

Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.jfma-online.com

Clinical Practice

2018 TSOC guideline focused update on diagnosis and treatment of pulmonary arterial hypertension

Wei-Chun Huang^{a,b,c}, Chih-Hsin Hsu^d, Shih-Hsien Sung^{b,e},
Wan-Jing Ho^f, Chun-Yuan Chu^g, Chih-Ping Chang^h,
Yu-Wei Chiuⁱ, Chun-Hsien Wu^j, Wei-Ting Chang^k, Lin Lin^l,
Shoa-Lin Lin^m, Chin-Chang Cheng^{a,b,c,n}, Yih-Jer Wu^{o,p},
Shu-Hao Wu^p, Tsu-Yi Hsieh^q, Hsao-Hsun Hsu^r, Morgan Fu^s,
Zen-Kong Dai^g, Ping-Hung Kuo^t, Juey-Jen Hwang^{u,v,*},
Shu-Meng Cheng^{j,**}, TSOC pulmonary hypertension
committee

^a Department of Critical Care Medicine, Kaohsiung Veterans General Hospital, Kaohsiung, Taiwan

^b School of Medicine, National Yang-Ming University, Taipei, Taiwan

^c Department of Physical Therapy, Fooyin University, Kaohsiung, Taiwan

^d Department of Internal Medicine, National Cheng Kung University Hospital, Tainan, Taiwan

^e Department of Internal Medicine, Taipei Veterans General Hospital, Taipei, Taiwan

^f Department of Internal Medicine, Chang Gung Memorial Hospital, Linkou, Taoyuan, Taiwan

^g Division of Cardiology, Department of Internal Medicine, Kaohsiung Medical University Hospital, Kaohsiung, Taiwan

^h Division of Cardiology, China Medical University Hospital, Taichung, Taiwan

ⁱ Department of Internal Medicine, Far Eastern Memorial Hospital, New Taipei City, Taiwan

^j Department of Internal Medicine, Tri-Service General Hospital, National Defense Medical Center, Taipei, Taiwan

^k Division of Cardiovascular Medicine, Chi-Mei Medical Center, Tainan City, Taiwan

^l Cardiovascular Center, National Taiwan University Hospital, Hsinchu Branch, Hsinchu, Taiwan

^m Department of Internal Medicine, Yuan's General Hospital, Kaohsiung, Taiwan

ⁿ Pulmonary Hypertension Center, Kaohsiung Veterans General Hospital, Kaohsiung, Taiwan

^o Department of Medicine, Mackay Medical College, New Taipei City, Taiwan

^p Pulmonary Hypertension Interventional Medicine, Cardiovascular Center, Mackay Memorial Hospital, Taipei City, Taiwan

^q Department of Internal Medicine, Taichung Veterans General Hospital, Taichung, Taiwan

^r Department of Surgery, National Taiwan University Hospital, Taipei, Taiwan

^s Department of Internal Medicine, Chang Gung Memorial Hospital, Kaohsiung, Taiwan

<https://doi.org/10.1016/j.jfma.2018.12.009>

0929-6646/Copyright © 2019, Formosan Medical Association. Published by Elsevier Taiwan LLC. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Please cite this article as: Huang W-C et al., 2018 TSOC guideline focused update on diagnosis and treatment of pulmonary arterial hypertension, Journal of the Formosan Medical Association, <https://doi.org/10.1016/j.jfma.2018.12.009>

^t Department of Internal Medicine, National Taiwan University Hospital, Taipei, Taiwan

^u Cardiovascular Division, Department of Internal Medicine, National Taiwan University College of Medicine and Hospital, Taipei, Taiwan

^v National Taiwan University Hospital Yunlin Branch, Douliu City, Taiwan

Received 3 September 2018; received in revised form 18 November 2018; accepted 14 December 2018

KEYWORDS

Guideline;
Pulmonary arterial
hypertension;
Pulmonary
hypertension

Pulmonary arterial hypertension (PAH) is characterized as a progressive and sustained increase in pulmonary vascular resistance, which may induce right ventricular failure. In 2014, the Working Group on Pulmonary Hypertension of the Taiwan Society of Cardiology (TSOC) conducted a review of data and developed a guideline for the management of PAH.⁴ In recent years, several advancements in diagnosis and treatment of PAH has occurred. Therefore, the Working Group on Pulmonary Hypertension of TSOC decided to come up with a focused update that addresses clinically important advances in PAH diagnosis and treatment. This 2018 focused update deals with: (1) the role of echocardiography in PAH; (2) new diagnostic algorithm for the evaluation of PAH; (3) comprehensive prognostic evaluation and risk assessment; (4) treatment goals and follow-up strategy; (5) updated PAH targeted therapy; (6) combination therapy and goal-orientated therapy; (7) updated treatment for PAH associated with congenital heart disease; (8) updated treatment for PAH associated with connective tissue disease; and (9) updated treatment for chronic thromboembolic pulmonary hypertension.

Copyright © 2019, Formosan Medical Association. Published by Elsevier Taiwan LLC. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Introduction

Pulmonary arterial hypertension (PAH), defined by a resting mean pulmonary arterial pressure (mPAP) ≥ 25 mmHg, and pulmonary artery wedge pressure (PAWP) ≤ 15 mmHg with pulmonary vascular resistance (PVR) > 3 Wood units, is a life-threatening condition.^{1–4} During the 2018 6th World Symposium on Pulmonary Hypertension held in Nice, France, PH was redefined as both mPAP ≥ 20 mmHg and PVR ≥ 3 Wood units.⁵ However, the new definition did not change the criteria for initiation of PAH therapy, because most evidences were based on previous definition. PAH is characterized as a progressive and sustained increase in pulmonary vascular resistance, which may induce right ventricular failure.

In 2014, the Working Group on Pulmonary Hypertension of the Taiwan Society of Cardiology (TSOC) conducted a review of data and developed a guideline for the management of PAH.⁴ In recent years, several advancements in diagnosis and treatment of PAH has occurred. Therefore, the Working Group on Pulmonary Hypertension of TSOC decided to come up with a focused update that addresses clinically important advances in PAH diagnosis and treatment. This 2018 focused update deals with: (1) the role of echocardiography in PAH; (2) new diagnostic algorithm for the evaluation of PAH; (3) comprehensive prognostic

evaluation and risk assessment; (4) treatment goals and follow-up strategy; (5) updated PAH targeted therapy; (6) combination therapy and goal-orientated therapy; (7) updated treatment for PAH associated with congenital heart disease; (8) updated treatment for PAH associated with connective tissue disease; and (9) updated treatment for chronic thromboembolic pulmonary hypertension. The recommendations were developed with the same methodology used for the initial 2014 guidelines.

Echocardiography

Transthoracic echocardiographic (TTE) examination is the first step in the assessment of patients presenting with a relevant history, symptoms and signs showing a high index of suspicion for pulmonary hypertension (PH).⁶ The primary purpose of this examination is to determine the probability of PH. Based on echocardiographic findings, the probability of PH is classified into low, intermediate, or high.⁶

Systolic pulmonary artery pressure (SPAP) can be estimated using continuous wave Doppler echocardiography via assessment of the peak tricuspid regurgitation velocity (TRV) and taking into account the right atrial pressure (RAP), which is calculated using the modified Bernoulli equation ($SPAP = 4 \times TRV^2 + RAP$).⁷ The RAP can be estimated echocardiographically based on the diameter

¹ Both corresponding authors contributed equally to this work.

List of abbreviations

ALAT	alanine aminotransferase	MR	magnetic resonance
ASAT	aspartate aminotransferase	NO	nitric oxide
ASD	atrial septal defect	NT-proBNP	N-terminal pro-brain natriuretic peptide
BNP	brain natriuretic peptide	PA	pulmonary artery
BPA	balloon pulmonary angioplasty	PaCO ₂	arterial carbon dioxide pressure
BREATHE	Bosentan Randomised trial of Endothelin Antagonist THERapy	PAH	pulmonary arterial hypertension
CCB	calcium channel blocker	PAP	pulmonary arterial pressure
CHD	congenital heart disease	PAWP	pulmonary artery wedge pressure
CMR	cardiac magnetic resonance	PDA	patent ductus arteriosus
COPD	chronic obstructive pulmonary disease	PDE-5i	phosphodiesterase type 5 inhibitor
CPET	cardiopulmonary exercise testing	PE	pulmonary embolism
CTD	connective tissue disease	PEA	pulmonary endarterectomy
CTED	chronic thromboembolic disease	PFTs	pulmonary function tests
CTEPH	chronic thromboembolic pulmonary hypertension	PH	pulmonary hypertension
CTPA	computed tomography pulmonary angiogram	PoPH	porto-pulmonary hypertension
DECT	dual-energy CT	PVOD	pulmonary veno-occlusive disease
DL _{CO}	diffusing capacity of the lung for carbon monoxide	PVR	pulmonary vascular resistance
ECG	electrocardiogram	PVRi	pulmonary vascular resistance index
EIF2AK4	eukaryotic translation initiation factor 2 alpha kinase 4	RA	right atrium/atrial
ERA	endothelin receptor antagonist	RAP	right atrial pressure
ESC/ERS	European Society of Cardiology/European Respiratory Society	RCT	randomized controlled trial
ET	endothelin	RHC	right heart catheterization
FDA	US Food and Drug Administration	RV	right ventricle/ventricular
HIV	human immunodeficiency virus	RVOT	right ventricular outflow tract
HFpEF	heart failure with preserved left ventricular ejection fraction	6MWD/6MWT	6-minute walking distance/6-minute walking test
HRCT	high resolution computed tomography	SC	subcutaneous
INR	international normalized ratio	sGC	soluble guanylate cyclase
IPAH	idiopathic pulmonary arterial hypertension	sPAP	systolic pulmonary arterial pressure
IPF	idiopathic pulmonary fibrosis	SSc	systemic sclerosis
IV	intravenous	SvO ₂	mixed venous oxygen saturation
IVC	inferior vena cava	TEE	transesophageal echocardiography
LSIM	lung subtraction iodine mapping	TRPG	tricuspid regurgitation peak gradient
LV	left ventricle/ventricular	TRV	tricuspid regurgitant velocity
mPAP	mean pulmonary arterial pressure	TSOC	Taiwan Society of Cardiology
		TTE	transthoracic echocardiography
		VE/VCO ₂	minute ventilation – carbon dioxide production relationship
		V/Q	ventilation/perfusion
		VSD	ventricular septal defect
		WHO FC	World Health Organization functional class

and inspiratory collapsibility of the inferior vena cava (IVC) — an IVC diameter < 2.1 cm with collapsibility > 50% during a sniff suggests a normal RAP of 3 mmHg (range 0–5 mmHg), whereas an IVC diameter > 2.1 cm with collapsibility < 50% during a sniff or < 20% on quiet inspiration suggests a high RAP of 15 mmHg (range 10–20 mmHg). Other than these, RAP 8 mmHg (range 5–10 mmHg) can be used.⁸ Despite the strong correlation between SPAP determined echocardiographically and that determined via right heart catheterization (RHC); Doppler-derived SPAP cannot be used as a cut-off value to define PH because of a common overestimation of >10 mmHg for SPAP estimated from echocardiographic evaluation. Additionally, underestimation and inaccurate measurements are observed in patients presenting with severe TR.⁹ Owing to inaccuracies in estimation of SPAP and RAP, the peak TRV rather than the estimated SPAP is

used as a primary parameter to determine the echocardiographic probability of PH (Table 1⁶).

However, in approximately 10–25% of patients with PH who are referred for evaluation, the TRV cannot be assessed because of trivial or mild TR with a weak Doppler profile.¹⁰ In such cases, the use of contrast-enhanced echocardiographic examination by agitated saline may increase Doppler signals and enable assessment of the peak TRV.¹¹ Additionally, other echocardiographic parameters that raise the suspicion of PH independent of TRV should be sought. These signs include assessment of the RV size and pressure overload, the pattern of blood flow at the right ventricular outflow tract (RVOT), the diastolic pulmonary regurgitation velocity, the PA diameter, an estimated RAP, and the RA area (Table 2).⁶

In summary, a TRV that cannot be measured or a peak TRV < 2.8 m/s with no associated echocardiographic signs

of PH indicates a low probability of PH; however, when associated with echocardiographic signs of PH, the probability of PH is determined to be intermediate. A peak TRV of 2.9–3.4 m/s with no associated echocardiographic signs of PH indicates an intermediate probability of PH; however, when associated with echocardiographic signs of PH, the probability of PH is high. A peak TRV of >3.4 m/s indicates that the probability of PH is high even without associated echocardiographic signs of PH (Table 1).⁶

The recommended plan for the management of symptomatic patients in terms of further investigation based on echocardiographic probability of PH is shown in Table 3⁶ and that for asymptomatic patients is shown in Table 4⁶, considering the association with or without risk factors of pulmonary arterial hypertension (PAH) or chronic thromboembolic pulmonary hypertension (CTEPH).⁶ Following interpretation of all clinical contexts and echocardiographic results, the primary concern that needs to be addressed is to decide the need for cardiac catheterization.

In addition to the detection of PH, echocardiographic evaluation can identify the most common cause of PH, which is related to left-sided heart disease such as valvular heart disease, particularly mitral or aortic valve disease as well as LV systolic and/or diastolic dysfunction. Moreover, Doppler and contrast echocardiography are useful aids to diagnose congenital heart disease (CHD).

Diagnostic algorithm for the evaluation of pulmonary arterial hypertension

When echocardiographic findings are suggestive of a high or intermediate probability of PH, further clinical surveys including chest radiograph, pulmonary function tests, and high resolution computed tomography (HRCT) of the chest are requested to identify the presence of Group 2 or Group 3 PH (Fig. 1). If the diagnosis of left heart or lung parenchymal diseases is excluded, a ventilation/perfusion (V/Q) lung scan should be performed for the differential diagnosis between CTEPH and PAH. If the V/Q scan shows multiple segmental perfusion defects, a diagnosis of Group 4 PH (CTEPH) should be suspected. For patients with suspected Group 4 PH, CT pulmonary angiography (CTPA) and selective pulmonary arterial angiogram on top of right heart catheterization (RHC) is indicated to confirm the diagnosis and to evaluate the feasibility of pulmonary endarterectomy (PEA). When the V/Q scan shows normal or minimal perfusion defect, group 1 (PAH) or rare conditions of group 5 PH should be considered.

The diagnostic algorithm is illustrated in Fig. 1, it starts immediately when clinical symptoms and signs, and the echocardiographic features are compatible with PH to identify the most common etiologies of PH (Groups 2 and 3 PH), then to differentiate Group 4 PH (CTEPH) from Group 1 PAH and the rare conditions in Group 5 PH.

Group 2 (left heart disease) PH

The most common etiology of PH is left heart disease, which accounts for about two-third of patients with increased tricuspid regurgitation peak gradient (TRPG).¹² The phenotypes of left heart diseases varies from heart failure with either reduced or preserved ejection fraction (HFpEF) due to ischemic or non-ischemic causes, valvular heart diseases, and pericardial diseases. The mechanism of PH in patients with left heart disease is primarily related to the backward transmission of the elevated left atrial pressure to the pulmonary vein. Borlaug et al. have demonstrated every increase of pulmonary artery wedge pressure (PAWP) was almost identical to the changes of systolic pulmonary artery pressure (SPAP) during exercise in a study population of HFpEF and healthy controls.¹³ However, pulmonary arteries may undergo remodeling due to prolonged pressure overload, resulting in further increases of pulmonary arterial pressure and PVR. The hemodynamic study may therefore illustrate a combined pre and post capillary PH rather than an isolated post-capillary PH.⁶

TTE is usually the standard examination to make the diagnosis. Given there is a growing population of HFpEF, it would be helpful to survey whether the patients have typical heart failure symptoms (paroxysmal nocturnal dyspnea, orthopnea), multiple morbidities, atrial arrhythmia, and absence of right axis deviation to conduct diagnosis.¹⁴ Eventually, RHC is the gold standard to diagnose Group 2 PH by showing an elevated PAWP of ≥ 15 mmHg.

Group 3 (lung disease) PH

The limited data available has shown that PH was present in 31.6% and 50.2% of patients with idiopathic pulmonary fibrosis (IPF) or chronic obstructive pulmonary disease (COPD), respectively, when they were referred for lung transplantation or lung volume reduction surgery.^{15,16} HRCT, pulmonary function tests (PFTs), including diffusing capacity for carbon monoxide (DLco), and arterial blood gas are essential to identify significant airway obstruction, lung parenchymal disease, hypercapnia or mechanical defects of

Table 1 Echocardiographic probability of pulmonary hypertension.

Peak TRV (m/s)	Presence of associated echocardiographic signs of PH	Echocardiographic probability of PH
≤ 2.8 or not measurable	No	Low
≤ 2.8 or not measurable	Yes	Intermediate
2.9–3.4	No	
2.9–3.4	Yes	High
>3.4	Not required	

PH: pulmonary hypertension, TRV: tricuspid regurgitation velocity.

Table 2 Echocardiographic signs suggesting pulmonary hypertension in addition to tricuspid regurgitation velocity measurement.

A. The ventricles	B. Pulmonary artery	C. Inferior vena cava and right atrium
1. Right ventricle/left ventricle basal diameter ratio >1.0	1. Right ventricular outflow Doppler acceleration time <105 ms and/or mid-systolic notching	1. Inferior vena cava diameter >2.1 cm with decreased inspiratory collapse (<50% with a sniff or < 20% with quiet inspiration).
2. Flattening of the interventricular septum (LV eccentricity index > 1.1 during systole and/or diastole	2. Early diastolic pulmonary regurgitation velocity >2.2 m/s	2. Right atrial area (end-systole) > 18 cm ²
	3. PA diameter >2.5 cm	

PA: pulmonary artery, LV: left ventricle.

