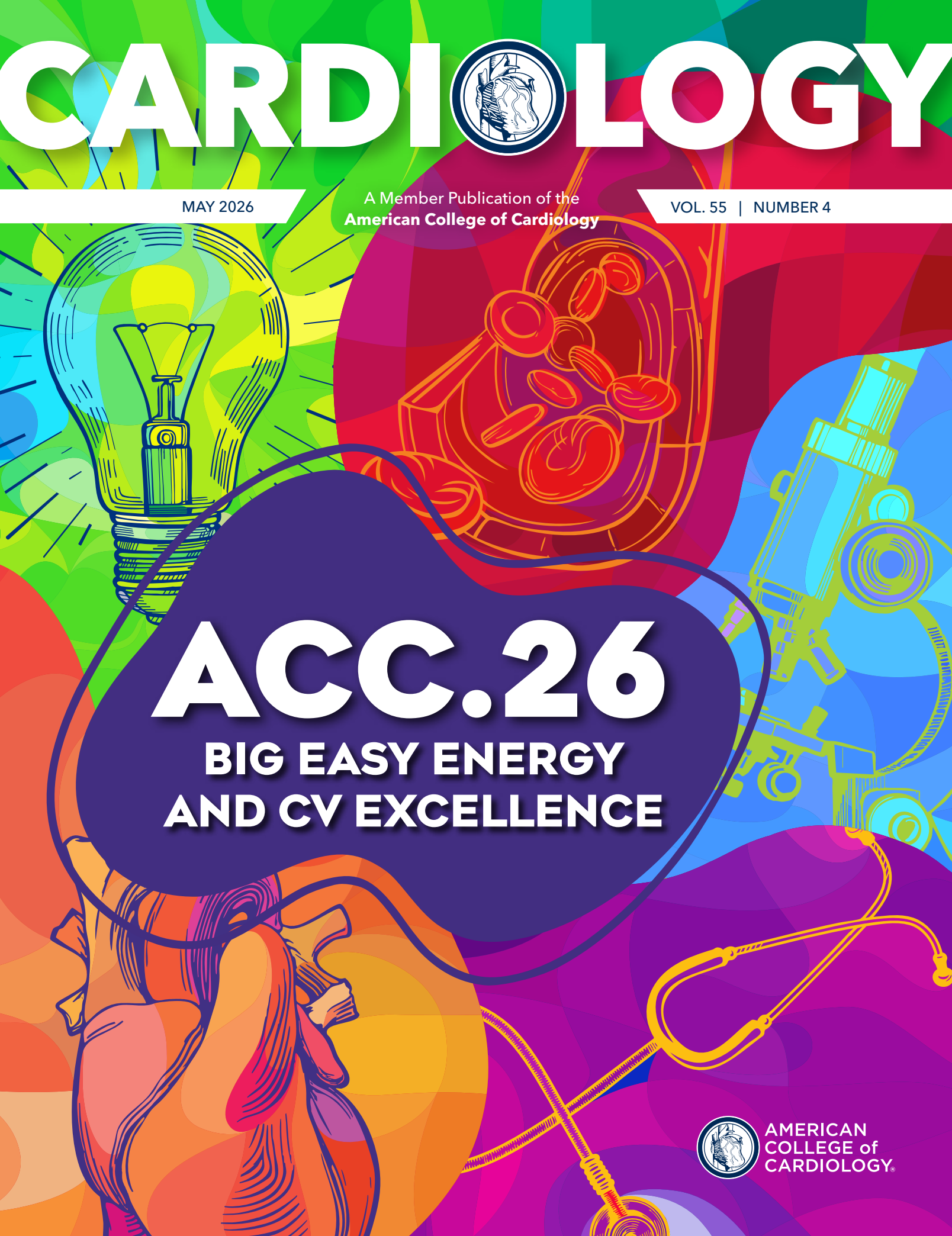
CARDIOLOGY

MAY 2026

A Member Publication of the
American College of Cardiology

VOL. 55 | NUMBER 4



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**MAY 2026**
Vol. 55 No. 4

WHAT'S INSIDE



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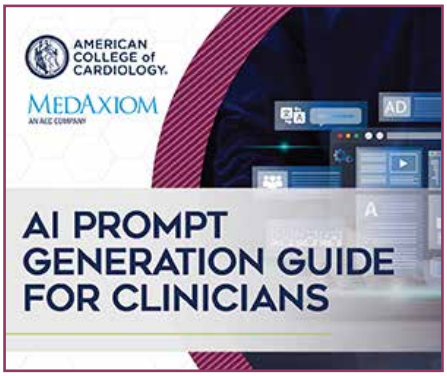


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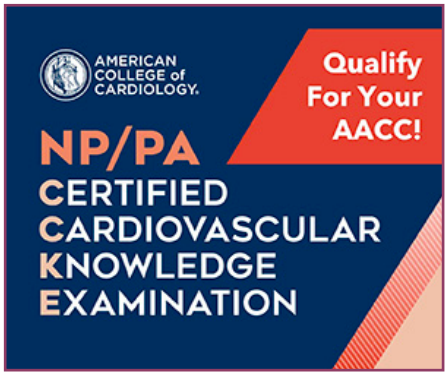


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**Scan the QR code** to learn more.

# The Magic of ACC.26: Science, Community and a New Era of Learning

**Katie Berlacher, MD, MS, FACC**
ACC.26 Chair

## There are scientific meetings – and then there is ACC.26 in New Orleans.

From the opening moments, we intentionally designed an experience to engage, connect and transform. Built on the science of learning, ACC.26 reimagined how cardiovascular professionals absorb and apply knowledge. Interactivity was not a feature; it was the foundation. Whether in Late-Breaking Clinical Trial After Chats or in the Gameshow session debates, attendees were not passive observers, but instead active participants.

And, wow, the science delivered! With record-breaking submissions, ACC.26 showcased the most important research in cardiovascular medicine today. Landmark trials, including HI-PEITHO, CHAMPION-AF and STEMI Door-to-Unload, headlined a program that featured science all day, every day with many studies simultaneously published in high impact journals, reinforcing the meeting's role as a global stage for practice-changing discovery.

What truly set ACC.26 apart was its seamless integration of innovation across every pathway. Artificial intelligence (AI) emerged not as a buzzword, but as a practical tool reshaping care in the office, the hospital, the lab and beyond. The meeting's Intensive Sessions tackled AI's real-world impact, while hands-on opportunities in the Personalized Skills Zone allowed clinicians to engage directly with emerging technologies.

Equally compelling was the meeting's emphasis on community. In a city that understands connection like no other, ACC.26 leaned into its diverse membership – Fellows, Associates, international attendees and first-timers alike. The energy of shared purpose was palpable, from spontaneous conversations to structured Townhall sessions with experts.

The Lounge & Learn Pavilion was a hub of activity, blending professional development, networking and hands-on learning. In addition, the Expo, with its more than 250 exhibitors, offered everything from innovative pitches to unexpected moments of joy, including puppies and even pickleball.

Importantly, ACC.26 also looked forward. Through the Future Hub and Health Equity Hub, the meeting underscored a commitment not only to advancing science, but to ensuring its benefits reach all patients. The Closing Ceremony and Convocation and its nearly 250 new Fellows and Associates, as well as new ACC leadership, including ACC President **Roxana Mehran, MD, FACC**, provided an opportunity to celebrate the future of the College and the profession.

At the end of the day, ACC.26 did more than inform – it inspired. It successfully demonstrated what is possible when cutting-edge science, thoughtful design and a vibrant global community come together with purpose. I, along with Vice Chair **Julie Damp, MD, FACC**, and CV Team Lead **Kristen Bova Campbell, PharmD, BCPS, CPP, FACC**, couldn't be more proud! The bar is set for ACC.27-WCC next April! ■



Cardiology (ISSN: 2165-3674) is published ten times a year by the American College of Cardiology, 2400 N Street NW, Washington, DC, 20037-1153. Periodical postage at Washington, DC, and additional mailing offices.

POSTMASTER: Send address changes to American College of Cardiology, 2400 N Street NW, Washington, DC, 20037-1153.



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# The Numbers Behind ACC.26

**16K+**
The total number of people who attended ACC.26 in New Orleans or virtually.

**11K+**
The number of queries answered by Artie – ACC.26's in-app AI assistant.

**700+** The number of people who attended one of the five new **ACC.26 pre-conferences**, including the sold-out Essentials in Critical Care Cardiology and *JACC* Education Workshop sessions.

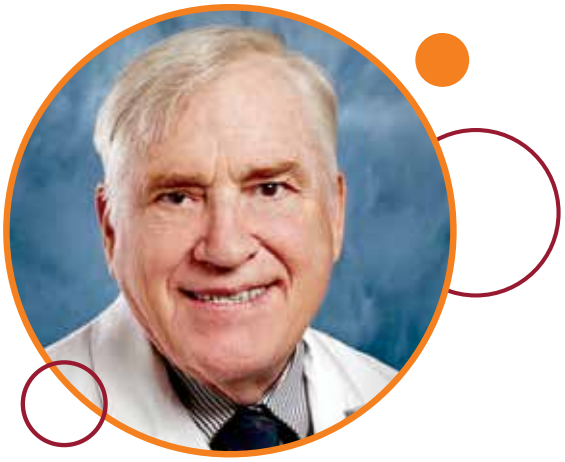

**60** The total number of simultaneous publications across *JACC* Journals, including oral presentations, posters and editorials. **Scan the QR code** to explore the science.

