Capture it LIVE in the Main Arena

Don’t miss today’s LIVE demonstrations in the Main Arena

With LIVE demonstrations from Fu Wai Hospital, Chinese Academy of Medical Sciences, National Centre for Cardiovascular Diseases – Beijing, China; Swiss Cardiovascular Centre, Bern University Hospital – Bern, Switzerland; and Contilia Heart and Vascular Centre, Elisabeth Hospital – Essen, Germany

**Coronary interventions: Left main PCI**
08.30-09.40 – Beijing, China
What would your strategy for these LM bifurcation and mid-RCA stenosis in a 57-year-old patient with good LVEF be?

**Valvular interventions: TAVI**
09.45-10.55 – Bern, Switzerland
How would you treat this severe aortic stenosis in an 86-year-old woman with tortuous aorta?

**Coronary interventions: Bifurcation PCI**
11.00-12.10 – Essen, Germany
How would you treat this mid LAD bifurcation involving the ostial diagonal artery?

**Coronary interventions: Calcified lesion PCI**
14.45-16.15 – Essen, Germany
How would you treat these long lesions in the RCA and LAD?

**What would your strategy for these LM bifurcation and mid-RCA stenosis in a 57-year-old patient with good LVEF be?**

**How would you treat this severe aortic stenosis in an 86-year-old woman with tortuous aorta?**

**How would you treat this mid LAD bifurcation involving the ostial diagonal artery?**

**How would you treat these long lesions in the RCA and LAD?**
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Wednesday 17th May 2017
TOOLS AND TECHNIQUES
12:30 - 14:30: Théâtre Bleu
Left main and complex bifurcation stenting
Chairpersons: M.C. Morice, A. Serre

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Capture it LIVE in...

Don't miss today's LIVE demonstrations in Theatre Bleu, Theatre Bordeaux and Theatre Havane

With LIVE demonstrations from Institut Cardiovasculaire Paris Sud – Massy, France; and Swiss Cardiovascular Centre, Bern University Hospital – Bern, Switzerland; Fu Wai Hospital, Chinese Academy of Medical Sciences, National Centre for Cardiovascular Diseases – Beijing, China; and Clinique Pasteur – Toulouse, France

... Theatre Bordeaux

China@EuroPCR – New BRS for bifurcation lesion
10.30-12.00 – Beijing, China
In this 58-year-old woman, would you treat this bifurcation with a DES or a BVS?

Achieving immediate TAVI patient benefit and setting-up for superior long-term outcomes (TNT MEDTRONIC)
12.30-14.30 – Bern, Switzerland
Which valve and access would you choose for this patient?

Percutaneous edge-to-edge repair for degenerative mitral regurgitation
14.45-16.15 – Bern, Switzerland
Do you think an edge to edge repair is feasible for this degenerative mitral regurgitation?

Contemporary management of calcified multivessel disease (TNT BOSTON SCIENTIFIC)
16.30-18.00 – Toulouse, France
How would you treat this heavily calcified LAD? Would you also treat this ostial LCX?

... Theatre Bleu

Left main and complex bifurcation stenting (TNT TERUMO) – Case 1
12.30-14.30 – Massy, France
Which technique would you use for this left main bifurcation?

Left main and complex bifurcation stenting (TNT TERUMO) – Case 2
12.30-14.30 – Massy, France
How would you treat each of these bifurcation lesions (LM, LAD, and circumflex marginal arteries)?

How to optimise PCI with advanced imaging technologies: Benefits of the combined use of OCT and fluoro real-time stent enhancement (TNT ABBOTT & SIEMENS HEALTHINEERS)
16.30-18.00 – Bern, Switzerland
Would the use of OCT affect the management of this patient?

... Theatre Havane

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16.30-18.00 – Toulouse, France
How would you treat this heavily calcified LAD? Would you also treat this ostial LCX?

Below-the-knee angioplasty: streamlining complex CTO interventions
08.30-10.00 – Toulouse, France
How would you treat this patient with below-the-knee lesions?
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Wednesday 17th May

ABBOTT SPONSORED SYMPOSIUM
STEMI AND MULTIVESSEL DISEASE: EVIDENCE ON FFR-GUIDED TREATMENT PUT INTO PRACTICE
12:30–13:30, Room: 351
Chairpersons: E. Barbato, P. Smit
Panellist: P. MacCarthy

ABBOTT SPONSORED CASE IN POINT SESSION
HOW TO BEST MANAGE CONCOMITANT PROCEDURES IN STRUCTURAL HEART THERAPIES?
12:30–13:30, Room: 251
Chairpersons: F. Maisano, D. Teléchea
Panellists: L. Sondergaard, D. Arzamendi

ABBOTT & CYPATH SPONSORED SYMPOSIUM
INTRODUCTION TO POLYMER TECHNOLOGY – WHAT IS RELEVANT FOR THE INTERVENTIONAL CARDIOLOGIST
16:30–18:00, Room 252B
Chairpersons: R. Virmani, W. Wijns
Panellists: B. Ratner, A. Finn, T. Palmerini, J. Diaz

ABBOTT & SIEMENS HEALTHINEERS SPONSORED TOOLS AND TECHNIQUES SESSION
HOW TO OPTIMISE PCI WITH ADVANCED IMAGING TECHNOLOGIES: BENEFITS OF THE COMBINED USE OF OCT AND FLUORO REAL-TIME STENT ENHANCEMENT
16:30–18:00, Room: Theatre Bleu
Chairpersons: A. Baumback, N. Menoveau
Panellists: F. Burzotta, N. Gonzalez

ABBOTT SPONSORED SYMPOSIUM
TRANS Catheter MITRAL VALVE REPLACEMENT AND REPAIR: WHAT’S THE FUTURE?
13:35–14:35, Room: 251
Chairpersons: C. Tamburino, A. Vahanian
Panellists: C. Frierer, F. Maisano, S. Von Bardeleben

ABBOTT SPONSORED SYMPOSIUM
LAA OCCLUSION THERAPY IN THE REAL WORLD
16:30–17:30, Room: 251
Chairpersons: L. Sievert
Panellists: O. Hildick-Smith, J.E. Nielsen-Kudsk, G. Montalescot

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Capture it LIVE in Theatre Havane

Don't miss today's LIVE demonstrations in Theatre Havane

With LIVE demonstrations from Clinique Pasteur – Toulouse, France; and Contilia Heart and Vascular Centre, Elisabeth Hospital – Essen, Germany

Transradial approach for iliac interventions
10.30-12.00 – Toulouse, France
What would your selection according to access and further intervention be?

Fully percutaneous AAA treatment
14.45-16.15 – Toulouse, France
How would you treat this abdominal aortic aneurysm?

Challenges in diabetic patients: EVOlving PCI’s clinical outcome through innovative technology (TNT ALVIMEDICA)
12.30-14.00 – Toulouse, France
How would you treat this bifurcation lesion in a diabetic patient with three-vessel disease?

SYMETIS ACURATE neo TF TAVI system: demonstrating the unique self-expandable valve technology (TNT SYMETIS)
16.30-18.00 – Essen, Germany
What kind of valve would you use for TAVI in this patient?

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Opening Ceremony welcomes the EuroPCR family with a special tribute to 40 years of angioplasty

At yesterday’s Opening Ceremony, EuroPCR course co-directors Jean Fajadet and William Wijns on behalf of other course co-directors Alberto Cremonesi, Michael Haude and the EuroPCR scientific committee paid a special tribute celebrating the 40th anniversary of angioplasty. J. Fajadet said: “EuroPCR has grown to become the platform for exchange and networking, helping us to look after our patients. PCR brings together community initiatives and in the last 40 years we have seen a tremendous and fantastic improvement and progress in catheter-based procedures and this is due to innovation…2017 is a special year and all of us together are celebrating the 40 years of angioplasty. The story started in 1977 when a man, Andreas Grüntzig, had the idea to treat a proximal left anterior descending (LAD) stenosis with a balloon. Today, there are more than 50,000 interventional cardiologists treating more than one million patients per year in the world.”

Given the importance of this event, J. Fajadet noted how the European Society of Cardiology (ESC) at this year’s ESC meeting—in August, in Barcelona—will be highlighting “the impact of percutaneous coronary intervention (PCI) over all treatments of cardiovascular diseases” and introduced ESC president, Professor Jeroen Bax, who praised the contribution of interventional cardiology in the cardiovascular world at the Opening Ceremony.

J. Bax commented: “40 years of PCI; that is a long term! Over the years we have witnessed a lot of innovations, we have seen many contributions coming from the interventional cardiology field. We started with the introduction of coronary angiography, then followed by the introduction of bypass surgery and coronary angioplasty. Later on the superiority of primary PCI over thrombolysis was shown, and the next step was the introduction of drug-eluting stents. All these developments, step-by-step, contributed tremendously to the care of our patients.”

During the Opening Ceremony, a tribute to the pioneers of PCI was presented in a video format.

W. Wijns brought special attention to three special events aimed at celebrating the 40th anniversary of angioplasty at EuroPCR including the “Meet the Pioneers” sessions where participants will be able to ask questions face-to-face to the pioneers in the field. The 40 Year of Angioplasty Exposition at the third level, which features the origins, evolution and future of interventional cardiology. And the third highlight of this celebration includes the book “The History of Coronary Angioplasty” written by Philippe Gaspard, which will be given to EuroPCR participants.

Closing the Opening Ceremony, J. Fajadet acknowledged the work of the “next generation” of peers who participated actively in the preparation of this year’s programme creating four new formats: My Tool Box, Treatment Dilemmas, Evidence-Practice Mismatch and Burning Questions. “Our future is the next generation for the next 40 years,” he said.

“We wish you a very nice meeting, we hope you all enjoy your time in Paris and I would like to quote my mentor Prof Jean Marco who says ‘We are working for our successors’, “ J. Fajadet noted.
EAPCI Fellows Course brings together the experts of today and tomorrow

Yesterday marked the conclusion of the two-day European Association of Percutaneous Cardiovascular Interventions (EAPCI) Fellows Course; a programme of specialist training for young interventional cardiologists. Featuring interactive lectures from leaders in the field, as well as ample time for discussion, the Course offered a rich educational platform for interventional cardiologists-in-training.

Peppered within the packed scientific programme were a high number of breaks, designed to foster conversation between expert faculty and fellows, and encourage the establishment of longer-term mentor-and-pupil relationships, as well as international fellow-to-fellow networking. Placed next to the “40 Years of Angioplasty” Exposition—a special exhibit tracing the history of interventional cardiology, requested by young cardiologists—the session further emphasised the importance of collaboration between the expert interventional cardiologists of today, and the future experts of tomorrow.

The Course—which accepted only 100 applicants—took fellows through coronary interventions from the basics of vascular access and the interventional armamentarium to advanced techniques of intravascular diagnostics, bifurcations, acute coronary syndrome and dealing with unexpected major complications. Presentations took the form of both instructional lectures and case reviews. As well as learning the theory behind practical techniques, the Course also included a focus on performing clinical research.

