29th Annual Scientific Sessions and Judkins Cardiac Imaging Symposium

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SCAI Advocacy Yields Medicare Victory

Amid dire predictions of across-the-board cuts for physicians who treat Medicare patients came a victory for the invasive/interventional cardiology community. In early August, when the Centers for Medicare and Medicaid Services (CMS) published the proposed 2006 physician fee schedule, SCAI members found the fruits of their Society’s advocacy efforts. For years, SCAI has been gathering and presenting data to CMS, demonstrating that invasive cardiology procedures have been undervalued in the Medicare system. Last month, CMS delivered proof that it heard SCAI’s message: the new fee schedule increases the relative values units (RVUs) for invasive cardiology procedures by about 2 percent in 2006 and promises another increase of 3 percent by 2009. The result will be a net gain in Medicare payments of about $50 million annually, or more than $10,000 for the average invasive cardiologist, and more in future years.

At first glance, the victory might seem small, but it’s a giant step in the right direction, said SCAI President Barry F. Uretsky, M.D., FSCAI. “These RVU changes are all revenue neutral, thus our gains came while other specialties, such as ophthalmology, which is facing 4 percent reductions in RVUs. We achieved these improvements through several years of data gathering, (continued on page 2)

SCAI’s New Interventionalists Bridge Gap Between Youth and Experience

When a handful of SCAI’s early-career interventionist members formed a committee at the Society’s 2004 Scientific Sessions in San Diego, they had no idea they would be drawing a crowd just one year later. But that’s what happened in Ponte Vedra Beach, FL, when more than 30 “early-career” interventionalists showed up to learn more about the group.

“This past year has been great,” said Michael J. Lim, M.D., assistant professor of medicine at St. Louis University in Missouri, and co-chair of SCAI’s Interventional Career Development (ICD) Committee. “I’m amazed at how fast we’ve gained acceptance and appreciation by the Society as a whole. We have been universally encouraged in every aspect by all members. It’s a pleasant surprise. It wasn’t expected, but it’s very nice to see.”

Experience + Youthful Enthusiasm = Great Synergy

Senior SCAI members are getting energized by their younger counterparts, who remind them of themselves when they were just starting out in practice, added Dr. Lim. “The SCAI staff, the present and past presidents of the organization, … everybody has relayed to me how they remember when they were first starting out. They remember the excitement of finishing their training and starting out new. They want to participate in our growing experiences. We can bring our youth, enthusiasm, and fresh ideas to them, so it’s a fruitful exchange for both.”

The committee, which welcomes all SCAI members, hasn’t wasted any time establishing some priorities and going after them. They are in the process of setting up a mentoring program that will more formally connect them with seasoned interventionalists and also facilitate dialogue between the Society’s experienced members and the “new kids on the block.” (con’t on page 3)
"SCAI Advocacy (continued from page 1)"
effective analysis, and good advocacy with CMS. This is solid confirmation that persistent advocacy works,” he stressed. “SCAI expresses appreciation to all its volunteers who have worked on this issue, led by Advocacy Committee Chair Dr. Joe Babb and Co-chair Dr. Carl Tommaso.

Persistence may be the key word, Dr. Uretsky added. The specific advocacy efforts led by SCAI, with partners such as the ACC, focused on two key points. First, SCAI surveyed interventional cardiologists to get a clear picture of how significant the work of non-physician clinical office staff is in the care of cardiovascular patients. The indisputable finding: these office staff make a crucial contribution to care, and CMS had, until the release of the draft 2006 fee schedule, undervalued the cost of employing these skilled staffers. Second, SCAI convinced Medicare officials that angioplasty and stenting are indeed highly complex procedures and should be assigned malpractice RVUs commensurate with that complexity.

This summer, having accepted these recommendations by SCAI, CMS recalculated the RVUs for invasive cardiology procedures. Other areas within cardiology, such as in-office diagnostic procedures, saw significant RVU losses, with the average cardiology RVU declining by 2.1 percent by 2009. Getting RVUs adjusted is one important step toward fixing the system CMS uses for calculating Medicare fees. The bigger challenge lies in averting scheduled changes to the standard conversion factor that CMS uses to calculate all physician fees for treating Medicare patients (see graph). The problems with this conversion factor threaten to unhinge the entire Medicare system in the near future.

SCAI, like the rest of the House of Medicine, views fixing the Medicare system as a top priority.

Call to Action: Medicare System Needs an Overhaul

“While we feel fortunate for invasive cardiology and our patients that CMS is taking steps to more accurately reimburse invasive cardiology procedures, we cannot escape the fact that the Medicare system is deeply flawed,” said Dr. Uretsky. “We are fighting alongside the entire physician community in all efforts to fix Medicare.”

