

Frank T. Bunch, MD

An expert in coronary and peripheral interventions talks about training on the early atherectomy devices, the coronary skills he applies in peripheral interventions, and what's on the coronary frontier.

How do you divide your clinical practice time between coronary procedures and peripheral interventions, such as your work in carotid artery therapy?

I am in a single-specialty cardiology group where my procedures are divided into approximately 40% coronary and 60% peripheral. I was the first interventional cardiologist in my area who was fellowship trained in both cardiac and peripheral interventions. Early on, cardiac work was more the bulk of my practice, but as time went on, the shift was more toward peripheral interventions. As this grew, opportunities came about that allowed me to become involved in training other physicians and be a part of several clinical trials. Currently, we are involved in several trials, including carotid and lower extremity studies. Also, I conduct hands-on teaching courses for carotid training, as well as peripheral vascular training courses that include treatments for critical limb ischemia with below-the-knee interventions.



Do you see this as an increasing trend for your practice or for all of cardiology?

I see this as a trend. When I graduated from my fellowship in 1996, I attended the Duke Fellows Course. On the last day, Dr. Spencer King gave a talk of the crossover trend he predicted would occur with increasing numbers of peripheral interventions being performed by cardiology interventionists. He was right. There are an increasing number of interventional cardiology fellowships that incorporate peripheral interventions into their training. There are an increasing number of requests for training outside of fellowships by cardiologists who did not have the opportunity while they were in training.

What tips and tricks translate from coronary to peripheral work?

The major advantage of being trained in coronary interventions and then peripheral is the skill set that is achieved. After learning all the different nuances of

catheter support and use, as well as the wire skills achieved working with the much smaller and tortuous coronary arteries, transition to the larger peripheral arteries is easier. This is even more evident with the trend to downsize equipment for peripheral interventions.

The skills learned in the coronary setting, as well as the understanding of guide placement and support, have made the carotid stenting procedure (from the technical aspect) a more natural transition for the cardiologist. I have found also that the use of small wires in the coronary vessels has also aided me in my treatment of the below-the-knee vessels.

As far as tips and tricks go, I do not think that a well-trained interventional cardiologist will have much technical difficulty. The main obstacles are an understanding of the anatomy and how to approach it. Each area (brachiocephalic, aortic and visceral, and above- and below-the-knee vessels) has its own nuances. To truly be successful in your procedures, this knowledge base is one of the most important. I would also add that the use of CT angiography has greatly aided me in decision making for how I would approach peripheral interventions.

How has your work changed after the results of the COURAGE trial were published?

The COURAGE trial, which compared medical therapy to percutaneous coronary intervention (PCI), showed similar efficacy in patients with stable angina. As for my practice, it did not change our work very much. I have always individualized my patients and will treat them depending on several factors. Lifestyle, symptoms, and activity level are important and are a significant basis of how I treat patients. I am fortunate to live in an area that is warm the majority of the year, and people of all ages are active. This gives me a good idea of their exercise tolerance and if it changes. The change in symptoms, level of activity, and how it compares over time will guide my therapy. I do believe that to treat coronary artery disease, a good knowl-

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edge of the patient's anatomy is important. This used to only be achieved by cardiac catheterization but now, with coronary CT angiography, it is much easier to achieve.

Has the COURAGE trial changed your use of drug-eluting stents?

Not really. I think that drug-eluting stents should be used in certain settings. One has to ask, in which arteries are they most useful and in what patient population? Smaller vessels, diabetics, and heavy tobacco users are some of the profiles that have to be considered. Compliance with long-term anticoagulation also needs to be considered.

How do you use coronary calcium scoring in your practice?

I have been using calcium scoring for quite some time. My group has had a CT scanner for several years and has performed many coronary CT scans. We have offered calcium scoring to our patients during that time also. The use of calcium scoring in the asymptomatic, high-risk population has been very beneficial. Another good use for calcium scoring is to reassure patients who are concerned about the potential of coronary artery disease. The information yielded aids in the approach of long-term lifestyle modifications for many of our patients. It is a great screening tool for the cost. My group educates the local primary care doctors on the utility and uses of calcium scoring as a screening tool for their patients.

What is the next frontier for coronary or peripheral intervention?

We must first take what we are doing and improve on it. On the coronary side, we must find ways to shorten the length of anticoagulation time after drug-eluting stent placement, whether it is different inhibitory drugs, how they are delivered, or even different types of stents. The length of time for anticoagulation has been an albatross in my practice, especially with the elective surgeries or other procedures that patients go through. The science of bioabsorbable stents is exciting and may well pan out to be something that will take us to the next step.

From the peripheral aspect, the next frontier has to do with the earlier stages of treatment. The equipment is continuing to improve, and there needs to be improvement in the treatment of infrainguinal disease and the restenosis rates, as well as stent fractures. ■

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