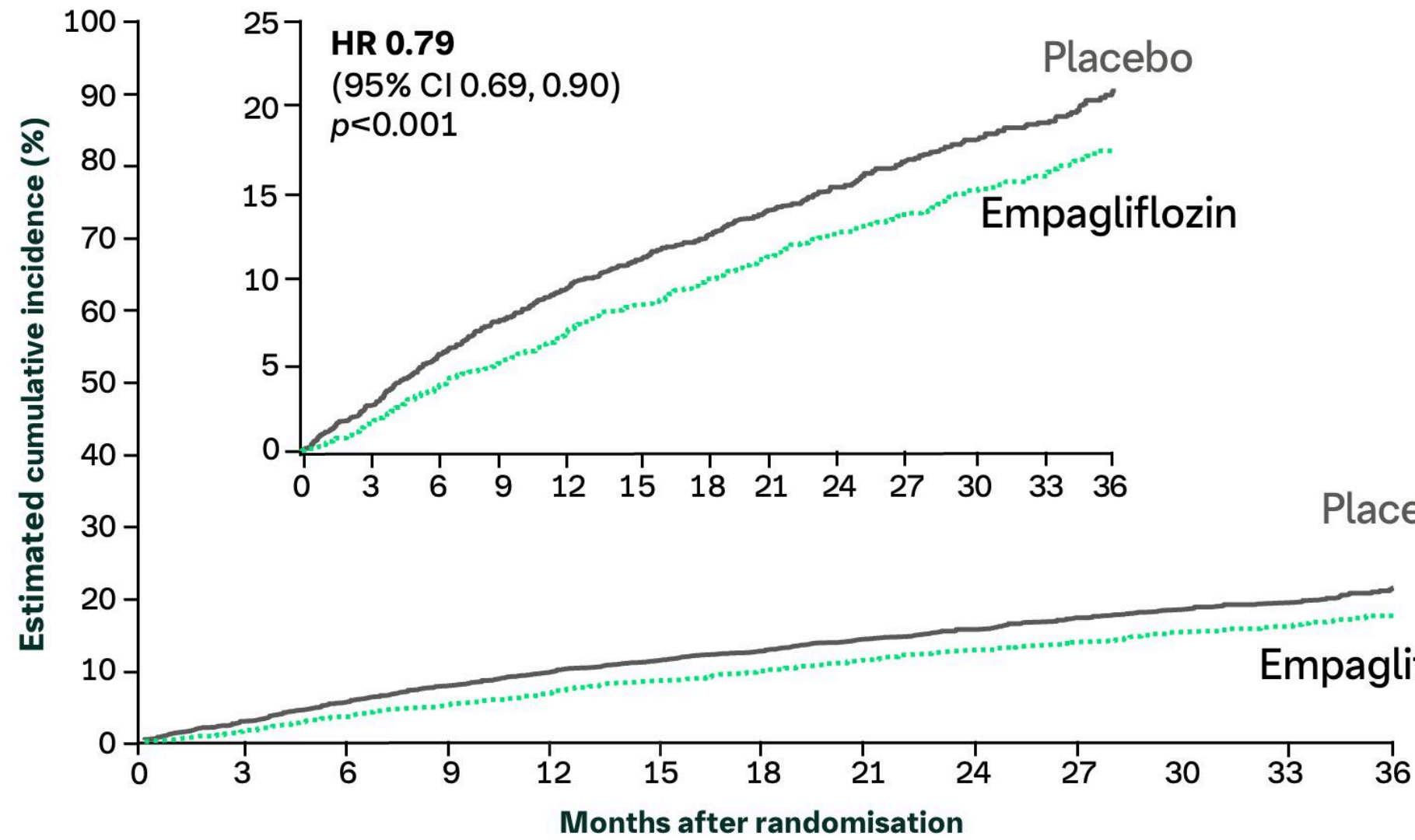
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Guideline recommendations for SGLT2 inhibitors are based on clinical trial data (1/2)



**EMPEROR-Preserved:
HFmrEF (LVEF 41–49%), HFpEF (LVEF ≥50%)**

**RRR
21%**

**CV death or first HHF
in 5988 patients with
HFmrEF and HFpEF
(LVEF >40%)**

**ARR
3.3%**

**HR 0.79
(95% CI 0.69, 0.90)**

Empagliflozin versus placebo

No. at risk

Placebo	2991	2888	2786	2706	2627	2424	2066	1821	1534	1278	961	681	400
Empagliflozin	2997	2928	2843	2780	2708	2491	2134	1858	1578	1332	1005	709	402

ARR, absolute risk reduction; CV, cardiovascular; HFmrEF, heart failure with mildly reduced ejection fraction; HFpEF, heart failure with preserved ejection fraction; HHF, hospitalisation for heart failure; LVEF, left ventricular ejection fraction; RRR, relative risk reduction; SGLT2, sodium-glucose co-transporter-2
Anker SD et al. *N Engl J Med* 2021;385:1451
Figure adapted from: Anker SD et al. 2021



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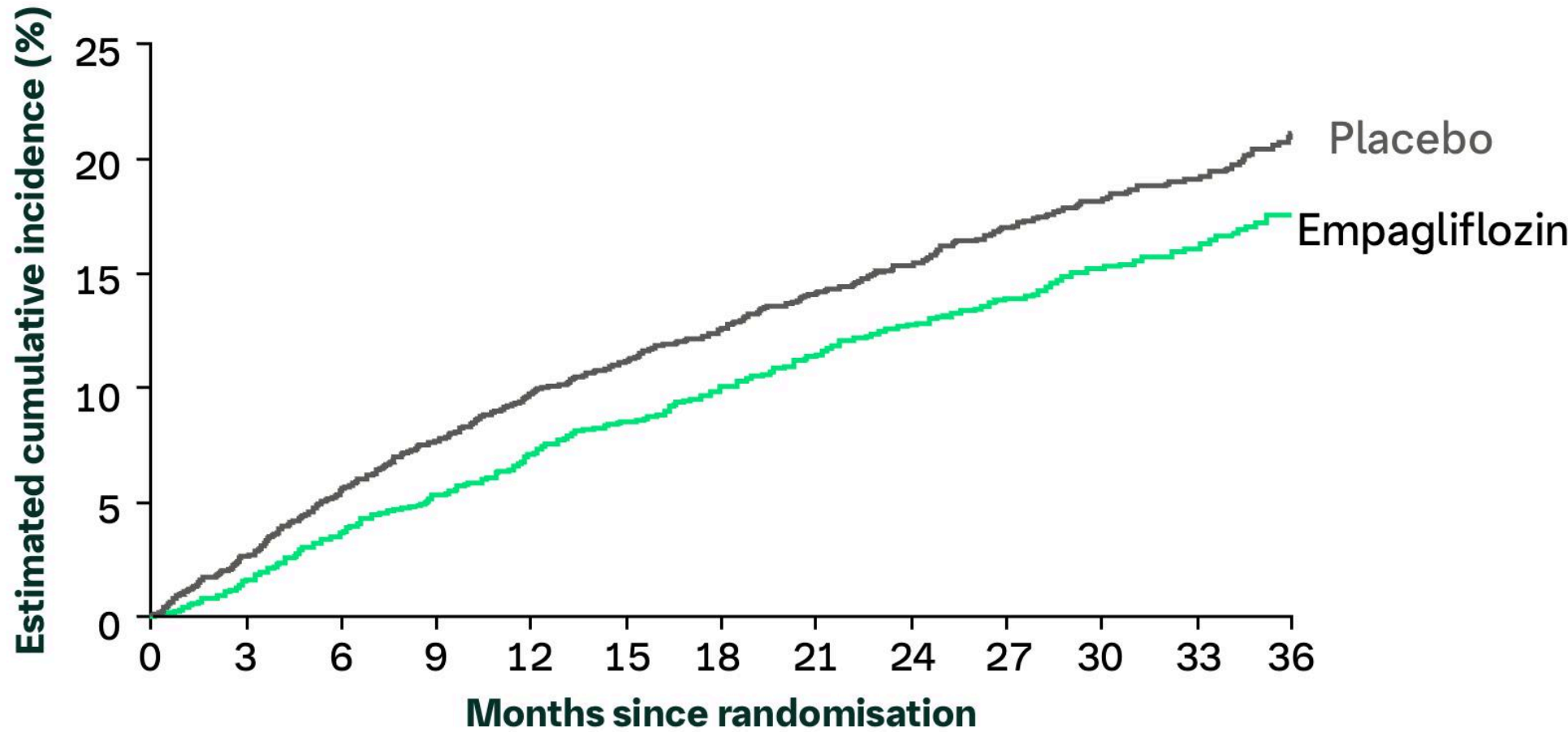
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A patient with HFpEF

