



National Scleroderma Foundation

Dear Friend,

Thank you for your recent inquiry about scleroderma. Our goal is to provide the most up-to date information available. In addition to providing resources designed to give you a better understanding of scleroderma, we also strive to provide strategies for coping challenges scleroderma causes. As you begin to learn more about scleroderma, it is important to know that its symptoms and the severity of the disease vary greatly from person to person.

Become a Member

You don't have to face scleroderma alone! Becoming a member of the Scleroderma Foundation connects you to a nation-wide family dedicated to supporting those affected by this disease.

Together, we are working to find a cure. Membership also ensures that you receive our quarterly magazine, the Scleroderma Voice, which contains current and information important to the scleroderma community. In addition, the magazine frequently features news about support groups, patient education programs, physician referrals, peer counseling and much more. Please take a moment to fill out and return the enclosed membership form. Don't miss out on the benefits of membership!

What's Happening in Your Local Area?

The Scleroderma Foundation has a nation-wide network of chapters and support groups that offers numerous opportunities that may be of interest to you. Throughout the country, our chapters and support groups provide educational programs to learn more about the disease; networking opportunities with others affected by scleroderma; events to raise awareness about scleroderma; and ways to raise money to fund some of the most promising scleroderma-related research. You'll find a list of chapters and support groups enclosed. If you live in an area served by a chapter or support group, we urge you to contact them to learn what's happening in your community.

We are Here for You

We hope that you'll join us in supporting those living with this disease. Whether membership is or isn't your thing, donating to the Scleroderma Foundation contributes to the search for a cure. We encourage you to contact the national office or any of our chapters if we can be of assistance. Much more about the Scleroderma Foundation and the disease can be found at www.scleroderma.org. We believe that you'll find it a valuable resource.

The Scleroderma Foundation is a national support system dedicated to helping each other— and working toward the day when a cure is found. Please join us!

Sincerely yours,

Mary J. Wheatley, IOM, CAE
Chief Executive Officer



300 Rosewood Drive, Suite 105
Danvers, MA 01923



scleroderma.org
sfinfo@scleroderma.org



(800) 722-4673



National Scleroderma Foundation

Scleroderma Facts

- Scleroderma is a rare disease that affects connective tissue and the vascular system by producing excessive collagen.
- The disease causes fibrosis in the skin (*localized scleroderma*) or internal organs (*systemic sclerosis*). The result can be disfigurement or disability, and it can be life-threatening.
- No one knows what causes scleroderma and there is no cure.
- Symptoms may include sensitivity to cold in extremities, thickening of the skin, shortness of breath, difficulty swallowing, joint stiffness and pain, and damage to internal organs.
- Scleroderma is considered part of the family of autoimmune disease that affect more than 50 million Americans and are the third leading cause of death in the United States.
- It's estimated that there are 300,000 cases of scleroderma in the United States.
- Women make up 80 percent of scleroderma cases, but men, young children and teens also get scleroderma.
- Scleroderma typically strikes between the ages of 25 and 55.
- In 95 percent of cases, scleroderma begins with Raynaud Phenomenon (hands and feet abnormally sensitive to cold).
- Federal funding for scleroderma research lags behind funding for other diseases of similar prevalence.
- Misdiagnosis is common. It can take three years or more for an individual to be diagnosed and to receive appropriate treatment.
- Medical professionals often lack familiarity with scleroderma and might not recognize that symptoms are directly associated with the disease.



Connections



National
Scleroderma
Foundation

Chapter Listing

Delaware Valley

*Delaware, Eastern Pennsylvania,
Southern New Jersey*
(866) 675-5545
scleroderma.org/delawarevalley
DVchapter@scleroderma.org

Georgia

(770) 925-7037
scleroderma.org/georgia
GChapter@scleroderma.org

Greater Chicago

Illinois, Indiana, Wisconsin
(312) 660-1131
scleroderma.org/chicago
GCchapter@scleroderma.org

Greater Washington, D.C.

*District of Columbia, Maryland,
Virginia*
(703) 282-3016
scleroderma.org/dc
DCchapter@scleroderma.org

Heartland

Iowa, Nebraska, South Dakota
(515) 661-8089
scleroderma.org/heartland
HeartlandChapter@scleroderma.org

Michigan

(248) 595-8526
scleroderma.org/michigan
MIchapter@scleroderma.org

Minnesota

(877) 794-0347
scleroderma.org/minnesota
MNChapter@scleroderma.org

Missouri

(636) 527-3599
scleroderma.org/missouri
MOchapter@scleroderma.org

New England

*Maine, Massachusetts, New
Hampshire, Rhode Island, Vermont
and parts of Connecticut*
(978) 887-0658
scleroderma.org/newengland
admin@sfnewengland.org

Northwest

Washington State & Idaho
(800) 722-4673
scleroderma.org/washington
Northwest@scleroderma.org

Ohio

(866) 849-9030
scleroderma.org/ohio
OHchapter@scleroderma.org

Oklahoma

(800) 722-4673
scleroderma.org/oklahoma
SFinfo@scleroderma.org

Oregon

(503) 245-4588
scleroderma.org/oregon
ORchapter@scleroderma.org

Rocky Mountain

Colorado
(303) 806-6686
scleroderma.org/rockymountain
RMchapter@scleroderma.org

South Carolina

(864) 617-0237
scleroderma.org/southcarolina
SCchapter@scleroderma.org

Southeast Florida

*Miami-Dade, Broward and Palm
Beach Counties*
(954) 798-1854
scleroderma.org/sefl
SEFLchapter@scleroderma.org

Southern California

*Santa Barbara to borders of Mexico
and Arizona*
(424) 227-6475
scleroderma.org/socal
SOCALchapter@scleroderma.org

Texas Bluebonnet

(866) 532-7673
scleroderma.org/texas
TXchapter@scleroderma.org

Tri-State

*New York, Connecticut, Northern
New Jersey*
(800) 867-0885
scleroderma.org/tristate
Tri-State@scleroderma.org



Scleroderma Overview and Causes

Introduction

Scleroderma is an autoimmune disease which means that it is a condition in which the body's immune system attacks its own tissues. The normal role of the immune system is to provide protection from outside invaders such as bacteria and viruses. In autoimmune disorders, this ability to distinguish foreign from self is compromised. As immune cells attack the body's own tissue, inflammation and damage result. Scleroderma (the name means "hard skin") can vary a great deal in terms of severity. For some, it is a mild condition; for others it can be life-threatening. Although there are medications to slow down disease progression and help with symptoms, right now there is no cure for scleroderma.

TYPES OF SCLERODERMA

There are two main forms of scleroderma: systemic (systemic sclerosis, SSc) that usually affects the internal organs or internal systems of the body as well as the skin, and localized that affects a local area of skin either in patches (morphea) or in a line down an arm or leg (linear scleroderma), or as a line down the forehead (scleroderma en coup de sabre). It is very unusual for localized scleroderma to develop into the systemic form.

SYSTEMIC SCLEROSIS (SSc)

To make matters more confusing, there are two major types of systemic sclerosis or SSc: limited cutaneous SSc and diffuse cutaneous SSc. The difference between limited cutaneous and diffuse cutaneous SSc is the extent of skin involvement. In limited SSc, skin thickening only involves the hands and forearms, lower legs and feet. In diffuse cutaneous disease, the hands, forearms,

upper arms, thighs, or trunk are affected. The face can be affected in both forms. The importance of making the distinction between limited and diffuse disease is that the extent of skin involvement tends to reflect the degree of internal organ involvement.

Systemic Sclerosis sine (without) skin thickening refers to the unusual occurrence (only about 5% of all cases) in which there is evidence of internal organ complications of SSc but no skin thickening.