According to chairperson Andreas Baumbach, the Course was brought to attendees “by the community of young interventional cardiologists; full of energy, but also full of the will to teach and communicate.” He described the Course as representative of a “global movement” in the field. Yesterday’s Course sessions focused on both coronary and structural interventions. The first session of the day—chaired by Antonio Colombo and Gabor G. Toth—offered the audience of young cardiologists an insight into how to perform percutaneous coronary interventions when presented with resistant lesions. Following this, A. Baumbach and Francesco Saia took active participants through the basics of structural intervention, from transcatheter aortic valve implantation to left atrial appendage closure.

“I have one wish,” A. Baumbach told audiences at the close of the Course. “And that is that you continue in this community—you actually see the worth of that community for the rest of your careers.”

CV Pipeline overflowing with innovation

Yesterday’s CV Pipeline on Innovation in aortic and mitral valve interventions was bursting with new ideas and devices, with many of the presentations featuring data from first-in-human trials. Stefan Toggweiler investigated if TAVI using the TrueFlow balloon and the Symetis ACURATE neo can be safely performed without a provisional pacemaker electrode and without insertion of a femoral venous sheath. The TrueFlow valvuloplasty balloon (Bard Peripheral Vascular) has been designed to provide continuous blood flow during inflation. According to Toggweiler, the balloon facilitates valvuloplasty without the need for rapid pacing. The device is available in diameters from 18mm to 26mm and 3.5cm length. Toggweiler reported that the TrueFlow valvuloplasty balloon enables TAVI without a provisional pacemaker and without insertion of a venous sheath and may have the potential to reduce procedure time, costs, and vascular complications. Diego Gaia presented the Inovare Proseal, a new transcatheter prosthesis aiming to achieve zero paravalvular leak (PVL). Up to now, 600 of these valves have been implanted in South America. According to Gaia, unique about the Inovare Proseal is the synthetic membranes added to the outer prosthetic aspect in order to improve annulus-prosthesis sealing without increasing radial force.

He reported that so far the results have been encouraging with no significant PVL in preliminary patients and adequate clinical results and no complications (thrombosis/concomitant occlusion/AV block).

The first-in-human experience with a next-generation pre-packaged self-expandable dry-tissue TAVI device was presented by Zhen-Gang Zhao. The Venibri DTA-Valve system, he explained, is a self-expanding frame, tri-leaflet pericardial tissue valve, with proprietary “dry,” ready-for-use, strong, durable and biologically compatible tissue. The Venibri system performed as a well-functioning prosthetic aortic valve, with no paravalvular leak and no adverse events at three-month follow-up in the first-in-human experience, Zhao reported.

Another first-in-human experience was with transvalvular lithotripsy for aortic leaflet restoration. Todd Brinton reported the successful treatment of four patients with severe aortic stenosis. “Independent core lab adjudicated that all patients had improvement in AVA with reduction in peak/mean gradients (Average 19 & 12mmHg). Reduction in mean gradient of at least 8mmHg was observed in all patients and there was no significant change in aortic regurgitation in any patients,” Brinton stated.

Willard Hennebmann demonstrated the experience with the MIA (minimally invasive aminuloplasty) implant, a highly engineered, low-profile implant. The STTAR study is a prospective, randomised, multicentre, safety and performance study with the objective of evaluating the safety and effectiveness of the device. Up to now, Hennebmann said, safety and feasibility have been demonstrated, a reduction in annular dimensions has been achieved and a reduction in Tricuspid Regurgitation has been observed.

The MAVERIC study, presented by Stephen Worthley, is investigating the ARTO System for transcatheter annular reduction therapy (TART). “This study demonstrates the 30-day safety and efficacy of the ARTO System for the treatment of FMR. MR grade and AP diameter were significantly reduced at 30 days as was NYHA Class. The major adverse event rate was low at 30 days (7.1%) and importantly, there were no deaths, strokes or myocardial infarctions,” Worthley noted. The 30-day compassionate use results the Edwards PASCAL transcatheter mitral valve repair system, were reported by Konstantinos Spargias. He said that the device has been found to be safe and feasible, with implantation of at least one device successful in all patients resulting in procedural residual MR ≤2+ in 96% of the patients. Technical success according to MVARC was achieved in 96% of the patients and early signs of reverse remodelling were observed at 30 days. “Peer-reviewed data will be available soon,” Brinton told the audience.

Up to now, 27 patients have been followed with functional, degenerative, and mixed disease including those with anatomical complexities,” Spargias concluded.

Reporting the use of the Vienna mitral valve, Guilherme Agreli, noted that in preliminary results indicate adequate sealing and fixation. The first animal implantation to left atrial appendage closure.

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A good day for switched DAPT, MiStent, the Lotus valve and deferral with iFR and FFR

Yesterday’s late breaking trials and trial updates session showcased up-to-the-minute data from the TOPIC study of platelet inhibition following acute coronary syndrome and the DESSOLVE III randomised comparison of the MiStent and Xience drug-eluting stents, as well as a pooled analysis of the DEFINE FLAIR and IFR SWEDEHEART trials investigating revascularisation deferral with both iFR and FFR, and data from the REPRISE III comparison of Lotus and CoreValve.

TOPIC
The TOPIC randomised study investigated the benefit of switching dual anti-platelet therapy (DAPT) after acute coronary syndrome (ACS). According to Thomas Cuisset, initial DAPT strategy after ACS should be P2Y12 blockers prasugrel and ticagrelor. The study found that in patients without adverse events during the first month post ACS treated with PCI, the switched DAPT strategy was superior to unchanged DAPT strategy to prevent bleeding complication without increased ischaemic event risk. The study patients were ACS patients undergoing PCI who were free of major adverse cardiac events (MACE) one month after PCI and treated with aspirin and prasugrel or ticagrelor. “We observed a significantly lower incidence of the primary endpoint in the group of patients randomised to switch DAPT strategy compared to the unchanged strategy. This difference in the primary endpoint was not related to difference in ischaemic events—as the rate of ischaemic complication was not different—but related to a significant reduction of bleeding complication with the switched DAPT strategy compared to the unchanged DAPT. We observed a better prognosis in patients deferred when presenting with ACS compared with SCD. There is room for improvement and it has to come from understanding what is happening in ACS compared to SCD. There is room for improvement and it has to come from understanding what is happening in ACS patients,” he said.

DESSOLVE III
Results from the DESSOLVE III trial presented by Robbert de Winter show that the MiStent device (Stentys) is non-inferior to the Xience stent (Abbott) at 12 months in a real-world, all-comers population. The study was a randomised comparison of the Xience polymer everolimus-eluting stent vs. MiStent which releases embedded sirolimus microcrystals from the vessel wall. DESSOLVE III included 1,308 patients from 20 sites in four European countries.

“At one-year the incidence of target lesion failure was 5.8% for the MiStent and 6.5% for the Xience. The non-inferiority hypothesis was met with p<0.001,” R. de Winter reported. He added, “MiStent was non-inferior to the Xience stent for target lesion failure at 12 months. There were no statistical differences across the stratified analyses and sub groups, supporting the hypothesis that long-term cytostatic inhibition of early neoointima could prevent the late neointimal growth seen in the medium and long term with a conventional drug-eluting stent.”

Deferral safe with both iFR and FFR
According to a pooled analysis of the DEFINE FLAIR and IFR SWEDEHEART trials presented by Javier Escaned, coronary revascularisation deferral is safe with both iFR and FFR. The analysis investigated if one-year outcomes of deferred patients are similar when the decision is based on FFR or iFR measurements and whether the decision is influenced by clinical presentation (stable coronary disease (SCD) or ACS). The primary endpoint was MACE rate (composite of death, non-fatal myocardial infarction and unplanned revascularisation) at one year. “We found consistent agreement with earlier trials in that decision making using iFR results in treating fewer and deferring more patients—45% of FFR patients were deferred vs. 50% with iFR. The good news is that the long-term outcomes of these patients are excellent with a 4% MACE rate at one year, about half that observed in the DEFER study, and identical with iFR and FFR. This suggests that although iFR defers more patients, they do as well as if you defer with FFR,” J. Escaned explained.

For ACS, J. Escaned reported interesting results: “In deferred patients, clinical presentation makes a difference in terms of long-term events, so it was clear there were significantly more events in patients deferred when presenting with ACS compared with SCD. There is room for improvement and it has to come from understanding what is happening in ACS patients,” he said.

REPRISE III
REPRISE III trial data presented by Ted Feldman indicate that the Lotus valve is non-inferior to the CoreValve for one-year safety and effectiveness. REPRISE III is a global, prospective, multicentre, randomised, controlled, non-inferiority trial comparing safety and effectiveness with the Lotus valve versus the self-expanding CoreValve in patients at extreme or high surgical risk.

The trial randomised 912 patients in a 2:1 ratio to Lotus valve (607) or CoreValve (305). According to T. Feldman, the primary effectiveness endpoint—one-year composite of all death, disabling stroke and moderate or greater paravalvular aortic leakage (PVL)) was lower with Lotus compared to CoreValve (16.7% vs. 29%, p<0.001). The Lotus valve also demonstrated non-inferiority to CoreValve for the primary safety endpoint—a composite of all mortality, stroke, life-threatening and major bleeding events, stage 2/3 acute kidney injury or major vascular complications through 30 days. The pre-specified secondary endpoint demonstrated the Lotus valve had significantly lower rates of moderate to severe PVL compared to CoreValve (2% vs. 11.1%, p<0.001).

“The Lotus valve is safe and effective compared to a commercially available self-expanding TAVI valve in this large randomised global trial,” T. Feldman concluded.

Visit us at booth M53 – Level 2
Share TAVI learning between East and West
With the collaboration of PCR-CIT China Chengdu Valves, PCR London Valves and PCR Tokyo Valves

The prevalence of severe aortic valve stenosis in China is unknown. There are relatively fewer candidates for transcatheter aortic valve implantation (TAVI) in the Chinese population than there are in the West, but as the population ages the prevalence of aortic stenosis will probably increase. The Chinese hospitals where TAVI is performed have waiting lists. Device choice is also limited, and the morphological characteristics of aortic disease in the Chinese population presenting for TAVI are different from that in the West.

In a focus on international collaboration meeting today, Runlin Gao chairs a plenary session on TAVI in the East and the West. R. Gao says: “TAVI operators are less experienced in Asia than in the Western world, and there are far fewer of them. In China, there are less than 10 experienced operators in the whole country; only 500 cases of TAVI were performed in 14 centres, with more than half of these in only three institutions. Most operators are still learning—aademic exchange and technique training are very important.”

The key themes of this session include: aortic stenosis in western and Asian populations—similarities and differences; anatomical challenges in TAVI—lessons from the Asian experience; innovative TAVI devices from Asia—design features and clinical outcomes; and current and future obstacles to the dissemination of TAVI—what can we learn from each other?

