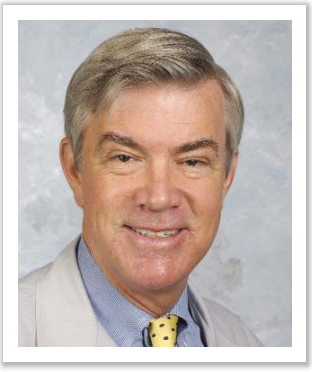
Timothy Sanborn, MD

Dr. Sanborn discusses his NorthShore facility, door-to-balloon time initiatives, and future developments in the field of cardiology.

What can you tell us about your facility and practice at NorthShore University HealthSystem?

I am the Head of the Division of Cardiology at NorthShore University HealthSystem, a four-hospital network providing care in the northern suburbs of Chicago. It is a combination of employed medical group physicians and private practice affiliate cardiologists. We provide complete cardiac care, including catheterization, electrophysiology, and open heart surgery. We have an affiliation with the University of Chicago, so if we have a patient who requires a heart transplant, they would be referred there. We have a total of seven outpatient cardiology offices, some of which are attached to the hospital and others that are freestanding.



What is the current focus of your research energy?

Most of my current research is in supporting Ted Feldman, MD, in his work in valvular and structural heart disease. I also do some independent work, primarily in the treatment of myocardial infarction. I recently published an article in *Circulation: Cardiovascular Interventions*, which reported reduced access site bleeding complications with bivalirudin and vascular closure devices.

I've been working in interventional cardiology for 25 years. I started in the basic science evaluation of balloon angioplasty in atherosclerotic rabbits with Dave Faxon, MD, and Chris Haudenschild, MD. I then moved on to device development, taking them from preclinical to clinical investigation and then to US Food and Drug Administration approval. This included devices such as lasers, atherectomy devices, and vascular closure devices.

Now, I am doing more mentoring than actual hands-on research. I have shifted to more administrative and operational areas. We currently have a big push to improve quality throughout our network and adherence to American Heart Association/American College of Cardiology/Society for Cardiovascular Angiography and Interventions guidelines. We are also looking to improve our door-to-balloon times for ST-segment elevation myocardial infarction. We have evaluated some of our statistics to determine which intervention was most effective in improving our door-to-balloon times and are in the process of preparing those results for publication.

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

There are still some challenges to be faced in coronary intervention, primarily in chronic total occlusions and bifurcation lesion treatment. There are a number of devices that are under investigation for bifurcation lesions and chronic total occlusions. I think that the next big wave of advancements is going to be in the realm of percutaneous and minimally invasive treatment of valvular and structural heart disease.

Is the current goal of door-to-balloon initiatives enough? What more needs to be done?

Some of the guideline papers are saying door-to-balloon as soon as possible. We can always try to improve on the 90-minute guideline, and many institutions are achieving door-to-balloon times of 60 minutes or less. I think we are also moving toward a regional approach to door-to-balloon times; it certainly has been proposed by the American Heart Association in their mission guidelines. In Illinois, we have regions of emergency medical support, and each one is looking at how best to improve not only door-to-balloon time but also symptom-to-door time.

It really comes down to how quickly you can get the patient to the emergency department or a facility that can treat those patients. We are starting to look at 12-lead electrocardiograms in the field, which could go a long way to help achieve this.

Another important aspect of door-to-balloon initiatives has to do with how well we are treating our patients with cardiovascular disease. Are we effectively

(Continued on page 57)

(Continued from page 58)

treating patients who have hypertension? Are patients with known coronary disease being treated correctly? I think that more can be done across the board in treating asymptomatic patients so that fewer of them progress to become symptomatic patients in whom door-to-balloon times become a factor.

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

I think the acute myocardial infarction interventions are the most rewarding. When a patient presents with severe chest pain and dramatic ST-segment elevation and you successfully open the vessel, you can see dramatic and immediate improvement. The patients are very thankful for what you have done for them.

What hobbies or interests do you engage in during your free time?

I enjoy sports; I play golf in the spring, summer, and fall and a sport called platform tennis during the winter. I also enjoy reading and creative writing. I recently had an editorial published in *Catheterization and Cardiovascular Interventions,* titled "Occupational Sciatica." It is a personal look at my experience with sciatica brought on by 25 years of wearing lead aprons. It is surprising how many interventional cardiologists are afflicted with this. Perhaps regular spine exercises can help others avoid these problems without the need for surgery or spinal injections. ■

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