

FP Essentials

Call for Authors – May 2026

Cardiovascular Disease Update

We are seeking an author or author group to write a manuscript for this edition of *FP Essentials* on the topic of cardiovascular disease. This edition will cover four topics:

1. Hypertension
2. Heart Failure With Preserved Ejection Fraction
3. Heart Failure With Reduced Ejection Fraction
4. Hyperlipidemia

The main text of the manuscript should be approximately 10,000 words in length, divided into four sections of approximately 2,500 words each, plus an abstract of approximately 200 words for each section. In addition, there should be key practice recommendations, a maximum of 15 tables/figures total, and up to 200 references to provide support for all recommendations and factual statements in the manuscript. References must be numbered sequentially by section, with each new section starting over at “1.”

This edition should focus on what is new in each topic and should answer the key questions listed for each section. Each section should begin with an illustrative case, similar to the examples provided, with modifications to emphasize key points; each case should have a conclusion that demonstrates resolution of the clinical situation. The references provided here include information that should be considered in preparation of this edition of *FP Essentials*. However, these should be used only as a starting point in identifying the most current guidelines and references to include in the edition.

Needs Assessment

Family physicians encounter many patients with hypertension and hyperlipidemia in both the inpatient and outpatient settings. It is challenging for family physicians to apply multiple guidelines effectively to minimize the risk of morbidity and mortality for patients. Classifications of hypertension, hyperlipidemia, and heart failure (eg, preserved, reduced, and recovered ejection fractions) continue to confuse clinicians regarding appropriate diagnostic, treatment, and follow-up paradigms. Surveys of family physicians and residents consistently identify gaps in knowledge and confidence in managing these conditions. This edition of *FP Essentials* will provide family physicians with an update on the most current and evidence-based approaches to the diagnosis and management of these common and important cardiovascular conditions.

Section 1: Hypertension

Example Case

TD is a 34-year-old patient with no significant past medical history who presents for an annual physical examination and to establish care in your practice. He has no acute concerns, is physically active, drinks alcohol socially several times per week, and denies tobacco/nicotine and marijuana use. During his office visit today, his blood pressure is 165/92 mmHg, on repeat it is 162/90 mmHg, with a regular pulse of 84 beats per minute. His body mass index is 28 kg/m² and his abdominal waist circumference is 38 inches (97 cm).

Key Questions to Consider

Epidemiology and Pathophysiology

- How common are hypertension and elevated blood pressure readings in adults?
- What pathophysiologic, genetic, and environmental and social factors increase the risk of hypertension?
- What is the dietary relationship among the electrolytes (eg, sodium, potassium, magnesium, calcium) and hypertension?

Clinical Presentation and Diagnosis

Note: clarify the following terms: prehypertension, elevated blood pressure, stage 1 and 2 hypertension, primary and secondary hypertension, severe hypertension, severe asymptomatic hypertension, and hypertensive emergency. Consider using a table.

- How should blood pressure be accurately measured in the ambulatory care setting and at home? What factors can cause blood pressure readings to be inaccurately higher or lower? What new methodologies are available or being developed to more accurately measure blood pressure?
- What factors account for variability in blood pressure measurements, and how much variability is acceptable across readings?
- What are the common clinical presenting signs and symptoms, and physical examination findings, in patients with each of these conditions?
- What physical exam and laboratory assessments are recommended for evaluating patients with hypertension (when assessing complications, etc.)?
- What are the current evidence- and guideline-based criteria for these conditions, according to various organizations (eg, ACC/AHA, ISH, NICE, AAFP)? How do these definitions vary across guidelines? Which guideline criteria are most commonly used for various quality metrics?
- What common medical comorbidities contribute to and commonly coincide with hypertension? How does this vary across men and women?
- What is the recommended cost-effective evaluation for an adult with each of these conditions?

Treatment

- What are the blood pressure goals in different settings (at home, ambulatory, and inpatient)?
- What lifestyle modifications have demonstrated benefit for improving hypertension and helping patients to reach goals, and stop antihypertensive medications?
- What are the current evidence- and guideline-based treatment recommendations for each of these conditions in the ambulatory care setting?

