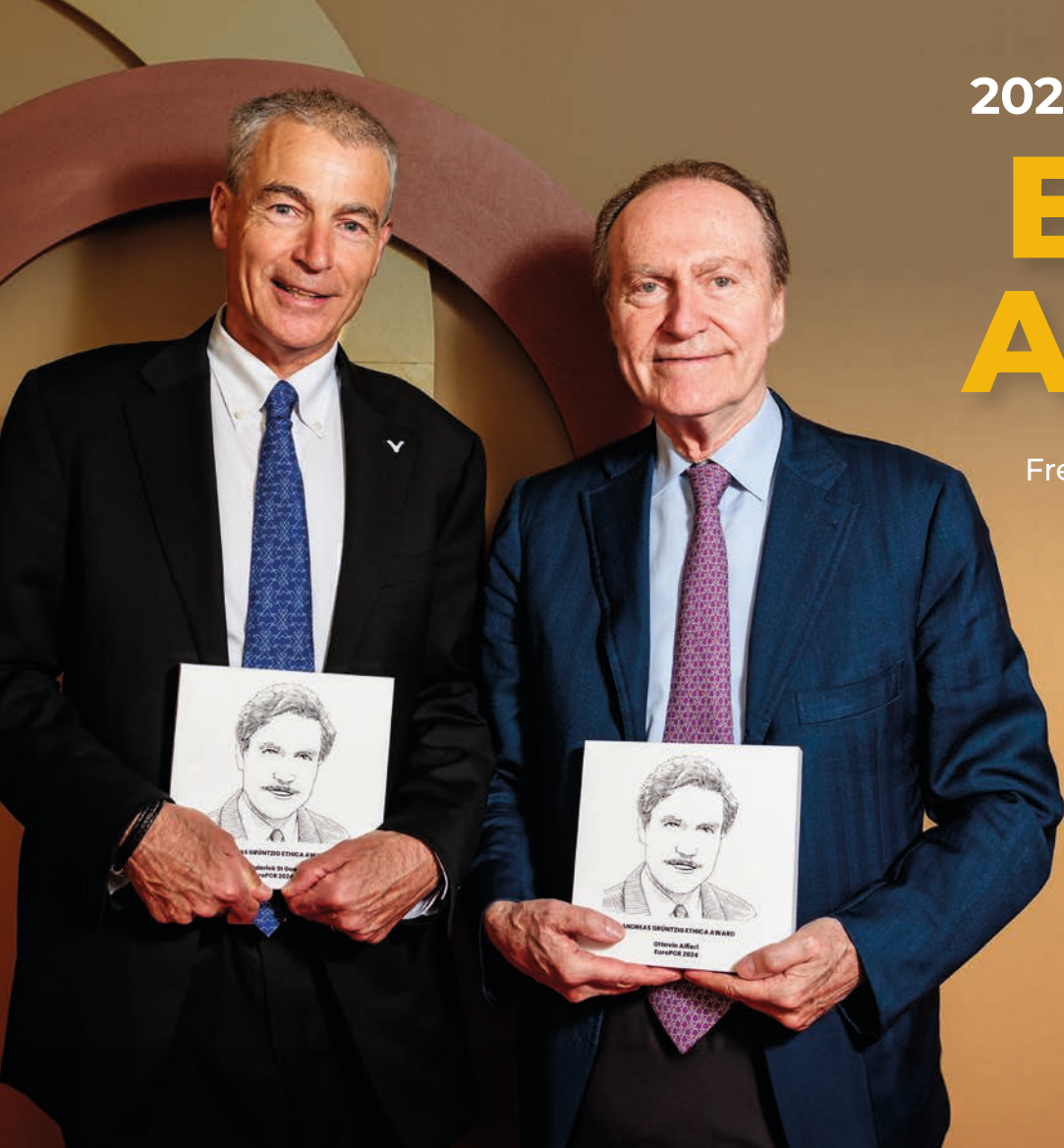


The Daily Wire

THE OFFICIAL EUROPCR COURSE NEWSPAPER

EDITION THREE, 16 MAY 2024



2024 Andreas Grüntzig

ETHICA AWARD

Frederick St Goar and Ottavio Alfieri
who transformed the treatment
of mitral regurgitation

NEW RECORD!

12,000
PARTICIPANTS
at EuroPCR 2024

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More to Life

Major Late-Breaking Trial of EuroPCR 2024

Accepted in **THE LANCET**

LANDMARK

Randomised Controlled Trial

Randomised non-inferiority comparison of newer generation Myval THV series with contemporary THV series (Sapien and Evolut) in real-world patients with severe symptomatic native aortic stenosis



Chairman & Study Director
Prof. Patrick W. Serruys

768 Patients | 31 Sites | 16 Countries

On behalf of
Landmark RCT Investigators



Global Principal Investigator
Prof. Andreas Baumbach

Non-inferiority of Myval THV series ($p < 0.0001$) was achieved with an absolute risk difference of -2.3% when compared to the contemporary THV series.

The primary composite endpoints @ 30 days.

24.7%

Myval THV series

VS

27.0%

Sapien THV series + Evolut THV series

Key Findings

The LANDMARK RCT is the **first head-to-head trial** comparing 2 balloon expandable valves and 1 self-expanding valve based on VARC-3 criteria.

The LANDMARK RCT establishes the **non-inferiority** of Myval THV series compared to contemporary THV series (Sapien and Evolut) for early safety and effectiveness composite endpoints at 30 days (all cause mortality, all stroke, bleeding type 3 & 4, AKI stage 2-4, moderate or severe PVR, new PPI and major vascular complication).

The LANDMARK RCT has **expanded the indications** of TAVI to those with complex anatomy, such as small annulus ($< 430\text{mm}^2$, 31.9%) and bicuspid aortic valves (6.8%).

When comparing the effective orifice area (EOA) of conventional THV sizes (20, 23, 26, and 29 mm), the Myval series **matches or exceeds** the Sapien series and is comparable to the Evolut series for the 26 and 29 mm sizes.

Additionally, intermediate Myval sizes (21.5, 24.5, 27.5 mm) show EOAs **equivalent to or better** than as compared to conventional size (23, 26, 29 mm) of Sapien series respectively

The availability of **intermediate sizes** in Myval THV series enables precise and appropriate matching of devices to an individual patient's anatomy and was used in **48.1%**.

Continued follow-up up to 10 years will unravel whether the documented EOA of the Myval THV series will have a beneficial impact on the long-term patient prognosis and valve durability.

Meet the Andreas Grüntzig Ethica Awardees

Each year, the Andreas Grüntzig Ethica Award – the highest honour in the interventional cardiology community – is presented to individuals who have contributed in an extraordinary way to the PCR mission.

Ottavio Alfieri and Frederick St Goar received the award for their important work on developing new opportunities for expanding indications of interventions targeting mitral regurgitation in patients with heart failure, with benefits including mortality reduction in selected cases. Find out more about the achievements of this year's very worthy winners:



Ottavio Alfieri

What inspired you to specialise in cardiac surgery?

When I graduated from medical school in 1971, cardiac surgery was in its pioneering phase. Nothing appeared impossible – the doors were opened to congenital heart surgery, valve repair and replacement, coronary artery bypass grafting and heart transplantation, etc. Of course, at this time, there was no interventional cardiology and surgery was the only way to treat heart disease. Who wouldn't have been attracted to this field? The work of Alain Carpentier then motivated me to focus on valve surgery.

“Receiving this award jointly with Fred St Goar highlights that important achievements are frequently the result of joint efforts and I would also like to share the honour with all the co-workers who have contributed to the successful story of edge-to-edge repair.”

What are your main career achievements?

I would have to say that developing the edge-to-edge technique for mitral valve repair – which was inspired by observations of the congenital double-orifice mitral valve anomaly – is the greatest achievement of my career, given its subsequent basis for percutaneous treatment. Another major contribution is the invention of the clover technique, which has turned out to be extremely useful for many patients with tricuspid regurgitation. Finally, I am proud that for the past two decades or so I have been promoting cross-training in catheter technologies among my surgical colleagues. I recognised early that huge steps forward could be made with transcatheter technologies and that we, as cardiac surgeons, could become experts at both.

What are you working on at the moment?

I'm still a senior consultant at the San Raffaele University Hospital and this gives me the opportunity to share my experience as part of the heart team and continue in patient care. I am also busy with the Alfieri Heart Foundation I founded, which keeps me at the forefront of cardiac research, as we endeavour to invent and test new treatments and devices for heart valve diseases. We also aim to promote the training of highly trained professionals, with a progress-oriented mindset, who will be able to apply the most advanced techniques and technologies for the benefit of patients.



Frederick St Goar

What inspired you to specialise in interventional cardiology?

I think that many interventional cardiologists are like myself, slightly frustrated engineers who really enjoy fixing problems. I have always been interested in physiology and I like to think of myself as a 'human hydrologist', solving flow issues in a human model. I consider it a real privilege and pleasure to be able to do this and I never think of it as work.

What are your main career achievements?

I was part of the team involved in the development of intravascular ultrasound, but my main achievement would have to be the MitraClip. Training at Stanford University, I was encouraged to push the envelope of healthcare and to think about problem-solving at a higher level. I heard of Professor Alfieri's edge-to-edge technique when I was investigating percutaneous ideas for mitral valve repair using much more complex techniques, revolving around annuloplasty, and it was like a light-bulb moment, I thought that something so elegant and simple could be achievable with a catheter.