Several clinical features occur in both limited and diffuse cutaneous SSc. Raynaud phenomenon, for example, occurs in both. Raynaud phenomenon is a condition in which the fingers turn pale or blue upon cold exposure, and then become ruddy or red upon warming up usually associated with a numb or tingling sensation in the fingers. These episodes are caused by a spasm of the small blood vessels in the fingers. As time goes on, these small blood vessels become damaged to the point that they may become totally blocked. This can lead to ulcerations of the fingertips. Raynaud phenomenon occurs in almost all (95%) SSc patients with either limited or diffuse disease, and painful finger ulcers can also be seen in both forms.

The esophagus is also affected in almost all SSc patients with loss of the usual movement. As a result, food can "hang up" in the esophagus, and stomach acid can reflux back up into the esophagus, causing heartburn.

Telangiectasias are small red spots that appear on the hands, arms, face, and/or trunk. These are tiny blood vessels in the skin that have widened. They are usually not dangerous in themselves, but are cosmetically unpleasing, particularly

if they occur on the face. Some people have telangiectasias in the esophagus, stomach, and bowel that can be a source of bleeding.

People with the diffuse form of SSc are at a greater risk of developing pulmonary fibrosis (scar tissue in the lungs that interferes with breathing, also called interstitial lung disease), kidney disease, and bowel disease.

All patients with SSc should have periodic pulmonary function tests to monitor for the development of pulmonary fibrosis. Symptoms of pulmonary disease include a dry cough and shortness of breath. However, in the early stages there may not be any symptoms at all.

Kidney involvement occurs more frequently in the diffuse than in the limited form of SSc, especially in the first five years after disease onset, and typically takes the form of a sudden increase in blood pressure. As is the case with usual high blood pressure, there are no symptoms at first. However, if undetected and untreated, this high blood pressure can damage the kidneys in a matter of weeks, which is why it is called scleroderma renal crisis. The key to management and prevention of permanent kidney damage is early detection and treatment of high blood pressure with a class of medications called ACE inhibitors.

The risk of extensive gut involvement, with slowing of the movement or motility of the stomach and bowel, is higher in those with diffuse rather than limited SSc. Symptoms include feeling bloated after eating, diarrhea, or alternating diarrhea and constipation.

Calcinosis refers to the presence of calcium deposits in, or just under, the skin. This takes the form of firm nodules or lumps that tend to occur on the fingers or forearms, but can occur anywhere on the body. These calcium deposits can sometimes break out to the skin surface and drain whitish material (described as having the consistency of toothpaste).

Pulmonary hypertension (PH) is high blood pressure in the blood vessels of the lungs. It is totally independent of the usual blood pressure that is taken in the arm. This tends to develop in patients with limited SSc after several years of disease. The most common symptom is shortness of breath on exertion. However,

several tests need to be done to determine if PH is the real culprit. If the ultrasound of the heart, called an echocardiogram, is abnormal, then a right heart catheterization should be done to actually measure the pressure in the lung blood vessel (pulmonary artery) and to test for other abnormalities that can cause PH. Because there are now many medications to treat PH, the earlier it is detected and treated, the better the result will be.

LOCALIZED SCLERODERMA

Localized scleroderma is almost always a purely skin condition, and is virtually never associated with the severe and potentially life threatening complications of SSc.

Morphea

Morphea consists of patches of thickened skin that can vary from half an inch to six inches or more in diameter. Some people have only one or a few such patches, while others have multiple ones all over the body. The patches can be lighter or darker than the surrounding skin and thus tend to stand out. Also there is usually a loss of the fatty layer underneath the morphea spots. Morphea, as well as the other forms of localized scleroderma, does not affect internal organs.

Linear scleroderma

Linear scleroderma consists of a line of thickened skin down an arm or leg on one side. The fatty layer under the skin can be lost, so the affected limb is thinner than the other one. In growing children, the affected arm or leg can be shorter than the other.

Scleroderma en coup de sabre

Scleroderma en coup de sabre is a form of linear scleroderma in which the line of skin thickening occurs on the forehead or elsewhere on the face. In growing children, both linear scleroderma and en coup de sabre can result in distortion of the growing limb or lack of symmetry of both sides of the face.

WHAT CAUSES SCLERODERMA?

The cause of scleroderma is unknown. However, we do understand a great deal about the biological processes involved. In localized

scleroderma, the underlying problem is the overproduction of collagen (scar tissue) in the involved areas of skin. In systemic sclerosis, there are three processes at work: blood vessel abnormalities, fibrosis (which is overproduction of collagen) and immune system dysfunction, or autoimmunity.

In systemic sclerosis, the small blood vessels are damaged and become narrowed. This is what is responsible for Raynaud phenomenon and the painful ulcers that can occur on the fingers. This vascular damage also occurs in the internal organs and is responsible for scleroderma renal crisis and PH.

The small arteries are normally capable of constricting (narrowing) or dilating (relaxing) to adjust blood flow to the needs of the body. For example, in very cold weather the blood vessels to the hands and feet narrow in order to maintain central body warmth. However, in SSc the blood vessel loses its normal method of relaxation, becoming prone to episodes of vasospasm (contraction of the muscle wall that closes the vessel). The vessels become overly sensitive to cold temperatures and other stimuli like emotional stress, which results in Raynaud attacks.

The thickened skin in scleroderma is caused by overproduction of collagen, which is the basic component of scar tissue. Abnormal accumulation of collagen is called fibrosis. Collagen is a normal part of skin and many organs. However, in scleroderma the balance of collagen formation and collagen breakdown is altered so that too much collagen builds up.

In localized scleroderma this process is confined to some areas of the skin. In SSc, excess collagen can cause fibrosis in the heart, lungs, and the muscles that line the GI tract.

Collagen is made by fibroblasts (a type of cell that is part of almost every tissue in the body) which can be provoked or activated to make more collagen. Under normal circumstances, the production of a scar is the last step in healing following an injury or an infection, for example, the production of a scar following a cut in the skin. Fibroblasts are activated by the immune system to produce collagen as part of the normal healing process. However, in SSc fibroblasts are activated for no apparent reason. The resulting

scar causes tissue damage, decreased flexibility, and malfunction of the organ involved.

The third problem in SSc is the dysregulation of the immune system resulting in an immune attack on the body's own tissues. In patients with early disease, immune cells such as B cells, T cells and macrophages appear to be activated and poised to attack the patient's own tissues. This might be particularly prominent in the skin and the lungs. In addition, the body generates self-directed antibodies called autoantibodies. Some of these autoantibodies are found in several autoimmune diseases, while others are highly specific for scleroderma.

One way to detect activation of the immune system is to find antibodies (proteins made by immune cells, the bullets of our immune army) in the blood that targets the body's own tissue (autoantibodies). A very specific set of autoantibodies is found in scleroderma. These autoantibodies can be thought of as footprints of the scleroderma disease process because they are only made under very specific conditions. At this point, it is still not clear what role, if any, these autoantibodies play in damaging the blood vessels or stimulating collagen overproduction in SSc.

WHO GETS SCLERODERMA?

There are many clues that define susceptibility to develop scleroderma. A genetic basis for the disease has been suggested by the fact that SSc is more common among patients whose family members have other autoimmune diseases (such as lupus). In rare cases, SSc runs in families, although for most patients there are no other family members affected. Scleroderma may affect some Native Americans and African Americans more severely than Caucasians.

Women are more likely to get SSc.

Environmental factors may trigger the disease in the susceptible host. For example, silica exposure (as in coal mining or sand blasting) has been associated with systemic scleroderma and certain drugs can cause scleroderma-like reactions. Localized scleroderma is more common in children, whereas SSc is more common in adults. However, both can occur at any age.

PUTTING IT ALL TOGETHER?

