36TH ANNUAL CARDIOVASCULAR CONFERENCE AT SNOWMASS
January 17–21, 2005
Snowmass, Colorado

Directed by John H.K. Vogel, M.D., FSCAI, MACC

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TWO FANTASTIC MEETINGS FROM SCAI!

Directed by Theodore A. Bass, M.D., FSCAI

May 4–7, 2005

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Taking Stands When It Counts

**SCAI Leads the Way on Carotid Stenting**

In preparation for the Food and Drug Administration’s (FDA) approval of carotid artery stenting this year, SCAI is getting ready on all fronts: advocacy, education, guidelines, registries, and more. More than ready, actually, because the Society has been quietly working behind the scenes on issues relevant to carotid artery stenting with embolic protection for many months. As a leader of a coalition, including the Society for Vascular Medicine and Biology (SVMB), the Society of Vascular Surgery (SVS), and the American College of Cardiology (ACC), SCAI has been responding to a steady stream of requests for information and input from federal agencies, all working under tight deadlines.

“SCAI is really at its best in situations like this, where we’re asked to be bold — to take a position without delay,” said SCAI President Michael J. Cowley, M.D., FSCAI. “The way we’ve tackled the issues surrounding carotid artery stenting really highlights SCAI’s strengths: we’re willing to take a tough stand, we’re happy to work with other groups, and we move FAST.”

**SCAI: On Call 24/7**

Indeed, SCAI has been out in front of the questions surrounding carotid artery angioplasty and stenting.

*SCAI ADVOCACY NEWSFLASH*

**Reports on Medicare, Practice Expense, and More**

In this issue of SCAI News & Highlights, we continue our regular column intended to keep you up to date on the advocacy issues SCAI is pursuing on behalf of the membership, the profession, and the patients. Our goal is to give you at-a-glance updates on both progress and problems, and to point out ways you can help — for example, by writing a letter, calling your congressional representative, assisting the Society’s Advocacy Committee, participating in an SCAI e-survey, or joining SCAI leaders for a visit to Capitol Hill.

The one constant in advocacy efforts is that strength lies in numbers, especially if the people who comprise the “numbers” are vocal. SCAI is well over 3,000 members strong. Please contact us at info@scai.org if you’d like to join your voice with those of your colleagues.

**Good News on Medicare**

In a rare bit of good news from the Centers for Medicare and Medicaid Services (CMS), interventional cardiologists learned that their overall Medicare revenue in 2005 would increase nearly 2 percent. This increase results from SCAI-supported Medicare legislation in 2003 that set the annual update for the fee schedule at 1.5 percent (instead of allowing a scheduled payment reduction of approximately 4 percent to go into effect in January 2005) and other technical changes in relative values units sought by SCAI. This increase exceeds all but one cardiology subspecialty (echocardiography) and is higher than the average.

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*Good News Abounds for CCI* ................................................................. page 4
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stenting. Together with its coalition partners, SCAI has fielded questions from the government about which physicians should be allowed to perform the procedure (answer: those who, regardless of specialty, have been rigorously trained), recommended guidelines for training and credentialing, and advised the Centers for Medicare and Medicaid Services (CMS) on reimbursement (see p. 8 for details on SCAI’s meeting with CMS).

“The background noise on some of our spur-of-the-moment conference calls has been almost comical,” laughed Joseph D. Babb, M.D., FSCAI, who co-chairs SCAI’s Advocacy Committee with Carl Tommaso, M.D., FSCAI. “It’s really a sign of dedication that everyone’s been finding time to call in, even as they’re battling traffic to get home after a long day, walking the dog, or getting ready for dinner with their kids.”

Logging more hours than anyone has been Kenneth Rosenfield, M.D., FSCAI, who chairs SCAI’s Committee on Peripheral Vascular Disease. He testified before the FDA, alongside William Gray, M.D., on the potential of carotid artery stenting in preventing stroke as well as on the critical role that the interventional community has played in developing and refining the procedure. He also burned a lot of midnight oil while drafting a competency statement in time for the mid-August town-hall meeting called by CMS.

