MATTERS OF THE HEART

CLINICAL REVIEW DRAFT / NOVEMBER 4, 2026

A Community Education Toolkit on

Transthyretin Amyloid Cardiomyopathy (ATTR-CM)

KNOW YOUR HEART. KNOW THE SIGNS.

A Resource for Pastors, First Ladies, Health Ministries, Sorority & Fraternity Health Chairs, Barbershop & Salon Networks, Senior Group Leaders, and Community Champions

THE HEALTHY HEART COMMUNITY PREVENTION PROJECT

presented in partnership with community and clinical organizations

Developed by Healthy Heart Community Prevention Project

For use in congregations, organizations, and community networks

This toolkit is educational, not diagnostic. It is designed to help community leaders raise awareness so members can recognize warning signs and start informed conversations with their own doctors. It does not replace medical advice, diagnosis, or treatment.

About this review edition Original toolkit wording is retained. Clearly labelled notes flag claims needing clinical or editorial correction. Ms. Daphne and Dr. Ferdinand must review the content before distribution.

USING THE TOOLKIT

How to Use This Toolkit

You don't need a medical background to lead a life-changing conversation. This toolkit was built so that trusted community leaders - the people members already listen to and trust - can teach the basics of ATTR-CM in plain language and help members know when and how to seek care.

What's Inside

- Section 1 - What Is ATTR-CM? A plain-language explanation of the condition.
- Section 2 - Why This Matters for Our Community The health equity case for paying attention.
- Section 3 - Signs & Symptoms What to watch for, inside and outside the heart.
- Section 4 - When to Seek Care How to know it's time to talk to a doctor.
- Section 5 - What to Ask Your Doctor A self-advocacy script members can bring to appointments.
- Section 6 - The Path to Diagnosis What testing actually looks like, step by step.
- Section 7 - Facilitator's Guide A ready-to-use session plan, agenda, and discussion questions.
- Section 8 - Take-Home Quick Reference Card A one-page summary members can keep.
- Section 9 - Glossary Plain-language definitions of medical terms used in this toolkit.

Ground Rules for Leading This Conversation

- Lead with hope, not fear. The goal is early recognition and empowerment, not alarm.
- You are not diagnosing anyone. You are helping people recognize patterns worth asking a doctor about.
- Respect privacy. Some members may recognize symptoms in themselves or a loved one during the session - allow space for that without putting anyone on the spot.
- Encourage self-advocacy. Many members grew up learning not to question a doctor. Part of your role is giving them permission and language to ask questions.
- Know your limits. If someone shares a personal health concern, thank them for trusting you and encourage them to follow up with their own physician - don't attempt to advise on their specific situation.

Review edition note

The review notes are editorial additions, not part of the original toolkit and not clinician approval. The original Word document remains unchanged. Do not distribute this annotated draft or detach the quick-reference card for public use before review.

SECTION 1

What Is ATTR-CM?

ATTR-CM stands for transthyretin amyloid cardiomyopathy. That's a mouthful - so let's break it into plain language, one piece at a time.

Breaking Down the Name

- Transthyretin (TTR): a protein made mostly by the liver. Think of it like a delivery truck that carries vitamin A and thyroid hormone through your bloodstream.
- Amyloid: the name for abnormal protein clumps that build up in the body and don't belong there.
- Cardiomyopathy: a disease of the heart muscle itself - the muscle has trouble squeezing or relaxing the way it should.

Normally, TTR protein travels through the blood in a stable, folded shape. In ATTR-CM, the protein comes apart and refolds incorrectly. The misfolded pieces stick together into tiny clumps called amyloid fibrils. Those fibrils build up inside the walls of the heart, making the heart muscle stiff - like a sponge that's been replaced with cardboard. A stiff heart can't relax and fill with blood properly, and over time it struggles to pump enough blood to the rest of the body.

Simple way to explain it to your group: “Imagine gutters on a house slowly filling up with debris. The house still stands, but water can't flow through the way it should. That's similar to what happens inside the heart with ATTR-CM - deposits build up and the heart can't do its job as well.”