That realisation was the start of Evalve, Inc., the company that went on to develop the MitraClip. It was a huge team effort, involving passionate physicians and clever engineers, and success was hard won – we faced initial hostility from some in the surgical sector and potential failure on several occasions. And although MitraClip was first implanted less than a year after the first TAVI procedure, the success of this approach has taken much longer to be realised, perhaps due to complexities of the AV valves.

What are you working on at the moment?

As well as really enjoying continuing to practice clinical medicine and taking care of patients, I am also inspired to use innovation to try to make healthcare more scalable and more equitable globally. I teach at Stanford Biodesign, am Vice Chairman of the Board of a non-profit incubator, Fogarty Innovation, and support several different healthcare projects in Africa. Part of my work currently is in the perinatal, maternal and infant health space, which has a huge unmet need. We have developed the US standard-of-care device for managing postpartum haemorrhage, the JADA system, and are now focusing on preterm labour. I want to leverage the successes and failures I've had in different projects to try to smooth the path for the next generation of innovators.

“Sharing this honour with Ottavio Alfieri – my hero and good friend – is a celebration of two things: the amazing innovation that has occurred in structural heart disease therapy over the last 20 years and the remarkable progress that can be achieved when surgeons and cardiologists collaborate.”

★ TODAY'S ★

MUST-ATTEND

EVENTS

EAPCI Fellowship Grants Award ceremony

Main Arena, 10:15 – 10:30

Personalised Vascular Care Award ceremony

Theatre Bleu, 13:45 – 14:00

Strengthening Cardiovascular Care Resilience: The RESIL-Card Project

PCR Companions Lounge – level 2, 10:15 – 10:30

Journey to Asia Pacific: discovering AICT-AsiaPCR

PCR Companions Lounge – level 2, 14:30 – 14:50

Gen AI: rewards and risks for healthcare professionals

PCR Companions Lounge – level 2, 16:15 – 16:45

LIVE CENTRES IN FOCUS

The ever-popular LIVE educational cases demonstrate the clinical excellence of renowned centres across the world, providing an unparalleled experience to learn best practices from international experts. Meet the teams behind the masks.



"It is a privilege to partake in an interventional cardiology forum catering to diverse educational needs across the globe. Collaboration at EuroPCR is unique!"

Netcare Sunninghill Hospital - Johannesburg, South Africa

Centre established 35 years ago

Practitioners include 18 cardiologists (9 paediatric), 2 full-time fellows. 5 cardiothoracic surgeons, 5 vascular surgeons, numerous rotating fellows, 12 cathlab nurses, 5 technologists, 3 radiographers and 2 stock controllers

Most frequent types of interventions/procedures: Complex coronary and structural interventions, congenital heart interventions and electrophysiology

How would you describe your centre? It is a referral centre for interventions in complex and high-risk cases, and a large congenital heart surgery facility. The centre offers 2-year fellowships in complex interventional procedures

Number of times the centre has participated in EuroPCR: 4 times



"Serving as a LIVE centre provides us with the opportunity to share our everyday way of working with colleagues from all around the world, and to extract from it valuable and transformative learning experiences."

Hospital Clinico San Carlos - Madrid, Spain

Centre established in 1951

Practitioners include 32 cardiologists, 9 interventional cardiologists, 8 cardiac surgeons, 11 fellows in interventional cardiology and 15 nurses in interventional cardiology

Most frequent types of interventions/procedures: The centre serves as the interventional hub for Cardioried, a network of hospitals, providing care for chronic and acute patients, particularly complex coronary interventions and structural heart procedures, including TAVI, mitral edge-to-edge repair, tricuspid interventions, LAA closure, etc. Hospital Clinico is a world reference in the field of coronary imaging and physiology, and has led multiple trials in different areas of interventional cardiology

How would you describe your centre? What makes Hospital Clinico San Carlos special is the blend of clinical excellence, research and commitment to education. Fully aligned with the spirit of PCR, the centre has been pivotal in exploring new educational approaches in the field of interventional cardiology. The fellowship programme has a strong international character, having trained interventional cardiologists from 5 continents

Number of times the centre has participated in EuroPCR: 8 times



"Our interventional cardiology team is honoured to open the doors of our cathlabs to the EuroPCR community! We will try to share the passion we have in treating our patients."

Policlinico Universitario Fondazione Agostino Gemelli - Rome, Italy

Centre established in 1968

Practitioners include 51 cardiologists (staff members) and 82 cardiology fellows

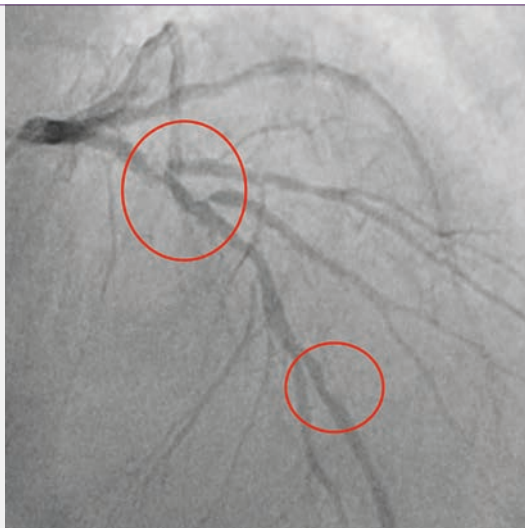
Most frequent types of interventions/procedures: Coronary interventions (with a sizeable proportion of complex PCI), all the main structural interventions (TAVI, TEER, TMVI, congenital defects percutaneous treatment, LAA occlusion) and peripheral interventions such as carotid and iliac-femoral stenting

How would you describe your centre? The teamwork spirit animates our interventional cardiology team, which also strongly cooperates with the other groups (clinical cardiologists, cardiac surgeons etc). In the last decades, our department embraced a transformation of the organisation, increasingly moving towards multidisciplinary clinical management pathways

Number of times the centre has participated in EuroPCR: Twice

LIVE EDUCATIONAL CASES TODAY!

- 86 years old
- Unstable angina
- LAD in-stent restenosis of a 1° generation DES involving D1 and D2 (jailed), calcification
- *De novo* mid LAD stenosis
- High bleeding risk



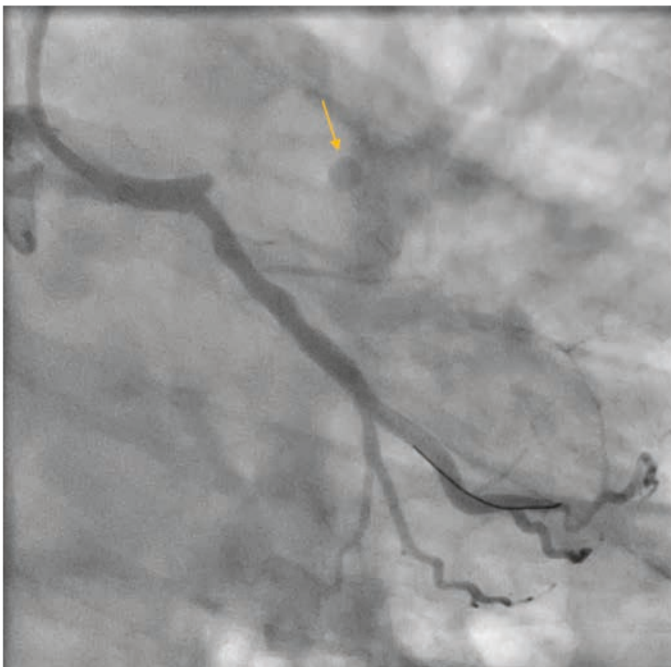
Madrid, Spain

In the first of two LIVE cases from Madrid, Javier Escaned and Nieves Gonzalo provide a masterclass in using imaging to tackle stent failure

Imaging-guided PCI for stent failure: LIVE from Hospital Clínico San Carlos - Madrid, Spain

- How would you image these two lesions?
- Given the high bleeding risk of this patient, what are the PCI considerations?

Main Arena 08:30 – 10:00



Johannesburg, South Africa

There are two LIVE cases from Johannesburg today. Learn more about antegrade CTO strategies with Farrel Hellig and Pieter Van Wyk

Antegrade CTO: LIVE from Netcare Sunninghill Hospital - Johannesburg, South Africa

- Is dual injection mandatory?
- Which CTO PCI approach would you start with?
- Would an initial IVUS evaluation help?

Main Arena 14:45 – 16:15



TODAY'S OTHER LIVE CASES

LAA closure: LIVE from Netcare Sunninghill Hospital, Johannesburg - South Africa

Main Arena, 10:30 – 12:00

Multivessel disease: LIVE from Hospital Clínico San Carlos, Madrid - Spain

Main Arena, 16:30 – 18:00

TOMORROW'S LIVE CASES

Imaging-guided left main PCI: LIVE from Policlinico Universitario Fondazione Agostino Gemelli, Rome - Italy

Main Arena, 08:30 – 10:00

Non left main bifurcation: LIVE from Policlinico Universitario Fondazione Agostino Gemelli, Rome - Italy

Main Arena, 10:45 – 12:15





EuroPCR 2024's major late-breaking trials make their mark!

Three major late-breaking trials caused a buzz in Theatre Bleu and online yesterday as important clinical questions were answered by international experts, pushing the boundaries of knowledge and advancing clinical practice.



Can DAPT be de-escalated in ACS patients treated with DCBs?

