**IRIS-MAIN Registry: Assessing Generalizability of EXCEL and NOBLE**

Dr. Pil Hyung Lee will present the results of a study that uses large-scaled IRIS-MAIN registry to assess the generalizability of the findings from recent EXCEL and NOBLE trials. These two important left main trials showed somewhat similar but also opposing comparative results of PCI and CABG. EXCEL found PCI to be comparable to CABG, while NOBLE suggested CABG to be still better than PCI. With this background, the investigators intended to compare baseline clinical and procedural characteristics of patients who were enrolled in EXCEL and NOBLE with those of patients who were enrolled in unrestricted, "all-comers" IRIS-MAIN registry, as well as to compare the relative treatment effect of PCI and CABG in EXCEL and NOBLE with the results from the real-world registry.

There were between-study differences in patient risk profiles (age, body-mass index, diabetes, and clinical presentation), lesion complexities, and procedural characteristics (stent type, the use of off-pump surgery and radial artery); the proportion of diabetes and acute coronary syndrome was particularly lower in NOBLE than in other studies. With respect to serious composite outcome (death, MI, or stroke), the risks were similar between PCI and CABG in EXCEL (HR, 1.00; 95% CI, 0.79–1.26; p=0.98) and in matched cohort of IRIS-MAIN (HR, 1.08; 95% CI, 0.85–1.38, p=0.53), while it was significantly higher after PCI than after CABG in NOBLE (HR, 1.47; 95% CI, 1.06–2.05, p=0.02), which was driven by more common MI and stroke after PCI (Figure 1).

Although several issues of EXCEL and NOBLE trials exist, it appears that the baseline characteristics and results are relatively similar in EXCEL and in this large registry, and, therefore, EXCEL is more generalizable than NOBLE in terms of inclusion and outcomes.

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**Figure 1.**

Continued on page 4.
Program at a Glance: Thursday, April 27, 2017

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Live Case Transmission from World-Renowned Medical Centers

Asan Medical Center, Seoul, Korea
- 08:30 AM ~ 10:00 AM @ Coronary Theater, Level 1
- Operator(s): Jung-Min Ahn
- Echo Interpreter: Jung-Min Ahn
- IVUS Interpreter: Jung-Min Ahn

Severance Hospital, Seoul, Korea
- 10:00 AM ~ 11:20 AM @ Coronary Theater, Level 1
- Operator(s): Myeong-Ki Hong, Byeong-Keuk Kim, Yongsung Suh
- IVUS Interpreter: Jung-Min Ahn

St. Paul Hospital, Vancouver, Canada
- 08:30 AM ~ 10:00 AM @ Valve Theater, Level 1
- Operator(s): John Graydon Webb, David Wood

EMO Centro Cuore Columbus, San Raffaele Hospital, Italy
- 03:30 PM ~ 04:30 PM @ Coronary Theater, Level 1
- Operator(s): Antonio Colombo, Azeem Latib, Matteo Montorfano

Graziano Hospital, Verona, Italy
- 04:30 PM ~ 05:30 PM @ General Theater, Level 1
- Operator(s): Graziano Hospital, Verona, Italy

Korea Medical Center, Seoul, Korea
- 03:30 PM ~ 04:30 PM @ General Theater, Level 1
- Operator(s): Graziano Hospital, Verona, Italy

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2017 New Data from AMC; Novel and More

Asan-MV Registry: Confusing MI Definition in Comparing PCI and CABG

Next, Dr. Min Soo Cho will present the results of Asan-MV Registry to assess the incidence and clinical impact of peri-procedural MI according to different definitions of MI. Until recently, the definition of MI was mostly different in recent landmark clinical trials comparing PCI with CABG, and the novel definitions could lead to an imprecise estimate of the overall treatment effect. This work was also highlighted in the EXCEL and NOBLE trials, since the different results of two left main trials were partly attributed to the different definition of MI used by protocol. The investigators evaluated 7,697 patients with multivessel disease who received PCI (n=3,183) or CABG (n=4,514) between January 2003 and December 2013, and for whom follow-up information was complete. Patients were followed for major cardiovascular events (death from cardiovascular causes and spontaneous or PCI-mediated MI) and death for a median of 4.7 years. They found that, according to different MI definitions, MI had a different occurrence and clinical impact. The risk-adjusted relative risks for MI after PCI compared with CABG with different MI definitions were 1.18 (vs. 1.29, p=0.02 vs. second definition), 1.74 (vs. 2.01, p=0.00 vs. third definition), and 1.91 (vs. 2.01, p=0.00 vs. third definition) with Multivessel Index. Based on this study, it can be concluded that PCI and CABG are associated with different rates of MI, with PCI associated with better clinical outcomes, and medical treatment would be a safe and reasonable strategy.

