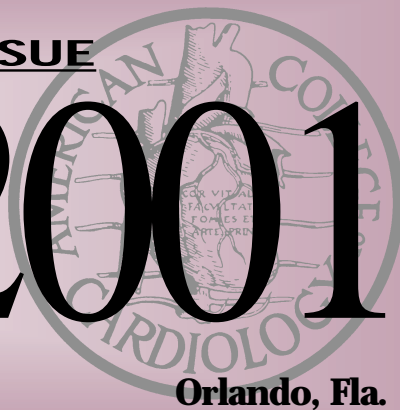




SCIENTIFIC SESSION NEWS SPOTLIGHT ISSUE

ClinCard 2001



American College of Cardiology Clinical Cardiology Symposium

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SPOTLIGHT ON

CLINICAL CARDIOLOGY

Get the Latest Updates on Common Cardiac Conditions at ClinCard 2001

The treatment of common cardiac conditions has undergone such tremendous advances in recent years that physicians often find themselves overwhelmed trying to keep up with important clinical information. Thanks to ClinCard 2001, one of five spotlights sessions kicking off the American College of Cardiology 50th Annual Scientific Session, cardiovascular, primary care, and subspecialty physicians who care for patients with common cardiovascular conditions can participate in a comprehensive, focused forum covering a range of clinical cardiology topics.



Kim A. Eagle, MD

tional format addressing eight of the most important treatment topics in clinical cardiology: pericardial disease, aortic dissection, acute myocardial infarction, chronic coronary artery disease, preventive cardiology, acute coronary syndromes, heart failure, and valvular heart disease.



Prediman K. Shah, MD

“This is a tried-and-true program, designed with both generalists and subspecialists in mind,” said Prediman K. Shah, MD, co-chair of ClinCard 2001. Dr. Shah is the Shapell and Webb chair and director of the Division of Cardiology and the Atherosclerosis Research Center at Cedars-Sinai Medical Center. He is also a professor of medicine at



After a successful debut last year at ACC 2000 in Anaheim, Calif., ClinCard 2001 once again features a faculty of renowned physicians who will discuss the latest research, techniques, and technology related to eight specific areas of cardiology.

the University of California—Los Angeles.

Co-chairing ClinCard 2001 with Dr. Shah is Kim A. Eagle, MD, who is the Albion Walter Hewlett Professor and chief of clinical cardiology at the University of Michigan Medical Center in Ann Arbor.

“In just one day, ClinCard attendees will have the opportunity to gather a great deal of specific information about clinical cardiology,” said Dr. Eagle. “We’re taking some of the most important information from randomized trials and the proliferation of new

data and discussing how to integrate this information into clinical practice.”

To help attendees learn more about current areas of controversy regarding common cardiac problems as well as gain insight from experts on how to apply this knowledge to patients, each of the ClinCard 2001 sessions includes a state-of-the-art lecture, a case presentation, and panel discussion.

The day will start with a look at pericardial disease. “One of the issues we face with pericardial disease is relevant to patients who present with heart failure in the presence of normal systolic function. It’s sometimes difficult to determine if those symptoms are due to a pericardial or a myocardial process,” explained Dr. Eagle. “Noninvasive identification of pericardial disease has evolved recently, and this session is taking a close look at these important advances.”

ClinCard faculty are also presenting a comparison of constriction vs. myocardial restriction and review of the pathophysiology and diagnosis of tamponade. A case presentation will examine a patient with congestive manifestations and normal systolic left ventricular function.

Although it’s a very rare problem, said Dr. Eagle, aortic dissection is usually lethal. Speakers at this session will discuss the more recent major advancements in its evaluation and treatment, including the potential use of

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Researchers Gain Ground on Diastolic Heart Failure

Although diastolic heart failure is relatively rare in young patients, its prevalence exceeds 50 percent in people over 75, and it is more common in women than men. Overall, about one-third of congestive heart failure patients have diastolic heart failure, yet research over the years has concentrated on the prevalence of systolic heart failure.

According to William H. Gaasch, MD, thousands of patients with systolic dysfunction have been studied in dozens of well-designed, prospective, randomized clinical trials.

