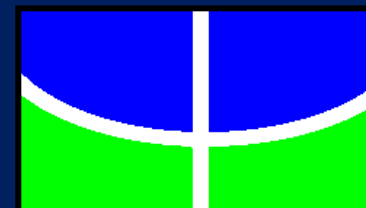


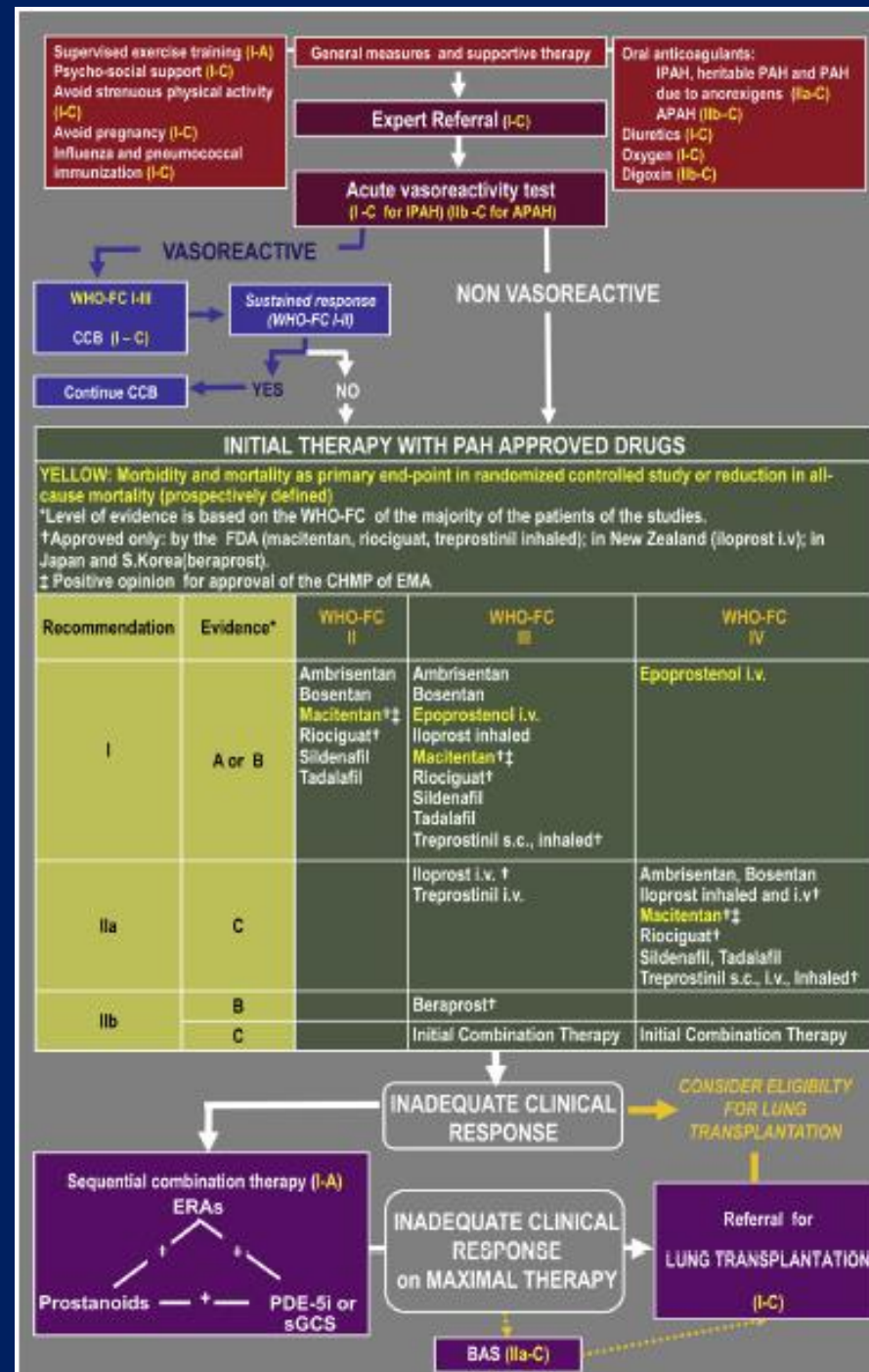
Tratamento da Hipertensão Arterial Pulmonar

Veronica M. Amado

Universidade de Brasília – UnB

Hospital Universitário de Brasília - HUB





Supervised exercise training (I-A)
Psycho-social support (I-C)
Avoid strenuous physical activity (I-C)
Avoid pregnancy (I-C)
Influenza and pneumococcal immunization (I-C)

General measures and supportive therapy

Oral anticoagulants:
IPAH, heritable PAH and PAH due to anorexigens (IIa-C)
APAH (IIb-C)
Diuretics (I-C)
Oxygen (I-C)
Digoxin (IIb-C)

Expert Referral (I-C)

Acute vasoreactivity test
(I-C for IPAH) (IIb-C for APAH)

VASOREACTIVE

WHO-FC I-III

CCB (I-C)

Sustained response
(WHO-FC I-II)

Continue CCB

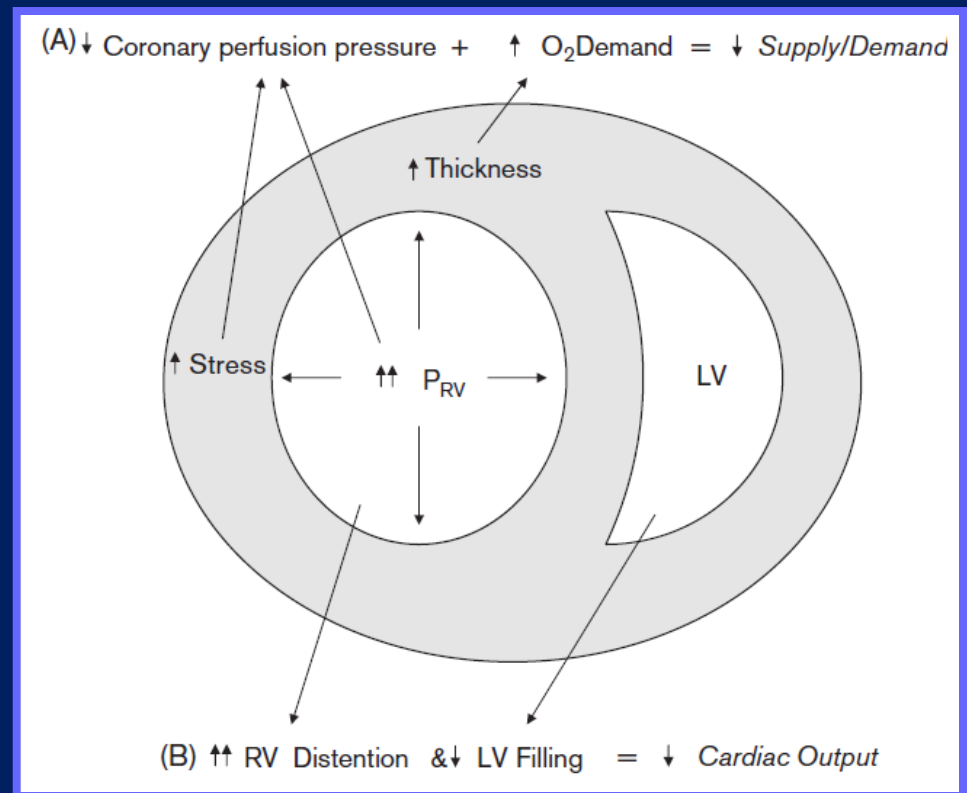
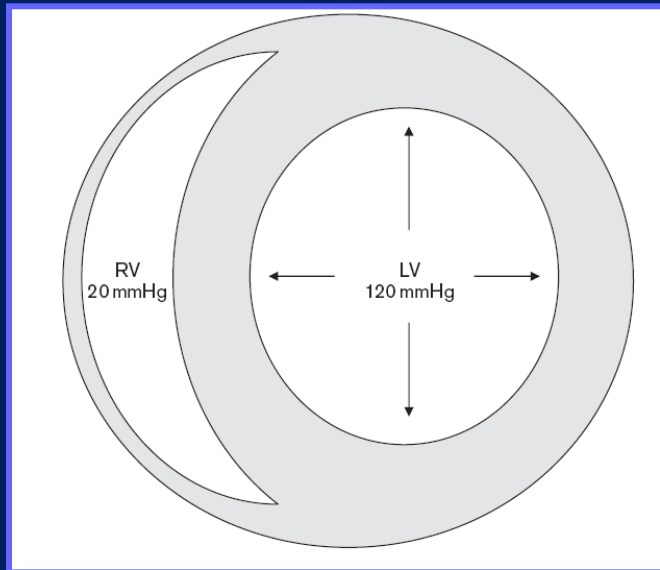
YES

