METHODS FOR IMPROVING THE SAFETY OF TREATING PEDIATRIC PATIENTS WHO ARE CANDIDATES FOR INHALED NITRIC OXIDE TREATMENT

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ABSTRACT

Disclosed are methods of reducing the risk that a medical treatment comprising inhalation of nitric oxide gas will induce an increase in pulmonary capillary wedge pressure in pediatric patients, leading to pulmonary edema. The methods include avoiding or discontinuing administration of inhaled nitric oxide to a pediatric patient determined to have pre-existing left ventricular dysfunction but otherwise is a candidate for inhaled nitric oxide treatment (e.g., for pulmonary hypertension), and administering inhaled nitric oxide to pediatric patients who are candidates for such treatment and who are determined not to have pre-existing left ventricular dysfunction.
METHODS FOR IMPROVING THE SAFETY OF TREATING PEDIATRIC PATIENTS WHO ARE CANDIDATES FOR INHALED NITRIC OXIDE TREATMENT

CROSS REFERENCE TO RELATED APPLICATIONS

[0001] Not applicable.

STATEMENT CONCERNING GOVERNMENT INTEREST

[0002] Not applicable.

BACKGROUND OF THE INVENTION

[0003] INOmax® (nitric oxide) for inhalation is an approved drug product for the treatment of term and near-term (>34 weeks gestation) neonates having hypoxic respiratory failure associated with clinical or echocardiographic evidence of pulmonary hypertension.


SUMMARY OF THE INVENTION

[0005] One aspect of the invention relates to a prescreening methodology or protocol having exclusionary criteria to be evaluated by a medical provider prior to treatment of a patient with iNO. One objective of the invention is to evaluate and possibly exclude from treatment patients eligible for treatment with iNO, who have pre-existing left ventricular dysfunction (LVD). Patients who have pre-existing LVD may experience, and are at risk of, an increased rate of adverse events or serious adverse events (e.g., pulmonary edema) when treated with iNO. Such patients may be characterized as having a pulmonary capillary wedge pressure (PCWP) greater than 20 mm Hg, and should be evaluated on a case-by-case basis with respect to the benefit versus risk of using iNO as a treatment option.

[0006] Accordingly, one aspect of the invention includes a method of reducing the risk or preventing the occurrence, in a human patient, of an adverse event (AE) or a serious adverse event (SAE) associated with a medical treatment comprising inhalation of nitric oxide, said method comprising the steps or acts of (a) providing pharmaceutically acceptable nitric oxide gas to a medical provider; and, (b) informing the medical provider that excluding human patients who have pre-existing left ventricular dysfunction from said treatment reduces the risk or prevents the occurrence of the adverse event or the serious adverse event associated with said medical treatment.

[0007] Further provided herein is a method of reducing the risk or preventing the occurrence, in a human patient, of an adverse event or a serious adverse event associated with a medical treatment comprising inhalation of nitric oxide, said method comprising the steps or acts of (a) providing pharmaceutically acceptable nitric oxide gas to a medical provider; and, (b) informing the medical provider that human patients having pre-existing left ventricular dysfunction experience an increased risk of serious adverse events associated with said medical treatment.

[0008] Another aspect of the invention is a method of reducing one or more of an AE or a SAE in an intended patient population in need of being treated with iNO comprising the steps or acts of (a) identifying a patient eligible for iNO treatment; (b) evaluating and screening the patient to identify if the patient has pre-existing LVD, and (c) excluding from iNO treatment a patient identified as having pre-existing LVD.

[0009] Another aspect of the invention is a method of reducing the risk or preventing the occurrence, in a patient, of one or more of an AE or a SAE associated with a medical treatment comprising iNO, the method comprising the steps or acts of (a) identifying a patient in need of receiving iNO treatment; (b) evaluating and screening the patient to identify if the patient has pre-existing LVD; and (c) administering iNO if the patient does not have pre-existing LVD, thereby reducing the risk or preventing the occurrence of the AE or the SAE associated with the iNO treatment. Alternatively, step (c) may comprise further evaluating the risk versus benefit of utilizing iNO in a patient where the patients has clinically significant LVD before administering iNO to the patient.

[0010] In an exemplary embodiment of the method, the method further comprises informing the medical provider that there is a risk associated with using inhaled nitric oxides in human patients who have preexisting or clinically significant left ventricular dysfunction and that such risk should be evaluated on a case by case basis.

[0011] In another exemplary embodiment of the method, the method further comprises informing the medical provider that there is a risk associated with using inhaled nitric oxide in human patients who have left ventricular dysfunction.

[0012] In an exemplary embodiment of the methods described herein, a patient having pre-existing LVD is characterized as having PCWP greater than 20 mm Hg.

[0013] In an exemplary embodiment of the method, the patients having pre-existing LVD demonstrate a PCWPa20 mm Hg.

[0014] In another exemplary embodiment of the method, the iNO treatment further comprises inhalation of oxygen (O2) or concurrent ventilation.

[0015] In another exemplary embodiment of the method, the patients having pre-existing LVD have one or more of diastolic dysfunction, hypertensive cardiomyopathy, systolic dysfunction, ischemic cardiomyopathy, viral cardiomyopathy, idiopathic cardiomyopathy, autoimmune disease related cardiomyopathy, drug-related cardiomyopathy, toxin-related cardiomyopathy, structural heart disease, valvular heart disease, congenital heart disease, or associations thereof.

[0016] In another exemplary embodiment of the method, the patient population comprises children.
In another exemplary embodiment of the method, the patient population comprises adults.

In another exemplary embodiment of the method, the patients who have pre-existing LV systolic dysfunction and increased rate of one or more AEs or SAEs selected from pulmonary edema, hypotension, cardiac arrest, electrocardiogram changes, hypoxemia, hypoxia, bradycardia or associations thereof.

