Heart failure disease has been one of the major chronic cardiovascular diseases that cause morbidity, mortality, and hospitalization of all cardiac patients. Heart failure has a significantly increased lifetime risk of development is about 20%. Symptomatic predictions are usually non-specific and hardly can discriminate the occurrence of heart failure from other diseases. It represents a challenging problem because of its economical and medical burden on the health care system. However, the management and presentation of a patient with heart failure remain in the fields of doubt. This review will highlight the importance of diagnosing and managing Congestive heart failure patients for primary health care physicians. This review was collected and classified from eligible published English written documents, articles, clinical trials. This electronic research engine was included: PubMed. This review discussed the diagnosis and management of Congestive heart failure and the details regarding this topic including definitions classifications, were included in this review. The primary care physician approach is often concerned with traditional palliative therapies before worsening the condition and plans to assess different reports regarding heart failure patients throughout their follow-up schedules.

Keywords: Congestive heart failure, Diagnosis, Management, Prognosis, Primary health care

INTRODUCTION
Heart failure disease has been one of the major chronic cardiovascular diseases that cause morbidity, mortality, and hospitalization of all cardiac patients. Heart failure has a significantly increased lifetime risk of development is about 20% [1, 2]. Other studies estimated the overall lifetime risk percent according to gender, where men 33% are higher in developing heart failure than women 28% [3, 4]. Although, congestive heart failure prevalence differs according to the specific studied population. However, the estimated prevalence of heart failure is roughly 1.2% and might increase to >10% among people over 70 of age [4, 5]. Furthermore, there has been a remarkable escalation in the incidence of chronic cardiovascular diseases in recent decades [6, 7].

The final stage of various cardiac issues is usually congestive heart failure. It is represented as a challenging problem because of its economical and medical burden on the health care system. Understanding the pathological and physiological condition of congestive heart failure has improved over the past 20 -30 years, where new modalities for identifying therapies are developed [4, 8].

However, the management and presentation of a patient with heart failure remain in the fields of doubt. In this review, we will highlight the importance of diagnosing and managing Congestive heart failure patients for primary health care physicians.

Low-frequency neuromuscular stimulation is a safe and effective rehabilitation protocol that could partially reverse the abnormal response to exercise in advanced heart failure patients helping in their symptoms and improved activities [9].

In a study, Rano K. sinuraya et al. revealed that the Cost related to CVD in all primary health care centers in Bandung...
is higher after the implementation of national health insurance [10].

### Materials and Methods

This review was collected and classified from eligible published English written documents, articles, clinical trials. This electronic research engine was included: PubMed. The keywords “Congestive” ‘Heart’ and ‘Failure’ including words used in Mesh (‘Diagnosis’ [Mesh]), (‘Prognosis’ [Mesh]), (‘Management’ [Mesh]), (‘Primary’ [Mesh]) were used in combinations. This review discussed the diagnosis and management of Congestive heart failure and the details regarding this topic including definitions classifications, were included in this review.

### Review

### Diagnosis

#### Symptoms and Signs in Clinical Presentation

The progression and prognostic assessment of congestive heart failure depend on the European Society of Cardiology (ESC) 2016 guidelines for diagnosing and treating acute and chronic heart failure and the American college of cardiology\ American heart association (ACC\AHA) [11]. Symptomatic predictions are usually non-specific and hardly can discriminate the occurrence of heart failure from other diseases. However, detection of the early signs of heart failure can be more specific, such as apical impulse displacement and jugular venous pressure elevation (Table 1) [11-13].