“The bottom line is that this is an intricate procedure that involves the brain, so the training must be very rigorous,” said Dr. Rosenfield. “That being said, the ability to perform carotid artery angioplasty and stenting should not be limited to a single specialty. It should be accessible for all who have done the appropriate rigorous training and preparation.”

At the Table With Friends

The statement represents the consensus of several groups, not just SCAI, stressed CCI Editor-in-Chief Christopher J. White, M.D., FSCAI, who noted in his recent editorial “The Mother of Turf Wars: Carotid Stents” that at least “seven different and distinct specialties may seek hospital privileges to perform carotid angiography and stent placement with distal protection.”

Among those seven specialties are at least three groups — ACC, SVMB, and SVS — that have been working side by side with SCAI to advocate for decisions that will best serve the thousands of patients whose lives could be saved, or quality of life improved, if they underwent carotid artery angioplasty and stenting. It has been estimated that the procedure could benefit approximately 200,000 Americans each year, people who otherwise would not be candidates for stroke-prevention treatment.

Many of these patients come to the attention of cardiologists because they are being treated for co-morbid conditions that make carotid endarterectomy a high-risk option at best. For this reason, noted Dr. Rosenfield in his testimony to the FDA, the cardiovascular community has championed the procedure and is now advocating that the appropriate patients — those whom clinical trials, have shown to benefit — have access to it. The best way to remove unnecessary barriers, he stated, is to ensure proper training of physicians who wish to perform the procedure, to systematically monitor outcomes during the post-market phase of roll-out, and to develop mechanisms for continuous quality improvement.

Supporting the Practitioners

Such a statement is exactly the kind of thing that rank-and-file practitioners need, said Howard Feldman, M.D., FSCAI, who recently joined SCAI’s Committee on Peripheral Vascular Disease for the express purpose of helping physicians who, like him, have been “flogging in the trenches politically.” He explained that he thinks SCAI is “the natural agent to create some common ground between cardiologists and groups that feel they are being robbed of a procedural birthright.”

Carotid artery angioplasty and stenting really speaks to the “vascular” in cardiovascular, noted Dr. Cowley. “As a group, interventional cardiologists are uniquely trained to steer a catheter, and our patients are so often the best candidates for this procedure.

“You don’t often see an issue that applies so universally to SCAI’s mission,” Dr. Cowley continued. “The medical community needs guidelines on this procedure, so we’re working furiously to write them; our members need someone advocating for their right to perform this procedure, and we’ve been in the thick of
Following the rigorous evaluation process conducted every four years by the Accreditation Council for Continuing Medical Education (ACCME), SCAI has again been awarded accreditation as a provider of continuing medical education for physicians. The Society has maintained its accreditation since 1993, when Joseph D. Babb, M.D., FSCAI, in conjunction with Rita Watson, M.D., FSCAI, and Carl Tommaso, M.D., FSCAI, worked tirelessly to meet the stringent requirements of the ACCME, which evaluates an institution’s overall CME programs according to standards adopted by the Council’s seven sponsoring organizations.

For the next decade, Dr. Babb served as chair of the Society’s CME Committee and saw to it that SCAI continued to meet the requirements of the ACCME. Ted Feldman, M.D., FSCAI, then joined the committee as co-chair. They were ably assisted during this year’s evaluation by SCAI’s CME expert Anne Marie Smith. “ACCME accreditation is like the Good Housekeeping seal of approval — a recognizable mark of approval for the consumer,” said Dr. Babb. “Since professional education and advocacy are among the Society’s most vital mission areas, it would be unthinkable for us to let our ACCME accreditation lapse. We view it as essential to achieving our education mission.”

The reaccreditation process is important, too, added Dr. Babb. “In the process of examining your entire educational program, you are forced to be objective and you are able to identify how the organization has evolved since the last evaluation. The process itself helps you improve your programming.”