Echocardiographic signs suggesting pulmonary hypertension from at least two different categories (A/B/C).

Table 3 Suggested diagnostic management based on echocardiographic probability of pulmonary hypertension in **symptomatic** patients with or without associated risk factors for pulmonary arterial hypertension or chronic thromboembolic pulmonary hypertension.

Echocardiographic probability of PH	Without risk factors or associated conditions for PAH or CTEPH	With risk factors or associated conditions for PAH or CTEPH
Low	Alternative diagnosis should be considered	Echocardiographic follow-up should be considered
Intermediate	Alternative diagnosis, echocardiographic follow-up, should be considered Further investigation of PH may be considered	Further assessment of PH including RHC should be considered
High	Further investigation of PH (including RHC) is recommended	Further investigation of PH including RHC is recommended

CTEPH: chronic thromboembolic pulmonary hypertension, PAH: pulmonary arterial hypertension, PH: pulmonary hypertension, RHC: right heart catheterization.

Table 4 Suggested diagnostic management based on echocardiographic probability of pulmonary hypertension in **asymptomatic** patients with or without associated risk factors for pulmonary arterial hypertension or chronic thromboembolic pulmonary hypertension.

Echocardiographic probability of PH	Without risk factors or associated conditions for PAH or CTEPH	With risk factors or associated conditions for PAH or CTEPH
Low	No work-up required for PAH	Echocardiographic follow-up may be considered
Intermediate	Echocardiographic follow-up should be considered	Echocardiographic follow-up is recommended In the presence of associated scleroderma, RHC should be considered
High	RHC should be considered	RHC is recommended

CTEPH: chronic thromboembolic pulmonary hypertension, PAH: pulmonary arterial hypertension, PH: pulmonary hypertension, RHC: right heart catheterization.

lung. Screening overnight oximetry or polysomnography will disclose whether patients have significant sleep apnea/hypopnea.¹⁷

Group 4 PH (CTEPH)

Although CTPA has been the gold standard to diagnose patients with acute pulmonary emboli, the sensitivity to disclose the chronic distal pulmonary artery obstruction is low. The V/Q scan is the best screening tool for CTEPH when

multiple segmental perfusion defects are present.¹⁸ The selective pulmonary angiogram and RHC may clearly demonstrate the extent of CTEPH to evaluate the operability, while PEA provides the most appropriate intervention as a potential cure for this debilitating disorder.

Group 1 PAH

The etiologies of developing PAH include idiopathic or hereditary, connective tissue disease (CTD), CHD, drugs or

toxins, portopulmonary hypertension (PoPH), human immunodeficiency virus (HIV) infection, and schistosomiasis. A number of drugs or toxins have been reported to be associated with the development of PAH (Table 5).⁶ Therefore, a careful history taking may disclose whether the patients have been exposed to these drugs or toxins to confirm the etiology of PAH.

CTD is a well-known risk factor of developing PAH. In addition to blood tests, including anti-nuclear antibodies (ANA), scleroderma-70, anti-phospholipid antibodies, anti-ribonuclear protein, rheumatoid factors, etc., consultation with a rheumatologist is recommended.

PAH is common in adult patients with CHD.¹⁹ The transesophageal echocardiography (TEE) is essential to identify the intra- or extra-cardiac defects with systemic-to-pulmonary shunts. In addition, blood gas analysis during RHC may also disclose the presence of intra- or extra-cardiac shunts.

Otherwise, the tests for viral infections, including HIV antibody, hepatitis B surface antigen (HbsAg), anti-hepatitis C antibody are warranted. If patients have chronic viral hepatitis, work-up of liver cirrhosis, such as abdominal sonography, should be performed. During RHC, we may also measure the pressures of hepatic vein and portal vein to survey for portal hypertension. Although schistosomiasis is supposed to be the most prevalent etiology of PAH, the treatment of schistosomiasis-PAH has not been well studied. Identification of eggs in stools or urine,

or antibody detection may confirm the infection of schistosomiasis.

Pulmonary veno-occlusive disease (PVOD) is a special entity of PAH. When the therapeutic effects with PAH-specific drugs are with uncertainty, it is suggested to refer the patients to a transplant center once the diagnosis of PVOD is confirmed. PVOD mostly affects small pulmonary veins, leading to an elevation of pulmonary capillary pressure and pre-capillary pulmonary arterial pressure. The patients may have low DLco and the HRCT may show typical findings of ground-glass opacities with centrilobular pattern, poorly defined nodular opacities, septal lines and mediastinal lymphadenopathy. In addition, the bronchial alveolar lavage may disclose hemosiderin-laden macrophages. A combination of clinical findings, physical examination, bronchoscopy and radiological findings or the identification of a bi-allelic EIF2AK4 mutation are recommended to diagnose PVOD without histological confirmation.⁶

Comprehensive prognostic evaluation and risk assessment

In Taiwan, PH has high mortality, especially in females, and patients with older age and with chronic diseases.²⁰ Idiopathic PAH (IPAH) still has a poor prognosis despite advances in drug therapy that target the endothelin, nitric

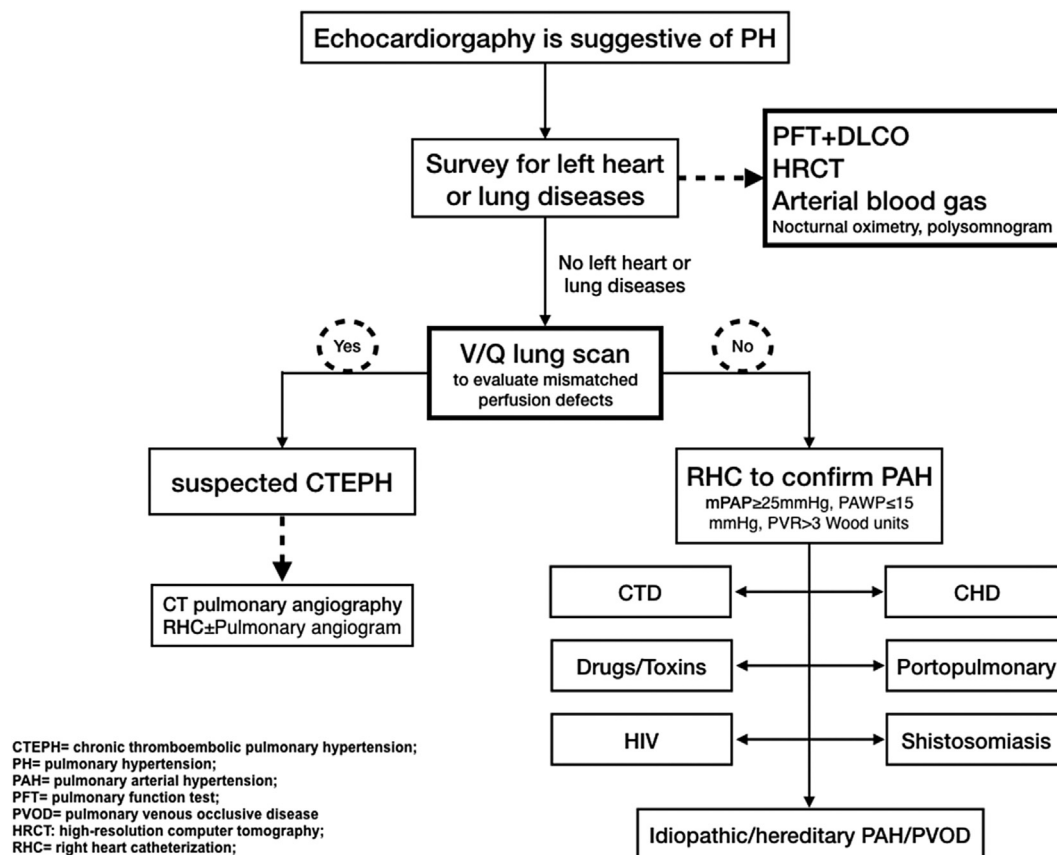


Figure 1 Diagnostic algorithm for the evaluation of pulmonary arterial hypertension. CTEPH = chronic thromboembolic pulmonary hypertension; PH = pulmonary hypertension; PAH = pulmonary arterial hypertension; PFT = pulmonary function test; PVOD = pulmonary veno-occlusive disease; HRCT = high-resolution computed tomography; RHC = right heart catheterization.

oxide, and prostacyclin pathways. Right heart failure is the most common cause of death in PAH and measures that reflect right ventricle (RV) performance predict outcome at baseline and during follow-up.^{6,21,22} Regular evaluation of patients with PAH is strongly recommended based on variables with predictive importance. A comprehensive assessment is necessary since no single variable could offer sufficient diagnostic and prognostic information. A multi-dimensional approach is required and stepwise evaluation at each visit should include the following: any evidence of clinical deterioration, the etiology of clinical deterioration, stability and sufficiency of RV function, and the achievement of the stable and satisfactory criteria. Table 6⁶ demonstrates prognostic variables that are most frequently advised in clinical practice guidelines.²¹ Not all these parameters must to be evaluated at each visit. The basic programme should comprise determination of the functional class (FC) and at least one measurement of exercise capacity, e.g. 6MWD or CPET. It is also recommended to acquire some information on RV function, either by measuring BNP/NT-proBNP or by performing echocardiography. Most of the proposed variables and cut-off values are based on expert opinions. These prognostic parameters may be used to guide therapeutic decisions, but application to individual patients must be done carefully. In recent investigations of risk assessment in PAH from three European registries, an abbreviated version of the risk stratification strategy listed in Table 6 has validated the benefit of reaching a stable and satisfactory profile.^{22–24} RHC remains the gold standard of diagnosis of PAH, and the data acquired by RHC remain the standard hemodynamic values. The magnitude of the PAP correlates poorly with clinical symptoms since it is influenced by the degree of PVR and CO. Therefore, the PAP alone should not be used for therapeutic decision making. The indicated mortality rates are crude estimates and the illustrated variables have been studied mostly in patients with IPAH. Not all variables may be in the same risk group, and it is the comprehensive assessment of individual patients that should guide treatment decisions. Patients often do not completely fall into one of the three categories, and in these cases the patient's overall risk should be judged based on the worse parameters. The individual risk is further modified by other factors, such as the rate of disease progression, the presence or absence of signs of right heart failure, syncope, comorbidities, age, sex, background therapy, and PAH subtype. Finally, the assessment of PAH patients should

provide information on clinical worsening, disease complications and hospitalization for PAH. ECGs should be acquired on a regular basis to detect clinically relevant arrhythmias found frequently in the PAH population. Since PAH patients may be candidates for long-term O₂ therapy and a low PaCO₂ is associated with reduced pulmonary blood flow and has prognostic implications, arterial or capillary blood gases provide important information and should be part of the regular clinical assessment, at least in case of clinical deterioration. Peripheral O₂ saturation may be used alternatively, but it is less reliable and does not provide information on PaCO₂. The recommended basic laboratory workup includes complete blood counts, BNP/NT-proBNP, International normalized ratio (INR) in patients receiving vitamin K antagonists, sodium, potassium, creatinine, aspartate aminotransferase (ASAT)/alanine aminotransferase (ALAT) (in patients receiving ERAs) and bilirubin. The extended laboratory workup comprising troponin, uric acid, iron status and thyroid function should be checked at least once a year or whenever PAH patient presents with clinical worsening.

Table 7 demonstrates comprehensive recommendations on the follow-up assessments of patients with PAH.⁶

Definition of patient status

PAH patients can be categorized as stable and satisfactory, stable but not satisfactory or unstable and deteriorating based on the prognostic evaluation and risk assessment defined in Table 6.⁶ Although reliable individual predictions are always difficult, patients categorized as stable and satisfactory have an estimated 1-year mortality <5%. Basically, these patients present with non-progressive disease in WHO-FC I or II with a 6MWD of at least 440 m and no signs of clinically relevant RV dysfunction. The estimated 1-year mortality in the stable but not satisfactory category is 5–10%. These patients typically present in WHO-FC III, with moderately impaired exercise capacity and signs of RV dysfunction, but not with RV failure. Patients in the unstable and deteriorating category have an estimated 1-year mortality >10%. These patients present in WHO-FC III or IV with progressive disease and signs of severe RV dysfunction, or with RV failure and secondary organ dysfunction.

PAH patients often do not completely fall into one of the three categories, and the overall risk should be judged based on the worse parameters. Importantly, the assessment of PAH patients should provide information on clinical

Table 5 Drugs and toxins known to induce pulmonary arterial hypertension.

Definite	Likely	Possible
Aminorex	Amphetamines	Cocaine
Fenfluramine	Dasatinib	Phenylpropanolamine
Dexfenfluramine	L-tryptophan	St. John's wort
Toxic rapeseed oil	Chemotherapeutic agents	Amphetamine-like drugs
Benfluorex	Methamphetamines	Interferon α and β
SSRIs (PPHN only)		Some chemotherapeutic agents such as alkylating agents (mytomyicine C, cyclophosphamide) ^a

^a Alkylating agents are possible causes of pulmonary veno-occlusive disease.

worsening, disease complications and hospitalization for PAH. Again, these risk categories are intended for risk assessment before initiating treatment and can be used for further disease management decisions. Aggressive and timely intervention based on multi-parameter and individualized assessment offers the best chance of gaining control over disease progression and subsequently optimizing the long-term outlook for every patient with PAH.

Treatment goals and follow-up strategy

Treatment goals for PAH patients are those listed in the 'stable and satisfactory' category of Table 6. Treatment goals and target values are not the same in all patients, and which are adjusted according to the individual patient. For example, the value of 6MWD depends on the age and >400 m is acceptable for older PAH patients, and younger patients can aim to walk 500 m or more despite the presence of severe PH and RV dysfunction. More tests such as CPET and/or RHC should be performed in these patients in order to obtain more reliable assessments of RV function. Severe PAH patients with accompanying cardiac arrhythmias or acute RV failure, increasing frequency of syncope are contraindicated for maximal exercise testing. Peak VO_2 , an abnormally high VE/VCO_2 slope, O_2 pulse, peak systolic blood pressure during exercise and diminished aerobic capacity are typically seen in patients with RV failure, and these are also important information about RV function during exercise. In addition, biomarkers, echocardiography,

and RHC are valuable tools to determine whether the patient can be considered stable.

RHC is required to assess the severity of the hemodynamic impairment and is essential during the initial evaluation of new patient. There is no accepted consensus about the timing for follow-up RHC worldwide. However, some expert centers perform RHC every once a year. It mostly depends on the centers and in case of clinical worsening and/or changes in treatment. Some centers perform RHC 3–6 months after initiation or change of treatment to determine whether hemodynamics is in the desired range. The most important prognostic indicators are those variables that reflect RV function, and these are CO, RA pressure, and mixed-venous oxygen saturation.

Not all parameters need to be assessed at every visit. Recommendations for evaluation of severity and follow-up are summarized in Table 7⁶ and as follows:

- 1) Clinical evaluation, CPET, biochemical markers, echocardiographic and hemodynamic assessments by RHC while making the diagnosis should be performed.
- 2) For every patient, regular follow-up with clinical evaluation, 6MWD and BNP/NT-pro-BNP should be performed every 3–6 months even in stable PAH patients.
- 3) A goal-oriented treatment is recommended in PAH. Treatment goals for PAH patients are those listed in the "stable and satisfactory definition".
- 4) Echocardiography should be performed in presence of deterioration of symptoms and RHC should be performed

Table 6 Risk assessment in patients with pulmonary arterial hypertension.

Determinants of prognosis ^a	Stable and satisfactory	Stable but not satisfactory	Unstable and deteriorating
estimated 1-year mortality	<5%	5–10%	>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 (CPET)	Peak VO_2 > 15 ml/min/kg (>65% pred.)	Peak VO_2 11–15 ml/min/kg (35–65% pred.)	Peak VO_2 < 11 ml/min/kg (<35% pred.)
	VE/VCO_2 slope <36	VE/VCO_2 slope 36–44.9	VE/VCO_2 slope \geq 45
BNP or NT-proBNP plasma levels	BNP <50 ng/l	BNP 50–300 ng/l	BNP >300 ng/l
	NT-proBNP <300 ng/l	NT-proBNP 300–1400 ng/l	NT-proBNP >1400 ng/l
Imaging (echocardiography, CMR imaging)	RA area <18 cm ²	RA area 18–26 cm ²	RA area >26 cm ²
	TAPSE > 2.0 cm	TAPSE 1.5–2.0 cm	TAPSE < 1.5 cm
	No pericardial effusion	No or minimal pericardial effusion	Pericardial effusion
Hemodynamics	RAP <8 mmHg	RAP 8–14 mmHg	RAP >14 mmHg
	CI \geq 2.5 l/min/m ²	CI 2.0–2.4 l/min/m ²	CI < 2.0 l/min/m ²
	SvO ₂ >65%	SvO ₂ 60–65%	SvO ₂ <60%

6MWD = 6-minute walking distance; BNP = brain natriuretic peptide; CI = cardiac index; CMR = cardiac magnetic resonance; NT-proBNP = N-terminal pro-brain natriuretic peptide; pred. = predicted; RA = right atrium; RAP = right atrial pressure; SvO₂ = mixed venous oxygen saturation; TAPSE = tricuspid annular plane systolic excursion; VE/VCO_2 = ventilatory equivalents for carbon dioxide; VO_2 = oxygen consumption; WHO = World Health Organization.