NO

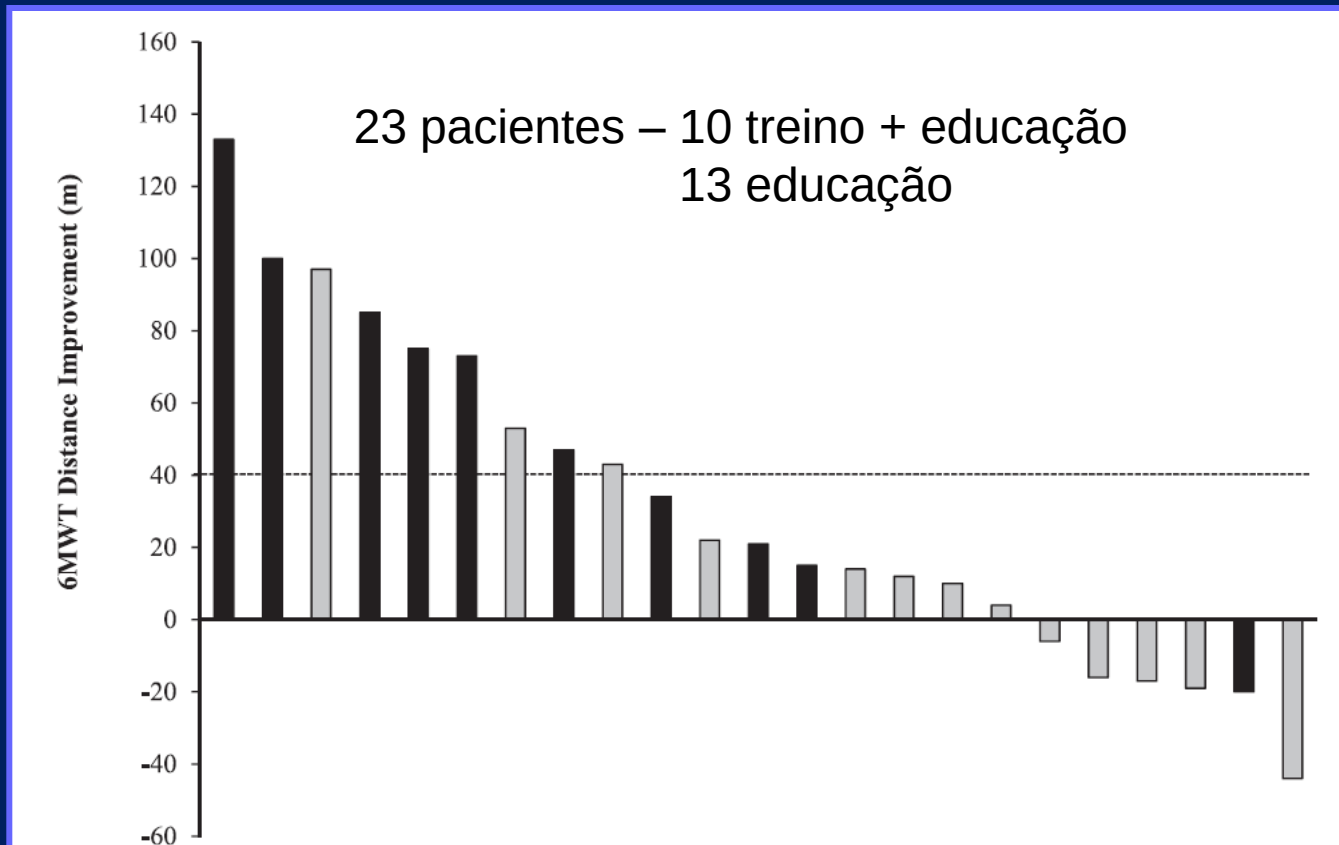
NON VASOREACTIVE

Insuficiência de VD

- Diuréticos
- Digital



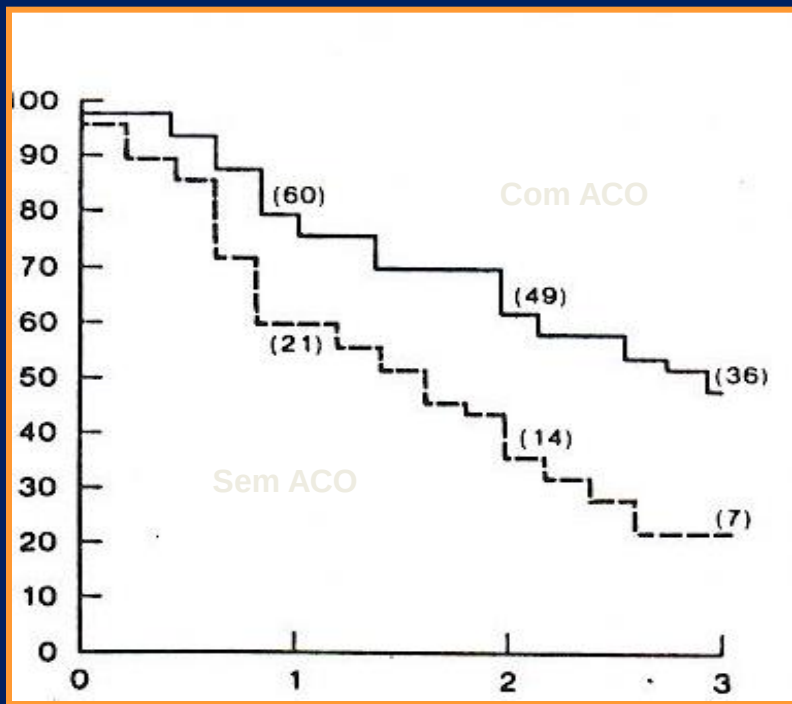
Reabilitação



- Qualidade de vida

Fisiopatología

Trombose *in situ*

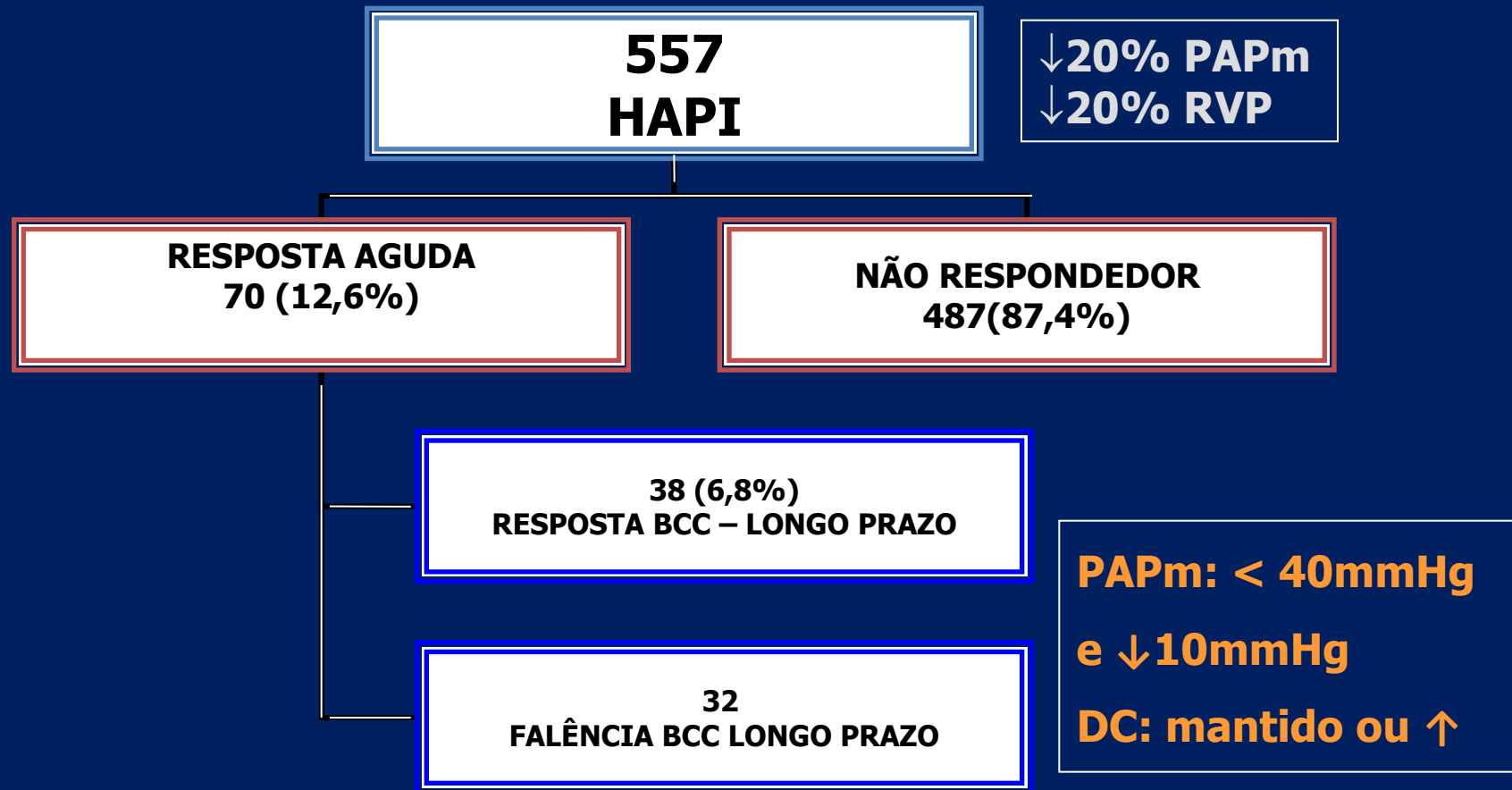


