Appetite suppressants and pulmonary hypertension

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Introductory article

Appetite-suppressant drugs and the risk of primary pulmonary hypertension

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Background. Recently in France, primary pulmonary hypertension developed in a cluster of patients exposed to derivatives of fenfluramine in appetite suppressants (anorexic agents), which are used for weight control. We investigated the potential role of anorexic agents and other suspected risk factors for primary pulmonary hypertension. Methods. In a case-control study, we assessed 95 patients with primary pulmonary hypertension from 35 centers in France, Belgium, the United Kingdom, and the Netherlands and 355 controls recruited from general practices and matched to the patients' sex and age. Results. The use of anorexic drugs (mainly derivatives of fenfluramine) was associated with an increased risk of primary pulmonary hypertension (odds ratio with any anorexic-drug use, 6.3; 95 percent confidence interval, 3.0 to 13.2). For the use of anorexic agents in the preceding year, the odds ratio was 10.1 (95 percent confidence interval, 3.4 to 29.9). When anorexic drugs were used for a total of more than three months, the odds ratio was 23.1 (95 percent confidence interval, 6.9 to 77.7). We also confirmed an association with several previously identified risk factors: a family history of pulmonary hypertension, infection with the human immunodeficiency virus, cirrhosis, and use of cocaine or intravenous drugs. Conclusions. The use of anorexic drugs was associated with the development of primary pulmonary hypertension. Active surveillance for this disease should be considered, particularly since the use of anorexic drugs is expected to increase in the near future.

Primary pulmonary hypertension (PPH), also called unexplained pulmonary hypertension, is a rare disease with at least three different recognised histological presentations, of which the so-called plexogenic arteriopathy is the most commonly encountered. The disease occurs with a predominance in young women, but incidence peaks have been noted also in children and in a geriatric population. PPH is clinically characterised by non-specific symptoms of dyspnoea or cough and therefore is quite often initially misdiagnosed. Occasionally the first clinical presentation is with signs of right heart failure. The median survival after diagnosis of PPH has been estimated to be 2.8 years. Thus, in many patients the disease takes a rapidly progressive very malignant course.

In recent years associations of plexogenic pulmonary arteriopathy have been found with portal hypertension and with AIDS. Until 1993 when Brenot and co-workers published their observations entitled Primary pulmonary hypertension and fenfluramine use, the historical context of appetite depressants and their possible role as pulmonary hypertension-inducing drugs had been nearly forgotten. This was particularly apparent in a number of contemporary reviews of pulmonary artery hypertension where the potential aetiological role of anorexigens was not mentioned. T he introductory article by Abenhaim et al describes the first prospective study which attempts to estimate the relative risk for the development of PPH from anorexigen use. As stated, PPH is a rare disease and its incidence in any population group where an unusually high prevalence has been established - for example, in patients with liver cirrhosis and portal hypertension or patients with AIDS - is still rather small. The most likely explanation is a low prevalence of a "pulmonary hypertension gene" or of a constellation of genetic factors. Given such a low prevalence of genetic predisposition, any trigger or expression factor will raise the number of patients with PPH to only a small extent. T he introductory article by Abenhaim et al describes the first prospective study which attempts to estimate the relative risk for the development of PPH from anorexigen use.
been isolated case reports which strongly indicated that anorexigen intake can be associated causally with PPH. Usually such association can be claimed when a patient develops unexplained pulmonary hypertension in close temporal relation to anorexigen use and when no other drugs are involved. Analysis of the data collected for the primary pulmonary hypertension registry of the US National Institutes of Health showed that 5% of the patients with PPH had a history of anorexigen use, and Brenot et al. found that, among their 125 cases of PPH, 14% had a history of anorexigen use (25% of all their female patients). Based on these data, it is not likely that anorexigen use is currently the overwhelming cause of PPH, but if anorexigen use continues to increase, it is likely to become an increasingly important cause of PPH.

For the prospective International Primary Pulmonary Hypertension Study (IPPHS) Group, 35 centres in France, Belgium, the Netherlands, and the UK agreed to participate and to report cases of PPH diagnosed between September 1992 and September 1994. A total of 95 patients with PPH were identified, 64 of whom had been reported by French centres. Definite use of anorexigen had been reported by 30 of the 95 patients with PPH but by only 26 of 355 controls. Although the study was international in design, the data largely represented the French experience. Perhaps the most striking finding of the IPPHS was that roughly 12% of the patients with PPH had taken anorexigen for 12 months or longer (compared with 0.6% in the control group).

Anorexigen and PPH: the historical context

Several medical centres in Switzerland, Austria, and Germany registered an increased incidence of severe pulmonary hypertension beginning in 1967. Roughly 18 months after the anorexigen fenfluramine (aminorex fumarate) had been released in these three countries; by 1970 150 cases of PPH associated with anorexigen use had been reported. The 1985 review by Gurtner concluded that altogether 582 cases of anorexigen-induced PPH had been reported. The early experience with this epidemic in Vienna (Fig. 1) illustrates the latency period between the time of introduction of the drug and the time when an increased incidence of PPH was recognised (the drug had been released in December 1965). Although the drug was taken off the market in November 1968, cases of anorexigen-induced PPH were diagnosed for several years thereafter (box). Symptoms consistent with PPH occurred 9–14 months after the start of the anorexigen treatment, approximately one per 1000 anorexigen users developed PPH, and the lesions of anorexigen-induced PPH were histologically indistinguishable from those recognised in sporadic cases of PPH. Gurtner followed 71 patients with anorexigen-induced PPH and found that 34 patients had died (with a median survival of 3.5 years). There was no clearcut relationship between the amount of the drug taken and mortality, but the risk of developing anorexigen-induced PPH increased with increased drug intake. Attempts to induce pulmonary hypertension by feeding anorexigen to rodents, dogs, and cattle failed, which would not be surprising if there is a specific human genetic susceptibility. The retrospective data analysis of the anorexigen epidemic also showed that approximately 10% of the patients with PPH had used anorexigen in combination with chlorphentermine, phenoxybenzamine, or amphetamine. Since the anorexigen epidemic, sporadic cases of PPH related to the use of fenfluramine or phentermine have been reported.