- What are the current evidence- and guideline-based recommendations for treating hypertension in hospitalized patients? What factors affect blood pressure control in the hospital setting?
- How effective are dietary and exercise factors in reducing systolic and diastolic pressures?
- When should a patient be referred to a specialist (eg, cardiologist or nephrologist) for management of secondary or poorly controlled hypertension?
- What complementary and integrative medicine therapies have proven effective in treating hypertension? What are their impacts on cardiovascular morbidity and mortality? How effective is behavioral therapy? Which supplements may raise blood pressure?
- What is the role of telehealth and AI in hypertension management? How effective are these tools?
- How does managing hypertension as a quality metric affect treatment decisions?
- What factors influence adherence to patients taking prescribed antihypertensive medications? Do combination pills and polypills improve adherence and outcomes? What is the impact on cost? Consider using a table to highlight pharmacotherapy.
- After a treatment for hypertension has been prescribed, what is the recommended interval for follow-up until a patient reaches their goal and after they have reached their goal?
- What is the role of ambulatory care pharmacists in the management of hypertension? Have they been shown to be cost-effective and effective in improving practice quality metrics for hypertension management?

Prognosis

- How effective are the various pharmacologic strategies for treating hypertension in achieving goals and reducing cardiovascular morbidity and mortality?
- How is therapeutic response to medication best monitored? How often should monitoring for adverse effects occur (eg, electrolyte abnormalities, elevated creatinine) occur? When should home blood pressure monitoring be recommended?
- How effective are dietary and exercise strategies in patients with hypertension in achieving goals and reducing cardiovascular morbidity and mortality, independent of pharmacologic therapy (eg, in patients who decline anti-hypertensive therapy)?
- What are the short-term and long-term risks of poorly controlled hypertension?
- What is the impact of quitting tobacco/nicotine, alcohol, and/or marijuana on improving hypertension and reaching/maintaining blood pressure goals?

Initial References to Consider

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Section 2: Heart Failure With Preserved Ejection Fraction

Example Case

CP is a 60-year-old patient with a past medical history of hypertension, obesity class 1, and a 40 pack-year history of tobacco use now in remission, who comes to your office with dyspnea on exertion and orthopnea. She has gained 10 pounds in the past few months and reports some swelling in her feet and ankles.

Key Questions to Consider

Definitions, Epidemiology and Pathophysiology

- How is heart failure with preserved ejection fraction (HFpEF) defined?
- How common are these conditions? How does epidemiology vary across gender?
- What pathophysiologic, genetic, environmental, and lifestyle factors increase risk of HFpEF and heart failure with recovered ejection fraction (HFrecEF)?

Clinical Presentation and Diagnosis

- What are the common clinical presenting signs and symptoms, and physical examination findings, in patients with HFpEF and HFrecEF?
- What are the current evidence- and guideline-based criteria for these conditions? How do these definitions vary across guidelines (eg, ACC/AHA, European)? Which guideline criteria are commonly used for various quality metrics? When does an echo finding of diastolic dysfunction constitute HFpEF?
- What are the currently accepted classification categories for clinical heart failure based upon ejection fraction and functional status?
- What is the recommended cost-effective evaluation for a patient who presents with signs and symptoms of heart failure?
- What common medical comorbidities contribute to and commonly coincide with HFpEF and HFrecEF? When should patients with HFpEF be screened for cardiac amyloidosis and what are the recommended tests?

Treatment

- What are the current evidence- and guideline-based treatment recommendations for treatment of acute and chronic HFpEF and HFrecEF (guideline-directed medical therapy [GDMT] with starting and target doses; consider using a table)? Should GDMT be continued or modified for patients with HFrecEF?
- What is the role of GLP-1 agonists and SGLT2 inhibitors in the treatment of HFpEF and HFrecEF?
- What are the current evidence- and guideline-based recommendations for treating acute and chronic HFpEF and HFrecEF in hospitalized patients (GDMT)?
- What lifestyle modifications have demonstrated benefit in improving HFpEF and HFrecEF and helping patients to reach goals, and stop medications?
- How effective are dietary and exercise factors in improving outcomes in HFpEF and HFrecEF?
- When should a patient be referred to a specialist (eg, a cardiologist) for management of HFpEF and HFrecEF?
- What complementary and integrative medicine therapies have proven effectiveness in treating HFpEF and HFrecEF? What are their impacts on cardiovascular morbidity and mortality? Which supplements may worsen volume status?