The reaccreditation process involved a “self-study” program designed to review the content of the Society’s CME offerings and to assess members’ needs. The process took almost two years and involved hard work from the self-study committee. SCAI partnered with the ACC to review program content and the needs of the cardiovascular community. Members were surveyed to ascertain their real CME needs and goals. “The self-study process highlighted the importance of maintaining the unbiased, practical, and current content of our Annual Scientific Sessions,” said Dr. Feldman. “The end result of the process was a four-year recertification.”

Certainly, the numbers demonstrate that SCAI is doing things right. Since its last accreditation, membership has doubled (now over 3,000), and attendance at the flagship event, the Annual Scientific Sessions, continues to grow at a pace that keeps things bustling without being too busy for people to get reacquainted in peace.

SCAI Awarded ACCME Reaccreditation Status

Dr. Babb  Dr. Feldman  Ms. Smith
It’s just a tool for ranking journals. Correction: It’s the tool. It’s the tool that the Institute for Scientific Information (ISI) uses to measure impact—which, in a word, means how often a journal is cited and, therefore, how important it is to the field. It's the tool that churns out numbers called impact factors. And those are the numbers that many an editor-in-chief loses sleep over.

But not the editor-in-chief of SCAI's journal: *Catheterization and Cardiovascular Interventions*. No, Christopher J. White, M.D., FSCAI, has a very relaxed attitude about CCI’s impact factor. While Dr. White won’t deny that he was pleased when publisher John Wiley & Sons announced that CCI’s impact factor had climbed from 1.074 to 1.519 in 2003, the Journal’s ISI impact factor simply isn’t his top priority.

“Our focus is on quality,” he explained. “Over the past three years of my editorship, we have focused on improving the scientific quality of the manuscripts while preserving access for the practical ‘how-to’ case reports that are the lifeblood of the Journal.”

In other words, although Dr. White may be gratified that, according to impact-factor data, more people are reading his journal and more people are citing its articles, the bottom line for him is “making sure that the Journal is relevant to the daily practice of the invasive adult and pediatric cardiologist.”

Ironically, CCI’s emphasis on the “how-to” case reports that are so useful to practitioners could lower the infamous impact factor. That’s why it’s all the more meaningful that the Journal’s impact factor rose.
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

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.

Important Safety Information
Patients taking Coreg should avoid abrupt cessation of therapy following abrupt cessation of therapy with certain β-blocking agents, exacerbations of angina pectoris and, in some cases, anginal recurrence have occurred. The dosage should be reduced gradually over a 1- to 2-week period and the patient should be clinically monitored.

Coreg is contraindicated in patients with hypersensitivity to the active ingredients of Coreg or carvedilol or second- or third-degree AV block, sick sinus syndrome or severe bradycardia (unless effectively managed in part), or patients with cardiogenic shock or who have decompenated heart failure requiring the use of intravenous isotropic therapy (such patients should first be weaned from intravenous therapy before initiating Coreg), or patients with clinically manifest hepatic impairment.

The most common side effects reported in the controlled trials in heart failure (reported by 10% of patients and more frequently on Coreg) were dizziness, fatigue, weight increase, hypotension, edema, hypo- or hyperglycemia, and dyspnea. Other side effects were also reported, but with equal or greater frequency in placebo-treated patients. The profile for side effects with Coreg in the CAPRICORN trial were consistent with the profile of the drug in the US heart failure trials and the CAPRICORN trial was conducted as the health status of patients. The only additional common adverse events reported more frequently on Coreg were dyspnea.

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


GSK AD FRONT F.P.O.
CCI (continued from page 4)

an unprecedented amount last year. Dr. White explained: “We have not ‘tried’ to improve the impact factor because case reports are never cited, which translates into a weakened impact factor.”

Except that, in CCI’s case, it didn’t. Here’s why, again in Dr. White’s words: “The fact that our impact factor has risen, despite continuing to include case reports, reflects more citations and increased readership of the high-quality papers that we publish.”

It also may be an extension of the efforts of Dr. White and his editorial group to broaden the Journal’s readership to include invasive cardiologists interested in peripheral vascular disease (an area that is a major interest for Dr. White) while preserving its long-time core readership by pediatric and adult interventionalists.