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A patient with HFpEF, CKD and T2D

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Guideline recommendations for SGLT2 inhibitors are based on clinical trial data (2/2)



**EMPEROR-Preserved:
HFmrEF (LVEF 41–49%), HFpEF (LVEF ≥50%)**

**RRR
21%**

**CV death or first HHF
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Suggested simultaneous or rapid sequence initiation of combination medical therapy for HFmrEF or HFpEF

Therapy	Day 1	Week 4	Week 8	Week 12	Week 16	Clinical benefits
SGLT2 inhibitor	Initiate					20% RRR for CV death or HHF Improvement in patient-reported health status (mean 1- to 6-point improvement in KCCQ)
nsMRA*	Initiate	Titrate as tolerated				16% RRR for CV death or worsening HF Improvement in patient-reported health status (mean 1.6-point improvement in KCCQ-TSS)
GLP-1 RA (obesity)	Initiate	Titrate as tolerated	Titrate as tolerated	Titrate as tolerated	Titrate as tolerated	38% RRR for CV death or worsening HF Improvement in patient-reported health status (mean 6- to 8-point improvement in KCCQ-CSS)
ARNi (EF <55–60%)†	Initiate	Titrate as tolerated	Titrate as tolerated			Potential 22% RRR for total HHF or CV death
Steroidal MRA* (ns-MRA non-feasible)	Initiate	Titrate as tolerated				Potential 18% RRR for CV death, aborted cardiac arrest, and HHF amongst individuals in the Americas
Beta-blocker (EF 41–49%)‡	Initiate	Titrate as tolerated	Titrate as tolerated	Titrate as tolerated		Potential CV death benefit for patients in sinus rhythm

*For nsMRA and steroidal MRA, close laboratory monitoring of serum potassium is required. Assessment of tolerability includes monitoring for hyperkalaemia; †For ARNi-eligible individuals in whom ARNi therapy is not feasible, treatment with an angiotensin II receptor blocker therapy can be considered. ARNi may be titrated more frequently than every 4 weeks, as tolerated; ‡Beta-blocker may be titrated more frequently than every 4 weeks, as tolerated
 ARNi, angiotensin receptor–neprilysin inhibitor; CV, cardiovascular; EF, ejection fraction; GLP-1 RA, glucagon-like peptide-1 receptor agonist; HHF, hospitalisation for heart failure; HFmrEF, heart failure with mildly reduced ejection fraction; HFpEF, heart failure with preserved ejection fraction; KCCQ, Kansas City Cardiomyopathy Questionnaire; KCCQ-CSS, Kansas City Cardiomyopathy Questionnaire clinical summary score; KCCQ-TSS, Kansas City Cardiomyopathy Questionnaire total symptom score; MRA, mineralocorticoid receptor antagonist; nsMRA, non-steroidal mineralocorticoid receptor antagonist; RRR, relative risk reduction; SGLT2, sodium-glucose co-transporter-2
 Greene SJ et al. JAMA Cardiol 2025;10:407
 Figure adapted from: Greene SJ et al. 2025



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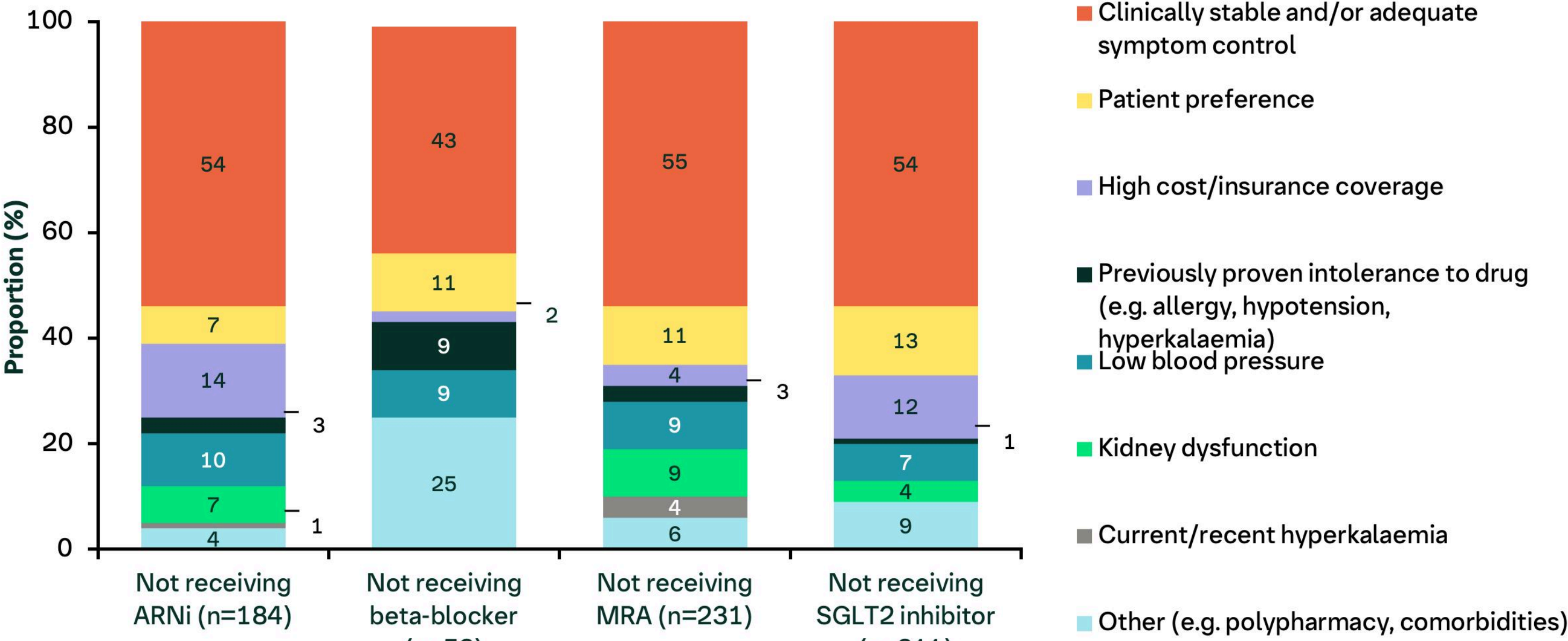
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Clinical inertia was reported to be the leading barrier to prescribing GDMT, including SGLT2 inhibitors

Physician-reported reasons for not prescribing GDMT at index visit



ARNi, angiotensin receptor–neprilysin inhibitor; GDMT, guideline-directed medical therapy; MRA, mineralocorticoid receptor antagonist; SGLT2, sodium-glucose co-transporter-2
 Greene SJ et al. JACC Heart Fail 2024;12:2120
 Figure adapted from: Greene SJ et al. 2024



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How do you approach the use of SGLT2 inhibitors in elderly patients with heart failure?



