The right heart and pulmonary circulation (VI)

Current Therapeutic Approaches to Pulmonary Arterial Hypertension

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Pulmonary hypertension is a heterogeneous hemodynamic and pathophysiological state that is observed in a number of clinical conditions, which have been divided into six diagnostic groups. Although the increase in pulmonary pressure observed in these clinical groups may be similar, underlying disease mechanisms, diagnostic methods, and prognostic and therapeutic consequences are completely different.

Pulmonary arterial hypertension is associated with several rare conditions that have comparable clinical and hemodynamic characteristics and exhibit virtually identical anatomical and pathological alterations in the lung microcirculation. These conditions include idiopathic and familial forms of the disease and disease forms associated with connective tissue disease, congenital heart defects involving systemic-to-pulmonary arterial shunts, portal hypertension, and HIV infection. It has been shown that treatment with specific drugs (e.g. prostanoids, endothelin-receptor antagonists and phosphodiesterase type-5 inhibitors) is effective in these patients and that these drugs can also be administered in various combinations. An evidence-based treatment algorithm has been developed for these patients.

In patients with pulmonary hypertension due to left heart disease or lung disease, treatment focuses on the underlying condition and there is no convincing evidence that agents approved for pulmonary arterial hypertension are effective. For patients with chronic thromboembolic pulmonary hypertension, the treatment of choice is pulmonary endarterectomy. However, drugs intended specifically for the treatment of pulmonary arterial hypertension may be considered in inoperable cases or after suboptimal surgery.

**Key words:** Pulmonary hypertension. Prostanoids. Endothelin-receptor antagonists. Phosphodiesterase inhibitors.

**INTRODUCTION**

Pulmonary hypertension (PH) is a hemodynamic and pathophysiological condition defined as an increase in mean pulmonary arterial pressure (PAP) ≥25 mmHg at rest as assessed by right heart catheterization (RHC).
PH is heterogeneous from the pathophysiological point of view and the diversity is also reflected in the hemodynamic classification (Table 1).2

The different hemodynamic forms of PH can be found in multiple clinical conditions which have been classified in 6 main groups and at least 26 subgroups (Table 2). Each main clinical group shows specific pathologic changes in the lung distal arteries, capillaries and small veins. If we combine the hemodynamic and clinical heterogeneity we understand the importance of an accurate diagnosis in the individual patient, which is crucial for the prognostic assessment and the treatment strategy. In addition, the concomitant presence of different hemodynamic and clinical mechanisms cannot be excluded in individual patients.

The presence of PH as defined above is always an ominous prognostic sign even if the severity may differ according to hemodynamic changes and the underlying clinical condition.

The therapeutic approach also is markedly different according to the clinical groups and the symptomatic and hemodynamic severity.

The classifications are described in an initial common paragraph while the treatment strategies of the four more frequent clinical groups are discussed individually.

**DEFINITIONS AND CLASSIFICATIONS**

**Hemodynamic Classification**

PH has been defined as an increase in mean PAP ≥25 mmHg at rest as assessed by RHC.3,4 Recent re-evaluation of available data have shown that the normal mean PAP at rest is 14 (3) mmHg with an upper limit of normal of approximately 20 mmHg.5,6 The significance of mean PAP between 21 and 24 mmHg is unclear. Patients presenting with PAP in this range need further evaluation in epidemiological studies. The definition of PH on exercise as a mean PAP >30 mmHg as assessed by RHC is not supported by published data; healthy individuals can reach much higher values.5,7 Thus no viable definition for PH on exercise as assessed by RHC can be provided at the present time.

An additional very important haemodynamic parameter which characterizes the definitions of PH is pulmonary wedge pressure (PWP). In fact, according to various combinations of values of PWP, pulmonary vascular resistance (PVR) and cardiac output (CO), different hemodynamic types of PH are shown in Table 1. Pre-capillary PH (PH with normal PWP) is found in the clinical groups 1, 3, 4, and 5 while post-capillary PH (PH with elevated PWP) is found in the clinical group 2 (Table 2).8 The distinction between pre-capillary and post-capillary PH is extremely important because the treatment strategy may differ markedly between the two hemodynamic conditions; therapies effective in the pre-capillary form may be detrimental in the post-capillary type and vice versa.

**Clinical Classification**

The more updated clinical classification of PH is presented in Table 2.9 Clinical conditions with PH are classified into six groups according to similar pathological, pathophysiological and therapeutic characteristics: pulmonary arterial hypertension (PAH - group 1), pulmonary veno-occlusive disease (group 1’), PH due to left heart disease - group 2, PH due to lung diseases (group 3), chronic thromboembolic PH (CTEPH, group 4) and PH with unclear and/or multifactorial mechanisms (group 5). Despite possible comparable elevations...
TABLE 2. Updated Clinical Classification of Pulmonary Hypertension (Dana Point, 2008)

1. Pulmonary arterial hypertension (PAH)
   1.1 Idiopathic PAH
   1.2 Heritable
      1.2.1 BMPR2
      1.2.2 ALK1, endoglin (with or without hereditary haemorrhagic telangiectasia)
   1.2.3 Unknown
   1.3 Drugs and toxins induced
   1.4 Associated with (APAH):
      1.4.1 Connective tissue diseases
      1.4.2 HIV infection
      1.4.3 Portal hypertension
      1.4.4 Congenital heart disease
      1.4.5 Schistosomiasis
      1.4.6 Chronic haemolytic anaemia
   1.5 Persistent pulmonary hypertension of the newborn

