



Friday, May 01, 2015

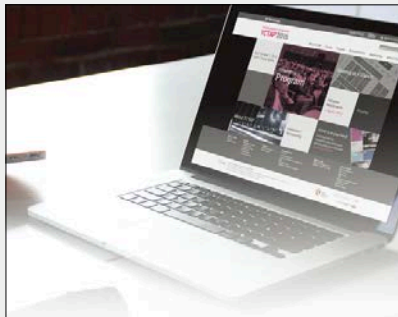
3

Today's Highlights

Morning Roundtable Forum
7:00 AM - 8:10 AM

Challenging Case Competition with Experts' Focus Review I, II, III
8:30 AM - 12:40 PM

18th KCTA Symposium
8:20 AM - 12:48 PM
Endovascular & Structural Heart Theater, Level 1



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After meeting, you can enjoy not only all the presentation slides presented, but also video clips of Wrap-up Interview, Live demonstration, photos taken and Daily Newspapers distributed during conference via our official website.

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- 3rd Best Young Scientist Award page 5
- Interesting Abstracts and Cases from Competition Session page 6
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Highlights from Yesterday

Late Breaking Clinical Trials



Interesting clinical trials were presented in Seoul on April 30th, 2015 during the Late Breaking Session. It inspired attendees and audiences in terms of providing useful knowledge and introducing new devices and technologies. Three fascinating presentations were shared. The duration of dual antiplatelet therapy (DAPT) still remains unclear for the second generation drug eluting stent (DES) era. The data from the subgroup analysis for the OPTIMA-C study and optical coherence tomography was presented primarily focusing on outcomes of 6 months versus 12 months DAPT after implantation of second generation DES. We also had a chance to share long-term experiences of absorb bioreabsorbable vascular scaffold in the Asia-Pacific area. The new method was shown to detect automatically lipid-rich plaque with optical coherence tomography (OCT).

Duration of Dual Antiplatelet Therapy after DES



Byoung Kwon Lee, MD
Gangnam Severance Hospital

Because one strong predictor for stent thrombosis is early discontinuation of clopidogrel, prolonged DAPT is highly recommended. However, prolonged use of clopidogrel is associated with many potential risks and no additional benefits. Several

us-eluting stent (SES); however recent OCT studies reported sufficient strut coverage and outcomes following zotarolimus-eluting stent (ZES) implantation. Byoung Kwon Lee, MD, Gangnam Severance Hospital (Korea) gave a presentation comparing the efficacy and safety between 6-months and 12-months DAPT after implantation of ZES and BES. Furthermore, he compared neointimal coverage between ZES and BES at 6 months as a secondary endpoint. In this study, there were no significant differences in MACE including death, myocardial infarction, target vessel failure, stroke, and non-target PCI in 6-month and 12-month DAPT. (Figure 1) Also, angiographic follow up data were not different. The 6-month OCT follow up data showed a slightly decreased tendency of malapposed strut in BES, but it is not significant. Dr. Lee concluded that 6-month DAPT might be safe after 2nd generation DES implantation based on clinical, angiographic, and favorable results of 6-month OCT sub-study.

Continued on next page

studies have suggested that the optimal duration of DAPT was different depending on the type of DES. More complete strut coverage of biolimus-eluting stent (BES) was shown when compared with sirolim-

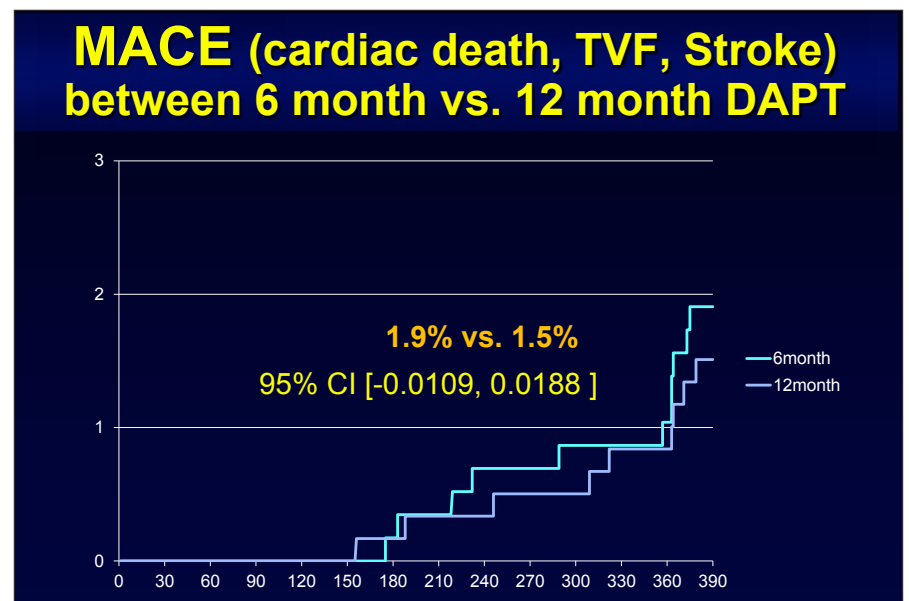


Figure 1.

