

Jason H. Rogers, MD

Dr. Rogers, a next-generation interventional cardiologist, shares his insights on percutaneous valvular treatments, his role in the ZEN trial, and future coronary/cardiac developments.

What can you tell us about your facility and practice at UC Davis Health System?

For the past 6 years, I have worked at the University of California, Davis Medical Center, which is a 613-bed, tertiary-care teaching hospital that serves a 65,000-square-mile area across northern and central California. We are located in California's Central Valley in the state capital, Sacramento. We have a growing cardiovascular division with four general cardiology fellows per year, two cardiac and peripheral interventional fellows, and a cardiovascular imaging fellow. My colleagues are great friends and mentors, especially our division chief Reginald Low and the director of our vascular center, John Laird. Interaction with our cardiology fellows is one of the most enjoyable aspects of my job. I serve as the Director of Interventional Cardiology and also as Director of the Cardiovascular Clinical Trials Unit. My time is divided between direct patient care, research, teaching, and administrative duties. I spend a fair amount of time in direct patient care and teaching—I have weekly outpatient clinics and attend in the catheterization laboratory, CCU, and consult service. In the remaining time, I focus on cardiovascular research projects, both investigator-initiated and industry collaborations. Living in proximity to the northern California Bay Area has given me the opportunity to work closely with several start-ups and to learn the challenges of device development and regulatory approval pathways.

What is the current focus of your research energy?

I have several focus areas. One area is the percutaneous treatment of valvular heart disease. During the last several years, I helped to develop a novel percutaneous approach for the treatment of functional mitral regurgitation (percutaneous septal sinus shortening) and had the opportunity to participate in first-in-man implantations with colleagues in Venezuela. I am currently involved in a new effort with a start-up named Millipede (Ann Arbor, MI) to develop percutaneously delivered mitral and tricuspid annular rings. I have also been institutional co-PI on the EVEREST II and REALISM studies utilizing the MitraClip (Abbott Vascular, Santa Clara, CA) for mitral regurgitation. These studies have given me the opportunity for some

novel investigations, as well as to interact with many referring cardiologists in our region.

Another area of focus has been in the development of a procedure for the interventional treatment for erectile dysfunction (ED). It sounds like a bit of a non sequitur, I know, but ED is a prevalent problem among patients with coronary artery disease, and we have found that many men have

atherosclerotic narrowings of their internal pudendal arteries that can result in ED. I am national Co-PI of the currently enrolling phase 1 ZEN trial, sponsored by Medtronic (Minneapolis, MN), which looks at the safety and feasibility of percutaneous intervention with a drug-eluting stent for internal pudendal artery stenoses causing ED.

Finally, a collaborative project that I am proud of is a California multicenter stent thrombosis registry that we have coordinated among UC Davis, UC San Diego, and UC San Francisco. The idea behind this reg-

istry is that although the incidence and clinical predictors of early and late stent thrombosis have been previously reported, there is very little information on current practice patterns for stent thrombosis and how these may translate into outcomes. When a patient presents to the lab with stent thrombosis, we really have no idea what the best treatment approach is for these patients—POBA, BMS, DES? We have identified more than 160 patients, from 2005 to the present, who have presented with angiographically confirmed stent thrombosis, and we have made some novel observations regarding treatments and outcomes.

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

Very simply, I would love to see an end to all open surgical cardiac procedures, with minimally invasive or transcatheter therapies supplanting these invasive procedures. Cardiac surgery is undoubtedly effective, but the reality is that it is a highly invasive procedure that we need to evolve away from. I am pretty sure that in my lifetime I will see CABG become something that is shown for historical interest. Clearly, we have moved toward this goal, but due to limitations of restenosis, late stent thrombosis, lack of dedicated bifurcation stents, and cost, we still have a lot of work to do. Similarly, the arena of structural and valvular heart disease is a huge area with unmet clinical need and is ready

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for new technologies. Innovation must be a priority for the future—and I would like to see this innovation remain stateside. I am concerned that the current regulatory hurdles in the United States will increasingly put us at a disadvantage compared to other countries.

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

Despite an increasing complexity and array of procedures performed in the catheterization laboratory, some of the most satisfying procedures remain the STEMI and high-risk NSTEMI, which can be treated rapidly and are truly life-saving. Restoring coronary flow appeals to a basic instinct in all of us, and results are often aesthetically pleasing as well. Treating “no-option” patients with emerging valvular technologies, such as the MitraClip, has also been extremely rewarding. There exists a large population of patients who are at high risk for surgery, or are nonsurgical candidates, who will benefit immensely from these new technologies.

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

I think it is important for us to consider the future of academic cardiology and academic medical centers. In my experience, few graduates seem motivated to enter an academic career for a variety of reasons. It is imperative that we support academic medical centers and their missions to train and inspire the next generation. My own career choice was borne out of positive interactions with mentors during my training years.

The subject of conflict of interest is an issue that is receiving increasing attention. The current movement to eliminate ties between industry and academia is concerning. I read this week that some academic medical centers have forbidden speaker's fees from any pharmaceutical company for any physician. This strikes me as excessive, and there must be equipoise in balancing this delicate relationship.

Finally, I have been thinking about health care reform and how it might affect me and our profession. I refuse to be swept into a culture of negativity on this subject as many others have. I thoroughly support the concept of universal health coverage and believe that it is important for the United States to move in this direction.

What hobby or interest are you engaged in during your free time?

I have numerous interests outside my work. My family is a priority, with a wife and two young children. I play the violin and almost considered a career in music before choosing medicine. I am an avid cyclist and have a “stable” of different breeds of bikes. On non-call days, I will often commute by bicycle. I greatly enjoy the natural beauty of California. ■

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