Clínica Mayo
Seguimiento 120 pacientes
Mínimo 5 anos

Pacientes

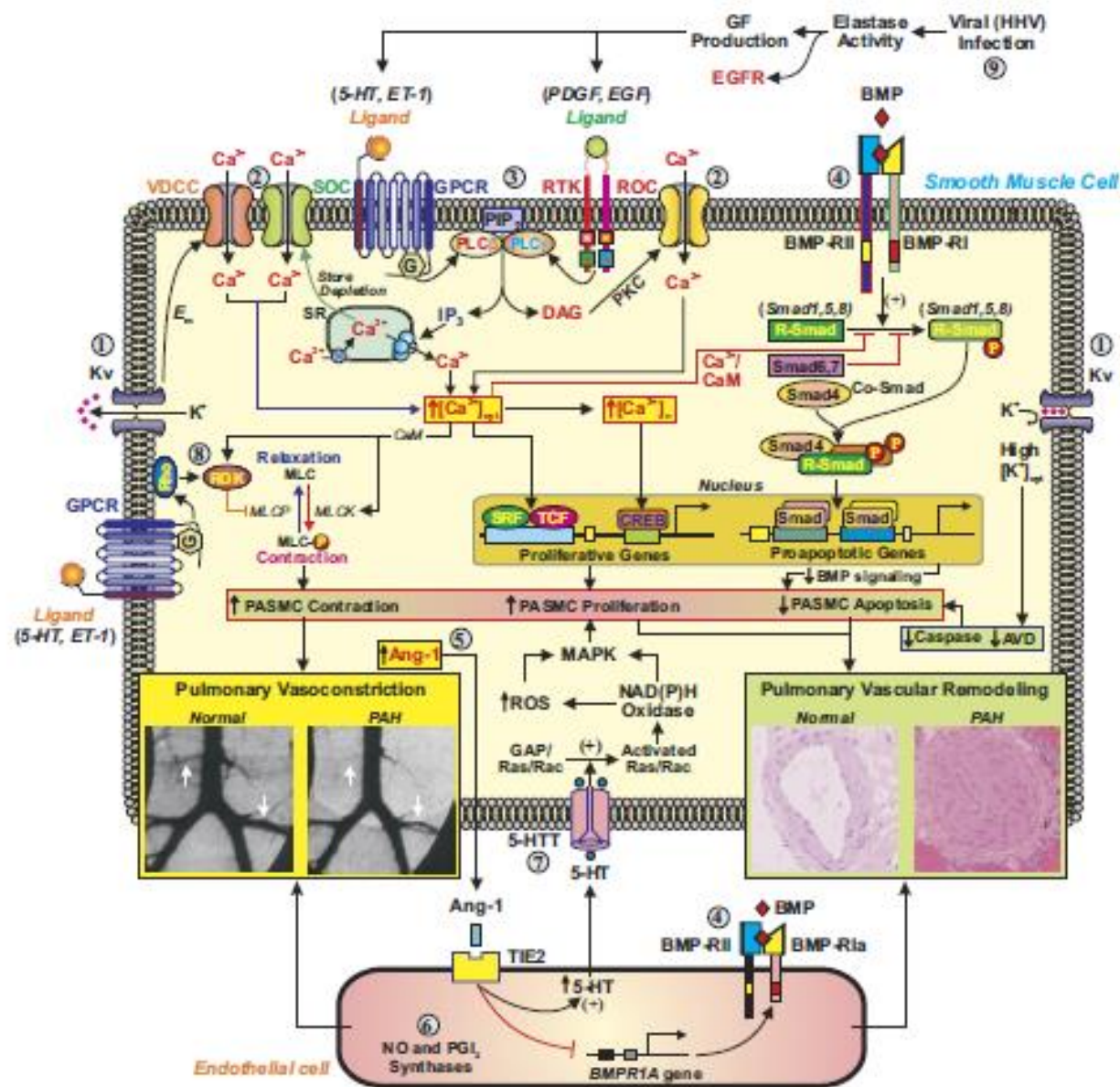
TROMBOSE	32 (57%)
ARTERIOPATIA	21 (38%)
VENOOCCLUSIVA	3 (5%)

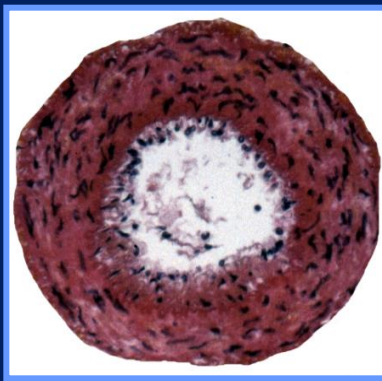
Critério de resposta x Benefício a longo prazo



