Mark Your Calendar: SCAI’s Annual Scientific Sessions

Ask Theodore A. Bass, M.D., FSCAI, to describe the 28th Annual Scientific Sessions he’s organizing for SCAI, and the answer is easy: The meeting, which will take place May 4–7 in Ponte Vedra, FL, will be an excellent educational opportunity and forum for the interchange of ideas.

“Our agenda is really geared toward the needs of practicing interventionalists, including pediatric interventionalists,” said Dr. Bass, who chairs the meeting along with co-chairs J. Jeffrey Marshall, M.D., FSCAI, Marco Costa, M.D., FSCAI, Jose A. Ettedgui, M.D., FSCAI (Pediatric Program co-chair), and Robert N. Vincent, M.D., FSCAI (Pediatric Program co-chair). At the top of the list of interventionalists’ educational needs this year is information about the newly approved technique of carotid stenting. “A good part of the program will be committed to carotid and peripheral interventions,” he said. “We’re also hoping to look at some of the newer imaging modalities, including interventional magnetic resonance imaging and CT scanning.”

Another highlight of this year’s meeting will be international flavor, noted Dr. Bass, who explained that interventional societies from Asia, Europe, and South America will hold special symposia during the Scientific Sessions. “These symposia will enable us not only to dialogue with our international counterparts but also to expose practicing interventionalists in

(continued on page 2)
Advocacy Newsflash (continued from page 1)
Committee chair, will be working closely with Mr. Powell. “He is widely known and deeply respected in the physician community and the advocacy field,” stressed Dr. Babb. “I am confident that we could find no better person than Wayne Powell to lead us forward.”

The Right Stuff
A look at Mr. Powell’s resume supports that assertion. He has a master’s degree in Policy Studies and extensive experience in all aspects of medical policy-making. He worked for two years in the U.S. General Accountability Office and then eight years with the Inspector General’s office. Those posts led to his deep understanding of physician reimbursement. He was instrumental in setting up the Medicare fee schedule as well as other aspects of Part B.
He also knows how medical societies work and understands the needs of their physician members. For five years, he worked on federal reimbursement issues, advocated on Capitol Hill, and managed regulatory issues on behalf of the American Academy of Ophthalmology. And, after six years at the ACC, he has a solid grasp on the unique issues facing cardiologists and cardiovascular patients.
Mr. Powell has a network of contacts throughout the advocacy field. But contacts are one thing, friends something else altogether. Mr. Powell has both. Many of the people he has worked with over the years welcome his input because he manages to be both reasonable and authoritative. They respect his command of the nuances of regulatory issues, and they appreciate his soft-spoken yet confident manner. But what has made Mr. Powell many friends in Washington and elsewhere is his approach to advocacy. “Having served in government for eight years, I really believe that most of the people in government are trying to do the right thing,” he explained. “Our job is to help them figure out what that is.”

Good Timing
This is the right time for SCAI to bring its advocacy efforts under its own roof, said Advocacy Co-chair Carl Tommaso, M.D., FSCAI, who was quick to praise the work of the advocacy firm MARC Associates, which has for three years “done a skillful job representing SCAI.”
He elaborated: “The combined efforts of MARC Associates and our hard-working volunteer members have brought SCAI respect and credibility among agencies, legislators, and payers. They are coming to us routinely for advice, guidance, and feedback on clinical and policy issues. We must be able to respond to their requests fast. That’s where Wayne comes in.”
He also comes to SCAI prepared to “anticipate legislative and regulatory issues,” added Dr. Babb. “Of course, we must be nimble, but we also want to be proactive. Wayne is so well networked that he can help us to stay ahead of the curve.”

The Marriage of Advocacy and Guidelines
The aspect of his new job that Mr. Powell is most excited about is the opportunity to strengthen “the natural connection between advocacy and guidelines.”
“Practice guidelines, competency statements, quality standards … these are the tools that take us to quality, and quality of care is — and always has been — SCAI’s mission,” said Dr. Tommaso. “What better way to make sure that guidelines get implemented than to have them under the supervision of one person?”

High on Mr. Powell’s short-term priority list is driving SCAI’s advocacy around a multispecialty carotid artery stenting registry. “A good advocacy program works first and foremost for quality — quality standards, quality practice, quality care,” he explained. “That’s our goal with carotid stenting. Are we advocating for appropriate reimbursement — of course. But the bottom line, pardon the pun, is making sure that this new technology is being used by appropriately credentialed physicians and the outcomes are being monitored to guarantee patient safety.”
Scientific Sessions (continued from page 1)
the United States to some of the newer technologies that are being developed overseas,” he explained. The meeting’s international scope is apparent even in the choice of two world-renowned keynote speakers: Patrick Serruys, M.D., Ph.D., of the Netherlands, and Gary Roubin, M.D., Ph.D., of New York City.