“By contrast, no large prospective clinical trials on patients with diastolic heart failure have been published,” he said. “Therefore, most of our treatment is empirical and based

on clinical and anecdotal experience.”

Dr. Gaasch is presenting a state-of-the-art lecture titled “What Is Diastolic Heart Failure, and How Should I Treat It?” as part of ClinCard 2001. Dr. Gaasch is a consultant in cardiology at the Lahey Clinic Medical Center in Burlington, Mass., and a professor of medicine at the University of Massachusetts Medical School in Worcester.

Dr. Gaasch emphasizes the need for physicians to be aware of two requirements when making a determination of diastolic heart failure. Both the signs and symptoms of congestive heart failure and a normal left ventricular ejection fraction must be present. In contrast, systolic heart failure patients exhibit a depressed ejection

fraction, he said.

The most common causes of diastolic heart failure are coronary artery disease with myocardial ischemia and hypertension with cardiac hypertrophy, Dr. Gaasch added. If a patient has evidence of coronary disease with myocardial ischemia, he recommends that physicians treat the myocardial ischemia with revascularization techniques or medical therapies. Certainly, hypertension must be controlled. He suggests that treatment can be accomplished with an angiotensin-converting enzyme inhibitor, a diuretic, reduced salt intake, and an angiotensin receptor blocking agent.

Dr. Gaasch emphasizes the need for well-designed clinical therapeutic trials.

Medical Therapy vs. Revascularization in Patients With CAD

A positive exercise test may be the standard for referring coronary artery disease patients for invasive revascularization, but at least one ClinCard 2001 presenter thinks the criteria for when to perform this treatment should be reexamined.

Bertram Pitt, MD, professor of medicine at the University of Michigan Medical Center in Ann Arbor, will use his presentation time at ClinCard 2001 to answer the question, "When Should a Coronary Artery Disease Patient Be Considered

for Invasive Revascularization, and What Type of Revascularization?" Dr. Pitt recognizes that people with high Duke treadmill scores or limited exercise capacities certainly do poorly over the long run, and he recommends them for possible revascularization.

When a patient has a positive exercise test, according to Dr. Pitt, the current strategy is to refer the person to a cardiologist and a catheterization laboratory for angiography. "My contention is that many people with pos-

itive exercise tests may not need such an early angiography and referral for revascularization," he said.

Instead, Dr. Pitt looks to medical therapy for patients with low- and intermediate-level scores. He suggests that stable patients do well with medical therapy, specifically a high-dose statin, a beta-blocker, aspirin, and an angiotensin-converting enzyme (ACE) inhibitor.

He points to two obstacles that can occur after revascularization: First, these patients often experience infarc-

tions in other nonrepaired vessels; and, second, they still require a course of medical therapy to lower their lipid levels.

"In stable patients with low and intermediate Duke scores, we have options," he said. "The evidence shows that within six months of therapy many people with stable angina stay stable for many, many years. In lipid-lowering and ACE trials, we've seen fewer events, infarctions, and deaths. All of these people have less need for revascularization."

Research Could Provide Alternatives for Predicting Risk

As director of the Center for Cardiovascular Disease at Brigham and Women's Hospital in Boston, Paul Ridker, MD, MPH, is concerned about predicting myocardial infarction (MI) risk factors.

"The issue at hand is how can we better predict MI risk," said Dr. Ridker, who is also an associate professor of medicine at Harvard Medical School. "Cholesterol screening is a critically important tool, but the reality is that half of all MIs and strokes occur in people with normal cholesterol levels."

Dr. Ridker will give the state-of-the-art lecture "Novel Risk Factors for

Myocardial Infarction" during the ClinCard 2001 preventive cardiology session.

He will describe a variety of new blood tests for determining risk—tests that provide reliable and reproducible measurements to predict cardiac events when added to standard cholesterol testing.

One such test involves the measurement of high-sensitivity C-reactive protein (hs-CRP), which reflects the level of systemic inflammation, an important process in coronary disease. Research conducted by Dr. Ridker and his colleagues suggests that elevated

levels of hs-CRP may be a significant predictor of future cardiac events. The researchers also found that the inflammation associated with high levels of hs-CRP was independent of the traditional cardiovascular risk factors, such as high cholesterol, hypertension, smoking, and aging.