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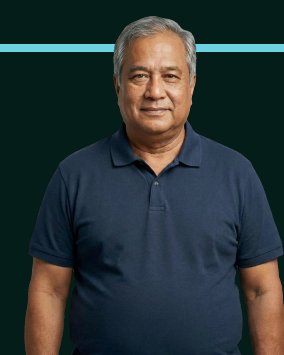
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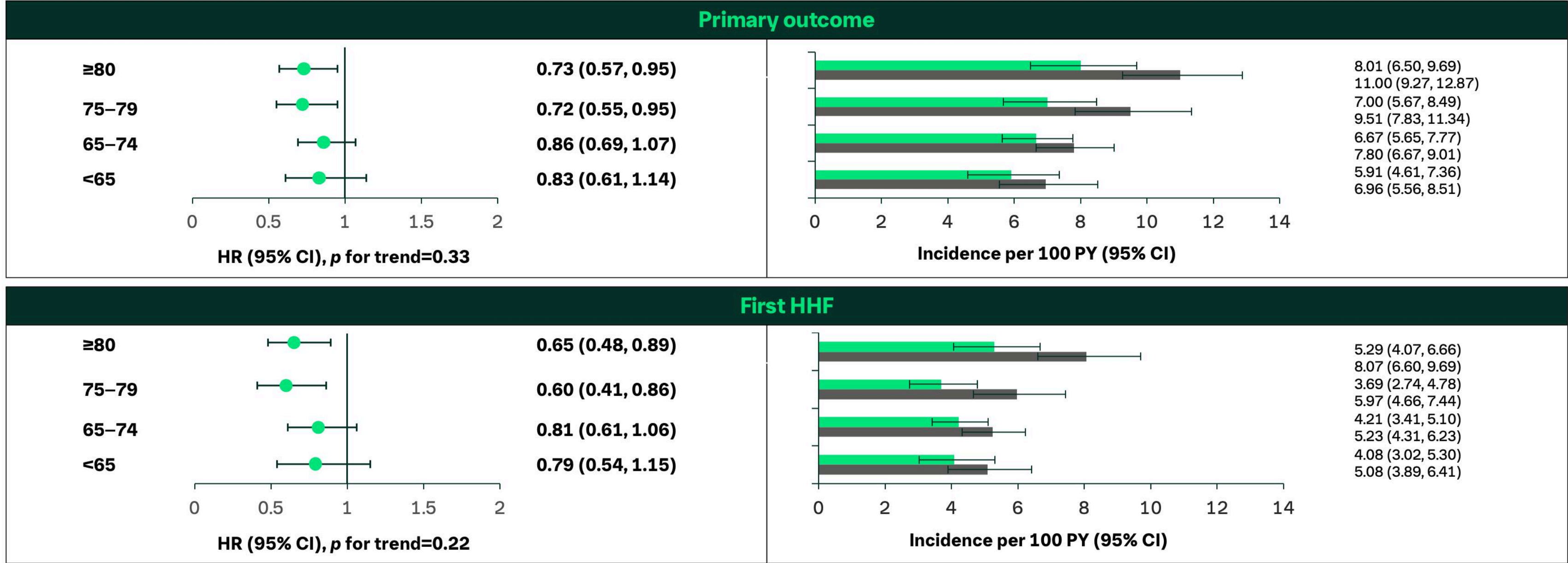
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SGLT2 inhibitors improve outcomes versus placebo in patients with heart failure of all ages

EMPEROR-Preserved age analysis



HHF, hospitalisation for heart failure; HR, hazard ratio; PY, patient-years; SGLT2, sodium-glucose co-transporter-2
 Böhm M et al. *J Am Coll Cardiol* 2022;80:1
 Figure adapted from: Böhm M et al. 2022



Placebo Empagliflozin

HFpEF diagnosis



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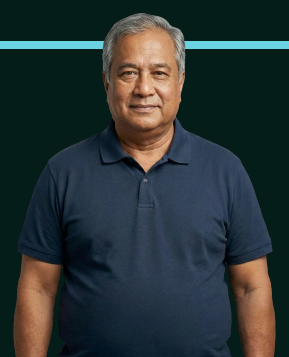
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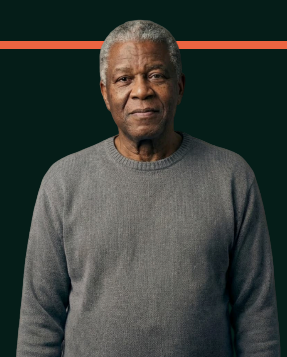
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Patients aged ≥ 80 years face higher rates of CV death or worsening heart failure* but may miss out on GDMT due to age-related bias or comorbidities

A retrospective study evaluated the efficacy and safety of **SGLT2 inhibitors in adults aged ≥ 80 years**

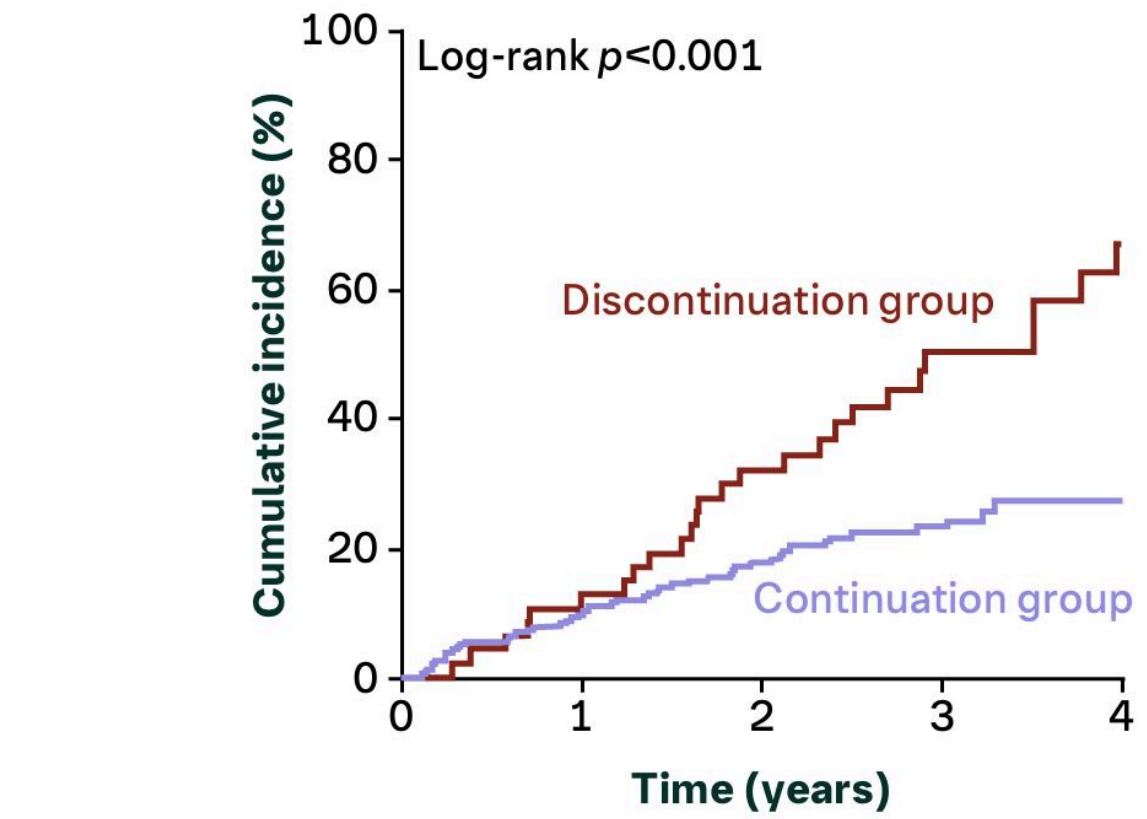
Patients who discontinued SGLT2 inhibitors showed a significantly higher incidence of CV death or worsening heart failure
(sHR 2.54; 95% CI 1.67, 3.85; $p < 0.001$)

