SOLACI DAILY

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Welcome to SOLACI'11

XVII SOLACI Congress
XIV SOCHICAR Interventional Cardiology Meeting

By Gastón Dussaillant, MD

Dear colleagues,

As President of the XVII Congress of the Latin American Society of Interventional Cardiology (SOLACI), it is a pleasure to give you the warmest welcome to this event.

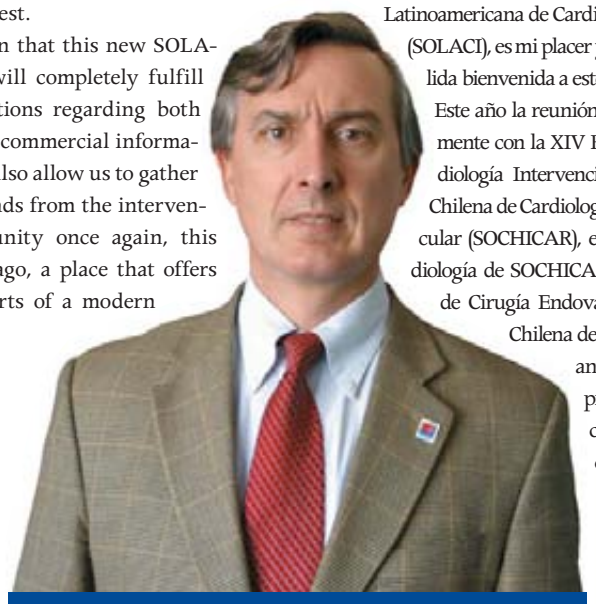
This year the meeting is held jointly with the XIV Annual Interventional Cardiology Meeting of the Chilean Society of Cardiology and Cardiovascular Surgery (SOCHICAR), the Annual SOCHICAR Cardiology Course and the Annual Endovascular Surgery Meeting of the Chilean Surgical Society. As in previous years, SOLACI 2011 presents a scientific program which includes state-of-the-art conferences, emerging techniques, debates, symposia, workshops, live cases transmissions and clinical case review sessions.

The Scientific and Organizing Committees have worked hard in order to put together a compelling program that will include all areas of coronary interventions, congenital, structural and valvular heart disease, peripheral vascular interventions, adjunctive pharmacotherapy, images and functional assessment among other topics of interest.

We are certain that this new SOLACI congress will completely fulfill your expectations regarding both scientific and commercial information and will also allow us to gather with our friends from the interventional community once again, this time in Santiago, a place that offers all the comforts of a modern and safe city.

Kind regards,

Gastón Dussaillant,MD
President XVII
SOLACI
Congress 2011



Gastón Dussaillant, MD

Bienvenido a SOLACI'11

XVII Congreso SOLACI
XIV Reunión de Cardiología Intervencionista SOCHICAR

Por Dr. Gastón Dussaillant

Estimados Colegas,

Como Presidente del XVII Congreso de la Sociedad Latinoamericana de Cardiología Intervencionista (SOLACI), es mi placer y orgullo darles una cálida bienvenida a este evento.

Este año la reunión se celebrará conjuntamente con la XIV Reunión Anual de Cardiología Intervencionista de la Sociedad Chilena de Cardiología y Cirugía Cardiovascular (SOCHICAR), el Curso Anual de Cardiología de SOCHICAR y la Reunión Anual de Cirugía Endovascular de la Sociedad Chilena de Cirugía. Como en años anteriores, SOLACI 2011 presenta un programa científico muy atractivo que incluye conferencias sobre el estado de la disciplina, las nuevas técnicas, debates, simposios, talleres, transmisiones en vivo de los casos clínicos y sesiones de revisión de casos clínicos.

Los Comités Científicos y Organizadores han trabajado arduamente para poder organizar un atractivo programa que incluye todas las áreas de las intervenciones coronarias, cardiopatía congénita, estructural y valvular, intervenciones vasculares periféricas, farmacoterapia adyuvante, imágenes y evaluación funcional entre otros temas de interés.

Estamos seguros de que este nuevo Congreso SOLACI cumplirá completamente con sus expectativas en lo que respecta a la información científica y comercial, así como también nos permitirá reunirnos una vez más con nuestros amigos de la comunidad intervencionista, esta vez en Santiago, lugar que ofrece todas las comodidades de una ciudad segura y moderna.

Saludos Cordiales,

Gastón Dussaillant, MD
Presidente
XVII Congreso SOLACI 2011

Objetive and Mission of SOLACI Regional Conferences

By Ariel Durán, MD, FACC*

In order to ensure we reach the medical community throughout Latin America, in 2007 SOLACI created annual "conferences" across the region. Since then, 14 conferences have taken place all over Latin America.

Our intent is to conduct annual conferences in each of the 3 SOLACI regions including the Southern Cone, Andean region and Central America-Caribbean.

So far 3,804 health care practitioners, including doctors, nurses and technicians, have been present at the conferences. Also, more than 300 hours of lectures and live cases of complex procedures in eight countries with more than 30 hours of transmission were executed. In some cases, it was the first occasion that certain invasive technique was performed. For example, the case of the first alcohol septal embolization in Peru, the first carotid angioplasty in Bolivia, the first live transmission in Panama, and also the first use of the intravascular ultrasound.

Ariel Durán, MD

In 2008 in Paraguay, the first carotid angioplasty was held; in 2009 the first...

(Cont. Page 3)

IVUS and FFR in the Clinical Practice

By Gary S. Mintz, MD*

The debate of intravascular ultrasound (IVUS) versus intracoronary physiology assessed using fractional flow reserve (FFR) is ill-conceived and artificial. Each has its specific uses, and the selection of the technique should depend on the question asked.