Research suggests that the susceptible host for scleroderma is someone with a genetic predisposition to injury from some external agent, such as a viral or bacterial infection or a substance in the environment. In localized scleroderma, the resulting damage is confined to the skin. In SSc, the process causes injury to blood vessels, or indirectly perturbs the blood vessels by activating the immune system. Fibroblasts are activated as part of the response to tissue injury. Interacting networks of immune inflammation and injury from inadequate blood supply drive the process, so it becomes chronic. Collagen made in excess interferes with normal organ function, sometimes leading to organ failure. In many cases, the process goes into remission after some years of activity. Research continues to assemble the pieces of the scleroderma puzzle to identify the susceptibility genes, to find the external triggers and cellular proteins driving fibrosis, and to interrupt the networks that perpetuate the disease.

Please note that this brochure is provided for educational purposes only. It is not intended to substitute for informed medical advice.

###

The National Scleroderma Foundation thanks **Maureen Mayes, MD, MPH**, University of Texas/Houston and **John Varga, MD**, Northwestern University, for their assistance in the preparation of this brochure.

Fact Sheet



National
Scleroderma
Foundation

Our Mission: Support, Education, and Research

Lisa's Story

Lisa Hendricks was just seven years old when her parents noticed she was limping. Lisa couldn't lay her hands flat on a table. She did not complain of pain and learned to play the piano despite finger stiffness, but her parents knew something was wrong.

One day, Lisa suddenly could not stand up from a chair. Her parents rushed her to the doctor, who immediately recognized the symptoms of the linear and morphea forms of scleroderma. Two months later, Lisa's diagnosis was confirmed by specialists at the University of California, San Francisco. Her new life with scleroderma began.

Today, Lisa is a recent college graduate, elementary school teacher and church volunteer. She still plays the piano. She just does it all with scleroderma.

The National Scleroderma Foundation's resources, including research updates and support groups, have made a significant, positive impact on Lisa's life, she says.

"When you talk to other members of a National Scleroderma Foundation support group, you know they understand what you are talking about. It's very comforting," said Lisa, who belongs to the Foundation's Sacramento support group. "We get together once a month, but really, a lot of us are in constant contact. I finally found where I belong."

The National Scleroderma Foundation's mission is to advance medical research, promote disease awareness, and provide support and education to people with scleroderma, their families and support networks.

Awareness campaigns inform and educate individuals who have scleroderma, their families, medical professionals, and the public. The Foundation also funds innovative research to discover the cause, to understand the mechanism, and to overcome scleroderma forever.

"When you talk to other members of a National Scleroderma Foundation support group, you know they understand what you are talking about. It's very comforting. We get together once a month, but really, a lot of us are in constant contact. I finally found where I belong." – Lisa Hendricks

Support

Scleroderma is rare, affecting about 300,000 people in the U.S., mostly women. People newly diagnosed with scleroderma often feel alone. In the Foundation's local chapters and support groups, they find a safe and welcoming place to share, learn, cry and laugh. They can connect through online support groups through Inspire (www.inspire.com) and chat in a secure environment 24/7, or speak with each other on Facebook and Twitter.

Education

Scleroderma can be difficult to diagnose. It mimics other diseases, has many forms, and may cause varied symptoms.

The Foundation's education programs help individuals affected by scleroderma, and their families, to better understand scleroderma. Education helps individuals manage and cope with their disease more effectively. Both chapters and support groups host regular scleroderma education events, including seminars with

medical experts who discuss scleroderma treatments and research.

Here are other scleroderma education resources from the National Scleroderma Foundation:

- Our website, www.scleroderma.org, provides individuals and families with the latest health information, FAQs, events news, links to chapter and support groups, and opportunities to make a donation or serve as an advocate.
- The Scleroderma VOICE quarterly magazine, available to all members and supporters, includes inspiring personal stories, and news on research and advocacy.
- At the annual **National Scleroderma Conference**, scleroderma clinical and research experts engage with individuals affected by the disease in informative workshops and panel discussions.
- The *eLetter*, a weekly online newsletter, shares current medical information and Foundation event updates.
- The Foundation's toll-free hotline, (800) 722-HOPE, has dedicated staff available to help individuals affected by scleroderma and their families to find resources and information near their home.

Research

The National Scleroderma Foundation is a leading global funder of scleroderma-related research, allocating at least \$1 million per year. New and established investigators annually apply for Foundation research grants that are evaluated by a Peer-Review Research Committee of scleroderma experts. Panelists use a model based on best practices established by the National Institutes of Health (NIH) to objectively critique and rank applications for funding. The goal is to foster new research and provide vital "seed" funding to allow new, younger investigators to advance their work, so they may go on to receive larger funding through the NIH and other sources.

Thanks to recent advances in research and treatment, people with scleroderma may now expect to live longer, more productive lives. The future offers more hope, yet research costs continue to climb. The Foundation's

commitment to scleroderma research is unwavering. We are determined to achieve our ultimate goal of a cure.

Advocacy

Advocacy blends each element of our mission. Volunteer advocates educate elected and appointed officials about scleroderma. They explain the critical need for public funding of scleroderma research, and the need to elevate the public profile of scleroderma and the needs of everyone whose life the disease affects. The Foundation's broad healthcare advocacy priorities include health insurance reform and expanding federal orphan drug research and development programs.

To support the Foundation's mission, volunteer with your local chapter, get involved in fundraising, or serve as an advocate, call (800) 722-HOPE (4673) or visit our website, www.scleroderma.org.

###



Pulmonary Fibrosis in Systemic Sclerosis: Diagnosis and Management

Pulmonary disease is an important component of systemic sclerosis (SSc). It is estimated that 90% of patients with SSc have some evidence of pulmonary disease¹. This makes pulmonary disease second only to esophageal disease as the most common manifestation of SSc found on the inside of your body (visceral) component.

Moreover, pulmonary involvement portends a poorer prognosis and pulmonary disease is now the leading cause of death amongst patients with SSc with an estimated mortality from pulmonary disease of all causes to be 33%¹. While multiple pulmonary manifestations have been associated with SSc including pleural effusions², bronchiectasis³, lung neoplasms⁴, aspiration pneumonia and drug induced pneumonitis, the most common pulmonary manifestations of SSc include pulmonary hypertension and interstitial lung diseases (ILDs). The significant prevalence of ILD in SSc is reflected in the classification criteria of SSc² with the finding providing 2 points towards diagnosis of SSc.

Lung Fibrosis in SSc

Like pulmonary fibrosis of most origins including idiopathic pulmonary fibrosis, the precise molecular events that occur in the pathogenesis of lung fibrosis is not well understood.

There is likely a complex interplay between inflammatory⁵, antibody production⁶⁻⁷, oxidative stress and fibrosis occurring in the setting of blood vessel hyperreactivity⁸.

Environmental or genetic factors may contribute to the development of ILD in SSc and researchers are actively trying to identify these targets³. While environmental triggers have been considered in the pathophysiology of SSc in general and environmental exposures such as polyvinylchloride, and an impurity in one

preparation of L-tryptophan have been known to trigger scleroderma like syndromes, there has never been a clearly established environmental link. The lung injury specific to inhalation of inorganic or organic dusts in the environment are termed pneumoconiosis or hypersensitivity pneumonitis, which are not the same as ILD. There has never been an environmental exposure implicated specific to ILD associated with SSc.

A genetic contribution to scleroderma is supported by observed familial aggregation, ethnic predispositions, gene association studies and genome wide studies⁹. Pedigrees have been described that demonstrate members with SSc as well as members with ILDs not known to be related to SSc in numbers higher than would be expected by chance, suggesting a shared genetic predisposition between SSc, SSc ILD and non SSc¹⁰. As with all genetic studies, the heterogeneous nature of SSc complicates the detection and interpretation of genetic studies and better characterization of phenotype may aid the understanding of scleroderma in general and the development of ILD specifically⁹.