How To Manage Gray Zone FFR: Data from IRIS Registry

Finally, Dr. Seung-Jung Park will present the results of a prospective, multicenter IRIS registry to determine the best strategy for PCI and CABG in patients with gray zone FFR, a condition where FFR is not associated with better clinical outcomes, and medical treatment would be a safe and reasonable strategy.

DECISION-CTO: Treat or Not Treat CTO

Dr. Min Soo Cho will present the results of DECISION-CTO clinical trial involving patients with coronary CTO. The primary endpoint was a composite of death, cardiac death, spontaneous MI, and the composite of death and spontaneous MI also did not differ between groups, while the rate of the event of MI (only including peri-procedural MI) was higher (HR: 0.79, 95% CI: 0.65-0.95, p=0.016) and target vessel revascularization was higher (6.7% vs. 4.8%, p=0.03). However, the periprocedural MI rate did not meet the predefined criterion for non-inferiority (estimated event rate ratio, 0.88; one-sided 97.5% confidence limit, 0.75-1.05; p=0.024). From first-generation DES, the rates of MI with CABG (n=3,183) between January 2003 and December 2013, and for whom follow-up information was complete. Patients were followed for major cardiovascular events (death from cardiovascular causes and spontaneous or PCI-mediated MI) and death for a median of 4.7 years. They found that, according to different MI definitions, MI had a different occurrence and clinical impact. The risk-adjusted relative risks for MI after PCI compared with CABG with different MI definitions were 1.18 (vs. 1.29, p=0.02 vs. second definition), 1.74 (vs. 2.01, p=0.00 vs. third definition), and 1.91 (vs. 2.01, p=0.00 vs. third definition) with Multivessel Index. Based on this study, it can be concluded that PCI and CABG are associated with different rates of MI, with PCI associated with better clinical outcomes, and medical treatment would be a safe and reasonable strategy.

2017 Late Breaking Clinical Trials

Early Clinical Outcomes Following “Off-” Versus “On-label” Indications of Bioresorbable Vascular Scaffolds for the Treatment of 1-Year Patients’ Incomplete Clinical Outcomes. Results from the Prospective “Registro Absorb Italiano” (RAI) Registry

Dr. Alfonso Ielasi (Bologna Hospital, Senate, Italy) will present the results of the prospective “Registro Absorb Italiano” (RAI) Registry. In the RAI (Clinical Trials) Gov Identifier NCT02394943 is an Italian, prospective multicentre registry, not funded by the manufacturer, which was established to investigate the clinical performance through a 3-year follow-up of all consecutive patients who have undergone the implantation of 1 or more BVS in different lesions subsets. Co-primary endpoints included angiographic (TVF) failure and TVF (defined as death, MI, or target lesion revascularization). The Registry started in October 2012 and the last patient was enrolled in December 2015. Dr. Ielasi will present interesting data about off-label using of BVS in real-world practice from the RAI Registry. The purpose of the early clinical outcomes following “off-” versus “on-label” indications of BVS was to evaluate the 30 day-clinical outcome, following BVS (Absorb BVS) Abbott Vascular, Santa Clara, CA, implantation in patients with complex lesions. BVS appears to be an attractive alternative to metallic DES and has rapidly extended its off-label usage (Figure 2). However, recent studies have reported the risk of scaffold thrombosis, which might be related to procedural factors, as well as patients’ characteristics. After hearing today’s presentation, we wonder if the audience will be able to use the off-label strategy of BVS in complex coronary anatomy.