R. Gao says: “Physicians from the East can learn from the TAVI experiences of Western physicians, and physicians from the West can learn about the different morphological characteristics of aortic disease in Asia, to help them understand more clearly the racial and regional differences of aortic disease, and to improve treatment by sharing experiences.”

Attend this session if you want to appreciate the differences in epidemiology and pathophysiology of aortic stenosis in Western and Asian populations, to understand how the exchange of knowledge in procedural techniques and novel devices may improve clinical outcomes in Western and Asian patients, and to discuss the most recent data concerning innovative TAVI devices and in real world in Asian patients.

Mao Chen, Bernard Prendergast, and Shigeru Saito also chair.

Room 241: 08.30-10.00

Percutaneous edge-to-edge repair has proven benefits for patients with degenerative mitral regurgitation

Surgery is still the gold standard approach for managing patients with degenerative mitral regurgitation, but percutaneous edge-to-edge repair with MitraClip (Abbott Vascular) has proven benefits for such patients who are unable to undergo surgery—of whom, there are many. Today’s session Percutaneous edge-to-edge repair for degenerative mitral regurgitation provides a comprehensive appraisal of the procedural techniques and associated outcome data.

Ted Feldman, co-chair of today’s session alongside Michael Haude, explains that there “are now a large number of prospective registries that have shown good outcomes with MitraClip in poor surgical candidates with degenerative mitral regurgitation”. He adds that a subgroup of patients (127) in the EVEREST II high-risk registry (351 patients overall) had degenerative mitral regurgitation and these patients had a mean age of more than 82 years and a mean Society for Thoracic Surgery risk calculator score for mortality of 13%. “Despite these characteristics, the rate of 30-day mortality was less than 6%, almost all patients had symptomatic improvement, and—importantly—there was a nearly 50% reduction in heart failure hospitalisations,” T. Feldman notes. Additionally, at five years, patients with degenerative mitral regurgitation who received percutaneous edge-to-edge repair had the same rates of mortality and re-intervention as those in the surgical group. According to T. Feldman, the “excellent five-year results” of the EVEREST II randomised trial—conducted at a time when the single leaflet detachment rate for MitraClip and the overall patient perception of procedure success were poor compared with the results we see in clinical practice today—prompt speculation that MitraClip may be a potentially reasonable therapy for some low risk surgical candidates with degenerative mitral regurgitation.

Today’s session will look at the current status and future direction for MitraClip use in the degenerative mitral regurgitation population.

Theatre Bordeaux: 14.45-16.15
Predicting outcome after primary PCI

Selected abstract submissions will form the backbone of the Predicting outcome after PCI session held today, which is chaired by Sasko Kedev. Sergio Bravo Baptista will be the first speaker and will present the abstract “Early peripheral endothelial dysfunction predicts myocardial infarct extension and microvascular obstruction in patients with STEMI”. Dejan Milasinovic will present on the topic of the impact of chronic total occlusion (CTO) in non-culprit arteries on in-hospital and post-discharge mortality in patients with STEMI undergoing primary percutaneous coronary intervention (PCI). Mélanie Ramambason will look at socioeconomic factors that influence presentation delays in the current setting of STEMI networks, and how these might be addressed.

Out-of-hospital cardiac arrest will then be the focus of Benoit Lattuca’s presentation, which will discuss the place of post-resuscitation electrocardiogram for coronary angiogram indication. The SCAAR (Swedish Coronary Angiography and Angioplasty Registry) will provide the data for Elmir Omerovic’s presentation, which will analyse differences in mortality rates between male and female STEMI patients. The focus on STEMI patients will continue into Hazim Rahbi’s discussion of length of hospital stay and 30-day mortality, with data gleaned from the experience of a large tertiary centre.

The Singaporean experience of “off-hours” vs. “on-hours” presentation of STEMI and its impact on door-to-balloon time and clinical outcome will be shared by Violet Hoon, and Daniel Jeffery will argue that stent thrombosis remains a predictor of poor long-term outcome among patients with stent thrombosis undergoing primary PCI for STEMI.

The panelists for this session will be Fernando Cura, Samuel Mathew and Olivier Varenne.

Room 343: 08.30-10.00

Learn the tools of the trade at EuroPCR

New at EuroPCR this year is a series of “My Toolbox” sessions—aimed at young interventional cardiologists—that focus on the daily practice of key opinion leaders. Each session will concentrate on the expertise of a different pioneer or specialist.

Jean Fadajet is the facilitator for this morning’s session My toolbox for standard PCI, bifurcation and resistant stenosis. He outlined the thinking behind the new programme.

“Young interventional cardiologists proposed a special session for them to discuss the tools that we use in daily practice, so that they could get advice from leaders in interventional cardiology with many years of experience in the field. Sometimes they want a more precise answer about different tools. There are so many tools available in cath labs—different types of balloon, of guidewires, of stents, and so on—that we sometimes have the feeling that young interventional cardiologists can get a little bit lost.” Three cases will be presented, one each on standard percutaneous coronary intervention (PCI), bifurcation, and resistant stenosis. J. Fadajet explained: “In daily practice when you have, for example, a bifurcation lesion, what are the tools that we use for most of the procedures? We will discuss each step of the procedure and the tools needed to achieve optimal results. He said that even in cases where the lesion is complex and the patient is complex, the procedure should remain simple. “When you have a tool that gives you a high success rate and low complication rate, there is no major reason to change.”

“When you have a tool that gives you a high success rate and low complication rate, there is no major reason to change.”

Don’t miss this week...

40 Years of Angioplasty Exhibition

PCR is proud to commemorate the 40 years of angioplasty by setting up a retrospective exposition that retraces the major milestones in the history of interventional cardiology.

Level 3

Room 252B: 08.30-10.00

RayFlow MULTIPURPOSE INFUSION CATHETER

Recover ASPIRATION CATHETER

SYMPOSIUM

Thursday 18th May, 2017 - 12:30-13:30  Room 252B

Acute Coronary Syndrome patients: “TINOX Bioactive Stent & Microcirculation!”

CHAIRPERSONS: N. Pijls, R. Wiseth  SPKERS: P. Karjalainen, J. Van der Heyden

HEXACATH PIONEER IN BIO ACTIVE COATING

Booth #N20
Session to explore the most frequent complications of PCI
With the collaboration of the Sociedad de Cardiologia Intervencionista de Mexico (SOCIME)

A session today will review some of the most frequent complications and challenging situations that occur during primary percutaneous coronary intervention (PCI). Chair Juan Gustavo del Angel says that the three most difficult events that can occur during PCI are dissection, thrombus, and no reflow. He adds that the cases presented in today’s session will provide insights into how these situations can be prevented and, if they do occur, how they can be managed. Furthermore, there will be plenty of opportunities for discussion between the audience, panel, and case presenters.

The key reasons for attending this session, J.G. Del Angel explains, are that it will enable you “acquire an overview on the management of frequent complications during primary PCI and gain a better understanding of what could be done to avoid these complications, reduce patient mortality, and to maximise the patient’s long-term outcomes and quality of life.”

Javier Goicolea is chairing the session alongside J.G. Del Angel, and the panel consists of Jose I. Leiva Pons and Leocadio Munoz.

Room 242A: 16.30-18.00

Decide whether iFR or FFR works best for your practice

Fractional flow reserve (FFR) is measured during maximal hyperaemia, which is induced by intravenous infusion or intracoronary injection of a vasodilator. Instantaneous wave free ratio (iFR) is calculated by measuring the resting pressure gradient across a coronary stenosis during a defined portion of diastole, when microvascular resistance is low and stable. Therefore iFR is designed to be faster, simpler, and less expensive than FFR.

Two studies, DEFINE FLAIR and iFR SWEDHEART, randomised patients with stable angina or acute coronary syndromes who had stenoses of intermediate severity on angiography to undergo invasive functional assessment with the use of either FFR or iFR. A session today chaired by Ralf Birkemeyer and Neal Uren, Will Define Flair and iFR SWEDHEART change my practice: iFR instead of FFR?, analyses the results of these trials.

This is an important session for you to attend if you want to understand what was known before DEFINE FLAIR and iFR SWEDHEART, how iFR and FFR were employed in both trials, and the findings of the studies. R. Birkemeyer says: “The rationale, design and the outcomes of DEFINE FLAIR and iFR SWEDHEART will be discussed in depth. Keeping in mind the broad recommendation for FFR assessment in the current guidelines, how iFR and FFR were applied in both trials will be appraised, as well as how these findings might relate to your current practice.”

Room 252A: 16.30-18.00

Advancing treatment for vulnerable plaque

Understanding the pathology, diagnosis and treatment of vulnerable plaque will take centre stage today in a session chaired by Ron Waksman and Philippe L’Allier.

By attending this session, participants will understand the pathology of the vulnerable plaque. They will also be able to gain valuable experience in the role of intracoronary and non-invasive imaging modalities to detect and assess the vulnerable plaque and its progression. Finally, participants will receive updates on the latest evidence and ongoing trials evaluating the optimal treatment strategy for vulnerable plaque.

Renu Virmani will address the question of whether vulnerable plaque exists and will discuss the issue from a pathological perspective. Christos Bourantas will show participants how intracoronary imaging can be useful in detecting said vulnerable plaque, and the methods to use to get the best results. Neal Uren will outline how to detect plaque by using non-invasive methods, while David Erlinge will look at the data from the PROSPECT and PREVENT trials to explain how to best treat vulnerable patients. After each presentation, the audience will have the opportunity to ask questions and discuss the concepts raised.

The session panelists will be Carlo Di Mario and Peter Ludman.

Room 351: 10.30-12.00

Resist the pressure of a reflex reaction

The “oculo-stenotic reflex” is a commonly used expression in interventional cardiology. It describes a process during angiography in which a physician identifies a coronary stenosis that looks significant, and the reflex of the interventional cardiologist is to directly treat the lesion with a stent, without prior functional evaluation. However, except in cases of acute coronary syndrome, proving the functional significance of a coronary stenosis, rather than just an anatomical evaluation, should be a fundamental part of the process.

A session today, Eyes can lie: turn on the pressure and resist the oculo-stenotic reflex, focuses on helping young practitioners identify the correct way to proceed. The facilitator of the session, Romain Didier, says “In order to resist the reflex to over treat the patient, functional evaluation must remain the cornerstone.” Different methods can be used to evaluate a coronary stenosis—stress echo, nuclear medicine, stress magnetic resonance imaging (MRI). However, none of these additional tests can be performed during the procedure. A functional evaluation using fractional flow reserve (FFR) allows a specific stenosis to be assessed during angiography, and helps you to decide if a percutaneous coronary intervention (PCI) is needed.

If you want to understand when FFR is needed, to become familiar with the use and the interpretation of FFR measurements, and to learn tricks on how to recognise and avoid potential pitfalls, this session is essential for you to attend.

