Condensed Non-Ischemic Heart Failure Work-Up

Society of Hospital Medicine

Systematic evaluation when CAD is excluded as the primary etiology. Early identification of treatable causes, particularly cardiac amyloidosis, can dramatically alter management and prognosis.

NON-ISCHEMIC ASSESSMENT DOMAINS	NON-ISCHEMIC DISEASE CONSIDERATIONS
Family History	Cardiomyopathy, Sudden cardiac death <50 years, Heart transplant, ICD/pacemaker, Neuromuscular disease, Genetic syndromes
Toxic Exposures	Alcohol (>7-8/day × 5y = alcoholic CMP), Cocaine, Methamphetamine, anabolic steroids, Heavy metals (lead, cobalt)
Cardiotoxic Treatments	Anthracyclines (risk → >400 mg/m²), Trastuzumab, HER2-targeted therapy, Immune checkpoint inhibitors, Chest/mediastinal radiation
Inflammatory/Infectious	Recent viral illness, COVID-19, HIV, Hepatitis B/C, Chagas, Lyme, Autoimmune disease (SLE, RA, scleroderma, sarcoid)
Other	Pregnancy within 5 months, prior peripartum CMP, Neuromuscular symptoms (weakness, gait abnormalities)

AMYLOIDOSIS: When To Consider Further Evaluation:
HFpEF (or HFmrEF) + increased LV wall thickness on echo (often with biatrial enlargement/restrictive filling), especially if the degree of hypertension doesn't explain the "LVH.
Voltage–mass discordance: low QRS voltage on ECG despite thick walls on echo; or new conduction disease/AV block out of proportion to other findings.
Disproportionately elevated NT-proBNP/troponin relative to the apparent volume status/clinical trajectory.
Systemic clues: bilateral carpal tunnel syndrome, lumbar spinal stenosis, biceps tendon rupture, peripheral/autonomic neuropathy, unexplained weight loss.
AL clues (urgent): nephrotic-range proteinuria, hepatomegaly, macroglossia, periorbital purpura, unexplained anemia/renal dysfunction.
Older adults (often men) with HF + aortic stenosis or recurrent "unexplained HF admissions" despite preserved EF.

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AMYLOIDOSIS: WHAT TO DO WHEN SUSPECTED:
Document the suspicion ("possible cardiac amyloidosis/infiltrative cardiomyopathy") and involve cardiology (ideally HF/cardiomyopathy if available)
Rule out AL first (time-sensitive): order serum free light chains + serum immunofixation + urine immunofixation. If any are abnormal, urgent hematology involvement is warranted.
If AL screen is negative, pursue ATTR evaluation (often via Tc-99m PYP scintigraphy per local protocol/cardiology pathway).
Ensure Medication safety while awaiting diagnosis: prioritize gentle diuresis; use extra caution with hypotension-prone GDMT; avoid or be very cautious with digoxin and non-DHP calcium channel blockers.
Order Ferritin/TSAT for hemochromatosis (TSAT >45%), HIV, HepB, HepC, Chagas, Lyme, ANA, anti-dsDNA, ACE level, ESR, and CRP if not done recently.
Consider Cardiac MR when echo/PYP results are equivocal or to characterize infiltrative cardiomyopathy (coordinate inpatient vs expedited outpatient based on stability/resources).
If arrhythmia/conduction disease is present, ensure telemetry and a plan for rhythm management/anticoagulation.