Pulmonary hypertension has been identified as one of the well known life threatening complications of connective tissue diseases. In patients with connective tissue diseases pulmonary hypertension occurs with little or no evidence of parenchymal lung disease. As in primary pulmonary hypertension, the pathophysiology is unknown but the clinical course and pathological findings are similar. Scleroderma, particularly in its CREST variant (calcinosis, Raynaud’s phenomenon, oesophageal dysmotility, sclerodactyly, telangiectasias), represents the main connective tissue disease associated with pulmonary hypertension. Prevalence varies from 2.3% to 35% in scleroderma1–3 and may reach 50% in the CREST variant.4 Pulmonary hypertension occurs in 23–53% of patients with mixed connective tissue diseases,4,6 in 0.5–14% of cases of systemic lupus erythematosus,7–10 and much more rarely in those with rheumatoid arthritis, Sjögren’s syndrome, and dermatomyositis. Connective tissue diseases represented around 10% of the 601 cases of pulmonary hypertension referred to our department from 1981 to 1998. Prognosis is very poor and no curative treatment is available. Stupi et al4 reported a two year survival rate of 40% in patients with CREST syndrome and pulmonary hypertension compared with 88% in patients with CREST syndrome without pulmonary hypertension. There are no consensus guidelines for the treatment of pulmonary hypertension secondary to connective tissue diseases. Treatment recommendations, modelled on those of primary pulmonary hypertension, enable us to propose a specific treatment for these patients who were once considered untreatable. Because of the specificity of pulmonary hypertension evaluation and monitoring it is necessary to refer these patients to a centre with expertise in the management of pulmonary vascular diseases. Indeed, the risk of sudden death exists in these patients and the treatment itself can be dangerous, particularly the high doses of calcium channel blockers which may precipitate heart failure because of their negative inotropic properties.

General measures
Patients displaying pulmonary hypertension have a restricted pulmonary circulation. Any increase in cardiac output can precipitate worsening of the pulmonary hypertension and right heart failure. Furthermore, the addition of hypoxic pulmonary hypertension will increase pulmonary artery pressures and therefore the load on the right heart. In this patient population exercise should be restricted and guided by symptoms. High altitude should be avoided because of hypoxic vasoconstriction. Warm baths should be taken carefully because the induced cutaneous vasodilation may dramatically decrease cardiac output. Pregnancy is contraindicated because haemodynamic physiological changes may precipitate the patient to fatal right sided heart failure.11,12 Contraception is therefore always recommended in women of childbearing age (usually mechanical or progestative contraception). Lastly, surgical procedures including open lung biopsies should be avoided as much as possible.

Specific measures
ANTICOAGULANT THERAPY
The rationale for anticoagulant therapy in the conventional medical treatment for primary pulmonary hypertension is based on the observation, reported in large pathological series,13–14 of pulmonary arteriopathy with thrombotic lesions defined by the presence of eccentric intimal fibrosis and recanalised thrombi. Moreover, in patients with primary pulmonary hypertension who die suddenly, fresh intrapulmonary clots may be found at necropsy. One retrospective study15 found that survival was significantly improved in patients treated with anticoagulants.

Despite the lack of a randomised prospective long term trial analysing the efficacy of anticoagulation in pulmonary hypertension secondary to connective tissue diseases, anticoagulant therapy is recommended for several reasons. Firstly, pathological findings available in patients with connective tissue diseases have reported the same microthrombotic lesions.17–20 Secondly, these patients are at a high risk for thromboembolic events due to their sedentary life style, venous insufficiency, dilated right sided heart chambers, and low cardiac output which also promotes in situ thrombosis into the pulmonary vascular bed. Thirdly, antiphospholipid antibodies, which are often present in patients with systemic lupus erythematosus, are a well known risk factor for thrombosis.21 Warfarin is the most widely used drug in sufficient doses to increase the international normalised ratio (INR) to around 2.0. Some authors recommend an INR of about 3.0 in the presence of antiphospholipid antibodies.22 In some cases curative doses of low molecular weight heparin or unfractionated heparin can be used.
**Table 1** Immunosuppressive therapy in patients with pulmonary hypertension secondary to connective tissue diseases (selected literature)