“The key themes of this session will be to discuss the indications of FFR and the possible limitations of this test.”

“The key themes of this session will be to discuss the indications of FFR and the possible limitations of this test. We will detail how to properly perform this test. And, finally, we will share some specific situations of complex FFR evaluations, such as in multiple lesions, left main, post PCI, and bifurcation” explains R. Didier.

Lukasz Kołtowski is also a facilitator, Bernard De Bruyne the senior advisor, and Vincent Floré acting as the media driver.

Room 352B: 10.30-12.00

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Go to My PCR - Bag pick up Area on Level 2!
Patients.
Our mission for life.

Together, we can do even more than help patients. Join us on our mission to change lives.
This year’s Ethica Award—the twentieth in its history—was presented to John Ormiston yesterday by William Wijns and Jean Fajadet. J. Ormiston was recognised for his pioneering work bringing numerous revolutionary procedures to New Zealand, as well as for his wider contributions to the international field of interventional cardiology. J. Ormiston was the first person to perform a transcatheter aortic valve implantation (TAVI) in the Asia Pacific region, and a directional atherectomy in his native New Zealand. A key player in the opening of the country’s first private angiography suite (Mercy Angiography, Auckland) and a past president of the Asia Pacific Society for Interventional Cardiology, his domestic work has been honoured by the New Zealand Order of Merit, of which he became an Officer in 2011.

In addition to his commitment to bringing new devices and First-in-Man procedures to his home country, J. Ormiston is respected internationally for his work studying and bench-testing the architecture of stents using micro-computed tomography in what Wijns referred to as his “stent torture chamber” laboratory. As well as testing the limits of stents, J. Ormiston has pioneered the use of novel stent technology, performing the world’s first implantation of a fully bioresorbable drug-eluting stent in 2007. Taking the audience through some of the highlights of his recent research, his work as a mentor, and his interests outside of medicine, Wijns congratulated J. Ormiston on the many ways his research has impacted common practice.

“You are also known as a great mentor and an inspiring teacher,” W. Wijns said, introducing former fellow Nick West to the stage. N. West described his time under J. Ormiston’s tutelage, remembering in particular the physician’s “disdain” for the torqueing device, which N. West took as an early indication of J. Ormiston’s “attention to detail” and emphasis on the importance of “tactile feedback” during percutaneous coronary intervention. Recognising the common experience of his fellow mentees, N. West told the audience, “J. Ormiston is good-humoured and generous. He fosters a relaxed environment, is a pioneer and leader in interventional cardiology, and is someone who pushes the limits.”

Handing the Ethica award to J. Ormiston, J. Fajadet said, “I have admired what you have done over the past 20 years for our whole community. Thank you for all of your work.”

J. Ormiston thanked a number of prominent cardiologists, including fellow New Zealander, Barry Rutherford and EuroPCR advisor Patrick W. Serruys for being an inspiration to him during his career.

Characteristically humble, J. Ormiston told the audience, “I am very, very grateful for this enormous honour, and I keep thinking that there must be some kind of mistake—that W. Wijns will phone me and say ‘I am sorry but we made a mistake and you have to give the award back.’ “It has been a real joy working with people from Europe, and I am very grateful for this award and what it means to me, to my country, and to my colleagues. It is an honour to our health system.”

You can find out more about John Ormiston, his proudest achievements and his career mentors in the 40 Years of Angiography Exposition on Level 3. You can also read about the other pioneers who he now joins on the honour roll past Ethica Award winners.

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Chairpersons: M.B. Leon, W. Wijns

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EXPOSITION CONTINUES TO EDUCATE AND ENTERTAIN

The “40 Years of Angioplasty” Exposition on Level 3—a project borne out of cooperation between the PCR Board and a group of young practitioners—is continuing to attract participants, both young and old, to learn about and reflect on the history of angiography.

A COLLECTION OF VISIONARIES

There were many precursors to Andreas Grünzig whose work made his achievement possible. The Exposition features a gallery of six of these pioneers. One such visionary was Charles Dotter (1920–1985), who in 1963, with the first use of a diagnostic catheter for a therapeutic purpose, invented interventional radiology.

C. Dotter became chief of the radiology department at Oregon State University (Corvallis, USA) at just 32 years old. His first arterial recanalisation was actually unintentional; when using an abdominal aortography to assess a renal artery stenosis, he saw the he had involuntarily recanalised an occluded right iliac artery by retrogradely introducing a catheter via the femoral artery. When the catheter was removed, the channel remained open, demonstrating improved leg perfusion. This experience gave C. Dotter his vision of treating vessels without surgery. C. Dotter went on to perform the first intentional transluminal angioplasty in January 1964. The 82-year-old female patient had previously refused amputation for her left leg ulcer with gangrenous toes, and had a short stenosis of the left superficial femoral artery—an ideal lesion in which to test C. Dotter’s percutaneous dilatation catheters. The final result was complete healing of the ulcer, with femoral artery patency confirmed at three weeks. Although the patient died three years later from congestive heart failure, until then she walked on two feet without difficulty.

Known by some as “Crazy Charlie” his unconventional and innovative ideas—for example that atheromatous plaque could be compressed like snow, a.k.a. “the Dotter effect”—remained relatively unknown and were criticised for some time, especially in his home country.

MAPPING PROGRESS

The First Timers’ Map has been a popular part of the Exposition so far, with many participants adding their personalised flags to the large world map to mark their achievements in the field. Already, flags are flying from Uruguay all the way to New Zealand, for traditional centres of excellence like Switzerland, to less well-known pioneering countries like Mauritius. Be sure to add your flag to the growing chronicle.
Spencer B. King performed some of the first coronary angioplasty procedures in the USA—having recently received a thank-you from the first patient that he treated. He tells The Daily Wire that the steerable guidewire, rather than the stent, was the greatest advance in angioplasty and that obviating the need for angioplasty, by successfully managing atherosclerosis with medicine, would be the greatest advance in the next 40 years.

IT WAS CHARLES DOTTER WHO FIRST SUGGESTED USING CATHETERS TO TREAT VASCULAR DISEASE. WHAT WAS THE EVOLUTION FROM HIS IDEA TO ANDREAS GRÜNTZIG TO PERFORMING THE WORLD'S FIRST CORONARY ANGIOPLASTY?

C. Dotter’s procedure was for the legs rather than for the heart, which he achieved by passing large catheters into the leg and the pelvis. A. Grüntzig, after listening to a lecture about the procedure, adapted the technique for the heart. He envisioned using a balloon that was small enough to be used in the coronary arteries but could be expanded to open up a blocked artery and, therefore, his real breakthrough was to achieve this. He is the father of interventional cardiology.

YOU WERE ONE OF THE FIRST OPERATORS TO PERFORM ANGIOPLASTY IN THE USA. WHAT WERE THOSE INITIAL PROCEDURES LIKE?
The first coronary angioplasty procedure in the USA was performed by Richard Myler in San Francisco and Simon Stretzer in New York. I started doing the technique after that. I actually recruited A. Grüntzig to come work at Emory to perform angioplasty but my colleagues and I had started to do it before he arrived. I found the procedure scary to begin with; the equipment was very primitive and we did not have any stents to use as a bailout procedure if you occluded the artery. If there was a problem, the patient had to be rushed to surgery. In those days, the equipment we had was not able to adequately cope with complications.

Another limitation with the equipment was that you were not able to reach areas of heart that we are able to do these days. We had rudimentary catheters that were only useful in certain kinds of obstruction—i.e. ones that were pretty straightforward.

HOW MANY PATIENTS WOULD REQUIRE CONVERSION TO SURGERY IN THOSE EARLY DAYS?
Back then, you absolutely needed to have surgery on site. During the first year that we started to perform angioplasty at Emory, 6% of patients had to go to surgery because the angioplasty procedure had failed.

THE FIRST PATIENT TO UNDERGO ANGIOPLASTY IS STILL ALIVE. DO YOU KNOW WHAT HAPPENED TO YOUR INITIAL PATIENTS?
I recently received a call from the first patient that I ever treated—he had apparently been meaning to call me to say thank-you for 37 years but “had not gotten around to it”. As angioplasty was not available in many places in the first years, we saw a lot of interesting people from the USA and abroad undergo angioplasty at our centre.

WHAT WAS THE INITIAL REACTION IN THE CARDIOLOGY COMMUNITY TO ANGIOPLASTY?
There was an enormous interest in the procedure from the outset—we literally had 600–800 operators coming to our centre to be trained in angioplasty each year. By the middle of the 80s, there were thousands of hospitals around the world performing angioplasty. Therefore, there was a lot of enthusiasm about the procedure in the overall cardiology community. However, cardiothoracic surgeons were not as enthusiastic about the procedure because they saw it as a direct competitor to surgery. Also, they believed that they would do a more complete job with surgery—which was probably fair.

THE FIRST ANGIOPLASTY PATIENTS HAD STABLE DISEASE. WHEN DID THE PROCEDURE START TO BE USED TO TREAT ACUTE PATIENTS?
Initially, angioplasty was only used for patients with stable coronary artery disease whose symptoms were particularly bothersome. At that stage, a patient with ST-segment elevation myocardial infarction (STEMI) was treated with thrombolysis. However, three or four years after the first procedure—when angioplasty had become really popular—people then began to explore opening up an acutely occluded artery with a balloon as well.

Today, the vast majority of patients treated with angioplasty are acute patients. They either have had a myocardial infarction or are without infarction but are unstable and have symptoms suggestive of an ongoing process. Angioplasty is still used to treat stable patients, but the proportion is diminishing compared with the acute patients.

EUROPCR IS HOLDING AN EXHIBITION OF THE 40TH ANNIVERSARY OF ANGIOPLASTY. WHY DO YOU THINK THE EXHIBITION IS WORTH ATTENDING?
History is always important; we need to learn from the past to understand where technologies came from. I recently gave a lecture about the 40th anniversary for a Society of Coronary Angiography and Interventions (SCAI) training programme. They invited me because apparently they discovered many interventional cardiology fellows were not able to identify A. Grüntzig by picture or by name.

I think understanding the blind alleys we went down with angioplasty is helpful; there were so many technologies that we tried in the late 80s and early 90s before we eventually abandoned them and started to use stents. If you are going to make progress in the future you have to understand the past.

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WHAT ADVANCES DO YOU HOPE WILL HAPPEN IN THE NEXT 40 YEARS IN ANGIOPLASTY?
The most important advance would be for angioplasty to become unnecessary and I am not saying that in jest! If atherosclerosis can be controlled by medical means alone, then we would not need to open arteries with angioplasty. But the advances that we need now is to be able open up the artery and leave nothing behind in the long run. This need has led to the development of bioresorbable scaffold technology. At the moment, we have some concerns about this technology and it has not been proven to be better than second-generation drug-eluting stents. However, we will continue to look for ways to improve these devices.