More intimate than other cardiology meetings, SCAI’s Annual Scientific Sessions offer a perfect balance between breadth and intimacy. The format ranges from lectures and debates to case presentations and even live cases. “We’ll have several large sessions and concurrent smaller sessions where attendees will have the chance to interact with one another and faculty in an intimate, collegial setting,” said Dr. Bass. “We’re fortunate to have a meeting site that can accommodate many things going on at the same time.”

The meeting’s venue offers plenty to do after hours as well. Located between Jacksonville and St. Augustine on Florida’s Atlantic coast, Ponte Vedra features a lovely setting, beautiful weather, and endless recreational opportunities. “May is a spectacular time of year to be on the coast of Florida,” said Dr. Bass.

The combination of first-class education and first-class venue makes early registration a must, added Dr. Bass, who expects more than 1,000 participants. “Keep your eyes open for updates on the program, and sign up fast,” he urged, “because we do anticipate a record turnout.”

Registration includes admission to all the scientific sessions and the Melvin P. Judkins Cardiac Imaging Symposium, workshops, exhibit hall, president’s reception, and annual banquet. Register before April 4 to receive a discount. For more information and a registration form, visit www.scai.org.

Editor’s Message: How to Get Your Paper Published

Publication activity is a difficult yet highly rewarding experience. After an appropriate apprenticeship with a mentor who can help you write a case report or brief scientific paper, your thoughts can be widely appreciated by all and ultimately could improve patient care through enhanced knowledge. At the 2004 SCAI Annual Scientific Sessions in San Diego, I was asked to talk to our SCAI fellows-in-training about how to get a paper accepted into a scientific cardiology journal (a process fully described in Kern M and Bonneau HN, Catheterization and Cardiovascular Interventions 2003; 58:391–396). I was delighted to receive positive feedback from those who had attended my lecture, and I am pleased to share an abbreviated presentation here.

There are 10 steps in manuscript preparation and submission for publication:
1. Identify a mentor.
2. Identify your project idea.
3. Begin data organization.
4. Establish an abstract from collected data.
5. Initiate a first draft.
6. Revise the first draft with your mentor.
7. Revise a second draft with your mentor.
8. Prepare a final draft.
9. Submit a manuscript to a journal.
10. Evaluate comments for resubmission and submit either for final acceptance or to a new journal.

Don’t Go It Alone

This approach to manuscripts applies to both case reports and more formal scientific projects, which are referred to as “data-driven” projects. Working through each step is best done in consultation with an experienced writer but may be attempted by a novice and then reviewed with someone later. On beginning any new project, the writer should always remember the important six phases of a project (see sidebar) Unless the new author-to-be is intrinsically highly talented, learning to write a medical paper is an apprenticeship activity. Most novices cannot filter out the important from the unimportant items. For data-driven projects, it is worthwhile to identify a research team leader who may assist in the collection and organization of data. The writer should become friendly with the study coordinator, who will assist him or her in the initial data collection and study organization, maintenance of the data in separate data files, and

The Six Phases of a Project

1. Enthusiasm
2. Disillusionment
3. Panic
4. Search for the guilty
5. Punishment for the innocent
6. Praises and honors for the nonparticipants

(continued on page 4)
extra copies. The investigator should examine each set of study data as it is generated.

A Manuscript Is Born

The birth of a manuscript begins with a novel observation or, for a data-driven project, a formulation of a hypothesis. This hypothesis will be the one and usually only one question to ask and answer. For example, “We hypothesize that…coronary flow reserve after angioplasty will be normalized.” What data do we need to demonstrate or refute our hypothesis? The next step is to identify data that will be used to support the hypothesis. Some early-career investigators may be concerned that they cannot collect every data point on every patient and thus may not complete the work. Fear not — many clinical studies will have some missing data points. Do not be discouraged, continue collecting data, and then organize the data into tables for review with your mentor and study team. A preliminary statistical analysis after several patients’ data sets can be performed to identify early results. At this point you can begin thinking about the format and display of data in figures for your manuscript.

The Hardest Part — Writing!

Now comes the hardest part: Writing the first draft is among the most difficult steps for new writers. It is helpful to begin by writing the abstract of the manuscript from the results produced first. Answer the five fundamental questions:

- What question was asked? (background)
- What was supposed to happen? (testing the hypothesis)
- How and in whom was the study done? (methods)
- What did you find? (results)
- What does it mean to others? (conclusion)

It is important to remember that brevity and clarity are essential to an abstract presentation.