More Good News

There’s more evidence of CCI’s increasing importance in the field of cardiovascular medicine.

First, the Journal now ranks in the top third of cardiac and cardiovascular systems journals, as calculated by the ISI.

And, second, more and more medical journalists are reporting on the studies published in CCI. The result has been increasing visibility for the Society and the Journal among professional and consumer audiences. This outcome is partially the result of efforts by SCAI Public Relations Committee Chair J. Jeffrey Marshall, M.D., FSCAI, to drum up publicity for the Society and the field. Each month, with Dr. White’s help, Dr. Marshall’s team distributes news releases to an extensive list of trade and mainstream reporters. To check out some recent news releases distributed by your Society, visit the Pressroom at sci.org. You’ll be among good company — some highly regarded journalists check out the site each month and they have quoted SCAI and CCI in print, radio, television, and on the Internet.

And Easier Access, Free to SCAI Members

Staff from SCAI and John Wiley & Sons recently put their heads together to make it much easier and convenient for Society members to access CCI online. No longer do members need to have their member number handy. Nor do they have to log in twice, once at sci.org and a second time on Wiley's Web site.

Instead, just bookmark www.scai.org, click on “Publications,” and log in. In no time, you’ll be reading CCI online and downloading the articles that interest you most.
SCAI ADVOCACY NEWSFLASH

(continued from page 1)

for all physicians. Thanks in large part to the establishment of SCAI’s aggressive advocacy program in 2000, this year is the third in a row where we have good news to report.

Although these CMS estimates could vary according to a physician’s geographic location or practice mix, the increases were welcome news, said Advocacy Committee Chair Joseph Babb, M.D., FSCAI. “We are very pleased that SCAI’s advocacy efforts have delivered a positive result for the membership,” said Dr. Babb. “For the past two years, we have faced potential reductions in Medicare reimbursement for interventional procedures. Each time, working with our colleagues in cardiology and with other medical societies, we have been able to persuade Congress and CMS to set aside the reductions in favor of modest improvement. I appreciate the contributions of so many of the members who took the time to contact their congressional representatives in support of more sensible, rational payment. SCAI will need their help in 2005 as Congress revisits the issue of physician payment.”

Some of the other provisions in the proposed physician fee schedule for 2005 include the following:

- For all newly enrolled Medicare beneficiaries, Medicare will provide coverage for an initial physical examination, including an electrocardiogram. Until now, routine physical examinations were not covered by Medicare.
- Another new preventive service that will be covered beginning in 2005 is a cardiovascular screening blood test consisting of a total cholesterol test, a test for HDL, and a triglycerides test. Additional cardiovascular screening tests may be added in the future.

Progress on Practice Expense

SCAI has again demonstrated that perseverance pays. The Centers for Medicare and Medicaid Services recently notified SCAI that it has accepted data gathered through a practice-expense survey funded by SCAI, ACC, and other cardiovascular societies. These data show that the average hourly practice expenses for cardiologists are in fact much higher than the current data used in the Medicare formula. Although the CMS has indicated that it needs to resolve several policy questions related to calculating payment for technical components of certain cardiology procedures, SCAI is cautiously optimistic that all of the cardiology subspecialties will see an increase in their practice expense payments in the future. When this happens, it will be the second time since the SCAI advocacy program was fully established that progress was made on members’ behalf to fix the practice expense problem.

SCAI presented compelling data correcting CMS’s incorrect assumption that clinical office staff had no involvement in catheterization services performed in the hospital. CMS reviewed the data and agreed that clinical office staff provide meaningful support for such services, including scheduling the lab and the equipment, obtaining prior approval and informed consent, and conveying patient instructions. The practice expense values have since been corrected.

Be assured — your Society intends to continue monitoring and pursuing the practice expense issue carefully. Your concerns will continue to be voiced, through your Society, until it is resolved.