Assessment of intermediate lesions

FFR is the appropriate technique to assess the functional significance of a stenosis. Based on the DEFER and FAME studies, stenosis with an FFR >0.75 (DEFER) or >0.80 (FAME) can be treated medically without implanting a stent. However, it should be noted that the 5-year death/myocardial infarction rates in the reference group of DEFER (the group with an FFR <0.75 in whom no intervention was performed) were only 15 per cent indicating that FFR is better suited to deferring intervention and avoiding unnecessary stent implantation than identifying lesions that will cause adverse events.

Gary S. Mintz, MD

Ten year old studies using IVUS in largish (3.5mm) epicardial arteries ....

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Article by Cordis

Twelve-month outcomes with adaptive closed cell design stent systems in the treatment of stenotic coronary artery lesions from the PIONIR study

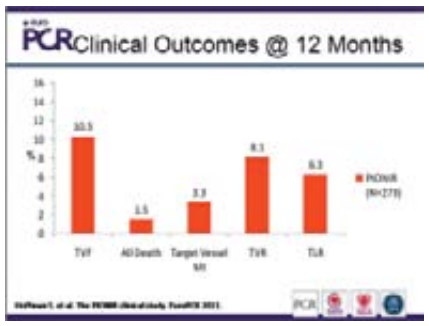
By Darío Echeverri, MD*

In spite of the important results with drug-eluting stents (DES) in many clinical conditions and which surpass bare metal stents (BMS), these continue to play an important role in the treatment of stenotic coronary lesions in selected patients. BMS penetration in most Latin American countries is more than 50%, which is similar to Eastern EU and the Middle East. Given their frequent use, it is important to consider new BMS generations for the treatment of coronary disease.

Recently Hoffman S. et al. from Germany presented the PIONIR clinical study at the EuroPCR 2011. One-year results from the 278-patient, multi-center (sites in Europe and Israel), non-randomized, prospective, single-arm study with the next generation RESILLION™/PRESILLION™ Plus (Cordis-Johnson&Johnson) cobalt-chromium bare metal stent systems. The patients were enrolled for treatment of non complex de novo stenotic coronary lesions. Device success was achieved in 98.2% of patients. Reported TLR of 6.3%, TVR of 8.1% and TVF was 10.3% at one year FU. The rate of subacute ST was 0.7%. There was no ST observed after 30 days (Figure).

This study shows how new generations of stents (design, strut thickness, and materials) offer benefits for implantation and allow good deliverability, vessel conformability and scaffolding. In addition, it has important clinical implications as it shows that this ¨2nd generation¨ BMS, in selected cases, provides excellent results in terms of efficacy and short and long term safety.

**President of SOLACI*



(Cont. of "Objetive and mission of solaci regional conferences")

live case transmission in Ecuador occurred as well as the first case of the SOL-SOL program, which consists of cardiovascular interventions in public hospitals. All materials were contributed free of charge by the industry (SOLACI Solidarity Program).

Other events also took place such as the foundation of the Cuban Society of Interventional Cardiology during the XIII Conference in Havana in October 2010.

Each one of these conferences has stirred the curiosity of the media, producing interviews and written articles.

The SOLACI's commitment to countries that do not organize the annual Congress has created a large amount of expectation. It is also important for bringing interventional cardiology information that is generated annually for general practitioners, not just for cardiologists.

This huge effort, which is being carried on with great enthusiasm and passion, represents not only a renewed interventionism in the region, but has also provided a space for knowledge, recognition and sharing experiences within the Latin American interventional cardiology community.

This year's next conferences will be held in Bogotá (Colombia) on October 27 and 28 (Andean region) and in San Pedro Sula (Honduras) on November 24 and 25 (Central America-Caribbean region).

Hope to see you there!

**Interventional Cardiologist, Associate Professor of Cardiology, University Hospital, Montevideo-URUGUAY. SOLACI Conferences Director.*

Today´s Program

Wednesday August 3rd	Vitacura Auditorium	Cordillera A Auditorium	Manquehue Auditorium	De las Esculturas Auditorium	Cordillera B Auditorium	Del Parque Auditorium	Del Polo Auditorium	Los Andes Auditorium
08:30 - 09:55	Live Cases 1, 2 & 3. Coronary Peripheral Interventions		Epidemiology and Physiopathology of Atherosclerotic Diease	Lectures on Congenital Heart Disease	ACS Whitout ST Elevation. Antithrombotics. ACS with ST Elevation		**08.30- 12:30** Posters Session I	
10:00 - 11:25	Cleveland Clinic@SOLACI		Sublicnical Atherosclerosis	Symposium on Septal Defects	Diagnosis and Treatment of Arrhythmias in the Coronary Unit.			
11:30 - 12:25	Abstracts Session I:Structural Interventions	Abstracts Session II: Coronary Interventions	Prevention of Atherosclerotic Disease	Abstracts on Congenital Heart Disease I	Nurses and Technicians Abstracts Session I	Abstracts Session III: Basic Research		Abstracts Session IV: Peripheral Interventions
12:30 - 13:55	Lunch Symposium Sponsored by Cordis	TAVI Summit: CoreValve (Lunch Symposium Sponsored by Medtronic)			Role of Nursing and T.M. in Percutaneous Aortic Valve Raplacement. Multidiciplinary Integration		**13:00 - 17:00** Posters Session II	(13:00 - 15:30) Abbott: hands on Training (First Group)
14:00 - 15:25	Live Cases 4, 5 & 6. Congenital Heart Disease and Structural Interventions	Symposium on Aortic Disection			Complementary Technologies in the Cathlab			(13:00 - 15:30) Abbott: hands on Training (First Group)
15:30 - 16:55	Symposium on Aortic Stenosis	Symposium on Infrainguinal Peripheral Arterial Disease	Technique for Chronic Total Occlusions. Clinical Cases	Symposium on Congenital Valvulopathies				(15:30 - 17:30) Abbott: hands on Training (Second Group)
17:00 - 18:25	Live Cases 7, 8 & 9. Coronary, Pathology and Structural Interventions	Symposium on Antiplatelet	Diagnosis and Treatment of Chronic Stable Angina	WIN@SOLACI		ProEducar Session I: Endoluminal Treatement of Renal and Carotid Disease		(15:30 - 17:30) Abbott: hands on Training (Second Group)
18:30 - 19:00	Controversy: Surgery or Angioplasty for Multi-Vassel Coronary Disease?	Controversy: When to Intervene Carotid Stenosis?						**17:30 - 18:00 SOLACI 2012** Presentation for Industry Representatives
19:15 - 20:00	Opening Ceremony. Cocktail Reception							

