Dear Guests,

It is with great pleasure that we welcome you to participate in CardioAlex 2013; this conference is organized by the Egyptian society of Cardiology & the Cardiology department – Alexandria University. We are delighted to announce that it is taking place in Alexandria, Bibliotheca Alexandrina, from 11th to 14th June 2013. CardioAlex is undoubtedly the most comprehensive event and the meeting point of cardiologists, not only from Egypt, but from Middle East area and North Africa region. The 2013 edition is certainly one not to miss as, for the first time ever, CardioAlex 2013 will be held alongside 13 international bodies, so we encourage you to be part of this unique learning and networking experience. The aim of the conference is to arm you with the latest practice-changing advice in cardiovascular field, bringing you up-to-date with all the developments in primary and secondary care. The Scientific Program includes an exciting mix of joint state of the Art lectures, personal practice sessions, International Live cases, courses, workshops, symposia and tech-Nurse sessions. Prestigious speakers from all over the world will show their expertise and offer updates on key clinical issues and the latest cardiovascular science. Our intention is to create an opportunity for all delegates to actively participate in the conference in a variety of ways. Therefore, we will be happy to evaluate your abstracts and cases and offer you a chance to present your work. Taking this opportunity we proudly announce CardioAlex 2013 Prize in imaging science “Magdy Rashwan Prize”, this great man who shared during the last years our success and empowered us by his inspired vision. We are welcoming you in our beautiful Alexandria & we wish you an informative and enjoyable week.

CardioAlex Chairman
Prof. Mohamed Sobhy
Head of Cardiology Department, Alexandria University

CardioAlex - Executive board
Prof. Mahmoud Hassanain
Professor of Cardiology, Alexandria University
Prof. Tarek El Zawawy
Professor of Cardiology, Alexandria University

President of EgySC
Prof. Sherif El Tobgi
Professor of Cardiology, Cairo University

Prof. Moustafa Nawar
Professor of Cardiology, Alexandria University

“Magdi Rashwan” will remain in our hearts forever

We would like to express our sincere condolences for the unexpected death of our colleague Prof. Magdy Rashwan. On behalf of the entire department; please accept our sympathy; we can imagine what a difficult loss this will be for the entire medical field and for his family as he was a valuable asset to the medical field.

With loving memories of “Magdy Rashwan”

For whom who didn’t meet Prof. Magdy Rashwan, except for few occasions; they didn’t have the chance to know his kindness and his great prospect of life. We must be proud that God had blessed us with such amazing personality, the words are not enough to heal this great loss but we need to keep patience. All the members of CardioAlex board send their sincere sympathy to his family. We will greatly Miss Prof. Magdy Rashwan. It is a national tragedy that this amazing Doctor has been lost. God bless his Soul.
Hot topics from the top

* What is new at ACC.13: heart failure and hypertension
* New ESC guidelines on Valvular Heart Disease
* Added value of echocardiography in acute coronary syndromes
* ESC Guideline Sessions
* Heart Failure
* Acute Coronary Syndrome
* Silent Atrial Fibrillation: Implication for medical, ablative and surgical management
* Renal denervation step by step, tips and tricks
* LAA closure
* Acute stroke interventions for cardiologists?
* Update in antithrombotic therapy in ACS
* FFR and IVUS... step by step, tips and tricks
* TEVAR in acute type-b aortic dissection; Prerequisites for program success
* Great cases in nuclear cardiology
* Risk stratification with nuclear cardiology: making the cath no cath decision
* Practical implementation of the ESC heart failure Guidelines.
* The latest ESC Hypertension Guidelines update. What is new?
* How to optimize heart failure drug therapy. A tricky task.
* The renal denervation therapy using the second generation catheters.
* Bioabsorbable scaffold update where to go?
* WHERE ARE WE IN ECHO IN THE CARDIAC IMAGING ERA 2013?
* Sudden Cardiac Death 2013: Scientific, Social, and Economic Issues
* "25 by 25" - the new global agenda for prevention of cardiovascular disease.
* Diabetes mellitus and prevention of cardiovascular disease: new treatment targets.
* Current pharmaco-mechanic approach to STEMI patients
* Stent For Life Initiative
* STEM/AAC transfer strategies 2013
* How to diagnose and treat peripheral arterial disease (PAD) for cardiologists
* Endovascular treatment of arterial occlusive disease
* Diagnosis and treatment of chronic venous insufficiency by cardiologists
* Current limitations of Primary PCI in STEMI
* Innovative protocols and technology to reduce radiation in nuclearcardiology and cardiovascular CT
* Intervention
* Nuclear Imaging
* Basic Science
* Echocardiography
* Clinical Seminar
* Research & Present
* Pediatric
* Valvular
Mohammad Shenasa  
MD PHD, FACC, FESC, FAHA, FHRS, O’Conner Hospital San Jose, CA