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Sex</th>
<th>Age</th>
<th>CTD</th>
<th>PAP s/d/m</th>
<th>CI/CO</th>
<th>Immunosuppressive therapy</th>
<th>Vasodilator therapy</th>
<th>Outcome</th>
<th>Last PAP s/d/m</th>
<th>Last CI/CO</th>
<th>Remarks</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>22</td>
<td>SLE</td>
<td>94/41/57</td>
<td>2,2/3</td>
<td>500 mg pulse methylprednisolone for 3 days; prednisone 0.5 mg/kg; 20 mg cyclophosphamide courses (750 mg) over a period of 32 months</td>
<td>Prasosin 5 mg/day over a period of 55 months</td>
<td>Improvement</td>
<td>54/18/32</td>
<td>3,8/</td>
<td>Treatment with vasodilator alone was ineffective</td>
<td>25</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>27</td>
<td>SLE</td>
<td>78/76/56</td>
<td>ND</td>
<td>Plasma exchange + 500 mg pulse prednisone for 3 days; 20 mg dexamethasone + 20 mg methotrexate iv every week for 4 weeks; cyclosporin A 5 mg/kg/day + fluocortolone 100 mg/week for 4 weeks</td>
<td>None</td>
<td>Improvement</td>
<td>42/–/</td>
<td>ND</td>
<td>Negative acute</td>
<td>26</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>31</td>
<td>SLE</td>
<td>67/59/42</td>
<td>ND</td>
<td>20 mg dexamethasone iv + 20 mg methotrexate iv once a week + cyclosporin A 5 mg/kg/day for 2 months</td>
<td>None</td>
<td>Improvement</td>
<td>42/–/</td>
<td>ND</td>
<td>Negative acute</td>
<td>26</td>
</tr>
<tr>
<td>4</td>
<td>F</td>
<td>20</td>
<td>MCTD</td>
<td>–/–/58</td>
<td>ND</td>
<td>Sequential administration of methylprednisolone + cyclosporine + cyclophosphamide</td>
<td>None</td>
<td>Improvement</td>
<td>–/–/41</td>
<td>ND</td>
<td>10 years of follow up</td>
<td>27</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>33</td>
<td>SLE</td>
<td>88/34/52</td>
<td>1,8/3</td>
<td>Cyclophosphamide infusions 0.5 mg/m² monthly for 6 months followed by once/3 months in combination with 7.5 mg/day prednisolone</td>
<td>None</td>
<td>Improvement</td>
<td>66/34/46</td>
<td>3/</td>
<td>Negative acute vasodilator testing; last PAPs 67 mm Hg after 2 years</td>
<td>28</td>
</tr>
<tr>
<td>6</td>
<td>F</td>
<td>29</td>
<td>SLE</td>
<td>115/40/65</td>
<td>3,8/4</td>
<td>500 mg pulse methylprednisolone for 3 days; prednisolone 80 mg/day</td>
<td>Diltiazem 180 mg/day</td>
<td>Improvement</td>
<td>65/32/50</td>
<td>4,6/</td>
<td>Last PAPs 35 mm Hg after 18 months</td>
<td>29</td>
</tr>
<tr>
<td>7</td>
<td>F</td>
<td>49</td>
<td>PSjö</td>
<td>100/36/60</td>
<td>ND</td>
<td>Methylprednisolone 4 mg/day, azathioprine 100 mg/day</td>
<td>Nifedipine and enalapril</td>
<td>Improvement</td>
<td>55/18/32</td>
<td>ND</td>
<td>Vasodilators were ineffective; two years of follow up</td>
<td>30</td>
</tr>
<tr>
<td>8</td>
<td>F</td>
<td>28</td>
<td>SLE</td>
<td>74/40/52</td>
<td>3,4/3</td>
<td>Prednisone 60 mg/day</td>
<td>None</td>
<td>Aggravation</td>
<td>78/40/56</td>
<td>2,5/–</td>
<td>Negative acute vasodilator testing</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>F</td>
<td>29</td>
<td>SLE</td>
<td>70/38/47</td>
<td>2,4/3</td>
<td>Prednisone 80 mg/day</td>
<td>None</td>
<td>Stabilisation</td>
<td>63/37/43</td>
<td>2,5/–</td>
<td>Negative acute vasodilator testing</td>
<td>8</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>23</td>
<td>SLE</td>
<td>70/34/50</td>
<td>ND</td>
<td>Prednisone 60 mg/day</td>
<td>None</td>
<td>Aggravation</td>
<td>ND</td>
<td>ND</td>
<td>Negative acute</td>
<td>8</td>
</tr>
<tr>
<td>11</td>
<td>F</td>
<td>36</td>
<td>SLE</td>
<td>58/35/40</td>
<td>1,1/3</td>
<td>Prednisone 60 mg/day</td>
<td>None</td>
<td>Death</td>
<td>ND</td>
<td>ND</td>
<td>Negative acute</td>
<td>8</td>
</tr>
</tbody>
</table>