Subsets of Scleroderma Associated with ILD

The estimated prevalence of ILD in SSc ranges from 25-90% depending on the methods utilized and the subset of SSc patients evaluated. There are currently no reliable means to consistently predict which SSc patients will develop ILD. There are some clinical predictors that have been associated with a higher prevalence of ILD. These include African American ethnicity, higher skin score (diffuse cutaneous, dcSSc), muscle inflammation (elevated serum CPK levels), hypothyroidism, and cardiac involvement¹².

The association between SSc and ILD is strongest in patients who suffer from dcSSc. Patients with diffuse SSc typically develop the ILD early in the course of their disease. However, ILD is also has a well described association with limited skin involvement (lcSSc)¹³. Specific autoantibodies such as the anti-SCL-70, RNP, anti U11/ U12 RNP, anti Th/ To and antihistone antibodies have been reported to be associated with an increased risk of ILD in SSc¹⁴ and others such as anticentromere antibodies are protective¹⁵. However, these associations are not specific are not absolutely predictive and serologies have low sensitivity¹³ limiting the effectiveness of the serologies as a clinical predictor of ILD.

Diagnosis of ILD in SSc

The onset of ILD in scleroderma is often difficult to detect. Factors that may mask the onset of disease include mild lung involvement, musculoskeletal, or hematologic (such as anemia) manifestations of SSc or other comorbid conditions. When studied systematically, approximately 50% of patients with ILD will demonstrate a measurable decline in pulmonary function within the first three years of diagnosis of SSc although many of these patients report no pulmonary symptoms¹⁶. Once the presence of a pulmonary disease is established, care must be taken to differentiate between ILD and other pulmonary manifestations, specifically pulmonary arterial hypertension (PAH), which may co-exist with ILD or be present in the absence in ILD. Thus, it is clear that correctly identifying and managing ILD in scleroderma is a critical issue in the management of SSc.

There are a number of tests that can be applied to the diagnosis of ILD in SSc. Physical examination can be revealing with the presence of bibasilar crackles, but often times these are subtle or absent early in the disease. Thus, additional testing is required to assess for the presence of ILD in SSc.

Pulmonary Function Testing

Pulmonary function testing (PFTs) are cornerstone tests in the evaluation of dyspnea and for detection of pulmonary involvement in patients with SSc. While not diagnostic of ILD, patients with ILD will demonstrate restriction on lung function testing. Total Lung Capacity

(TLC) by means of plethysmography is the most reliable measure of restriction and will confirm the presence of true lung restriction. However, spirometry is more typically utilized in clinical practice provides a good estimation of true restriction. Spirometry provides measures of the forced vital capacity (FVC) and the forced expiratory volume in one second (FEV₁). In a restrictive lung disease, the FVC should be reduced and the FEV₁/FVC ratio should be normal.

The diffusing capacity (DLCO) provides a measure of gas transfer between the air inhaled into the alveoli to the red blood cells in the systemic circulation. The DLCO is one of the most valuable measures in the evaluation of the scleroderma patient as a decreased value may be the earliest signal of lung disease in SSc and is reduced in 70% of SSc patients¹⁷⁻¹⁸. Moreover, the DLCO correlates most closely with the degree of disease seen on the high-resolution computed tomography (HRCT) scan¹⁹. The DLCO will be reduced in both pulmonary hypertension and ILD. Thus, the DLCO is not specific for the diagnosis of SSc ILD, but does indicate further evaluation is indicated.

The rate of decline of both the FVC and the DLCO are important prognosticators of survival^{16,19}. The most rapid decline in the FVC occurs within the first three to five years of disease onset¹⁶. This implies that lung injury is an early event and suggests that frequent monitoring in lung function in early-stage disease is important.

High Resolution CT

As with ILDs of all types, the HRCT is the most sensitive and specific modality for detecting and characterizing any ILD present in the setting of SSc. It is more sensitive than chest radiograph and is the imaging technique of choice²⁰. The most common radiographic pattern is that of NSIP. Early in the disease, ground glass opacities are prominent in a peripheral distribution and then progress to reticular changes. The classic UIP pattern with bibasilar reticulation, traction bronchiectasis and honeycombing is also observed in patients with SSc but less commonly than NSIP. Honeycombing is seen more frequently in patients with lcSSc than in those

with diffuse SSc²¹. Tracheobronchial disease can be seen in patients with an overlap of Sjögren's syndrome. A HRCT is required to make these radiographic distinctions.

The HRCT scan has limited prognostic significance. The finding of ground glass opacities does not universally connote reversible disease or alveolitis and is often fine reticulation below the threshold of CT detection²². The extent of ILD seen on HRCT has prognostic significance with those patients demonstrating more than 20% involvement demonstrating increased mortality²³. There are several computer-aided tools in development to help better understand meaningful change on HRCT scan, but these are mainly research tools. Additionally, the role of low radiation dose HRCT and lung ultrasound for serial monitoring the progression of ILD is also under investigation.

Bronchoalveolar Lavage (BAL)

The role of BAL in patients with SSc ILD is controversial and most often utilized when there is concern about infection, malignancy, or drug toxicity. When a cell count is done on BAL from patients with SSc-associated ILD, elevated numbers of granulocytes may be seen, especially neutrophils and eosinophils. Increased numbers of lymphocytes and mast cells may also be seen²⁴. Early studies correlated increased granulocytes in BAL with increased response to immunosuppression presumably because this represented active alveolitis²⁵⁻²⁶. Subsequently, BAL granulocytosis has been shown to correlate with the degree of ground glass opacity seen on HRCT²¹ and with more advanced interstitial disease²⁷. However, data from the Scleroderma Lung Study suggest that BAL granulocytosis does not add any additional prognostic information to HRCT and pulmonary function measures and is not a predictor of treatment response²⁷⁻²⁸. There is no question that BAL is an important test in the consideration of infection, especially when a patient is taking medications that suppress the immune system.

Biopsy

Similar to radiographic appearances, there are a variety of histologic subtypes found in SSc ILD. NSIP is seen most commonly, estimated to be the histopathology in 76% of the cases¹⁹. In this

same series, UIP occurred in 11% of the cases and there were rare cases of organizing pneumonia and diffuse alveolar damage. Importantly, the clinical outcome does not correlate with the observed histology^{19, 29}. Patients with scleroderma ILD can often experience stabilization after the initial development of their lung disease. These patterns are in stark contrast to idiopathic ILDs where UIP is the most common pathology, the pathologic finding of UIP is associated with a poorer prognosis and stabilization of UIP for decades is rarely seen. Specifically, in a series of 80 patients, survival does not differ between cellular NSIP, fibrotic NSIP and UIP. Thus, histology has no prognostic value. Given this data, there is rarely value to a surgical biopsy in the evaluation of a patient with scleroderma associated ILD. The exception to this may be in cases of an unusual CT pattern, which does not fit a predicted pattern seen in SSc.

Treatment of ILD in SSc

The decision of who requires treatment in the ILD associated with SSc is not always simple. The goals of therapy are to provide an effective agent to a patient in order to prevent progression to fibrosis and to target active inflammation or alveolitis as this may represent a reversible component of the disease. A patient's symptoms of shortness of breath and cough are important.

Thus, the appropriate candidates for therapy are those who have symptoms, early-stage lung disease, ground glass opacities on CT scan or who are demonstrating progression of disease.

It is notable that therapeutic interventions remain primarily anti-inflammatory in nature as inflammation is still believed to be the primary driver of lung disease progression. This is in contrast to the IPF model where inflammation is felt to be less important than an aberrant fibrotic pathway. Only a small number of drugs have been assessed via randomized controlled studies and few therapeutic options exist for patients with SSc ILD.