A Hybrid Strategy with Bioresorbable Vascular Scaffolds

Breaking Trials session at TCTAP 2017, the 22nd annual cardiovascular summit TCTAP meeting, sponsored by DSVF and held April 25-27th, 2017 at Cox Convention Center in Seoul, South Korea. The trial should have showed the result of revascularization with the first generation drug eluting stents (DES). Later the second generation DES relieved the late or very late stent thrombosis of the first generation by developing biocompatible or biodegradable polymers and thinner struts. Despite these improvements, restenosis and late loss remain persistent issues. BVS, because of their unique design and material properties, may offer a solution. However, the optimal strategy in the treatment of diffuse disease has been more simplified, and need to discuss how to reduce the rate of clinical events with evaluation of procedural technique and selection of device. Today, the Late-Breaking Clinical Trial session will focus on the results of the IRIS-DES Registry Temporal Trend of Bifurcation Treatment and outcomes. The registry started in October 2012 and the last patient was enrolled in December 2015. Dr. Ielasi will present interesting data about off-label using of BVS in real-world practice from the RAI Registry. The purpose of the early clinical outcomes following “off-” versus “on-label” indications of BVS was to evaluate the 30 day-clinical outcome, following BVS (Absorb BVS) Abbott Vascular, Santa Clara, CA, implantation in patients with complex lesions. BVS appears to be an attractive alternative to metallic DES and has rapidly extended its off-label usage (Figure 2). However, recent studies have reported the risk of scaffold thrombosis, which might be related to procedural factors, as well as patients’ characteristics. After hearing today’s presentation, we wonder if the audience will be able to use the off-label strategy of BVS in complex coronary anatomy.
The second presentation of Dr. Ielasi will be "A Hybrid Strategy with Bioresorbable Vascular Scaffolds and Drug Eluting Stents for Treating Complex Coronary Lesions". Although interventional cardiologists widely use BVS for various coronary lesions, they still find it difficult to use because of its structural limitations or problems of the vessel itself. In this situation, the physicians could choose a hybrid approach that allows DES and BVS to operate on the appropriate lesions. Dr. Ielasi and investigators studied the feasibility and results following the use of a hybrid approach using BVS (Absorb BVS, Abbott, Abbott Vascular, Santa Clara, CA) and DES for the treatment of complex coronary artery lesions (Figure 3). This study was a retrospective multicenter cohort study. The primary endpoint was target lesion failure (TLF) defined as a composite of cardiac death, target- vessel myocardial infarction (MI), and TLR at 12 months. The audience will have the opportunity to discuss how to overcome diffuse long lesions with different vessel size and side branch lesion, as well as the results after using the hybrid approach with BVS and DES.

30-day Clinical Outcomes Following Bioresorbable Vascular Scaffolding Implantation in Patients Presenting with Acute Coronary Syndromes Versus Stable Coronary Artery Disease: Results from the Italian RAI Registry

Dr. Moscarella will present the 30-day clinical outcomes following BVS implantation in acute coronary syndrome (ACS) versus stable coronary artery disease from the RAI registry. ACS has shown to increase the risk of DES thrombosis and, to date, data on percutaneous coronary intervention with BVS implantation in patients presenting with ACS are still limited. BVS would be a more attractive choice in ACS because the patients are generally younger with a longer life expectancy, and have soft plaque to expand the BVS. However, the use of BVS in ACS could be dangerous because of higher pro-thrombotic state and larger strut of BVS compared with DES. We need to pay attention to the frequency of using vascular imaging and potential antithrombotic agent like glycoprotein IIb/IIIa inhibitors in the RAI registry.

First-in-human Evaluation of a Novel Poly-L-lactide Based Sirolimus-eluting Bioresorbable Vascular Scaffold for the Treatment of De Novo Native Coronary Artery Lesions: MeRes-1 Trial

