Program innovations designed to increase interactivity at Scientific Sessions

For the thousands of doctors, researchers and other healthcare professionals attending the American Heart Association’s Scientific Sessions, plotting each day is akin to picking from an all-you-can-eat buffet at a five-star restaurant. No matter what you like, there’s plenty to choose from — and the quality will be top notch. “There’s something for everybody — really, more than you can handle,” said Clifton Callaway, MD, FAHA, and the Chairman of the Committee on Scientific Sessions Program (CSSP). “It’s a great problem to have.”

Consider this small sample of options:

• Interested in learning more about the finer points of how clinical trials work, from start to finish? There’s a full-day event organized by Elliott Antman, MD, FAHA, and Robert Harrington, MD, FAHA, the pair who combined to oversee the last four Sessions.

• Interested in the growing field of vascular medicine? How about arrhythmia? You could delve into either subject so deeply that you might think you’re attending a convention devoted to it.

• Held an artificial heart or an LV AD lately? If not, check out the Simulation Zone, which features everything from those hands-on demonstrations to computerized challenges offering case-based situations for non-scientists and practitioners.

ILCOR releases advisory statement on temperature management after cardiac arrest

In an advisory statement published in October by the Advanced Life Support Task Force of the International Liaison Committee on Resuscitation (ILCOR), therapeutic hypothermia has been renamed “targeted temperature management.” The new wording is a more concise formulation of the underlying concept of controlling core temperature to achieve specific therapeutic outcomes, said Michael Donnino, MD, lead author of the advisory statement. The new wording covers any form of temperature control within cardiac arrest.

“The statement recommends that you perform targeted temperature management for patients who suffer cardiac arrest,” said Donnino, associate professor of medicine at Harvard Medical School and director of the Center for Resuscitation Science at Beth Israel Deaconess Medical Center in Boston.

Scientific Sessions attendees can expect repeated reference to the ILCOR advisory statement during the Resuscitation Science Symposium (ReSS) Saturday and Sunday. The symposium will also explore the latest research in targeted temperature management and related topics in resuscitation.

A Saturday session titled “Therapeutic Hypothermia: My Target Temperature is …” will highlight the latest clinical research on the therapeutic effects of
HIGHLIGHTS FROM THE PROGRAM CHAIR

By Frank W. Sellke, MD, FAHA, Committee on Scientific Sessions Program Chair

Welcome to the American Heart Association’s Scientific Sessions, the premier cardiovascular science meeting in the world. This year’s meeting looks to be one of the best ever.

The Committee on Scientific Sessions Program, along with Vice Chair Eric D. Peterson, MD, MPH, and the AHA staff have done a truly outstanding job arranging the meeting content in an all-new format, focusing on 30 areas of interest (tracks) within basic, clinical and population science. We have also added new educational and simulation programs alongside the usual outstanding scientific, clinical and translational lectures and poster presentations.

Saturday’s highlights include the Early Career Day Program (9 a.m. to 5 p.m.) with specialty science breakout, including the Peripheral Vascular Disease Fit Workshop. The program concludes with a reception from 5 to 6:30 p.m. Whatever their field or interest, young investigators can attend a number of outstanding programs and learn new techniques and cutting-edge science, and network with both young and established colleagues.


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The latest Institute on Medicine (IOM) report on cardiac arrest will sound familiar to AHA members who work in cardiac arrest. The IOM’s findings on the burden of cardiac arrest, the need for additional research, its call for a national cardiac arrest registry and strategy recommendations to improve patient care echo work the AHA has done and plans to do in the future.

“The IOM report resonated very strongly with the work of the AHA, specifically the work of the Emergency Cardiovascular Care Committee and the Get With The Guidelines program,” said Robert Neumar, MD, PhD, professor and chair of emergency medicine at the University of Michigan Health System in Ann Arbor. Neumar chaired the AHA’s response to the IOM’s June report on “Strategies to Improve Cardiac Arrest Survival: A Time to Act.”

The IOM report will be discussed in depth today during a one-hour session that begins at 8:15 a.m. in the Valencia Ballroom – W415AB.

One of the most important recommendations from the report is to establish a national cardiac arrest registry at the local, state and national levels, Neumar said.

“Having data on the incidence, system performance and outcomes is foundational to know where we are now, and also to measure any impact from the strategies proposed by the IOM or the AHA,” he said. “If we can’t measure where we are, we can’t measure where we are going or the impact of our investments.”

A second key recommendation is to foster a culture of action in response to cardiac arrest. Basic life support begins with recognizing cardiac arrest, calling 911, performing CPR and using an AED if one is available.

“Cardiac arrest is the most critically ill human condition that exists,” Neumar said. “People need to understand that their individual actions can be the difference between life and death. Cardiac arrest is unique in health care in that we have put so much effort on what bystanders can and must do to initiate that chain of survival.”

A third key recommendation is increased support for cardiac arrest research. Despite the prevalence of cardiac arrest, support for research is disproportionate compared to cancer, stroke, myocardial infarction and other diseases, Neumar said.

