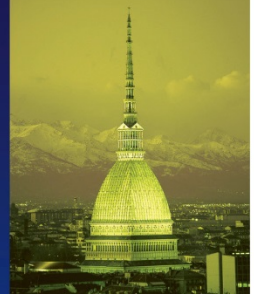
TURIN,
October
25th-27th
2018
Starhotels
Majestic

GIORNATE
CARDIOLOGICHE
TORINESI



UNIVERSITÀ DEGLI STUDI DI TORINO

AZIENDA OSPEDALIERO - UNIVERSITARIA
Città della Salute e della Scienza di Torino

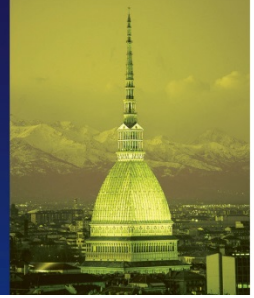
Turin experience in PAH setting

DANIELA LIBERTUCCI

Pneumology Division

Cardiothoracic Department

AOU Città della salute



Gruppo multidisciplinare aziendale per la gestione di pazienti affetti da Ipertensione Arteriosa Polmonare si struttura in modo organizzato nel 2009 - 2010

Dal 2007 inseriti su Registro Malattie rare Regione Piemonte (Pneumologia + Cardiologia)

60 + 47 pts con codice RG0120
Ipertensione arteriosa polmonare idiopatica

12 + 3 pazienti con Codice RNG111
Anomalie congenite

ATTUALE GRUPPO DI LAVORO AZIENDALE IPERTENSIONE POLMONARE
A.O.U. Città della Salute