^a Most of the proposed variables and cut-off values are based on expert opinion. They may provide prognostic information and may be used to guide therapeutic decisions, but application to individual patients must be done carefully. One must also note that most of these variables have been validated mostly for IPAH and the cut-off levels used above may not necessarily apply to other forms of PAH. Furthermore, the use of approved therapies and their influence on the variables should be considered in the evaluation of the risk.

^b Occasional syncope during brisk or heavy exercise, or occasional orthostatic syncope in an otherwise stable patient.

^c Repeated episodes of syncope, even with little or regular physical activity.

if clinical worsening is suspected and we would like to change the treatment.

Prostacyclin analogues and prostacyclin receptor agonists

Prostacyclin, a prostanoid metabolized from arachidonic acid through the cyclooxygenase pathway, is produced predominantly by endothelial cells and induces vasodilatation of vessels. It is also a potent endogenous inhibitor of platelet aggregation and has both cytoprotective and antiproliferative activities.²⁵ In PAH patients' pulmonary arteries, the decrease of prostacyclin synthase expression was found, which may contribute to the pathogenesis of PAH.²⁶ Clinically it has been identified as one of the most effective drugs for the treatment of PAH.

Epoprostenol

Intravenous (IV) epoprostenol (synthetic prostacyclin) is the first prostacyclin analogue used for the treatment of PAH and is a first-line treatment for patients with severe PAH (WHO FC IV). Epoprostenol is available as a stable freeze-dried preparation that needs to be dissolved in alkaline buffer for intravenous infusion. Epoprostenol has a short half-life (3–5 minutes) and a rapid onset of action, reaching plasma steady-state concentrations within 15 minutes. It is stable at room temperature for only 8 hours after dissolution in buffer. It needs to be given continuously by an infusion pump via a permanent catheter. Continuous

intravenous administration of epoprostenol improves survival in patients with IPAH^{27,28} and those with PAH associated with the scleroderma spectrum of diseases.²⁹ Epoprostenol improves symptoms, exercise capacity and hemodynamics, and is the only treatment shown to improve survival in treating IPAH patients²⁸ and was approved by the FDA in 1995 for the long-term treatment in severe symptomatic IPAH and PAH associated with scleroderma patients.³⁰ It was only approved for the treatment of IPAH in Taiwan. Long-term efficacy has also been shown in open label registries of IPAH³¹ as well as in other APAH conditions^{32–34} and non-operable CTEPH.^{30,35} Treatment with epoprostenol is initiated at a dose of 2–4 ng/kg/min and increased gradually if no severe side effects. Side effects include flushing, headache, jaw pain, diarrhea and leg pain. The optimal dose varies between individual patients, ranging between 20 and 40 ng/kg/min in majority of the patients.³¹ Serious adverse events related to the delivery system include pump malfunction, local site infection, catheter obstruction and sepsis. Guidelines for the prevention of central venous catheter bloodstream infections have been proposed.³⁶ Abrupt discontinuation of the epoprostenol infusion should be avoided as it may lead to rebound increases in PAP with severe symptomatic deterioration and even death. Due to this safety concern, epoprostenol should be used in experienced PAH center and patient should be well educated before starting epoprostenol. Because of the complexity of its administration, epoprostenol is generally reserved for patients with advanced PAH and those who have had poor response to oral therapies. For the FC IV PAH patients, it could be used initially, either as mono or combination therapy. A

Table 7 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 dyspnea score	+	+	+	+	+
CPET	+		+		+ ^e
Echo	+		+	+	+
Basic lab ^b	+	+	+	+	+
Extended lab ^c	+		+		+
Blood gas analysis ^d	+		+	+	+
Right heart catheterization	+		+	+ ^e	+ ^e

ALAT = alanine aminotransferase; ASAT = aspartate aminotransferase; BNP = brain natriuretic peptide; CPET = cardiopulmonary exercise testing; Echo = echocardiography; ECG = electrocardiogram; ERAs = endothelin receptor antagonists; INR = international normalized ratio; lab = laboratory assessment; NT-proBNP = N-terminal pro-brain natriuretic peptide; TSH = thyroid stimulating hormone; 6MWT = 6-minute walking test.

^a Intervals to be adjusted according to patient needs.

^b Basic lab includes blood count, INR (in patients receiving vitamin K antagonists), serum creatinine, sodium, potassium, ASAT/ALAT (in patients receiving ERAs), bilirubin and BNP/NT-proBNP.

^c Extended lab includes TSH, troponin, uric acid, iron status (iron, ferritin, and soluble transferrin receptor) and other variables according to individual patient needs.

^d From arterial or arterialized capillary blood; may be replaced by peripheral oxygen saturation in stable patients or if blood gas analysis is not available.

^e Should be considered.

thermostable formulation of epoprostenol has been developed and does not usually require cooling packs to maintain stability beyond 8–12 hours.³⁷ However, this formulation is not available in Taiwan as of 2017.

Iloprost

Iloprost is a synthetic analogue of prostacyclin available for intravenous (IV) and inhaled administrations. Inhaled iloprost was approved in 2004 by the FDA for the treatment of WHO FC III/IV PAH and has the theoretical advantage of being selective for the pulmonary circulation with less systemic hypotension. Inhaled iloprost has been evaluated in one randomized controlled trial (RCT) in which daily repetitive iloprost inhalations (6–9 times, 2.5–5 µg/inhalation, median 30 µg daily) were compared with placebo inhalation in patients with PAH and CTEPH.³⁸ The study showed an increase in exercise capacity and improvement in symptoms, PVR and clinical worsening events in enrolled patients. A second RCT with 60 patients on background oral bosentan did not reach its endpoint but did demonstrate safety in the subjects randomized to the addition of inhaled iloprost in comparison with placebo.³⁹ With these two (2) trials the FDA approved iloprost for PAH. Overall, inhaled iloprost was well tolerated, with flushing and jaw pain being the most frequent side-effects. Inhaled iloprost is initiated at a dose of 2.5 µg/inhalation and increased to 5 µg/inhalation as tolerated (as delivered at the mouthpiece of the inhalation device). The different nebulization device need different volume to provide a total dose of 5 µg of iloprost delivered at the mouthpiece.⁴⁰ The maximum recommended dose is 45 µg/day. Because of the short half-life of iloprost (20–30 minutes), daily inhalations for 6 to 9 times is suggested. Continuous intravenous administration of iloprost appears to be as effective as epoprostenol in a small series of patients with PAH and CTEPH.⁴¹ Inhaled iloprost has been approved for group I PAH. The IV formulation is approved for group I PAH in New Zealand. Effects of oral iloprost have not been assessed in PAH. Only inhaled iloprost is available in Taiwan now.

Treprostinil

Treprostinil is a tricyclic benzidine analogue of epoprostenol, with sufficient chemical stability to be administered at room temperature. This characteristic allows administration of the compound by the IV, SC and oral routes. The effects of SC treprostinil in PAH were studied in a worldwide RCT and showed improvements in exercise capacity, hemodynamics and symptoms.⁴² The greatest exercise improvement was observed in patients who were more compromised at baseline and in subjects who were able to tolerate the upper quartile dose (>13.8 ng/kg/min). Infusion site pain is the most common adverse effect of SC treprostinil which often leads to withdrawal of the therapy or insufficient dosage titration. Infusion site pain was independent of treprostinil dose or infusion rate but dependent on the volume. Further support of its efficacy was reported in an open-label study in patients with IPAH or CTEPH followed up for a mean of 26 months.⁴³ Treatment

with SC treprostinil is started at a dose of 1–2 ng/kg/min, with doses increasing at a rate limited by side-effects (injection site pain, flushing, headache). The optimal dose varies between individual patients, ranging between 20 and 80 ng/kg/min in majority of patients.

Bioequivalence data on IV versus SC treprostinil prompted clinical trials to explore dosing and safety in PAH.⁴⁴ Tapson et al. reported that newly diagnosed patients started on intravenous therapy dramatically improved 6MWD and hemodynamics.⁴⁵ Gomberg-Maitland's data suggested that transition from intravenous epoprostenol to intravenous treprostinil is safe and effective.⁴⁶ The intravenous treprostinil effects appear to be comparable with those of epoprostenol, but at a dose which is two to three times higher.^{45–47} The FDA approved the use of intravenous (IV) treprostinil in WHO FC II, III and IV PAH patients in whom SC infusion is not tolerated. IV and SC treprostinil are available but not approved for the treatment of IPAH in Taiwan. Oral treprostinil has been evaluated in two (2) RCTs in PAH patients on background therapy patients, however both the primary endpoints of 6MWD did not reach statistical significance.^{48,49} An additional RCT in PAH treatment-naïve patient showed improvement in 6MWD by 26 m at peak dose.⁵⁰ FDA has approved oral treprostinil for the treatment of PAH in Group I PAH patients to improve exercise capacity on December 2013. Oral treprostinil is not available in Taiwan.

Beraprost

Beraprost is the first oral prostacyclin analogue. In two (2) clinical trials it showed an improvement in exercise capacity but no hemodynamic improvements nor long-term outcome benefits.^{51,52} Headache, flushing, jaw pain and diarrhea were the most frequent adverse events. It has been approved for the treatment of PAH only in Japan and South Korea but not in Taiwan.

Selexipag

Selexipag is an orally available, selective prostacyclin IP receptor agonist. The vasodilator effect of prostacyclin works via IP receptor; thus, IP receptor agonist may have similar therapeutic effect as prostacyclin in PAH patients. In GRIPHON study, a large RCT in PAH patients (either not receiving PAH-specific treatment or receiving a stable dose of an endothelin-receptor antagonist, a phosphodiesterase type 5 inhibitor, or both), selexipag alone or on top of mono- or double therapy with ERAs and/or PDE-5i was able to reduce the composite morbidity and mortality endpoint (including all causes mortality, hospitalization for worsening of PAH, clinical worsening of PAH resulting in the need for lung transplantation or atrial septostomy, initiation of parenteral prostanoids or chronic O₂ for worsening of PAH and disease progression) by 40% (hazard ratio 0.60, 99% CI 0.46 to 0.78, P < 0.001) in median duration of 1.4 years.⁵³ Common side effects observed in those treated with selexipag in the trial include headache, diarrhea, jaw pain, nausea, muscle pain (myalgia), vomiting, pain in an extremity, and flushing. In a subgroup analysis of CTD-PAH patients from GRIPHON trial, selexipag also reduced the risk of composite morbidity/mortality events in patients

with PAH-CTD by 41% (HR 0.59; 95% CI 0.41–0.85).⁵⁴ It has been approved for Group I PAH treatment by FDA, but not officially available in Taiwan as of 2017. Generally it can be used as mono or combination therapy in WHO FC I-III PAH patients. For WHO FC IV PAH patients, IV form prostacyclins, especially epoprostenol, should still be considered as first-line treatment choice.

Endothelin receptor antagonists

Overexpression of endothelin-1 (ET-1), a vasoconstrictive peptide, is the result of the endothelial cell dysfunction observed in PAH and plays a prominent role in the pathogenesis of PAH.⁵⁵ ET-1 exerts its vascular effects by binding to two distinct receptor isoforms in the pulmonary vascular smooth muscle cells, endothelin-A (ET_A) and endothelin-B (ET_B) receptors. Dual ET_A and ET_B receptor antagonist and the selective ET_A receptor antagonist drugs have been developed for treatment of PAH.^{56–58} There are currently three available FDA-approved endothelin receptor antagonists, including bosentan, ambrisentan, and macitentan.

Bosentan

Bosentan is an oral active dual ET_A/ET_B receptors antagonist that received FDA approval in 2001. Bosentan was approved for the treatment of PAH (idiopathic, CTD-APAH and Eisenmenger syndrome) in patients of WHO FC II–IV to improve exercise ability, functional class, hemodynamics, and to decrease clinical worsening.^{56,59–61}

COMPASS-2 was a long term, prospective, double-blind, event-driven trial evaluating 334 PAH patients who were symptomatic on at least 3 months of stable dose sildenafil and were randomized to receive placebo or bosentan. The study did not demonstrate adding bosentan to stable sildenafil therapy was superior to sildenafil monotherapy in delaying the time to first morbidity/mortality event, defined as all-cause death, hospitalization for PAH worsening or intravenous prostanoid initiation, atrial septostomy, lung transplant, or PAH worsening (HR = 0.83; 95% CI 0.58 to 1.19; *p* = 0.2508).⁶² However, on exploratory secondary analysis, bosentan and sildenafil combination therapy improved 6MWD 21.8m (95% CI + 5.9–37.8m; *p* = 0.0106) at 16 weeks. There were several limitations of the COMPASS-2 trial and the results must be interpreted with caution.⁶² Bosentan is available and approved for the treatment of IPAH and CHD with Eisenmenger syndrome patients in Taiwan.

Ambrisentan

Ambrisentan is a selective ET_A receptor antagonist that received FDA approval in 2007 for patients with PAH WHO FC II–III. According to the clinical trials, ambrisentan led to improved exercise capacity, symptoms, WHO FC, hemodynamics and time to clinical worsening of patients with IPAH and PAH associated with CTD, anorexigen and HIV infection.^{63,64} The AMBITION (Study of First-Line Ambrisentan and Tadalafil Combination Therapy in Subjects with PAH) trial was a multicenter, double-blind, phase 3 trial of 500 treatment-naïve WHO FC II and III PAH patients, randomly assigned to receive monotherapy with tadalafil or ambrisentan or both

tadalafil and ambrisentan to show dual combination is better than monotherapy.⁶⁵ Initial combination with tadalafil and ambrisentan showed marked improvement in a primary composite endpoint of death, hospitalization for worsening PAH, disease progression, and unsatisfactory long-term clinical response in comparison to ambrisentan and tadalafil monotherapy. Ambrisentan is available but only approved for the treatment of IPAH in Taiwan.

Macitentan

Macitentan is the newest dual ERA and approved by FDA in 2013 for PAH patients with FC II and III symptoms. Macitentan has been evaluated in a long-term, event-driven SERAPHIN (Study with an Endothelin Receptor Antagonist in PAH to Improve Clinical Outcomes) study.⁵⁸ The primary endpoint was the time from the initiation of treatment to the first occurrence of a composite endpoint of death, worsening PAH, atrial septostomy, lung transplantation, initiation of treatment with parenteral prostanoids or death. Macitentan significantly reduced this composite endpoint of morbidity and mortality, and reduced secondary endpoints at 6 months (Functional class and exercise capacity) among patients with PAH. Benefits were shown both for patients who had not received treatment previously and for those receiving additional therapy for PAH. Macitentan also significantly reduced risk of all-cause hospitalization and PAH-related hospitalization⁶⁶ and improved quality of life⁶⁷ in the SERAPHIN study. Macitentan was also shown to reduce disease progression in the treatment-naïve cohort of SERAPHIN in both incident (diagnosed <6 months) and prevalent (>6 months) patients taking macitentan.⁶⁸ Macitentan is available and approved for the treatment of IPAH and WHO Group I PAH in Taiwan.

Soluble guanylate cyclase (sGC) stimulator

Riociguat

The first 'sGC stimulator', YC-1, was discovered by Taiwanese researchers in the mid-1990s.^{69,70} Riociguat is the first sGC stimulator approved for use in PAH or CTEPH. Riociguat directly stimulates the native sGC while also increasing the sensitivity to low levels of nitrogen oxide (NO).^{71,72} It is a new agent for the treatment of PAH and CTEPH.^{71,72} The Phase III PATENT study focusing on patients with PAH revealed a statistically significant improvement of 36 meters in the 6MWD (*p* < 0.0001) after 12 weeks in the group treated with riociguat compared with placebo.⁷¹ In another Phase III CHEST study, patients with non-operable CTEPH or persistent/recurrent PH after PEA presented with a mean increase of 39 meters in the 6MWD (*P* < 0.001) and an improvement of PVR (*P* < 0.001) post treatment with riociguat for 16 weeks.⁷² In the sub-group analysis of PATENT study, riociguat was well tolerated and associated with positive trends in 6MWD in patients with PAH-CTD and PAH-CHD.^{73,74} Riociguat did not show any effect on PAP in patients with left heart disease induced PH compared to placebo.⁷⁵ Notably, the combination of riociguat and PDE-5 inhibitor is contraindicated due to hypotension.⁷⁶ Nevertheless, according to the results of RESPITE study in PAH

patients not responding adequately to previous PDE-5i, treatment with riociguat led to improvements in 6MWD, NT-proBNP levels, and WHO FC.⁷⁷ Collectively, riociguat has been approved by FDA in 2013 and is available and also approved for the treatment of IPAH and persistent/recurrent and inoperable CTEPH in Taiwan.

PAH treatment algorithm (Table 8) (Fig. 2)

Combination therapy and goal-orientated therapy

The term combination therapy describes the simultaneous use of more than one PAH-specific class of drugs, e.g. ERAs, PDE-5 inhibitors, prostanoids, sGC stimulator and investigational therapies. Combination treatment causes a synergism between administered drugs, increasing the effectiveness of the treatment and allowing dose reductions of the individual agents with a subsequent lower risk of toxicity. As the field of PAH progresses, combination therapy has become the standard of care in many PAH centers. Numerous case reports have suggested that various drug combinations appear to be safe and effective.^{39,60,78–84} The use of combination therapy according to predefined treatment goals proved to be better in all objective outcomes compared with a historical control group from the authors' own practice.⁸⁰

Concomitant administration of drugs may cause drug–drug interactions, compromising efficacy or increasing side effects, with a negative influence on disease progression. For example, a pharmacokinetic interaction exists between bosentan and sildenafil, acting as inducers and inhibitors of CYP3A4, respectively. The co-administration of both substances results in a decline of sildenafil plasma levels and in an increase in bosentan plasma levels.⁸⁵ So far there is no indication that these interactions are associated with decreased safety,⁸⁶ but the issue of whether the clinical efficacy of sildenafil is

significantly reduced is still under debate. A pharmacokinetic interaction is also known with tadalafil and bosentan.⁸⁷ The PHIRST study's substudy of subjects on background bosentan demonstrated clinical improvements despite this pharmacokinetic interaction. Other drug–drug interactions are listed on Table 9 and should be taken into consideration.