CTD = connective tissue disease; SLE = systemic lupus erythematosus; MCTD = mixed connective tissue disease; PSjö = primary Sjögren’s syndrome; PAP s/d/m = pulmonary arterial pressure systolic/diastolic/mean (mm Hg); CI = cardiac index (l/min/m²); CO = cardiac output (l/min).

**IMMUNOSUPPRESSIVE THERAPY**

The pathogenesis of pulmonary hypertension secondary to connective tissue diseases is unknown but several authors have hypothesised that immunological disturbances promote the development of pulmonary arteriopathy in these patients. Quismorio et al have reported the presence of antinuclear antibody and rheumatoid factor in the walls of the pulmonary blood vessels in two patients with pulmonary hypertension secondary to systemic lupus erythematosus. Other studies have reported IgG and complement fraction deposits in the vascular endothelium of patients with pulmonary hypertension secondary to connective tissue diseases. Interestingly, such immune deposits are similar to those observed in renal glomeruli. However, disseminated immune deposits have also been found in the lungs of patients with systemic lupus erythematosus unaffected by pulmonary hypertension.

Some publications have reported a dramatic improvement in patients with pulmonary hypertension secondary to connective tissue diseases following immunosuppressive therapy (table 1). The analysis of the available literature comes up against several difficulties. Firstly, most of the papers are case reports and unpublished negative data are presumably more common. Secondly, it is difficult to evaluate the effects of immunosuppressive therapy alone because of the frequent use of oral vasodilator therapy. Thirdly, immunosuppressive protocols vary from one study to another and comparison is therefore difficult. Lastly, there are no placebo controlled studies of immunosuppressive therapy in patients with pulmonary hypertension secondary to connective tissue diseases. It is therefore difficult to provide guidelines on immunosuppressive therapy in the management of pulmonary hypertension secondary to connective tissue diseases. However, the current literature shows that systemic sclerosis is less responsive to immunosuppressants than systemic lupus erythematosus. Corticosteroids associated with immunosuppressants such as cyclophosphamide in bolus infusion seem to be the most effective treatment to date. Strict clinical and/or haemodynamic criteria are necessary to evaluate the efficacy of such treatments. In the absence of clear clinical and/or haemodynamic improvement after a few weeks or months the treatment should be...
stopped because of possible life threatening adverse events (mainly infections).

**VASODILATOR THERAPY**

Pulmonary vasoconstriction is believed to be an important component of the pathogenesis of pulmonary hypertension. This is based on histopathological studies reporting medial hypertrophy of muscular pulmonary arteries in primary pulmonary hypertension as well as in pulmonary hypertension secondary to connective tissue diseases. Raynaud’s phenomenon is present in 83% of patients with connective tissue diseases with pulmonary hypertension secondary to connective tissue diseases and in 10–14% of patients with primary pulmonary hypertension. These findings suggest an underlying vasospastic predisposition of pulmonary vessels, the so-called Raynaud’s phenomenon of the lung.

