SOLACI DAILY

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Mexico City
Mexico

Welcome to SOLACI '12

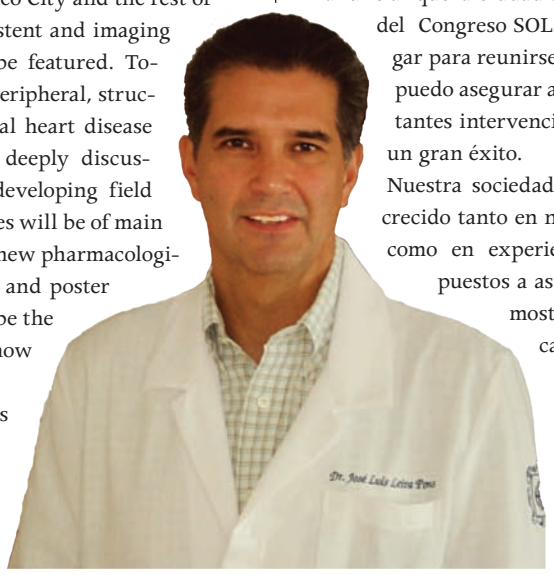
By José Luis Leiva Pons, MD
President of SOCIME

Dear friends and colleagues:

On behalf of the Mexican Society of Interventional Cardiology (SOCIME) and its members, I have the great pleasure to announce that Mexico City, host of the SOLACI Congress 2012, will be the place to meet, and from now I can assure all our interventional visitors that it will be a great success. Our Society is now mature, and has grown both in membership and expertise. We are ready to take the challenge to show our Latin American, and rest of the world friends, how Mexican interventionalists offer the best quality of care to our cardiac patients. With Dr. Joel Estrada, future president of SOCIME, Dr. Jorge Gaspar, president of the Scientific Committee, and all the SOCIME membership, I have the honor of leading this adventure.

Faculty from Mexico, Latin America, and the rest of the world will be joining us. Keeping with SOLACI's philosophy, SOCIME will take good care to organize high-level academic sessions, state of the art symposia, case presentation forums, and live case transmissions from the most important national hospitals both in Mexico City and the rest of the country. New stent and imaging technologies will be featured. Topics on coronary, peripheral, structural and congenital heart disease treatment will be deeply discussed. The rapidly developing field of valvular therapies will be of main interest, as well as new pharmacological strategies. Oral and poster presentations will be the window to show how Interventional Cardiology grows steadily in our Latin American countries.

(Cont.Page 3)



Bienvenido a SOLACI '12

Por Dr. José Luis Leiva Pons
Presidente SOCIME

Estimados amigos y colegas:

En nombre de la Sociedad Mexicana de Cardiología Intervencionista (SOCIME) y sus miembros, tengo el gran placer de anunciar que la Ciudad de México como sede del Congreso SOLACI 2012, será el lugar para reunirse, y a partir de ahora puedo asegurar a todos nuestros visitantes intervencionistas que va a ser un gran éxito.

Nuestra sociedad ha madurado y ha crecido tanto en número de miembros como en experiencia. Estamos dispuestos a asumir el desafío para mostrar a nuestra América Latina y el resto de los amigos del mundo, cómo los intervencionistas de México ofrecen la mejor calidad de atención a nuestros pacientes cardíacos. Con el doctor Joel Estrada, futuro presidente de SOCIME, el Dr. Jorge Gaspar, presidente del Comité Científico, y todos los miembros SOCIME, tendré el honor de dirigir esta aventura.

México, América Latina, y el resto de las facultades del mundo estarán con nosotros. Siguiendo con la filosofía de SOLACI, SOCIME tendrá buen cuidado de organizar sesiones de alto nivel académico, simposios de excelencia, foros de discusión donde se presentarán casos específicos y transmisiones en vivo de casos en los hospitales nacionales más importantes, tanto en la Ciudad de México como en el resto del país. Se presentarán nuevas tecnologías sobre stent e imagen. Los temas sobre el tratamiento de enfermedades cardíacas coronarias, periféricas, estructurales y congénitas serán debatidos intensamente.

(Cont.Pág. 3)

Acute Aortic Syndromes

By Leandro Lasave, MD

The term acute aortic syndrome (AAS) refers to a special acute condition of the aortic wall that affects the middle layer and carries a high risk of rupture. This condition causes a common set of signs and symptoms, the foremost of which is aortic pain. The pain is acute, intense and may be described as tearing, ripping or pulsating.

There are three interrelated entities that may cause an AAS: Aortic Dissection (AD-80%), Intramural Hematoma (IMH-15%) and Penetrating Aortic Ulcer (PAU-5%). The estimated incidence is about 2.6-3.5 cases per 100,000 persons/year. The associated risk factors are hypertension, dyslipidemia, age (>65 years), male and smoking. Marfan's syndrome and other genetic conditions are also associated with the syndrome.

AASs are classified according to the Stanford system: Type A involves the ascending aortic and Type B does not. This classification has both prognostic and therapeutic implications.