1’ Pulmonary veno-occlusive disease and/or pulmonary capillary haemangiomatosis

2. Pulmonary hypertension due to left heart disease
   2.1 Systolic dysfunction
   2.2 Diastolic dysfunction
   2.3 Valvular disease

3. Pulmonary hypertension due to lung diseases and/or hypoxia
   3.1 Chronic obstructive pulmonary disease
   3.2 Interstitial lung disease
   3.3 Other pulmonary diseases with mixed restrictive and obstructive pattern
   3.4 Sleep-disordered breathing
   3.5 Alveolar hypoventilation disorders
   3.6 Chronic exposure to high altitude
   3.7 Developmental abnormalities

4. Chronic thromboembolic pulmonary hypertension

5. PH with unclear and/or multifactorial mechanisms
   5.1 Haematological disorders: myeloproliferative disorders, splenectomy.
   5.2 Systemic disorders, sarcoidosis, pulmonary Langerhans cell histiocytosis, lymphangioleiomyomatosis, neurofibromatosis, vasculitis
   5.3 Metabolic disorders: glycogen storage disease, Gaucher disease, thyroid disorders
   5.4 Others: tumoral obstruction, fibrosing mediastinitis, chronic renal failure on dialysis

ALK-1 indicates activin receptor-like kinase 1 gene; APAH, associated pulmonary arterial hypertension; BMPR2, bone morphogenetic protein receptor, type 2; HIV, human immunodeficiency virus; PAH, pulmonary arterial hypertension.

PULMONARY ARTERIAL HYPERTENSION

PAH (Table 2) represents the type of PH in which the most important advances in the understanding and treatment have been achieved in the past decade. It is also the group in which PH is the “core” of the clinical problems and may be treated by specific drug therapy.

Pathobiology and Pathophysiology

PAH comprises apparently heterogeneous conditions (Table 2) that share comparable clinical and hemodynamic pictures and virtually identical pathological changes of the lung microcirculation. Pathological lesions affect the distal pulmonary arteries (<500 µm) in particular. They are characterized by medial hypertrophy, intimal proliferative and fibrotic changes (concentric, eccentric), adventitial thickening with moderate peri-vascular inflammatory infiltrates, complex lesions (plexiform, dilated lesions) and thrombotic lesions. Pulmonary veins are classically unaffected. Additional pathological changes include dilatation of the proximal elastic pulmonary arteries and of the bronchial arteries (likely due to a compensatory mechanism intended to provide supplementary blood flow to hypoperfused lung parenchyma areas). The exact processes that initiate the pathological changes seen in PAH are still unknown, even if it is recognized that PAH has a multifactorial pathobiology that involves
various biochemical pathways and cell types. The increase in PVR is related to different mechanisms, including vasoconstriction, proliferative and obstructive remodeling of the pulmonary vessel wall, inflammation and thrombosis. The PVR increase leads to right ventricular (RV) overload, hypertrophy and dilatation and eventually to RV failure and death. The importance of the progression of RV failure on the outcome of idiopathic PAH (IPAH) patients is confirmed by the prognostic impact of right atrial pressure, cardiac index (CI) and PAP,\(^4\) the 3 main parameters of RV pump function. The depression of myocardial contractility seems to be one of the primary events in the progression of heart failure in a chronically overloaded RV. Changes in the adrenergic pathways of RV myocytes leading to reduced contractility have been shown in IPAH patients.\(^11\) Afterload mismatch remains the leading determinant of heart failure in patients with PAH and CTEPH because its removal, as follows successful pulmonary endarterectomy or lung transplantation,\(^12\) leads almost invariably to sustained recovery of RV function. The hemodynamic changes and the prognosis of patients with PAH are related to the complex pathophysiological interactions between the rate of progression (or regression) of the obstructive changes in the pulmonary microcirculation and the response of the overloaded RV, which may also be influenced by genetic determinants.\(^13\)

**Initial Treatment Approach**

The suggested initial approach after the diagnosis of PAH is the adoption of the general measures, initiation of supportive therapy and referral to an expert centre for vasoreactivity testing. General measures are recommendations on general activities of daily living including physical activity, birth control and pregnancy, travel, psychosocial support, infection prevention, and elective surgery. Supportive therapies include oral anticoagulants, diuretics, oxygen, digoxin, and other inotropic drugs. These treatments are recommended even if no formal randomised controlled trials (RCTs) have been performed in PAH. Supportive therapies are largely used in PAH patients, as demonstrated by the baseline treatment of PAH patients included in the RCTs testing the efficacy of modern targeted treatments.\(^14\) Calcium channel blockers agents (CCBs) are included in this chapter because they represent the first class of drugs developed for the treatment of a minority of patients with PAH, those responders to the acute vasoreactivity test. In these cases, the clear favourable response of the long-term treatment with high doses of CCBs has discouraged the performance of RCTs for ethical reasons.

**General Measures**

Patients with PAH require sensible advice about general activities of daily living and need to adapt to the uncertainty associated with a serious chronic life-threatening disease. The diagnosis usually confers a degree of social isolation.\(^15\) Encouraging patients and their family members to join patient support groups can have positive effects on coping, confidence and outlook.

**Physical Activity and Supervised Rehabilitation**

Patients should be encouraged to be active within symptom limits. Mild breathlessness is acceptable but patients should avoid exertion that leads to severe breathlessness, exertional dizziness, or chest pain. Patients should therefore avoid excessive physical activity that leads to distressing symptoms but when physically deconditioned may undertake supervised exercise rehabilitation.\(^16\) There is growing evidence supporting loss of peripheral muscle mass in patients with advanced PAH and this may be corrected by a defined rehabilitation program.

