Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/essential-aspects-of-the-new-ersesc-treatment-guidelines-patients-without-comorbidities/15843/

Time needed to complete: 1h 49m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Essential Aspects of the New ERS/ESC Treatment Guidelines: Patients Without Comorbidities

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCE curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Channick:
So hello, my name is Richard Channick. I'm from UCLA Medical Center. And I'm going to be talking about Essential Aspects of the New ERS/ESC Treatment Guidelines with a focus on patients with no comorbidities.

If we look at the overall treatment algorithm, as recommended by the ESC/ERS and their guidelines, there were some changes compared to prior recommendations. One of the notable changes was separating patients into those with cardiopulmonary or cardiovascular comorbidities, and those without. And the treatment algorithm for those two groups of patients is somewhat different. If we have patients with comorbidities, the concept of monotherapy as initial therapy was outlined, versus those without comorbidities where initial dual combination therapy, in general, is still the recommendation.

One of the things that is important with these ERS/ESC guidelines is the evidence, the level of evidence. And evidence-based guidelines, by their very definition, critically look at all the evidence and grade it. So our recommendation comes with that level of evidence. And if one looks at, for each of the recommendations for initial treatment, let's say in those without comorbidities where we're talking about initial combination therapy, you can see the level of evidence outlined here. So if we're using endothelial receptor antagonists and a PDE5 inhibitor together, that's pretty high level of evidence, because that's been shown in a very well-done randomized controlled trial, the AMBITION trial, to have significant clinical benefit. And so I think, as you go through these guidelines, it's very useful to really look at what is the level of evidence because in effect, you're trying to apply these recommendations to your patients and your practice. And I'm not going to go through every aspect in every level of evidence, but in general, if there's a well-done randomized controlled trial, that's going to get a higher grade than if there wasn't. And likewise, if the magnitude of effect was greater, that's going to get a higher grade. So these are important things to look at, when you're looking at evidence-based guidelines.

One of the things that we certainly know is that patients who are at high risk, so they're, they're characterized as the highest risk or the sickest patients, that parenteral prostacyclins are recommended as a treatment of choice. Now, we have to admit that there's no real randomized controlled trials in purely high-risk patients, proving that that's the case. But our extensive clinical experience over many years with parenteral prostacyclin analogs, really is convincing and very impactful, showing that these parenteral therapies are very effective, in even the patients who are very high risk. And because there hasn't been a big randomized controlled trial in these patients, you know, you're not going to see huge, you know, high levels of evidence, but nevertheless, that's the recommendation as shown here.

The other thing which I think is underscored in these new guidelines, is that in patients who are on or started on parenteral prostacyclin, that it's still recommended that one adds combination oral therapy, so typically a PDE5 inhibitor and an endothelial receptor antagonist. And there certainly is some data of enhanced effect in patients who are very sick and being started on so-called triple combination therapy, including a parenteral prostacyclin, and that's why in these newer ESC/ERS guidelines, that's the recommendation that we use combination therapy that includes a parenteral prostacyclin. And I should also say that in patients who are on three, let's say oral drugs,

or non-parenteral drug and are still not reaching low-risk status, that that's another area where one would want to transition or apply a parenteral prostacyclin. So we still have those therapies, which at least in the case of epoprostenol, have been around, you know, since 1996, at our disposal and are still being shown to be very, very efficacious.

Thank you very much for listening. I hope you learned something.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME, LLC. and is part of our MinuteCE curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.