



SCIENTIFIC SESSION NEWS

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DON'T FORGET

The Second Annual American College of Cardiology International Lecture will be held Tuesday, from 8:30 to 9:30 a.m., in Room S104 of McCormick Place.

The 34th Annual Louis F. Bishop Lecture will be held Tuesday, from 2 to 3 p.m., in the Grand Ballroom S100B of McCormick Place.

The 52nd Annual Convocation will be held Tuesday, from 6 to 8 p.m., in the Grand Ballroom of the Chicago Hilton & Towers.

The Annual Meeting Highlights session will be held Wednesday, from 10:30 a.m. to 12:30 p.m., in Hall D of McCormick Place.

Presidential Address

Dr. Fye Calls for Vigilance in Maintaining Integrity of Trial-Guideline-Education Process

The phenomenal growth of cardiovascular clinical trials over the past decade, and the concomitant rise in industry funding for these trials, has increased the potential for conflicts of interest, said ACC President W. Bruce Fye, MD, in his Presidential Address on Monday morning.

And all participants in the process are responsible for avoiding bias and self-interest.

"In the past 15 years, the parallel clinical trial, practice guideline, and continuing education movements combined to create one of the greatest paradigm shifts in the history of medicine," Dr. Fye said. "What I call the 'trial-guideline-education process' is having profound effects on cardiology research and practice."

Although the modern randomized clinical trial was invented in the middle of the twentieth century, the clinical trial movement grew slowly until the 1970s, when the National Institutes of Health (NIH) and industry began to



W. Bruce Fye, MD, delivered the annual Presidential Address on Monday morning.

devote much more funding to this type of research.

"Today, the number of cardiovascular trials is mindboggling," Dr. Fye said. "For example, a recent PubMed search for the term 'acute myocardial infar-

tion' limited to clinical trials published in English since 1990 returned 1,740 references. Consider this: on average, a new cardiovascular trial is launched every other day."

The College and the American Heart Association began developing clinical practice guidelines largely in response to the boom in clinical trials, Dr. Fye explained.

"Today, guidelines are woven into the fabric of modern medicine, especially in cardiology and in America," Dr. Fye said. "The ACC/AHA guidelines are authoritative, evidence-based documents that synthesize and organize vast amounts of relevant information. Practitioners, payers, and policy makers respect and use our guidelines because they fulfill most of the criteria that define optimal guidelines."

Various approaches have been developed to help incorporate guideline recommendations into patient care, such as the ACC-sponsored Guidelines Applied

See **PRESIDENTIAL ADDRESS**, page 6

Cardiac Resynchronization Therapy Reduces Hospitalizations and Mortality

Cardiac resynchronization therapy (CRT) significantly reduced the risk of all-cause mortality and hospitalizations in patients with moderate-to-severe heart failure, according to results reported yesterday from the COMPANION trial.

The study also found that patients who had CRT plus defibrillation therapy (CRT-D) had an even more dramatic reduction in the risk of all-cause mortality.

The COMPANION ("Comparison of Medical, Resynchronization, and Defibrillation Therapies in Heart Failure") trial included 1,520 patients with moderate-to-severe heart failure who were first randomized to optimal

pharmacological therapy or optimal pharmacological therapy plus cardiac resynchronization therapy. The pharmacological/CRT patients were further randomized to CRT-D therapy. The randomization was 1:2:2.

Optimal pharmacological therapy included diuretics, ACE inhibition or angiotensin receptor blockers substitution, beta-blockade, and spironolactone. Digoxin was optional.

All patients in the study had NYHA Class III or IV chronic heart failure and had been hospitalized for heart failure within the previous 12 months. They also had to have a QRS width of 120 ms due

to an ischemic or nonischemic cardiomyopathy.

Lead investigator Michael R. Bristow, MD, PhD, University of Colorado Health Sciences Center, said patients were followed for a median of 14 months. The implant success rate was 90 percent, Dr. Bristow explained, and the serious adverse event rate was 8.8 percent. Perioperative mortality was 1.5 percent.