Two Types of ATTR-CM

- Hereditary (also called ATTRv, “v” for variant): caused by a change (mutation) in the TTR gene that a person is born with and can pass on to their children. This is the type most relevant to Black communities (see Section 2).
- Wild-type (also called ATTRwt): not inherited - it happens when normal TTR protein simply becomes unstable with age. It's most common in men over age 70.

Review note: ancestry and disease type (M2)

V142I is associated with African ancestry, but race or ethnicity does not establish a person's genotype. The variant also occurs in Hispanic/Latino populations. Both hereditary and wild-type ATTR-CM affect Black adults; ancestry or age alone should not rule the condition in or out. [S2, S3]

Why It's Often Missed

ATTR-CM is frequently mistaken for more common conditions like high blood pressure-related heart disease, ordinary aging, or general heart failure. Its symptoms overlap heavily with other conditions, and there's no single obvious sign that says “amyloid.” Research shows people often live with symptoms for years before getting an accurate diagnosis - one study found a mean delay of over six years from first symptoms to diagnosis for the wild-type form. That's exactly why community awareness matters: the earlier it's suspected, the sooner someone can get properly tested.

Editorial source check (E1)

The historical "mean delay of over six years" needs a named study and date. Diagnostic-delay estimates vary by study and time period. Confirm the citation before public use.

SECTION 2

Why This Matters for Our Community

ATTR-CM is not evenly distributed across the population. The hereditary form is disproportionately common among people of West African descent - which includes most Black Americans - making this a health equity issue as much as a medical one.

The Numbers

- A specific change in the TTR gene, known as V142I (also written as V122I), is carried by an estimated 3 to 4% of Black Americans.
- That translates to roughly 1.5 to 1.6 million Black Americans nationwide who carry this gene change.
- This gene variant is found almost exclusively in people of West African descent - it is a genetic thread connecting many Black American families, whether they know it or not.
- The gene change is passed down in what's called an autosomal dominant pattern - if a parent carries it, each of their children has roughly a 50% chance of inheriting it.

Important nuance: Carrying the gene change does not guarantee someone will develop ATTR-CM, and not everyone who carries it will develop symptoms. But carriers do have meaningfully elevated risk, especially as they age - which is exactly why awareness and family history conversations matter.

Review note: carriers are not diagnoses (M1)
The 3-4% figure describes carriers of one TTR variant, V142I/V122I, not the percentage of Black Americans with ATTR-CM. A carrier may never develop symptoms; risk increases with age. The national carrier count is an approximate estimate, not a count of diagnosed cases. [S1]

Review note: ancestry wording (M2)
The ancestry statements need review. V142I is not exclusive to one racial or ethnic group, and Black adults can have either hereditary or wild-type ATTR-CM. [S2, S3]

SECTION 2

Why This Matters for Our Community

Why Under-Diagnosis Hits Our Community Hardest

- Symptoms are frequently misattributed to more common conditions like hypertension, general aging, or “just getting older and slowing down.”
- Because the condition is under-recognized by many clinicians, testing is often not offered unless a patient or family specifically raises the possibility.
- Historical and ongoing mistrust of the medical system, rooted in real harms, can make some community members less likely to push for further testing or a second opinion - which makes self-advocacy tools even more essential.
- Because it's hereditary, one missed diagnosis can mean an entire family remains unaware of a risk that could be identified and monitored early.

The Empowerment Message

This is not a call to fear - it's a call to knowledge. Knowing this history means a community leader can help members connect dots that a rushed clinical visit might miss: a grandfather with unexplained heart failure, an aunt with carpal tunnel surgery on both hands, a father who “slowed down” in his 70s and was told it was just old age. Naming the pattern out loud, in a trusted setting, is often the first step toward a correct diagnosis.

Editorial source check (E2)

The comparative and causal claims about underdiagnosis, access to testing and mistrust need supporting sources and clinical-editor review. These statements are retained from the original draft rather than newly verified here.

