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Will Lowering the Hemodynamic Threshold for PH Impact “Discovery” of New Patients?

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Dr. McLaughlin:
So hello, I'm Val McLaughlin from the University of Michigan, and welcome to this roundtable discussion on how the change in the hemodynamic definition might impact the discovery of new patients with pulmonary hypertension. I'm joined by my friends and colleagues, Rich Kasuski from Duke, and Dinesh Khanna also from Michigan.

So you guys, as you know, the recent ERS/ESC guidelines tweaked the hemodynamic definition again, a little bit. At the last World Symposium, we lowered the pressure threshold from 20 to 25. And now they've also lowered the PVR threshold from 3 to 2. So Rich, do you think that we will now discover more patients with pulmonary arterial hypertension with these changes in thresholds?

Dr. Krasuski:
Yeah, Val, I do think we're probably going to see more people get a diagnosis. The question is going to be how is that going to impact in terms of what we do clinically? I think clearly, it's going to increase sensitivity, we're going to see many more patients with a label as having pulmonary arterial hypertension, but it's still, I think, the onus is going fall on us to try to differentiate whether it's truly pulmonary venous or pulmonary arterial, and that PVR change, I think is going to be a big one for that.

Dr. McLaughlin:
Yeah, I think that's a great point. When I think about my practice, the opportunities I have for the earliest diagnosis are in the scleroderma patient that Dinesh screens and sends to us. I think what you're talking about, all those patients with a lot of comorbidities, is it really Group 2? Is it Group 1? That's going to be a challenge to differentiate

Dr. Krasuski:
It sure is.

Dr. McLaughlin:
Dinesh, you know, we have to be more cognizant of socioeconomic climate and diversity and healthcare disparities. You know, do you think that this is going to impact patients of all socioeconomic statuses as we look at the earlier diagnosis?

Dr. Khanna:
That's a great question, Val. I think that is a hope. But when you look at our practice, in Michigan, most of the patients that we see are - tend to be more well-educated, Caucasian patients. I do see that in scleroderma or other connective tissue diseases, there's a clear disparity in the diagnosis and screening. So we really have to push that forward in that as a whole. But I don't think, at this time, we have been able to really bridge the socioeconomic gap that we see in the screening and diagnosis of pulmonary hypertension.

Dr. McLaughlin:
Yeah, I absolutely agree. We have a lot of work to do on that. You know, there are whole areas that don't have centers, that don't have

a lot of education about this or don't have the resources. So it certainly is an opportunity for improvement.

Rich, I know you're very passionate about congenital heart disease. Do you think that patients with congenital heart disease might be impacted or diagnosed earlier? Not as early? You know, will this impact CHD as much as IPAH?

Dr. Krasuski:
Yeah, Val, I think it's a complex question. In congenital heart disease, we tend to break folks down into different groupings. As you know, there are people with repaired shunts. There are people with unrepaired shunts. There are people with Eisenmenger. And then there's the small shunts with, you know - that probably aren't related to the PH.

And then there's the much more complicated group and that's the patients with segmental pulmonary hypertension, Fontan related. I think the biggest impact we're going to see this in is in the Fontan population. When you don't have a subpulmonic pumping chamber, your pressures, your resistances are going to be quite low. And you know, we don't tolerate any increase in PVR. The patients don't tolerate that. Once that Fontan pressure rises because the PVR is a little bit elevated, that's a real problem. So I think lowering that threshold for that population, we're going to be diagnosing a lot more people who could potentially benefit from therapy.

I don't think it'll affect the people with uncorrected shunts. The corrected shunts, I think we'll be identifying more patients. And I think the small defects will be impacted the same way we're going to impact IPH.

Dr. McLaughlin:
Great. And Dinesh, you've really been a champion for screening and early detection of PAH in the scleroderma population, published a great deal on this, and really execute it in practice. Like, the earliest patients I see are the scleroderma patients that your team screens and sends to us. So do you think this change in definition will impact how aggressive patients are screened? Or how early we might see scleroderma patients?

Dr. Khanna:
Yeah, absolutely. I mean, you and I work together pretty closely. And, you know, you and I have published on this in the *European Respiratory Journal* in 2019. And we looked at our Michigan cohort for the 6th World Symposium definition. And when they lowered the mean PAP to greater than 20, but kept the PVR at 3 or greater, it really did not add more patients. But by decreasing the PVR to 2, you know, we will be adding about 25 to 30% more patients in our cohort that are now classified as pulmonary arterial hypertension.

We also looked at the DETECT database, and in there, there's an additional 50% - 5-0, patients that are added to it. So I think it will substantially add the CTEPH patients who meet this hemodynamic definition.

Now the key question is, does the treatment impact how do these patients do? And I'm sure we'll talk more about that in other sessions.

Dr. McLaughlin:
Yeah. And I think that's a really great point. So in the ERS/ESC guidelines, while they lowered the definition, and we'd certainly have opportunities to see some of these patients earlier, they were very clear that the treatment algorithm did not apply to those with a PVR of 2 to 3.

So Rich, Dinesh, thanks for joining me. This has been a really interesting conversation on how some of these hemodynamic changes might affect our everyday practice. And thanks to the audience for joining us at this roundtable.

Announcer:
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