

Editor's Memo

This issue marks my transition to editor-in-chief from my esteemed colleague, Dr Deborah J. Levine. Deb had the challenge of an extended editorship related to the pandemic and oversaw the successful transition of *Advances in Pulmonary Hypertension* to a fully online journal. I congratulate her on her tenure at *Advances* and further commend Deb for her continued, selfless dedication to our pulmonary arterial hypertension (PAH) community.

In my inaugural issue, Drs Layton and Avitabile tackle the critical impact of exercise on patients with pulmonary hypertension. It's hard to imagine that only 70 years ago recommending that a patient sit in a chair (rather than lying continually flat) within 1 week of a heart attack was considered medical heresy.¹ It would take almost another decade until early ambulation after such events was attempted.² The landmark Bethesda Conference nearly 20 years ago addressed competitive athletics for patients with cardiovascular disease. In this expert statement, the presence of concomitant pulmonary hypertension in patients with structural lesions was considered an absolute contraindication to participation in competitive athletics.³ It's therefore not surprising that PAH treatment algorithms as recently as a decade ago discouraged routine exercise.⁴ Exercise is a complex physiological event that impacts cardiovascular, pulmonary, and musculoskeletal systems. There are many forms of exercise (including

aerobic, resistance, and inspiratory muscle training) and, of course, significant disease heterogeneity among the PAH patient population. This limits the “one size fits all” paradigm, as so elegantly reviewed in the roundtable discussion.

Medical providers are often challenged with providing an “exercise prescription” for patients. It's important to realize that exercise is generally very safe, except for the sickest (World Health Organization Class IV) PAH patients. I often find myself saying, “Start slow and build your way up...” In almost every case, walking is a good place for patients to start—many are unaware that smart phones contain GPS tracking, which can help them follow their activity. Getting patients to increase their daily steps is essential. Though challenges for financial coverage remain, a referral for cardiac or pulmonary rehabilitation provides better motivation and individualized attention. It's important to remind resistant insurance companies that supervised exercise training is now a Class I recommendation for patients receiving medical therapy for PAH.⁵

The wonderful reviews that follow remind us that exercise has numerous beneficial effects on skeletal muscle biology, lung mechanics, and cardiovascular function. And even more importantly, exercise has been consistently shown to improve quality of life in PAH patients. Despite these demonstrated benefits, in 2020 less than a quarter of the US popu-

lation over 18 years of age met the 2018 physical activity guidelines for aerobic and muscle-strengthening activities.⁶ The main costs for patients (particularly with walking) is simply time and personal effort. Like any healthy lifestyle change, reinforcement during routine office visits is essential for continued success. And now it's time to “move on” to this issue...

References

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