In recent years, many studies have investigated de-escalating dual antiplatelet therapy (DAPT) in patients with acute coronary syndrome (ACS) who have been treated with drug-eluting stents (DES). With the emergence of drug-coated balloons (DCBs) as a promising strategy for the management of ACS, there remains a knowledge gap surrounding the optimal DAPT strategy for patients with ACS treated with DCBs. "Patients treated with DCBs may require less intense antiplatelet therapy due to the lack of metallic scaffold and polymer inside the coronary artery and the short retention of anti-proliferative drugs," explained Ling Tao (Xijing Hospital - Xi'an, China), Chair of the REC-CAGEFREE II trial and presenter at yesterday's session. "However, there is currently no consensus on the appropriate antiplatelet strategy in patients with ACS treated with DCBs – most centres use the same approach as with DES or use modified

regimens that are not backed by data from randomised trials, both of which may be associated with potentially avoidable major bleeding."

The REC-CAGEFREE II trial was designed to assess the non-inferiority of a stepwise DAPT de-escalation strategy (aspirin plus ticagrelor for 1 month, followed by 5 months of ticagrelor monotherapy and then 6 months of aspirin monotherapy) compared with a standard 12-month DAPT strategy with respect to clinical outcomes, including both ischaemic and bleeding events, in patients treated exclusively with DCBs. The primary efficacy endpoint was net adverse clinical events (NACE, a non-hierarchical composite of all-cause death, stroke, MI, revascularisation and BARC type 3 or 5 bleeding) assessed at 12 months.

Across 41 sites in China, 1,948 patients were randomised to the stepwise DAPT de-escalation group or the standard



DAPT group. Overall, the mean age was 59.2 years, 74.9% were men, 13.2% had prior MI, 32.2% had prior PCI and 20.6% had high-bleeding risk.

The primary endpoint of NACE occurred in 9.0% patients in the stepwise de-escalation group and 8.7% in the standard DAPT group.

The difference between the two groups was 0.31% (95% CI -1.81 to 2.43) and the upper boundary of the 95% CI met the pre-specified criteria of 3.2% for non-inferiority ($P_{\text{non-inferiority}} = 0.013$). Rates of BARC type 3 or 5 bleeding were 0.4% and 1.7% in the stepwise de-escalation and standard DAPT groups, respectively. When analysed by hierarchical clinical importance using the win-ratio method, the stepwise de-escalation group had more wins (14.4%) than the standard DAPT group (10.1%) for the composite endpoint of all-cause death, stroke, MI, BARC type 3 bleeding, revascularisation and BARC type 2 bleeding (win ratio 1.43; 95% CI 1.12 to 1.83; $P=0.004$).

A novel feature of the trial was that a mobile application operating on the WeChat platform was used to facilitate adherence to the allocated medications. Participants were contacted monthly through this application to assess their health status and medication compliance. Over 12 months, 85.4% of patients in the stepwise DAPT de-escalation group and 85.9% in the standard DAPT group adhered to their allocated regimens.

Summing up, Professor Tao concluded, "The results of the REC-CAGEFREE II trial are encouraging – the non-inferiority criteria were met for the primary endpoint and the win ratio and major bleeding rates favoured the stepwise de-escalation. We believe these findings help to fill the knowledge gap and provide support for a less intense antiplatelet regimen in patients with ACS treated with DCBs."



How does TAVI compare to SAVR in young, low surgical risk patients with severe tricuspid or bicuspid aortic valve stenosis?

“In recent years, randomised controlled trials have demonstrated the non-inferiority – or, in some trials, even the superiority – of TAVI to SAVR in low surgical risk patients. However, such trials mainly included older patients and excluded those with bicuspid aortic stenosis,” noted the presenter of the second trial, Ole De Backer (Rigshospitalet, Copenhagen University Hospital - Copenhagen, Denmark).

He described how the NOTION-2 trial was the first to compare transcatheter and surgical replacement in younger (≤ 75 years) low-risk patients with severe bicuspid or tricuspid aortic stenosis and/or requiring coronary revascularisation. The primary endpoint was the composite rate of death, stroke or rehospitalisation (related to the procedure, valve or heart failure) within 1 year. The study population of 370 patients were younger than in previous trials (mean age, 71 years) and had a very low median STS-PROM score of 1.1%. In total, 63% were men and 27% had bicuspid aortic valves.

For the primary endpoint, the outcome with TAVI (10.2%) was similar to SAVR (7.1%) at 1 year, with an absolute risk difference of 3.1%

(95% CI -2.7% to 8.8% ; $P=0.3$), which was within the prespecified non-inferiority margin of 5%; although, the upper limit of the 95% CI surpassed this margin.

The secondary endpoint of death or disabling stroke at 1 year occurred in 3.2% of patients in the TAVI arm and 1.6% in the SAVR arm (absolute risk difference of 1.6%; 95% CI -2.8% to 6.1% ; $P=0.3$). In a subanalysis, the primary endpoint was similar between the TAVI and SAVR groups in the tricuspid cohort (8.7% and 8.3%, respectively; hazard ratio [HR] 1.0; 95% CI 0.5 to 2.3) but appeared higher for TAVI versus SAVR in the bicuspid cohort (14.3% and 3.9%, respectively; HR 3.8; 95% CI 0.8 to 18.5). Similarly, death or disabling stroke occurred at a comparable rate for the TAVI and SAVR groups in the tricuspid cohort (2.2% and 1.5%, respectively; HR 1.4; 95% CI 0.2 to 8.5) but appeared higher for TAVI versus SAVR in the bicuspid cohort (6.1% and 2.0%, respectively; HR 3.1; 95% CI 0.3 to 30.0).

Professor De Backer highlighted that the event rates were notably low in both groups, with comparability overall and with safety findings as expected, but said that the subanalysis findings indicate the

need for additional studies: “As well as the truly young age, the inclusion of patients with bicuspid aortic stenosis was an important differentiator in NOTION-2 compared with other trials. For young patients, with an age of 60 to 75 years, and with a tricuspid aortic stenosis, there was clinical equipoise between TAVI and SAVR. However, in young patients with bicuspid aortic stenosis, outcomes

seemed more favourable with SAVR than TAVI, although patient numbers were relatively low. Such findings warrant further investigation and may impact future trial designs and the management of young patients with bicuspid aortic stenosis, for example, by being more selective about which bicuspid phenotypes to accept for TAVI and increasing the use of cerebral embolic protection.”



How does Myval compare with contemporary THVs for aortic stenosis?

The new balloon-expandable Myval transcatheter heart valve (THV) has shown efficacy in observational studies in low operative risk patients but its role in the context of established contemporary THV devices was unknown until the LANDMARK trial sought to address this important question. “The Myval is a new balloon-expandable valve, with unique features, including a wide

size selection that allows for more accurate sizing of the valve,” explained Global Principal Investigator, Andreas Baumbach (William Harvey Research Institute, Queen Mary University of London and Barts Heart Centre - London, UK). “The LANDMARK trial is a bold step to test this new valve to the highest academic standard – a randomised controlled trial against the reference

series of Evolut and SAPIEN valves in a representative population.”

As presented by Study Chairman, Patrick W. Serruys (University of Galway - Galway, Ireland), the LANDMARK non-inferiority trial assessed the safety and efficacy of the Evolut and SAPIEN series and the Myval series in patients with severe symptomatic native aortic stenosis and any surgical risk status. The composite primary and safety efficacy endpoint at 30 days (VARC-3) comprised all-cause mortality, all stroke, major bleeding (VARC type 3 and 4), acute kidney injury, major vascular complications, moderate or severe prosthetic valve regurgitation and conduction system disturbances resulting in a new permanent pacemaker implantation.

Altogether, 768 patients were enrolled in 16 countries. In each arm, the mean age was 80 years, around 50% of patients were male and the median STS-PROM risk score was 3%.

The primary endpoint demonstrated non-inferiority of the Myval (24.7%) compared with contemporary THV (27.0%), with an absolute risk difference of -2.3% (non-inferiority $P<0.0001$).

Event rates for individual components of the primary endpoint were similar between arms. When the effective orifice areas (EOAs) of conventional nominal THV sizes (20, 23, 26 and 29 mm) were compared, Myval showed even (20 mm) or significantly larger EOA (23, 26 and 29 mm) than the SAPIEN series and similar EOA to the Evolut series (26 and 29 mm).

Summing up, Professor Serruys concluded: “The really exciting take-home message is that the Myval series is not simply a ‘me too’ valve. Beyond the non-inferiority to standard THVs, the potential to offer flexibility in sizing is invaluable. Multiple observational studies have shown that intermediate valve sizes are required for up to 50% of patients and this was reflected in the LANDMARK trial, in which 48% of the patients required intermediate sizing. While we don't yet know the long-term implications of more accurate sizing, LANDMARK's EOA results are interesting because this parameter has been linked to potentially improved durability. The 10-year follow-up of patients in the trial will provide important information on this and other aspects of the Myval series.”



SESSION IN THE SPOTLIGHT

How to set up a successful renal denervation programme

Now firmly established in the European Society of Hypertension (ESH) 2023 guidelines,¹ there's no better time to learn how to successfully implement renal denervation for patients with resistant hypertension.

"Following the publication of several randomised sham-controlled trials supporting its efficacy and safety, renal denervation is now back in the 2023 edition of the ESH guidelines," explains Felix Mahfoud, Anchorperson of a Case-based Discussion session this afternoon. "With a considerable upgrade from the previous Class 3 recommendation, it is now firmly placed as the third pillar of antihypertensive treatment options in patients with uncontrolled blood pressure, with the same level of evidence as spironolactone. This is a big change; renal denervation is once again a part of clinical practice and it is important that we understand how to implement it successfully and safely in all patients who may benefit."

