Registration form enclosed and online at www.scai.org

This year’s SCAI annual meeting will reflect the breathtaking pace of developments in interventional cardiology. Uniquely, SCAI’s annual meeting features superb education and a world-class faculty in an intimate, collegial setting. The focus will be on “news you can use” immediately upon returning to the lab.

This year’s Program Committee promises another outstanding meeting: Jonathan M. Tobis, MD (San Diego Chair), Jesse W. Currier, MD (Co-Chair), Frank F. Ing, MD (Pediatric Chair), Warren K. Laskey, MD (Judkins Symposium Chair), Barry F. Uretsky, MD (Fundraising Chair) and Mark Reisman, MD (SCAI Program Committee Chair).

The program will feature mini-symposia, abstracts, a peripheral vascular course, device workshops, case review sessions and more. Wednesday’s Judkins Symposium will present the latest in cardiac imaging, a course within a course “invaluable for physicians and technologists alike.

A new “can’t miss” symposium: the latest in flat-panel imaging systems, helping you evaluate options from leading manufacturers. Evening satellite symposia will be held April 28 and 29. Keynote addresses: the Founders’ Lecture (Paul G. Yock, M.D., FSCAI) and the Hildner Lecture (Antonio Colombo, M.D., FSCAI).

An informative exhibition hall will help you learn the latest from industry partners. The President’s Reception and Annual Banquet round out the program.

HOTEL DEADLINE: SCAI has reserved a block of rooms at the San Diego Sheraton Hotel and Marina. RESERVE EARLY: contact the hotel at 877-734-2726 and identify yourself as a participant of the SCAI meeting. Deadline for this special rate: March 19.

Experience San Diego

San Diego is known for its near-idyllic climate, pristine beaches and world-class family attractions: the San Diego Zoo and Wild Animal Park, SeaWorld and LEGOLAND. San Diego County features 92 golf courses, exciting sports, beachfront resorts and luxury spas, and a dynamic downtown.

San Diego’s arts and culture are renowned internationally. Balboa Park features fifteen museums, art galleries, beautiful gardens and the Globe Theatres. San Diego is home to many of the nation’s most creative chefs, who prepare award-winning meals in the region’s 6,400 restaurants.

Register today for this exciting meeting. We’ll see you in San Diego!
You’ve all been aware of this ethical dilemma. The Jones family waited anxiously in the visitor’s area, not sure what was happening in the catheterization lab. Mr. Jones had been seen by the local Cardiology Specialty Group (CSG) for episodic chest pains (these events are fictitious, for illustration only). Dr. Smith, the founding partner of CSG, had recommended a stress sestimibi scan, which could conveniently be done right in the offices of the CSG-owned building. After Dr. Smith reviewed the scan, he had recommended a catheterization, which was scheduled for the next day in CSG’s newly completed catheterization lab located on the first floor of its building.

Since Dr. Smith was well known in the community and had been written up in the local papers on numerous occasions for his involvement in the latest trials, the Joneses did not hesitate to agree to his recommendations. The next day, Dr. Smith was running late, so he asked his research nurse, Kathy, to “finish up” with the preparations. Mr. Jones signed several papers, which Kathy assured him Dr. Smith would want “just in case” so Mr. Jones could get the latest in investigational therapy.

The case had started well enough. Dr Smith joined the team after Mr. Jones was comfortably sedated. A bit late as usual, Kathy noted. She surmised he had been giving one of his frequent breakfast talks for a local pharmaceutical representative. After a few pictures, a 50% smooth lesion was noted in the left anterior descending coronary. He wasn’t quite sure, but Dr. Smith recalled that the sestimibi showed a possible inferior defect. Regardless, the patient was perfect for the new atherectomy trial Dr. Smith had waited four years to convince Newdevices Corporation to sponsor. Consent was on the chart, and Kathy was ready with the device!

The Jones family was a bit unsettled when they saw three nurses race to the lab area in response to an overhead alarm. Thirty minutes later, a tearful Kathy approached them with the bad news. Dr. Smith had tried valiantly but could not control the accidental bleeding that had occurred when he treated the coronary blockage. How could this have happened? the family asked.

Indeed, we all understand how such things can happen. After all, the patient did have coronary disease and needed to be treated. Or did he? Was his stress test really that “positive”? Was the intermittent pain really the result of the left anterior descending lesion? Was the experimental atherectomy device the best choice for treating this lesion? Had Mr. Jones really understood what he was getting involved in that morning? Had Dr. Smith’s evaluation and treatment been appropriate, ethical, and in the best interest of the patient and his family?

Thorny issues to be sure, issues we face every day. Admittedly, I have taken some liberty in the example presented, but I do so to highlight the importance of ethical issues in our everyday practice.

Your Society has promoted ethical and evidence-based practice since its inception in 1978. While much has been written on the subject of ethics in medicine, it has been difficult to find guidance specific to the unique situations that interventional cardiologists face almost daily. Indeed, the incredible pace of change in our field makes it even more difficult to find relevance in the more general ethical guidelines that are available.