Also, what we would really like to know—which is sort of the Holy Grail of coronary intervention—is which people with atherosclerosis (if they get old enough, most people develop atherosclerosis) are likely to have a heart attack and in what part of the artery the attack will occur. While we have a substantial amount of research in this area, we do not yet have a good way of identifying vulnerable plaque that will result in a heart attack.
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Thanks to the support of our committed Industry Partners, the EuroPCR 2017 Scientific Programme is, once again, adequately complemented by 46 Sponsored Sessions, and 9 companies providing hands-on and clinical practice-oriented learning opportunities in the Training Village.

This very significant contribution by our Partners—be they medical device firms, imaging equipment, software providers or pharmaceutical companies—characterises the field of cardiovascular interventions: in the cathlab, these tools help you—healthcare professionals—provide your patients with the best care possible. At EuroPCR like any PCR Course, the proposed Sponsored sessions are carefully reviewed by the Board of Directors to make sure that:

- They complement the Scientific Programme
- They are well integrated in the learning pathways
- Their educational value is aligned with the Programme’s spirit

Different formats are available, answering all the specific needs you may express:

- Tools and Techniques (TNT): from LIVE or recorded LIVE demonstrations, technologies are featured in actual clinical practice
- Symposium: learn about clinical research outcomes that may affect your daily practice
- Case in Point: from actual clinical cases, understand how you apply relevant clinical data in your daily practice
- Training Village: hands-on or focused workshops

For legibility purposes, the Sponsored sessions (Symposia, TNT and Case in Point) are scheduled from 12:30 to 14:30 (Wednesday and Thursday) and from 17:15 to 18:45 (on Tuesday) and from 16:30 to 18:00 (on Wednesday). With regards to the Training Village, since seats are limited, please don’t hesitate to pre-register with the sponsoring Partner on-site.

Take another look at renal denervation
Sponsored by Medtronic

The future for renal denervation as a treatment for resistant hypertension was cast into doubt by the results of the SYMPPLICITY HTN-3 trial, which failed to meet its primary efficacy endpoint. SYMPPLICITY HTN-3 showed that the first-generation Symplicity system (Medtronic) was not associated with a significant reduction in blood pressure compared with a sham procedure in patients with resistant hypertension. This finding was in contrast to previous studies of the system that indicated that renal denervation therapy, in comparison to sham control, for blood pressure significantly reduced blood pressure compared with a sham procedure in patients with resistant hypertension. This finding was in contrast to previous studies of the system that indicated that renal denervation therapy, in comparison to sham control, for blood pressure significantly reduced blood pressure compared with a sham procedure in patients with resistant hypertension.

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M. Gilard added: “This session will work in the same way as a training village. You will get an overview of all cardiac imaging capacities in this session and then you are free to go to the sub-sections of the Training Village.”

Room Maillot: 12.30–14.30

Learn the tools and techniques for imaging in complex patients
Sponsored by Boston Scientific and GE Healthcare

An improvement in cardiac imaging techniques, such as the combinations of multislice computed tomography (CT) with fractional flow reserve (FFR) or regular angiography with FFR, has made it easier for physicians to select between percutaneous coronary intervention (PCI) and surgery as the most appropriate treatment—particularly for complex patients. Imaging can also help with left atrial appendage (LAA) occlusion procedures, and the fusion of cardiac CT and fluoroscopy is the cornerstone of the success of this procedure. It helps with planning the procedure—including defining the optimal size of the device—in guiding the transseptal puncture, and in assessing the device position at the end of the procedure.

Keith G. Oldroyd co-chairs this session, which will help you to understand how CT angiography and the SYNTAX III score impact the decision-making between surgery and PCI, how to select and execute the optimal techniques for percutaneous revascularisation of complex left main and multivessel disease, and how to accurately plan an LAA closure intervention from a CT scan. M. Gilard added: “This session will work in the same way as a training village. You will get an overview of all cardiac imaging capacities in this session and then you are free to go to the sub-sections of the Training Village to go through specific questions in detail.”

Room 241: 12.30–13.30

Today’s sessions at Training room GE Healthcare-Boston Scientific

Sponsored by Boston Scientific and GE Healthcare

09.00-10.00: LAA closure procedure planning and device positioning with advanced imaging (repeated at 16.00-17.00)
10.30-11.30: Complex PCI guidance
14.30-15.30: When to use rotablator as primary optimal strategy in heavily calcified lesion

“Today’s industry Sponsored sessions”
Find out more

Join our Case in Point Session, Thursday 12:30 room 352
Visit our STENTYS booth on Level 2
Optimise blood pressure management strategies
With the collaboration of the Practical Course on Hypertension (PCH)

Blood pressure (BP) measurement has evolved very little over the past few decades, and the only real improvements in devices have been in the automation of BP measurement and data storage, and its transmission to smart phones or remote servers. Longitudinal measurement of BP at home is superior to clinic (office) BP. Ambulatory BP monitoring (ABPM) is useful for the diagnosis of hypertension, as it avoids masked or “white coat” hypertension; however, the role of ABPM in BP monitoring in the longer term remains unclear.

The SPRINT study has shown that it is possible to treat hypertension to optimal targets in non-diabetic patients although, importantly, unattended office BP measurement as used in SPRINT is not valid for comparison to targets established from attended office BP measurement, as used in the majority of previous randomised controlled trials.

Melvin David Lobo and Roland Schmieder chair a session today on what is new and relevant in hypertension management. M.D. Lobo commented: “Adverse effects from antihypertensive therapy using aggressive targets for BP lowering were quite common in the SPRINT study, and it may be dangerous for patients to pursue a ‘SPRINT strategy’ if they are not kept under the close scrutiny that it is usual in clinical trials.”

The key themes of the session are the technology of BP measurement and the optimal setting, whether it is at home or in the clinic, the optimal targets for BP control, and whether SPRINT has changed the goalposts, and how to optimally treat hypertension with pharmacotherapy.

M.D. Lobo said: “I hope that you will come away from this session with a clear idea of the available BP measurement modalities, and will recognise the clear difference between clinic (office) and out-of-office measurement. In addition you will learn about optimal BP targets in the context of up-to-date clinical trials data, with reference to current guidelines. To round off the session, our lecture on antihypertensive drug therapy will give you a good insight into using multiple antihypertensive medications in an ordered fashion to achieve BP control to target, which should then assist you in making the appropriate treatment decisions in your day-to-day clinical practice.”

Location: Room 252B: 14.45-16.15

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EuroIntervention

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EuroPCR 2017 // May 16-19, 2017

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WEDNESDAY 17 MAY 2017
12.30-14.30 - Theatre Bordeaux
TOOLS AND TECHNIQUES
Achieving immediate patient benefit and setting-up for superior long-term outcomes

Chairpersons: A. Linke, G. Manoharan
Panellists: J. Forrest, N. Moat, G. Nickenig, N. Van Mieghem

LIVE demonstration from Bern University Hospital, Switzerland.
Operators: M. Asami, T. Pilgrim, S. Stortecky, S. Windecker

THURSDAY 18 MAY 2017
12.30-14.00 - Room 251
CASE IN POINT
Experience Evolut™ R in complex cases

Chairpersons: F. Maisano, A.S. Petronio
Panellists: M. Abdel-Wahab, U. Gerckens, D. Mylotte, N. Piazza

Evolut™ PRO is an investigational device that has not been approved for commercial use by regulatory agencies at the moment that this file has been sent to print.

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Stay safe while images are seen

Nowadays, many lesions treated by percutaneous coronary intervention (PCI) are complex, either due to their length, the presence of calcification, vessel tortuosity, or because the patient has a bifurcation. These lesions are time-consuming and require more imaging than simple lesions. Operators and nurses and allied professionals (NAP) in the cath lab must be aware of the potential biological implications of the increased radiation exposure associated with this extra imaging for their patients, and for themselves. Today’s plenary session on radiation safety for NAPs will explore the steps that can be taken to remain safe in day-to-day practice.

Chairs Hervé Faltot and Sarah Carson said: “During this session, we will see the common strategies employed to minimise radiation exposure, and the recommendations we have to follow in a cath lab. And we will also look at new practical ways to reduce this radiation dose—new ways of radioprotection for patients and the cath lab team—in particular, when the procedure is long and irradiant.”

They added: “The final objective is to analyse the balance between imaging and dose. If the operator needs an image of very fine quality—for instance, of a micro channel in a chronic total occlusion—can we adopt measures to help us to reduce the dose?”

Use the past to inform the future

A panel of experts who have been influential in the development of interventional cardiology will answer questions today from young physicians, in a unique opportunity to learn from the early innovators. Facilitator Allan Spencer outlined the rationale behind the plenary session, Meet the pioneers: “This session has been specifically requested by a group of young cardiologists who want to understand how the past continues to influence future developments and treatments within interventional cardiology.”

He added: “Young physicians will ask a panel of experts who have been significant in setting the background trends and the nature of interventional cardiology about what lessons can be learnt from their experience. We are looking at how to use some of the best from the past to build a successful and forward-looking future.”

Topics will cover all areas of interventional cardiology, including managing difficult items of technology and tricky situations, and the changing profile of patients eligible for treatment. EuroPCR has already solicited some questions through the website, but there will also be an opportunity for delegates attending today to add further queries. The pioneers at this meeting are Jorge A. Belardi, Pim De Feyer, Runlin Gao, and EuroPCR cofounder Jean Marco.

A. Spencer said: “We will hear about the fundamental things that our pioneers learned that they would like to pass on to the younger generation to help them improve their performance, get better outcomes for patients, and manage some of the complexities of this fast moving and intricate medical technology.”

“You can learn first-hand from people who were there at the start and who have seen it all. It is a chance to use the past to inform the future and an opportunity genuinely not to be missed,” he added.

Debate the big issues with the experts

The burning questions in coronary intervention will be tackled this morning in a session that gives delegates the chance to discuss current major talking points with a panel of experts.

Felix Mahfoud, facilitator of the session Burning questions on coronary interventions, said that for him the significant issues centre around scaffolds, multivessel disease, and fractional flow reserve (FFR) measurement. “What are we doing in clinical practice with scaffolds? That’s a burning question. Also, how do we handle patients with multivessel disease? Should physicians go with coronary artery bypass grafting (CABG) surgery or with percutaneous coronary intervention (PCI)? And, importantly, how do we use physiological assessment and imaging in routine clinical practice? That is also a burning question.”

Recent findings suggest that instantaneous wave-free ratio (iFR) may be the new standard for assessing coronary lesions rather than FFR. Two studies, DEFINE-FLAIR and IFR-SWEDHEART, have indicated that iFR is non-inferior to FFR with respect to the one-year rate of major adverse cardiac events (MACE). Both studies also found that FFR was associated with significantly more procedural-related adverse events than iFR.