Dr. Adirsh Seth (Fortis Escorts Heart Institute, India) will present data from the MeRes-1 trial. The MeRes-1 is a prospective, multicenter, first-in-human trial of MeRes-100 Sirolimus-eluting bioresorbable vascular scaffolds (BRS) (MeRes-100, MeRes, Vapi, India, Figure 6), which evaluated BRS as the solution to overcome the limitations of DES, which interfere with the restoration of vasomotion and restrict quality lesion imaging during repeat surgical or percutaneous treatment. The primary endpoint was major adverse cardiac events (MACE) at six months, defined as a composite of cardiac death, myocardial infarction, and ischemia driven-target vessel revascularization (TVR). The secondary endpoints were MACE, scaffold thrombosis (ST), in-scaffold late loss (LLL), and device-related serious adverse events at all follow-up visits. Clinical follow-ups were scheduled at 1, 6, 12, 24, and 36 months. Angiographic, OCT and IVUS follow-ups were scheduled at 6 and 24 months. Today’s new BRS has a low profile delivery system with thinner struts (100 μm) and three radiopaque markers at each end. We can see the results of the first step among several studies that will be conducted in the future (Figure 7). We hope that the new BRS can successfully remain in the hands of physicians through these future trials. The BRS has shown the possibility to repair coronary artery. However, recent large trials raised concerns about the safety and efficacy. The investigators should conduct well-designed research for development of the next generation of BRS, and physicians should pay attention to select suitable lesion for treating with BRS. So far, we have had a rapid evolution of the DES, and the next BRS with further development would replace the position of the DES.
A 71-year-old female was admitted for effort-induced chest pain 1 year ago. Thallium SPECT findings showed normal-gated myocardial perfusion. Coronary sottonography was performed, which revealed very tight stenosis at the left main coronary ostium and diffuse stenosis at the mid LAD. A 7F catheter was inserted through the right femoral artery. To prevent damage to the LM ostium, we first passed a wire through the LCX near the LM ostium. The left coronary ostium was engaged with a 7F 5.5 guiding catheter according to LCX wire. After 0.014 inch BMW wires were inserted into the LAD and LCX, we tried to pass IVUS. But the IVUS failed to enter the LM due to severe calcification. After the LM was predilated with Penetta LEO 3.0x15 mm, we could pass the IVUS. IVUS findings show severe stenosis with heavy calcification at the LM ostium (IVUS 6.0 mm, 90% stenosis). Xenoreal 12 mm was then implanted at the LM ostium and Sapphire NC 5.0x10 mm was 24 atm. Fin lavulon and angioplasty showed a good result with a well-expanded stent. After the PCI at the LM, we measured an FVP value in the mid LM, and the FVP value was 0.79 (gray zone) during maximal hyperemia. We decided to defer PCI for the mid LAD lesion.

Evolut R 29 mm valve was introduced without intubation to pass the narrow femoral artery. Under fluoroscopy control, a 29-mm Evolut R prosthesis was placed at the best position of the aortic annulus, and was successfully deployed. After valve implantation, fluoroscopy showed well-positioned Evolut R valve without significant AR. After the intervention, puncture site was sutured with single Proglide.

### Morning Roundtable Forum: BRS and DES

**BRS & DES**

**What is the optimal duration of DAPT after PCI with DES?**

**Dual antiplatelet therapy is recommended after coronary intervention to prevent thrombotic complications and to benefit from the benefits of prolonged DAPT.** The Dual Antiplatelet Therapy (DAPT) study was the largest interventional study conducted to determine the benefits and risks of continuing dual antiplatelet therapy beyond 1 year after the placement of a coronary stent.

- **Patients**: Enrolled 72 hours after stent placement and were given aspirin and clopidogrel for 12 months. Without an ischemic or bleeding complication and with documented compliance were randomized in a 1:1 fashion to receive additional 18 months of DAPT or matching placebo. A total of 9,961 patients were randomized at 452 sites in 11 countries: 1,020 to prolonged DAPT and 4,941 to placebo. Approximately two thirds of the patients received clopidogrel, whereas the rest received prasugrel.

- **Primary endpoint**: For major adverse cardiac and cerebrovascular events (MACCE) was significantly lower in the continued DAPT arm compared with placebo (4.3% vs. 5.0%, p=0.03).

- **Secondary endpoints**: Cerebrovascular events (0.62% vs. 0.21%, p=0.03), death (1.7% vs. 2.2%, p=0.02), and all-cause mortality (1.8% vs. 2.2%, p=0.05) were significantly lower in the DAPT arm compared with placebo (1.4% vs. 1.7%, p=0.05); driven mostly by an increase in non-cardiovascular deaths (1.7% vs. 1.9%, p=0.02) and bleeding-related deaths (0.2% vs. 0.3%, p=0.02). Compared with placebo, moderate and severe bleeding was also higher with DAPT (2.5% vs. 1.6%, p<0.001), as was BMS 3, 5, and bleeding (5.6% vs. 2.9%, p<0.001).

- **DAPT Score**: The DAPT score is a useful tool for individualizing decisions regarding dual antiplatelet duration in patients post-PCI, but it will need further validation.