CT scanning, TEE, and MRI are all extremely accurate in the diagnosis of AAS. Therefore, the imaging strategy in patients with suspicion of AAS depends on both the equipment available and the experience of the operator and institution.

Aortic Dissection (AD) is characterized by the rapid development of an intimal flap separating the true and false lumens. Type A is more frequent (75%) and is highly lethal, with a mortality of 1-2% per hour after symptoms onset. Without surgery, mortality exceeds 50% at 1 month. Uncomplicated Type B has a 1-month mortality of 10% and may be medically managed.

The initial medical therapy is mandatory to avoid extension and rupture. Surgery is indicated on type A and endovascular... *(Cont.Page 3)*

SOLACI Online

By Gustavo Bren, MD

Dear SOLACI 2012 in partnership with TCT Participants:

We are honored with your presence.

We are living in a constant changing world, with new paradoxes, that is why as Albert Einstein said: "The measure of intelligence is the ability to change."

SOLACI is adapting to the new circumstances, and as always remains committed to offer to the LATAM community the most updated information in interventionism. We deliver this through means of our annual congress in different countries, educational initiatives such as regional meetings, and ProEducar for our colleagues Fellows. Our interactive web page and smartphone application are based on the most innovative platforms and provide fast, reliable information. The world is everyday shifting toward more technological users and devices, and because of this we are proud to offer our new app "SOLACI Inmotion." Several new sections were created to satisfy not only the needs of Interventionist but also, Clinical Cardiologists, Patients, Technicians and Nurses. The industry has clear and concrete channels to get in touch with these decision makers throughout LATAM by hosting with cutting edge technology on our new web page. Important agreements with entities such as CRF/TCT, ACC, The Heart, EuroPCR and SBHCI among others, maximize our expertise. The objective is to transform SOLACI into the Interventionism LATAM source where you will find the most essential data.

Many challenges are ahead in this changing world and we leave you with one: **Become a SOLACI Associate.**

Gustavo Gabriel Bren
General Manager, SOLACI

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[SOLACI 2012]

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(Cont. of "Welcome to SOLACI 2012")

Nurses and cath lab technicians will also have their own meeting. These "real heroes behind the scenes" are also willing to share their knowledge and skills, to assure excellent results to our patients. Interventional Cardiology fellows will also have the opportunity to get together with their teachers and other admired physicians from other countries. After SOLACI Mexico 2012, they will certainly be eager to continue with their training and become part of this family.

Mexico will not only be for science. I invite everybody to discover our culture, visit our historical buildings, and to treat yourselves with our Mexican wines, beers, and spicy hot tacos, while you listen to the mariachi.

Be part of the greatest Latin American interventional experience!

Sincerely,
José Luis Leiva Pons
President, SOCIME

(Cont. of "Bienvenido a SOLACI 2012")

El campo que se desarrolla rápidamente sobre terapias valvulares será de mayor interés, así como las nuevas estrategias farmacológicas. Las presentaciones orales y en stands serán la ventana para mostrar cómo la Cardiología Intervencionista crece de manera constante en nuestros países Latinoamericanos.

Las enfermeras y técnicos de laboratorio de cateterismo también tendrán su propia reunión. Estos "héroes reales detrás de la escena" también están dispuestos a compartir sus conocimientos y habilidades, para asegurar el excelente resultado a nuestros pacientes. Compañeros de cardiología de intervención también tendrán la oportunidad de reunirse con sus maestros y médicos admirados de otros países. Después de SOLACI México 2012, tendrán sin duda ánimos de seguir con su formación e integrarse a ésta gran familia.

México no sólo mostrará su capacidad para la ciencia. Los invito también a descubrir nuestra cultura, visitar nuestros edificios históricos y museos, disfrutar nuestra gastronomía con vinos mexicanos, cervezas y tacos picantes calientes, mientras escuchan mariachis.

¡Sean parte de la mayor experiencia de intervencionismo de América Latina!

Atentamente,
José Luis Leiva Pons
Presidente SOCIME

(Cont. of "Acute Aortic Syndromes")

treatment could be considered in complicated type B (persistent or recurrent pain, aortic expansion, dissection progression, and end-organ malperfusion syndromes).

Intramural Hematoma (IMH) is defined as a contained hemorrhage within the aortic layers in the absence of an intimal tear. It has a dynamic evolution with regression (10%), progression to AD (28-47%) and a risk of rupture (25-45%). The following variables are associated with worst prognosis: age >70, aortic diameter >50mm (type-A) or >60 mm (type-B), hematoma thickness >11 mm, localized dissection, pleural/pericardial effusion, cardiac tamponade and recurrent pain. On imaging, IMH appears as a smooth, crescentic or circular thickening greater than 5-7 mm.