Recognizing this vacuum, one of my predecessors (Dr. Carl Tommaso, SCAI president during 2000–01) moved your Society into taking a leadership role in this area. He urged the Society to actually take a stand (as it has done in so many other areas) on an important—and potentially controversial—set of issues. How should a physician who also owns lucrative diagnostic equipment behave? What about the physician-inventor or the physician-researcher? What about the common practice of self-referral?
In response, SCAI created an ad-hoc Task Force on Medical Ethics, enlisting the assistance of many previous SCAI presidents and interested members. Their charge: research the field and recommend guidance for the practicing interventionalist. Under the leadership of Society Fellows and Past Presidents Airlie A.C. Cameron, M.D., Warren K. Laskey, M.D., and William C. Sheldon, M.D., the task force has prepared an excellent review and recommendation statement, subsequently approved by SCAI’s Executive Committee.

How would our fictitious Dr. Smith stack up against the points made in the Ethics Statement? First, he had an obvious conflict of interest in recommending testing (sestimibi and diagnostic catheterization) using facilities and equipment in which he had ownership. Such relationships should be disclosed at the very least, but additional independent and prospective quality-assurance monitoring should be in place to ensure the appropriateness of such referrals.

A much more common conflict existed in the ad-hoc angioplasty procedure. Again, ongoing quality-assurance monitoring by the lab’s medical director not just of outcomes, but also of indications, is mandatory. In this case, presumably a “buddy hospital” had agreed to “cover” the freestanding lab for interventional work. That “buddy” institution has an added responsibility to oversee Dr. Smith’s activities. If Dr. Smith was found to be consistently ordering stress tests that frequently resulted in diagnostic catheterization referrals, then some red flags should have been raised.

Dr. Smith’s “informed consent” practice leaves much to be desired as well. It was delegated to a research nurse (who, of course, is paid to do research and recruit patients). Mr. Jones wasn’t sure he even had coronary disease, let alone was he ready to sign up for a treatment or, even less certainly, an experimental treatment. Informed consent in these cases needs to be very detailed and offer much opportunity for questioning and reflection. Updates should be provided to the patient and the family so that they can provide ongoing consent as the procedure evolves from diagnostic to therapeutic to experimental.

Finally, it appears that Dr. Smith may have had a vested interest in the new atherectomy device. His full relationship to the company and any potential financial gain from device success should have been disclosed. In these cases, an independent colleague may be required to “authorize” enrollment in order to avoid overzealous recruitment or over-optimistic procedural execution. Dr. Smith might be deterred from being less than fully ethical if he practiced in an environment that offered close oversight and was empowered to effectively comment on his activities.

The medical director of the catheterization lab should be the point person in this process. Hospitals should support their medical directors with sufficient staff to collect data, committee time to review cases, and administrative clout to restrict practices when they are found to be significantly off base. While Dr. Smith’s individual actions may have been medically appropriate in each case, his overall practice raises significant concern that he was not first and foremost acting as his patient’s advocate.

In the stir that would undoubtedly develop after Mr. Jones’s untimely death, Dr. Smith would likely find himself backpedaling rapidly to explain his actions! I suspect he would find himself suddenly quite alone. If a strong oversight environment existed, this system would then be his advocate, indicating a pattern of sound practice endorsed by the hospital and lab quality-assurance committees. Oversight, therefore, provides safety not only for the patient but also for the physician.

We are all human. We are all subject to external pressures. I encourage you to read the SCAI Ethics Statement and reflect on your own personal situation. Do appropriate safeguards exist to assist you in being the best patient advocate you can be? If not, take a reprint of the statement and meet with your catheterization lab medical director and hospital administration. It’s not too late to start.

By the way, I hear Mrs. Jones just registered to see Dr. Smith at the CSG clinic. It seems that since her husband passed away she, too, has had intermittent chest pains!
Strange things do happen. Arnold is the governor of California. The Cubs made the playoffs. Coronary in-stent restenosis is in single digits. The SCAI membership is over 3,000!