Nintedanib

The Food and Drug Administration (FDA) approved the first specific therapy for SSc-ILD, following a randomized, double-blind placebo-controlled trial among patients with

ILD associated with SSc that showed that the annual rate of decline in FVC was lower with nintedanib than with placebo. While no clinical benefit of nintedanib was observed for other manifestations of SSc, nintedanib, a tyrosine kinase inhibitor, demonstrated antifibrotic and antiinflammatory effects.

Cyclophosphamide

This drug has been rigorously assessed for use in SSc-ILD. In general, there is evidence that it has a small benefit for long stabilization by PFT and breathlessness (PMID 29297205). The Scleroderma Lung Study (SLS) 28 was a double-blind, 13 center trial of 158 patients with early SSc-associated ILD who demonstrated evidence of active alveolar inflammation with either ground glass opacities on HRCT or increased cellularity on BAL. Patients were randomized to receive either oral cyclophosphamide (≤ 2 mg/kg) or placebo daily for one year. In this study, the cyclophosphamide group had a smaller decline than the placebo group (-1.0 versus -2.6 percent predicted). This difference, while small, was statistically significant. This difference was seen at the end of the first year of treatment. In addition, a HRCT scan study was done on a subset of the SLS patients. With comparison of the initial CT scan and follow-up CT scan at one year, less progression of fibrosis was seen in the cyclophosphamide group³⁰.

Cyclophosphamide is an effective, albeit with small impact, agent for treatment of SSc-associated ILD, there are several additional considerations. There is significant toxicity associated with daily oral cyclophosphamide including blood in the urine (hematuria), low blood counts (cytopenias), and malignancies. There is also concern that the response seen at one year is not persistent. While patient's reports of respiratory symptomatology and objective skin improvements were still present at the 24-month SLS follow-up study, the differential improvement in FVC had disappeared³¹.

IV administration of cyclophosphamide is less rigorously studied but several uncontrolled studies³²⁻³⁴ and one randomized trial have been done. In the 45 patient double blind placebo-controlled study, there was a trend toward improved FVC in the cyclophosphamide group

but this did not achieve statistical significance³⁵. Thus, it remains unclear what the true role of IV cyclophosphamide might be in the management of SSc related ILD.

Mycophenolate Mofetil

Mycophenolate is an inhibitor of lymphocyte proliferation. This drug has been the subject of retrospective studies and observational studies. These small studies have had mixed results but observed improvements in FVC and DLCO have been documented³⁶⁻³⁸. The second Scleroderma Lung Study (SLS II) compared in a double-blind fashion 142 SSc-ILD patients with 7 years disease duration or less to receive either mycophenolate mofetil (MMF) (n = 69) for 2 years or oral cyclophosphamide (n = 73) for 1 year followed by a year of placebo treatment. This study showed equivalence for both therapies, but MMF was better tolerated.

Rituximab

The monoclonal antibody rituximab depletes B cells that play in the pathogenesis of SSc. In a randomized controlled trial in 14 patients with SSc-ILD, rituximab (4 weekly infusions followed by 4 weekly infusions at 24 weeks) was associated with significant improvement in both FVC(%) and DLCO(%) at 1 year. Case control studies with anti-B-cell therapy were associated with stability or improvement in pulmonary function tests. In these studies, the medication was well tolerated. However, a recent prospective cohort study of 254 patients treated with rituximab compared with 9575 propensity-score-matched patients showed that treated patients did not have significantly different rates of decrease in FVC or DLCO, although they were more likely to have improvement in skin fibrosis. More data is needed to fully evaluate the efficacy of rituximab in SSc-ILD. Currently, there are 2 clinical trials of rituximab in patients with ILD connective tissue disease that are currently recruiting patients (clinicaltrials.gov: NCT02990286 and NCT01862926).

Intravenous Immunoglobulin

Intravenous Ig (IVIg) is a pooled plasma product that is sometimes used in SSc patients with ILD and inflammatory muscle disease (myositis). It is sometimes used off-label with increasing

frequency for refractory cases that have failed to respond to immunosuppression. Although associated with less systemic toxicity and global immunosuppression than traditional agents, IVIg is much more costly.

Corticosteroids

The role of corticosteroids remains unclear in SSC related ILD. In general, these drugs are avoided because of the well-known risk of scleroderma renal crisis. This phenomenon has been well documented³⁹ and occurs at low prednisone doses with a mean dose of only 7.4 mg in one series⁴⁰. However, in most clinical trials, use of prednisone was permitted with the drug in question. Thus, while monotherapy with glucocorticoids is not recommended, the role that the accompanying prednisone plays in combination with cyclophosphamide, mycophenolate or other therapies remains unknown.

Other therapies

There are a large number of other possible therapies that are under investigation. Beyond the consideration of inflammation as the primary driver of lung fibrosis, other pathways have been targets of study. The anti-fibrotic effects of pirfenidone are under investigation in SLSIII, which is a Phase II multi-center, double-blind, parallel group, randomized and placebo-controlled clinical trial addressing the treatment of patients with active and symptomatic SSc-ILD. Patients who are either treatment naive or only recently started treatment (≤ 6 months of prior treatment) will be randomized in a 1:1 assignment to receive either oral mycophenolate mofetil (MMF) and a placebo or a combination of oral MMF and oral pirfenidone, with both regimens administered for 18 months.

Conclusion

ILD in SSc is a common manifestation that is associated with poor prognosis.

Careful evaluation by the clinician is warranted to detect the presence of an ILD and to select patients for consideration of therapy. Factors to consider in the initiation of therapy include early disease, evidence of progression and evidence of alveolitis. Possible side effects of therapy must be weighed against the known benefits. At the

current time, nintedanib, cyclophosphamide and mycophenolate mofetil remain the best studied therapeutic agents although alternatives are actively being evaluated. The role of other immunosuppressive agents or other pathways remains undetermined and offer hope for future therapeutic interventions, but there is some evidence for rituximab, tocilizumab, and pirfenidone. More data is necessary to best understand the role of these agents for SSc-related ILD. For some patients with access to specialty centers hematopoietic stem cell transplantation and lung transplantation may be an option. Additional research is needed to determine which patients will benefit from SSc-ILD therapy, how to best measure their treatment response, and long-term management plans after initial therapy in order to optimize outcomes among patients with SSc-ILD.

###

The National Scleroderma Foundation thanks **Mary Beth Scholand, MD, Elisabeth Carr, MD** and **Tracy Frech, MD** for their assistance in the preparation of this brochure.

References:

1. Ferri C, Valentini G, Cozzi F, et al. Systemic sclerosis: demographic, clinical, and serologic features and survival in 1,012 Italian patients. *Medicine (Baltimore)* 2002;81:139-53.
2. Highland KB, Heffner JE. Pleural effusion in interstitial lung disease. *Curr Opin Pulm Med* 2004;10:390-6.
3. Andonopoulos AP, Yarmenitis S, Georgiou P, Bounas A, Vlahanastasi C. Bronchiectasis in systemic sclerosis. A study using high resolution computed tomography. *Clin Exp Rheumatol* 2001;19:187-90.
4. Pontifex EK, Hill CL, Roberts-Thomson P. Risk factors for lung cancer in patients with scleroderma: a nested case-control study. *Ann Rheum Dis* 2007;66:551-3.
5. Atamas SP, Yurovsky VV, Wise R, et al. Production of type 2 cytokines by CD8+ lung cells is associated with greater decline in pulmonary function in patients with systemic sclerosis. *Arthritis Rheum* 1999;42:1168-78.

