A new ‘village’ system to keep subject themes closer together

Your forum for education, research and networking

WITH MORE THAN 400 scientific sessions, an abstract programme selected from more than 10,000 submissions, and around 30,000 in attendance, ESC Congress 2011 will once again be the world’s biggest and brightest meeting in cardiovascular medicine.

The spotlight of this year’s event is “controversial issues in cardiology”, which, says programme committee chairman Professor Michael Böhm, are a consequence of so many new developments and their introduction into routine practice. Many sessions in the prearranged programme specifically address the difficulties they raise. “We see controversy in drug treatment, interventional treatment and in public health,” says Böhm.

The ESC Congress is now indisputably the number one international event in cardiology, reflected in the high number of submissions from non-European countries and in participant registrations. Indeed, says Böhm, more abstract submissions for 2011 were received from Japan than from any other country.

As ever, the Hot Line sessions will make headlines around the world, and the outcome of many of the featured trials will shape the treatment of cardiovascular disease in the years to come. Of particular interest this year, says Böhm, will be anticoagulation in atrial fibrillation with factor Xa-inhibitors and thrombin antagonists.

Updates from registries
In addition, among the many reports submitted for the Hot Line and Clinical Trial Update sessions were results from several registries, many deemed so important that two dedicated registry sessions have now been introduced into the late-breaking scientific programme. “Registry data has been a big trend this year,” says Böhm, “and these details will bring a new insight into how we manage our patients.”

This year the congress will be organised on a village system, with presentations on each topic kept in close geographical proximity with each other. “We’re hoping that participants will find it easier to follow their areas of interest,” says Böhm.

Two innovations introduced last year will be prominent once again. The “ESC Cardiologists of Tomorrow” group has provided a complete track throughout the programme, including 43 case reports selected from 340 submitted, to be presented in interactive sessions. Today will also feature a bilingual practical training day for general medical practitioners, with sessions held in French and English. “This is an initiative which involves a range of specialists,” says Böhm, “including family doctors and consultant cardiologists, nurses and lab technicians. They will all play a part in this year’s scientific programme, with something here for everybody.”

And all will find a welcome at ESC Congress 2011, with endless opportunities for education, research and networking with colleagues from around the world. With the continuing support of industry, the latest pharmaceutical and equipment innovations will also be on show in what is undoubtedly the world’s largest medical exhibition centre.

With more than 150 prearranged sessions featuring debates, symposia, clinical seminars and “how to” and “meet the expert” sessions, there are multiple opportunities for updating clinical skills. FOCUS sessions, in imaging and everyday practice, integrate the live audiovisual experience with expert review and comment.

Each of this year’s record 10,881 submitted abstracts has been peer reviewed, with 4300 accepted. The highest score will be presented in nine State of the Art and Featured Research sessions. Also new this year is a Gender track presenting abstracts on gender-related topics in CVD. And the prearranged programme will as always cover all the latest developments in cardiovascular medicine. Böhm singles out progress in resistant hypertension and in the non-invasive treatment of valve disease as two likely areas of interest.
La Parisienne Isabel Bardinet, the ESC’s Chief Executive Officer, takes us on a guided tour of the Paris she grew up in.

Statistically, congresses held in Paris have always attracted more participants than those in other major European cities. And today Paris remains as attractive as ever, a city with many unique selling points for the congress organiser. Having lived there for many years, I can say from experience that this city is a kaleidoscope of attractions, whether cultural, architectural, gastronomical, fashionable or others less obvious. To enjoy and discover Paris you need to choose your theme – as a lifetime is not long enough to do everything!

**Architectural**
The not-to-be-missed Eiffel tower, the Arc de Triomphe with a breathtaking view from the roof, or the top floor of the Tour Montparnasse with its unique panorama of Paris (and a restaurant) and of the multitude of churches from the middle ages to the 19th century.

**Gastronomical**
Food . . . where to start? Or more to the point, it’s a never-ending list! Try the original Paris bistro, Chartier, in Montmartre, very cheap and cheerful, the brasseries, brunch on a barge at the foot of Notre Dame, ice cream on the Ile Saint Louis at Berthillon’s, or elegant Michelin star restaurants . . . the choice is yours.