In another exemplary embodiment of the method, the intended patient population in need of being treated with inhalation of nitric oxide has one or more of idiopathic pulmonary arterial hypertension characterized by a mean pulmonary artery pressure (PAPm)>25 mm Hg at rest, PCWP≥15 mm Hg, and, a pulmonary vascular resistance index (PVRi)>3 u·m⁻²; congenital heart disease with pulmonary hypertension repaired and un repaired characterized by PAPm>25 mm Hg at rest and PVR>3 u·m⁻²; cardiomyopathy characterized by PAPm>25 mm Hg at rest and PVR>3 u·m⁻²; or the patient is scheduled to undergo right heart catheterization to assess pulmonary vasoreactivity by acute pulmonary vasodilatation testing.

In another exemplary embodiment of any of the above methods, the method further comprises reducing left ventricular afterload to minimize or reduce the risk of the occurrence of an adverse event or serious adverse event being pulmonary edema in the patient. The left ventricular afterload may be minimized or reduced by administering a pharmaceutical dosage form comprising nitroglycerin or calcium channel blocker to the patient. The left ventricular afterload may also be minimized or reduced using an intra-aortic balloon pump.

DETAILED DESCRIPTION OF THE EXEMPLARY EMBODIMENTS

INOMax® (nitric oxide) for inhalation was approved for sale in the United States by the U.S. Food and Drug Administration ("FDA") in 1999. Nitric oxide, the active substance in INOMax®, is a selective pulmonary vasodilator that increases the partial pressure of arterial oxygen (PaO₂) by dilating pulmonary vessels in better ventilated areas of the lung, redistributing pulmonary blood flow away from the lung regions with low ventilation/perfusion (V/Q) ratios toward regions with normal ratios. INOMax® significantly improves oxygenation, reduces the need for extracorporeal oxygenation and is indicated to be used in conjunction with ventilatory support and other appropriate agents. The current FDA-approved prescribing information for INOMax® is incorporated herein by reference in its entirety.

INOMax® is a gaseous blend of NO and nitrogen (0.08% and 99.92% respectively for 800 ppm; and 0.01% and 99.99% respectively for 100 ppm) and is supplied in aluminum cylinders as a compressed gas under high pressure. In general, INOMax® is administered to a patient in conjunction with ventilatory support and O₂. Delivery devices suitable for the safe and effective delivery of gaseous NO for inhalation include the INOvent®, INOMax DS®, INOpulse®, NOblender®, or other suitable drug delivery and regulation devices or components incorporated therein, or other related processes, which are described in various patent documents including U.S. Pat. Nos. 5,588,083; 5,732,693; 5,752,504; 5,732,694; 6,089,229; 6,109,260; 6,125,846; 6,164,276; 6,581,592; 5,918,956; 5,835,433; 7,114,510; 5,417,950; 5,670,125; 5,670,127; 5,692,495; 5,514,204; 5,623,752; 5,699,790; 5,885,621; U.S. patent application Ser. No. 11/355,670 (US 2007/0190184); Ser. No. 10/520,270 (US 2006/0093681); Ser. No. 11/401,722 (US 2007/0202083); Ser. No. 10/053,535 (US 2002/0155166); Ser. No. 10/367,277 (US 2003/0219496); Ser. No. 10/439,632 (US 2004/0052866); Ser. No. 10/371,666 (US 2003/0219497); Ser. No. 10/413,817 (US 2004/0055367); Ser. No. 12/050,826 (US 2008/0167609); and PCT/US/2009/045266, all of which are incorporated herein by reference in their entirety.

Such devices deliver INOMax® into the inspiratory limb of the patient breathing circuit in a way that provides a constant concentration of NO to the patient throughout the inspired breath. Importantly, suitable delivery devices provide continuous integrated monitoring of inspired O₂, NO, and NO, a comprehensive alarm system, a suitable power source for uninterrupted NO delivery and a backup NO delivery capability.

As used herein, the term “children” (and variations thereof) includes those being around 4 weeks to 18 years of age.

As used herein, the term “adult” (and variations thereof) includes those being over 18 years of age.

As used herein, the terms “adverse event” or “AE” (and variations thereof) mean any untoward occurrence in a subject, or clinical investigation subject administered a pharmaceutical product (such as nitric oxide) and which does not necessarily have a causal relationship with such treatment. An adverse event can therefore be any unfavorable and unintended sign (including an abnormal laboratory finding), symptom, or disease temporarily associated with the use of a medicinal/investigational product, whether or not related to the investigational product. A relationship to the investigational product is not necessarily proven or implied. However, abnormal values are not reported as adverse events unless considered clinically significant by the investigator.

As used herein, the terms “adverse drug reaction” or “ADR” (and variations thereof) mean any noxious and unintended response to a medicinal product related to any dose.

As used herein, the terms “serious adverse event” or “SAE” (or “serious adverse drug reaction” or “serious ADR”) (and variations thereof) mean a significant hazard or side effect, regardless of the investigator’s opinion on the relationship to the investigational product. A serious adverse event or reaction is any untoward medical occurrence that at any dose: results in death; is life-threatening (which refers to an event/reaction where the patient was at risk of death at the time of the event/reacton, however this does not refer to an event/reaction that hypothetically may have caused death if it were more severe); requires inpatient hospitalization or results in prolongation of existing hospitalization; results in persistent or significant disability/incapacity; is a congenital anomaly/birth defect; or, is a medically important event or reaction. Medical and scientific judgment is exercised in deciding whether reporting is appropriate in other situations, such as important medical events that may not be immediately life-threatening or result in death or hospitalization but may jeopardize the subject or may require medical or surgical intervention to prevent one of the other outcomes listed above—these are also considered serious. Examples of such medical events include cancer, allergic bronchospasm requiring intensive treatment in an emergency room or at home, blood dyscrasias or convulsions that do not result in hospitalizations, or the development of drug dependency or drug abuse. Serious clinical laboratory abnormalities directly associated with relevant clinical signs or symptoms are also reported.
Left Ventricular Dysfunction. Patients having pre-existing LVD may be described in general as those with elevated pulmonary capillary wedge pressure, including those with diastolic dysfunction (including hypertensive cardiomyopathy), those with systolic dysfunction, including those with cardiomyopathies (including ischemic or viral cardiomyopathy, or idiopathic cardiomyopathy, or autoimmune disease related cardiomyopathy), and side effects due to drug related or toxic-related cardiomyopathies, or structural heart disease, valvular heart disease, congenital heart disease, idiopathic pulmonary arterial hypertension, pulmonary hypertension and cardiomyopathy, or associations thereof. Identifying patients with pre-existing LVD is known to those skilled in the medical arts, and such techniques for example may include assessment of clinical signs and symptoms of heart failure, or echocardiography diagnostic screening.

