Letter to the Editor — Editöre Mektup

Right heart catheterization datas may not reflect the pulmonary hypertension epidemiology accurately

Dear Editor,

We read the recent article published by Hacıyev et al.[1] about their center's experience with pulmonary hypertension (PHT) with great interest. It was noted that left-heart disease PHT, defined by the World Health Organization as Group 2, is the most common type of PHT and that valvular disease is the most frequent cause of Group 2 PHT. In this study, 21.6% of the patients were Group 1 PHT, pulmonary arterial hypertension, and 1.6% of the patients were classified as Group 3 PHT, a result of lung disease.

Group 2 is the most common subtype of PHT. Heart failure with reduced ejection fraction (HFrEF), heart failure with preserved EF, and valvular diseases are common causes of Group 2 PHT.[2] The authors of this study also stated that valvular diseases were the most frequent reason for PHT in the Group 2 patients. Group 2 PHT is an expected result in patients with HFrEF, so right-heart catheterization (RHC) is not usually performed. Verification of PHT and assessment of pulmonary vascular hemodynamics are required before valvular surgery. Therefore, the prevalence of HFrEF should be underestimated in Group 2 PHT.

It was also reported that Group 3 PHT patients accounted for a small portion of the study population. This can be explained by the hypothesis that patients with lung disease undergo RHC less frequently than is optimal since mild PHT is an expected outcome of lung diseases.

Congenital heart disease-related PAH was the most common type of PAH in the study. It is noteworthy to mention that the frequency of the PAH subtypes encountered is associated with the expertise areas of the center. Centers that follow a large number of patients with connective tissue disease (CTD) will see more CTD-related PAH, while in centers that follow more patients with chronic liver disease, portopulmonary hypertension will likely be the most common subtype. Therefore, to assess the real prevalence of PAH subtypes, multicenter studies are needed.

Yusuf Ziya Şener, M.D., Metin Okşul, M.D., Vedat Hekimsoy, M.D.

Department of Cardiology Hacettepe University Faculty of Medicine, Ankara, Turkey

e-mail: yzsener@yahoo.com.tr

doi: 10.5543/tkda.2019.56250

Conflict of interest: None declared.

References

1. Hacıyev R, Ünlü S, Yalçın MR, Taçoy G, Çengel A. Pulmonary hypertension spectrum: 16 years of experience from a single center. Turk Kardiyol Dern Ars 2018;46:667–74. [Article in Turkish] [CrossRef]
2. Galiè N, Humbert M, Vachiery JL, Gibbs S, Lang I, Torbicki A, et al.; ESC Scientific Document Group. 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;37:67–119. [CrossRef]