Professor Mahfoud thinks there are two important aspects to broadening the use of renal denervation. "One is informing referring physicians that a programme exists at a particular centre because in most circumstances, the interventional cardiologist is not initially involved in the management of patients with severe uncontrolled hypertension. In fact, among the whole community, we need greater awareness of where there are local opportunities for renal denervation and this is where the multidisciplinary hypertension team takes centre stage."

The other aspect concerns the role interventionalists should play in



identifying suitable patients they are seeing for other indications. "We have to bear in mind that many patients we see every day in the cathlab have high blood pressure that is uncontrolled despite multiple medications. Rather than just perform the procedure for which we have been enlisted, e.g. the PCI, we need to consider other risk factors, including blood pressure and lipids, as these will significantly impact on outcomes. According to current guidelines, as soon as patients receive three drugs and still have high blood pressure, we could consider renal denervation."

The next steps involve considering the patient's suitability in detail, including obtaining out-of-office blood pressure readings and ruling out any secondary causes of hypertension. Once renal denervation is selected in a shared decision-making process, the procedure must be carried safely. "Renal denervation

is not a very difficult procedure, but still, the interventionalist has to be comfortable with the renal arteries, preprocedural imaging – commonly endovascular ultrasound – the technique itself, the device and the technology underlying the different devices," notes Professor Mahfoud.

And what is the appropriate work up for the patient? Professor Mahfoud says that the answer to this and many questions about renal denervation will be answered in this afternoon's session. "Everybody who's interested in renal denervation – who is considering setting up a programme or advancing an existing programme to the next level – should come. It's a very practical session and we'll share experiences on who to treat, how to integrate patient preference, and a range of procedural aspects, all in an open forum."

1. Mancia G, et al. J Hypertens. 2023;41:1874–2071.

DON'T MISS

Successful implementation of renal denervation in hypertension management (the hardest part is getting started)
Thursday, Room 243, 10:30 – 12:00

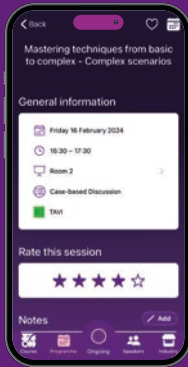
AND ALSO:
Evolving strategies for renal interventions
Thursday, Poster Lab, 08:30 – 10:00



Your feedback matters!

Please rate the educational value of the sessions

★★★★★



SESSION IN THE SPOTLIGHT

When the side branch causes troubles



Jens Flensted Lassen

Interventional cardiologist / Cardiologist
Odense University Hospital - Odense, Denmark

Today's 'Learning from your case' session uses this new format to help unravel some of the intricacies of side-branch management. One of the session facilitators, Jens Flensted Lassen, describes the session set-up and tells us why everyone involved in bifurcation stenting should attend.

"During the submissions meeting in February, we identified two cases that we thought had real educational potential in the tricky area of side-branch management," notes Professor Lassen. "This afternoon the submitters of the cases, Kazuhiro Ashida and Chandrashekhar Patil, will take us through the details, while Nicola Ryan and I help draw out some of the learning points for discussion along the way."

Side-branch preservation is highly relevant and was the main focus of a recent consensus document published by the European Bifurcation Club.¹ "Although generally under-acknowledged, side-branch occlusion occurs commonly and is the Achilles heel of treating bifurcation lesions," comments Professor Lassen. Fear of side-branch occlusion may lead operators to choose an elective two-stent strategy despite anatomical suitability for stepwise provisional

stenting, but then a two-stent strategy has its own technical difficulties in terms of side-branch access. "If you are embarking on treating a bifurcation, whatever method you are using, you need to have a toolbox so you can save the side branch if it closes," he notes.

The European Bifurcation Club document describes several ways to protect and restore side-branch flow, and some of these strategies will be discussed during today's session. "The session has a philosophical element in helping participants anticipate what issues they may likely face with different routes. Dr Ryan and I will then help participants develop their toolbox of techniques to overcome these issues." In addition, prevention and management of complications during side-branch management will be discussed.

Trying to avoid the information overload that can occur in sessions on highly complicated techniques, Professor Lassen is quick to point out that just like provisional stenting, a stepwise approach will be employed, building up the cases in easy-to-understand sections. That said, the session will appeal not only to inexperienced operators but also to highly skilled experts. "Side-branch management is not an issue that disappears when you reach a certain level of experience – we all continue to be challenged by it. Dr Ryan and I hope for lively discussions around these real-life cases where we can all learn from each other."

1. Pan M, et al. *EuroIntervention*. 2023;19:26–36.

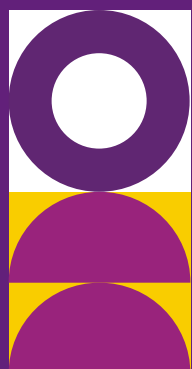
DON'T MISS

Learning from your case: Bifurcation - When the side branch causes troubles
Thursday, Room Learning 2 (342AB), 16:30 – 18:00

AND ALSO:

Provisional bifurcation stenting: step-by-step technique description and troubleshooting
Thursday, Room Learning 1 (242AB), 08:30 – 10:00

How to select optimal two-stent strategy for true complex distal left main bifurcation
Thursday, Room Learning 2 (342AB), 08:30 – 10:00



Get your **CME**, attendance and **presentation** certificates in your **My PCR** account from **24 May!**



Yesterday’s catch up

PCI cases with treatment dilemmas

Two cases submitted by fellows were carefully selected for presentation at a NextGen session yesterday, providing valuable learning points on some challenging clinical scenarios related to when and how to intervene with PCI.

The first case, presented by Orianne Weizman, described a 43-year-old woman with no previous history of CVD who experienced chest pain for 6 hours before calling the emergency services. Troponin levels were high and the initial ECG showed ST elevation and an anterior Q wave, with no ventricular arrhythmias and stable haemodynamics. Initial intervention with a small balloon did not improve flow and based on the angiography and the patient’s characteristics, a SCAD was suspected. A lively discussion ensued about whether a conservative approach or PCI, with its associated challenges, should be considered. Although not generally recommended by guidelines, Dr Weizman explained that OCT was used next to provide further information about the dissection since this was considered important to refine the treatment approach. An AngioSculpt 2.0*15 scoring balloon

catheter was employed in an attempt to puncture the haematoma, but upon wire removal, flow deteriorated and it was concluded that the balloon size had been too small. A larger cutting balloon was then used with success. The participants debated the most appropriate antiplatelet strategy, which is not currently guided by evidence from randomised trials, and it was noted that the patient received aspirin alone. Extra-cardiac work up was performed to look for aneurysms and the patient was referred for screening to detect systemic connective tissue disorders. It was considered important to discuss the likelihood of recurrence of SCAD with the patient.

David Bridge presented a case of a 62-year-old male who attended the hospital with chest pain, elevated troponin and no significant valvular abnormalities. NSTEMI was diagnosed but initial angiography was ambiguous, with suspicion of a thrombus in the LCx and a bifurcation lesion in the OM artery. The patient was given GPIIb/IIIa inhibitor therapy before a second angiogram was performed. No apparent differences were observed from the first and the focus shifted to treating the bifurcation lesion. Due to uncertainties, IVUS was performed

Dilemma Case 1

Orianne Weizman

Dilemma Case 2

David Bridge

2024 euro PCR

PCI Cases

with Treatment Dilemmas

Valeria Paradies

Erik Rafflenbeul

Aaysha Cader

Andreas Baumbach

PCR

EAPCI

to help provide information on lesion length and stent sizing. An inverted provisional technique was chosen for stenting the OM. The LCx was then rewired and sequential balloon dilatation was used to open the LCx stent struts. There was additional IVUS evaluation on the AV Cx before it was stented with an inverted culotte technique and with kissing balloon inflation. Dr Bridge summarised the learning points from the case, highlighting the versatility of the stepwise layered provisional stenting, the importance of intracoronary imaging and the suitability of inverted culotte stenting when a side branch is compromised.

DON'T MISS

Left main: presentation and diagnosis

Session comprising selected EuroPCR 2024 Clinical Case submissions

Thursday, Case Corner D, 08:30 – 10:00



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Michele Pighi

Young Investigator Award



“Only a pure soul like his can teach and inspire trainees.”

Flavio Ribichini

Yesterday, Ryota Kakizaki was the first-ever recipient of the Michele Pighi Young Investigator Award.

This new award was initiated in remembrance of Michele Pighi, a much-loved member of the PCR Community who tragically passed away in 2022. The winner of the abstract competition, open only to young physicians under the age of 40 years, was announced by Flavio Ribichini, on behalf of the Division of Cardiology of the University of Verona, Italy and the EuroPCR Board of Directors.

The winning case centred around the frequency and fate of clinically silent plaque ruptures in non-infarct related coronary arteries. Dr Kakizaki received a €3,000 grant to allow him to spend time at a selected European interventional centre.



Yesterday’s catch up

The challenges of femoral access

A session from the Nurses and Allied Professionals track provided valuable insights into femoral access complications and how to prevent and treat them.

Speaking ahead of the session, Anchorperson, David Rodrigues explained that the topic was identified as a “community need” based on a survey of NAP participants after EuroPCR 2023.

The session began by answering the question, “Why are we discussing an access site that was first described 71 years ago?” The reasons were twofold. Firstly, because when complications happen with femoral access, they tend to be more serious than with radial access, and secondly, because femoral access is the only route suitable for certain procedures.