SECTION 3

Signs & Symptoms to Watch For

ATTR-CM symptoms show up in two categories: symptoms of the heart struggling, and “red flag” clues elsewhere in the body that often show up years before the heart symptoms do. Teaching both categories - and especially the connection between them - is one of the most valuable things a community leader can do.

Heart & Circulation Symptoms

☐ Shortness of breath - with activity, or even lying flat or resting

☐ Swelling in the legs, ankles, feet, or belly (fluid buildup)

☐ Unusual fatigue or feeling “wiped out” doing things that used to be easy

☐ Irregular or noticeably fast/slow heartbeat, or palpitations (a fluttering or pounding feeling)

☐ Dizziness or fainting, especially when standing up

☐ A heart that looks enlarged or thick-walled on an echocardiogram or EKG, even without high blood pressure to explain it

Review note: echo versus EKG (M3)

An echocardiogram measures heart-wall thickness. An EKG records electrical activity and may provide clues, but it does not directly show or measure thickened heart walls. [S4]

☐ Heart failure that isn't improving as expected with standard treatment

“Outside the Heart” Red Flag Clues

These symptoms often appear years before heart symptoms and are among the most important clues, especially when they show up alongside heart symptoms or run in the family:

☐ Carpal tunnel syndrome - especially in both hands, or requiring surgery

☐ Spinal stenosis (narrowing of the spinal canal, causing back or leg pain)

☐ Ruptured biceps tendon, especially without an obvious injury

☐ Numbness, tingling, or pain in the hands or feet (peripheral neuropathy)

☐ Lightheadedness or fainting related to blood pressure drops (autonomic nervous system involvement)

☐ Unexplained weight loss

☐ Unusual bruising

Review note: bruising is not ATTR-specific (M4)

Unusual bruising has many causes and is not a specific ATTR-CM sign. Bruising around the eyes is a recognized clue to AL amyloidosis, a different condition requiring prompt medical evaluation. [S4, S5]

The pattern to teach your group: one symptom alone rarely means much. It's the combination - especially heart failure symptoms PLUS a history of carpal tunnel surgery, spinal stenosis, or a family member with unexplained heart failure - that should prompt a conversation with a doctor.

Safety clarification (M5)

Even one severe or sudden symptom can be urgent. Do not wait for a symptom combination. Follow the emergency clarification in Section 4. [S6, S7]

SECTION 4

When to Seek Care

You don't need to wait for a crisis. Encourage members to schedule a conversation with their doctor if any of the following apply - this is not an emergency checklist, it's an “it's time to ask” checklist.

Time to Talk to a Doctor If...

☐ You have ongoing heart failure symptoms (shortness of breath, swelling, fatigue) that haven't been fully explained, or that haven't improved with standard treatment

☐ You've had carpal tunnel syndrome in both hands, especially if you've also had heart symptoms

☐ You've had spinal stenosis or a biceps tendon rupture along with heart symptoms

☐ A parent, sibling, or child has been diagnosed with ATTR-CM, cardiac amyloidosis, or unexplained heart failure

☐ You are a Black man or woman over 60 with heart failure symptoms that don't have a clear explanation

☐ Your heart looks thickened on a scan, but your blood pressure has never been high enough to explain it

Review note: checklist limits (M2)

The checklist is not a screening rule. Ancestry or age alone should not rule ATTR-CM in or out, and symptoms can have many causes. [S2, S3]

When to Seek Care Right Away

Some symptoms warrant prompt medical attention rather than waiting for a routine appointment. Encourage members to seek care the same day, or call 911, if they experience:

☐ Sudden or severe shortness of breath, especially at rest

☐ Chest pain or pressure

☐ Fainting or loss of consciousness

☐ A rapid or irregular heartbeat that doesn't resolve

☐ Sudden, severe swelling

Safety clarification: emergency versus urgent care (M5)

Do not wait for a symptom combination. Call 911 for chest pain or pressure, severe trouble breathing, fainting, or a rapid/irregular heartbeat with chest pain, breathlessness or fainting. These are not symptoms to defer to a same-day appointment. New or worsening swelling or a persistent heartbeat change without emergency symptoms needs prompt clinician advice. [S6, S7]

Facilitator note: Make clear that this toolkit is about recognizing patterns and starting conversations - not self-diagnosing. The goal is to move someone from “I didn't think anything of it” to “I'm going to ask my doctor about this.”