(Cont. of "IVUS and FFR in the Clinical Practice")

....suggested that a minimum lumen area (MLA) >4mm2 was also a suitable criterion to defer intervention. While this is still true, it did not mean that the converse is also true – that an MLA <4mm2 is indicative of ischemia and the need for stent implantation. More recent studies have shown that the IVUS MLA that best correlates with an FFR <0.80 is (1) variable, (2) inconsistent among studies, and (3) depends on vessel size, lesion length, lesion location, and other factors depending on the analysis. Furthermore, unlike FFR, IVUS cannot take into account the amount of viable myocardium perfused, presence of collaterals, etc. As a result and at the current time, IVUS should not be used to assess the severity of lesions in the major epicardial arteries. Furthermore, more lesions can be left untreated using FFR than IVUS regardless of the IVUS criterion.

The one exception is the left main coronary artery (LMCA) where IVUS data is more in agreement with FFR data; this is not surprising since the LMCA does not vary a lot in terms of diameter, length, and the amount of myocardium supplied. Furthermore, IVUS studies are consistent; and an MLA of 6mm2 seems to separate LMCA lesions that are significant from ones that are not significant. However, both IVUS and FFR have limitations. LMCA disease is rarely isolated, and a significant stenosis in the LAD or LCX can confound FFR assessment of the LMCA. The LMCA should be imaged using IVUS pullback from both the LAD and LCX in order to assess whether LMCA disease involves the ostium of the LAD and LCX and to define the smallest MLA.

Percutaneous coronary intervention and follow-up

IVUS is the predicate intravascular imaging technique to guide stent implantation. It can assess lesion morphology, select stent size and length (based on vessel size and lesion length), optimize acute results (expansion and lesion coverage), and assess complications. A meta-analysis of seven randomized IVUS-guided versus angiography-guided BMS implantation trials showed that IVUS reduced restenosis, repeat revascularization, and major adverse cardiac events (MACE). While there are no randomized trials in the DES era, there are three propensity-score-matched IVUS versus angiographic studies showing a reduction in early stent thrombosis and late target vessel revascularization, death, and myocardial infarction.

With the exception of optical coherence tomography, IVUS is the ideal technique to assess mechanisms of stent thrombosis and in-stent restenosis. While most cases of in-stent restenosis are caused by intimal hyperplasia, a surprising number are caused by chronic stent underexpansion (or other mechanical problems) that occurred and were not recognized at the time of angiography-guided stent implantation.

Conversely, with one exception, FFR has no role in guiding and optimizing stent implantation. The one exception is the assessment of a sidebranch after a bifurcation is treated with cross-over stenting. Regardless of the post-stent angiographic appearance of the sidebranch ostium, an FFR >0.75 is associated with a low rate of subsequent repeat revascularization of that sidebranch.

*Cardiovascular Research Foundation, New York, NY

Article by Meril

BioMimeTM - Sirolimus Eluting Stent Receives Brazilian Approval

Meril Life Sciences has announced that its BioMimeTM sirolimus-eluting coronary stent has been approved by ANVISA, the Brazilian health agency. The device has previously received the CE mark.

The base stent of BioMimeTM is made of Cobalt Chromium (L605) and has an ultra-low (65µm) strut thickness. Its novel design incorporates an intelligent mix of open and closed cells allowing for Morphology Mediated ExpansionTM of the stent. This hybrid stent has a high radial strength and comes pre-mounted on a flexible delivery system that maintains short-abrupt balloon shoulders to minimize balloon related edge injuries.

The entire stent surface is coated with a 2µm mix of known biodegradable polymers – Poly-L-Lactic acid (PLLA) and Poly-L-Glycolic acid (PLGA) along with the active anti-proliferative drug Sirolimus (1.25µg/mm2). The drug is timed to elute over a period of 30days, while the polymeric mixture degrades soon via hydrolysis and eventual elimination as CO2 & H2O.

Clinical trials include a single, de novo, non-complex lesion study involving 30 patients. BioMimeTM demonstrated high safety with 0% major adverse cardiac events (MACE) and 0% stent thrombosis at eighteen months while maintaining a high efficacy standard of 0.15mm late luminal loss at eight months QCA and 0% binary restenosis or target lesion revascularization (TLR) or target vessel revascularization (TVR).

In a larger study involving 250 real-world patients, roll-in phase data reveal similar safety and efficacy. Major adverse cardiac events were found to be <3% and preliminary QCA on 100 patients demonstrates an excellent median in-stent late loss of 0.13mm.