**8** The number of **guidelines** covered throughout ACC.26 sessions, including the newest 2026 Dyslipidemia Guideline. Access all ACC clinical guidance at ***ACC.org/Guidelines.***

**1,300+ & 150+**
The total number of new FACCs and AACCs, respectively, welcomed to the ACC family during the Closing Ceremony and Convocation.

**10K+**
The record-breaking number of abstracts and cases submitted to ACC.26 from around the world. More than 4,500 were accepted.

# **In Memoriam:** James Stuart Forrester III, MD, FACC



**James Stuart Forrester III, MD, FACC**, passed away on March 30, leaving behind countless contributions to the field of cardiology along with a legacy of scholarship and mentorship.

Forrester is credited for several major advancements in cardiovascular care, including the development of the "Forrester hemodynamic subsets" used to monitor patients with acute myocardial infarction at the bedside in the 1970s. He and **George A. Diamond, MD**, created in the 1980s the Diamond-Forrester method for calculating a patient's post-test likelihood of coronary heart disease. In the 1990s, Forrester also led a team responsible for the development of coronary angioscopy and contributed to the understanding and treatment of acute coronary syndrome.

In addition to his impressive clinical contributions, Forrester had an extraordinary career at Cedars-Sinai Medical Center in Los Angeles, CA, including serving as chief of the division of cardiology for many years. He also published more than 400 papers and authored *The Heart Healers: The Misfits, Mavericks, and Rebels Who Created the Greatest Medical Breakthrough of Our Lives* in 2015.

Among his numerous awards, Forrester was awarded ACC's Distinguished Lifetime Achievement Award in 2009 and the 2011 Simon Dack Award for Outstanding Scholarship from *JACC*. In 2014, he co-authored the *Past is Prologue* with ACC Past President **John Gordon Harold, MD, MACC**, commemorating the 65th anniversary of the ACC and the birth of modern cardiovascular medicine.

"Cardiology lost a giant," says Harold. "Yet, what many of us will remember most is the man himself: warm, witty, humble and relentlessly generous. He was a mentor to hundreds, a leader to generations and a friend to all who knew him." ■

# **In Memoriam:** R. Joe Noble, MD, FACC

An extraordinary cardiovascular teacher and educator, **R. Joe Noble, MD, FACC**, passed away on March 14.

Noble graduated from the Indiana University School of Medicine, subsequently completing an internship at Emory University School of Medicine and residency at Indiana University.

Following his fellowship at Emory, Noble served in the military as a Major, USAF and chief of internal medicine at Tinker Air Force Base in Oklahoma. Following his time in the military, Noble returned to Indianapolis, IN, to begin his career as an academic cardiologist, ultimately spending nearly four decades at Northside Cardiology.

A prolific writer, Noble authored more than 300 papers and books. He was also an active local and national ACC leader, serving as governor of the ACC Indiana Chapter, chair of ACC's Board of Governors and a member of the ACC Board of Trustees. He also held several leadership positions associated with the ACC's Annual Scientific Session, served on the ACCEL Editorial Board and more.

"More important than any award or recognition was his love of treating patients," said his family. "He often started rounds at 5:30 a.m. and saw a record number of patients most days. He would always look for the reasons behind the symptoms and could decide what to do for a complex patient very quickly." ■

# PHILANTHROPY IN THE SPOTLIGHT AT ACC.26


Nearly $55K was raised to support travel awards for early career clinicians as part of ACC's annual Giving Day during ACC.26. A big thank you to everyone who stopped by the booth or texted to donate, and special thanks to **Harvey J. White Jr., MD, FACC**, for his $25K matching gift.

Congratulations to this year's recipients of the William A. Zoghbi Cardiovascular Research Awards and the Hani Najm Global Scholar Awards. These awards are among the many growing initiatives funded through the generous support of ACC members to the ACC Foundation. Learn more about all the award winners at ***ACC.org/Convocation*** and **scan the QR code** to apply for 2027 awards.


ACC Foundation efforts to advance science, empower people and transform care were the focus of two events at ACC.26 – a special reception recognizing donors and their collective impact and a Heart2Heart Stage panel featuring Philanthropy Committee Chair **Pamela B. Morris, MD, FACC**; **Jeffrey T. Kuvin, MD, FACC**; and **Patricia Keegan, NP, DNP, FACC**, discussing "Giving Back, Moving Forward: Why Philanthropy Matters."

# **Tonlamarsen Reduces Plasma AGT;** Delivers Mixed Results For Uncontrolled BP

A monthly dose of the novel drug tonlamarsen significantly reduced plasma angiotensinogen (AGT) levels in patients with uncontrolled hypertension compared with a single dose of the drug followed by a placebo, but its impact on systolic blood pressure (SBP) was less clear, according to results from the KARDINAL trial presented at ACC.26 and simultaneously published in *JACC*.

The trial enrolled 485 patients from 39 states in the U.S. who had SBP ≥135 mm Hg and were taking two to five antihypertensive medications. The mean age of patients was 61 years, 41 were women, 49% were Black, 33% had diabetes. The co-primary endpoints were the differences between patient groups in the change from baseline to week 20 in plasma AGT and office SBP.

After receiving an initial placebo injection, all participants received one dose of tonlamarsen at the start of the trial (week 0). For the four monthly injections from weeks four to 20, half of participants were randomized to receive tonlamarsen and half placebo.

At 20 weeks, AGT levels had dropped by 67.2% from baseline, on average, among those who continued taking tonlamarsen and by 23% among those who switched to placebo.

This was a significant between-group difference of 44.1% in favor of continuous tonlamarsen. Clinic SBP dropped by 6.7 mm Hg, on average, across both study groups. This decrease occurred after the first dose of tonlamarsen and was sustained in both groups at week 20, with no significant between-group difference at this time point. No significant differences in secondary BP outcomes including change in home BP or percentage of participants achieving target BP levels were observed.

Serious adverse events occurred in 2% of the tonlamarsen/placebo group and 5% of the tonlamarsen group.

"We did not anticipate the finding that the percentage of [AGT] reduction didn't necessarily correspond to [BP] lowering 20 weeks out," said **Luke Laffin, MD, FACC**, the study's lead author. "This trial raises more questions than it gives answers … but it gives us data that's unique."

Researchers attribute the mixed results to an unexpectedly long-lasting impact of tonlamarsen. However, the specific drivers behind the mixed findings are not known, although they identified several possible explanations. "One possibility, which we think is most likely, is that tonlamarsen lowers [BP] by about 6-7 mm Hg, and this is maintained even as [AGT] rise," Laffin said. "Another possibility is that residual angiotensin suppression among placebo participants resulted in greater [BP] reduction than expected. It's also possible that decreasing angiotensin with tonlamarsen doesn't reduce [BP], although we think that's probably not likely based on the fact that [BP] dropped during the drug run-in period." ■

Laffin LJ, Wang Q, Sarraju A, et al. *JACC*. 2026;March 28: https://doi.org/10.1016/j.jacc.2026.03.034.

## *JACC* Journals at ACC.26

**Scan the QR code** for all the simultaneous publications in the *JACC* Journals from ACC.26.

## ACC.26 News Hub

Visit ***ACC.org/ACC2026*** for all of ACC's live coverage from the meeting, including summaries of the hottest Late-Breaking Clinical Trials, video interviews and more.

# Electronic Alerts Improve Management of AS, MR

Automated electronic clinician notification (ECN) alerts improved the timely evaluation and treatment of patients with severe aortic stenosis (AS) or mitral regurgitation (MR), according to findings from ALERT, presented at ACC.26 and simultaneously published in *JACC*.

Conducted at 35 hospitals across five U.S. health systems from August 2024 to September 2025, the trial tested whether sending alerts identifying significant AS or MR with accompanying care recommendations to clinicians' electronic health record inboxes improved adherence to guideline-based performance metrics, including timely multidisciplinary health team (MHT) clinic evaluation and valve intervention.

In the modified intention-to-treat analysis, 765 clinicians had been randomized to ECN Alert or No Alert. Randomization was stratified by the number of echocardiograms ordered in a two-month pre-enrollment quality control period at each site. More clinicians in the ECN Alert group than the No Alert group ordered echocardiograms (1,137 vs. 879). Although the distribution of AS and MR was similar in the two groups, more patients in the ECN Alert group had an echocardiogram (42% vs. 33%).

The primary endpoint analysis at 90 days showed the ECN alert was superior to usual care (win ratio, 1.27; p=0.007), with higher rates of valve intervention (13% vs. 10%; p=0.005) and MHT evaluation (23% vs. 18%; p=0.005); times to both components were also shorter. The effect sizes were similar for AS and MR patients and results were similar across subgroups. ■

Batchelor WB, Lindman BR, Coylewright M, et al. *JACC*. 2026;March 29: https://doi.org/10.1016/j.jacc.2026.03.037.

# **Novel PCSK9 Inhibitor** Reduces LDL-C in Patients Not Meeting Goals

The novel PCSK9 oral inhibitor enlicitide effectively lowered LDL-C in adults being treated with statins, demonstrating a potential role as an add-on option for patients not meeting LDL-C goals, according to the CORALreef AddOn trial presented at ACC.26 and simultaneously published in *JACC*.

Conducted in eight countries, 301 statin-treated patients were randomized: 101 to enlicitide 20 mg, 50 to bempedoic acid 180 mg, 50 to ezetimibe 10 mg and 100 to bempedoic acid plus ezetimibe 10 mg.

