



SCIENTIFIC SESSION NEWS

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DON'T FORGET

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.

Shuttle service between hotels and the convention center will begin as usual on Wednesday at 6:30 a.m., but will end at 2:30 p.m.

Sessions from this year's Scientific Session are available at ACC '03 Online at <http://www.acc03online.acc.org>.

Physicians may obtain CME credits for the various programs available on ACC '03 Online, which include Conference Rapid News Summaries, Lipids Subspecialties Online, Late Breaking Clinical Trials III, and the Meeting Highlights Session.

Dr. Pepine Installed as 52nd ACC President

Carl J. Pepine, MD, was officially installed as the 52nd president of the American College of Cardiology at Tuesday night's convocation ceremony.

Dr. Pepine is chief of the Division of Cardiovascular Medicine, professor of medicine, and eminent scholar, American Heart Association—Suncoast Chapter chair, at the University of Florida College of Medicine, in Gainesville.

Prior to his association with the University of Florida, Dr. Pepine was an assistant professor of medicine at the Jefferson Medical College of Thomas Jefferson University, Philadelphia. He also directed the cardiac catheterization laboratory at the Naval Regional Medical Center.

He earned his bachelor's degree at the University of Pittsburgh and his medical degree from New Jersey Medical School. He completed his medical internship at Allegheny General Hospital. His residency in internal medicine at Jefferson Medical College Hospital was followed by a fellowship in cardiopulmonary physiology and cardiovascular disease at the Regional Naval Medical Center and Jefferson Medical College Hospital.

A member of the ACC since 1974, Dr. Pepine currently serves on the Board of Trustees and on the Annual Scientific Session Program Committee. He also is a member of the Political Action



ACC Immediate Past President W. Bruce Fye, MD, (left) passes the gavel to ACC President Carl J. Pepine, MD. Dr. Pepine was installed as the 52nd president of the College during Tuesday evening's Convocation Ceremony.

Committee (PAC) Executive Committee, an associate editor of *ACCCEL*, and chair of the Task Force on Property.

He belongs to the ACC/AHA Joint Officers Committee, chairs the NHLBI Clinical Trials Review Committee, and is part of the ACC/European Society of Cardiology Joint Leadership Group.

He was recognized as one of America's Top Doctors in 2002. The Florida

Chapter of the ACC awarded him with its Gifted Teacher Award in 2001.

A prolific author, Dr. Pepine has contributed nearly 500 scientific papers to the profession's cardiovascular literature. He has edited six cardiology textbooks and written dozens of chapters for other cardiology publications.

Born in Pittsburgh, he served in the

See DR. PEPINE INSTALLED, page 5

Distal Protection Using Filter Yields Similar Outcomes to Balloon Occlusion

Morbidity and mortality among patients undergoing PCI procedures of saphenous vein grafts using a still-investigational distal protection filter device was similar to that of patients treated using an FDA-approved distal balloon-occlusion device, according to results from the FIRE trial.

Preliminary results from this multicenter trial were presented here on Monday. The trial randomized 651 patients who were undergoing balloon angioplasty or stenting for saphenous vein grafts to protection of the distal microvascular environment with the

totally-occlusive GuardWire device or with the investigational FilterWireEx.

Major adverse cardiac event (MACE) rates at 30 days for treatment with the two devices were approximately equivalent. The MACE rate for the filter device was 9.5 percent, versus 11 percent for the balloon occlusion system. The mortality rate was 0.9 percent in each treatment group.

Important Treatment Advance

It's no surprise that distal protection devices have been greeted with a good deal of enthusiasm. More than 50 per-

cent of saphenous vein grafts become significantly occluded after five to 10 years. Angioplasty and stenting of these grafts have proved problematic because the procedures often cause embolization and serious complications. By catching fragments of embolic material dislodged during the intervention, the devices avert some of the serious complications.

