

CIMS-CON DAILY

Saturday, January 7, 2012 - Day-2

Editorial Board :

Scientific Editor :

Dr. Keyur Parikh

Dr. Parloop Bhatt

Editor :

Preeta Chag

Today's Highlights

- Interactive ECGs
- Plenary Lectures
- CVD: Recent Concepts and Future
- Heart Disease- Management: Present and Future
- Real Life Cases
- Evening Plenary Lectures
- CIMS-CON Young Interventional Course

Tomorrow's Highlights

January 8, 2012
Sunday (Day-3)
Certification Course

Venue : The Grand Bhagwati

- Clinical Cardiology
- Internal Medicine
- Critical Care/Pulmonary
- Neonatal and Pediatric Critical Care

Venue : CIMS Hospital

- Trauma Care

TODAY'S WEATHER



Sunrise : 7.23 AM

Max
27°C

Sunset : 6.04 PM

Min
13°C

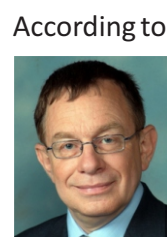
Innovation Through Education Continues.... Welcome to Day Two of CIMS-CON 2012!



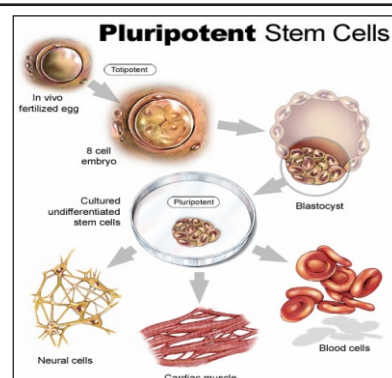
A near - full house on Day-1 at CIMS-CON 2012

The Era of Stem Cells in Cardiology— Where are we now?

Stem cell research is more exciting today with new directions and approaches requiring extensive basic and applied research worldwide



According to **Prof. Rafel Beyar, MD, DSc**, Human embryonic stem cells (HESC) can integrate with the myocardium and function as pacemakers when injected in large number to acutely infarcted tissue; they enhance ventricular function as demonstrated in a rat model. Despite enormous advances in basic research, and its clinical applications, this technology has been hampered by ethical and religious issues like HESC which are used are obtained from an 8-day old embryo and the issue of resolving the immune response against these cells.



Recently, a new approach has been developed using genetic manipulation of adult fibroblasts to generate pluripotent cells (HIPC) using cells from skin biopsy. The ability of these cells to differentiate into cardiac cells can also be used to generate auto-transplanted cells from the same patients. Although an extremely appealing solution, problems regarding safe gene transfer technology and the potential of those cells to function in vivo need to be evaluated before feasible clinical testing.

Dealing with Diastolic Heart Failure

Prof. Uri Elkayam, MD, a professor of Medicine, University of Southern California in Los Angeles describes diastolic heart failure with preserved ejection fraction as a clinical syndrome characterized by the symptoms and signs of heart failure, a preserved ejection fraction (>50%), and an abnormal diastolic function. This syndrome is more commonly seen in women, older individuals, and in patients with past or current history of hypertension. The clinical presentation is usually the same as in patients with systolic heart failure with slightly lower mortality rate. Multiple clinical trials in heart failure secondary to diastolic dysfunction using ACEI's and ARB's have failed to show substantial clinical outcome. The guidelines recommend control of blood pressure; control of tachycardia and restoration of sinus rhythm in patients with atrial fibrillation; use of diuretics to lower blood volume and revascularization where ischemia leads to diastolic dysfunction. Recent studies have demonstrated beneficial effect of phosphodiesterase 5 inhibitor sildenafil citrate in the reduction of pulmonary hypertension and LV filling pressure in patients with diastolic heart failure.

Lucky Winners of Kaun Banega iPad Pati



Day-1 at CIMS-CON 12 began with a scintillating round of KBC-like quiz wherein iPads and Samsung galaxy phones were given away to the winners. The quiz created an entertaining ambience at the academic driven conference. The lucky winners of iPads were Dr. Amrut Suthar and Dr. Ankur Rawal. While Dr. Gaurav Chayya and Dr. Paras Doshi won the phones.

The Present and Future in Acute Heart Failure Management

Identification of acute triggers for the decompensation as well as noninvasive characterization of cardiac filling pressures and output is central to management.