"Most important, hs-CRP screening appears to predict risk even among patients with below-average cholesterol levels and may help us to better

target statin therapy, particularly in primary prevention," said Dr. Ridker. "I believe we all need to look closely at the data before we can ascertain whether these types of blood tests will be useful in determining who is at risk for MI, but it looks very promising," he said.

The session will also examine the latest information regarding the effectiveness of lipid-lowering drugs and aspirin in reducing risk.

New Options Evolving in Treating Valvular Heart Disease

The surgical management of three of the heart's four valves—the aortic, mitral, and tricuspid valves—are of particular concern to clinical cardiologists, according to Lawrence H. Cohn, MD. During the "Valvular Heart Disease" portion of the ClinCard 2001 spotlight session, Dr. Cohn will discuss the surgical options for diseases of these valves.

Dr. Cohn, who is chief of cardiac surgery at Brigham and Women's Hospital and a professor of surgery at Harvard Medical School, will present a state-of-the-art lecture titled "Advances in the Surgical Management of Valvular Heart Disease." He is enthusiastic about the options now available for physicians and their patients.

"Treating valvular heart disease is very exciting, and the tools for treatment are revolutionary," he said.

Consider, for example, patients for aortic valve concerns, he continued. There are a number of alternatives, depending on the age and lifestyle of the patient. Dr. Cohn will describe

how indications for aortic valve surgery have changed, and he will present several alternatives for patients, including pulmonary autograph, homograft, stentless porcine valves, and bioprosthetic valves.

For mitral and tricuspid valve patients, Dr. Cohn looks to repair, rather than replace, the valves in the majority of patients. "With the good methods we now have for evaluation, physicians can preserve the patient's cardiac structure instead of opt for metal or artificial tissue," he said. In particular, he looks to repair techniques for ischemic and floppy mitral valves and suture and ring repair options for moderate to severe cases of tricuspid regurgitation.

Dr. Cohn is hopeful about the promise of less invasive surgery. "In our center, we are increasingly performing minimally invasive valve operations," he said, "and the future is even going toward a robotic cardiac repair operation."

Inflammatory Cells May Be Culprits of Atherosclerosis and Related Complications

Arterial clots...acute myocardial infarction...stroke...sudden death. Although cardiovascular specialists have come to know the complications of atherosclerosis all too well, they remain tenacious in the quest to understand the causes of disease. That's why new ground is being gained in the ongoing effort to understand the causes of atherosclerosis and associated complications.

Prediman K. Shah, MD, is one cardiologist focusing on this issue, and he will deliver a state-of-the-art lecture titled "Pathophysiology of Acute Coronary Syndromes—Role of Inflammation, Plaque Disruption, and Thrombosis" as part of the ClinCard 2001 session on acute coronary syndromes.

Dr. Shah is the Shapell and Webb chair and director of the Division of Cardiology and the Atherosclerosis Research Center at Cedars-Sinai Medical Center. He is also a professor of medicine at the University of California—Los Angeles, and he is the co-chair of ClinCard 2001.

Dr. Shah's lecture will provide

data and evidence suggesting that inflammatory cells—the circulating white blood cells that find their way into atherosclerotic lesions—may play a critical role throughout the process of atherosclerosis.

In particular, Dr. Shah will describe the potential molecular mechanisms and pathways responsible for plaque disruption and thrombosis that ultimately trigger the most lethal complications of atherosclerosis. Dr. Shah will also highlight the potential factors that may provoke inflammation in the arteries, both infectious and noninfectious.

"By gaining a better understanding of how inflammation takes its toll on the arteries and triggers myocardial infarction and stroke, we hope physicians will be able to learn how to use both current and promising new strategies, including the use of statin drugs, to prevent and reduce inflammation and complications of atherosclerotic plaque," said Dr. Shah. "Once we understand these triggers, we can make advances in prevention."

Expert Points to Pericardium as Culprit for Cardiac Problems

Constrictive pericarditis may develop when the pericardium has been infected, invaded by cancer, or traumatized. When this occurs, the pericardium becomes an “inelastic scar,” according to Ralph Shabetai, MD.