Pulmonary Capillary Wedge Pressure. Pulmonary capillary wedge pressure, or “PCWP”, provides an estimate of left atrial pressure. Identifying patients with pre-existing PCWP is known to those skilled in the medical arts, and such techniques for example may include measure by inserting balloon-tipped, multi-lumen catheter (also known as a Swan-Ganz catheter). Measure of PCWP may be used as a means to diagnose the severity of LVD (sometimes also referred to as left ventricular failure). PCWP is also a desired measurement when evaluating pulmonary hypertension. Pulmonary hypertension is often caused by an increase in pulmonary vascular resistance (PVR), but may also arise from increases in pulmonary venous pressure and pulmonary blood volume secondary to left ventricular failure or mitral or aortic valve disease.

In cardiac physiology, afterload is used to mean the tension produced by a chamber of the heart in order to contract. If the chamber is not mentioned, it is usually assumed to be the left ventricle. However, the strict definition of the term relates to the properties of a single cardiac myocyte. It is therefore only of direct relevance in the laboratory; in the clinic, the term end-systolic pressure is usually more appropriate, although not equivalent.

The terms “left ventricular afterload” (and variations thereof) refer to the pressure that the chamber of the heart has to generate in order to eject blood out of the chamber. Thus, it is a consequence of the aortic pressure since the pressure in the ventricle must be greater than the systemic pressure in order to open the aortic valve. Everything else being equal, as afterload increases, cardiac output decreases. Disease processes that increase the left ventricular afterload include increased blood pressure and aortic valve disease. Hypertension (increased blood pressure) increases the left ventricular afterload because the left ventricle has to work harder to eject blood into the aorta. This is because the aortic valve won’t open until the pressure generated in the left ventricle is higher than the elevated blood pressure. Aortic stenosis increases the afterload because the left ventricle has to overcome the pressure gradient caused by the stenotic aortic valve in addition to the blood pressure in order to eject blood into the aorta. For instance, if the blood pressure is 120/80, and the aortic valve stenosis creates a trans-valvular gradient of 30 mmHg, the left ventricle has to generate a pressure of 110 mmHg in order to open the aortic valve and eject blood into the aorta. Aortic insufficiency increases afterload because a percentage of the blood that is ejected forward regurgitates back through the diseased aortic valve. This leads to elevated systolic blood pressure. The diastolic blood pressure would fall, due to regurgitation. This would result in an increase pulse pressure. Mitral regurgitation decreases the afterload. During ventricular systole, the blood can regurgitate through the diseased mitral valve as well as be ejected through the aortic valve. This means that the left ventricle has to work less to eject blood, causing a decreased afterload. Afterload is largely dependent upon aortic pressure.

An intra-aortic balloon pump (IABP) is a mechanical device that is used to decrease myocardial oxygen demand while at the same time increasing cardiac output. By increasing cardiac output it also increases coronary blood flow and therefore myocardial oxygen delivery. It consists of a cylindrical balloon that sits in the aorta and counterpulsates. That is, it actively deflates in systole increasing forward blood flow by reducing afterload, and actively inflates in diastole increasing blood flow to the coronary arteries. These actions have the combined result of decreasing myocardial oxygen demand and increasing myocardial oxygen supply. The balloon is inflated during diastole by a computer controlled mechanism, usually linked to either an ECG or a pressure transducer at the distal tip of the catheter; some IABPs, such as theDatascope System 98XT, allow for asynchronous counterpulsation at a set rate, though this setting is rarely used. The computer controls the flow of helium from a cylinder and out of the balloon. Helium is used because its low viscosity allows it to travel quickly through the long connecting tubes, and has a lower risk of causing a harmful embolism should the balloon rupture while in use. Intraaortic balloon counterpulsation is used in situations when the heart’s own cardiac output is insufficient to meet the oxygenation demands of the body. These situations could include cardiogenic shock, severe septic shock, post cardiac surgery and numerous other situations.

Patients eligible for treatment with iNO. In general, patients approved for treatment of iNO are term and near-term (>34 weeks gestation) neonates having hypoxic respiratory failure associated with clinical or echocardiographic evidence of pulmonary hypertension, a condition also known as persistent pulmonary hypertension in the newborn (PPHN). Due to the selective, non-systemic nature of iNO to reduce pulmonary hypertension, physicians skilled in the art further employ INOmax® to treat or prevent pulmonary hypertension and improve blood O₂ levels in a variety of other clinical settings, including in both pediatric and adult patients suffering from acute respiratory distress syndrome (ARDS), pediatric and adult patients undergoing cardiac or transplant surgeries, pediatric and adult patients for testing to diagnose reversible pulmonary hypertension, and in pediatric patients with congenital diaphragmatic hernia. In most, if not all, of these applications, INOmax® acts by preventing or treating reversible pulmonary vasoconstriction, reducing pulmonary arterial pressure and improving pulmonary gas exchange.

A small proportion of INOmax® sales stem from its use by clinicians in a premature infant population. In these patients, INOmax® is generally utilized by physicians as a rescue therapy primarily to vasodilate the lungs and improve pulmonary gas exchange. Some physicians speculate that INOmax® therapy may promote lung development and/or reduce or prevent the future development of lung disease in a subset of these patients. Although the precise mechanism(s)
responsible for the benefits of INOmax® therapy in these patients is not completely understood, it appears that the benefits achieved in at least a majority of these patients are due to the ability of INOmax® to treat or prevent reversible pulmonary vasoconstriction.