There are many open questions regarding combination therapy, including the selection of combination medications, when to switch and when to combine. Goal-orientated strategies may provide predefined, structure, and reproducible ways for clinicians to assess response to treatment. Goal-orientated therapy is becoming a standardized treatment strategy, but the selection of goals needs refinement to correlate closely with clinical outcome. Sequential combination therapy is mostly preferred at present time. However, there are more and more evidences supporting initial combination therapy in recent years. The first initial combination therapy RCTs started with the BREATHE-2 study, which failed to demonstrate any significant difference between patients treated initially with the combination epoprostenol and bosentan as compared with epoprostenol alone.⁶⁰ A pilot study on initial triple combination in 19 severe PAH patients (WHO FC III and IV) provided preliminary evidence of the long-term benefits of upfront triple combination therapy in patients with severe PAH.⁸⁸ A recent multicenter, multinational, blinded, placebo-controlled trial compared first-line monotherapy with tadalafil or ambrisentan with upfront combination therapy with tadalafil and ambrisentan in de novo WHO FC II and III PAH patients. The results revealed a 50% reduction in risk for clinical failure events in the combination group versus pooled monotherapy group. In addition, improvements were observed in exercise capacity, rate of satisfactory clinical response and NT-proBNP plasma levels.⁶⁵ According to these results, a higher grade of recommendation was given to this initial combination with

Table 8 Recommendations for initial monotherapy for PAH.

Drugs	WHO Functional Class Level					
	II	III	IV			
Calcium channel blocker	I	C	I	C	–	–
Endothelium receptor antagonists	Ambrisentan	I	A	I	A	IIb C
	Bosentan	I	A	I	A	IIb C
	Macitentan	I	A	I	A	IIb C
Phosphodiesterase type 5 inhibitors	Sildenafil	I	A	I	A	IIb C
	Tadalafil ^a	I	A	I	A	IIb C
Soluble guanylate cyclase stimulators	Riociguat	I	A	I	A	IIb C
Prostacyclin analogues	Epoprostenol	I.V.	–	I	A	I A
	Iloprost	IH	–	I	B	IIb C
		I.V. ^a	–	IIa	C	IIb C
	Treprostinil	SC	–	I	B	IIb C
		IH	–	I	B	IIb C
		I.V.	–	IIa	C	IIb C
		Oral ^a	–	IIb	B	–
IP receptor agonists	Beraprost ^a	–	–	IIb	B	–
	Selexipag	I	B	I	B	–

I.V.: intravenous, IH: inhaled, SC: subcutaneous.

^a Beraprost, tadalafil, I.V. iloprost and oral treprostinil are not available for PAH in Taiwan.

ambrisentan plus tadalafil. Initial combination therapy was also recommended by 2015 ESC/ERS PH guidelines, especially for intermediate to high risk patients.⁶ Initial combination therapy including IV prostacyclin was recommended for WHO FC IV patients (Table 10).^{60,65,88,89} In case of inadequate clinical response to initial combination therapy or initial monotherapy, sequential double or triple combination therapy is recommended according to Table 11.^{53,58,71,84,90–92} The combination of riociguat and PDE-5i is contraindicated.⁶

Pulmonary arterial hypertension associated with congenital heart disease

PAH is found in about 5–10% of adults with CHD.⁹³ Systemic-to-pulmonary shunts due to the congenital cardiac defects led to increased PVR. If an early correction cannot be made, a wide range of cardiac defects can lead to PAH, including ventricular septal defects, atrial septal defects,

atrioventricular septal defects, and patent ductus arteriosus.⁹³ Eisenmenger syndrome, PAH with reversed central shunt, represents the most severe form. Patients of PAH associated with CHD (PAH-CHD) can be classified clinically into four (4) subgroups (Table 12): Eisenmenger syndrome, PAH associated with systemic-to-pulmonary shunts, PAH associated with small defects, and PAH after cardiac defect correction.^{6,94} Two additional types of pulmonary vascular disease, segmental pulmonary arterial hypertension and raised PVR in Fontan patients, should be included in the spectrum of PAH-CHD due to their distinct features and clinical outcomes (Table 12).⁹⁵ Furthermore, to better characterize each individual patient, an anatomical-pathophysiological classification^{6,94} can be applied to describe the type and severity of the defects, direction of shunt, associated abnormalities and the repair status (Table 13). For pediatric patients, pulmonary vascular disease is characterized by complex heterogeneity.⁹⁶ The 2011 Panama classification further categorize pediatric PH into 10 subgroups.⁹⁷

Table 9 Drug–Drug interaction of pulmonary hypertension medication.

Class/Drug	CYP interaction	Other interaction
PDE5 inhibitor Sildenafil	CYP3A, CYP2C9	Amlodipine Doxazosin Nitrates Alpha-blockers
Tadalafil sGC stimulator Riociguat	CYP3A CYP3A	Nitrates Nitric oxide donors PDE-5 inhibitors Antacids
Endothelin Receptor Antagonists Ambrisentan Bosentan	CYP2C9, CYP3A4, CYP1A2 CYP2C9, CYP3A4, CYP2C19	Cyclosporine Cyclosporine Glyburide Hormonal contraceptives Rifampin HIV medication
Macitentan	CYP3A4	
Prostanoids Epoprostenol	Not known	Diuretics Anti-hypertensives Vasodilators Anti-platelets Anticoagulants Digoxin
Iloprost	Not known	Anti-hypertensives Anticoagulants Platelet inhibitors Vasodilators
Treprostinil	CYP2C8	Diuretics Anti-hypertensives Vasodilators Anticoagulants Gemfibrozil Rifampin
Selective Prostacyclin Receptor Agonist Selexipag	CYP2C8, CYP2C9, CYP3A4	

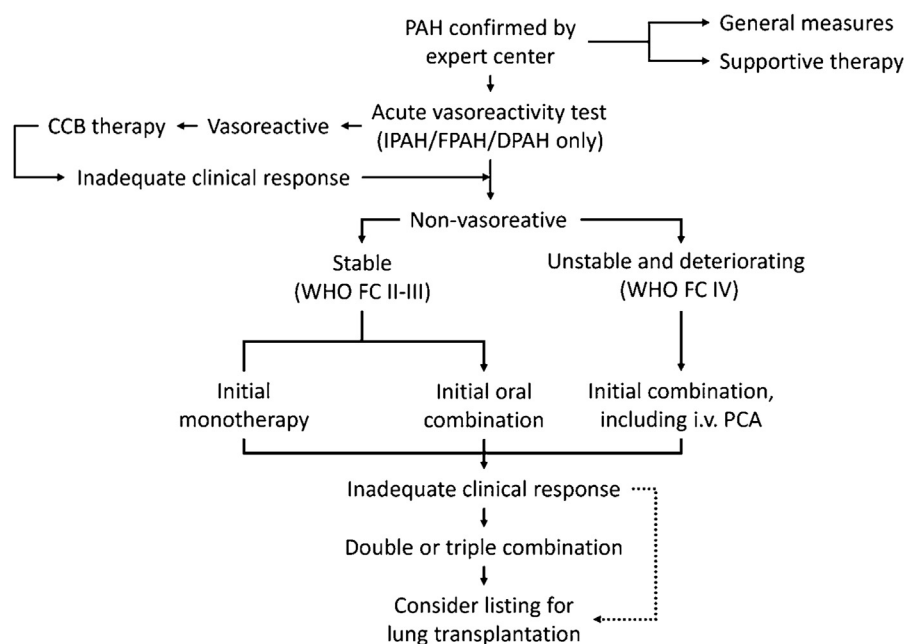


Figure 2 Treatment algorithm for pulmonary arterial hypertension (PAH). CCB = calcium channel blocker; IPAH = idiopathic pulmonary arterial hypertension; FPAH = familiar idiopathic pulmonary arterial hypertension; DPAH = drugs and toxins related pulmonary arterial hypertension; WHO FC: World Health Organization functional class; IV: intravenous; PCA = prostacyclin analogue.

Table 10 Recommendations for efficacy of initial drug combination therapy for pulmonary arterial hypertension (WHO Group 1) according to World Health Organization functional class.

Drugs	WHO Functional Class Level					
	II		III		IV	
Ambrisentan + tadalafil ⁶⁵	I	B	I	B	IIb	C
Other ERA + PDE-5i	IIa	C	IIa	C	IIb	C
Bosentan + sildenafil + I.V. epoprostenol ⁸⁸	—	—	IIa	C	IIb	C
Bosentan + I.V. epoprostenol ^{60,89}	—	—	IIa	C	IIa	C
Other ERA or PDE-5i + SC treprostinil	—	—	IIb	C	IIb	C
Other ERA or PDE-5i + other I.V. prostacyclin analogues	—	—	IIb	C	IIb	C
Riociguat + PDE-5i	III	B	III	B	III	B

Modified from 2015 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension.

ERA = endothelium receptor antagonist; PDE-5i = Phosphodiesterase type 5 inhibitor; I.V. = intravenous; SC = subcutaneous.

Table 11 Recommendations for efficacy of sequential drug combination therapy for pulmonary arterial hypertension (WHO Group 1) according to World Health Organization functional class.

Drugs	WHO Functional Class Level					
	II		III		IV	
Macitentan added to sildenafil ⁵⁸	I	B	I	B	IIa	C
Riociguat added to bosentan ⁷¹	I	B	I	B	IIa	C
Selexipag added to ERA and/or PDE-5i ^{53,91}	I	B	I	B	IIa	C
Sildenafil added to epoprostenol (I.V.) ⁸⁴	—	—	I	B	IIa	B
Treprostinil (IH) added to sildenafil or bosentan ⁹⁰	IIa	B	IIa	B	IIa	C
Tadalafil added to bosentan ⁹²	IIa	C	IIa	C	IIa	C
Bosentan added to epoprostenol (I.V.)	—	—	IIb	C	IIb	C
Other double combinations	IIb	C	IIb	C	IIb	C
Other triple combinations	IIb	C	IIb	C	IIb	C
Riociguat added to sildenafil or other PDE-5i	III	B	III	B	III	B

Modified from 2015 ESC/ERS Guidelines for the diagnosis and treatment of pulmonary hypertension.

ERA = endothelium receptor antagonist; PDE-5i = Phosphodiesterase type 5 inhibitor; I.V. = intravenous; SC = subcutaneous.

Table 12 Clinical classification of pulmonary arterial hypertension associated with congenital heart disease (PAH-CHD).

A. Eisenmenger syndrome	1.Reversed (pulmonary-to-systemic) or bidirectional shunt. 2.Cyanosis, erythrocytosis, and multiple organ involvement are present
B. Pulmonary arterial hypertension associated with systemic-to-pulmonary shunts	1. Moderate to large defects with increased PVR (mild to moderate) 2. No cyanosis is present at rest.
C. Pulmonary arterial hypertension with small defects	1.Small defects (usually ventricular septal defects < 1 cm and atrial septal defects < 2 cm of effective diameter assessed by echocardiography) 2. The clinical picture is very similar to idiopathic PAH
D. Pulmonary arterial hypertension after corrective cardiac surgery	1.Congenital heart disease has been corrected but PAH is either still present immediately after surgery or has recurred several months or years after surgery 2. Absence of significant post-operative residual congenital lesions or defects that originate as sequelae to previous surgery.
*Additional types of pulmonary vascular disease related to CHD ⁹⁵	
Segmental Pulmonary arterial hypertension	In pulmonary atresia with multiple aortopulmonary collateral arteries, or right/left pulmonary artery stenosis in truncus arteriosus. Only part of the lung vasculature develops pulmonary vascular disease.
Raised PVR in Fontan patients	Patients with a previous Fontan-type operation can develop a rise in PVR, despite low pulmonary arterial pressures

Based on Taiwan's National Health Insurance Administration database between 1999 and 2011, PAH-CHD accounts for 11% of patients with a discharge diagnosis of pulmonary hypertension.²⁰ Patients with PAH-CHD were younger (mean age 27 years old) and had a better outcome (estimated survival rates at 1, 5, and 10 years were 95.3%, 91.64% and 87.09%) compared with patients with other etiologies of pulmonary hypertension.

Considering the four (4) different clinical groups of PAH-CHD (Table 12), data from a single-center cohort in Italy showed that patients with PAH after cardiac defect

correction have a worse outcome than patients with Eisenmenger syndrome or those with systemic-to-pulmonary shunts.⁹⁸ These findings suggest careful evaluation of the operability before the shunt closure is extremely important.

Therapy

The treatment strategy comprises early surgical repair (or interventional therapy) of the shunt prior to the onset of pulmonary vascular disease, and the treatment of existing PAH. The only curative option for end-stage disease is heart-lung transplantation or lung transplantation in combination with repair of CHD. The issue of organ availability and the prolonged survival of patients of Eisenmenger syndrome make it difficult to determine optimal timing for transplantation.⁹⁹ Furthermore, the results of disease-targeting therapies are reassuring, with two (2) recent reports showing disease-targeting therapies offer better survival in Eisenmenger syndrome.^{100,101}

Surgical (or interventional therapy) treatment

An early correction can prevent subsequent development of PAH among patients with systemic-to-pulmonary shunt. However, the patients who develop or have persistent PAH after cardiac defect correction have a worse prognosis than patients with unrepaired shunt.⁹⁸ Assessment of the operability, which is defined based on the likelihood of a favorable versus an unfavorable outcome, is crucial.^{102,103} Traditionally, a baseline pulmonary vascular resistance index (PVRi) of <6 Wood units•m² with a pulmonary to systemic resistance ratio of <0.3 has been interpreted as indicative of favorable outcome following shunt closure, and a vasoreactivity test may be considered in patients with PVRi between 6 and 9 Wood units•m² and resistance ratio between 0.3 and 0.5 to see if at least 20% decrease of the value can be achieved.¹⁰⁴ In 2015 ESC/ERS guidelines, a modified threshold was proposed to define PVRi < 4 Wood units•m² as "correctable", PVRi > 8 Wood units•m² as "not correctable", and individualized evaluation in tertiary centers is suggested in patients with PVRi between 4 and 8 Wood units•m².⁶

Medical treatment

General measures and supportive therapies of PAH-CHD are mostly based on clinical experiences rather than evidence-based data, and follow similar principles to IPAH, including patient education, supplemental oxygen therapy, diuretic and digoxin treatment in RV failure, and correction of anemia and iron status.⁶ Several issues on treatment; however, are distinct from IPAH. First, the use of calcium channel blockers (CCBs) should be avoided in patients with PAH-CHD,¹⁰⁵ because CCBs may decrease systemic arterial pressure and increase right-to-left shunting, leading to syncope and sudden death. Second, the use of anticoagulation is controversial, concerning the increased risk of hemoptysis.¹⁰⁶ Third, phlebotomy may be considered in patients of PAH-CHD if symptoms of hyperviscosity are present, usually when the hematocrit is >65%.¹⁰⁷

With the advances in disease-targeting therapies, the outcomes of Eisenmenger syndrome has improved. Two of

Table 13 Anatomical-pathophysiological classification of congenital systemic-to-pulmonary shunts associated with pulmonary arterial hypertension (modified from Venice 2003).

1. Type
1.1 Simple pre-tricuspid shunts
1.1.1 Atrial septal defect (ASD)
1.1.1.1 Ostium secundum
1.1.1.2 Sinus venosus
1.1.1.3 Ostium primum
1.1.2 Total or partial unobstructed anomalous pulmonary venous return
1.2 Simple post-tricuspid shunts
1.2.1 Ventricular septal defect (VSD)
1.2.2 Patent ductus arteriosus
1.3 Combined shunts
Describe combination and define predominant defect
1.4 Complex congenital heart disease
1.4.1 Complete atrioventricular septal defect
1.4.2 Truncus arteriosus
1.4.3 Single ventricle physiology with unobstructed pulmonary blood flow
1.4.4 Transposition of the great arteries with VSD (without pulmonary stenosis) and/or patent ductus arteriosus
1.4.5 Other
2. Dimension (specify for each defect if more than one congenital heart defect exists)
2.1 Hemodynamic (specify Qp/Qs)
2.1.1 Restrictive (pressure gradient across the defect)
2.1.2 Non-restrictive
2.2 Anatomic (applied to adult patients)
2.2.1 Small to moderate (ASD \leq 2.0 cm and VSD \leq 1.0 cm)
2.2.2 Large (ASD $>$ 2.0 cm and VSD $>$ 1.0 cm)
3. Direction of shunt
3.1 Predominantly systemic-to-pulmonary
3.2 Predominantly pulmonary-to-systemic
3.3 Bidirectional
4. Associated cardiac and extracardiac abnormalities
5. Repair status
5.1 Unoperated
5.2 Palliated [specify type of operation(s), age at surgery]
5.3 Repaired [specify type of operation(s), age at surgery]

these agents, bosentan and sildenafil, are currently approved in Taiwan for patients with PAH-CHD.

