LETTER TO THE EDITOR

Monitoring treatment response in precapillary pulmonary hypertension using non-invasive haemodynamic measurements

Lee et al should be commended for showing that non-invasive haemodynamic monitoring using inert gas rebreathing (IGR) might be a valuable tool to detect treatment response in patients with precapillary pulmonary hypertension (PH). Even under resting conditions, haemodynamic parameters may be more sensitive than the 6-minute walk distance. This is especially interesting as it may facilitate frequent therapy monitoring. Although pulmonary blood flow (PBF) equals cardiac output (CO) in the absence of relevant intrapulmonary shunting, it should be noted that a reliable shunt correction algorithm based on the haemoglobin value has already been implemented in the IGR device. Since using solely PBF significantly increased the measurement bias as compared with the non-invasive gold standard of cardiac MRI, shunt correction should always be applied. A fixed haemoglobin concentration of 14.0 g/dl can be used, if the exact value is not known. This seems to be especially important as pulmonary shunting might be altered in PH. In serial measurements, therapeutic effects and changes in CO may also be due to shunting. This may remain undetected when solely measuring PBF. In analogy to the 6-minute walk distance, IGR measurements require active collaboration, which may limit their application in patients with advanced disease, high WHO functional class or lack of motivation. In these cases, other techniques of measuring CO such as impedance cardiography or continuous-wave Doppler may become potentially valuable, although they are not sufficiently applicable under exercise conditions. There is a rather large variation when compared with IGR or cardiac MRI; however, the reproducibility is high, which is of tremendous importance in serial measurements. Although the overall PBF values in the study at hand were between 3.1 and 6.5 l/min, we would like to mention that there is a significantly worse agreement for IGR in large heterogeneous patient collectives at extreme CO states represented by values between 2–4 and 6.4–9.6 l/min, respectively. However, this seems to be negligible considering the aims of the study as the reproducibility is not affected. We agree that based on the very promising findings of Lee et al, non-invasive haemodynamic measurements in PH justify further studies to improve and monitor specific therapy. IGR seems to be perfectly suitable for measurements during exercise as it is the only non-invasive device to be used under these conditions.

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