**Pregnancy and Birth Control**

Pregnancy is associated with a 30%-50% mortality in patients with PAH\(^17\) and as a consequence PAH is a contra-indication to pregnancy.\(^1\) Barrier contraceptive methods are safe for the patient but with an unpredictable effect. Progesterone-only preparations such as medroxyprogesterone acetate and etonogestrel are effective approaches to contraception and avoid potential issues of estrogens such as those included in the mini-pill.\(^18\) It should be remembered that the endothelin receptor antagonist (ERA) bosentan may reduce the efficacy of oral contraceptive agents. The Mirena coil is also effective.\(^18\) A combination of 2 methods may also be utilized. The patient who becomes pregnant should be informed of the high risk of pregnancy and termination of pregnancy discussed. Those patients who choose to continue pregnancy should be treated with disease targeted therapies, planned elective delivery and effective close collaboration between obstetricians and the PAH team.\(^19,20\)

**Travel/Altitude**

Air travels are considered to be of potential harm for patients with underlying pulmonary hypertension because of the generalized pulmonary vasoconstriction at O\(_2\) concentration <21%.\(^21\) The known physiological effects of hypoxia suggest that in-flight O\(_2\) administration should be considered for patients in World Health Organization (WHO)
functional class III and IV and those with arterial blood $O_2$ pressure consistently less than 8 kPa (60 mmHg). Similarly, such patients should avoid going to altitudes above 1500 to 2000 metres without supplemental $O_2$. Patients should be advised to travel with written information about their PAH and be advised how to contact local PH clinics in close proximity to where they are travelling. Prolonged air travel is considered a risk factor for deep venous thrombosis and for PAH patients who are not treated with oral anticoagulants and have potential additional risk factors such as WHO functional class III and IV or obesity, preventive measures (low-molecular-weight heparin, leg exercises) on long-haul flights over 5000 km may be considered.

**Psychosocial Support**

Many PAH patients develop anxiety and depression leading to impairment in quality of life. Timely referral to a psychiatrist or psychologist should be made when appropriate. Patient support groups may also play an important role in this area and patients should be advised to join such groups.

**Infection Prevention**

Patients with PAH are susceptible to developing pneumonia, which is the cause of death in 7% of cases.22 Whilst there are no controlled trials, it is recommended to vaccinate against influenza and pneumococcal pneumonia.

**Elective Surgery**

Elective surgery is expected to have an increased risk in patients with PAH. It is not clear as to which form of anaesthesia is preferable but epidural is probably better tolerated than general anaesthesia. Patients usually maintained on oral therapy may require temporary conversion to intravenous or nebulised treatment until they are able to both swallow and absorb drugs taken orally.

**Hemoglobin Level**

PAH patients are highly sensitive to reduction of hemoglobin levels. Any kind of anaemia even of milder degrees should be corrected. On the other hand, especially patients with long-standing hypoxemia like those with right-to-left shunts tend to develop erythrocytosis with elevated levels of hematocrit. In these circumstances, venesections are indicated only if hematocrit is above 65% and hyperviscosity symptoms are present.23

**Concomitant medications**

Currently 3 classes of drugs are approved in PAH (ERA, phosphodiesterase type-5 inhibitors, and prostanoids) and care is needed to avoid interactions between them and with any other drug.1 Even if non-steroid anti-inflammatory drugs seem not to be associated to PAH in a case-control study,24 their use may further reduce glomerular filtration rate in patients with low cardiac output and pre-renal azotaemia. Anorexigens that have been linked to the development of PAH are no longer available on the market. The effects of the new generation serotonin-related compounds (eg, antidepressants) are unknown but no clear relationships with PAH have yet been demonstrated. The efficacy of current treatments for chronic “biventricular” heart failure like ACE-inhibitors and beta-blockers has not been tested in patients with PAH. In addition, the use of these compounds may favour hypotension and progression of right heart failure in PAH patients due to vasodilatation and negative inotropic effects.

**Supportive Treatments**

**Oral Anticoagulants**

There is a high prevalence of vascular thrombotic lesions at post mortem in patients with IPAH.25,26 Abnormalities in coagulation and fibrinolytic pathways have also been reported, and mural thrombi have been shown in central elastic pulmonary arteries of patients with IPAH26 and Eisenmenger’s syndrome patients.23,27

All the above factors together with the non-specific increased risk for venous thromboembolism, including heart failure and immobility, may represent the rationale for oral anticoagulation in PAH.

Evidence in favor of oral anticoagulation is confined to patients with IPAH, heritable PAH and PAH due to anorexigens; it is generally retrospective and based on single centre experience.25,28,29 In recent clinical trials, oral anticoagulant treatment was present at inclusion in a fraction of patients ranging from 50% to 80%.30 The potential benefits of oral anticoagulation should be weighed against the risks in patients with other forms of PAH, especially when there is an increased risk of bleeding such as PAH associated with Eisenmenger’s syndrome and hemoptysis, connective tissue diseases and gastrointestinal tract abnormalities (predisposing to bleeding), portal hypertension (severe oesophageal varices, coagulation abnormalities, low platelet count) and HIV infection (low platelet count, poor compliance). Generally, patients with PAH receiving therapy with long-term intravenous
prostaglandins are anticoagulated in the absence of contra-indications, due in part to the additional risk of catheter-associated thrombosis. Advice regarding the target international normalized ratio in patients with IPAH varies from 1.5 to 2.5 in most centres of North America to 2.0 to 3.0 in European centres.