“This scar limits dilation of the heart during diastole and, like tamponade, impairs filling of the cardiac chambers,” he said. “Thus, congestion and low cardiac output occur, simulating heart failure. The treatment in this case is surgical removal of the pericardium — a very different form of therapy than would be prescribed for heart failure.”

During the ClinCard 2001 pericardial

disease session, Dr. Shabetai, who is professor of medicine emeritus at the University of California—San Diego, will present a state-of-the-art lecture on the “Pathophysiology and Diagnosis of Tamponade: Constriction vs. Myocardial Restriction.”

In his presentation, he will describe the pathophysiology, indications for diagnosis, and treatment options for three conditions that resemble heart failure — cardiac tamponade, constrictive pericarditis, and restrictive cardiomyopathy.

When cardiac tamponade occurs from blood or fluid accumulation in the

pericardial sac, elevated diastolic pressure in the cardiac chambers causes congestion. The heart is unable to pump out more than it receives, causing blood pressure to fall. These two conditions are classic features of cardiac failure, but the treatment of tamponade and heart failure are entirely different, Dr. Shabetai emphasized.

He urges cardiologists to consider the pericardium as a possible source of the problem when patients without a history of hypertension or coronary disease present with unexplained hemodynamic problems.

The former chief of cardiology, now a

cardiologist at La Joya Veterans Affairs Health Care System, Dr. Shabetai will also examine the effects of accumulating fluid in the pericardial space and treatment options for cardiac tamponade.

He will also look at the diagnosis and treatment of restrictive cardiomyopathy, a small but important subset of diastolic heart failure.

According to Dr. Shabetai, the clinical picture of restrictive cardiomyopathy closely resembles that of constrictive pericarditis. “It is critical not to confuse these two conditions, as the treatment is also radically different,” he added.

Doppler Echocardiography Helps Identify Pericardial Disease

Although restrictive cardiomyopathy and constrictive pericarditis are not the most common causes of cardiac failure, they can be difficult to diagnose. To help physicians determine whether one of these two debilitating conditions may be present in patients, Fletcher A. Miller, Jr., MD, is giving a case presentation on “A Patient With Congestive Manifestations and Normal Systolic Left Ventricular Function to Highlight Constriction vs. Restriction” during the pericardial disease session of ClinCard 2001.

Dr. Miller uses Doppler echocardiography along with a Mayo-devel-

oped device to measure respiration cycles to differentiate restrictive cardiomyopathy from constrictive pericarditis. A physician can use the device’s respiration recording and the Doppler’s profiles of blood flow velocity from three crucial areas to make a diagnosis.

In the past, the only way to exclude constriction in some cases was to have a surgeon open the chest. This means that many patients with restrictive cardiomyopathy who were not treated surgically had to undergo surgery as a diagnostic procedure. In contrast, once constrictive pericarditis has been identified with Doppler

echocardiography, surgeons can strip the inflamed and thickened pericardium off, thus allowing the heart to relax.

“This technology allows us to see how the heart is relaxing and get at whether the pressure inside the chamber is elevated,” said Dr. Miller, who is a professor of medicine, consultant of cardiovascular diseases, and co-director of the Echocardiography Laboratory at the Mayo Clinic and Foundation in Rochester, Minn.

Although constriction is uncommon it is important to identify these patients because “this is a form of heart failure that’s curable without a

heart transplant,” said Dr. Miller.

Dr. Miller will present the case of a young man who, after developing a viral illness, became severely debilitated in a matter of a few months with swelling of his abdomen and fluid in his legs. Physicians at another institution had performed invasive tests, including a heart biopsy, and a complication arose when a sheath shattered in the patient’s vein during catheterization. At Mayo, Dr. Miller identified the patient’s constriction with Doppler echocardiography, the patient had surgery, and the patient is now back at work and feeling well.

Presidential Plenary Address

Dr. Beller to Outline Challenges Facing Cardiologists

When ACC President George A. Beller, MD, officially launches the 50th Annual Scientific Session with his Presidential Plenary Address on Monday, he will discuss a number of important challenges facing cardiologists in all areas of practice.

Dr. Beller will outline both the good news and the bad news regarding an issue important to him as a cardiovascular specialist.