Interventional cardiology procedures now extend into all vascular beds and are advancing on valvular repair through novel nonsurgical techniques, born from the minds of innovators moving beyond wires, balloons, and metal mesh. How wonderful it is to be connected to a field with continuing innovation bringing forth new procedures nearly every 6–12 months over the last decade. In addition to the ever-widening types and designs of coronary and non-coronary stents with their associated pharmacological dressings, just consider the following problems and recent solutions through applied catheter-based techniques:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Catheter-Based Solutions</th>
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</thead>
<tbody>
<tr>
<td>ASD</td>
<td>Nitinol mesh, fabric, etc.</td>
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<tr>
<td>PFO</td>
<td>Nitinol mesh, fabric, etc.</td>
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<tr>
<td>PDA</td>
<td>Nitinol mesh, fabric, etc.</td>
</tr>
<tr>
<td>VSD</td>
<td>Nitinol mesh, fabric, etc.</td>
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<tr>
<td>HOCM</td>
<td>Selective alcohol delivery</td>
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<tr>
<td>Carotid embolization during stenting</td>
<td>Distal protect devices</td>
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<tr>
<td>SVG No-reflow during PCI</td>
<td>Distal protect devices</td>
</tr>
<tr>
<td>Total vascular occlusion</td>
<td>Blunt micro-dissectors, radiofrequency ablators, optical relectometric guided-wires</td>
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<tr>
<td>Aortic aneurysms</td>
<td>Stent grafts</td>
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<tr>
<td>Arterial puncture closures</td>
<td>Percutaneous suture and plug delivery, collagen and/or thrombin solutions</td>
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<tr>
<td>MR</td>
<td>Leaflet clips, annulus constrictors, peri-valvular closure devices</td>
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It is especially gratifying to think that the majority of these innovations have arisen from the work of groups with strong ties to SCAI. The translation of membership in SCAI to our daily practice resides in the ability to develop, transmit, teach, monitor, and improve ways to take care of our patients’ most critical cardiac problems.

Here’s one specific example of how SCAI can help. You are asked to see a 62-year-old woman who had aortic and mitral St. Jude prosthetic valves implanted several years ago and who presented with pulmonary edema, pulmonary hypertension (reversible), severe COPD, and severe perimital valvar regurgitation though a 3x1 mm anterior-lateral defect (by TEE). Her presentation has stabilized in the intensive care unit but remained critical. The CT surgical consultant indicated an extraordinarily high risk for a second valve replacement surgery in this setting. Her attending cardiologist requested percutaneous perivalvular leak closure, if possible. What can you do to (1) find out if such a procedure exists, and (2) get the procedure done? This was my recent problem. Like me, you can call your friends in SCAI and track down the people with knowledge and experience. Past presidents are a good place to start. I spoke to Dr. Ted Feldman and then to my SCAI colleague Dr. Ziyad Hijazi in Chicago, who was not only familiar with the procedure but also highly experienced, having performed several to date. He recommended an Amplatzer closure device (either VSD or PDA or a plug), explaining the technique of crossing the defect retrograde with a wire from the LV to the LA, going trans-septal to snare and then exteriorize the wire, and then passing a device delivery sheath via the LA to LV to position a closure device in the leak. The case descriptions and techniques for perivalvular leak closure by Hijazi et al. will soon be published in CCI. Armed with this information and approach, my colleagues and I at St. Louis University will be able to address the needs of this critically ill woman and hopefully repair her MR without the high risk of a second valve surgery.

This example is just one of many that may go unappreciated by some interventionalists. As an SCAI member, you are not alone. There is a universe of experience, knowledge, and innovative ideas available to each of us through communication among ourselves as colleagues in SCAI. As you read through these newsletter pages, keep in mind this enormous resource. Make it stronger by participating however and whenever you can. Come to the meetings. Contact the developer(s) of your journals. And, of course, call your friends in SCAI when strange things happen.
In 2001, SCAI began an aggressive advocacy program on behalf of invasive and interventional cardiologists. At that time, the Board set five goals for that program. What have we accomplished since then?

**Goal 1: Monitor the activities of the Centers for Medicare and Medicaid Services, and respond accordingly**

- Gather data from SCAI members to demonstrate that clinical office staff provide essential support services in cath lab care
- Persuade the Practice Expense Advisory Committee that the services of interventional cardiologists and their staff are undervalued
- Convince CMS to increase Medicare payments for cardiac cath lab practice expense services in 2004
- Create a major multidisciplinary task force to address the implications of drug-eluting stents

**Goal 2: Monitor the activities of key regulatory agencies, the Department of Health and Human Services, and federal agencies whose actions affect SCAI members**

- Track all activities of the Nuclear Regulatory Committee that pertain to brachytherapy
- Establish SCAI representation on the panel that reviews the medical use of isotopes
- Respond to FDA requests for input on complications of drug-eluting stents

**Goal 3: Monitor the activities of Congress, and deliver SCAI messages to congressional representatives**

- Monitor congressional response to the medical liability insurance crisis
- Work with the AMA and the ACC in coordinating a response to proposed legislation related to tort reform
- Arrange personal visits of SCAI members to Capitol Hill and state agencies

**Goal 4: Organize and maintain a grassroots governors’ network for state- and local-level advocacy**

- Identify members interested in serving as regional/state governors

**Goal 5: Communicate with SCAI members on advocacy issues and how they can get involved**

- Notify SCAI members when their voices are needed to strengthen SCAI advocacy efforts
- Send e-news updates to all SCAI members who have supplied their e-mail addresses
- Add new members to the Advocacy Committee, representing members in private practice
- Publish periodic progress reports in SCAI News & Highlights and CCI as well as on www.scai.org

We’re off to a promising start, but there is much hard work ahead. Call SCAI headquarters at 800-992-7224 to see how you can help!