Anorexigen-associated pulmonary hypertension: the pharmacological context

The exact pathogenetic events leading to the manifestation of PPH are still unknown. It appears, however, that for the anorexigen-associated cases of PPH, 5-hydroxytryptamine (5-HT, serotonin) might be a common denominator. Figure 2 shows the structures of some of the anorexigen, including anorexigen, and also the frequently used antidepressant agents such as sertraline hydrochloride and fluoxetine hydrochloride. All of these agents release 5-HT from storage sites or inhibit uptake of 5-HT, or both. Although anorexigen resembles amphetamine and has been shown to release noradrenaline (norepinephrine), anorexigen also releases 5-HT. Gahl and coworkers found no increase in levels of metabolites of 5-HT in the urine of patients with anorexigen-induced PPH. However, these measurements were conducted many months after the anorexigen intake. Nevertheless, a unifying hypothesis operating with a 5-HT paradigm may be justified at the present time. Herve and coworkers reported the case history of a patient with PPH and a platelet storage disorder and, more recently, described the plasma 5-HT levels in patients with PPH. Of great interest is their finding that, in their patients with PPH (some of whom had taken anorexigen), there was an increase in plasma 5-HT levels and an increased release of 5-HT from the platelets. Moreover, this increase in plasma levels of 5-HT
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Phentermine hydrochloride

Amphetamine

Aminorex

5-Hydroxytryptamine (5-HT)

Dexfenfluramine hydrochloride

Sertraline hydrochloride

Fluoxetine hydrochloride

Figure 2. Chemical structures of 5-hydroxytryptamine (5-HT, serotonin) and 5-HT-releasing appetite suppressants or antidepressants.

HT persisted in those patients who had received lung transplantation. If this finding of raised levels of 5-HT in patients with PPH can be confirmed in other populations with PPH, it would be tempting to speculate that agents which alter the metabolism of 5-HT could be trigger factors for PPH (figs 3 and 4). It is clear from experimental data that 5-HT does, indeed, cause pulmonary vasoconstriction and produces both hyperplasia and hypertrophy of isolated cultured pulmonary artery smooth muscle cells. The proliferative effect of 5-HT is apparently transduced through the 5-HT2 receptor. However, the relationship between alteration in 5-HT metabolism and PPH is probably more complex, as evidenced by the absence of reports of a relationship between the chronic intake of antidepressants such as fluoxetine hydrochloride (a very widely used drug) and PPH. However, in our centre we have recently diagnosed PPH in a woman who had not taken anorexigens but had been treated for her depression with sertraline hydrochloride (unpublished observation).

Figure 3. Scheme depicting the confluence of a presently ill described genetic disposition and trigger factors in the development of primary pulmonary hypertension. It is clear that the trigger factors are of a vastly varied nature, including high blood flow or increased shear stress, viral infections, and anorexigens.

Figure 4. Scheme depicting a hypothetical sequence of events involving appetite suppressants which alter the metabolism of 5-hydroxytryptamine (5-HT) or affect release of 5-HT from platelets and mast cells. In susceptible individuals, that is, those with a genetic disposition, increased levels of 5-HT could both alter pulmonary vascular tone and also affect pulmonary vascular cell growth.
Anorexigen-associated pulmonary hypertension and obesity: risk-benefit ratio

It should be clear from the above that anorexigens can cause pulmonary hypertension. It should also be appreciated that many patients are looking for a pharmacological solution to their obesity problem. In the USA dieting and weight management are a multibillion dollar industry. Hundreds of new diet pill clinics have opened during the last year. Presently we have no good understanding of the relationship between body weight and pulmonary hypertension – apart from the well known association of the obesity/hypertension/poly- cystyana syndrome and pulmonary hypertension.

Gurtner, summarising his experience of 71 patients with presumed anorexigen-induced PPH, found that 50% of the patients had used aminorex while being only mildly overweight (110% of ideal body weight). While the normal incidence of PPH is about 1.2 cases per one million population/year, the risk of developing PPH for non-overweight users of dexfenfluramine has been estimated at 28 per million/year, and that for overweight users at 55 per million/year. This implies that obesity might be a co-factor for the development of PPH, but there is much controversy as to whether obesity is independently related to PPH. The IPPHS data indicate that about 36% of the 95 patients with PPH had a body mass index of ≥30 compared with only 18.3% in the control group (the controls having been matched with the cases for age and sex only). The difference is probably explained by obese women being more likely to use anorexigens and the authors concluded that the effect of anorexigen intake on PPH “was the same whether patients had a high body mass index or not.” However, obese patients are not infrequently depressed and they may also be hypoxaemic; it is not known to what extent obesity, depression and hypoxaemia contribute to the development of PPH. It should also be appreciated that many patients are looking for a pharmacological solution to their obesity problem. In the USA dieting and weight management are a multibillion dollar industry. Hundreds of new diet pill clinics have opened during the last year. Presently we have no good understanding of the relationship between body weight and pulmonary hypertension – apart from the well known association of the obesity/hypertension/poly-cystyana syndrome and pulmonary hypertension.

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