The GuardWire is the only distal protection device currently approved by the FDA. It was approved in June 2001 based on the results of the SAFER trial, where its use reduced the incidence of MACE by almost half compared to

See FIRE TRIAL RESULTS, page 4

2nd Annual International Lecture

Novel Therapies Raise Hope for Better Outcomes in Heart Failure Patients

Heart failure is a global problem with tremendous costs in human life and suffering. It affects some 5 million people in the United States and 7 million in Europe, and in some parts of the world, mortality is as high as 1,300 per 100,000 population.

In the Annual International Lecture on Tuesday morning, Magdi Yacoub, MB, professor of cardiothoracic surgery at Royal Brompton and Harefield Hospitals in London, UK, outlined the size of the problem and described novel treatment strategies that are raising hopes for better outcomes in heart failure patients.

"Severe heart failure remains a huge problem of titanic proportions," Dr. Yacoub said. "Several novel strategies, particularly reverse remodeling and physiologic hypertrophy, are starting to deliver."

The current options for the treatment of heart failure are separate medical and surgical therapies. However, the novel strategies he described involve combin-

ing surgery with pharmacotherapy. The surgery aspect is the implantation and explantation of a left-ventricular assist device. The medication is clenbuterol, an agent that induces hypertrophy.

The combined therapy, which Dr. Yacoub and colleagues have successfully developed experimentally, is designed to induce reverse remodeling of the myocardium and subsequent physiologic myocardial hypertrophy.

He and his colleagues have applied this combined therapy approach to 19 patients at Harefield Hospital with great success, he said. After implanting an LVAD, administering clenbuterol to the patients, and monitoring their progress, at one month the researchers began switching the LVAD off and performing echocardiography to see if patients could survive without the device. Those who could survive, underwent exercise testing and had the devices explanted.

"There were four deaths, three in the perioperative period and one about

three months later from infection around and inside the device," Dr. Yacoub said. Among the 15 remaining patients, 11 showed signs of recovery from heart failure and had their LVADs explanted. One patient died from arrhythmia 24 hours after explantation.

"All of the rest have survived very well," he said. "There have been no deaths in the follow-up period up to two and half years. Interestingly, the probability of recovery with explantation increased with the passage of time. The patients have excellent exercise capacity with remarkable improvement in ejection fraction. Their quality of life is excellent, and all are back to normal lives."

At the end of his lecture, Dr. Yacoub cautioned his audience not to raise false hope in heart failure patients based on the promise of novel therapies for the disease, but he expressed confidence that new strategies will ultimately pay off and help improve outcomes.



Magdi Yacoub, MB, discussed novel therapies for treating heart failure during Tuesday morning's International Lecture.

Young Investigators Awards Presented at Convocation

The winners of the 2003 Young Investigators Awards were announced at Tuesday's 52nd Annual Scientific Convocation.

Molecular and Cellular Cardiology

First Place

Rajiv Gulati, MD, of the Mayo Clinic, Rochester

Second Place

Vasant Jayasankar, MD, of the University of Pennsylvania School of Medicine

Honorable Mention

Hiroshi Furukawa, MD, of the University of California, Los Angeles, Medical Center; Xinqiang Han, MD, of the University of Minnesota; Toshihiro Tsuruda, MD, PhD

Physiology, Pharmacology, and Pathology

First Place

Alexander J. Dick, MD, of the National Heart, Lung and Blood Institute

Second Place

Atsushi Iwakura, MD, of Tufts University School of Medicine

Honorable Mention

Luciano Amado, MD, of Johns Hopkins University; Marilia Harumi Higuchi Dos Santos, of Sao Paulo School of Medicine; and Mohammed Yousufuddin, MD, of the Cleveland Clinic Foundation

Clinical Investigations—Cardiology and Cardiovascular Surgery

First Place

Arjun Deb, MD, of the Mayo Foundation

Second Place

Martin Penicka, MD, of the OLV Hospital, Brussels, Belgium

Honorable Mention

Antonio Abbate, MD, of the Catholic University, Rome; Ilene Claudius, MD, of the University of California, Los Angeles, Medical Center; R. Christopher Jones, MD, of the Cleveland Clinic Foundation

Meeting Reminders

Registration

The ACC '03 registration area is located in Hall A of McCormick Place South and is open Wednesday from 8 a.m. to 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 on Wednesday from 8 a.m. to noon

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 Wednesday from 7 a.m. to 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 Wednesday from 6:30 a.m. to 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.