6. Terrier B, Tamby MC, Camoin L, et al. Antifibroblast antibodies from systemic sclerosis patients bind to {alpha}-enolase and are associated with interstitial lung disease. *Ann Rheum Dis* 2010;69:428-33.
7. Baroni SS, Santillo M, Bevilacqua F, et al. Stimulatory autoantibodies to the PDGF receptor in systemic sclerosis. *N Engl J Med* 2006;354:2667-76.
8. Tamby MC, Chanseaud Y, Guillevin L, Mouthon L. New insights into the pathogenesis of systemic sclerosis. *Autoimmun Rev* 2003;2:152-7.
9. Agarwal SK, Tan FK, Arnett FC. Genetics and genomic studies in scleroderma (systemic sclerosis). *Rheum Dis Clin North Am* 2008;34:17-40; v.
10. Frech T, Khanna D, Markewitz B, Mineau G, Pimentel R, Sawitzke A. Heritability of vasculopathy, autoimmune disease, and fibrosis in systemic sclerosis: a population-based study. *Arthritis Rheum* 2010;62:2109-16.
11. White B. Interstitial lung disease in scleroderma. *Rheum Dis Clin North Am* 2003;29:371-90.
12. McNearney TA, Reveille JD, Fischbach M, et al. Pulmonary involvement in systemic sclerosis: associations with genetic, serologic, sociodemographic, and behavioral factors. *Arthritis Rheum* 2007;57:318-26.
13. Fischer A, Swigris JJ, Groshong SD, et al. Clinically significant interstitial lung disease in limited scleroderma: histopathology, clinical features, and survival. *Chest* 2008;134:601-5.
14. Steen VD. Autoantibodies in systemic sclerosis. *Semin Arthritis Rheum* 2005;35:35-42.
15. Kane GC, Varga J, Conant EF, Spirn PW, Jimenez S, Fish JE. Lung involvement in systemic sclerosis (scleroderma): relation to classification based on extent of skin involvement or autoantibody status. *Respir Med* 1996;90:223-30.
16. Steen VD, Medsger TA, Jr. Severe organ involvement in systemic sclerosis with diffuse scleroderma. *Arthritis Rheum* 2000;43:2437-44.
17. Wells AU, Hansell DM, Rubens MB, et al. Fibrosing alveolitis in systemic sclerosis: indices of lung function in relation to extent of disease on computed tomography. *Arthritis Rheum* 1997;40:1229-36.
18. Owens GR, Fino GJ, Herbert DL, et al. Pulmonary function in progressive systemic sclerosis. Comparison of CREST syndrome variant with diffuse scleroderma. *Chest* 1983;84:546-50.
19. Bouros D, Wells AU, Nicholson AG, et al. Histopathologic subsets of fibrosing alveolitis in patients with systemic sclerosis and their relationship to outcome. *Am J Respir Crit Care Med* 2002;165:1581-6.
20. Schurawitzki H, Stiglbauer R, Graninger W, et al. Interstitial lung disease in progressive systemic sclerosis: high-resolution CT versus radiography. *Radiology* 1990;176:755-9.
21. Goldin JG, Lynch DA, Strollo DC, et al. High-resolution CT scan findings in patients with symptomatic scleroderma-related interstitial lung disease. *Chest* 2008;134:358-67.
22. Remy-Jardin M, Giraud F, Remy J, Copin MC, Gosselin B, Duhamel A. Importance of ground-glass attenuation in chronic diffuse infiltrative lung disease: pathologic-CT correlation. *Radiology* 1993;189:693-8.
23. Goh NS, Desai SR, Veeraraghavan S, et al. Interstitial lung disease in systemic sclerosis: a simple staging system. *Am J Respir Crit Care Med* 2008;177:1248-54.
24. Kowal-Bielecka O, Kowal K, Highland KB, Silver RM. Bronchoalveolar lavage fluid in scleroderma interstitial lung disease: technical aspects and clinical correlations: review of the literature. *Semin Arthritis Rheum* 2010;40:73-88.
25. Silver RM, Miller KS, Kinsella MB, Smith EA, Schabel SI. Evaluation and management of scleroderma lung disease using bronchoalveolar lavage. *Am J Med* 1990;88:470-6.
26. Harrison NK, Glanville AR, Strickland B, et al. Pulmonary involvement in systemic sclerosis: the detection of early changes by thin section CT scan, bronchoalveolar lavage and 99mTc-DTPA clearance. *Respir Med* 1989;83:403-14.
27. 1989;83:403-14.
28. Strange C, Bolster MB, Roth MD, et al. Bronchoalveolar lavage and response to cyclophosphamide in scleroderma interstitial lung disease. *Am J Respir Crit Care Med* 2008;177:91-8.
29. Tashkin DP, Elashoff R, Clements PJ, et al. Cyclophosphamide versus placebo in scleroderma lung disease. *N Engl J Med* 2006;354:2655-66.
30. Nakamura Y, Chida K, Suda T, et al. Nonspecific interstitial pneumonia in collagen vascular diseases: comparison of the clinical characteristics and prognostic significance with usual interstitial pneumonia. *Sarcoidosis Vasc Diffuse Lung Dis* 2003;20:235-41.
31. Goldin J, Elashoff R, Kim HJ, et al. Treatment of scleroderma-interstitial lung disease with cyclophosphamide is associated with less progressive fibrosis on serial thoracic high-resolution CT scan than placebo: findings from the scleroderma lung study. *Chest* 2009;136:1333-40.
32. Tashkin DP, Elashoff R, Clements PJ, et al. Effects of 1-year treatment with cyclophosphamide on outcomes at 2 years in scleroderma lung disease. *Am J Respir Crit Care Med* 2007;176:1026-34.

33. Giacomelli R, Valentini G, Salsano F, et al. Cyclophosphamide pulse regimen in the treatment of alveolitis in systemic sclerosis. *J Rheumatol* 2002;29:731-6.
34. Griffiths B, Miles S, Moss H, Robertson R, Veale D, Emery P. Systemic sclerosis and interstitial lung disease: a pilot study using pulse intravenous methylprednisolone and cyclophosphamide to assess the effect on high resolution computed tomography scan and lung function. *J Rheumatol* 2002;29:2371-8.
35. Pakas I, Ioannidis JP, Malagari K, Skopouli FN, Moutsopoulos HM, Vlachoyiannopoulos PG. Cyclophosphamide with low or high dose prednisolone for systemic sclerosis lung disease. *J Rheumatol* 2002;29:298-304.
36. Hoyles RK, Ellis RW, Wellsbury J, et al. A multicenter, prospective, randomized, double-blind, placebo-controlled trial of corticosteroids and intravenous cyclophosphamide followed by oral azathioprine for the treatment of pulmonary fibrosis in scleroderma. *Arthritis Rheum* 2006;54:3962-70.
37. Koutroumpas A, Ziogas A, Alexiou I, Barouta G, Sakkas LI. Mycophenolate mofetil in systemic sclerosis-associated interstitial lung disease. *Clin Rheumatol* 2010;29:1167-8.
38. Simeon-Aznar CP, Fonollosa-Pla V, Tolosa-Vilella C, Selva-O'Callaghan A, Solans-Laque R, Vilardell-Tarres M. Effect of mycophenolate sodium in scleroderma-related interstitial lung disease. *Clin Rheumatol* 2011;30:1393-8.
39. Swigris JJ, Olson AL, Fischer A, et al. Mycophenolate mofetil is safe, well tolerated, and preserves lung function in patients with connective tissue disease-related interstitial lung disease. *Chest* 2006;130:30-6.
40. Steen VD, Medsger TA, Jr. Case-control study of corticosteroids and other drugs that either precipitate or protect from the development of scleroderma renal crisis. *Arthritis Rheum* 1998;41:1613-9.
41. DeMarco PJ, Weisman MH, Seibold JR, et al. Predictors and outcomes of scleroderma renal crisis: the high-dose versus low-dose D-penicillamine in early diffuse systemic sclerosis trial. *Arthritis Rheum* 2002;46:2983-9.
42. Seibold JR, Denton CP, Furst DE, et al. Randomized, prospective, placebo-controlled trial of bosentan in interstitial lung disease secondary to systemic sclerosis. *Arthritis Rheum* 2010;62:2101-8.
43. King TE, Jr., Brown KK, Raghu G, et al. BUILD-3: a randomized, controlled trial of bosentan in idiopathic pulmonary fibrosis. *Am J Respir Crit Care Med* 2011;184:92-9.
44. Gordon J, Spiera R. Tyrosine Kinase Inhibitors in the Treatment of Systemic Sclerosis: The Difficulty in Interpreting Proof-of-Concept Studies. *Int J Rheumatol* 2011;2011:842181.
45. Spiera RF, Gordon JK, Mersten JN, et al. Imatinib mesylate (Gleevec) in the treatment of diffuse cutaneous systemic sclerosis: results of a 1-year, phase IIa, single-arm, open-label clinical trial. *Ann Rheum Dis* 2011;70:1003-9