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SCAI Advocacy: A Year-End Progress Report

SCAI has found an efficient and effective way to keep a finger on the pulse of its membership. Using Web-based surveys, the Society gets almost instantaneous member feedback on a gamut of issues and turns it into immediate action.

“The surveys are an effective, inexpensive method for making sense of what the members want of the Society,” said Lloyd W. Klein, M.D., FSCAI, chair of SCAI’s Interventional Cardiology Committee.

“We’ve been able to be proactive on the issues that are truly important, rather than spending energy and resources on something that may not be as crucial to practicing interventionalists right now.”

Fortunately, SCAI members are never shy about sharing their views on issues of importance to patient care or health care in general. “With these surveys, we are addressing critical issues,” said SCAI President (continued on page 6)
E-mail Surveys Let Members Guide SCAI Priorities (cont.)

John McB. Hodgson, M.D., FSCAI. “The Society is strengthened by routine contact with the membership, and we take very seriously our job of making sure our members’ opinions and thoughts are heard, loud and clear, by appropriate audiences.”

A Survey-Savvy Society
The data compiled from the surveys almost always translate into swift action. The appropriate SCAI committee is asked to analyze the data and recommend next steps. A good example is the survey on infection control in the cath lab. The Society e-mailed the survey to the membership in July and already the Laboratory Standards Committee (Charles Chambers, M.D., FSCAI, chair) is developing guidelines. “It was clear from the data that our members want us to pursue guidelines in this area,” said Dr. Klein. “We’re taking immediate steps to deliver on this need.”

Similarly, another summer survey asked members where and how they earn CME credits. The results gave the Society invaluable guidance on how to invest its CME resources so that members would reap the greatest benefits for themselves, their practices, and their patients. One conclusive finding pertains to the highly regarded SCAI slide library. Based on members’ responses to a handful of simple questions, the Society’s CME/Education Committee is enhancing the existing SCAI teaching slides and exploring ways to expand this important member benefit.

Most recently, the Society fielded a survey in a long-neglected area of great concern to interventional cardiologists: the health risks and ramifications of a long career in cardiac catheterization. The findings suggest good and bad news. First, the good news – it’s probably just a myth that exposure to radiation damages the Y chromosomes, lessening interventional cardiologists’ odds of having sons. A number of respondents are the proud parents of bouncing baby boys. The bad news is worrisome, however. An alarming 43 percent of respondents reported back problems. Also disturbing were findings related to their injured hips, knees, and ankles.

James Choi, M.D., who helped develop the survey, thinks that this survey is the first step toward preventing health problems for doctors entering the profession. “As a young physician just beginning my career in cardiac catheterization, I wondered if the occupational health issues related to catheterization are real or simply based on anecdotal stories,” he said.

The survey only scratches the surface of the problem, said lead author James A. Goldstein, M.D., FSCAI. “The survey was very helpful. It provides the initial validation of the existence of a substantial problem,” he explained. “Further studies are being planned.”

Click, Click: Member Feedback Delivered Fast
The response rates for the surveys have been growing consistently, with several hundred of each coming back over the course of just a few days – an excellent response given the lives of busy physicians. Maintaining good response rates – or better yet, improving them – may even help the Society to achieve victories in the advocacy arena. In fact, one survey has already led to a triumph on a physician-reimbursement issue.

The Society turned to its membership with an e-mail survey last year, when the Centers for Medicare and Medicaid Services was digging in its heels on reimbursement for clinical staff time invested in cath lab care. Data collected from the survey proved conclusively that time spent by members’ staff booking appointments, obtaining informed consent, and so forth should, indeed, be reimbursed. “It’s difficult for anyone, even government agencies, to argue with data,” said Dr. Hodgson. “We owe our victory on the clinical staff time issue to the members who completed that survey.”

In conclusion, Dr. Hodgson has two messages for members regarding future surveys: “First, we need to get an e-mail address for every member. Quite simply, we can’t get your input if we can’t reach you,” he explained. “And, second, I can’t stress enough how much we need members to respond to the surveys. These surveys are our eyes and ears – the whole point is to identify and meet your needs.”