- 1) Endothelin receptor antagonists: Bosentan has the strongest supporting dataset of all targeted therapies for CHD-PAH. The double-blind, placebo-controlled BREATHE-5 (Bosentan Randomized Trial of Endothelin Antagonist Therapy-5) study, the only such study in patients with Eisenmenger syndrome, demonstrated that bosentan was well tolerated and improved exercise capacity and hemodynamics without compromising transcutaneous oxygen saturation.¹⁰⁸ These findings were sustained in the open-label extension study.¹⁰⁹ Early experiences with ambrisentan and macitentan on PAH-CHD have been reported recently.^{110,111}
- 2) Prostanoids: Several compounds and administration methods of prostacyclin (prostaglandin I₂) analogues have been studied, such as intravenous epoprostenol,³² subcutaneous treprostinil⁴² and inhaled iloprost,¹¹² and demonstrated improved functional status and hemodynamic parameters.

- 3) Phosphodiesterase type 5 inhibitors (PDE-5i): Sildenafil¹¹³ and tadalafil¹¹⁴ have been shown to improve exercise capacity and hemodynamics in patients with Eisenmenger syndrome.
- 4) Soluble guanylate cyclase (sGC) stimulator: Riociguat has been shown to be well tolerated in patients with PAH-CHD and to improve clinical outcomes including 6MWD, PVR, functional class and NT-proBNP level in a subgroup analysis of PATENT study.⁷⁴
- 5) Combination therapy: In one randomized study, adding sildenafil to bosentan in Eisenmenger syndrome did not significantly improve walking distance but did increase O₂ saturation at rest.¹¹⁵ Despite the scarce evidence supporting the use of combination therapy in Eisenmenger syndrome, recently published cohort studies on Eisenmenger syndrome reported around 30–50% of these patients were receiving two or more disease targeting therapies.^{100,101}

The strategy of “treat and repair”, which means treating the inoperable patients with disease targeting therapies to

reduce PVR and to increase their chances of successful defect closure, is under study.¹¹⁶ More data are needed to determine the long-term benefits and risks of this strategy.¹¹⁷

Pulmonary arterial hypertension associated with connective tissue disease

PAH is a well-known complication of CTDs, such as SSc, SLE, rheumatoid arthritis, MCTD, dermatomyositis, and Sjogren syndrome.^{17,118} Previous experience found that ankylosing spondylitis rarely develops PH. SSc represents the main CTD associated with PAH in Europe and the USA.⁴⁵ However, SLE is more common in Asia.^{119,120}

Diagnosis

Clinical presentations of CTD associated with PAH are very similar to IPAH, CTD may be confirmed by immunological screening studies. Thus, the diagnosis of CTDs usually will not be missed if we follow the proposed diagnostic algorithm, which can be obtained from previous section of this guideline (Fig. 1). There are a few specific rheumatologic markers that should be studied during diagnosis of PH in CTDs.

Systemic sclerosis (SSc)

From previous reports, the prevalence of PAH in patients with SSc, confirmed by right heart catheterization, ranged from 7.9% to 12%.^{118,121} In these patients, PAH may be a result of an isolated pulmonary arteriopathy, interstitial lung fibrosis, and/or pulmonary venous hypertension due to venous fibrosis or left heart disease. It is important to determine which mechanism is operative because current specific PAH medications are only reimbursed in Group 1 PAH (IPAH) in Taiwan. Pulmonary involvement of SSc patients can be detected by chest x-ray, HRCT, and DLco studies. Echocardiography and RHC are useful in confirming the PAH and evaluating the left ventricular systolic and diastolic functions.

Systemic lupus erythematosus

Cardiac involvements in SLE include pericardial effusion, pericarditis, endocarditis, myocarditis, coronary artery disease, and cardiac valvular involvement.

Echocardiography and cardiac catheterization are useful in evaluating and defining the cardiac involvement in patients with SLE.

Pericardial effusion may be a sign of serositis due to SLE¹²² or a sign of advanced PAH with right heart failure.¹²³ Since the presence of pericardial effusion in SLE patients indicates the lupus activation phenomenon, it demands multidisciplinary consultation to ascertain the cause of pericardial effusion and to treat the underlying disease.

Therapy

Treatment of patients with CTD-associated PAH is similar to the treatment algorithm for IPAH.¹⁷ Sildenafil and macitentan had been approved for the treatment of CTD-associated PAH in Taiwan. Several important issues should be mentioned about treatment. First, retrospective studies

concluded that a substantial portion of patients with SLE or MCTD may benefit from concomitant immunosuppressive therapy.¹²⁴ Second, therapy in patients with CTD-associated PAH is more complex than that of IPAH. In CTD-associated PAH patients, the long-term favorable response to CCB treatment is reported in <1% of cases.¹⁰⁵ Third, in SSc, the long-term risk to benefit ratio of oral anticoagulation is less favorable in SSc patients compared to the IPAH patients because of an increased risk of bleeding in SSc patients.¹²⁵

Follow-up

The long-term survival of CTD-PAH patients, especially SSc-PAH patients, is lower than that of IPAH patients.^{120,126} When CTD-PAH patients received PAH-specific medications, the one-year survival rates of SLE, MCTD and SSc with PAH patients were 94%, 88% and 82%, respectively.¹²⁶ Thus, early diagnosis and early management is important in this specific population.

Chronic thromboembolic pulmonary hypertension (CTEPH)

Epidemiology

As it is challenging to diagnose CTEPH, limited epidemiological studies have been reported. Based on recent studies, the incidence of CTEPH after an acute pulmonary embolism (PE) is 0.1–9.1% in Europe and the USA, and 10% in Japan. The estimated annual incidence of CTEPH is

Table 14 Chronic thromboembolic pulmonary hypertension prediction score.

Unprovoked PE	+6 points
Known hypothyroidism	+3 points
Symptom onset >2 weeks before PE diagnosis	+3 points
RV dysfunction on CT or echocardiography	+2 points
Known diabetes mellitus	-3 points
Thrombolytic therapy or embolectomy for the acute PE event	-3 points
• Low risk -6 to 6 points	
• High risk >6 points	

RV: right ventricular, CT: computed tomography.

Table 15 Chronic thromboembolic pulmonary hypertension rule out criteria.

- ECG criteria (absence of signs of RV overload)
 - Right axis
 - rSR' or RSr' in lead V1
 - R:S > 1, R > 0.5 mV in lead V1
- Normal NT-proBNP

Table 16 Comparison of computed tomography images between acute pulmonary embolism vs. chronic thromboembolic pulmonary hypertension.

Findings	Acute pulmonary embolism	Chronic thromboembolic pulmonary hypertension
Total occlusion	Vessel expanded	Vessel narrowing/ amputation
Partially occlusive filling defects	Acute angles with the vessel lumen; polo mint sign; railway track sign	Obtuse angles with the vessel lumen; webs; bands; intimal irregularities; laminated thrombus
Systemic findings	RV dilation	RV dilation and hypertrophy; dilation of the central pulmonary arteries; collateral vessels, including bronchial artery dilation
Lung parenchymal findings	Triangular subpleural consolidation; ground-glass opacity with fine reticular changes	Mosaic attenuation; fibrotic bands, which could be resolved infarcts, subpleural scar/ cavitation; focal pleural thickening

30–50 per million population per year in Europe and the USA, and 19.4 per million population per year in Japan.¹²⁷ Different genetic backgrounds, population demographics and lifestyles may account for the discrepancy among Japan, Europe, and the USA.

Risk factors

Apart from pulmonary embolism, other risk factors associated with CTEPH include deep vein thrombosis, thyroid replacement therapy, malignancy, anti-phospholipid antibodies/lupus anticoagulant, Factor VIII, von Willebrand factor, non-O blood group, ventriculoatrial shunt, cardiac pacemaker, splenectomy, inflammatory bowel disease, chronic inflammatory disorders, infection with Staphylococcal species, and aging.^{128–130}

Screening

Owing to the low incidence of CTEPH after PE and multifactorial mechanism of CTEPH, routine screening for CTEPH in asymptomatic survivors of PE is not recommended by 2015 ESC/ERS.⁶ Recently, CTEPH prediction score (Table 14)¹³¹ was proposed and it might be used with rule-out

criteria (Table 15).^{132,133} An ongoing trial may give us more information whether the screening algorithm is accurate and cost effective.

Diagnosis

If CTEPH is suspected according to clinical assessments and basic examinations, TTE is recommended as the first-line diagnostic modality. Nevertheless, 10–31% of cases may be missed by TTE alone. Previous retrospective studies^{134,135} and a prospective cohort study¹³⁶ showed CPET and V/Q scan could serve as complementary tools in diagnosing CTEPH by using “4-parameter-CPET (4-P-CPET) score”.¹³⁴ Although further clinical trials are warranted, other tools may be considered for symptomatic patients with normal echocardiography.

For the diagnosis of CTEPH, V/Q scan and newer generation CTPA may both be accurate methods.¹³⁷ Several findings on CT can help to differentiate acute PE from CTEPH (Table 16).^{138,139} However, some pitfalls should be noted. First, mismatched defect, mosaic pattern, and bronchial hypervascularization could be seen not only in patients with CTEPH but also other conditions.^{129,138,140} Second, subsegmental disease is more difficult to be detected by CTPA. For pulmonary vascular interventions distal to subsegmental arteries, cone-beam CT or electrocardiogram-gated area detector CT may be helpful.^{141–144}

Dual-energy CT (DECT) is a promising tool that permits a simultaneously combined functional and morphological analysis of the lung. Excellent correlation has been shown between perfusion maps and mismatched defect on V/Q scan.¹⁴⁵ By using automated quantification of perfused blood volume (PBV), pulmonary hemodynamics, especially mPAP and PVR, could be estimated.^{146,147} Similar to DECT, lung subtraction iodine mapping (LSIM) CT may offer “one-stop” assessment without extra radiation exposure.¹⁴⁸ However, further validation of LSIM is needed due to limited data.

Magnetic resonance (MR) imaging has significant advances in many techniques recently, such as cine techniques, tissue feature tracking, contrast enhanced MR angiography, phase-contrast MR imaging, 4D phase contrast sequences, and lung perfusion MR imaging. Although MR imaging is less accurate at the subsegmental level,¹⁴⁹ MR imaging can provide anatomical and hemodynamic information in single examination without radiation exposure.

Apart from differential diagnosis,¹²⁹ positron emission tomography may be also useful for monitoring right ventricle metabolic functions in severe pulmonary hypertension.¹⁵⁰

An algorithm for CTEPH diagnosis is shown in Fig. 3.

Vasoreactivity testing

If CTEPH is highly suspected by imaging study, RHC must be performed for hemodynamic confirmation. Although vasoreactivity testing is not recommended in patients with CTEPH by 2015 ESC/ERS guideline,⁶ a decrease in mPAP to vasoreactivity testing is associated with better survival.^{151–153}

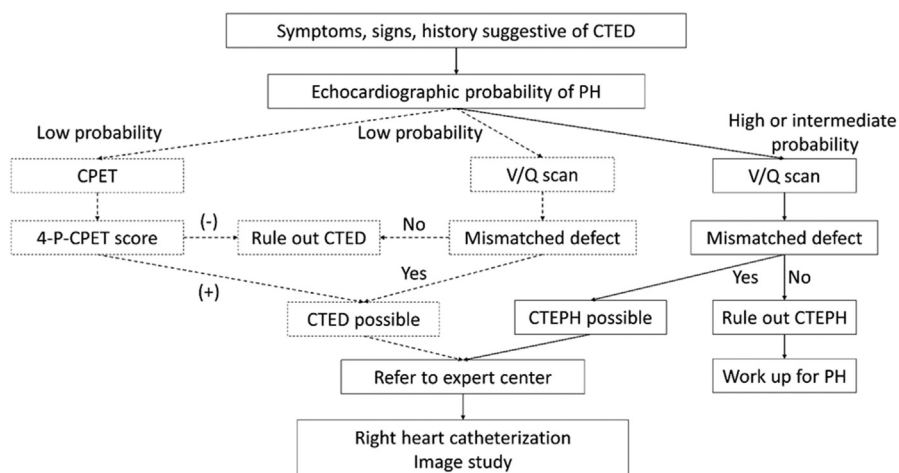


Figure 3 Diagnostic algorithm for chronic thromboembolic pulmonary hypertension (CTEPH) or chronic thromboembolic disease (CTED). Dash-lines or boxes indicate the diagnostic algorithm for CTED, and solid ones for CTEPH. CTED = chronic thromboembolic disease; PH = pulmonary hypertension; CPET = cardiopulmonary exercise testing; V/Q = ventilation-perfusion; CTEPH = chronic thromboembolic pulmonary hypertension.

Treatment

Surgical

CTEPH is a potential curable disease and PEA is the first-line treatment.⁶ Hemodynamics, functional parameter, and quality of life improved in most patients after PEA.^{154–157} After PEA, up to one third of patients after PEA may have persistent pulmonary hypertension because of incomplete removal of thrombi or concomitant distal pulmonary vasculopathy. Recurrent pulmonary hypertension after PEA may also occur due to poor anticoagulation therapy. However, the definition of persistent or recurrent PH is not well defined. A recent cohort study suggested that $mPAP \geq 38$ mmHg and $PVR \geq 425$ dynes \cdot s $^{-1}\cdot$ cm $^{-5}$ are correlated with worse long-term survival in patients undergoing PEA.¹⁵⁸ This level of $mPAP$ is much higher than the definition of pulmonary hypertension. On the other hand, some studies that enrolled symptomatic patients with normal $mPAP$, a condition known as chronic thromboembolic disease (CTED), showed significant improvement in terms of hemodynamics, functional status, and quality of life after PEA.^{135,159} However, with limited evidence, PEA is only confined to this patient group with symptoms.

Interventional

Balloon pulmonary angioplasty (BPA) is an emerging treatment for inoperable,⁶ persistent, or recurrent CTEPH.¹⁶⁰ Initially, high complication rates raised the concern about the safety of BPA.¹⁶¹ Growing body of experience has demonstrated "refined BPA" is able to improve, though not immediately, hemodynamics, functional parameters, and quality of life,¹⁶² with low complication rates and post-procedural mortality.¹⁶³ Although there is no consensus about the "refined BPA", following strategies may be applied - starting with soft device,¹⁶⁴ image-guided interventions,^{144,165} stepwise balloon size-up approach,¹⁴⁴ angioplasty guided by "Pulmonary Edema Predictive Scoring Index (PEPSI)",¹⁶⁶ and pressure-wire-guided technique.¹⁶⁷ With improved outcomes and safety of the

procedure, BPA can be considered for symptomatic CTED patients. One study demonstrated further improvement in symptoms, exercise capacity and hemodynamics by extensive revascularization beyond hemodynamic normalization.¹⁶⁸ A meta-analysis reported the improvement in $mPAP$ and PVR were significantly greater for BPA than targeted medical therapy.¹⁶⁹ However, BPA for CTEPH still lacks large randomized control trials and long-term results.

Apart from BPA, some techniques used for treatment of other causes of pulmonary hypertension have been studied in patients with CTEPH, such as atrial septostomy¹⁷⁰ and pulmonary artery denervation.¹⁷¹ Further studies to confirm the results are required.

Medical

Diuretic agent and oxygen supplement may be considered when patients with CTEPH suffered from acute decompensated heart failure and hypoxia. Although there are no

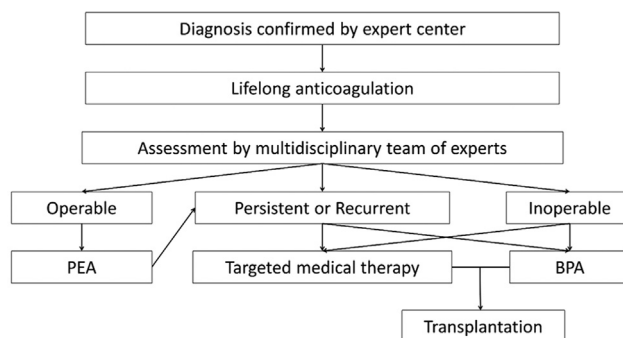


Figure 4 Treatment algorithm for chronic thromboembolic pulmonary hypertension. The operability may be different according to the facility and experience of different centers. Some "inoperable" patients may be operable in high PEA volume centers.¹⁸⁰ For those with inoperable, persistent or recurrent CTEPH, either medical therapy or BPA can be served as the treatment of choice. PEA = pulmonary endarterectomy; BPA = balloon pulmonary angioplasty.

Table 17 Recommendations for chronic thromboembolic pulmonary hypertension.

Recommendations	Class	Level
Routine screening asymptomatic survivors of PE for CTEPH is not recommended.	III	C
The possibility of CTEPH should be evaluated for symptomatic survivors of PE.	IIa	C
Patients with CTEPH should be treated by a multidisciplinary team of experts.	I	C
PEA for patients with CTEPH is recommended to perform in deep hypothermia circulatory arrest.	I	C
BPA may be considered in symptomatic patients with inoperable, persistent, or recurrent CTEPH.	IIa	B
Lifelong anticoagulation is recommended in patients with CTEPH.	I	C
Riociguat and macitentan are recommended in symptomatic patients with inoperable, persistent, or recurrent CTEPH.	I	B
Targeted medical therapies approved for PAH may be considered in symptomatic patients with inoperable CTEPH.	IIb	B

PE = pulmonary embolism; CTEPH = Chronic thromboembolic pulmonary hypertension; PEA = pulmonary endarterectomy; BPA = Balloon pulmonary angioplasty.

randomized studies, lifelong anticoagulation therapy is strongly recommended by 2015 ESC/ERS guideline⁶ irrespective of pulmonary arterial pressure. Non-vitamin K oral anticoagulants have demonstrated superior safety and non-inferior efficacy in venous thromboembolism with some experience in CTEPH, but clinical studies in patients with CTEPH are lacking.¹⁵⁶

Among all targeted therapies, riociguat, a soluble guanylate cyclase stimulator, is still the only approved medication for CTEPH. Randomized controlled CHEST-1 study,⁷² extension CHEST-2 study,¹⁷² and long term extension study have shown sustained benefits in exercise and functional capacity for up to 4 years.¹⁷³ Another randomized controlled trial, MERIT-1, treated CTEPH patients with macitentan reported significantly improved PVR and exercise capacity.¹⁷⁴ Other randomized trials have failed to show significant improvement in patients treated with bosentan, sildenafil, intravenous epoprostenol, subcutaneous treprostinil, or inhaled iloprost.^{175,176} Riociguat is approved for the treatment of persistent/recurrent and inoperable CTEPH in Taiwan.