Preliminary results reported by Dr. Bristow Monday showed that the risk of hospitalization was reduced by 18.6 percent for those implanted with a CRT

See **COMPANION**, page 8

35 Consecutive Scientific Sessions... and Counting

Bernardo Boskis, MD, is one of those people at whom you can't help but marvel—a remarkably vibrant man who, at the age of 70 “and some coins,” has the vigor of somebody half his age, if not younger. His attendance at this year's Annual Scientific Session is a perfect example. It's his 35th consecutive meeting, an astounding feat no how matter you measure it. When he attended his first meeting in

1968 in San Francisco, the world population was a little more than half its current level (3.5 billion vs. 6.24 billion) and Scientific Session attendance rang in at approximately 5,000, a far cry from the 30,000 or so who participate in the meeting these days. Three and a half decades of ACC Scientific Sessions have given him exposure to “unimaginable scientific information,” Dr. Boskis said. Just as important, though, are the lessons he has learned about the management of associations and medical meetings, the latter of which has come in particularly handy in his native Argentina, where he has been deeply involved in Argentinean and South American medical societies, including serving as president of the Interamerican Society of Cardiology from 1985-1989.

It's his dedication to advancing cardiovascular medicine, especially his use of the newest innovations and technologies, that has impressed many of his colleagues.

“Each year he finds the latest and most important concepts, developments, and equipment to bring back to his colleagues in Argentina,” said ACC Past-President Richard L. Popp, MD, a long-time colleague and friend of Dr. Boskis. “He is an exemplary supporter of the College and helped create an identity for those truly excellent cardiologists and surgeons in South America who could be designated FACC.”

Although he has undoubtedly seen and experienced many unforgettable events during his 35 Scientific Sessions, it is an event that occurred at his second meeting in 1969 that resonates in his memory.

“I was appointed as a member of the dais party,” he recounted. “At that time, we were gathered together and were told to march to the rhythm of the music. ... When the music stopped, I was on the stage in front of a seat with my name and a plaque on it. ‘Amazing!’ I thought to myself. ‘This institution really knows how to make things happen.’”

That impression “has been reconfirmed year after year,” he continued. “The ACC

has become the model that many cardiology societies hope to reach.”

Not surprisingly, Dr. Boskis' two sons have followed in his illustrious footsteps. Both are FACCs and both regularly attend the Scientific Session. Given their father's dedication to his work and his patients, it seems only logical that they would want to carry on his legacy—a legacy that is still evolving.

“I am still actively practicing medicine with the ardor of a passion,” Dr. Boskis explained. “And I cannot imagine the unpleasant placidity of retirement. I am pretty sure that I will die practicing cardiology.”



Bernardo Boskis, MD, is in Chicago this week for his 35th consecutive ACC Scientific Session.

Meeting Reminders

Registration

The ACC '03 registration area is located in Hall A of McCormick Place South and is open during the following hours:

Tuesday7:30 a.m.–5 p.m.
Wednesday8 a.m.–noon

ACC Office

The ACC Office is located in Room S501 of McCormick Place South. Telephone: 312-791-6737; fax: 312-791-6735. ACC staff are available to help you during the following hours:

Tuesday7:30 a.m.–5:30 p.m.
Wednesday8 a.m.–noon

ACC Gala Dinner

Always a highlight of the Annual Scientific Session, the ACC Gala Dinner will be held Tuesday from 8:30 to 11:30 p.m. Guests will be able to choose where they sit when they arrive at the event. No advance seating assignments will be made, with the exception of the president's tables. Each table will seat 10 guests and will be filled on a first-come, first-served basis. If you would like to sit with certain people, arrive early to hold the table for your group.

Questions can be posed at the ACC Gala Dinner Desk, located in the Grand Concourse of McCormick Place.

Locator System

The Locator System kiosks will allow attendees to search for other attendees, exhibiting companies, and products. The system includes a computerized ACC '03 Exposition layout. Attendees may also send and retrieve messages using this system. These kiosks are located in the registration area (McCormick Place South, Hall A) and the Hall D foyer (McCormick Place East/Lakeside building).

Audiotapes/Audio-CDs

Audiotapes and audio-CDs of selected sessions will be available two hours after each session concludes and may be purchased at Audiotape Sales, located in the Hall D foyer of McCormick Place (East/Lakeside building). Hours of operation are as follows:

Tuesday8 a.m.–8 p.m.
Wednesday7 a.m.–4 p.m.

