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## Understanding the Proposed 3-Strata Approach for Initial Risk Assessment (RA) at Diagnosis

### Announcer:

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### Dr. McLaughlin:

Hello, I'm Val McLaughlin from the University of Michigan. Welcome to this didactic session on PH risk stratification in 2023: Understanding the Proposed 3-Strata Approach for Initial Risk Assessment at Diagnosis.

Well, we all know that risk assessment is complex and it involves a variety of parameters. When we see patients in clinic, we assess them clinically, we assess their functional class, their signs, their symptoms, we often do some sort of exercise tests on them. Most of us use a 6-minute hall walk. But occasionally there are centers that primarily focus on cardiopulmonary exercise testing. We assess their labs, the biochemical markers that we've learned a tremendous amount about - amount about over the recent years. Often, we look at imaging such as echo or MRI. And then occasionally we do hemodynamics as well.

This table was most recently updated at the ERS/ESC guidelines that were published in 2022. And this has been around for a while, and the more we learn about risk assessment and prognosis, the more we add to this. So this table demonstrates a number of different prognostic determinants and cut-offs that put a patient in the low-risk, intermediate-risk, or high-risk category. So everything from symptoms and physical exam findings, to how we grade functional class, exercise tolerance, biomarkers. And of course, we've learned a lot about imaging, both echo and MRI. And hemodynamics are really important in terms of risk assessment as well.

And we've learned so much about risk assessment over the years. These papers from Europe; one from Sweden, and one from the COMPERA registry, look at the 3-strata approach. And what happens in the 3-strata approach is that we look at those determinants of risk, we assign a patient 1 point if that variable is in low risk, 2 points if that variable is an intermediate risk, and 3 points if that variable is in high risk, and then we divide by the number of variables measured and round to the nearest integer. And you can see from these survival curves that risk assessment at baseline portends prognosis with patients who fall into the low-risk category, doing better over time than those who are in the intermediate-risk category. And of course, those in the high-risk category, do the worst of all.

Now, the problem with this assessment is that, unfortunately, most of the patients fall into the intermediate-risk category. Certainly, there are some patients who are at high risk, and we need to be very aggressive with in terms of treatment, and a small number of patients who are at lower risk, and we often treat a little bit more conservatively. But in many series, about 70% of the patients fall into this intermediate-risk group.

Nevertheless, the most data that we have, particularly at the time of the initial treatment decision, is using this 3-strata approach. And so this is what is currently in the ERS/ESC guidelines to help guide those decisions at the time of initial diagnosis. It's based on the 3 risk strata with patients who are at high risk getting aggressive therapy with - that often includes a parenteral prostanoid in addition to oral agents, and then the majority of the rest of the patients getting double upfront combination therapy.

And while this is an evidence-based approach and it's what's in the guidelines, I just want to make a little bit of an editorial comment that

that intermediate-risk group is so wide, there's patients who fall on the lower end of the intermediate risk, and there are patients who technically are at intermediate risk by an objective risk score, but have a lot of high-risk characteristics. And I personally think those patients should sometimes be treated a bit more aggressively the way that we treat high-risk patients. And although in the table, you see that 3-strata; low, intermediate, high, if you read the actual text of the guidelines, they make very similar comments that there are some patients who are at intermediate risk, but have high-risk features, particularly hemodynamics, that perhaps should be treated a little bit more aggressively.

So that's a summary of the 3-strata approach. It looks at the different variables that are measured at baseline that fall into low, intermediate, or high, assign a point value, and divide by the number of variables, and then you get a score for that patient; low, which is a small proportion of patients; high which is a small proportion of patients; and then the vast majority of patients fall into intermediate risk. And that's how the guidelines recommend our initial treatment decision be based on that.

So thank you very much for joining me for this overview of the 3-strata risk assessment approach.

**Announcer:**

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