The effort that is taking precedence right now is drumming up support for H.R. 3617, “The Preserving Patient Access to Physicians Act of 2005,” a

(continued on page 15)
New Interventionalists (continued from page 1)

“Bridging the gap between more experienced and new interventionalists has been the biggest cry that we’ve heard from the people who want to be in our group,” said Dr. Lim. “So, that’s our top priority right now.”

SCAI Mentors – Just a Click Away

Information exchange is crucial and, to this end, the ICD Committee has enlisted the help of Bonnie Weiner, M.D., MSEC, MBA, FSCAI, the Society’s Internet “guru.” She is working with the ICD Committee to set up computer programs that will facilitate interactions and foster discussions with other SCAI members.

“The idea is for us to be able to go to the Internet and get advice on how to handle certain problems, difficult patients, and cases. We’re also working on ways to bring together the early and more experienced interventionalists at SCAI’s national meeting every spring to encourage dialogue,” said Dr. Lim.

The ICD Committee has also begun forging closer ties with the American College of Cardiology and the American Heart Association with regard to fellowship training in interventional cardiology, said ICD Committee Co-chair John J. Young, M.D., FSCAI, associate medical director of the Lindner Center and director of interventional services at the Ohio Heart Health Center in Cincinnati. “SCAI is developing valuable partnerships with ACC and AHA in the interventional cardiology arena, particularly as it relates to training. We are in the process of utilizing one of our committee members on each of the ACC and AHA young faculty development committees, so that we can get effective cross-pollination of ideas,” said Dr. Young.

The ICD Committee also plans to set up a separate forum at future SCAI Scientific Sessions so that interventionalists-in-training can become acquainted with the Society before they finish their fellowship training. “Hopefully, when they go into practice, they will be interested in joining the Society,” said Dr. Young.

And, added Dr. Lim, both the Society and its early-career members will benefit as the specialty’s newest physicians become familiar with SCAI’s inner workings. He explained: “Getting to know how SCAI works to achieve its mission will be a good learning experience for us, and the Society itself will get first-hand accounts about our concerns and views on important issues.”

Equally important on the committee’s to-do list is developing opportunities for writing, research, and publication – areas of career development where mentorship is crucial. The overarching goal of the committee, stressed both co-chairs, is to develop opportunities for career development that are relevant to practice. The group is making plans to recruit senior interventionalists for new device proctoring and for assistance in getting junior interventionalists involved in clinical trial work.

SCAI Says, “Welcome Aboard!”

The ICD Committee is a valued addition to the Society, said SCAI President Barry F. Uretsky, M.D., FSCAI. “These young cardiologists are showing the kind of initiative that launched the Society,” he explained. “They perceived a need and are proactively addressing it. We are very pleased to see the ICD Committee taking off so well and are committed to supporting their goals in any way possible.”

The Society is demonstrating that it is sensitive to the needs of its membership, said Lloyd W. Klein, M.D., FSCAI, who was instrumental in setting up the early-career group, first as a subcommittee of the SCAI Interventional Committee, which Dr. Klein chairs.

“The Society is to be applauded for supporting its younger members,” Dr. Klein said. “Their support shows that SCAI is sensitive to the needs of its membership. The leadership understands that some members are in the young-career category and we want them to feel enfranchised about what goes on.”

This understanding sets SCAI apart from many other organizations, he added. “When we first started this initiative, it was a new concept. I don’t know of any other national specialty organization that has tried as hard as SCAI to bring young thought-leaders into positions where their needs can be heard and addressed. SCAI is unique in formally recognizing that these young physicians are the future of SCAI as well as the next generation of interventionalists.”

For more information about SCAI’s ICD Committee, contact Andrea Frazier at afrazier@scai.org or 800-992-7224.
Last year, SCAI membership topped 3,000. From this ever-growing body emerged a new and enthusiastic collection of interventionalists who recently completed their fellowships and launched their careers. Some of these “early-career interventionalists,” or ECIs, have entered academic practice while others have joined private groups. The enthusiasm, motivation, and desire of these young physicians to learn, contribute, and help their patients and the Society have been evident and refreshing.

If you are reading this column and fall into the above category, I urge you to read the rest of my “message” and then join your colleagues in SCAI. (The committee roster is maintained on www.scai.org.)

If you, like I, have passed the early-career stage of your career, please read on, too. I think you will be pleased that your Society is fostering the careers of the next generation of interventionalists in this unique way. You might also find that you want to get involved in your Society via this committee, perhaps in a mentoring capacity.

Having once been an ECI myself, though never part of a formally recognized committee, I feel qualified, and delighted, to inform the membership-at-large of this source of new vigor in SCAI. Starting a career is daunting, yet exhilarating. After I completed my fellowship and joined an academic cath lab, I was curious about how one succeeds in the business. I’m sure all ECIs ponder this question. Now, following more than 20 years in academic interventional cardiology and a recent change of career direction, I have some insights into the worlds of both the private practitioner and the academic.

