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Pulmonary Hypertension

GEORGIOS PARCHARIDIS

Professor of Cardiology

Pulmonary hypertension is a disease that has attracted great interest in recent years. This clinical entity has escaped medical attention, especially that of the cardiology community, for a long time and there are many reasons for this.

Firstly, there used to be a perception that the disease affected very few patients, whose prognosis was very poor, without any available treatment options, while the pathophysiology of the disease was largely unknown. Lately, probably driven by basic research as well as by industry, in which tremendous strides have been made in both understanding the mechanisms behind pulmonary hypertension and producing novel pharmaceutical compounds, the medical community has turned its interest towards this disease.

The definition of pulmonary hypertension is purely haemodynamic; namely, we have pulmonary hypertension when the mean pulmonary artery pressure is greater than 25 mmHg. The diagnosis should always be based on the findings of right heart catheterisation.

We have now recognised that pulmonary hypertension affects a significant number of patients who suffer from various disorders. The greatest percentage (around 80%) concerns patients who suffer from diseases of the left heart, i.e. heart failure (systolic and diastolic), valvular diseases, etc. About 10% are patients with chronic pulmonary diseases, a very small percentage have chronic thromboembolic disease, and a small number (about 3-4%) are patients with pulmonary arterial hypertension. This latter group is inhomogeneous and includes patients with idiopathic or heritable pulmonary arterial hypertension, patients with connective tissue diseases, congenital heart disease, HIV infection, portal hypertension, etc. Novel targeted therapies have been shown to be safe and efficacious for patients in this group and, therefore, these drugs have been officially approved only for these patients.

Cardiologists have a defining role in the diagnosis of pulmonary hypertension. Patients are initially evaluated with echocardiography, while right heart catheterisation confirms the diagnosis of the disease. Echocardiographic evaluation of the right ventricle plays an important role in monitoring patients with pulmonary hypertension, since the right ventricular function determines the prognosis.

It is becoming apparent that specialised centres need to be created for the diagnosis, evaluation and follow up of patients with pulmonary hypertension. These should be staffed by cardiologists, but should also enlist the collaboration of other specialties, such as pulmonologists, rheumatologists, haematologists, hepatologists, radiologists, etc., aiming at a thorough and comprehensive workup of these patients.

The Hellenic Cardiological Society will assist in keeping cardiologists – and physicians of all specialties – up to date with the latest data relating to pulmonary hypertension, and will also address the Greek state regarding the creation and support of tertiary centres specialising in pulmonary hypertension.