

Corrigendum to ‘ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure 2008’ [Eur Heart J 2008;29:2388–2442 and Eur J Heart Fail 2008;10:933–989]

The Task Force for the Diagnosis and Treatment of Acute and Chronic Heart Failure 2008 of the European Society of Cardiology. Developed in collaboration with the Heart Failure Association of the ESC (HFA) and endorsed by the European Society of Intensive Care Medicine (ESICM)

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The European Society of Cardiology and the publishers regret that a table containing errors was published in these Guidelines. Table 22 (page 2412 in the *European Heart Journal* and page 957 in the *European Journal of Heart Failure*) should be replaced by the table below (the errors are identified by red type). The corrected table appears in the online editions of *European Heart Journal* and *European Journal of Heart Failure*.

Table 22 Diuretic dosages in patients with heart failure

Diuretics	Initial dose (mg)		Usual daily dose (mg)	
Loop diuretics*				
• Furosemide	20–40		40–240	
• Bumetanide	0.5–1.0		1–5	
• Torasemide	5–10		10–20	
Thiazides**				
• Bendroflumethiazide	2.5		2.5–10	
• Hydrochlorothiazide	25		12.5–100	
• Metolazone	2.5		2.5–10	
• Indapamide [†]	2.5		2.5–5	
Potassium-sparing diuretics***				
	+ACEI/ARB		+ACEI/ARB	
• Spironolactone/epplerenone	12.5–25		50	
	–ACEI/ARB		–ACEI/ARB	
• Amiloride	2.5		20	
• Triamterene	25		100	
			100–200	
			40	
			200	

*Dose might need to be adjusted according to volume status/weight; excessive doses may cause renal impairment and ototoxicity.

**Do not use thiazides if eGFR <30 mL/min, except when prescribed synergistically with loop diuretics.

***Aldosterone antagonists should always be preferred to other potassium-sparing diuretics.

[†]Indapamide is a non-thiazide sulphonamide.