Penetrating Aortic Ulcer (PAU) is a focal atherosclerotic plaque that corrodes a variable depth through the elastic lamina into the media. Similar to IMH, most are type B and occurs in patients with advanced atherosclerosis. There is a strong association with concomitant abdominal aneurysms. Complications of PAU include development of pseudoaneurysm, progression to AD or rupture in up to 40% of patients. Recurrent pain, increasing pleural effusion, PAU diameter >20mm and depth >10 mm are associated with worst prognoses. On imaging, PAU can be distinguished from an atheromatous plaque by presence of a focal, contrast-filled outpouching surrounded by a hematoma.

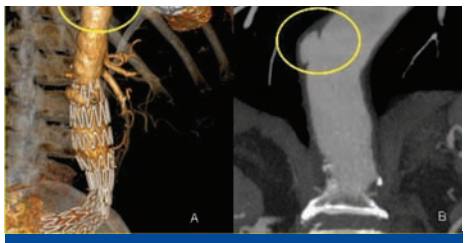

Figure 1: 64-slide TC. Type B PAU in patient with previous endovascular treatment of AAA

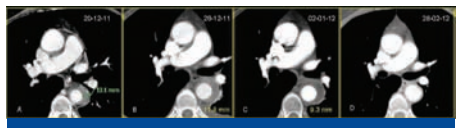

Figure 2: 64-slide TC. Regression of Type B IMH in a stable patient medically treated

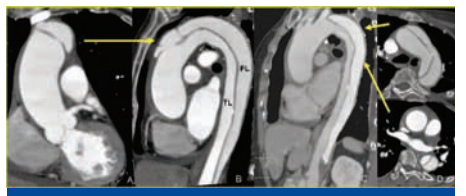

Figure 3: 8-slide TC. Type A Aortic Dissection

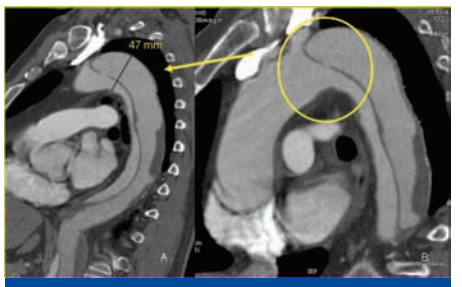

Figure 4: 64-slide TC. Type B Aortic Dissection

Leandro Lasave, MD
Department of Interventional Cardiology, Instituto Cardiovascular de Rosario, Rosario, Argentina.
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ProEducar SOLACI, Director of Educational Newsletter.

	MAIN ARENA TERRAZAS	ROOM CHAPULTEPEC	ROOM MOLINO DEL REY	ROOM ARCOIRIS	ROOM JARDÍN
8:00 - 10:00	Live Cases I-IV	Peripheral Intervemtions Carotid Revascularization	Clinician's Forum_ Periprocedural Managemen of the PCI Patient	Abstract Sessions I- II	Health Services Quality, a Current Need
10:00 - 10:15				BREAK	
10:15 - 11:45	Plenary Session Coronary Stents		Peripheral: Systemic Venous Diseases: New Opportunities for Catherer-based Treatment	Pediatric Interventions Wich, When and How: Imaging Techniques or Congenital Heart Disease Interventions	
11:45 - 13:15	Live Cases V- VII	Interventional Pharmacology I Antiplatelet Agents	Bioabsorbable Stents	Pediatric Interventions Hybrid Procedures for Congenital Heart Disease	Acute Coronary Syndromes
13:15 - 13:30				BREAK	
13:30 - 15:00	Lunch Symposium sponsored by **MERIL LIE SCIENCE** New rontiers in Interventional Cardiology	Lunch Symposium sponsored by **BOSTON SCIENTIFIC** Innovation in Interventional Cardiology	Lunch Symposium sponsored by **MEDTRONIC** Complex Cases	Lunch Symposium sponsored by **ST. JUDE** Amplatzer Cardiac Plug and New Devices or Structural HD	
15:00 - 15:15				BREAK	
15:15 - 16:45	EuroPCR @SOLACI2012 Current Management of NSTEMI-ACS	Peripheral Thoracic and Abdominal Aorta	Clinician's Forum_ Stent Thrombosis and Restenosis	Canned Cases I Cases 1 to 6	Diagnostic Methods
16:45 - 17:00				BREAK	
17:00 - 19:00	Live Cases VIII - XI	Critical Limb Ischemia	Clinician's Forum_ Patient Selection for TAVR	Adult Congenital HD: Aortic Coarctation & PDA	Abstracts Presentation
19:00 - 19:15				BREAK	
19:15 - 20:45	Opening Ceremony & Cocktail				

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Endoluminal Treatment for Critical Lower Limb Ischemia

By José L. Assad-Morell, MD

Critical limb ischemia (CLI) includes persistent ischemic rest pain (Rutherford Category 4), ulceration or gangrene of foot or toes (Rutherford Category 5 and 6), critical reduction of arterial perfusion with objective criteria such as ankle systolic pressure < 50 mmHg, systolic pressure of the toe < 30 mmHg and ABI < 0.5. The first aim of angioplasty in CLI is to restore a direct blood flow to the foot circle.