“The IOM’s call to action needs to be responded to,” he said. “The AHA is willing to step up, even take the lead in much of the response. But we can’t do it alone. Improving outcomes requires the active support and involvement of other stakeholders, including government agencies and funding bodies, to implement these clearly defined strategies.”

There are about 535,200 out-of-hospital and 209,000 in-hospital cardiac arrests each year in the United States. At a national level, only 25.5 percent of adults who suffer cardiac arrest in a hospital setting survive to discharge. For out-of-hospital cardiac arrest, only 10.6 percent of patients survive to hospital discharge.

Survival rates vary widely based on personal factors such as age, race, gender and health status. Survival rates also vary widely based on the characteristics of local emergency medical services and local health care systems. While some communities and hospitals have significantly improved cardiac arrest outcomes, there are pronounced variations and disparities in care. Local resources and personnel must provide appropriate, timely and high quality care in order to save more lives locally.

MEMBER SPOTLIGHT

Michelle M. Fennessy, PhD, RN
Assistant Professor at The Ohio State University, College of Nursing
Columbus, Ohio

How long have you been an AHA/ASA Professional Member?
Four years at the professional level but I have been a general member of the AHA for 10 years.

Why did you join?
I have always enjoyed the learning and networking that takes place within the American Heart Association. Membership provides me with access to a range of resources and allows me to connect with others in the field of cardiovascular health.

Are you involved in AHA councils?
Yes, very much so! I am currently involved with multiple AHA councils, including the Council on Cardiovascular and Stroke Nursing (CVSN). I am a member of the CVSN council, which focuses on advancing the field of cardiovascular and stroke nursing.

What do you enjoy most about these roles?
I enjoy the opportunity to connect with other professionals and contribute to the advancement of the field. It is rewarding to work on committees and projects that address important issues in cardiovascular health.

How else are you involved with the AHA?
I contribute to various AHA initiatives and committees, including the AHA’s advocacy efforts. I also participate in local AHA events and meetings.

What message would you like to convey to your colleagues about being an AHA member?
Being an AHA member offers numerous benefits, including access to resources, networking opportunities, and the ability to contribute to important initiatives in cardiovascular health.
Researched presented at Scientific Sessions, based on data collected through AHA registries that track cardiac events and patient outcomes from millions of providers and patients, could help transform the provision of cardiac care.

“Get With The Guidelines and Mission: Lifeline have, as their primary goal, the improvement of patient care and outcomes,” said Deepak L. Bhatt, MD, MPH, executive director of interventional cardiovascular programs at Brigham and Women’s Hospital Heart & Vascular Center and professor of medicine at Harvard Medical School in Boston. Bhatt chairs the Quality Oversight Committee, a group of volunteers that oversees the AHA’s quality improvement programs. Get With The Guidelines focuses on stroke, heart failure, resuscitation and atrial fibrillation. Mission: Lifeline links EMS providers and health systems to improve care for myocardial infarction. Both are designed to help healthcare professionals deliver evidence-based care that’s focused on improving patient outcomes.

“The basic premise is that the more the quality of healthcare improves, the more patient outcomes improve,” Bhatt said. “All of the quality programs include registries that are intended to generate research, presentations and publications that change the way cardiac care is delivered. We are seeing research being presented this year that has the potential to dramatically improve the ways we deliver care and the outcomes our care produces.”

On Monday, Shanshan Li, MD, MSc, ScD, an epidemiologist at the Harvard School of Public Health in Boston, will present new findings on sex- and race-related disparities in care, based on data from Get With The Guidelines-Coronary Artery Disease. Li will present the abstract, “Sex and Race Related Disparities in Care and Outcomes After Hospitalization for Coronary Artery Disease Among Older Adults,” at 11:15 a.m. in W203. Also on Monday, lead author Emily O’Brien, PhD, will present an abstract titled “Clinical Effectiveness of Statin Therapy After Ischemic Stroke: Primary Results from the PROSPER Study” at 9:30 a.m. in the Best of AHA Specialty Conferences section of Hall A2. The study examines the efficacy of statins in patients who have had ischemic stroke, using data from Get With The Guidelines-Stroke. O’Brien is a member of the Duke University Clinical Research Institute and an instructor in the Duke University School of Medicine in Durham, North Carolina.

“This is research from patients with strokes in the real world and what impact statins might have on outcomes patients have told us they care about most,” Bhatt said. “They value time at home, which means discharge to a skilled nursing facility, and months of rehab may not be something they consider a desirable outcome.”

On Tuesday, Jacob P. Kelly, MD, a fellow at the Duke Clinical Research Institute, will present a study titled “The Potential Impact of Expanding Cardiac Rehabilitation Coverage in Heart Failure: Insights From Get With The Guidelines-Heart Failure.” This new analysis examines the impact of the recently expanded indications for cardiac rehabilitation. Kelly will present the study’s findings at 6:30 p.m. in W300.

Mission: Lifeline is also generating new findings.