Watch upcoming issues of CCI for reports on the findings from these surveys.
NEW CME OPTIONS FROM SCAI AND PARTNERS

ONLINE CME: Emerging Nonpharmacological Therapies in Cardioembolic Stroke Prevention
This program is designed for cardiologists and electrophysiologists who want to expand their knowledge of the latest nonpharmacological interventions developed for embolic stroke prevention.
Only $15 for 1.5 hours of CME credit
For details, visit — http://www.healthstream.com

ENDOVASCULAR SUMMIT 2004
Date: Jan. 14–17, 2004
Location: Irvine, CA
Director: Subbarao V. Myla, MD, FSCAI
This advanced endovascular interventional course will cover the nuances of peripheral vascular disease in terms of anatomical definition, pathology, diagnostic testing, and treatment options with emphasis on endovascular techniques.
For details, call 949-760-5820

UCLA CARDIOLOGY UPDATE 2004
Date: Feb. 27–Mar. 1, 2004
Location: Snowbird, UT
Directors: Jonathan Tobis, MD, FSCAI, and Dave Steiber, MD
This comprehensive program will explore treatment of complex coronary artery lesions; paradoxical embolism and closure of ASD/PFOs; pathologic correlations of sudden death; inflammation and chemokines in CAD, fibrosis, and neoplasia; evidence-based treatment of heart disease; the molecular basis of electrophysiology; new anti-arrhythmic therapies; drug-eluting stents; less invasive cardiac surgery; treatment of severe CHF and cardiac transplantation; emerging therapies for CHF; magnetic resonance and fast CT; mechanical assist devices and the artificial heart; and IVUS training.
For details, e-mail — JFried@mednet.ucla.edu or call 310-794-2620

CONCEPTS IN CONTEMPORARY CARDIOLOGY
Date: Apr. 1–3, 2004
Location: Houston, TX
Directors: Steven Bailey, MD, FSCAI, Neal Kleiman, MD, FSCAI, Zvonimir Krajcer, MD, Albert E. Raizner, MD, FSCAI, Richard Smalling, MD, FSCAI
Cardiac Nurses and Technicians Program: Patricia Chesnick, RN, CME
This 18-credit course will feature live cases, workshops, multiple multi-day symposia, didactic lectures, and hot topic debates.
For details, e-mail — cardioconcepts@meetingmanagers.com or call 713-965-0566

ADVANCED CARDIOVASCULAR INTERVENTIONS
Date: Jun 14–18, 2004
Location: Hilton Head Island, SC
Director: Charles A. Simonton, MD, FSCAI
The agenda is brimming with a diverse mixture of faculty, workshops, panels, and intriguing cases. Learn how to integrate results of major clinical trials with practical decision making in case management.
For details, e-mail — www.cvintervene.org or call 704-444-4031

SEVENTH LIVE SYMPOSIUM OF COMPLEX CORONARY & VASCULAR CASES
Date: Jun 17–18, 2004
Location: New York City
Director: Samin K. Sharma, MD, FSCAI
Join a stellar faculty as they conduct 16 live case presentations and cover hot topics, such as recent trial results, challenging and emerging interventional strategies, lesion-specific approaches, and emerging issues.
For details, e-mail — tricia@verizon.net or call 425-788-9060

STRATEGIES FOR SUCCESS XIII
Date: Jun 24–26, 2004
Location: Orlando, FL
Director: Christopher Cates, MD, FSCAI
How can you succeed in your practice? This program focuses on practice management and will include topics such as the overhaul of Medicare: What it means for cardiology; how we are going to pay for health care; the malpractice crisis and tort reform; choosing an electronic medical record for your practice; fraud and abuse; how to deal with turf wars; how to set up a peripheral vascular screening program in your practice; financial benchmarking tools for a cardiology practice; and new wireless technology in health care.
For details, e-mail — mboone2@emory.edu or call 404-727-1626
In the Trenches

Legacy of SCAI Founder Comes Full Circle

This special contribution to SCAI News & Highlights was written by the daughter of Dr. F. Mason Sones, the father of coronary angiography and co-founder of the SCAI.

By Mrs. Patricia Wheat

In the early morning of April 29, 2003, I found myself following a speeding ambulance on a small, two-lane highway in rural Sedona, Ariz. In the ambulance was my mother, who was on her way to the small community hospital in Cottonwood for emergency care for a heart attack. As I drove, I was remembering scenes from my childhood, and attempting to figure out how to get my mother stabilized, air-evacuated to a large urban hospital in Phoenix, further stabilized, and then “home” to the Cleveland Clinic for treatment.

My father, Dr. F. Mason Sones, Jr., developer of the technique called coronary angiography, was a man, small in stature, who was larger than life in person. My earliest memories are of playing in the corridors of the B-10 Cardiac Catheterization Laboratory of the Cleveland Clinic on weekends while my father reviewed films of patients. That early laboratory was small, in the basement with no windows, and very quiet on weekends—a wonderland for a small child. I marveled at the pictures of beating hearts but had no idea of their significance. Once, while watching a cardiac catheterization in the lab, I got faint and passed out. My last memory was of my father yelling at the patient. “Cough! Cough!! Cough, you b#&*!!!” I locked my knees trying to stay on my feet and went over like a toy soldier. When my head hit the metal floor, it sounded like a split watermelon. Coming to in the emergency room with a concussion, I found out that during a catheterization if a patient were to go into fibrillation, coughing could sometimes restore normal rhythm to the heart.

