GUIDELINE BRIEFING / SEPTEMBER 2026

What Changed in 2026

Four documents published between August 2025 and August 2026 change what a correct answer looks like — in the clinic, in a report, and in a viva. This briefing covers what moved, why, and what you have to stop saying.

The short version

Myocardial infarction is no longer typed 1 to 5. Three clinical categories replace them: primary, secondary and procedure-related.

HFmrEF no longer exists. Heart failure is now HFrEF below an ejection fraction of 50 per cent, and HFpEF at 50 per cent and above.

Asymptomatic severe aortic stenosis can now be intervened on in carefully selected patients, as a class IIa recommendation.

Two entirely new ESC guidelines exist — cardiac rehabilitation, and cardiovascular disease in chronic kidney disease.

1. Fifth Universal Definition of Myocardial Infarction

Published jointly by the ESC, ACC, AHA and WHF and presented at ESC Congress 2026 in Munich, 28-31 August 2026. Endorsed by EACTS and STS, with affirmation of value by SCAI.

WHAT MOVED	NOW

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Sudden death	The old type 3 is gone and is replaced by two coded outcomes. Sudden death *without* evaluation — age over 40, preceding chest pain or equivalent, known coronary disease, or ventricular fibrillation with no known cardiomyopathy or channelopathy — is coded **unspecified myocardial infarction**. Sudden death with *incomplete* evaluation — ischaemic symptoms, ST-segment change, or a regional wall motion abnormality — is coded **myocardial infarction of unknown aetiology**. Both routes then prompt autopsy or post-mortem imaging.

2. 2026 ESC Guidelines for the management of heart failure

A restructuring rather than an incremental revision, published alongside the Second Universal Definition of Heart Failure (2026).

WHAT MOVED	NOW
Phenotypes	Three become two. **HFrEF is an ejection fraction below 50 per cent. HFpEF is 50 per cent and above.** The mildly reduced category, 41 to 49 per cent, is removed.
Why	Patients formerly classified as mildly reduced share pathophysiology and treatment response with the reduced group rather than the preserved group. A single cut-off simplifies the decision at the bedside.
Structure	A staging approach is introduced, running from prevention in at-risk patients through to advanced heart failure, with recommendations across the whole spectrum.
Vocabulary	**Acute heart failure** becomes **decompensated heart failure**. **GDMT** is retired in favour of foundational, additional and guideline-informed therapy terminology. Both changes travel with the phenotype change.
What to stop saying	HFmrEF, acute HF and GDMT. Every teaching slide, structured report dropdown, protocol and revision note that carries them is now out of date.

3. 2025 ESC/EACTS Guidelines on valvular heart disease

WHAT MOVED	NOW
Asymptomatic severe aortic stenosis	A new class IIa recommendation, level of evidence A, for intervention in carefully selected patients with genuinely asymptomatic severe disease. Watchful waiting is no longer the automatic answer.
Grading severity	Integrated assessment is reaffirmed: gradients, valve area, flow state and ventricular function together. Low-flow states are more clearly categorised and sex-specific stroke volume thresholds are endorsed.
Discordant cases	CT aortic valve calcium scoring is given a defined role where echocardiographic findings disagree.
Structure of care	The Heart Team and Heart Valve Centres are placed centrally, with clearer criteria for complex and multi-valve disease.

4. Two entirely new ESC guidelines

DOCUMENT	WHAT IT DOES
Cardiac rehabilitation (first edition, 2026)	The first dedicated ESC guideline on the subject. It sets out the benefits, including quality of life, and extends rehabilitation beyond the traditional post-infarction population to congenital heart disease, atrial fibrillation, heart valve replacement and cancer-therapy-related cardiac complications.

DOCUMENT	WHAT IT DOES
Cardiovascular disease and chronic kidney disease (first edition, 2026)	The first dedicated ESC guideline linking the two. Its headline instruction is that every patient with heart disease should be assessed for kidney disease — a screening obligation, not an optional extra.

If you are sitting an examination in the next twelve months

Examiners follow guidelines with a lag, and candidates are caught in both directions — quoting a superseded classification, or quoting a new one the examiner has not yet absorbed.

Name both, but **do not treat secondary infarction as a straight rename of type 2**. It is a narrower subset: vasospasm, SCAD and coronary embolism were type 2 events and are now *primary*. For a demand-ischaemia case say *"secondary myocardial infarction under the Fifth Universal Definition — supply-demand imbalance, which would have fallen under the old type 2"*. For a SCAD case, say primary.

The same applies to HFmrEF. Say *"ejection fraction 45 per cent, which the 2026 ESC guidelines classify as HFrEF"* rather than relying on either label alone.

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Scope. A summary briefing for qualified clinicians and clinicians in training, prepared from the published guideline documents and from society reporting of ESC Congress 2026. It is a signpost, not a substitute for the full texts, and it does not reproduce the recommendation tables, classes or levels of evidence in full. Read the primary documents before changing practice.

Principal sources. Fifth Universal Definition of Myocardial Infarction (2026), ESC/ACC/AHA/WHF, published simultaneously in European Heart Journal, Circulation, JACC and Global Heart — the Global Heart version (doi 10.5334/gh.1578) is open access. Note that it is a consensus statement rather than a guideline, and states that it should be applied alongside national and regional practice guidelines. 2026 ESC Guidelines for the management of heart failure, and the Second Universal Definition of Heart Failure (2026). 2025 ESC/EACTS Guidelines for the management of valvular heart disease. 2026 ESC Guidelines on cardiac rehabilitation, and on cardiovascular disease and chronic kidney disease. All at escardio.org/guidelines.