Pre-empting Questions About Carotid Stenting Reimbursement

Four SCAI leaders dropped everything for an impromptu meeting with CMS Director of Coverage Steve Phurrough, M.D., on the subject of reimbursement for carotid artery angioplasty and stenting. SCAI President Michael J. Cowley, M.D., FSCAI, Past Presidents Ted Feldman, M.D., FSCAI, and Joseph D. Babb, M.D., FSCAI, and SCAI Peripheral Vascular Disease Committee Chair Kenneth Rosenfield, M.D., FSCAI, were flanked by representatives from the Society for Vascular Medicine and Biology, the Society of Vascular Surgery, and the American College of Cardiology.

CMS has made it clear that its decision-making process for reimbursement of carotid stenting is the dawn of a new era at CMS. As critical new technologies are introduced, this new process involves, simply put, MORE. More rigorous analysis, more testimony, more data, much more careful review than ever. CMS has also made it clear that it earnestly seeks this input from professional societies, and it will listen carefully.

In response, your colleagues listed above and staff worked intensively to provide the input CMS requested during that impromptu meeting. While CMS appreciated the information, all SCAI representatives agreed that this was simply the first step in what will be “a marathon, not a sprint.” We will keep you posted as events unfurl.
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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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Registration for guests includes the President’s Reception and Annual Banquet but not the Scientific Sessions.
Guest Name(s) ________________________________________________________________
# of guests _____ x $100= $ ___________

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Questions? Phone (800) 992-SCAI

President’s Reception, May 5, 2005
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_____ 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)

Refunds will only be given if written notification is received by April 8, 2005. Refunds are subject to a $50 processing charge and will be mailed within 8 weeks after the meeting. No telephone cancellations will be accepted.
Dr. Manu Rajachandran, MD, FSCAI, FACC, joined Deborah Heart Institute in Burlington, N.J., five years ago to launch a peripheral vascularization program. At that time, the Institute was doing a mere 10 endovascular procedures a year, said Dr. “Raj” — as he is known at Deborah and elsewhere.

“Since I was tapped to take the helm, that figure has increased tenfold,” he said, adding that he and his team are continuing to grow the program, in part by tackling a new, and perhaps greater, challenge. He is determined to mitigate the turf conflict between interventional cardiologists and vascular surgeons.

“I’d like to play a role in seeing the disciplines work together to provide seamless care with minimal competitiveness,” he explained.

Bringing the Players Together

His vision of an interdisciplinary approach is primarily what brought Dr. Raj to SCAI. “I thought that by working with the great luminaries I could learn about policy and advocacy and help promote the concept that interventional cardiology and peripheral vascular intervention go hand in hand,” he said.

As a member of the Society’s Credentials and Advocacy committees, he is working with colleagues to realize this goal. “Supporting catheter-based therapy has been the Society’s first step toward promoting the role of interventional cardiologists in peripheral vascular intervention,” he said.

Dr. Raj trained in interventional cardiology at Miami Heart Institute. In 1996, it was on to St. Elizabeth’s Medical Center of Tufts School of Medicine in Boston for a fellowship in vascular medicine and peripheral vascular intervention. At the time, there were only two programs in the country focused on this discipline.

Interlacing Two Cultures

A native of Madras, India, Dr. Raj came to the United States when he was seven years old. By the seventh grade, he had become enamored with the idea of using hands-on skills to dramatically affect a person’s life and had decided he wanted to be a physician. Today, his approach to his patient care reflects an interlacing of Indian and American cultures.

“For example,” he said, “one strong carryover from India that has resonated throughout my career has been ‘respect’ — respect for my colleagues, my patients, and all people as human beings.”

American culture has influenced Dr. Raj, too. “Americans have a kind of swagger, which is a good trait for a surgeon,” he explained. “You need a persona that says, ‘Hey, we can take care of this.’ This quality gives the patient and your colleagues confidence in you as an operator,” he said.

Both attitudes have served Dr. Raj at Deborah, especially as he works to develop an interdisciplinary model that combines the talents of interventional cardiologists, vascular surgeons, and radiologists to advance the concept of a comprehensive cardiovascular center.