Matteo Migliorini began his presentation by discussing the importance of a “safety first approach” and noted that knowledge is the most powerful safety tool in the cathlab. Knowledge of the major complications associated with femoral access and their risk factors – including bleeding (e.g. female sex,

older age, peripheral vascular disease) and arterial dissection (tortuosity and calcification) – is essential. He also mentioned retroperitoneal haemorrhage, pseudoaneurysm, arteriovenous fistula and perforation vs. rupture. Communication was noted as a powerful tool to prevent complications and he emphasised the need for a short preprocedural briefing and also debriefing, even if the procedure has gone well.

Angeliki Kolyda covered the use of ultrasound and computed tomography to guide access and prevent complications. In a poll with the audience, it appears that the use of these tools varies widely between different practices, sometimes depending on availability, budget constraints and also on the experience of the operator.

David Creber discussed how new techniques and technologies can be used to facilitate femoral access, particularly with current trends for shorter procedure times, greater numbers of patients treated per day and more complex cases. With the increased use of TAVI, often with single femoral access, he explained that many patients in his centre have intravascular lithotripsy to reduce

the issue of calcifications. Combining tools such as imaging with lithotripsy can have positive effects for patient outcomes, reducing the risk of complications and also shortening procedure time.

Then followed two presentations on femoral closure devices. Kristin Rykkje-Johannessen discussed how and when to use non-invasive approaches – manual compression and FemoStop – and how to manage vasovagal reactions if they occur. Christina Grima explained the benefits of vascular closure devices and described the properties of different invasive femoral devices, outlining their pros and cons. She explained how to choose the right device for each patient and then how to care for them when a device is in place.

The session was concluded by Alison Dahlmann who said that the challenges of femoral access need to be addressed long before procedures begin and that part of the NAPs’ role is to learn how and when to use available tools to smooth the patient journey.

DON'T MISS

Abstracts from Nurses and Allied Professionals
Thursday, Room 352B,
08:30 – 10:00

Focus on patient centred care
Thursday, Room 352B,
16:30 – 18:00



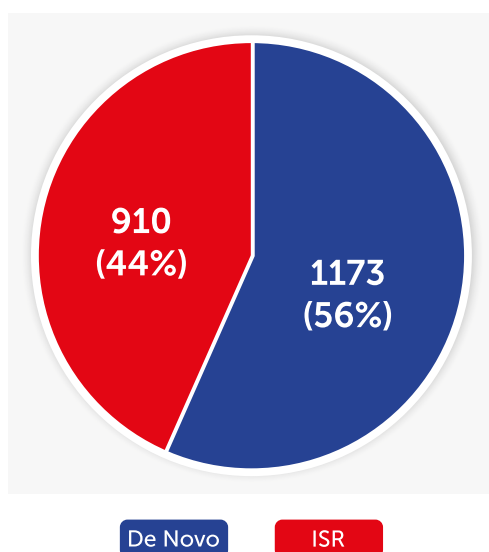
THE EASTBOURNE

THE ALL COMERS SIROLIMUS-COATED BALLOON EUROPEAN REGISTRY

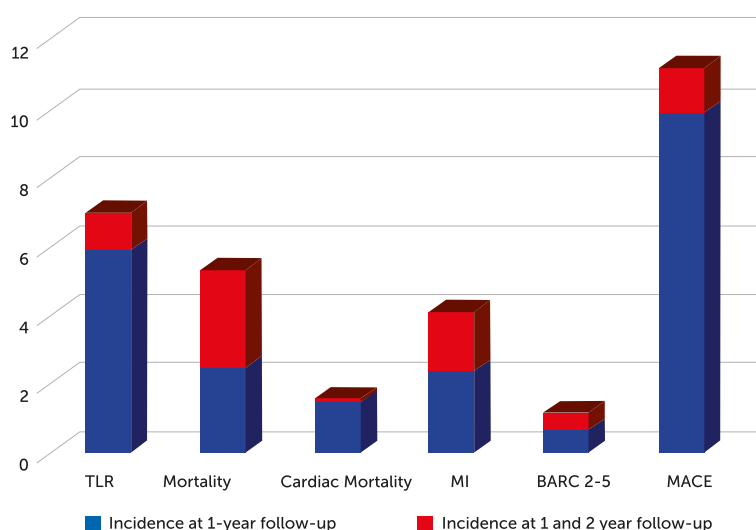
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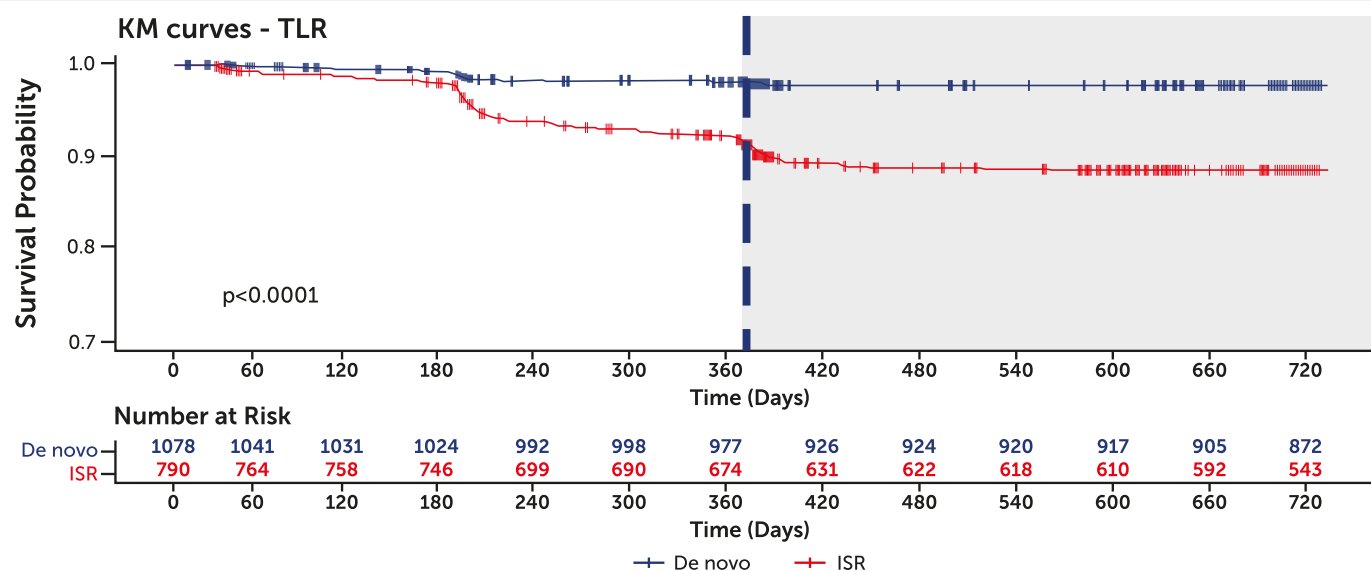
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PP Leone, B Cortese et Al, Eurointervention 2024, in press

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Yesterday’s catch up

Pivotal study on the ShortCut transcatheter aortic valve leaflet splitting device

Promising results on the first-ever dedicated leaflet splitting device were presented in yesterday’s TAVI Hotline session.

Coronary obstruction is a major concern in patients undergoing TAVI for degenerated bioprostheses (valve-in-valve [ViV]) and is associated with a 30-day mortality rate of around 50%.¹ While several transcatheter techniques to lacerate bioprosthetic valve leaflets prior to TAVI placement (such as BASILICA) have been described, they are considered complex, time- and resource-consuming, and are associated with an unpredictable success rate, especially for cases at risk for double coronary obstruction.

Didier Tchetché (Clinique Pasteur - Toulouse, France), Principal Investigator of a trial with the new dedicated leaflet splitting ShortCut device, explains why such a device is particularly relevant for today’s TAVI patient: “Lifetime management for patients with aortic stenosis is an increasingly important consideration as the use of bioprosthetic valves is rising in younger patients. During a ViV procedure, the leaflets of the prior valve are displaced towards the coronary ostia, potentially resulting in an obstruction of coronary blood flow. A device such as ShortCut is necessary to facilitate the treatment of patients requiring multiple valve therapies throughout their lifetime.”

During the ShortCut procedure, the catheter is introduced through the femoral artery and advanced to

the aortic valve over a pre-shaped guidewire. Once the device is properly aligned at the annular level, the positioning arm is exposed and rotated towards the targeted leaflet. Having achieved the desired position, a splitting element is activated, penetrating the bottom of the leaflet from the ventricular side. If the splitting of a second leaflet is required, the positioning arm can be rotated towards the targeted leaflet and the procedure repeated.

As presented yesterday by Principal Investigator, Danny Dvir (Sha’are Zedek - Jerusalem, Israel), the pivotal investigational device exemption (IDE) ShortCut trial involved 60 patients – including 70% females – who presented for a ViV TAVI procedure for an approved indication and who were at risk for TAVI-induced coronary artery ostium obstruction based on anatomical criteria. The patient population, described as being “very representative of contemporary daily practice,” had a median age of 77 years, included patients presenting with failed surgical and TAVI bioprostheses, with 63% of patients at risk for single coronary obstruction and 37% at risk for double coronary obstruction.

Leaflet splitting with ShortCut met the primary safety endpoints of procedure-related mortality and stroke assessed within 7 days, with no procedural mortality and one stroke (1.7%).

In addition, the primary efficacy endpoint of successful leaflet splitting, confirmed by transoesophageal



echocardiography (TOE), was achieved in 100% of patients.

“Leaflet split was achieved efficiently with a single attempt in all cases despite being performed by first-time users, which is not the case with the complex BASILICA technique,” explains Professor Tchetché. “Furthermore, ShortCut does not prolong the procedural time to any great extent as seen with the BASILICA technique. If needed, coronary access can still be achieved after the ShortCut procedure, adding to its beneficial safety profile.”