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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;11:1587-1604.

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The ABSORB EXTEND Study in the Asia-Pacific Region



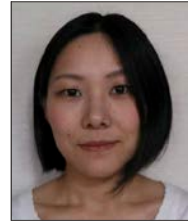
Chung-Jen Wu, MD
Chang-Gung Memorial Hospital

The safety and performance of the Absorb Bioresorbable Vascular Scaffold (Absorb BVS) system (Abbott Vascular, Santa Clara, CA, USA) has been previously established in 131 patients from cohort A and cohort B of the first-in-man ABSORB trial. Following this trial, ABSORB EXTEND was initiated as a global continued access study (outside of the USA) to expand experience with the Absorb BVS system to different geographies, including the Asia-Pacific region, with broader inclusion criteria to include the treatment of longer lesions and multiple vessels. Dr. Chiung-Jen Wu (Chang-Gung Memorial Hospital, Taiwan) reported 3-year clinical outcomes from the first 450 patients in ABSORB EXTEND. In the first 450 patients enrolled, the mean age at implant was 62 years. Major comorbidities included previous MI (29%), unstable angina (33%), and diabetes mellitus (27%). Lesion locations were 44%, 26%, and 30% for LAD, LCX, and RCA, respectively. The mean RVD was 2.58 mm and mean lesion length was 11.7 mm. The lesions were 2.5%, 58.4, 34.9%, and 4.2% for Class A, B1, B2, and C, respectively. At 2-year, the composite endpoints of MACE, TVF, and TLF of the first 450 patients were 6.7%, 7.4%, and 6.5%, respectively. Cumulative scaffold thrombosis (ST) was 1.1% through 2 years, of which 0.2% was very late ST events. The 3-year clinical outcomes were finally presented at the time of

the conference (Figure 2). Also, there were no different events of thrombosis between Absorb and Xience.

Dr. Wu discussed the safety and efficacy of Absorb demonstrated in these 450 patients through 3 years after their PCI procedure.

Automated Detection of Lipid-rich Plaque



Aiko Shimokado, MD
Wakayama Medical University

Dr. Aiko Shimokado (Wakayama Medical University, Japan) introduced a new OCT device to detect lipid plaque in human coronary arteries. She said, "Conventional OCT systems are used to detect lipid-rich plaques, but the accuracy depends on the proficiency of the physician because of the strong attenuation of OCT signal in lipids. So, we developed a novel OCT system. This OCT can detect lipid tissue automatically using 1,700 nm wavelengths because short-wavelength infrared (SWIR) had a potential to distinguish water and lipid." In this presentation, twenty-nine coronary arteries from 10 cadavers were examined. SWIR-OCT was performed at physiological pressure, and the images were acquired at 94 frames/s and digitally archived. After SWIR-OCT imaging, the arteries were pressure-fixed, sliced by a cryostat, stained with H&E and Oil Red O, and then corresponding histology was collected in matched images. Lipid-enhanced images generated by SWIR-OCT were validated by comparison with histology via selected regions (Figure 3). SWIR-OCT showed

high sensitivity (90%) and specificity (94%) for identifying lipid tissue within coronary plaques. The positive predictive value and negative predictive value were 99% and 58%, respectively.

Dr. Shimokado concluded that SWIR-OCT accurately identified lipid tissue in human

coronary arteries at autopsy. This new technique may hold promise for identifying histopathological features of coronary plaque at risk for rupture.

Thursday, April 30, 9:30 AM - 10:12 AM,
Coronary Theater, Level 1

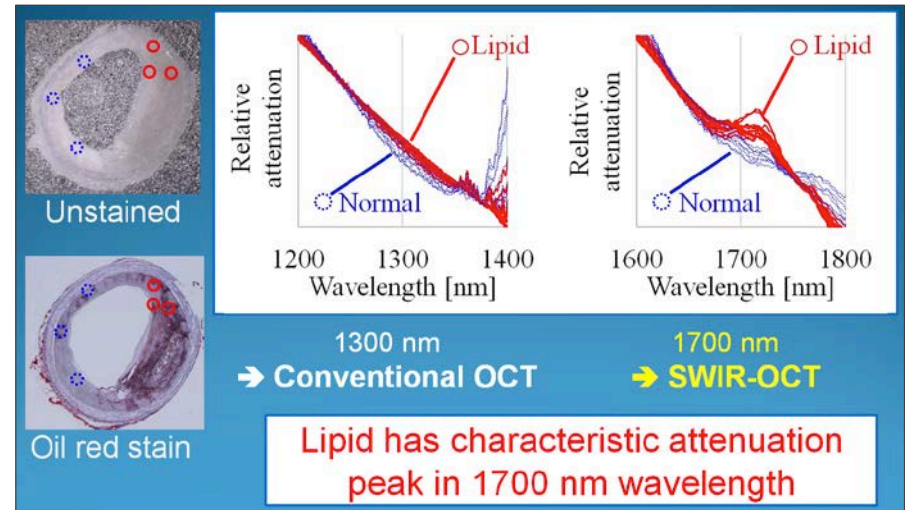


Figure 3.