**Fashionable**
Shopping . . . well, shopping is the favourite Parisian sport, from the flea markets on Saturday, Sunday, Monday, to the big department stores on Boulevard Haussmann, to the fun and exclusive Rive Gauche shops at St Germain des Prés, or to the bright lights of Champs Elysées. And don’t forget the Place Vendôme jewelers or the more exotic Chinatown in the 13th district.

But most of all, Paris is made for walking, left bank or right bank, Eiffel Tower, Champs Elysées, Le Marais or Bou’ Mich, Montmartre or l’Ile Saint Louis, the Sorbonne and the Latin quarter. Just stroll along and discover that special thing made just for you.

**Cultural**
Museums begin with the world famous Louvre. Don’t miss the French paintings before or after Mona Lisa, as they are quite unique. Impressionists are at the Musée d’Orsay. You’ll find Pierre and Marie Curie’s still radioactive office at the Curie Museum. Roman baths and the Dame à la licorne at Cluny Museum are some other favorites . . .

If museums and galleries are your choice, consider buying a museum pass, which grants you a fast-track access and can be bought on a one, two or more day basis - and can include transport with metro and bus rides.

**Ellie Tower, Arc de Triomphe, Montparnasse**

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**ESC Congress returns to Paris after more than 30 years**

Michel Bertrand, President of ESC from 1991 to 1994, looks back on the early days

**IT IS NOW 31 YEARS since an ESC Congress was last in Paris. In 1980 ESC congresses were quadrennial and always organised by a National Society. Thus, the Board of the French Cardiac Society duly appointed a committee, which included Paul Puech (Montpellier, chairman), Henri Bricaud (Bordeaux), Michel Degeorges (Paris), Jean-Pierre Delahaye (Lyon), Michel Bertrand (Lille), André Barrillon (Paris), Philippe Coumel (Paris) and Samuel Levy (Marseille). For the four years before the congress the committee would regularly meet in the cardiology library of the Pitié-Salpêtrière hospital to deliberate.**

The congress, held in the Convention Centre of Porte Maillot under the presidency of Professor Puech, was very well attended, with almost 6800 participants. Along with the scientific programme, a superb reception was organised in l’Orangerie of the Chateau de Versailles (pictured left). The next ESC Congress, in Düsseldorf in 1984, was the last to be organised by a National Society. The ESC Board thereafter agreed to move to an annual event centrally organised. The first was held in Vienna in 1988, but two others were later staged in France, in Nice in 1989 and 1993. Thus, after 31 years, the ESC Congress is back to Paris with another superb scientific programme and excellent organisation performed by the staff of the European Heart House.
By JEROEN J. BAX
Professor of Cardiology
Leiden University Medical Center,
The Netherlands

FOUR NEW guidelines have been completed this year, and all will be introduced during this congress. The first, on the ESC Guidelines on the management of cardiovascular diseases during pregnancy, was headed by Professor Vera Regitz-Zagrosek from Berlin. The initial ESC expert consensus document on this subject was published in 2003. Now, the new ESC guidelines have nicely summarised our currently available data and provide comprehensive guidance for the pre-pregnancy counselling of women with heart disease and the management of any cardiovascular disease during their pregnancy and delivery, including the post-partum phase.

The second is the joint ESC/European Atherosclerosis Society guideline on the Management of dyslipidaemias, whose Task Force was headed by Professors Zeljko Reiner and Alberico Catapano. Since 1994 both the ESC and the EAS have contributed jointly to the guidelines on CVD prevention, but now for the first time both societies have collaborated on recommendations for dyslipidaemias. Clinicians from both societies have worked together and considered all the available evidence and expertise on the effectiveness and safety of lifestyle and drug treatments within the broader framework of CVD prevention.

The third 2011 guideline concerns the ESC Guidelines on the diagnosis and treatment of peripheral artery diseases and was jointly chaired by Professors Michal Tendera and Victor Aboyans. These guidelines are a new departure for the ESC, and the document addresses the atherosclerotic changes in the carotid, vertebral, upper extremity, mesenteric, renal and lower extremity arteries. Importantly, the guidelines propose management strategies in patients with multi-site arterial disease, especially those with involvement of the coronary arteries. Representatives of many specialties worked together in the preparation of this document, including cardiology, vascular surgery, neurology and angiology.