**Diuretics**

 Decompensated right heart failure leads to fluid retention, raised central venous pressure, hepatic congestion, peripheral oedema, and ascites (in advanced cases). Clinical experience shows clear symptomatic benefit in fluid overloaded patients treated with this therapy. The appropriate diuretic dose is strictly individual and theoretically should be the lowest dose that maintains an optimal fluid balance and minimizes symptoms of congestion. Proper fluid balance can be facilitated by a controlled salt and water intake. Intravenous administration of diuretics is temporarily preferred in cases of fluid retention to overcome the reduced oral bioavailability. Loop diuretics are generally used and furosemide oral doses may vary from 20-25 mg/day up to 500 mg/day. The addition of aldosterone antagonists should also be considered.

**Oxygen**

 The oxygen content of arterial blood and oxygen delivery to tissues are generally not reduced unless the PaO$_2$ falls <60 mmHg. Most patients with lung diseases are hypoxemic because of altered ventilation-perfusion matching. In contrast, most patients with PAH (except those with associated congenital heart disease) present with only mild degrees of arterial hypoxemia at rest. No consistent data are currently available on the effect of long-term O$_2$ treatment in patients with PAH. Guidance may be empirically based on the guidelines of parenchymal lung diseases: when arterial blood O$_2$ pressure is consistently less than 8 kPa (60 mmHg) patients are advised to take O$_2$ to achieve arterial blood O$_2$ pressure >8 kPa. Ambulatory O$_2$ may be considered in patients when there is evidence of symptomatic benefit and correctable desaturation on exercise. There is little rationale to treat with long-term oxygen therapy patients with hypoxaemia predominantly due to right-to-left shunt through a patent foramen ovale, atrial or ventricular septal defects or patent ductus arteriosus. In these cases a consistent increase of oxygen saturation and symptomatic improvement on oxygen therapy should be demonstrated.

**Inotropic Drugs**

 The effects of adrenergic inotropic drugs on the failing right ventricle have received little attention by investigators. Data on humans are available mostly for the prevalent beta 2-adrenergic receptor agonist isoproterenol that was administered to IPAH patients for its supposed effects of vasodilatation on pulmonary circulation. Dobutamine is a prevalent beta 1-adrenergic receptor agonist that exerts inotropic and vasodilator effects comparable to isoproterenol but has a less pronounced chronotropic activity. Dopamine is a beta-, alpha- and dopaminergic-receptor agonist and its profile of action may present some advantages over the prevalent beta-receptor agonist drugs. In fact, the alpha-adrenergic activity helps to preserve the blood pressure levels and even to increase them. The absence of systemic hypotensive effects together with the renal blood flow increase suggest the use of dopamine alone or in combination with dobutamine as the inotropic strategy of choice in PAH patients.

 Although digoxin has been shown to improve cardiac output acutely in IPAH, its efficacy is unknown when administered chronically. It may be given to slow ventricular rate in patients with PAH who develop atrial tachyarrhythmias.

**Acute Vasoreactivity Test and Long-Term Treatment With Calcium-Channel Blockers (CCBs)**

 A minority of patients with PAH (in particular idiopathic PAH) respond with a meaningful reduction of pulmonary artery pressure associated to a reduction of pulmonary vascular resistance on acute vasoreactivity tests. In these cases, a favourable effect of long-term treatment with high doses of CCBs, in particular with nifedipine and diltiazem, has been demonstrated.

 In PAH, vasoreactivity testing should be performed at the time of diagnostic right heart catheterization to identify patients who may benefit from long-term therapy with CCBs. Acute vasodilator challenge should only be performed with short-acting, safe and easy to administer drugs with no or limited systemic effects. Currently the agent most used in acute testing is nitric oxide; based on previous experience intravenous epoprostenol or intravenous adenosine may also be used as an alternative (but with a risk of systemic vasodilator effects). Inhaled iloprost and oral sildenafil may be associated with significant vasodilator effects. Their role in the prediction of response to CCB therapy has not yet been demonstrated. Due to the risk of potentially life-threatening complications, the use of CCBs...
given orally or intravenously as an acute test is discouraged. A positive acute response is defined as a reduction of mean PAP ≥10 mmHg to reach an absolute value of mean PAP ≤40 mmHg with an increased or unchanged CO. Only about 10% of patients with IPAH will meet these criteria. Positive acute responders are most likely to show a sustained response to long-term treatment with high doses of CCB and they are the only patients that can safely be treated with this type of therapy. About half of IPAH positive acute responders are also positive long-term responders to CCBs and only in these cases is the continuation of CCB as a single treatment warranted. The usefulness of acute vasoreactivity tests and long-term treatment with CCBs in patients with other PAH types, such as heritable PAH, connective tissue diseases, and HIV infection is less clear than in IPAH. Acute vasoreactivity studies to identify patients with a long-term favourable response to CCB is not recommended in patients with pulmonary hypertension associated with left heart disease, lung diseases, CTEPH, and PH due to multiple mechanisms.

The CCBs that have been predominantly used in reported studies are nifedipine, diltiazem and amlodipine, with particular emphasis on the first. The daily doses of these drugs that have shown efficacy in IPAH are relatively high, 120-240 mg for nifedipine, 240-720 mg for diltiazem, and up to 20 mg for amlodipine. It is advisable to start with a low dose, eg, 30 mg of slow release nifedipine twice a day or 60 mg of diltiazem 3 times a day or 2.5 mg of amlodipine once a day and increase cautiously and progressively to the maximum tolerated dose. Limiting factors for dose increase are usually systemic hypotension and lower limb peripheral oedema. Patients with IPAH who meet the criteria for a positive vasodilator response and are treated with CCB should be followed closely for both safety and efficacy with an initial reassessment after 3-4 months of therapy including RHC.