“The good news is the tremendous advances our specialty has made in the past few decades. The bad news is that a few societal trends are working against us,” explained Dr. Beller. “We’re going to see the number of elderly Americans double in the near future, and we’re already seeing epidemic proportions of people with diabetes and obesity.”

The combination of an aging population and an expected marked increase in the prevalence of coronary heart disease fueled by obesity, physical inactivity, and type-2 diabetes will

present challenges for cardiologists, noted Dr. Beller. “One way to be as prepared as possible for these new challenges is to focus on quality of cardiovascular care now,” he said.

“The quality of care is quite variable and undertreatment using proven therapies promulgated in our clinical practice guidelines is a problem,” said Dr. Beller.

He will review major issues that must be addressed to achieve enhanced physician performance, better quality of health care, and improved patient outcomes.

Finally, Dr. Beller will outline quality initiatives being undertaken throughout the country as well as at the College. “There are definitely some challenges ahead, but a lot of good work is being done to help cardiologists to deliver the very best care to patients,” he said.

The Presidential Plenary Session will be held in Hall E at 8 a.m.

Dr. Eagle to Present Findings of First GAP Project

The findings of an important project undertaken by the ACC to improve physician adherence to clinical guidelines will be presented during an ACC 2001 session on Monday. Kim A. Eagle, MD, co-chair of ClinCard 2001 and principal investigator of the Guidelines Applied in Practice (GAP) Project, will discuss the results of the first GAP project in a session titled “Optimizing Care in Acute MI.” The session will begin at 11:00 a.m. in Room A3 of the convention center.

The GAP project was designed in partnership with the Southeast Michigan Quality Forum Cardiovascular Subgroup and the Michigan Peer Review Organization (MPRO) to develop interventions to facilitate the use of the ACC/AHA acute myocardial infarction (AMI) guideline in practice settings.

Last January, 32 hospitals in Southeast Michigan were invited to apply to participate in the GAP

Project. All of these hospitals had been previously engaged in an improvement initiative that involved data abstraction from the MPRO. Ten hospitals were selected to participate, and they began implementing the project between April and July. Post-implementation performance data were collected for the period from September to December. The data were then analyzed to assess performance based on the Health Care Financing Administration’s current national AMI quality indicators.

Dr. Eagle will discuss the initial findings, based on data from each of the 10 participating GAP hospitals, which show that major improvements occurred as a result of this unique partnership.

Final reports will be distributed to each hospital’s physician and nurse leaders, quality improvement staff, and administration at a presentation in April 2001.

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percutaneously inserted aortic stents in treatment.

Next, reflecting the fact that acute myocardial infarction is a common problem with high mortality, ClinCard 2001 will address the most up-to-date strategies for managing ST elevation in myocardial infarction.

One of the most common problems seen by cardiologists, said Dr. Eagle, is chronic coronary artery disease. During this session, presenters and attendees will review the best management practices for treating this disease, including the role of lifestyle changes, medical therapy, stress testing, and newer technologies, such as electron beam computed tomography.

“Preventive cardiology is an area that is close to physicians’ hearts because patients are truly seeking the best preventive options available,” said Dr. Eagle. Despite tremendous progress in exercise, diet, and drug therapies, patients often query their physicians about other options. ClinCard 2001 will provide a forum for physicians to discuss preventive therapies, including the potential of eating garlic and drinking wine.

In contrast to ClinCard’s earlier look at ST elevation in myocardial infarction, the hour devoted to acute coronary syndromes will tackle current treatments for non-ST-segment elevation acute coronary syndromes. Issues regarding risk assessment and new antithrombotics will be examined via a case presentation about a patient with unstable angina and positive troponin.

Because heart failure is the most common reason for hospital admissions, said Dr. Shah, the focus of the heart failure–dedicated section of ClinCard will be to provide an update for physicians who treat these patients. The state-of-the-art lecture will focus on the treatment of diastolic heart failure.

The goal of the valvular heart disease session is to provide an update on new approaches for the surgical repair of valves and valve substitutes.

The broad range of topics covered during ClinCard 2001 will serve as a perfect lead-in for the more in-depth offerings of the Annual Scientific Session itself, explained Dr. Eagle. “After getting a taste of everything at ClinCard 2001, attendees can extend their knowledge during the next three days by focusing on specific areas that are of most interest to them,” he said.