Mean age was 64 years and 37% were women. All had hypercholesterolemia with either a history of a major atherosclerotic cardiovascular disease (ASCVD) event plus an LDL-C level ≥55 mg/dL (44% of patients) or were at intermediate to high risk for a first major ASCVD event plus an LDL-C level ≥70 mg/dL at screening (56% of patients). Mean LDL-C was 91.6 mg/dL.

Results showed there was a significant 65% reduction in the primary endpoint of percent change in LDL-C to day 56 with enlicitide vs. 6% with bempedoic acid, 28% with ezetimibe and 37% with bempedoic acid plus ezetimibe. Results were similar across subgroups. Additionally, patients receiving enlicitide had a significantly greater reduction in the secondary endpoints of ApoB and non–HDL-C than those in the other groups.

Adverse events and discontinuations (2-4%) were similar across groups.

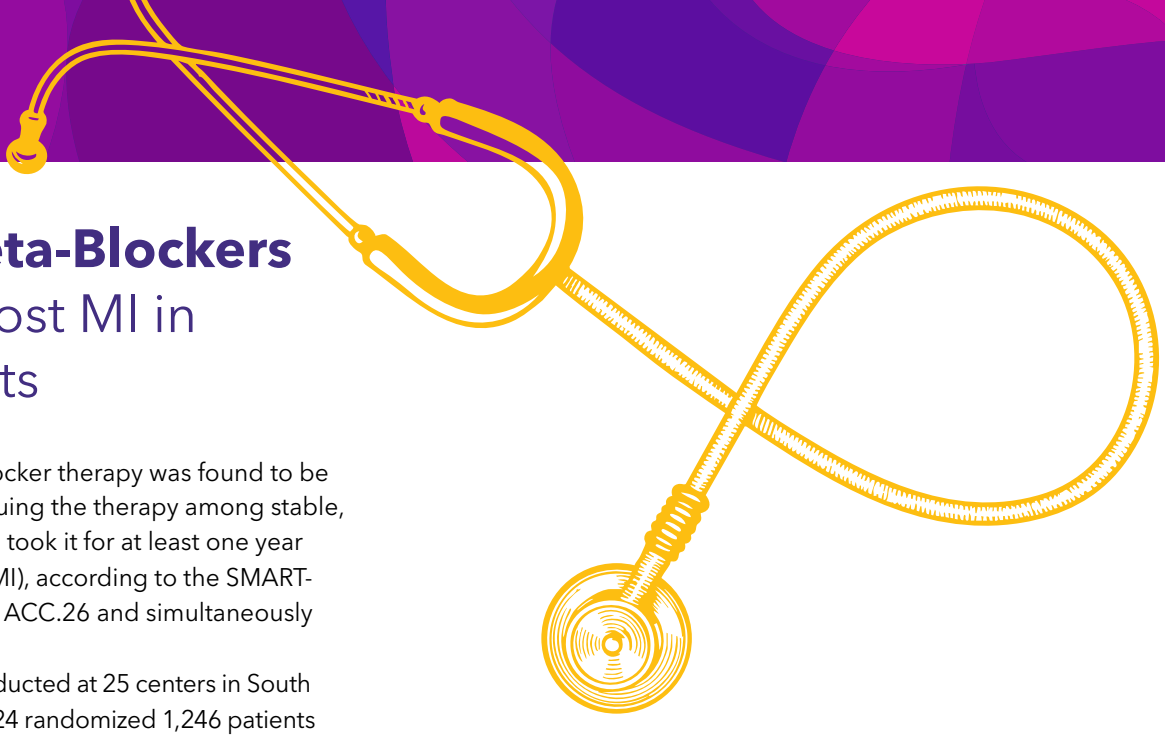
"These data support the potential of enlicitide as a new therapeutic option for patients who need lipid lowering beyond what can be provided with statins alone," concluded the authors.

Meanwhile, results from two separate post hoc on-treatment analyses conducted using data from CORALreef Lipids and CORALreef HeFH were also presented at ACC.26. In both, individuals who remained on treatment experienced significant and sustained reductions in LDL-C through Week 52 with an adverse event profile similar with placebo.

Specifically, in CORALreef Lipids, on-treatment placebo-adjusted mean percent LDL-C reductions were –62.9% at Week 24 and –58.0% at week 52. In CORALreef HeFH, on-treatment placebo-adjusted mean percent LDL-C reductions were –62.2% at week 24 and –65.3% at week 52. ■

Catapano AL, Mikhailova E, Navar AM, et al. *JACC*. 2026;March 30: https://doi.org/10.1016/j.jacc.2026.03.036.

# Stopping Beta-Blockers
## Safe 1 Year Post MI in Stable Patients



Discontinuing beta-blocker therapy was found to be noninferior to continuing the therapy among stable, low-risk patients who took it for at least one year post myocardial infarction (MI), according to the SMART-DECISION trial presented at ACC.26 and simultaneously published in *NEJM*.

The open-label trial conducted at 25 centers in South Korea between 2021 and 2024 randomized 1,246 patients to beta-blocker discontinuation and 1,294 to beta-blocker continuation. All had an LVEF ≥40% and none had heart failure (HF). Mean age was 63 years and 13% were women.

At a median follow-up of 3.1 years, the primary endpoint, a composite of all-cause death, recurrent MI or HF hospitalization, occurred in 7.2% (n=58) of the beta-blocker discontinuation group and 9.0% (n=74) of the beta-blocker continuation group (hazard ratio, 0.80; p=0.001 for noninferiority). For each component of the primary endpoint, as well as new-onset atrial fibrillation, unfavorable changes in LV function, changes in quality of life and serious adverse events, results were similar with beta-blocker discontinuation.

"In appropriately selected patients who survived a heart attack and do not have [HF] or left ventricular systolic dysfunction, routine continuation of beta-blockers indefinitely may not be necessary," says **Joo-Yong Hahn, MD**, the trial's senior author. "In practice, for stable patients who are several years out from a heart attack, discontinuation can be considered through shared decision-making and with monitoring of blood pressure and heart rate. For patients with beta-blocker-related side effects … the case for discontinuation is even stronger." ■

Choi KH, Kang D, Kim W, et al. *NEJM*. 2026;394:1302-12.

# Evolocumab Cuts CV Risk in Diabetes Without ASCVD

The PCSK9 inhibitor evolocumab reduced the risk of a first major cardiovascular event in patients with diabetes without known significant atherosclerosis, according to a prespecified subgroup analysis of the VESALIUS-CV trial, presented at ACC.26 and simultaneously published in *JAMA*.

This analysis examined outcomes in 3,655 patients with diabetes and without known atherosclerosis, defined as no prior arterial revascularization, arterial stenosis ≥50% or elevated coronary calcium. Of them, 1,849 had been randomized to evolocumab and 1,806 to placebo. Median age was 65, 57% were women and median baseline LDL-C was 132 mg/dL. At baseline, 89% were on lipid-lowering therapy (64% on high-intensity statin therapy).

At 48 weeks, LDL-C levels fell to 52 mg/dL with evolocumab vs. 111 mg/dL with placebo (p<0.001). During a median 4.8-year follow-up, 83 evolocumab patients vs. 117 placebo patients experienced a first primary endpoint event, a composite of coronary heart disease death, myocardial infarction (MI) or ischemic stroke (3-P MACE) (hazard ratio [HR], 0.69; p=0.009). Additionally, 127 evolocumab patients vs. 178 placebo patients experienced the second primary endpoint, 3-P MACE plus ischemia-driven revascularization (IDR) (HR, 0.69; p=0.009), with a 2.9% between-group difference.

A consistent benefit was seen with evolocumab vs. placebo for prespecified secondary endpoints: 34% reduction in MI, stroke or IDR; 31% reduction in coronary heart death, MI or IDR; and 32% reduction in cardiovascular death, MI or ischemic stroke. ■

Marston NA, Bohula EA, Bhatia AJ, et al. *JAMA*. 2026;March 28:doi: 10.1001/jama.2026.3277.

# Sotatercept Significantly Benefits Patients With CpcPH, HFpEF

Sotatercept was associated with significant improvements in blood pressure and vascular health in patients with heart failure with preserved ejection fraction (HFpEF) and severe combined post and precapillary pulmonary hypertension (CpcPH), according to results from CADENCE presented at ACC.26 and simultaneously published in *Circulation*.

In the phase 2 trial, investigators enrolled 164 patients (mean age, 75 years; 70% women) with both HFpEF and severe CpcPH to sotatercept at 0.3 mg/kg (n=54), sotatercept at 0.7 mg/kg (n=55) or placebo (n=55) every three weeks.

All patients were on guideline-directed medications for HFpEF at baseline. Baseline median pulmonary vascular resistance (PVR) was 5.2 Wood units, mean pulmonary artery pressure (mPAP) was 43 mm Hg and pulmonary arterial wedge pressure (PAWP) was 21 mm Hg.

Results at 24 weeks showed a statistically significant reduction in the primary endpoint of PVR, with a median change from baseline of –0.67 Wood units with sotatercept 0.3 mg/kg and –0.33 Wood units with sotatercept 0.7 mg/kg, vs. 0.26 Wood units with placebo. PVR in the two treatment groups, respectively, was –1.02 Wood units and –0.75 Wood units.

Both the 0.3 mg/kg and 0.7 mg/kg groups saw improvements in mPAP (–9.19 mm Hg and –9.22 mm Hg), PAWP (–3.04 mm Hg and –2.53 mm Hg) and six-minute walking distance (20.3 meters and 5.8 meters, respectively). Time to clinical worsening was 82% lower in the 0.3 mg/kg group but not significantly reduced in the 0.7 mg/kg group.

