Canadian Cardiovascular Society and Canadian Thoracic Society position statement on pulmonary arterial hypertension

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The Canadian Cardiovascular Society and the Canadian Thoracic Society requested a position statement on pulmonary arterial hypertension from leading Canadian experts. The present document provides a brief overview of that progress. It is intended to act as an update for the clinician, to provide a template for the initial evaluation of patients, to enable the understanding of current therapeutic paradigms based on approved indications for Canada, to highlight new therapies on the horizon, and to state the positions of the Canadian Cardiovascular Society and the Canadian Thoracic Society on resource management for pulmonary arterial hypertension in Canada.

Key Words: Canadian health system; Endothelin; Nitric oxide; Prostaglandins; Pulmonary artery; Pulmonary hypertension

In the past decade, considerable progress has been made in the understanding, diagnosing and treating of pulmonary hypertension. The present document provides a brief overview of that progress. It is intended to act as an update for the clinician, to provide a template for the initial evaluation of patients, to enable the understanding of current therapeutic paradigms based on approved indications for Canada, to highlight new therapies on the horizon, and to state the positions of the Canadian Cardiovascular Society and the Canadian Thoracic Society on resource management for pulmonary arterial hypertension (PAH) in Canada.

DEFINITIONS

The normal adult pulmonary vasculature is a low-pressure, high-capacitance bed that can accommodate increases in cardiac output with little or no increase in pressure. Many factors contribute to this low resistance, including the large cross-sectional area of the pulmonary vascular bed and the availability of a low-pressure drainage area (ie, the left atrium) for blood leaving the lung. All disorders that increase pulmonary vascular resistance will increase pulmonary arterial pressure (Ppa). However, when assessing pulmonary hemodynamics, the pulmonary arterial blood flow must also be considered because some types of hyperdynamic circulation can raise Ppa without it representing a true increase in pulmonary vascular resistance. Thus, in defining pulmonary hypertension, the pulmonary vascular resistance should exceed 3 Wood units (ie, greater than 240 dynes×s×cm⁻⁵). Conversely, in conditions with only mildly increased pulmonary vascular resistance, pulmonary hypertension may not be evident at rest, and may be revealed only with exercise or pharmacological elevation of cardiac output. Precapillary pulmonary hypertension, which includes PAH, is defined for clinical purposes as a mean end-expiratory Ppa of greater than 25 mmHg at rest, with a mean end-expiratory pulmonary artery wedge pressure (Pwedge) of less than 15 mmHg and a calculated pulmonary vascular resistance of greater than 3 Wood units. It is critical to have reliable and accurate Pwedge tracing. If a Pwedge cannot be obtained reliably, then the left ventricular end-diastolic pressure should be less than 15 mmHg at end-expiration, to exclude left heart disease, and there should be no indication of left-sided cardiovacular disease.

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This position statement was jointly commissioned by the Canadian Cardiovascular Society and the Canadian Thoracic Society. The content has been approved by both societies and is being published simultaneously in The Canadian Journal of Cardiology and the Canadian Respiratory Journal.

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ETIOLOGY AND CLASSIFICATION

Numerous classification schemes have been developed since the 1950s, when Dresdale et al (1) first described primary pulmonary hypertension (PPH) and Wood et al (2) performed seminal studies on the effects of vasodilators. Because several etiologies as well as PPH seem to cause similar morphological changes in the precapillary vessels (see below), and these etiologies have many common features of pathogenesis and abnormal mediators, the consensus group of the World Health Organization has included them in the PAH classification (3). This classification was slightly revised in June 2003 at the Third World Symposium on PAH in Venice, Italy, and is now termed the "Venice" classification (4) (Table 1). With the recognition that some patients formerly diagnosed with PPH in fact have an identifiable, specific genetic abnormality, notable changes in the Venice classification are the replacement of 'PPH' with 'idiopathic PAH', and the inclusion of 'familial PAH' as a distinct type of PAH. The classification has proven to be extremely useful in clinical research and studies of pathogenesis. The present document will concentrate on PAH. A functional classification for PAH was also established by the World Health Organization, and is analogous to that of the Canadian Cardiovacular Society for angina and the New York Heart Association for congestive heart failure, with four classes of severity of symptoms (5).