All interventionalists, whether early in their careers or not, routinely are in the position to make specific, and often critical, observations about the performance of our craft. For example, we ask ourselves: How did the intervention go? What were the drawbacks? What is the past experience with a patient like this? Why didn’t the patient fare as well as he or she should have? How could we have done better? What equipment or information do I need to do better? How do I find out from my colleagues what they do when confronted with the same, or a similar, problem? Who can I talk to about this patient, problem, or technique?

Although ECIs are not alone in asking these questions, they may find them to be more vexing because of the brief time in which they have been in practice. Early-career academic interventionalists have somewhat of an advantage because they work surrounded by a cadre of fellows-in-training, residents, and senior staff. Even so, more seasoned associates may not have the time or interest to provide the mentorship or counsel that would eventually facilitate an early-career physician’s growth and maturation. This situation is all the more true for ECIs in private practice. Senior partners, through no fault of their own, often cannot allocate time to devote to younger partners’ growth. I must add that, regardless of the setting, this is unfortunate because young partners will be able to contribute more to the practice, and much sooner, if they have quality mentorship. And young practitioners pose less of a liability if they have at their disposal the broad knowledge of senior partners.

How can ECIs help to improve their situations? I offer a few suggestions. First, each early-career interventionalist should formulate a “game plan” for having his or her clinical and/or research activities reviewed, critiqued, and tracked by an experienced associate or group of associates. Of course, this process should be taken on in an exclusively constructive and positive way and, if possible, the review should apply to a cross-section of young practitioners. Review activities should be an ongoing process with the stated goal of improving quality of care. A good place to start is with a weekly conference in a hospital setting.

Morton Kern, M.D., FSCAI

SCAI offers countless opportunities for early-career interventionalists to meet, and learn from, seasoned physicians. At the 2005 Scientific Sessions in Florida, the Society’s Interventional Career Development Committee Co-chair Michael Lim, M.D. (left), met SCAI Past President Morton J. Kern, M.D., FSCAI.
Cases, techniques, and pertinent data might be presented and reviewed.

Next, I encourage all ECIs to publish at least one case report every year. Surely, something unique happens over the course of several hundred cases! In developing this report, the ECI is forced to talk to peers about similar cases, review the literature (Note: Throughout your career, make time to read the contributions of other practitioners), and perhaps call some of the senior members of SCAI to discuss the case. By publishing a case report, an ECI gains recognition among peers and lays claim to a small piece of expert knowledge that may contribute to another practitioner’s treatment of a patient whose case is similar although unusual.

I urge ECIs to remember that membership in SCAI connects you to thousands of invasive/interventional cardiologists who will always be available and willing to discuss interesting cases with you. We are a community united by our mission of enhancing patient care and achieving quality. I want to stress that the interactions ECIs have with their SCAI colleagues may be among the most productive of their early activities.

To my fellow senior interventional cardiologists, I make the following request: If you meet or know any of our ECI members, please consider extending your talents as a mentor. Advise in a friendly and constructive way. My experience as a mentor has enhanced both my own and my younger partners’ work life and led to important relationships throughout my career.

Finally, I remind ECIs to take advantage of the growth opportunities presented by attending meetings and joining SCAI committees. These settings present unparalleled opportunities to exchange information and opinions as well as to network throughout one’s career. The SCAI Annual Scientific Sessions provide an excellent forum for such exchange, but time and space can also be found at the meetings of other groups. SCAI staff are always delighted to assist members with information about meetings and committee activities.

Just a few words for the academic ECI: I believe the key to advancement, as well as local and national recognition, is through publishing papers in popular and peer-reviewed journals. This is not news. Writing is a difficult task and is expected of everyone in academic practice. Writing remains a challenge piled on to the usual work of being a physician, caregiver, teacher, attending physician, and perhaps administrator. However, you will be known in the field by what you publish. Write something everyday. Write anything that you think someone like you would like to know. Write a case report, a review, an editorial, a letter, an abstract, a manuscript. If you don’t know where to start, ask the chief of your lab or your division. If there are any truths that hold for career advancement, they are that “talk is cheap” and “action speaks volumes.” In a nutshell, if something is news to you, then it is news to someone else. Write it down and send it in. Every article done well will have a home. The official journal of our Society, Catheterization and Cardiovascular Interventions, is only one such home — a good one but not the only one.

The future of our profession and our Society lies with our ECIs. Through communication, camaraderie, shared troubles, and mentorship, ECIs will take up the leadership of SCAI and continue the Society’s tradition of helping our patients through new knowledge and better care.
Announcing...

