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Essential Aspects of the New ERS/ESC Guidelines on PH Treatment: An Overview

Announcer:
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Dr. Channick:
So hello, my name is Richard Channick. I'm at UCLA Medical Center. And this lecture is on Essential Aspects of the New ERS/ESC Guidelines on PH Treatment: An Overview.

Now, the overall strategy for treating PAH really hasn't changed with these guidelines. We still focus on basic principles of making the proper diagnosis and make sure what you're treating is actually PAH. Doing risk assessment to determine how severe that patient is, and then maybe most importantly, close follow-up. We also still feel that combination therapy for PAH is the most efficacious and it's clearly been proven in numerous studies. And these guidelines still focus on overall treatment strategy, meaning treating a patient to get to low-risk status. That's an important continued basic principle.

There are some differences, however. So one of the big differences that we can talk about is this concept of comorbidities versus no comorbidities. So in a group of patients with PAH, there's a different therapy recommended for those without comorbidities compared to those with comorbidities. The patients who have no comorbidities, now we're talking about cardiopulmonary and cardiovascular comorbidities, would get what we might call the usual approach of initial combination therapy, followed by close follow-up, in addition of therapy after that. On the other hand, patients who do have comorbidities, the concept of monotherapy as a recommended approach, is advanced in these guidelines. Now, we'll get into this in a minute, but I will say that those patients still may end up on combination therapies, but that initial monotherapy approach.

The other big change in the algorithm or the guidelines relates to the 3 versus 4-strata model. So as it turns out, if you separate patients into low, intermediate, or high risk, based on all the different parameters we can measure, many patients, if not most, will fall into intermediate risk. So to make it more useful or discriminating, breaking that intermediate-risk group into low-intermediate and high-intermediate with the so-called 4-strata model, better delineates and predicts prognosis. And that's recommended in the new guidelines in terms of the follow-up testing. And I think that this is how we apply these guidelines to our practice, that, you know, we have the initial approach. And I think that the issue of comorbidities is one that we can talk about in other venues, but the follow-up is really critical.

Now, as we go down the algorithm, the other big change is at the bottom of that algorithm, where there is the option of switching from one PAH medicine to another and this has previously not been recommended in general. But we have studies suggesting that in some patients, switching, for instance, from a PDE5 inhibitor to a soluble guanylate cyclase stimulator can improve patients. And so that's the bottom of that algorithm, an option for patients who are not low risk after initial dual combination therapy. One could potentially switch or you could add a prostacyclin pathway agent. Those are both reasonable approaches for making that change down the road. So that's another overall change or addition to the algorithm. So the comorbidities, the 4-strata follow-up, risk assessment, and then that option of switching versus adding a third therapy.

Thank you for participating. I hope you learned something today.

Announcer:
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