PATHOGENESIS

The earliest hypotheses regarding the development of PPH proposed that vasoconstriction was the initial and principal abnormality and that it led to structural changes in vessels (ie, remodelling), resulting in 'fixed' disease (ie, unresponsive to vasodilators). However, recent studies (6) have suggested that the remodelling may be the first and most predominant abnormality. Moreover, at the time of hemodynamic evaluation, by which time most patients have advanced disease, less than 10% of patients with idiopathic PAH have a significant vasodilator response to exogenous dilators such as inhaled nitric oxide or intravenous epoprostenol. PAH is associated with structural alterations in normally thin-walled precapillary pulmonary microvessels of approximately 300 µm to 50 µm in size. The lesions consist of endothelial intimal thickening, smooth muscle proliferation and plexiform lesions (7). The vessel lumen is narrowed or obliterated, leading to increased pulmonary vascular resistance. Plexiform lesions, which are vascular tufts consisting principally of endothelial cells, form mainly downstream from bifurcations (6). These abnormal structures may result from increased cell proliferation and decreased apoptosis. Based on the finding that in some patients with idiopathic PAH, the endothelial 'expansion' is monoclonal, this growth may represent a form of localized neoplasia (8). Plexiform lesions may appear late in the course of the disease and are not universally present, but the intimal thickening of 'plexogenic arteriopathy' is an early and almost universal finding (6). Recent evidence (9) suggests that endothelial cell apoptosis, likely a result of environmental factors and genetic predisposition, may be an initiating event in PAH, which leads secondarily to endothelial proliferation and, in some cases, to the emergence of apoptosis-resistant endothelial cell populations. Larger conduit arteries develop medial smooth muscle hypertrophy and hyperplasia, further thickening and stiffening the vessel wall (7).

A deficiency in the expression of certain voltage-gated potassium channels, particularly Kv1.5, which results in membrane depolarization and increased intracellular calcium levels in smooth muscle, has been described in patients with idiopathic PAH (10,11). This ionic remodelling may contribute to vasoconstriction and hypertrophy, and is also involved in suppression of apoptosis through its effects on intracellular potassium. Adventitial thickening and inflammation can also be present, and the inflammatory process may be an essential element in the development of vascular lesions (12). Increased levels of elastase and other proteinases contribute to disorganization of the vascular wall matrix and may promote remodelling (13).

The recognition that idiopathic PAH may be genetically transmitted in families led to the identification of mutations causing dysfunction in the gene for the type-II bone morphogenetic protein receptor (BMPR-II) (14,15). These mutations have been found in up to 66% of familial cases and up to 20% of sporadic cases of idiopathic PAH, although estimates vary between centres that are performing the genetic analyses, with some estimates being much lower. Bone morphogenetic protein is a member of the transforming growth factor beta superfamily of peptides and is thought to normally suppress cell proliferation or to induce apoptosis (16). Although loss of these negative growth influences on normally quiescent lung vascular cells could result in increased cell proliferation and deficient apoptosis, the actual mechanisms by which BMPR-II

TABLE 1

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<thead>
<tr>
<th>Pulmonary arterial hypertension</th>
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<td>• Idiopathic</td>
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<td>• Familial</td>
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<td>• Associated with:</td>
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<tr>
<td>• Connective tissue disease</td>
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<td>• Congenital systemic-to-pulmonary shunts</td>
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<td>• Portal hypertension</td>
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<td>• HIV infection</td>
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<td>• Drugs and toxins</td>
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<td>• Other</td>
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<tr>
<td>• Associated with significant venous or capillary involvement (eg, pulmonary veno-occlusive disease or pulmonary capillary hemangiomatosis)</td>
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<tr>
<td>• Pulmonary hypertension with left heart disease</td>
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<tr>
<td>• Left-sided atrial or ventricular disease</td>
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<td>• Left-sided valvular heart disease</td>
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<tr>
<td>• Pulmonary hypertension associated with lung diseases and/or hypoxemia</td>
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<td>• Chronic obstructive pulmonary disease</td>
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<td>• Interstitial lung disease</td>
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<td>• Sleep-disordered breathing</td>
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<td>• Alveolar hypoventilation syndromes</td>
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<td>• Developmental abnormalities</td>
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<td>• Pulmonary hypertension due to chronic thrombotic and/or embolic disease</td>
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<td>• Thromboembolic obstruction of proximal pulmonary arteries</td>
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<td>• Thromboembolic obstruction of distal pulmonary arteries</td>
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<td>• Nonthrombotic pulmonary embolism (eg, tumour, parasites and foreign material)</td>
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<tr>
<td>• Miscellaneous</td>
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<tr>
<td>• Sarcoidosis, histiocytosis X, lymphangiomatosis or compression of pulmonary vessels</td>
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Data from reference 4
RECOGNIZING PULMONARY HYPERTENSION