Rewrite — Again and Again

In the advanced draft stage, reexamine the abstract and rewrite it in no more than 250 words using one to two sentences each for background, hypothesis, methods, results, and conclusion. Then, rewrite the Introduction, which should generally be no more than two to three pages. Add section headings to the Methods section, such as “patient population,” “inclusion criteria,” and “exclusion criteria.” State whether IRB approval was obtained. In this section, answer the most commonly asked questions of your study — that is, how and why were measurements made? How long between steps? What were the controls? What were the drug dosings? Where were there omissions or inclusions of various types of measurements? Consult the Methods sections from similar and previously published studies. Extra methodological detail can be added in an appendix, if needed. Rewrite the statistical methods and provide rationale for sample size collection. State what the significant P values, standard deviation, and other statistics mean. A statistician may be a helpful individual to consult at this point.

With regard to the Results section, organize these into the following five segments. Start with subject groups; present comparisons within and between subgroups. Next, identify the measurement type, such as hemodynamics or echocardiography, and present these results. Describe important changes from the baseline and correlative data. The percent change and absolute change should be included. For clinical studies, emphasize all outcome data whenever possible. Avoid presenting data in both the text and in a graph. Most data are better presented in graph format. Rewrite the Discussion section with emphasis on the five major sections below:

1. Present the major findings first: “These data show that…”
2. Present the scientific significance of the data: “These data imply that…”

“Learning how to write a medical paper is an apprenticeship activity.” — Dr. Kern 

Editor’s Message (continued from page 3)
3. Compare the data in a scholarly fashion to previous work: “These data are similar to and different from...”
4. Present weaknesses of the current study: “There are limitations to this work...”
5. Conclude with the clinical significance: “These data mean that... and future studies may include...”

These five phrases are commonly used and provide an easy fill-in-the-blanks approach for novice writers.

Invite Feedback
When you have completed all of the above, circulate the near-final draft with tables and proposed figures to your coauthors and indicate you would appreciate their comments by a specific date. If you cannot obtain comments by this date, review the criteria of authorship with your mentor. (For the hangers-on: no pain, no gain.) Additional drafts are usually required. On final revision, keep four thoughts in mind:
1. Limit ambiguity and hyperbole.
2. Keep tense and voice consistent.
3. Do not become attached to your own words (i.e., If you can say the same thing in four words versus ten, go to four).
4. Edit yourself with impunity.

Before submitting the manuscript to your chosen journal, spell out all abbreviations, eliminate redundancies, and add units of measure and statistical markings to all tables and graphs. Figure legends should have sources cited if they are borrowed from other works. References should be correct for the journal format. Take the time to review the presentation so that it is both clear and appropriately brief. Add an acknowledgments statement about the team members and secretarial help. On submitting the paper to a journal, follow the instructions provided to authors. Write a cover letter to the editor; be brief, but tell the editor what is especially new or unusual in the work. Be honest and modest. Make extra copies of your manuscript and keep them in a file for future correspondence. Obtain written permission for submission from each coauthor, and cross your fingers.

Take Heart
On receipt of a second submission, either after rejection or acceptance with a requirement for revision, do not become disheartened. The reasons for rejection are generally because of one or more of the following flaws: invalid statistics; using a method that cannot answer the question asked; an error in the methods; too small a sample size; drawing the wrong conclusion from the data; poor scholarship; wrong references; citation errors; or problems with grammar, spelling, or structure.

Every Article Has a Home
After overcoming rejection, consider this saying, “Every article has a home.” Work on the manuscript again. Read the comments of the reviewers objectively. Ask your mentor what they mean. Ignore any mean-spirited language from the reviewers. Revise the manuscript with attention to which comments can and cannot be addressed and state the reasons why this is so. Write a response to the reviewers in a respectful, clear, and identifiable format, key to the changes of the manuscript. Discuss with your mentor whether to submit to the same journal or a different one. On final acceptance of your manuscript, be sure to read the acceptance letter fully, feel good, tell your friends, send copies to your coauthors, call your mentor, and start your next paper.

I hope these suggestions will be helpful and would encourage all cardiology fellows as well as experienced cardiologists to share their ideas with their colleagues, especially SCAI members. After all, if we cannot depend on one another to advance our professional lives, on whom can we depend? We all have benefited from the knowledge that SCAI and its members promote. We must remain committed to the education of cardiologists to better our patients’ lives.
Flat-Panel Imaging — Coming Soon to a Cath Lab Near You

Conventional image-intensifier (II) x-ray systems, the mainstay of cardiac imaging for 40 years, are on their way to being overshadowed in the imaging industry, thanks to the emergence of digital flat-panel imaging technology. SCAI members with an interest in the field say flat-panel imaging offers an array of advantages over traditional II systems, including better resolution and the potential for decreased radiation exposure.

“Flat-panel technology is an entirely new way to do x-ray imaging, eliminating the image intensifier,” said Mitchell A. Driesman, M.D., FSCAI, director of Interventional Cardiology and Cardiac Catheterization at Bridgeport Hospital in Bridgeport, CT. “The flat panel has allowed us to get better pictures with less x-ray dosage. It is really a major advance.” Dr. Driesman organized a symposium on flat-panel imaging at this year’s SCAI Annual Scientific Sessions in San Diego. The session was made possible by a generous unrestricted grant from GE Healthcare.