Competitive athletes are among the healthiest and most fit groups in society; therefore, sudden cardiac death is a very tragic event to the community including family, friends, teams, physicians, coaches, social media influence as well as legal issues that are involved etc. The overall incidence of sudden cardiac death in athletes is low and is estimated at 0.3-3/100,000 per year. The ratio of sudden cardiac death between men and women is 10 to 1 and it is more common in Europe. Sudden cardiac death in basketball players in the United States and soccer players in Europe. The ratio of sudden cardiac death in North America and arrhythmogenic right ventricular dysplasia is the most common cause in Europe and the Mediterranean. The Italian model of mandating preparation and cost effective or not. It is very important to be able to differentiate the presence of structural or electrical abnormalities or cause remodeling of the cardiovascular system, over time.

Hypertrophic cardiomyopathy is the most common cause of sudden cardiac death in athletes. After all safety is the number one issue. Screening that relies solely on a history and physical examination has limited sensitivity to identify athletes at risk because most individuals with undetected cardiovascular diseases are asymptomatic and cardiac arrest most often represents the first manifestation of disease in athletes with SCD. Figure 1 demonstrates the five common causes of sudden cardiac death in athletes. After all safety is the number one issue.
**Alpha-Blocker and Angiotensin Converting Enzyme Inhibitor in the management of critical pulmonary valve stenosis. From bench to bedside.**

**Mohammed Omar Galal**
M.D., PhD, MBA
Prince Salman Heart Center, Riyadh, Saudi Arabia

**Background**
Patients with valvar pulmonary stenosis have increased density and responsiveness of alpha 2 adrenoceptors on the circulating cells [1]. After balloon dilation there is an immediate drop in these values to normal levels. It was speculated that alpha2 adrenoceptors on the circulating cells represent distribution of these receptors on cardiac, systemic and pulmonary vascular myocytes [1]. Occasionally alpha2 adrenoceptors do not decrease after balloon valvuloplasty and elevated alpha2 receptor activity could explain oxygen desaturation in a subset of these patients, despite successful balloon valvuloplasty [2].

**Hypothesis**
Alpha2 blocker and Angiotensin Converting Enzyme inhibitor (ACE-I) have a role in the treatment of critical pulmonary valve stenosis.

**Methods / Results**
Based on this speculation, phentolamine infusion has been used successfully in two neonates who remained critically ill after a successful intervention. Phentolamine application improved their clinical status dramatically [2]. Alpha2 blocker showed also effective in a patient who remained prostaglandin and oxygen dependent for 2 weeks post successful pulmonary valvuloplasty. [3]. Before discontinuing phentolamine, oral (ACE-I) was initiated assuming its similar effect on pulmonary vasculature and right ventricular compliance. Encouraged by this experience [3], in a case with oxygen dependency in the absence of major clinical distress, the patient received oral ACE-I. Within 12 hrs, the patient was weaned off oxygen completely. [4].

**Discussion**
Stimulating alpha adrenergic receptors on the peripheral vessels as well as in pulmonary vessels leads to vasoconstriction. The blocking of these receptors with phentolamine leads to vasodilatation. Also angiotensin II leads to vasoconstriction of the peripheral as well as the pulmonary vascularity. ACE-I blocks the conversion of angiotensin I to angiotensin II. This does not only lower arteriolar resistance and increases venous capacity, but also can lower the resistance in the pulmonary vasculature. In the rat model ACE inhibitor decreases pulmonary arterial pressure through preservation of endothelial nitric oxide synthase. [5] It has been also shown that ACE-I increases bradykinin, an agonist of Nitric oxide synthase (NOS). Nitric oxide is a well known vasodilator of the pulmonary vascularity [6]. By facilitating forward flow into the lung as well as reducing the afterload, through vasodilatation, cardiac output is increased and hence perfusion and overall oxygenation improved. The other effect of nitric oxid e (NO) is to modulate cardiac function by abbreviating the systolic contraction = enhancement of diastolic relaxation, which was seen in patients with severe pressure-overload hypertrophy. Additionally, NO exerts a decrease in left ventricular end-diastolic pressure without affecting left ventricular systolic pump function [7]. If this mechanism is also effective in the right ventricle, this would facilitate right ventricular inflow and would add to the noticed improvement of oxygenation in our patient.