Benefício em longo prazo HAP

	Anorexígeno (n=127)	DTC (n168)	HPoP (n=153)	HIV (n=124)	CC (n=50)	DVOP/HP (n041)
Resposta aguda ↓ PAPm e RVP > 20%	17 (13,4)	17 (10,1)	2 (1,3)	2 (1,6)	0	5 (12,2)
Resposta longo prazo BCC (%entre respondedores agudos)	12 (70,6)	1 (5,8)	1 (50)	2 (100)	0	0
% resposta longo prazo BCC da população geral	9,4	0,6	0,7	1,6	0	0





VIA ENDOTELINA

Pre-ET → pro-ET

Antagonistas
Receptor
Endotelina

Endotelina 1-1

ET_A

ET_B

Vasoconstrição
Proliferação

VIA ÓXIDO NÍTRICO

L-arginina → L-citruline

Óxido Nítrico

cGMP

Vasodilatação

PDE5

Anti-proliferação

Inibidor fosfodiesterase

VIA PROSTACICLINA

Ácido aradonico → PgI₂

Prostaciclina (PgI₂)

Derivados da
Prostaciclina

cAMP

Vasodilatation

anti-proliferation

INITIAL THERAPY WITH PAH APPROVED DRUGS

YELLOW: Morbidity and mortality as primary end-point in randomized controlled study or reduction in all-cause mortality (prospectively defined)

*Level of evidence is based on the WHO-FC of the majority of the patients of the studies.

†Approved only: by the FDA (macitentan, riociguat, treprostinil inhaled); in New Zealand (iloprost i.v); in Japan and S.Korea(beraprost).

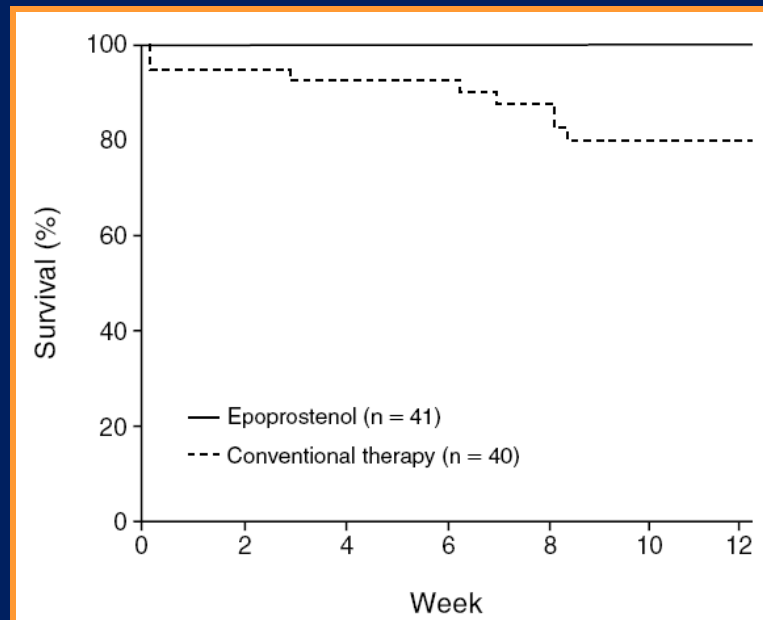
‡ Positive opinion for approval of the CHMP of EMA

Recommendation	Evidence*	WHO-FC II	WHO-FC III	WHO-FC IV
I	A or B	Ambrisentan Bosentan Macitentan †‡ Riociguat† Sildenafil Tadalafil	Ambrisentan Bosentan Epoprostenol i.v. Iloprost inhaled Macitentan †‡ Riociguat† Sildenafil Tadalafil Treprostinil s.c., inhaled†	Epoprostenol i.v.
IIa	C		Iloprost i.v. † Treprostinil i.v.	Ambrisentan, Bosentan Iloprost inhaled and i.v.† Macitentan †‡ Riociguat† Sildenafil, Tadalafil Treprostinil s.c., i.v., Inhaled†
IIb	B		Beraprost†	
	C		Initial Combination Therapy	Initial Combination Therapy

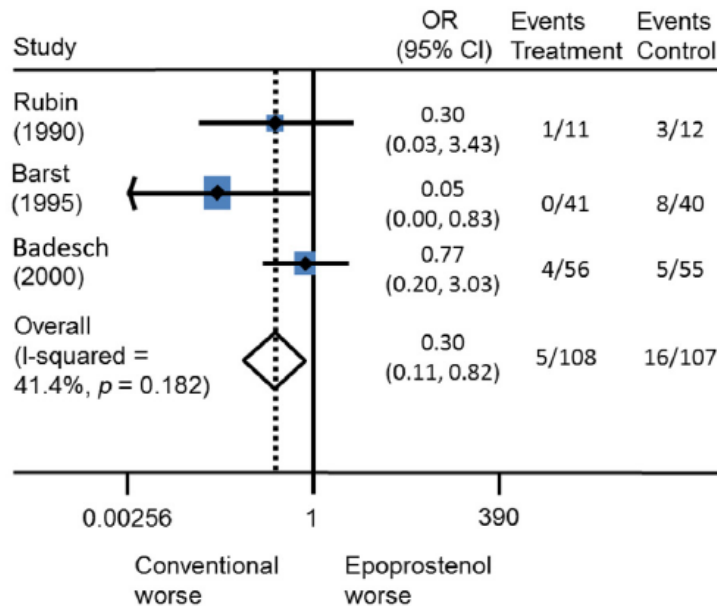
A COMPARISON OF CONTINUOUS INTRAVENOUS EPOPROSTENOL (PROSTACYCLIN) WITH CONVENTIONAL THERAPY FOR PRIMARY PULMONARY HYPERTENSION

ROBYN J. BARST, M.D., LEWIS J. RUBIN, M.D., WALKER A. LONG, M.D., MICHAEL D. MCGOON, M.D.,
STUART RICH, M.D., DAVID B. BADESCH, M.D., BERTRON M. GROVES, M.D., VICTOR F. TAPSON, M.D.,
ROBERT C. BOURGE, M.D., BRUCE H. BRUNDAGE, M.D., SPENCER K. KOERNER, M.D.,
DAVID LANGLEBEN, M.D., CESAR A. KELLER, M.D., SRINIVAS MURALI, M.D.,
BARRY F. URETSKY, M.D., LINDA M. CLAYTON, PHARM.D., MARIA M. JÖBSIS, B.A.,
SHELMER D. BLACKBURN, JR., B.A., DENISE SHORTINO, M.S., JAMES W. CROW, PH.D.,
FOR THE PRIMARY PULMONARY HYPERTENSION STUDY GROUP*