The difference was maintained after balancing baseline covariates
($n=64$; sHR 1.89; 95% CI 1.01, 3.55; $p < 0.05$)

*Worsening heart failure was defined as either unplanned HHF or an urgent visit for heart failure
CV, cardiovascular; GDMT, guideline-directed medical therapy; HHF, hospitalisation for heart failure; SGLT2, sodium-glucose co-transporter-2; sHR, subdistribution hazard ratio
Noiri J et al. *Int J Cardiol* 2025;439:133647
Figure adapted from: Noiri J et al. 2025



Cumulative incidence of CV death or worsening heart failure in patient groups



Number at risk		0	1	2	3	4
Continuation	238	190	127	58	17	
Discontinuation	0	40	29	13	3	

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SGLT2 inhibitors have a consistent safety profile in patients with HFpEF, irrespective of age (1/2)

Incidence of AEs in people with HFpEF, stratified by age, who were receiving empagliflozin treatment or placebo

Category of AEs	<65 years					65-74 years				
	Placebo N=605	Incidence rate/100 PY	Empagliflozin N=594	Incidence rate/100 PY	p-value	Placebo N=1092	Incidence rate/100 PY	Empagliflozin N=1121	Incidence rate/100 PY	p-value
Patients with any AEs	513 (84.8)	140.06	491 (82.7)	115.94	0.28	926 (84.8)	134.08	951 (84.8)	128.65	0.89
AEs leading to discontinuation	97 (16.0)	8.43	91 (15.3)	8.03	0.69	179 (16.4)	8.56	198 (17.7)	9.35	0.42
Serious AEs	279 (46.1)	32.87	258 (43.4)	30.37	0.32	528 (48.4)	34.61	513 (45.8)	31.79	0.26
Hypotension	33 (5.5)	2.95	44 (7.4)	4.02	0.18	87 (8.0)	4.33	114 (10.2)	5.72	0.07
Acute renal failure	72 (11.9)	6.57	60 (10.1)	5.58	0.24	146 (13.4)	7.43	137 (12.2)	6.83	0.45
Confirmed hypoglycaemic events	15 (2.5)	1.32	15 (2.5)	1.34	0.95	26 (2.4)	1.26	26 (2.3)	1.24	0.99
UTIs	32 (5.3)	2.87	48 (8.1)	4.39	0.06	89 (8.2)	4.44	96 (8.6)	4.52	0.67
GTIs	6 (1.0)	0.52	14 (2.4)	1.25	0.09	22 (2.0)	0.38	22 (2.0)	1.04	0.01
Symptomatic hypotension	20 (3.3)	1.77	27 (4.5)	2.43	0.28	54 (4.9)	2.63	75 (6.7)	3.67	0.08

Category of AEs	75-79 years					≥80 years					
	Placebo N=613	Incidence rate/100 PY	Empagliflozin N=662	Incidence rate/100 PY	p-value	Placebo N=679	Incidence rate/100 PY	Empagliflozin N=619	Incidence rate/100 PY	p-value	p-value for interaction between groups
Patients with any AEs	548 (89.4)	162.05	579 (87.5)	143.48	0.22	598 (88.1)	172.57	553 (89.3)	165.58	0.44	0.39
AEs leading to discontinuation	125 (20.4)	10.97	141 (21.3)	11.33	0.69	150 (22.1)	12.45	141 (22.8)	12.67	0.72	0.73
Serious AEs	337 (55.0)	44.41	336 (50.8)	37.08	0.1	399 (58.8)	49.90	329 (53.2)	40.34	0.04	0.37
Hypotension	59 (9.6)	5.42	80 (12.1)	6.88	0.17	78 (11.5)	6.88	73 (11.8)	7.02	0.88	0.28
Acute renal failure	72 (11.7)	6.58	79 (11.9)	6.79	0.95	94 (13.8)	8.29	87 (14.1)	8.38	0.90	0.31
Confirmed hypoglycaemic events	19 (3.0)	1.69	15 (2.3)	1.21	0.33	18 (2.7)	1.51	17 (2.7)	1.54	0.98	0.78
UTIs	44 (7.2)	3.99	65 (9.8)	5.47	0.07	78 (11.5)	6.81	88 (14.2)	8.58	0.20	0.87
GTIs	5 (0.8)	0.44	24 (3.6)	1.96	0.002	3 (0.4)	0.25	7 (1.1)	0.63	0.NA	0.56
Symptomatic hypotension	34 (5.5)	3.06	50 (7.6)	4.19	0.15	48 (7.1)	4.12	45 (7.3)	4.19	0.87	0.38

Values are n(%) unless otherwise indicated

*Statistical testing for subgroups with <14 events was not calculated

AE, adverse event; GTI, genital tract infection; HFpEF, heart failure with preserved ejection fraction; PY, patient-years; SGLT2, sodium-glucose co-transporter-2; UTI, urinary tract infection

Böhm M et al. *J Am Coll Cardiol* 2022;80:1

Table adapted from: Böhm M et al. 2022



HFpEF diagnosis



Guideline implementation for HFpEF



Elderly patients



Dosing



Urinary tract infections/ genital tract infections



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When to stop, pause and restart treatment



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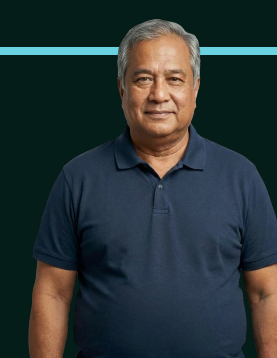
Susan

A patient with HFpEF



Ramesh

A patient with HFrEF, CKD and T2D



Jerry

A patient with acute decompensated heart failure



SGLT2 inhibitors have a consistent safety profile in patients with HFpEF, irrespective of age (2/2)

Incidence of AEs in people with HFpEF aged ≥80 years receiving empagliflozin treatment or placebo

Category of AEs	Placebo		Empagliflozin		p-value	p for interaction trend between age groups
	n=679	Incidence/100 PY	n=619	Incidence/100 PY		
Patients with any AEs	598 (88.1)	172.57	553 (89.3)	165.58	0.44	0.39
AEs leading to treatment discontinuation	150 (22.1)	12.45	141 (22.8)	12.67	0.72	0.73
Serious AEs	399 (58.8)	49.90	329 (53.2)	40.34	0.04	0.37
Hypotension	78 (11.5)	6.88	73 (11.8)	7.02	0.88	0.28
Acute renal failure	94 (13.8)	8.29	87 (14.1)	8.38	0.90	0.31
Confirmed hypoglycaemic events	18 (2.7)	1.51	17 (2.7)	1.54	0.98	0.78
Urinary tract infections	78 (11.5)	6.81	88 (14.2)	8.58	0.20	0.87
Genital tract infections	3 (0.4)	0.25	7 (1.1)	0.63	NA*	0.56
Symptomatic hypotension	48 (7.1)	4.12	45 (7.3)	4.19	0.87	0.38