The fourth publication concerns the management of acute coronary syndromes in patients without ST-segment elevation and its Task Force was co-chaired by Professors Christian Hamm and Jean-Pierre Bassand. There have been ESC guidelines on this subject since 2000, with updates in 2002 and 2007. This latest document, ESC Guidelines for the management of acute coronary syndromes in patients presenting without persistent ST-segment elevation, provides another high quality edition.

The production of these four new ESC guidelines would not have been possible without the enormous efforts of the ESC guidelines team, headed by Veronica Dean. They ensured not only the timely publication of the documents, but also the delivery of essential messages, the handy pocket guidelines and the accompanying slide sets.

The four Task Forces and their respective chairs are to be congratulated for their extensive efforts! All four 2011 ESC Guidelines provide an excellent summary of the latest information on these different topics and will provide an invaluable resource for all healthcare professionals involved in the care of patients with cardiovascular disease.

There are two sessions of Meet the Guidelines Task Force on Tuesday morning, when all four documents will be presented and discussed.

Satellite Symposium:
A New Implantable Wireless Device* for Monitoring Pressure in Heart Failure Patients

LOCATION: Parc des Expositions de Paris Nord Villepinte, ZAC Paris Nord 2 - 93420 Villepinte France
ROOM: Tunis - Zone F
TIME: 12:00-13:30
DATE: Saturday, 27 August 2011

CHAIRPERSONS
John Cleland, MD
William Abraham, MD

SPEAKERS
Martin Cowie, MD
Philip Adamson, MD
William Abraham, MD

*Lunch Will Be Served
*This device has CE mark for limited indications

organised by: cardiomers
**Is diet alone sufficient to reduce the risk of cardiovascular disease?**

**Yes**, say Steven F. Horowitz, Stanford Hospital, Connecticut, and Columbia University College, New York, USA, and Dean Ornish, Preventive Medicine Research Institute, University of California, San Francisco, USA

CORONARY ARTERY disease represents the end-product of a myriad of complex interactions between genetic susceptibility, environmental factors and lifestyle choices. Numerous genetic markers have been discovered that are tied to the development of the disease, and new genes are discovered with increasing frequency.

Nonetheless, patterns of disease occurrence around the world suggest that CVD is an acquired condition more than a truly genetic one. For example, disease incidence varies widely from country to country, can change with time within the same region and affects migrant populations as they take on the risk of their adopted homelands.

The nature of large-scale dietary interventions precludes the use of placebo-controlled trials. However, confirmatory evidence of the value of very low saturated fat diets rich in plant-based whole-foods has been derived from trials using an assortment of other accepted techniques. Methods used to study the impact of dietary interventions have included serial quantitative coronary angiography, positron emission tomography, large prospective observational studies, meta-analyses, meta-regression, condition, biomarkers and gene expression. Using quantitative angiography and positron emission tomography, we were the first to demonstrate (in 1990) the engineering of CAD regression without the use of medication in patients who adhered closely to a lifestyle intervention programme that included a low fat vegetarian diet.\(^1\) The study, extended to four years, showed progressive quantitative angiographic improvement compared to controls.

More recently, Dod et al compared 27 study participants with coronary disease who followed a low fat, vegetarian diet and lifestyle intervention with 20 matched controls. After the intervention group demonstrated reductions in high sensitivity C-reactive protein, interleukin-6 and adhesion molecule expression while endothelial-dependent flow-mediated dilatation increased.

**No**, says Peter Sleight, Professor Emeritus of Cardiovascular Medicine, University of Oxford, UK

WE CAN ALL agree that diet alone can indeed reduce CVD risk, particularly if a person cannot afford the money to overeat, or if they have an iron will, or if they are supervised by Dean Ornish?

But the problem is that most people do not have the will power to resist the temptation to overeat, or to eat unhealthy food, or to resist the oversized portions they are offered in restaurants or shops. Despite valiant public health education and initiatives, these are hugely under-resourced compared with the financial muscle of fast-food outlets. At the same time and in all countries the availability and increasing use of either public or private transport equates to decreasing energy expenditure. And so for the vast majority of people at increased risk medication is sadly now the norm. Great public health efforts have been made to improve population behaviour and diet, but too little avail. Populations increase their weight – particularly when they become more prosperous as in India and China.