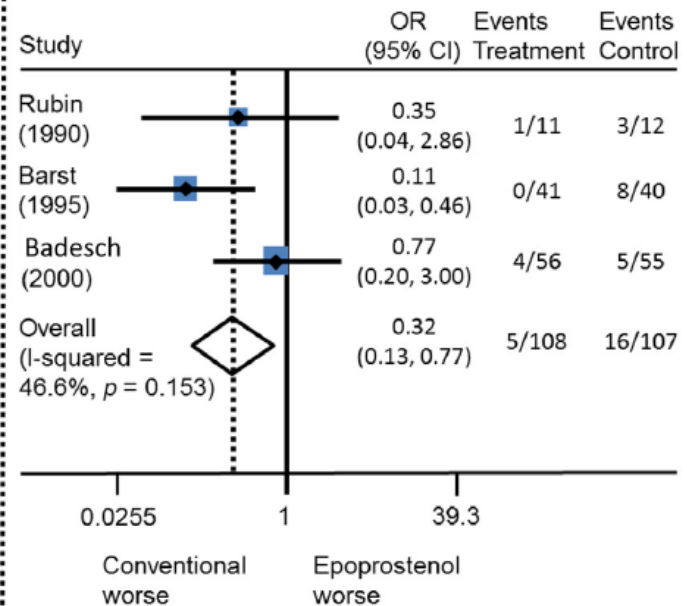
- 80 pacientes c/ HAPi, WHO III e IV, 12 semanas
 - 6MWT: epoprostenol 315 → 362 (p<0,002)
 - controle 270 → 204



Epoprostenol



Mantel-Haenszel $z = 2.35$ $p = 0.019$
Heterogeneity $p = 0.182$
RR = 70%

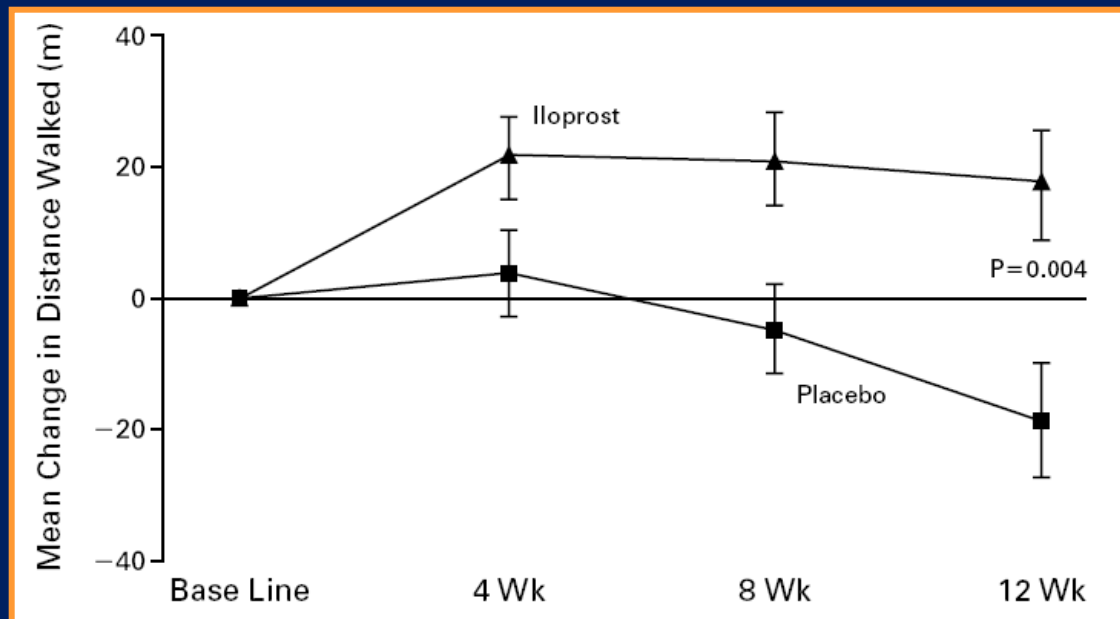


Peto $z = 2.52$ $p = 0.012$
Heterogeneity $p = 0.153$
RR = 68%

INHALED ILOPROST FOR SEVERE PULMONARY HYPERTENSION

HORST OLSCHESKI, M.D., GERALD SIMONNEAU, M.D., NAZZARENO GALIÈ, M.D., TIMOTHY HIGENBOTTAM, M.D., ROBERT NAEIJE, M.D., LEWIS J. RUBIN, M.D., SYLVIA NIKKHO, M.D., RUDOLF SPEICH, M.D., MARIUS M. HOEPER, M.D., JÜRGEN BEHR, M.D., JÖRG WINKLER, M.D., OLIVIER SITBON, M.D., WLADIMIR POPOV, M.D., H. ARDESCHIR GHOFrani, M.D., ALESSANDRA MANES, M.D., DAVID G. KIELY, M.D., RALPH EWERT, M.D., ANDREAS MEYER, M.D., PAUL A. CORRIS, F.R.C.P., MARION DELCROIX, M.D., MIGUEL GOMEZ-SANCHEZ, M.D., HARALD SIEDENTOP, DIPL.STAT., AND WERNER SEEGER, M.D.,
FOR THE AEROSOLIZED ILOPROST RANDOMIZED STUDY GROUP*

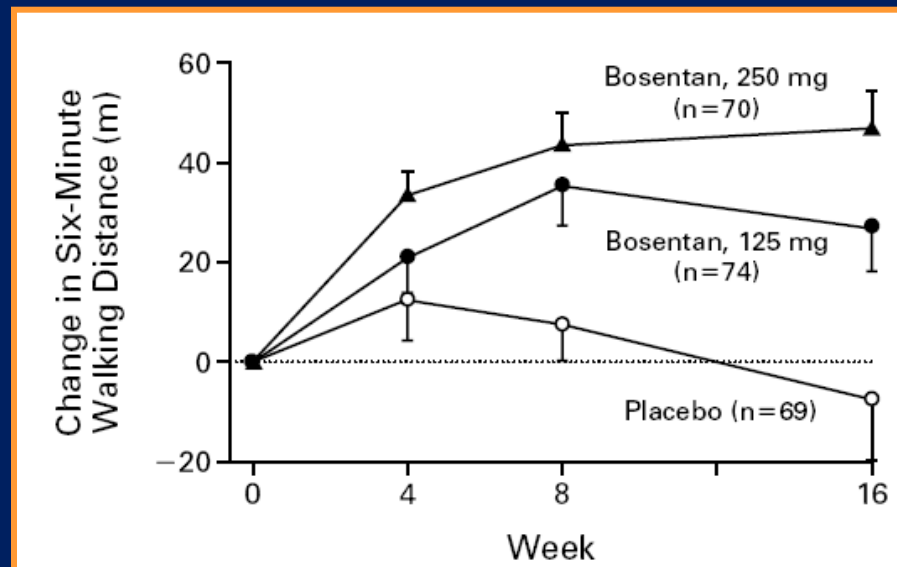
- 203 pacientes: HAPi, anorexígenos, colagenoses e CTEPH
- NYHA III e IV
- Dose: 2,5 – 5 mcg 6 a 9 vezes ao dia



