

APRIL 25

19<sup>th</sup> CARDIOVASCULAR SUMMIT  
TCTAP 2014

# Daily News

April 22-25, 2014, COEX, SEOUL, KOREA

## Today's Highlights

**17th TCTAP 2014 KCTA Symposium**  
Endovascular & Structural Heart Theater, Level 1,  
8:20 AM – 12:40 PM

**Cardiopulmonary Rehabilitation Workshop**  
Room 1-3, Level 1,  
8:20 AM – 12:00 PM

**Morning Roundtable Forum**  
(Next-generation Invasive Imaging, Bifurcation PCI)  
7:00 AM – 8:10 AM

**Challenging Case Competition**  
With Experts' Focus Review I, II, III  
8:30 AM – 12:40 PM



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TCTAP 2014



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⟨Highlights from Yesterday⟩

## Late Breaking Clinical Trials

Thursday, April 24, 9:30 AM - 10:55 AM, Main Arena, Level 3

Three hot topics from late-breaking trials presented at in Seoul, April 24, 2014, provided a wealth of new information for attendees to digest and translate into clinical practice. One of the late-breaking trials presented was a comparison of right to left radial access in 1,100 patients who underwent transradial intervention (TRI) using propensity score matched (PSM) analysis. The data from subgroup analysis for Paclitaxel-Eluting PTCA-Balloon Catheter in Coronary Artery Disease for In-Stent Restenosis (PEPCAD ISR) trial was presented specially focused on diffuse long ISR. Paravalvular leak (PVL) after transcatheter aortic valve replacement (TAVR) compared the morphological characteristics and underlying mechanism between the CoreValve (Medtronic, Santa Rosa, California) and the Edwards valve (Edwards Lifesciences, Irvine, California) using pre and post-procedural multidetector computed tomography (MDCT).

### Right versus Left Radial Artery Approach: Which One is Better?

The transradial intervention (TRI) has several advantages such as reduction of bleeding risk, improvement of patients' convenience, and immediate ambulation as compared with the transfemoral intervention. In TRI, there are some anatomical and technical differences between right and left radial approach. Ji Young Park, MD, of Eulji General Hospital (Korea) presented the impact of the choice

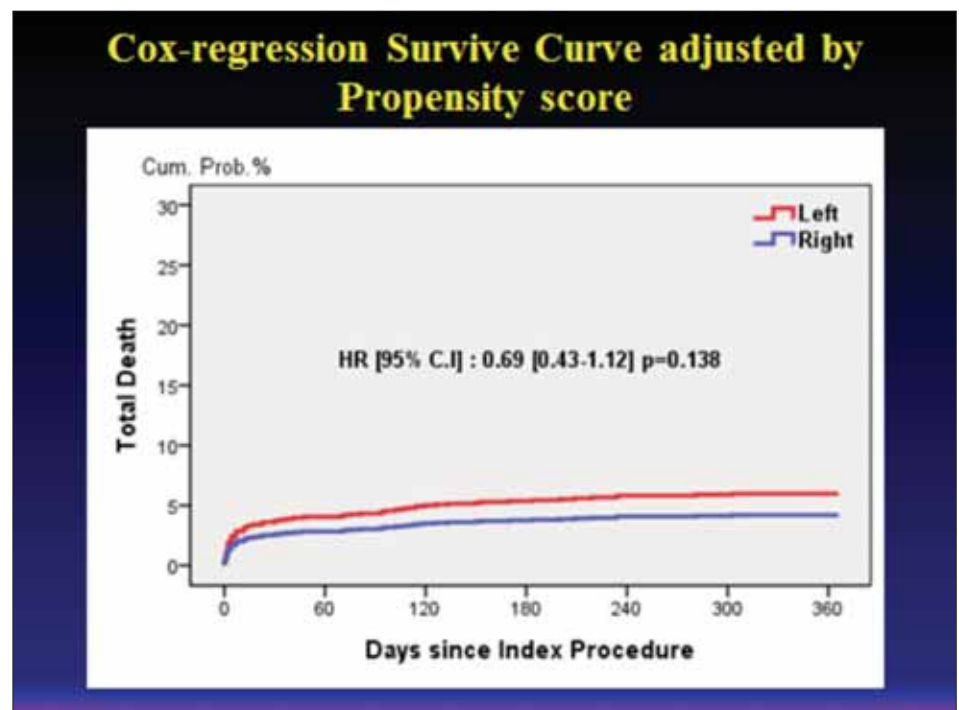


Figure 1.

of the right or left radial approach on 12 months clinical outcomes in patients undergoing TRI. Right radial approach was associated with larger contrast volume ( $259.3 \pm 119.6$  cc vs.  $227.0 \pm 90.7$  cc, p-value  $<0.001$ ) and longer fluoroscopic time ( $22.5 \pm 28.0$  min vs.  $17.1 \pm 12.6$  min, p-value  $<0.001$ ) while left radial approach had longer procedure time ( $49.2 \pm 30.4$  min vs.  $55.4 \pm 28.7$  min, p-value=0.003). Both right and left radial approach demonstrated similar efficacy with regard to the 1-year cumulative clinical outcomes including mortality, recurrent myocardial infarction (MI), repeat revascularization, and stent thrombosis. "With appropriate patient assessment and preparation, the right and left routes to transradial catheterization are equally safe and effective," Dr. Park said. "Also, to be proficient with both approaches, the operator needs to understand the differences between these two routes in terms of patient preparation."

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2011 ACC/AHA/SCAI guideline for PCI are supporting the use of PFT

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from page 1

ration, procedural technique, catheter selection, and laboratory setup.”