One of the key strategies to improve outcomes for ST-elevation myocardial infarction and out-of-hospital cardiac arrest is to provide appropriate care within recommended timeframes. This could mean bypassing a hospital in favor of a more distant facility.

“When you have a STEMI, what’s best for the patient is to get to a center that can deliver primary PCI as rapidly as possible,” Bhatt said. “When that means bypassing another hospital, that bypassed hospital has to cooperate even though doing the right thing may put them at an economic disadvantage. One of the real questions is whether appropriate state policies can encourage that kind of cooperation.”

Jacqueline Green, MD, a cardiology fellow at the University of Michigan in Ann Arbor, worked with Mission: Lifeline data to examine the effects of a state bypass policy. She will present her findings at 9 a.m. Monday in the Special Focus section of Hall A2. The abstract is titled “Are State Policies that Permit Prehospital Bypass Associated with Better Treatment Patterns Among Patients with ST-Elevation Myocardial Infarctions? A Report from AHA’s Mission: Lifeline Program.”

“This will be a very interesting analysis of how best to treat STEMI patients prior to their arrival to the hospital,” Bhatt said. “Should they be bypassing smaller facilities that can’t deliver primary PCI rapidly? And does it help to have state policies that encourage that kind of bypass? These are the sorts of questions our registries are uniquely positioned to address.”
What more is there to learn about platelet activation and aggregation?

Find out at Booth 701
Bugher Foundation trustee Dan Adams remembered as inspirational, creative force

Dan Adams, who oversaw a family foundation that blossomed into one of the nation’s leading funders of stroke research, died on June 30. He was 75.

Adams died accompanied by his loved ones into one of the nation’s leading funders of stroke research. He had been diagnosed with acute myeloid leukemia.

Although his professional specialty was corporate branding, Adams became a leader in the fight against stroke through his involvement in the Henrietta B. and Frederick H. Bugher Foundation. The Bugher Foundation has funded more than $36 million in heart and stroke studies overseen by the American Heart Association/American Stroke Association. This foundation is the most generous research donor in the AHA’s history.

The Adams family has been intimately involved in the foundation since its inception. Dan’s father, Nelson Adams, helped start the Bugher Foundation, and Dan’s sons, Bryan and Bruce, are among the trustees. Interestingly, the Adamses are not related to the namesake benefactors, nor are they connected to cardiovascular disease, except for their devotion through this foundation.

Formally known as the American Stroke Association-Bugher Centers of Excellence in Stroke Collaborative Research, its focus on recovery, resilience and prevention includes psychology, psychiatry and neuropyschology. This met Adams’ oft-stated goal of “getting the mind into the mix.”

“Through his compassionate leadership of the Bugher Foundation, Dan Adams and his family have supported stroke research in this country like no one else,” said Ralph Sacco, a past president of the AHA/ASA who is chairman of neurology at the University of Miami Miller School of Medicine and director of the school’s center in the current Bugher research project. “There are so many fellows, faculty, researchers and patients who are indebted to Dan and his family for their generosity and guidance of the Bugher Foundation in improving outcomes for patients with stroke and heart disease. I am incredibly grateful to have known and worked with Dan and I know his legacy will continue.”

With nearly 30 years of funded research, the Bugher alumni club includes more than 200 researchers, many of whom have become leaders in the field. Perhaps the most prominent is Andrew Marks, creator of the first drug-eluting stent approved by the Food and Drug Administration in 2003.

The current Bugher-funded project involves teams of researchers at UCLA, the University of Colorado at Denver and the University of Miami. They are in the second of four years of studying a broad range of issues — including stroke in children, rehabilitation and recovery, neuropsychology and cognition — and are working together in a collaborative format championed by Adams.

“Dan meant so much to our organization,” said Nancy Brown, chief executive officer of the AHA/ASA. “As an individual leader, he helped shape the future of the AHA in research, as a trustee of the Bugher Foundation he was inspirational to so many others and as a friend he was always gracious and compassionate. His presence and input will be greatly missed.”

Survivors include Adams’ wife, Suzanne, sons Bryan and Bruce, Bruce’s wife, Lee, and Bruce and Lee’s daughters, Margaret and Lucy. He was preceded in death by another son, Danny.

IN PARTNERSHIP WITH
Cardiology News®  Family Practice News®  Internal Medicine News®

YOU ARE INVITED TO ATTEND A CME/CE SYMPOSIUM
Challenges in Cholesterol Management: What Your Patients Might Not Be Telling You
A TOWN HALL SYMPOSIUM
Tuesday
November 10, 2015
6:30 AM – 8:30 AM

Hyatt Regency
9801 International Drive
Orlando, Florida
Orlando Ballroom, N

Faculty
Antonio M. Gotto Jr., MD, DPhil, FNLA, Chair
Dean Emeritus, Weill Cornell Medical College
Provost for Medical Affairs Emeritus, Cornell University
New York, NY

Carl E. Orringer, MD, FNLA
President, National Lipid Association
Associate Professor of Medicine
University of Miami Miller School of Medicine
Miami, FL

Elizabeth J. Jackson, MSN, FNLA
Clinical Nurse Specialist
CardioTexas, St. David’s Medical Center
Austin, TX

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• Enter the authorization code you received with your attendee badge.
• Complete the evaluation.
• Claim your credit(s).