Success Is Sweet

It seems Dr. Raj is entitled to some of that swagger. Working together, his team has seen a sweeping increase in volume with minimal mortality and morbidity. “We are treating very sick people and haven’t lost one patient yet,” he said.

Dr. Raj is, of course, proud of that fact, but his contact with certain patients really drives home the importance of what his team is doing. He recalls one patient with critical ulcerative vascular disease of her leg. The vascular surgeons in her community said there was a 50 percent chance that the leg could be saved with bypass and were discussing amputation.

“We ballooned open the totally occluded artery in multiple spots and put the stents in. Once the ulcers healed, there were tears in her eyes,” he said. “This is what you live for — the immediate gratification that comes from being able to restore a person’s quality of life.”

IN THE TRENCHES

Cardiologist Bridges Cultures and Specialties

“I’m the guy in the civilian clothes,” said Dr. Rajachandran, who was joined for this photo by the members of the interdisciplinary team he has assembled at Deborah Heart Institute.

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IN THE TRENCHES

Cardiologist Bridges Cultures and Specialties
The 2005 SCAI Research Program for Interventional Cardiology
Fellowship Awards
Up to $25,000

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

The program will award one or more 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 only. 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.

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

Application deadline: January 6, 2005.

Eligibility
Applicants eligible for the 2005 SCAI Research Program for Interventional Cardiology Fellowship Awards 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 interventional cardiovascular medicine through physician education and representation, and the advancement of quality standards to enhance patient care.
SCAI invites you to an unparalleled opportunity to learn about advances in general cardiovascular disease and enjoy the spectacular Snowmass Ski Resort.

SAVE THE DATE!

When: Jan. 17–21, 2005
Where: Snowmass Conference Center, Snowmass, Colorado
Director: John H.K. Vogel, M.D., FSCAI, MACC

The Society is proud to sponsor the renowned Cardiovascular Conference at Snowmass. Designed for cardiovascular specialists, cardiac nurses, and technicians, this program provides a comprehensive update for diagnostic evaluation and medical/surgical treatment of cardiovascular disease.

Topics include—
• New ICD trials, including Scud-HFT
• Echo and athletes with heart disease
• Controversies in cardiac pacing
• Vascular disease in modern cardiology
• Stem cell therapy
• Angiogenesis for peripheral vascular disease
• New guidelines and directions
• When healthy people should start statins
• Carotid stenting
• Best therapy in diabetics with renal disease and heart failure
• Management of congenital heart disease in adults
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• Angiotensin-receptor blockers for heart failure
• Surgical ventricular remodeling
• Contrast perfusion
• Percutaneous approach to valvular repair
• Advances in the management of acute myocardial infarction, acute coronary syndromes, and heart failure
• Advances in anticoagulation therapy

Contact SCAI for more information:
Phone: 800-992-7224
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Online: http://www.scai.org
View the program online at www.scai.org

More CME Opportunities From SCAI and Partners

EIGHTH PEDIATRIC INTERVENTIONAL CARDIAC SYMPOSIUM (PICS-VIII) AND SECOND EMERGING NEW TECHNOLOGIES IN CONGENITAL HEART SURGERY (ENTICHS-II)

When: Sept. 19–22, 2004
Where: Chicago, IL
Directors: Ziyad M. Hijazi, M.D., FSCAI, and William E. Hellenbrand, M.D., FSCAI

For details, e-mail zhijazi@peds.bsd.uchicago.edu or call 773-702-6172

NEW ENGLAND CATHETERIZATION CONFERENCE

When: Oct. 14–16, 2004
Where: Stowe, VT
Director: Harold Dauerman, M.D., FSCAI

For details, call 802-656-2292, fax 802-656-1925, or visit http://cme.uvm.edu
The high rate at which members responded to SCAI’s latest e-survey, on groin closure, was nothing short of astonishing, according to Bonnie H. Weiner, M.D., FSCAI, who designed the survey and is currently analyzing the feedback.

“Over 20 percent of our members with e-mail responded, which points to two things: First, in today’s health care environment, we all need to be looking at costs, risks, workforce use, and so forth,” said Dr. Weiner, “And, second, there simply aren’t a lot of good data on the issues surrounding groin-closure devices.”