[0036] In clinical practice, the use of INOmax® has reduced or eliminated the use of high risk systemic vasodilators for the treatment of PPHN. INOmax®, in contrast to systemic vasodilators, specifically dilates the pulmonary vasculature without dilating systemic blood vessels. Further, iNO preferentially vasodilates vessels of the alevoli that are aerated, thus improving V/Q matching. In contrast, systemic vasodilators may increase blood flow to alveolar (deflated or collapsed) alevoli, thereby increasing V/Q mismatch and worsening arterial oxygenation. (See Rubin I J, Kerr K M, Pulmonary Hypertension, in Critical Care Medicine: Principles of Diagnosis and Management in the Adult, 2d Ed., Parillo J E, Dellinger R P (eds.), Mosby, Inc. 2001, pp. 900-09 at 906; Kinsella J P, Abman S H, The Role of Inhaled Nitric Oxide in Persistent Pulmonary Hypertension of the Newborn, in Acute Respiratory Care of the Neonate: A Self-Study Course, 2d Ed., Askin DF (ed.), NICU Ink Book Publishers, 1997, pp. 369-378 at 372-73).

[0037] INOmax® also possesses highly desirable pharmacokinetic properties as a lung-specific vasodilator when compared to other ostensibly "pulmonary-specific vasodilators." For example, the short half-life of INOmax® allows INOmax® to exhibit rapid "on" and "off" responses relative to INOmax® dosing, in contrast to non-gaseous alternatives. In this way, INOmax® can provide physicians with a useful therapeutic tool to easily control the magnitude and duration of the pulmonary vasodilation desired. Also, the nearly instantaneous inactivation of INOmax® in the blood significantly reduces or prevents vasodilatation of non-pulmonary vessels.

[0038] The pivotal trials leading to the approval of INOmax® were the CINRG1 and NINOS study.


[0040] This study was a double-blind, randomized, placebo-controlled, multicenter trial of 186 term and near-term neonates with pulmonary hypertension and hypoxic respiratory failure. The primary objectives of the study was to determine whether INOmax® would reduce the receipt of extracorporeal membrane oxygenation (ECMO) in these patients. Hypoxic respiratory failure was caused by meconium aspiration syndrome (MAS) (35%), idiopathic persistent pulmonary hypertension of the newborn (PPHN) (30%), pneumonia/sepsis (24%), or respiratory distress syndrome (RDS) (8%). Patients with a mean PaO2 of 54 mm Hg and a mean oxygenation index (OI) of 44 cm H2O/mm Hg were randomly assigned to receive either 20 ppm INOmax® (n=97) or nitrogen gas (placebo; n=89) in addition to their ventilatory support. Patients that exhibited a PaO2<60 mm Hg and a pH<7.55 were weaned to 5 ppm INOmax® or placebo. The primary results from the CINRG1 study are presented in Table 4. ECMO was the primary endpoint of the study.

### TABLE 1
Summary of Clinical Results from CINRG1 Study

<table>
<thead>
<tr>
<th></th>
<th>Placebo</th>
<th>INOmax®</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death or ECMO</td>
<td>51/89 (57%)</td>
<td>30/97 (31%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Death</td>
<td>5/89 (6%)</td>
<td>3/97 (3%)</td>
<td>0.48</td>
</tr>
</tbody>
</table>

[0041] Significantly fewer neonates in the ECMO group required ECMO, and INOmax® significantly improved oxygenation, as measured by PaO2, OI, and alveolar-arterial gradient.

[0042] NINOS study. (See Inhaled Nitric Oxide in Full-Term and Nearly Full-Term Infants with Hypoxic Respiratory Failure; NEJM, Vol. 336, No. 9, 597).

[0043] The Neonatal Inhaled Nitric Oxide Study (NINOS) group conducted a double-blind, randomized, placebo-controlled, multicenter trial in 235 neonates with hypoxic respiratory failure. The objective of the study was to determine whether iNO would reduce the occurrence of death and/or initiation of ECMO in a prospectively defined cohort of term or near-term neonates with hypoxic respiratory failure unresponsive to conventional therapy. Hypoxic respiratory failure was caused by meconium aspiration syndrome (MAS; 49%), pneumonia/sepsis (21%), idiopathic primary pulmonary hypertension of the newborn (PPHN; 17%), or respiratory distress syndrome (RDS; 11%). Infants 14 days of age (mean, 1.7 days) with a mean PaO2 of 46 mm Hg and a mean oxygenation index (OI) of 43 cm H2O/mm Hg were initially randomized to receive 100% O2 with (n=114) or without (n=121) 20 ppm NO for up to 14 days. Response to study drug was defined as a change from baseline in PaO2 30 minutes after starting treatment (full response>=20 mm Hg, partial=10-20 mm Hg, no response=<10 mm Hg). Neonates with a less than full response were evaluated for a response to 80 ppm NO or control gas. The primary results from the NINOS study are presented in Table 2.

### TABLE 2
Summary of Clinical Results from NINOS Study

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>NO</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death or ECMO*</td>
<td>77 (64%)</td>
<td>52 (46%)</td>
<td>0.006</td>
</tr>
<tr>
<td>Death</td>
<td>20 (17%)</td>
<td>16 (14%)</td>
<td>0.60</td>
</tr>
<tr>
<td>ECMO</td>
<td>66 (55%)</td>
<td>44 (39%)</td>
<td>0.014</td>
</tr>
</tbody>
</table>

*Extracorporeal membrane oxygenation
† Death or need for ECMO was the study's primary endpoint

[0044] Adverse Events from CINRG1 & NINOS. Controlled studies have included 325 patients on INOmax® doses of 5 to 80 ppm and 251 patients on placebo. Total mortality in the pooled trials was 11% on placebo and 9% on INOmax®, a result adequate to exclude INOmax® mortality being more than 40% worse than placebo.

[0045] In both the NINOS and CINRG1 studies, the duration of hospitalization was similar in INOmax® and placebo-treated groups.