The goal of vasodilator therapy is to reduce pulmonary arterial pressure, increase cardiac output, and thus decrease pulmonary vascular resistance without symptomatic systemic hypertension. Unfortunately no clinical, demographic, or haemodynamic variables can predict significant vasoreactivity in patients with pulmonary hypertension. Moreover, systematic administration of oral vasodilators in all patients with pulmonary hypertension can induce severe adverse events in non-responders. For these reasons it is important to test pulmonary vasoreactivity in all patients during initial right heart catheterisation in pulmonary vascular units where there is expertise in this form of testing and treatment with a potent, short acting, and titratable vasodilator such as intravenous epoprostenol (prostacyclin), adenosine, or inhaled nitric oxide (NO). NO has the advantage of being the most selective agent for the pulmonary vascular bed; moreover, it induces a comparable individual pulmonary vasodilation to that achieved with epoprostenol. Responders are usually defined by having a significant fall in both mean pulmonary arterial pressure and total pulmonary resistance of at least 20% during acute vasodilator testing. They should be treated with an oral vasodilator such as calcium channel blockers. In primary pulmonary hypertension a few patients (about 20%) are responders. Few data are available in patients with pulmonary hypertension secondary to connective tissue diseases. Williamson et al reported that five out of seven patients with systemic sclerosis and pulmonary hypertension had a decrease in total pulmonary resistance of at least 20% during acute NO testing, but only one had a decrease in both mean pulmonary arterial pressure and total pulmonary resistance. In our experience 15 out of 57 patients with pulmonary hypertension secondary to connective tissue diseases had a significant fall in total pulmonary resistance, but only four had a combined fall (>20%) in both mean pulmonary arterial pressure and total pulmonary resistance. This proportion seems to be even smaller than that observed in primary pulmonary hypertension.

**Oral vasodilators**

As indicated above, oral vasodilators should be given to patients who respond acutely to NO or epoprostenol. Of all the vasodilators tested, calcium channel blockers are the most efficient drugs for long term treatment. Nifedipine and diltiazem are widely used drugs in primary pulmonary hypertension. Rich et al reported prolonged survival in patients with primary pulmonary hypertension who were responsive to acute vasodilator testing and were treated with calcium channel blockers compared with those who were unresponsive. Several studies have also reported an acute and a long term improvement with calcium channel blockers in patients with pulmonary hypertension secondary to connective tissue diseases. Verapamil is not recommended because of its negative inotropic effects. The choice between nifedipine and diltiazem depends on the heart rate at rest; in our institution diltiazem is given to patients with a heart rate of >80 beats/min. High doses of calcium channel blockers (nifedipine 90–180 mg/day and diltiazem 360–720 mg/day) are often necessary in this indication. Adverse effects such as systemic hypotension or lower limb oedema may occur.

Angiotensin converting enzyme inhibitors have also been studied in patients with pulmonary hypertension secondary to connective tissue diseases with various results. Niarchos et al reported an acute decrease by 26% of total pulmonary resistance but without any change in mean pulmonary arterial pressure in four out of six patients with pulmonary hypertension secondary to connective tissue diseases. Alpert et al showed an acute and sustained reduction in both mean pulmonary arterial pressure and total pulmonary resistance in eight patients with pulmonary hypertension secondary to connective tissue diseases.