The 2006 SCAI Research Program for Interventional Cardiology

FELLOWSHIP AWARDS
UP TO $25,000

Application online at www.scai.org  Application Deadline: January 19, 2006

Program Description

Cordis, a Johnson & Johnson company, and The Society for Cardiovascular Angiography and Interventions (SCAI) are pleased to announce the 2006 SCAI/Cordis Fellowship Program for Interventional Cardiology.

The program will award two fellowships to physicians-in-training with demonstrated medical excellence whose research promises advances in cardiovascular invasive/interventional techniques.

Awards will be made directly to the recipient's nonprofit sponsoring institution and will be applied to direct research costs, not salary support. Grants are limited to research done in the United States or Canada.

Mission

The purpose of the award is to encourage meaningful scientific investigation into invasive/interventional techniques and to foster new insights into patient care.

Eligibility

Applicants eligible for the 2006 SCAI/Cordis Fellowship Program for Interventional Cardiology Fellowship Awards are those who—

1. Will be serving as a fellow in an accredited adult or pediatric interventional cardiology training program recognized by the Accreditation Council on Graduate Medical Education;
2. Have the approval of the training program director; and
3. Are sponsored by an SCAI Member or Fellow from the applicant’s institution. (A physician who has a current membership application on file may also act as a sponsor.)

Sponsors

For more than 40 years, Cordis Corporation, a Johnson & Johnson company, has pioneered less invasive treatments for coronary and vascular disease. Technological innovation and a deep understanding for the medical marketplace and the needs of patients have made Cordis the world’s leading developer and manufacturer of breakthrough products for interventional medicine.

The Society for Cardiovascular Angiography and Interventions promotes excellence in invasive and intervention al cardiovascular medicine through physician education, representation, and the advancement of quality standards to enhance patient care.

Application Process

All applications must be submitted online. Visit www.scai.org and click on “Fellowship Programs” to submit an application.

Application deadline: January 19, 2006.
SCAI and Cordis, a Johnson and Johnson company, honored two promising interventional cardiologists-in-training at the Society’s Annual Scientific Sessions in Ponte Vedra Beach, FL. SCAI Past President and Founding Editor of Catheterization and Cardiovascular Interventions Frank J. Hildner, M.D., FSCAI, honored Justin Levisay, M.D., and Angel Caldera, M.D., the first recipients of the SCAI/Cordis Fellowships in Interventional Cardiology. Marcia Schallehn, director of Customer Relations at Cordis Cardiology Systems, joined Dr. Hildner in congratulating the awardees, presenting each with a research grant for $25,000.

Dr. Hildner, who chairs the awards committee for the new program, explained that the SCAI/Cordis program recognizes interventional cardiology fellows-in-training who have proposed innovative research projects with the potential to advance cardiovascular invasive/interventional techniques. “Drs. Levisay and Caldera also have track records of medical excellence, which is an important criterion for receiving the award,” added Dr. Hildner.

Dr. Levisay, an interventional cardiology fellow at the University of Illinois at Chicago, will pursue a research project titled, “Effect of Rosiglitazone on Inflammatory Biomarkers and Endothelial Dysfunction in Patients Treated With Percutaneous Coronary Interventions.” Dr. Caldera, an interventional cardiology fellow at Baylor College of Medicine in Houston, will explore “The Impact of Clopidogrel Dosing on Outcomes in Patients Undergoing Percutaneous Coronary Intervention With Drug-Eluting Stents.”

SCAI is pleased to partner with Cordis to offer this program, emphasized Dr. Hildner, because the awards further both organizations’ missions. “Both SCAI and Cordis want to see that the next generation of interventional cardiologists is well supported as they undertake scientific research. It is impossible to underestimate the value of encouraging young interventionalists to pursue careers in academic cardiology, and that is exactly what this program does.”

SCAI will welcome Drs. Levisay and Caldera at the SCAI 29th Annual Scientific Sessions, May 10–13, 2006, in Chicago, where they will present the findings of their research to date. “Being invited to update their peers on their research at SCAI’s national meeting is a significant part of this award,” said Dr. Hildner. “It will be an opportunity for Drs. Levisay and Caldera to meet the Society’s leaders and others who are doing major work in invasive/interventional cardiology.”

Submit Research Proposals for 2006 Program

SCAI has begun accepting applications for the 2006 SCAI/Cordis Fellowship Program in Interventional Cardiology. Eligible candidates will meet the following criteria:
1. An applicant must be serving as a fellow in an accredited invasive/interventional cardiology fellowship program recognized by the Accreditation Council on Graduate Medical Education;
2. He or she must have the approval of the training program director;
3. He or she must be sponsored by an SCAI member or Fellow from the applicant’s institution (Note: A physician who has a current SCAI membership application on file may also act as a sponsor); and
4. The proposed research must be done in the United States or Canada, with grant monies applied to direct research costs.