If the patient does not show an adequate response (defined as being in WHO functional class I or II and with a marked hemodynamic improvement), additional PAH therapy should be instituted. Patients who have not undergone a vasoreactivity study or those with a negative study should not be started on CCBs because of potential severe side-effects (eg, hypotension, syncope, and RV failure).

Vasodilator responsiveness does not appear to predict a favourable long-term response to CCB therapy in patients with PAH in the setting of connective tissue diseases, and high dose CCB are often not well tolerated in such patients.

No clear data support the use of CCBs in patients with Eisenmenger’s syndrome and the empirical use of CCB is dangerous and should be avoided.

**Specific Drug Therapies**

Specific therapies include those targeting the pathobiological abnormalities of PAH such as prostanoids, ERA and phosphodiesterase type-5 inhibitors.

**Prostanoids**

Prostacyclin is produced predominantly by endothelial cells and induces potent vasodilatation of all vascular beds studied. This compound is the most potent endogenous inhibitor of platelet aggregation and also appears to have both cytoprotective and antiproliferative activities. Dysregulation of the prostacyclin metabolic pathways has been shown in patients with PAH as assessed by reduction of prostacyclin synthase expression in the pulmonary arteries and of prostacyclin urinary metabolites.

Epoprostenol (synthetic prostacyclin) is available as a stable freeze-dried preparation that needs to be dissolved to allow intravenous infusion. Epoprostenol has a short half-life (3–5 min) and is stable at room temperature for only 8 h; this explains why it must be administered continuously by means of infusion pumps and permanent tunnellized catheters. The efficacy of continuous intravenous administration of epoprostenol has been tested in three unblinded RCTs in patients with IPAH and in those with PAH associated with the scleroderma spectrum of diseases. Epoprostenol improves symptoms, exercise capacity and hemodynamics in both clinical conditions, and is the only treatment shown to improve survival in IPAH in a randomized study. Long-term treatment with epoprostenol is initiated at a dose of 2–4 ng/kg/min, with doses increasing at a rate limited by adverse effects (flushing, headache, diarrhea, leg pain). Optimal dose varies between individual patients, ranging from 20 to 40 ng/kg/min. Serious adverse events related to the delivery system include pump malfunction, local site infection, catheter obstruction and sepsis. Abrupt interruption of the epoprostenol infusion should be avoided as this may, in some patients, lead to a rebound worsening of their PH with symptomatic deterioration and even death.

Treprostinil is a tricyclic benzidine analogue of epoprostenol, with sufficient chemical stability to be administered at ambient temperature.
These characteristics allow administration of the compound by the intravenous as well as the subcutaneous route. The subcutaneous administration of treprostinil can be accomplished by micro-infusion pumps and small subcutaneous catheters. The effects of treprostinil in PAH were studied in the largest worldwide randomized controlled trial performed in this condition, and showed improvements in exercise capacity, hemodynamics and symptoms. The greatest exercise improvement was observed in patients who were more compromised at baseline and in subjects who could tolerate upper quartile doses (>13.8 ng/kg/min). Infusion site pain was the most common adverse effect of treprostinil, leading to discontinuation of the treatment in 8% of cases on active drug and limiting dose increase in an additional proportion of patients. Among the 15% of patients who continued to receive subcutaneous treprostinil alone, survival appears to be improved.

In another long-term, open-label study, sustained improvement in exercise capacity and symptoms with subcutaneous treprostinil was reported in patients with IPAH or CTEPH, with a mean follow-up of 26 months. Treprostinil has been recently approved in the USA for intravenous use in patients with PAH: the effects appear to be comparable with those of epoprostenol but at a dose 2 to 3 times higher. It is more convenient for the patient because the reservoir can be changed every 48 hours as compared to 12 hours with epoprostenol. A phase III randomised controlled trial of inhaled treprostinil was recently completed and preliminary data show improvements in exercise capacity. Oral treprostinil is currently being evaluated in PAH Iloprost is a chemically stable prostacyclin analogue available for intravenous, oral and aerosol administration. Inhaled therapy for PAH is an attractive concept that has the theoretical advantage of being selective for the pulmonary circulation. Inhaled iloprost has been evaluated in one RCT in which daily repetitive iloprost inhalations (6 to 9 times, 2.5–5 µg/inhalation, median 30 µg daily) were compared with placebo inhalation in patients with PAH and CTEPH. The study showed an increase in exercise capacity and improvement in symptoms, PVR and clinical events in enrolled patients. A second RCT on 60 patients already treated with bosentan increased in exercise capacity in the subjects randomized to the addition of inhaled iloprost, compared with placebo. Overall, inhaled iloprost was well tolerated. Continuous intravenous administration of iloprost appears to be as effective as epoprostenol in a small series of patients with PAH and CTEPH.

Endothelin Receptor Antagonists

Activation of the endothelin (ET)-1 system has been demonstrated in both plasma and lung tissues of PAH patients. Although it is not clear if the increases in ET-1 plasma levels are a cause or a consequence of PH, studies on tissue ET system expression support a prominent role for ET-1 in the pathogenesis of PAH.

Bosentan is an oral active dual ET_{A} and ET_{B} receptor antagonist and was the first molecule of this class of drugs to be synthesized. Bosentan has been evaluated in PAH in five RCTs that have shown improvement in exercise capacity, functional class, haemodynamics, echocardiographic and Doppler variables, and time to clinical worsening. Two randomised controlled trials have enrolled exclusively patients with WHO/New York Heart Association (NYHA) functional class II or patients with Eisenmenger Syndrome. Long-term observational studies have demonstrated the durability of the effect of bosentan over time. Increases in hepatic aminotransferases occurred in 10% of the subjects but were found to be dose dependent and reversible after dose reduction or discontinuation. For these reasons liver function tests should be performed at least monthly in patients receiving bosentan.