[0046] From all controlled studies, at least 6 months of follow-up is available for 278 patients who received INOmax® and 212 patients who received placebo. Among these patients, there was no evidence of an AE of treatment on the need for re-hospitalization, special medical services, pulmonary disease, or neurological sequel.
In the NINOS study, treatment groups were similar with respect to the incidence and severity of intracranial hemorrhage, Grade IV hemorrhage, per ventricular leukomalacia, cerebral infarction, seizures requiring anticonvulsant therapy, pulmonary hemorrhage, or gastrointestinal hemorrhage.

The table below shows adverse reactions that occurred in at least 5% of patients receiving INOmax® in the CINRGI study. None of the differences in these adverse reactions were statistically significant when INO patients were compared to patients receiving placebo.

### TABLE 3

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Placebo (n = 89)</th>
<th>Inhaled NO (n = 97)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaphylaxis</td>
<td>5 (4.5%)</td>
<td>7 (6.5%)</td>
</tr>
<tr>
<td>Bilirubinemia</td>
<td>6 (5.5%)</td>
<td>7 (6.5%)</td>
</tr>
<tr>
<td>Hypokalemia</td>
<td>5 (4.8%)</td>
<td>9 (8.3%)</td>
</tr>
<tr>
<td>Hypertension</td>
<td>3 (2.9%)</td>
<td>6 (5.6%)</td>
</tr>
<tr>
<td>Thromboembolus</td>
<td>20 (19.2%)</td>
<td>16 (14.8%)</td>
</tr>
</tbody>
</table>

Post-Marketing Experience. The following AEs have been reported as part of the post-marketing surveillance. These events have not been reported above. Given the nature of spontaneously reported post-marketing surveillance data, it is impossible to determine the actual incidence of the events or definitively establish their causal relationship to the drug. The listing is alphabetical: dose errors associated with the delivery system; headaches associated with environmental exposure of INOmax® in hospital staff; hypotension associated with acute withdrawal of the drug; hypoxemia associated with acute withdrawal of the drug; pulmonary edema in patients with CRUST syndrome.

An analysis of AEs and SAEs from both the CINRGI and NINOS studies, in addition to post-marketing surveillance, did not suggest that patients who have pre-existing LVD could experience an increased risk of AEs or SAEs. Nor was it predictable to physicians skilled in the art that patients having pre-existing LVD (possibly identified as those patients having a PCWP greater than 20 mmHg) should be evaluated in view of the benefit versus risk of using iNO in patients with clinically significant LVD, and that these patients should be evaluated on a case by case basis.

**EXAMPLE 1**

**INO22 Study**

The INO22, entitled “Comparison of supplemental oxygen and nitric oxide for inhalation plus oxygen in the evaluation of the reactivity of the pulmonary vasculature during acute pulmonary vasodilatory testing” was conducted both to access the safety and effectiveness of INOmax® as a diagnostic agent in patients undergoing assessment of pulmonary hypertension (primary endpoint), and to confirm the hypothesis that iNO is selective for the pulmonary vasculature (secondary endpoint).

During, and upon final analysis of the INO22 study results, applicants discovered that rapidly decreasing the pulmonary vascular resistance, via the administration of iNO to a patient in need of such treatment, may be detrimental to patients with concomitant, pre-existing LVD. Therefore, a precaution for patients with LVD was proposed to be included in amended prescribing information for INOmax®. Physicians were further informed to consider reducing left ventricular afterload to minimize the occurrence of pulmonary edema in patients with pre-existing LVD.

In particular, the INOT22 protocol studied consecutive children undergoing cardiac catheterization that were prospectively enrolled at 16 centers in the US and Europe. Inclusion criteria: 4 weeks to 18 years of age, pulmonary hypertension diagnosis, i.e. either idiopathic pulmonary hypertension (IPAH) or related to congenital heart disease (CHD) (repaired or unrepaired) or cardiomyopathy, with pulmonary vascular resistance index (PVRI)>5 μm². Later amendments, as discussed herein, added an additional inclusion criteria of a PCWP less than 20 gmmHg. Patients were studied under general anesthesia, or with conscious sedation, according to the practice of the investigator. Exclusion criteria: focal infiltrates on chest X-ray, history of intrinsic lung disease, and/or currently taking PDE-5 inhibitors, prostanycin analogues or sodium nitroprusside. The study involved supplemental O₂ and NO for inhalation plus O₂ in the evaluation of the reactivity of the pulmonary vasculature during acute pulmonary vasodilator testing. Consecutive children undergoing cardiac catheterization were prospectively enrolled at 16 centers in the US and Europe. As hypotension is expected in these neonatal populations, the comparison between iNO and placebo groups is difficult to assess. A specific secondary endpoint was evaluated in study INOT22 to provide a more definitive evaluation.

The primary objective was to compare the response frequency with iNO and O₂ vs. O₂ alone; in addition, all subjects were studied with iNO alone. Patients were studied during five periods: Baseline 1, Treatment Period 1, Treatment Period 2, Baseline 2 and Treatment Period 3. All patients received all three treatments; treatment sequence was randomized by center in blocks of 4; in Period 1, patients received either NO alone or O₂ alone, and the alternate treatment in Period 3. All patients received the iNO and O₂ combination treatment in Period 2. Once the sequence was assigned, treatment was unblinded. Each treatment was given for 10 minutes prior to obtaining hemodynamic measurements, and the Baseline Period 2 was at least 10 minutes.

Results for the intent-to-treat (ITT) population, defined as all patients who were randomized to receive drug, indicated that treatment with NO plus O₂ and O₂ alone significantly increased systemic vascular resistance index (SVRI) (Table 4). The change from baseline for NO plus O₂ was 1.4 Woods Units per meter² (WU m²) (p=0.007) and that for O₂ was 1.3 WU m² (p=0.004). While the change from baseline in SVRI with NO alone was -0.2 WU m² (p=0.899) which demonstrates a lack of systemic effect.

