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Essential Aspects of the New ERS/ESC Treatment Guidelines: Patients With Comorbidities

Announcer:
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Dr. Channick:
Hello, my name is Richard Channick. I'm at UCLA Medical Center, and I'll be discussing the Essential Aspects of the New ERS/ESC Guidelines in PH treatment with a focus on patients who have comorbidities.

As you may know, the recently published ERS/ESC treatment algorithm and guidelines had made some changes from previous guidelines and algorithms. And specifically, one of the prominent changes was separating patients into those with PAH and comorbidities and those without comorbidities. And the concept that initial treatment for those patients with these comorbidities might be different than patients without comorbidities. And specifically, one might consider monotherapy in these patients.

Now, let's look at that a little bit further. In the European Respiratory Society and ESC guidelines, they separated phenotypes of comorbidities into two; what they call the left heart phenotype, which were the patients who may have an element or risk factors for heart failure and preserved ejection fraction, that might be obese, have diabetes, hypertension, coronary disease, but they also had pre-capillary pulmonary hypertension. So those patients, you know, often have atrial fibrillation. This is a left heart phenotype. The other phenotype was what they called a cardiopulmonary phenotype. These are patients often elderly, more male than female, with a low diffusing capacity, maybe heavy smoking history. And they may also have risk factors for left heart disease. But they had what's called a cardiopulmonary phenotype. It has been shown in these patients who have PAH but also have one of these phenotypes, that these patients often, you know, are pretty common. And in recent registries, you know, the PAH population is older and often have these comorbidities. In fact, I think in the COMPERA registry, 36% of patients presented with a left heart phenotype, and over half of patients had a cardiopulmonary phenotype.

And I think it's pretty clear from data and experience, that, for instance, patients who left heart phenotype may get more edema developing and not tolerate PAH therapies, as well as those who don't have that. And that's a problem. Patients with a cardiopulmonary phenotype may also respond less well to PAH therapies, may have more side effects, may actually have to discontinue the drugs more. So they're calling out a difference between these patients, and let's say a young person with typical pulmonary arterial hypertension. And the concept was to possibly treat those patients differently.

And that's why in the guidelines, and the level of evidence, of course, is not that high because there aren't big randomized controlled studies. But the suggestion was that one should consider monotherapy with either a PDE5 inhibitor or an ERA in these patients with comorbidities, whether it's cardiopulmonary or left heart phenotype comorbidities. And one should consider monotherapy in those patients, and then potentially add on therapy as needed if the patient is tolerating the single agent.

Now, let's think about that for a minute. So we have a 75-year-old patient, who has, you know, obesity, maybe some sleep apnea, hypertension, diabetes, and you do a workup for pulmonary hypertension, they have, you know, elevated pulmonary artery pressures, but a borderline wedge pressure, they already have significant edema, I would certainly agree in a patient like that, that that's a patient

with significant left heart phenotype, and would have a reasonable likelihood of having more edema in response to combination therapy. And that's a patient I might start monotherapy on. I think that's perfectly appropriate and probably reflects these guidelines.

However, we should really not extrapolate that patient to all patients with comorbidities, not all comorbidities are created equal. Let's take a 45-year-old woman with scleroderma and severe pulmonary arterial hypertension, who also happens to have maybe well-controlled hypertension and mild diabetes. Well, you could look at that patients say, well, they have comorbidities maybe we should just start a single drug on that patient. I would disagree with that. I think this is a type of patient that we really can't extrapolate these guidelines to and that's a patient who likely shouldn't be put on the usual therapies, and that really includes combination therapy.

So I think the really the overall message here is that although comorbidities and assessment of the overall phenotype of the patient is important and may inform your treatment, you need to go beyond that and really look at the overall patient. How severe is the PAH? How severe are the comorbidities? To really make a reasonable decision about how you should treat these patients. So I think this is a step forward in modernizing the guidelines, if you will, but needs to be looked at in the bigger picture.

Thank you very much for your attention.

Announcer:
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