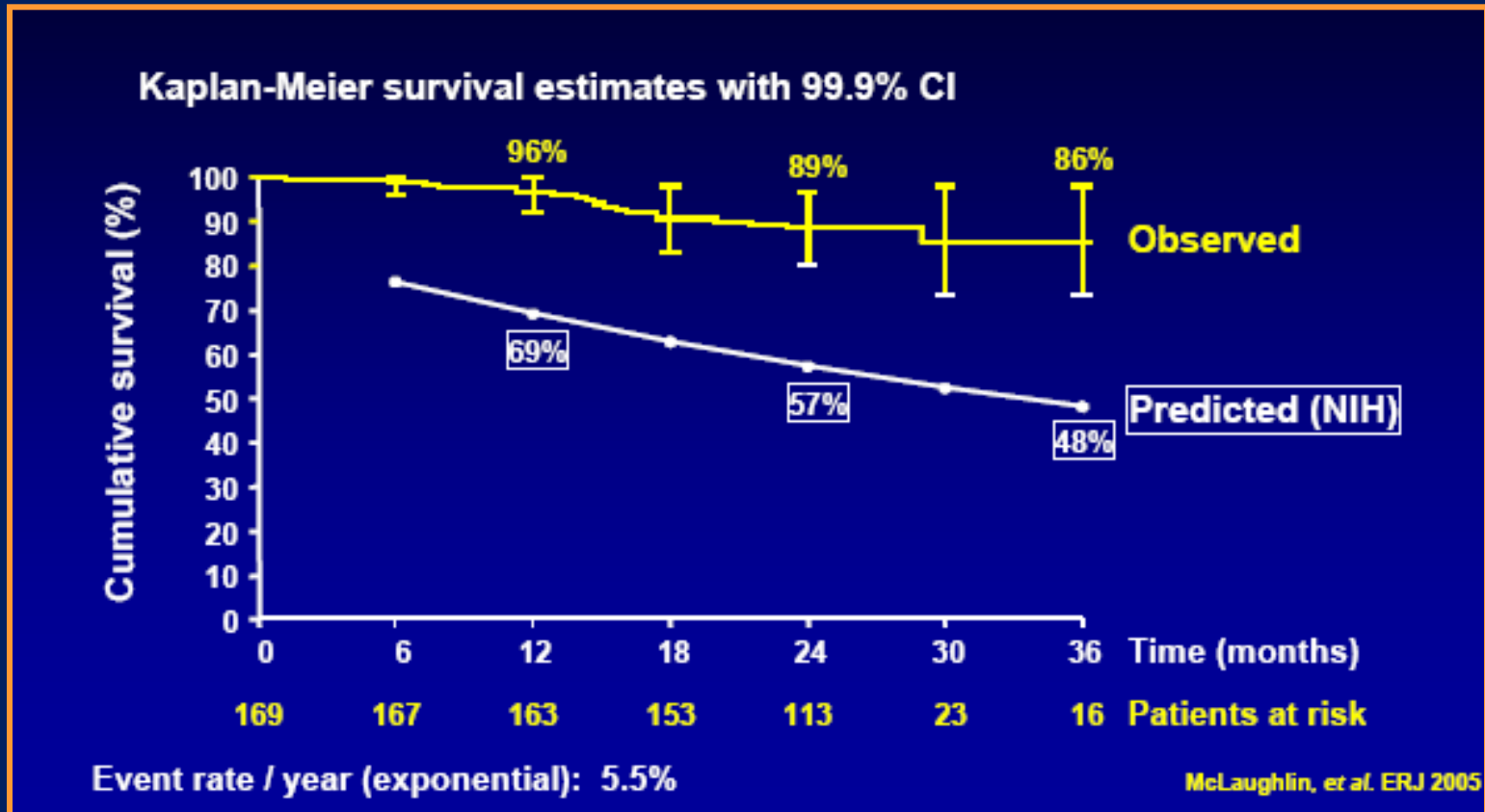
BOSENTAN THERAPY FOR PULMONARY ARTERIAL HYPERTENSION

LEWIS J. RUBIN, M.D., DAVID B. BADESCH, M.D., ROBYN J. BARST, M.D., NAZZARENO GALIÈ, M.D.,
CAROL M. BLACK, M.D., ANNE KEOGH, M.D., TOMAS PULIDO, M.D., ADAANI FROST, M.D., SÉBASTIEN ROUX, M.D.,
ISABELLE LECONTE, Ph.D., MICHAEL LANDZBERG, M.D., AND GÉRALD SIMONNEAU, M.D.,
FOR THE BOSENTAN RANDOMIZED TRIAL OF ENDOTHELIN ANTAGONIST THERAPY STUDY GROUP

- 213 pacientes, randomizado, duplo cego
- NYAH III/IV
- HAPi, colagenoses (havia pacientes com cardiopatias congênitas)



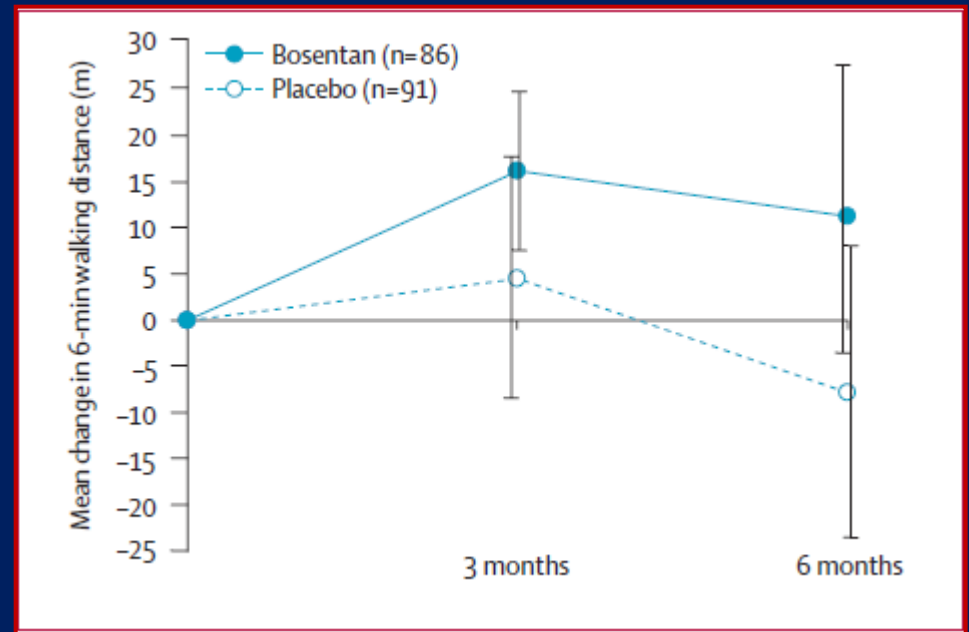
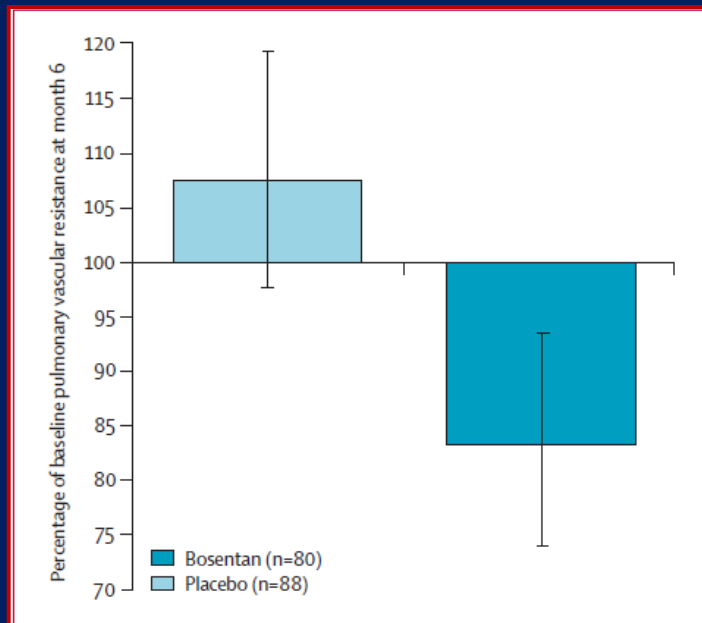
Bosentana – longo prazo



