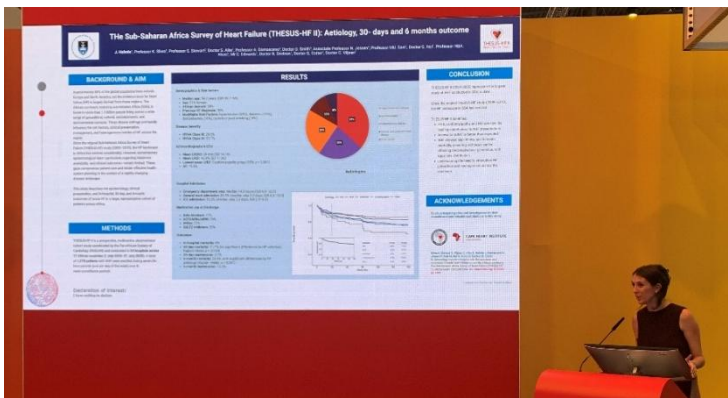


HeFSSA Educational Grant ESC Congress 2026: Feedback Report

HeFSSA is proud to continue its commitment to supporting education, research, and professional development through the Educational Grant Programme. In 2026, the grant was awarded to Dr Julia Hähnle, Medical Doctor and PhD Candidate at the University of Cape Town, to attend the Annual ESC Congress. The report below outlines her experience at the Congress and highlights the educational and professional value derived from this opportunity.

ESC 2026 Reflection by Dr Julia Telse Marie Hähnle



It was an exceptional privilege to attend and present at the ESC Congress this year, which was held from 28–31 August in Munich, Germany. I had the privilege of presenting the findings of the Sub-Saharan Africa Survey of Heart Failure II (THESUS-HF II) on behalf of the investigators, focusing on the clinical characteristics, aetiology, management, and outcomes of acute heart failure (AHF) across a broad range of hospitals in sub-Saharan Africa (SSA). The study provides important insights from an SSA perspective, which remains significantly underrepresented in the global heart failure literature.

I was thrilled by the feedback and questions following the presentation, which were overwhelmingly positive. Prof. Simon Stewart also presented THESUS-HF II regional perspectives, highlighting regional differences in gender, risk factors, and aetiology. His presentation highlighted significant geographical differences and raised important questions about the effects of urbanisation and weather patterns on HF profiles across different regions.

At the same time, our paper, *“Aetiology, management, and outcomes of acute heart failure in 17 African countries (THESUS-HF II): a prospective, multicentre, observational cohort study,”* was published in *The Lancet* on 30 August. This marked an important milestone for HF research in Africa and was a particularly proud moment for the THESUS-HF II and Pan-African Society of Cardiology (PASCAR) team.

Beyond the opportunity to present, the ESC Congress was particularly interesting this year. With more than 33,000 participants, it was exciting to see such a diverse demographic, including people across different age groups and from a wide range of healthcare platforms and settings involved in cardiovascular care.

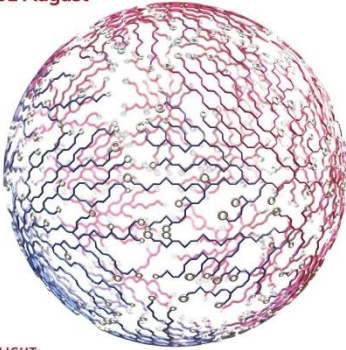
With the increasing integration of AI into healthcare, there were several fascinating discussions about the future use of AI in cardiovascular (CV) care. I found the insights into the democratisation of health data, and how to make healthcare information more accessible to individuals, particularly interesting. The newly adopted European Health Data Space (EHDS) Regulation will give individuals greater access to, and control over, their electronic health data. The regulation will be implemented progressively, with key provisions coming into application from March 2029, initially covering priority categories such as patient summaries and electronic prescriptions.



This shift towards greater patient access to and control of health data will enable individuals to better understand and manage their own information, while making it easier to share data with different healthcare providers and industry. This will likely lead to an increase in healthcare start-ups focused on helping individuals interpret their health data and, ultimately, empowering patients to take greater ownership of their health.

ESC CONGRESS 2026 MUNICH

28-31 August



SPOTLIGHT:
Artificial Intelligence

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Transforming
cardiology,
together

The ESC is also developing a chatbot designed to provide access to evidence-based answers. AI is likely to become integrated into almost every step of the clinical care pathway, and we need to recognise that this will inevitably change the role of healthcare professionals. It will be incredibly interesting to see how this shift develops.