### TABLE 4

<table>
<thead>
<tr>
<th>SVRI Change From Baseline by Treatment (Intent-to-Treat)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SVRI (WU m²)</th>
<th>NO Plus O₂ (n = 109)</th>
<th>O₂ (n = 106)</th>
<th>NO (n = 106)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (room air)</td>
<td>Mean 17.2 17.6 18.0</td>
<td>Standard Deviation (SD) 8.86 9.22 8.44</td>
<td>Median 15.9 16.1 16.2</td>
</tr>
</tbody>
</table>
TABLE 4—continued

<table>
<thead>
<tr>
<th>SVRI Change From Baseline by Treatment (Intent-to-Treat)</th>
<th>( n = 105 )</th>
<th>( n = 105 )</th>
<th>( n = 105 )</th>
</tr>
</thead>
<tbody>
<tr>
<td>SVRI (WU \cdot \text{m}^2)</td>
<td>NO Plus O\textsubscript{2}</td>
<td>O\textsubscript{2}</td>
<td>NO</td>
</tr>
<tr>
<td>Post-treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>18.7</td>
<td>18.9</td>
<td>17.8</td>
</tr>
<tr>
<td>SD</td>
<td>9.04</td>
<td>8.78</td>
<td>9.40</td>
</tr>
<tr>
<td>Median</td>
<td>17.1</td>
<td>17.1</td>
<td>15.4</td>
</tr>
<tr>
<td>Minimum, maximum</td>
<td>3.0, 47.4</td>
<td>3.9, 43.6</td>
<td>3.3, 50.7</td>
</tr>
<tr>
<td>Change From Baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>1.4</td>
<td>1.3</td>
<td>-0.2</td>
</tr>
<tr>
<td>SD</td>
<td>5.94</td>
<td>5.16</td>
<td>4.65</td>
</tr>
<tr>
<td>Median</td>
<td>1.2</td>
<td>1.0</td>
<td>0.2</td>
</tr>
<tr>
<td>Minimum, maximum</td>
<td>-20.5, 19.1</td>
<td>-18.1, 17.7</td>
<td>-12.5, 12.7</td>
</tr>
<tr>
<td>p-value&lt;sup&gt;a&lt;/sup&gt;</td>
<td>0.007</td>
<td>0.004</td>
<td>0.899</td>
</tr>
</tbody>
</table>

Pairwise comparisons
NO plus O\textsubscript{2} versus O\textsubscript{2}, \( p = 0.952 \)
NO plus O\textsubscript{2} versus NO, \( p = 0.014 \)
O\textsubscript{2} versus NO, \( p = 0.017 \)

<sup>a</sup> p-value from a Wilcoxon Signed Rank Test. Only patients with data to determine response at both treatments are included in this analysis.

Source: INOT22 CSR Table 6.4.1 and Appendix 16.2.6 (ATTACHMENT 1)

[0056] The ideal pulmonary vasodilator should reduce PVRI and/or PAP/m while having no appreciable effect on systemic blood pressure or SVRI. In this case, the ratio of PVRI to SVRI would decrease, given some measure of the selectivity of the agent for the pulmonary vascular bed. The change in the ratio of PVRI to SVRI by treatment is shown in Table 5.

TABLE 5

<table>
<thead>
<tr>
<th>Change in Ratio of PVRI to SVRI by Treatment (Intent-to-Treat)</th>
</tr>
</thead>
<tbody>
<tr>
<td>( n = 108 )</td>
</tr>
<tr>
<td>Ratio PVRI/SVRI</td>
</tr>
<tr>
<td>Baseline</td>
</tr>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>SD</td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>Minimum, Maximum</td>
</tr>
<tr>
<td>Post Treatment</td>
</tr>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>SD</td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>Minimum, Maximum</td>
</tr>
<tr>
<td>Change from Baseline</td>
</tr>
<tr>
<td>Mean</td>
</tr>
<tr>
<td>SD</td>
</tr>
<tr>
<td>Median</td>
</tr>
<tr>
<td>Minimum, Maximum</td>
</tr>
<tr>
<td>P Value&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>Wilcoxon Signed Rank Test
Source: INOT22 CSR Table 6.5.2 (ATTACHMENT 3)

[0058] NO Plus O\textsubscript{2} appeared to provide the greatest reduction in the ratio, suggesting that NO plus O\textsubscript{2} was more selective for the pulmonary vasculature than either agent alone.

[0059] Overview of Cardiovascular Safety. In the INOT22 diagnostic study, all treatments (NO plus O\textsubscript{2}, O\textsubscript{2}, and NO) were well-tolerated. Seven patients of 134 treated experienced an AE during the study. These included cardiac arrest, bradycardia, low cardiac output (CO) syndrome, elevated ST segment (the portion of an electrocardiogram between the end of the QRS complex and the beginning of the T wave) on the electrocardiography (ECG) decreased O\textsubscript{2} saturation, hypotension, mouth hemorrhage and pulmonary hypertension (PH). The numbers of patients and events were too small to determine whether risk for AEs differed by treatment, diagnosis, age, gender or race. Eight patients are shown in Table 5 due to the time period in which events are reported. AEs were reported for 12 hours or until hospital discharge (which limits the period in which such events can be reported). There is technically no time limit in which SAEs are to be reported. So, there were 7 AEs during the study and at least one SAE after the study.

[0060] A total of 4 patients had AEs assessed as being related to study drug. These events included bradycardia, low CO syndrome, ST segment elevation on the ECG, low O\textsubscript{2} saturation, PH and hypotension. All but 2 AEs were mild or moderate in intensity and were resolved. Study treatments had slight and non-clinically significant effects on vital signs including heart rate, systolic arterial pressure and diastolic arterial pressure. When an investigator records an AE, they are required to say if (in their opinion) the event is related to the treatment or not. In this case, 4 of 7 were considered by the investigator to be related to treatment.