Shuttle Service

Complimentary shuttle service will operate daily from McCormick Place and the official hotels of the Annual Scientific Session. Check the shuttle sign posted in the lobby of each hotel for additional information, changes, frequency of service, and specific departure times for the designated route. General hours of operation are as follows:

Tuesday6:30 a.m.–6:30 p.m.
Wednesday6:30 a.m.–1 p.m.

The scheduled end times are when the last shuttles will depart from McCormick Place. The last shuttles will depart from hotels approximately 90 minutes before this time.

Name Badges

Your badge serves as your passport to education sessions, the Exposition, and complimentary shuttle service. Attendees must wear their name badges at all times. ACC security will not allow people without badges to attend events. For your safety, we recommend that you do not wear your name badge after leaving the convention center.

Restaurant Reservations

The ACC '03 Restaurant Reservation Service booth is located in the Grand Concourse of McCormick Place and will be open Tuesday from 9 a.m. to 5 p.m.

The restaurant reservation service is also available by calling 312-791-6746.

EPHESUS Results:

Eplerenone Reduces Mortality in AMI Patients with LV Dysfunction, Heart Failure

ACE inhibition with beta-blockade is the therapy of choice in patients with left ventricular dysfunction after acute MI, but mortality and morbidity in these patients remains high. Research has shown that blocking the aldosterone receptor effectively reduces mortality and morbidity in patients with severe heart failure and left ventricular dysfunction who are also treated with an ACE inhibitor. With the 6,600-patient EPHESUS, presented on Monday, researchers went another step further and examined the effect of adding the selective aldosterone blocker eplerenone to optimal medical therapy to treat AMI patients with LV dysfunction and heart failure. The results were impressive.

Compared to placebo, eplerenone on top of optimal medical therapy reduced overall mortality by 15 percent. It also

significantly reduced cardiac death and cardiac-related hospitalization.

EPHESUS was a double-blind, randomized, placebo-controlled protocol, explained lead investigator Bertram Pitt, MD, University of Michigan, Ann Arbor. All EPHESUS patients had suffered an AMI, had signs of heart failure and had a left ventricular ejection fraction of 40 percent or less. The study will be published in the April 2 *New England Journal of Medicine*, but was released early on the journal's Web site.

Patients were randomized three days to 14 days post acute MI to an initial eplerenone dose of 25 mg daily—titrated to a target dose of 50 mg daily—or to placebo, in addition to optimal medical therapy. The mean dose of eplerenone used in the trial was 43 mg. The trial,

See EPHESUS RESULTS, page 7

Simon Dack Lecture

Second Century of Cardiology Will Look Much Different than the First

The history of cardiology began somewhat modestly, with Willem Einthoven's first recorded electrocardiogram.

"Innumerable advances have brought cardiology from the tiny thread that was Einthoven's discovery to the enormous multicolored tapestry that is cardiology today," said Eugene Braunwald, MD, in this year's Simon Dack Lecture. Dr. Braunwald used the speech to reflect on cardiology's illustrious past, assess the current challenges facing the specialty, and meditate on how current trends will affect the very role of the cardiologist in the coming decades.

The practice of cardiology over the past century has been marked by many significant achievements, Dr. Braunwald continued, including the electrocardiogram, catheterization, hemodynamics, cardiovascular surgery, coronary arteriography, interventional cardiology, coronary care units, beta blockers, ACE inhibitors, statins, echocardiography, pacemakers, ICDs, and preventive cardiology.

"In stepping back and considering these spectacular achievements, which have so improved human life and health, two points are notable," he said. "First is that none developed *de novo*. All were built on many decades of research, usually by basic scientists and engineers, the unsung heroes of progress in clinical cardiology.

"Second, in almost every instance, these advances came from an interdisciplinary collaboration."

As for the current state of the specialty: "There is no doubt that cardiology is now a robust, vibrant specialty," Dr. Braunwald said.

However, he added, several negative trends need to be addressed, such as the work force shortage, which is putting a strain on the entire specialty.

Dr. Braunwald also cautioned against an overemphasis on subspecialization, which can fragment cardiology.