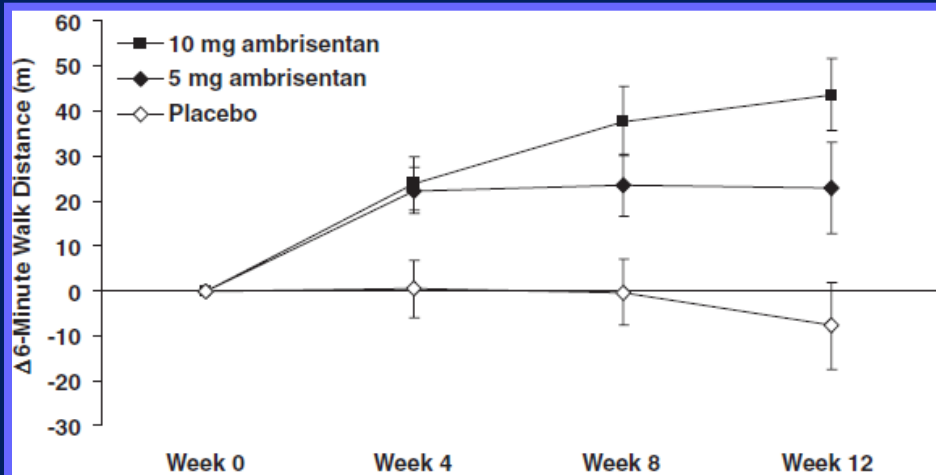
Treatment of patients with mildly symptomatic pulmonary arterial hypertension with bosentan (EARLY study): a double-blind, randomised controlled trial

N Galiè, L J Rubin, M M Hoeper, P Jansa, H Al-Hiti, G M B Meyer, E Chiossi, A Kusic-Pajic, G Simonneau

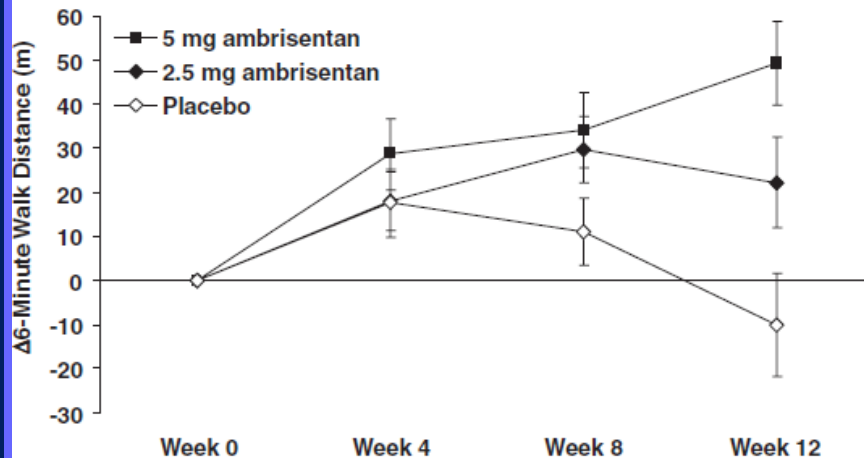
- 80 pacientes bosentan x 88 placebo em CF II



Ambrisentan



ARIES-1



ARIES-2

202 Pacientes – HAP
CF II e III

192 Pacientes – HAP
CF II e III

Sildenafil

278

HAPI, cardiopatia congênita, colagenose
NYHA I-II-III-IV

Placebo
68

20mg 3x/d
67

40mg 3x/d
65

80mg 3x/d
65

41m

44m

47m

TC6M

-0,6

-2,1

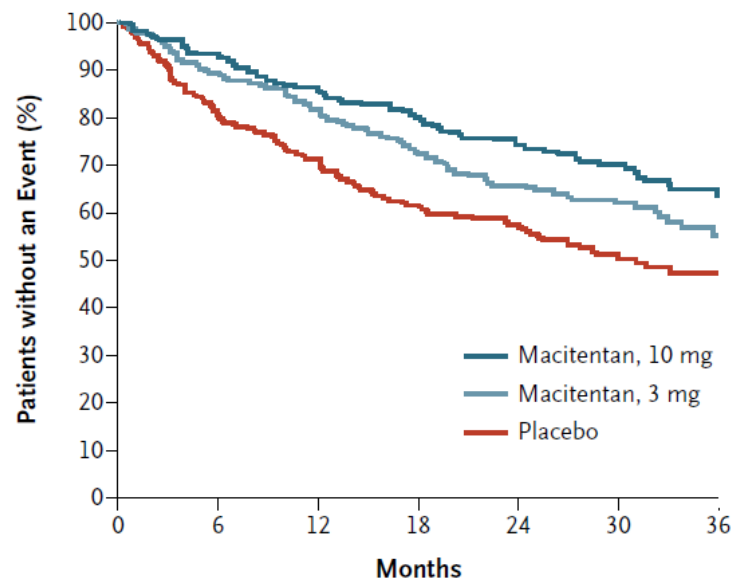
-2,6

-4,7

PAP

ORIGINAL ARTICLE

Macitentan and Morbidity and Mortality in Pulmonary Arterial Hypertension

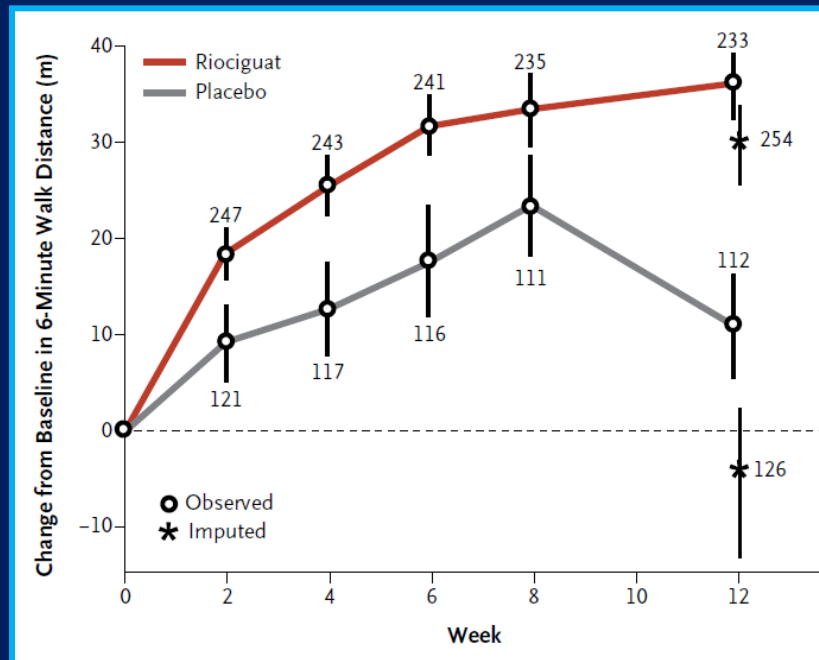


No. at Risk

Placebo	250	188	160	135	122	64	23
Macitentan, 3 mg	250	213	188	166	147	80	32
Macitentan, 10 mg	242	208	187	171	155	91	41

ORIGINAL ARTICLE

Riociguat for the Treatment of Pulmonary Arterial Hypertension



INITIAL THERAPY WITH PAH APPROVED DRUGS

YELLOW: Morbidity and mortality as primary end-point in randomized controlled study or reduction in all-cause mortality (prospectively defined)

*Level of evidence is based on the WHO-FC of the majority of the patients of the studies.