- What is the role of telehealth and AI in HFpEF and HFrecEF management? How effective are these tools?
- How does managing HFpEF and HFrecEF as a quality metric affect treatment decisions?
- What factors influence adherence for patients taking prescribed medications for HFpEF and HFrecEF? Do combination pills and polypills improve adherence and outcomes? What is the impact on cost? Consider using a table.
- After a treatment for HFpEF and HFrecEF has been prescribed, what is the recommended interval for follow-up until a patient reaches their goal and after they have reached their goal?
- What is the role of ambulatory care pharmacists in the management of HFpEF and HFrecEF? Have they been shown to be cost-effective and effective in improving practice quality metrics for HFpEF and HFrecEF management?

Prognosis

- How effective are the various pharmacologic strategies for treating HFpEF and HFrecEF in achieving goals and reducing cardiovascular morbidity and mortality?
- How is therapeutic response to medication best monitored? When should home weight monitoring be recommended?
- How effective are dietary and exercise strategies in patients with HFpEF and HFrecEF in achieving goals and reducing cardiovascular morbidity and mortality, independent of pharmacologic therapy (eg, in patients who decline therapy for HFpEF and HFrecEF)?
- What are the short-term and long-term risks of poorly controlled HFpEF and HFrecEF?
- What is the impact of quitting tobacco/nicotine, alcohol, and/or marijuana on improving HFpEF and HFrecEF and reaching/maintaining GDMT goals?
- What are effective strategies to prevent hospital admission and readmission in patients with HFpEF and HFrecEF?

Initial References to Consider

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Section 3: Heart Failure with Reduced Ejection Fraction

Example Case

LA is a 64-year-patient with a past medical history of morbid obesity, type 2 diabetes mellitus, hypertension, and cardiometabolic syndrome who comes to your office for a hospital followup visit. He was recently admitted for chest pain, shortness of breath, and lower extremity edema. He had a mild troponin elevation but ruled out for myocardial infarction, received diuretic therapy, and on echocardiogram was found to have a left ventricular ejection fraction of 40%. Upon discharge, he was started on several new medications and dietary restrictions, which he finds confusing to implement in his daily routine.

Key Questions to Consider

Definitions, Epidemiology and Pathophysiology

- How are heart failure with reduced ejection fraction (HFrEF), heart failure with mildly reduced ejection fraction (HFmrEF), and heart failure with recovered ejection fraction (HFrecEF) defined?
- How common is HFrEF? How does its epidemiology vary across gender?
- What pathophysiologic, genetic, environmental, and lifestyle factors increase risk of HFrEF?

Clinical Presentation and Diagnosis

- What are the common clinical presenting signs and symptoms, and physical examination findings, in patients with HFrEF?
- What are the current evidence- and guideline-based criteria for HFrEF? How do these definitions vary across guidelines (eg, ACC/AHA, European)? Which guideline criteria are commonly used for various quality metrics?
- What are the currently accepted classification categories for clinical heart failure based upon ejection fraction and functional status?
- What is the recommended cost-effective evaluation for the patient who presents with signs and symptoms of heart failure?
- What common medical comorbidities contribute to and commonly coincide with HFrEF?

Treatment

- What are the current evidence- and guideline-based treatment recommendations for treatment of acute and chronic HFrEF (guideline-directed medical therapy [GDMT], with starting and target doses; consider using a table)?
- What are the roles of GLP-1 agonists and SGLT2 inhibitors in the treatment of HFrEF?
- What are the current evidence- and guideline-based recommendations for treating acute and chronic HFrEF in hospitalized patients and patients with cardiorenal syndrome?
- What lifestyle modifications have demonstrated benefit in improving HFrEF and helping patients to reach goals, and stop medications?
- How effective are dietary and exercise factors in improving outcomes in HFrEF?
- When should a patient be referred to a specialist (eg, cardiologist) for management of HFrEF? When should an implantable device (eg, cardioverter-defibrillator) or cardiac resynchronization therapy be considered?

- What complimentary and integrative medicine therapies have proven effectiveness in treating HFrEF? What are their impacts on cardiovascular morbidity and mortality? Which supplements may worsen volume status?
- What is the role of telehealth and AI in HFrEF management (eg, cardiomechs, implantable devices)? How effective are these tools?
- How does managing HFrEF as a quality metric affect treatment decisions?
- What factors influence adherence for patients taking prescribed medications for HFrEF? Do combination pills and polypills improve adherence and outcomes?
- After a treatment for HFrEF has been prescribed, what is the recommended interval for follow-up until a patient reaches their goal and after they have reached their goal?
- What is the role of ambulatory care pharmacists in the management of HFrEF? Have they been shown to be cost-effective and effective in improving practice quality metrics for HFrEF management?