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).

Cardiologist's Care Makes a Difference

Patients with acute coronary syndromes (ACS) have half the risk of dying before discharge if cared for by a cardiologist (3 percent mortality rate), compared with those treated by a noncardiologist physician (6 percent mortality rate), according to a new study.

The study, from the Duke Clinical Research Institute, also found that ACS patients treated by cardiologists have lower rates of recurrent MI (3 percent versus 4 percent); congestive heart failure (8 percent versus 14 percent); and stroke (0 percent versus 1 percent).

And length of stay was one day shorter for those treated by a cardiologist, four days versus five days, said Eric D. Peterson, MD, in his presentation of the study data on Tuesday.

"While it may not be too surprising that specialists were more up-to-date

with their therapeutic choices, the impact of this on patient outcomes was quite surprising," Dr. Peterson said during a Tuesday morning news conference.

The Duke researchers analyzed data from the national CRUSADE registry ("Can Rapid risk stratification of Unstable angina patients Suppress ADverse outcomes with Early implementation of the American College of Cardiology and American Heart Association guidelines"), and identified more than 30,000 patients in 44 states admitted to hospital with an ACS diagnosis. (Approximately 12 percent of patients were excluded from analysis because they were transferred to a different hospital, so the study data were on 15,589 patients treated by cardiologists and 10,758 treated by noncardiologists.)

Cardiologists cared for 54 percent of

all patients, and noncardiologists cared for 46 percent—an unexpected finding.

"We thought cardiologists today would have treated a much higher percentage," Dr. Peterson said. He speculated that these percentages are representative of hospital care for ACS patients across the country.

Regarding acute in-hospital care, the researchers found that within 24 hours of hospital admission, cardiologists prescribed aspirin in 92 percent of inpatients, versus 89 percent for noncardiologists; beta blockers in 78 percent of inpatients, versus 74 percent; heparin in 87 percent, versus 78 percent; GP IIb/IIIa in 39 percent, versus 21 percent; and clopidogrel in 43 percent, versus 27 percent.

There were also significant differences in the in-hospital procedures ordered.

Patients of cardiologists had far more catheterizations—78 percent, versus 48 percent with noncardiologists—and more percutaneous coronary interventions, 46 percent and 22 percent, respectively.

"We've got to get the message out to cardiologists as well as noncardiologists about the importance of evidence-based care," Dr. Peterson concluded.

He thought it reasonable for a patient to ask to be cared for by a cardiologist, or to be seen by one during the hospital stay.

"Other studies have shown that if a cardiologist even sees them in consult, the likelihood of dying falls," he said. "Recommending the right therapies and getting the patients on it makes a difference."

New JNC Report Recommends More Aggressive Blood Pressure Treatment

When the National Heart, Lung and Blood Institute released the First Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC I) in 1977, the emphasis was on treatments and lifestyle modifications to decrease elevated levels of diastolic blood pressure. Now, with the release of JNC VI, recommendations focus more on the importance of lowering systolic levels and the aggressive treatment of not just hypertension (systolic over 140), but elevated blood pressure in

general. That was the subject of a Meet the Experts session held on Tuesday morning, "Hypertension: Joint National Committee Recommendations: How Low is Low?"

The JNC VI recommendations, approved by the Coordinating Committee of the NHLBI's National High Blood Pressure Education Program, contain new treatment strategies, a risk-group stratification system, and new evidence regarding indications for certain antihypertensive medications.

"In JNC I, there were no goals stated

for the treatment of systolic blood pressure. At that time, there was not a lot of data and the benefits of treatment were unclear," according to session co-moderator Gary L. Schwartz, MD, of the Division of Hypertension at the Mayo Clinic in Rochester, Minn. "A lot has changed since that first report. We recognize now that systolic blood pressure is the significant risk predictor that we need to try and modify, and we have ample evidence to support more aggressive treatment goals."