April 2014

1. Schurawitzki, H. et al. Interstitial lung disease in progressive systemic sclerosis: high-resolution CT versus radiography. *Radiology* 176, 755-759, doi:10.1148/radiology.176.3.2389033 (1990).
2. van den Hoogen, F. et al. 2013 classification criteria for systemic sclerosis: an American College of Rheumatology/European League against Rheumatism collaborative initiative. *Arthritis Rheum* 65, 2737-2747, doi:10.1002/art.38098 (2013).
3. Tochimoto, A., Kawaguchi, Y. & Yamanaka, H. Genetic Susceptibility to Interstitial Lung Disease Associated with Systemic Sclerosis. *Clin Med Insights Circ Respir Pulm Med* 9, 135-140, doi:10.4137/CCRPM.S23312 (2015).

Funded by a grant from
Janssen Pharmaceutical Companies of Johnson & Johnson





Pulmonary Hypertension

Pulmonary hypertension (PH) is high blood pressure in the blood vessels of the lungs. If the high blood pressure in the lungs is due to narrowing of the pulmonary arteries leading to increased pulmonary vascular resistance, it is known as pulmonary arterial hypertension (PAH). When the blood pressure inside the pulmonary vessels is high, the right side of the heart has to pump harder to move blood into the lungs to pick up oxygen. This can lead to failure of the right side of the heart. Patients with scleroderma are at increased risk for developing PH from several mechanisms. Frequently patients with scleroderma have multiple causes of their PH.

Patients who have limited cutaneous scleroderma (formerly known as CREST syndrome) are more likely to have PAH than those patients who have diffuse cutaneous systemic sclerosis. PAH may be the result of the same processes that cause damage to small blood vessels in the systemic circulation of patients with scleroderma. The lining cells of the blood vessels (endothelial cells) are injured and excessive connective tissue is laid down inside the blood vessel walls. The muscle that constricts the blood vessel may overgrow and narrow the blood vessel.

Other scleroderma patients may have PH because they have significant scarring (fibrosis) of their lungs. This reduces the blood oxygen level, which in turn, may cause a reflex increase in blood pressure in the pulmonary arteries.

What are the Symptoms of Pulmonary Hypertension?

Patients with mild PH may have no symptoms. Patients with moderate or severe PH usually notice shortness of breath (dyspnea), especially

with exercise. Patients may also notice unusual chest pains and symptoms of right-sided heart failure, such as worsening shortness of breath and swelling of the feet and legs. Other symptoms that patients cite include a cough, lightheadedness or fainting, palpitations (heart racing or fluttering), and swelling.

How is Pulmonary Hypertension Diagnosed?

In a patient with scleroderma, the development of unexplained shortness of breath should lead to consideration of possible PH.

A laboratory clue that a patient might have PH is a reduced diffusing capacity (DLCO) on pulmonary function tests (PFTs). The DLCO measures the ability of gas to move from the air, across the lung tissue and blood vessel wall, into the blood. In the absence of lung fibrosis, if the DLCO is less than 50 percent of its predicted value, this is a clue that PH may be present. Your provider might also order a blood test (called either BNP or nt-proBNP), which is a biomarker used to screen for and follow PH. Another test commonly used to screen patients for PH is the echocardiogram. It can estimate the pulmonary artery pressure fairly well in most patients in a noninvasive manner.

In order to confirm the presence of PH, a right heart catheterization is required to measure the actual pressure in the pulmonary arteries. This invasive test is done to more accurately measure the pressures in the lung blood vessels; to assess the blood flow generated by the heart (the cardiac output); to exclude an underlying leak or shunt contributing to the PH; to assess the function of the left side of the heart; and possibly to assess the patient's responsiveness to vasodilator therapy. The results of this test may

change the therapy prescribed by the physician. Right heart catheterization is the “gold standard” for diagnosing PAH and should always be done before being started on therapy.

An exercise test known as the six-minute walk test is often helpful in assessing exercise capacity in patients with PH. In addition, a Functional Class is often assigned to patients based on their activity tolerance, ranging from Class I to IV (with I being mildest and IV the most severe).

It is recommended that all patients with scleroderma should be screened annually for the presence of pulmonary hypertension.

What is the Typical Course of PAH in Scleroderma?

It was previously thought that the development of PAH in patients with scleroderma was always associated with a poor prognosis. However, ongoing educational efforts regarding the risk of PAH in scleroderma has led to earlier diagnosis. Studies now suggest that patients identified with mild or early PAH will fare better if drug therapy is started before symptoms and exercise capacity worsen.

What is the Treatment of PAH?

Supplemental oxygen and diuretics are often important parts of general treatment measures for PAH. If the oxygen level at rest, with exercise, or during sleep is low, supplemental oxygen therapy may be given. The decision to treat with anticoagulation is made on an individual basis by the patient and their physician, based on the potential risk of bleeding.

Calcium channel blockers (such as amlodipine, diltiazem or nifedipine) can help a small proportion of patients with PAH. Such treatment is successful in only a minority of scleroderma patients with PAH.

PAH Specific Medications

The list of drugs for treating PAH continues to expand and include the following FDA-approved drugs: epoprostenol (generic, Flolan[®], and Veletri[®]), treprostinil SQ or IV (Remodulin[®]), treprostinil inhaled (Tyvaso[®]), treprostinil oral (Orenitram[®]), iloprost (Ventavis[®]), bosentan (Tracleer[®]), ambrisentan (Letairis[®]),

macitentan (Opsumit[®]), sildenafil (generic, Revatio[®]), tadalafil (generic, Adcirca[®]), riociguat (Adempas[®]), and selexipag (Uptravi). Each of these drugs falls within one of three separate categories based on different mechanisms of action. These drugs are used alone or in combination with drugs in one or more other classes. Each will be briefly reviewed below.

Prostacyclin Analogs

Epoprostenol

Epoprostenol (generic, Flolan[®], Veletri[®]) is a potent vasodilator that must be given by a constant intravenous infusion. This requires an indwelling central venous catheter and an infusion pump. In a multicenter, randomized, controlled clinical trial of chronic intravenous epoprostenol, in patients with PAH and scleroderma, there was improvement in exercise capacity and hemodynamics. A survival benefit was not seen in this population over the period of study, but the study was not designed to detect a difference in survival. Common side effects of epoprostenol therapy include headache, flushing, jaw pain with initial chewing, diarrhea, and bone pain. Other side effects include the potential for serious infection associated with the catheter. Chronic intravenous epoprostenol has been approved by the FDA for the treatment of patients in Functional Class III and IV PAH related to scleroderma.