Sitaxsentan, a selective orally active ET_{A} receptor antagonist, has been assessed in 2 RCTs in patients with WHO/NYHA class II/III PAH. Aetiology included IPAH and PAH associated with connective tissue diseases or congenital heart diseases. The studies demonstrated improvements in exercise capacity and hemodynamics. A one-year, open-label observational study demonstrated the durability of the effects of sitaxsentan over time. Incidence of abnormal liver function tests, which reversed in all cases, was 3%-5% for the approved dose of 100 mg (monthly monitoring is required). Interaction with warfarin requires the reduction of the anticoagulant dose by about 80% to stabilize the international normalized ratio.

Ambrisentan, a non-sulfonamide, propanoic acid-class, ERA that is selective for the ET_{A} receptor, has been in evaluated in a pilot study and in 2 large RCT that demonstrated efficacy on symptoms, exercise capacity, hemodynamics and time to clinical worsening. The open-label continuation study has demonstrated the durability of the effects of ambrisentan for at least one year. Ambrisentan has been approved for the treatment of WHO/NYHA functional class II patients. The current approved is 5 mg once daily (OD), which can be increased to 10 mg OD if the drug is tolerated with the initial dose. Incidence of abnormal liver function tests ranges from 0.8% to 1.3%.
to 3%. However even in patients treated with ambrisentan, liver function tests are required at least monthly. Caution is suggested for the co-administration of ambrisentan with ketoconazole and cyclosporine.

**Phosphodiesterase Type-5 Inhibitors**

Sildenafil is an orally active, potent and selective inhibitor of phosphodiesterase type-5 that exerts its pharmacological effect by increasing the intracellular concentration of cGMP. A number of uncontrolled studies have reported favourable effects of sildenafil in IPAH, PAH associated to connective tissue diseases and to congenital heart diseases, and in CTEPH.70-72 A pivotal RCT in 278 PAH patients treated with sildenafil 20, 40, or 80 mg 3 times daily (TID) has confirmed favourable results on exercise capacity, symptoms and hemodynamics.73 Although the approved dose is 20 mg TID, the durability of effect up to one year has been demonstrated only with the dose of 80 mg TID. In clinical practice, up-titration beyond 20 mg TID, (mainly 40 to 80 mg TID) is frequently needed. Most side effects of sildenafil were mild to moderate and mainly related to vasodilation.

Tadalafil is an OD dosing, selective phosphodiesterase-5 (PDE-5) inhibitor, currently approved for the treatment of erectile dysfunction. A pivotal RCT on 406 PAH patients treated with tadalafil 5, 10, 20, or 40 mg OD has shown favourable results on exercise capacity, symptoms, hemodynamics and time to clinical worsening for the largest dose.74 Side effects profile was similar to sildenafil.

**Combination Therapy**

Combination therapy is the simultaneous use of more than one PAH-targeted class of drugs, eg, ERA, PDE-5 inhibitors, prostanoids, and novel substances. Although long-term safety and efficacy have not yet been amply explored, numerous case series have suggested that various drug combinations appear to be safe and effective. Different randomised controlled studies have shown the efficacy of the combination of bosentan and epoprostenol,65 of the addition of inhaled iloprost to patients on background therapy with bosentan,75 of bosentan in patients on background therapy with sildenafil,63 of sildenafil in patients on background treatment with epoprostenol,76 of inhaled treprostinil in patients with background treatment with either bosentan or sildenafil and of tadalafil in patients on background treatment with bosentan.74 Additional trials with novel compounds are on going. There are many open questions regarding combination therapy, including the optimal combination and timing. Candidates to combination therapy are patients whose status is defined as stable but unsatisfactory or unstable and deteriorating. Given the complexities related to combination therapy, it is recommended that candidates be referred to expert centers.

**Interventional Procedures**

**Balloon Atrial Septostomy**

The role of balloon atrial septostomy in the treatment of patients with PAH is uncertain because its efficacy has been reported only in small series and case reports.77 In addition to symptomatic and hemodynamic improvement, increased survival compared with historical control groups has been shown. In most circumstances, this intervention has been performed in severely ill patients as a palliative bridge to lung transplantation, which may explain a procedure mortality rate of 5%–15%. In expert centers this procedure is now performed in cases of failure of available medical treatments.

**Lung transplantation**

Lung and heart–lung transplantation in PAH has been assessed only in prospective uncontrolled series, since formal RCTs are considered unethical in the absence of alternative treatment options.77 The 3-year and 5-year survival after lung and heart–lung transplantation is approximately 55% and 45%, respectively.78 Both single and bilateral lung transplantation have been performed for IPAH and these operations have been combined with repair of cardiac defects in Eisenmenger’s syndrome. Recipient survival rates have been similar after single and bilateral lung transplantation and after heart–lung transplantation for PAH. However, many transplant centres currently prefer to perform bilateral lung transplantation. Lung and heart–lung transplantation are indicated in PAH patients with advanced WHO/NYHA class III and class IV symptoms that are refractory to available medical treatments. The appropriate timing of listing for transplantation is complicated by the unpredictable waiting period and the donor organ shortage.