To submit an application, visit www.scai.org and click on “Fellowship Programs” for instructions and more details. Applications must be completed by January 19, 2006, to be considered.

Dr. Hildner urges all fellows-in-training who are interested in conducting research applicable to patient care to consider applying. “The committee has a preference for human work over animal work,” he added. “We try to keep the program as clinical as possible.”

“Cordis is committed to providing educational support for interventional cardiology fellows. After all, the hearts of the future live in the hands of fellows,” said Ms. Schallehn.

For more information about the awards, call 800-992-7224 or email breyes@scai.org.
SCAI, GE Healthcare Encourage Applications for 2006 Fellows Grant Program

At SCAI’s 28th Annual Scientific Sessions in beautiful Ponte Vedra Beach, FL, Mehmet Cilingiroglu, M.D., and Jason R. Wallmoth, M.D., were honored as the first recipients of the newly launched SCAI/GE Healthcare Fellows Grant Program. The two interventional cardiologists-in-training were selected by the SCAI/GE Healthcare Fellowship Awards Committee based on demonstrated medical excellence in cardiovascular research focused on quality in diagnostic imaging and invasive cardiology.

Drs. Cilingiroglu and Wallmoth each received a grant in the amount of $20,000 to fund one year of research in angiography and diagnostic imaging. Dr. Cilingiroglu, of the University of Texas Health Science Center at San Antonio, plans to investigate the use of optical coherence tomography in the detection and characterization of vulnerable plaque. Dr. Wallmoth, of Washington University in St. Louis, will explore MRI evaluation of contractile mechanics and myocardial scarring in patients with a single ventricle after Fontan operation.

“These researchers demonstrate great potential for advancing our current understanding of cardiology, and we are pleased to be able to support the medical community by funding new research,” said Neal Kleiman, M.D., FSCAI, who chairs the SCAI/GE Healthcare Grant Program Committee.

SCAI Accepting Applications for 2006 Program

SCAI and GE Healthcare introduced the joint fellows grant program one year ago with the specific goal of fostering excellence in patient care through investment in the careers of the next generation of cardiologists. “This program is an excellent example of how we are accomplishing our mission at GE Healthcare,” said Dr. Kleiman.

SCAI is accepting applications for the 2006 program. Both SCAI and GE Healthcare encourage all fellows who are serving in an accredited invasive/interventional cardiology training program to consider applying. Applicants must have the approval of their training program director and must submit their applications to SCAI by November 30, 2005. To submit an application, visit www.scai.org, and click on “Fellowship Programs” for instructions and more details. Grants are limited to research conducted in the United States or Canada.

Once the application period has ended, the submissions will be reviewed by SCAI leaders comprising the SCAI/GE Healthcare Grant Program Committee, chaired by Dr. Kleiman and co-chaired by Steven R. Bailey, M.D., FSCAI. The committee will select several applicants to be considered for three sets of awards. First, six to eight applicants will receive $2,000 each to write an article on their proposed research topic. Next, based on the quality of these proposals, four of the applicants will be awarded a trip to SCAI’s 29th Annual Scientific Sessions in Chicago as well as complimentary SCAI membership for two years. Finally, two of the four finalists will be honored at the Scientific Sessions, where they will each be presented with a one-year grant of $20,000 to support their cardiology research.

One year after receiving their grants, SCAI will welcome the awardees back to the Scientific Sessions, where they will present their research findings to date.

For more information about the awards, call 800-992-7224 or email breyes@scai.org.
What Is the SCAI/GE Healthcare Fellows Grant Program?
The SCAI/GE Healthcare Fellows Grant Program is a new opportunity for adult or pediatric cardiologists-in-training to support their research during their fellowship program (see www.scai.org and click on "Fellowship Programs" for a description of research areas of interest).

The program reflects the shared commitment and partnership of GE Healthcare and The Society for Cardiovascular Angiography and Interventions (SCAI) to foster excellence in patient care through investment in the careers of the next generation of cardiologists.

How Will the Fellowships Be Awarded?
The SCAI Research Awards Committee will select applicants whose research proposals show significant potential for advancing the science and who have demonstrated medical excellence.

A committee of senior SCAI physician leaders will review all proposals and select several applicants to be considered for three sets of awards:

**Award Group #1**
Six to eight applicants will be selected to write a monograph on their proposed research topic. Each will receive a monetary award ($2,000) to support their efforts.

**Award Group #2**
The committee will select the top four applicants from Award Group #1. Each will be awarded an all-expenses-paid trip (transportation, hotel, meals, registration) to SCAI’s 2006 Annual Scientific Sessions (May 10–13, 2006) in Chicago, Illinois. Each will also receive complimentary SCAI membership for two years.

