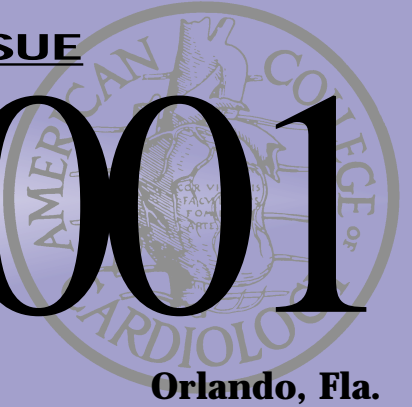


SCIENTIFIC SESSION NEWS SPOTLIGHT ISSUE

# ACCIS 2001



American College of Cardiology Interventional Symposium

March 18-21, 2001

Orlando, Fla.

SPOTLIGHT ON

## INTERVENTIONAL CARDIOLOGY

### ACCIS Serves Up Full Menu of Interventional Cardiology

ACC 2001 is offering physicians involved in interventional cardiology a unique opportunity to learn about the



Jeffrey J. Popma, MD

latest advancements in coronary and peripheral arterial disease during three and a half days of lectures and discussions devoted to these topics.

ACCIS 2001, the College's Interventional spotlight session, co-sponsored by the Society for Cardiac Angiography & Interventions, is back for its third year and has made a name for itself as an important forum for interventional cardiologists to discuss the latest topics in the field through plenary lectures, live case demonstrations, late-breaking clinical trial updates, analyses of controversies in

the field, and workshops about specific problem areas for patients with coronary artery disease.

"The planning committee set out to make the ACCIS 2001 program as clinical as possible by including comprehensive discussions about the practical issues facing clinicians today," said



George W. Vetrovec, MD

Jeffrey J. Popma, MD, co-chair of ACCIS 2001.

Dr. Popma's co-chair is George W. Vetrovec, MD, chair of the Division of Cardiology and professor of medicine at Virginia Commonwealth University, Medical College of Virginia in Richmond.

ACCIS 2001 attendees will leave this spotlight session with a compre-



Building on the success of the College's previous two interventional cardiology spotlight sessions, ACCIS 2001 once again offers three and a half days of programming covering the latest in clinical trial information, device developments, live demonstrations, and case presentations.

hensive understanding of existing and new interventional modalities as well as knowledge regarding the most current techniques and management strategies in interventional cardiology.

"All interventional cardiologists can benefit by participating in this important meeting. Plus, the opportunity for faculty and participant interaction provides the best kind of educational experience," said Dr. Popma, who is director of interventional cardiology at Brigham and Women's Hospital and associate professor of medicine at Harvard Medical School in Boston.

ACCIS 2001 attendees will also obtain a better understanding of the indications and contraindications for coronary and peripheral intervention, learn practical tips for performing complex interventions, and enhance their overall understanding of coronary and vascular interventions, noted Dr. Vetrovec.

Drs. Popma and Vetrovec pointed to several compelling presentations, including the first session on treatment of ischemic coronary artery disease. "The Sunday morning plenary sessions will review the controversies in the management of coronary artery disease, with Dr. Steven Nissen discussing why he believes that medical therapy is an underused option in

patients with coronary artery disease, Dr. David Holmes discussing advances in coronary intervention that make it the treatment of choice in patients with coronary artery disease, and Dr. Patrick Serruys providing a glimpse into future technologies," said Dr. Popma.

The ACCIS spotlight session will also cover late-breaking clinical trials in interventional cardiology; live and taped interventional case demonstrations; physiologic and anatomic assessment case reviews; arterial access issues; complications of prevention, recognition, and management; problem solving in interventional cardiology; investigations into coronary stents; diagnosis and percutaneous treatment of peripheral vascular disease; matching lesions and devices; and predictors of restenosis.

"ACCIS 2001 will continue throughout the ACC Annual Scientific Session, with a seamless format of additional late-breaking clinical trials, meet-the-expert sessions focused on specialty topics in interventional cardiology, clinical symposia, evening panel discussions, and featured and moderated abstracts relating to topics in coronary and peripheral vascular intervention," Dr. Popma said.