Recently, in MERIT-1 study, a multicenter, phase 2, randomized, double-blind, placebo-controlled study, macitentan significantly improved PVR in patients with inoperable CTEPH. In this patients, 61% received background therapy, including PDE-5i and/or oral/inhaled

prostanoids.^{174,177} In another study, initial combination therapy with ERA and PDE-5i was shown to improve exercise capacity and hemodynamics in patients with inoperable CTEPH.¹⁷⁸

However, medical therapy should be considered only for patients with inoperable, persistent, or recurrent CTEPH rather than as an alternative therapy to potentially curative PEA. Operable patients should proceed to PEA without delay since bridging therapy with targeted therapies before PEA yielded worse surgical outcomes.¹⁷⁹ Although riociguat as a bridge to BPA may potentially enhance procedural safety, the results had been reported only in a couple of conferences.

An algorithm is shown in Fig. 4. The recommendations for CTEPH are summarized in Table 17.

Conflict of interest

The authors have no conflicts of interest relevant to this article.

Acknowledgments

The development of this guideline is conducted and funded by the Taiwan Society of Cardiology. We would like to thank Jou-Kou Wang, Jing-Ming Wu and Chun-Yi Wu for their expert opinions.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.jfma.2018.12.009>.

References

1. Hoeper MM, Bogaard HJ, Condliffe R, Frantz R, Khanna D, Kurzyna M, et al. Definitions and diagnosis of pulmonary hypertension. *J Am Coll Cardiol* 2013 Dec 24;62(25 Suppl): D42–50.
2. McLaughlin VV, Archer SL, Badesch DB, Barst RJ, Farber HW, Lindner JR, et al., American College of Cardiology Foundation Task Force on Expert Consensus Documents; American Heart Association; American College of Chest Physicians; American Thoracic Society, Inc; Pulmonary Hypertension Association. ACCF/AHA 2009 expert consensus document on pulmonary hypertension a report of the American college of cardiology foundation task force on expert consensus documents and the American heart association developed in collaboration with the American college of chest physicians; American thoracic society, Inc.; and the pulmonary hypertension association. *J Am Coll Cardiol* 2009 Apr 28;53(17):1573–619.
3. Galiè N, Simonneau G. The fifth World Symposium on pulmonary hypertension. *J Am Coll Cardiol* 2013 Dec 24;62(25 Suppl):D1–3.
4. Hsu CH, Ho WJ, Huang WC, Chiu YW, Hsu TS, Kuo PH, et al. 2014 Guidelines of Taiwan society of cardiology (TSOC) for the management of pulmonary arterial hypertension. *Acta Cardiol Sin* 2014 Sep;30(5):401–44.
5. Simonneau G. Should we redefine pre-capillary PH? In: Simonneau G, Souza (Chair) R, editors. *PH haemodynamic definitions and clinical classifications and characteristics of*

- specific PAH subgroups. 6th World Symposium on pulmonary hypertension, Nice, France; 2018, February.*
6. Galiè N, Humbert M, Vachiery JL, Gibbs S, Lang I, Torbicki A, et al. 2015 ESC/ERS guidelines for the diagnosis and treatment of pulmonary hypertension: the joint task force for the diagnosis and treatment of pulmonary hypertension of the European society of cardiology (ESC) and the European respiratory society (ERS); endorsed by: association for European paediatric and congenital cardiology (AEPC), International society for heart and lung transplantation (ISHLT). *Eur Heart J* 2016;**37**(1):67–119.
 7. Rudski LG, Lai WW, Afilalo J, Hua L, Handschumacher MD, Chandrasekaran K, et al. Guidelines for the echocardiographic assessment of the right heart in adults: a report from the American society of echocardiography endorsed by the European association of echocardiography, a registered branch of the European society of cardiology, and the Canadian society of echocardiography. *J Am Soc Echocardiogr* 2010;**23**(7):685–713.
 8. Lang RM, Badano LP, Mor-Avi V, Afilalo J, Armstrong A, Ernande L, et al. Recommendations for cardiac chamber quantification by echocardiography in adults: an update from the American society of echocardiography and the European association of cardiovascular imaging. *Eur Heart J Cardiovasc Imag* 2015;**16**(3):233–70.
 9. Fisher MR, Forfia PR, Chamera E, Houston-Harris T, Champion HC, Girgis RE, et al. Accuracy of Doppler echocardiography in the hemodynamic assessment of pulmonary hypertension. *Am J Respir Crit Care Med* 2009;**179**(7):615–21.
 10. Hinderliter AL, Willis 4th PW, Long WA, Clarke WR, Ralph D, Caldwell EJ, et al., PPH Study Group. Frequency and severity of tricuspid regurgitation determined by Doppler echocardiography in primary pulmonary hypertension. *Am J Cardiol* 2003;**91**(8):1033–7. A9.
 11. Beard 2nd JT, Byrd 3rd BF. Saline contrast enhancement of trivial Doppler tricuspid regurgitation signals for estimating pulmonary artery pressure. *Am J Cardiol* 1988;**62**(7):486–8.
 12. Strange G, Playford D, Stewart S, Deague JA, Nelson H, Kent A, et al. Pulmonary hypertension: prevalence and mortality in the Armadale echocardiography cohort. *Heart* 2012;**98**(24):1805–11.
 13. Borlaug BA, Nishimura RA, Sorajja P, Lam CS, Redfield MM. Exercise hemodynamics enhance diagnosis of early heart failure with preserved ejection fraction. *Circ Heart Fail* 2010;**3**(5):588–95.
 14. Lam CS, Roger VL, Rodeheffer RJ, Borlaug BA, Enders FT, Redfield MM. Pulmonary hypertension in heart failure with preserved ejection fraction: a community-based study. *J Am Coll Cardiol* 2009;**53**(13):1119–26.
 15. Lettieri CJ, Nathan SD, Barnett SD, Ahmad S, Shorr AF. Prevalence and outcomes of pulmonary arterial hypertension in advanced idiopathic pulmonary fibrosis. *Chest* 2006;**129**(3):746–52.
 16. Thabut G, Dauriat G, Stern JB, Logeart D, Lévy A, Marrash-Chahla R, et al. Pulmonary hemodynamics in advanced COPD candidates for lung volume reduction surgery or lung transplantation. *Chest* 2005;**127**(5):1531–6.
 17. Galiè N, Hoeper MM, Humbert M, Torbicki A, Vachiery JL, Barbera JA, et al., ESC Committee for Practice Guidelines (CPG). Guidelines for the diagnosis and treatment of pulmonary hypertension: the task force for the diagnosis and treatment of pulmonary hypertension of the European society of cardiology (ESC) and the European respiratory society (ERS), endorsed by the International society of heart and lung transplantation (ISHLT). *Eur Heart J* 2009;**30**(20):2493–537.
 18. Skoro-Sajer N, Becherer A, Klepetko W, Kneussl MP, Maurer G, Lang IM. Longitudinal analysis of perfusion lung scintigrams of patients with unoperated chronic thromboembolic pulmonary hypertension. *Thromb Haemostasis* 2004;**92**(1):201–7.
 19. Duffels MG, Engelfriet PM, Berger RM, van Loon RL, Hoendermis E, Vriend JW, et al. Pulmonary arterial hypertension in congenital heart disease: an epidemiologic perspective from a Dutch registry. *Int J Cardiol* 2007;**120**(2):198–204.
 20. Chang WT, Weng SF, Hsu CH, Shih JY, Wang JJ, Wu CY, et al. Prognostic factors in patients with pulmonary hypertension—a nationwide cohort study. *J Am Heart Assoc* 2016;**5**(9).
 21. Benza RL, Miller DP, Gomberg-Maitland M, Frantz RP, Foreman AJ, Coffey CS, et al. Predicting survival in pulmonary arterial hypertension: insights from the registry to evaluate early and long-term pulmonary arterial hypertension disease management (REVEAL). *Circulation* 2010;**122**(2):164–72.
 22. Kylhammar D, Kjellström B, Hjalmarsson C, Jansson K, Nisell M, Söderberg S, et al. A comprehensive risk stratification at early follow-up determines prognosis in pulmonary arterial hypertension. *Eur Heart J* 2018;**39**(47):4175–81.
 23. Hoeper MM, Kramer T, Pan Z, Eichstaedt CA, Spiesshoefer J, Benjamin N, et al. Mortality in pulmonary arterial hypertension: prediction by the 2015 European pulmonary hypertension guidelines risk stratification model. *Eur Respir J* 2017;**50**(2).
 24. Boucly A, Weatherald J, Savale L, Jaïs X, Cottin V, Prevot G, et al. Risk assessment, prognosis and guideline implementation in pulmonary arterial hypertension. *Eur Respir J* 2017;**50**(2).
 25. Jones DA, Benjamin CW, Linseman DA. Activation of thromboxane and prostacyclin receptors elicits opposing effects on vascular smooth muscle cell growth and mitogen-activated protein kinase signaling cascades. *Mol Pharmacol* 1995;**48**(5):890–6.
 26. Galie N, Manes A, Branzi A. Prostanoids for pulmonary arterial hypertension. *Am J Respir Med* 2003;**2**(2):123–37.
 27. Rubin LJ, Mendoza J, Hood M, McGoon M, Barst R, Williams WB, et al. Treatment of primary pulmonary hypertension with continuous intravenous prostacyclin (epoprostenol). Results of a randomized trial. *Ann Intern Med* 1990;**112**(7):485–91.
 28. Barst RJ, Rubin LJ, Long WA, McGoon MD, Rich S, Badesch DB, et al., Primary Pulmonary Hypertension Study Group. A comparison of continuous intravenous epoprostenol (prostacyclin) with conventional therapy for primary pulmonary hypertension. *N Engl J Med* 1996;**334**(5):296–301.
 29. Badesch DB, Tapson VF, McGoon MD, Brundage BH, Rubin LJ, Wigley FM, et al. Continuous intravenous epoprostenol for pulmonary hypertension due to the scleroderma spectrum of disease. A randomized, controlled trial. *Ann Intern Med* 2000;**132**(6):425–34.
 30. Gomberg-Maitland M, Dufton C, Oudiz RJ, Benza RL. Compelling evidence of long-term outcomes in pulmonary arterial hypertension? A clinical perspective. *J Am Coll Cardiol* 2011;**57**(9):1053–61.
 31. McLaughlin VV, Gentner DE, Panella MM, Hess DM, Rich S. Compassionate use of continuous prostacyclin in the management of secondary pulmonary hypertension: a case series. *Ann Intern Med* 1999;**130**(9):740–3.
 32. Rosenzweig EB, Kerstein D, Barst RJ. Long-term prostacyclin for pulmonary hypertension with associated congenital heart defects. *Circulation* 1999;**99**(14):1858–65.
 33. Nunes H, Humbert M, Sitbon O, Morse JH, Deng Z, Knowles JA, et al. Prognostic factors for survival in human immunodeficiency virus-associated pulmonary arterial hypertension. *Am J Respir Crit Care Med* 2003;**167**(10):1433–9.
 34. Krowka MJ, Frantz RP, McGoon MD, Severson C, Plevak DJ, Wiesner RH. Improvement in pulmonary hemodynamics during intravenous epoprostenol (prostacyclin): a study of 15 patients with moderate to severe portopulmonary hypertension. *Hepatology* 1999;**30**(3):641–8.

35. Cabrol S, Souza R, Jais X, Fadel E, Ali RH, Humbert M, et al. Intravenous epoprostenol in inoperable chronic thromboembolic pulmonary hypertension. *J Heart Lung Transplant* 2007; **26**(4):357–62.
36. Doran AK, Ivy DD, Barst RJ, Hill N, Murali S, Benza RL. Scientific leadership council of the pulmonary hypertension association. Guidelines for the prevention of central venous catheter-related blood stream infections with prostanoid therapy for pulmonary arterial hypertension. *Int J Clin Pract Suppl* 2008;(160):5–9.
37. Sitbon O, Delcroix M, Bergot E, Boonstra AB, Granton J, Langleben D, et al. EPITOME-2: an open-label study assessing the transition to a new formulation of intravenous epoprostenol in patients with pulmonary arterial hypertension. *Am Heart J* 2014; **167**(2):210–7.
38. Olschewski H, Simonneau G, Galiè N, Higenbottam T, Naeije R, Rubin LJ, et al., Aerosolized Iloprost Randomized Study Group. Inhaled iloprost for severe pulmonary hypertension. *N Engl J Med* 2002; **347**(5):322–9.
39. McLaughlin VV, Oudiz RJ, Frost A, Tapson VF, Murali S, Channick RN, et al. Randomized study of adding inhaled iloprost to existing bosentan in pulmonary arterial hypertension. *Am J Respir Crit Care Med* 2006; **174**(11):1257–63.
40. Olschewski H, Rohde B, Behr J, Ewert R, Gessler T, Ghofrani HA, et al. Pharmacodynamics and pharmacokinetics of inhaled iloprost, aerosolized by three different devices, in severe pulmonary hypertension. *Chest* 2003; **124**(4):1294–304.
41. Higenbottam T, Butt AY, McMahon A, Westerbeck R, Sharples L. Long-term intravenous prostaglandin (epoprostenol or iloprost) for treatment of severe pulmonary hypertension. *Heart* 1998; **80**(2):151–5.
42. Simonneau G, Barst RJ, Galie N, Naeije R, Rich S, Bourge RC, et al., Treprostinil Study Group. Continuous subcutaneous infusion of treprostinil, a prostacyclin analogue, in patients with pulmonary arterial hypertension: a double-blind, randomized, placebo-controlled trial. *Am J Respir Crit Care Med* 2002; **165**(6):800–4.
43. Lang I, Gomez-Sanchez M, Kneussl M, Naeije R, Escribano P, Skoro-Sajer N, et al. Efficacy of long-term subcutaneous treprostinil sodium therapy in pulmonary hypertension. *Chest* 2006; **129**(6):1636–43.
44. Laliberte K, Arneson C, Jeffs R, Hunt T, Wade M. Pharmacokinetics and steady-state bioequivalence of treprostinil sodium (Remodulin) administered by the intravenous and subcutaneous route to normal volunteers. *J Cardiovasc Pharmacol* 2004; **44**(2):209–14.
45. Tapson VF, Gomberg-Maitland M, McLaughlin VV, Benza RL, Widlitz AC, Krichman A, et al. Safety and efficacy of IV treprostinil for pulmonary arterial hypertension: a prospective, multicenter, open-label, 12-week trial. *Chest* 2006; **129**(3):683–8.
46. Gomberg-Maitland M, Tapson VF, Benza RL, McLaughlin VV, Krichman A, Widlitz AC, et al. Transition from intravenous epoprostenol to intravenous treprostinil in pulmonary hypertension. *Am J Respir Crit Care Med* 2005; **172**(12):1586–9.
47. Sitbon O, Manes A, Jais X, Palladini M, Humbert M, Presotto L, et al. Rapid switch from intravenous epoprostenol to intravenous treprostinil in patients with pulmonary arterial hypertension. *J Cardiovasc Pharmacol* 2007; **49**(1):1–5.
48. Tapson VF, Torres F, Kermeen F, Keogh AM, Allen RP, Frantz RP, et al. Oral treprostinil for the treatment of pulmonary arterial hypertension in patients on background endothelin receptor antagonist and/or phosphodiesterase type 5 inhibitor therapy (the FREEDOM-C study): a randomized controlled trial. *Chest* 2012; **142**(6):1383–90.
49. Tapson VF, Jing ZC, Xu KF, Pan L, Feldman J, Kiely DG, et al., FREEDOM-C2 Study Team. Oral treprostinil for the treatment of pulmonary arterial hypertension in patients receiving background endothelin receptor antagonist and phosphodiesterase type 5 inhibitor therapy (the FREEDOM-C2 study): a randomized controlled trial. *Chest* 2013; **144**(3):952–8.
50. Jing ZC, Parikh K, Pulido T, Jerjes-Sanchez C, White RJ, Allen R, et al. Efficacy and safety of oral treprostinil monotherapy for the treatment of pulmonary arterial hypertension: a randomized, controlled trial. *Circulation* 2013; **127**(5):624–33.
51. Galiè N, Humbert M, Vachiéry JL, Vizza CD, Kneussl M, Manes A, et al., Arterial Pulmonary Hypertension and Beraprost European (ALPHABET) Study Group. Effects of beraprost sodium, an oral prostacyclin analogue, in patients with pulmonary arterial hypertension: a randomized, double-blind, placebo-controlled trial. *J Am Coll Cardiol* 2002; **39**(9):1496–502.
52. Barst RJ, McGoon M, McLaughlin V, Tapson V, Rich S, Rubin L, et al., Beraprost Study Group. Beraprost therapy for pulmonary arterial hypertension. *J Am Coll Cardiol* 2003; **41**(12):2119–25.
53. Sitbon O, Channick R, Chin KM, Frey A, Gaine S, Galiè N, et al., GRIPHON Investigators. Selexipag for the treatment of pulmonary arterial hypertension. *N Engl J Med* 2015; **373**(26):2522–33.
54. Gaine S, Chin K, Coghlan G, Channick R, Di Scala L, Galiè N, et al. Selexipag for the treatment of connective tissue disease-associated pulmonary arterial hypertension. *Eur Respir J* 2017; **50**(2).
55. Galiè N, Manes A, Branzi A. The endothelin system in pulmonary arterial hypertension. *Cardiovasc Res* 2004; **61**(2):227–37.
56. Channick RN, Simonneau G, Sitbon O, Robbins IM, Frost A, Tapson VF, et al. Effects of the dual endothelin-receptor antagonist bosentan in patients with pulmonary hypertension: a randomised placebo-controlled study. *Lancet* 2001; **358**(9288):1119–23.
57. Galiè N, Badesch D, Oudiz R, Simonneau G, McGoon MD, Keogh AM, et al. Ambrisentan therapy for pulmonary arterial hypertension. *J Am Coll Cardiol* 2005; **46**(3):529–35.
58. Pulido T, Adzerikho I, Channick RN, Delcroix M, Galiè N, Ghofrani HA, et al., SERAPHIN Investigators. Macitentan and morbidity and mortality in pulmonary arterial hypertension. *N Engl J Med* 2013; **369**(9):809–18.
59. Rubin LJ, Badesch DB, Barst RJ, Galie N, Black CM, Keogh A, et al. Bosentan therapy for pulmonary arterial hypertension. *N Engl J Med* 2002; **346**(12):896–903.
60. Humbert M, Barst RJ, Robbins IM, Channick RN, Galiè N, Boonstra A, et al. Combination of bosentan with epoprostenol in pulmonary arterial hypertension: BREATHE-2. *Eur Respir J* 2004; **24**(3):353–9.
61. Galiè N, Rubin LJ, Hoepfer M, Jansa P, Al-Hiti H, Meyer G, et al. Treatment of patients with mildly symptomatic pulmonary arterial hypertension with bosentan (EARLY study): a double-blind, randomised controlled trial. *Lancet* 2008; **371**(9630):2093–100.
62. McLaughlin V, Channick RN, Ghofrani HA, Lemarié JC, Naeije R, Packer M, et al. Bosentan added to sildenafil therapy in patients with pulmonary arterial hypertension. *Eur Respir J* 2015; **46**(2):405–13.
63. Galiè N, Olschewski H, Oudiz RJ, Torres F, Frost A, Ghofrani HA, et al., Ambrisentan in Pulmonary Arterial Hypertension, Randomized, Double-Blind, Placebo-Controlled, Multicenter, Efficacy Studies (ARIES) Group. Ambrisentan for the treatment of pulmonary arterial hypertension: results of the ambrisentan in pulmonary arterial hypertension, randomized, double-blind, placebo-controlled, multicenter, efficacy (ARIES) study 1 and 2. *Circulation* 2008; **117**(23):3010–9.
64. Oudiz RJ, Galiè N, Olschewski H, Torres F, Frost A, Ghofrani HA, et al., ARIES Study Group. Long-term