International attendees can obtain their attendance verification certificate at the registration center. For a full list of conference accreditation statements and credit hours, visit scientificsessions.org.
AHA/ASA journals provide instant feedback of online impact

Since 1950, the American Heart Association/American Stroke Association journals have accelerated advancements in patient care through scientific research. Here are some of the 12 journals’ latest metrics:

- **Recognition:** 364,700 total cites*
- **Reputation:** 58.5 million article downloads†
- **Discoverability:** 31 million online visits‡
- **Exposure:** 3.4 billion media impressions‡
- **Reach:** 12,500 institutions with access‡
- **App-peat:** More than 138,000 iPad app downloads‡

In addition, Altmetric is now available on the journals’ websites. It analyzes the online impact of journal content by tracking discussions on Twitter, Facebook, science blogs, mainstream news outlets and other sources. The data is available to authors and readers by clicking the “Metrics” link in the menu alongside each journal article. Visit www.ahajournals.org/site/altmetric.

“With Altmetric, the AHA/ASA journals can provide instant feedback as to how articles are received by the reading public. Seeing how articles are trending in the social media realm is appealing in this fast-paced environment,” said Robert M. Carey, MD, MACP, FAHA, FRCPI, chair of the AHA Scientific Publishing Committee. “Combine the Altmetric feature with the robust metrics that we report, and the journals continue to look at measures of quality beyond the Impact Factor.”

Another enhancement is the Open Access option that’s now available for Original Research articles submitted to the journals. Visit www.ahajournals.org/site/openaccess for more information.

**JAH**A, the AHA/ASA’s fully Open Access journal, represents the 16 AHA scientific councils. Submissions are encouraged from AHA/ASA members, and members are eligible for discounted article publication charges. Pick up a free JAH**A** booklet with featured articles, information about authors and more at AHA HeartQuarters (booth 859) or the Wiley exhibit (booth 950) in the Science & Technology Hall. You can also visit jaha.ahajournals.org.

Complimentary copies of the AHA’s five print journals and information about all of the journals are also available in the Science & Technology Hall. You can view AHA/ASA journal apps and other new features in the hall. Stop by AHA HeartQuarters or the Wolters Kluwer exhibit (booth 951) for more information.

Many of the AHA/ASA journals have Facebook pages, tweets of the latest study results, connections via LinkedIn and blogs with readers about cases or recently published articles. For the latest, visit www.ahajournals.org/site/socialmedia.  

†Average per year based on 2014 metrics.
Welcome, New 2015 American Heart Association Fellows

As a Fellow of the American Heart Association/ American Stroke Association, you are a part of one of the world’s most eminent organizations of cardiovascular and stroke professionals. The American Heart Association recognizes your scientific and professional accomplishments and volunteer leadership and service.

Fellows, stop by the FAHA Lounge in the West Building, West Concourse, Lobby Area, Level 1 to relax, network and recharge.

If you are interested in Fellowship, please stop by Booth 859 to learn more.
different target temperatures, as well as the need for individualized care and an examination of the role of hypothermia in trauma. The session begins at 2:30 p.m. in the Valencia Ballroom – W415AB.

An oral abstract session on Saturday will provide a glimpse of other targeted temperature management strategies, while a pair of concurrent oral abstract sessions on Sunday will explore the expanding world of targeted temperature management in clinical and trauma care.

All of these sessions draw from the research considered by the ILCOR task force when drafting its advisory statement. The group considered three questions, Donnino said. The first was whether some form of targeted temperature management should be used in comatose post-cardiac arrest patients. The second and third questions involved appropriate targets and duration of the intervention when targeted temperature management is used.

The task force reached its conclusions based on systematic review and, as appropriate, meta-analyses for each of the three questions. Members completed a bias assessment for all studies included in the review and used GRADE methodology to evaluate the evidence and develop treatment recommendations. The answer to the first question is yes — targeted temperature management is appropriate for essentially all adults suffering cardiac arrest who remain comatose after resuscitation and return to spontaneous circulation, Donnino said. The ILCOR statement expands the temperature management target to a consistent temperature within the range of 32°C to 36°C. Prior recommendations called for a target range between 32°C and 34°C.

“We also addressed how long to maintain target temperature management, the third question,” Donnino said. “While there are no randomized data to answer that question definitively, we ultimately recommended at least 24 hours. That is consistent with the approximate times of the large randomized trials.”

With regard to the timing of hypothermia, the task force recommended against the use of prehospital cooling with rapid infusion of large volumes of cold IV fluid immediately after return to spontaneous circulation. The group concluded that other cooling strategies and cooling during cardiopulmonary resuscitation in the prehospital setting have not been studied adequately and further research is needed.