Strut-level analysis	ZES (n=30)	BES (n=30)	p-value
Mean NIH thickness (µm)	61.9 ± 39.6	81.6 ± 57.1	0.126
% of uncovered strut	3.0 ± 5.2	2.4 ± 5.3	0.636
% of malapposed strut	1.0 ± 3.4	0.7 ± 2.1	0.636
Presence of intra-stent thrombi, n (%)	0 (0.0)	0 (0.0)	-

Table 1.

Scaffold Thrombosis (Def/Prob)	Absorb (n=319)	XIENCE (n=319)	p-value
<1 day (Acute, %)	0.0	0.0	NA
1 - 30 days (Subacute, %)	0.6	0.0	0.4992
31 - 365 days (Late, %)	0.0	0.3	1.0000
366 - 758 days (Very Late, %)	0.3	0.6	1.0000
Cumulative			
0 - 393 days (%)	0.6	0.3	1.0000
0 - 758 days (%)	0.9	0.9	1.0000
0 - 1123 days (%)	1.3	0.9	1.0000

Table 2.

Scaffold Thrombosis (Def/Prob)		Histology Lipid		Total	
		(+)	(-)		
SWIR-OCT	Lipid	(+)	67	1	68
	(-)	8	11	19	
Total			75	12	87

Table 3.

ABSORB EXTEND 3-Years Clinical Outcomes Propensity Score Matched

Hierarchical	1 Year (N=319 per arm)			2 Years (N=319 per arm)			3 Years (N=319 per arm)		
	Absorb	XIENCE	P-value	Absorb	XIENCE	P-value	Absorb	XIENCE	P-value
MACE (%)	4.4	5.3	0.713	7.5	7.8	1.000	8.8	9.1	1.000
TVF (%)	4.7	7.5	0.186	8.5	11	0.350	10.0	12.5	0.381
TLF (%)	4.4	5.0	0.852	7.2	7.5	1.000	8.5	5.8	1.000

Non-hierarchical	1 Year (N=319 per arm)			2 Years (N=319 per arm)			3 Years (N=319 per arm)		
	Absorb	XIENCE	P-value	Absorb	XIENCE	P-value	Absorb	XIENCE	P-value
Cardiac death (%)	0.0	0.6	0.499	0.3	1.3	0.373	0.9	1.6	0.7248
MI (%)	2.8	2.2	0.801	4.4	3.1	0.533	4.4	4.1	1.000
QMI	0.9	0.6	1.000	0.9	0.6	1.000	0.9	0.9	1.000
NQMI	1.9	1.6	1.000	3.4	2.5	0.643	3.4	3.1	1.000
ID-TVR (%)									
ID-TLR	1.9	2.8	0.603	4.4	4.1	1.000	5.3	5.0	1.000
ID-non-TLTVR	0.3	2.8	0.021	1.9	5.0	0.049	2.2	6.0	0.026

Figure 2.

All accepted abstracts and cases of TCTAP 2015 are published in the online JACC supplement.

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Meeting Information

- ▶ **Bus**
Free shuttle bus is provided between COEX and several hotels. Visit the **CVRF Booth** for more information.
- ▶ **Certificate of Attendance**
• **Level 1, Registration Booth**
Certificate of Attendance for TCTAP 2015 will be distributed along with badges.
- ▶ **Conference Bag Pick-up**
• **Level 1, Registration Booth**
Friday, May 1 6:00 AM – 12:30 PM
- ▶ **CVRF Booth (Organizing Secretariat)**
• **Level 1, Grand Ballroom Lobby, CVRF Booth**
Friday, May 1 6:00 AM – 12:30 PM
- ▶ **Cyber Station**
• Level 1, Grand Ballroom Lobby, CVRF Booth
• Level 1, B2 Hall, Exhibition Lounge
- ▶ **Faculty Lounge**
• **Invited Faculty Lounge: Level 2**
• **Faculty of the Year Lounge: Level 1, B2 Hall Lobby**
Friday, May 1 6:00 AM - 12:30 PM
- ▶ **Free Mobile Recharge**
• Level 1, Grand Ballroom Lobby, CVRF Booth
• Level 1, B2 Hall, Exhibition Lounge
• Level 1, B2 Hall Lobby, Registration Lounge
- ▶ **Information Desk**
• Level 1, Grand Ballroom Lobby, CVRF Booth
• Level 3, Main Arena Lobby
- ▶ **Learning Center**
• Level 1, B2 Hall, Exhibition Lounge
• Level 2, Room 209, Room 210
- ▶ **Lost and Found / Coat Room**
• Level 1, B2 Hall Lobby, Coat Room (Next to the Registration Booth)
- ▶ **Preview Room (Slide Upload)**
• **Level 2, Room 208**
Friday, May 1 6:00 AM - 12:30 PM
- ▶ **Registration**
• **Level 1, B2 Hall Lobby, Registration Booth**
Friday, May 1 6:00 AM - 12:30 PM
- ▶ **Wi-Fi Zone**
• Level 1 - Coronary Theater, Endovascular & Structural Heart Theater, Room 104 & 105, CVRF Lounge, Exhibition Hall, Faculty of the Year Lounge, Registration Booth
• Level 2 - Invited Faculty Lounge, Preview Room
• Level 3 - Main Arena