"Subspecialists might be likened to

virtuosi playing the different instruments of an orchestra," he said. "But where is the conductor? Often, the skilled subspecialist can perform a procedure, but how carefully does someone consider the question of whether or not it should be performed in the first place."

Cardiologists also need to focus more on risk-factor reduction and disease prevention.

"Most patients receive their ongoing cardiac care not from cardiologists, but from primary care internists and family practitioners," Dr. Braunwald said.

See DACK LECTURE, page 8




Thank You to ACC '03 Spotlight and Track Supporters


The ACCF expresses sincere gratitude to the following companies for their support of ACC '03 Spotlight Sessions and Educational Tracks:

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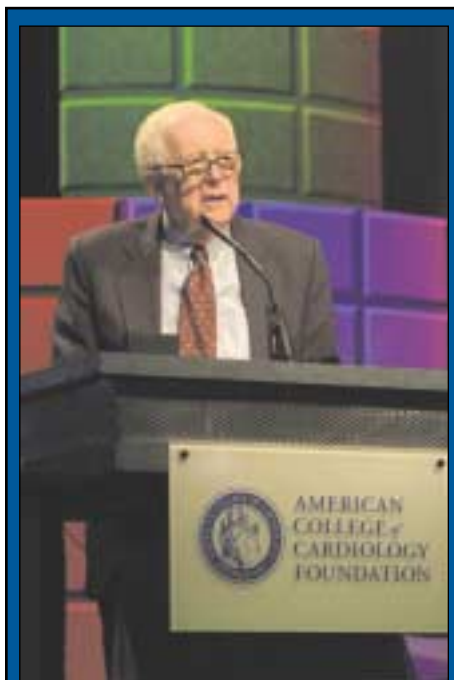
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Commitments as of March 23, 2003.



Eugene Braunwald, MD, delivered this year's Simon Dack Lecture on Monday.

Distinguished Physicians to be Honored at Convocation

The American College of Cardiology will honor nine cardiovascular physicians this evening at the 52nd Annual Convocation ceremony for their outstanding achievements and contributions.

The following are the 2003 ACC award recipients:

Dr. Samuel J. Asirvatham, of Mayo Clinic in Rochester, Minn., will receive the ACC W. Proctor Harvey Young Teacher Award. Dr. Asirvatham has been awarded by nurses, technical staff and cardiology fellows in the electrophysiology laboratory at Mayo Clinic, who particularly enjoy his dedicated approach to education through weekly early morning lectures on the fundamentals of intracardiac electrophysiology, pacing and ICD therapy.

Dr. James C. Fang, Training Program Director for Cardiovascular Medicine in the Department of Medicine at Brigham and Women's Hospital in Boston, is also a recipient of the ACC W. Proctor Harvey Young Teacher Award. His significant contributions to the Cardiovascular Fellowship Training Program at Brigham and Women's Hospital include: organization and authorship of a written CV core curriculum; conceiving and implementing a weekly fellow-directed core curriculum lecture series; organization and presentation of teaching rounds dedicated to ECG and hemodynamic interpretations; creation of a videotape on physical diagnosis; and the leadership of a seven-day "boot camp" total immersion course for the orientation of incoming first year fellows.

Dr. Elliott M. Antman, Associate Professor of Medicine at Harvard Medical School (HMS) and Director of the Samuel A. Levine Cardiac Unit at Brigham and Women's Hospital in Boston, will accept the ACC Gifted Teacher Award. For more than a decade, he has served as a lecturer in the HMS-Massachusetts (MIT) Cardiovascular Pathophysiology Course, a lecturer and section leader in the HMS Human Services Systems Course, and a lecturer in the HMS Fourth Year Course on Pharmacology and Clinical Therapeutics. He also has authored and co-authored more than 140 original articles as well as multiple review articles and book chapters.

Dr. Prediman K. Shah, Director of Cardiology at Cedars-Sinai Medical Center as well as Director of the Arteriosclerosis Research Center in Los Angeles, also will receive an ACC Gifted Teacher Award. Dr. Shah has been the recipient of numerous teaching awards including the

Golden Apple from both the University of California Los Angeles (UCLA) School of Medicine and Cedars-Sinai Medical Center. He has more than 250 publications and is responsible for several million dollars of grant support from National Institutes of Health (NIH). Also, he remains an advocate, with a 20-year history of dedicated service as a teacher to the ACC.