The ability to do direct imaging without the image intensifier improves image quality because it lessens the amount of image degradation, explained SCAI member Merrill Wondrow, of Clarté Imaging Solutions, Inc. He provided the clinical image engineering support to the developers of flat-panel imaging, having run the world’s first prototype of the system on 47 patients at the Mayo Clinic in 1995.

Better Images Mean Better Patient Care

With conventional II systems, the x-ray signal is transmitted from the x-ray tube, through the patient, and into the image intensifier, where it is converted into a light signal. Then, the light signal is coupled out of the image intensifier into a charged coupled device (CCD) camera, where it is digitized and displayed on a monitor. At each of these steps, the x-ray signal is degraded, so that often less than 40 percent of the original image is transferred for display. With flat-panel imaging, the x-ray photons are converted immediately to a digital signal and displayed on a monitor without going through the image intensifier and CCD camera. Fewer steps, therefore, mean an enhanced image, said Mr. Wondrow.

“The image intensifier exhibits quite a bit of image degradation due to light scatter. But with flat-panel imaging, where there is no image intensifier, there is minimal degradation. That was the motivation to go to flat panels, to make a sharper, more contrasted image,” added Mr. Wondrow.

Flat-panel technology has the ability to capture “almost limitless shades of gray” compared to image intensifiers, which work with only 256 shades of gray. The new technology also has significant improvement in dynamic range, said Charles Chambers, M.D., FSCAI, who chairs SCAI’s Catheterization Laboratory Performance Standards Committee.

Other advantages of flat-panel imaging include uniform brightness across the entire image, no grid distortion, superior object detectability, and easier maneuverability. “The smaller size of the flat-panel device gives the operator the ability to rotate or spin gantries very fast. This was impossible to do with II architecture. Contrast injections last a few seconds, so it is highly desirable to be able to spin patients faster,” said Mr. Wondrow.

All these advantages should ultimately translate to better treatment for patients. “High-resolution images that are accurately displayed and easily interpreted are key to guiding appropriate therapy. Spatial, temporal, and contrast resolution are all improved with flat-panel imaging, and these improvements should enhance decision making and the ability to perform therapeutic procedures,” said John F. Robb, M.D. FSCAI, director of the cardiac catheterization laboratory at Hitchcock Medical Center in Dartmouth, NH.

The Downside — Sticker Shock

One downside to flat-panel imaging is the price. The equipment is expensive, but as competitive pressures increase, the cost will come down. GE Healthcare, Philips, Siemens, and Toshiba all have come out with a version of flat-panel technology, and they presented information about their devices at the special SCAI ’04 session. More manufacturers are in the wings.

Another downside is less reduction in radiation dose than had been anticipated. “There’s certainly some improvement in radiation reduction, but I don’t know if we have seen as much as we would have liked.

(continued on page 9)
Save More Lives With Coreg
Adding Coreg to modern Post-MI therapy saves more lives

Coreg reduced the risk of all-cause mortality by 23% in Post-MI LVD patients.\(^{1,2}\)

Asymptomatic Post-MI heart failure patients

31% mortality risk reduction

Coreg Provides Proven Cardioprotection, Broad-spectrum Blockade
—Coreg reduces mortality in Post-MI LVD and in mild to severe HF—

Coreg is indicated in hypertension, Post-MI LVD, and mild to severe heart failure.\(^1\)

Important Safety Information
Patients taking Coreg should avoid abrupt cessation of therapy. Following abrupt cessation of therapy with certain \(\beta\)-blocking agents, exacerbations of angina pectoris and, in some instances, myocardial infarction have occurred. The dosage should be reduced gradually over a 1- to 2-week period and the patient should be observed.

Coreg is contraindicated in patients with symptomatic congestive heart failure (New York Heart Association class III or IV); in patients with asthma or chronic bronchitis who would be expected to experience bronchospasm; in patients with a history of bronchospasm or a reaction to \(\beta\)-blockers; or in patients who have clinically manifested hepatic impairment.

The most common side effects reported in the controlled trials in heart failure (reported in >10% of patients and more frequently on Coreg) were dizziness, fatigue, weight increase, hypokalemia, and hypotension. These adverse reactions were also reported, but with equal or greater frequency in placebo-treated patients. The most commonly side effects reported with Coreg in the CAPRICORN trial were consistent with the profile of the drug in the U.S. heart failure market, including edema and orthostatic hypotension, as was the health status of patients. The only additional common adverse events reported more frequently on Coreg in CAPRICORN were dysuria.

The most common side effects in hypertension (dizziness and fatigue) of Coreg were generally mild and comparable to placebo.