One of the most significant changes since JNC V was issued in 1992 is the concept of stratifying patients by blood pressure stage (1, 2, 3) and into risk groups (A, B, and C) to guide treatment decisions. The JNC VI report places significantly more emphasis than earlier reports on absolute risk and benefit and uses this concept of risk stratification as part of the treatment strategy.

The report strongly encourages lifestyle modification to prevent high blood pressure as definitive therapy for some, and as adjunctive therapy for all persons with hypertension.

On the basis of outcomes data from randomized controlled trials, JNC VI recommends starting pharmacologic therapy with diuretics and beta-blockers for patients with uncomplicated hypertension and provides compelling indications for specific agents in certain clinical situations. The report also covers the appropriate use of other classes of anti-

hypertensive agents in certain clinical situations and in patients with comorbid conditions.

JNC VI addresses treatment considerations for older persons with hypertension and for a number of other special populations, including African Americans. Compared with whites, hypertension in African Americans develops earlier in life and average blood pressures are much higher. As a result, African Americans have an 80 percent higher rate of death from stroke, a 50 percent higher rate of death from heart disease, and a 320 percent greater rate of hypertension related end-stage renal disease than those in the general population. Lifestyle changes are particularly important for African Americans who have a high prevalence of risk factors for heart disease—such as obesity—and also increased sensitivity to salt. Diuretics should be the drug of first choice for this population, according to the report. Monotherapy with beta-blockers or ACE inhibitors is less effective, but the addition of diuretics markedly improves response.

"This new report definitively outlines certain therapeutic objectives we need to follow," said C. Venkata S. Ram, MD, of the University of Texas Southwestern Medical Center in Dallas, who served as the other co-moderator for the session. "We know now, based on a large number of studies and lots of data, that every millimeter of blood pressure reduction counts."

Drug Interchange Carries Risk of Potential Drug Interactions

Hospitals are under increasing pressure to improve outcomes and reduce costs at the same time. Sometimes they take measures to achieve both goals that produce unintended results.

A case in point is a study presented Monday by Peter Dumo, PharmD, from Wayne State University and Harper University Hospital in Detroit. In an effort to reduce the cost of statin drugs for their patients, the hospital system decided to switch all patients prescribed statins to a single statin as part of a therapeutic interchange policy.

After the switch, Dr. Dumo and his colleagues conducted a study to determine if the interchange had any effect on the risk of potential drug interactions. They found that the risk of potential drug interactions increased, but that there were no actual side effects and the potential for interactions lasted only three days.

"Finding a balance between evidenced-based care, patient safety, and cost-effective care is always challenging," Dr. Dumo said. "Therapeutic interchange can be a useful tool for achieving this triple goal. However, when the therapeutic interchange is implemented, it is very important to assess potential safety issues and develop a plan for assessing the long-term implications of the process."

Dr. Fye Reflects on His Year as ACC President

W. Bruce Fye, MD, completed his term as ACC president at Tuesday evening's Convocation. Dr. Fye shared some of his thoughts on the past year and what lies ahead for the College.

What do you consider the highlights of your year as president?

Because I am a medical historian as well as a cardiologist, I tend to look at contexts and trends as much as individual events or individuals. My term as college president is part of a continuum that goes back more than 50 years. Several things that seem to have "happened" during my term were, in fact, the final result of decisions that originated months or years before I became president. For example, the formal launch of Cardiosource in November 2002 represents just one stage in the ongoing evolution of the ACC's Web-based educational system, first proposed almost five years ago.