All the different reports of alpha blocker as well as ACE-I could explain their beneficial actions and potential important role in the management of patients with critical pulmonary stenosis described by us.

**Conclusions**
Using this therapeutic approach as early as possible, may shorten oxygen / PGE dependency in these patients and save them from further interventions. Unfortunately, awaiting a controlled study is very difficult to achieve, as the disease is extremely rare.

**LIVE TRANSMISSION FROM THE JIM**

**Dr. Antonio Colombo**
MD practices Cardiovascular Medicine since 1978. He works in Milan, Italy, as a Director of Cardiovascular Interventions in San Raffaele Scientific Institute (a major University Hospital in Italy), in Columbus Hospital as well as in New York, USA at Columbia Medical Center as a Visiting Professor of Medicine.

**CASE 1**
**Demographics**
• 69 year-old
• Hypercholesterolaemia
• Previous MI

**Presentation**
• Exertional chest pain

**Investigations & initial treatment**
• ECHO - Normal LV function
• Angiogram revealed 3-vessel disease with diffuse disease in LAD and significant diffuse disease in dominant RCA
• Patient preference and poor quality of LAD for grafting led to decision to treat with PCI
• LAD treated with 4 ABSORB BVS (3.5/12, 3/28, 3/28 and 2.5/28) 6 weeks ago

**Risk scores**
• EuroSCORE – 0.69%
• SYNTAX - 16
• SYNTAX II - 20

**CASE 2**
**Demographics**
• 57 year-old
• HTN
• DM II (on insulin)
• Ex-smoker

**Presentation**
• Exertional chest pain

**Investigations**
• +ve ETT with anterior ischaemic changes
• ECHO – apical hypokinesia, preserved LV function
• Angiogram – Significant diffuse LAD disease and significant discrete lesions in mid and distal RCA

**Risk scores**
• EuroSCORE – 0.71%
• SYNTAX - 18
• SYNTAX II - 22

**Live with Dr. Antonio Colombo**
@ Middle Hall 14:30

**From**
OSPEDALE SAN RAFFAELE
VIA OLGETTINA, 69 - 20132 MILANO

**Strategy** – BVS implantation on LAD

www.cardio-alex.com
Isolated left ventricular apical hypoplasia is a newly recognized type of cardiomyopathy, it was first described in 2004 by Frenandz Valls et al.

* A truncated and spherical left ventricle.
* Fatty material into left ventricular apex.
* Abnormal origin of papillary muscle from the flattened apical left ventricle.
* An elongated right ventricle wrapping around the deficient apex.

Clinical presentation vary widely from asymptomatic to congestive heart failure.
Pathophysiological basis and natural history of this entity remain unknown.
When cardiologists become familiar with this new cardiomyopathy, more insights may become available.
Look closer

With XIENCE, the rate of stent thrombosis in patients interrupting DAPT* after 3 months is no higher than in those with no interruption out to 2 years.1

- Results over 2 years from 13,259 patients of which 40% were high risk
- ~37% of patients interrupted DAPT at some point

*XAPT Interruption: aspirin and/or thienopyridine not taken for at least 1 day, for any reason

Data on file at Abbott Vascular.
Abbott Vascular International BVBA
Park Lane, Culliganlaan 2B, B-1831 Diegem, Belgium. Tel: 32.2.714.14.11 Fax: 32.2.714.14.12
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For more information, visit our website at www.AbbottVascular.com
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Complex Coronary Disease
High Risk PCI Live Case Transmission From: Mount Sinai Hospital, New York, USA
Icahn School of Medicine @ Mount Sinai Medical Center
Presentation: Late presentation. Episode of CP 1 week prior. Presented to ER in pulmonary edema. Troponin 2 None. LVEF 40% on TTE.
Past History: HTN, s/p PPM, CKD with Serum Creatinine 2.5mg/dl (eGFR<30ml/mon.1.73m²), Hyperlipidemia, Ex-Smoker, paroxysmal AFib, Gout, s/p Fall episode(s)
Medications: Aspirin, Plavix, Rosuvastatin, Lopressor, ISDN, Pepcid
Cath: R+L H Cath on 6.3.13 with 3V CAD Left main: < 30%
Syntax score: LAD: Ca++, prox 80-90%, D1 total occlusion (1,1,1) 31: LCx: prox 30-50%, OM1 subtotal occlusion
STS 9.9%: RCA: ostium 30-50%, mid with a subtotal occlusion
Progress: 6/3/13 Rota/PCI of prox. LAD (too high risk for CABG)
Plan: RCA PCI today