[0061] The upper limit of normal PCWP in children is 10-12 mm Hg and 15 mm Hg in adults. In INOT22, a baseline PCWP value was not included as exclusion criteria. However, after the surprising and unexpected identification of SAEs in the early tested patients, it was determined that patients with
pre-existing LVD had an increased risk of experiencing an AE or SAE upon administration (e.g., worsening of left ventricular function due to the increased flow of blood through the lungs). Accordingly, the protocol for INOT22 was thereafter amended to exclude patients with a baseline PCWP greater than 20 mm Hg after one patient experienced acute circulatory collapse and died during the study. The value "20 mm Hg" was selected to avoid enrollment of a pediatric population with LVD such that they would be most likely at-risk for these SAEs.

[0062] SAEs were collected from the start of study treatment until hospital discharge or 12 hours, whichever occurred sooner. Three SAEs were reported during the study period, and a total of 7 SAEs were reported. Three of these were fatal SAEs and 4 were nonfatal (one of which led to study discontinuation). In addition, one non-serious AE also led to discontinuation. A list of subjects who died, discontinued or experienced an SAE is provided in Table 5 below.

<table>
<thead>
<tr>
<th>Subjects that died, discontinued or experienced SAEs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient number</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>01020</td>
</tr>
<tr>
<td>02002</td>
</tr>
<tr>
<td>04001</td>
</tr>
<tr>
<td>04003</td>
</tr>
<tr>
<td>04008</td>
</tr>
<tr>
<td>05002</td>
</tr>
<tr>
<td>07003</td>
</tr>
<tr>
<td>17001</td>
</tr>
</tbody>
</table>

[0063] Two of the 3 fatal SAEs were deemed related to therapy. All 4 non-fatal SAEs were also considered related to therapy. The numbers of patients and events were too small to determine whether risk for SAEs differed by treatment, diagnosis, age, gender or race. At least two patients developed signs of pulmonary edema (subjects 05002 and 02002). This is of interest because pulmonary edema has previously been reported with the use of iNO in patients with LVD, and may be related to decreasing PVRI and overfilling of the left atrium. (Hayward C S et al., 1996, Inhaled Nitrile Oxide in Cardiac Failure: Vascular Versus Ventricular Effects, J Cardiovascular Pharmacology 27:80-85; Bocchi E A et al., 1994, Inhaled Nitrile Oxide Leading to Pulmonary Edema in Stable Severe Heart Failure, Am J Cardiology 74:70-72; and, Semigran M J et al., 1994, Hemodynamic Effects of Inhaled Nitrile Oxide in Heart Failure, J Am Coll Cardiology 24:982-988).

[0064] Although the SAE rate is within range for this population, it appears that patients with the most elevated PCWP at baseline had a disproportionately high number of these events. (Bocchi E A et al., 1994; Semigran M J et al., 1994).

[0065] In the INOT22 study, 10 of the total 134 patients had a baseline PCWP of 18 mm Hg (7.5%), of which, 3 subjects (04001, 02002 and 04003) had a SAE or were prematurely discontinued from the study (30%) compared to 6.5% for the entire cohort.

[0066] Although there were very few significant AEs in the INOT22 study, these events are consistent with the expected physiologic changes in patients with severe LVD. The events also corroborate prior observations that iNO is rapidly acting, selective for the pulmonary vasculature, and well-tolerated in most patients. The actual incidence of acute LVD during acute ventricular failure (AVF) is unknown. However, it is reasonable to expect that a significant number of patients are at-risk for an increased incidence of SAEs upon iNO treatment based upon the nature of the underlying nature of the illness, i.e., pulmonary hypertension and cardiovascular disease more generally. Thus, it would be advantageous to have physicians identify these patients prior to beginning iNO treatment, so that the physicians are alerted to this possible outcome.

[0067] Benefits and Risks: Conclusions. The INOT22 study was designed to demonstrate the physiologic effects of iNO in a well defined cohort of children (i.e., intended patient population) with pulmonary hypertension using a high concentration, 80 ppm, of iNO, i.e., one that would be expected to have the maximal pharmacodynamic effect. INOT22 was the largest and most rigorous pharmacodynamic study of iNO conducted to date, and it confirms a number of prior observations, such as iNO being rapidly acting, selective for the pulmonary vasculature, and well-tolerated in most patients.

[0068] It is also acknowledged that rapidly decreasing the PVR may be undesirable and even dangerous in patients with concomitant LVD. In the INOT22 study, the overall numbers of SAEs and fatal SAEs are within the expected range for patients with this degree of cardiopulmonary disease. The overall rate is 7/124 (5.6%), which is closely comparable to the rate of 6% recently reported in a very similar cohort of patients. (Taylor C J et al., 2007, Risk of cardiac catheterization under anaesthesia in children with pulmonary hypertension, Br J Anaesth 98(5):657-61). Thus, the overall rate of SAEs would seem to be more closely related to the underlying severity of illness of the patients rather than to the treatments given during this study.

[0069] The INOT22 study results demonstrate that patients who had pre-existing LVD may experience an increased rate of SAEs (e.g., pulmonary edema). During the course of the study, the protocol was amended to exclude patients with a PCWP>20 mm Hg. The benefit/risk of using iNO in patients with clinically significant LVD should be evaluated on a case by case basis. A reduction in left ventricular afterload may perhaps be applied to minimize the occurrence of pulmonary edema.