### DEB versus DES in ISR: Substudy of PEPCAD China ISR Trial

The paclitaxel-coated balloon catheter versus a paclitaxel-coated stent for the treatment of ISR (PEPCAD ISR II) study was a prospective, randomized, multicenter, two-arm phase II pilot study conducted in Germany, which examined the safety and efficacy of the SeQuent Please® compared with the TAXUS Liberté drug-eluting stent (DES) for treatment of ISR in native coronary arteries (n = 131 patients, reference diameter 2.5



mm, 3.5 mm; lesion length: ≤22 mm). However, treatment of DES-ISR is still challenging especially in diffuse lesions. Ye-lin Zhao, DM, Fu Wai Hospital, National Center for Cardiovascular Disease (China) presented subgroup analysis to compare the safety and effectiveness of paclitaxel-coated balloon (PCB) versus paclitaxel-

eluting stent (PES) in the treatment of patients with diffuse DES-ISR. PEPCAD China ISR was a prospective, multicenter, randomized (1:1), single blind trial conducted in China (n = 220). There were 33 patients in PCB (SeQuent Please®, B.Braun Melsungen AG, Germany) group and 44 patients in PES (Taxus® Liberté, Boston Scientific, Natick, MA, USA) group with diffuse in-stent restenotic lesions (Mehran type II-IV). The rates of 9-month in-segment binary restenosis, 12-month TLF, composite of all cause death, all MI and any revascularization, and definite/probable ST were no statistical differences between both treatment groups (27.3% vs. 32.4%, p = 0.65; 21.2% vs. 15.9%, p = 0.55; 27.3% vs. 29.5%, p = 0.83; 3.0% vs. 0.0%, p = 0.43, respectively). Dr. Zhao said, “this subgroup analysis offers preliminary evidence that DES-ISR patients with diffuse lesions receiving PCB therapy were non-inferior to PES implantations.” And she suggested that further innovative therapies would be needed to address diffuse ISR lesions because either PES or PCB were not optimal for diffuse ISR lesions after DES failure.

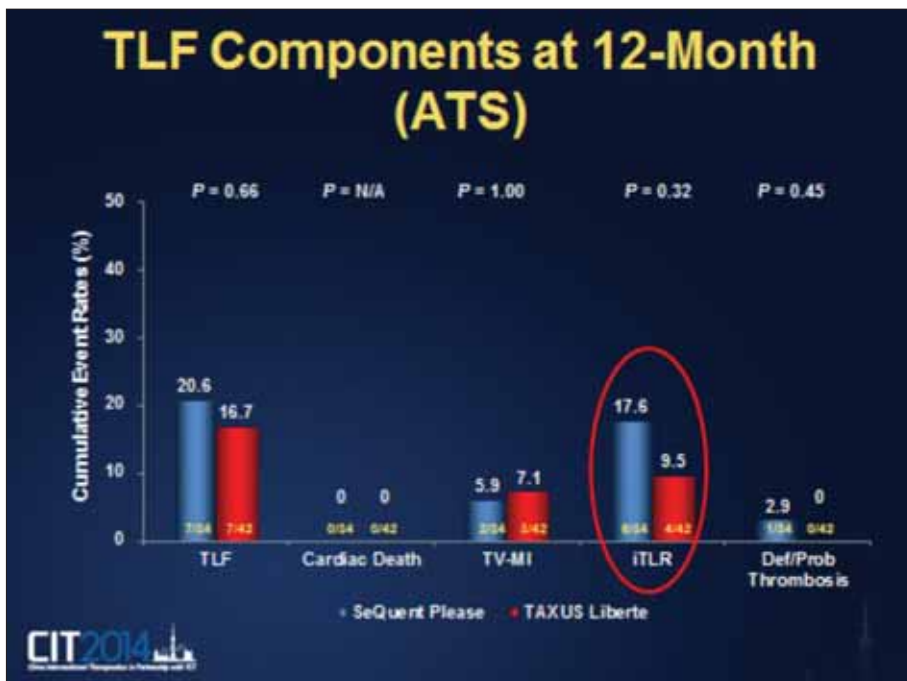


Figure 2.

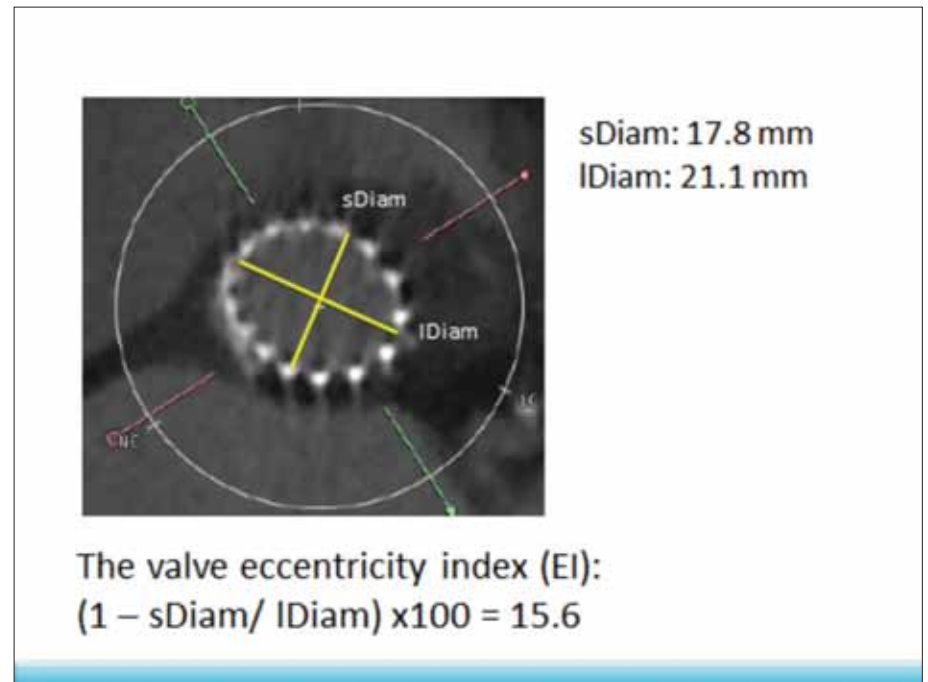


Figure 3.