Today's Programs: Friday, May 1, 2015

Morning Roundtable Forum: Meet the Experts Over Breakfast

7:00 AM - 8:10 AM

Functional Angioplasty

Organized by CVRF and Supported by Educational Grant from St. Jude Medical
Coronary Theater, Level 1

Invasive Imaging

Organized by CVRF and Supported by Educational Grant from Boston Scientific
Room 104, Level 1

Drug-coated Balloons in Clinical Practice: Why? Where? How?

Organized by CVRF and Supported by Educational Grant from BIOTRONIK
Room 105, Level 1

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

8:30 AM - 12:48 PM

Coronary Theater, Room 104 & 105, Level 1

18th TCTAP 2015 KCTA Symposium

Annual Conference for Cardiovascular Nurse & Technologist Joint Program with TCTAP 2015

Co-organized by Korean Cardiovascular Technology Association
8:20 AM - 12:40 PM
Endovascular & Structural Heart Theater, Level 1

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The TCTAP2015 mobile app is your essential tool for navigating the conference and planning your schedule.

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- Find sessions, events, speakers and exhibitors

Interact with experts

- Real-time communication between attendees and panels
- Download presentation slides
- Review and rate all abstracts and cases presented

Plan your schedule

- Scheduling tools to create a customized agenda
- Take notes

Exhibition

- Exhibitor & Exhibit hall information

View the latest news

- Video Recordings of highlights and wrap-up interviews
- Receive real-time reminders and updates

Look into TCTAP2015

- General Information of TCTAP
- Venue map



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ACT Program

Asan Medical Center International Cardiology Training Program

"Left Main Intensive Course"
"FFR & IVUS Guided PCI"
"CTO LIVE from the Experts"
"TAVI LIVE"

Organizing Directors
Seung-Jung Park, MD, Cheol Whan Lee, MD

Program

Catheterization Laboratory Activities

- Live Case Demonstration
- Cath Lab Experience
- Free Discussion in the Training Center during the Procedure
- Dynamic Round Table Discussions
- Asan Medical Center Tour
- Case Presentation & Discussion:
Nightmare Complications-Untangling the Knots!
- Hands-on Learning: FFR, IVUS, VH-IVUS, OCT

and much more...

Evidence-Based Lectures

- DES Issues
- Technical Tips & Tricks
- Imaging: IVUS, VH-IVUS, OCT, CT, MR, FFR, etc.
- Adjunctive Pharmacology
- Up-to-date Clinical Trials and Registries
- How to Make Good Clinical Trials

and much more...

Place

Atrium (Training Center), 3rd Floor, East Building, Asan Medical Center, Seoul, Korea