In CLI patients, to achieve pulsatile flow, treatment of foot arteries is essential. Dilation of a proximal (inflow) lesion alone in the setting of a distal arterial occlusion may not be adequate to achieve wound healing. The clinical goals in treatment of CLI are no ischemic rest pain, wound healing and avoidance of amputation, mobilization and improvement of survival.

The below the knee (BTK) crossing strategies techniques are the Antegrade Femoral Approach (endoluminal, subintimal, trans-collateral, pedal plantar loop technique) and Retrograde Approach with puncture under fluoroscopy and contrast injection, using the sheathless approach for transpedal recanalization. The modern Retrograde Approach includes no introducer using a 20-G radial needle, 0.014'' regular, hydrophilic or CTO wires, OTW low profile balloons and a snare kit. The Potential Solutions in the Antegrade Femoral Approach include Plain Old Balloon Angioplasty (POBA), improved angioplasty to avoid stenting (Cutting Balloon, Scoring Balloon, Crioplasty, Drug Eluting Balloons/DEB), Atherectomy (directional, rotational, laser) and improved stenting concepts (Drug Eluting Stents / DES and Bioabsorbable stents).

The Acute Results Optimization is obtained with 4F low profile balloons, the balloon race is ''longer is better,'' conic shape, high pressure and bailout stenting when necessary.

Prevention of Restenosis can be improved with DES and Nitinol Self Expandible Stents, as well as DEB. Recent Randomized Controlled Trials using DES (Achilles, Destiny, Yukon-BTK and Multicentric European Trial with Sirolimus and Everolimus eluting stents) have shown patency at one year of 80 – 85%. Also, the randomized trials using Drug Eluting Balloons, such as the Debellum and Debate Trials (Paclitaxel), and also the Leipzig Registry, have shown that DEB are superior to POBA, reducing the rate of restenosis, reocclusion and target vessel revascularization in patients with diabetes, long and multilevel lesions. Prevention of Amputation is just part of the puzzle. Though revascularization is imperative, wound management and mobilization are also crucial.

In conclusion, surgery has been replaced by endovascular revascularization for CLI. Emergence of Endovascular Treatment has resulted in marked decrease in bypass and amputation. If measured at follow up in the period 12 to 24 months, rescue revascularization with creative surgery and endovascular technique in patients with CLI achieves a goal of 85-90%.

José L. Assad-Morell, MD
Director, Division of Cardiopulmonary Studies, Christus Muguerza Alta Especialidad Hospital, Monterrey University School of Medicine, Monterrey, N.L., México

Article by Meril Life Sciences

NOVEL DES CONCEPTS - BIOMIME™ - SIROLIMUS ELUTING CORONARY STENT SYSTEM

Meril's BioMime™ Sirolimus Eluting Coronary Stent pushes DES towards biomimicry concept.

The base stent is an ultra-low (65µm) thickness Cobalt Chromium (L605).
Its novel design incorporates an intelligent mix of open and closed cells allowing for morphology mediated expansion. This hybrid stent demonstrates high radial strength combining with flexibility. The delivery system maintains short-abrupt-balloon-shoulders to minimize balloon related edge injuries.
The stent surface is coated with a formulation of biodegradable polymers – PLLA+PLGA and Sirolimus (1.25µg/mm2), which elutes over 30days.

meriT-1, 2 and 3 studies have established BioMime's safety and efficacy in clinical settings and currently the device is routinely used in cathlabs.

meriT-1 (n=30), the FiM study and has consistently demonstrated 0% MACE/ST >2 years offollow-up, with a late-loss of 0.15mm. meriT-2 (n=250) complex patients and demonstrates low(<5%) TVF rates and 0.5% ST beyond 1year. meriT-3 (n=1161) documented low MACE of 4.4% and 0.5% ST in real world patients.

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.

