

AN INTERVIEW WITH...

J. Dawn Abbott, MD, FACC, FSCAI

Dr. Abbott shares her leadership goals and values, insights into the National Cardiovascular Data Registry CathPCI registry, research needs for PCI, and more.



You have a packed schedule these days: published papers across a variety of disease states and procedures, clinical trials, academic and societal appointments, speaking engagements, and more. What part of your

work excites you right now?

I just accepted the role of Director of Interventional Cardiology at the Lifespan Cardiovascular Institute of Rhode Island and Director of the Cardiac Catheterization Laboratories at Rhode Island and The Miriam Hospitals in Providence, Rhode Island. There are several aspects of this administrative role that are exciting. I want to foster a culture of teamwork and innovation so that we can improve operational efficiency and carry out best practices to optimize quality care for our patients. We have a talented group of interventional faculty, and I'm looking forward to promoting their expertise, expanding clinical programs, and bringing emerging technologies to our patients through clinical research. I'll consider my leadership a success if the staff find meaning in their work and come with a positive attitude every day because health care has been a strenuous environment over the past several years.

One of your many appointments is Associate Chief of Faculty Development and Academic Advancement at Brown University. What are your goals for this position?

This is one of my favorite positions, as the main objective is to help others achieve their career goals. Navigating promotion tracks at universities is challenging, and physicians in academic medicine have varying degrees of focus on clinical, educational, and scholarly pursuits. I assist faculty in identifying the track that aligns with their interest and monitoring progress toward promotion. We have put in place lists of opportunities for teaching at the medical school and in postgraduate training programs, developed a research-in-progress conference so that faculty can share ideas and build collaborations, and have a dedicated cardiovascular statistical consultant.

As Past Chair of the National Cardiovascular Data Registry (NCDR) CathPCI registry Research & Publications Subcommittee, can you give us a preview of what the group has in store for this year? How would you explain the benefit of the registry to those considering participation?

The NCDR CathPCI registry was established in 1998 for the purpose of quality improvement. It is the longest continually running registry of the American College of Cardiology and now is in partnership with the Society for Cardiovascular Angiography & Interventions (SCAI). The program has captured the maturation of percutaneous coronary intervention (PCI) over decades and includes millions of patient records detailing demographic, clinical, and procedural characteristics, as well as numerous in-hospital outcomes of patients undergoing cardiac catheterization and/or PCI. The most recent update to the data elements was implemented in 2018 and captures more information on cardiac arrest, cardiogenic shock, and appropriate use criteria determination. The benefits of participation are numerous for institutions, administrators, lab directors, and operators. By participating, you have access to a wealth of information on performance measures to identify areas of strength or improvement, comparisons to other institutions, and risk-stratified outcomes.

For investigators interested in using the data for research, there is a process in place for proposals that is overseen by the Research and Publication Committee. I just completed a 6-year term as Chair of the committee, and during that time, we reviewed hundreds of applications and funded > 30 proposals. The committee is in excellent hands with Dr. Ian Gilchrist as the new Chair. You can find more information on the NCDR website.

Using data from said NCDR CathPCI registry, you and colleagues recently published a paper studying predictors of de-escalation of P2Y12 inhibitors to clopidogrel in patients with acute myocardial infarction undergoing PCI, with the conclusion that there is an inappropriate prevalence of therapeutic de-escalation.¹ With this knowledge, what are the necessary next steps?

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Thank you for pointing out that study, which was led by one of our current interventional fellows. We observed that many patients at high risk for recurrent ischemic events post-PCI were de-escalated from a potent P2Y12 inhibitor to clopidogrel at or before hospital discharge. This was rarely due to bleeding risk, such as concomitant treatment with an oral anticoagulant, and physicians were not good at documenting reasons for the decision. Based on this study, we recommend physician education on trial data supporting use of the more potent P2Y12 agents, potential to use bleeding-risk scores to identify patients in whom shorter durations of dual antiplatelet therapy or less potent agents may be reasonable, and importance of documenting medical decision-making. We are also concerned that some of the disparities in care are related to prescription insurance coverage and a mechanism to overcome this problem, such as prescription assistance programs, may be helpful.

One of your research interests lately has been complex PCI procedures—what do you consider to be the most pressing research needs there?

This is a tough question because complex PCI does not have a standard definition. The area void of data that is of interest to me is the population of patients who are poor candidates for surgical revascularization. We have so many well-designed trials on PCI versus coronary artery bypass grafting or revascularization compared to medical therapy, but when it comes down to it, interventionalists are caring for a large population of patients with symptomatic ischemic cardiomyopathy who are not surgical candidates. We need studies evaluating the impact that interventions are having on these patients and outcomes such as improvements in ventricular function, reduced risk of heart failure admissions, and quality of life.

The relationship between sex and outcomes has been a theme of your recent published work, and earlier this year, you were the Co-Chair of the SCAI expert consensus statement on sex-specific considerations in myocardial revascularization.² What was that experience like, and how would you summarize the key points made in the statement?

Working on the consensus document with colleagues who have expertise in cardiovascular disease in women was a valuable experience for me. Despite all the progress that has been made over the past decade, there are numerous evidence gaps we identified and opportunities to design clinical trials that provide the needed data in women. For now, I keep in mind that many of the recommendations I make to my female patients are based on data from men. As a clinical researcher, I encourage

my patients to participate in trials and take additional time to find strategies to overcome barriers to participation, which are particularly relevant in women.

Over the years, you have led or been on abstract selection committees for multiple prominent meetings in our space. What do you think makes for a compelling submission or meeting? Is there anything you wish you saw more of in the submissions you review?

The best abstract submissions clearly identify the knowledge gap, aims of the study, and have sound methodology. Often, studies are confirmatory but do not push the field. I'm always looking for mechanistic studies and novel therapies being evaluated in animal models or first-in-human experiences, so I know what possibilities are on the horizon for our field.

As Director of the Interventional Cardiology Fellowship at Brown and a mentor in SCAI's Emerging Leadership Mentorship program, you are in a unique position to foster the next generation of interventional cardiologists. Along with the technical "hard" skills these physicians must learn, what "soft" skills do you hope to instill in your trainees and mentees in these programs?

Being an educator is one of my most important roles. Finding your identity as a physician is important for one's well-being. I encourage fellows to pursue their interests within and outside medicine and put themselves out there in the interventional community because there is strength in the relationships formed over the years. Always remember that the patient is at the center of all decisions, and be an advocate for them. ■

1. Williams MJ, Lang WR, Wark T, et al. Predictors of in-hospital de-escalation of P2Y12 inhibitors to clopidogrel in patients with acute myocardial infarction treated with percutaneous coronary intervention. *Cardiovasc Revasc Med*. Published February 3, 2022. doi: 10.1016/j.carrev.2022.01.029

2. Lansky A, Baron SJ, Grines CL, et al. SCAI expert consensus statement on sex-specific considerations in myocardial revascularization. *J Soc Cardiovasc Angio Interv*. 2022;1:100016. doi: 10.1016/j.jscv.2021.100016

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