Meanwhile, two-year data from the ABSORB III study indicate that a biodegradable vascular scaffold is associated with a significantly higher rate of target lesion failure than is a permanent polymer everolimus-eluting stent. NOBLE and EXCEL are two large scale studies on management on multivessel disease comparing PCI to CABG published very recently, these trials provide important aspects for daily clinical practice. F. Mahfoud promised: “This is a very informal session. It has an open format, so you can ask a question. You can address these questions to the experts in the field and they will take their time to discuss it with you. It is a customised and personalised session aimed at addressing your unmet needs.”

William Wijns also facilitates.

Stay safe while images are seen

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Today’s plenary session on radiation safety for NAPs will explore the steps that can be taken to remain safe in day-to-day practice.

Chairs Hervé Faltot and Sarah Carson said: “During this session, we will see the common strategies employed to minimise radiation exposure, and the recommendations we have to follow in a cath lab. And we will also look at new practical ways to reduce this radiation dose—new ways of radioprotection for patients and the cath lab team—in particular, when the procedure is long and irradiant.”

They added: “The final objective is to analyse the balance between imaging and dose. If the operator needs an image of very fine quality—for instance, of a micro channel in a chronic total occlusion—can we adopt measures to help us to reduce the dose?”
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ENVISION SCIENTIFIC ADVANCING INNOVATION
Hear important TAVI results at first hand
Session comprising selected EuroPCR 2017 late-breaking trial submissions

A hotline session this morning will report the latest findings on transcatheter valve interventions, with results from late-breaking trials. Chair Eric Eekhout said: “This session will address data from ongoing registries, review the role of antiplatelet therapy after transcatheter aortic valve implantation (TAVI), and report results with new TAVI devices. You will be able to hear the results of these important studies first hand.”
The 30-day outcomes of a new self-expanding transcatheter heart valve will be revealed, as will the four-year follow-up data from the NOTION trial (which reviewed the clinical, safety, and echocardiographic outcomes of patients with severe aortic valve stenosis undergoing TAVI), and the 30-day clinical outcomes of TAVI with VitaFlow will also be presented. Furthermore, there will be an update from the global registry of the one-year outcomes following transcatheter mitral valve implantation in patients with severe mitral annular calcification, and there will be a presentation on the early results from the prospective VIVA post-market study into TAVI for failed surgical aortic bioprostheses using a self-expanding device. Additionally, the ARTE trial on aspirin versus aspirin plus clopidogrel following TAVI will be outlined, and results will be reported for the impact of bicupid aortic valve morphology on outcomes after TAVI.

Commenting about what had biggest TAVI trial this year, E. Eekhout said: “The major trial this year is SURTA VI, which randomised TAVI versus surgery and showed that TAVI with a self-expanding valve is non-inferior to surgical valve replacement in patients with symptomatic severe aortic stenosis and an intermediate surgical risk.”

Axel Linke is also a chair.

There is an “eye” in team

In the decade following the first PARTNER trial, the field of structural heart interventions has rapidly advanced—thanks, in part, to the involvement of imaging specialists. Furthermore, these improvements and innovations have enabled complicated conditions to be managed with transcatheter devices. Imaging specialists. Furthermore, these improvements and innovations have enabled complicated conditions to be managed with transcatheter devices.

Chair Hatin Al Lawati described it as: “An outstanding opportunity for those interested in structural heart interventions to discuss the approach and rationale used to tackle complex cardiovascular anatomical anomalies”. He adds “The highly interactive presentations by skilled operators will form the basis for the discussion, and key learning points from the various cases presented will be highlighted by experts in the field”.

The cases presented today include the percutaneous treatment of a coronary artery fistula, to abolish a coronary steal syndrome; percutaneous use of a septal occluder for the management of aortic insufficiency post-left ventricular assist device; and a successful combined transcatheter closure of mitro-aortic intervalvular fibrosa pseudoaneurysm and aortic paravalvular leak.

Patrick Calvert will co-chair the session. H. Al Lawati said: “We anticipate a very lively forum for discussion between the presenters and the audience who will share their respective experiences and opinions of the cases and approaches presented.”

Do not settle for ordinary
Session comprising selected EuroPCR 2017 clinical case submissions

Today’s session on extraordinary structural interventions is a showcase of a series of examples in which operators used innovative percutaneous techniques, commonly used in structural heart interventions, to tackle complex anatomy in high-risk patients.

Chair Hatin Al Lawati described it as: “An outstanding opportunity for those interested in structural heart interventions to discuss the approach and rationale used to tackle complex cardiovascular anatomical anomalies”. He adds “The highly interactive presentations by skilled operators will form the basis for the discussion, and key learning points from the various cases presented will be highlighted by experts in the field”.

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Going for gold: The best approaches for treating failed surgical devices
With the collaboration of the Warsaw Course on Cardiovascular Interventions (WCCI)

The WCCI@EuroPCR – Transcatheter valve-in-valve and valve-in-ring interventions: the gold standard treatment for bioprosthetic valve failure session takes place today and will review the optimal treatment approaches for patients with degenerate aortic or mitral valve bioprostheses. Adam Witkowski, who is chairing the session with Alec Vahanian, says that valve-in-valve procedures with a transcatheter aortic valve implantation (TAVI) device have become the “gold standard” approach for treating failed surgical aortic valves “maybe with the exception of very young patients”. However, he adds that percutaneous treatment for patients with failed surgical mitral valves/rings is less well established. At present, A. Witkowski explains, a TAVI device—rather than a specific transcatheter mitral device—is sometimes used.

“There are three key reasons to attend this session: first, to learn about the use of transcatheter valves in different locations of prosthetic valves and rings; second, to understand the role of imaging in guiding valve-in-valve and valve-in-ring interventions; and third, to share current experience with different transcatheter valves and techniques for valve-in-valve and valve-in-ring interventions,” he adds.

Don’t miss today…
An image is worth 1,000 words
Room Arlequin: 12.30-13.30
There are multiple advantages of the transradial approach for iliac interventions

The transradial approach has traditionally been used as an alternative approach in iliac interventions when the transfemoral approach cannot be used. However, according to Roberto Lorenzoni, it can also be used as a first-line approach because of “its safety and effectiveness”.

The transradial approach is increasingly being used for iliac interventions, particularly by operators who are used to using the approach for coronary interventions. R. Lorenzoni says: “The advantages of transradial access in iliac interventions are multiple: first, the puncturing of the femoral artery, which is usually diseased in these patients, is avoided; second, both iliac arteries can be treated easily with a single access; and last but not least, the procedure finishes with the procedure itself. The sealing of a radial puncture is a nurse-led, safe procedure, whereas the manual or device-mediated sealing of a diseased femoral artery can be cumbersome.”

Today, he chairs a session with Piotr Musialek about the transradial approach in iliac interventions. The session will review the choice of materials and techniques to effectively complete an iliac intervention with the transradial approach and will also review the strategies to address possible complications. According to R. Lorenzoni, the main challenge of performing iliac interventions with the transradial approach is the long distance between the entry point and the target lesion. He says: “Transradial access requires a stable guide positioning in the common iliac artery. The choice of the left radial artery permits a shorter and more direct route to the distal aorta; moreover, the use of sheathless catheters allows a stable engagement of the common iliac artery.”

Another concern with the transradial approach is the risk of iliac artery rupture, with R. Lorenzoni commenting “it is difficult to seal a rupture from the transradial approach”. However, he states: “Nonetheless, the complication can be controlled with an inflated balloon via transradial access while a second transfemoral access is used to definitively treat the target lesion with a covered stent.”

Therefore, by attending this session, you will learn how to select the patients that will benefit the most from transradial access, learn to choose appropriate equipment, and additionally gain a better understanding of strategies that ensure safe and effective transradial treatment of iliac lesions.

PCR Peripheral and GISE to join forces

Interventional cardiologists are invited to join the PCR Peripheral Course when it will be at GISE later this year. PCR Peripheral@GISE will take place at the MICO Congress Centre in Milan (Italy) between 11 and 12 October.

PCR Peripheral, like all PCR Courses, is “by and for” interventional cardiologists—meaning that it is created by the international interventional community to address the challenges you face in everyday clinical practice. The overarching vision of PCR Peripheral board is to have life-saving translational interventional medicine.

There will be two tracks at PCR Peripheral: one for beginners and one for advanced practitioners, each one focusing on their individual needs. As always, LIVE case transmissions will be at the core of the Course because they spotlight real-life clinical practice. There will also be practice-based Learning sessions that look at specific needs; these sessions are designed to generate debate between attendees and the expert opinion leaders that will be facilitating these sessions. PCR Peripheral will soon be calling for case and abstract submissions that can be presented during the Course at GISE.

As evidenced by its work with GISE, PCR Peripheral seeks opportunities to work with national societies. The ultimate aim is to encourage active participants across the Europe and beyond to attend PCR Peripheral Courses.

GISE president Giuseppe Musumeci said that the goal of the PCR Peripheral@GISE was intercultural exchange. “We want to ensure the formation and scientific growth of interventionist cardiologists through direct confrontation between colleagues and experts. For that to happen, intercultural exchange and the sharing of various clinical experiences will be crucial. We need cardiologists to discuss peripheral interventions in order to evaluate our point of view and our experience with other specialists. GISE decided to work with PCR Peripheral because PCR is the best form of education in Europe and worldwide, and it is a great honour for GISE to be able to collaborate.”

We look forward to seeing in Milan!
For information, see: https://www.pcronline.com/Courses/PCR-peripheral/PCRPeripheral-GISE-2017
Device therapy is the future for chronic heart failure

The field of device-based therapy for chronic heart failure continues to develop at a fast pace. This includes ventricle restoration strategies, the creation of inter-atrial shunts, and device-based approaches to modulate the autonomic system. Horst Sievert chairs today’s session providing an update on the development of and outcomes for these therapies. He predicted: “I believe that this will be the next big wave in interventional cardiology after coronary, structural, and valvular interventions. All these techniques are in an early phase. We need to see more new developments in the near future, as well as controlled clinical trials to prove safety and clinical efficacy.”

Stefan Verheye will co-chair the plenary session, which is essential to attend if you are keen to learn about existing and emerging device-based approaches in advanced heart failure, and their role in multidisciplinary heart failure management, to understand when and for which patient a device-based approach may be considered, and to learn about the procedural aspects and implantation techniques of individual devices and existing clinical development and evidence.

H. Sievert said: “There will be techniques for re-shaping the left ventricle, and the creation of inter-atrial shunts for decompressing the left atrium (LA), as well as an overview about techniques to modulate the autonomic system.”

Daniel Burkhoff will start the session with a critical appraisal of device-based interventions in chronic heart failure, analysing the opportunities and challenges presented, and outlining the priorities. A look at left ventricular cavity reshaping by Jozef Bartunek will examine the percutaneous-based approach, and Ted Feldman will present a left atrial decompression in heart failure with preserved ejection fraction. The final presentation, by Felix Mahfoud, is on the approaches and outcomes of restoring autonomic balance. There will be opportunities for discussion and audience interaction between each presentation, with an evaluation of the key learnings of the session by H. Sievert at its conclusion.