Pneumologia Prof Bucca Dr. Libertucci

Reumatologia Dr. Fusaro

Medicina Urgenza Dr. Baron Dr. Ferrera

Gastroenterologia Dr.Ottobrelli

Rianimazione Cardiovascolare Dr.ssa Pasero

Cardiochirurgia Prof. Rinaldi Dr.Ricci

Cardiologia Universitaria Dr. Grosso Marra

Cardiologia pediatrica Dr. Agnoletti

Ematologia COES Dr. Beggiato

Medicina nucleare Prof. Bisi

Malattie infettive Prof. Di Perri Dr. Bonora

Direzione Sanitaria Presidio Molinette Dr. Scarmozzino

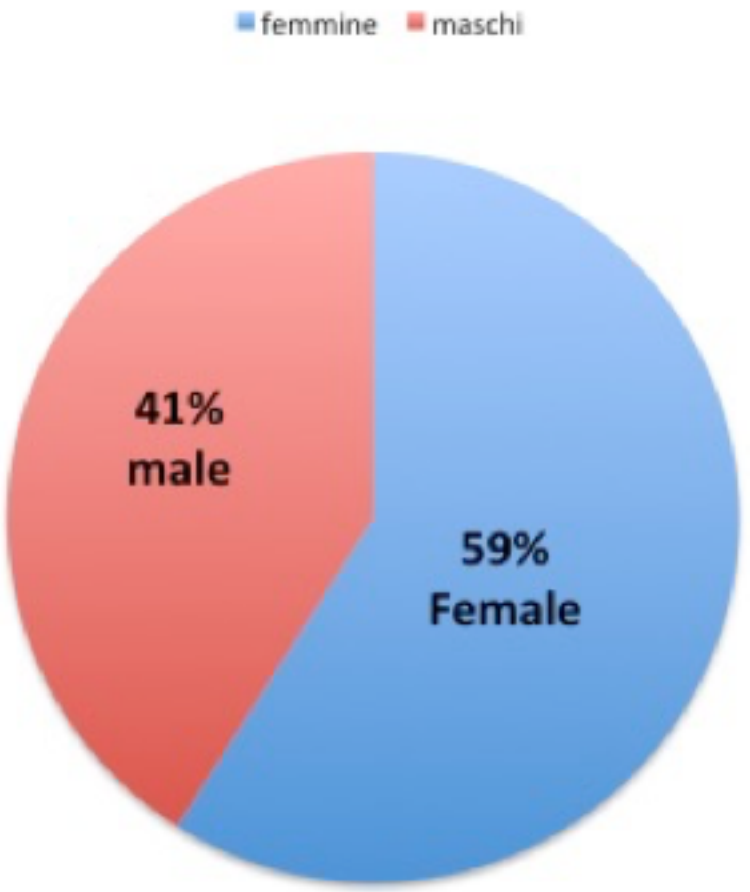
Farmacia ospedaliera Dr. Cattel

Radiologia P.S. Dr.ssa Garabello

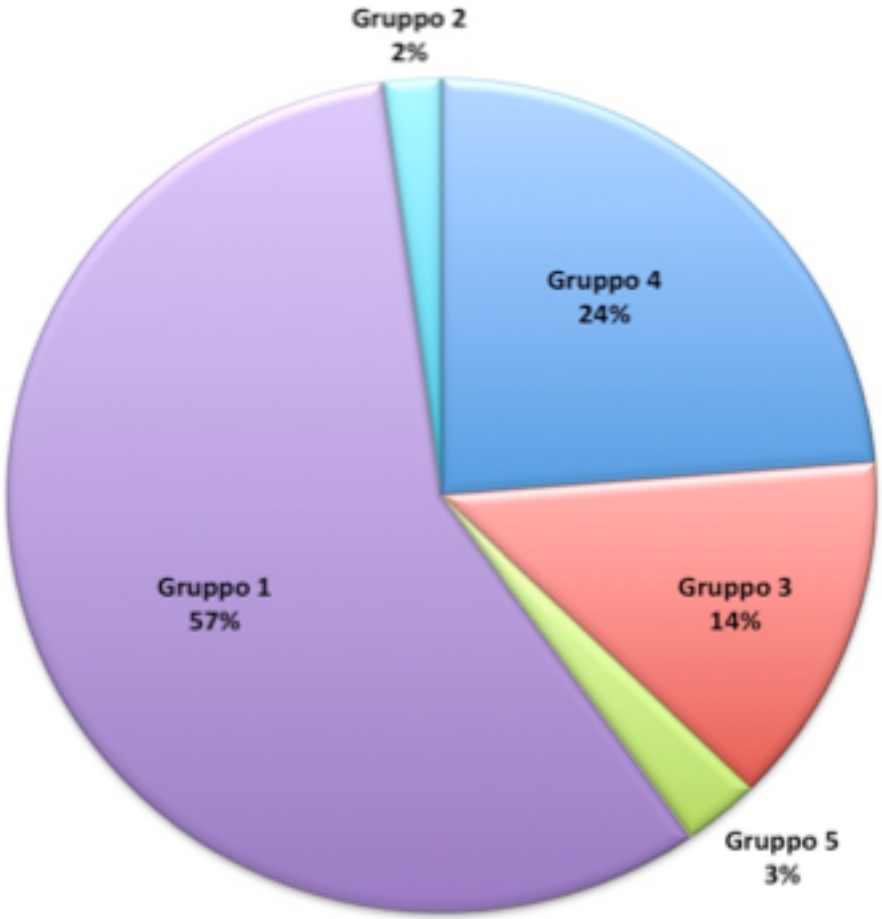
2018

136 patients

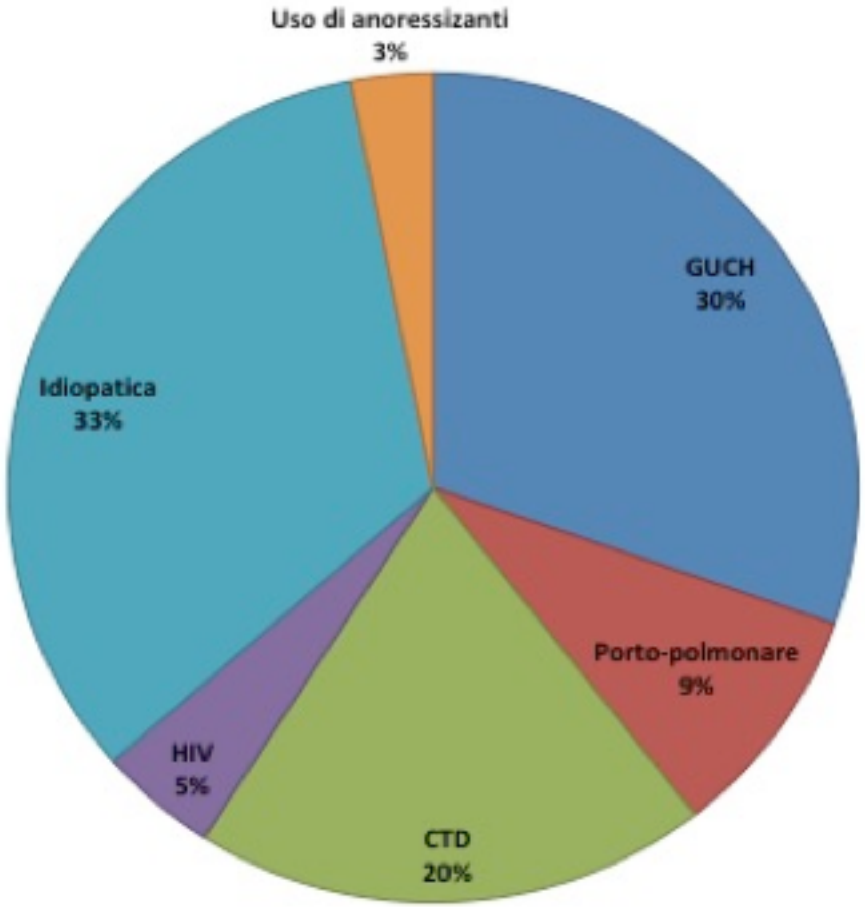
Mean Age 66,3 years



Distribuzione per gruppo



Gruppo I


Uso di anoressizanti
3%
GUCH
30%
Idiopatica
33%
Porto-polmonare
9%
HIV
5%
CTD
20%