SECTION 5

What to Ask Your Doctor

What to Ask Your Doctor: A Self-Advocacy Script

Many people - especially in our community - were raised to not question a doctor. Part of this toolkit's purpose is giving members permission and exact language to advocate for themselves. Encourage members to bring this page (or the take-home card in Section 8) to their appointment.

Opening the Conversation

"I've learned that some cases of heart failure are caused by a condition called ATTR-CM, or cardiac amyloidosis, which is more common in Black Americans. Could this be a possible explanation for what I'm experiencing?"

Review note: wording of the opening script (M2)

ATTR-CM is one form of cardiac amyloidosis. The ancestry statement should refer to a specific inherited variant rather than implying that all cardiac amyloidosis is more common in Black Americans. [S2, S3, S4]

"I have [carpal tunnel syndrome / spinal stenosis / a biceps tendon rupture] along with my heart symptoms - could these be connected?"

"A member of my family had unexplained heart failure. Is that something I should be evaluated for, given my own symptoms?"

Specific Questions to Ask

- “Can I be evaluated for cardiac amyloidosis, or ATTR-CM specifically?”
- “Would a PYP scan (a type of nuclear heart scan) or a cardiac MRI be appropriate to help rule this in or out?”
- “Should I have blood or urine testing to rule out a different, related condition called light chain amyloidosis before moving forward?”

Review note: test questions (M6)

PYP and cardiac MRI are not interchangeable confirmation tests. The AL screen requires serum free light chains plus serum and urine immunofixation. The treating clinician selects and interprets testing. See the detailed clarifications in Section 6. [S4, S5, S8]

SECTION 5

What to Ask Your Doctor

- "Given my background, should I be offered genetic testing for the TTR gene variant?"
- "If I test positive, should my children or siblings also be tested or counseled?"

Review note: genetic testing has a different purpose (M8)

A TTR gene test identifies an inherited variant; it does not by itself diagnose active ATTR-CM. After ATTR-CM is confirmed, genetic testing distinguishes hereditary from wild-type disease. Family testing and genetic counseling depend on finding an inherited disease-causing variant, not simply a positive heart scan. [S3, S10]

- "If this is confirmed, what treatment options are available to slow it down?"
- "Is there a cardiologist who specializes in amyloidosis or heart failure that I could be referred to?"

What to Bring to the Appointment

☐ A written timeline of symptoms - when they started and how they've changed

☐ A list of any non-heart symptoms (carpal tunnel, nerve pain, tendon issues)

☐ Family health history - especially any relatives with heart failure, an enlarged heart, or an amyloidosis diagnosis

☐ This toolkit or the take-home reference card

☐ A trusted friend or family member, if possible, for support and a second set of ears

Remind your group: asking these questions is not being difficult - it's being an informed patient. A good clinician will welcome the conversation. If a concern is dismissed without explanation, it's reasonable to seek a second opinion, especially from a cardiologist.

SECTION 6

The Path to Diagnosis

The Path to Diagnosis, Step by Step

Members often feel more empowered walking into an appointment when they know what the process might look like. Here is the general pathway, explained simply. (Every case is different, and a clinician may adjust this order.)

Step 1 - Share your story: describe your symptoms, timeline, and family history to your doctor. This is where the self-advocacy questions from Section 5 come in.

Step 2 - Rule out the “cousin” condition: a simple blood and urine test checks for a different, related condition called light chain (AL) amyloidosis, which needs to be ruled out early because it's treated very differently.

Review note: the complete AL screen (M7)
The initial AL screen includes serum free light chains plus serum AND urine immunofixation. Routine blood work or protein electrophoresis alone is insufficient. Abnormal results require specialist interpretation and may require biopsy; they do not by themselves prove AL. AL must be assessed before relying on a PYP scan to diagnose ATTR-CM. [S4, S5]

Step 3 - Look at the heart's structure: an echocardiogram (an ultrasound of the heart) checks wall thickness and how well the heart is relaxing and pumping.