**Clinical Response to Treatment**

The treatment algorithm includes the concept of adequacy of response to initial treatment. Adequate clinical response is defined as the achievement of a stable and satisfactory clinical status, including absence of clinical signs of RV failure,51 stable WHO functional class I or II without syncope, a 6-minute
walk distance >500 meters\textsuperscript{51,79}, a peak VO\textsubscript{2} >15 mL/min/kg,\textsuperscript{80,81} normal or near-normal BNP/NT-proBNP plasma levels,\textsuperscript{82,83} no pericardial effusion,\textsuperscript{84} tricuspid annular plane systolic excursion >2 cm,\textsuperscript{85} right atrial pressure <8 mmHg, and a CI >2.5 L/min/m\textsuperscript{2}.\textsuperscript{4,50,51,79,86}

Inadequate clinical response to treatment for patients initially in WHO functional class II or III is considered a clinical status defined as stable and not satisfactory: some of the limits described above for a stable and satisfactory condition are not fulfilled, and the patient and treating physician consider the status, although stable, to be less than desirable.

Alternatively, a clinical state defined as unstable and deteriorating is also an inadequate clinical response: the patient is characterized by evidence of progression of RV failure symptoms and signs, worsening WHO functional class, ie, from II to III or III to IV, a 6-min walk distance <300 meters,\textsuperscript{51,79} a peak VO\textsubscript{2}<12 mL/min/kg,\textsuperscript{80} rising BNP/NT-proBNP plasma levels,\textsuperscript{82,83} evidence of pericardial effusion,\textsuperscript{84} tricuspid annular plane systolic excursion <1.5 cm,\textsuperscript{85} right atrial pressure >15 mmHg and rising, and a CI that is <2 L/min/m\textsuperscript{2} and falling.\textsuperscript{4,50,51,79,86} Clinical warning signs include increasing oedema and/or the need to escalate diuretic therapy, new onset or increasing frequency/severity of angina (which can be a sign of deteriorating RV function), and the onset or increasing frequency of syncope which is often a grim prognostic sign and requires immediate attention as it heralds low output heart failure. Supraventricular arrhythmias may be seen in this condition and contribute to clinical deterioration.

Finally, inadequate clinical response for patients who were initially in WHO functional class IV is considered the absence of a rapid improvement to WHO functional class III or better.

**Treatment Algorithm**

The treatment algorithm for PAH patients (Figure) is not appropriate for patients in other clinical groups and in particular for patients in PH associated with left heart diseases or with parenchymal lung diseases.

General measures and supportive therapy need to be initiated after PAH diagnosis.

Due to the complexity of the additional evaluation and the treatment options available, it is strongly recommended that patients with PAH be referred to a specialized center.

Acute vasoreactivity testing should be performed and high-dose CCBs therapy performed as appropriate.

Non-responders to acute vasoreactivity testing, or responders who remain in (or progress to) WHO functional class III should be considered candidates for treatment either an ERA, a PDE-5 inhibitor or a prostanoid. As head-to-head comparisons among different compounds are not available, no evidence-based first-line treatments can be proposed. In this case, the choice of therapy depends on a variety of factors, including the approval status, route of administration, the side effect profile, patient’s preferences and physician’s experience. Some settings still use first-line intravenous epoprostenol in WHO functional class III patients, due to its demonstrated survival benefits.

Continuous intravenous epoprostenol may be considered as first-line therapy for WHO functional class IV PAH patients because of the demonstrated survival benefit in this subset. Intravenous and subcutaneous treprostinil have also been approved for the treatment of WHO functional class IV patients in the USA. Although no randomised controlled trials have been performed with the intravenous delivery of iloprost, this PGI2 analogue has been approved in New Zealand. Both ERA and PDE-5 inhibitors are considered as a second line for severely ill patients. In WHO functional class IV patients, initial combination therapy may be considered.

In case of inadequate clinical response, sequential combination therapy can be considered. Combination therapy may include a prostanoid plus an endothelin receptor antagonist, an endothelin receptor antagonist plus a PDE-5 inhibitor, a prostanoid plus a PDE-5 inhibitor. Appropriate protocols for timing and dosing to limit possible side effects of the combination have yet to be defined.

Balloon atrial septostomy and/or lung transplantation are indicated for PAH with inadequate clinical response despite optimal medical therapy or where medical treatments are unavailable. These procedures should be performed only in experienced centers.

**PULMONARY HYPERTENSION DUE TO LEFT HEART DISEASE**

PH carries a poor prognosis for patients with chronic heart failure.\textsuperscript{87} The mechanisms responsible for the increase in PAP are multiple and include the passive backward transmission of the elevated pressure (post-capillary passive PH, Table 1). In these cases the transpulmonary pressure gradient (TPG = mean PAP minus mean PWP) and PVR are within the normal range. In other circumstances the elevation of PAP is greater than that of PWP (increased TPG) and an
increase in PVR is also observed (postcapillary reactive or “out of proportion” PH, Table 1). The elevation of PVR is due to an increase in pulmonary arteries vasomotor tone and/or to fixed structural obstructive remodelling of the pulmonary artery resistance vessels: the former component of reactive PH is reversible under acute pharmacological testing while the latter, characterized by medial hypertrophy and intimal proliferation of the pulmonary arteriole, does not respond to the acute challenge.