SCAI may be the answer to the second dilemma. The data collected from its simple, seven-question e-survey could be the first step toward some clarification in the controversial area of groin closure. In addition to indicating members’ interest in the subject, the survey results also reveal that respondents are using these devices for a number of reasons, including to facilitate early ambulation and discharge (86%), for patient comfort (78%), for safety (26%), and to achieve cost savings (7%).

There was some good news embedded in the data, too, said Dr. Weiner. “I was really pleased to see that 63 percent of labs track outcomes,” she explained.

“That dispelled some of my early concerns — for example, that no one knew what was going on once patients left the cath lab.”

And what makes that finding even more encouraging is that 60 percent of respondents whose labs track outcomes said they would be willing to share those data with a multicenter registry. Echoing the remarks of several respondents who made notations in the write-in section of the survey, Dr. Weiner stressed that SCAI is the type of organization that should take the lead in such a registry.

That’s the next step, she said — to analyze the data further, perhaps do a follow-up survey, and then perhaps develop a short, voluntary registry. “Doing that would enable us to get an even better sense of what’s going on in the field and what the real rates of complication are,” she concluded.

Dr. Weiner welcomes more feedback from SCAI members. Send your comments to info@scai.org.

Let’s face it — most of us are burdened with too many user names and password combinations. It’s nearly impossible to keep track of them all. To help SCAI members, the Society has made it easy to customize your user name and password so that you can easily access the wealth of content available to members only on scai.org.

Here’s how you can customize things for quick entry into the members’ area of the site, where you’ll find the slide library, proceedings from the Annual Scientific Sessions and other meetings, access to CCI, and more:

1. Log in using your last name and SCAI member ID.
2. Click your name, which will appear as a link in the upper-right corner of the screen.
3. The next screen will contain all of your personal information. At the bottom of that screen, you’ll see two fields — “Login Username” and “Login Password.” Enter a friendly username and password in these fields, and then click “Update.”

Once you’ve completed this simple process, you’ll be able to use either of two rather easy approaches to the members’ portion of scai.org:

1. Your last name and SCAI ID number, or
2. Your newly customized user name and password.

This tip was provided by Karl Wilkens, president of CME Development Group in Cleveland, who designed SCAI’s new Web site.
Good-Bye...Well, Not Really

Good-byes are never easy, but they’re not too bad for SCAI Board members whose terms have come to an end. That’s because all SCAI members know that their input, expertise, and assistance are always welcomed … and often sought with just a moment’s notice. The Board members listed below, whose terms wrapped up at SCAI ’04, can attest to the importance of rapid response, especially as the Society tackles important advocacy issues, such as restoring fair reimbursement to cardiologists.

SCAI THANKS EACH OF THESE FELLOWS FOR YEARS OF DEDICATED SERVICE ON ITS BOARD.

...And Welcome Aboard – Really!

The Society is pleased to welcome the following officers and trustees. SCAI extends its thanks, in advance, to these Fellows for the time and talent they will contribute to the Society during their terms.

Officers

- **Michael J. Cowley, M.D., FSCAI**
  - President

- **Barry F. Uretsky, M.D., FSCAI**
  - President-Elect

- **John McB. Hodgson, M.D., FSCAI**
  - Immediate Past President

- **Carl M. Tommaso, M.D., FSCAI**
  - Treasurer

- **Gregory J. Dehmer, M.D., FSCAI**
  - Secretary

New Trustees

- **Steven R. Bailey, M.D., FSCAI**
  - University of Texas Health Sciences Center
  - San Antonio

- **Raoul Bonan, M.D., FSCAI**
  - Montreal Heart Institute
  - Montreal, Canada

- **George D. Dangas, M.D., FSCAI**
  - Lenox Hill Heart and Vascular Institute
  - New York City

- **Lloyd W. Klein, M.D., FSCAI**
  - Rush Medical Center/Gottlieb Memorial Hospital
  - Chicago