Each issue of SCAI News & Highlights profiles a member in private practice, describing the challenges faced by invasive cardiologists. Highlighted in this issue is Jim Dwyer, M.D., FSCAI, who recently treated the wife of Dr. F. Mason Sones. Dr. Dwyer reports that his patient is doing well.

Jim Dwyer, M.D., FSCAI, undertook what he calls “the challenge of the West” when he launched Arizona’s first coronary interventional program to perform elective and emergency coronary interventions without on-site surgical backup.

A native of St. Louis, Dr. Dwyer accepted positions as director of cardiology and director of the cardiac catheterization lab at Verde Valley Medical Center (VVMC) in northern Arizona in 2000. “The opportunity to live in an area of breath-taking views was just too exciting to pass up,” he explained.

Dr. Dwyer expected his new posts at VVMC to entail more office practice and less cath lab time than had his job as the director of the cardiac catheterization lab at St. Joseph Hospital in St. Louis County, Mo. “I envisioned driving the two hours to Phoenix once a week to do elective coronary interventions,” he said.

Within a short time, Dr. Dwyer saw an opportunity to get “out of the box.” The community-based Northern Arizona Healthcare had a vision of offering previously unavailable coronary interventions in nonmetropolitan Arizona for the area’s growing retired population as well as the nearly four million annual visitors. “Within six months, we had created a model...
My father was a colorful man who demanded (and gave) great loyalty to those around him. His secretary, Elaine, and laboratory nurse, Lucille, were members of our family. We were constantly surrounded by visiting physicians from all over the world who came to learn from the staff at the Cleveland Clinic. His early staff members, Drs. Sheldon and Shirey, were well known to me. My first job, at 15 years old, was working in the Admissions Department of the hospital and repeatedly typing, “Sones/Sheldon/Shirey” on the admissions documents of the majority of the patients. It was a long journey from those days in the small, two-building hospital to modern times and Saudi Arabian royalty arriving at the hospital with wives, food tasters, children, and personal chefs. Wonderful to be a part of such a large legacy.

I drove, remembered, and attempted to figure out the logistics involved in getting Mother “home.” We pulled into the emergency entrance of the Verde Valley Medical Center. Dr. James Dwyer was at the door as my mother was unloaded from the ambulance and rushed into a triage room. Having seen the electrocardiogram tracings sent across the phone lines from Mother’s apartment, he was ready for action. Quick introductions... quick and thorough history....signing of permission forms....Mom on her way to the Catheteterization Laboratory within 15 minutes of arrival at the medical center!!

That morning, my mother had a cardiac catheterization, angioplasty, and insertion of two stents within an hour of her arrival. I believe that my father was present in the person of Dr. James Dwyer...efficient, reassuring, and completely competent. Together my father’s techniques and Dr. Dwyer’s experience, conviction, and prompt intervention saved my mother’s life. At the very least, her quality of life has been preserved and the damage possible from a massive heart attack minimized. My father died before angioplasty and stent placement became as commonplace as they are today. He would have been so excited at the reality of preservation of heart muscle and quality of life through immediate intervention. My family and I are so grateful to this new generation of Cardiac Interventionalists like Dr. Dwyer and his associate Dr. Bruce Peek, who continue to push my father’s legacy in new and exciting directions.

Dr. Dwyer developed patient-selection protocols and arranged transfer agreements with three hospitals and three cardiac surgery groups in Phoenix. Northern Arizona Healthcare purchased a helicopter to keep on site at VVMC as a backup for elective PCI procedures.

Initially, to give the cath lab time to coalesce, Dr. Dwyer performed only elective cases. It wasn’t long until the team began doing emergency PCIs for acute MIs. “We made a concerted effort to make PCI the preferred treatment for MI at VVMC,” he said.

“We have now performed approximately 430 coronary interventions, of which about 25 percent have been done as direct therapy for acute MI,” Dr. Dwyer summarized. “We have not sent a single patient for CABG for failed coronary intervention nor have there been any direct deaths related to these procedures.”

His team has also treated a few patients who were in cardiogenic shock and likely would not have lived if services had not been immediately available. “These patients probably wouldn’t have survived the 40-minute helicopter flight to Phoenix,” he said.

“For acute MIs, our door-to-balloon times have been excellent and continue to decrease. Our shortest time has been 28 minutes.”

Building an emergency PCI program without surgical backup is not an undertaking for the novice interventionalist, stressed Dr. Dwyer. The success of the program is due to his extensive experience before heading West—at St. Joseph Hospital as well as years in private practice. And no such endeavor is without a few hardships, he added. “I was on call 24/7 for 10 months straight after starting emergency PCI. Thankfully, another experienced interventionalist, Bruce Peek, M.D., joined me in practice in 2002.”

It is said that imitation is the greatest praise. Dr. Dwyer’s program has been proven praiseworthy, indeed, as evidenced by the addition of at least two similar programs in Arizona.