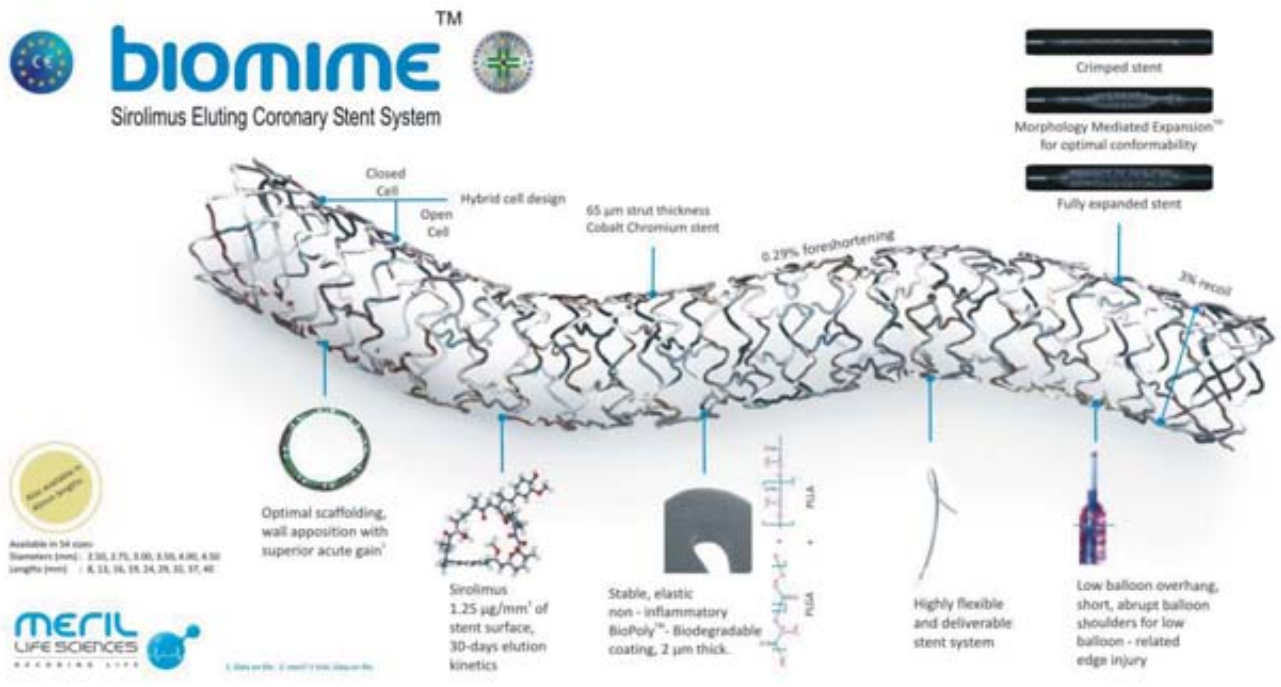
Meril Life Sciences has also invented its own anti-proliferative agent – Merilimus (a third-generation sirolimus analogue) and has developed a 40µm strut thickness stent – MitsuTM. The drug is released via nano-technology based solid-lipid formulation. MitsuTM will soon undergo pre-clinicals and later first-in-man with an objective of entering the US coronary stent market.

Meril Life Sciences is a young, dynamic medical device development and manufacturing company based in India at Vapi (150kms north of Mumbai). www.merillife.com

The company was established in 2006 and has been working on creating low injury coronary stent systems which allow for superior conformability, leading to early endothelialisation.

Meril's current portfolio are all CE marked -

- BioMimeTM - Sirolimus Eluting Coronary Stent System
- NexGenTM - Cobalt Chromium Coronary Stent System
- CryptonTM - Stainless Steel Coronary Stent System
- MozecTM - Rx PTCA Balloon Dilatation Catheter
- HaikuTM - Inflation Device



PCR: Innovation and education at work

PCR is an organisation dedicated to education and information in the field of cardiovascular intervention.

Article by PCR

Patient-centred and innovative session formats, open-mindedness, interactivity, continuous evaluation and improvement are the fundamental building blocks of all PCR Courses. In 2010, more than 15,000 participants from all over the world attended one of the available courses.

- EuroPCR is the leading interventional cardiovascular Course and the official annual meeting of the EAPCI,
- AsiaPCR/SingLIVE is built by and for the Asia-Pacific cardiovascular community to reach a wider international audience, to share and learn from the expertise in Asia-Pacific, and to stimulate regional projects,
- PCR London Valves is a meeting centred on the "Heart-team" approach, fully dedicated to the new modalities of valves treatment,
- GulfPCR-GIM is a partnership between the Gulf Interventional Working Group & PCR, built for the cardiovascular community in the Gulf and Middle East region, to share and learn from the regional expertise and stimulate new regional projects.

Communication tools have been built that fulfil the PCR mission relying on a rich database of more than 30,000 cardiovascular physicians worldwide.

- PCRonline is an online reference platform to inform and impulse the new formats of education to the whole community.
- PCR Publishing primarily edits scientific publications, as well as the PubMed/Medline referenced EuroIntervention Journal, the official journal of the EAPCI. The first two textbooks are available and a third is in process for 2012.

Sessions that will revolutionise your daily patient approach and treatment strategies

Created by Professor Jean Marco in 2007, the LTT (Learning The Techniques) sessions are the most innovative, interactive and popular sessions at EuroPCR. They aim at presenting a case and associated treatment options in a logical, step-by-step way that focuses on the decision-making process. Live in-a-box cases are included to enable attendees to engage fully with the session facilitators and audience participation is strongly encouraged.

As a result of a strong partnership with SOLACI, PCR is hosting two LTT sessions this Friday 5th August:

PCR@SOLACI Joint session

Introductory lecture on Educative solutions and Learning The Techniques (LTT) concept by C.K. Naber (Germany)
8:30-8:40, Vitacura Auditorium

LTT on "How to treat a patient with multivessel coronary disease"
Facilitators: C.K. Naber (Germany), M. Heigert (Austria), S. Kedev (Macedonia)
Live in-a-box case from Clinique Pasteur, Toulouse, France
8:40-10:00, Vitacura Auditorium

LTT on "How to treat a patient with coronary bifurcation lesions"
Facilitators: C.K. Naber (Germany), M. Heigert (Austria), S. Kedev (Macedonia)
Live in-a-box case from Institut Cardiovasculaire Paris Sud, Massy, France
10:00-11:30, Vitacura Auditorium

Article by Medtronic

EVAR 2011: How new stent-graft technologies have transformed the AAA landscape

By Frank J Criado, MD, FACS, FSVM


Frank Criado, MD

In the U.S. alone 1.1 million individuals (aged 50-84) harbor an AAA. More than 100,000 new cases are diagnosed each year, and 50,000+ aneurysm repairs are performed. Surgical techniques to treat AAA were developed in the 1950s, and by the 1970s, the operation had become a relatively common procedure. But significant challenges loomed in the horizon related to its morbid nature. The need for less-invasive options was clear. History's first EVAR operation was performed by Parodi et al. in 1990. It signaled the dawn of a whole new era in vascular surgery.