- **William K. LaFoe, M.D., FSCAI**
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  - Cape Girardeau, MO

  **Douglass A. Morrison, M.D., Ph.D., FSCAI**
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  **Stephen R. Ramee, M.D., FSCAI**
  - Ochsner Clinic
  - New Orleans, LA

  **Mark Reisman, M.D., FSCAI**
  - Swedish Hospital
  - Seattle, WA

  **Larry S. Dean, M.D., FSCAI**
  - University of Washington
  - Seattle

Nominating Committee Member-at-Large
Time is a precious commodity for everyone in today’s world, but even more so for interventional cardiovascular specialists. As we grapple with the explosive growth of technology and devices as well as ever-increasing patient volume, we become more and more vulnerable to the effects of time constraints in the catheterization laboratory. Juggling the artistic and the scientific sides of our practice along with the reality that there is indeed a business side is often difficult — and frequently elusive. Here are a few examples of situations in which the business of interventional cardiovascular medicine can throw the art and science of the specialty off course.

The art of coronary angiography is in visually estimating the severity of coronary stenosis. This art has stood the test of time. Studies have shown both reliability and accuracy in such assessment when it is performed by well-trained and experienced interventionalists. The science of coronary angiography is in performing all of the required orthogonal angles, using intravascular ultrasonography (IVUS) when conventional contrast angiography fails to reliably show a stenosis, when a moderate-grade angiographic stenosis exists with compelling clinical presentation, or when there is a “Mach effect” — due to vessel overlap — that precludes accurate lesion assessment. The business of coronary angiography intrudes on the art and the science when a physician feels pressured to perform a procedure hastily without multiple orthogonal views, to judge and report disease severity and extent with an intent to revascularize, or to avoid IVUS use to complement contrast angiography findings merely because of the extra time it takes to perform an IVUS procedure and analysis.

The art of valvular disease assessment lies in conducting a thorough physical examination of a patient referred to the invasive cardiovascular laboratories for valvular or congenital heart disease evaluation, in suspecting intracardiac shunts as the underlying etiology of dyspnea or fatigue, and in correlating symptoms to a disease state and objective findings. The science of valvular congenital disease evaluation is in the use of appropriately calibrated pressure transducers, in persevering through painstaking measurements from appropriate anatomic locations, and in maintaining a thorough understanding of the pitfalls of various invasive and noninvasive modalities. The business of valvular congenital disease assessment interferes when one performs only coronary angiography when a comprehensive right- and left-heart catheterization is called for, when one avoids performing detailed and accurate shunt oximetry runs, and/or when one uses computer-generated pressure values without manual over-reads.

The art of coronary intervention lies in understanding the limitations of devices, patient substrates, and operator factors before embarking on a revascularization strategy and in devising novel approaches to complex anatomic and clinical problems. The science of coronary intervention lies in understanding the hazards of radiation from long and multiple complex procedures to both the patient and the clinician, in judiciously using state-of-the-art technology to achieve maximal clinical gain with minimal risk to the patient, and in employing physiologic information obtained from Doppler or the pressure-wire when making clinical decisions. The business of coronary intervention obstructs the art and the science when percutaneous revascularization is performed when a surgical approach is called for, when one fails to refer a patient for alternative therapeutic approaches after conventional percutaneous interventions have provided insufficient symptom relief, when one intervenes on a moderate-grade coronary lesion without physiologic confirmation of functional significance, or when thrombolytic therapy is prescribed for an after-hours myocardial infarction even though the optimal therapy is primary coronary angioplasty.

Yes, most of us are part of the medical business enterprise in one capacity or another, but we must never lose sight of the fact that our patients rely on us to be, first and foremost, practitioners of the art and the science of cardiovascular medicine. It is incumbent on all of us to keep the art of our discipline thriving and the science of cardiovascular intervention at the forefront of progress in cardiovascular care. A humble appreciation of human nature and its follies, along with periodic reevaluation of our own individual approach to the practice of interventional cardiology, will help each of us to keep the business side of patient care in its proper place.