**Award Group #3**
From the four awardees selected (group #2), the committee will then select the top two individuals for a one-year grant ($20,000) in support of his or her research.

Who Is Eligible to Apply?
To be eligible for the 2006 SCAI/GE Healthcare Fellows Grant Program, an applicant must be serving as a fellow in an accredited invasive/interventional cardiology fellowship training program recognized by the Accreditation Council on Graduate Medical Education and have the approval of the training program director, and the support of an SCAI member. Grants are limited to research conducted in the United States or Canada.

How Do I Apply?
Applications must be received by November 30, 2005, to be considered. Visit www.scai.org and click on "Fellowship Programs" for an application and instructions.

Application Deadline: November 30, 2005
For more information, call 800-992-7224 or email breyes@scai.org.
IN THE TRENCHES
Cardiologist Looks Out for Lost Causes, Finds “Awesome” Patients Along the Way

Douglass Morrison, M.D., Ph.D., FSCAI, may well be the St. Jude of interventional cardiology. St. Jude, you may recall, is the patron saint of lost causes. For years, Dr. Morrison has been working to provide care for patients who have been considered by many to be the “lost causes” of cardiology — those with medically refractory ischemia who are at high risk for adverse outcomes with revascularization. Such patients have been excluded from nearly all revascularization randomized clinical trials (RCTs).

For 30 years, the Veterans Affairs health care system has been Dr. Morrison’s professional home, a place where he has been able to pursue clinical care options and research that might have been difficult in the private sector. From this base, he has written a number of epidemiological studies as well as two textbooks. And he has overcome many obstacles to design and conduct the RCT known as AWE-SOME, which compared CABG with PCI in patients with medically refractory ischemia and high risk of adverse outcomes.

Dr. Morrison recently earned his doctoral degree in epidemiology, a step that he hopes will bring him closer to answers for these patients.

A Mini-History Lesson
“In the mid-1980s,” explained Dr. Morrison, “the prevailing opinion nationwide was that CABG was the revascularization choice for high-risk patients, and PCI was of value in only a small subset of low-risk patients.”

At that time, the VA-wide, congressionally mandated CABG surveillance program was run out of Denver, where Dr. Morrison worked. He and his surgical colleagues were seeing many ischemic patients who appeared to have very high risk of mortality and/or morbidity with CABG because of ischemic and/or hemodynamic instability and/or comorbidity.

“There was concern that the VA surgical programs would be closed if CABG mortality exceeded certain guidelines,” continued Dr. Morrison, “so, increasing numbers of patients with refractory ischemia were being turned down for CABG based on the perception of ‘prohibitive risk.’”

However, after a number of patients and families requested “treatment with the new balloon” (meaning angioplasty or PCI), Dr. Morrison sought and obtained permission from Ethics and Human Subjects committees to begin offering palliative, or “salvage,” angioplasty to these patients.

Although the concept of using PCI for patients labeled “too high-risk” for CABG seemed counterintuitive and even unethical to many authorities at the time, Dr. Morrison’s results after some 34 consecutive surgical “turn-downs” (30-day mortality estimated risk with CABG 25% vs. observed angioplasty mortality of 11%) encouraged him to propose an RCT to demonstrate that PCI was a reasonable option for these patients.

When he had trouble finding funds to conduct such a trial, Dr. Morrison assembled a group of experts to write Medically Refractory Rest Angina, a textbook that stresses the heterogeneity of acute coronary syndromes and focuses on patients with unstable and medically refractory ischemia, and additional high-risk factors.
Eventually, Dr. Morrison’s wish was granted, and the VA funded AWESOME, which stands for Angina With Extremely Serious Operative Mortality Evaluation. The trial focused on people who were having refractory ischemia and needed revascularization but were at high risk of dying with surgery by virtue of age greater than 70; one or more previous bypass operations; severely reduced pump function, as measured by a LVEF less than 35 percent; hemodynamic instability necessitating an intraaortic balloon pump; or being within seven days of an AMI.

“The majority of previous randomized trials comparing either medicine to surgery, medicine to angioplasty, or angioplasty to surgery had excluded all five of those groups,” Dr. Morrison said.

AWESOME randomized 454 patients to CABG or PCI and found no difference in overall survival or quality of life between the two groups after three years of follow-up.

The data were encouraging but, for Dr. Morrison, inspiration came from the patients. “What was truly AWESOME was that the patients were willing to participate and agreed to be randomized,” he stressed.

“There were disappointments, however,” he added, “the biggest being that we could not get a larger proportion of the approximately 2,500 clinically eligible patients into the randomized trial. Fortunately, we were able to follow the nonrandomized patients in prospective registries, which served to increase the generalizability of the primary result—namely, that PCI is an alternative for many high-risk patients.”