The strategies designed to reverse this accelerating problem have so far had little effect. Even if educational and/or exercise programmes do result in weight loss, the relapse rate over the next months and years is frighteningly high. A recent study of over 120,000 US healthcare professionals followed for 12-20 years has shown just how complex are the lifestyle factors which led to weight gain or weight loss in this well-informed population – crisps, chips, and sugary drinks were of course culpable, but TV watching and sleep duration were also important, and perhaps inter-related. Relatively small differences in energy balance had important long-term consequences.\(^4\)

Modern strategies to increase physical activity by the design of buildings – strategies which include elevators, locating related offices at a distance from each other; or making car use less easy, have all been advocated – but so far have been little implemented.

On the other hand the development of affordable out-of-patent remedies is steadily increasing. The new emphasis on potentially cheap single pills containing several off-patent and proven remedies (Wald’s polypill, Yusuf’s polypill) will clearly reduce costs and increase compliance with preventive treatment.\(^3\)

Thus, the pressure to address primary prevention of cardiovascular disease have so far been ineffective on a mass scale. This a great pity, but, if we face reality, it is presently more cost effective to develop well tolerated and widely used polypills which target multiple risk factors – even if individual risk reduction is less than ideal.

**Is diet alone sufficient to reduce CVD risk?**

**Sunday 28 August 11:00 - 12:30, Madrid - Zone D, FPH 357-360**

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Primary care takes centre stage today with a dedicated five-session programme

For the second year running, ESC Congress 2011 will begin with a day-long session designed specifically for primary care physicians and nurses. The programme, in five sessions, has been built around real clinical cases to be presented and discussed by expert panels of cardiologists and family doctors from France. The sessions, which will be presented in English and French especially for a local audience, cover the management of atrial fibrillation, dyspnea (with a focus on biomarkers), acute coronary syndrome, rhythm disturbances and heart failure. All are common problems and hot topics in the main scientific programme this year, and will give many local primary care physicians and nurses an opportunity to squeeze the best from the congress without leaving their desks for too long.

The programme has been organised in conjunction with the ESC Council for Cardiology Practice, the ESC Council on Cardiovascular Primary Care and the ESC Council on Cardiovascular Nursing and Allied Professions.

One of the speakers, Professor Yves Cottin from Dijon, previews this morning’s session on the post-ACS patient, with a focus on therapeutic targets and antiplatelet drugs.

Post ACS in primary care
By Yves Cottin, Centre Hospitalier Universitaire, Dijon

The management of acute coronary syndrome has changed considerably over the last ten years, and two major points should be underlined: the rate of hospitalisation for STEMI has fallen, and, above all, in-hospital mortality has improved. As a result, primary care is playing and will continue to play an increasingly important role in the management of patients with coronary artery disease.

Recent studies on the impact of primary prevention show a substantial increase in the number of patients on long-term treatment before the acute event. For example, over the last ten years the proportion of patients on statins before the ACS has risen from 10% to 35%, while that for ACE inhibitors or ARBs has risen from 20 to 35%.

There has also been an improvement in the short and especially long-term prognosis in patients after ACS. This also has a number of repercussions on primary care and the collaboration between GPs and cardiologists. ESC recommendations have been behind a road map for patients, with the management of risk factors with measurable objectives on the one hand, and the latest pharmacological approach on the other. Studies show at both the local and European level how difficult it is to maintain all the recommendations in the long term - and why the role of primary care is so important.

It should be emphasised that the ESC has made four class-1 non-pharmacological recommendations: smoking cessation, physical activity, diabetes management, and diet and weight reduction. In parallel, the pharmacological approach is becoming more strictly codified, but this too presents a number of difficulties: compliance over the very long term, and the concomitant management of other acute or chronic diseases.