Dr. A. Jamil Tajik, Thomas J. Watson Jr. Professor of Medicine and Professor of Pediatrics at the Mayo Medical School in Rochester, Minn., is the 2004 ACC Distinguished Fellow. He has contributed to teaching at both national and international levels by his famous and popular Continuing Medical Education programs at ACC, have developed the ACC Video Seminar Series (12 volumes), which is used nationwide in most teaching and non-teaching hospitals and cardiologists' offices. He also has also authored 432 scientific articles and 23 book chapters.

Dr. Douglas L. Wood, Vice-Chair for the Department of Medicine at the Mayo Clinic in Rochester, Minn., receives the ACC Distinguished Service Award. He has served in key leadership roles such as Chair of the Evaluation and Management Services Workgroup for the American Medical Association (AMA), Chair of the Committee on Regulatory Simplification appointed by Department of Health and Human Services Secretary Tommy Thompson, and Chair of the ACC Coding and Nomenclature Committee. His extensive knowledge in coding, reimbursement, and state and federal government has also made him a contributing member to many other committees such as the AMA CPT editorial panel, the ACC Carrier Advisory Committee at both the national and state level, and Practicing Physicians Advisory Committee.

Dr. Harold J. C. Swan, scientist, mentor and humanitarian, of Pasadena, Calif., will receive the ACC Distinguished Scientist Award. Early in his career, Dr. Swan took his understanding of vascular physiology into the catheterization laboratory, where he defined both the anatomic and physiologic perturbations that accompany congenital heart disease. His work, "Pulmonary Hypertension in Congenital Heart Disease" has become a classic. In 1968, Dr. Swan invented the pulmonary artery balloon catheter, which bears his name. At the time, this knowledge changed and impacted the manage-



Dr. Asirvatham



Dr. Fang



Dr. Antman



Dr. Shah



Dr. Tajik



Dr. Wood



Dr. Swan



Dr. Ryan



Dr. Lenfant

ment of disorders as diverse as myocardial infarction, critical burn injury, acute respiratory failure, and surgical anesthesia. Dr. Swan remains a leader within the ACC. Based on his many contributions to the ACC, he was named the 1985 Distinguished Fellow and received the Distinguished Service award in 1999.

Dr. Thomas J. Ryan, Professor of Medicine at Boston University in Boston receives the ACC Master American College of Cardiology award. He has been a leader in the development and conduct of numerous National Heart, Lung and Blood Institute (NHLBI) sponsored clinical trials addressing the role of bypass surgery, thrombolytic therapy and angioplasty in patients with coronary artery disease. Dr. Ryan has been active in the development of practice guidelines by serving as the Chairman of the ACC/AHA Subcommittee that generated the original guidelines for PTCA in 1988 and the revisions of them in 1993. Most recently, he chaired the ACC/AHA Subcommittee that has revised the guidelines for the Management of Acute Myocardial Infarction. Dr. Ryan continues to serve the ACC in many capacities as the Program Director of ACC Education Programs.

Dr. Claude Lenfant, a physician and medical scientist whose many contributions have helped to enhance and prolong the lives of people around the world, will be awarded the ACC Presidential Citation. Dr. Lenfant, director of the National Heart, Lung and Blood Institute (NHLBI) in Bethesda, Md., has been an influential leader by working through research and public education to reduce the mortality rates of cardiovascular, pulmonary, and hematological diseases nationwide. In 2002, the Institute funded almost \$45 million in investigator-initiated cardiovascular clinical trials and another \$12 million in Institute-initiated cardiovascular clinical trials. Several Institute-sponsored trials have had a profound effect on medical practice. He also is a prolific author and respected editor, having written and co-authored more than 200 papers.

34th Bethesda Conference Focuses on Imaging Techniques for Atherosclerosis

There has been a great deal of discussion and speculation about the potential for atherosclerosis imaging technologies to enhance the detection and treatment of patients at risk for coronary heart disease. But there are still many unanswered questions about this issue, even as imaging technologies are quickly moving into clinical practice. The 34th Bethesda Conference put this issue under the microscope, and a review of the final report from the conference will be presented on Tuesday afternoon.