Values are n(%) unless otherwise indicated
 *Statistical testing for subgroups with <14 events was not calculated
 AE, adverse event; HFpEF, heart failure with preserved ejection fraction; PY, patient-years; SGLT2, sodium-glucose co-transporter-2
 Böhm M et al. J Am Coll Cardiol 2022;80:1
 Table adapted from: Böhm M et al. 2022



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 A patient with HFpEF

Ramesh
 A patient with HFpEF, CKD and T2D

Jerry
 A patient with acute decompensated heart failure

What are the practical benefits of empagliflozin's dosing approach in patients with heart failure?



HFpEF diagnosis



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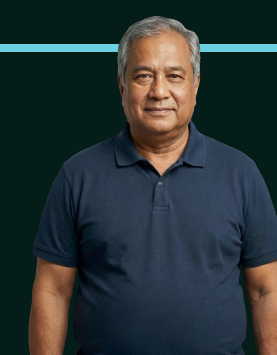
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A patient with HFpEF



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Jerry

A patient with acute decompensated heart failure



SGLT2 inhibitors are initiated at a single, fixed dose without the need for titration

-  Single dose^{1,2} 
-  Once daily^{1,2} 
-  No titration^{1,2} 
-  With or without food^{1,2} 
-  Any time of day but regularly^{1,2} 



Early benefits with SGLT2 inhibitors³









The **beneficial effects of SGLT2 inhibitors occurred early after randomisation** in clinical trials and were associated with improvements in QoL and symptoms³

Due to the benefits observed, irrespective of LVEF or background heart failure therapy, **early administration of SGLT2 inhibitors is recommended³**

 Pharmacokinetics of SGLT2 inhibitors are not influenced by co-administration with a wide range of drugs*^{1,2}

*Other heart failure/CV medications also do not need to be adjusted when initiating SGLT2 inhibitors in most patients with heart failure^{1,2}
 CV, cardiovascular; LVEF, left ventricular ejection fraction; QoL, quality of life; SGLT2, sodium-glucose co-transporter-2
 1. Jardiance® (empagliflozin) summary of product characteristics. Apr 2026; 2. AstraZeneca. Forxiga® (dapagliflozin) summary of product characteristics. Apr 2026; 3. Metra M et al. Eur J Heart Fail 2023;25:1115



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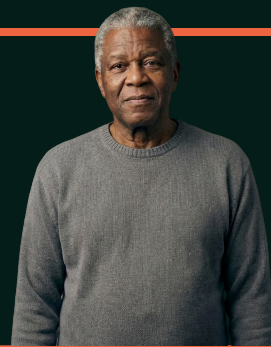
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Your patient has developed a urinary tract infection/genital tract infection. What do you advise them?



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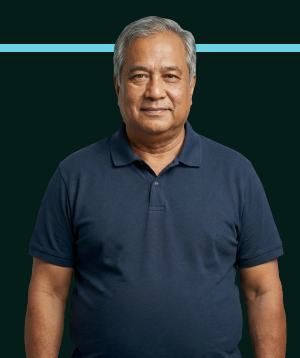
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A patient with HFrEF,
CKD and T2D











Jerry

A patient with acute
decompensated
heart failure





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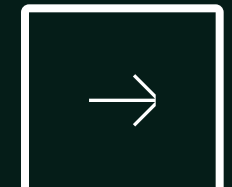
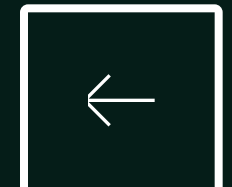
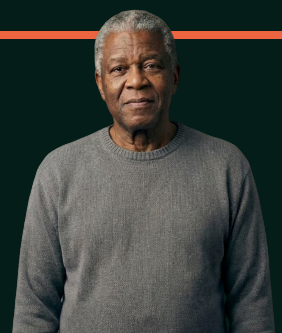
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A patient with HFpEF



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A patient with acute decompensated heart failure



Infections are often mild, responsive to treatment and do not usually require SGLT2 inhibitor discontinuation¹



Similar rates (<6%) of genital tract infections are observed with different SGLT2 inhibitors^{2,3}

Complicated genital tract infections are uncommon^{*4,5}




Urinary tract infection rates were **generally comparable between SGLT2 inhibitor treatment and placebo groups**^{†2,3}

How to manage¹:

Genital tract infections









-  **Raise awareness** at initiation of SGLT2 inhibitor treatment to manage expectations and promote early intervention¹
-  **Provide practical hygiene advice** to patients (and their partners) to prevent infections¹
-  **Topical treatments or appropriate oral treatments** can be used for mild to moderate infections¹

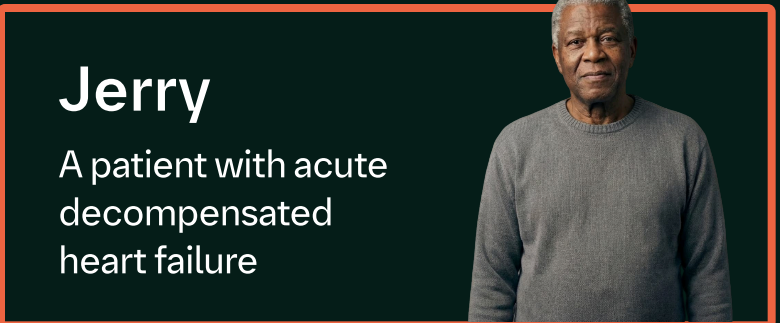
Urinary tract infections

-  **Encourage** patients to maintain good personal **hygiene** to reduce the risk of urinary tract infections¹
-  Treat with **standard oral antibiotics**¹
-  In patients with complicated urinary tract infections (including pyelonephritis and urosepsis), **temporary interruption of treatment should be considered**^{2,3}

*Evidence from empagliflozin trials; †The overall frequency of urinary tract infection reported as adverse event was similar in patients treated with empagliflozin 25 mg and placebo (7.0% and 7.2%) and higher in empagliflozin 10 mg (8.8%); urinary tract infections were more frequently reported for dapagliflozin 10 mg compared to placebo (4.7% versus 3.5%, respectively)^{2,3}
 SGLT2, sodium-glucose co-transporter-2
 1. Wilding J et al. *Diabetes Ther* 2018;9:1757; 2. Jardiance® (empagliflozin) summary of product characteristics. Apr 2026; 3. AstraZeneca. Forxiga® (dapagliflozin) summary of product characteristics. Apr 2026; 4. Packer M et al. *N Engl J Med* 2020;383:1413; 5. Anker SD et al. *N Engl J Med* 2021;385:1451



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Your patient has developed hypotension. What do you do?



