The statistics pertaining to heart failure are awesome. It now affects 4.6 million Americans, and 400,000 new cases are diagnosed each year. After a diagnosis is made, less than 50% of patients survive more than five years, and less than 25% survive more than 10 years. Class IV heart failure carries about a 50% mortality in one year. Deaths from heart failure rose 120% from 1979 to 1996, and hospital discharges rose from 377,000 to 870,000. Heart failure is the number one hospital DRG in the Medicare population.

This epidemic of heart failure has spawned a new organization, the Heart Failure Society of America. They have designated February 14–21 as Heart Failure Awareness Week. Part of the reason for this is to highlight relative inequities of NIH funding for heart failure research. For example, in 1997 the NIH allocated $28 million for breast cancer research and $132 million for lung cancer research. Yet the prevalence of heart failure is double that of the other two diseases combined.

There are three main goals of this heart failure initiative:

1. Enhance the public’s recognition of heart failure as a defined cardiac disease of epidemic proportions.
2. Educate the public that a diagnosis of heart failure is not a death sentence.
3. Educate the public that with early recognition, appropriate therapy, and careful emphasis on the salient aspects of diet, exercise, and medical care, patients can lead productive lives.

The last two decades of the twentieth century included a remarkable number of pharmaceutical trials involving patients with heart failure. We learned that positive inotropic agents increase mortality, although digoxin was mortality-neutral. Angiotensin-converting enzyme (ACE) inhibitor trials were remarkably uniform in decreasing morbidity and mortality and slowing down remodeling. It is surprising that spironolactone reduced mortality in class IV patients who were already receiving the standard triple therapy of digoxin, diuretics, and ACE inhibitors. Beta blockers reduced mortality in class II and class III patients. Thus, there is now standard quadruple therapy in at least some subsets of patients. The angiotensin receptor blockers emerged as a major drug class in patients with heart failure. The neurohormonal hypothesis of heart failure was validated, and a number of new antagonists are being tested. Despite these advances, sudden death, the mode of death in about half of heart failure patients, remains a challenge.

Diastolic heart failure has emerged as a common disorder, especially in older patients. Such patients remain a challenge to the clinician because we have scant trial data on how best to treat them. A complete understanding of the causes of dilated cardiomyopathy also remains an elusive goal. These are only a few of the challenges facing us in this new century. In any event, this common disorder will command more of our attention in the future and certainly justifies the designation of a week as Heart Failure Awareness Week. The odds are good that each of us will be treating several such patients during that very week.