**Epoprostenol (prostacyclin)**

Epoprostenol (prostaglandin I₂, prostacyclin) is a potent vasodilator and inhibitor of platelet aggregation produced by the vascular endothelium. It reduces pulmonary vascular resistance and increases cardiac output and oxygen delivery when administered acutely to some patients with primary pulmonary hypertension. Moreover, continuous intravenous epoprostenol produces substantial and sustained haemodynamic and symptomatic responses as well as improving survival in patients with severe primary pulmonary hypertension refractory to conventional medical treatment including oral calcium channel blockers. Few data are available in pulmonary hypertension secondary to connective tissue diseases. De La Matta et al have studied the effects of iloprost, a stable prostacyclin analogue, in three patients with severe pulmonary hypertension secondary to systemic sclerosis who did not respond to oral vasodilators. They showed an improvement in New York Heart Association (NYHA) functional class and exercise tolerance in all patients which contrasted with the modest haemodynamic
benefit. We have recently reported our experience in 17 patients with connective tissue diseases who developed severe pulmonary hypertension despite immunosuppressive therapy and were unresponsive to oral vasodilator therapy. All patients received epoprostenol administered by portable infusion pump. During the first six weeks of the study two patients died of pulmonary oedema (n = 1) and severe sepsis (n = 1). In the 15 remaining subjects the NYHA functional class, exercise capacity, and all haemodynamic parameters improved significantly. These patients were then monitored for a mean (SD) of 80 (48) weeks (range14–154) after initiation of epoprostenol. Five patients died of right heart failure (n = 2), syncope (n = 1), or severe sepsis (n = 2) and two patients were successfully transplanted. Seven of the remaining eight patients had persistent clinical and haemodynamic improvement. These results indicate that short term continuous intravenous epoprostenol together with conventional therapy is effective in most patients with severe pulmonary hypertension secondary to connective tissue diseases who fail to respond to oral calcium channel blockers. However, further studies are needed to evaluate the efficacy of long term epoprostenol therapy in pulmonary hypertension secondary to connective tissue diseases.

Other intravenous vasodilators Ketanserin, a selective antagonist of S2-serotonergic receptors, has been tested acutely in patients with pulmonary hypertension secondary to systemic sclerosis with a modest vasodilator effect in a few patients.

Transplantation Heart-lung, single, and double lung transplantations have been performed successfully in patients with primary pulmonary hypertension. Patients with connective tissue diseases have been often excluded from transplantation because of previous immunosuppressive therapy and possible involvement of other organs such as the kidneys or liver with the underlying disease. Nonetheless, Levy et al reported prolonged survival after heart-lung transplantation in patients with pulmonary hypertension secondary to connective tissue diseases. In our centre three patients, two with a CREST syndrome and one with systemic lupus erythematosus, have been successfully transplanted.

Minor measures

OXYGEN THERAPY

Moderate hypoxia is a common finding at rest in pulmonary hypertension secondary to connective tissue diseases. It is the consequence of one or more of the following mechanisms: (1) impaired cardiac output resulting in low mixed venous pulmonary saturation (SVO2), (2) right-to-left shunting through a patent foramen ovale, (3) alveolar hypoxia in cases of parenchymal lung disease which may in turn worsen pulmonary hypertension by hypoxic vasoconstriction. One study reported a beneficial haemodynamic effect of an acute administration of oxygen in patients with pulmonary hypertension associated with systemic sclerosis.

DIURETICS

Diuretics are used to reduce intravascular volume and hepatic congestion which occur in patients with right sided heart failure. However, hypovolaemia induced by excessive diuresis can provoke a fall in cardiac output due to a decreased right ventricle preload and careful monitoring is required to prevent it. Furosemide and/or spironolactone may be prescribed and the dose increased as needed.

DIGITALIS COMPOUNDS

Some authors prescribe digitalis compounds in association with diuretics. These agents are less efficient than specific therapies such as vasodilators. Furthermore, toxicity to digitalis may be enhanced if hypoxaemia and diuretic induced hypokalaemia are also present.

Conclusion

In the absence of major trials in pulmonary hypertension secondary to connective tissue diseases, treatment should be conducted in the same way as for primary pulmonary hypertension. The only difference is that immunosuppressive therapy may be effective in a few patients with pulmonary hypertension secondary to connective tissue diseases (mainly pulmonary hypertension related to systemic lupus erythematosus). Conventional therapy includes general measures, supplemental oxygen, diuretics, anticoagulants and, in some institutions, digitalis compounds. Oral vasodilators such as calcium channel blockers should only be given to patients with an acute vasodilator response revealed during right heart catheterisation. The use of continuous epoprostenol treatment is currently being evaluated in this indication. The results of a large multicentre study in the USA will be published shortly and should confirm our preliminary results. However, the efficacy of long term epoprostenol infusion on survival has to be evaluated in this patient population. Lastly, lung and heart-lung transplantation can be indicated in some patients with severe pulmonary hypertension secondary to connective tissue diseases.

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Treatment of pulmonary hypertension secondary to connective tissue diseases


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