Heart Failure Staging — ACC/AHA vs NYHA

Two Systems, One Patient — How They Work Together

Every HF patient is described by two classification systems simultaneously. The **ACC/AHA stages** track disease progression — structural and biological changes that are permanent. The **NYHA classes** track functional status today — how the patient feels right now. They answer different questions. You need both.

Part 1 — ACC/AHA Stages: Where Is the Disease?

ACC/AHA stages describe the natural history of heart failure. They move in only one direction: forward. A patient who improves clinically is still the stage they reached — stages do not reverse.

Stage	Definition	Clinical Meaning
A	At risk; no structural disease, no symptoms	Hypertension, diabetes, CAD, cardiotoxin exposure, family history of cardiomyopathy. Heart is structurally normal.
B	Structural disease; no current or prior symptoms	Reduced LVEF (≤40%), LV hypertrophy, wall motion abnormality, elevated filling pressures — but the patient has never had HF symptoms. Pre-HF.
C	Structural disease with current or prior symptoms	The dominant clinical population. Patient has had symptomatic HF at some point. Remains Stage C even if now asymptomatic on GDMT.
D	Advanced/refractory HF	Marked symptoms interfering with daily life; recurrent hospitalizations despite attempts to optimize GDMT. Requires consideration of advanced therapies (LVAD, transplant, palliative care).

Key fact: Stage B is not a diagnosis of heart failure — it is pre-HF. With optimal treatment of risk factors and structural disease, some Stage B patients never develop symptoms. Stage still does not reverse.

Part 2 — NYHA Classes: How Does the Patient Feel Today?

NYHA classes describe functional capacity at this point in time. They fluctuate with treatment, disease activity, and adherence. A patient can move from Class III to Class I with effective therapy — and back to Class III with decompensation.

Class	Definition	Clinical Meaning
I	No symptoms with ordinary activity	No limitation. Ordinary physical activity does not cause fatigue, dyspnea, or palpitations.
II	Slight limitation; symptoms with moderate exertion	Comfortable at rest. Ordinary activity (climbing stairs, walking briskly) produces symptoms.
III	Marked limitation; symptoms with minimal exertion	Comfortable at rest. Less than ordinary activity (getting dressed, walking across a room) causes symptoms.
IV	Symptoms at rest	Unable to carry on any physical activity without symptoms. Symptoms may be present at rest.

Key fact: NYHA class guides GDMT dose titration, device therapy eligibility, and endpoint tracking in clinical trials. It does not determine whether to continue therapy.

Part 3 — How They Coexist

ACC/AHA stage and NYHA class are independent. Any combination is possible, and understanding the combination tells you where the patient is and what they need.

ACC/AHA Stage	NYHA Class	What This Looks Like
B	—	No NYHA class assigned. Patient has structural disease but has never been symptomatic. No HF diagnosis yet.
C	III	Newly diagnosed HFrEF. Symptomatic on minimal exertion. On GDMT but not yet at target doses.
C	I	Stage C patient now on optimized GDMT. Feels well. No exertional symptoms. Still Stage C — GDMT must continue.
D	I	Patient with advanced HFrEF on LVAD or cardiac transplant. Functionally well, but disease is Stage D by history and biology.
D	IV	End-stage HF not responding to GDMT. Symptoms at rest. Candidate for palliative care or advanced therapies.

> **Stage D ≠ Class IV.** A patient on optimal GDMT with an LVAD may be Stage D (advanced disease by structural and historical criteria) but functional Class I (no symptoms). Stage tracks biology. Class tracks function. They are not the same question.

How guidelines use each system:

System	Primary Clinical Use
ACC/AHA Stage	Drives treatment decisions: when to start GDMT, when to refer for device evaluation, when to initiate advanced HF specialist involvement. Stage C with LVEF ≤35% after ≥3 months of GDMT triggers ICD evaluation regardless of NYHA class.
NYHA Class	Drives dose titration, endpoint tracking, and eligibility criteria for specific therapies. ARNI is indicated for NYHA Class II–III. CRT requires NYHA Class II–IV. Ivabradine requires Class II–III. Class IV triggers palliative care discussion.

CLINICAL RULE

ACC/AHA stage tells you where the patient is in the natural history of their disease.

NYHA class tells you how they feel today.

Use both. A patient who improves from Class III to Class I is still Stage C — do not stop their GDMT.

APP Specialist Academy Free Reference Series. Based on: 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure (Heidenreich et al.); 2024 ACC Expert Consensus Decision Pathway for HFrEF (Maddox et al.).