FDA approval of the first 2 stent-graft devices in 1999 marked the true beginning of the endograft age. In all, 6 FDA-approved stent-grafts are currently available in the U.S. The latest addition was Medtronic's Endurant endograft that is generally considered the first "next-generation" device as its design reflects many of the lessons learned over the past decade: lower profile, enhanced deliverability and flexibility, and a highly-evolved suprarenal fixation apparatus with integrated anchoring pins.

Despite its impressive achievements, EVAR continues to have limitations. Mainly these 3:

-*The short and/or angulated proximal neck*. Endurant (again) was designed specifically to address this challenge. A large clinical experience in Europe and elsewhere has shown excellent results in some of the most adverse proximal-neck anatomies. This is perhaps the main reason why Endurant has become a true landscape-changer in every market it has entered so far – now including the U.S. Other endografts (such as Lombard's Aorfix) have aimed for the same objective.

-*Lower profile*. It remains an important target for future developments as it can obviate difficult access issues and improve deliverability. Availability of AAA stent-grafts with a delivery system of <16F OD will be a rapidly increasing reality in the foreseeable future, accelerating the gradual shift to percutaneous EVAR.

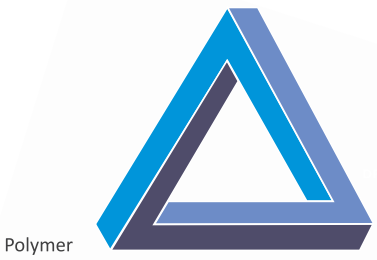
-*Branches*. Branch management represents the next EVAR frontier. Cook Medical pioneered these technologies with the development of fenestrated designs more than 10 years ago. While feasibility and safety are no longer questioned, the procedures have proven long and complex, and the customization process tends to take several weeks and the costs are very high. A focus on less customization and more off-the-shelf capabilities is the current trend and may well represent the future in this important area of development.

The EVAR-1 and DREAM trials (largely) have contributed immensely to establish a scientific foundation for EVAR providing the necessary level-1 evidence that now guides contemporary AAA therapy. In particular, the demonstrated 3.5-fold decrease in operative mortality when compared with open repair was – truly – an eye-opening finding. However, long-term complications and reintervention rates favored open surgery. In the most recent publication of the EVAR-1 trial results with follow-up extended up to 10 years, the AAA-related mortality benefit had been lost by the end of the study. There were also a number of late aneurysm ruptures and new complications developing up to 8 years postoperatively. While we can all agree these randomized trials did show favorable results for EVAR, on closer scrutiny, the emerging overall picture is mixed. Worthy of note also is the fact that these trials were planned and executed more than 10 years ago. A great many lessons have been learned since then, together with significant device improvements and better case selection strategies. It would not be far-fetched to postulate that endovascular experts today can achieve better results than those produced by the EVAR-1 and DREAM investigators all those years ago.

EVAR's above-described shortcomings notwithstanding, the advent of endovascular repair has had a profound impact on the field of AAA therapy overall. Since EVAR technologies became commercially available in the U.S. in 1999, elective aneurysm repairs have increased by 8%, but ruptured AAA repairs have plummeted by 35%. EVAR overtook OR as the most common procedure in 2004. Overall, AAA-related deaths have decreased by 42%. The rapid shift from time-tested surgical principles and old 'gold standards' to an entirely new way of managing the majority of AAA patients has been dramatic and groundbreaking. Furthermore, EVAR developments have induced a profoundly positive transformation of the entire AAA landscape as more undiagnosed aneurysms are being uncovered, the rate of elective repairs continues to rise, and treatment of ruptured AAAs has been set on a downward spiral. Best of all, deaths from AAA disease overall are declining significantly.