Bimal R. Shah, MD, from Duke Clinical Research Institute, embarks on the fact that identification of acute triggers for the decompensation as well as noninvasive characterization of cardiac filling pressures and output is central to management. Diuretics, vasodilators, continuous positive airway pressure and inotropes can be used to alleviate symptoms. However, few agents currently available for the treatment of acute decompensated heart failure have been definitively shown in large prospective randomized clinical trials to provide meaningful improvements in intermediate-term clinical outcomes. Multiple novel therapies are in the early clinical phase.



Don't Miss

Today
7.30 pm onwards

- Venue :-
CIMS Hospital,
Off Science City Road,
Sola, Ahmedabad.

*Conference Gala Dinner
with Musical Entertainment of
Khandekar Brothers*



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**Don't Miss
Today 5.00 PM**

How to live life ? Lessons to
learn (Inspirational Oration
for All) and Cloud Computing

**Win prizes at
CIMS-CON 2012**

Lucky Draw prizes

iPad, Pen Drives etc. will be
distributed at 5.30 pm today

For those who came in late
yesterday and today, a lucky draw
will be held for delegates coming
in between 2.00 - 3.30 pm. To
participate, please collect your
lucky draw coupon from your
registration no. counter to win
Galaxy Phone, Pen Drives etc.

You will have to be physically
present to be eligible for the lucky
draw at 5.30 pm

Therapeutic Options to Vulnerable Plaque

Prof. Guy R Heyndrickx MD, PhD,



Cardiovascular
Center Aalst,
Belgium
highlights
therapeutic
options to

vulnerable plaque.

Acute coronary syndromes (ACS) are
due to destabilization of the
atheroma plaque secondary to
plaque rupture, fissure or erosion. In
an effort to ascertain the prevalence
and clinical significance of non-flow
limiting lesions defined as
vulnerable plaque, the Prospect trial
was launched whereby in 697
patients with ACS, treated with
primary PCI, the non-culprit vessels
were studied with coronary
angiography, IVUS-VH and
palpography. Subsequent MACE
during FU (20.4% over 3 years) were

equally attributable to recurrence at
the site of culprit lesions and to non-
culprit lesions (NCL). NCL,
responsible for unanticipated
events (11.6% patients) were
angiographically mild and most
were thin-capped fibroatheroma
(TCFA) with large plaque burden and
small luminal area (26/51).
Specificity of plaque
characterization to predict MACE is
insufficient since only 26 out of 595
TCFA were sites of recurrent events.
Potential therapeutic options to
treat vulnerable plaques are: plaque
sealing, pharmacologic reduction in
lipid core and pharmacologic
inhibition of plaque
neovascularization. Further studies
are required to prove that by
inhibiting neovascularization,
plaque stability is enhanced and
clinical outcome is improved.



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¹Bench test data vs. Abbott Vience Prime and Boston Scientific Promus Element DES on file at Medtronic, Inc.
These tests are not indicative of clinical performance.
²RESOLUTE All Corners 12-month data. RESOLUTE All Corners evaluated the Resolute stent.
For distribution only in markets where Resolute Integrity DES is approved. Not for distribution in the USA or Japan. © 2010 Medtronic, Inc. All rights reserved. UC20110340SEE 10/10

Treatment of Chronic Stable Systolic Heart Failure: From Diuretics to VADs -Explains Dr. Vinit Lal ,MD

Director of Cardiac Cath Lab at Texas Health Arlington Heart and Vascular Hospital and Director of Heart Failure Clinic and Cardiac Rehab at the Arlington Memorial Hospital, USA.