The results provide proof of concept for improved pulmonary vascular and cardiac hemodynamics with activin signaling inhibitor with sotatercept in this patient population, write the authors. ■

Gomberg-Maitland M, Tedford RJ, Langleben D, et al. *Circulation*. 2026;March 29: https://doi.org/10.1161/CIRCULATIONAHA.126.0799.

# Sirolimus-Coated vs. Uncoated Balloons
## For Infrainguinal Artery Disease

For patients with symptomatic infrainguinal artery disease, angioplasty with a sirolimus-coated balloon, vs. an uncoated balloon, reduced major adverse limb events at one year, according to the SirPAD trial presented at ACC.26 and published simultaneously in *NEJM*.

The investigator-initiated all-comers trial was conducted at 44 vascular care centers in Switzerland. Eligible adult patients had symptomatic peripheral artery disease in the femoropopliteal arteries or arteries below the knee that warranted endovascular intervention and they were referred to one of two trial sites for enrollment and endovascular procedures that were performed by 15 operators.

A total of 1,252 patients (median age 75, 35% women) were randomized 1:1 to a sirolimus-coated balloon or an uncoated-balloon.

At one year, 55 patients (8.8%) in the sirolimus-coated balloon group and 94 patients (15%) in the uncoated balloon group experienced a primary outcome event, a composite of unplanned major amputation affecting the target limb or endovascular or surgical revascularization of the target lesion for critical limb ischemia (CLI). The median unbiased estimate of risk difference was −4.9 percentage points (p<0.001 for noninferiority; p=0.009 for superiority). The difference in primary outcome events was driven by "concordant effects on both individual components of the primary composite outcome."

A key secondary outcome, a composite of any unplanned amputation affecting the target limb or revascularization of the target lesion for CLI or non-CLI within one year, occurred in 144 patients (23%) and 193 patients (31%) in the sirolimus-coated balloon and uncoated balloon groups, respectively (absolute risk difference, −7.8 percentage points; p=0.002 for superiority). ■

Barco S, Engelberger RP, Held U, et al. *NEJM*. 2026;March 30: DOI: 10.1056/NEJMoa26003.

# **Leading With Purpose:** How ACC is Shaping Workforce Culture and Engagement

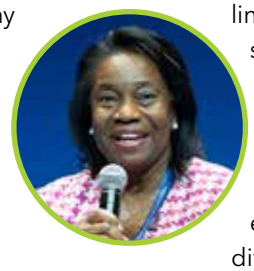
"Cultures Change When People Change" - **Thich Nhat Hanh**

A growing body of evidence underscores a simple but powerful truth: the strength of the cardiovascular workforce directly shapes the health of the patients it serves. For the ACC, this connection is not theoretical – it is central to its Mission to transform cardiovascular care and improve heart health for all.

At the heart of that Mission lies a commitment to building a workforce that is not only highly skilled, but also inclusive, collaborative and rich in the perspectives needed to serve all cardiovascular patient communities. These qualities are increasingly recognized as essential drivers of better patient outcomes, stronger clinical teams and more innovative research.

## A Representative Workforce as a Clinical Imperative

Research highlighted by the ACC shows that a cardiovascular workforce representing a wide array of backgrounds and experiences improves patient care, enhances learning environments and leads to higher-quality research.



"A workforce comprised of professionals from many different backgrounds is better able to appreciate the varied lived experiences of our patients," says **Jennifer H. Mieres, MD, FACC**, chair of the College's Workforce Culture and Engagement Committee. "This understanding helps us communicate more effectively and build the trust that is essential for improving treatment adherence and health outcomes."

This is particularly important in cardiovascular disease, where significant variations in health outcomes linked to patients' racial, ethnic and socioeconomic backgrounds are observed. A more representative workforce helps close these gaps by aligning clinical care with patients' lived experiences and social contexts. Studies over the last decade have shown that workforce representation in cardiology is linked to improved access, patient satisfaction and clinical outcomes.

But representation alone is not enough. Inclusion – the creation of environments where all professionals feel valued and empowered – is what enables diverse teams to function effectively.

"Inclusion is central to the profession and its future," says ACC Chief Health Equity Advancement Officer **Melvin R. Echols, MD, MSCR, FACC**. "Diversity of experiences and perspectives is critical for meeting the challenges of today and implementing solutions that will guide us into the future."

The 2025 Health Equity Summit convened clinicians, industry, cardiovascular society and community health partners for robust discussions on topics ranging from the business case for health equity to real-world solutions that leverage both community involvement and clinical engagement in care delivery.

## The Power of Teamwork and Culture

High-performing cardiovascular care is inherently team-based. Cardiologists, nurses, advanced practice providers, researchers and trainees must work collaboratively to deliver complex, often life-saving care.

"The value of an inclusive team is about performance. It's not just about creating a positive culture, but also building a more effective team," says Mieres. "They bring broader perspectives to clinical problem-solving, reduce blind spots in decision-making and foster creativity in research and quality improvement."

Creating such teams, however, requires intentional cultural change. The ACC has made leading this change a priority, focusing on building a professional environment rooted in respect, belonging and opportunity. Aligning with the College's broader emphasis on developing essential nonclinical competencies, such as leadership, communication and systems-based practice, ACC's Workforce Culture and Engagement Committee is leading efforts to ensure that all members of the cardiovascular team can thrive, contribute and lead.[1,2] Examples include regularly published peer-reviewed science and expert commentary on workforce-related topics in *JACC* and *JACC: Advances* and a robust library of online training and discussions at ***ACC.org/HealthEquity.***

"Every team member is critical to changing the culture of cardiovascular care," says **Melanie S. Sulistio, MD, FACC**, incoming chair of the Workforce Culture and Engagement Committee. "Developing skills like how to navigate difficult conversations compassionately and leading with respect, inclusion and shared humanity are foundational to advancing health equity and achieving excellence in patient care."

"We are tied together in our Mission to improve heart health for all and have a common sense of purpose to ensure our clinical research and leaders reflect the population we are caring for," said **Tracy Wang, MD, MHS, MSc, FACC**, about the Clinical Trials Research Program.

## Developing the Next Generation of Clinicians

Truly transforming the workforce begins long before fellowship training. The ACC is actively working to expose students at every stage, including high school, medical school and residency, to careers in cardiology.

Efforts like the popular Internal Medicine and Pediatric Cardiology program, Young Scholars and the Hani Najm Global Scholar Award, are key to demystifying the field and encouraging talented individuals from all backgrounds to enter the profession.

"Through mentorship, education and real-world experiences, these programs provide the guidance and support needed to navigate a complex and competitive career path," says Echols. "Longer term, our goal is to close longstanding gaps in representation and ensure that the future workforce reflects the richness and variety of the communities being served."

To sustain progress, the College is working to specifically incorporate workforce culture and engagement across its other structured leadership and mentoring programs and educational offerings ranging from online platforms like the NCD Academy to in-person forums like Emerging Faculty and the ACC Annual Scientific Session. Taken together, these efforts emphasize not only clinical excellence, but also collaboration, communication and cultural competence – skills essential for modern health care leadership. These skills are cornerstones of the nonclinical competencies the College has identified as vital for the next generation of leaders.[3]

"We've been able to grow and sustain the majority of our workforce programs over the last several years thanks to the incredible philanthropic support from ACC members – many of whom once benefited from these same programs," says Mieres. "Change doesn't happen overnight, but it's powerful to watch it evolve from a spark into something enduring."

## Supporting Emerging Researchers

Innovation in cardiovascular medicine also depends on a robust and inclusive research ecosystem, and research leaders who will mentor future leaders. To date, nearly 200

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individuals have completed ACC's Clinical Trials Research Program, which launched in 2019 and is now starting its fifth cohort. Additionally, the ACC offers dedicated research fellowships like those funded under the umbrella of the William A. Zoghbi Global Research Initiative and the new Thad and Gerry Waites Rural Cardiovascular Research Fellowship to provide resources and training pathways for emerging investigators.

These initiatives are particularly important because a breadth of perspective among researchers influences the research questions that are asked, the populations who are studied and the applicability of findings.

"Studies over the last decade have shown that building a more representative research workforce can lead to broader clinical trial participation and improved clinical outcomes across the full spectrum of our patient population," says Mieres. "By fostering inclusive research environments, the ACC is helping to ensure that scientific advances benefit all patients – not just a subset of the population."

## Aligning Workforce and Mission

Ultimately, the ACC's focus on workforce culture and engagement is not separate from its Mission – it is foundational to it. Achieving the Mission to improve heart health for all requires more than scientific advancement; it requires a transformation of the people and systems delivering that care.

By fostering an inclusive culture, investing in growing the next generation of clinicians and leaders, and supporting emerging researchers, the ACC is advancing a vision of cardiovascular medicine that is both excellent and accessible for all.

"This approach," says Echols, "reflects a broader understanding of health care: that better outcomes are not driven by clinical expertise alone, but by the collective strength of teams that offer varied perspectives, united in purpose and committed to improving heart health for all." ■

*References available with the online version of this article at ACC.org/Cardiology.*

## HEALTH EQUITY AT ACC.26


The Health Equity Hub returned, providing a dedicated space for recognizing leaders and community volunteers, discussing community-level solutions, and sharing best practices for improving patient access and improving heart health for all.

The ACC DEI Town Hall and LGBTQ+ Reception was a time to celebrate community prior to the start of the meeting.