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- **NexGen™ - Cobalt Chromium Coronary Stent System**
- **Crypton™ - Stainless Steel Coronary Stent System**
- **Mozec™ - Rx PTCA Balloon Dilatation Catheter**
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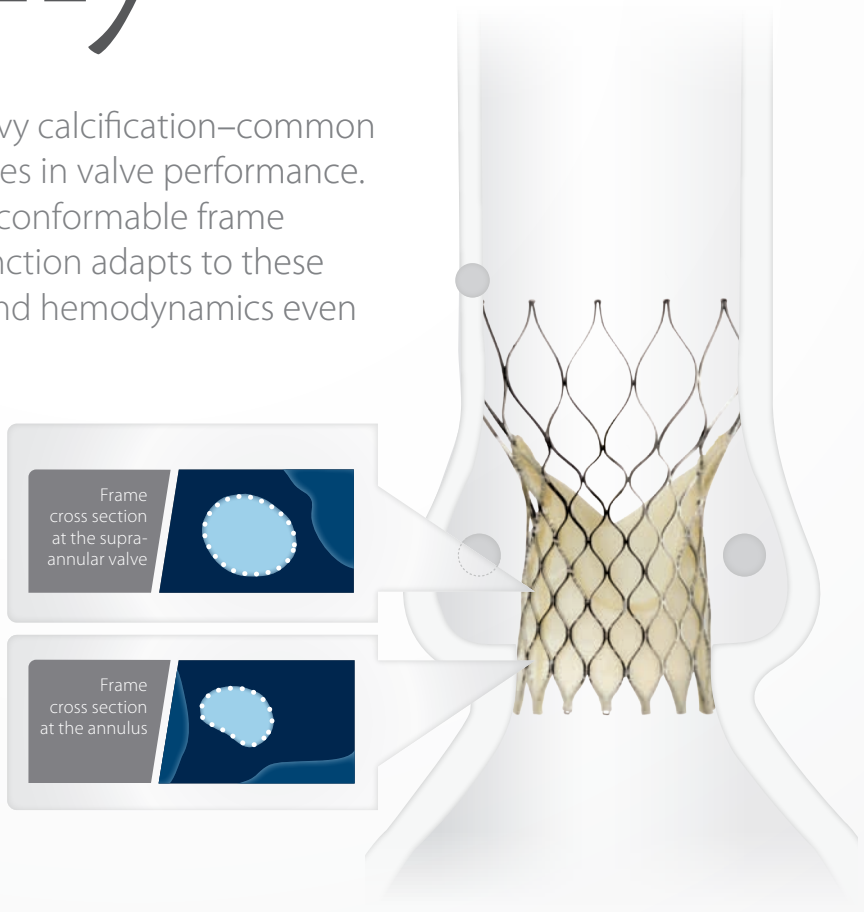

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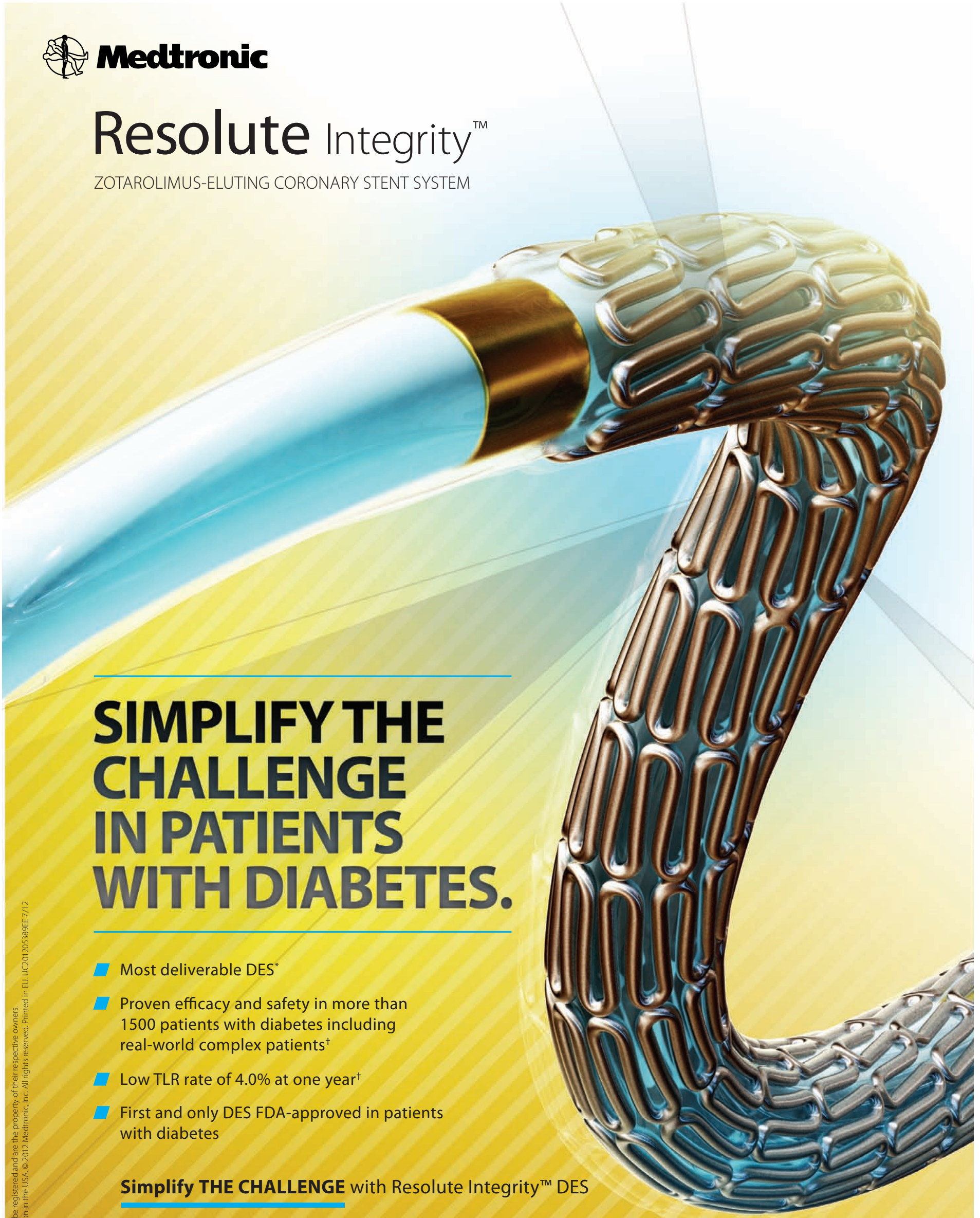

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* Bench test data vs. competitors on file at Medtronic, Inc.
† Silber S. Pooled post-hoc analysis of Resolute ZES in patients with DM. TCT 2011.