### MDCT for PVL after TAVI: CoreValve versus Edwards Sapien Valve

PVL is a frequent complication of TAVR and higher rates are seen after TAVR than after surgical aortic valve replacement. Recent reports suggesting that PVL may be correlated with increased late mortality have raised concerns. However, the heterogeneity of methods for assessing and quantifying PVL, and inconsistency of assessment time, prevents from



understanding the morphological characteristics and underlying mechanism after TAVR. Yusuke Watanabe, MD, Institut Cardiovasculaire Paris Sud (France) studied 68 TAVI patients (aged 84.2±7.4 years, Logistic EuroSCORE 21.5±12.4) who had pre, and post-procedural multidetector computed tomography (MDCT). In this cohort, 43 (63.2%) patients were treated with the CoreValve and the remaining 25 (36.8%) patients received the Edwards valve. Post-TAVI

eccentricity index was significantly higher in patients of the CoreValve group at each level of prosthesis (stent bottom 18.4 ± 9.23 vs 5.2 ± 4.0, p < 0.01, annulus level, 19.0 ± 8.9 vs 5.8 ± 7.8, p<0.01, leaflet level 16.6 ± 8.3 vs 4.5 ± 3.5, p < 0.01). By multivariate analysis, only the Valve Calcification Index (aortic valve calcification volume/body surface area) was identified as independent predictor of any post-procedural PVL after CoreValve implantation (odds ratio [OR] 1.002, 95% confidence interval [CI] 1.000-1.004, p=0.03). In patients with Edwards valve, post-TAVI eccentricity index (leaflet level) was identified as an independent predictor of post-procedural PVL (OR 1.31, 95% CI 1.02-1.68, p=0.04). Dr. Yusuke Watanabe concluded that post-TAVI valve eccentricity was more frequently observed in CoreValve implantation than after Edwards valve implantation. Valve eccentricity was associated with PVL after Edwards valve implantation but not after CoreValve implantation probably because of the supra-annular design of the CoreValve.

TCTAP meets the Journal of American College of Cardiology!

Visit the online JACC website to view full content of all abstracts and cases.

# Today's Programs: Friday, April 25

## Morning Roundtable Forum: Meet the Experts over Breakfast

7:00 AM - 8:10 AM

### Next-generation Invasive Imaging

Organized by CVRF and Supported by Educational Grant from St. Jude Medical  
Room 1-1, Level 1

### Bifurcation PCI

Organized by CVRF  
Room 1-2, Level 1

## Challenging Case Competition with Experts' Focus Review I, II, III

8:30 AM - 12:40 PM

Room 1-1, Room 1-2, Coronary Arena, Level 1

## 17th TCTAP 2014 KCTA Symposium

### Annual Conference for Cardiovascular Nurse & Technologist Joint Program with TCTAP 2014

Co-organized by Korean Cardiovascular Technology Association

8:20 AM - 12:40 PM

Endovascular & Structural Heart Theater, Level 1

## Cardiopulmonary Rehabilitation Workshop

### 8th Cardiopulmonary Rehabilitation Workshop in Conjunction with CardioVascular Summit-TCTAP 2014

Co-organized by Korean Association of Cardiovascular and Pulmonary Rehabilitation (KACVPR)

8:20 AM - 12:00 PM

Room 1-3, Level 1

## Meeting Information

### Registration / Badge Pick-up

• 1F, Grand Ballroom Lobby  
Friday 25 6:00 AM – 12:30 PM

### Congress Bag Pick-up

• 1F, Grand Ballroom Lobby  
Friday 25 6:00 AM – 12:30 PM

### Invited Faculty Lounge, 2F

• Friday 25 6:00 AM – 12:30 PM

### Preview Room, 2F (Slide Upload)

• Friday 25 6:00 AM – 12:30 PM

### CVRF Booth, 1F (Organizing Secretariat)

• Friday 25 6:00 AM – 12:30 PM

### Information Desk

• 3F, Main Arena Lobby  
• 1F, CVRF Booth

### Tour Information Desk

• 1F, CVRF Booth

### Lounge

• 3F, Exhibition Hall, Registration  
• 1F, CVRF Booth

### Learning Center

• 3F, Exhibition Hall  
• 2F, Room 2-5 (Room 209)

### WiFi Zone

• 2F, Faculty Lounge, Preview Room  
• 1F, CVRF Booth, Coronary Arena, Structural Heart & Endovascular Theater

### Cyber Station

• 1F, CVRF Booth

### Free Mobile Recharge

• 1F, CVRF Booth

### Certificate of Attendance


• Friday 25: 1F, Service Booth

### Shuttle Bus


• Free shuttle bus is provided between COEX and several venue hotels. Ask at the CVRF booth, 1F or Information desk, 3F for more information.

