

that the authors support the utilization of biomarkers for the detection and monitoring of heart failure, as advocated in our consensus statement.<sup>2</sup> Indeed, natriuretic peptides represent a valuable tool for detecting congestion and monitoring disease progression, complementing rather than replacing comprehensive cardiac assessment. We concur with the insight of Thomas Lewis, who stated that ‘*the very essence of cardiovascular medicine is the recognition of early heart failure*’. In this context, natriuretic peptides play a crucial role, offering important diagnostic and prognostic value. Indeed, natriuretic peptides represent a valuable tool for detecting congestion and monitoring disease progression, complementing rather than replacing comprehensive cardiac assessment.

We acknowledge the authors’ observation regarding the emerging role of handheld ultrasound devices and those with artificial intelligence (AI) capabilities in democratizing cardiac imaging. These technological advances are promising for enhancing bedside assessment and routine monitoring of patients with heart failure and may indeed facilitate more widespread access to cardiac function evaluation in resource-constrained environments. Much to our surprise, the authors appear to endorse the repetition of LVEF measurements—but only when conducted using handheld AI-enabled devices. However, it is not the technology itself that holds primary relevance, but rather the recognition of the dynamic nature of cardiac function. However, whilst we recognize some healthcare system constraints highlighted by the authors, such limitations should not serve as justification for providing sub-optimal care to patients with heart failure. The serial assessment of LVEF remains clinically relevant and evidence-based. It is also specifically recommended in specific scenarios, including post-optimization evaluation of guideline-directed medical therapy, to confirm the candidacy for implantable cardioverter-defibrillator or cardiac resynchronization therapy after optimization of medical therapy and to monitor response to drug-device therapies. Serial assessment of LVEF is also recommended to monitor disease progression in patients with underlying cardiomyopathies or valve disease. These recommendations are supported by current guidelines for heart failure management. The evidence base for these assessments is robust and forms the cornerstone of contemporary heart failure care.

While we appreciate the pragmatic concerns regarding resource allocation and waiting times, we must emphasize that

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**Healthcare system deficiencies should never be employed as justification for delivering sub-standard care to heart failure patients. Letter regarding the article ‘Serial assessment of left ventricular ejection fraction for the management of heart failure: Unnecessary and unrealistic?’**

We read with interest the viewpoint by Palazzuoli *et al.* regarding serial assessment of left ventricular ejection fraction (LVEF) in heart failure management.<sup>1</sup> While we found a disconnect between the title and the content of the viewpoint, we are pleased to note

healthcare system deficiencies should never be employed as justification for delivering sub-standard care to heart failure patients. Rather than accepting limitations, we should advocate for improved resources, training, and infrastructure to ensure that all patients receive evidence-based, guideline-recommended care.

The goal of optimal heart failure management requires a comprehensive approach that incorporates both biomarker assessment and appropriate imaging studies when clinically indicated. We must not allow resource constraints to compromise the standard of care that our patients deserve and that evidence-based medicine demands.

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