1) Unexplained dyspnea, decreased exercise tolerance or syncope? and/or
2) Incidental finding on physical examination, chest radiograph, or ECG suggestive of PH? and/or
3) Familial history of PH
4) Other risk factor for PAH (connective tissue disease, HIV, portal hypertension, anorexigen, etc)

MEDIATORS AND MARKERS OF PAH

Abnormal tissue, plasma or urinary levels of several vasoactive mediators have been described in PAH (17). Reduced expression and synthesis of prostacyclin, increased expression and synthesis of thromboxane A2 and endothelin-1, and increased levels of serotonin and serotonin reuptake receptors have been described (18-22). All of these changes favour vasoconstriction and cellular proliferation. Reduced fibrinolytic activity and a prothrombotic state have also been reported, with increased levels of tissue factor. Identification of these abnormalities has provided a rationale for much of the currently used therapy. In addition, brain natriuretic peptide, troponin and uric acid may be useful, although nonspecific, markers of PAH severity (23-25). Troponin or brain natriuretic peptide measurement may allow the noninvasive monitoring of therapy in PAH using point-of-care testing.

SCREENING AND IDENTIFICATION

Pulmonary hypertension should be considered in the differential diagnosis of unexplained dyspnea (Figure 1). When pulmonary hypertension is in more advanced stages, it may be detected during physical examination or by electrocardiography (P pulmonale, right axis deviation, right bundle branch block, right ventricular hypertrophy) or chest radiography. However, physical examination is often too insensitive to detect milder forms of the disease. In this regard, two-dimensional and Doppler echocardiography have greatly improved the detection rate. While echocardiography is an extremely useful tool, it provides only an estimate of right ventricular systolic pressure, and is less sensitive and specific when Ppa is closer to normal. This is also a problem when stress echocardiography is used to assess the effects of exercise on Ppa. Pulmonary hypertension is a hemodynamic disorder and cardiac catheterization remains the gold standard for its diagnosis because it provides the ability to directly measure Ppa, calculate pulmonary blood flow, determine the response to acute vasodilators (in appropriate patients), determine disease severity (ie, prognosis) and exclude secondary causes of pulmonary hypertension. Cardiac magnetic resonance imaging is an emerging tool for the evaluation of right ventricular function. It is able to estimate right ventricular mass, volume and ejection fraction. Magnetic resonance imaging studies of the right ventricle do not require injection of gadolinium or other contrast material.

INVESTIGATIONS AT SPECIALIZED HYPERTENSION CLINICS

Beyond the initial screening, all patients suspected of having PAH should be referred to specialized pulmonary hypertension clinics at academic centres that provide a critical mass of expertise and patient volume (Figures 1 and 2). This avoids inadequate or duplicate testing, and fosters research in these relatively rare and complex patients. Given Canadian provincial population sizes, one or two adult care centres per province should suffice. Despite increasing recognition of specific genetic abnormalities in idiopathic PAH, the specific diagnosis remains in the domain of the clinician through the exclusion of a variety of other causes of pulmonary hypertension, and genetic testing is not yet routinely advocated. All patients with pulmonary hypertension require a careful history and physical examination followed by testing to identify specific abnormalities (Figure 2). A basic battery of tests will allow for the correct classification of most patients with pulmonary hypertension. In more complex cases, other testing may be needed. For patients...
ACCESS TO THERAPY

Medications currently approved for the treatment of PAH substantially improve survival and/or quality of life. However, with few exceptions, they are extremely expensive and well beyond the means of individual citizens. The availability of high-quality health care in Canada is a right and a national priority. It is the authors’ position that these medications should be available and financially supported within all provincial formulations across Canada in a timely fashion (ie, within three months of approval by Health Canada). These medications should be prescribed only by the provincially designated pulmonary hypertension centres regardless of the method of administration (oral, subcutaneous, intravenous or other), and these centres must have mechanisms in place for adequate follow-up to ensure that the chosen therapy remains effective and does not have deleterious side effects.