\(^{1}\) Patients were receiving ACE inhibitors or angiotensin receptor blockers (97%), aspirin (89%), diuretics (34%), lipid lowering agents (23%), and anti-coagulants (20%).\(^2\)

CAPRICORN was a double-blind study comparing Coreg and hydrochlorothiazide (HCTZ) in 2,396 patients with asymptomatic heart failure (within 21 days) and left ventricular ejection fraction of ≤40%, with (47%) or without (53%) symptoms of heart failure who were started on fixed-dose Coreg 6.25 mg bid, titrated as tolerated to 25 mg bid. Patients must have had a systolic blood pressure ≥90 mm Hg, a sitting heart rate ≥60 beats per minute, and not received any additional \(\beta\)-blocker use. All-cause mortality was 15% in the placebo group and 12% in the Coreg group, indicating a 23% risk reduction in patients treated with Coreg (HR 0.78; 95% CI 0.62 to 0.99). All-cause mortality in asymptomatic heart failure patients was 12% in the placebo group and 8% in the Coreg group, indicating a 30% risk reduction in patients treated with Coreg (HR 0.70; 95% CI 0.50 to 0.98).\(^3\)

\(^{1}\) Please see brief summary of prescribing information for indications and dosing at the end of this advertisement.

Fellows Selected for “Reporter Program”

For several years, SCAI and GE Healthcare (formerly Amersham Health) have supported a unique program designed to identify tomorrow’s thought leaders in cardiovascular medicine and to support their interest in academic research. Through this program, several interventional cardiology fellows-in-training are selected by a committee of SCAI leaders to attend the Society’s Annual Scientific Sessions as “educational reporters.” This year’s SCAI/GE Healthcare (formerly Amersham Health) Fellows received expenses-paid trips to San Diego. GE Healthcare also covers the annual fee for each fellow’s membership in SCAI.

Once in San Diego, each fellow was assigned a “hot topic” addressed in the presentations made by experts throughout the three-day program. Each then drafted an original manuscript that critically reviews his or her assigned topic. The manuscripts are posted on scai.org and will soon be published in an online monograph by Anderson Publishing. The Society extends congratulations to each of these fellows:

- Deepak Banjeree, M.D.
- Adam Brodsky, M.D.
- Harun A. Otieno, M.D.
- Michael L. Phan, M.D.
- John T. Schindler, M.D.
- Suzanne Sorof, M.D.

The SCAI leadership committee also reviewed the manuscripts and evaluated them on several criteria, including scientific accuracy, originality, creativity, and writing style.

Based on their critiques, two manuscripts were selected as deserving special recognition. Dr. Brodsky, whose manuscript on percutaneous approaches to aortic valve replacement was deemed the best of the group, has been awarded a $3,000 unrestricted educational grant. The runner-up, Dr. Schindler, will receive a $1,000 unrestricted educational grant for his work on endovascular treatment of carotid artery disease and abnormal aortic aneurysms.

SCAI thanks GE Healthcare for its generous support of this program and its continued interest in the next generation of interventional cardiologists. For details on the fellowship awards program just launched by SCAI and GE Healthcare, see pages 10 and 11.

“We believe that industry has a role to play — almost a responsibility, really — in the careers of fellows because many of the ideas that carry academic researchers through their careers are generated during fellowship,” said GE Healthcare representative Marc S. Kerachsky. “Our ultimate goal is to provide solutions that move us toward better patient care. Our partnership with SCAI supports that objective.”

Flat-Panel Imaging (continued from page 6)

to have seen,” said Mr. Wondrow. Most U.S. cath labs will make the transition to flat-panel imaging when it comes time either to upgrade or to build new facilities, said John D. Carroll, M.D., Ph.D., FSCAI, chief of cardiology and director of the Cardiac and Vascular Center at the University of Colorado Hospital in Denver. This is just as well, he said, because image intensifiers are no longer being manufactured.

“I don’t think we have a choice anymore. All the major imaging companies have moved from the older II systems to flat-panel technology. But there’s no learning curve, and there are the clinical advantages. It not only provides enhanced resolution; it also allows us to image more difficult patients with more clarity. Its use will result in better placement of catheters,” Dr. Carroll said.

Warren K. Laskey, M.D., FSCAI, and several of his colleagues have developed an educational “overview” of flat-panel technology that is published in the November issue of CCI. “There is no question that flat-panel technology has made a significant incremental contribution to image quality in the catheterization laboratory,” noted Dr. Laskey. “This advance, however, carries with it the additional responsibility of the user to fully understand its advantages and potential limitations when compared with the ‘old’ technology.”

SCAI has consistently emphasized that a credible image-quality assessment program includes not only acceptance testing but also an ongoing program to allow for software modifications and their effects on image quality and dosimetry, said Dr. Laskey. “This will be even more important with this new technology as our initial enthusiasm matures into an informed advocacy,” he said.