All of these points will be addressed today. In particular, data from "real world" registries as well as other recent data show that at a national level between 25 and 35% of patients do not benefit from all the recommended treatments. It should also be emphasised that there is a correlation between treatment interruption or non-compliance and long-term morbidity and mortality. Other major subjects, such as the role of vaccinations after ACS or the impact of chronic disease associated with CHD (such as those linked to dental health or rheumatoid arthritis) will also be discussed.
Don’t worry, be happy: how positive emotions can help protect the heart

A session tomorrow looks at the evidence for laughter, music and job stress (less of it) in enhancing cardiovascular health

By Janet Fricker
ESC Congress News

COUCH POTATOES the world over can sit back and smile at the research of Michael Miller, who suggests that you can derive as much cardiovascular benefit from watching your favourite comedy programme as going for a run.

“We're not talking about a simple chuckle,” says Miller, “but mindful laughter - which is more of a deep belly laugh that brings tears to your eyes and makes you almost feel as though you’ve almost had a workout.” Miller, from the University of Maryland, Baltimore, believes that laughter needs to last for about 15 seconds.

Laughter, he will tell the symposium, exerts its beneficial effects through the release of endorphins by the brain, which activate receptors on the endothelium which in turn lead to the release of nitric oxide. “Nitric oxide dilates blood vessels, reduces inflammation, cholesterol deposition and clotting,” says Miller.

In their first study Miller and colleagues gave questionnaires and ultrasound scans measuring the diameter of the brachial artery in 150 patients who had suffered an MI to either standard of care or similar to the effects of exercise or taking a statin,” says Miller, who now believes that a study is needed which looks at the long-term effects of laughter on cardiovascular health.

The ideal study, he says, would involve randomising people who have had an MI to either standard of care or standard of care plus a programme of positive emotions on a regular basis. Unfortunately, funding for such a study has proved impossible to find.

In the meantime, Miller prescribes humour for all his patients. “The number one thing is not to take yourself too seriously,” he says, adding somewhat disappointingly that probably the best thing you could do for your heart would be to run on a treadmill while watching a humorous film.

And women who on one day watched clips of comedy films, while on another day watched the stressful opening sequence of Saving Private Ryan. The results showed that blood flow was enhanced by 22% in those watching the stressful film. “The magnitude of the effects we saw were similar to the effects of exercise or taking a statin,” says Miller, who now believes that a study is needed which looks at the long-term effects of laughter on cardiovascular health.

The study found that music with faster tempos resulted in increased breathing, heart rate and blood pressure, while the slower music caused declines in heart rates; swelling Crescendos (gradual volume increases) induced moderate arousal while decrescendos (gradual volume decreases) induced relaxation. Furthermore, they found that specific music phrases (frequently at a rhythm of 6 cycles/minute in famous arias by Verdi) synchronised inherent cardiovascular rhythm.

“Music as therapy would be an option for all since it has been reported that musicians and non-musicians alike showed similar qualitative responses,” said Trappe, who in May made an organ recording for the German Heart Foundation in St Sulpice, Church, Paris.

Trappe and colleagues are currently undertaking studies in 36 pigs and 60 healthy human volunteers to see if there are differences in blood pressure, respiration rate and cortisol levels when exposed to Bach, the heavy metal group “Disturbed” and controlled episodes of silence.

“From this study we hope to understand more about why music produces its beneficial effects on blood pressure. If our hypothesis is correct we should see the same effects in animals and humans,” said Trappe, who has found that some subjects listening to heavy metal showed episodes of atrial fibrillation.

“Heavy metal has the potential to be dangerous. It encourages rage, disappointment and aggressive behaviour while causing both heart rate and blood pressure to increase,” he said.

The scientific basis that classical music offers the ideal therapy for patients with hypertension and increased heart rates. He is now planning a prospective study.

“Bach - beta blockers” - in which patients with hypertension will be randomised to one of the other and followed with continuous blood pressure monitoring.

Study finds stress at work associated with ‘excess CHD’

Psychosocial job strain has been shown to be an independent risk factor for cardiovascular disease, Tea Lallukka will tell the symposium tomorrow.

While specific physical and chemical occupational hazards with a direct impact on cardiovascular pathology have been identified, a far larger proportion of the workforce in modern economies is exposed to mental and emotional demands at work.