Prognosis

- How effective are the various pharmacologic strategies for treating HFrEF in achieving goals and reducing cardiovascular morbidity and mortality?
- How is therapeutic response to medication best monitored? When should home weight monitoring be recommended?
- How effective are dietary and exercise strategies in patients with HFrEF in achieving goals and reducing cardiovascular morbidity and mortality, independent of pharmacologic therapy (eg, in patients who decline therapy for HFrEF)?
- What are the short-term and long-term risks of poorly controlled HFrEF?
- What is the impact of quitting tobacco/nicotine, alcohol, and/or marijuana on improving HFrEF and reaching/maintaining GDMT goals?
- What are effective strategies to prevent hospital admission and readmission in patients with HFrEF?

Initial References to Consider

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Section 4: Hyperlipidemia

Example Case

AZ is a 39-year-old patient who comes to your office to discuss laboratory results obtained from recent life insurance screening tests. She considers herself to be in good health, is a non-smoker, is physically active and avoids fast food, so she was surprised to learn the following results from her laboratory tests: total cholesterol 245 mg/dL, triglycerides 206 mg/dL, high density lipoprotein (HDL) cholesterol 45 mg/dL, non-HDL cholesterol 200 mg/dL, and low density lipoprotein (LDL) cholesterol 159 mg/dL.

Key Questions to Consider

Definitions, Epidemiology and Prevention

- How are the terms “hyperlipidemia”, “dyslipidemia” and “pure/familial hypercholesterolemia” defined?
- How common are these conditions in adults?
- What pathogenetic factors contribute to and predict hyperlipidemia and dyslipidemia?

Clinical Presentation and Diagnosis

- What are the current evidence- and guideline-based recommendations for screening for lipid disorders in adults?
- What common medical comorbidities are often seen in patients with lipid disorders?
- What clinical signs and symptoms may patients exhibit due to hyperlipidemia and dyslipidemia?
- If lipid values are within normal limits, how often should adults be screened based upon their risk factors?
- If lipid values are abnormal, how often should follow up testing occur? What other laboratory studies should be obtained and followed in patients with hyperlipidemia or dyslipidemia?
- When should additional laboratory studies (eg, hsCRP, lipoprotein (a), apolipoprotein B, coronary artery calcium score, etc.) be evaluated in patients with or without elevated lipid values? What is the cost of these additional laboratory studies?

Treatment

- What are the current evidence- and guideline-based pharmacologic options and recommendations for treatment of hyperlipidemia and dyslipidemia, for both primary and secondary prevention of atherosclerotic cardiovascular disease (ASCVD)? When should combination therapy be considered?
- What is the role of nanoparticles in the treatment of lipid disorders?
- What is the role of probiotics in the treatment of lipid disorders?
- What are the current evidence- and guideline-based dietary and exercise recommendations for treatment of hyperlipidemia and dyslipidemia?
- For what level of ASCVD risk should each level of statin intensity be recommended (eg, low-, moderate-, high-intensity)?
- What cardiovascular risk calculators are recommended for predicting cardiac events based upon lipid values and other related factors (eg, Pooled Cohort, QRISK2, ASCVD, PREVENT)? How accurate are they in predicting cardiovascular outcomes? What are their limitations and biases? Which patients are the calculators best suited for, and which ones are excluded?

- What are the mechanisms of action and potential adverse effects of current pharmacologic options for lipid lowering medications? Consider using a table.
- What complementary and integrative medicine therapies have proven effectiveness in lowering lipid values? What are their impacts on cardiovascular morbidity and mortality?
- At what age and comorbidities is lipid-lowering therapy no longer recommended (for primary prevention and for secondary prevention), based upon limited data on favorable outcomes? When should lipid-lowering therapy be discontinued?

Prognosis

- How effective are the various pharmacologic strategies for lipid lowering in reducing cardiovascular morbidity and mortality? How is therapeutic response to medication best monitored?
- How effective are dietary and exercise strategies in patients with hyperlipidemia in reducing cardiovascular morbidity and mortality, independent of pharmacologic therapy (eg, in patients who decline lipid lowering therapy)?

Initial References to Consider

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