For him, however, it all boils down to an adventure in his new home: “The challenge of the West has been met—and it continues.”
Important Information from Industry Supporters

SCAI greatly appreciates the generous unrestricted educational grant support provided by many industry supporters. This support makes possible high-quality educational programs, such as the SCAI Annual Scientific Sessions. The following company profiles have been provided for your information by two of those supporters; the content below is solely their own and does not represent the viewpoint of SCAI. Please contact these firms directly for further information.

About Aventis

This year, Aventis celebrated the 10th anniversary of its drug Lovenox. Hervé Gisserot, MBA, vice president of thrombosis sales and marketing for Aventis, said the company continues to perform further clinical trials on its products to improve patient care.

Lovenox (enoxaparin sodium injection) is the major product in Aventis’ thrombosis division. The drug is a low-molecular-weight heparin originally developed to prevent and treat deep-vein thrombosis. In the mid-1990s, clinical trials revealed that Lovenox could be used as a treatment for unstable angina and non–ST-segment elevation MI (STEMI) as well.

“This was a major change for the product,” Mr. Gisserot said. “It gave Aventis the opportunity to enter the cardiology arena and to strive to become the new standard of care in the United States by replacing unfractionated heparin in this setting.”

Mr. Gisserot said that Aventis focuses on demonstrating the value of its products with the support of clinical as well as real-life data to make those products more attractive to physicians.

“In the acute care setting, there is a tendency to focus more on cost, especially the drug-acquisition cost,” Mr. Gisserot said. “At Aventis, we demonstrate that our products provide value to the total health care system—the physicians, the patients, and obviously the payers.”

Mr. Gisserot said that Aventis pays particular attention to research focused on expanding the indications of its products that are currently on the market.

“Just because a company has a product on the market a few years ago, it cannot say the job is done,” he said. “Companies need to keep developing their products. Ongoing clinical trial development is critical to Lovenox’s success, especially in the cardiology field.”

Aventis is currently sponsoring the SYNERGY (Superior Yield of the New Strategy of Enoxaparin, Revascularization & Glycoprotein IIb/IIIa Inhibitors) trial; results are expected to be presented in early 2004. SYNERGY is investigating the efficacy of Lovenox versus unfractionated heparin in combination with GP IIb/IIIa inhibitors in patients with non–ST-segment

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Boston Scientific Corporation

Boston Scientific Corporation (NYSE: BSX) is the world’s largest medical device company dedicated to less-invasive therapies. The Company’s products and technologies are designed to reduce risk, trauma, cost, procedure time, and the need for aftercare.

These products and technologies are generally used for enlarging narrowed blood vessels to prevent heart attack and stroke; clearing passages blocked by plaque to alleviate pain; opening obstructions and bringing relief to patients suffering from various forms of cancer; performing biopsies and ultrasounds; mapping electrical problems in the heart; placing filters to prevent blood clots from reaching the lungs, heart or brain; and treating urological, renal, pulmonary, cerebrovascular and gastrointestinal diseases. These less-invasive therapies are designed to improve outcomes, which help patients return to fuller lives sooner.

Patients of all ages are benefiting from improved quality of life.

Boston Scientific’s history began in the late 1960s, when co-founder John Abele acquired an equity interest in Medi-tech, Inc., a research and development company focused on developing alternatives to traditional surgery. Medi-tech’s first products, a family of steerable catheters, were introduced in 1969 and were used in some of the first less-invasive procedures. Versions of these steerable catheters are still used today. In 1979, Abele and Pete Nicholas partnered to buy Medi-tech and together formed Boston Scientific Corporation.

Driven by the needs of the medical community for innovative products, the Company grew from revenues of approximately $2 million in 1979 to more than $2.67 billion in 2001.

Since its public offering in 1992, Boston Scientific has undertaken a smart acquisition strategy, assembling the lines of business that allow it to continue to be a leader in the medical industry. Outside of North America, the Company’s development, manufacturing, marketing, and sales are managed through its operations in Europe, Japan, and Asia-Pacific, as well as representatives in 40 countries. Today, Boston Scientific employs approximately 14,000 people and operates 21 technology centers worldwide. Corporate headquarters are located in Natick, Mass.
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elevation acute coronary syndrome (ACS) treated with an early invasive strategy. In addition, Aventis is hoping to expand the indication for Lovenox in the treatment of patients with STEMI with ExTRACT-TIMI 25 (Enoxaparin and Thrombolysis Reperfusion for Acute Myocardial Infarction Treatment-Thrombolysis In Myocardial Infarction – Study 25).

“We are not at the end of the clinical development of Lovenox,” Mr. Gisserot said. “We keep performing clinical trials to better understand the use of our product in specific subpopulations.”

Aventis utilizes GRACE, a global patient registry that enables physicians to bridge the gap between evidence-based medicine and day-to-day practice. Participating physicians receive confidential data about patients, showing their outcomes side-by-side with the aggregate outcomes of all participating hospitals. “It is an interesting way for physicians to improve the health care to their patients,” Mr. Gisserot said. “It is very critical, also, for us. This fuels our clinical and educational programs with real-life data.”