- ambrisentan therapy for the treatment of pulmonary arterial hypertension. *J Am Coll Cardiol* 2009;**54**(21):1971–81.
65. Galiè N, Barberà JA, Frost AE, Ghofrani HA, Hoeper MM, McLaughlin VV, et al., AMBITION Investigators. Initial Use of Ambrisentan plus Tadalafil in pulmonary arterial hypertension. *N Engl J Med* 2015;**373**(9):834–44.
 66. Channick RN, Delcroix M, Ghofrani HA, Hunsche E, Jansa P, Le Brun FO, et al. Effect of macitentan on hospitalizations: results from the SERAPHIN trial. *JACC Heart Fail* 2015;**3**(1): 1–8.
 67. Mehta S, Sastry BK, Souza R, Torbicki A, Ghofrani HA, Channick RN, et al. Macitentan improves health-related quality of life for patients with pulmonary arterial hypertension: results from the randomized controlled SERAPHIN trial. *Chest* 2017;**151**(1):106–18.
 68. Simonneau G, Channick RN, Delcroix M, Galiè N, Ghofrani HA, Jansa P, et al. Incident and prevalent cohorts with pulmonary arterial hypertension: insight from SERAPHIN. *Eur Respir J* 2015;**46**(6):1711–20.
 69. Wu CC, Ko FN, Kuo SC, Lee FY, Teng CM. YC-1 inhibited human platelet aggregation through NO-independent activation of soluble guanylate cyclase. *Br J Pharmacol* 1995 Oct;**116**(3): 1973–8.
 70. Papapetropoulos A, Hobbs AJ, Topouzis S. Extending the translational potential of targeting NO/cGMP-regulated pathways in the CVS. *Br J Pharmacol* 2015 Mar;**172**(6): 1397–414.
 71. Ghofrani HA, Galiè N, Grimminger F, Grünig E, Humbert M, Jing ZC, et al., PATENT-1 Study Group. Riociguat for the treatment of pulmonary arterial hypertension. *N Engl J Med* 2013;**369**(4):330–40.
 72. Ghofrani HA, D'Armini AM, Grimminger F, Hoeper MM, Jansa P, Kim NH, et al., CHEST-1 Study Group. Riociguat for the treatment of chronic thromboembolic pulmonary hypertension. *N Engl J Med* 2013;**369**(4):319–29.
 73. Humbert M, Coghlan JG, Ghofrani HA, Grimminger F, He JG, Riemekasten G, et al. Riociguat for the treatment of pulmonary arterial hypertension associated with connective tissue disease: results from PATENT-1 and PATENT-2. *Ann Rheum Dis* 2017;**76**(2):422–6.
 74. Rosenkranz S, Ghofrani HA, Beghetti M, Ivy D, Frey R, Fritsch A, et al. Riociguat for pulmonary arterial hypertension associated with congenital heart disease. *Heart* 2015;**101**(22):1792–9.
 75. Bonderman D, Ghio S, Felix SB, Ghofrani HA, Michelakis E, Mitrovic V, et al., Left Ventricular Systolic Dysfunction Associated With Pulmonary Hypertension Riociguat Trial (LEPHT) Study Group. Riociguat for patients with pulmonary hypertension caused by systolic left ventricular dysfunction: a phase IIb double-blind, randomized, placebo-controlled, dose-ranging hemodynamic study. *Circulation* 2013;**128**(5):502–11.
 76. Galiè N, Müller K, Scalise AV, Grünig E. PATENT PLUS: a blinded, randomised and extension study of riociguat plus sildenafil in pulmonary arterial hypertension. *Eur Respir J* 2015;**45**(5):1314–22.
 77. Hoeper MM, Simonneau G, Corris PA, Ghofrani HA, Klingler JR, Langleben D, et al. RESPITE: switching to riociguat in pulmonary arterial hypertension patients with inadequate response to phosphodiesterase-5 inhibitors. *Eur Respir J* 2017;**50**(3).
 78. Hoeper MM, Faulenbach C, Golpon H, Winkler J, Welte T, Niedermeyer J. Combination therapy with bosentan and sildenafil in idiopathic pulmonary arterial hypertension. *Eur Respir J* 2004;**24**(6):1007–10.
 79. Hoeper MM, Taha N, Bekjarova A, Gatzke R, Spiekerkoetter E. Bosentan treatment in patients with primary pulmonary hypertension receiving nonparenteral prostanoids. *Eur Respir J* 2003;**22**(2):330–4.
 80. Hoeper MM, Markevych I, Spiekerkoetter E, Welte T, Niedermeyer J. Goal-oriented treatment and combination therapy for pulmonary arterial hypertension. *Eur Respir J* 2005;**26**(5):858–63.
 81. Gombert-Maitland M, McLaughlin V, Gulati M, Rich S. Efficacy and safety of sildenafil added to treprostinil in pulmonary hypertension. *Am J Cardiol* 2005;**96**(9):1334–6.
 82. Gombert-Maitland M. Learning to pair therapies and the expanding matrix for pulmonary arterial hypertension: is more better? *Eur Respir J* 2006;**28**(4):683–6.
 83. Mathai SC, Girgis RE, Fisher MR, Champion HC, Houston-Harris T, Zaiman A, et al. Addition of sildenafil to bosentan monotherapy in pulmonary arterial hypertension. *Eur Respir J* 2007;**29**(3):469–75.
 84. Simonneau G, Rubin LJ, Galiè N, Barst RJ, Fleming TR, Frost AE, et al., PACES Study Group. Addition of sildenafil to long-term intravenous epoprostenol therapy in patients with pulmonary arterial hypertension: a randomized trial. *Ann Intern Med* 2008;**149**(8):521–30.
 85. Paul GA, Gibbs JS, Boobis AR, Abbas A, Wilkins MR. Bosentan decreases the plasma concentration of sildenafil when coprescribed in pulmonary hypertension. *Br J Clin Pharmacol* 2005;**60**(1):107–12.
 86. Humbert M, Segal ES, Kiely DG, Carlsen J, Schwierin B, Hoeper MM. Results of European post-marketing surveillance of bosentan in pulmonary hypertension. *Eur Respir J* 2007;**30**(2):338–44.
 87. Wrishko RE, Dingemans J, Yu A, Darstein C, Phillips DL, Mitchell MI. Pharmacokinetic interaction between tadalafil and bosentan in healthy male subjects. *J Clin Pharmacol* 2008;**48**(5):610–8.
 88. Sitbon O, Jaïs X, Savale L, Cottin V, Bergot E, Macari EA, et al. Upfront triple combination therapy in pulmonary arterial hypertension: a pilot study. *Eur Respir J* 2014;**43**(6):1691–7.
 89. Kemp K, Savale L, O'Callaghan DS, Jaïs X, Montani D, Humbert M, et al. Usefulness of first-line combination therapy with epoprostenol and bosentan in pulmonary arterial hypertension: an observational study. *J Heart Lung Transplant* 2012;**31**(2):150–8.
 90. McLaughlin VV, Benza RL, Rubin LJ, Channick RN, Voswinkel R, Tapson VF, et al. Addition of inhaled treprostinil to oral therapy for pulmonary arterial hypertension: a randomized controlled clinical trial. *J Am Coll Cardiol* 2010;**55**(18):1915–22.
 91. Simonneau G, Torbicki A, Hoeper MM, Delcroix M, Karlócai K, Galiè N, et al. Selexipag: an oral, selective prostacyclin receptor agonist for the treatment of pulmonary arterial hypertension. *Eur Respir J* 2012;**40**(4):874–80.
 92. Galiè N, Brundage BH, Ghofrani HA, Oudiz RJ, Simonneau G, Safdar Z, et al., Pulmonary Arterial Hypertension and Response to Tadalafil (PHIRST) Study Group. Tadalafil therapy for pulmonary arterial hypertension. *Circulation* 2009;**119**(22):2894–903.
 93. Diller GP, Gatzoulis MA. Pulmonary vascular disease in adults with congenital heart disease. *Circulation* 2007;**115**(8): 1039–50.
 94. Simonneau G, Robbins IM, Beghetti M, Channick RN, Delcroix M, Denton CP, et al. Updated clinical classification of pulmonary hypertension. *J Am Coll Cardiol* 2009;**54**(1 Suppl): S43–54.
 95. Dimopoulos K, Wort SJ, Gatzoulis MA. Pulmonary hypertension related to congenital heart disease: a call for action. *Eur Heart J* 2014 Mar;**35**(11):691–700.
 96. Chen IC, Dai ZK. Insight into pulmonary arterial hypertension associated with congenital heart disease (PAH-CHD): classification and pharmacological management from a pediatric cardiological point of view. *Acta Cardiol Sin* 2015;**31**(6): 507–15.

97. Cerro MJ, Abman S, Diaz G, Freudenthal AH, Freudenthal F, Harikrishnan S, et al. A consensus approach to the classification of pediatric pulmonary hypertensive vascular disease: report from the PVRI pediatric taskforce, Panama 2011. *Pulm Circ* 2011;1(2):286–98.
98. Manes A, Palazzini M, Leci E, Bacchi Reggiani ML, Branzi A, Galiè N. Current era survival of patients with pulmonary arterial hypertension associated with congenital heart disease: a comparison between clinical subgroups. *Eur Heart J* 2014;35(11):716–24.
99. Galiè N, Manes A, Palazzini M, Negro L, Marinelli A, Gambetti S, et al. Management of pulmonary arterial hypertension associated with congenital systemic-to-pulmonary shunts and Eisenmenger syndrome. *Drugs* 2008;68(8):1049–66.
100. Hascoet S, Fournier E, Jaïs X, Le Gloan L, Dauphin C, Houeijeh A, et al. Outcome of adults with Eisenmenger syndrome treated with drugs specific to pulmonary arterial hypertension: a French multicentre study. *Arch Cardiovasc Dis* 2017;110(5):303–16.
101. Arnott C, Strange G, Bullock A, Kirby AC, O'Donnell C, Radford DJ, et al. Pulmonary vasodilator therapy is associated with greater survival in Eisenmenger syndrome. *Heart* 2018;104(9):732–7.
102. Myers PO, Tissot C, Beghetti M. Assessment of operability of patients with pulmonary arterial hypertension associated with congenital heart disease. *Circ J* 2014;78(1):4–11.
103. Lu CW. The challenges in managing pulmonary arterial hypertension associated with congenital heart disease. *Acta Cardiol Sin* 2015;31(6):516–7.
104. Lopes AA, O'Leary PW. Measurement, interpretation and use of hemodynamic parameters. *Cardiol Young* 2009;19(Suppl. 1):8–12.
105. Montani D, Savale L, Natali D, Jaïs X, Herve P, Garcia G, et al. Long-term response to calcium-channel blockers in non-idiopathic pulmonary arterial hypertension. *Eur Heart J* 2010;31(15):1898–907.
106. Broberg CS, Ujita M, Prasad S, Li W, Rubens M, Bax BE, et al. Pulmonary arterial thrombosis in Eisenmenger syndrome is associated with biventricular dysfunction and decreased pulmonary flow velocity. *J Am Coll Cardiol* 2007;50(7):634–42.
107. Broberg CS, Bax BE, Okonko DO, Rampling MW, Bayne S, Harries C, et al. Blood viscosity and its relationship to iron deficiency, symptoms, and exercise capacity in adults with cyanotic congenital heart disease. *J Am Coll Cardiol* 2006;48(2):356–65.
108. Galiè N, Beghetti M, Gatzoulis MA, Granton J, Berger RM, Lauer A, et al. Bosentan randomized trial of endothelin antagonist therapy-5 (BREATHE-5) Investigators. Bosentan therapy in patients with Eisenmenger syndrome: a multicenter, double-blind, randomized, placebo-controlled study. *Circulation* 2006;114(1):48–54.
109. Gatzoulis MA, Beghetti M, Galiè N, Granton J, Berger RM, Lauer A, et al., BREATHE-5 Investigators. Longer-term bosentan therapy improves functional capacity in Eisenmenger syndrome: results of the BREATHE-5 open-label extension study. *Int J Cardiol* 2008;127(1):27–32.
110. Zuckerman WA, Leaderer D, Rowan CA, Mituniewicz JD, Rosenzweig EB. Ambrisentan for pulmonary arterial hypertension due to congenital heart disease. *Am J Cardiol* 2011;107(9):1381–5.
111. Herbert S, Gin-Sing W, Howard L, Tulloh RMR. Early experience of macitentan for pulmonary arterial hypertension in adult congenital heart disease. *Heart Lung Circ* 2017;26(10):1113–6.
112. Chon MK, Cho KI, Cha KS, Seo JS, Kim DS. Effects of long-term iloprost treatment on right ventricular function in patients with Eisenmenger syndrome. *J Cardiol* 2017;69(5):741–6.
113. Zhang ZN, Jiang X, Zhang R, Li XL, Wu BX, Zhao QH, et al. Oral sildenafil treatment for Eisenmenger syndrome: a prospective, open-label, multicentre study. *Heart* 2011;97(22):1876–81.
114. Mukhopadhyay S, Nathani S, Yusuf J, Shrimal D, Tyagi S. Clinical efficacy of phosphodiesterase-5 inhibitor tadalafil in Eisenmenger syndrome—a randomized, placebo-controlled, double-blind crossover study. *Congenit Heart Dis* 2011;6(5):424–31.
115. Iversen K, Jensen AS, Jensen TV, Vejlstrop NG, Søndergaard L. Combination therapy with bosentan and sildenafil in Eisenmenger syndrome: a randomized, placebo-controlled, double-blinded trial. *Eur Heart J* 2010;31(9):1124–31.
116. Dimopoulos K, Peset A, Gatzoulis MA. Evaluating operability in adults with congenital heart disease and the role of pre-treatment with targeted pulmonary arterial hypertension therapy. *Int J Cardiol* 2008;129(2):163–71.
117. van der Feen DE, Bartelds B, de Boer RA, Berger RMF. Pulmonary arterial hypertension in congenital heart disease: translational opportunities to study the reversibility of pulmonary vascular disease. *Eur Heart J* 2017;38(26):2034–41.
118. Mukerjee D, St George D, Coleiro B, Knight C, Denton CP, Davar J, et al. Prevalence and outcome in systemic sclerosis associated pulmonary arterial hypertension: application of a registry approach. *Ann Rheum Dis* 2003;62(11):1088–93.
119. Hao YJ, Jiang X, Zhou W, Wang Y, Gao L, Wang Y, et al. Connective tissue disease-associated pulmonary arterial hypertension in Chinese patients. *Eur Respir J* 2014;44(4):963–72.
120. Chung WJ, Park YB, Jeon CH, Jung JW, Ko KP, Choi SJ, et al., KORPAH Investigators. Baseline characteristics of the Korean registry of pulmonary arterial hypertension. *J Kor Med Sci* 2015 Oct;30(10):1429–38.
121. Hachulla E, Gressin V, Guillevin L, Carpentier P, Diot E, Sibilia J, et al. Early detection of pulmonary arterial hypertension in systemic sclerosis: a French nationwide prospective multicenter study. *Arthritis Rheum* 2005;52(12):3792–800.
122. Hochberg MC. Updating the American college of rheumatology revised criteria for the classification of systemic lupus erythematosus. *Arthritis Rheum* 1997;40(9):1725.
123. Raymond RJ, Hinderliter AL, Willis PW, Ralph D, Caldwell EJ, Williams W, et al. Echocardiographic predictors of adverse outcomes in primary pulmonary hypertension. *J Am Coll Cardiol* 2002;39(7):1214–9.
124. Jaïs X, Launay D, Yaici A, Le Pavec J, Tchérakian C, Sitbon O, et al. Immunosuppressive therapy in lupus- and mixed connective tissue disease-associated pulmonary arterial hypertension: a retrospective analysis of twenty-three cases. *Arthritis Rheum* 2008;58(2):521–31.
125. Olsson KM, Delcroix M, Ghofrani HA, Tiede H, Huscher D, Speich R, et al. Anticoagulation and survival in pulmonary arterial hypertension: results from the comparative, prospective registry of newly initiated therapies for pulmonary hypertension (COMPERRA). *Circulation* 2014;129(1):57–65.
126. Frost AE, Farber HW, Barst RJ, Miller DP, Elliott CG, McGoon MD. Demographics and outcomes of patients diagnosed with pulmonary hypertension with pulmonary capillary wedge pressures 16 to 18 mm Hg: insights from the REVEAL Registry. *Chest* 2013;143(1):185–95.
127. Gall H, Hoeper MM, Richter MJ, Cacheris W, Hinzmann B, Mayer E. An epidemiological analysis of the burden of chronic thromboembolic pulmonary hypertension in the USA, Europe and Japan. *Eur Respir Rev* 2017;26(143).
128. Delcroix M, Kerr K, Fedullo P. Chronic thromboembolic pulmonary hypertension. epidemiology and risk factors. *Ann Am Thorac Soc* 2016;13(Suppl. 3):S201–6.