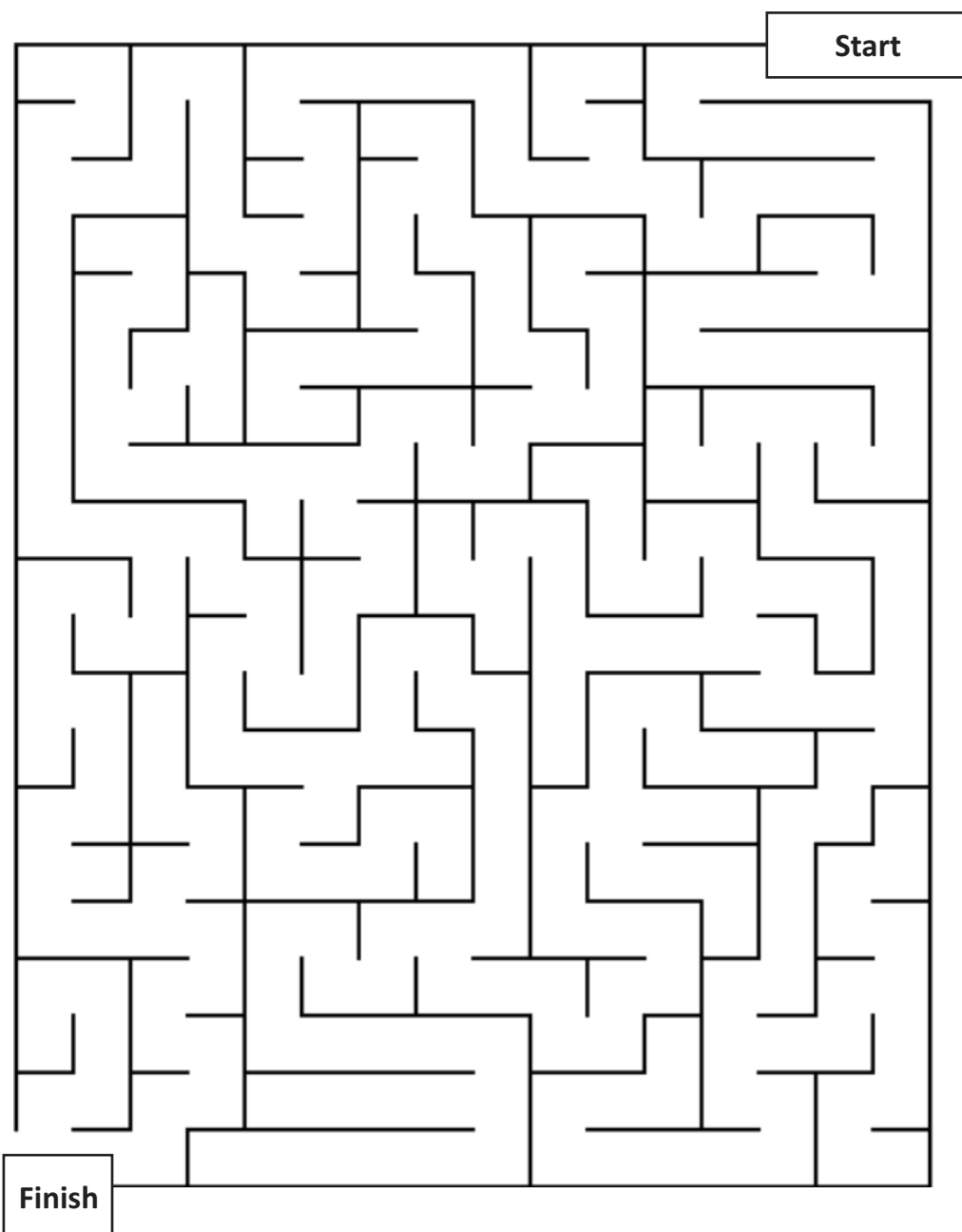


Depending on the severity of illness,

lifestyle modification, avoidance of drugs that may contribute to heart failure(HF), treatment of the underline cause of HF; pharmacologic therapy to relieve symptoms; slowing the progression of HF and improving patient's survival; use of devices like Implantable Cardioverter- Defibrillator (ICD), Cardiac Resynchronization Therapy (CRT), and Ventricular Assist

Devices (VAD) are part of the treatment protocol. Pharmacologic therapy includes diuretics, digoxin, beta-blockers, ACEIs, and ARBs. Prolongation of patient survival has been documented with ACEI's, beta-blockers, ARBs, hydralazine/nitrates, and aldosterone antagonists. Majority of patients with HF due to systolic dysfunction (Heart failure with reduced ejection fraction) respond well to the above therapy. However, some patients with refractory HF do not improve or experience rapid recurrence of symptoms. Specialized strategies are needed for these patients which includes continuous IV inotropic therapy, CRT, VADs, or eventual cardiac transplantation.