SCAI Thanks Corporate Partners for Their Support

▲ (L to R) Walt Sandulli and Dr. Nathalie Rouviere (both from Aventis) with Norm Linsky (SCAI staff)
▲ (L to R) SCAI President Dr. John McB. Hodgson and Board member Dr. Bonnie Weiner with Donna M. Collins Wilson from Medtronic Vascular
▲ (L to R) Kevin Purnell, Judy Johnson, and Tom Meskan (all from Boston Scientific), SCAI Board member Dr. Barry Uretsky, Mark Novotny (Boston Scientific), Norm Linsky
▲ Dr. John McB. Hodgson and Marcia Schallehn (Cordis Cardiology Systems)
▲ (L to R) Norm Linsky, SCAI President-Elect Dr. Michael Cowley, Michiko Tanabe and Kevin Rhatigan (both from Guidant), Dr. Bonnie Weiner, Dr. Jonathan Tobis
▲ Barbara Wolf (Bracco Diagnostics, Inc.) and Dr. Hodgson
As the years go by, the nuances of history often get lost. A mythology develops around some milestones, while others fade away even if their impact was every bit as great as those that are glorified. What's more, the role of serendipity often gets overlooked, and many of the best stories — those that make us chuckle or contain volumes of wisdom for future generations — fall victim to the whimsical nature of political correctness.

Unless, of course, someone who saw it all takes the time to record it for posterity.

The field of interventional cardiology has been so blessed. Frank Hildner, M.D., FSCAI, was both a participant and an observer as the discipline of invasive/interventional cardiology was born. He was in the trenches along with the specialty’s founding fathers (who included Drs. F. Mason Sones and Melvin P. Judkins, who had the foresight to organize SCAI in 1976). He was the founding editor of CCI, which has become the most successful international journal on cardiac catheterization. His accomplishments as a physician, a teacher, a mentor, and an editor are the stuff of legends, but these days one of his greatest passions is telling the stories of genius, daring, and just plain luck that resulted in interventions that have saved millions of lives over the past 35 years.

A few examples:

- The development of coronary arteriography was the result of a mistake that nearly killed a patient but instead revolutionized the care of heart patients. In 1958, Dr. Sones was performing an aortic root flush when the catheter erroneously migrated into the patient’s right coronary artery. Once disaster was averted, Dr. Sones zeroed in on the lesson to be learned — that selective use of contrast media could be used to examine the coronary arteries.

- The first iliac angioplasty came about as a radiologist, Dr. Charles Dotter, inadvertently passed a catheter through a stenotic lesion. After he pulled out the catheter, he saw that the vessel was open — and, months later, when he re-examined the patient, it was still open! Dr. Dotter saw potential in what many would have dismissed and he developed a technique later named for him. By gradually enlarging catheters, passing one over the other and then removing them all, he could open blocked arteries.

- The cardiologist who proposed that angioplasty was (and still is) the best way to treat an AMI was regarded as such a cowboy that the medical community scoffed, never imagining that one day his theory would become state-of-the-art care for heart attack patients.

Dr. Hildner told these and many other revealing stories one day last summer to a group of physicians and others who gathered in Cleveland to hear his renowned talk titled, “A Politically Incorrect Look at 35 Years of Invasive Cardiology.” Along with those stories are some lessons that Dr. Hildner believes are vitally important for current and future generations of cardiologists. “There’s a pattern to be seen here,” said Dr. Hildner. “In cardiology, the pendulum never swings slightly. It careens from one side to the other, eventually settling in the middle. If there’s one lesson we should learn from our history, it’s how to avoid letting that pendulum swing out of control.”

Thanks to a generous grant from John Wiley & Sons, Inc., publisher of CCI, Dr. Hildner’s lecture was recorded on a CD that is now available for SCAI members and anyone else interested in an entertaining, thought-provoking, and vitally important examination of where the specialty has been and where it is headed. The CD is both PC and MacIntosh compatible. It is available for only $25, plus $4 for shipping and handling, by calling 800-992-7224.

Dr. Hildner’s lecture was followed by a priority-setting “Leadership Roundtable,” held in Cleveland and hosted by SCAI President John McB. Hodgson, M.D., FSCAI. SCAI thanks Guidant Corporation and Sanofi Synthelabo for their grants in support of the moderated Leadership Roundtable.

The Society thanks Dr. Hildner for the tremendous time and effort he devoted to preparing and delivering this important lecture; Dr. Hodgson for painstakingly converting and reformatting Dr. Hildner’s slides into Microsoft PowerPoint; and Mr. Shawn Morton, CCI publisher and vice president of John Wiley & Sons, Inc., for recognizing the value in Dr. Hildner’s talk and helping to make it available on CD.