A panel discussion on the Heart2Heart Stage focused on ways to fortify the future of the cardiovascular workforce.

Congratulations to **Stephen C. Cook, MD, FACC**, for receiving the 2026 Pamela S. Douglas Award for Leadership in Diversity and Inclusion. Cook has worked diligently over the past 30 years to make cardiovascular care more accessible and welcoming to members of the LGBTQ+ community, as well as for other groups that have historically faced discrimination and suffered poorer health outcomes. **Scan the QR code** to read more about Cook and the award.

# Health Care Payment Trends on the **Heart2Heart Stage**

As cardiovascular care evolves, so does the system that supports it. At ACC.26, payment experts mapped out key payment trends redefining care delivery on the Heart2Heart Stage.

Panelists covered new payment policies that took effect in 2026, such as the Medicare Physician Fee Schedule conversion factor, the efficiency adjustment reduction, site-of-service payment differential policy, and the impact of the *One Big Beautiful Bill Act (OBBBA)* on Medicaid funding.

They also touched on developments in the ambulatory care setting, like the sunsetting of the Inpatient-Only List, and raised awareness about the Ambulatory Specialty Model. (Visit ***ACC.org/ASMForHF*** for more resources on this topic.)

ACC Advocacy remains committed to making the Medicare system more sustainable and educating members about legislative solutions. Learn more about the College's efforts, and view a new Medicare Payment Building Blocks video series, at ***ACC.org/MedicarePayment***. ■


**Cardiology After the One Big Beautiful Bill**

Looking for more on payment policy and its impacts? An ACC.26 session unpacking what frontline clinicians and health system leaders need to know about the *OBBBA* is available on demand on ACC Anywhere. **Scan the QR code** to subscribe and watch.

# **4 Ways** ACC State Chapters Are Advancing CV Policy

ACC State Chapters have been hard at work advancing policies that expand access to life-saving cardiovascular care and support the health care workforce. Recent highlights include:

**1. Partnering With the NFL to Raise SCA Awareness**

**Alfred Danielian, MD, FACC**, joined the Las Vegas Raiders for an event focused on increasing public access to AEDs. Representing the ACC Nevada Chapter, he delivered a keynote address and engaged community members in discussions on sudden cardiac arrest (SCA) and cardiac emergency preparedness.

**2. Showcasing the Strength of the CV Care Team**

ACC members in Alabama hosted **Rep. Shomari C. Figures (D-AL)** at Mobile Infirmary, offering an inside look at the coordinated effort required to deliver high-quality cardiovascular care. Following ongoing engagement with the Chapter, Figures has cosponsored several ACC-endorsed bills.

**3. Testifying in Support of Athlete Well-Being**

In both Connecticut and Maryland, ACC members specializing in sports cardiology testified before state legislative committees on proposals requiring cardiac components in athlete physicals. Their expertise underscored evidence-based best practices for protecting competitive athletes from cardiac events.

**4. Building Lasting Relationships With Lawmakers**

Recent state lobby days in Iowa, Kansas, Missouri, New York, Tennessee and Vermont brought cardiovascular clinicians directly to state capitols to discuss priority health policy issues. These in-person events continue to build momentum and cultivate relationships with decisionmakers at the state level.

Interested in helping shape cardiovascular policy? Save the date for **ACC Legislative Conference 2026**, taking place Oct. 4-6 in Washington, DC. Registration will open soon! ■

# ACC.26: BIG EASY ENERGY AND CV EXCELLENCE

In true New Orleans style, ACC.26 delivered a dynamic, all-encompassing experience that blended cutting-edge science, immersive education and a strong sense of community across the global cardiovascular field.

Celebration, reflection and forward-looking vision was center stage over the course of the three-day event – providing thousands of cardiovascular professionals with countless opportunities to learn, share and connect.

"This meeting is intentionally designed to pull you in at every turn…so you can return home with knowledge that you can put into practice on Tuesday morning," said ACC Scientific Session Chair **Katie Berlacher, MD, MS, FACC**. "It has been a journey filled with innovation, transformation, challenge, creativity and so much joy. I could not be prouder of what we accomplished." ■


From beads to jazz, a little bit of New Orleans rhythm and culture was integrated throughout ACC.26.

ACC.26 Chair **Katie Berlacher, MD, MS, FACC**, Vice Chair **Julie Damp, MD, FACC**, and CV Team Lead **Kristen Bova Campbell, PharmD, BCPS, CPP, FACC**, along with the larger Annual Scientific Session Program Committee, were responsible for bringing ACC.26 to life.


ACC President **Christopher M. Kramer, MD, MACC**, kicked off the Opening Showcase, using the "Fantastic Voyage" as a framework to explore how innovation, mentorship and resilience continue to shape the College.

Yes, we can! Incoming ACC President **Roxana Mehran, MD, FACC**, challenged new Fellows and Associates to stand together to transform cardiovascular care for all.

# FRIENDLY COMPETITION, FIERCE BRAGGING RIGHTS

Two **Escape Rooms** challenged teams to use their skills to make it out "alive."


**Massachusetts** beat the buzzer in FIT Jeopardy, winning the Battle of the State Chapters. **Malaysia** came out the winner in the International Jeopardy final.



Congratulations to this year's **Young Investigator Award** winners!

**Pickleball** debuted in the Expo this year, adding an additional element of competition to the meeting.

The **ACC.26 Innovation Pitch Challenge** winners from Day 2, plus the **2026 CardioSim Creator Award** winner.



**Scan the QR code** to read more about the winner of the **ACC.26 Heart Tank Tournament of Champions.**

The **Gameshow Room** generated laughs and learning with sessions based on *Family Feud*, *Who Wants to Be a Millionaire* and more.

# LEARNING SPOTLIGHT

On the education front, high-level keynotes featuring leading experts in their respective fields covered topics ranging from artificial intelligence to team-based care. Other sessions, including **Heart2Heart Stage** discussions and **Fireside Chats**, allowed for bidirectional communication with ACC leaders, sharing of best practices, and deeper dives into new and evolving areas of cardiovascular care.


REMARKABLE
CONVERSATIONS LIVE
ACC's Mission in Motion


THE ACC FOUNDATION
ADVANCING SCIENCE.
EMPOWERING PEOPLE.
TRANSFORMING CARE.

# MEMORABLE MOMENTS

ACC.26 delivered unforgettable moments – from breakthrough insights and inspiring connections to adorable puppies that stole the show. This photo spread captures the energy, innovation and joy that made this year's conference truly one to remember.

Puppies!

The **ACC seal** was a popular meet-up point and a photo backdrop for countless attendees.

ACC **Board of Trustees** members getting ready for Convocation.

**Roxana Mehran, MD, FACC**, joins an inspiring group of women who have served as ACC President.

Nearly 250 new Fellows and Associates took part in **Convocation** and for many it was a family affair. **Scan the QR code** for the complete list of new FACC and AACC members.

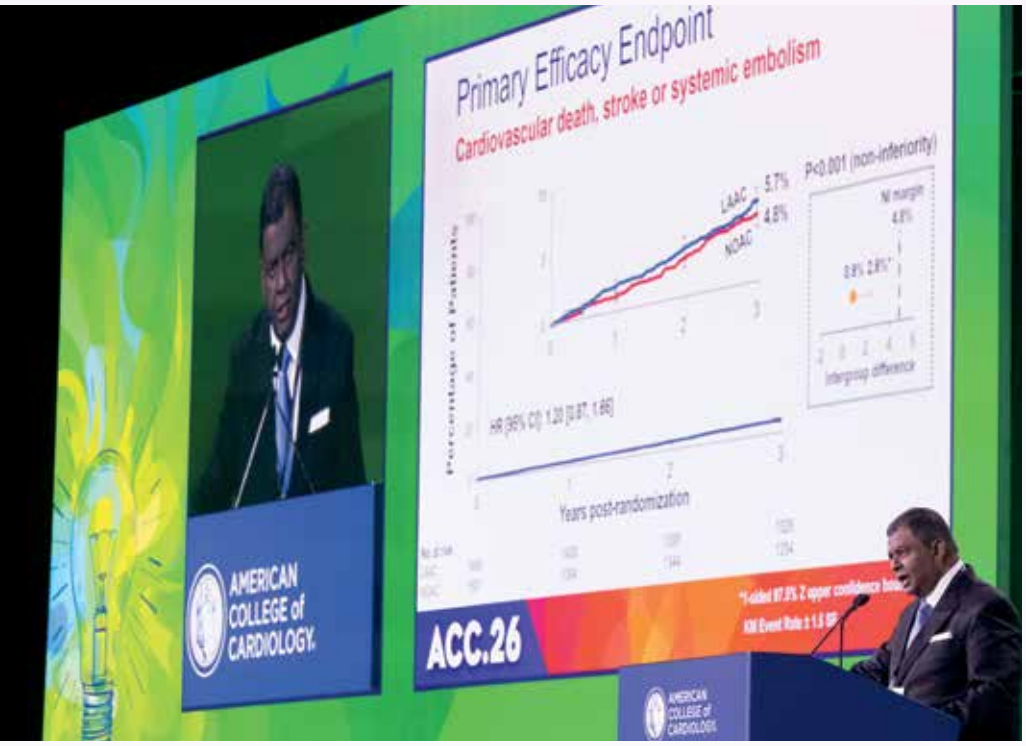
ACC Lifetime Achievement Award recipient **Zohair Y. Alhalees, MBBS, FACC**, and Presidential Citation recipient **Thad F. Waites, MD, MACC**, were recognized at the Opening Showcase. Learn more about 2026 awardees at *ACC.org/Convocation*.