In BioMime™, the polarized triad of DES design is *taken care of!*

Stent architecture

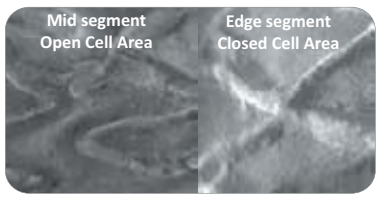


Polymer — Drug

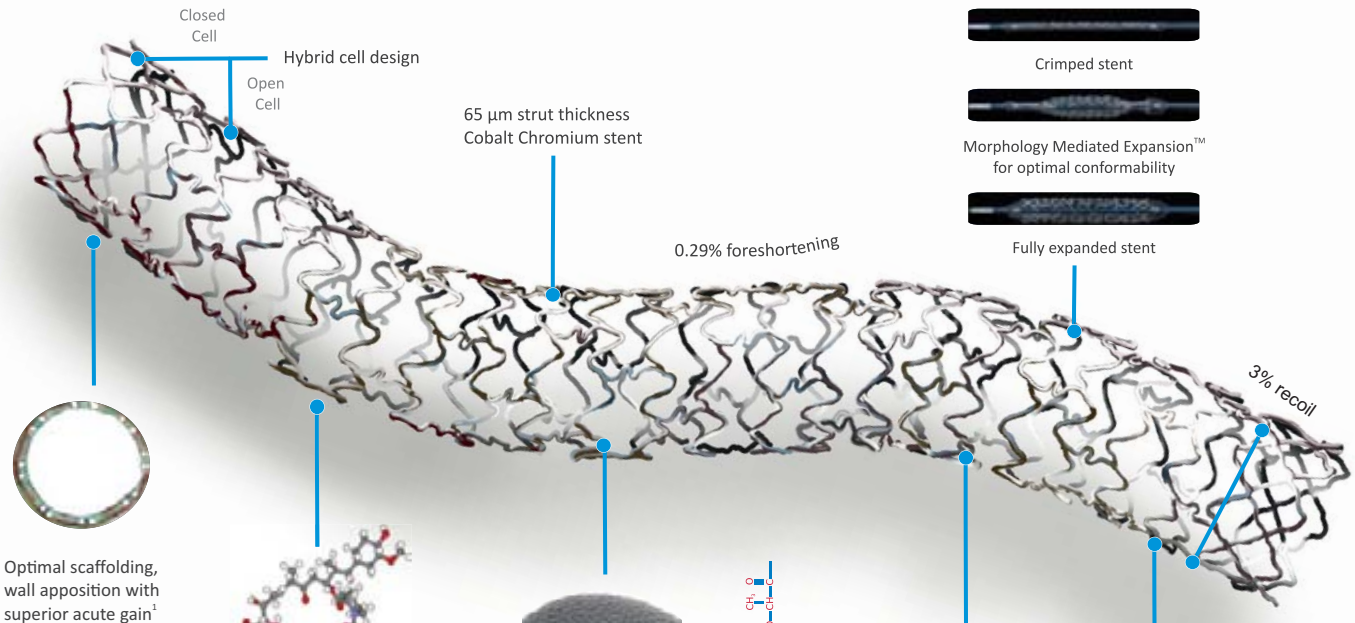
Taken Care!

The resultant stent blends the safety of a BMS with efficacy of a DES

SEM pictures of BioMime™ endothelialization in porcine coronary artery, < 30 days[1]



0% MACE at 18 months[2]
0% Thrombosis at 18 months[2]
0.15mm Late Lumen Loss[2]



Crimped stent

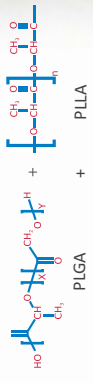
Morphology Mediated Expansion™ for optimal conformability

Fully expanded stent

Optimal scaffolding, wall apposition with superior acute gain[1]

Sirolimus 1.25 µg/mm² of stent surface, 30-days elution kinetics

Stable, elastic non - inflammatory BioPoly™- Biodegradable coating, 2 µm thick



Highly flexible and deliverable stent system

Low balloon overhang, short, abrupt balloon shoulders for low balloon - related edge injury

Also available in 40mm lengths

Available in 54 sizes -
Diameters (mm): 2.50, 2.75, 3.00, 3.50, 4.00, 4.50
Lengths (mm) : 8, 13, 16, 19, 24, 29, 32, 37, 40

1. Data on file. 2. meriT-1 data on file.

Contact: sanjay.yadav@merillife.com
Mobile: +91 98925 59225

meril LIFE SCIENCES DECODING LIFE

Article by CID

(Drug-eluting?) Coronary stenting in patients on chronic oral anticoagulation

By Andrea Rubboli, MD*

Triple therapy of aspirin, clopidogrel and oral anticoagulation with vitamin K antagonists (VKA) is the most effective antithrombotic treatment after percutaneous coronary intervention with stent implantation (PCI-S) to prevent both stent thrombosis and thromboembolism related to the clinical condition for which VKAs are indicated. Available data, however, suggest that triple therapy is associated with a relevant incidence of major bleeding, which may occur up to three to five times more frequently than with dual antiplatelet treatment. Moreover, an increasing incidence of major haemorrhages has been reported as triple therapy prolongs: whereas an average 6% of major bleeding has been observed at one month, as much as about 10% has been reported at six and 12 months or more (Figure 1). Since major haemorrhagic complications after an acute coronary syndrome unfavourably impact on prognosis, meticulous care needs to be paid in preventing such events. This is especially true after percutaneous coronary intervention with stent implantation, when (even minor) bleeding may lead to premature discontinuation of aspirin and/or clopidogrel, which in turn exposes patients to a potentially catastrophic event as stent thrombosis. Of note, prophylactic administration of proton pump inhibitors in the attempt to reduce the risk of gastrointestinal bleeding appears not applicable as a routine, because of the several recent reports suggesting a negative interaction between these agents and clopidogrel.

Therefore, in patients on chronic VKAs undergoing percutaneous coronary intervention the implantation of bare metal, rather than drug-eluting, stents is currently recommended in the light of the short (one month) need for clopidogrel (and accordingly, triple) therapy. Certainly, such strategy may prove much less than optimal in situations where the occurrence of restenosis is higher (i.e., long lesions and/or small vessels, diabetic patients, etc.) or troublesome (i.e., last remain vessel). The availability of drug-eluting stents which allow a shorter duration of clopidogrel treatment therefore, is more than welcome. Optima (CID Vascular, Saluggia, Italy) is a polymer-free, Carbofilm coated stent eluting Tacrolimus from abluminal reservoirs, which has been widely tested in patients with either stable or unstable coronary artery disease showing an excellent safety and efficacy profile. Of note, post-hoc analyses of the clinical studies carried out with Optima showed the efficacy of a clopidogrel duration as short as two months, which had been carried out in about 30 to 50% of patients. The subsequent Multicenter registry with Antiplatelet Treatment two-sIX months (MATRIX), in which more than 500 patients were prospectively enrolled, confirmed the safety and efficacy of a two-month only dual antiplatelet treatment regime (Figure 2). This device, which is now being tested in another prospective, multicentre registry named Ongoing WARfarin and coronary STENTing (WARSTENT)-Optima, where patients on chronic VKAs undergoing PCI-S are enrolled, may prove the drug-eluting stent of choice in this increasingly large and fragile patient subset.