Path Finder



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29/12/2011-3-2-01

Selection of Guiding Catheters, Guide Wires and Balloons-Guy Heyndrickx and Dr. Keyur Parikh



Prof. Guy Heyndrickx



Dr. Keyur Parikh

Technical knowledge and understanding the behavior how catheters, guide wires and balloons perform together with operator experience will enhance the success rate of PCI, especially in difficult cases. Guiding catheters (GC) do function as a conduit for transport of wires and devices; support for device delivery against resistance; contrast injection and recording arterial pressure. Size of GC will depend on the size of the access vessel (radial versus femoral) and type of the procedure (simple versus complex, need for



Cutting Balloon

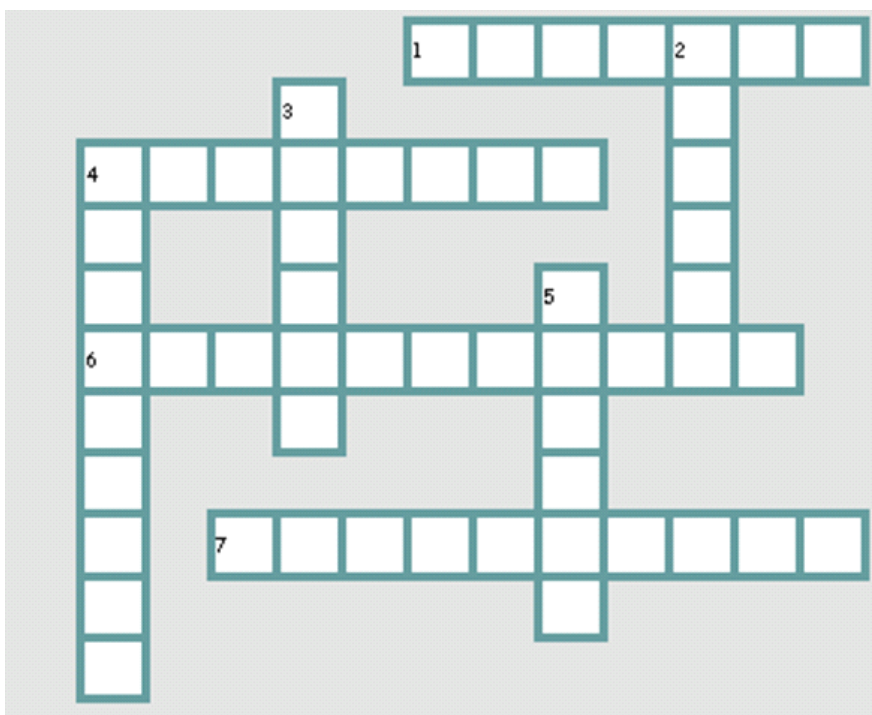
special devices such as rotator, Tornus). Guide wires are used to steer through the vessel in order to access the index lesion (steerability, flexibility and visibility) and to cross the lesion (visibility and crossability). In addition they need to support and facilitate delivery of any interventional device required to treat a specific anatomy or to resolve any potential complication (support). Special cases have dedicated wires such as CTO procedures. Balloons come in different materials: compliant, semi-compliant, non-compliant (high pressure). Special balloons such as cutting balloon and CTO balloons are available for dedicated procedures.

- Guidelines and Strategies for PCI in STEMI
- Pharmacoinvasive strategies in STEMI
- Shock



Dr. Manish Parikh, MD, USA, and Dr. Hemang Baxi, MD, DM discuss in-depth guidelines and strategies of PCI for STEMI and the number of recent trials and consensus documents governing all aspects of the diagnosis, management and therapeutic options currently available in 2012. In addition, most of the recent trials and meta-analysis with respect to facilitated, rescue and transfer PCI in the treatment and triage of STEMI will be presented with special attention to the current needs of practicing physicians in India.

Cross word



Across

1. Drowsiness, dehydration, electrolyte imbalances, gout, nausea, pain, hearing loss, blood ____ abnormalities, elevated cholesterol and lipoprotein levels, muscle cramps, dizziness, light-headedness
4. To prevent ____ aggregation and subsequent clot formation
6. Angiotensin Receptor ____ Indications
7. Nitrates ____

Down

2. To strengthen the heart's pumping force to increase cardiac ____ and decrease electrical conduction through the AV node
3. Gastric irritation (aspirin), bleeding or hemorrhage, leg or pelvic pain, rash, ____ fibrillation, tachycardia, dizziness, confusion
4. Easily bruising, joint or abdominal pain, difficulty in breathing or swallowing, ____, unexplained swelling, unusual or uncontrolled bleeding, rib and vertebral fractures
5. Dizziness, insomnia, anxiety, confusion, stroke, hypotension, ____ changes, GI/GU effects, cough, upper respiratory infection, myalgia, many other various but less common side effects