1-30. (canceled)

31. A method of improving the safety of treating hypoxic respiratory failure in neonates by reducing the risk of inducing pulmonary edema, the method comprising:
(a) identifying a plurality of neonatal patients who have hypoxic respiratory failure;
(b) determining that a first patient of the plurality does not have pre-existing left ventricular dysfunction;
(c) administering a first treatment regimen to the first patient, wherein the first treatment regimen comprises administration of 20 ppm inhaled nitric oxide for 14 days or until the first patient’s hypoxia has resolved;
(d) determining that a second patient of the plurality has pre-existing left ventricular dysfunction, so is at particular risk of pulmonary edema upon treatment with inhaled nitric oxide; and
(e) based on the determination of (d), selecting and administering a second treatment regimen to the second patient, wherein the second treatment regimen does not comprise either (i) administration of inhaled nitric oxide...
for 14 days or (ii) administration of inhaled nitric oxide until the second patient’s hypoxia has resolved, and does
comprise one or more other therapies selected from vasodilators, intravenous fluids, bicarbonate therapy and mechanical ventilation.
32. The method of claim 31, wherein the second treatment regimen comprises mechanical ventilation.
33. The method of claim 31, wherein the second treatment regimen does not comprise administration of inhaled nitric oxide.
34. The method of claim 31, wherein the second treatment regimen comprises beginning administration of inhaled nitric oxide, but discontinuing the administration upon determining that inhaling nitric oxide has increased the second patient’s pulmonary capillary wedge pressure (PCWP), the discontinuation being at a point before the second patient has received 14 days of inhaled nitric oxide administration and before the second patient’s hypoxia has resolved.
35. The method of claim 31, wherein the second treatment regimen comprises beginning administration of inhaled nitric oxide, but discontinuing the administration upon determining that inhaling nitric oxide has induced pulmonary edema in the second patient, the discontinuation being at a point before the second patient has received 14 days of inhaled nitric oxide administration and before the second patient’s hypoxia has resolved.
36. The method of claim 31, comprising performing a diagnostic process to identify the second patient as having hypoxic respiratory failure.
37. The method of claim 36, wherein the diagnostic process comprises echocardiography.
38. The method of claim 31, wherein the first and second patients are term or near-term neonates.
39. The method of claim 31, wherein the selection of the second treatment regimen is based not only on a determination that the second patient is at particular risk of pulmonary edema, but also on a determination that the second patient is at particular risk of other serious adverse events, upon treatment with inhaled nitric oxide.
40. A method of improving the safety of treating hypoxic respiratory failure in neonates by reducing the risk of inducing pulmonary edema, the method comprising:
   (a) identifying a plurality of neonatal patients who have hypoxic respiratory failure;
   (b) determining that a first patient of the plurality does not have pre-existing left ventricular dysfunction;
   (c) administering a first treatment regimen to the first patient, wherein the first treatment regimen comprises administration of 20 ppm inhaled nitric oxide;
   (d) determining that a second patient of the plurality has pre-existing left ventricular dysfunction, so is at particular risk of pulmonary edema upon treatment with inhaled nitric oxide; and
   (e) based on the determination of (d), selecting and administering a second treatment regimen to the second patient, wherein the second treatment regimen does not comprise administration of inhaled nitric oxide, and does comprise one or more other therapies selected from vasodilators, intravenous fluids, bicarbonate therapy and mechanical ventilation.
41. The method of claim 40, wherein the second treatment regimen comprises mechanical ventilation.
42. The method of claim 40, comprising performing a diagnostic process to identify the second patient as having hypoxic respiratory failure.
43. The method of claim 42, wherein the diagnostic process comprises echocardiography.
44. The method of claim 40, wherein the second patient is a term or near-term neonate.
45. The method of claim 40, wherein the selection of the second treatment regimen is based not only on a determination that the second patient is at particular risk of pulmonary edema, but also on a determination that the second patient is at particular risk of other serious adverse events, upon treatment with inhaled nitric oxide.
46. A method of improving the safety of treating pulmonary hypertension in pediatric patients by reducing the risk of inducing pulmonary edema, the method comprising:
   (a) identifying a pediatric patient having pulmonary hypertension and pre-existing left ventricular dysfunction;
   (b) determining that, because the patient has pre-existing left ventricular dysfunction, the patient is at particular risk of increased PCWP leading to pulmonary edema, when treated with inhaled nitric oxide;
   (c) treating the patient with 20 ppm inhaled nitric oxide;
   (d) determining that the patient’s PCWP increased during the treatment; and
   (e) based on the determinations of (b) and (d), discontinuing the inhaled nitric oxide treatment.
47. The method of claim 46, wherein the pulmonary hypertension is associated with hypoxia, and the discontinuation occurs at a point before the patient has received 14 days of inhaled nitric oxide administration and before the patient’s hypoxia has resolved.
48. The method of claim 46, wherein the discontinuation is based not only on a determination that the patient is at particular risk of increased PCWP leading to pulmonary edema, but also on a determination that the patient is at particular risk of other serious adverse events, upon treatment with inhaled nitric oxide.
49. The method of claim 46, comprising performing a diagnostic process to identify the patient as having pulmonary hypertension.
50. The method of claim 46, wherein the patient is a neonate.
51. The method of claim 46, wherein the patient is a term or near-term neonate.
52. The method of claim 46, wherein the patient’s pulmonary hypertension is associated with hypoxic respiratory failure.
53. The method of claim 52, wherein the patient is a neonate.
54. A method of improving the safety of treating hypoxic respiratory failure in neonates by reducing the risk of inducing pulmonary edema, the method comprising:
   (a) identifying a neonatal patient as having hypoxic respiratory failure and pre-existing left ventricular dysfunction;
   (b) determining that, because the patient has pre-existing left ventricular dysfunction, the patient is at particular risk of pulmonary edema when treated with inhaled nitric oxide;
   (c) treating the patient with 20 ppm inhaled nitric oxide; and
   (d) discontinuing the inhaled nitric oxide treatment due to the determination of (b).
55. The method of claim 54, wherein the discontinuation occurs at a point before the patient has received 14 days of inhaled nitric oxide administration and before the patient’s hypoxia has resolved.

56. The method of claim 54, comprising performing a diagnostic process to identify the patient as having hypoxic respiratory failure.

57. The method of claim 56, wherein the diagnostic process comprises echocardiography.

58. The method of claim 54, wherein the patient is a term or near-term neonate.

59. The method of claim 55, wherein the patient is a term or near-term neonate.

60. The method of claim 54, wherein the discontinuation is due not only to the determination that the patient is at particular risk of pulmonary edema, but also due to a determination that the patient is at particular risk of other serious adverse events, upon treatment with inhaled nitric oxide.

* * * * *