**Need Doesn’t Equal Access**

“The message of the AWESOME trial has not met with universal acceptance,” acknowledged Dr. Morrison. “Surgeons would prefer not to cede any part of the coronary disease population to interventionalists. Similarly, interventionalists and hospitals would, in many cases, prefer to focus on large volumes of simple, low-risk cases, which do not engender the costs or complications implicit in complex, high-risk intervention.”

And then there is the issue of change, he added. “The (continued on page 13)
SCAI Past President Advocates on Capitol Hill: “Office-Based Imaging Is Good Medicine”

SCAI Past President and current Advocacy Committee Co-chair Joseph D. Babb, M.D., FSCAI, joined 25 other physicians in making calls on Capitol Hill. Representing SCAI and the Coalition for Patient-Centered Imaging (CPCI), of which SCAI is a founding member organization, Dr. Babb spoke in person with key Capitol Hill officials, urging them to reject assertions by the radiological community and instead defend patients’ access to care.

“All of the people we talked to on the Hill said they had been visited by radiologists seeking to limit access by nonradiologists and their patients to advanced imaging techniques,” said Dr. Babb. “After discussing the issue with various leaders and their staff, it was clear that the radiologists had not persuaded them; however, I feel strongly that our elected officials need to continue to hear from nonradiologists about the benefits patients reap when they can have imaging procedures done in their physicians’ offices.”

Dr. Babb and his colleagues in 25 other specialties represented by CPCI, including urology and orthopedics, explained to numerous U.S. Senators and Representatives that patients benefit in many ways when they can undergo imaging procedures in the offices of the physicians who are most familiar with their clinical condition, medical history, and previous test results. For example, noted Dr. Babb, “when cardiologists perform imaging services in their offices, rather than referring patients to a radiologist, diagnosis and treatment are expedited, often minimizing the anxiety of the patients themselves and their families.”

CPCI organized 70 meetings between physicians and Congressional representatives and/or their staffers. Dr. Babb contributed to that total by personally meeting with health legislative staff in the offices of U.S. Senators Elizabeth Dole and Richard Burr and Representative Walter B. Jones. He was accompanied by SCAI’s Senior Director for Advocacy and Guidelines, Wayne Powell. “We professional advocates can meet with leaders on the Hill all the time, but there is no substitute for hearing from their constituents,” said Mr. Powell. “A phone call or visit from someone from their state or district makes the issue seem more real and the recommendations more urgent.”

The day-long effort follows months of concerted advocacy by CPCI and its member organizations to counter a campaign by the radiological community aimed at blaming nonradiologists for recent growth in imaging services. “As part of its efforts to claim all imaging procedures for radiologists, the American College of Radiology has distorted data pertaining to increased utilization of imaging services,” stressed Dr. Babb, “and it is important that we set the record straight with our elected representatives.

“That’s what we were doing in Washington,” Dr. Babb continued. “We were making sure Congress knows the whole story, especially that office-based imaging is in the best interest of patients and is, therefore, a top priority.”

SCAI Urges Insurer to Revise Policy Denying Inpatient PCI

In response to members’ requests, SCAI is working closely with hospitals to convince several large insurers to revise policies that inappropriately deny inpatient admission for PCI. Most recently, SCAI was invited by hospital representatives to participate in a meeting with the medical directors of Empire Blue Cross Blue Shield, one of the country’s largest insurers.

SCAI Past President and Advocacy Committee Co-chair Carl Tommaso, M.D., FSCAI, joined local hospital association officials in discussions with Empire. He presented data demonstrating that overnight stays are the norm for PCI patients and provided clinical rationales.

Dr. Tommaso also explained to Empire medical directors that the insurer’s policy is based on a misun-
In the Trenches (continued from page 11)

health care systems have been accustomed to the paradigm that high-risk complex cases go to CABG, where, among other advantages, there is at least the appearance of greater control,” said Dr. Morrison. “Meanwhile, the population is aging, with its attendant higher risk, and surgeons are feeling increased pressure to monitor and maintain low rates of mortality and morbidity.”

Like St. Jude, Dr. Morrison maintains his optimism. “In the ensuing decade-and-a-half, PCI technology and methods have improved dramatically,” he said. He cites as examples stents, including the newer drug-eluting stents, and adjunctive pharmacologic agents. He also notes that the application of PCI has expanded tremendously: “For example,” said Dr. Morrison, “the treatment of patients with both STEMI and non-STEMI has been revolutionized by the widespread application of PCI. These are specific examples of populations with medically refractory ischemia and high risk of adverse outcomes that have benefited from PCI.”