### Impact of implantation Technique on Clinical Outcomes

**Figure 3. Impact of Implantation Technique on Clinical Outcomes**

- **BRS III was a multicenter, long-term, randomized controlled clinical trial. After successful predilatation, patients were randomly assigned in a 2:1 ratio to receive one of the two devices (the Absorb everolimus-eluting bioresorbable scaffold or the Xience everolimus-eluting cobalt– chromium stent).** The trial had randomization of 2008 patients with stable or unstable angina and up to two lesions in separate coronary arteries to receive either the Absorb BVS (n=1,322) or Xience (n=686). One year results from the ABSORB III trial in China showed bicuspid aortic valve (AV) and severe aortic stenosis with normal systolic function, without need for a follow-up and 293 patients with AV fraction (TEOahir) Aortic valve area by continuity equation was 0.56 cm². Maximal transvalvular flow velocity was 4.2 m/s. Mean and peak pressure gradients were 42 and 6.0 mmHg, respectively. The STS score was 9.67%, and EuroSCORE 3 was 4.60%. Annulus size on the CT was about 24 mm, and perimeter was 77 mm. Distance from annulus to LM and RCA ostium were 11 mm and 18 mm, respectively. The lowest diameter of the final stent was 5.0 mm. After discussion, we decided to implant the 20 mm Medtronic Evolut R heart valve. Under general anesthesia, 6F sheath and temporary pacemaker were inserted through the left femoral vein and 7F sheath and 6F pig-tail catheter were inserted through the left femoral artery. 8F sheath was inserted through the right femoral artery, and the right femoral artery was dilated with an 18 mm balloon. A diagnostic catheter with a 0.035 inch stiff wire was used to cross the aortic valve and pre-balloonning was performed with the 18 mm-size balloon. Then, the DES results in lower rates of ischemic events compared with the 12-month duration of DAPT, although bleeding and all-cause mortality were higher with prolonged therapy. Based upon current investigations including the DAPT trial, the optimal duration of DAPT could be summarized as the following.

1. **For most patients undergoing PCI with current-generation DES, 6-12 months of DAPT represents a reasonable balance between safety and efficacy.** For selected patients, at very high risk of bleeding, shorter durations of DAPT (3-6 months) are likely sufficient. For patients who present with ACS and have additional risk factors for adverse events, longer-term therapy (>2 years) should be strongly considered as long as bleeding risk is not excessive. Finally, the DAPT score may be a useful tool for individualizing decisions regarding dual antiplatelet duration in patients post-PCI, but it will need further validation.
Orsiro
Robust clinical program with 45,000+ patients*

*Bioresorbable scaffolds were developed to overcome some of the drawbacks of metallic stents in that they gradually degrade in the body over time and leave no residual implant. Up to now, the majority of data including large randomized trials and patient-level, pooled meta-analyses assessing 1-year clinical outcomes had demonstrated promising results. However, with the advent of Orsiro, the clinical outcomes and data on Orsiro were collected as of January 2017.

TCTAP 2017 Wrap-up Interview: Bioresorbable Vascular Scaffolds: Current Status & Future Perspectives

Moderators: David J. Cohen
Interviewees: Ashok Seth, Alan C. Yeung

Bioresorbable scaffolds have been shown to have a lower risk of target lesion failure (TLF) compared to metallic stents. However, the long-term clinical outcomes for these devices are still uncertain. In the present study, the 5-year clinical outcomes of Orsiro were assessed in a large clinical trial, and compared to Resolute Integrity, a metallic stent.

The 5-year clinical outcomes of Orsiro were presented at TCTAP 2017, and compared to Resolute Integrity, a metallic stent. The study showed that the rate of target lesion failure was significantly lower in the Orsiro group compared to the Resolute Integrity group. The rate of scaffold thrombosis was also significantly lower in the Orsiro group compared to the Resolute Integrity group. The rates of stent thrombosis, target vessel-related myocardial infarction, and clinically indicated target lesion revascularization were also lower in the Orsiro group compared to the Resolute Integrity group.

The study also showed that the rate of scaffold thrombosis was significantly lower in the Orsiro group compared to the Resolute Integrity group. The rates of stent thrombosis, target vessel-related myocardial infarction, and clinically indicated target lesion revascularization were also lower in the Orsiro group compared to the Resolute Integrity group.