Professor Dvir concludes, “First results from the pivotal trial are highly promising – this easy-to-use device acts as an adjunct to TAVI and addresses an important unmet clinical

need for the increasing numbers of patients who will likely require multiple valve interventions and for whom there are currently no straightforward solutions. Given that the device is so simple and safe, why wouldn’t I use it for many procedures, even just to improve post-TAVI coronary access? We can predict that leaflet modification will grow dramatically in upcoming years, hopefully as a simple add-on step for our procedures, which can probably be done without changing the setup – under conscious sedation, without TOE and only rarely, with a neuroprotection device. Our next step is to gather longer-term outcomes data and acquire more experience with the device in larger cohorts of patients.”

1. Ribeiro HB, et al. Eur Heart J. 2018;39:687–695.

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PCR Webinars: Bringing the hot topics in interventional cardiology to your home



Dejan Milasinovic

Medical Director, PCR Webinars
University Clinical Centre of Serbia - Belgrade, Serbia

According to Medical Director of PCR Webinars, Dejan Milasinovic, two novel additions to the platform will increase the interactive experience and take webinar-based learning to a new level.

“PCR Webinars are all about providing insights into the current trends of interventional cardiology practice and creating a forum for peer-to-peer discussions on future directions, all in a free and easy way, accessible by all companions, at any time. Indeed, the first part of the year was dedicated

to several webinars on drug-coated balloons (DCBs). In line with the growing interest of the community, the webinars serve as a platform for exchanging experiences about the increased use of this technology in daily practice. Following the central PCR motto of “by and for”, our webinars are produced by peers from around the world, sharing their local practice and thoughts with the worldwide community. As the year progresses, we will see more webinars on this topic, focusing on specific issues, such as lesion preparation and post-DCB result assessment.

We are also excited to welcome two new formats to the family of PCR digital education, which we think will bring us closer to the goal of providing a continuous overview and debate around the hot topics in interventional cardiology in the digital space. The first new format is the LIVE Debate in which an important interventional cardiology

issue is debated between two key opinion leaders. This format has been developed against the backdrop of *EuroIntervention* debate articles, which crystallise a pertinent juncture point in our understanding of a particular topic in interventional cardiology. With the LIVE Debate we create an opportunity to actively participate and take sides. We were thrilled with the reaction to the first of these, entitled ‘Bioresorbable scaffolds - back to the future? Pros and Cons debated by Andreas Baumbach and Manel Sabate, with Emanuele Barbato in the role of coordinator, which complemented a similarly titled *EuroIntervention* article published last year.¹

Another addition to our digital family is PCR Heart-to-Heart Conversations. In this series, we invite leading members of the interventional cardiology community to share their thoughts on the hottest topics of the day. Want the most relevant information in a

short and concise format that you can listen to in the car or between cases in the cathlab? Stay tuned as the first editions – TAVI in low-risk patients with Moritz Seiffert and complete revascularisation for STEMI with Valeria Paradies – will be released soon after EuroPCR!

Finally, I would like to encourage interventionalists to have their say in helping us to maximise the learning experience of PCR Webinars. Only by listening to your feedback can we build a better post-graduate education platform for interventional cardiovascular medicine. And it’s easy to do – simply go to the online survey and tell us what you think!”

Discover upcoming webinars and explore our entire Replay library here:

1. Stone GW, et al. *EuroIntervention*. 2023;19:199–202.



Transcatheter tricuspid valve interventions – what’s new?



Fabien Praz

Interventional cardiologist / Cardiologist
Bern University Hospital, University of Bern - Bern, Switzerland

The PCR Tricuspid Focus Group promotes awareness, education and research in the fast-moving field of tricuspid regurgitation (TR). Find out more about the group’s activities and its widening reach.

Treatment options for TR have increased over the last year, with two new approvals in Europe and the USA: a tricuspid transcatheter edge-to-edge repair device (TriClip), following the demonstration of improved quality of life,¹ and a device for tricuspid valve replacement (EVOQUE). “These are important steps forward but the goals of the PCR Tricuspid Focus Group – to raise awareness of TR and standardise its treatment – are still very relevant and our work continues,” explains founding member, Fabien Praz.

This morning, the PCR Tricuspid Focus Group will lead a case-based session entitled ‘Patient management before, during, and after transcatheter tricuspid valve replacement,’ which will



put the latest treatment developments into context. “This session will help participants understand that it’s not just a case of replacing or repairing a valve,” says Professor Praz. “We have to consider the management of the patient as a whole in order to get the best possible outcomes. For example, we need to understand the underlying anatomy beforehand and optimise the counteraction of fluid overload with diuretics, then after the procedure, there is the need for an individualised antithrombotic regimen and/or the monitoring of any conduction disorders.”

The increasingly frequent clinical entity cardiac implantable electronic device-related TR is the focus of a recent publication by the group.² This multidisciplinary review article – developed by electrophysiologists, interventional cardiologists, imaging specialists and cardiac surgeons – aims to give an overview on diagnosis, preventive strategies and treatment algorithms. Some of the authors

will be involved in a ‘How Should I Treat?’ session this afternoon entitled ‘Pacemaker lead and the tricuspid valve: navigating challenges for optimal care.’ “About one-third of patients undergoing tricuspid procedures has a pacemaker lead in place, which can be challenging if you are not equipped to deal with it,” explains Professor Praz. This interactive case-based practical session, organised jointly with electrophysiologists, will discuss different aspects, including how to determine whether a pacemaker lead is causing TR or is just a bystander, and lead implant/explant techniques.

Explaining more about their activities, Professor Praz describes how heightened interest has led the group to expand in size and in geographical area. “We have set up new regional chapters,” he comments, “And an increasing number of referral meetings are taking place, where expertise accumulated by core group members is disseminated with standardised messages and educational content.” He also draws attention to another recent publication from the group, which highlights the under recognised condition of atrial secondary TR (A-STR).³ Characterised by dilation of the right atrium and normal right and left ventricular function, A-STR often occurs in elderly women with atrial fibrillation and is associated with heart failure with preserved ejection

fraction. “We have developed an expert opinion document that describes the pathophysiology, diagnosis, outcomes and management of A-STR as a distinct phenotype and partnering with the Tricuspid Valve Academic Research Consortium we have proposed a new standard disease definition. We hope our work on A-STR will help better differentiate between patients with different care pathways and prognosis, and support future research to identify optimal management strategies.”

Want to learn more about the group’s activities and referral meetings near you?



1. Sorajja P, et al. *N Engl J Med*. 2023;388:1833–1842.
2. Andreas M, et al. *Eur Heart J*. 2024;45:346–365.
3. Muraru D, et al. *Eur Heart J*. 2024;45:895–911.

DON'T MISS

Patient management before, during, and after transcatheter tricuspid valve replacement
Thursday, Room 252A, 08:30 – 10:00

Pacemaker lead and the tricuspid valve: navigating challenges for optimal care
Thursday, Room 252A, 14:45 – 16:15



How ViTAL makes the learning experience at PCR so unique

A story of the continuous improvement of education at PCR

ViTAL, our training and assessment programme, is one of the modus operandi behind the practical, relevant and immersive educational experience that participants enjoy at PCR Courses. The original ViTAL Training is now being further enhanced by the other face of the coin – ViTAL Assessment. How did it all start? What does this new initiative involve? Learn more about the great energy that goes into building your Courses!

Back to the origins

ViTAL was launched 15 years ago by Professor Jean Marco, the renowned pioneer who is also behind the genesis of EuroPCR in the 80s. The term ViTAL stands for Visionary Transformative Adult Learning. This reflects the Professor's certitude that medical advancement lies in the effective transmission of patient-centred knowledge and experience between peers.

Accordingly, the aim is that, besides the intrinsic relevance of their medical content, PCR sessions are designed following adult learning principles. The teaching (called facilitation at PCR) is dynamic, collegial and highly interactive – enabling participants to play an active role, share their experience, and express questions and doubts.

ViTAL Training

The first face of the coin provides continuous training for the facilitators and speakers who are involved in building and delivering PCR sessions. This consists of 3 pillars:

- ViTAL Focus: a series of face-to-face seminars organised in advance of PCR Courses. They provide guidance on how to design and run the associated PCR sessions.

- ViTAL Library: an online platform with 70+ video modules and tutorials. They cover topics such as choice of course content, presentation materials, public speaking and how to run sessions. Over 1,500 physicians have already taken advantage of open access to these fundamentals of adult education, and its practical application at PCR.
- ViTAL Curriculum: a new project to enable the definition of an individual training pathway according to one's experience, needs and specific ambition in becoming an outstanding programme producer, anchorperson, spokesperson or LIVE operator. These "Top Notch" trainees may then become ViTAL trainers themselves.

Key ingredients for preparing and delivering a great session at EuroPCR

For Martine Gilard, the quality of a session can only stem from good preparation and great teamwork: "Faculty first have to identify the unmet needs of the attendees in their daily practice. Secondly, they have to define 2 or 3 clear, focused and realistic learning objectives of their session. Thirdly, they must identify key messages at the end of each section of their session. Engaging the audience in peer-to-peer discussion is also key."



When asked for examples of tips that faculty are given for preparing and delivering a session, Emanuele Barbato, who is a member and co-founder of the PCR Teaching Assessment Board (TAB) and one of PCR's most acclaimed facilitators, shared the following:

- 1: Imagine yourself as a participant in your session. What are your expectations?
- 2: Develop educational content that is entirely relevant to the daily clinical practice of your participants (leave no space for ego-tripping or showing-off)!
- 3: Establish a friendly chemistry with your facilitation team and have fun working together. If you enjoy delivering your session, the participants will enjoy it too!