“Stressful experiences at work seem to be elicited by a lack of reciprocity between efforts spent at work and rewards received in return,” says Lallukka, a social epidemiologist at the University of Helsinki. Those rewards might include money, promotion prospects, job security, and self-esteem, together with low job control to meet job demands imposed by a “24 hour society” requiring work to be done at any time and place.

Indeed, a systematic review and meta-analysis of 14 prospective cohort studies by Mika Kivimäki, which included more than 83,000 employees, showed that work stress was associated with a 50% excess of coronary heart disease.

But the association between job strain and cardiovascular disease is not clear cut. Job strain shows strong associations with behavioural coronary risk factors, such as physical inactivity, smoking, unhealthy eating habits and heavy drinking, which may each lead to indirect effects of

Bach or beta blockers?

In tomorrow’s symposium Hans-Joachim Trappe, pictured right, an organist and cardiologist from the University of Bochum, Herne, Germany, will explore how listening to classical music has the potential to decrease blood pressure and heart rate.

Some evidence for the effect of music on the cardiovascular system comes from a study by Luciano Bernardi and colleagues from the universities of Milan, Oxford and Pavia who tracked the cardiovascular and respiratory profile of 24 healthy objects aged 24 to 26 years while they were exposed to various pieces of music (Circulation 2009; 30: 3171-80). Twelve of the subjects were experienced choristers and 12 were naive- and sex-matched controls with no musical training.

The study found that music with faster tempos resulted in increased breathing, heart rate and blood pressure, while the slower music caused declines in heart rates; swelling Crescendos (gradual volume increases) induced moderate arousal while decrescendos (gradual volume decreases) induced relaxation. Furthermore, they found that specific music phrases (frequently at a rhythm of 6 cycles/minute in famous arias by Verdi) synchronised inherent cardiovascular rhythm.

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“Bach - beta blockers” - in which patients with hypertension will be randomised to one of the other and followed with continuous blood pressure monitoring.
Greater political commitment needed for the wider uptake of primary PCI

By Simon Brown
ESC Congress News

The latest European guidelines on the management of ST elevation MI, published in 2008, left no doubt about the importance of speed of action. "A well-functioning regional system of care . . . and fast transport to the most appropriate facility is key to the success of the treatment," they say. Primary PCI is the "preferred treatment" if available within two hours of first medical contact, and if not, thrombolysis should be performed as soon as possible.

Yet despite the high level of evidence and the emphatic recommendation, the uptake of primary PCI throughout Europe is patchy at best, and in some countries altogether absent. "Not all hospitals nor all regions have the emergency networks or PCI services recommended altogether absent," says Steen Dalby Kristensen from Aarhus University Hospital in Denmark. "Current registry data suggest that around 20-30 per cent of all STEMI patients in Europe still receive no reperfusion therapy."

Kristensen, who will speak tomorrow at a symposium on the uptake of primary angioplasty in Europe, says that the availability of PCI services in Europe is improving, but its wider application in many regions still needs a local political commitment. "There’s not much doubt about the medical arguments," he says, "but what’s needed is the system to make it work."

This is not just dependent on a continuously active cath lab, but will also require a pre-hospital service able to diagnose with accuracy (12-lead ECG) and provide effective reperfusion treatment. Time, as the guidelines suggest, is crucial to outcome, and Kristensen says there is now "good evidence" for the strategic establishment of PCI centres within a two-hour range.

A campaign - known as the Stent for Life Initiative - launched in 2009 under the umbrella of the European Association of Percutaneous Cardiovascular Interventions (EAPCI) and EuroPCR - aims to identify those countries where the use of primary PCI can be encouraged, and thereby the quality of care improved. The basis for the Initiative is a survey carried out with local cardiac societies in Europe and an assessment of individual requirements for a national programme. So far, ten countries (Bulgaria, Egypt, France, Greece, Italy, Portugal, Romania, Serbia, Spain and Turkey) are actively taking part, but many others - such as the UK - have local initiatives well up and running.

Indeed, says Carlo Di Mario, President of EAPCI, both Italy and the UK (where the evidence for thrombolysis was assembled beyond doubt in the ISIS 2 and GISSI 1 trials) are now at the forefront of primary angioplasty in Europe, using various models focused on pre-hospitalisation diagnosis (by a doctor or trained paramedic in the ambulance or by telemedicine), on rapid transfer to the nearest 24/7 centres, and on the minimisation of door-to-balloon time.