**Table 1. Symptoms and Signs in Heart failure presentation: [11-13]**

| Symptoms                          | Signs                                      |
|-----------------------------------|--------------------------------------------|
| Conventional symptoms             |                                            |
| Breathlessness                    | More specific                              |
| Orthopnea                         | Jugular venous pressure elevation          |
| Reduced exercise tolerance        | Hepatojugular reflux                       |
| Paroxysmal nocturnal dyspnea      | Gallop heart rhythm                        |
| Tiredness, fatigability, more     | Lateral apical impulse displacement        |
| time for exercise recovery        |                                            |
| Swelling on the ankles            |                                            |
| Less conventional                 |                                            |
| Wheezing                          | Less specific                              |
| Blated feeling                    | Weight gain                                |
| Nocturnal coughing                | Sudden weight loss                         |
| Loss of appetite                  | Tissue wasting                             |
| Confusion                         | Cardiac murmur                             |
| Depression                        | Peripheral oedema (Ankle, sacral, scrotal) |
| Palpitations                      | Pulmonary crepitations                     |
| Dizziness                         | Dullness to percussion and reduced air entry|
| Syncope                           | Tachycardia                                |
| Bendopnea                         | Cheyne Stokes respiration                  |
|                                   | Hepatomegaly                               |

Unplanned hospitalization of patients with heart failure, nomimates marks of mortality, and recurrent hospitalization [16, 20, 21]. Cardiovascular and non-cardiovascular comorbid diseases play a sensitive role in maintaining the prognostic statements of congestive heart failure progression. These comorbidities highly impact the diagnosis and management of heart failure. Diabetes, anemia, and metabolic iron deficiency (Table 3) are often observed in congestive heart failure patients and are acknowledged to complication the prognostic assessment of heart failure.

**Table 2. Women Characteristic physiological and anatomical features in comparison to men: [19]**

| Physiological and Anatomical features | Women compared to men |
|---------------------------------------|-----------------------|
| Mass at the left ventricle            | Lower                 |
| Apoptosis and cell turnovers          | Lower                 |
| Blood pressure                        | Lower                 |
| Resting heart rate                    | Higher                |
| Contractility                         | Greater               |
| Catecholamine-mediated vasoconstriction| Less                  |
| Coronary vessel caliber               | Smaller               |

**Table 3. Heart failure impact on Anemia and iron deficiency [22]**

| Anemia                                | Iron deficiency       |
|---------------------------------------|-----------------------|
| Renal impairment                      | Iron absorption impairment. |
| Chronic inflammatory disorder         | Malnutrition and iron intake reduction. |
Diabetes mellitus risk of presence might not worsen the survival rate after all, but it does interplay a significant role with the etiology that increases the risk of deaths in patients with heart failure. This depends on the duration, other comorbidities, and damaged organs (Table 4) [22, 23]. Diabetes type 2 is found to have strong mortality risks in heart failure patients compared with cardiac patients without diabetes [22, 24].

Table 4. Classes of cardiovascular risk in diabetic patients [22, 23]

| Cardiovascular risk degree | Condition |
|---------------------------|-----------|
| Very high                 | • Existing cardiovascular disease and diabetes accompanied by end-organ damage.  
• Cardiovascular risk for more than 3 years  
• Diabetes for more than 20 years |
| High                      | • Diabetes for more than 10 years not associated with organ damage, but with cardiovascular risks.  
• Type 1 diabetes in patients more than 35 years of age with no cardiovascular risks.  
• Type 2 diabetes in patients more than 50 years of age with no cardiovascular risks. |
| Moderate                  | None |

CONCLUSION
Heart failure has a significantly increased lifetime risk of development is about 20%. The final stage of various cardiac issues is usually congestive heart failure. It is represented as a challenging problem because of its economical and medical burden on the health care system. Ethnicity and gender differences had often a greater impact impairing the quality of life in patients. However, the progression and prognostic assessment of congestive heart failure depend on the European Society of Cardiology (ESC) 2016 guidelines for diagnosing and treating acute and chronic heart failure and the American college of cardiology/American heart association (ACCAHA). In the practical management of congestive heart failure, patients might experience various levels of intense symptoms and signs underlying this condition. The primary care physician approach is often concerned with traditional palliative therapies before worsening the condition and plans to assess different reports regarding heart failure patients throughout their follow-up schedules. If the role of palliative care is ineffectual then a referral should be noted.

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