Step 4 - A specialized scan: a nuclear scan called a PYP (pyrophosphate) scan, or sometimes a cardiac MRI, can detect TTR amyloid in the heart. In many cases, this scan - combined with the blood work from Step 2 - can confirm ATTR-CM without needing a heart biopsy.

Review note: PYP and MRI have different roles (M6)
Cardiac MRI can show evidence of cardiac amyloidosis but cannot establish the amyloid type. A correctly performed PYP scan, including SPECT imaging, can support a non-biopsy ATTR-CM diagnosis when uptake meets diagnostic criteria and AL amyloidosis has been excluded. MRI and PYP are not interchangeable confirmation tests. [S8, S9]

Step 5 - Genetic testing: a simple blood test can determine whether the hereditary (variant) form is present. This matters not just for the patient, but for their children, siblings, and parents, who may benefit from genetic counseling and their own testing.

Review note: genetic testing has a different purpose (M8)
A TTR gene test identifies an inherited variant; it does not by itself diagnose active ATTR-CM. After ATTR-CM is confirmed, genetic testing distinguishes hereditary from wild-type disease. Family testing and genetic counseling depend on finding an inherited disease-causing variant, not simply a positive heart scan. [S3, S10]

SECTION 6

The Path to Diagnosis

On Treatment

There is no cure for ATTR-CM, but treatment has changed dramatically in recent years. Medications now exist that are specifically designed to stabilize the TTR protein and slow the disease's progression, and additional therapies are in active development. Existing heart damage generally cannot be reversed - which is exactly why early diagnosis matters so much. The earlier ATTR-CM is caught, the more treatment options are available and the more heart function can be preserved.

Key message for your group: a diagnosis today is not the same as a diagnosis was ten years ago. There is real reason for hope - but only if the condition is found.

Treatment update: checked November 2026 (M9)

U.S. treatment options now include TTR stabilizers tafamidis and acoramidis, and the TTR silencer vutrisiran. Treatment choice is individual. Earlier diagnosis can preserve the opportunity for treatment, but does not guarantee a particular option, reversal of heart damage or a specific outcome. [S5, S11, S12]

SECTION 7

Facilitator's Guide

Facilitator's Guide: Leading an Education Session

This section is for you, the community leader. It offers a ready-to-use structure so you can confidently lead a 45-60 minute session with your congregation, chapter, or network.

Before the Session

- Print or share the take-home Quick Reference Card (Section 8) for each attendee.
- Arrange the room so people can see and hear each other - this works best as a conversation, not a lecture.
- If possible, invite a local clinician, nurse, or health educator to co-facilitate or field detailed medical questions.
- Have contact information ready for local cardiology clinics or screening resources members can be referred to.

Sample 50-Minute Session Agenda

Time	Segment	What to Do
0-5 min	Welcome & Purpose	Open with why this matters to your community; introduce yourself and any co-facilitator.
5-15 min	What Is ATTR-CM?	Use the plain-language explanation and analogy from Section 1.
15-25 min	Why It Matters for Us	Share the health equity facts from Section 2 - this is often the moment that shifts the room.
25-35 min	Signs, Symptoms & When to Act	Walk through the checklists in Sections 3-4. Invite reflection, not disclosure.
35-45 min	Advocating for Yourself	Practice the self-advocacy script from Section 5 - consider reading it aloud together.
45-50 min	Closing & Next Steps	Distribute the take-home card, share local resources, and open the floor for questions.

Discussion Questions for Your Group

- Has anyone in your family experienced heart failure that never seemed to have a clear explanation?
- Have you or someone you love had carpal tunnel surgery, especially in both hands?

Facilitator privacy note (M10)

Use these questions for private reflection or voluntary discussion. Nobody needs to disclose symptoms, diagnoses, genetic results or a relative's medical history. Avoid recording identifiable health stories; offer a private way to ask for help finding clinical care.