### Prayer Room

• 2F, Room 202A  
• Friday 25 8:00 AM – 12:00 PM



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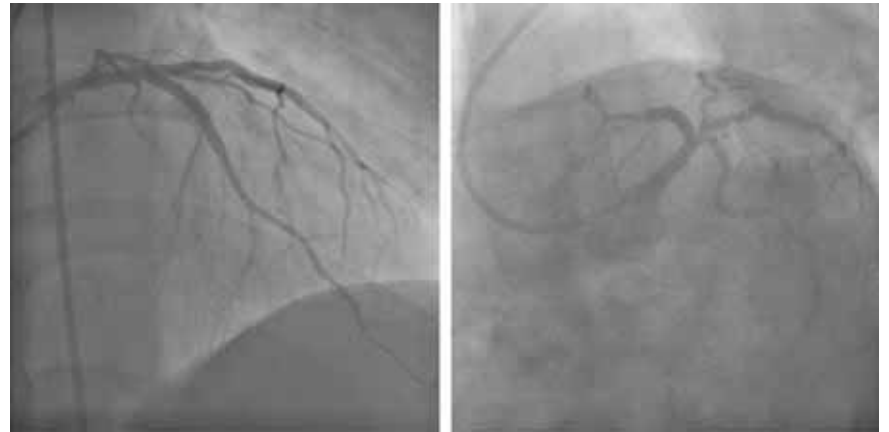
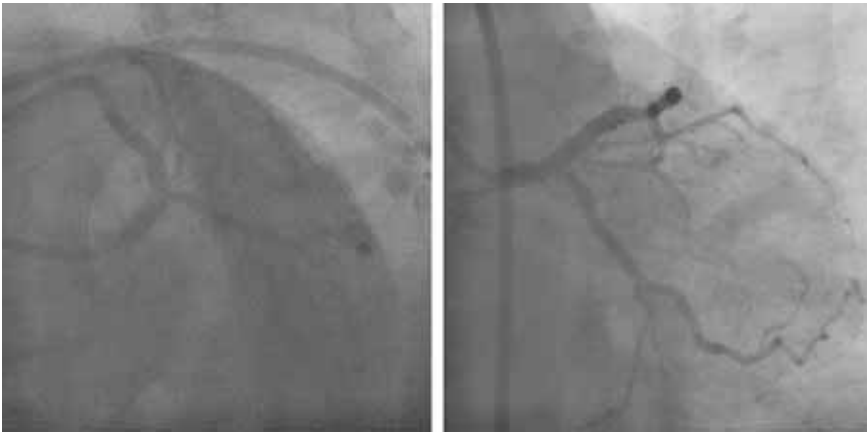
**Place**  
atrium (Training Center), 3rd Floor, East Building,  
Asan Medical Center, Seoul, Korea



## Yesterday's Hot Lives

**A** The IVUS was helpful to decide a treatment plan for LM PCI. The IVUS showed mild stenosis at LCX ostium. Therefore, they treated LM disease with **simple crossover technique**.

**A** Firstly, they performed IVUS examination to determine the treatment strategy for the distal LM bifurcation disease. The IVUS showed mild stenosis at LCX ostium. Therefore, they treated LM disease with **simple crossover technique**. In residual RCA CTO, they decided to treat by **medical treatment**.



〈Highlights from Yesterday〉

## 2nd Best Young Scientist Award Given to Dr. Yusuke Watanabe

Thursday, April 24, 10:55 AM - 11:00 AM, Main Arena, Level 3

### Post-dilatation Reduces Paravalvular Aortic Regurgitation During TAVR Procedure with the Balloon-Expandable Edwards Valve

Yusuke Watanabe, MD (Institut Cardiovasculaire Paris Sud, France), who made a presentation about the usefulness of post-dilatation after implantation of the Edwards valve, won the Best Young Scientist Award on Thursday in recognition of his accomplishments in the field of complex PCI and TAVR.

### Remarkable Career in Interventional Cardiology

Dr. Watanabe is a Japanese cardiologist who graduated from Tsukuba University School of Medicine (Ibaraki, Japan). He practiced as an interventional cardiologist in Sakaibara Heart Institution doing remarkable researches in various subjects of cardiovascular intervention including aortic dissection, late stent malapposition after DES-implantation, and transcatheter aortic valve implantation. He was given credit for those activities when he was awarded for Best Scientific Research at

TOPIC in 2012. He has been building up his career in France since 2011 and focusing on the TAVR procedure.

### Interview with Dr. Watanabe

#### Q1) How do you feel about the award?

I am very honored to receive this award and grateful to the TCTAP committee for giving me this award. I greatly appreciate the support of the ICPS catheter team (Massy, France) and especially to my mentors of TAVI, Dr. Thierry Lefevre and Dr. Kentaro Hayashida.

#### Q2) What is your favorite valve in TAVR procedure?

I prefer to use Edwards Sapien XT valve because implantation procedure of Sapien is somewhat like coronary stenting procedure we interventional cardiologists are getting used to. However, limitation of Sapien valve definitely exists. I want to learn about CoreValve and other self-expanding valve implantation procedures next.

#### Q3) What is the best indicator in device size selection to avoid paravalvular regurgitation?

MDCT measurement of annulus sizing is crucial to avoid paravalvular regurgitation

after TAVI. I think application of Valve/CAAD (calculated average annulus diameter) ratio is very useful for optimal device sizing. Value of Valve/CAAD ratio 1.05-1.10 is optimal range for valve sizing. If there is a lot of calcification in the aortic root and LVOT, underfilling method is very useful.

#### Q4) What should we be cautious about when getting an optimal valve expansion without risk of annulus rupture?

We should carefully get accurate annulus size from MDCT image. Evaluation of the distribution and the amount of calcifica-

tion is necessary to avoid adverse event like annulus rupture. The application of underfilling method will be useful in that case. If there is a certain risk of annulus rupture, choosing a self-expanding valve is good option.

#### Q5) How do you manage the remaining paravalvular regurgitation even after post-dilatation?

In that case, paravalvular regurgitation is due to calcification or position of valve, or the valve sizing is too small. The 2nd valve implantation sometimes provides good results in that case.