ViTAL Assessment

The second face of the coin closes the loop on a virtuous circle that empowers continuous improvement in teaching and excellence in education@work.

Martine Gilard, co-chairperson of the PCR TAB, describes what the ViTAL assessment process involves. "The teaching quality is evaluated by companions and 'vitalised'* physicians directly during the sessions using an online evaluation tool. After the course, members of the PCR TAB review the evaluation results and provide constructive feedback to the delivery teams, the programme producers, the track leaders and the course directors."

EuroPCR participants learned more about how to take an active part in the continuous improvement of PCR sessions, as a PCR Evaluator, in the Companions Lounge yesterday.

Sonia Petronio, who is also an active member of the PCR TAB, sums up how the two faces of the education mantra are connected: "...ViTAL Training provides all the necessary information to build and fine tune every single session, while ViTAL Assessment summarises and focuses on the outcome, with the purpose of praising best practices and suggesting any possible improvement."

Improved teaching = improved learning

The ViTAL Assessment's overall objectives are threefold for Martine Gilard: "They are to personally help our colleagues improve their teaching skills, to incrementally increase the educational quality of the course, and finally to inform the community about the top-rated sessions made available on PCRONline."

Keen to see your vitalised* peers in action?

All Learning and LIVE Educational sessions happening at EuroPCR were fine-tuned during a ViTAL Focus seminar. Don't hesitate to take part and volunteer to provide your feedback.

*Physicians who have already successfully completed ViTAL Training



Face-to-face seminar organised in advance of EuroPCR



Building on 15 years of life-saving work



Jan J. Piek

Chair, Stent – Save a Life!

As Stent – Save a Life! celebrates its 15th anniversary, its Chairs discuss achievements to date and explain what is needed to help extend the benefits and improve the outlook for even more patients with STEMI around the world:

“From its early beginnings in Europe, Stent – Save a Life! (SSL) has expanded globally, into Asia, Africa and LATAM, such that the community now boasts more than 40 member countries. The very latest three – Bangladesh, Pakistan and Tanzania – were officially acknowledged in Monday’s signing ceremony during the SSL Annual Forum in Paris.

The success of our work over the last 15 years has hinged on our tried-and-tested hub-and-spoke model^{1,2} developed with broad applicability across low- and middle-income countries (LMIC). We have also established protocols, training materials and digital tools that make a huge difference in overcoming infrastructure deficiencies. Another key



Thomas Alexander

Chair, Stent – Save a Life!

element to our success is the support provided by committed local and regional cardiologists, along with the dedicated global team.

Pilot studies with our model are currently ongoing in Azerbaijan, Egypt and Peru and are planned for Tanzania and Uganda. We have interest in membership from additional candidate countries, including Botswana, Rwanda, Indonesia, Nepal, Oman, Vietnam and Yemen, but a major missing part of the jigsaw puzzle at this stage is funding. We wish to expand our life-saving work even further, but a lack of partnerships/ sponsorship is a key issue, despite being vital for the sustainability of the initiative and its activities. The financial input required, before pilot projects are taken forward and expanded by the national government partner, is relatively modest but additional contributions could make a huge difference in these countries where there is currently very little access to PCI. One avenue being explored in the search for new partners is collaboration with philanthropic organisations

and foundations, such as the Mission Aviation Fellowship in Uganda.

A focus of SSL in the last few years has been to try to address the substantial unmet needs of LMIC and to reduce inequity in healthcare. A session held jointly with SSL yesterday used a regional case-based approach to look at ways to tackle the considerable disparity in access to STEMI for women in LMIC, which is even greater than that documented in better-resourced countries. The extent of healthcare needs in LMIC also prompted the ongoing STEMI reperfusion survey that is being conducted in collaboration with SOLACI in LATAM countries. Discussions on other potential regional collaborations are underway with several African countries, looking at gaining insights into STEMI incidence and treatment resources, organising advocacy activities to raise awareness and developing roadmaps to enhance STEMI management.

In order to support the expansion in SSL’s candidacy demand, steps have been taken to strengthen the regional organisation by establishing a central office and by creating a Regional Ambassador, along with two Regional Champions, in Asia. Activities at congresses and courses, including SOLACI, AICT-AsiaPCR, APAC, the China Chest Pain conference, the Africa Heart Team conference, the Azerbaijan

Annual Society meeting and GulfPCR-GIM have all led to wider visibility of SSL’s efforts at a global level.

One of the most innovative ongoing initiatives is the development of the SSL Travel App, in collaboration with Cardiology Centers Netherlands, which is being designed to enable cardiac patients travelling abroad to proactively identify the nearest PCI centre should they need to find acute coronary care. The plan is to eventually also include the patient’s medical information on the app so that the local treating physician has easy access to it in an emergency situation.

The next 15 years could be even more successful for SSL, but we need sufficient funding. We welcome support from the PCR community to help us make new connections for our continued global expansion.”

1. Candiello A, et al. *EuroIntervention*. 2022;17:1313–1317.
2. Alexander T, et al. *JAMA Cardiol*. 2017;2:498–505.





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Thursday 16th May | 12:15 – 13:15 | Room 243

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Discussants:

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What's to come **TOMORROW?**

It may be the final day of EuroPCR 2024 tomorrow, but there's still much to see and do in a packed morning full of learning and sharing.

Management of PCI complications - Part 2

Friday, Room 251, 08:30 – 10:00

With facilitators, Samir Alam, Jose Luis Leiva-Pons and Rishi Sethi, this session – built on your Clinical Case submissions – promises to intrigue and educate as presenters describe occasions where PCI went wrong and what they did about it, including 'when the cutter gets caught' and when the 6F guide is stuck in the axillary artery.



**Samir
Alam**

American University of Beirut Medical Center - Beirut, Lebanon

"As we tackle increasingly complex cases in the interventional arena, complications are inevitable and are consequential. Join us for a special session where uncommon challenges are brought to focus and learn about the skills and tools that can save your patients and get you out of trouble. Entrapped burr and a stuck balloon are among the exciting cases featured in the session."

PCI of bifurcation lesions: management of complications - Part 3

Friday, Room 251, 10:30 – 12:00

Join Fazila Malik and Matthias Heigert in a submitted case-based session specifically on the management of complications during PCI of bifurcation lesions. Iatrogenic LM dissection will be discussed along with unexpected and unusual occurrences during 1,1,0 LAD diagonal bifurcation and LM DK crush.



**Fazila
Malik**

National Heart Foundation Hospital and Research Institute - Dhaka, Bangladesh

"PCI of a bifurcation lesion can be tricky, especially when the side branch is large with heavy disease burden. Indeed, complications involving the main branch or side branch are not infrequent. What should we do if the IVUS catheter gets stuck in the LM? This, as well as other iatrogenic complications, will be highlighted in tomorrow's session. Join us if you want to understand how to tackle bifurcation lesions, how to avoid complications and how to tackle them when required."

TOMORROW'S MUST-ATTEND EVENTS

EuroPCR 2024 Best Abstract and Best Clinical Case Award ceremony
Main Arena, 10:30 – 10:45

EuroPCR 2024 Closing Ceremony & PCR's Got Talent competition ceremony
Main Arena, 12:15 – 12:50

Journey to China: discovering PCR-CIT China Chengdu Valves
PCR Companions Lounge – level 2, 10:00 – 10:30

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Enjoy access to the revised and updated **PCR Trials Book**

This 2024 edition again consists of a compilation of concise one-page summaries of published randomised trials in the field of interventional cardiology.

Each one has a clinical outcome as a primary endpoint and has been published within the last 5 years in one of 11 high-ranking medical journals: the *New England Journal of Medicine*, *Lancet*, *JAMA*, *BMJ*, *European Heart Journal*, *Journal of the American College of Cardiology*, *Circulation*, *JAMA Cardiology*, *JACC Cardiovascular Interventions*, *Circulation Cardiovascular Interventions* and *EuroIntervention*.

- The latest update to the book includes nine new clinical trials:
- Transcatheter or surgical treatment of aortic-valve stenosis - **DEDICATE-DZHK6**
 - FFR-guided complete or culprit-only PCI in patients with myocardial Infarction - **FULL REVASC**
 - Coronary sinus reducer for the treatment of refractory angina - **ORBITA-COSMIC**
 - 1 month vs. 12-month DAPT in ACS - **ULTIMATE DAPT**
 - Self-expanding or balloon expandable TAVR in small aortic annuli - **SMART**
 - Alcohol-mediated renal denervation effects on blood pressure - **TARGET BP I**
 - IVUS vs. angiography guided PCI in ACS - **IVUS-ACS**
 - Microaxial flow pump in infarct related cardiogenic shock - **DANGER SHOCK**
 - Preventive PCI vs. optimal medical therapy alone for vulnerable atherosclerotic plaques - **PREVENT**



The PCR Trials Book is a valuable tool for the busy cardiologist as a quick reference to support evidence-based clinical decision-making. You're invited to pick up your copy on the racks or browse the educational content on PCRONLINE.COM.