Which factors lead to reactive (out of proportion) PH and why some patients develop the acutely reversible vasoconstrictive or fixed obstructive components or both is poorly understood. Pathophysiological mechanisms may include vasoconstrictive reflexes arising from stretch receptors localized in the left atrium and pulmonary veins, and endothelial dysfunction of pulmonary arteries that may favour vasoconstriction and proliferation of vessel wall cells. The prevalence of PH in patients with chronic heart failure increases with the progression of functional class impairment. Up to 60% of patients with severe left ventricular systolic dysfunction and up to 70% of patients with isolated left ventricular diastolic dysfunction may present with PH. In left-sided valvular diseases, the prevalence of PH increases with the severity of the defect and of the symptoms. PH can be found in virtually all patients with severe symptomatic mitral valve disease and up to 65% of those with symptomatic aortic stenosis. Currently, there is no specific therapy for PH due to left heart diseases. A number of drugs (including diuretics, nitrates, hydralazine, angiotensin converting enzyme inhibitors, beta-adrenoceptors blockers, nesiritide, and inotropic agents) or interventions (left ventricular assist device implantation, valvular surgery, resynchronization therapy and heart transplantation) may lower PAP more or less rapidly through a drop in left-sided filling pressures. Therefore, management of PH due to left heart disease should be aimed at the optimal treatment of the underlying disease. No heart failure drugs are contra-indicated because of PH.

Few studies have examined the role of drugs currently recommended in PAH. The use of inhaled nitric oxide has been shown to reduce PAP but also to increase PWP, increasing the likelihood of lung oedema. RCTs evaluating the effects of chronic use of epoprostenol and bosantan in advanced heart failure have been terminated early due to an increased rate of events in the investigational drug treated group compared with conventional therapy. A small study recently suggested that sildenafil may improve exercise capacity and quality of life in patients with PH due to left heart disease. The history of medical therapy for heart failure is full of examples where drugs had positive effects on surrogate endpoints but eventually turned out to be detrimental, such as the phosphodiesterase type-3 inhibitors. Thus, the use of PAH-specific drugs is not recommended until robust data from long-term studies are available, in particular in “out of proportion” PH associated with left heart disease.

PULMONARY HYPERTENSION DUE TO LUNG DISEASE

PH is a poor prognostic factor in either chronic obstructive pulmonary disease (COPD) or interstitial lung diseases. The pathobiological and pathophysiological mechanisms involved in this setting are multiple and include hypoxic vasoconstriction, mechanical stress of hyperinflated lungs, loss of capillaries, inflammation and toxic effects of cigarette smoke. There are also data supporting an endothelium-derived vasoconstrictor–vasodilator imbalance. Based on published series, the incidence of significant PH in COPD patients with at least one previous hospitalization for exacerbation of respiratory failure is 20%. In advanced COPD, PH is highly prevalent (>50%), although generally of mild severity. In interstitial lung disease, the prevalence of PH is 32%-39%. The combination of lung fibrosis with emphysema is associated with a higher prevalence of PH. Currently there is no specific therapy for PH associated with COPD or interstitial lung diseases. Long-term O₂ administration has been shown to partially reduce the progression of PH in COPD. Nevertheless, with this treatment PAP rarely returns to normal values and the structural abnormalities of pulmonary vessels remain unaltered. In interstitial lung diseases, the role of long-term O₂ therapy on PH progression is less clear. Treatment with conventional vasodilators is not recommended because they may impair gas exchange due to the inhibition of hypoxic pulmonary vasoconstriction and their lack of efficacy after long-term use. Published experience with specific PAH drug therapy is scarce and consists of the assessment of acute effects and uncontrolled studies in small series.

The treatment of choice for patients with COPD or interstitial lung diseases and associated PH who are hypoxemic is long-term O₂ therapy. Patients with “out of proportion” PH due to lung diseases (characterized by dyspnoea insufficiency explained by lung mechanical disturbances and mean PAP ≥40-45 mmHg) should be referred to expert centres and enrolled in clinical trials targeting PAH specific
drug therapy. The use of targeted PAH therapy in patients with COPD or interstitial lung diseases and mean PAP<40 mmHg is currently discouraged because there are no systematic data regarding its safety or efficacy.

**CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION**

Non-resolution of acute embolic masses which later undergo fibrosis leading to mechanical obstruction of pulmonary arteries is the most important pathobiological process in CTEPH. The obstructive lesions observed in the distal pulmonary arteries of non-obstructed areas (virtually identical to those observed in PAH) may be related to a variety of factors, such as shear stress, pressure, inflammation, and the release of cytokines and vasculotrophic mediators. Although more recent papers suggest that the prevalence of CTEPH is up to 3.8% in survivors of acute pulmonary embolism, most experts...
believe that the true incidence of CTEPH after acute pulmonary embolism is 0.5%-2%. CTEPH can be found in patients without any previous clinical episode of acute pulmonary embolism or deep venous thrombosis (up to 50% in different series).\textsuperscript{113}

Patients with CTEPH should receive life long anticoagulation, usually with vitamin K antagonists adjusted to a target international normalized ratio between 2.0 and 3.0. Despite anticoagulation, CTEPH patients without additional treatments have a poor prognosis.

Therapeutic decisions concerning patients with CTEPH should be made at an expert centre based upon interdisciplinary discussion among internists, radiologists and expert surgeons. Pulmonary endarterectomy is the treatment of choice for patients with CTEPH, as it is a potentially curative option. As a rule, a patient should not be considered inoperable until the case has been reviewed by an experienced surgeon.

The general medical intensive treatment of advanced WHO functional class III or class IV CTEPH patients does not differ substantially from treatment of PAH. An urgent pulmonary endarterectomy should be planned as soon as reasonable hemodynamic conditions have been restored.

Specific PAH drug therapy may play a role in selected CTEPH patients, mainly for three different scenarios: a) patients are not considered candidates for surgery; b) preoperative treatment is deemed appropriate to improve hemodynamics; and c) patients present with symptomatic residual/recurrent PH after pulmonary endarterectomy surgery.
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