RCTs May Not Be the Answer

Dr. Morrison is a strong believer in RCTs, but he stresses that such trials have limitations. “Large-scale RCTs have given us support for the use of stents, drug-eluting stents, dual antiplatelet therapy, glycoprotein IIb/IIIa inhibitors, and thrombin-specific agents,” he explained. “As in cardiology generally, RCTs are behind nearly every major advance, but RCTs have limits, particularly when physicians and/or patients will not allow random allocation to take place.” That is often the case for patients who are the sickest and at the highest risk, he noted. “In addition, comparative trials of procedures involve several sorts of complexity, such as the different techniques and comfort levels of different institutions and individuals. Accordingly, many of the decisions we have to make on a day-to-day basis involve patients who would have been excluded from all of the major trials,” Dr. Morrison said.

For these patients, epidemiological studies, rather than RCTs, may yield answers, Dr. Morrison hopes. That hope led him back to graduate school to study epidemiology.

What’s Next?

Dr. Morrison believes that his work has been a small but rewarding part of the PCI evolution. “It has been an extraordinary privilege to practice interventional cardiology during this era,” he said. “PCI has grown exponentially over the past two decades. Increasingly, the evidence suggests that PCI has incredible impact for patients with STEMI and non-STEMI, and other presentations of refractory myocardial ischemia, with high-risk factors. Conversely, as medical therapy has improved, the case for managing stable, low-risk patients with medicines alone has continued to get stronger.”

PCI may be the answer, he said. “In a world population that is growing older, more comorbid, and higher risk, a strategy that combines comparable or better survival, with much less morbidity, is poised to reach its full potential. PCI may be that strategy.”

SCAI has stressed to the guideline writing group that misunderstandings are arising and that the guideline is being misused to justify denial of most inpatient admissions.

The SCAI recently polled members about the appropriateness of outpatient PCI procedures. The results of that survey will be published in a forthcoming issue of CCI.

SCAI encourages its members to report problems like this one to the Society by emailing Senior Director for Advocacy and Guidelines Wayne Powell at wpowell@scai.org. “SCAI is dedicated to focusing on the issues affecting members and their patients,” said Mr. Powell. “If your facilities are having problems with inappropriate denial of claims, let us know.”
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INTERVENTIONS
When: October 27–29, 2005
Where: Frankfurt, Germany
Director: Horst Sievert, M.D.

For details, call +49-6106-770383, fax: +49-6106-770384 or email nkoebke@convents.biz.
bipartisan bill introduced by Rep. Nancy Johnson in July. If passed, this bill would repeal the deeply flawed formula that CMS uses to set the standard conversion factor and, therefore, to establish physician fees. Using this formula, which is known as the sustainable growth rate, or SGR, Medicare officials plan to cut the conversion factor by 4.3 percent for all procedures. This drastically reduced conversion factor was used to calculate the fees in the 2006 Medicare fee schedule. This is why even the RVUs for invasive cardiology procedures show up in the schedule as negatives.

Even in the short term, there is a great deal at stake for both invasive cardiology and cardiology as a whole. If the SGR is fixed before the 2006 Medicare fee schedule, with its proposed 1.5 percent increase, is enacted in November, then the average fee for interventional procedures will grow about 3.5 percent in 2006. The legislation would include annual conversion factor increases of about 2 percent from 2007 to 2009 and, on top of those, an additional 2 percent increase in RVUs would be phased in.

In the longer term, if cuts slated for the next six years are not averted, average physician fees will be reduced by approximately 26 percent over time, starting with the 4.3 percent cut slated for Jan. 1, 2006. “The SGR needs to be fixed, and soon,” said Dr. Uretsky. “Until the flawed Medicare system is fixed, the physician community will be forced to absorb the increased costs of delivering optimal patient care while accepting reduced reimbursements year after year. That will create overwhelming challenges for us and it could endanger patients’ access to care. We’ll be doing our patients a real service when we get the SGR repealed.”

What Can SCAI Members Do?

✓ First, said Dr. Uretsky, communicate your support for H.R. 3617 to your Congressional representatives. The American Medical Association offers, at http://www.amaassn.org/ama/pub/category/13097.html, a tool for sending e-messages directly to your representatives. The AMA site also offers talking points and contact information for elected officials in every Congressional district.

✓ Second, join SCAI on Capitol Hill. “There is no substitute for a constituent talking to his or her elected officials face-to-face,” stressed Dr. Uretsky. SCAI members may wish to participate in ACC’s Capitol Hill lobbying efforts on Sept. 18–20, 2005, and the Society is considering holding its own advocacy effort during this year’s TCT conference, Oct. 16–21.

✓ If you have any interest in helping SCAI take the Medicare fight straight to Congress, call SCAI Senior Director for Advocacy and Guidelines Wayne Powell. This requires a time commitment of one day, during which SCAI will brief you on the specifics of the issue, provide in-depth talking points, and then help you navigate the halls of Congress for scheduled appointments with Congressional staffers and elected representatives. Contact Mr. Powell at wpowell@scai.org, or call 800-992-7224.