Innovation was front and center at the meeting, with the **Personalized Skills Zone** offering various opportunities for hands-on learning.


Next up: **ACC.27-WCC in Houston**!

# ACC.26 SCIENCE: MOVING PATIENT CARE FORWARD

ACC.26 delivered a "heard it here first" glimpse at the science poised to reshape cardiovascular care. From interventional insights and advances in structural heart and heart failure to growing evidence on Food is Medicine and community-based approaches, these late-breaking findings are already influencing what comes next.




In the first study to compare ultrasound-facilitated, catheter-directed fibrinolysis plus anticoagulation vs. anticoagulation alone in patients with acute, intermediate-risk pulmonary embolism (PE), **HI-PEITHO** showed that the catheter intervention led to a lower risk of the primary composite endpoint of PE-related death, cardiorespiratory decompensation or collapse, or symptomatic PE recurrence within seven days of randomization. Among 544 patients who also had two indicators of clinical severity, half were randomized to catheter treatment and half to standard systemic anticoagulation: 4% and 10.3% of each arm experienced a primary outcome at 30 days. The 61% between-arm difference significantly favored the catheter-based treatment arm and was driven by a reduction in cardiorespiratory decompensation or collapse. There were few deaths in either arm, no brain bleeds, and no significant difference in all-cause deaths or major bleeding complications. "If the right patients are selected for this procedure, it can prevent patients from deteriorating and it can do so at an acceptably low risk of bleeding complications," said **Stavros V. Konstantinides, MD, PhD**.

In another first, the noninferiority **CHAMPION-AF** trial showed that device-based left atrial appendage closure (LAAC) was comparable to non-vitamin K antagonist oral anticoagulant (NOAC) therapy in reducing the combined rate of death from cardiovascular causes, stroke or systemic embolism at three years in patients with nonvalvular atrial fibrillation (AFib) who were candidates for anticoagulation. LAAC also was superior to long-term NOAC therapy for prespecified nonprocedure-related bleeding. In the multinational trial of 3,000 patients, a primary outcome occurred in 5.7% and 4.8% of the patients in the LAAC group with the WATCHMAN FLX device and NOAC group at three years. "This is an important finding because we studied people who we thought were good candidates for blood thinners," said **Saibal Kar, MD, FACC**, co-principal investigator. "They are not contraindicated for long-term anticoagulation and they have a low bleeding risk; in spite of that, they had increased bleeding over time."

In **STEMI-DTU**, compared with immediate PCI alone, the combination of mechanical left ventricular (LV) unloading using a transvalvular micro-axial flow pump (TVmAFP) plus delayed PCI did not reduce infarct size in patients with anterior STEMI


without cardiogenic shock. Among 527 adults without a prior myocardial infarction (MI) in the multinational trial, 30 minutes of LV unloading before PCI vs. PCI alone resulted in no significant difference in the extent of heart-muscle damage in the two arms (30.8% and 31.9%, respectively). The 30-day rate of device-related major bleeding or blood vessel complications was 30.8% in the intervention group, exceeding the 26.5% predefined performance goal. Bleeding rates were significantly higher in the TVmAFP arm (34% vs. 6% PCI alone). **Gregg W. Stone, MD, FACC**, co-author of the trial, said that while the study did not meet its primary endpoint, the findings suggest several avenues for further research.

Unloading the LV before complex PCI in **CHIP-BCIS3** did not reduce the risk of major adverse clinical outcomes in patients with severe LV dysfunction (LVEF ≤35%) and carried a greater risk of all-cause and cardiovascular mortality. "Our findings strongly suggest that we shouldn't be using this device routinely without more evidence of benefit," said **Divaka Perera, MD**, first author of the study. The open-label trial conducted in the UK found more patients who had elective unloading with a micro-axial flow pump vs. standard of care experienced the primary outcome (79.3% vs. 73.6%), a hierarchical composite of all-cause death, disabling stroke, spontaneous MI, cardiovascular hospitalization and periprocedural myocardial injury. Of 22,496 pairwise comparisons, 36.6% favored the micro-axial flow pump and 43.0% favored standard care, with a win ratio of 0.85 (p=0.30).

## More Interventional Insights

Findings from **ALL-RISE** may signal a shift to angiography-derived fractional flow reserve (FFR) over the traditional wire-based assessment in patients with coronary artery disease (CAD) undergoing PCI, thus providing an integrated, first-line FFR and immediate functional estimate to inform revascularization decisions. The novel FFRangio method, assisted by artificial intelligence and minimally invasive, performed the same as wire-based testing, with a similar rate of the composite primary endpoint at one year (6.9% vs. 7.1%; p<0.001 for noninferiority). No differences were observed in bleeding, acute kidney injury (AKI) or procedure-related adverse events.

Another novel technique, vFFR, was also considered an important step toward a new standard of care, showing it was noninferior to pressure-wire-based FFR in patients with intermediate coronary lesions, with the composite primary outcome occurring in 7.5% of each group, respectively. In the open-label **FAST III** trial, the occurrence of key secondary endpoints was also similar. Using 3D quantitative angiography, vFFR identified a higher percentage of functionally significant lesions and procedures were shorter with fewer intraprocedural complications.

Angina and quality of life were improved more with angioplasty for symptomatic single-vessel coronary chronic total occlusion (CTO) in **ORBITA-CTO** vs. placebo in the blinded trial of 50 patients. While the results showed that angina scores improved in the placebo group, overall results found CTO PCI led to an immediate and sustained improvement in angina symptom scores, largely due to a reduction in the number of angina episodes. On average during the 168-day follow-up, patients who received CTO PCI had 31 more angina-free days than those in the placebo group.

Three different trials looked at the use of IVUS guidance for PCI. In **DKCRUSH VIII**, when using the two-stent double-kissing crush technique for PCI to treat complex coronary artery bifurcation lesions, IVUS-guided PCI was associated with

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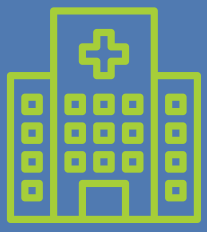
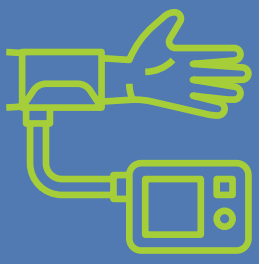
## QUICK TAKES: FOOD AND FUNDING



Providing financial support early after hospital discharge to economically vulnerable patients with HF reduced ejection fraction was feasible and significantly improved adherence to prescribed medication in the **FUND-HF** pilot. At one month, the key outcome of tested medication adherence was higher in the financial support group vs. the control group (mean adherence 0.74 vs. 0.54; p=0.001). The findings will inform future larger trials with a longer duration and extended follow-up.



A culturally tailored food-is-medicine intervention significantly reduced systolic blood pressure (SBP) in Black and Hispanic adults with hypertension, compared with those who received an equivalent amount of fresh produce without the additional supports in **THRIVE**. At 24 weeks, participants in the intervention group saw a significantly greater reduction in SBP, by 6.8 mm Hg on average vs. 0.3 mm Hg in the control group.

A structured grocery home-delivery program aligned with the DASH diet along with dietitian counseling significantly reduced SBP and LDL-C among Black adults with hypertension living in a food desert compared with a grocery stipend and basic dietary guidance in **GoFreshRx**. At three months, SBP was 7 mm Hg lower on average in the grocery delivery vs. 2 mm Hg in the grocery stipend group. LDL-C was reduced by 7 mg/dL vs. 1.8 mg/dL. These reductions persisted three months after the intervention ended.

a greater reduction in target vessel failure vs. angiography-guided PCI. In contrast, in **IVUS-CHIP** and **OPTIMAL**, IVUS-guided PCI was not superior in patients with complex coronary arteries or in patients with unprotected left main CAD, respectively.

**Scan the QR code** to read more on STEMI-DTU, ORBITA-CTO and DKCRUSH VIII in *JACC*.

### Structural Heart Interventions

Transcatheter tricuspid edge-to-edge repair (T-TEER) on top of standard-of-care medical therapy in **TRI-FR** vs. medical therapy alone reduced the risk of death, MI, stroke and hospitalization for heart failure (HF) in patients with severe symptomatic tricuspid regurgitation. At two years, 20% and 35% of the two groups, respectively, experienced a primary endpoint; 14% and 23% were hospitalized for worsening HF, representing a 40% reduction in risk.

Looking at re-do interventions, a reduction in death or disabling stroke at one year was found in **SURVIV** in patients with a failed mitral bioprosthetic valve who underwent transcatheter mitral valve-in-valve (mVIV) vs. a standard repeat mitral valve replacement surgery (rMVR). The study conducted in Brazil with 150 patients showed that 5.3% and 20.8% of the mVIV and rMVR groups experienced the primary endpoint. At 30 days, the rates of cardiovascular death, AKI and life-threatening or major bleeding complications were higher in the rMVR group.

Deferring PCI until after TAVI in older patients with severe aortic stenosis and substantial CAD was safe and reduced bleeding compared with PCI before TAVI in **PRO-TAVI**. In the deferred-PCI and PCI-first arms, there was a similar, noninferior rate of the primary composite outcome (24% and 26%, respectively) of all-cause death, MI, stroke or moderate to severe bleeding. Notably, there was a significant difference in the rate of major bleeding at 6% in the deferred-PCI arm and 15% in the PCI-first arm, which investigators attributed to the dual antiplatelet therapy prescribed post PCI.