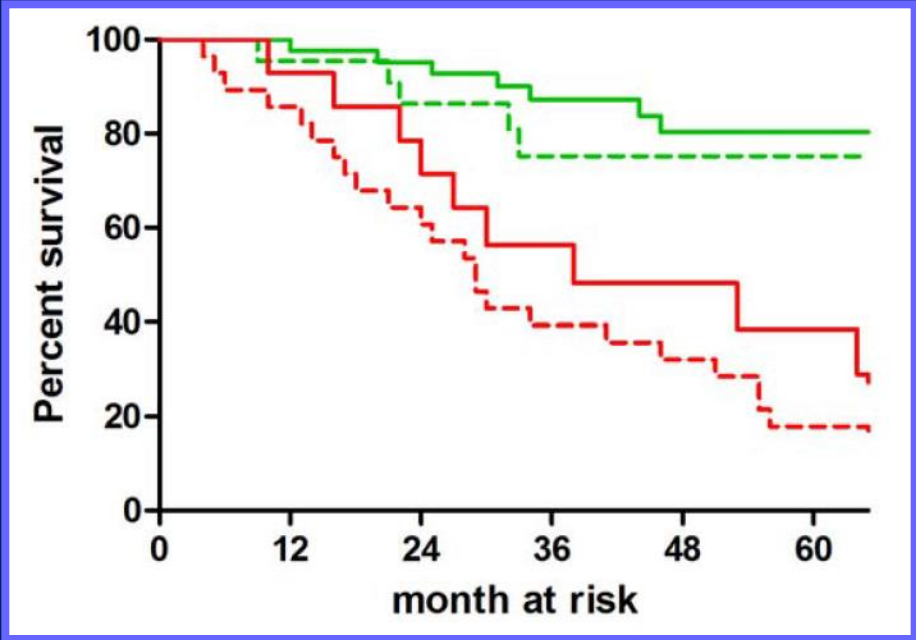
†Approved only: by the FDA (macitentan, riociguat, treprostinil inhaled); in New Zealand (iloprost i.v); in Japan and S.Korea(beraprost).

‡ Positive opinion for approval of the CHMP of EMA

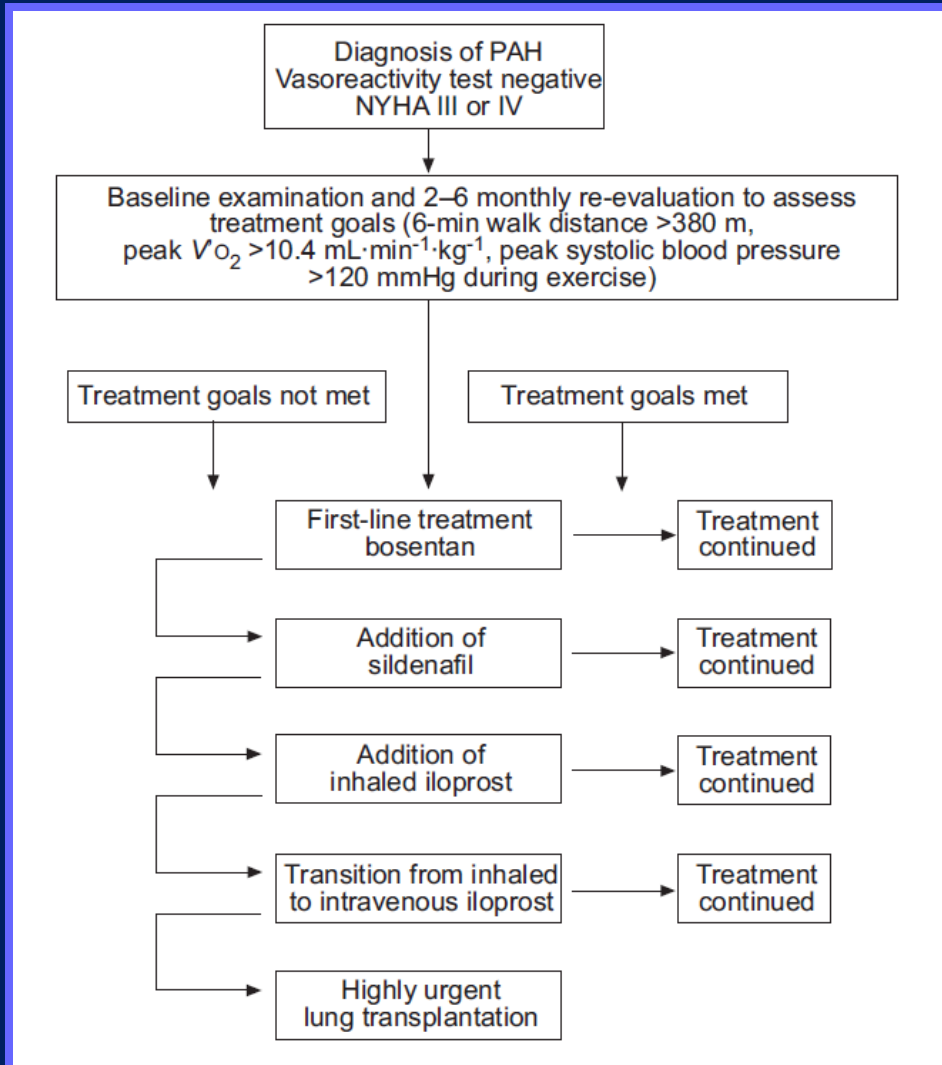
Recommendation	Evidence*	WHO-FC II	WHO-FC III	WHO-FC IV
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IIb	B		Beraprost†	
	C		Initial Combination Therapy	Initial Combination Therapy

Melhor prognóstico	Determinantes do prognóstico	Pior prognóstico
Não	Sinais clínicos de IVD	Sim ↘
Lenta	Progressão da doença	Rápida ↘
Não	Síncope	Sim
I,II	CF WHO	IV ↘
>500m	TC6M	< 300m ↘
Pico VO2 > 15mL/min/Kg	Ergoespirometria	Pico VO2 < 12mL/min/Kg
Normal ou quase normal	BNP e NT-pró-BNP	Muito elevado e subindo ↘
TAPSE > 2,0 cm Derrame pericárdico -	Ecocardiograma	TAPSE < 1,5 cm ↘ Derrame pericárdico +
PAD < 8 mmHg IC ≥ 2,5 L/min/m2	Hemodinâmica	PAD > 15mmHg ↘ IC ≤ 2,0 L/min/m2

	Stable/satisfactory		Unstable/deteriorating	
	Group 1	Group 2	Group 3	Group 4
WHO functional class	WHO functional class I or II at baseline and during follow up	WHO functional class III-IV at baseline, WHO functional class I-II during follow up	WHO functional class I-II at baseline, WHO functional class III-IV during follow up	WHO functional class III-IV at baseline and during follow up
Cardiac index	CI ≥ 2.5 l/min/m ² at baseline and during follow up	CI < 2.5 l/min/m ² at baseline, but ≥ 2.5 during follow up	CI ≥ 2.5 l/min/m ² at baseline, but < 2.5 during follow up	CI < 2.5 l/min/m ² at baseline and during follow up
SvO₂	SvO ₂ $\geq 65\%$ at baseline and during follow up	SvO ₂ $< 65\%$ at baseline but $\geq 65\%$ during follow up	SvO ₂ $\geq 65\%$ at baseline, but $< 65\%$ during follow up	SvO ₂ $< 65\%$ at baseline and during follow up
NT-proBNP	NT-proBNP $< 1,800$ ng/l at baseline and during follow up	NT-proBNP $\geq 1,800$ ng/l at baseline, but $< 1,800$ ng/l during follow up	NT-proBNP $< 1,800$ ng/l at baseline, but $\geq 1,800$ ng/l during follow up	NT-proBNP $\geq 1,800$ ng/l at baseline and during follow up



Tratamento combinado



Tratamento sequencial
x início com duas
drogas concomitantes

Transplante de pulmão

- Pacientes em classe funcional III e IV
- Considerar para fila quando em terapêutica combinada

	1 year	5 years	10 years
Pittsburgh (Toyoda et al., 2008 [74])	86	75	66
Paris (Fadel et al., 2010 [75])	79	52	43
Toronto (de Perrot et al., 2012 [76])	78	60	45
Vienna (Klepetko, unpublished data, 2011)	73	71	—