Room 242B: 08.30-10.00

NEW TECHNOLOGIES FOR COMPLEX PCI

Complex PCIs can be a challenge for any physician and utilizing innovative technologies to assist in these procedures can help to increase your success.

To learn more, attend today’s Case In Point session on Complex PCI.

Wednesday 17 May 12:30-13:30 Room 342A

Complex PCI: New technologies as a key to success

Chairpersons: M. Haude, M. Joner
Panellists: E. Christiansen, S.T. Lim, D. Weilenmann

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Trials show the way forward in FFR measurement
Session comprising selected EuroPCR 2017 CV Pipeline submissions

A focus on innovation session, today, will look at results from trials into new techniques in fractional flow reserve (FFR) measurement. Chair Keith G. Oldroyd explained: “The main focus of this session is on studies employing new equipment and protocols for measuring fractional flow reserve. These will include comparative studies of new fibre optic pressure wires and pressure sensing microcatheters, as well as a trial of intravenous versus intracoronary adenosine infusion.”

Results of the comparisons between a pressure wire and a microcatheter are taken from the PERFORM study. There will also be a presentation on a randomised comparison of simultaneous data from two different pressure wires from the COMET trial, and the primary results of the assessment of catheter-based interrogation and standard techniques for fractional flow reserve measurement (ACIST-FFR) study will be discussed.

K.G. Oldroyd said: “You should come to this session if you are interested in new methods for the invasive functional assessment of coronary stenosis severity.”

The session is also co-chaired by Ricardo Petraco, and the panellists are Oliver Gämperli and David Muller.

Room 351: 14.45-16.15

Trials update examine future prospects
With the collaboration of Uppsala Clinical Research Center (UCR), Cardiovascular Research Foundation (CRF) and Cardiovascular European Research Center (CERC)

Planned and ongoing trials on the use of imaging in coronary intervention are the theme of a clinical research outcomes session this afternoon. This is a great opportunity to be updated on planned or ongoing clinical trials that may change future practice, and to learn about upcoming milestones. Presentations include a focus on the study status of the COMPARE ABSORB trial (a randomised comparison of ABSORB versus Xience in patients at high risk of restenosis using updated implantation protocols) and the outcome study of the ILUMIEN IV trial on optimal coherence tomography (OCT) guided percutaneous coronary intervention (PCI) versus angiography. Among other studies to be discussed is a registry-based randomised clinical trial: the FULL REVASC trial into fractional flow reserve (FFR) guidance for complete non-culprit revascularisation.

Chair Michael Joner told The Daily Wire: “This session has an emphasis on strategic decisions during PCI, rather than on a direct comparison of devices. You should attend this session in order to learn about outcomes of biodegradable scaffolds in high-risk lesions for restenosis, to understand the impact of intravascular OCT imaging on PCI outcomes, and to get insights into FFR-guided revascularisation of non-culprit lesions, as well as to understand best practice for treating highly calcified lesions.” Stefan Verheyen co-chairs.

Room 343: 13.35-14.35

A complex lesion but a simple procedure
Bifurcation lesions with side branches greater than 2.5mm in diameter are challenging to treat by percutaneous coronary intervention (PCI), and are even more complicated when the distal left main (LM) stem is involved. Furthermore, the complexity of bifurcations with PCI is expected to grow as the population ages and as indications for LM stenting increase. Most bifurcations can be treated with a provisional side-branch stenting approach, but an upfront two stent technique may be needed in some cases.

This morning’s plenary session on the current thinking on optimising bifurcation PCI will tackle these thorny issues. Chair Jens Fleistred Lassen promised: “You can expect to learn how to keep PCI simple, even in very complex bifurcation lesions. The way to do this is to aim at using a limited numbers of stents, and for well-expanded, well-opposed, and single-layer-limited overlapping stents. Finally, you must aim for reconstruction of the initial bifurcation anatomy. You need to come to this session to understand the unique characteristics of bifurcation stenting, to learn the latest approaches to bifurcation optimisation, and to obtain tips and tricks on achieving the best results.”

Goran Stankovic also chairs.

Theatre Bleu: 10.30-12.00

China demonstrates BRS in a bifurcation lesion
With the collaboration of The China Interventional Therapeutics Conference (CIT), the PCR-CIT China Chengdu Valves Course and the Left Main and Coronary Bifurcation Summit (CBS)

China and EuroPCR have had a close collaboration for several years. This year, there is also a special session on coronary interventions. EuroPCR course co-director Jean Fadajet, host of this morning’s session, China@EuroPCR - New BRS for bifurcation lesion, told The Daily Wire: “Our Chinese colleagues proposed to have a session focusing on bifurcation lesions and on biodegradable scaffolds (BRS). We will be discussing the treatment of a bifurcation lesion using a new Chinese biodegradable scaffold.”

There will be a LIVE case demonstration from the National Centre for Cardiovascular Diseases at Fu Wai Hospital in Beijing, China. Attend this session, also chaired Mao Chen, Runlin Gao, and Bo Xu, if you want to learn about a new thinner strut poly-L-lactic acid-based BRS from China, to share the optimal techniques of implantation with BRS, and to learn how to use a BRS in the treatment of coronary bifurcation lesion.

J. Fadajet said: “This session is important because we will be exchange and discussing with our Chinese colleagues on techniques, strategies, and new devices.”

Theatre Bordeaux: 10.30-12.00

Don’t miss this week...
Visit the Training Village throughout EuroPCR for practical sessions—built by our Industry Partners—that are dedicated to small groups and focus on innovative technologies. For more information, see the Training Village programme.
Overcome the challenges of valve-in-valve procedures
Session comprising selected EuroPCR 2017 clinical case submissions

Valve-in-valve procedures with transcatheter aortic valve implantation (TAVI) devices are becoming increasingly important in clinical practice, due to the large number of patients at risk after surgical aortic valve replacement (SAVR). They represent one of the most challenging situations in patients who would otherwise have no treatment option. The challenges of valve-in-valve procedures will be addressed in a case-based session this morning.

Chair Ulrich Gerckens told The Daily Wire: “This session provides clinically relevant case presentations highlighting the specific issues of the valve-in-valve procedures and how to avoid complications. The design differences of surgical valves and the related challenges will be discussed in detail. Also, the clinical problem of how to differentiate between central and para-prosthetic regurgitation will be addressed, as well as how to treat this special failure mode of surgical valves.”

Among the cases featured will be a TAVI through an excessively degenerated bioprosthesis with out-of-range dimensions; a valve-in-valve TAVI in a 21mm Mitroflow valve, a valve-in-valve TAVI into a novel, sutureless bioprosthesis; and an occlusion of para-valvular leaks after valve-in-valve in the mitral position. U. Gerckens said: “Everybody starting to adopt this new indication for TA VI and an occlusion of para-valvular leaks after valve-in-valve in the mitral position. A new technique, called endogenous tissue restoration, uses a scaffold made out of advanced polymers that is structured as a working valve with working leaflets. This is implanted into a patient and, because it is almost porous, the patient’s cells become attracted to it—creating new tissue and completely covering the structure. Eventually the whole scaffold erodes and you are left with a functional valve created by the patient’s own cells.”

Chair Azeem Latib told The Daily Wire: “A new technique, called endogenous tissue restoration, uses a scaffold made out of advanced polymers that is structured as a working valve with working leaflets. This is implanted into a patient and, because it is almost porous, the patient’s cells become attracted to it—creating new tissue and completely covering the structure. Eventually the whole scaffold erodes and you are left with a functional valve created by the patient’s own cells.”

Chair Steven Bolling is a co-chair.

Chair Nicola Piazza said: “Several percutaneous transcatheter tricuspid valve therapies are currently in development, or in pre-market clinical use, to treat patients with tricuspid regurgitation. I would encourage you to attend this session if you would like to better understand the current challenges and management options for patient with tricuspid regurgitation.”

This session will help you to learn more about tricuspid valve anatomy and the prognostic importance of tricuspid regurgitation, to appreciate current surgical and percutaneous treatment options for functional tricuspid regurgitation, and to fully understand which patients will benefit from treatment and the advantages of earlier intervention.

Steven Bolling is a co-chair.

Predict and prevent TAVI complications
Session comprising selected EuroPCR 2017 abstract submissions

Vascular complications are some of the most frequent causes of complications after TAVI. Others include electrical disturbances, paravalvular leaks, stroke, valve mispositioning, and heart or renal failure. Several TAVI complications can be predicted because they are related to a patient’s existing comorbidities. Today’s session Complications after TAVI: predictors and consequences will tackle this challenging topic. Panellist Oscar Mendiz said: “Although there have been improvements in techniques and technology for TAVI, we still can have complications. We need to try to prevent these complications, and be prepared to solve them when they do happen.”

Hélène Eltchaninoff chairs the session, which is abstract based. The focus on clinical research meeting will examine baseline predictors of renal failure in TAVI in an analysis from the Swiss TAVI registry. It will also look at recovery of renal function after TAVI-associated acute kidney injury, and its impact on mid-term clinical outcomes, as well as subclinical left heart thrombosis and stent frame geometry in self-expanding transcatheter heart valves. Among other abstracts featured are a meta-analysis of cerebral embolic protection devices during TAVI and a comparison between balloon-expandable and self-expanding prostheses in thrombocytopenia after TAVI.

O. Mendiz advised: “You should attend this session if you want to know how to prevent and treat TAVI complications.”

Get up to speed with the latest therapy options in tricuspid regurgitation

Tricuspid valve repair with an annuloplasty ring is the most common surgical approach for correcting tricuspid regurgitation (TR), particularly in patients with secondary TR. But it is seldom performed in isolation—up to 80% of such procedures are combined with either mitral valve repair, aortic valve repair, or with coronary artery bypass grafting (CABG); they are seen as moderate to high-risk procedures. Many patients with secondary TR will experience recurrent TR, and the morbidity and mortality associated with re-do tricuspid valve surgery is prohibitive.

Today, a plenary session on surgical and transcatheter treatment options for TR will examine the choices available.

Chair Nicola Piazza said: “Several percutaneous transcatheter tricuspid valve therapies are currently in development, or in pre-market clinical use, to treat patients with tricuspid regurgitation. I would encourage you to attend this session if you would like to better understand the current challenges and management options for patient with tricuspid regurgitation.”

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Steven Bolling is a co-chair.

Room 241: 10.30-12.00

Novel device aims to create a valve out of patient’s own cells

A plenary session focusing on innovation will this morning look at exciting future developments in the field of bioresorbable valves. Current biological valves are developed from animal tissue, but durability of these valves is a concern—particularly in those with long life expectancies.

Chair Azeem Latib told The Daily Wire: “A new technique, called endogenous tissue restoration, uses a scaffold made out of advanced polymers that is structured as a working valve with working leaflets. This is implanted into a patient and, because it is almost porous, the patient’s cells become attracted to it—creating new tissue and completely covering the structure. Eventually the whole scaffold erodes and you are left with a functional valve created by the patient’s own cells.”

