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The Director of the TCT meeting discusses what we can expect in this year's sessions, as well as the evolving cardiology field.

What can we expect from the TCT meeting this year? Each year, TCT attempts to evolve and change, and I think we are going to build off some of the prior successes and continue to iterate the meeting and emphasize certain areas of growth. We believe that the meeting this year will be more academic and more clinically practical than ever. It is interesting that what we think are the greatest areas of growth right now involve endovascular, or noncoronary intervention, and an area that we call structural heart disease.

There will be a dedicated program with increased emphasis on didactic teaching, live cases, workshops, and training sessions that relate to all aspects of peripheral intervention that will extend from Sunday afternoon through Friday morning. That is something we started last year that will evolve and will be enhanced this year.

The area of structural heart disease really involves nonvascular intervention—PFO closure, ASD closure, left ventricle appendage closure, and the whole new field of percutaneous heart valve therapy. We are certainly going to focus on some of the core technologies that have driven the field of coronary intervention, so there will be a lot of new data to supplement the already existing growing body of knowledge of drug-eluting stents. We will feature a lot of new innovative therapies—the central core of TCT has been to focus on innovation. One focus on innovation this year will highlight nanotechnology and cell-based therapies.

We will also have the largest live-case menu that we have ever had. Cases will be broadcast (live) from four venues at the convention center, and from a minimum of 25 sites representing 13 non-US sites and 12 OUS sites.

We understand that your role in the TCT meeting is very demanding. What are some of the ways in which this is rewarding for you? TCT began as a boutique-niche meeting in the area of new device development in interventional cardiology. It has evolved into what has been a seminal meeting that defines the expanding field of interventional vascular or extravascular therapy. What is rewarding to me is that I have the opportunity to network with 600 faculty members to put together the most provocative program possible, and to help influence in a positive way the future of this subspecialty in the hope that by putting all these people together, the subspecialty will move in a positive direction.

What do you think the future role of the cardiologist will be in treating patients with peripheral vascular disease? Just based on the last 5 to 10 years, I think everybody realizes that the role of the cardiologist is moving out of the heart and into other more distant vascular domains. Where before cardiologists were dabbling in noncoronary intervention, it is going to soon become part of the core curriculum, and it is going to become part of what an interventionist is going to be expected to know—all aspects of peripheral intervention.

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Certainly, the iliacs, renals, and carotids are going to be central therapies for the cardiologist, if they dedicate the time and make the effort to understand the disease, understand the techniques, and get the proper training. I do not propose that any cardiologist move out his area of direct subspecialty unless he is willing to commit the time and the intellectual effort, and get the training to be a very high-level operator in these other areas. I think we see it now in the carotids and in the fellow-training programs. The fellows are certainly very excited, if not insisting, to learn more than just coronary intervention.

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What is the current health of the cardiology specialty from the standpoint of fellows enrolling in membership and as members in training? Interventional cardiology is very strong. I cannot think of a more exciting time to be an interventional cardiologist than now. Social programs are increasing in number and in size. The duration of training is increasing because, clearly, a 1-year clinical fellowship is inadequate for many people to understand all of the vagaries of what is not just coronary but what is coronary and extracardiac vascular intervention.

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In terms of the growth with regard to patient numbers, it is an interesting dynamic that has occurred with drug-eluting stents—we have certainly drastically reduced, if not eliminated, the frequency of patient recurrence. The numbers have gone down a little bit in terms of total number of procedures. However, because we have drug-eluting stents, we can treat the high restenosis risk scenarios, so we are treating a much more complex disease, patients who might have gone to surgery. I think we will be able to develop a stable patient number over the next several years, with a slight single-digit growth, but with an emphasis on increasing complexity, which places a demand on operator skills.

Do you believe that percutaneous valve technology will open up a new turf war and become similar to the CAS turf issue, or has a lesson been learned? That is a great question. I hope the lesson has been learned. I have become an apostle of interdisciplinary collaboration, and I am adamant that the mistakes that were made with CAS should not be duplicated in any of these cross-discipline, exciting new fields. An example is the transcatheter valve therapy. The way our vascular surgery colleagues were alienated in the early days of CAS and the antagonism that the situation engendered was truly unfortunate and certainly had a negative impact on the development of the field.

Now, regarding transcatheter valve work, we are absolutely including our surgical colleagues as equal partners in all of the work that is being done from the standpoint of device development, clinical trials, clinical trial involvement—even to the extent that we are starting to train cardiac surgeons in our cath lab so that they can begin to acquire an understanding and some skill sense that would help them to collaborate with us on these projects. It has to be an interdisciplinary effort.

What are the problems we face with drug-eluting stent technology for PVD, and what do you think its role in the periphery will ultimately be? I think there are a lot of unknowns, and that everybody simply assumed that we'd be able to take the current drug-eluting stent technology, upsize it to the periphery, and we would have similar success. That was very naïve. The stent designs are different, as is the anatomy in terms of its response to vascular injury. Therefore, the drug concentrations and elution profiles have to be different.

The first two studies that were done in the renals and the SFA (the GREAT study and SIROCCO) were both disappointments. Everyone has taken a deep breath and is saying, "Okay, now what do we do to design proper devices and proper studies that would demonstrate there is enhanced efficacy of those devices?" It is going to take a complete redesign and a better understanding of the pathophysiology of the mechanistic issues, and there will be anatomy-specific devices; they are not simply going to be clones of the coronary devices that suddenly apply to the periphery, which is so often the case.

Are you happy with the recent move you made to Columbia University? We are absolutely delighted. It is a wonderful platform. We attempted to set up a not-for-profit research and educational organization called the Cardiovascular Research Foundation about 16 years ago. We felt at that time that most of the innovative work being done in interventional vascular medicine was not done at major universities, it was done largely in the private sector. We felt that we had more control over the academic process in the private sector than we did at universities, so we linked very strong private interventional groups with the research foundation to accomplish the academic mission. Now, we have taken that as far as we could and we are at a point in the biotechnology revolution, that if you truly want to make an impact at the next level, you have to bring it back to the universities.
The move to Columbia provides just that. It gives us a base at a great university with wonderful collaborators with great basic science, and administrators that have a mission for growth. They have helped us to set up a center for interventional vascular therapy, and it has become affiliated with the Cardiovascular Research Foundation. So for all of those reasons, I think that the transition has been smooth, although exhausting, and the move has been good. ■