In **PROTECT H2H**, in the first head-to-head comparison of two embolic protection devices used during TAVR, the investigational Emboliner protection catheter performed comparably to the approved Sentinel cerebral protection system among 466 high-risk patients (mean age 81 years, 36% women). Results at 30 days showed that 4.9% of Emboliner patients vs. 5.0% of Sentinel patients experienced a primary endpoint event, a composite of all-cause death, stroke and acute kidney failure. Stroke within 30 days occurred in 2% and 2.1% of the two groups, "the lowest rates of stroke that have been achieved in a trial of this size," noted study author, **Adam B. Greenbaum, MD, FACC**. Adverse event rates were similar in both groups.

## Heart Failure

In adolescents with obstructive hypertrophic cardiomyopathy (oHCM), mavacamten vs. placebo significantly improved the primary endpoint of change in Valsalva LV outflow tract gradient, with an average drop of 48.5 mm Hg vs. 0.5 mm Hg in the respective groups at 28 weeks in **SCOUT-HCM**. Greater improvements were also seen for secondary endpoints. Overall, 43 patients with NYHA class II or III oHCM aged 12-17 were randomized in the international trial. "Beyond symptom relief, there's a signal that this may be favorably remodeling the heart, which could improve the natural history of the disease," said first author **Joseph William Rossano, MD, FACC**, suggesting it could be important to start children on this therapy when they are young.

No improvement was seen with spironolactone over placebo in HF hospitalizations and cardiovascular death at 24 months in 730 patients with symptomatic HF with preserved or mildly reduced ejection fraction (HFpEF, HFmrEF) in **SPIRIT-HF**. The event rate of the composite primary outcome was 12.7 and 10.8 per 100-patient years in the respective groups. Notably, secondary endpoints were significantly higher in the spironolactone group, including total hospitalizations, hypotension, renal events and elevated potassium, with a trend toward increased cardiovascular hospitalizations. Noting the high rate and trend toward increased cardiovascular hospitalizations, the researchers said careful interpretation is needed because the trial is too small, yet there were some issues regarding safety and efficacy for the community to consider. ■

## DIVE IN AND LEARN MORE

Visit ***ACC.org/ACC2026*** to access all of ACC's live coverage from ACC.26, including journal scans, expert commentaries, video interviews and more. Plus, all LBCT sessions are available to watch at ***ACC.org/ACCAnywhere*** – free for three months for all attendees.

# Meet New ACC President **Roxana Mehran**

ACC President **Roxana Mehran, MD, FACC**, has built a career defined by scientific achievement, innovation and a clear commitment to advancing cardiovascular care. The ceremonial passing of the presidential chain from **Christopher M. Kramer, MD, MACC**, during ACC's annual Convocation at ACC.26 in New Orleans marked the beginning of her one-year term.

As she steps into her new role, Mehran is focused on strengthening the College's global partnerships while maintaining close engagement with members to foster growth, opportunity and impact. Looking ahead, Mehran says she is "optimistic about our future and our collective ability to shape it, guided by science and driven by a commitment to caring for the most vulnerable patients."

A renowned interventional cardiologist, researcher and advocate for women in medicine, Mehran brings a global perspective and a collaborative approach to her presidency. She is an endowed professor of cardiovascular clinical research and outcomes, and a professor of medicine in cardiology and population health science and policy at the Icahn School of Medicine at Mount Sinai, where she completed fellowships in cardiovascular disease and interventional cardiology. She is also director of the Women's Heart and Vascular Center at Mount Sinai Fuster Heart Hospital, leading a multidisciplinary program designed to address the unique needs of women's cardiovascular health.

Throughout her career, Mehran has led numerous global studies, contributed to the development of clinical guidelines and authored thousands of peer-reviewed publications. She is the founder and chief scientific officer of the Cardiovascular Research Foundation and the founder of Women as One, an independent nonprofit organization dedicated to advancing opportunities for women in medicine. Her dedication to the College is reflected in her longstanding ACC service, including serving as chair of the Interventional Section Leadership Council and contributing as an author on several guidelines.

*Cardiology* spoke with Mehran about her inspirations, defining career moments, mentors and mentorship, leadership style, and vision for the future of cardiology.

### What initially inspired you to pursue cardiology, and what drew you to your areas of focus?

I was drawn to cardiology early in my medical training, beginning as a medical student, by both the intellectual rigor of cardiovascular physiology and the extraordinary pace of innovation in treating cardiovascular disease. That early enthusiasm led me to pursue internal medicine and ultimately a cardiology fellowship.

During my residency at the University of Connecticut, I had the privilege of working with one of the most influential mentors of my career, **Arnold Katz, MD**. He introduced me to basic science research and fostered collaborations with exceptional scientists, helping to shape my academic trajectory. During my fellowship at Mount Sinai, under the mentorship of **Richard Gorlin, MD**; **Valentin Fuster, MD, PhD, MACC**; **Andrew R. Marks, MD**; **John A. Ambrose, MD, FACC**; **Milton Packer, MD, FACC**; **and Samin K. Sharma, MD, FACC**, I trained alongside extraordinary clinicians and scientists deeply committed to excellence. It was during this time that my passion for bench-to-bedside research crystallized, and the cardiac catheterization laboratory became my professional home – a place where science, innovation and lifesaving patient care converge.

### What milestones stand out as defining moments in your professional journey?

There have been many milestones that shaped my journey – most of them rooted in caring for patients and delivering evidence-based, science-driven care. Equally defining were the mentors and sponsors who helped me navigate the challenges of an academic and clinical career. Their guidance and belief in my potential were instrumental and for that I remain deeply grateful.

### How did your mentors shape your path? What lessons do you carry forward?

My mentors were foundational to my growth, especially **Martin B. Leon, MD,**

**FACC.** They saw my potential, energized and encouraged me, and provided thoughtful guidance when opportunities arose. None of what I have achieved would have been possible without their leadership and vision. I, in turn, worked tirelessly to honor that investment. This reciprocal commitment – vision paired with hard work – proved to be a powerful formula for success. It is a model I strive to carry forward with those I mentor today.

**How would you describe your leadership style, particularly when driving innovation and collaboration across different teams?**

I would describe my leadership style as visionary, optimistic and deeply collaborative. I am enthusiastic about our work, our professional societies and our members. I fundamentally believe that no challenge is insurmountable. With commitment, collaboration, hard work and a shared pursuit of excellence, even the most complex problems can be solved.

**What excites you most about stepping into the role of ACC President?**

I am honored and excited to assume this unique leadership role within the College. The ACC is a remarkable global organization devoted to improving human health by transforming cardiovascular care. Our members are on the front lines every day seeking evidence, diagnosing diseases and caring for patients.

As president, my role will be to advance the strategic vision set by our Board of Trustees – one that is intentional, forward-looking and focused on meaningful impact. We will work collaboratively across cardiovascular societies worldwide to achieve these goals. Cardiovascular disease remains the leading cause of death worldwide, yet it is also one of the most dynamic fields for innovation and progress. I look forward to working with our exceptional staff and leadership to bring this vision to life.

**Is there an area of the ACC's Strategic Plan that you are particularly passionate about?**

ACC's Strategic Plan is built on four interrelated pillars, all of which are critically important. The College serves as the professional home for all cardiovascular professionals, generates and delivers actionable knowledge at the point of care, advances quality with a clear commitment to equity and value, and sustains organizational growth. I am deeply passionate about each of these priorities, as together they create opportunities for innovation, intentional leadership and steadfast commitment to our Mission.

**Reflecting on your career, what achievements are you most proud of and why?**

While I am proud of my contributions to advancing evidence-based cardiovascular care, my greatest pride comes from promoting and lifting others – particularly women. Addressing the global burden of cardiovascular disease requires a strong, healthy and truly representative workforce. Talent is all around us, and with every step forward, we have a responsibility to reach back and lift others. This principle has guided my entire career. You must lift as you climb!

**What advice would you offer ACC members, especially those aspiring to leadership roles?**

The opportunities are there to be claimed. The ACC is deeply committed to its members and to ensuring inclusive and representative leadership. My advice – particularly to women – is to be bold, work hard and move beyond imposter syndrome. Your voice, expertise and leadership are needed.

**Looking ahead, where do you see the greatest opportunities and challenges for cardiology over the next five years?**

While we face significant global challenges, moments of disruption also create extraordinary opportunities. Advances in technology, data science and digital health coupled with a renewed focus on closing gaps in diagnosis and treatment have the potential to be transformative. I remain optimistic about our future and our collective ability to shape it, guided by science and driven by a commitment to caring for the most vulnerable patients.