However, there is also significant potential for misuse and misinformation. We need to be careful not to lose the human and social aspects of healthcare or inadvertently deskill ourselves through over-reliance on technology. Even as AI platforms become increasingly sophisticated, healthcare professionals will remain the interface between technology and the patient. We therefore need to educate ourselves and adapt to these developments while ensuring that AI is used responsibly and appropriately.

Another exciting part of the ESC Congress this year was the release of three new clinical practice guidelines, as well as the 5th Universal Definition of Myocardial Infarction, all published on 28 August 2026.

As I continue my PhD, with a focus on HF in Africa, the new 2026 ESC Guidelines for Heart Failure were particularly insightful. The guidelines represent a major update. While they do not completely overturn the approach taken in the 2021 and 2023 guidelines, they reframe HF around disease stages, LVEF, prevention, and earlier intervention, while also updating terminology and treatment recommendations.

One of the key changes is the new approach to classification. HF remains divided according to LVEF into HFrEF ($\leq 40\%$), HFmrEF (41–49%), and HFpEF ($\geq 50\%$). However, the new guidelines also introduce a stronger stage-based framework, emphasising that HF is a disease continuum rather than something that only begins once overt symptoms and congestion develop. The practical message is therefore increasingly one of risk → structural/functional cardiac disease → pre-HF → symptomatic HF → advanced HF. This places considerably greater emphasis on preventing disease progression and identifying patients earlier.

For patients with HFrEF, the four pillars of disease-modifying therapy remain central: ARNI/ACE inhibitor/ARB, β -blocker, MRA, and SGLT2 inhibitor. The key principle remains to initiate all four pillars early, rather than sequentially waiting months to optimise one medication at a time. SGLT2 inhibitors remain foundational because of their benefits across a broad spectrum of LVEF and irrespective of diabetes status.

There has also been an important conceptual shift in the management of HFmrEF and HFpEF. HFpEF is no longer regarded as a condition with essentially no effective pharmacological treatment. SGLT2 inhibitors are now an important component of HF treatment across the EF spectrum, with benefits particularly evident in reducing HF hospitalisation. Management of HFpEF continues to focus heavily on the identification and treatment of associated comorbidities and contributing factors, including hypertension, atrial fibrillation, obesity, diabetes, chronic kidney disease, coronary disease, sleep-disordered breathing, iron deficiency, and physical inactivity. Exercise and rehabilitation, alongside appropriate management of congestion with diuretics, are also important. The approach is therefore increasingly phenotype- and comorbidity-driven, rather than simply viewing HFpEF as a condition requiring diuretics alone.

Another important practical concept is that LVEF can change over time, but treatment should not necessarily be stopped. In patients with previous HFrEF whose LVEF subsequently improves substantially, disease-modifying therapy should generally be continued, as the underlying HF substrate may persist and withdrawal of treatment can result in relapse.

The updated approach to AHF also reinforces the importance of rapid phenotyping, identification of precipitating factors, decongestion, and initiation or optimisation of disease-modifying therapy before discharge, followed by early follow-up. The transition from hospital to outpatient care is particularly important. For my THESUS-HF II work, this is highly relevant, as it reinforces the concept that AHF should not be viewed simply as an isolated hospital event, but rather as an opportunity to alter a patient's long-term trajectory.

Finally, the guidelines place substantial emphasis on multidisciplinary care, including patient education, self-care, exercise and rehabilitation, comorbidity management, medication optimisation, and palliative and supportive care where appropriate. The ESC also explicitly highlights rehabilitation as an important component of modern HF management.

Overall, the updated guidelines reinforce a broader shift in HF care towards earlier identification, prevention of progression, comprehensive phenotyping, rapid optimisation of therapy, and long-term, multidisciplinary management. These principles are particularly relevant to HF in SSA, where delayed presentation, limited access to guideline-directed therapies, and a high burden of comorbidities and diverse aetiologies continue to shape patient outcomes.

This leads to another particularly thought-provoking presentation by Associate Professor Bamba Gaye, who presented *“Global Patterns of Wealth-Related Cardiometabolic Care Cascade Inequalities and Their Impact on Predicted 10-Year Cardiovascular Risk.”* The study showed that wealth-related inequalities tend to widen along the cardiometabolic care cascade, with the greatest disparities occurring at the stage of disease control rather than awareness. Importantly, simply expanding detection without ensuring access to treatment and effective disease control is unlikely to reduce health inequities.