GFR classification
Revised CKD Classification based upon GFR and albuminuria

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<th>GFR stages</th>
<th>GFR (mL/min/1.73m²)</th>
<th>Terms</th>
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<tbody>
<tr>
<td>G1</td>
<td>&gt;90</td>
<td>Normal or high</td>
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<tr>
<td>G2</td>
<td>60-90</td>
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<tr>
<td>G3a</td>
<td>45-59</td>
<td>Mild to moderately decreased</td>
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<td>G3b</td>
<td>30-44</td>
<td>Moderately to severely decreased</td>
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<td>G4</td>
<td>15-29</td>
<td>Severely decreased</td>
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<tr>
<td>G5</td>
<td>&lt;15</td>
<td>Kidney failure (add D if on dialysis)</td>
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Albuminuria

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<th>Stages</th>
<th>AER (mg/day)</th>
<th>Terms</th>
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<td>A1</td>
<td>&lt;30</td>
<td>Normal to mildly increased</td>
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<tr>
<td>A2</td>
<td>30-300</td>
<td>Moderately increased</td>
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Appropriateness Criteria for Coronary Revascularization
Pharmaceutical Article

Effectiveness and tolerability of fixed dose combination of amlodipine/valsartan in treatment of hypertension in real-life setting among Egyptian patients

1-Head of internal medicine department, Menofya University 2-Professor of cardiology, Alex University 3- Consultant cardiologist, NHI 4-Professor of cardiology, Alex University 5-Novartis Pharma S.A.E

Aim: To evaluate the effectiveness, safety and tolerability of the single-pill combination of amlodipine/valsartan among Egyptian patients with arterial hypertension in the real-life setting.

Methods and Results: This prospective, open-label, multi-center, non-comparative post-marketing surveillance study enrolled adults with arterial hypertension (systolic BP >140 mmHg and/or diastolic BP >90 mmHg) treated with single-pill combination (SPC) of amlodipine/valsartan 5/160 or 10/160 mg once daily dose. Patients were observed over a 3-months period with approximately monthly intervals between clinic visits. Primary objectives were comparison of systolic and diastolic blood pressure and heart rate at study start and after 12 weeks of therapy. Secondary objectives were evaluation of the blood pressure lowering effect in terms of response rates, evaluation of safety and tolerability of study medication.

The results showed: a total of 2489 patients were evaluated. Mean age was 54 years and 85% of patients had received prior antihypertensive therapy. At study end, a significant mean BP reduction of -39.4/-21.7 mmHg (baseline: 171.5/103.4 mmHg; p<0.001) was seen in the overall population (Fig 1). The corresponding mean BP reduction for patients on amlodipine/valsartan 5/160 mg was -34.6/-19.2 mmHg (baseline: 166/101 mmHg; p<0.001) and for patients on amlodipine/valsartan 10/160 mg was -47.1/-24.3 mmHg (baseline: 178.6/106.4 mmHg; p<0.001). In a post-hoc analysis for subgroups with important co-morbid conditions, the corresponding mean BP reductions were: patients with diabetes, -41.1/-21.6 mmHg (baseline 173.2/103.5 mmHg; p=0.00001); patients with heart failure, -45.2/-22.8 mmHg (baseline 175.9/104.6 mmHg; p=0.00001); patients with history of coronary heart diseases, -43/22.7 mmHg (baseline: 175.8/105 mmHg; p=0.00001).

70.3% of patients had their blood pressure controlled (BP<140/90 mmHg).

Subjective investigators assessment as “excellent to very good” for amlodipine/valsartan SPC was 97.3% for effectiveness and 96.8% for tolerability. The corresponding investigators and patients assessment for compliance was 96.6% and 93.3% respectively.

Adverse events were reported in 4.4% of patients mainly due to edema in 3.6%. Amlodipine/valsartan SPC was generally well tolerated.

Conclusion: In a large cohort of uncontrolled hypertensive patients, SPC of amlodipine/valsartan provided effective blood pressure reduction and control with good tolerability. This data provides beneficial evidence of this combination in Egyptian hypertensive patients.
Return lines (in the return round please look for your hotel line no)

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Tuesday 11 June 2013

**INFO**
- Down to B1 Floor
- Up to Mezzanine Floor
- Out to Registration Tent
- Main Entrance

**Mezzanine Floor**

**First Floor**

**Second Floor**

**Entrance Floor**

**B1 Floor**
EXFORGE®HCT
5mg/160mg/12.5mg

EXFORGE®HCT
10mg/160mg/25mg

3 AGENTS IN A SINGLE PILL