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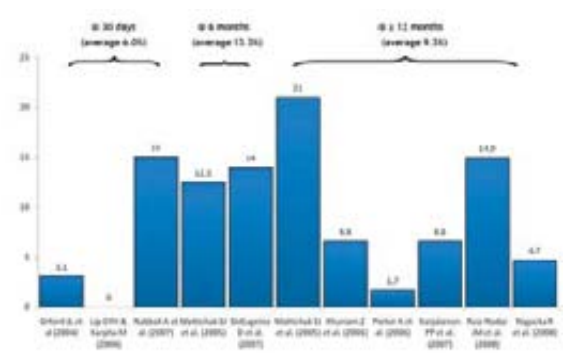

Figure 1. Triple therapy (ASA, clopidogrel and VKAs) & major bleeding (Above the image)
Rubboli A et al. Ann Med 2008;40:428-36

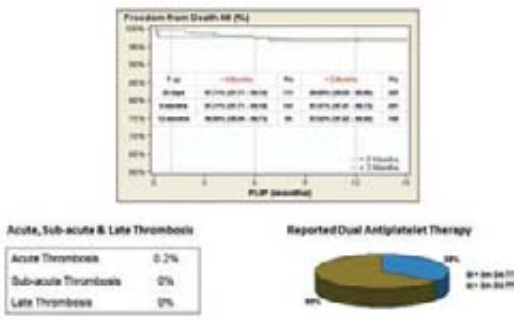

Figure 2. Multicenter Registry with Antiplatelet TReatment two – sIX months (MATRIX) (Above the image). Interim analysis:12-month data presented at GISE08/TCT08/JIM09

New SOLACI website

The meaning of websites to Scientific Medical Societies

By Juan Carlos Millán Gómez, MD*

In the current state of globalization and expansion of knowledge, the relevance of websites for Scientific Medical Societies is unquestionable. A well-designed and updated website not only provides the best tool to spread and share information widely, both in their own specific field as other related disciplines, but also ensures their presence in the global context.

While the Scientific Society may disclose their organizational structure, policies, programs and other activities, having a common virtual space is a huge opportunity to encourage their members to exchange views, knowledge and experiences. Furthermore, by a careful and responsible selection of content, the web portal can offer those who consult its pages, high quality, reliable, relevant and up-to-date information. This feature establishes an overwhelming difference between the websites of Scientific Societies and thousands of existing medical portals on the World Wide Web (WWW); so it is an intangible asset that must be protected and preserved permanently.

Such are the core principles that have guided the redesign of the SOLACI website. Today, in accordance with the needs and expectations of the Latin American Society of Interventional Cardiology, this resource has a greater repertoire of sections and content as well as a modern and dynamic configuration. The new website gives users a deeper, broader, and more engaging experience through enhanced search and navigation in a friendly environment.

The new www.solaci.org, launched February 28th, includes a Virtual Library and NEWS (“Noticias”) where visitors can access the latest topics in the field of interventional cardiology. On the right and left sides of the homepage the users find a vertical navigation menu with content organized under categories of services like ProEducar (teaching cases and bulletins added every month), Registry SOLACI OnLine, Committees and more. Finally, on the centre of the homepage the users find the latest news and announcements of SOLACI.

On behalf of the Website Committee, it is my pleasure to invite all SOLACI members to visit our new website and contribute decisively to its continuous enrichment and improvement by sending your feedback, comments, suggestions and contributions.

*Editor In Chief-SOLACI website

Carotid Stenting by Radial Approach: Are We Ready?

Innovations in Carotid Angioplasty

By Alberto Sampaolesi, MD*

Carotid Angioplasty Stenting (CAS) is a safe and effective therapeutic alternative, which is not inferior to surgery when performed by experienced centers and operators. Nevertheless, its indication has been controversial and fluctuating as a consequence of conflicting outcomes of multicenter studies. Transfemoral access has been used as the routine access for more than two decades, but when peripheral vascular disease and abdominal aortic disease coexist (30-40 per cent of patients), along with anatomical and technical difficulties in type II & III aortic arches, especially in the so-called "bovine aortic arch", the selective catheterization may prevent its use, thus increasing the risk of embolic complications or vascular access bleeding. These disadvantages compel us to find alternatives to expand its application, as well as to improve safety and efficacy of CAS.

Transradial approach (TRA) is currently our first choice for coronary percutaneous interventions (PCI). TRA has proved to have less access site related complications, is more comfort, allows earlier ambulation and discharge, and it could be useful to solve the problems mentioned in complex anatomy.

Right radial approach is preferred in most patients while left radial approach is a good option in patients who also need left vertebral artery PTA or in acute angulated innominate trunk bifurcation.

Alberto Sampaolesi, MD

The procedural technique is quite similar to the femoral approach since it uses for selective CCA catheterization a 5-6 F, type Simons or FR shape (without manipulation of the arch Ao); the hydrophilic guide is then anchored at the external carotid, the catheter is advanced and an extra stiff guidewire is exchanged followed by advancing and positioning of a long hydrophilic sheath or guiding catheter (FR, Envoy, FL) usually 6 or 7F. All procedures are done under distal protection and sheaths are immediately removed without vasovagal phenomena.

Among limitations we can list the impossibility to use proximal protection systems and the drawbacks inherent functional or anatomic radial artery. We report data from our experience, and a pilot multicenter observational study in Argentina, in unselected patients.

Our personal experience of 45 patients with 46 lesions (L) with aortic arch type II and III by 71per cent. Of these 28 (62 per cent) patients (p) had lesions (L) of IRC, 16p (35 per cent) in ILC and 1p (2 per cent) both. Use distal protection in 100%. Technical success was 98.8% with a conversion, no hospital events. There was one minor stroke (2 per cent) at 30 days. The multicenter study with the Favaloro Foundation and the Sanatorio Allende, with the limitations of being small, observational and retrospective study included 88 P 89 (L), with 89.8 per cent of aortic arch type II and III. Use distal protection in 100%. The technical and clinical success was 98.8per cent with only 2.2 per cent of Stroke at 30 days, no deaths, myocardial and vascular complications.