# Highlights of Wrap-up Interview

## Renal Stenting Controversy

Wednesday, April 23, 9:00 AM - 9:30 PM, Main Arena Lobby

Renal artery stenting has become a widespread therapy utilized in patients who present with what is perceived to be high grade stenosis of the renal artery and hard to control blood pressure. Atherosclerotic renal artery stenosis (ARAS) may manifest as progressive renal dysfunction, difficult-to-treat HTN, and cardiac disturbance syndromes. Identifying patients in whom ARAS is actually causing HTN and/or chronic kidney disease remains very challenging. Incidentally, discovered RAS is never reason enough for interventional treatment. Current guidelines suggest that treatment of ARAS should be offered to symptomatic patients only. Patients with hemodynamically significant ARAS and otherwise unexplained cardiopulmonary disturbance syndromes, such as unstable angina, recurrent unexplained congestive heart failure or sudden unexplained pulmonary edema, should be treated. Despite these recommendations, there is controversy regard-

ing which patients benefit from intervention, as not all patients respond favorably to such treatment. In addition, there is no accepted tool that is uniformly used in everyday practice to predict which patients will respond with improved blood pressure control and prevention of deterioration in renal function. Several prospective trials have examined the efficacy of renal artery angioplasty with stenting as compared with medical treatment. However, any randomized trials of renal-artery angioplasty or stenting did not show a benefit with respect to clinical outcomes. Recently, the CORAL study has been published in the New England Journal of Medicine (figure 1). In the study, 947 patients with renal artery stenosis and either refractory systolic hypertension or chronic kidney disease were randomized to receive medical therapy with or without renal-artery stenting. At median follow-up of 43 months, the rate of the primary composite endpoint (death from

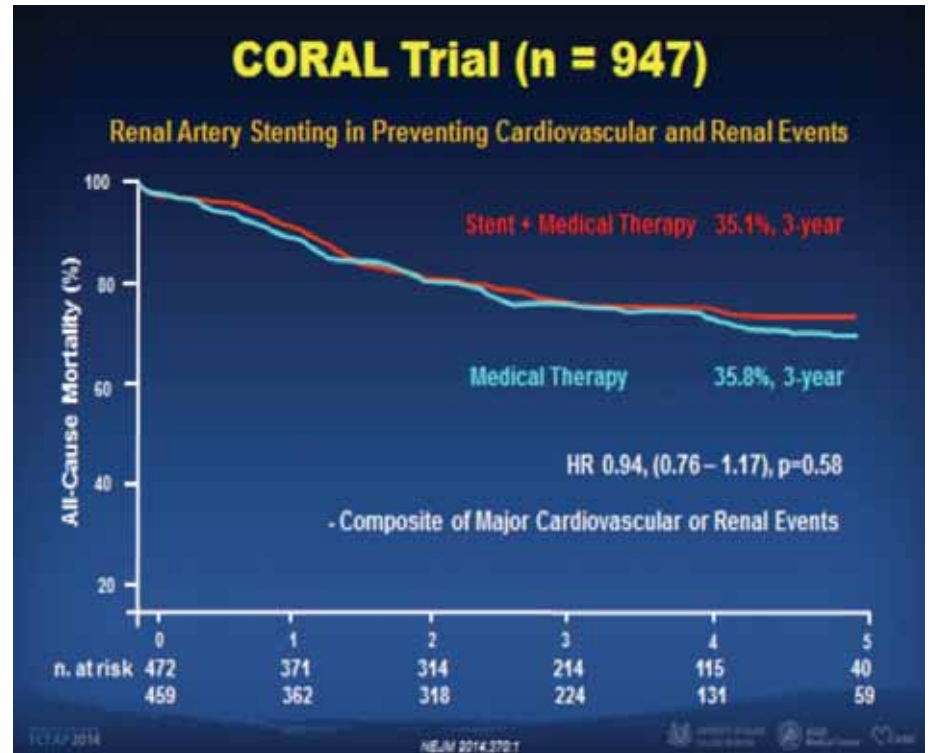


Figure 1.

Continued on page 7

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from page 6

CV or renal causes, MI, stroke, hospitalization for congestive heart failure, progressive renal insufficiency, or need for kidney replacement) was not different between groups. Also, subgroup analysis including hypertension patients and patients with severe angio-

graphically defined renal artery stenosis of >80%, did not show benefit in the composite outcome. Many feel that the negative results of CORAL will be the end of renal-artery stenting. However, CORAL is not without flaws; for example, there is trial design issues and

patient selection bias. Revascularization will benefit selected RAS patients but convincing evidence of improved cardiovascular outcomes in meet patients is lacking. Subsequent study is anticipated to assess the true clinical value of renal stenting.

The finished interviews will be broadcasted on our websites at [www.summit-tctap.com](http://www.summit-tctap.com), [www.summitmd.com](http://www.summitmd.com) and [www.youtube.com/CVREvents](http://www.youtube.com/CVREvents) after the meeting.