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"Critical Analysis of the Scientific Program: Have We Met the Objectives?" From IMPRESS to CEREA-DES

By Jorge Gaspar Hernández, MD

I have been asked to write a note for the SOLACI 2012 Daily with the abovementioned title. As Chair of the Scientific Committee, to judge the scientific program makes me play the role of arbitrator and player in unison (a simile in keeping with the current Olympic game ambience). To minimize the inconvenience of this bias-prone situation, I aim to make this note an exercise of self-criticism, similar to how we as interventional cardiologists should act: not to be routinely content with our results.

Having mentioned this, I seize the opportunity to state my personal opinion that it is becoming too often said during Live Cases "I think it is a good result!" despite a result that could –and on occasions should- be improved on. When this is said by the moderator it is usually by reason of politeness (a demeanor certainly to be commended), but when voiced by the operator it denotes a lack of self-criticism. In both situations this contentedness can send a wrong message to the attendees, particularly to our younger colleagues. We all have sensed true satisfaction following certain interventions: this reaction is at it's most when the procedure was flawless and the result was ideal. This is because we know that a flawless procedure translates as safety, and an ideal result as better outcomes. Why then, not strive to achieve this in every single procedure? Much can be said of attaining a flawless procedure but I'll have to leave it in a nutshell called **"clean technique"** and still more would have to be pondered about striving for an ideal result, this I'll have to put in a USB labeled **"perfection curbed by a lucid mind".**

Have we met the objectives of the scientific program?

These objectives, as agreed with the Governing Council, were: 1) to emphasize those topics at the top of current interest as well as those that are spearheading the ever advancing field of cardiovascular interventions, 2) to have the leaders in the latter fields as invited faculty, 3) to offer topics as updated as possible, 4) to increase the content of non-coronary interventions while maintaining a balance considering the significantly higher prevalence of coronary procedures in every day practice, 5) to expand the program content to attract the interest of the clinical cardiologists while keeping within the field of interventional cardiology.

These objectives were to be met while also accomplishing the goals a) of keeping the practical aspects in focus (i.e., what to take, not home, but to the office, the hospital wards and cath labs), and b) of increasing the participation of Latin American colleagues as faculty.

The first objective, curbed by the goal of practicality, has been met by the program (OCT, CTO, TAVI, SRD) although it should be recognized that the second objective was only partially met because the original faculty had to be significantly cut back by cost restrictions. To accomplish the third objective, the topics were selected and their precise titles were carefully worded with most of the scientific committee to assure precise and updated lectures; although emphasis was made to key speakers to include updated information of ongoing trials, it has already been noted to us that there is no late-breaking trial session, a need that we accept should be specifically addressed in following meetings. A glance at the program will suffice to note that the fourth objective has been amply carried out and it should be pointed out that these sessions have been enriched by the participation of excellent leaders in cardiovascular imaging, interventional radiology, neurointervention, neurology, endocrinology, as well as by angiologists, cardiovascular surgeons and clinical cardiologists. Finally, the fifth objective has been so taken into account that a series of sessions labeled as **"Clinician's Forum"** were planned and in which the experiences, doubts and ideas that will be exchanged will surely help improve the medical care that we provide. However, I recognize that the goal of increasing the Latin American faculty could not be fully met as a significant number of colleagues of distinction have not been included.

Now I'll return to "flawless procedure and ideal result" as leitmotiv: the planning and execution of the scientific program was not flawless, however I am confident that we will have a "good result". This is to say we recognize errors made and are evaluating how to best avoid them as well as how to correct them if they should again occur and transmit this experience to the organizers of following SOLACI meeting, in observance of the leitmotiv.

To close, I want to thank Dr. Oscar Mendiz, Dr. José Luis Leiva Pons, Dr. Guering Eid-Lidt and Ms Carolina Serra: your tremendous commitment and many hours of hard work resulted in a perfect stent for this procedure.

Jorge Gaspar H, FESC, FACC, FSCAI
Head, Interventional Cardiology,
Instituto Nacional de Cardiología
Ignacio Chávez

Article by Boston Scientific

ION STENT
The perfect balance between experience and evolution

By Pablo Kantor, MD

Among the first DES to appear in the marketplace, the ION stent (an improved version of the TAXUS stent) is the only one to have stood the test of time. This is undoubtedly so due to the excellent clinical outcomes obtained in a large number of scientific studies and to the fact that the ION stent has reinvented itself time and again, adapting to new demands inherent in the increased complexity of procedures.