The Board of Trustees voted unanimously to relocate Heart House to another Washington-area site because we outgrew our present location. Again, this important decision was just one stage of a long and thoughtful process launched two years ago. At times during

the past year, it seemed inevitable that cardiovascular specialists would continue to face draconian cuts in Medicare reimbursement. The advocacy staff never gave up, and many members joined with them to ensure that our voice was heard in Washington. The result was a very important legislative victory. A personal highlight on the advocacy front was the fact that I was invited to participate in the Presidential Economic Forum in Waco where I had the opportunity to present the College's advocacy agenda to HHS Secretary Tommy Thompson and speak with President Bush.

I also had the opportunity to create a taskforce on workforce to seek solutions to what I believe is a serious and worsening shortage of cardiovascular specialists. Later this year the taskforce will produce a number of recommendations for addressing this problem that has important implications in terms of patient access and career satisfaction. One thing we must do now is to make our specialty more attractive to female physicians, as I outlined in a president's page in *JACC* last year.

Finally, I think it's very exciting that we have created a new membership cat-

egory for international associates and, as announced earlier this week, non-physician clinicians, such as nurse clinicians and physicians assistants whose career is focused on cardiovascular care.

As a historian, is there anything that happened this year either within the ACC or in cardiovascular medicine in general that you think will truly "make history"?

This is a difficult question because history teaches humility, and things that seem to be "breakthroughs" today are often forgotten or become obsolete in a short period of time. When I was researching the history of the ACC and the invention of our specialty, I was amazed in reading the verbatim minutes of the College's board of trustees that they seemed unaware of the truly incredible advances that were transforming their specialty in real time. Consider this: in eight short years between 1953 and 1961, all of the following things were invented: open-heart surgery, coronary angiography, prosthetic heart valves, implantable pacemakers, the coronary care unit concept, and CPR. It will take more time to appreciate whether any of this year's

many discoveries, inventions, and innovations have as much impact on cardiovascular care as these earlier developments.

After a busy, productive year, are there any special thanks or acknowledgements you'd like to make?

First, I thank Lois, my wife of 33 years, and our daughters, Katherine and Elizabeth, for their love, encouragement, and constant support. I also thank my valued colleagues at the Mayo Clinic for helping to cover my practice this year so I was able to focus on my duties as ACC president.

I thank the College's Officers, Executive Committee, Board of Trustees, and Board of Governors for their dedication, their vision, and their support. I'd also like to thank our volunteers and full-time staff. Hundreds of volunteer fellows spend countless hours serving the ACC. These dedicated volunteers are complemented by a fantastic full-time staff who work under the direction of our superb senior staff. It's been a pleasure getting to know so many ACC staff members over the years. 🌈

Statin Studies Show Beneficial Effects on Psychological Well-Being and Risk of Atrial Fibrillation

A large body of scientific evidence has confirmed the fact that statin medications have benefits in lowering cholesterol levels and the prevention of coronary artery disease. But new research is also showing that statins have nonlipid-lowering benefits as well, including reducing the risk of stroke, progression of aortic stenosis, macular degeneration, osteoporosis, and possibly dementia.

Two studies presented by a Harvard research group this week, one on Tuesday and the other on Sunday, found that statins also protect patients against atrial fibrillation and improve their psychological well-being.

According to Charles M. Blatt, MD, from the Lown Cardiovascular Center in Brookline, Mass., who presented both studies, "In a cohort of patients with chronic coronary disease, statin use was associated with a reduced likelihood of atrial fibrillation. This association remained significant after adjusting for potential confounders, and the association was independent of serum total cholesterol."

The study looked at the effect of statins on 449 patients aged 40 to 87 with chronic stable coronary artery disease and without prior atrial fibrillation. Approximately 60 percent of the patients received statin therapy regularly or intermittently during the seven-year study period.

Fifty-two patients (12 percent) developed atrial fibrillation during the follow-up period. The patients who received statins had much lower levels of atrial fibrillation than those who did not. The beneficial effect of statins was evident in both men and women and at all age levels, with or without hypertension.

The mechanisms behind the effect were unclear, Dr. Blatt said, but they were possibly due to the impact of statins on C-reactive protein, inflammation, or the autonomic nervous system. "The mechanisms behind this effect warrant further investigation in randomized clinical trials," he concluded.