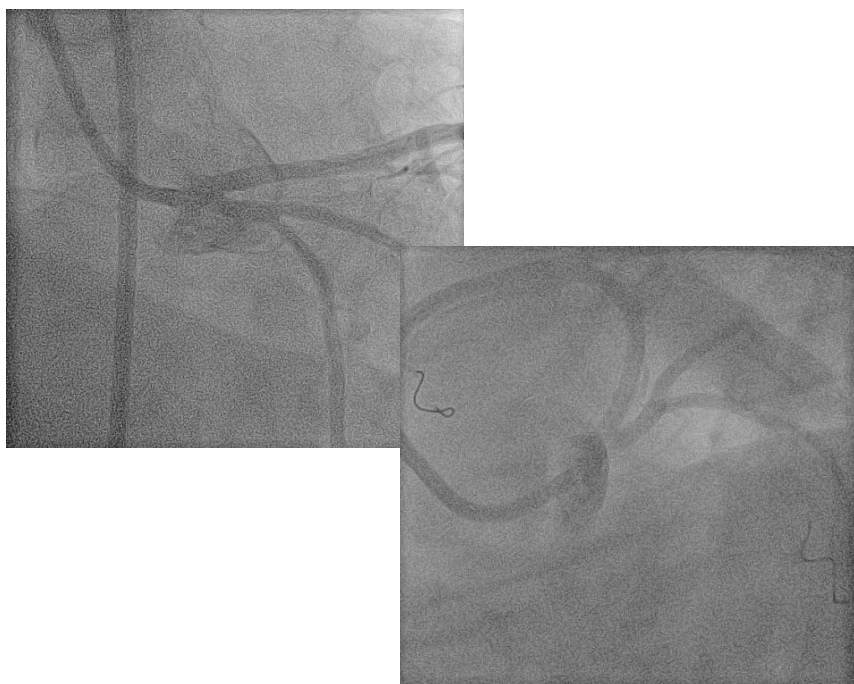
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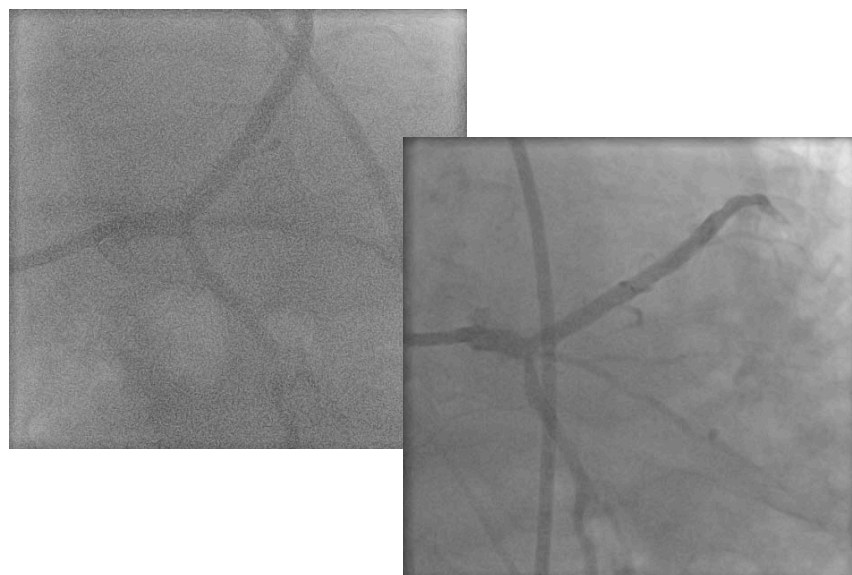


Yesterday's Hot Lives 2

A The answer to the yesterday's question is 'Simultaneous Kissing Stent' technique.



A Diffuse and continuous calcified plaque from LM to mid portion of LAD was identified on the IVUS examination. Since the LCX ostium showed insignificant stenosis, 2 stents were implanted to cover the whole lesion from LM to LAD with *simple crossover technique*. Although post-PCI angiogram showed intermediate stenosis of ostial LCX, the FFR value was 0.81 and the treatment of the lesion was deferred.



Highlights from Yesterday

3rd Best Young Scientist Award Given to Dr. I-Ming Chen

Remarkable Career in Cardiac Surgery

Dr. I-Ming Chen is an attending surgeon at the Division of Cardiovascular Surgery at the Taipei Veterans General Hospital, one of the most historical and outstanding hospitals in Taiwan. He has previously served as the chief of Hybrid Operation Room at the Taipei Veterans General Hospital and is currently serving as the director of the Taiwan Society of Vascular Surgery since September 2013. Previously, he had worked as a fellow in cardiac surgery at the Berlin Heart Center and in vascular surgery at the Epworth Hospital in Melbourne. He was awarded many prizes during his career including Best Teacher at Taipei Veteran General Hospital in 2011, Winner of the Record Case Presentation contest for the Taiwan Society for Vascular Surgery (TSVS) in 2012 and 2013, and Best Abstract Presenter at TCTAP in 2014.

Interview with Dr. Chen

Q1) You have won so many awards for your presentations. Do you have some tips or ideas for making a good presentation?

First of all, I have to thank all the panelists and judges for the award. For every presentation, no matter what kind of contest or whether it is an ordinary speech, I always prepare and ask myself if I meet these three requirements:

1. Is my material good enough?
2. Are my slides good enough to help the

audience understand my talk?
3. Am I expressing myself clearly so that the audience can easily know what I want to talk about?

These 3 things are important in daily life and not just for giving a good presentation. Practice makes perfect.

Q2) What makes you devoted to aortic disease?

Treating aortic disease is really challenging work. Actually, there is no so-called standard treatment when treating aortic aneurysm or dissection. Of course, we could treat aortic disease by endovascular stent grafting or by traditional open repair. But as a surgeon, there is a lot of room for hybrid procedures. The accomplishment of saving lives from aortic pathology really makes me devoted to treating aortic disease.

Q3) How did you spend your fellowship at the Berlin Heart Center in German and the Epworth Hospital in Australia?

In Taiwan, cardiac surgery and vascular surgery are in the same division. So, I have been trained as a cardiovascular surgeon at the Taipei Veterans General Hospital. After completing residency training, I first spent my overseas fellowship training in the Berlin Heart Center for advanced cardiac surgery such as ventricular assist device and heart transplantation. After Germany, I went to the Epworth Hospital, in Melbourne, Australia for clinical fellow-



ship training in vascular surgery. I learned a lot of advanced endovascular skills for aortic stent grafting, PAD intervention, carotid intervention, etc., which helped me a lot when I got back to Taiwan.