“This ILCOR advisory is the latest statement on targeted temperature control, not the last. There has been and will continue to be additional research that affects future evaluations of these and other issues,” Donnino said. “The ReSS offers cutting-edge research in resuscitation from experts around the world. This is the ideal symposium for all of those who are interested in the clinical, operational or research aspects of resuscitation.”

CPR GUIDELINES continued from page 1

Pushing hard,” Callaway said. “Ribs bend with chest compressions and the ‘injury’ is usually very mild. It definitely is not life-threatening.”

The new resuscitation guidelines also re-emphasize the value of breaths during CPR by people willing and able to deliver them. Callaway expects conventional CPR with breaths as compared to Hands-Only CPR will be a topic of discussion among experts as new research emerges.

But for those untrained or unable to give the breaths, “it’s better to give compressions than not do anything at all,” Callaway said.

The AHA’s resuscitation guidelines have been updated every five years through a partnership involving more than 250 international experts from the AHA and six other resuscitation councils that form the International Liaison Committee on Resuscitation (ILCOR). At an AHA-hosted ILCOR conference in January, seven expert panels reached consensus on hundreds of resuscitation topics based on research published since the 2010 guidelines.

More than 326,000 people experience cardiac arrest outside of a hospital each year and about 90 percent of them die, often because bystanders don’t know how to start CPR or are afraid they’ll do something wrong. Guidelines recommend that CPR be given immediately after someone collapses and continue until a defibrillator is ready to use, emergency medical services take over or a victim starts moving.
Unofficial Satellite Events

SUNDAY, NOV. 8
7-9 p.m. University/Nonprofit Symposium Cardio-Oncology: A New Evolving Discipline
Sponsored by Mayo Clinic Division of Cardiovascular Diseases
Rosen Centre Hotel, Grand Ballroom A
Registration: 6:30–7 p.m.

7-9 p.m. Industry-supported Symposium New Tools for Managing Hyperkalemia: Cases in Heart Failure and Renal Disease
Supported by ZS Pharma
Rosen Centre Grand Ballroom D

7–8:15 p.m. Industry-supported Symposium Optimizing LDL-Targeted Cardiovascular Risk Reduction
Jointly Provided by the University of Massachusetts Medical School and CMEducation Resources, LLC
Supported by an Independent Educational Grant from Sanofi and Regeneron Pharmaceuticals
Hyatt Regency Orlando, Plaza Ballroom D-G
Registration: www.reg-LDL.com

7–10 p.m. Industry-supported Symposium AF Spotlight: Using NOACs Safely
Supported by Postgraduate Institute for Medicine and Medintelligence
Supported by Boehringer Ingelheim Pharmaceuticals, Inc. and Daichi Sankyo, Inc.
Hyatt Regency Orlando, Windermere Ballroom W
Convention Level
Registration: http://events.medintelligence.net/ha2015.html

7–10 p.m. Industry-supported Symposium Repatha™ (evolocumab): Product Overview
Sponsored by Amgen
Supported by Amgen
Hyatt Regency Orlando, Windermere X Room

MONDAY, NOV. 9
7-8 p.m. Industry-supported Symposium Considerations in the Clinical Use of Non-Warfarin Oral Anticoagulation in Thrombosis
This activity is provided by Global Education Group. Paradigm Medical Communications, LLC is the educational partner.
Supported by an educational grant from Daichi Sankyo, Inc.
Rosen Centre Hotel, Ballroom: Executive H
Registration: 6:30 p.m.; www.paradigmcmc.com/422

7-8 p.m. Industry-supported Symposium Anticoagulation Management and Evolving Standards of Care
Supported by Boehringer Ingelheim Pharmaceuticals, Inc
Hyatt Regency Orlando, Orlando Ballroom
Registration/dinner: 7–7:20 p.m.
Program: 7:20–9 p.m.

A NOVEL APPROACH TO THE TREATMENT OF HEART FAILURE

Monday, November 9, 2015
1:15 PM–2:00 PM
Cardiovascular Expert Theater
Booth 1559

Javed Butler, MD, MPH, MBA
Professor of Medicine, Chief of Cardiology
Stony Brook University
Stony Brook, New York

Please visit the Novartis Booth 1029

These events are not part of the official programming as planned by the 2015 Committee on Scientific Sessions Programming.
Scientific Sessions is widely regarded as the premier gathering of cardiovascular thought leaders in the United States. Organizers take great pride in upholding that reputation, so they’ve spent countless hours over the last year evolving, improving and refining the program to ensure its depth and breadth. Now comes the fun part: seeing it all play out over the next four days in Orlando.

“All over the globe, cardiovascular physicians, scientists and other related professionals build their calendars around AHA Scientific Sessions because of its extensive offerings, including Late-Breaking Clinical Trials, novel research discoveries and programs tailored for every cardiovascular specialty interest,” said AHA President Mark Creager, MD, FAHA. “It is a particular treat to listen to experts discuss the latest developments in their field. The knowledge gained at Scientific Sessions makes us all better at our jobs, whether it’s caring for patients or going back to the laboratory. The innovative programming at this year’s meeting will highlight a great learning experience. I am anticipating another outstanding Scientific Sessions.”