A separate prospective cohort study by the same research group looked at the effect of long-term statin use on depres-

sion, anxiety, and hostility in 850 CAD patients for an average follow-up period of four years and a maximum of seven years. Psychological well-being was assessed by standard psychometric measures at baseline and annually thereafter.

"Improvement in psychological state is an additional effect of statins," Dr. Blatt said. "Long-term use of statins among patients with coronary artery disease appeared to be associated with reduced

risk of anxiety, depression, and hostility. The reduction is progressive over time and independent of cholesterol lowering."

The researchers are unsure of the mechanisms that underlie the effect, he said. However, they did find that the effect occurred in patients who took lipophilic statins but not in a small group of patients who took a hydrophilic statin. 🌈

FIRE TRIAL RESULTS

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interventions performed without distal protection.

FIRE was the first trial to compare the total occlusion device to a filter device, said Greg W. Stone, MD, of the Cardiovascular Research Foundation at Lenox Hill Heart and Vascular Institute in New York City. Distal protection with a filter-based device, he said offers an important advantage over the total occlusion

device because perfusion is maintained during the procedure.

"What clinicians don't like about the balloon device is the six minutes of total occlusion," he said.

This trial, however, had a noninferiority design, and the safety and efficacy of distal protection using filter systems has not yet been demonstrated, Dr. Stone said.

DR. PEPINE INSTALLED AS ACC PRESIDENT

continued from page 1

U.S. Navy Medical Corps during the Vietnam era and was honorably discharged. Married to Lynn, the couple has three daughters, all of whom are involved in health care: Marci, a dermatologist; Anne, an internist; and Betsy, who is involved in health care policy.

Convocation Address

In welcoming the College's new Fellows, Dr. Pepine offered his thoughts on what the next decade holds for the College and its members.

"One of the difficult issues facing our nation today is the growing shortage of cardiovascular specialists," he said, citing a recent ACC survey indicating that, by the end of 2003, only one-third of the available openings for cardiovascular specialists will have been filled.

Dr. Pepine also touched on another concerning trend, the epidemics of obesity and diabetes, which will likely lead to a substantial increase in the prevalence of heart disease.

"As a result, you are likely to have more work than you will want or need," he said. "One potentially detrimental by-product of this scenario could be the perception among patients and families that you are disinterested—only there to diagnose the problem as quickly as possible, write a script, order some diagnostic and interventional procedures, and move on to the next warm body. We must guard against this."

Having chaired a task force that recommended to the Board of Trustees that the College move its headquarters into the District of Columbia, Dr. Pepine said he will encourage the College's leadership to "think big" when it comes to this important issue.

"Imagine a facility that is the preeminent showcase for the treatment of heart disease," he said, "a state-of-the-art building in the heart of the capital where visitors could tour exhibits that provide information about the cutting edge of cardiovascular care, procedure simulations, and kiosks where they can enter in their health information and get back details on their risk factors and potential diagnostic procedures—along with a listing of the FACCs in their vicinity who could aid in their care.

"Dignitaries, lawmakers, and others could participate in prevention and treatment programs run at the new Heart House, with access to exercise machines, and dieticians, and an on-staff cardiologist."

Dr. Pepine said he believes there will continue to be important advances in physician education like Cardiosource and the FAME simulation training project.

Dr. Pepine praised the emphasis at this year's Scientific Session on team-based care, noting that initial findings from investigations of well-coordinated, team-based care have included improved patient outcomes and more satisfied patients and members of the health care team.

"This is progress, and I believe that we all have a duty to promote it because it is in the best interests of our patients," he said.

Dr. Pepine concluded his speech by citing a recent editorial that appeared in the *New York Times Magazine*, in which novelist Ann Patchett expressed her satisfaction with the selection of Bill Frist as the new majority leader in the U.S. Senate.

"Ms. Patchett based her optimism about this change in leadership because Senator Frist is a physician," Dr. Pepine said. "She wrote: 'We still believe, no matter what the wait or cost or tortured

insurance forms, that this person is here to help us. What he or she knows we could not possibly figure out on our own.'