Q4) Did you have any mentors that were particularly influential, and if so, in what ways?

Professor Chun-Che Shih is the most the important mentor of mine. He has taught me the basics of endovascular and cardiac surgery since I was a resident. He was also my Ph.D. advisor and taught me in so many ways.

Q5) What is your proudest career moment?

This is my proudest career moment. Indeed, the TCTAP Best Presenter award (2014) is the first overseas award that I won.

Q6) Any advice for young cardiologists or vascular surgeons?

Opportunity favors the prepared mind. Always be devoted and be passionate about the work you like. Let's make life better.

Thursday, April 30, 10:54 AM - 11:00 AM, Coronary Theater, Level 1

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July 20(Mon) - November 20 (Fri), 2015

*Only online submission is available via submission website, for more information kindly contact abstract@summitmd.com.

Highlights from Yesterday: Interesting Abstracts & Cases

Is Final Kissing Ballooning Mandatory in the Treatment of Distal Left Main Disease Treated by Simple Cross Over Stenting?

Single stent approach and selective side branch intervention has demonstrated better clinical outcomes compared with double stent technique for the long term follow up for bifurcation coronary artery disease treatment. Interventional treatment of complex distal bifurcation lesion of unprotected left main (UPLM) coronary artery showed higher incidence of adverse events compared with shaft lesion. UPLM stenting with single drug eluting stent (DES) with a strategy of provisional side-branch procedure provided acceptable angiographic results and may be associated with better clinical outcomes. In the single stent strategy of bifurcation lesions, final kissing ballooning (FKB) after stenting of the main vessel (MV) cross the side branch (SB) was not associated better outcomes and routine FKB would be harmful, but most of the studies did not enroll left main bifurcation lesions.

Yesterday morning, Dr. Hee-Soon Park (Asan Medical Center, Korea) presented the results of her unique study. She mentioned that in the treatment of left main bifurcation lesions with simple stenting cross over left circumflex artery, the role of routine FKB after simple crossover stenting was not evaluated. The purpose of presenting this study is to evaluate whether

er routine FKB of bifurcation level of left main coronary improves clinical outcomes in patients who had been treated with simple crossover stenting of large, single center left main coronary disease registry. Between January 2003 and May 2012, a total of 413 patients having distal left main bifurcation lesions treated by simple stenting with DES crossover left circumflex artery were identified from the ASAN-MAIN registry. In patients treated with the simple crossover stenting, major adverse cardiac events (MACE; composite of death from any cause, myocardial infarction [MI], or left main-target lesion revascularization [LM-TLR]) were compared between those undergoing main vessel stenting only (No FKB group, n=318) or those undergoing FKB after main vessel stenting (FKB 3 group, n=95) at 2-year follow-up. The 2-year incidence of MACE was similar between two groups (FKB: 12.5% vs. No FKB: 8.5%, $p=0.24$, Figure 1). In addition, death (4.6% vs. 3.9%, $p=0.80$), MI (0% vs. 0.7%, $p=0.40$), and left main TLR was not significantly different (FKB: 8.1% vs. No FKB: 4.4%, $p=0.15$). After adjustment, the hazard ratio was 0.95 (0.26-3.51, 95% CI, $p=0.96$) for the composite of death or MI; 1.32 (0.46-3.75, 95% CI, $p=0.60$) for left main TLR; 1.10 (0.49-2.49, 95% CI, $p=0.82$) for MACE (Table 1).

Dr. Hee-Soon Park concluded that in patients treated with the simple crossover stenting for distal LMCA bifurcation stenosis, FKB after main vessel stenting was not associated with better clinical outcome compared with no FKB.

Novel Retrograde Access for Recanalization of Below-the-Knee Arteries: Medial Plantar Artery Puncture (“Sole Puncture”) Technique

Currently the advanced retrograde access technique in the intervention of below-the-knee arteries appears feasible and beneficial as a rescue strategy in challenging patients with a failed anterograde approach. Yesterday afternoon, Dr. Tatsuya Nakama

(Miyazaki Medical Association Hospital, Japan) introduced a novel retrograde access technique named “Sole Puncture.” An 80-year old diabetic male on dialysis was admitted to Dr. Nakama’s hospital due to non-healed, infected wounds on his left 5th toe. Skin perfusion pressure was remarkably reduced (dorsal: 12 mmHg, plantar: 10 mmHg). Ankle brachial pressure index (ABI) could not be measured. Dr. Tatsuya Nakama and his colleague decided to perform endovascular therapy (EVT) for limb salvage. A 5-Fr, 50 cm length sheath was inserted to his common femoral artery antegradely. Control angiogram was performed and it

