2026 European Society of Cardiology Guidelines

On August 28, 2026, the full texts of new clinical guidelines were posted on the official website of the European Society of Cardiology:
• on heart failure (HF);
• on cardiovascular diseases (CVD) and chronic kidney disease (CKD);
• on cardiac rehabilitation (CR);
• the 5th universal definition of myocardial infarction.
During the European Society of Cardiology Congress, held from August 28 to 31, 2026, the provisions of these clinical guidelines were presented to participants in a number of specially organized scientific sessions and served as a basis for active discussions.
As expected, the greatest interest among Congress delegates and physicians worldwide was aroused by the HF guidelines [1].

One of the main changes in these guidelines was the removal of the HF phenotype with mildly reduced (41–49%) left ventricular ejection fraction (EF). The two remaining phenotypes are now defined as HF with reduced (<50%) EF and HF with preserved (≥50%) EF. According to the authors of the guidelines, HF with EF up to 50% has a common pathophysiology and probably requires the same treatment, which has simplified clinical practice.

A division of HF into stages A–D has been adopted, by analogy with the current American HF guidelines:
• Stage A: individuals at risk of developing HF but without signs, symptoms, or structural/functional cardiac abnormalities.
• Stage B: pre-HF — presence of cardiac abnormalities in the absence of signs and symptoms of HF.
• Stage C: symptomatic HF — presence of cardiac abnormalities and current or previous signs and/or symptoms of HF.
• Stage D: advanced (progressive) stage of HF.

This was done to draw the attention of healthcare professionals to the prevention and early diagnosis of HF and to the timely adequate treatment of arterial hypertension, diabetes mellitus, obesity, and other modifiable risk factors that often lead to it.
New classifications of medical and interventional therapy for HF have been introduced:
• foundational medical therapy: medications for a broad range of patients with HF that have a Class I recommendation for reducing the risk of HF hospitalization and/or mortality;
• additional medical therapy: medications with Class IIa/IIb or Class I recommendations aimed at reducing symptom severity/improving quality of life or reducing morbidity or

mortality in certain subgroups of patients with HF;
• guideline-directed interventional therapy: all implantable devices or interventional treatment methods recommended in clinical guidelines.
The term "acute HF" has been abolished and replaced by the term "decompensated HF," since in most cases "acute" HF actually represents a gradual worsening of the condition.
Based on new data from large randomized controlled trials, important changes have been made to recommendations on specific treatment methods. These primarily include Class I recommendations for the use of mineralocorticoid receptor antagonists in HF regardless of EF to reduce the risk of HF hospitalization and/or mortality, as well as Class IIa recommendations for the use of semaglutide or tirzepatide in patients with HF with preserved EF and obesity to reduce body weight and improve exercise tolerance and quality of life (Class IIa).
In patients with HF, gradual uptitration of foundational medical therapy is recommended at least every 1–2 weeks, taking into account symptoms, vital signs, and laboratory data, in order to achieve optimal target doses of the drugs that ensured treatment efficacy with respect to reducing the risk of HF hospitalization or death in randomized controlled trials (Class I).
Recommendations for other treatment methods in specific situations have been updated, for example, on the use of digoxin/digitoxin in HF with EF ≤40% (Class IIa instead of the previous Class IIb), long-term mechanical circulatory support (Class I instead of the previous Class IIa), and transcatheter mitral valve repair (Class I instead of the previous Class IIa).
The recommendations for the management of patients with CVD and CKD were prepared by experts of the European Society of Cardiology for the first time [2]. The text of the recommendations is structured in accordance with the acronym "STAMP" for CKD. STAMP stands for Screen, Triage and Address CKD risk, Modify management of cardiovascular pathology, and Plan healthcare services at the local level. The first three letters of the acronym call on all clinicians, including the cardiology community, to actively identify CKD in order to initiate cost-effective disease-modifying interventions. Such an approach is necessary to reduce the global burden of CVD (acute and chronic coronary syndromes, HF, cardiac arrhythmias, stroke, atherosclerotic peripheral artery disease, sudden cardiac death) and CKD, given the close relationship between them.
S Screening involves determination of estimated glomerular filtration rate (eGFR) and albuminuria in all patients with CVD, including arterial hypertension, coronary heart disease, HF, peripheral atherosclerosis, and stroke. To confirm CKD, repeated determination of eGFR and albumin-to-creatinine ratio is recommended at an interval of at least 3 months.
T Risk stratification and determination of CKD stage should be performed using the generally accepted Kidney Disease: Improving Global Outcomes scale, which takes into account eGFR and/or albuminuria.
A Patients with CKD (not on dialysis) should routinely be offered intensive statin therapy with or without ezetimibe, regardless of blood lipid levels, to reduce the risk of atherosclerotic CVD. To reduce the risk of CKD progression and the development of CVD, most patients are recommended to take angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers, as well as sodium-glucose cotransporter 2 inhibitors.

