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Hot Topics from the New ERS/ESC Guidelines: Definitions and Risk Assessment

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Dr. Channick:
So hello, my name is Rich Channick. I'm from UCLA Medical Center. And today we're going to have a really interesting discussion on Hot Topics from the ERS/ESC Guidelines. And I'm delighted to be joined by my colleague, Rajan Saggar, also from UCLA. Welcome, Raj. And Ioana Preston, a good friend and colleague from Tufts University. Welcome, guys.

So what we'll do is go through a few areas that I think we've identified as controversial or just changes in these recent guidelines that came out. Let's just start right into it with the human dynamic definition. Now we've all, you know, seen these changes to the hemodynamic definition, the big thing was the recommended pressure was greater than 20 mmHg. But now the pulmonary vascular resistance cutoff for abnormal has dropped from 3 to 2, which is a change from the World Symposium guidelines. That's a pretty substantial change. And now we're defining a patient as having pulmonary arterial hypertension with a PVR over 2 Wood units. Do you think that's a wise change or not?

Dr. Preston:
It is a hot topic indeed. Because the change was based on studying the former papers that looked at normal values. And indeed, a normal pulmonary vascular resistance is 80 dynes, or 1, and 3 was the margin of error. And then if you look at more strictly two standard deviation, it brings you up to a PVR of 2. However, these studies enrolled young population of healthy individuals. And as we're dealing with an aging population, many of them developing some element of diastolic disease, not even heart condition, but dysfunction right? then all the numbers are a little bit different compared to a younger 25, 30-year-old.

Dr. Channick:
I guess I've got to jump in here, like, you're suggesting that we're probably going to be over-diagnosing pulmonary arterial hypertension.

Dr. Preston:
That is my fear.

Dr. Channick:
Raj, do you agree?

Dr. Saggar:
Yeah, I think, again, it's a hot topic, but I think that's exactly what we are at risk for, is over-diagnosing the condition. But I think - and I don't want to speak for the ERS and ESC, but I think what they were sort of going at was like, 'Look, you know, this is - hemodynamically, this is where abnormality begins.'

Dr. Preston:
Yeah.

Dr. Saggar:
And they're leaving it up to the clinician to determine whether that would warrant an actual therapeutic intervention.

Dr. Preston:
Yeah. They also specify that there are no studies that suggest treatment in this not, I shouldn't say gray area, but very mild range exactly. However, when you're in a busy clinical practice, and you have a 78-year-old male with systemic hypertension, diabetes, overweight, and they're short of breath, and you don't find quite exactly the cause. And you do a right heart cath, and they're PVR is 2.3 and a mean PA pressure is 22. Does that fit the phenotypic makeup of a PAH group 1 patient? No.

Dr. Channick:
Yeah. And I think that that's probably the message. It's not about cutoffs and definitions. In real life, we have to look at this as a total package, how we're phenotyping these patients. I think that's very important to put the guidelines in perspective.

I want to change gears a little bit. So that's the definition. Another big thing that's emerged is this risk assessment concept. And certainly, in previous guidelines and documents, the concept of risk assessment. One of the changes that this set of guidelines did was include this, so-called 4-strata model. Just tell us a little bit about where they came from, and what you think about it.

Dr. Saggar:
I think that the original 3-strata model, which I think was looked at by, you know, the French and the Europeans and the Swedes, all came to the same conclusion that, in fact, you could have a low-risk, an intermediate-risk, and a high-risk patient, all based on sort of 1-year mortality, if you will. But I think what was happening was not many patients were getting to low risk. And in addition to that, you know, a good two-thirds, or 70% of the cohort, were in this intermediate category. And because of that, the idea was, well, could we actually add another strata and break up that intermediate risk into maybe two buckets, sort of so-called low-intermediate risk and high-intermediate risk? And would that actually allow us - would you still get some survival? Would it be able to predict survival in sort of a graded fashion? Which in fact, is the case. I think the COMPERA registry looked at this as well as the French registry, to actually show that you could have incremental - you could actually, over time, as you follow these patients, determine one's risk, and actually add in this sort of, you know, breaking up that intermediat- risk group into two groups.

Dr. Channick:
Yeah. And that certainly makes sense. I mean, is the question - and this is pretty strongly recommended, at least in follow-up. I mean, I'll ask you, do you - I mean, there's other ways to do it as well. There's the REVEAL score, where you can get a you know, numeric score. And what do you use, let's say in your practice?

Dr. Preston:
So I think each practitioner should use what they're more comfortable with, what their EMR system is allowing them to use it easily in a busy practice, because they are specificity sensitive, the power to detect the severity of the disease, they're all very similar. So whatever fits your practice, I would say, you should use it. Two, make sure that what you feel like a gestalt is backed by objective data.

Dr. Saggar:
You know, I think the 4-strata system is an evolution. I think there's - I think folks are going to want to look into how to add in perhaps some type of measure of RV function or some type of echocardiographic finding, hemodynamics. And then, you know, we've always - we all see patients worried about the male patient with PAH, so gender plays an issue. Their renal function plays an issue. So I think, to your point, where we, you know, I think we're always going to be trying to sort of improve that 4-strata system. And I think there's going to be investigators from all of these other - from these registries, particularly that are going to go back and sort of, you know, sort of try to add in and sort of improve what we have.

Dr. Channick:
Yeah, no, that's – there's certainly a couple of very hot topics, of which are many others we can cover in other sessions. But thank you very much.

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