HFpEF diagnosis



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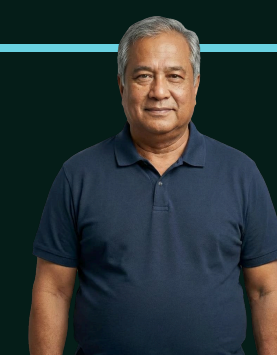
Susan

A patient with HFpEF



Ramesh

A patient with HFrEF,
CKD and T2D

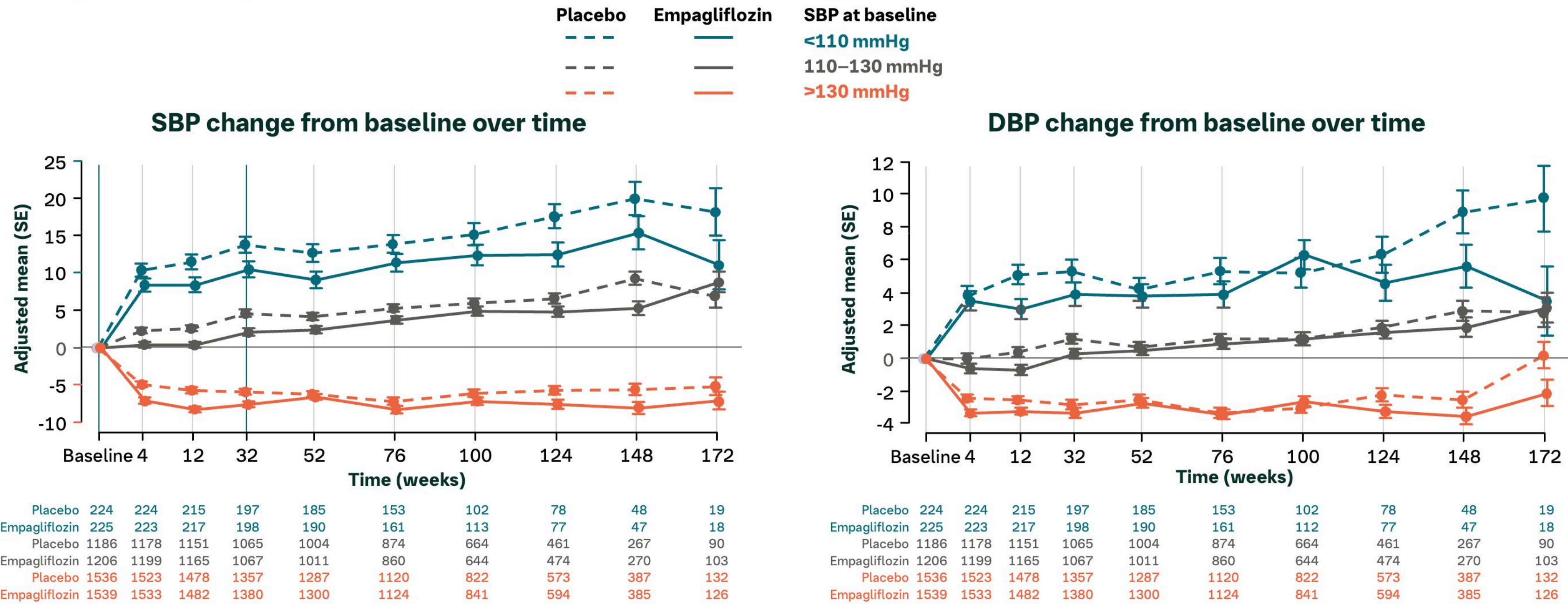


Jerry

A patient with acute
decompensated
heart failure



EMPEROR-Preserved: BP lowering with SGLT2 inhibitors and placebo was primarily observed in those with a higher baseline SBP



DBP, diastolic blood pressure; SBP, systolic blood pressure; SGLT2, sodium-glucose co-transporter-2
 Böhm M et al. *Eur Heart J* 2023;44:396
 Figure adapted from: Böhm M et al. 2023



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 A patient with acute decompensated heart failure

In patients with low systolic blood pressure, rates of hypotension and symptomatic hypotension were comparable between the placebo and SGLT2 inhibitor treatment groups

	<110 mmHg				p-value* for treatment comparison	110–130 mmHg				p-value* for treatment comparison
	Empagliflozin (n=228)		Placebo (n=227)			Empagliflozin (n=1213)		Placebo (n=1202)		
	n (%)	IR/100 PY	n (%)	IR/100 PY		n (%)	IR/100 PY	n (%)	IR/100 PY	
Any AEs	211 (92.5)	239.82	201 (88.5)	194.75	0.16	1047 (86.3)	133.24	1031 (85.8)	142.47	0.68
AEs leading to discontinuation	39 (17.1)	9.49	51 (22.5)	12.31	0.23	233 (19.2)	10.29	187 (15.6)	8.20	0.02
AEs of special interest										
Acute renal failure	27 (11.8)	7.11	31 (13.7)	7.93	0.74	146 (12.0)	6.84	155 (12.9)	7.21	0.50
Volume depletion	43 (18.9)	11.77	34 (15.0)	8.77	0.25	154 (12.7)	7.35	127 (10.6)	5.91	0.10
Hypotension	37 (16.2)	9.96	31 (13.7)	7.97	0.37	136 (11.2)	6.43	113 (9.4)	5.22	0.15
Symptomatic hypotension	26 (11.4)	6.81	19 (8.4)	4.78	0.20	85 (7.0)	3.89	67 (5.6)	3.03	0.15

	>130 mmHg				p-value* for treatment comparison	p-value* for trend test
	Empagliflozin (n=1555)		Placebo (n=1560)			
	n (%)	IR/100 PY	n (%)	IR/100 PY		
Any AEs	1316 (84.6)	128.21	1353 (86.7)	147.92	0.10	0.11
AEs leading to discontinuation	299 (19.2)	10.20	313 (20.1)	10.83	0.57	0.03
AEs of special interest						
Acute renal failure	190 (12.2)	6.86	198 (12.7)	7.21	0.60	0.99
Volume depletion	159 (10.2)	5.70	125 (8.0)	4.50	0.03	0.93
Hypotension	138 (8.9)	4.92	113 (7.2)	4.04	0.09	0.98
Symptomatic hypotension	86 (5.5)	3.01	70 (4.5)	2.46	0.18	0.87

*Logistic regression comparing frequencies
 AE, adverse event; SBP, systolic blood pressure
 Böhm M et al. Eur Heart J 2023;44:396
 Table adapted from: Böhm M et al. 2023



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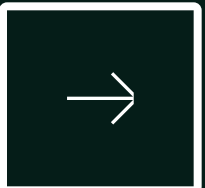
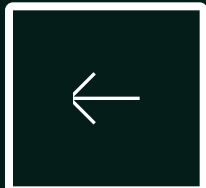
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Susan
 A patient with HFpEF

Ramesh
 A patient with HFrEF, CKD and T2D

Jerry
 A patient with acute decompensated heart failure



Management of symptomatic hypotension

Assess non-HF BP-lowering therapies* and stop/reduce as needed¹

Assess diuretic dose and lower dose as clinically feasible¹

Spread the heart failure medications throughout the day¹

If not tolerated, keep heart failure medications at low doses instead of stopping¹

Consider changing from a non-selective beta-blocker to a selective one²

*Calcium antagonists, centrally acting antihypertensive drugs, alpha-blockers¹
BP, blood pressure; SBP, systolic blood pressure

1. Cautela J et al. *Eur J Heart Fail* 2020;22:1357; 2. Abraham WT. *Congest Heart Fail* 2003;9:271



In parallel¹:

Evaluate SBP at ≥ 2 visits

Persistent low BP?
→ Refer to heart failure team

HFpEF diagnosis



Guideline implementation for HFpEF



Elderly patients



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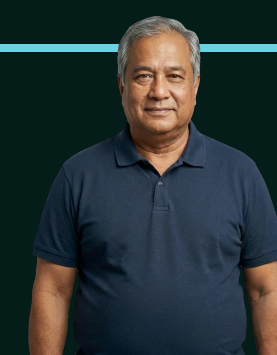
Susan

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A patient with acute decompensated heart failure



Susan has an upcoming knee surgery. Would you interrupt SGLT2 inhibitor therapy? What factors determine the timing of SGLT2 inhibitor therapy discontinuation and restart?