THERAPY

Approved therapies for PAH in Canada consist of two types: prostaglandins and endothelin receptor antagonists (Figure 3). Intravenous epoprostenol (prostacyclin) is approved for functional classes III and IV idiopathic PAH, and PAH related to connective tissue diseases without significant lung fibrosis. The medication must be kept cool and shielded from light. It has an extremely short half-life, necessitating continuous infusion with a portable pump and an indwelling central venous catheter. The major risks include interruption of the infusion, which can be fatal, and sepsis from catheter infections. Many patients experience troubling but nonserious side effects such as jaw pain, diarrhea, flushing and headache. Nevertheless, this is the only approved medication that has been shown to improve survival in PAH and it is an effective bridge to lung transplantation (30–34). Anecdotal evidence suggests that some patients may improve to a degree that they can be removed from transplant lists. A subcutaneously administered prostaglandin, treprostinil, is approved for functional classes III and IV PAH (35). It has a longer half-life and is stable at room temperature. The major side effect is injection site inflammation and pain, which in some patients may be intolerable. The orally active nonselective endothelin antagonist bosentan is approved for functional classes III and IV idiopathic PAH and PAH related to connective tissue diseases with or without significant lung fibrosis (36–38). The evidence for its use in functional class IV is weak. The principal risk associated with its use is hepatotoxicity, which may be severe. Monthly measurement of serum hepatic transaminase and bilirubin levels must be performed long-term. Of the approved agents, epoprostenol seems to provide the greatest degree of benefit. The oral route of bosentan makes it the initial treatment of choice for milder (functional class III) disease.

The Third World Symposium on PAH in Venice provided a paradigm for therapy, which includes all the medications available in Canada (39). It must be re-emphasized that acute vasodilator challenge should be reserved for idiopathic or anorexigen-related PAH, as should high-dose calcium channel blocker therapy (40,41). Calcium channel blockers should be reserved for patients with a true acute vasodilator response (as defined above), and one of nifedipine, amlopidine or diltiazem may be prescribed, the choice depending on the degree of right ventricular dysfunction and the heart rate. This therapy is used by Canadian specialists in an off-label fashion because the indication has never been evaluated or approved by Health Canada.
Canadian position statement on pulmonary hypertension

THERAPIES UNDER EVALUATION

Several therapies are under evaluation in phase III studies, and may soon be available if they prove to be safe and effective. Nitric oxide levels are reduced in PAH, as are levels of its downstream signalling messenger, cyclic GMP (cGMP). Sildenafil inhibits phosphodiesterase type 5, the enzyme that breaks down cGMP and is highly expressed in the lung and genitalia, accounting for the localization of its hemodynamic effects largely to these organs. The resultant increase in cGMP may in turn promote vasodilation and possibly lead to a reduction in smooth muscle proliferation. There are several case series and two small placebo-controlled crossover trials suggesting that sildenafil may be effective in PAH. The preliminary results of a placebo-controlled, blinded trial suggest that sildenafil may be an effective therapy for PAH, although there was an as yet unexplained dissociation between clinical benefit and hemodynamic benefit. Inhaled nitric oxide is effective as an acute vasodilator in PAH (26) but its use in chronic therapy awaits randomly assigned clinical trials and it seems unlikely to achieve widespread use due to the complexities of ambulatory administration of this very short-lived and expensive gas. New forms of endothelin antagonists are also being tested. Two endothelin antagonists, which have more selectivity for the endothelin-A receptor than for the endothelin-B receptor compared with bosentan, are also under evaluation in phase III trials. Sitaxsentan is highly selective for the endothelin-A receptor (endothelin-A to endothelin-B ratio of 6500:1), while ambrisentan is fourfold more selective (77:1) than bosentan. In a recent blinded, placebo-controlled trial, sitaxsentan was found to be both safe and effective in improving functional capacity in PAH patients with class II and class III symptoms (44). Preliminary data (45) using ambrisentan are also encouraging. Selective endothelin-A blockade may be preferable in PAH because it preserves endothelin-B activity, which is responsible for endothelin-1 clearance and stimulates production of beneficial endogenous prostacyclin and nitric oxide. However, whether selective endothelin blockers will be superior to nonselective blockers remains to be determined; similar to bosentan, selective endothelin blockers manifest hepatotoxicity as a class effect to varying degrees. Preliminary Canadian studies in animals, using cell-based gene therapy, are extremely encouraging and may translate into novel clinical therapies in 2005. Inhaled prostaglandins (eg, iloprost and treprostinil) are promising and may soon be available if they prove to be safe and effective.

CONCLUSIONS

Tremendous progress has been made in the past decade in understanding the pathogenesis of PAH, establishing its classification and providing effective therapy. This has brought great hope and encouragement to patients and caregivers. This progress must continue. The sobering reality is that most patients with PAH are still at risk of dying within a decade after diagnosis, and new insights into pathogenesis and novel therapies will be required to improve the situation.

FURTHER READING

This position statement provides an expert consensus of the authors, tailored for the Canadian health care system. For further information on PAH, and referenced sources, readers should consult two recent reviews: Chest 2004;126(Suppl 1):1S-92S and J Am Coll Cardiol 2004;43(12 Suppl S):S1-90. Please note that the Canadian position and conclusions may differ slightly from the comments in these reviews.

REFERENCES


