Request to “Update” the 2019 Update of Guidelines for Management of Pulmonary Arterial Hypertension

To the Editor:
We read with interest the long-awaited update on pulmonary arterial hypertension guidelines, published in CHEST in March 2019.1 We congratulate the panel for a great accomplishment in providing clear and concise guidance on a very challenging topic.

We would, however, like to point out that the current update (and the original guidelines in 2014) does not shed light on a pressing clinical challenge (ie, selecting/advocating/implementing advanced pulmonary arterial hypertension therapies in geriatric patient population). The particular age group of interest (from a clinical standpoint) would be patients between 70 and 90 years of age, a routine presentation age group in our outpatient pulmonary practice, where we evaluate and manage these patients for dyspnea. The challenges that we come across as clinicians include the following:

1. Vasoreactivity testing recommendations in geriatric patients: Do they remain the same for this specific population?
2. Guidelines do not address/recommend any alternative approach regarding the 6-min walk test because most patients within this category struggle with ambulatory dysfunction issues resulting from arthritis or other limitations and are not perfect candidates for 6-min walk distance testing.
3. A statement regarding role of these advance therapies in “probable” secondary pulmonary arterial hypertension would also be highly valuable because geriatric patients routinely have comorbid cardiac, pulmonary, and valvular heart diseases comorbidities that may or may not be causally related to elevated pulmonary artery pressures.

Although it may not be possible to draw an evidence-based statement (most of these patients do not make the cut because of the rigid inclusion/exclusion criteria in place for such drug trials), can we at least have a consensus-based statement addressing the issue of chronological age point beyond which advanced diagnostic workup and efforts to initiate/maintain patients on such therapies would be not recommended?

Jameel Durrani, MD, FCCP
Amit Toor, MD
Easton, PA

AFFILIATIONS: From the Department of Pulmonary and Critical Care Medicine, Easton Hospital, Steward Health System.
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CORRESPONDENCE TO: Jameel Durrani, MD, FCCP, Department of Pulmonary and Critical Care Medicine, Easton Hospital, Steward Health System, Easton Lung and Sleep Clinic, 2111 Washington Blvd, Ste 101, Easton, PA 18042; e-mail: Jameel.Durrani@steward.org
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Reference

Response

To the Editor:
We thank Drs Durrani and Toor for their thoughtful comments regarding our update of the CHEST Guidelines for the treatment of World Symposium on Pulmonary Hypertension (WSPH) group 1 pulmonary arterial hypertension (PAH).1 They are correct in noting that these guidelines do not address therapy in the geriatric population, which they define as 70 to 90 years of age.

PAH is less common in the elderly, whereas comorbidities such as chronic heart and lung diseases that are associated with WSPH group 2 (cardiac-related) or 3 (respiratory-related) pulmonary hypertension commonly affect older patients. PAH-specific therapies are ineffective and may be harmful in patients with WSPH group 2 and 3 pulmonary hypertension.
The American College of Chest Physicians update was an evidence-based guideline and consensus statement. Unfortunately, there is insufficient evidence to provide specific recommendations for treatment of PAH in patients older than 70 years of age; therefore, our limited responses should be considered opinion.

1. Based on insufficient data, we cannot offer an opinion on the value or safety of vasoreactivity testing in the elderly.

2. We do not perform 6-min walk distance testing in patients who are limited by musculoskeletal or neurologic disorders at any age.

3. The value of PAH-specific therapies in patients with PAH who manifest cardiac or pulmonary comorbidities as they age should be addressed for each patient, accounting for side effects, risks, and cost.

4. There is not a specific age beyond which treatment of PAH is inappropriate.

We believe that age alone should not prevent patients from being treated for PAH in accordance with the American College of Chest Physicians guidelines when they meet diagnostic criteria and have symptoms that are likely attributable to PAH. Limited data from the few studies that have included older patients do not suggest a need to differ from standard approaches. For example, studies show no increased risk of right heart catheterization in elderly patients evaluated for PAH. Despite lower baseline values, elderly patients achieve the same improvement in 6-min walk distance if normalized to percent predicted. In a post hoc analysis of 112 elderly patients enrolled in the randomized, controlled trial that led to approval of tadalafil for PAH, the efficacy and tolerability of full-dose tadalafil was the same as in patients younger than 65 years of age.

Lack of recommendations specific for elderly patients is a criticism of many clinical practice guidelines. Unfortunately, until geriatric patients are included in clinical trials of PAH, it will be difficult to offer specific evidence-based guidelines on their management.

Karen Fagan, MD
Mobile, AL
Julie Frantsve-Hawley, PhD
Glenview, IL
Steven M. Kawut, MD, FCCP
Philadelphia, PA
John J. Ryan, MD
Salt Lake City, UT
Erika B. Rosenzweig, MD
New York, NY
Nneka Sederstrom, PhD, FCCP
Minneapolis, MN
Virginia D. Steen, MD
Washington, DC
David B. Badesch, MD, FCCP
Aurora, CO

AFFILIATIONS: From the Department of Medicine (Dr Klinger), Rhode Island Hospital; Department of Medicine (Dr Elliott), Intermountain Medical Center; Department of Medicine (Dr Elliott), University of Utah; Department of Cardiothoracic Surgery (Dr Levine), University of Texas Health Science Center; Division of Cardiology (Dr Bossone), Amalfi Coast Hospital; Department of Pharmacy (Dr Duvall), OhioHealth; Division of Pulmonary and Critical Care (Dr Fagan), University of South Alabama; CHEST (Dr Frantsve-Hawley); Department of Medicine (Dr Kawut), Perelman School of Medicine at the University of Pennsylvania; Department of Medicine (Dr Ryan), University of Utah; Department of Pediatric Cardiology (Dr Rosenzweig), Columbia University Medical Center; Clinical Ethics Department (Dr Sederstrom), Children’s Hospitals and Clinics of Minnesota; Department of Medicine (Dr Steen), Georgetown University School of Medicine; and Department of Medicine (Dr Badesch), University of Colorado Health Sciences Center.

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CORRESPONDENCE TO: David Badesch, MD, FCCP, Department of Medicine, University of Colorado Health Sciences Center, 4200 E Ninth Ave, Box C-272, Denver, CO 80232; e-mail: david.badesch@ucdenver.edu

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References