Our experience indicates that the TRA for CAS is feasible and safe even in complex aortic arch anatomy without increasing vascular complications.

We recommend that CAS by TRA should be performed by centers and operators experienced with this site approach and that it is essential to know the anatomy of the arc to select the access. Although routine use can lead to more complications, it can be used in most of the cases. TRA should be of choice for "bovine aortic arc", type III and in patients at higher risk or contraindications to the femoral approach.

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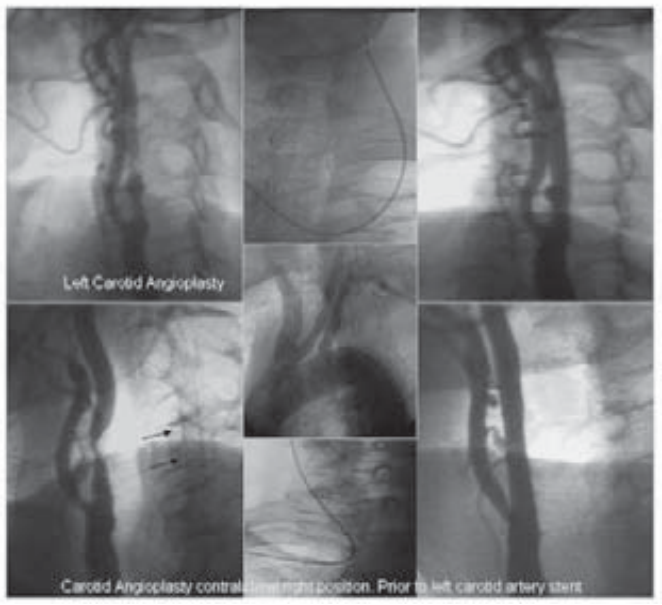

Figure. Bilateral Carotid Angioplasty by TRA in "Bovine Arc Aortic" with easy access to left artery.

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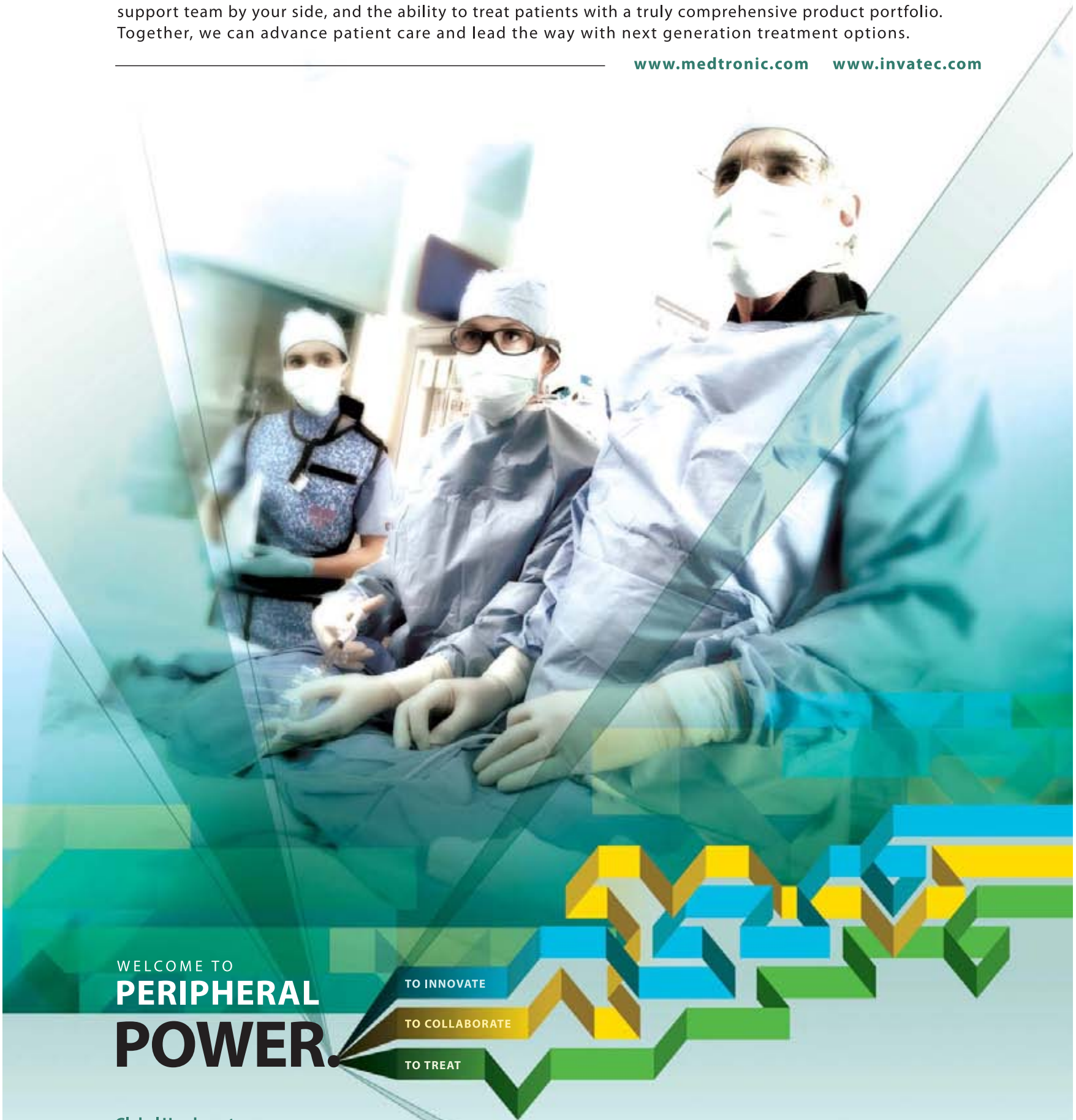

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