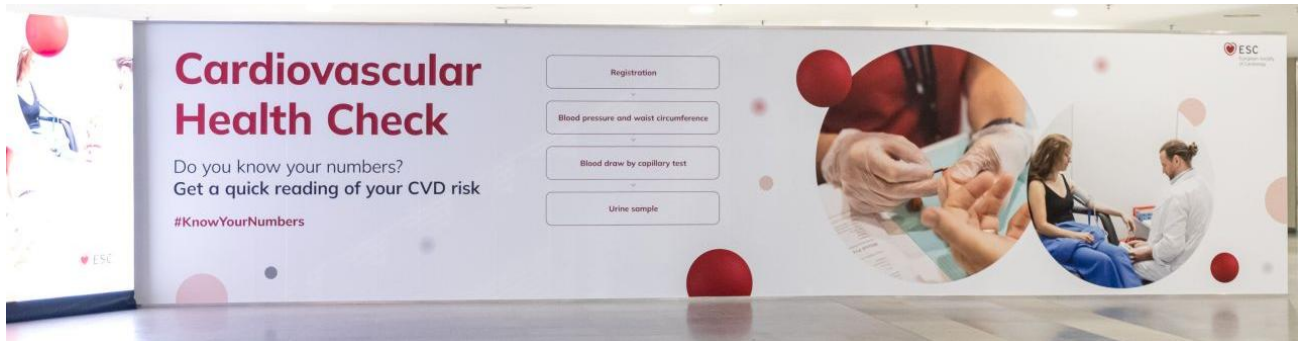
Another interesting finding was that the potential benefit of treatment is driven by baseline cardiovascular risk rather than simply by the size of the treatment gap. This means that countries with the lowest treatment coverage do not necessarily have the greatest potential population-level benefit from expanding treatment. I found this distinction between equity and achievable benefit particularly relevant to my PhD, which focuses on HF in Africa and differences in access to cardiovascular care across sites in SSA.

The findings highlight that improving cardiovascular outcomes requires looking beyond diagnosis and asking what happens throughout the entire care pathway: whether patients can access treatment, whether treatment is appropriately implemented, and whether it ultimately translates into disease control. This reinforces the importance of understanding the differences between healthcare settings and the structural barriers that influence access to cardiovascular care across SSA. Ultimately, it highlights the need to consider not only who is receiving care, but who is being left behind, what their underlying risk is, and where improvements in care could have the greatest impact on outcomes.



Not only was there a wide demographic represented at the Congress, but there was also remarkable representation from countries across the globe. As a proud South African, I found the dedicated session **“Hypertension in Women,”** held jointly with the South African Heart Association (SA Heart®), particularly insightful. I especially enjoyed the presentations on “Heart health challenges during pregnancy in a high-burden setting” by Prof. Mashudu Richard Nethononda and “Drug treatment of hypertension in pregnancy” by Dr Siyolise Sibeko. It was particularly rewarding to see South African clinicians contributing to the global cardiovascular conversation and addressing challenges that are highly relevant to our own setting.

Lastly, and perhaps more personally, was an interesting presentation on the ESC Congress 2025 **Cardiovascular Health Check**, which assessed more than 1,300 healthcare professionals who attended ESC Congress 2025 in Madrid and compared them with age- and sex-matched individuals from the general population.



Although healthcare professionals generally had a healthier cardiovascular risk profile than matched individuals from the general population, the study revealed important gaps in the recognition and management of their own cardiovascular risk factors. Almost half (46.8%) had excess body weight, 23.2% had hypertension, and 22.7% had high cholesterol, while subclinical atherosclerosis was identified in 21.8%. Furthermore, there were striking gaps in guideline-directed preventive treatment. Among eligible healthcare professionals, only 27.6% were receiving antihypertensive treatment, compared with 46.5% of controls, while glucose-lowering treatment was used by 60.0% versus 85.0%, respectively. There were also important gaps in secondary prevention, with only 22.2% of treated healthcare professionals achieving their LDL-C target.

I think the most relevant conclusion is that knowledge does not necessarily translate into implementation. Healthcare professionals know the cardiovascular risk factors and spend their careers advising patients about prevention, yet they experience many of the same barriers to prevention themselves.

I also took part in the second ESC Congress Cardiovascular Health Check this year. Let's see if we can practise what we preach a little better by the next Congress!