Plenary sessions and Late-Breaking Clinical Trials are foundational items on the agenda. Those remain among Sellke’s favorites because of the rigorous review required for each speaker and subject to make it to the stage. He becomes even more enthusiastic in describing the 2015 innovations.

“This is NOT the same old Sessions,” said Sellke, the chief of cardiothoracic surgery at Brown Medical School and the Lifespan Hospitals in Providence, Rhode Island. “If you haven’t been for five years, I don’t think you’d be able to recognize it.”

For instance, you can now be in two places at once. Technology makes it possible to virtually attend any session at any time. If you’re coming out of one session and there’s not enough time to get across the convention center, you can still “attend” the next session on your list via mobile phone, tablet or computer. And if you aren’t sure how to hook up such a connection, well, there’s another session that can help solve that problem.

“When you were here in 2004, there wasn’t as much going on; everyone was talking to each other. Now there’s bigger crowds while the same number of sessions are going on,” Sellke said. “There’s more audience involvement, which in turn should yield a greater exchange of information.”

“This is a major change for the better.”

A bigger change is that the number of oral presentations is going down. Going way up is the number of poster presentations — and, in another major shift, they’ll all be moderated.

Novel as this may sound, it’s actually an expansion of an existing concept: the “Poster Professor.”

This began a few years ago as a way for a presenter of a research poster, usually someone early in their career, to work one-on-one with a senior member of their field. The duo would discuss the science involved in the research featured on the poster, as well as the intricacies of sharing their work in this prestigious setting. The session proved so popular that the CSSP expanded it last year. Now it’s growing again, so much that Sellke believes there eventually could be year-round tutorials to train “professors.”

“It used to be that poster presenters sat around and hoped that people came to see them,” Sellke said. “Now there’s going to be an active exchange of information. First the presenter gives a couple-minute presentation of his poster, followed by a Q&A led by the professor and others in the audience. It’s great for the effectiveness of exchanging information, and also for networking. This is a major change for the better.”

Digital posters also will be more common. Some will be presented on big-screen TVs, accommodating — or perhaps luring — bigger crowds while also expanding the discussion accessible to someone who prefers to sit or stand outside the cluster around the presenters.

The Simulation Zone is brand new, and also expanding the discussion accessible to someone who prefers to sit or stand outside the cluster around the presenters.

Using feedback from attendees and presenters, and adding their own observations, these dedicated AHA volunteers focus on making sure everyone who takes the time and effort to be here gets what they need and want. That leads to one of the most prominent changes, one that can be described quite bluntly: fewer boring lectures.

Oral sessions have been reduced from 10–15 minutes with a five-minute discussion to seven minutes or less of oration with the rest of the time going to discussion. The aim is generating more audience involvement, which in turn should yield a greater exchange of information.

“Rather than doze off while someone is talking, you’re actually involved in discussions,” Sellke said.

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The Simulation Zone is brand new, and might be worth a look for even the most knowledgeable veteran for the simple reason that there’s likely to be a lot of people there having fun.

Lines may form around the machines offering activities that test diagnosis skills. A cousin, of sorts, to the popular “Case Theater” series — which features real cases on video that are started...
Call for Peer Reviewers

AHA is recruiting reviewers for upcoming study sections. Our reviewers are basic, clinical and population investigators who possess the following minimum qualifications:

- Minimum Assistant Professor (or equivalent) career level
- Current or recent independent peer reviewed funding, typically at national level
- Consistent record of peer reviewed publications within the past five years
- Knowledge of the AHA and commitment to its mission
- AHA Professional Membership is highly desired

If you would like to become a reviewer, please contact Sue Hageman at susan.hageman@heart.org

and stopped for discussion and debate — these are made for one person at a computer.

“You might see a picture of a diseased organ and lab data, and you have to come up with a diagnosis or conclusion or a treatment paradigm,” Sellke said. “Residents and medical students can benefit. It can also be used for postgraduate education for practicing physicians.”

Then there are the hands-on activities, which could take on a show-and-tell vibe, even among experienced cardiologists. As Sellke notes, it’s rare for anyone other than a surgeon to actually hold these devices and get a feel for them, to look inside and study all the various components.

“You don’t pass around an LVAD or artificial heart in the ER before you put it in,” Sellke said. “It’s sterile and packaged, so even the people who are there see it but don’t touch it. Our concern is we may have more interest than the space allotted can handle.”

Frequent attendees of Sessions may have become accustomed to plotting their calendars around seven “cores.” Even that has received a makeover.

Groupings are now based on science types: Basic Science, Clinical Science and Population. There are also groupings for “Frontiers in Science” and “Special Focus.” All told, there are 30 tracks you can follow under these various umbrellas.