Classe WHO al momento della diagnosi

25 % classe II

60% classe III

15 % classe IV

Terapia

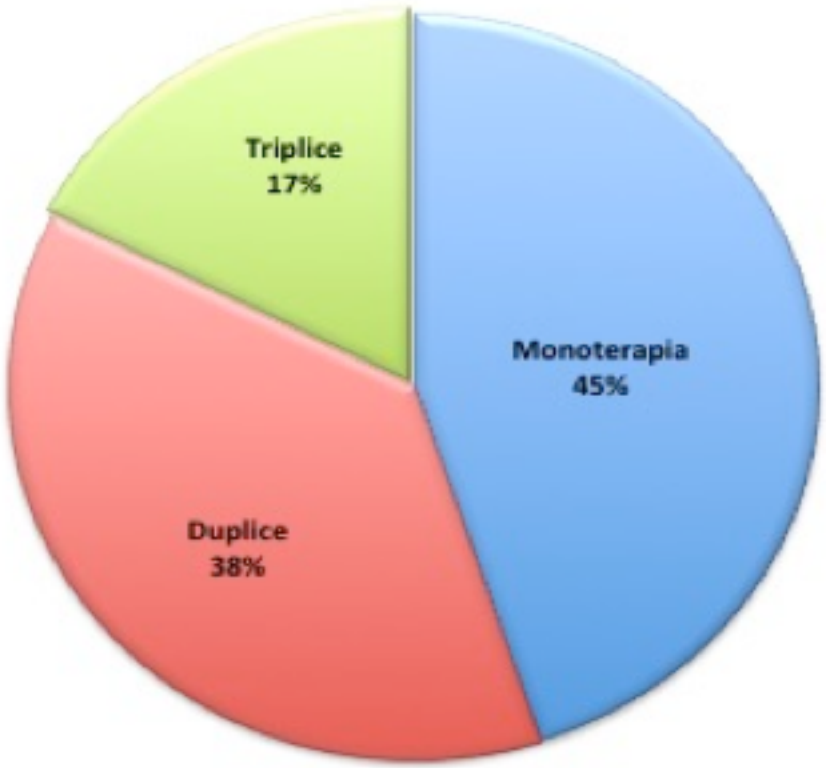
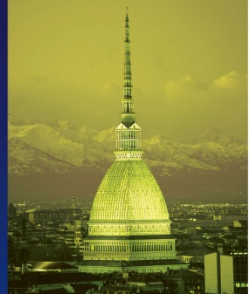
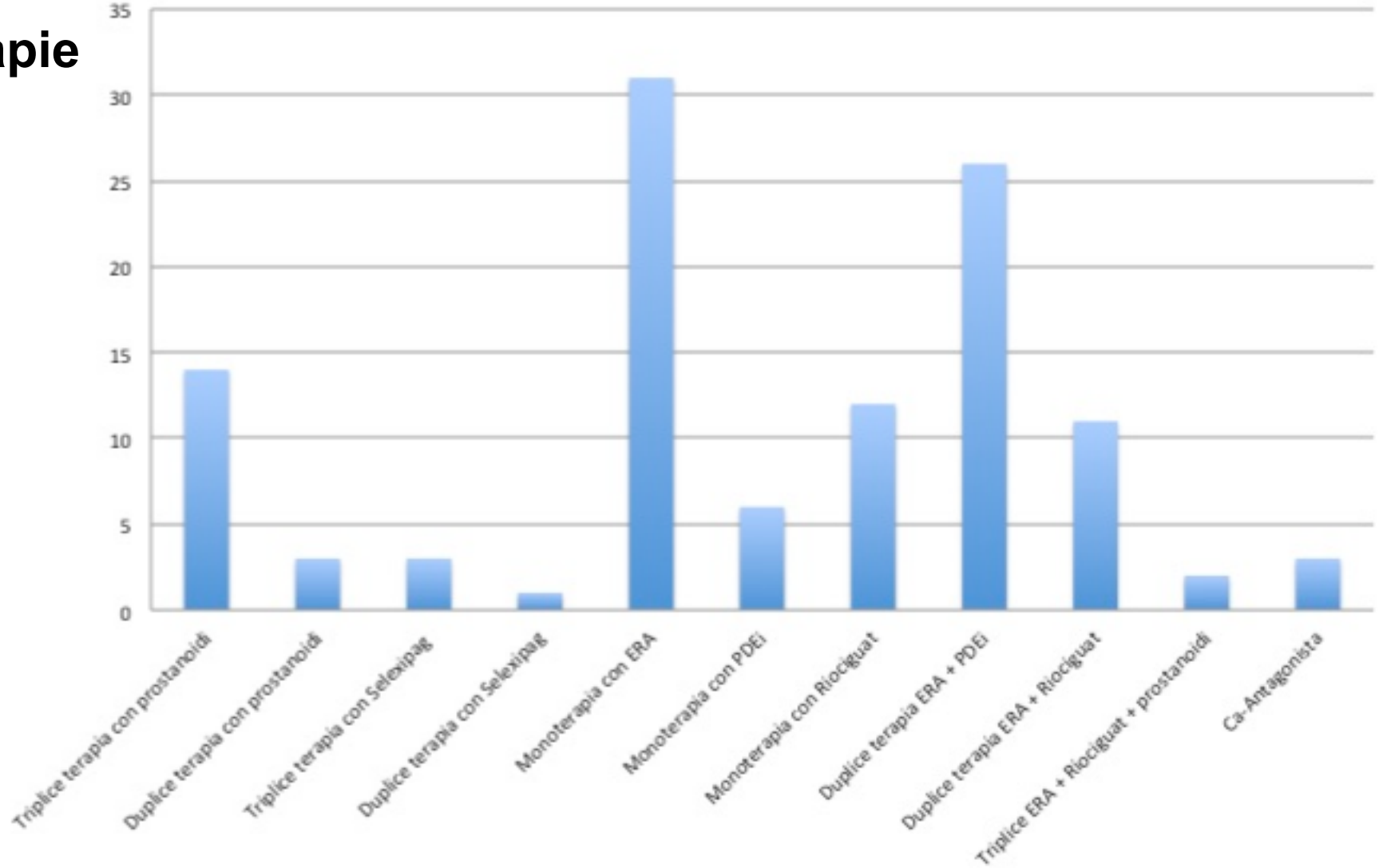


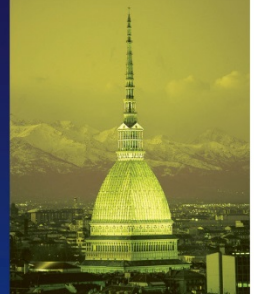
Table 13 Risk assessment in pulmonary arterial hypertension