Added Dr. Chambers: “No matter what you think of the II system, flat-panel imaging is on its way. Ready or not, here it comes.”
SCAI and Cordis Corporation Partner to Offer Interventional Research Fellowships

SCAI and Cordis Corporation, a Johnson & Johnson company, share a similar vision for, and a common commitment to, supporting research in interventional cardiology. Based on this shared outlook, SCAI and Cordis have forged a partnership aimed at advancing such research, encouraging physicians-in-training to pursue careers in academic medicine, and fostering new insights into patient care. The result is the awarding of two research fellowships of $25,000 to fellows-in-training offered through the 2005 SCAI/Cordis Fellowship Program for Interventional Cardiology.

Successful applicants will have a track record of medical excellence as well as a research proposal that promises advances in cardiovascular invasive/interventional techniques, explained Frank Hildner, M.D., FSCAI, who chairs the SCAI committee that will review all of the submissions and select the award recipients. “Good science is the prime requisite in our evaluation,” emphasized Dr. Hildner, “but we do have a list of ground rules we start with as we review proposals. One of those rules is a preference for human work over animal work. We try to keep the program as clinical as possible.”

This program builds on previous research fellowships awarded by the Society, beginning in the late 1980s. SCAI has periodically surveyed past awardees and consistently finds that the vast majority of its fellowship recipients have continued in teaching and academic research. “Those findings support the underpinnings of the Society,” noted Dr. Hildner. “Academic medicine is the basis for our mission of optimum patient care.”

Cordis Corporation, a Johnson & Johnson company, has a similar mission. The company has more than 7,000 employees worldwide who share a strong commitment to continue the company’s groundbreaking work in the fight against vascular disease. “We are so pleased to have Cordis on board with this program,” said Dr. Hildner. “I believe that Cordis has the same vision for the program that we do. We both want to see that good science and good research get done and that the next generation of interventional cardiologists is well supported.”

When asked which fellows-in-training he would encourage to apply, Dr. Hildner kept his reply simple: “If you have good clinical work that has the potential to impact patient care, you should take a shot at it.” The other eligibility criteria are straightforward as well:

1. 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;
2. He or she must have the approval of the training program director; and
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.)

The fellowships will be presented during the SCAI 28th Annual Scientific Sessions, May 4–7, 2005, in beautiful Ponte Vedra Beach, FL. The awards are limited to research done in the United States or Canada and will be applied to direct research costs.

In addition to the monetary support, these fellowships are a kind of vote of confidence from the profession’s top thinkers, emphasized Dr. Hildner. “The recipients of these fellowships can be sure that experts in the field have reviewed their work and find it valuable,” he explained. “And they should take pleasure in knowing that a totally dispassionate independent board of people who have been in the field for many years believes that their work is going to be productive and valuable to the field as a whole.”

Along with the honor comes a hidden benefit to receiving an SCAI research fellowship — the opportunity to network with the Society’s leaders and others who are doing major work in invasive/interventional cardiology. SCAI will underwrite expenses for the fellowship recipients to attend the 2006 SCAI Annual Scientific Sessions, where they will present an update on their research and enjoy the Society’s Annual Banquet. “This is an opportunity to rub shoulders with people who might very well be of help to them in the future. That in itself is invaluable for a young person early in his or her career,” said Dr. Hildner.

Time is running out to apply. The deadline for receipt of proposals is Jan. 6, 2005. All applications must be submitted online at www.scai.org. For more information, call SCAI at 800-992-7224 or visit www.scai.org.
The 2005 SCAI/Cordis Fellowship Program for Interventional Cardiology

Two Fellowship Awards
Up to $25,000

Application online at www.scai.org  Application Deadline: January 20, 2005

Program Description
Cordis, a Johnson & Johnson company, and The Society for Cardiovascular Angiography and Interventions (SCAI) are pleased to announce the 2005 SCAI/Cordis Fellowship Program for Interventional Cardiology.

The program will award two fellowships to physicians-in-training with demonstrated medical excellence and 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. 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 2005 SCAI/Cordis Fellowship Program for Interventional Cardiology are those who—
1. Will be serving as a fellow in an accredited invasive/interventional cardiology fellowship 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 and representation, and the advancement of quality standards to enhance patient care.

Application Process
All applications must be submitted online. Visit our Web site at www.scai.org for specific instructions to submit an application.

Application deadline:
January 20, 2005
Please print or type.

Name ________________________________________________________________________

Degree _______________________________________________________________________

Institution _____________________________________________________________________

Mailing Address _______________________________________________________________

City/State/Zip/Country _________________________________________________________

Daytime Telephone ____________________________________________________________

E-Mail ________________________________________________________________________

Program Director’s Signature (required for all trainees): _____________________________

28th Annual Scientific Sessions and Melvin P. Judkins Cardiac Imaging Symposium May 4-7, 2005

Registration for scientific sessions includes admission to all scientific sessions and the Melvin P. Judkins Cardiac Imaging Symposium, workshops, exhibit hall, President’s reception, and Annual Banquet. Admission to all events is by badge or ticket only.