**Outside of your professional life, what are some of your favorite ways to recharge and have fun?**

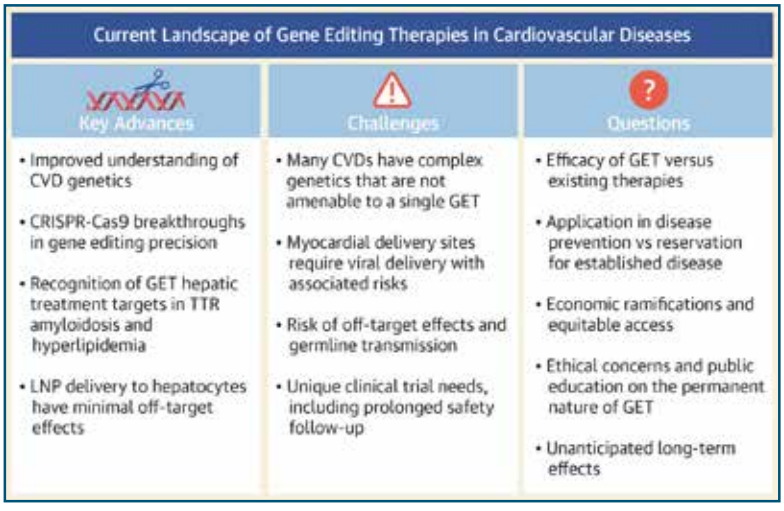
I find great joy in the outdoors, reading, cooking, the arts and, most importantly, time with my family. I recharge by reflecting on how fortunate I am to be surrounded by family, friends and colleagues near and far. I also love New York City for its global perspective and cultural richness, and for what I consider the world's greatest backyard: Central Park. ■

# New ACC Clinical Guidance: Dyslipidemia, CHD and Gene Editing

The new **ACC/AHA Guideline on the Management of Dyslipidemia** offers a comprehensive "one-stop shop" for addressing the evaluation, management and monitoring of individuals with dyslipidemias, including high blood cholesterol, hypertriglyceridemia and elevated lipoprotein(a). The document consolidates evidence-based recommendations for managing dyslipidemias and retires and replaces the 2018 Guideline on the Management of Blood Cholesterol. **Scan the QR code** to access the Hub.

To support clinicians caring for children with congenital heart defects (CHDs), the ACC has released new Concise Clinical Guidance (CCG) on **the outpatient management of isolated left-to-right shunt lesions**. These common defects, including atrial septal defect, ventricular septal defect, patent ductus arteriosus, and atrioventricular septal defect, are associated with significant variability in management, despite advances in treatment and improved outcomes. The document provides practical, expert-informed recommendations across surveillance, intervention, and post-intervention care, with a focus on echocardiography and electrocardiography in the outpatient setting. **Scan the QR code** for the complete CCG.

A new ACC Scientific Statement outlines **the rapidly evolving landscape of gene-editing therapies** and their growing relevance to cardiovascular disease, offering clinicians an overview of both the promise and challenges of this transformative technology. Published in *JACC*, the statement highlights cardiovascular diseases that are currently most amenable to early application of gene editing, particularly monogenic disorders that can be modified through protein knockdown and whose pathogenic protein synthesis occurs in the liver. **Scan the QR code** to read more. ■




## New All-In-One App For Smarter CV Risk Assessment

The new CVD Risk Estimator Plus app launched just in time for ACC.26. The app replaces the ASCVD Risk Estimator Plus app and incorporates new AHA PREVENT™ equations that are central to both the new high blood pressure and dyslipidemia guidelines for more completely assessing and calculating cardiovascular risk. The app's built-in risk categories and exportable results help streamline clinician patient conversations and direct guideline aligned care. **Scan the QR code** to download the app. ■

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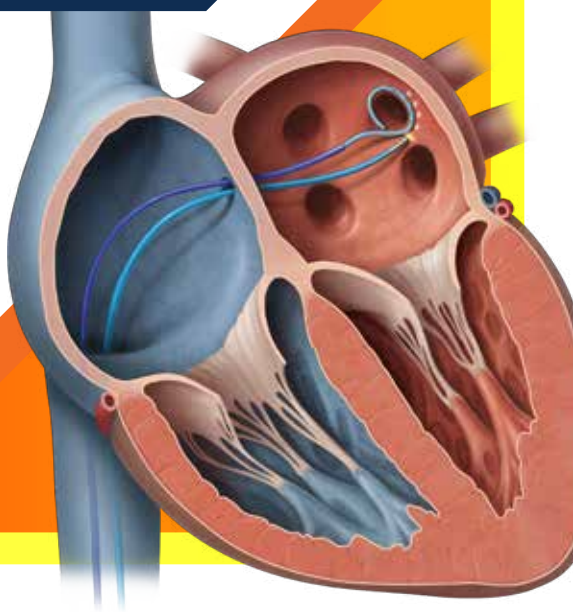
- Capture outcomes through 1-year follow-up to assess safety and effectiveness
- Leverage provider-level reporting to identify improvement opportunities
- Compare your program against national data to optimize performance and elevate care

Get the insights you need to lead in AFib care.

Visit ***CVQuality.ACC.org/AFib*** to learn more.



# **New Orleans Health Fair:** Health Equity in Action

ACC's New Orleans Health Fair welcomed more than 300 community members for a successful day of heart health education at the historic Treme Recreation Community Center. Participants engaged in free heart health screenings, interactive education sessions, and conversations with ACC health equity advocates and local chapter members.

Thanks to the dedication of volunteers and partners, the event showcased health equity in action and reinforced the College's commitment to expanding access to cardiovascular care. ■


## ACC Health Fair: Scale and Impact

- **300+** Community Members
- **52+** Volunteers
- **100+** Heart Screenings
- **50+** Blood Pressure Checks
- **25+** Local Organizations
- **10+** Heart Health Presentations

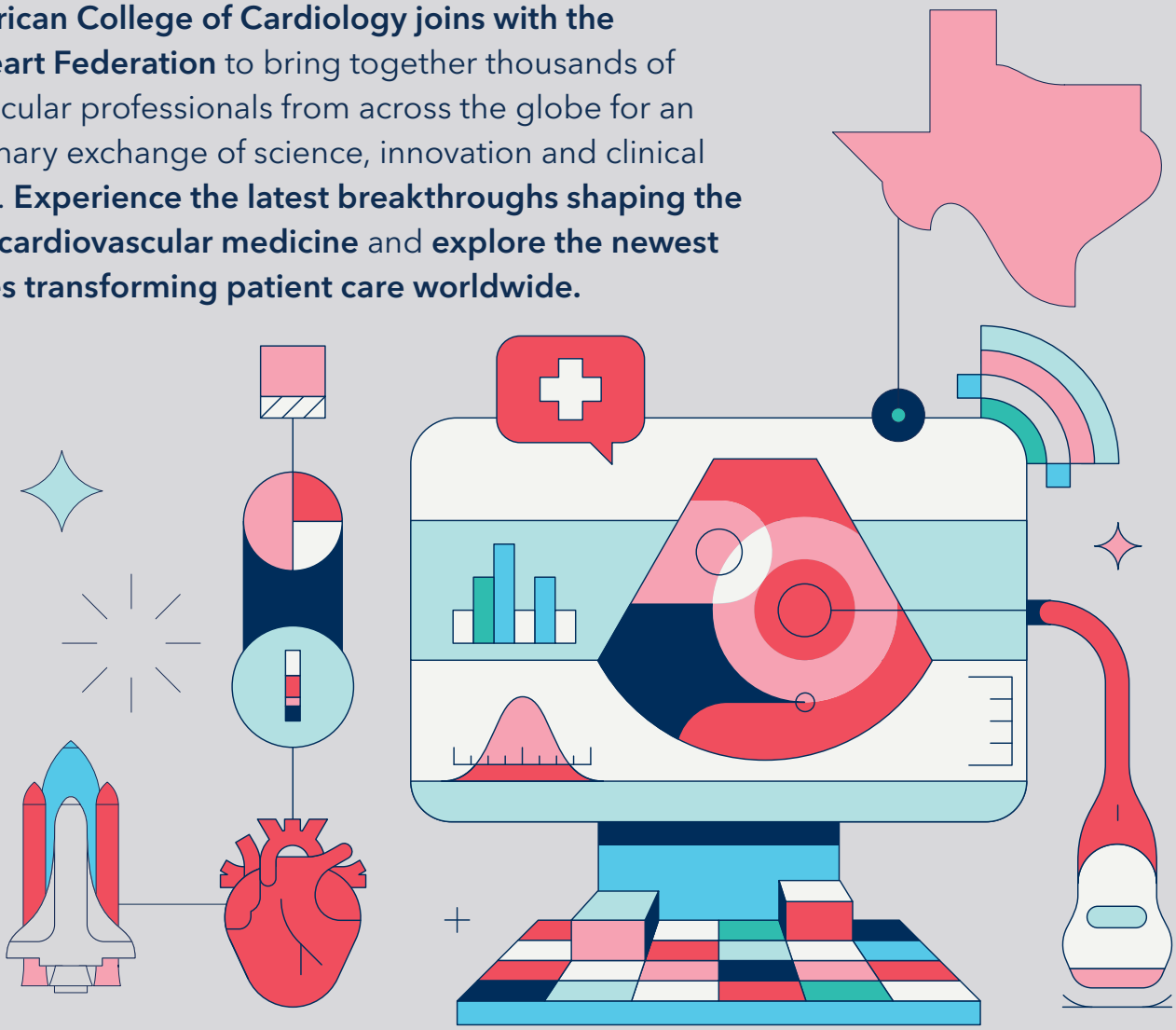
**Scan the QR code** for more event highlights.

# ACC.27

TOGETHER WITH WCC

**APRIL 10 – 12, 2027 | HOUSTON, TX**

**The American College of Cardiology joins with the World Heart Federation** to bring together thousands of cardiovascular professionals from across the globe for an extraordinary exchange of science, innovation and clinical expertise. **Experience the latest breakthroughs shaping the future of cardiovascular medicine** and **explore the newest guidelines transforming patient care worldwide.**



**Mark your calendar and make plans to join us in Houston, TX!**

AMERICAN COLLEGE of CARDIOLOGY

WORLD HEART FEDERATION

TRANSFORMING CARDIOVASCULAR CARE FOR ALL