The TAXUS stent, updated to its last generation, ION, has an undisputed history, since for more than 10 years it has written and transformed angioplasty indications, both regarding the type of device to use and treatment indications for different anatomic scenarios, previously considered almost exclusively for surgery or other treatments.

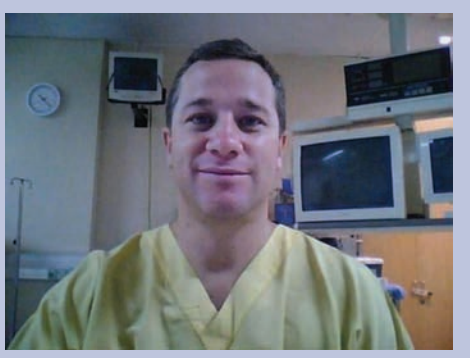
In its early days, the TAXUS IV study showed the DES safety and efficacy in 1,324 highly selected patients, paving the way to a new stage in Interventional Cardiology. Subsequently, the TAXUS DES was no longer just limited to selected patients but indicated for increasingly complex situations, such as for diabetic patients, where Paclitaxel (drug released by this DES) showed some advantages over "-olimus" drugs released by others.

Intrastent restenosis, typical of the BMS, was a clinical scenario that was very difficult to solve. At that point brachytherapy was the gold standard for that problem, but the TAXUS V ISR study allowed changing this treatment paradigm, leaving brachytherapy behind as an obsolete treatment.

When doubts about the stent thrombosis risk related to DES, the treatment of a highly thrombotic syndrome such as Acute MI arouse different opinions among interventional cardiologists regarding the use of DES in primary angioplasty. However, once again, by means of the HORIZONS study, the TAXUS stent went past that barrier when it proved the benefits of its use in this clinical scenario in over 3,000 patients.

For many years, surgery was considered to be almost the only possible treatment for the left main coronary artery lesion. The BMS restenosis in this complex anatomic scenario did away with the possibility of performing coronary angioplasty in these patients. Approximately 40% of patients included in the SYNTAX study had left main coronary artery lesion. Out of these, those without a high risk score had a similar or even better evolution after treatment with DES than with surgery, and this changed the treatment paradigm of myocardial revascularization once again.

Thus, the history of DES was written in part thanks to the results obtained with the TAXUS DES, which reinvented itself and adapted to new requirements, going from its first NIR platform in early research studies to its EXPRESS platform with which it was initially marketed. Subsequently, the need to reduce the metal thickness in the platform to facilitate its release with a potential benefit in clinical outcomes turned the LIBERTE platform into the next TAXUS stent version. Finally, the ELEMENT Platinum-Chromium platform, with one of the thinnest struts in the marketplace and a design that guarantees maximum flexibility, deliverability, conformability and radial strength, in addition to minimal recoil, resulted in the latest version of this DES generation, the ION stent which, supported by the PERSEUS work horse, PERSEUS long lesion and PERSEUS small vessel clinical studies, combines EXPERIENCE and EVOLUTION.



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Renal Denervation

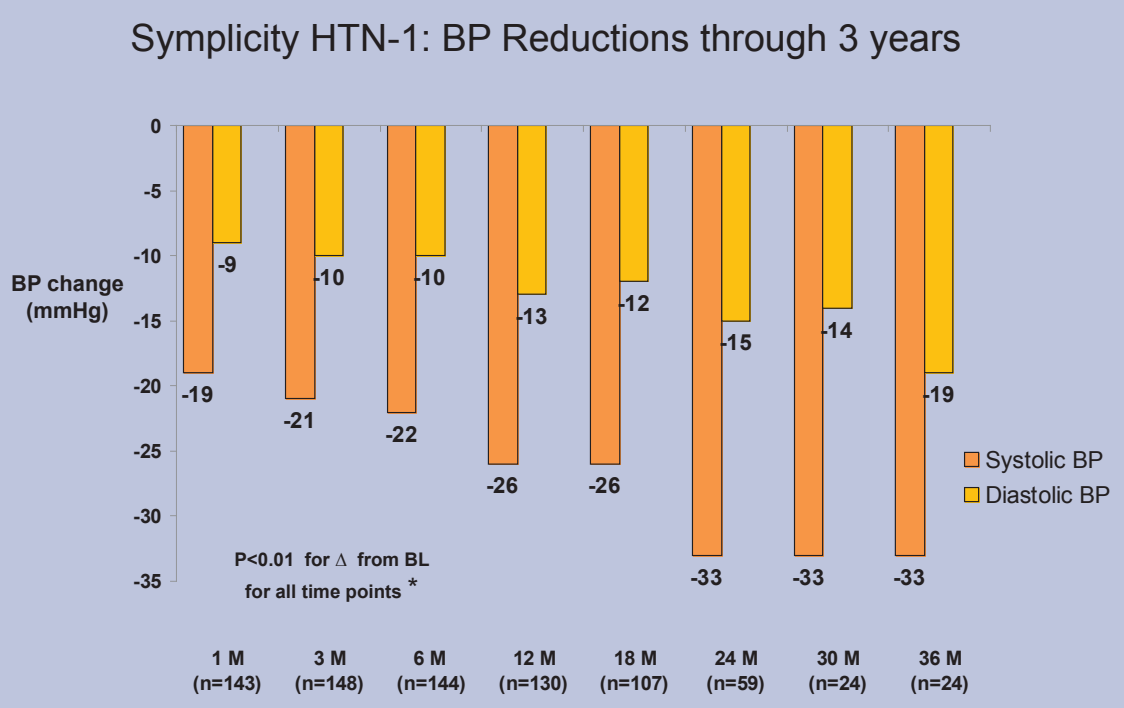
Renal Denervation for Resistant Hypertension