SECTION 7

Facilitator's Guide

- What has made it hard, in the past, to ask a doctor more questions or seek a second opinion?
- What would it look like for our community to talk about heart health as openly as we talk about other family traditions?

Facilitation Tips

- Lead with story before statistics. Personal stories (real or illustrative) land more than numbers alone.
- Normalize not knowing. Many attendees will be hearing these terms for the first time - that's the point of the session.
- Watch the emotional temperature of the room. If the health equity data feels heavy, pair it with the hope message: treatment exists, and early action changes outcomes.

Review note: hope without guarantees (M9)
Review the outcome wording. Earlier diagnosis can preserve treatment opportunities, but no specific treatment benefit or outcome should be promised. [S5, S11, S12]

- Close with a clear, simple call to action: talk to your doctor, and talk to your family about your family's health history.

What Not to Do

- Don't diagnose anyone, even informally - always redirect to “talk to your doctor about this.”
- Don't promise a specific test or treatment will be available at every clinic - encourage members to ask and advocate, and to seek a second opinion if needed.
- Don't let the session end on statistics alone - always close with actionable next steps and hope.

SECTION 8

Take-Home Quick Reference Card

Review status of this take-home card (Q1)
The original card below is retained for review. Do not print or share it separately until the clinical clarifications and local contact details have been approved.

Print or copy this page separately so each attendee can take one home.

What Is ATTR-CM?

A condition where abnormal protein deposits build up in the heart, making it stiff and less able to pump. Can be hereditary - and the gene change is carried by 3-4% of Black Americans.

Review note: the card needs this distinction (M1)
The 3-4% figure is the frequency of one inherited TTR variant, not the percentage of Black Americans with ATTR-CM. Carrying a variant does not mean a person has the disease. [S1]

Watch For (especially together):

☐ Shortness of breath, swelling, fatigue not explained by other causes

☐ Carpal tunnel syndrome (both hands), spinal stenosis, or biceps tendon rupture

☐ A family history of unexplained heart failure

Three Questions to Ask Your Doctor:

- "Could my symptoms be caused by ATTR-CM, or cardiac amyloidosis?"
- "Should I be tested with a PYP scan or genetic testing?"
- "If I test positive, should my family members be tested too?"

Review note: test and family questions (M8)
A gene test does not by itself diagnose active ATTR-CM. PYP interpretation requires assessment for AL amyloidosis and appropriate imaging criteria. Genetic counseling and family testing depend on an inherited disease-causing variant. [S4, S5, S10]

Remember

Early diagnosis means more treatment options. You have the right to ask questions and to seek a second opinion.

Review note: outcome wording (M9)
Earlier diagnosis does not guarantee a particular treatment option or outcome. Treatment choice is individual. [S5, S11, S12]

Presented by the Healthy Heart Community Prevention Project

in partnership with Heartbeats Life Center and community organizations

[Local contact / screening resource information]

Safety clarification: emergency versus urgent care (M5)
Do not wait for a symptom combination. Call 911 for chest pain or pressure, severe trouble breathing, fainting, or a rapid/irregular heartbeat with chest pain, breathlessness or fainting. These are not symptoms to defer to a same-day appointment. New or worsening swelling or a persistent heartbeat change without emergency symptoms needs prompt clinician advice. [S6, S7]

SECTION 9

Glossary of Terms

Plain-language definitions of the medical terms used throughout this toolkit.

Term	In Plain Language
Amyloid	Abnormal protein clumps that build up in organs and tissues and don't belong there.
Amyloidosis	The general condition of amyloid protein buildup in the body; ATTR-CM is one specific type.
ATTR-CM	Transthyretin amyloid cardiomyopathy - amyloid buildup specifically in the heart muscle.
ATTRv (hereditary)	The inherited form of ATTR-CM, caused by a TTR gene change passed down in families.
ATTRwt (wild-type)	The non-inherited, age-related form of ATTR-CM, most common in men over 70.
Cardiomyopathy	A disease of the heart muscle that affects its ability to pump or relax properly.
Carpal tunnel syndrome	Numbness, tingling, or pain in the hand caused by pressure on a wrist nerve; an early red-flag clue for ATTR-CM, especially in both hands.
Echocardiogram	An ultrasound scan of the heart that shows its structure and how well it's pumping.