Treprostinil

Due to the complexity of chronic intravenous epoprostenol therapy, studies have since been undertaken with various analogues of prostacyclin being administered via the subcutaneous (under the skin), oral, and inhaled routes. Continuous subcutaneous infusion of treprostinil (Remodulin[®]) resulted in a slight improvement in exercise capacity, which was dose-related. The use of subcutaneous treprostinil may be limited by infusion site pain and redness. Treprostinil is approved for intravenous or subcutaneous delivery for the treatment of patients in Functional Class II, III, and IV PAH. Inhaled treprostinil (Tyvaso[®]), when administered four times daily, has been shown to improve exercise capacity in patients with Class III PAH. It is also approved for PH as a consequence of interstitial lung disease, which

is also common in patients with scleroderma. An oral form of treprostinil (Orenitram®) was approved by the FDA in December 2013.

Iloprost

Iloprost (Ventavis®) is a prostacyclin analog delivered by inhalation 6–9 times daily that has been shown to improve a composite measure of exercise capacity and functional class. Inhaled iloprost has been studied in patients who remain symptomatic while on stable ERA (bosentan) therapy for at least three months. There was a borderline significant improvement in exercise capacity, and improvement in functional class. Combination therapy appeared to be safe and well tolerated. Inhaled iloprost has been approved by the FDA for treatment of patients with Functional Class III and IV PAH.

Selexipag

Selexipag (Uptravi®) is an oral prostacyclin receptor agonist that has been shown to delay disease progression and reduce the risk of hospitalization for PAH. Side effects are similar to that of prostanoids and include headache, flushing, jaw pain, nausea, diarrhea, and bone pain

Endothelin Receptor Antagonists (ERA)

Bosentan

Bosentan (Tracleer®) is an oral endothelin receptor antagonist (ERA). In a pilot study, bosentan was shown to improve exercise capacity and cardio-pulmonary hemodynamics in patients with Functional Class III and IV PAH. A larger study confirmed improvement in exercise capacity and showed a reduction in clinical worsening. There is a potential for liver injury with bosentan, and monthly blood tests are required while receiving treatment. Bosentan is likely to produce major birth defects if used by pregnant women. Pregnancy must be prevented, and monthly pregnancy tests are required while taking bosentan.

Ambrisentan

Ambrisentan (Letairis®), like bosentan, is an FDA-approved ERA drug treatment for patients with PAH. To be taken once daily for patients in Functional Class II or III, this drug has shown improvement in exercise capacity. Similar to bosentan, ambrisentan should not be

taken by pregnant women, or women thinking of becoming pregnant. Other side effects may include edema and nasal congestion.

Macitentan

Macitentan (Opsumit®) is the latest drug in the ERA class to be approved to treat PAH. Macitentan is approved for treatment of PAH to delay disease progression defined as death, initiation of intravenous (IV) or subcutaneous prostacyclin drugs, or clinical worsening of PAH (decreased 6-minute walk distance, worsened PAH symptoms and need for additional PAH treatment). The need for PAH hospitalization was also reduced. Like other ERA drugs, macitentan is contraindicated in pregnancy because it may harm the developing fetus, and females of reproductive potential should be counseled on the use of reliable contraception and have a negative pregnancy test prior to initiating therapy and monthly thereafter.

Phosphodiesterase-V (PDE-V) Inhibitors

Sildenafil

Sildenafil was previously approved for the treatment of erectile dysfunction under the trade name of Viagra®. It is also approved for the treatment of PAH, under the trade name of Revatio® (a generic preparation is now also available). Sildenafil has been shown to improve exercise capacity, pulmonary artery pressure, and functional class in patients with PAH. Potential side effects include flushing, dyspepsia, visual changes, and nosebleeds.

Tadalafil

Tadalafil (Adcirca®) is approved as a once-daily oral therapy for the treatment of PAH, and is indicated to improve exercise capacity in PAH patients. Side effects include headache, stomach upset, back pain, muscle pain, stuffy or congested nose, flushing, pain in arms or legs, or vision change.

Guanylate Cyclase Stimulators

Riociguat

Riociguat (Adempas®) is the first in a new class of drugs to be approved for treatment of PAH, including scleroderma patients with PAH, as well as for treatment of chronic thromboembolic pulmonary hypertension. Drugs in this new

class act to dilate blood vessels, thus reducing pulmonary vascular resistance and improving PAH. Riociguat has been shown to significantly improve exercise capacity, functional class, time to clinical worsening, and dyspnea score. Riociguat should not be used in pregnant women because it can harm the developing fetus.

###

The National Scleroderma Foundation wishes to thank **Kristin Highland, MD, Richard Silver, MD, and David Badesch, MD**, for their input on this brochure.

Lung Transplantation

Lung transplantation may be an option for patients with severe PAH who do not respond to medical therapy. Due to the relatively high operative and perioperative risks, as well as the significant long-term risks of infection and rejection, lung transplantation should not be considered as first-line therapy or a cure for PAH. Not all patients are suitable candidates for lung transplantation. Gastro-esophageal reflux disease (GERD), or esophageal dysmotility occurs frequently in scleroderma, and may be a reason not to attempt lung transplantation due to the risk of aspiration.

Putting it All Together

Pulmonary hypertension is not the only type of lung disease that can occur in patients with scleroderma. Interstitial lung disease (ILD), also called pulmonary fibrosis, is another potentially serious complication. Please contact the National Scleroderma Foundation for information on pulmonary fibrosis.

It is important to note that patients can have significant pulmonary involvement from their scleroderma before signs and symptoms appear. Therefore, it is important to have routine screening for possible pulmonary involvement, in particular pulmonary arterial hypertension and interstitial lung disease.

Due to the complexity of the diagnosis and treatment of scleroderma lung disease, strong consideration should be given to referral of patients to physicians with expertise in scleroderma, interstitial lung disease, and PH. This requires close collaboration between you, your rheumatologist, and your pulmonologist or cardiologist.

Please note that this brochure is provided for educational purposes only. It is not intended to substitute for informed medical advice.

Funded by a grant from
Janssen Pharmaceutical Companies of Johnson & Johnson





National
Scleroderma
Foundation

Join Now!

Your tax-deductible gift of \$25 or more makes you a member.

The National Scleroderma Foundation's **mission** is to advance medical research, promote disease awareness, and provide support and education to people with scleroderma, their families and support networks.

Our **vision** is to be a relentless force in finding a cure and improving the lives of people affected by scleroderma.

Membership: For only \$25 a year, you can become a member, support our mission and receive our quarterly magazine, *Scleroderma Voice*, which regularly features information like the following:

- Updates on the latest scleroderma research and treatments
- Articles by leading doctors and other healthcare professionals
- Answers to medical questions by healthcare professionals
- Practical tips on coping with scleroderma
- Heartwarming stories about people living with scleroderma and how they faced their challenges
- Articles about what the Foundation is doing for you—funding new research, advocating on Capitol Hill for more federal research funding, and working nationwide, year-round to raise public awareness of scleroderma and its impact on individuals and their families

It's easy to give! Here are a few options:

1. Call the Foundation toll-free at 1-800-722-4673 and make your gift via credit card.
2. Give online via our secure server. Visit our website at www.scleroderma.org and click on the donate box on the upper right side.
3. Mail your gift (check or credit card) to the Foundation at the address below.
4. Give through payroll deduction at work through the Combined Federal Campaign (CFC), United Way or your employer's workplace giving program. Our CFC # is 2615.

Thank you for your support!



300 Rosewood Drive, Suite 105
Danvers, MA 01923



scleroderma.org
sfinfo@scleroderma.org



(800) 722-4673