By Erwin Blessing –Interventional Cardiologist - Klinikum University Heidelberg, Germany -

Arterial hypertension remains the single largest contributor to death worldwide. Epidemiological data clearly demonstrate that even small decreases in systolic blood pressure (SBP) result in a significant reduction of cardiovascular mortality (2 mm reduction of SBP reduces stroke mortality by 10% and mortality due to ischemic heart disease by 7 %). Despite treatment, many patients with hypertension do not achieve blood pressure control.

The incidence of true treatment resistant hypertension is estimated to be in the rage of 5 to 15% among all hypertensive patients. Sympathetic over activity is frequently observed in that patient cohort. Renal denervation (RDN) therapy offers a catheter based therapeutic tool that directly tackles overactivity of the sympathetic nervous system.

Worldwide more than 5000 patients underwent RDN therapy up to date. Data from the Symplicity HTN-1 trial showed that the method can be applied without major complications and that renal denervation results in a significant (-33 mm Hg compared with baseline) and sustained reductions of office systolic blood pressure out to 3 years (Figure). Symplicity HTN-2, a randomized, controlled multicentre trial confirmed safety and efficacy of RDN therapy with a significant difference between treatment arm and control group (mean office SBP reduction of 32 mm Hg compared with control group after 6 months).



*Expanded results presented at the *American College of Cardiology Annual Meeting 2012* (Krum, H.)

The Symplicity HTN-3 study is a US trial, evaluating RDN in a double blind, randomized, controlled setting and started enrolment early this year. Furthermore, the Global Symplicity register is underway to evaluate the Symplicity system in a real-world scenario. Whether RDN might also be beneficial in other disease areas, associated with chronic overactivity of the sympathetic nervous system, such as heart failure and chronic kidney disease, is also going to be evaluated in future trials.

The vast majority of clinical trial data were obtained using the radiofrequency (RF) based Symplicity System (Medtronic). Results from other RF as well as from non RF-based therapies (ultrasound) were presented at this year's Euro PCR meeting in Paris. Several small, non randomized, first in man trials also demonstrated safety and efficacy of those devices, supporting the general concept of renal denervation in patients with treatment resistant hypertension. However, randomized controlled trials are required to demonstrate sustained results for these newer devices before they meet the benchmark set by the Symplicity system.

Education and Training in Interventional Cardiology

Interview with Dr. Guillermo Migliaro

By José Álvarez, MD

People usually use "education" and "training" as synonyms. Is this correct?

No, although closely related, education usually refers to the communication or acquisition of knowledge or information while training refers to acquisition of skills, either cognitive or psychomotor.

What is Virtual Reality Training (VRT) and how does it apply to Interventional Cardiology?

Training is a key area that must be tackled to positively affect the problem of medical errors.

Interventional Cardiology is a rapidly evolving speciality, but in Latin America training has remained unchanged. The majority of procedural training still occurs on patients with direct monitoring by experienced physicians during a clinical procedure. There are several concerns related to this method.

A vascular simulator is a device consisting of a personal computer-based software interface coupled with a mechanical device that allows the user to insert and manipulate catheters, wires, balloons, protection devices, stents or valves. Real instruments are used on the device and fluoroscopic imaging is simulated and activated with a foot pedal.

What are the advantages of VRT?

One of the major advantages of VRT is that the opportunity to train is available without exposing the patient to risk.

Do you think that VRT will replace the traditional mentored method with real patients?

Not really. VRT is more likely to be successful if it is systematically integrated into a complete education and training program, and we know that this kind of training is more likely to be successful if the training schedule takes place on an interval basis rather than massed into a short period of extensive practice, but it is only the beginning of training and does not replace practising on patients under proctor supervision.

Note: Dr. Migliaro is associated director in the post graduate course for the speciality of Interventional Cardiology in Argentina.

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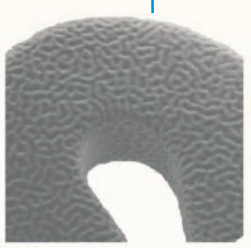

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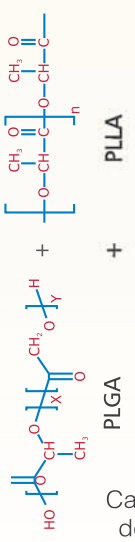

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1. Datos de los archibos de Meri Life Sciences

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