“Frontiers in Science” — with separate ones for vascular medicine and arrhythmias — are the deep dives that could feel like a meeting within the meeting. Sellke describes these offerings as a way of “getting a large amount of information in a very consolidated amount of time.”

“Special Focus” areas include Nursing Research Science and the Resuscitation Science Symposium, events that have long piggybacked with Sessions. Newcomers are “Lifelong CHD and Heart Health in the Young” and the Antman-and-Harrington-led event called “Clinical Trialists.”

“If you want to know about every aspect of clinical trials — from setup to executing, monitoring, working with the FDA, analysis and more — then go to this session,” Sellke said. “You can’t cover everything in four hours, but I’m sure it’s going to cover as much as possible, with input from international experts.

“It’s not just for young members. I think they’ll have an interest, but I would love to be there for this entire event, too. I’ve been involved in these my whole career, so I’m no novice, and I know I can learn a lot from these panelists.”

Sellke attended his first Sessions in 1988. He was a cardiac surgery resident, and his boss recommended that he attend to present his work. He enjoyed it so much that he’s returned every year since, usually presenting multiple abstracts. In fact, his lab at Brown is making six presentations this year.

Two years ago, Sellke joined the CSSP as an at-large member. A few months later, an illness forced the vice chair to step aside and Sellke took over that spot. He spent about 10 months watching Harrington prepare for the 2014 Sessions, and has spent the last year preparing for this weekend, along with help from the rest of the CSSP team, his predecessors and AHA staff.

“It’s really been a high point in my career,” said Sellke, who also will oversee planning of the 2016 Sessions in New Orleans.

Considering how many hours he’s carved from his life, personally and professionally, there must be something special about Sessions that drives Sellke.

“What I love is that there’s so much going on,” he said. “You’ve got the best clinical information, the best basic science, the best opportunities for networking, amazing plenary sessions and excellent Late-Breaking Clinical Trials. Now we’re trying to make it the best for education and maintenance of certification and simulation training.”

Sanofi and Regeneron Expert Lectures Series

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Nov 8th

12:00 PM - 12:30 PM Efficacy, Safety, and Tolerability With PCSK9 Inhibition
Harold Edward Bays, MD, FTOS, FACC, FACE, FNLA

3:15 PM - 3:45 PM Efficacy, Safety, and Tolerability of PCSK9 Inhibition in Special Populations
Michael Koren, MD, FACC

Nov 9th

1:00 PM - 1:30 PM Efficacy, Safety, and Tolerability With PCSK9 Inhibition
Norman Lepor, MD, FACC

Nov 10th

10:30 AM - 11:00 AM Efficacy, Safety, Tolerability, and Dosing Options With PCSK9 Inhibition
Paul Thompson, MD

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Nov 8th

Booth 1559

11:15 AM - 12:00 PM PCSK9 Inhibition: Long-term Safety and Efficacy
Michael Davidson, MD

Nov 9th

Booth 1601

12:00 PM - 12:45 PM PCSK9 Inhibition: Efficacy and Safety With Two Dosing Options
Yehuda Handlesman, MD, FACP, FACE, FNLA

LDL-C = low-density lipoprotein cholesterol; PCSK9 = proprotein convertase subtilisin/kexin type 9.
AHA-funded network boosts blood pressure research

Researchers from four institutions are delving into the causes and possible cures for high blood pressure as part of the American Heart Association’s new Strategically Focused Research Network on hypertension.

High blood pressure is a leading risk factor for death worldwide, responsible for roughly 7.5 million deaths, according to a 2009 report from the World Health Organization. It’s also a risk factor for heart disease, the world’s leading cause of death.

The new studies seek to change how the condition is diagnosed and treated and to better understand its molecular basis. Scientists also hope to improve its treatment in young people and provide a new predictor of preeclampsia to help pregnant women get better care.

The network will include investigators from the University of Alabama at Birmingham, Medical College of Wisconsin, Cincinnati Children’s Hospital and the University of Iowa.

The AHA will support the Strategically Focused Research Network on hypertension with an investment of $15 million over four years, beginning this year.

“The four successful centers are all international leaders in the field of hypertension,” said Christopher Wilcox, MD, director of the Center for Hypertension, Kidney and Vascular Research at Georgetown University.

“The proposed research entails a vibrant mix of basic studies to better understand the causes and consequences of hypertension, and population studies to assess their impact in the U.S. population,” said Wilcox, who serves as chair of the AHA’s Hypertension Council.

At the University of Alabama at Birmingham, researchers want to change how high blood pressure is diagnosed and treated. They will study whether nighttime hypertension can be treated through sodium reduction and how salt consumption leads to high blood pressure at night.

Researchers at the Cincinnati Children’s Hospital hope to improve how blood pressure is managed through lifestyle to limit the need for medication in children.

Another goal is to reduce the number of young people who need echocardiograms and to identify genes that influence the development of blood pressure-related organ damage.