The latter can be safely initiated at eGFR ≥20 mL/min/1.73 m^2 and continued even if eGFR falls below this level, up until the initiation of renal replacement therapy. Nonsteroidal mineralocorticoid receptor antagonists (finerenone) and glucagon-like peptide-1 receptor agonists (semaglutide) are recommended for patients with CKD, type 2 diabetes mellitus, and albuminuria to reduce the risk of kidney disease progression and cardiovascular complications.

M Modification of the management of patients with CVD may be required when they are combined with CKD. In patients with signs of hypervolemia, adequate doses of loop diuretics or combination diuretic therapy should be used to reduce congestion in decompensated HF and CKD. The increased risk of bleeding in patients with acute coronary syndromes and CKD may influence the choice of antiplatelet therapy regimen and its duration. In patients with atrial fibrillation and CKD with eGFR >30 mL/min/1.73 m^2, direct oral anticoagulants should be preferred over vitamin K antagonists. The use of oral factor Xa inhibitors (apixaban) may be considered in patients with eGFR 15–29 mL/min/1.73 m^2.

P Planning of medical care requires consideration of the specifics of managing patients with CKD. Patients should be informed and educated in an accessible form about the basic concepts of CKD. All physicians should participate in correcting the risks of CVD and CKD progression in order to reduce their overall burden. The healthcare delivery system should be organized in such a way as to identify patients with high-risk CKD and minimize possible delays in prescribing modern treatment to them.

Every third person encounters heart disease during their lifetime. CR is a multidisciplinary, patient-centered, physician-controlled intervention aimed at optimizing the patient's physical, mental, and social functioning and reducing the risk of new adverse events after a heart attack or a diagnosis of heart disease. The purpose of the new European Society of Cardiology guidelines on CR [3] is to provide comprehensive guidance on indications for CR and patient management in phase II CR programs. The document includes a description of requirements for infrastructure, staffing, core components, methods of care delivery, goal setting, and evaluation of CR outcomes. The recommendations apply to adults with CVD, as well as to patients with oncological diseases receiving cardiotoxic therapy or recovering after it.

It is stated that effective CR is not only physical exercise but also maintenance of mental health and educational programs for patients. Improving health literacy and self-management can lead to sustained lifestyle changes and increased adherence to medication.

CR should be considered a core component of treatment for a much broader range of cardiac diseases than is often implemented in clinical practice. The authors of the guidelines emphasize that in addition to generally accepted indications (acute coronary syndromes, chronic coronary syndromes, HF), CR may be useful for patients after surgical or transcatheter aortic valve replacement, with congenital heart defects, atrial fibrillation, or oncological diseases for which potentially cardiotoxic therapy is administered. Frailty, advanced age, and comorbidities are not contraindications to CR. Great attention is paid to comprehensive patient assessment and an individualized, patient-centered approach. CR should correspond to the patient's medical, functional, psychosocial needs, and lifestyle. Patients undergoing CR should be provided with

individualized recommendations on nutrition and body composition control in order to form a healthy diet and reduce cardiovascular risk and mortality. For patients with obesity, comprehensive weight reduction measures combined with strategies to prevent muscle mass loss are critically important, which is necessary to improve metabolic and functional status. A comprehensive approach to smoking cessation, including behavioral counseling, individual education, pharmacotherapy, and follow-up support, is recommended as an integral part of CR to maintain long-term smoking abstinence and improve cardiovascular outcomes. In patients with severe or moderate depression, the possibility of prescribing antidepressants should be considered.

Promoting return to work should be one of the goals of CR, especially for younger patients. To ensure timely and successful return to professional activity, comprehensive measures including counseling and physical training should be considered.

