

Ramon Quesada, MD

From transradial access to percutaneous mitral valve repair, Dr. Quesada gives us a personal look at the interventional cardiology field.

Do you think that as the transradial access approach gains prevalence in the United States, medical schools and fellowship programs will incorporate this technique?

Yes, I believe that one of the limitations to the growth of transradial access is that in the past, there have been very few training programs in the United States that have incorporated this technique. As interest in this technique increases and begins to take hold, hospitals with training programs have begun teaching transradial access to their fellows, which is very important. However, some operators, including myself, began incorporating the transradial approach more than 10 years ago. Basically, we learned the technique on our own with minimal training, but most who started performing these procedures had extensive experience with the brachial approach. Therefore, it was easier for us to make the transition to transradial access. Now that new catheters have been designed and techniques have improved, we see the interest among the younger generation of interventionists for adopting this approach.

One of the reasons that operators in the United States have not yet adopted this technique is that they are more comfortable with femoral access, and there is a learning curve associated with this new method. I saw the first transradial procedure around 1996, and I really jumped on the technique and was committed to mastering it. So, although it takes time to learn this technique, once the operator is comfortable using this access approach, applying it to varying subsets of cases is not problematic—you are going to the same place, just using a different direction.

In your opinion, where can interventionists find the best training programs to learn or better hone their transradial access skills?

There are very few hands-on training programs in the United States that I know of, but the training process can be didactic. Most interventionists who have adopted the transradial approach are advanced operators, so switching from femoral to transradial access is a commitment more than anything else. It would be great if there was access to hands-on training programs, but honestly, I do not believe that they are necessary. This is a technique that can be adopted

based on didactic courses that you can learn in a few steps using the basic tools, as long as you are committed to going through the associated learning curve.

Are you currently participating in any clinical trials?

Apart from my coronary work, I do a significant amount of structural work. At Baptist Cardiac & Vascular Institute, I have participated in a patent foramen ovale closure trial, which was completed and will be presented at the American Heart Association meeting in November. Currently, we are involved in two percutaneous mitral valve repair trials studying the MitraClip device (Abbott Vascular, Santa Clara, CA): the EVEREST trial and the current REALISM registry. I am also participating in left atrial appendage closure trials with the Watchman device (Atritech, Inc., Plymouth, MN), which include the initial PROTECT study, as well as the CAP registry. Additionally, we will be involved in the next phase of the PREVAIL study, which is a randomized trial that will begin shortly. Of course, we are eager to take on new protocols and devices.



Can you share a preview of some of the areas that ISET 2011 will focus on? Are there any new features or topics that you are excited about?

As a matter of fact, in the peripheral arena, there is going to be a lot of emphasis on the new forms of therapy, which is fascinating to me even though I don't perform peripheral interventions. In the vascular field, forms of therapy for multiple sclerosis will be one of the new features. In the cardiac arena, of course there will be a focus on complex coronary interventions, management of left main disease, bifurcations, chronic total occlusions, and new approaches to treating these challenging areas. For structural heart disease, we will have a full program on mitral valve repair, as well as aortic valve therapies/implantations with devices.

There will also be an interventional oncology symposium, which has been included in the ISET program for the last 2 years. Interventional oncology is a foreign land, and we have to learn everything. A lot of our general endovascular techniques apply to this new area of interest because the delivery of drug therapy is part of endovascular therapy as well.

(Continued on page 73)

(Continued from page 74)

What further exploration do you think is needed in regard to structural heart repair?

There has been an explosion of new devices for valve therapy, beginning with the first percutaneous implants in the pulmonary valve in children and then Cribier with the first implant in the aortic valve. Now, we are refining percutaneous mitral valve repair. Industry is also developing devices for the tricuspid valve, which is a source of a significant amount of disease. The entire field of percutaneous valve therapy is going to be a significant area of growth in interventional procedures in the near future.

What do you consider to be the most rewarding part of your work? Which procedures do you most enjoy performing?

I enjoy the challenge of difficult cases. For example, chronic total occlusions require a lot of patience and preparation. Expertise is achieved by solid preparation and striving to master both new techniques and the full array of complementary equipment (ie, wires and catheters). These cases bring great reward because these patients truly benefit from the procedures.

In the structural arena, performing percutaneous mitral valve repair is the most rewarding of all the interventional procedures that I do. Some of these are high-risk patients who have no option whatsoever because of the nature of the mitral valve—and the same applies to the aortic valve; interventionists always believed that this area could not be tackled. We see these patients who are very high risk, who have a predicted surgical mortality rate of 18%, and we are able to improve their condition over 24 hours from New York Heart Association class 4 (severe) to class 1 or 2 (mild/moderate), which is really incredible.

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

I love golf. I have been playing golf since I was a kid. I'm not a good golfer by any means, but I enjoy it very much. I go out early in the morning and spend 3 or 4 hours outside just enjoying nature. I'm the first one out there. This way, I have the rest of the day to spend with my family.

I also really enjoy learning about art and history. I am an avid reader and traveler; I believe that the practice of medicine requires technical expertise that is grounded in a broad humanistic knowledge. My grandfather (who was a physician and writer) and my father (a cardiologist) always said, "Physicians who only know medicine do not know even medicine." Hopefully, I have made this bit of wisdom part of my life in a positive way. ■

INDEX OF ADVERTISERS

AGA Medical Corporation	41
Phone (888) 546-4407 or (763) 513-9227	
Fax (763) 513-9226	
www.amplatzer.com	
Atrium Medical Corporation	Cover 3
Phone (603) 880-1433	
www.atriummed.com	
Daiichi Sankyo, Inc., Lilly USA, LLC, and Accumetrics, Inc.	7
Phone (800) 643-1640 or (866) 333-4368	
Edwards Lifesciences	Cover 2, 3
Phone (800) 424-3278	
www.edwards.com	
iCON 2011	5
www.iconmeeting.org	
ISet 2011	71
www.iset.org	
Re-Evolution Summit II	63
www.methodisthealth.com	
SCAI 2011	67
Phone (800) 992-7224	
www.scai.org/scai2011	
Volcano Corporation	Cover 4
Phone (916) 638-8008	
www.volcanocorp.com	
W. L. Gore & Associates	8
Phone (800) 437-8181	
www.goremedical.com	

This advertiser index is published as a convenience and not as part of the advertising contract. Although great care will be taken to index correctly, no allowance will be made for errors due to spelling, incorrect page number, or failure to insert.