## Interview with Winners from Oral Abstracts Competition Sessions on April 24

Thursday, April 24, 10:30 AM – 11:20 AM, Abstract Zone II

### Best Abstract Presenter

**Li-Tan Yang, MD (National Cheng Kung University Hospital Dou-Liou Branch, Yunlin, Taiwan)**

There were many interesting abstracts and winners in the abstract competition. Dr. Li-Tan Yang is one of the winners and her abstract was unique and excellent. Dr. Li-Tan Yang presented her topic entitled “Effects of Left Atrial Strain on Functional Capacity in Severe Organic Mitral Regurgitation.” She said that the aim of this study was to investigate the effects of LA deformation on severity of symptoms in patients with severe organic MR. This study recruited 110 consecutive patients with severe organic MR and preserved left ventricular systolic function. LA deformation including strain and strain rate were assessed by two-dimensional speckle tracking echocardiography with commercialized software. Global peak LA longitudinal strain (LAS), peak strain rate in reservoir phase (LASRr), and in conduit phase (LASRc) were identified from strain and strain rate curves. Severity of heart failure symptoms were evaluated by the New York Heart Association (NYHA) classification. There were 35 (32%) patients in NYHA I, 62 (56%) in NYHA II, and 13 (12%) in NYHA III. Presence of atrial fibrillation (0%, 13%, 31%;  $p = 0.007$ ), left ventricular mass index ( $100 \pm 28$ ,  $106 \pm 29$ ,  $128 \pm 33$  gm/m<sup>2</sup>;  $p = 0.017$ ), estimated pulmonary artery systolic pressure ( $31 \pm 15$ ,  $38 \pm 18$ ,  $50 \pm 30$  mmHg;  $p = 0.011$ ), LAS ( $29.9 \pm 8.9$ ,  $25.2 \pm 10.1$ ,  $18.8 \pm 6.4$  %;  $p = 0.002$ ), LASRr ( $2.5 \pm 0.5$ ,  $2.3 \pm 0.7$ ,  $2.0 \pm 0.8$  s<sup>-1</sup>;  $p = 0.055$ ), and LASRc ( $-2.4 \pm 0.7$ ,  $-2.1 \pm 0.8$ ,  $-1.70 \pm 0.5$  s<sup>-1</sup>,  $p = 0.015$ ) were changed gradually respective to NYHA functional class I to III. There were no differences in left ventricular ejection fraction, left atrial volume index, left atrial emptying fraction, effective regurgitation orifice, and regurgitation fraction of MR among NYHA functional classes. After multivariate logistic regression analysis, only LAS

(OR 0.891, 95% CI 0.796-0.997,  $p = 0.044$ ) was an independent factor for predicting severe symptoms of heart failure (NYHA III). Furthermore, we found that age (OR 1.081, 95%CI 1.033-1.132,  $p = 0.001$ ) and diabetes mellitus (OR 10.379, 95% CI 1.008- 106.83,  $P = 0.049$ ) were independent factors for decreased LAS in these patients. She concluded that in patients with severe organic MR, LAS was correlated with severity of heart failure symptoms. Age and diabetes mellitus were independent factors for decreased LAS in these patients.

### Interview with Dr. Yang



**Q1. Tell us about your medical center & cardiology department.**

National Cheng Kung University Hospital Dou-Liou Branch is located in Southern Taiwan. Out of 11 medical centers in this region, NCKU hospital is a medium-sized hospital performing about 2,000 cases per year, including coronary intervention, peripheral angiography, and intervention and interventions for structural heart disease.

**Q2. What topics you would like to study further?**

Generally, I do coronary intervention, but my expertise is in echocardiography specifically. In the near future, I wish I could go to Japan for training.

**Q3. Any comment to this TCTAP meeting?**

In Taiwan, TCTAP has a good reputation for a variety of high-quality programs and the best combination of presenters and researchers from each field. It is my third year visiting Seoul to attend TCTAP. There is one thing I would like to request to TCTAP; if possible, it would be great to have echocardiography sessions including the fundamentals of echocardiography, cutting-edge ultrasound technology, etc.