Determinants of prognosis[a] (estimated 1-year mortality)	Low risk <5%	Intermediate risk 5–10%	High risk >10%
Clinical signs of right heart failure	Absent	Absent	Present
Progression of symptoms	No	Slow	Rapid
Syncope	No	Occasional syncope[b]	Repeated syncope[c]
WHO functional class	I, II	III	IV
6MWD	>440 m	165–440 m	<165 m
Cardiopulmonary exercise testing	Peak VO_2 >15 ml/min/kg (>65% pred.) VE/VCO_2 slope <36	Peak VO_2 11–15 ml/min/kg (35–65% pred.) VE/VCO_2 slope 36–44.9	Peak VO_2 <11 ml/min/kg (<35% pred.) VE/VCO_2 slope ≥45
NT-proBNP plasma levels	BNP <50 ng/l NT-proBNP <300 ng/l	BNP 50–300 ng/l NT-proBNP 300–1400 ng/l	BNP >300 ng/l NT-proBNP >1400 ng/l
Imaging (echocardiography, CMR imaging)	RA area <18 cm^2 No pericardial effusion	RA area 18–26 cm^2 No or minimal, pericardial effusion	RA area >26 cm^2 Pericardial effusion
Haemodynamics	RAP <8 mmHg CI ≥2.5 l/min/m^2 SvO_2 >65%	RAP 8–14 mmHg CI 2.0–2.4 l/min/m^2 SvO_2 60–65%	RAP >14 mmHg CI <2.0 l/min/m^2 SvO_2 <60%



Terapie


35
30
25
20
15
10
5
0
Triplice terapia con prostanoidi
Duplice terapia con prostanoidi
Triplice terapia con Selexipag
Duplice terapia con Selexipag
Monoterapia con ERA
Monoterapia con PDEi
Monoterapia con Riociguat
Duplice terapia ERA + PDEi
Duplice terapia ERA + Riociguat
Triplice ERA + Riociguat + prostanoidi
Ca-Antagonista



Terapia infusionale

14 pazienti treprostinil s.c.

2 pazienti epoprostenolo ev

Possibilità avvio e titolazione farmaco in regime di DH con assistenza infermieristica domiciliare per il training

Table 14 Suggested assessment and timing for the follow-up of patients with pulmonary arterial hypertension

	At baseline	Every 3–6 months[a]	Every 6–12 months[a]	3–6 months after changes in therapy[a]	In case of clinical worsening
Medical assessment and determination of functional class	+	+	+	+	+
ECG	+	+	+	+	+
6MWT/Borg dyspnoea score	+	+	+	+	+
CPET	+		+		+[e]
Echo	+		+	+	+
Basic lab[b]	+	+	+	+	+
Extended lab[c]	+		+		+
Blood gas analysis[d]	+		+	+	+
Right heart catheterization	+		+[f]	+[e]	+[e]

Dal 2005 10 trapianti per IAP di cui 1 reTX

4 IAP

5 EIS con correzione difetto cardiaco

1 CTEPH

Attualmente in LAT polmone 4 pazienti IAP

2 EIS (1 cuore-polmone)
2 primitive (1 associata HIV)

Pulmonary Hypertension in Chronic Obstructive Pulmonary Disease and Pulmonary Fibrosis: Prevalence and Hemodynamic Differences in Lung Transplant Recipients at Transplant Center's Referral Time

P. Solidoro[a,*], F. Patrucco[a], R. Bonato[b], M. Boffini[b], D. Libertucci[a], D. Ricci[b], E. Allara[c], M. Rinaldi[b] and C. Bucca[a]

Transplantation Proceedings, 47, 2161–2165 (2015)

Table 2. Prevalence of mPAP in the 2 Populations

mPAP (in mm Hg)		Fibrosis	COPD	
<25	n.	24	6	30
Normal	%	68.6	15.8	41.1
25≤mPAP<35	n.	6	22	28
Mild	%	17.1	57.9	38.6
35≤mPAP<45	n.	4	8	12
Moderate	%	11.4	21.1	16.4
≥45	n.	1	2	3
Severe	%	2.9	5.3	4.1

Conclusions. COPD patients are referred to the Transplant Center with a higher prevalence of PH because of an echocardiographic screening or a late referral, but many patients survive on the waiting list and undergo the procedure. On the other hand, patients transplanted with interstitial diseases have a lower prevalence of PH; this can be explained by an earlier referral or a higher mortality on the waiting list and a more aggressive and rapidly progressing disease.

Grazie