Solution on page no. 7

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Ref.: 1. JNC VII Recommendation. 2. Data on File

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Technique, Results and Complications with Radial Artery Access



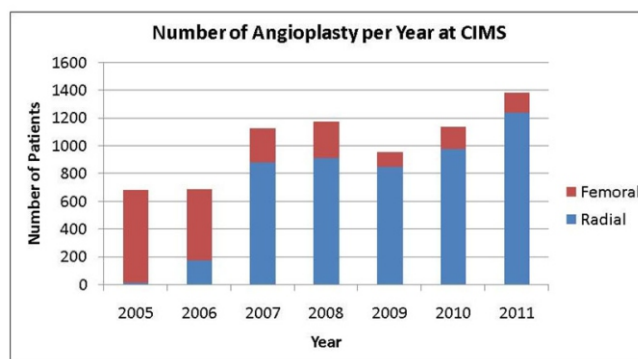
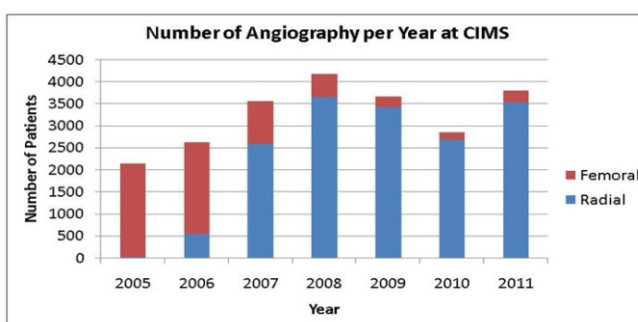
Dr. Joyal Shah



Dr. Satya Gupta

Thriving on their experience, **Dr. Joyal Shah**, and **Dr. Satya Gupta** both interventional cardiologists deliberate increased use of radial artery as the access site for cardiac interventions over the last decade. With this, its application to primary percutaneous coronary intervention (PCI) for ST-elevation myocardial infarction (STEMI) has also become more common and continues to rise.

While technically it may have some challenges, the most obvious benefits of this approach are the increased mobility and patient comfort that is afforded by avoiding a femoral approach.



However, as more data are generated for PCI in general and specifically for PCI for STEMI, the benefits of reductions in access site complications, and possibly major adverse cardiovascular events, are becoming apparent. These benefits are achieved without any significant reduction in efficacy. This combination suggests that the current trend of increasing adoption of the transradial approach in STEMI should continue to broaden. The technique is not difficult to learn, and the equipment is similar to that used in more traditional approaches. Patient safety and operator ease are of prime importance.

Sudoku

			5	9	4		
				1	7	5	
	2		4		9		3
1	9						8
8						3	4
4		8		7		2	
	5	3	1				
		7	8	4			

Solution on page no. 7



With risk coming from multiple directions, consider adding treatment beyond a single lipid focus.



lowers LDL-C, raises HDL-C, and lowers TG when added to a statin.

Significant improvements with 2 g/40 mg when added to a statin ($P < 0.001$)^{1,2,3}

LDL-C: -19%^c

HDL-C: 20%^c

TG: -25%^d

TREDAPTIVE[™] (nicotinic acid/laropirant, MSD) modified-release tablets is indicated for the treatment of dyslipidemia, particularly in patients with combined mixed dyslipidemia (characterized by elevated levels of LDL-C and TG and low HDL-C) and in patients with primary hypercholesterolemia (heterozygous familial and nonfamilial).

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Selected Safety Information

TREDAPTIVE[™] is contraindicated in patients with hypersensitivity to the active substances or to any of the excipients, significant or unexplained hepatic dysfunction, active peptic ulcer disease, or arterial bleeding. The most common side effect of TREDAPTIVE[™] is flushing (skin redness, warmth, and itching). Other common side effects include dizziness, headache, paresthesia, diarrhea, dyspepsia, nausea, vomiting, erythema, pruritus, rash, urticaria, feeling hot, and elevations in ALT or AST (consecutive, $\geq 3 \times \text{ULN}$), fasting glucose, and uric acid. Liver function tests are recommended before initiation, every 6 to 12 weeks for the first year, and periodically (eg, semiannually) thereafter.