Continued on next page

	FKB (N=95)	Non-FKB (N=318)	Adjusted HR (95% CI) [†]	P value
Death	4 (4.6%)*	12 (3.9%)	1.03 (0.28-3.82)	0.97
MI	0	2 (0.7%)	infinite	0.96
Death or MI	4 (4.6%)	13 (4.2%)	0.95 (0.26-3.51)	0.96
Any RR	9 (10.5%)	20 (6.7%)	0.99 (0.41-2.38)	0.98
TVR	7 (8.1%)	14 (4.8%)	1.12 (0.40-3.11)	0.83
LM-TLR	7 (8.1%)	13 (4.4%)	1.32 (0.46-3.75)	0.60
Definite ST	0	0	NA	NA
MACE‡	11(12.5%)	26(8.5%)	1.10 (0.49-2.49)	0.82

*Derived from Kaplan-Meier estimate

†Adjusted for age, DM, clinical presentation, stent number, pre-procedural LCX DS, post-stenting LCX DS

‡MACE defined as the composite of death, MI, or LM TLR

Table 1. Comparison of MACE after adjustment.



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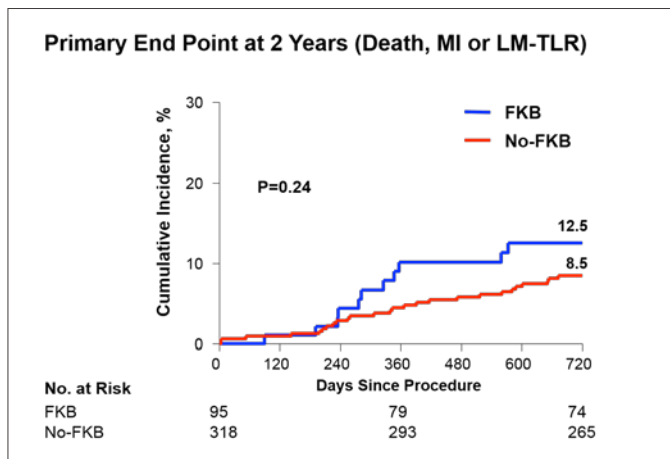


Figure 1. Two year primary end point.



Figure 2. Control angiogram showed occluded peroneal artery and posterior tibial artery.



Figure 3. Medial plantar artery was punctured with 22G needle.

showed the patent anterior tibial artery and occluded peroneal artery and posterior tibial artery. There was no proximal stump of occluded posterior tibial artery (Figure 2). Dr. Nakama mentioned that it seemed impossible to advance the guidewire into the occlusive posterior tibial artery with only conventional anterograde approach. He described their procedural process. At first, they tried to cross the guidewire with only conventional anterograde approach. However, there was no stump of posterior tibial artery. It was impossible to cross the guidewire to the occluded posterior tibial artery with only conventional technique. Then they tried to insert a retrograde access. However, there was no optimal and conventional retrograde puncture site.

Only medial plantar artery was observed at ankle level. They tried to puncture the medial plantar artery for retrograde access. Under local anesthesia, the medial plantar artery was punctured with 22G needle. Extreme trial of the puncture was succeeded, and they could finally insert the retrograde guidewire to the occluded posterior tibial artery (Figure 3). Polymer jacketed, hydrophilic-coated guidewire was carefully advanced and finally the guidewire could cross the occlusive posterior tibial artery. After the guidewire crossing, they externalized the retrograde guidewire with wire rendezvous technique. After success with the rendezvous technique, they dilated the occluded posterior tibial artery with 2.5/3.0

Figure 4. Pre- and post-angiogram.

mm tapered long balloon for 3 minutes. After the balloon dilatation, posterior tibial artery was optimally opened. Final angiogram showed a nice result (Figure 4). After this EVT, minor amputation surgery was performed immediately. A few weeks after the procedure, the patient's wounds cured. Dr. Nakama mentioned that this medial plantar puncture technique was named "sole puncture" technique. He concluded

that this extreme, extra-conventional pedal artery puncture is a good optional technique for complex below-the-knee and below-the-ankle occlusive lesion, and might possibly increase the procedural success rate of complex endovascular therapy.

Moderated Competition Session, Thursday, April 30, 8:30 AM - 12:30 PM / 2:00 PM - 6:00 PM