### Live Case Demos Reveal Up-and-Coming Advances in Interventional Cardiology

Live case demonstrations will offer ACCIS 2001 attendees an in-depth look at some of the more difficult patient complications physicians can encounter in interventional cardiology and how several new devices are being used to treat patients at risk for these complications.

The case demonstrations are being broadcast from a number of prestigious institutions, including the Mayo Clinic in Rochester, Minn.; Institute Dante Pazzanese of Cardiology in Sao Paulo, Brazil; and Stanford University Hospital in Palo Alto, Calif.

According to David R. Holmes, Jr., MD, director of the Cardiac Catheterization Laboratory, profes-

sor of medicine, and consultant in cardiovascular diseases at the Mayo Clinic, these sessions are geared toward giving attendees both broad and detailed information regarding what's on the horizon for interventional cardiologists.

"These sessions document the changes that are occurring in practice patterns, including patient selection, and they feature new devices that are being used to treat patients," he said.

Dr. Holmes hopes these intense cases will give attendees the troubleshooting knowledge they need to manage complications as well as outline strategies for encountering complications in high-risk patients.

ACCIS 2001

## GREAT DEBATES IN INTERVENTIONAL CARDIOLOGY

# Peripheral Vascular Disease: Panelists Debate Training

The level of training interventional cardiologists possess for performing peripheral vascular interventions certainly varies from physician to physician. Some work under a mentor in an academic program, some participate in a dedicated fellowship program, and some participate in hands-on mini-fellowships. As more and more patients require treatment for peripheral vascular diseases, the question of what constitutes adequate training has become a concern.

Two interventional cardiologists with varied training backgrounds are debating this issue during the ACCIS 2001 "Great Debates in Peripheral Vascular Disease" session. J. Michael Bacharach, MD, MPH, section head of vascular medicine and intervention at the North Central Heart Institute and assistant professor at the University of South Dakota in Sioux Falls, thinks more formal training is required. Christopher J. White, MD, chair of cardiology at the Ochsner

Clinic in New Orleans, believes that physicians with coronary interventional skills can be fast-tracked to provide this care.

Dr. Bacharach, who was a fellow in peripheral vascular intervention at the Cleveland Clinic, advocates that physicians make time to participate in formal training programs. Dr. Bacharach developed a tiered approach to training at the North Central Heart Institute, where several levels of peripheral vascular intervention training are provided. With each level of training, physicians advance from doing balloon angioplasty and stenting in legs to stenting visceral arteries to performing carotid angiography and stents.

"I don't want someone going to a weekend course to learn all the procedures for peripheral vascular disease interventions," said Dr. Bacharach.

Dr. White believes it is impractical to expect practicing physicians to return for one year of formal training

for such an endeavor. He suggests that the few existing peripheral vascular disease training programs cannot turn out enough trained physicians to meet patient demand.

"There is a huge demand for these services, and the few formally trained physicians cannot treat all the patients who need to be treated," said Dr. White. "We'd need to train an army of cardiologists, radiologists, and surgeons."

Because the number and diversity of peripheral interventions is vast, Dr. Bacharach thinks some kind of formal training is necessary. "Although cardiologists have the background and basic wire skills to perform these procedures well, you cannot extrapolate that cardiologists can do these procedures with little training," he said. "My approach is to take someone who is experienced and gradually bring them into the area of peripheral vascular intervention."

Dr. White believes that interven-

tional cardiologists already have the necessary technical skills to perform the procedures that are in greatest demand, such as iliac and renal interventions. He contends that a more appropriate solution is to place more emphasis on self-study and on quality assurance to ensure high-quality care.

"It doesn't take me a year to teach an interventional cardiologist how to place an iliac stent," said Dr. White. "It will require serious commitment by each practitioner to master the fund of knowledge required to treat patients with peripheral vascular disease."

Although Drs. Bacharach and White differ on the required level of training, they both agree that cardiologists, because of their expertise in percutaneous interventions and the fact that atherosclerosis is a systemic disease, are ideally suited for caring for patients with peripheral vascular disease.

