Covid-19 PH contingency management

1. Minimal necessary patient contact
   1. Telephone mainly
   2. Encourage patients to access BP & saturation monitors, weighing scales, thermometer etc
   3. Video where possible to assess JVP; AO, colour, resp rate
2. Access to available investigations
   1. IEP radiology
   2. ImageExchange echo
   3. Reports for blood Ix, available PFT, cath data; copy of recent ECG
3. Best Guess management
   1. Document PAH risk profile (HIV; Autoimmune symptomatology; 3 gen FHx; slimming/recreational drug exposure; chemotherapy exposure; Liver disease)
   2. Document HFpEF Risk: AFib; BP; DM; BMI; CAD; CKD
   3. Document lung disease risk: Pack year; ‘asthma’ formal Dx/duration; known lung disease; cough history; sleep apnea; clinical COPD history (3/12 sputum production/yr)
   4. Document thromboembolic risk: DVT; PE; FHx TE or clotting abnormality; Miscarriage; known APS; VA shunts; indwelling line Hx; splenectomy
   5. Document group 5 conditions: Sarcoid; Haemolytic disorders; CKD
4. Scoring:
   1. Probable PAH = Precapillary PH: TV > 3.4; septal flattening; LA/LV normal; EE’ < 8 + no features to suggest other group, with normal CT or near normal PFT available. Treat – document need for catheter/VQ scan later
   2. Probable CTEPH = Dilated right heart on CT (or precapillary echo) with evidence of CTED after 3 months of anticoagulation. Treat document need for full work up later.
   3. PAH more likely than not: Precapillary PH pattern echo; age < 50 with no co-morbidity and resting saturations >90% but no CT/PFT available. Treat document need for full Ix later
   4. PAH v PH equipoise: Precapillary pattern with minor CT abnormalities; FVC 60 -70%; FEV1 < 60% or TLCO < 50%; sat < 90%, more than 1 left heart risk factor; SSc. Where no CT/PFT if no comorbidity on history and aged 50 – 65. Cautious treatment – PDE5, assess response after 2-4 weeks, if good clinical response consider ERA. Document need for full Ix later
   5. PAH unlikely: LA enlarged; LVEF < 50%; EE’ > 14; > Mild CT abnormalities (emphysema/ILD etc); Abnormal PFT (FVC < 60%; FEV1 < 50%, TLCO < 30%); Age > 65 with co-morbidity from group 2, 3 or 5. Do not treat with PAH therapies. Log for reconsideration of Dx post crisis.
   6. PVOD/PCH – CT suggestive of PVOD/PCH should be considered separately from above – diuretics with consideration of cautious use of PDE5 inhibitors