SECTION 9

Glossary of Terms

Term	In Plain Language
Genetic counseling	A conversation with a trained professional about what a genetic test result means for you and your family.
Light chain (AL) amyloidosis	A different, related type of amyloidosis that must be ruled out during diagnosis because it is treated differently.
Peripheral neuropathy	Numbness, tingling, or pain, usually in the hands or feet, caused by nerve damage.
PYP scan	A nuclear medicine scan (technetium pyrophosphate) that can detect TTR amyloid in the heart, often without needing a biopsy.
Transthyretin (TTR)	A protein, made mainly by the liver, that carries vitamin A and thyroid hormone through the blood.
TTR stabilizer	A class of medication designed to keep the TTR protein in its normal shape and slow disease progression.
V142I / V122I	The specific TTR gene change most associated with hereditary ATTR-CM in people of West African descent; two names for the same variant.

Review note: PYP definition (M6)
PYP means technetium-99m pyrophosphate. A positive scan alone is not enough: interpretation requires the AL blood/urine screen and appropriate imaging criteria. [S4, S5, S8]

Review note: AL definition (M7)
The initial AL screen includes serum free light chains plus serum and urine immunofixation. Abnormal results need specialist interpretation. [S4, S5]

ORIGINAL ACKNOWLEDGMENTS

With Gratitude

This toolkit was developed as part of the Healthy Heart Community Prevention Project, an initiative committed to closing gaps in cardiovascular health equity through community education and early detection.

In Partnership With

☐ [Partner Organization Name]

☐ [Partner Organization Name]

☐ [Partner Organization Name]

Developed By

The Healthy Heart Community Prevention Project

[Contact information / website / phone]

Thank you for leading this conversation in your community. Awareness saves time, and time is what makes an early diagnosis possible. Your willingness to teach this material may be the reason someone in your circle gets answers years sooner than they otherwise would have.

Brand and contact review (B1)

The original project credits, partnership wording and contact placeholders are preserved. Confirm the current partner roster, wording and local contact details before distribution. No new partner logos or endorsements have been added.

REVIEW ANNOTATION SOURCES

References and review status

These references support the added review annotations, not the original toolkit as a whole. Sources were checked November 4, 2026. Medical fact-checking is not approval by Ms. Daphne or Dr. Ferdinand. All marked issues remain for their review before public distribution.

[S1] Cardiovascular Burden of the V142I Transthyretin Variant (JAMA, 2024)

[S2] Prevalence and Phenotype of Transthyretin Val122Ile Variant in the Hispanic Community Health Study/Study of Latinos (JACC: Advances, 2025)

[S3] Transthyretin Cardiac Amyloidosis in Older Black and Hispanic Individuals With Heart Failure (JAMA Cardiology, 2025)

[S4] 2023 ACC Expert Consensus on Cardiac Amyloidosis: Key Points (diagnosis only; treatment information is superseded)

[S5] 2025 ACC Concise Clinical Guidance: Key Takeaways (2026 summary)

[S6] Heart Failure: Symptoms and Causes (Mayo Clinic)

[S7] Heart Attack, Stroke and Cardiac Arrest Symptoms (American Heart Association)

[S8] 2023 ESC Guidelines for the Management of Cardiomyopathies

[S9] Canadian Guidelines for Hereditary Transthyretin Amyloidosis Polyneuropathy Management (2022)

[S10] 2023 ACC Expert Consensus Decision Pathway (full guideline)

[S11] FDA: Attruby (acoramidis) approval for ATTR-CM

[S12] FDA: AMVUTTRA (vutrisiran) prescribing information, revised March 2025

Editorial notes E1 and E2 flag missing or insufficient source support in the original. Privacy note M10 follows the original ground rules and session agenda. Q1 and B1 identify release and branding checks.