# When to Perform a Diagnostic Renal Arteriography

The debate over whether to perform a diagnostic renal arteriography during cardiac catheterization can be heated, and two expert cardiovascular physicians are taking opposite positions to reveal the pros and the cons of this controversy during Sunday's "Great Debates in Peripheral Vascular Disease" session.

Jeffrey W. Olin, DO, director of the Heart and Vascular Institute in Morristown, N.J., will present the con opinion, and Richard S. Stack, MD, co-director of the Interventional Cardiovascular Program at Duke

University Medical Center in Durham, N.C., will look at the pro side.

Dr. Olin offered sneak preview of his position: He noted that a diagnostic renal arteriography need not accompany every cardiac catheterization. Studies have shown that between 30 and 40 percent of cardiac catheterization patients will experience a narrowing of the arteries to their kidneys, he said. And he contends that only a clear clinical indication, such as poorly controlled blood pressure, renal insufficiency, or recurrent episodes of congestive heart failure, should be the

requirement for performing a diagnostic renal arteriography during cardiac catheterization.

Dr. Olin is concerned about what he calls a "cart-before-the-horse" mentality that is sometimes used. "Some physicians perform this procedure routinely, but often they do not know what to do when they find that one or both arteries are narrowed," said Dr. Olin. "They should not perform an arteriography, find a narrowing, and then ask for help."

He recommends that this consideration be made before a diagnostic test is

performed. "You have to have a real reason for doing a diagnostic test. You would not do a heart catheterization just to see if there is something there," he said.

In addition to adding time and requiring additional contrast material, combining the two procedures may not provide the most optimal views, he added.

ACCIS 2001 attendees will have the opportunity to hear more on this topic from Dr. Olin as well as the other side of this important debate from Dr. Stack.

# Experts Debate Femoral vs. Radial Approach for Stenting

Although a majority of angioplasties are performed via a femoral catheter, the newer radial approach is gaining momentum. Two interventional cardiologists will debate each approach during an ACCIS 2001 session focused on arterial access issues.

Habib Samady, MD, of the University of Virginia Health System in Charlottesville, will give a presentation titled "Radial Approach: A Helpful Advance." Jeffrey A. Breall, MD, PhD, director of the cardiac catheterization laboratories and interventional cardiology at Indiana University's Krannert Institute of Cardiology, will follow up with com-

ments titled "Radial Approach: Not in the Patient's Best Interest."

Dr. Breall explained that the radial approach evolved in response to a fairly high incidence of coronary stents clotting off. "To prevent this clotting off, we used to give patients tremendous amounts of blood thinners, which meant keeping patients in the hospital for a week or so," he said. "To the credit of the physicians who pioneered this field, they advocated going through the smaller, radial artery, where patients would not have to be immobilized for nearly as long and where the risk of complications could be reduced."

However, since the development of the radial technique, stenting by way of the femoral artery has made strides. According to Dr. Breall, physicians have learned the better way to insert stents, realized that blood thinners aren't a requirement, and discovered that the rate of any resulting acute thrombosis is the same regardless of the approach.

"We're now using very small tubes and going through a very small hole in the leg," said Dr. Breall, "and our closure devices allow patients to get up and walk around 60-90 minutes after the procedure."

He added that many physicians

aren't experienced at performing angioplasty via the wrist, which is more difficult than the femoral technique, and an entire set of guiding catheters must be on hand in catheterization laboratories. He's also concerned about the high risk of shutting the radial artery down, thus taking away a potential new blood supply for a future bypass surgery, which many of these patients require.

Dr. Breall said he recognizes that the radial approach has its place, especially for patients with severe peripheral disease, and Dr. Samady will present his stance on using the radial approach.

# Assessing Risk Requires Getting Beyond Statistics

Applying statistics to identify patients at risk for cardiac complications can be a complicated endeavor. Yet, beyond determining whether a patient has simply low or high risk, the equation for predicting the degree of risk and a patient's desire to know if a complication will actually occur is what concerns at least one ACCIS 2001 presenter.

Stephen E. Kimmel, MD, MS, assistant professor of medicine and epidemiology at the University of Pennsylvania Medical Center and director of cardiovascular epidemiology at the Hospital of the University of Pennsylvania in Philadelphia, will present "Common Sense and Statistics in Identifying the High-Risk Patient" during a session focused on complications.

