Indonesian Journal of Cardiology
Indonesian J Cardiol • Vol. 47 • 2026
pISSN: 2830-3105 / eISSN: 2964-7304
doi: 10.30701/ijc.2465

Erratum

Erratum: "Bridging HFpEF Across the Care Continuum: From Screening to Phenotyping and Targeted Management"

Vebiona Kartini Prima Putri[1], Siti Elkana Nauli[2], Raja Ezman Faridz Raja Shariff[3]

[1]Awal Bros Pekanbaru Hospital, Riau, Indonesia.
[2]Tangerang District Hospital, Banten, Indonesia.
[3]Department of Medicine, UiTM Faculty of Medicine Sungai Buloh, 47500, Selangor, Malaysia.

*Corresponding author:
Vebiona Kartini Prima Putri
vebiona@gmail.com

In "Bridging HFpEF Across the Care Continuum: From Screening to Phenotyping and Targeted Management" (Indonesian Journal of Cardiology, 47(2), 168-88. https://doi.org/10.30701/ijc.2190), there is an error noted. In the originally published article, Table 3 was inadvertently truncated during the layout process, resulting in some information being omitted from the published version.

The complete version of Table 3 is reproduced below and should replace the incomplete table in the originally published article.

[Before]

Table 3. Treatment strategy for heart failure with preserved ejection fraction.

Treatment Domain	Therapy/ Intervention	Mechanism / Target	Clinical Benefit	Key Evidence
Comorbidity Management	Hypertension control	↓ afterload, ↓ vascular stiffness	↓ HF incidence, disease progression	SPRINT, HYVET
	Diabetes management	Metabolic modulation	Improves outcomes	SGLT2i preferred
	CKD management	Cardiorenal protection	↓ progression, improved outcomes	SGLT2i, finerenone
	CAD management	Anti-ischemic therapy	Symptom relief	No HFpEF-specific RCT
	AF management (rate/ rhythm control)	Improve filling & haemodynamics	↓ symptoms, potential ↓ hospitalization	CABANA, ATHENA (post-hoc)
Foundational GDMT	Loop diuretics	Volume control (decongestion)	Symptom relief, ↓ congestion	No mortality benefit; careful titration required
	SGLT2 inhibitors (empagliflozin, dapagliflozin)	Osmotic diuresis, improved energetics, anti-inflammatory, renal protection	↓ HF hospitalization, improved outcomes	EMPEROR-Preserved, DELIVER; cornerstone therapy
	MRA (spironolactone, finerenone)	Anti-fibrotic, anti-inflammatory, RAAS modulation	↓ HF hospitalization (selected patients)	TOPCAT, FINEARTS-HF
Phenotype-Specific Therapy	Cardiometabolic phenotype	SGLT2i, MRA, blood pressure control	Target inflammation, fibrosis	RAAS-driven phenotype
	Obesity phenotype (semaglutide, tirzepatide)	Weight loss, ↓ inflammation	↑ quality of life, ↑ exercise capacity	STEP-HFpEF, SUMMIT
Non-Pharmacological Therapy	Cardiorenal phenotype	SGLT2i ± MRA	Renal protection, ↓ congestion	Strong benefit across CKD spectrum
	AF phenotype	Rhythm control, anticoagulation	Improve symptoms, prevent stroke	Individualized approach

This table summarizes a practical, phenotype-oriented approach to HFpEF management, integrating comorbidity optimization, guideline-directed medical therapy, and phenotype-specific interventions. Heart failure (HF), chronic kidney disease (CKD), coronary artery disease (CAD), atrial fibrillation (AF), sodium-glucose cotransporter 2 (SGLT2), mineralocorticoid receptor antagonist (MRA), renin-angiotensin-aldosterone system (RAAS), angiotensin receptor neprilysin inhibitors (ARNI).

[After]

Table 3. Treatment strategy for heart failure with preserved ejection fraction.

Treatment Domain	Therapy/ Intervention	Mechanism / Target	Clinical Benefit	Key Evidence
Comorbidity Management	Hypertension control	↓ afterload, ↓ vascular stiffness	↓ HF incidence, disease progression	SPRINT, HYVET
	Diabetes management	Metabolic modulation	Improves outcomes	SGLT2i preferred
	CKD management	Cardiorenal protection	↓ progression, improved outcomes	SGLT2i, finerenone
	CAD management	Anti-ischemic therapy	Symptom relief	No HFpEF-specific RCT
	AF management (rate/ rhythm control)	Improve filling & haemodynamics	↓ symptoms, potential ↓ hospitalization	CABANA, ATHENA (post-hoc)
Foundational GDMT	Loop diuretics	Volume control (decongestion)	Symptom relief, ↓ congestion	No mortality benefit; careful titration required
	SGLT2 inhibitors (empagliflozin, dapagliflozin)	Osmotic diuresis, improved energetics, anti-inflammatory, renal protection	↓ HF hospitalization, improved outcomes	EMPEROR-Preserved, DELIVER; cornerstone therapy
	MRA (spironolactone, finerenone)	Anti-fibrotic, anti-inflammatory, RAAS modulation	↓ HF hospitalization (selected patients)	TOPCAT, FINEARTS-HF
Phenotype-Specific Therapy	Cardiometabolic phenotype	SGLT2i, MRA, blood pressure control	Target inflammation, fibrosis	RAAS-driven phenotype
	Obesity phenotype (semaglutide, tirzepatide)	Weight loss, ↓ inflammation	↑ quality of life, ↑ exercise capacity	STEP-HFpEF, SUMMIT
	Cardiorenal phenotype	SGLT2i ± MRA	Renal protection, ↓ congestion	Strong benefit across CKD spectrum
	AF phenotype	Rhythm control, anticoagulation	Improve symptoms, prevent stroke	Individualized approach
	Chronotropic incompetence	Avoid excessive β-blockade	Improve exercise tolerance	RAPID-HF: pacing not beneficial
	Female-predominant phenotype	ARNI (sacubitril/ valsartan)	↑ natriuretic peptides, ↓ RAAS	↓ HF hospitalization (women subgroup)
	Ischemic phenotype	Anti-anginal therapy	Symptom control	Limited HFpEF-specific data
Non-Pharmacological Therapy	Cardiac rehabilitation	Improve peripheral function and peak oxygen consumption	↑ exercise capacity, ↑ quality of life	Strong evidence in HFpEF
	Lifestyle modification	Weight loss, exercise	Symptom improvement	Essential adjunct

This table summarizes a practical, phenotype-oriented approach to HFpEF management, integrating comorbidity optimization, guideline-directed medical therapy, and phenotype-specific interventions. Heart failure (HF), chronic kidney disease (CKD), coronary artery disease (CAD), atrial fibrillation (AF), sodium-glucose cotransporter 2 (SGLT2), mineralocorticoid receptor antagonist (MRA), renin-angiotensin-aldosterone system (RAAS), angiotensin receptor neprilysin inhibitors (ARNI).

The publisher apologizes for any inconvenience caused by this error.

DOI of the original article: https://doi.org/10.30701/ijc.2190