A. Latib said: “Come to this session to hear about this innovative development. In 10 to 15 years’ time, it may be standard to have prosthetic biological valves made out of a patient’s own tissue. We need more clinical studies, but data from children implanted with the valve show that it still works at two years. Further data are needed but if bioresorbable valves are found to be viable, it will be more biocompatible; therefore, there may be less thickening on the valves and the valves may be more durable. The dream is to give patients a long life with their new valves.”

Elazer Edelman also chairs.

Room 351: 08.30-10.00

Room Temes 2: 08.30-10.00

Room 341: 08.30-10.00

Room 351: 08.30-10.00

In today’s programme... Valvular disease
Teamwork is a vital component of a successful left atrial appendage closure programme

Gabor G. Toth is facilitating a session today, with Patrick Calvert, called Stop the clot: how to start a left atrial appendage occlusion programme. Therefore, the session will address correct patient selection and how to enhance collaboration with other departments; it will also provide a brief overview of the key steps of a LAA occlusion procedure.

David Holmes is the senior advisor and Eric Brochet is the expert advisor for this session.

Room 352B: 16.30-18.00

Increase your success rate in complex PCI by gaining insights into how to use rotablation

Session comprising selected EuroPCR 2017 clinical case submissions

Today’s case session on rotablation will, according to chair Jens Flensted Lassen, provide you with tips and tricks on how to undertake the procedure, enabling you to “increase your success rate” when performing complex percutaneous coronary intervention (PCI). Lassen adds: “Rotablation is a very valuable procedure to use during complex PCI, particularly when treating calcified vessels. These days, in complex PCI, the aim when using a rotablator is plaque modification not plaque debulking (smaller burr to vessel ratio). It can help to decrease the complexity of a procedure as well as decrease the risk of complications.”

The cases being presented today include Rotablation of the last remaining patient vessel (by Amin Amraoui), A story of a tortuous rotablation (by Chong Mow Chu), Difficult case of rotablation of anomalous right coronary artery rescued by cutting balloon and guideliner in ACS setting (by Gabor Dekany), Calcified lesions in primary PCI (by Sajan Narayanan), Too much calcium... a PCI challenge in a patient with aortic stenosis (by Manuel Oliveira-Santos), and Rotational atherectomy in a dissected calcific left anterior descending (by Fawz Bardooli). And What do we need? We need all (Yasser Sadek).

Room 352A: 14.45-16.15

Interventions for Stroke

Coronary Interventions

Coronary Interventions

Coronary Interventions

Coronary Interventions

Interventions for Stroke

in today’s programme...
Interventions for stroke

in today’s programme... Coronary

Wednesday 17 May, 2017
**“An excellent opportunity” to discuss cases seen in everyday clinical practice**

Current revascularisation guidelines from the European Society of Cardiology confer a Class IA indication for coronary artery bypass grafting (CABG) in multivessel disease (MVD). However, advances in percutaneous coronary intervention (PCI) have led to an increase in its use for MVD.

New to EuroPCR this year, we have a session format reflecting potential “Evidence-Practice Mismatch”. Today’s session asks the question: “Multivessel disease and diabetes: CABG or PCI?” Chair Elad Asher explained: “This new type of session was created to assist young practitioners in their daily practice. It is a case-based discussion of clinical situations of multivessel disease and diabetes involving potential cognitive conflicts (CABG versus PCI) between evidence/data and practice/experience.” Therefore, attend this session if you want to understand the components of this evidence-practice mismatch. E. Asher said: “I am going to present a case from daily practice and highlight the mismatch between evidence and practice. One speaker will argue in favour of the evidence, another will list the arguments for daily practice. This new format is an excellent opportunity for everyone to discuss cases that you normally meet in the catheterisation laboratory during your daily practice, but often you have to make this complex decision on your own in the middle of the night, and on the spot.” The session is also chaired by Haitham Amin.

**Interventional cardiologists are becoming more convinced about the benefits of OCT**

Optical coherence tomography (OCT) is increasingly being used in coronary interventions because a growing number of interventional cardiologists are recognising that the modality provides high-resolution images and is relatively simple to use. However, the adoption of OCT varies between countries, centres, and operators—these differences are, in part, related to reimbursement issues. However, the familiarity of the individual operator with the technology and the interpretation of the images plays an important role as well.

Today, Tom Adriaenssens and Martine Gilard will facilitate a session that aims to teach you the basic skills of OCT that are needed if you want to establish your own OCT programme. T. Adriaenssens says: “First, we will deal with the practical set-up of the machine and review how to acquire good quality images in a safe way; second, we will offer a basic understanding of how to interpret OCT images—e.g. the discrimination of lipid from calcified plaques; and third, we will discuss the most important indications for using OCT in daily clinical practice. These indications include angiographically unclear lesions (pre or post stenting), the optimisation of PCI procedures, and assessing stent failure.” The “Learning” format of the session will facilitate review of these topics in a practical way—the focus will be on tips and tricks, avoidance of complications, and the potential errors to be mindful of. Furthermore, it is designed to be interactive. “Participants are more than welcome to ask any questions that they may have. Also, we hope that they will share their personal experiences related to the topic—we, as the facilitators, will be walking around the room with microphones to ask for input,” T. Adriaenssens notes. He adds that the session is designed for interventional cardiologists who are new to the field of OCT or who want to refresh their skills, commenting: “Of course, you cannot become an expert in OCT in just 90 minutes, but you should obtain a solid basis from which to further build your skills by the end of the session.”

**Drug choice and treatment duration remain challenges with DAPT**

The objective of dual antiplatelet therapy (DAPT) after percutaneous coronary intervention (PCI) is to reduce the risk of ischaemic events without increasing the risk of major bleeding. As these risks depend on patient characteristics and the stent being used in PCI, a DAPT strategy should be individualised for each patient. Thomas Cuisset and Davide Capodanno will explore the need to individualise DAPT in the case-based session that they are chairing today. T. Cuisset comments that they will focus on four different scenarios that “we face in everyday clinical practice”: DAPT in patients undergoing elective PCI, DAPT for patients undergoing PCI for acute coronary syndromes, DAPT for patients with comorbidities, and DAPT for patients already receiving oral anticoagulation. These scenarios aim to address some of the “many unanswered questions”, T. Cuisset says, regarding the use of DAPT after PCI, including the optimal duration of DAPT in older patients or in patients with acute coronary syndromes. He adds that another important question is whether or not “we can skip aspirin when using newer P2Y12 blockers.” As well as reviewing these questions, the session aims to help you integrate newly available evidence for antiplatelet therapy choice and duration and reflect how to individualise antiplatelet strategies in daily practice. Furthermore, it will provide an opportunity to discuss potential innovative strategies for DAPT after PCI. While there are unresolved issues with DAPT, we now have a better understanding of the factors to consider when choosing DAPT duration. T. Cuisset explains: “We recently realised from clinical studies that patient characteristics have a stronger impact than PCI characteristics (i.e. stent choice) on the benefits/risks of long-term DAPT.” Also, second-generation drug-eluting stents are associated with a lower risk of stent thrombosis than are first-generation drug-eluting stents—meaning that DAPT, assuming that a patient did not have any characteristics associated with an increased ischaemic risk, could potentially be prescribed for a shorter duration.

**Be innovative in CTO revascularisation**

**Session comprising selected EuroPCR 2017 clinical case submissions**

One of the main advantages of successful revascularisation of a chronic total occlusion (CTO) is that symptoms of angina and dyspnoea improve significantly. Many non-randomised studies have shown that revascularisation is better than optimised medical therapy, although this is yet to be confirmed in populations with a high percentage of complex CTOs. Innovations during the last few years include the development of new double coil guidewires specifically designed for CTO revascularisation, and single and double lumen microcatheters.

**“The percentage of success in this complex procedure increases with experience, from about 50% among the less experienced and reaching up to 85% to 90% among expert operators.”**

CTO: Innovative approaches, chaired by Alfredo R. Galassi, will today use a case-based format to tackle the topic. A.R. Galassi said: “The percentage of success in this complex procedure increases with experience, from about 50% among the less experienced and reaching up to 85% to 90% among expert operators. This is mainly due to new materials and devices, and a rising awareness of the need for dedicated operators.” Included in the presentations today: the CHAMELEON technique without contralateral angiography for the treatment of CTO; a side-door solution for the stumpless and unseen distal target in CTO lesion: when simplicity overcomes the complexity; and a tandem right coronary artery CTO approached by ipsilateral retrograde and antegrade method with the “ping-pong” technique. A.R. Galassi advised: “Attending meetings held by expert opinion leaders is by far the most important way of increasing your skill and expertise in revascularisation.”

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**Room Learning: 08.30-10.00**

**Room 342A: 14.45-16.15**
Your A-B-C guide to managing cardiogenic shock

Salvatore Brugaletta says that cardiogenic shock “represents a nightmare” for interventional cardiologists because it is associated with high mortality—“up to 50%”. However, he believes a session today—for which he is a facilitator—will provide a step-by-step logical process for dealing with cardiogenic shock so that you can understand how to quickly identify and treat haemodynamic deterioration.

The issue of when to use PCI to treat a CTO will be explored today in a session entitled PCI of CTO in a symptom-free patient. I. Ilic, who is co-chairing the session with Hany Eteiba, says: “The question when—or if—PCI of a CTO should be undertaken in a symptom-free patient is rather a difficult one.” Therefore come to this session to better understand how to address it. “This session’s aim is to present evidence regarding the benefits of CTO PCI in symptom-free patients and additionally to outline the possible modalities available for detecting ischaemia. We will also look at the methods of assessing the potential difficulties and outcomes of an intervention,” I. Ilic comments.

Room 352B: 08.30-10.00

Conflicting evidence for the benefits of PCI in patients with CTO

Ivan Ilic states that the data assessing the role of percutaneous coronary intervention (PCI) to treat chronic total occlusions is “still confounding”. He notes that while there is substantial evidence that PCI of CTOs in non-culprit lesions is associated with a “substantial mortality and morbidity” benefit in patients who have had a myocardial infarction, not all CTO PCI is beneficial. “One should not forget that these interventions carry substantial risks and should be performed by experienced operators,” I. Ilic comments.

The focus on clinical research is not to be missed by anyone with an interest in learning more about this area.

Room 341: 12.30-13.30
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4.5 mm AND 5.0 mm sizes:
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WE INVITE YOU TO OUR SCIENTIFIC SESSIONS

WEDNESDAY 17 MAY 2017
13.35-14.35 - Room 351
CASE IN POINT
Practical approaches and novel technology to optimise left main procedure outcome

Chairpersons: A. Latib, O. Mendiz

THURSDAY 18 MAY 2017
12.30-13.30 - Room 241
CASE IN POINT
Individualised treatment decision and novel technology to improve patient outcome in complex radial PCI

Chairpersons: J. Nolan, S. Rao