"Physicians sometimes become bogged down in the statistical aspects of applying patient risk studies," he explained. "When this happens, it is easy to lose sight of the appropriateness of both the questions and the analyses being used to assign patients to different levels of risk."

That's why it's so important to make sure the questions and the analysis work together toward the determination. "If questions about risk are asked correctly and the analysis is done correctly, then the statistics should flow from there," he said.

Dr. Kimmel thinks physicians are good at determining whether a patient will be at very low risk or at high risk for a cardiac complication, but predicting the actual likelihood of a patient having a complication can be a tougher task.

Preventing improper use of the "C-statistic" may be what's needed to resolve this issue, he explained. This statistic measures how well a physician can separate a person who will have a complication from one who will not.

"The C-statistic serves an important function, but not for determining the level of risk of a patient or for risk adjustment. I think people have relied on the C-statistic to the point where studies are being done incorrectly," said Dr. Kimmel. "The statistic has its limitations. Plus, often what you really want to know is the overall chance that your patient will have a complication."

Dr. Kimmel also expressed concern that risk prediction may be inadequate, leading to unfair relevance being given to the media's listings of scorecards based on physician complication rates.

"What if a physician happens to treat high-risk patients? What if the model

for scoring calculates that 2 percent of his patients should have a complication but 5 percent of his patients actually have an event?" That physician would be scored as "worse than expected," he said.

But, Dr. Kimmel posed, "The equation could be wrong. What if his high-risk patients really do have a 5 percent chance of complications, and the calculated 2 percent is wrong. That's not

a huge difference, but it's certainly a concern for the physician whose name is published in a newspaper as an 'outlier.'"

The solution is to perform better studies, said Dr. Kimmel. Until such studies are completed, physicians, patients, and the media must understand the limits of currently available predictors, he said. "Improper use can lead to more harm than good."

## PCI Practice Guidelines to Be Released

Get an inside look at the writing process for the soon-to-be-released ACC/AHA practice guidelines on percutaneous coronary intervention. During a special session at 9:15 a.m. on Monday, Sydney Smith, Jr., MD, and Alice K. Jacobs, MD, will discuss the complex issues the group addressed while writing the new guidelines.

## ACC Thanks ACCIS 2001 Spotlight Supporters

The American College of Cardiology expresses sincere gratitude to the following companies for their educational grant support of ACCIS 2001.\*

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## Late-Breaking Clinical Trials to Be Presented at ACCIS 2001

Always a highlight of the annual meeting are the clinical trials sessions, which offer participants late-breaking results of some of the most important studies being conducted in the field of cardiovascular medicine.

The following are the Late-Breaking Clinical Trials sessions and presenters scheduled for Sunday:

### Session 22—Late-Breaking Trials in Interventional Cardiology

8:45–10:00 a.m.

- *Restenosis Intra-Stent: Balloon Angioplasty vs. Elective Stenting. Results of a Randomized Trial*—Fernando Alfonso, MD, of Madrid, Spain;

- *Direct Myocardial Laser Revascularization Using Biosense Left Ventricular Electromechanical Mapping: Final Results of the DIRECT Randomized Trial*—Martin B. Leon, MD, of New York City;

- *The Stent or Surgery Trial (SoS)*—Rodney Stables, MD, of Liverpool, United Kingdom;

- *The Medicine, Angioplasty, or Surgery Study (MASS II): A Randomized, Controlled Clinical Trial of Medical Therapy, Coronary Angioplasty, or Bypass Surgery for Multivessel Coronary Artery Disease*—Whady Hueb, MD, of Sao Paulo, Brazil;

- *The Washington Radiation for in-Stent Restenosis Trial for Saphenous Vein Grafts (SVG WRIST)*—Ron Waksman, MD, of Washington, D.C.; and

- *The Beta-Cath System Trial*—Richard E. Kuntz, MD, of Boston.

The American College of Cardiology expresses gratitude and appreciation to the Society for Cardiac Angiography and Interventions for its co-sponsorship of ACCIS 2001.

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