Periodic serum creatine kinase (CK) should be considered with any signs and symptoms of muscle pain, tenderness, or weakness during the initial months of therapy with TREDAPTIVE[™] and a statin and when dosage of either drug is increased. Caution should be used when treating Chinese patients with TREDAPTIVE[™] coadministered with simvastatin or ezetimibe/simvastatin (particularly simvastatin doses of 40 mg or higher) because of a higher than expected incidence of myopathy in those patients. Because the risk of myopathy with statins is dose-related, the use of TREDAPTIVE[™] with simvastatin 80 mg or ezetimibe/simvastatin 10/80 mg is not recommended in Chinese patients. It is unknown whether there is an increased risk of myopathy in other Asian patients treated with TREDAPTIVE[™] coadministered with simvastatin or ezetimibe/simvastatin. Diabetic or potentially diabetic patients should be observed closely. Adjustment of diet and/or hypoglycemic therapy may be necessary.

Please consult the full Prescribing Information before initiating therapy.

Data from a study of TREDAPTIVE 2 g/40 mg relative to placebo. The primary end point was safety and LDL-C percent change from baseline across weeks 12 to 24. Patients ($N = 1,613$; mean age: 58 years) were randomized to TREDAPTIVE[™] 1 g/20 mg ($n = 800$), nicotinic acid 1 g (prolonged-release formulation) ($n = 543$), or placebo ($n = 270$) for 4 weeks; patients then advanced directly to TREDAPTIVE 2 g/40 mg, nicotinic acid 2 g, and placebo, respectively, for a total treatment duration of 24 weeks.¹

a Each tablet of TREDAPTIVE contains 1 g of modified-release nicotinic acid plus 20 mg of laropirant, a novel flushing pathway inhibitor.¹

b Patients received the following statins: atorvastatin (29%), simvastatin (54%), other statins (pravastatin, fluvastatin, rosuvastatin, lovastatin; 17%). Nine percent of statin patients were taking ezetimibe. Baseline values for the entire cohort were: LDL-C, 113.5 mg/dL (2.9 mmol/L) (mean); HDL-C, 50.8 mg/dL (1.3 mmol/L) (mean); and TG, 127.0 mg/dL (1.4 mmol/L) (median).¹

c Mean percent change from statin-treated baseline.

d Median percent change from statin-treated baseline.

References: 1. MacCubbin D, Bays HE, Olsson AG, et al. Lipid-modifying efficacy and tolerability of extended-release niacin/laropirant in patients with primary hypercholesterolemia or mixed dyslipidemia. *Int J Clin Pract*. 2008;62:1959-1970. 2. Summary of Product Characteristics for TREDAPTIVE[™] (nicotinic acid/laropirant, MSD) modified-release tablets. European Medicines Agency (EMA) Web site. www.ema.europa.eu. Accessed 18 November 2010.



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Multidimensional Lipid Therapy



A peep into the exhibition area

Rationale for Functional Assessment of Lesions in Patients with MVD



Dr. Anish Chandarana, and Prof.

Guy Heyndrickx inform that while

a direct link between a flow limiting lesion and ischemia was apparent in symptomatic patients

with single vessel disease, this link was more elusive and difficult to establish for each lesion separately

in patients with multi vessel disease (MVD) due to limitations of coronary angiography as well as myocardial perfusion imaging.

Fractional Flow Reserve (FFR) measurement has been shown to be superior in sensitivity and specificity compared to

angiography and even myocardial

perfusion imaging in differentiating flow-limiting from non flow-limiting lesions. The FAME trial revealed that routine

measurements of FFR during PCI significantly reduced the rate of primary composite endpoint of

death, myocardial infarction and repeat revascularization at 1 year

and at the same time reduced the number of stents used while resulting in a similar if not

improved functional result. The FAME trial provides strong evidence that coronary