Yesterday's Glorious Best Presenters from Competition Sessions

Best Abstract Presenter

- 1-5. **Ping-Yen Liu** (Taiwan, National Cheng Kung University Hospital)
- 1-6. **Jia-Hui Zhang** (China, Fuwai Hospital, CAMS&PUMC)
- 1-7. **Wei-Chun Huang** (Taiwan, Kaohsiung Veterans General Hospital)
- 1-8. **Tairo Kurita** (Japan, Mie University graduate school of Medicine)
- 1-9. **Jin-Ho Choi** (Korea Republic of, Samsung Medical Center)
- 1-10. **Nicolas Foin** (Singapore National Heart Centre Singapore)
- 1-11. **Christopher Michael Cook** (UK, Imperial College London)
- 1-12. **Alfonso Ielasi** (Italy, Bolognini Hospital)
- 2-5. **Seung-Woon Rha, MD** (Korea Republic of, Korea University Guro Hospital)
- 2-6. **Taek Kyu Park** (Korea Republic of, Samsung Medical Center)
- 2-7. **Wojciech Wojakowski** (Poland, Medical University of Silesia)
- 2-8. **Hidefumi Ohya** (Japan Takeda General Hospital)
- 2-9. **Takahiro Tokuda** (Japan, Saiseikai Yokohama City Eastern Hospital)
- 2-10. **Koshi Matsuo** (Japan, Osaka Police Hospital)
- 2-11. **Kojiro Miki** (Japan, Hyogo College of Medicine)
- 2-12. **Dainis Krievins** (Latvia, Pauls Stradins Clinical University Hospital)

Best Case Presenter

- 1-5. **Emiko Ejima** (Japan, Kyushu Medical Center)
- 1-6. **Hiroko Kamitani** (Japan, Tottori University Hospital)
- 1-7. **Shih-Hung Chan** (Taiwan, National Cheng Kung University Medical Center)
- 1-8. **Lin Lin** (Taiwan, National Taiwan University Hospital, Hsin-chu Branch)
- 1-9. **Guang-Won Seo** (Korea Republic of, Inje University Haeundae Paik Hospital)
- 1-10. **Tomohiko Watanabe** (Japan, Sapporo Cardiovascular Clinic)
- 1-11. **Chun-Wei Lee** (Taiwan, MacKay Memorial Hospital)
- 1-12. **Yutaka Tadano** (Japan, Sapporo Cardiovascular Clinic)
- 2-5. **Huiping Zhang** (China, Beijing Hospital)
- 2-6. **Shozo Ishihara** (Japan, Mimihara General Hospital)
- 2-7. **Koji Yanaka** (Japan, Kansai Rosai Hospital)
- 2-8. **Dainis Krievins** (Latvia, Pauls Stradins Clinical University Hospital)
- 2-9. **Junichi Tazaki** (Japan, Kyoto University Hospital)
- 2-10. **Yoshinori Tsubakimoto** (Japan, Japanese Red Cross Dainil Hospital)
- 2-11. **Huai-Wen Liang** (Taiwan, National Taiwan University Hospital)
- 2-12. **Seung-Woon Rha** (Pakistan, Korea University Guro Hospital)
- 3-5. **Yusuke Yoshikawa** (Japan, Tenri Hospital)
- 3-6. **Joo Myung Lee** (Korea Republic of, Seoul National University Hospital)
- 3-7. **Ki-Hyun Jeon** (Korea Republic of, Sejong General Hospital)
- 3-8. **Hisao Otsuki** (Japan, Tokyo Women's Medical University)
- 3-9. **Chih-Kuo Lee** (Taiwan, National Taiwan University Hospital, Hsin-chu Branch)
- 3-10. **Kiyonori Nanto** (Japan, Kansai Rosai Hospital)
- 3-11. **Tatsuya Nakama** (Japan, Miyazaki Medical Association Hospital)
- 3-12. **Jang Yong Kim** (Korea Republic of, Seoul St. Mary's Hospital)

18th KCTA Symposium

Annual Conference for Cardiovascular Nurse & Technologist Joint Program with TCTAP 2015

The Nurse and Technologist Symposium at TCTAP 2015 is a preminent forum for cardiovascular learning. The symposium will cover the latest advances in BVS, TAVI, TRI, and brand-new imaging techniques. It will also feature a one day clinic.

The catheterization laboratory or cath lab requires a higher level of education from its staff. The cath lab involves a different type of collaboration with physicians. The expectation of nurses and technologists both in the cardiac cath lab and with research is that their education and knowledge is at a high level and able to handle a great deal of responsibility. If the physician is doing a case and things are not going smoothly, for example the guide catheter is not going into the vessel as it should, it is expected for someone in the cath lab to speak up and say, "Have you thought of trying this curve?" It's more about being part of a

team than receiving directives. Cath lab members are expected to be active, not passive and always act with respect, and to the best of their knowledge. There is an agreement and expectation that everyone will operate on a certain level.

This 18th symposium will expand into an international era. New sessions will be introduced, which include lectures from invited speakers from China and Japan. Topics include BVS, data management of PCI database, ultrasonography guided wiring for SFA CTO, and FD-OCT guided PCI. These are all cutting-edge themes for all attendees.

Be ready to attend the Nurse and Technologist Symposium which will be held at 2015 TCTAP on May 1, 2015.

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

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Reference 1) Drugs. 2010;70(1):41-56 / 2) Br J Pharmacol. 2001;133(8):1330-8 / 3) Circulation 2001;104(5):511-4

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