HFpEF diagnosis



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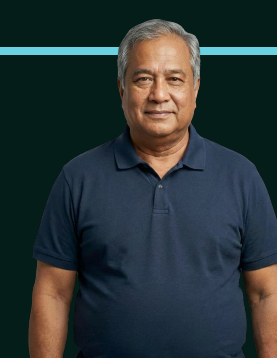
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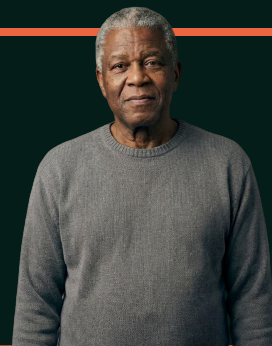
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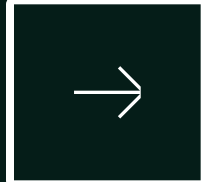
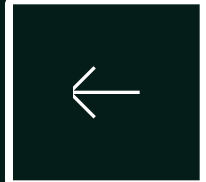
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When to pause SGLT2 inhibitor therapy

SGLT2 inhibitors should be paused in patients:



- If they have an acute **serious medical illness** (e.g. sepsis)^{1,2}
- If they have a condition that leads to **volume depletion or dehydration**, e.g. unable to eat and drink normally, persistent vomiting^{1,2}



- Patients who are **not eating and drinking** should **discontinue SGLT2 inhibitors and only restart when normal eating and drinking are resumed**^{1,2}
 - If a patient is to undergo a prolonged period of fasting, additional precautions apply³:

Ensure dose stabilisation prior to the fasting period

Increase fluid intake during non-fasting hours, if applicable



- Treatment should be interrupted at least 72 hours before all major surgeries^{2,4}
 - In patients with diabetes, blood glucose may be higher than usual – blood sugar should be checked more regularly until their levels are within range and **have stabilised**^{5,6}

Restart SGLT2 inhibitor therapy once the patient's condition has stabilised and blood ketone levels have returned to normal^{1,2}

SGLT2, sodium-glucose co-transporter-2
1. AstraZeneca. Forxiga® (dapagliflozin) summary of product characteristics. Apr 2026; 2. Jardiance® (empagliflozin) summary of product characteristics. Apr 2026; 3. Hassanein M et al. *Diabetes Res Clin Pract* 2020;169:108465; 4. Mazer C et al. *Curr Opin Cardiol* 2020;35:178; 5. Sreedharan R et al. *Perioper Med (Lond)* 2023;12:13; 6. Sudhakaran S & Surani SR. *Surg Res Pract* 2015;2015:284063



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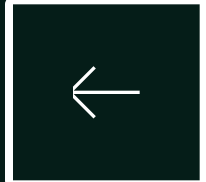
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A patient with acute decompensated heart failure



How can you collaborate with your Primary Care colleagues to support ongoing care for your patients with heart failure?



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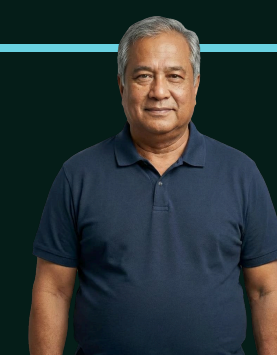
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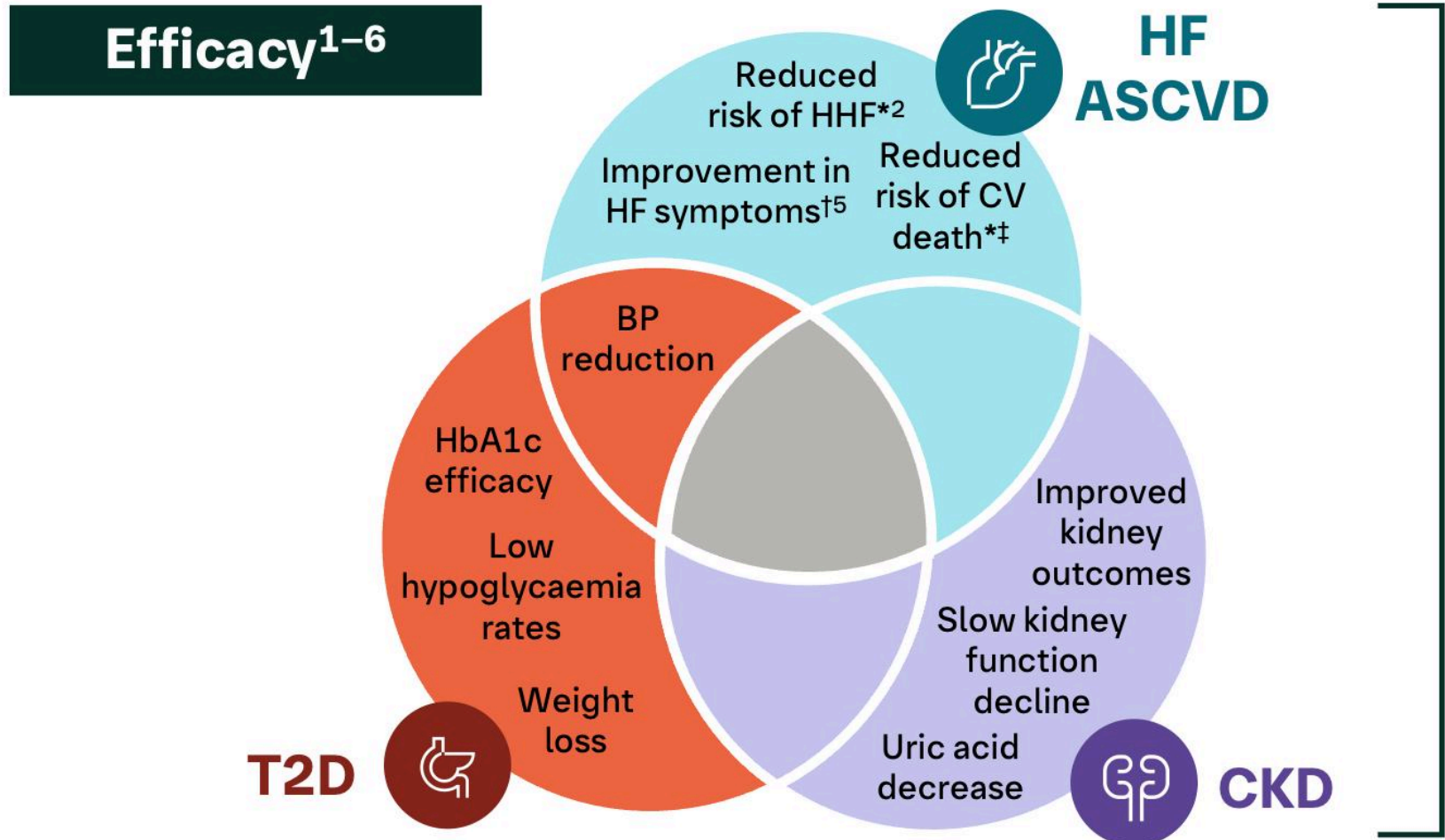


