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The next SCAI president talks about many exciting developments in interventional cardiology, from a possible replacement for warfarin to the potential of aortic valve implantation, as well as health care reform.

What can you tell us about your facility and practice at the University of Washington Medical Center?

The cardiovascular practice at the University of Washington is through a service line called Regional Heart Center that spans two institutions—the Harborview Medical Center and the University of Washington Medical Center. The Regional Heart Center includes not only the cardiology practice but also cardiovascular surgery. We have facilities for cardiac care in both institutions, and our facility at the University of Washington Medical Center actually integrates the cardiology practice with the cardiovascular surgery practice so we have a common clinic. This allows us to do consultations very rapidly and easily. We implemented this structure 10 years ago and have been moving in the direction of further integration. One of the issues surrounding heart centers is that they are mostly hospital-based and, therefore, are not physician-based practices. Aligning the physician practices with the hospital is always a challenge.

Of the many trial results that have been announced recently, which ones have caught your attention?

At the European Congress, there were presentations centered on a potential replacement for warfarin that could lead to a great improvement in anticoagulation for patients with heart valves, atrial fibrillation, and other anticoagulant indications. Many of these indications currently require multiple laboratory tests and very sophisticated follow-up; having a drug that does not require all of these restrictions and that can be easily administered would be of benefit.

Also, additional information is coming out about percutaneous valve replacement, specifically the aortic valve. We are involved in the PARTNER trial (Edwards Lifesciences, Irvine, CA), and I am very excited about it. The PARTNER trial has finished randomizing patients, but the follow-up will require a period of time for analysis.

There continue to be data published about the supe-

riority of drug-eluting stents over bare-metal stents. There was some suggestion that drug-eluting stents may have an effect on mortality, which is something that has been lacking. A few years ago, there was concern that drug-eluting stents were causing various problems related to thrombosis. Since then, closer scrutiny of the data, as well as subsequent studies, have shown that the concern is not as great as initially reported.

What is the current focus of your research energy, including your involvement with the PARTNER trial?

The PARTNER trial has been taking most of our energy for the past year. It has been a very complex protocol involving a very high-risk, elderly patient population. It has also presented some interesting challenges; how do you get a 90-year-old patient with severe aortic stenosis to Seattle from the middle of Montana? This can be a very significant challenge.

I am frequently asked, “What’s exciting in interventional cardiology?” To be honest, another stent isn’t all that exciting; there are many stents available, and there will always be more stents. But, transcatheter aortic valve implantation? It really has the potential to revolutionize the treatment of a certain patient population with aortic stenosis. I think it will be a game changer.

What coronary and cardiac developments do you think need to be explored in the coming years?

One of the interesting things right now is that percutaneous aortic valve implantation has “forced” cardiologists and cardiovascular surgeons to work more closely together than they have historically. I think that the amount of the so-called hybrid procedures—those in which surgeons are performing parts of the procedure and cardiologists are doing other parts—will increase during the next several years, especially when it comes to percutaneous aortic valve implantation. Interventional cardiologists and surgeons both excel at specific aspects of procedures, and working together to

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treat individual patients might result in a more optimal approach. For example, surgeons have an excellent conduit (the internal mammary graft to the left anterior descending artery); it basically lasts as long as the patient is alive. Because vein grafts are not particularly good for the other vessels, performing a combined procedure in a patient with multivessel disease in whom a left internal mammary artery graft is placed to the left anterior descending artery with stents placed in the other vessels might be an area of growth in the future. As the specialties begin to work together more frequently, the barriers surrounding the issue of “my turf versus your turf” begin to come down.

I think it is important for cardiovascular surgeons and interventional cardiologists to work together to come up with the best therapy for patients and not focus on one specialty’s therapy being better than the other, which has historically been the case.

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You will be inducted as President of the Society for Cardiac Angiography and Interventions (SCAI) at next year’s meeting. What will be the focus of the SCAI next year?

The SCAI has been and will be closely following the potential upcoming changes in health care reform. I suspect that the SCAI will continue to focus on getting the message out about what interventional cardiology is and what benefits it offers, as well as working with Congress to develop health care reform that addresses the issues that interventional cardiology has as a whole with what is being proposed. Advocacy and public relations have been and will increasingly be a major focal point for the SCAI. The SCAI is the voice of the practice of interventional cardiology, particularly on the national scene.

What can you tell us about the STEMI Summit? What is the most important message about ST-elevation myocardial infarction (STEMI) that needs to be conveyed?

The Washington chapter of the American College of Cardiology and the American Heart Association is doing a combined program focused around the issue of door-to-balloon time and treatment of STEMI. The STEMI

Summit will bring together physicians, both cardiologists and noncardiologists, to discuss the issue of managing STEMI in Washington State. The unique aspect of this meeting is that most cardiologists do not get the opportunity to deal with the emergency medical systems. This is an example of a situation in which you need to have all aspects of the process aligned to achieve successful outcomes—the EMS team, the emergency department physicians, and the cardiologists, as well as all of the associated support staff and infrastructure, need to be able to work together to make this happen. The STEMI Summit is designed to allow all parties involved in this process to have a discussion about what we are doing that works well, what needs to be improved, and what other programs are doing that makes them successful.

What do you consider to be the most rewarding procedures you perform?

When I am called in to treat a patient who has a STEMI, is in terrible pain, and is very unstable, and I and my team work together (somewhat like an orchestra) to open the vessel and can see immediate relief of discomfort and improvement in clinical status, I know that I have had an impact on the patient’s outcome and life. I think that is the most rewarding aspect of my job.

Would you like to comment on any specific issues that concern you?

Washington State, like many states, is financially strapped with big budget deficits. The State of Washington funds insurance for several groups, including state employees. The legislature has given coverage decision control to a health technology committee called the HTCC. They have been focusing on drug-eluting stents versus bare-metal stents and the impact of these stents on outcomes. They have decided to restrict the use of drug-eluting stents to a very narrow group of patients. This has been going on for more than 1 year, and they are very close to making their final pronouncement. I do not know the exact level of restriction, but it will not be what is on the package insert and will not be what physicians are currently doing from a clinical perspective.

This won’t affect cardiologists directly because we do not get paid based on what stent we decide to place, but this will impact the hospitals in which we practice. This committee is going to restrict the use of stents and will not reimburse the hospital when a drug-eluting stent is placed, even if that stent might be what is best for the patient clinically. I would not be surprised to see similar groups begin to pop up throughout the country. ■