In conclusion, the 5-year clinical outcomes of Orsiro were promising, showing a lower risk of target lesion failure compared to Resolute Integrity, a metallic stent. Further studies are needed to assess the long-term clinical outcomes of Orsiro.

Dr. Eberhard Grube was born in Hamburg, Germany in 1944. After graduation from the Rheinisch-Freiherr University in Bonn, Germany, he started his career as a Registrar in University Hospital Bonn from 1976 until 1981. Over the past decade, Dr. Grube has taken lead in the initial clinical testing of drug-eluting devices, percutaneous closure devices, new catheterization techniques, catherized valve surgery, and treatment of vulnerable plaque. He has been well known as an early investigator in the field of TAVR, his study for improving the performance of TAVR devices and developing new treatment for valvular heart disease laid the groundwork for future development. In recognition of his outstanding achievement, he received a Goff Muller Master Clinical Operator Award at the transcatheter cardiovascular Therapeutics (TCT) scientific symposium sponsored by the Cardiovascular Research Foundation (CRF) in 2009. Dr. Martin Bert Leon, who is his friend and the 2nd recipient of TCTAP Award "Master of the Masters", said, "He is truly an unique individual with an intuitive understanding of how devices work, how they can be applied for specific new clinical applications and has both the technical skills and the cognitive understanding to be able to make the connection so that we can begin the complex process of innovative new devices development". As a wise teacher and leader, his effort to contribute to the medical advance and the growth of next generation in interventional cardiology continues even now.
First Human Cases of New Self-expandable Percutaneous Pulmonary Valve Implantation Using Knitted Nitinol-wire Stent Mounted on a Trileaflet Porcine Pericardial Valve

Severe pulmonary regurgitation (PVR) and associated right ventricular (RV) failure (RVF) are hallmarks of congenital heart disease with pulmonary valve disease. In these patients, medical, percutaneous, and surgical therapies are challenging and still being studied in clinical trials. Today, Dr. Geon Bok Kim (from Seoul National University Childrens Hospital, Korea) reported the first human cases of new self-expandable percutaneous pulmonary valve implantation (PPVI) using newly made technique. A 75 years-old man was stent mounted with triflaflet porcine pericardial valve developed in South Korea. He reviewed 10 cases of new self-expandable PPVI at the Seoul National University Childrens Hospital. The self-expandable, valved stent was not developed by his research team with the cooperation of the Taewoong Medical Co., Ltd. in South Korea. This stented wire was made by knitted nitinol-wire backbones with wire-vane using porcine pericardium, with multiple steps for tissue preservation, including decellularization and alpha-galactosidase treatment. Ten patients underwent total correction of Tetralogy of Falot previously and showed severe PVR (mean RV: 34±4 mm, RV end-diastolic volume: 184±1 ml/m2). Two patients completed study, LV end-systolic volume showed improved by 25±18 to 13±11 ml/m2, from cardiac MRI.

IVUS-guided TPA in Claudicant with Renal Insufficiency

IVUS can be useful for reducing the amount of contrast dye and accurate measurement of the diameter of the vessel and the length of the lesion in SPA TTO lesions with renal insufficiency. Moreover, the use of IVUS in more complex lesions has been limited.

Sac Regression after Endovascular Relining of Perigraft Seroma after Open Repair of Abdominal Aortic Aneurysm with PTFE Graft