Jerry

A patient with acute decompensated heart failure



International guidelines increasingly and strongly recommend the use of SGLT2 inhibitors for their benefits across the cardio, renal and metabolic spectrum¹⁻¹⁵



International CKD, HF and T2D guidelines recommend the use of SGLT2 inhibitors as early as **foundational therapy**

HFpEF	T2D	CKD
ESC ⁷⁻⁹ AHA/ACC/HFSA ¹⁰ CCS/CHFS ¹¹	ADA-EASD ¹² ADA ¹³	ADA-KDIGO ¹⁴ ADA-EASD ¹² ADA ¹³ KDIGO ¹⁵

*In people with T2D and ASCVD or multiple risk factors for ASCVD (as reported in EMPA-REG OUTCOME,² CANVAS Programme³ and DECLARE-TIMI 58⁴); [†]Improvements in KCCQ symptom scores⁵; [‡]Significant reductions in the risk of CV death were observed only with empagliflozin in the EMPA-REG OUTCOME² trial. Empagliflozin is indicated to reduce the risk of CV death in people with T2D and established CV disease in the EU^{2,6}

ACC, American College of Cardiology; ADA, American Diabetes Association; AHA, American Heart Association; ASCVD, atherosclerotic cardiovascular disease; BP, blood pressure; CCS, Canadian Cardiovascular Society; CHFS, Canadian Heart Failure Society; CV, cardiovascular; EASD, European Association for the Study of Diabetes; ESC, European Society of Cardiology; EU, European Union; HbA1c, glycated haemoglobin; HFSA, Heart Failure Society of America; KCCQ, Kansas City Cardiomyopathy Questionnaire; KDIGO, Kidney Disease: Improving Global Outcomes; SGLT2, sodium-glucose co-transporter-2

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- HFpEF diagnosis
- Guideline implementation for HFpEF
- Elderly patients
- Dosing
- Urinary tract infections/genital tract infections Video
- Hypotension
- When to stop, pause and restart treatment Video
- Collaborating with Primary Care

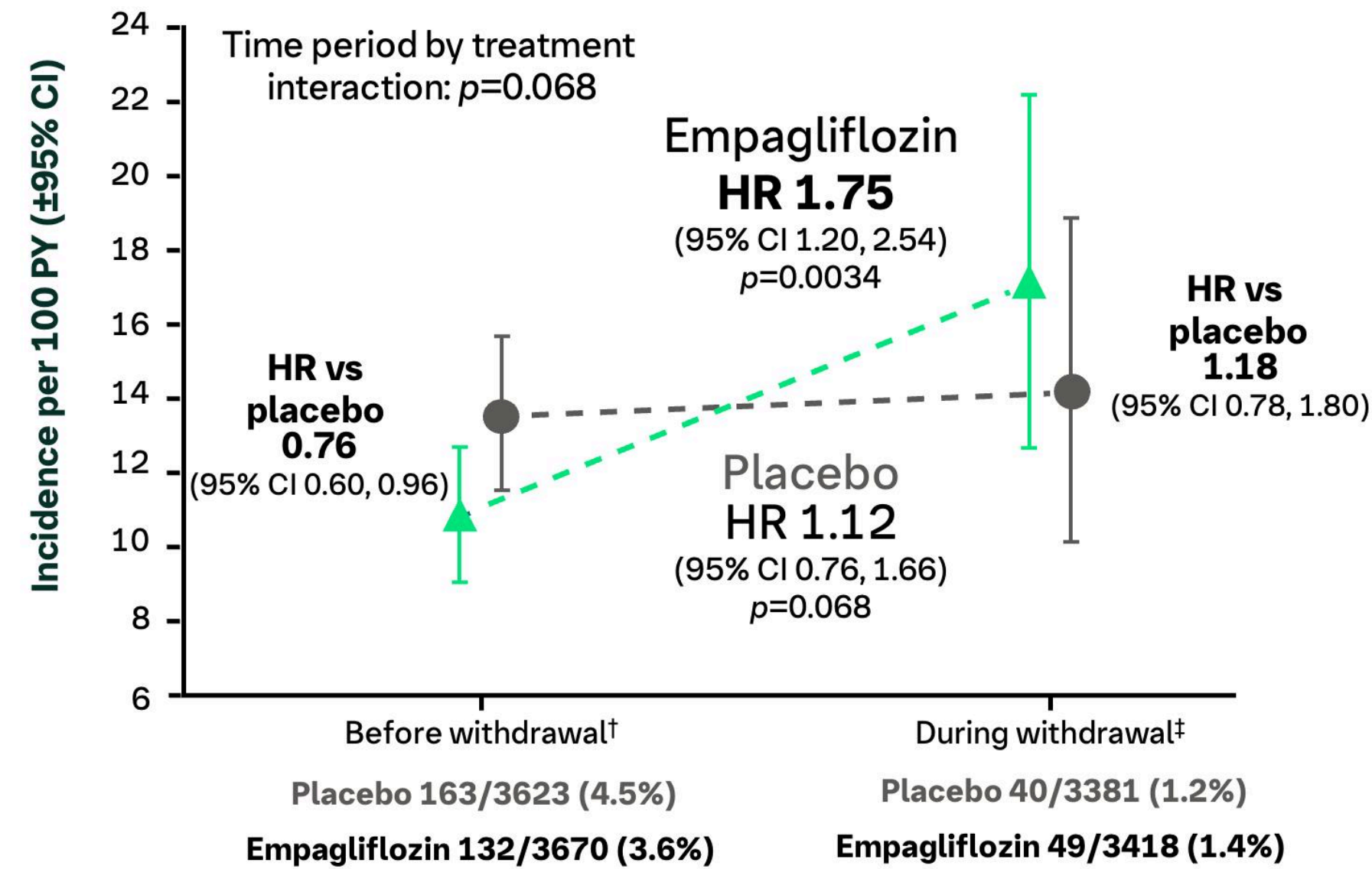
Susan
A patient with HFpEF

Ramesh
A patient with HFrEF, CKD and T2D

Jerry
A patient with acute decompensated heart failure

Why is continuation of therapy important?

Discontinuation of empagliflozin translated into increased clinical events in EMPEROR-Pooled*



*Pooled analysis of the EMPEROR-Reduced (patients with heart failure and LVEF $\leq 40\%$) and EMPEROR-Preserved (patients with heart failure and LVEF $> 40\%$) trials; †From 90 days before start of closeout up to planned end of double-blind treatment; ‡During 30-day withdrawal period
CV, cardiovascular; HHF, hospitalisation for heart failure; LVEF, left ventricular ejection fraction; PY, patient-years; RR, relative risk
Packer M et al. *Circulation* 2023;148:1011
Figure adapted from: Packer M et al. 2023



HFpEF diagnosis



Guideline implementation for HFpEF



Elderly patients



Dosing



Urinary tract infections/
genital tract infections



Video

Hypotension



When to stop, pause and restart treatment



Video

Collaborating with Primary Care



Home

Summary

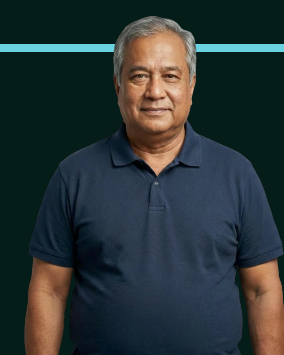
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