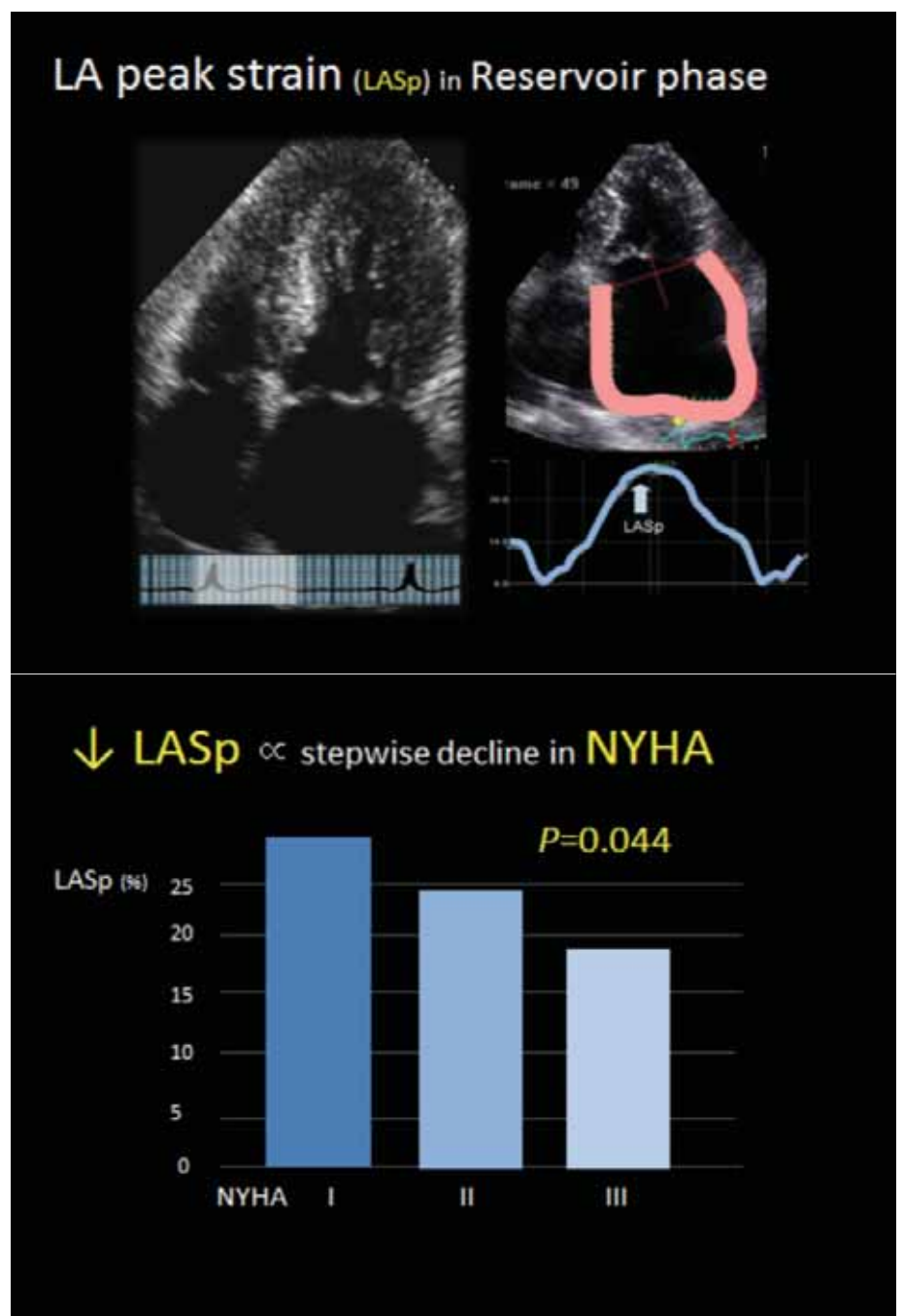


Figure 1.

### Call for Science

Abstracts & Cases July 23 - November 21, 2014  
The 3<sup>rd</sup> Best Young Scientist Award June 2 - October 6, 2014

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## References

1. Shepherd J. The role of the exogenous pathway in hypercholesterolaemia. *Eur Heart J Suppl.* 2001;3(suppl E):E2-E5. 2. Bays H. Ezetimibe. *Expert Opin Investig Drugs.* 2002;11(11):1587-1604.

## VYTORIN Selected Safety Information

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**[Indications and Usage]** VYTORIN is indicated as adjunctive therapy to diet for the reduction of elevated total-C, LDL-C, Apo B, and TG, and to increase HDL-C in patients with primary (heterozygous familial and nonfamilial) hypercholesterolemia or mixed hyperlipidemia. VYTORIN is indicated for the reduction of elevated total-C and LDL-C in patients with homozygous familial hypercholesterolemia, as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable. **[Dosage and Administration]** The patient should be placed on a standard cholesterol-lowering diet before receiving VYTORIN and should continue on this diet during treatment with VYTORIN. VYTORIN should be taken as a single daily dose in the evening, with or without food. The recommended usual starting dose is 10/20 mg/day. Initiation of therapy with 10/10 mg/day may be considered for patients requiring less aggressive LDL-C reductions. **[Contraindications]** Hypersensitivity to any component of this medication; active liver disease or unexplained persistent elevations in serum transaminases; pregnancy and lactation; patients with hereditary problems of galactose intolerance, Lapp lactase deficiency or of glucose-galactose malabsorption. **[Warnings]** Myopathy and rhabdomyolysis are known adverse reactions to HMG-CoA reductase inhibitors and other lipid-lowering drugs. Simvastatin, like other inhibitors of HMG-CoA reductase, occasionally causes myopathy manifested as muscle pain, tenderness or weakness with creatine kinase above 10 X ULN. Myopathy sometimes takes the form of rhabdomyolysis with or without acute renal failure secondary to myoglobinuria, and rare fatalities have occurred. The risk of myopathy is increased by high levels of HMG-CoA reductase inhibitory activity in plasma. In three placebo-controlled, 12-week trials, the incidence of consecutive elevations ( $\geq 3$  X ULN) in serum transaminases was 1.7% overall for patients treated with VYTORIN and appeared to be dose-related with an incidence of 2.6% for patients treated with VYTORIN 10/80. In controlled long-term (48-week) extensions, which included both newly-treated and previously-treated patients, the incidence of consecutive elevations ( $\geq 3$  X ULN) in serum transaminases was 1.8% overall and 3.6% for patients treated with VYTORIN 10/80. These elevations in transaminases were generally asymptomatic, not associated with cholestasis, and returned to baseline after discontinuation of therapy or with continued treatment. It is recommended that liver function tests be performed before the initiation of treatment with VYTORIN, and thereafter when clinically indicated. Patients titrated to the 10/80-mg dose should receive an additional test prior to titration, 3 months after titration to the 10/80-mg dose, and periodically thereafter (e.g., semiannually) for the first year of treatment. Patients who develop increased transaminase levels should be monitored with a second liver function evaluation to confirm the finding and be followed thereafter with frequent liver function tests until the abnormality(ies) return to normal. Should an increase in AST or ALT of 3 X ULN or greater persist, withdrawal of therapy with VYTORIN is recommended. VYTORIN should be used with caution in patients who consume substantial quantities of alcohol and/or have a past history of liver disease. Active liver diseases or unexplained persistent transaminase elevations are contraindications to the use of VYTORIN. **[Adverse Reactions]** VYTORIN has been evaluated for safety in more than 3900 patients in clinical trials. VYTORIN was generally well tolerated. Clinical AE reported in  $\geq 2\%$  of patients treated with VYTORIN and at an incidence greater than placebo regardless of causality assessment from three similarly designed, placebo-controlled trials were headache, influenza, upper respiratory tract infection, myalgia, pain in extremity. **[Pregnancy/Nursing mother/Should not take VYTORIN. (Pediatric/Geriatric Use)]** There are insufficient data in pediatric patients. The safety of VYTORIN was similar between geriatric and younger patients. Greater sensitivity of some older individuals cannot be ruled out. (2011, 12, 15)

\* Before prescribing, see full prescribing information for VYTORIN.



# 8th Cardiopulmonary Rehabilitation Workshop 2014

Friday, April 25, 8:20 AM - 12:00 PM, Room 1-3, Level 1

## In Conjunction with Cardiovascular Summit-TCTAP 2014, co-organized by Korea Association of CardioVascular and Pulmonary Rehabilitation (KACVPR)

After organization of KACVPR ([www.kacvpr.com](http://www.kacvpr.com)), the annual workshop for specialized cardiopulmonary rehabilitation program has been held during the Cardiovascular Summit-TCTAP meeting.