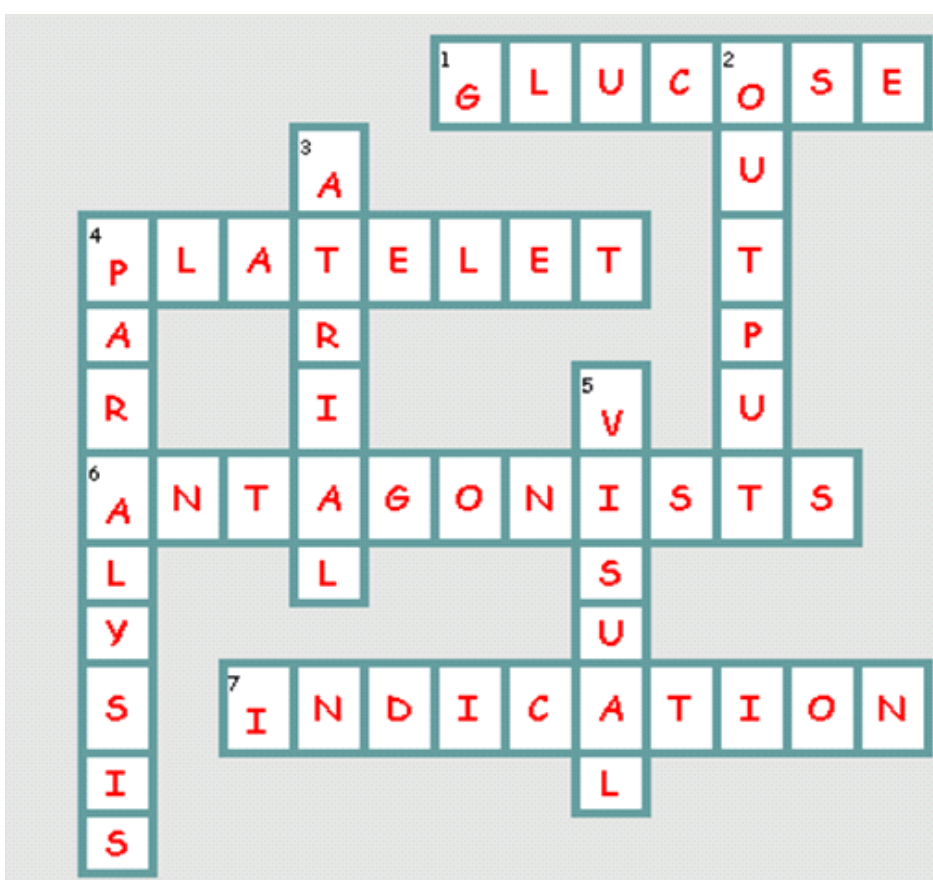
angiography and clinical data alone are not sufficient for decision making about the

appropriateness of revascularization of individual lesions in patients with MVD.

Answer of Sudoku

7	8	6	3	5	9	4	1	2
3	4	9	2	8	1	7	5	6
5	2	1	4	7	6	9	8	3
1	9	5	6	3	4	2	7	8
6	3	4	7	2	8	1	9	5
8	7	2	9	1	5	6	3	4
4	6	8	5	9	7	3	2	1
9	5	3	1	6	2	8	4	7
2	1	7	8	4	3	5	6	9

Answer of cross word



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Management Pathway

- 02.25 PM **Clinical Case-1** : A 68-year-old man with left main undergoes PCI of the unprotected left main coronary artery - **Dr. Samin Sharma / Dr. Keyur Parikh**
- 02.40 PM **Clinical Case-2** : A patient with 60 % lesion in LAD, after successful thrombolysis - **Prof. Guy Heyndrickx Robert / Dr. Joyal Shah**
- 02.55 PM **Clinical Case-3** : A patient with non-healing ulcer in leg - **Dr. Vinit Lal**
- 03.10 PM **Clinical Case-4** : A patient with severe Heart Failure and Coronary Artery Disease - **Dr. Manish Parikh/Dr. Hemang Baxi**
- 03.25 PM **Clinical Case-5** : A patient with severe triple vessel disease - **Prof. Rafael Beyar/Dr. Anish Chandarana**
- 03.40 PM **Clinical Case-6** : A patient with paravalvular leak closure - **Dr. Milan Chag**
- 03.55 PM **Clinical Case-7** : A Real life case of bioabsorbable stent - A glimpse into the future - **Dr. Charles Simonton / Dr. Urmil Shah**
- 04.10 PM **Clinical Case-8** : Mitral Regurgitation : innovative approach - **Dr. Dhiren Shah/Dr. Dhaval Naik**
- 04.25 PM **Clinical Case-9** : Radio Frequency segmental Ablation using VNUS Closure FAST catheter/Generator for Primary Varicose Veins - **Dr. Milan Chag/Dr. Rajesh Hydrabadi**



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