"Ms. Patchett was correct," Dr. Pepine said. "People still believe that physicians are there to help them, to make them feel better. In everything you do, I encourage you to take steps to reinforce that belief, strengthen that expectation, and live up to that high ideal." 🌈

INSPIRATION GROWS

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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www.cvfoundation.org

Aggressive Lifestyle Changes and Lipid Treatment Reduce Events, Improve Perfusion

Putting patients with coronary artery disease (CAD) on an extremely aggressive treatment regimen of a strict, low-fat diet, regular exercise, and a lipid treatment regimen with ambitious target HDL and LDL goals can significantly reduce coronary events over the long term, according to research presented on Tuesday.

In the study, researchers from the

University of Texas Medical School followed more than 400 patients with CAD for 7.5 years who were on one of three treatment regimens:

- “poor,” which involved no dietary changes or lipid-lowering drugs;
- “moderate,” which involved following the American Heart Association diet and use of lipid-lowering drugs, or a

strict, low-fat diet in which less than 10 percent of daily calories come from fat and no lipid-lowering drugs; or

- “maximal,” which involves a low-fat diet in which less than 10 percent of daily calories come from fat, regular exercise, and lipid-lowering therapy with treatment goals of LDL 90 mg/dl and HDL 45 mg/dl.

Participants in the study also underwent myocardial perfusion imaging using positron emission tomography at baseline and at 2.6 years “as another way to measure the effectiveness of the therapy in reversing coronary artery disease,” explained Stefano Sdringola, MD, from the University of Texas Medical School, Houston.

At five years follow-up, only 8 percent of patients on “maximal” treatment suffered any cardiac event, compared to 24 percent and 31 percent of the “moderate”- and “poor”-treatment patients. Similar results were seen for the need for CABG or PCI procedures (5 percent, 19 percent, and 23 percent, respectively) as well as death or nonfatal MI (3 percent, 15 percent, and 13 percent, respectively).

“We saw in the maximal therapy group ... a significant decrease in the size and significance of the [perfusion] defect,” Dr. Sdringola explained.

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Slate of Officers and Trustees Announced

The election of 2003–04 officers and trustees was held at Monday’s Annual Business Meeting.

- Carl J. Pepine, MD, MA, of Gainesville, Fla., automatically assumed the office of president at last night’s convocation.

- Michael J. Wolk, MD, of New York, NY, became president-elect, and Pamela S. Douglas, MD, Madison, Wisc., became vice president.

The following members were approved as trustees and began their five-year terms (2003–2008):

- Peter Alaguna, Jr., MD, Pompano Beach, Fla.;
- Pamela S. Douglas, MD, Madison, Wisc.;
- James W. Fasules, MD, Little Rock, Ark.;
- Linda D. Gillam, MD, Hartford, Conn.;
- Michael G. Kienzle, MD, Iowa City, Iowa;
- Bruce D. Lindsay, MD, St. Louis, Mo.

Per the College’s Bylaws, the role of ACC secretary is filled by the chair of the Board of Governors (BOG), and the chair of the Budget, Finance, and Investment Committee (BFIC) acts as treasurer of the College. For 2003–04, Alan Brown, MD, of Naperville, Ill., is chair of the BOG, and James T. Dove, MD, of Springfield, Ill., is the current BFIC chair.

EBCT Has Value in Evaluating CAD But Often Is Being Used in the Wrong Patients

The use of electron-beam computed tomography (EBCT) to detect coronary calcification in the evaluation of patients for coronary artery disease has become a much-debated and controversial issue in cardiology. Proponents point to the predictive value of coronary calcification, while skeptics say EBCT is being used by some more for commercial reasons than for sound scientific reasons.

In an attempt to clarify the debate and shed some light on the science, two experts led a meet-the-experts session Monday morning on the value of coronary calcification in the treatment of CAD.