"As a result," says Di Mario, "mortality from STEMI has dropped from more than 30% in the 1960s to less than 10% today, and is now very much lower in younger patients with no cardiogenic shock."

The first survey conducted by the Stent for Life Initiative revealed a patchy uptake in Europe. In those countries with a high availability of PCI - such as Denmark, Poland, Czech Republic and the Netherlands - the number of untreated STEMI patients was low. And conversely, in countries with a low use of primary PCI the number of untreated patients was high.

A second survey is now under way, and Kristensen believes that the availability of primary PCI - and the systems for its effective application - will have increased. "But we don’t yet have the data," he says. "What we do know, however, is that there are now many developments in the field. Primary PCI for acute STEMI is the gold standard of care, and its greater availability - to rates around 600 procedures per million population - would allow us to treat most patients suffering from STEMI throughout Europe."

A new option for your high-risk patients with aortic stenosis

In the landmark clinical study—The PARTNER Trial—Balloon-expandable transcatheter aortic valve implantation demonstrated a 20% absolute reduction in all-cause mortality versus standard treatment at one year.

Additionally, the reduction in mortality and rehospitalization versus standard treatment at one year was 40%.1

For more information, visit edwards.com/EU

What are the main controversies in cardiology?

“I’ve just finished writing the German Society of Cardiology’s position paper on drug eluting stents and in my view one of the biggest controversies today is the selection of patients to receive them. While plenty of studies have been performed in patients with angina, we still lack data on the specific topic of drug eluting stents in patients with acute coronary syndromes. I’m also aware of the fact that many stent studies only include patients under 70 years of age, so that they don’t represent real world situations, and we’re also lacking data of use in diabetes.”

“One of the difficulties of risk assessment tools, such as the Framingham Cardiac Risk Score, is that the identification of people at high risk of developing cardiovascular disease and stroke is driven by age. The consequence is that you may not treat someone with marked deviation in individual risk factors for the sole reason that they are young, and we don’t know enough to be sure that this is safe. We need to develop a more sophisticated tool that takes into account the years of life lost - ie, if someone is at risk of dying at 20 or 60 years.”

“A big future potential lies in the use of stem cells in cardiology, with major opportunities for patients with cardiomyopathy, ischaemic cardiomyopathy and dilated cardiomyopathy. But I feel that vested financial interests may be holding development back. Some cardiologists seem more interested in the use of stents and CABG, while only a handful of researchers are putting their efforts behind this very promising branch of medicine. In other areas of medicine, such as urology, haematology and oncology, stem cells are being used with successful results.”

“As part of my degree I’m doing research on BMI and have become interested in the obesity paradox controversy, where it appears that obese patients with cardiovascular disease do better than their normal weight or underweight counterparts. The real explanation, I feel, is that family doctors are more likely to refer obese patients to cardiologists so that they receive better treatments and that obese patients are more likely to be prescribed statins, which could confer other benefits on survival. Also, if you’re suffering from cachexia in heart failure, obese patients will have great margins before their weight loss causes difficulties.”

Benny Levenson
ESC Fellow Interventionalist
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Leonard Arnold
Academic cardiologist
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Mustafa Jaradat
Internal medicine
Jordan

Jan Sebastian Wolter
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Programme

Co-Chairs: Elaine Hylek & Gregory Lip

18:30 Stroke prevention in atrial fibrillation: where are we now?  
Elaine Hylek  
USA

18:45 New insights and results from the RE-LY trial that oral anticoagulation is evolving  
Gregory Lip  
UK

19:05 New treatment guidelines for anticoagulation in stroke prevention: the future is now  
Rattaolea De Caterina  
Italy

19:20 New landscape for stroke prevention in atrial fibrillation: implications for clinical practice  
Paul Dorian  
Canada

19:40 Round table wrap-up  
All Faculty

19:55 Closing remarks  
Gregory Lip  
UK

Monday 29 August 2011
18:30–20:00, Budapest, Zone E
Parc des Expositions de Paris Nord Villepinte

Boehringer Ingelheim