The conference was comprised of five task forces, each one charged with reviewing a different aspect of the issue:

- Is there a detection gap?
- What is the pathologic basis for new atherosclerosis imaging techniques?

- What is the spectrum of current and emerging techniques for the measurement of atherosclerosis?
- How do we select patients for atherosclerosis imaging?
- Is atherosclerosis imaging cost-effective?

During the session, reports from each of the task forces will be presented, including their recommendations on future directions for atherosclerosis imaging. The 34th Bethesda Conference Report, "Can Atherosclerosis Imaging Techniques Improve the Detection of Patients at Risk for Ischemic Heart Disease?", will be held today from 4 to 5 p.m. in Room S405, McCormick Place.

Bone Marrow Cell Transplants Shown to Be Safe and Effective for Heart Failure Patients

A small preliminary study presented yesterday suggested that the injection of immature autologous bone marrow cells in patients with severe ischemic heart failure is safe and improves patients' functioning in everyday activities.

"The study suggests the potential for improving symptoms, functional capacity, myocardial perfusion, and contractility with the injection of bone marrow-derived stem cells in humans," said Emerson C. Perin, MD, from the Texas Heart Institute in Houston, who presented the study.

"Transmyocardial injection of autologous bone marrow mononuclear cells is safe in humans with left-ventricular dysfunction," Dr. Perin said. "There were no associated major procedural or periprocedural complications. Further investigation and larger randomized, blinded trials are warranted."

Begun in December 2001, the prospective, nonrandomized, open-label, controlled trial included 21 patients with no other options for revascularization. It was conducted at the Texas Heart Institute and the Procardiaco Hospital in Rio de Janeiro. The inclusion criteria included a left-ventricular ejection fraction of less than 40 percent and ineligibility for percutaneous or surgical revascularization.

"An initial group of four patients was enrolled as a safety study and studied for four months before further study was allowed by an ethics committee," Dr. Perin said. Patients were then enrolled sequentially, with the first 14 enrolled in a

treatment group and the last seven in a control group.

Patients were evaluated by history and physical, laboratory tests, an exercise stress test, 2-D Doppler echocardiography, SPECT perfusion scan, 24-hour Holter monitor, and EKG. Those in the treatment group received transmyocardial catheter-tip injections of 50 cc of stem

cells aspirated from the posterior iliac crest.

All patients had follow-up evaluations after two months and four months. Within two months, one patient in the treatment group had died of sudden cardiac arrest. Lab studies showed that the ejection fraction rose in the treatment group from 30 to 35 percent, while the EF declined in the control group. Total

reversible defect decreased from 15 to 4 percent in the treatment group, but increased from 10 to 30 percent in the control group.

Among the limitations of the study were the small number of patients and the fact that the control group was not enrolled concurrently with the treatment group, Dr. Perin said.

I N S P I R A T I O N G R O W S

ANNOUNCING

The 2003 Recipients of Our Competitive Grants Awards for Young Investigators

ENVISION
THE FUTURE...

Lars Maier, MD
Georg-August-Universität Göttingen
Göttingen, Germany

Moussa Mansour, MD
Massachusetts General Hospital
Boston, MA

Tomohisa Nagoshi, MD
Massachusetts General Hospital
Charlestown, MA

Joseph Wu, MD
UCLA School of Medicine
Los Angeles, CA

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ACCEL Special Issue on Peripheral Interventions Available

Scientific Session attendees are encouraged to stop by the Medical Simulation Corporation booth (#3242) to receive a complimentary special edition of the College's audiojournal ACCEL. This special edition CD focuses on peripheral interventions and features five interviews with leading cardiovascular specialists. The ACCEL Special Peripheral Interventions CD is provided through a grant from Medical Simulation Corporation.



PRESIDENTIAL ADDRESS

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in Practice (GAP) program, which has shown that some methods designed to influence individual practice patterns and encourage institutional changes lead to improved outcomes.