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<th>Advance Registration (On or before 4/4/05)</th>
<th>Regular &amp; On-Site Registration (After 4/4/05)</th>
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<td>___ SCAI and/or SICP Member</td>
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<td>___ Abstract Presenter (presenter only)*</td>
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*Registration form needs to be submitted by speakers and abstract presenters even though there is no registration fee.

Guest(s)

Registration for guests includes the President’s Reception and Annual Banquet but not the Scientific Sessions.

Guest Name(s) ____________________________________________________________

# of guests _______ x $100= $ ___________

Total Amount Enclosed: $ __________

Payment Information

Payment must accompany registration.

• Check payable to SCAI
• Mastercard • VISA • American Express

Name on Card: ________________________________

Card Number: ________________________________

Expiration Date: ________________________________

President’s Reception, May 5, 2005

_____ I will attend
_____ I will not attend
_____ I will bring ___ guest(s) (guest registration required)

Annual Banquet, May 6, 2005

_____ I will attend
_____ I will not attend
_____ I will bring ___ guest(s) (guest registration required)

3 Easy Ways to Register!

Mail: SCAI
      9111 Old Georgetown Rd.
      Bethesda, MD 20814-1699

Fax: (301) 581-3408

On-line: www.scai.org

Questions? Phone (800) 992-SCAI
Wondering how you can squeeze in continuing education, vacation, and family time this year? Here’s the answer in a single word: Snowmass.

Thanks to the efforts of John H.K. Vogel, M.D., FSCAI, MACC, the Colorado ski resort has become synonymous with family-friendly continuing medical education. The 36th Annual Cardiovascular Conference at Snowmass will take place Jan. 17–21, 2005. Sponsored by SCAI and cosponsored by the ACC, the five-day event will feature world-class speakers and slopes.

Dr. Vogel has directed the conference since founding it in 1968. With the help of long-time co-director Spencer B. King, III, M.D., FSCAI, MACC, and Robert M. Bersin, M.D., FSCAI, Dr. Vogel has again put together a program that provides an update on the latest in cardiology and a look at what’s on the horizon.

Unparalleled, Comprehensive Content

After a kick-off reception on Sunday evening, participants will get down to the business of top-notch cardiovascular education on Monday morning. Monday’s theme is lipids, with a presentation on the Reversing Atherosclerosis with Aggressive Lipid Lowering trial by Steve E. Nissen, M.D.; a presentation on new directions in lipid therapy by Donald B. Hunninghake, M.D.; and a presentation of case studies in lipid abnormalities moderated by Robert Superko, M.D.

On Tuesday, heart failure will be a major focus. James B. Young, M.D., for example, will discuss which device to use for which heart failure patient, and he will moderate a presentation of case studies on heart failure drugs.

Another highlight of Tuesday’s program will be a discussion of diabetic patients with heart failure, presented by endocrinologist Kathleen Wyne, M.D. “While it’s wonderful to have cardiologists talking about the metabolic syndrome, we really need to have a diabetologist talk about it, too,” said Dr. Vogel. “Dr. Wyne is heavily involved in research and a great speaker.”

On Wednesday, attention will shift to acute coronary syndromes. Allan Ross, M.D., will share lessons learned in the management of AMI and moderate a discussion of case studies, for example. “Dr. Ross is a real guru,” noted Dr. Vogel.

On Thursday, participants will hear from highly regarded surgeons Delos Cosgrove, M.D., and Marco Turina, M.D. “Many surgeons come to our meeting, because they can get a good update on cardiology,” explained Dr. Vogel. Of course, participants will also learn about noninvasive approaches to such problems as valve replacement and repair. “I like to stay on the cutting edge, so that people know what’s coming at them,” he added.

The meeting’s final day will begin with a look at complementary medicine’s role in cardiology by Andrew T. Weil, M.D. Erminia M. Guarneri, M.D., will follow with a presentation on supplements and herbs. “Complementary and alternative medicine is sweeping the country, with patients spending millions of dollars and making innumerable visits to practitioners,” said Dr. Vogel. “It’s an important topic for conference-goers to start thinking about.”

Unbeatable Schedule

Each day’s schedule will follow the same formula, noted Dr. Vogel. Part of the reason the Snowmass meeting has been so successful is that it provides the ideal balance of rigorous education with time for recreation. Each day starts with a two-hour session, then a break for skiing or other fun, and finally a three-hour session that ends around 6:30. In addition to time with family, that mid-day break means plenty of time to interact with speakers. “At most meetings, people give a talk and then they’re gone,” said Dr. Vogel. “The nice thing about Snowmass is that most people are there for a week, so you can talk or even take a run together.” The long break also means ample time to enjoy Snowmass’s many attractions.