“Coronary calcification can be detected by two CT methods—electron-beam tomography and multislice spiral CT,” said Stephan Achenbach, MD, a cardiologist from the University of Erlangen-Nürnberg, Germany. EBCT is faster than spiral CT, he noted, with an acquisition time of 100 ms versus 200 to 250 ms for spiral CT. The faster speed helps avoid motion artifacts and improve the sensitivity of the test.

“The more calcium present in the artery, the more atherosclerotic plaques are in the artery,” Dr. Achenbach said. While only about 50 percent of plaques are calcified, the amount of calcium in the coronary arteries correlates with the amount of atherosclerotic plaque. The absence of calcium indicates little or no plaque formation.

“The presence of calcium in the coronary arteries is indicative of an increased risk of coronary events,” he said. “Studies have shown that as the EBCT calcium score goes up, the number of coronary events goes up.”

The sensitivity of EBCT for coronary calcification is 99 percent in men and 100 percent in women, but the specificity is only 23 percent in men and 40 percent in women. This low specificity devalues the test as a justification to perform coronary angiography in asymptomatic patients, Dr. Achenbach said. It would be a justification for a stress test, he argued.

Wrong Patients Getting Scans

“EBCT is being used by some to evaluate young, healthy individuals who don’t need it at all,” said Robert A. O’Rourke, MD, distinguished professor of medicine at the University of Texas Health Sciences Center in San Antonio. “Unfortunately, those who are using EBCT for the wrong reasons are making it difficult for those who use it properly to improve risk stratification.”

According to a consensus document of the American College of Cardiology and the American Heart Association, EBCT is not indicated for screening the general public for CAD, Dr. O’Rourke said.

“In patients at high risk for coronary events, EBCT may not add any addi-

tional information,” he said. More traditional methods of assessing coronary event risk, such as the Framingham risk-factor scores, provide the same information. Both experts agreed that EBCT is not a useful tool to demonstrate progression or regression of CAD in individuals.

The bottom line is that EBCT is best used in asymptomatic individuals who have multiple risk factors for CAD and as a reason to further evaluate those whose EBCT calcium scores are high, typically above 400. “We are against using it to evaluate patients who are at almost no risk,” Dr. O’Rourke said. 🌈

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ACC/ACP-ASIM Joint Symposium

Patient Safety: The Other Side of the Quality Equation

Speakers at Tuesday's ACC/ACP-ASIM joint symposium, "Patient Safety: The Other Side of the Quality Equation," offered insights on how to ensure patient safety in all areas of the health care process.

The session was based on an ACP-ASIM initiative of the same name. The program is a three-year, multifaceted initiative fund-

ed by the Agency for Healthcare Research and Quality to improve patient safety in ambulatory care.

"Most medical errors are caused by a system rather than by individual persons," said Christina Reimer, MD, of the Department of Internal Medicine at the University of Kansas School of Medicine-Wichita.

Dr. Reimer employed a swiss cheese analogy to illustrate her point. "If you have several layers of swiss cheese, at some point one of the holes will line up with another," she said.

Health care systems need to look beyond single incidents to diagnose systemic problems that allow such single incidents to occur.

John F. Schneider, MD, PhD, president of the Illinois State Medical Society, looked at the problem of medication errors.

Dr. Schneider cited reports estimating that 16 percent of physicians have illegible handwriting. "I think the number is substantially higher," he added.

He said that prescription errors are the second most prevalent cause of malpractice claims.

"The ultimate answer is that we must move to electronic prescribing and computerization," he said.

"Communication lies at the heart of patient care," said Jon W. Allen, MD, from the University of North Dakota.

Dr. Allen said that while one in four patients do not follow the physician's advice, the physicians themselves overestimate the amount of time spent on giving explanations to patients by as much as 900 percent.

Dr. Allen recommended using mnemonic devices to ensure effective physician-patient communication, such as SEGUE:

- Set the stage for the visit
- Elicit necessary information from the patient
- Give necessary information to the patient
- Understand the patient's perspective
- End encounter

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