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Reply to the Letter to the Editor: "From Measuring Treatment Burden to Acting on Patient-Reported Outcomes"

Editöre Mektup Yanıtı: "Tedavi Yükünün Ölçülmesinden Hasta Tarafından Bildirilen Sonuçlara Göre Harekete Geçmeye"

LETTER TO THE EDITOR REPLY
EDİTÖRE MEKTUP YANITI

To the Editor,

We thank the authors for their thoughtful and constructive comments on our article entitled "Quality of Life Outcomes in Patients with Pulmonary Hypertension Receiving Prostacyclin Therapy: Impact of Anxiety, Depression, Sociodemographic Characteristics, and Treatment-Related Factors" and for the opportunity to respond to the points raised in the Letter to the Editor.[1]

A high EmPHasis-10 score reflects poor quality of life, whereas a low score reflects good quality of life. However, no specific EmPHasis-10 threshold has been defined for reassessing a patient's ability to tolerate treatment. Given the cross-sectional design of our study and the absence of quality-of-life data before prostacyclin therapy, the magnitude of change in the EmPHasis-10 score that would warrant such reassessment cannot be determined from our current data. Therefore, we believe that the EmPHasis-10 score, or any change in it, should not be considered a standalone threshold and that the results should be evaluated alongside the patient's symptom burden, clinical status, psychological status, and treatment-related adverse effects.

In our study, prostacyclin-related vomiting was independently associated with higher EmPHasis-10 scores (B=7.559; 95% CI: 3.675–11.443; P<0.001).[2] However, because the frequency and severity of treatment-related adverse effects were not systematically assessed in our study, this finding alone is insufficient to conclude that vomiting should prompt intensified supportive management, dose adjustment, modification of titration, or reconsideration of the treatment route. Our findings support the importance of routinely assessing gastrointestinal adverse effects, such as vomiting, and individualizing their management according to the type and severity of symptoms and the patient's overall clinical status.

In our study, symptoms of anxiety were identified in 58.6% of patients and symptoms of depression in 29.3%; both anxiety and depression were significantly associated with higher EmPHasis-10 scores.[2] These findings support the importance of considering psychological status as part of the assessment of patients with PH. However, psychological or psychiatric interventions that could be implemented following the assessment of anxiety and depression symptoms were not evaluated in this study. In this context, taking into account patients' individual needs and symptom severity, psychosocial support approaches, such as peer-support sessions, may also be considered alongside professional psychological or psychiatric support.

This assessment is also important in the context of the findings of our study. In our multivariate analysis, age, symptom burden, anxiety, depression, and prostacyclin therapy-related vomiting were independently associated with higher EmPHasis-10 scores, and together, these variables explained 80.5% of the variance in EmPHasis-10 scores.[2] These findings suggest that high EmPHasis-10 scores should not be attributed to a single cause and that multiple factors, such as symptom burden, psychological status, and treatment-related adverse effects, should be considered together when assessing quality of life.

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In our study, EmPHasis-10 scores were significantly associated with symptom burden, anxiety, depression, oxygen saturation, and six-minute walk distance.[2] However, no direct comparison was made between EmPHasis-10 and categorical risk-stratification tools. Therefore, we believe that future prospective studies should evaluate whether these observed associations persist when categorical risk-stratification approaches are used.

This consideration is important in terms of the potential role of patient-reported outcomes in clinical follow-up. As our study was cross-sectional, changes in EmPHasis-10 scores over time and whether repeated assessments could identify clinical deterioration earlier could not be evaluated. We believe that future longitudinal studies would be valuable for determining the relationship between changes in patient-reported outcomes and clinical status, treatment tolerability, and treatment persistence. In this process, regular monitoring of patients' symptoms and treatment-related adverse effects by healthcare professionals may contribute to the integration of patient-reported outcomes with clinical assessment.

References

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