“Lots of people come back year after year, so their families grow up together,” said Dr. Vogel. “It’s a different kind of meeting. We’re just like a big family, and we always welcome new attendees with enthusiasm.”

To register for the program or obtain more information, visit SCAI’s Web site at www.scai.org or call 800-992-7224.
What Is the SCAI/GE Healthcare Fellows Grant Program?
The SCAI/GE Healthcare Fellows Grant Program is a new opportunity for interventional cardiologists-in-training to support their research in angiography and diagnostic imaging.

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 who have demonstrated medical excellence and whose research proposals show great potential for advancing angiography and/or diagnostic imaging.

A high-level committee of 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 an article on their proposed research topic. Each will receive a monetary award ($2,000) to support their efforts.

**AWARD GROUP #2**
Subsequently, 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 2005 Annual Scientific Sessions (May 4–7, 2005) in Ponte Vedra Beach, Florida. 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 2005 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. Grants are limited to research conducted in the United States or Canada.

How Do I Apply?
Applications must be received by February 3, 2005, to be considered. Visit www.scai.org and click on “Fellowship Programs” for an application and instructions.
Howard Feldman, M.D., FSCAI, spent 20 years in the trenches of private practice. He even made an occasional “house-call,” which meant personally flying patients from their homes in remote areas of California to his office. He thought he’d never return to that life. Ironically, it’s his desire to “be an agent of meaningful change” that is taking him back to those very roots.

Dr. Feldman left his practice in Northern California five years ago, recruited first to help start up an interventional cardiology program in North Dakota and then by the Great Falls Clinic in Montana. When we caught up with him, he was winding down after months of grueling double-duty — maintaining his caseload at the Great Falls multispecialty practice while relaunching his career as a private practitioner.

“A large environment where there’s a distinct assembly-line feel is not where I want to be,” he explained.

**Viewing Patients as Neighbors**

Where Dr. Feldman does want to be is at the Heartland Cardiac and Vascular Clinic, his new practice whose doors opened this fall and where he can implement his vision of “the neighborhood vascular diagnosis and treatment store.” He is looking forward to running into his patients around the rather small city of Great Falls, perhaps at the shops where he buys supplies for his furniture-building hobby or on the beautiful hiking trails that he and his wife, Marjorie, frequent.

Seeing his patients outside of the clinical context “strips away any anonymity, reinforces my role as a neighbor as much as a community resource” and takes him back to “the traditional physician–patient relationship.” He views that relationship as a two-way street; his job is to meet or exceed his patients’ expectations, while they realize that he has expectations of them, such as committing to a risk-factor-modification program, smoking cessation, and participation in a care strategy.

**Protecting Patients From Crossfire**

Dr. Feldman has a strong sense of what “feels appropriate” in patient care, and there’s one place he feels a patient should never be: in the crossfire of a specialty turf war. He’s passionate about this, likening battles over which doctors treat which vessels to a hair-pulling match, where patient care can be subordinated to one specialty’s sense of procedural birthright. Concerns about such fights, especially the skirmish over who gets to treat peripheral vascular disease, are what led him to SCAI three years ago.

“I see SCAI as an organization that holds out hope for genuine, meaningful input into the political environment and for developing important clinical directions,” he said, adding that he wants to do his part to help SCAI with some of the “heavy political lifting” that individual practitioners simply can’t do on their own. Recently welcomed onto SCAI’s Peripheral Vascular Disease Committee, Dr. Feldman can’t wait to roll up his sleeves and get to work.

“I think SCAI should establish itself as the foremost voice for cardiologists who want to take the time and devote the necessary energy to establishing a peripheral intervention program,” he said. “We can do that by developing reasonable, effective, and actionable recommendations for training and credentialing.”

This is the right time for Dr. Feldman to invest time and energy in a new practice as well as to assist SCAI in its advocacy efforts. His children, Julian and Anna, are busy launching careers of their own. And, in a unique twist of fate that “feels right,” Anna has stumbled across some of her father’s roots and into one of his passions. She recently began working in the Vascular Medicine Department of St. Elizabeth’s Hospital. “I did a peripheral vascular interventional mini-fellowship there a few years ago,” he said, “and now I’m very happy that Anna’s working in her first job with people I know and respect.”
36th Annual Cardiovascular Conference at Snowmass Jan. 17–21, 2005
Snowmass, Colorado

The most comprehensive update for diagnostic and medical/surgical treatment of cardiovascular disease

Directed by John H.K. Vogel, M.D., FSCAI, MACC
Co-directed by Spencer B. King, III, M.D., FSCAI, MACC, and Robert Bersin, M.D., FSCAI

Registration is easy – go to www.scai.org and click on the “Snowmass” button. Or call 800-992-7224

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