Today, Dr. Jung Yong Kim (Seoul, Republic of Korea) presented a unique case of sac regression after Endovascular Ralining of Perigraft Seroma after Open Repair of Abdominal Aortic Aneurysm with PTFE graft in a 75 years-old man presented with growing aneurysm after open repair surgery of AAA with PTFE graft six years ago. He complained of abdominal discomfort and a palpable mass in the absence of tenderness, pulse, and bruit. The patient had a history of PCI for coronary heart disease and a 10-year history of hypertension. Blood chemical examinations were within normal limits and creatinine (1.5 mg/dL). Contrast-enhanced computed tomography (CT) showed a huge perigraft seroma measuring approximately 111 mm in diameter, starting from the infrarenal aorta to the middle of both iliac arteries. PET/CT proved no evidence of infection in the seroma. Abdominal aortography showed no graft leak and communication between the sac and the iliac arterial blood flow. Relining of PTFE-graft was performed with 23 mm Aortic extender, Excluder cuff (and 23 mm) and Viabahn (10 mm x 10 cm sized stent-grafts, Viabahn). Excluder was deployed in the trunk of PTFE-graft (Figure 1). After the retrieval of the Excluder, 10 mm x 10 cm sized stent-grafts, Viabahn was successfully implanted within the both iliac limb with the chimney technique (Figure 2). The ancillary attachment between the original and the new stent-grafts was successfully made with a 6 mm x 12 cm compliant balloon. Simple puncture and aspiration were not performed. The final aortogram was performed and there was no endoleak or flow disturbance. During the 2-year follow-up, the symptoms disappeared and the CT showed a nonsignificant decreased aneurysm sac size (45 mm x 60 mm). Dr. Kim said that “Endovascular relining should be considered as an option in perigraft seromas after AAA open repair with PTFE graft.”
How did you choose to specialize in cardiology?

The rapidity of relief in a patient with STEMI obtained with emergent revascularization therapy attracted me to choose cardiology.

How do you think your wide range of experience in general cardiology affect your current practice?

The knowledge of general cardiology is important in treating patients with heart failure, arrhythmia, and associated systemic diseases.

What do you think about the role BVS in complex coronary artery disease?

My mentor, Dr. Ashok Seth from India, has used BVS to treat all possible complex coronary lesions with a negligible scaffold thrombosis rate. BVS is a new device altogether with different properties than the current metallic DES, so paying attention to technical details such as adequate pre-dilation, selection of optimally sized scaffold, high-pressure post-dilatation, and meticulous antiplatelet regimen will ensure less scaffold thrombosis and TLR rate, and thereby might improve the outcomes in most complex CAD.

What attracted you to the interventions for structural heart disease?

Although I was trained in basic interventions for structural heart disease during my DM cardiology course, it is my research work on balloon pulmonary valvuloplasty that triggered my attraction towards these interventions. This attraction is currently sustained by my endeavor for procedures like TAVR, Mitraclip, LAA closure etc.

Any advice for a young cardiologist?

There is a general misconception that research is time-consuming. Young cardiologists in pursuit of excellence must overcome this myth and realize that research work provides additional mileage to a professional career. It is high time to have an adequate balance of working in all fields, including research.
20th KCTA Symposium

This year is a special year that celebrates the 20th anniversary of Nurse & Technologist session held by KCTA at TCTAP. Before the session, President Min-Suk Lee of KCTA has expressed his excitement for the growth of the KCTA session into a key session involving around 1,000 members and 400 participants per year and the collaboration with China and Japan that established the KCTA session as an international one.

The 1st Complex PCI 2016, which was held on December 1-2, 2016 at Sheraton Grande Walkerhill has been successfully wrapped up with a large delegate of 690 participants from 21 countries. This meeting was newly designed to provide young interventionists of the Asia Pacific region with practical and comprehensive knowledge of interventional techniques from the bottom up to the newest trend in Complex Coronary Intervention field. Over 2 days, 20 live cases were demonstrated at Asian Medical Center, and, as the key features of the meeting, the live session provided the attendees with new interventional tips for dealing with difficult lesions like Cutting Balloon, Angioplasty, Angiographic-Guided BVS, Imaging & Physiology-guided PCI, DES, BVS, TAVR, etc. to break lesion subset. In addition, the session was even more distinguished with 13 valuable lectures from leading international experts. Interactive Q & A and panel discussions also added a more academic atmosphere to each session. 20 cases were submitted from 19 countries; and, among them, 52 challenging cases were accepted and enthusiastically presented by interventional cardiologists from various countries in the case presentation sessions. 16 medical companies attended the exhibition and introduced their latest products to attendees. The 2nd complex PCI will take place in Sheraton Grande Walkerhill, Seoul on November 30-December 1, 2017.
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I am participating as a moderator for the e-poster presentation. I think it went smoothly. I am particularly interested in the CTO sessions this year. I am enjoying my time in Korea and at the TCTAP – I would like to participate again.

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I’ve been here at the TCTAP for 10 years now and my focus is in coronary intervention. Of course, more recently, the development of valves or structural heart disease is gaining more popularity. As part of cardiology, we still have to keep abreast of the development in other areas.

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