“Although guidelines are a valuable adjunct to traditional clinical decision-making methods, they must never become the Pied Piper of physicians, leading each of us to write the same prescription for every patient,” Dr. Fye warned. “Clinical trials and practice

guidelines address populations and average patients; doctors take care of unique patients—one at a time.”

Although the trial-guideline-education process has helped to inform decisions and enhance care, he noted, financial conflicts of interest pose a threat to the vital but vulnerable interface between academic medicine and industry.

“A custom blend of altruism and pragmatic self-interest motivates each individual, institution, and company

involved in every phase of health care, whether it's inventing drugs, conducting trials, developing guidelines, educating doctors, or performing procedures,” Dr. Fye said. “As medical professionals, we must assure patients and the public that altruism is our primary motivating force.”

Academics have become key to this effort, he added, because they help design and carry out clinical trials, as well as publish papers, write editorials, give talks, and create guidelines that influence practice.

“These are valuable activities, and the

significant time and energy academics devote to them must be acknowledged—and compensated,” Dr. Fye said.

Likewise, industry's role in funding the nation's academic enterprise has grown in part because subsidizing research and education with patient-care dollars is now obsolete.

The U.S. government also has had a hand in this development. Dr. Fye pointed out that the Bayh-Dole Act of 1980, which allowed universities to patent and commercialize inventions resulting from federally funded research, served as a powerful catalyst of innovation and technology transfer—with benefits for patients and the public.

But the Bayh-Dole Act also increased the chance that research institutions and some of their staff members would confront conflicts of interest.

“In this context, academic centers under stress—and many are today—must not encourage faculty members to supplement their institutional salaries with income from industry that informed but disinterested observers would consider to be excessive for the services rendered,” Dr. Fye said.

This can be achieved, he added, by reaching a consensus on thresholds beyond which real conflicts are more likely to occur, setting reasonable dollar limits for specific services, and requiring detailed disclosures.

“Disclosure statements should be required not only for obvious end-product activities, such as publications and presentations, but also for other functions like committee and editorial work, where conflicts might influence outcomes,” Dr. Fye said. “To be effective, these statements must be explicit and accessible, and they must be used when appropriate.”

Dr. Fye said that the College has a special obligation to ensure the integrity of the trial-guideline-education process because the ACC, like other professional societies, depends on industry to help support its mission, and therefore must be alert to the potential for bias.

“Today's productive trial-guideline-education process depends on truth and trust, and we must protect each element of it from bias and excessive self-interest,” Dr. Fye said. “Although there's no vaccination to eliminate conflicts of interest, we're getting closer to a commonsense prescription to manage them in a productive way.

“Future doctors and patients are depending on us to further enhance the trial-guideline-education process as it continues to mature,” Dr. Fye concluded. “I think we are going in the right direction, and I hope you agree.”

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Meet the Experts: Beyond NCEP III

Focus on Primary Prevention in Persons with Multiple Risk Factors

In an effort to counter the growing heart disease epidemic, the Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults placed emphasis on primary prevention (NCEP III) in persons with multiple risk factors.

Two reviewers of the full report, Antonio Gotto, Jr., MD, DPhil., and Thomas Pearson, MD, PhD, offered their recommendations for fellow cardiologists in Monday's session, "Beyond NCEP III: What Is the Future?"

"U.S. heart disease prevalence is projected to double in the next half century," Dr. Pearson said. "By 2050, there will be more Americans with heart disease than there are Canadians, period."

He pointed out that, while the specialty has excelled at treatment and sec-

ondary prevention, initial incidence of myocardial infarctions have remained steady and in some cases risen.


"The addition of CHD risk equivalents to the highest risk group [to NCEP III] will greatly increase the number of individuals who are eligible for the most intensive treatment," Dr. Gotto said. "For example, now every diabetic is considered a CHD risk equivalent."

Among the other NCEP III implica-

tions outlined by Drs. Gotto and Pearson—

- Wider use of global-risk assessment
- Increasing emphasis on therapeutic lifestyle change, especially weight reduction
- Increasing prevalence of metabolic syndrome requires greater attention to triglycerides, non-HDL cholesterol, and HDL cholesterol
- Continued undertreatment in the

primary prevention setting: both untreated and not treated to goal

- Expanded use of combination therapies to reach LDL-C goals and to address HDL-C and triglyceride abnormalities
- Consider whether the medical (provider-patient) model is adequate to control population cholesterol levels. 