Scientists at the Medical College of Wisconsin said the lack of understanding about the molecular basis for hypertension is a big obstacle to examining new approaches for controlling it. To learn more, researchers there will look at how epigenetic changes throughout the entire human genome in people and animals with hypertension to identify new approaches for controlling high blood pressure.

At the University of Iowa, investigators aim to find a reliable, early predictor of preeclampsia to help doctors in areas with lower levels of obstetric care identify the highest-risk patients as early as the sixth week of pregnancy. Preeclampsia is associated with future cardiovascular disease in both women and their children.

The research networks in Wisconsin and Iowa are supported by special funding from the AHA’s Midwest Affiliate. About 80 million U.S. adults have been diagnosed with high blood pressure. At 50, life expectancy is about five years longer for people with normal blood pressure than for hypertensive people, according to the AHA. ▼
Corlanor® (ivabradine)

1. INDICATIONS AND USAGE

Corlanor is indicated to reduce the risk of hospitalization for worsening heart failure in patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction ≤ 0.35, who are in sinus rhythm with resting heart rate ≥ 70 beats per minute and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use.

2. PRECAUTIONS

2.1 Atrial Fibrillation

Corlanor may cause fatal atrial fibrillation when used to convert patients to sinus rhythm. Convert patients to sinus rhythm as indicated and continue on ivabradine therapy if needed. Initiate ivabradine at a reduced dose (1.25 mg BID) in patients with a history of atrial fibrillation or atrial flutter. Monitor heart rate when initiating ivabradine therapy to ensure heart rate is ≤ 60 bpm.

2.2 Clinical Trials Experience

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2.2 Clinical Trials Experience

The estimated background risk of major birth defects in the U.S. population is approximately 2% to 3%.

3. FEMALE REPRODUCTIVE POTENTIAL

Corlanor may cause fetal harm, based on animal data. Advise females of reproductive potential to use effective contraception during treatment (see Use in Specific Populations (8.1)).

4. Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

5. GERIATRIC USE

No pharmacokinetic differences have been observed in elderly patients (≥ 65 years or very elderly ≥ 75 years) patients compared to the general population. However, Corlanor has been studied in a limited number of patients ≥ 75 years of age.

6. Hepatic Impairment

No dose adjustment is required in patients with mild or moderate hepatic impairment. However, Corlanor has not been studied in patients with severe hepatic impairment (Child-Pugh C) and it is recommended that patients be monitored closely for destabilization of their congestive heart failure that could result from heart rate slowing.

7. OVERDOSAGE

Overdosage may lead to severe and prolonged bradycardia. In the event of bradycardia with poor hemodynamic tolerance, temporary cardiac pacing may be required. Supportive treatment, including intravenous (IV) fluids, atropine, and intravenous beta- stimulating agents such as dopamine, may be considered.

This Brief Summary is based on the Corlanor® Prescribing Information v1.0-14.
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Important Safety Information

- **Contraindications:** Corlanor® is contraindicated in patients with acute decompensated heart failure, blood pressure < 90/50 mmHg, sick sinus syndrome, sinoatrial block, 3rd degree atrioventricular block (unless a functioning demand pacemaker is present), a resting heart rate < 60 bpm prior to treatment, severe hepatic impairment, pacemaker dependence (heart rate maintained exclusively by the pacemaker), and concomitant use of strong cytochrome P450 3A4 (CYP3A4) inhibitors.

- **Fetal Toxicity:** Corlanor® may cause fetal toxicity when administered to a pregnant woman based on embryo-fetal toxicity and cardiac teratogenic effects observed in animal studies. Advise females to use effective contraception when taking Corlanor®.

- **Atrial Fibrillation:** Corlanor® increases the risk of atrial fibrillation. The rate of atrial fibrillation in patients treated with Corlanor® compared to placebo was 5% vs. 3.9% per patient-year, respectively. Regularly monitor cardiac rhythm. Discontinue Corlanor® if atrial fibrillation develops.

- **Bradycardia and Conduction Disturbances:** Bradycardia, sinus arrest and heart block have occurred with Corlanor®. The rate of bradycardia in patients treated with Corlanor® compared to placebo was 6% (2.7% symptomatic, 3.4% asymptomatic) vs. 1.3% per patient-year, respectively. Risk factors for bradycardia include sinus node dysfunction, conduction defects, ventricular dyssynchrony, and use of other negative chronotropes. Concurrent use of verapamil or diltiazem also increases Corlanor® exposure, contributes to heart rate lowering, and should be avoided. Avoid use of Corlanor® in patients with 2nd degree atrioventricular block unless a functioning demand pacemaker is present.

- **Adverse Reactions:** The most common adverse reactions reported at least 1% more frequently with Corlanor® than placebo and that occurred in more than 1% of patients treated with Corlanor® were bradycardia (10% vs. 2.2%), hypertension or increased blood pressure (8.9% vs. 7.8%), atrial fibrillation (8.3% vs. 6.6%), and luminous phenomena (phosphenes) or visual brightness (2.8% vs. 0.5%).

Please see Brief Summary of full Prescribing Information on adjacent page.