A separate chapter presents telemedicine and digital technologies in CR. The integration of digital tools into CR programs (for example, wearable sensors, smartphone applications, and artificial intelligence-based systems) makes it possible to improve self-management, personalize medical care, increase patient awareness and adherence to treatment, and also ensure early detection of cardiovascular complications, which ultimately contributes to achieving better rehabilitation outcomes.

Adapted CR models, including flexible schedules, home-based or hybrid formats, consideration of cultural characteristics, and age-appropriate support, can increase participation rates and the effectiveness of rehabilitation. CR is intended to empower patients to maintain cardiovascular health throughout their lives. In addition to short-term recovery, it provides the tools, knowledge, and motivation needed to consolidate behavioral changes and control CVD risk factors.

The Fifth Universal Definition of Myocardial Infarction (MI) is a joint statement of the European Society of Cardiology, the American College of Cardiology, the American Heart Association, and the World Heart Federation [4]. It is proposed to identify three clinical types of MI: primary, secondary, and procedure-related, which reflects the underlying pathophysiological mechanisms, corresponds to the clinical assessment of patients' condition, and ensures uniformity in the application of the definition in practical work.

The new classification of MI, which replaced the classification by types 1–5, assumes that MI can develop according to three scenarios. First, MI can occur spontaneously due to acute coronary pathology (primary MI). Previously, type 1 MI was associated exclusively with atherothrombosis, but the new classification of primary MI takes into account all variants of acute coronary pathology, including spontaneous coronary artery dissection, vasospasm, or coronary embolism, which can be detected using imaging and functional tests. This clinical type of MI now includes restenosis, stent thrombosis, and graft rejection more than 30 days after the procedure, since they often represent primary coronary pathology rather than a complication after revascularization.

Second, MI can be a consequence of another acute condition causing an imbalance between myocardial oxygen demand and supply (secondary MI). The diagnosis of secondary MI, which replaced type 2 MI, is confirmed if myocardial ischemia caused by a mismatch between oxygen demand and supply is a consequence of obstructive coronary heart disease without signs of acute coronary pathology and/or myocardial

damage caused by it sufficient to cause a new regional wall motion abnormality or loss of myocardial viability. Objective criteria are proposed for the use of cardiac and invasive or noninvasive coronary imaging methods, which will help reduce uncertainty, ensure uniformity in the diagnosis of secondary MI, and guarantee that the diagnosis will be taken into account when choosing treatment tactics.
Third, MI can occur as a complication of percutaneous or surgical cardiac interventions (procedure-related MI). This clinical type of MI replaces type 4 and type 5 MI and is diagnosed if acute ischemia and myocardial damage are a complication that occurred within 30 days after any cardiac procedure (percutaneous or surgical).
All MIs can be assigned to one of the three described clinical categories. If MI is the probable cause of death (previously called "type 3 MI"), the clinical classification (primary, secondary, procedure-related) should be determined depending on the circumstances or the results of postmortem examination.
The new document specifies upper reference (threshold) values of cardiac troponin for the 99th percentile taking into account sex, and also recommends the use of imaging techniques to determine the etiology of MI using special codes of the International Classification of Diseases, 11th Revision.

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References

1. Køber L, Adamo M, Ruwald AC, al.; ESC Guidelines Advisory Group. 2026 ESC Guidelines for the management of heart failure. Eur Heart J. 2026 Aug 28:ehag100. doi: 10.1093/eurheartj/ehag100. Online ahead of print.
2. Damman K, Ter Maaten JM, Mayne KJ, al.; ESC Guidelines Advisory Group. 2026 ESC Guidelines for the management of cardiovascular disease and chronic kidney disease, in collaboration with the European Renal Association (ERA). Eur Heart J. 2026 Aug 28:ehag098. doi: 10.1093/eurheartj/ehag098. Online ahead of print.
3. Bäck M, Wilhelm M, Marcin T, al.; ESC Guidelines Advisory Group. 2026 ESC Guidelines on cardiac rehabilitation. Eur Heart J. 2026 Aug 28:ehag099. doi: 10.1093/eurheartj/ehag099. Online ahead of print.
4. Mills NL, Newby LK, Zaman S, et al.; ESC/ACC/AHA/WHF Universal Definition Document Advisory Group. Fifth Universal Definition of Myocardial Infarction (2026). Eur Heart J. 2026 Aug 28:ehag101. doi: 10.1093/eurheartj/ehag101. Online ahead of print.