Satellite Symposium:

Why mechanical thrombectomy should be considered in the management of acute pulmonary embolism

Thursday 16th May | 13:30–14:30 | Room 251

Join us for an expert discussion on:

- Latest insights in acute Pulmonary Embolism management
- Patient selection and risk stratification for High and Intermediate-High Risk PE
- Establishing Pulmonary Embolism pathways in local centers
- Exploring mechanical thrombectomy in PE through case studies



Prof Thomas Cuisset

La Timone Hospital
in Marseille,
France



Dr Pablo Salinas

Hospital Clínico
San Carlos, Madrid,
Spain



Prof Irene Lang

Medical University
of Vienna,
Austria



Dr Gregor Leibundgut

University Hospital
of Basel,
Switzerland



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Learn about Gen AI in the PCR Companions Lounge today

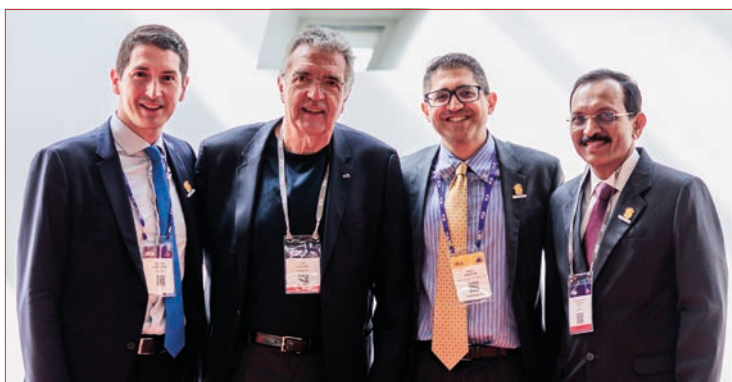
A workshop in the PCR Companions Lounge yesterday discussed Gen AI – technology that over the last few years has provided a new way to create original content, such as text, images and video, in response to users' prompts. Louis-Marie Desroche and Gregori Despeaux provided some tips on how to get the most out of Gen AI, such as providing context and being comprehensive and specific with instructions. And what are the risks? Privacy can be an issue and anonymising everything shared with Gen AI is essential.

Generating summaries, slide sets, patient resources and social media posts were just some of the examples given for how Gen AI can streamline your daily tasks.

Want to try Gen AI? *EuroIntervention* launched its AI-powered guide, *Cory*, in February as a premium feature for subscribers. In the language of your choice, it can summarise journal information – from high-level overviews to lay text for patients – and answer your questions in just a few clicks!

If you missed yesterday's Gen AI discussion, you can pop in this afternoon and debate the pros and cons with your colleagues.

Here's what Bettina Csanádi and Naomi Bora (Hungary) had to say yesterday: "This workshop was really useful in terms of showing us how Gen AI can support what we do. For example, giving us prompts to help create patient materials. We can use it to our advantage to speed up how we can develop a protocol rather than creating something from the beginning. Of course you have to check everything, but it helps to have a starting point. It is quite exciting!"



Celebrating the first Top Companions

Yesterday, Kyriakos Dimitriadis (Greece), Chandrashekhar Patil (India) and Arash Hashemi (Iran) met with PCR Vice-Chairman and EuroPCR Course Director, Jean Fajadet, to celebrate earning 100 PCR Companion points and becoming the first Top Companions. They were congratulated on their achievement and valuable contribution to the advancement of education in interventional cardiology.

It's happening today! PCR Companions Lounge – level 2

Thursday

10:10-10:30 Strengthening Cardiovascular Care Resilience: the RESIL-Card Project

14:30-14:50 Journey to Asia Pacific: discovering AICT-AsiaPCR

16:15-16:45 Gen AI: rewards and risks for healthcare professionals

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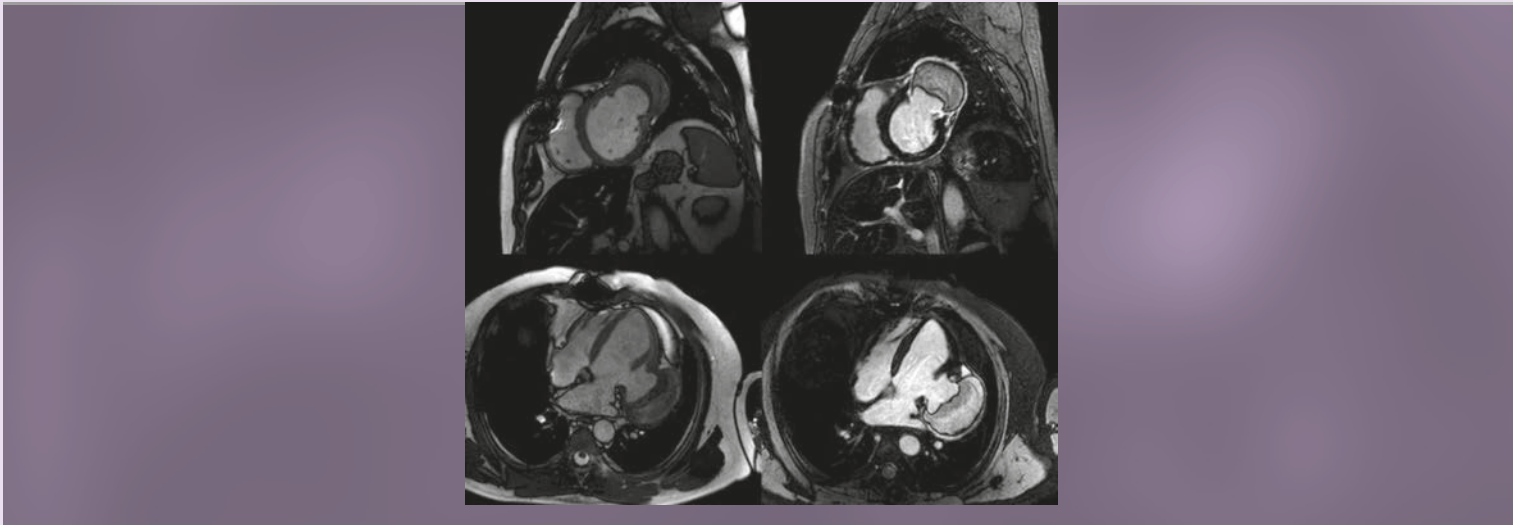
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PCR



AN IMAGE IS WORTH A 1,000 WORDS



Today's case:
A walking imminent disaster

A 48-year-old male presented late with an NSTEMI. He was found to have 3 vessel diseases and underwent triple coronary artery bypass. One year later, he presented with worsening exertional dyspnoea. A cardiac magnetic resonance was performed.

What do you see in this image?

- A. Post-infarct aneurysmatic dilation of the left ventricular anterolateral wall
- B. Left ventricular anterolateral wall contained rupture with pseudoaneurysm formation
- C. Giant pericardial mass infiltrating the anterolateral wall of the left ventricle

DON'T MISS

Imaging Learning Centre sessions today
in Simulation Learning Room 1 (Ternes)

Transcatheter aortic valve implantation
- ALL the answers are on the S-curve!
08:30 – 10:00

Mastering transseptal puncture
- New perspectives using
multi-modality imaging
10:30 – 12:00

Multimodality imaging for
transcatheter mitral valve interventions
- Anatomy and pre-procedural planning
14:45 – 16:15

Multimodality imaging for transcatheter
tricuspid valve interventions
16:30 – 18:00

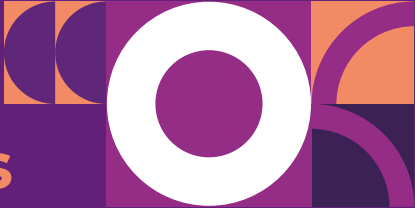
Answer: B
CMR revealed a dyskinetic (7 x 6 cm) anterolateral pseudoaneurysm filled with thrombus, with myocardial wall transmural necrosis and LGE of the outer layer – a late consequence of the past MI.

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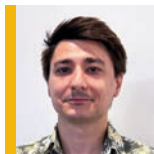


Save the date
for **PCR London Valves**
24-26 November 2024



FACES IN THE CROWD

What are you enjoying most at EuroPCR 2024?



**Sorin
Popescu**

There is so much to choose from at EuroPCR, but being able to replay sessions helps to make sure that I can watch everything I missed. My special interest is in STEMI and I am enjoying all the different types of sessions and learning about new devices. I come from a relatively small hospital in Austria, so it's great to hear about devices that I don't currently use and more information about how they compare is valuable.



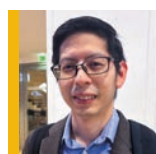
**Lotte van den Broek &
Mechelina Meeuwse**

The programme is very varied. The LIVE cases are very interesting to watch and the focus on imaging is valuable as this is an area we are really keen to learn more about. The sessions on complications have been interesting – we are involved with a range of different procedures and it is important that we can anticipate any problems and be ready for them. And there is always something to learn in the dedicated NAPs sessions.



**Aaysha
Cader**

EuroPCR 2024 is fantastic – I am loving the energy, particularly in the big rooms. It is my first time as a PCR NextGen facilitator and the interactive sessions are a really great experience. I think the Catchbox in the learning sessions is fun, is an excellent icebreaker and makes audience interaction so much better! In the middle of the packed schedule though, EuroPCR is also an opportunity to network with peers from around the globe, to make new friends, and to catch up with old friends and mentors. Plus the guest lounge is great!



**Danon
Kaewkes**

I enjoyed the LIVE cases and also the Clinical Case Corners – there's a really wide variety. I am interested in valvular heart disease and with so many sessions to choose from, it's difficult to pick which ones to go to. I am looking forward to attending as many sessions on valvular disease as I can today and also a joint international session this afternoon. I have been to EuroPCR many times – I love the Course!

WATCH REPLAY

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#EuroPCR





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