129. Gopalan D, Delcroix M, Held M. Diagnosis of chronic thromboembolic pulmonary hypertension. *Eur Respir Rev* 2017; **26**(143).
130. Lang IM, Pesavento R, Bonderman D, Yuan JX. Risk factors and basic mechanisms of chronic thromboembolic pulmonary hypertension: a current understanding. *Eur Respir J* 2013; **41**(2): 462–8.
131. Klok FA, Dzikowska-Diduch O, Kostrubiec M, Vliegen HW, Pruszczyk P, Hasenfuß G, et al. Derivation of a clinical prediction score for chronic thromboembolic pulmonary hypertension after acute pulmonary embolism. *J Thromb Haemostasis* 2016; **14**(1):121–8.
132. Klok FA, Surie S, Kempf T, Eikenboom J, van Straalen JP, van Kralingen KW, et al. A simple non-invasive diagnostic algorithm for ruling out chronic thromboembolic pulmonary hypertension in patients after acute pulmonary embolism. *Thromb Res* 2011; **128**(1):21–6.
133. Klok FA, Tesche C, Rappold L, Dellas C, Hasenfuß G, Huisman MV, et al. External validation of a simple non-invasive algorithm to rule out chronic thromboembolic pulmonary hypertension after acute pulmonary embolism. *Thromb Res* 2015; **135**(5):796–801.
134. Held M, Grün M, Holl R, Hübner G, Kaiser R, Karl S, et al. Cardiopulmonary exercise testing to detect chronic thromboembolic pulmonary hypertension in patients with normal echocardiography. *Respiration* 2014; **87**(5):379–87.
135. Donahoe L, Vanderlaan R, Thenganatt J, McRae K, Bykova A, Moric J, et al. Symptoms are more useful than echocardiography in patient selection for pulmonary endarterectomy. *Ann Thorac Surg* 2017; **104**(4):1179–85.
136. Held M, Hesse A, Gött F, Holl R, Hübner G, Kolb P, et al. A symptom-related monitoring program following pulmonary embolism for the early detection of CTEPH: a prospective observational registry study. *BMC Pulm Med* 2014; **14**:141.
137. He J, Fang W, Lv B, He JG, Xiong CM, Liu ZH, et al. Diagnosis of chronic thromboembolic pulmonary hypertension: comparison of ventilation/perfusion scanning and multidetector computed tomography pulmonary angiography with pulmonary angiography. *Nucl Med Commun* 2012; **33**(5):459–63.
138. Renapurkar RD1, Shrikanthan S, Heresi GA, Lau CT, Gopalan D. Imaging in chronic thromboembolic pulmonary hypertension. *J Thorac Imag* 2017; **32**(2):71–88.
139. Ruggiero A, Screaton NJ. Imaging of acute and chronic thromboembolic disease: state of the art. *Clin Radiol* 2017; **72**(5):375–88.
140. Gopalan D, Blanchard D, Auger WR. Diagnostic evaluation of chronic thromboembolic pulmonary hypertension. *Ann Am Thorac Soc* 2016; **13**(Suppl 3):S222–39.
141. Fukuda T, Ogo T, Nakanishi N, Ueda J, Sanda Y, Morita Y, et al. Evaluation of organized thrombus in distal pulmonary arteries in patients with chronic thromboembolic pulmonary hypertension using cone-beam computed tomography. *Jpn J Radiol* 2016; **34**(6):423–31.
142. Hinrichs JB, von Falck C, Hoepfer MM, Olsson KM, Wacker FK, Meyer BC, et al. Pulmonary artery imaging in patients with chronic thromboembolic pulmonary hypertension: comparison of cone-beam CT and 64-row multidetector CT. *J Vasc Intervent Radiol* 2016; **27**(3):361–368.e2.
143. Sugiyama M, Fukuda T, Sanda Y, Morita Y, Higashi M, Ogo T, et al. Organized thrombus in pulmonary arteries in patients with chronic thromboembolic pulmonary hypertension; imaging with cone beam computed tomography. *Jpn J Radiol* 2014; **32**(7):375–82.
144. Ogo T, Fukuda T, Tsuji A, Fukui S, Ueda J, Sanda Y, et al. Efficacy and safety of balloon pulmonary angioplasty for chronic thromboembolic pulmonary hypertension guided by cone-beam computed tomography and electrocardiogram-gated area detector computed tomography. *Eur J Radiol* 2017; **89**:270–6.
145. Nakazawa T, Watanabe Y, Hori Y, Kiso K, Higashi M, Itoh T, et al. Lung perfused blood volume images with dual-energy computed tomography for chronic thromboembolic pulmonary hypertension: correlation to scintigraphy with single-photon emission computed tomography. *J Comput Assist Tomogr* 2011; **35**(5):590–5.
146. Takagi H, Ota H, Sugimura K, Otani K, Tominaga J, Aoki T, et al. Dual-energy CT to estimate clinical severity of chronic thromboembolic pulmonary hypertension: comparison with invasive right heart catheterization. *Eur J Radiol* 2016; **85**(9):1574–80.
147. Koike H, Sueyoshi E, Sakamoto I, Uetani M, Nakata T, Maemura K. Quantification of lung perfusion blood volume (lung PBV) by dual-energy CT in patients with chronic thromboembolic pulmonary hypertension (CTEPH) before and after balloon pulmonary angioplasty (BPA): preliminary results. *Eur J Radiol* 2016; **85**(9):1607–12.
148. Tamura M, Yamada Y, Kawakami T, Kataoka M, Iwabuchi Y, Sugiura H, et al. Diagnostic accuracy of lung subtraction iodine mapping CT for the evaluation of pulmonary perfusion in patients with chronic thromboembolic pulmonary hypertension: correlation with perfusion SPECT/CT. *Int J Cardiol* 2017; **243**:538–43.
149. Ley S, Ley-Zaporozhan J, Pitton MB, Schneider J, Wirth GM, Mayer E, et al. Diagnostic performance of state-of-the-art imaging techniques for morphological assessment of vascular abnormalities in patients with chronic thromboembolic pulmonary hypertension (CTEPH). *Eur Radiol* 2012; **22**(3):607–16.
150. Sakao S, Miyauchi H, Voelkel NF, Sugiura T, Tanabe N, Kobayashi Y, et al. Increased right ventricular fatty acid accumulation in chronic thromboembolic pulmonary hypertension. *Ann Am Thorac Soc* 2015; **12**(10):1465–72.
151. Suntharalingam J, Hughes RJ, Goldsmith K, Doughty N, George P, Toshner M, et al. Acute haemodynamic responses to inhaled nitric oxide and intravenous sildenafil in distal chronic thromboembolic pulmonary hypertension (CTEPH). *Vasc Pharmacol* 2007; **46**(6):449–55.
152. Skoro-Sajer N, Hack N, Sadushi-Koliçi R, Bonderman D, Jakowitsch J, Klepetko W, et al. Pulmonary vascular reactivity and prognosis in patients with chronic thromboembolic pulmonary hypertension: a pilot study. *Circulation* 2009; **119**(2):298–305.
153. Xu QX, Yang YH, Geng J, Zhai ZG, Gong JN, Li JF, et al. Clinical study of acute vasoreactivity testing in patients with chronic thromboembolic pulmonary hypertension. *Chin Med J (Engl)* 2017; **130**(4):382–91.
154. Korsholm K, Andersen A, Mellekjær S, Nielsen DV, Klaaborg KE, Ilkjær LB, et al. Results from more than 20 years of surgical pulmonary endarterectomy for chronic thromboembolic pulmonary hypertension in Denmark. *Eur J Cardiothorac Surg* 2017; **52**(4):704–9.
155. Kim SH, Lee JW, Ahn JM, Kim DH, Song JM, Lee SD, et al. Long-term outcomes of surgery for chronic thromboembolic pulmonary hypertension compared with medical therapy at a single Korean center. *Kor J Intern Med* 2017; **32**(5):855–64.
156. Lankeit M, Krieg V, Hobohm L, Kölmel S, Liebetrau C, Konstantinides S, et al. Pulmonary endarterectomy in chronic thromboembolic pulmonary hypertension. *J Heart Lung Transplant* 2017; **37**(2):250–8.
157. Jenkins D, Madani M, Fadel E, D'Armini AM, Mayer E. Pulmonary endarterectomy in the management of chronic thromboembolic pulmonary hypertension. *Eur Respir Rev* 2017; **26**(143).
158. Cannon JE, Su L, Kiely DG, Page K, Toshner M, Swietlik E, et al. Dynamic risk stratification of patient long-term outcome after pulmonary endarterectomy: results from the

- United Kingdom National cohort. *Circulation* 2016;133(18):1761–71.
159. Taboada D, Pepke-Zaba J, Jenkins DP, Berman M, Treacy CM, Cannon JE, et al. Outcome of pulmonary endarterectomy in symptomatic chronic thromboembolic disease. *Eur Respir J* 2014;44(6):1635–45.
 160. Shimura N, Kataoka M, Inami T, Yanagisawa R, Ishiguro H, Kawakami T, et al. Additional percutaneous transluminal pulmonary angioplasty for residual or recurrent pulmonary hypertension after pulmonary endarterectomy. *Int J Cardiol* 2015;183:138–42.
 161. Feinstein JA, Goldhaber SZ, Lock JE, Fernandes SM, Landzberg MJ. Balloon pulmonary angioplasty for treatment of chronic thromboembolic pulmonary hypertension. *Circulation* 2001;103(1):10–3.
 162. Darocha S, Pietura R, Pietrasik A, Norwa J, Dobosiewicz A, Piłka M, et al. Improvement in quality of life and hemodynamics in chronic thromboembolic pulmonary hypertension treated with balloon pulmonary angioplasty. *Circ J* 2017;81(4):552–7.
 163. Lang I, Meyer BC, Ogo T, Matsubara H, Kurzyna M, Ghofrani HA, et al. Balloon pulmonary angioplasty in chronic thromboembolic pulmonary hypertension. *Eur Respir Rev* 2017;26(143).
 164. Mizoguchi H, Ogawa A, Munemasa M, Mikouchi H, Ito H, Matsubara H. Refined balloon pulmonary angioplasty for inoperable patients with chronic thromboembolic pulmonary hypertension. *Circ Cardiovasc Interv* 2012;5(6):748–55.
 165. Roik M, Wretowski D, Łabyk A, Kostrubiec M, Irzyk K, Dzi-kowska-Diduch O, et al. Refined balloon pulmonary angioplasty driven by combined assessment of intra-arterial anatomy and physiology—Multimodal approach to treated lesions in patients with non-operable distal chronic thromboembolic pulmonary hypertension—Technique, safety and efficacy of 50 consecutive angioplasties. *Int J Cardiol* 2016;203:228–35.
 166. Inami T, Kataoka M, Shimura N, Ishiguro H, Yanagisawa R, Taguchi H, et al. Pulmonary edema predictive scoring index (PEPSI), a new index to predict risk of reperfusion pulmonary edema and improvement of hemodynamics in percutaneous transluminal pulmonary angioplasty. *JACC Cardiovasc Interv* 2013;6(7):725–36.
 167. Inami T, Kataoka M, Shimura N, Ishiguro H, Yanagisawa R, Fukuda K, et al. Pressure-wire-guided percutaneous transluminal pulmonary angioplasty: a breakthrough in catheter-interventional therapy for chronic thromboembolic pulmonary hypertension. *JACC Cardiovasc Interv* 2014;7(11):1297–306.
 168. Shinkura Y, Nakayama K, Yanaka K, Kinutani H, Tamada N, Tsuboi Y, et al. Extensive revascularization by balloon pulmonary angioplasty for chronic thromboembolic pulmonary hypertension beyond hemodynamic normalization. *Euro-Intervention* 2018;13(17):2060–8.
 169. Phan K, Jo HE, Xu J, Lau EM. Medical therapy versus balloon angioplasty for CTEPH: a systematic review and meta-analysis. *Heart Lung Circ* 2018;27(1):89–98.
 170. Muller DW, Liebetau C. Percutaneous treatment of chronic thromboembolic pulmonary hypertension (CTEPH). *Euro-Intervention* 2016;12(Suppl X):X35–43.
 171. Chen SL, Zhang H, Xie DJ, Zhang J, Zhou L, Rothman AM, et al. Hemodynamic, functional, and clinical responses to pulmonary artery denervation in patients with pulmonary arterial hypertension of different causes: phase II results from the pulmonary artery denervation-1 study. *Circ Cardiovasc Interv* 2015;8(11), e002837.
 172. Simonneau G, D'Armini AM, Ghofrani HA, Grimminger F, Hoeper MM, Jansa P, et al. Riociguat for the treatment of chronic thromboembolic pulmonary hypertension: a long-term extension study (CHEST-2). *Eur Respir J* 2015;45(5):1293–302.
 173. Halank M, Hoeper MM, Ghofrani HA, Meyer FJ, Stähler G, Behr J, et al. Riociguat for pulmonary arterial hypertension and chronic thromboembolic pulmonary hypertension: results from a phase II long-term extension study. *Respir Med* 2017;128:50–6.
 174. Ghofrani HA, Simonneau G, D'Armini AM, Fedullo P, Howard LS, Jaïs X, et al. MERIT study investigators. Macitentan for the treatment of inoperable chronic thromboembolic pulmonary hypertension (MERIT-1): results from the multicentre, phase 2, randomised, double-blind, placebo-controlled study. *Lancet Respir Med* 2017;5(10):785–94.
 175. Yandrapalli S, Tariq S, Kumar J, Aronow WS, Malekan R, Frishman WH, et al. Chronic thromboembolic pulmonary hypertension: epidemiology, diagnosis, and management. *Cardiol Rev* 2018;26(2):62–72.
 176. Pepke-Zaba J, Ghofrani HA, Hoeper MM. Medical management of chronic thromboembolic pulmonary hypertension. *Eur Respir Rev* 2017;26(143).
 177. Ghofrani HA, Simonneau G, D'Armini AM, Fedullo P, Martin N, Howard L, et al. *Efficacy and safety of macitentan for inoperable chronic thromboembolic pulmonary hypertension: results from the randomized controlled MERIT study. Poster presented at American Thoracic Society Conference 2017, Washington, DC. 2017, May.*
 178. Sitbon O, Bourlier D, Jais X, Cottin V, Savale L, Bergot E, et al. *Initial combination therapy with endothelin receptor antagonist and PDE-5 inhibitor in inoperable chronic thromboembolic pulmonary hypertension.* San Francisco, CA: American Thoracic Society Conference 2016; 2016, May.
 179. Delcroix M, Lang I, Pepke-Zaba J, Jansa P, D'Armini AM, Snijder R, et al. Long-term outcome of patients with chronic thromboembolic pulmonary hypertension: results from an International prospective registry. *Circulation* 2016;133(9):859–71.
 180. Kim NH. Group 4 pulmonary hypertension: chronic thromboembolic pulmonary hypertension: epidemiology, pathophysiology, and treatment. *Cardiol Clin* 2016;34(3):435–41.