Cardiac Rehabilitation (CR) is a secondary prevention program with exercise as the cornerstone of a comprehensive intervention which includes an educational program, risk factors control, and the patient's voluntarily adoption of a healthy lifestyle to be kept for lifetime. Recently, enormous data about the clinical evidence of CR has been published in several journals with outstanding clinical benefits. Emerging science will advance the field further.

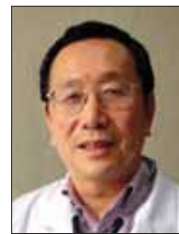
In the United States (U.S.) and elsewhere around the world, CR is accepted as a component of comprehensive cardiac care. Since 2006, typical indications for referring patients to CR have included: myocardial infarction, PCI, CABG surgery, stable angina pectoris, valve repair or replacement surgery, and heart or heart-lung transplant. According to the ACC/AHA evidence classifications, CR usually receives the highest level (Class I and Level of evidence, A).

This year, we want to raise interest from all physicians in the Asia Pacific region. We invited amazing staffs from USA, China, and Hong Kong. Especially using close cooperation with AACVPR (American Association of CardioVascular and Pulmonary Rehabilitation), we can cover USA area using webinar system.

In the first session, Patrick D. Savage, Ph.D. (Fletcher Allen Health Care), Peter Brubaker, Ph.D. (Wake Forest University), and Lenny Kaminsky, Ph.D. (Ball State



University's Human Performance) will present via webinar system between Korea and USA under moderation by Larry F. Hamm, Ph.D. (The George Washington University Medical Center, former President of AACVPR, and Editor-in-Chief of *Journal of Cardiopulmonary Rehabilitation & Prevention*). They will cover about the broad-extent of importance, measurement, and role of physical activity as a "vital sign" in cardiovascular disease.



In second session, we will cover the role of cardiac rehabilitation in Asia Pacific Society from Korea, Hong Kong, and China. Ngai-Yin Chan, MD., Ph.D. (Princess Margaret Hospital, Chairman of Asian Preventive Cardiology & Cardiac

Rehabilitation Conference), Dayi Hu, MD., Ph.D. (Peking University People's Hospital, President of Great Wall Congress of Cardiology, President of the Chinese Society of Cardiology), Guo Lan, MD., Ph.D. (Guangdong General Hospital), and Jong-Young Lee, MD., Ph.D. (Chief of Cardiac Rehabilitation Center in Asan Medical Center) will share their experiences, opinions, and data on the development of CR.

## Our Goal is Enhancement of Recognition, Creation of a Network, and Sharing Knowledge and Know-how about Cardiac Rehabilitation

We are very pleased to inform you that APCCRC Meeting 2015 to be held in Korea in conjunction with the Japanese Society of Cardiac Rehabilitation. Please come to join us and experience this emerging field!

# 17th KCTA Symposium

## Continuous Education Course for Nurses and Technologists: Care for Patients with Heart Disease

Friday, April 25, 8:20 AM - 12:40 PM, Endovascular & Structural Heart Theater, Level 1

## Joint Program with Cardiovascular Summit-TCTAP 2014 KCTA Symposium (The 17th Annual Conference for Cardiovascular Nurse and Technologist), Co-organized by Korean Cardiovascular Technology Association

During daily practice and research activities, the role and position of the cardiovascular nurse and technologist have been becoming increasingly important. So the CVRF (Cardiovascular Research Foundation) has provided substantial efforts for the growth of the Nurse-Tech Symposium. As a result, the last several years the Nurse-Tech symposium at

Cardiovascular Summit-TCTAP has grown and provided contributions to TCTAP meeting. The annual TCT Nurse-Tech course provides an invaluable opportunity for catheterization laboratory nurses, technologists, hospital administrators, and other allied healthcare personnel to be exposed to the most contemporary advances in the field and to learn from each other. The Nurse-Tech course has been the perfect complement to physician education at TCT, which together have contributed to improved outcomes for patients with cardiovascular disease. Especially, cutting-edge techniques in the cath lab will be covered in this meeting, such as renal denervation, hybrid operating room, transradial intervention, and LA appendage closure device.

## Must Visit Place in Seoul



**Insadong**, a traditional street for both locals and tourists

**Insadong** The area is well known for sightseeing; with approximately 100,000 visitors on Sundays reported in 2000. Insadong is also a popular spot for visting foreign dignitaries such as Queen Elizabeth II and the princes of Spain and the Netherlands. It contains 40 percent of the nation's antique shops and art galleries as well as 90 percent of the traditional stationery shops.

*Please visit Tour Information Desk, Level 1, for more information*



# CardioVascular Research Foundation (CVRF)

For the future of human being's health, we'll get together...

## Save the Dates

### 20<sup>th</sup> CardioVascular Summit-TCTAP 2015

April 28- May 1, 2015

Coex, Seoul, Korea

[www.summit-tctap.com](http://www.summit-tctap.com)

Call for Abstracts

July 21 ~ November 21, 2014

Call for Cases

July 21 ~ November 21, 2014

Advance Registration

~ April 3, 2015

### 4<sup>th</sup> TAVI (Transcatheter Aortic Valve Implantation) SUMMIT 2014

August 8-9, 2014

Grand Intercontinental Parnas, Seoul, Korea

[www.taviconference.com](http://www.taviconference.com)

Advance Registration

~ July 25, 2014

### 7<sup>th</sup> IMAGING & PHYSIOLOGY SUMMIT 2014

December 5-6, 2014

Grand Intercontinental Parnas, Seoul, Korea

[www.imaging-physiology.com](http://www.imaging-physiology.com)

Call for Cases

May 2 ~ August 14, 2014

Advance Registration

~ November 21, 2014

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CARDIOVASCULAR SUMMIT  
**TCTAP 2015**

**APRIL 28 - MAY 1**  
COEX, SEOUL, KOREA