EPHESUS

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sponsored by Pharmacia Corp., which manufactures eplerenone, enrolled patients from 37 countries.

In addition to the 15-percent relative reduction in total mortality at a mean of 16 months follow-up, cardiovascular mortality was reduced by 17 percent for treatment patients compared to placebo, and sudden cardiac death was reduced by 21 percent. The number of patients hospitalized for heart failure dropped by 15 percent in the treatment group compared with placebo, while the number of episodes of hospitalization dropped by 23 percent. "These effects were relatively consistent across pre-defined subsets of patients," Dr Pitt said.

He stressed that eplerenone treatment was not associated with excess gynecomastia (0.5 percent versus 0.6 percent with placebo) or impotence (0.9 percent for each trail arm). There was an increased incidence of serious hyperkalemia, Dr. Pitt said, 5.5 percent versus 3.9 percent for placebo. But Dr. Pitt pointed out that this was seen primarily in patients with a baseline creatinine clearance below 50 mL/minute. On the other hand, eplerenone treatment decreased the incidence of hypokalemia, to 8.4 percent versus 13.1 percent for placebo.

"Aldosterone blockade can further reduce mortality and morbidity on top of standard therapy, and should represent a new class of therapy in this group of patients," Dr. Pitt concluded. "On top of what we have today, we can do better."

**norvasc
PI**

DACK LECTURE

continued from page 3

“Essentially all of them know when beta blockers, ACE inhibitors, and statins are indicated. However, an enormous number of eligible patients either are not prescribed or do not take these life-prolonging medications. Cardiologists and cardiovascular organizations such as this college must now take the lead in correcting this unsatisfactory situation.”

Finally, Dr. Braunwald turned his attention to the future of cardiology.

In the near-term, subspecialization seems primed to continue, and the burden of heart failure, which he termed “the last great battleground of cardiology,” to grow.

“At the same time, preventive measures based on patient characteristics, i.e. phenotypes, will expand,” he said.

There also will be increasing applications of pharmacogenomics.

“Pharmacogenomics is the low hanging fruit of the genetics/genomics revolution,” he said. “The goal of this emerging field is to identify patients

likely to exhibit adverse drug effects and those most likely to respond well.”

Taking a longer view, Dr. Braunwald believes genetics and genomics will allow the subclassification of disease, which will lead to gene-informed therapy. Furthermore, genetic identification of the future development of risk factors will lead to gene-informed personalized prevention.

“In closing, I will go out on a limb and predict how this will all play out,” Dr. Braunwald said. In the near-term future, he predicted, cardiac interven-

tions, including operations, PCIs, and implantation of devices will continue to significantly outweigh prevention efforts because of their increasing usefulness and the growing prevalence of CAD.

“However, as gene-based treatment and gene-based prevention become more effective and widespread in the long-term future, the balance will tip and the need for interventions will then decline,” he said.

Even the primary role of the cardiologist will change, he noted.

“I predict that the principle role of the cardiologist will change, from recognizing and managing established disease, as is the case today, to interpreting and applying genetic information in prevention and treatment in 2020 and beyond,” he said. “The ultimate grand goal, beyond 2020, can be nothing less than the elimination of cardiovascular disease as a serious threat to life and health. I believe that this will come about by the middle of this century, when our professional descendants celebrate the 150th anniversary of Einthoven’s monumental achievement and the birth of modern cardiology.”

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COMPANION

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device compared to those who had standard pharmacological therapy. The risk of hospitalization was reduced by 19.2 percent for those who received a CRT-D device.

Mortality was reduced by 23.7 percent in CRT patients, compared with pharmacological therapy.

But the greatest improvement in mortality risk was in patients who had CRT-D therapy, a 43-percent reduction in the 12-month rate over pharmacological therapy alone.

Dr. Bristow speculated that CRT or CRT-D would likely be cost-effective, in as much as heart-failure hospitalizations are a major determinant of heart-failure-care costs. In the United States, heart failure is the leading cause of hospitalization for people over 65.

The COMPANION trial was sponsored by Guidant, which manufactures the CRT devices used in the study.

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