CARDIOALEX-REP FOUNDATION CVREP

CARDIOALEX.22

NEWSLETTER

WEDNESDAY 08 JUNE 2022
ISSUE 02

WWW.CARDIO-ALEX.COM

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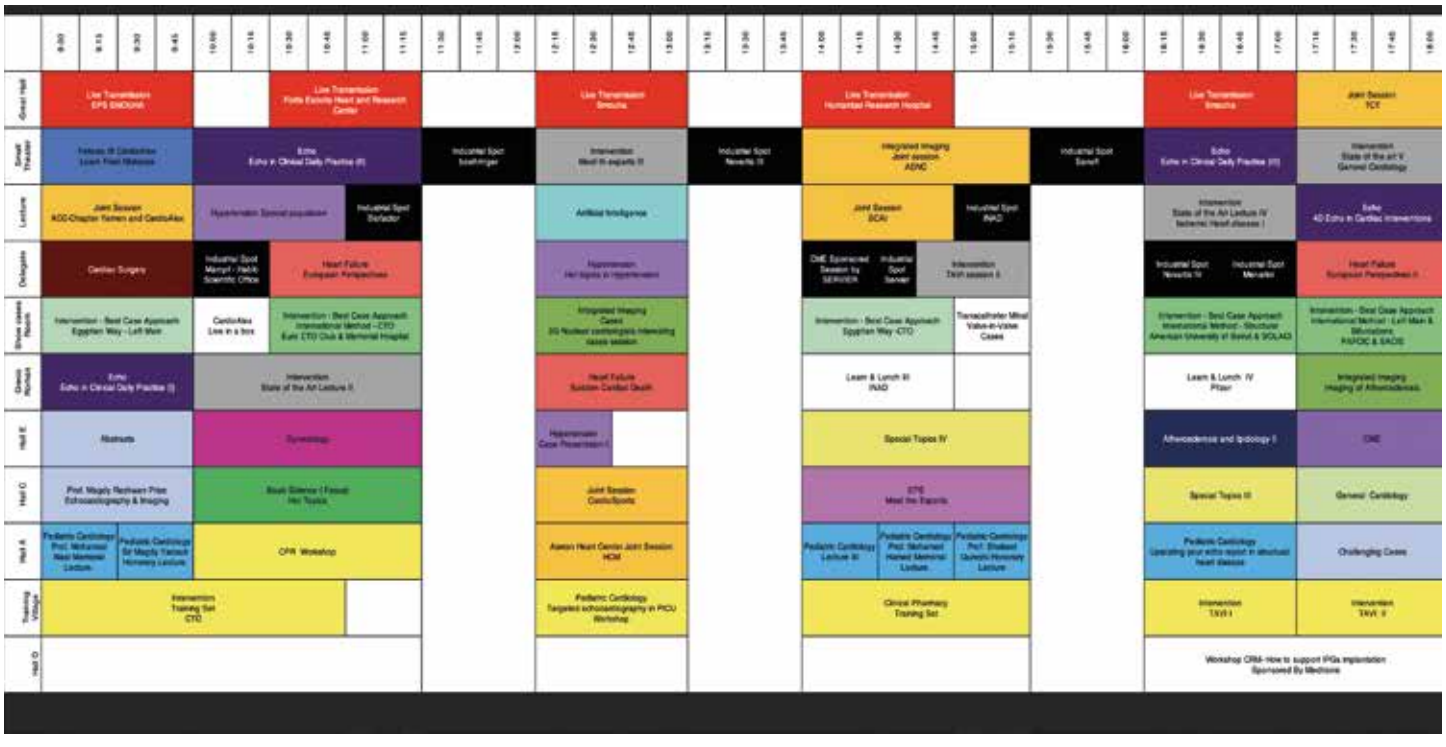
AT A GLANCE

WEDNESDAY, 08 JUN 2022



REGISTRATION & OPENING HOURS

- SCIENTIFIC OPENING HOURS
  09:00 – 19:30
- REGISTRATION AREA FOR SPEAKERS & CHAIRPERSONS
  11:00 – 19:30

sanofi

WORKSHOPS

EGYPTIAN RESUSCITATION COUNCIL IN COLLABORATION WITH EUROPEAN RESUSCITATION COUNCIL

10:00 - 11:30 Hall A

TARGETED ECHOCARDIOGRAPHY IN PICU WORKSHOP

12:15 - 13:15 Training Village

INTERNATIONAL JOINT SESSION

BEST CASE APPROACH INTERNATIONAL METHOD - CTO EURO CTO CLUB& MEMORIAL HOSPITAL

10:30 - 11:30 Show Cases Room

BEST CASE APPROACH INTERNATIONAL METHOD - STRUCTURAL AMERICAN UNIVERSITY OF BEIRUT&SOLACI

16:15 - 17:15 Show Cases Room

BEST CASE APPROACH INTERNATIONAL METHOD - LEFT MAIN & BIFURCATIONS PAN AFRICAN COURSE ON INTERVENTIONAL CARDIOLOGY (PAFCIC) & THE SAUDI ARABIA CARDIAC INTERVENTIONAL SOCIETY (SACIS)

17:15 - 18:15 Show Cases Room

CARDIOALEX.22
SYMPOSIA

WED, 08 JUN 2022

Marcyrl - Habib Scientific Office Industrial Spot
10:00 - 10:30 Delegate

Biofactor Industrial Spot
11:00 - 11:30 Lecture

Boehringer Industrial Spot
11:30 - 12:15 Small Theater

Novartis Industrial Spot
13:15 - 14:00 Small Theater

CME Sponsored Session by SERVIER
14:00 - 14:30 Delegate

Servier Industrial Spot
14:30 - 14:45 Delegate

INAD Industrial Spot
15:00 - 15:30 Lecture

Sanofi Industrial Spot
15:30 - 16:15 Small Theater

Novartis Industrial Spot
16:15 - 16:45 Delegate

Menarini Industrial Spot
16:45 - 17:15 Delegate

THU, 09 JUN 2022

Servier Industrial Spot
11:00 - 11:30 Small Theater

Sanofi Industrial Spot
12:30 - 13:00 Delegate

Abbot Vascular Industrial Spot
13:00 - 13:45 Small Theater

Boehringer Industrial Spot
13:45 - 14:15 Lecture

Biofactor Industrial Spot
14:15 - 14:45 Lecture

Novartis Industrial Spot
14:45 - 15:30 Small Theater

Pfizer Industrial Spot
16:30 - 17:15 Small Theater

TECH-NURSE

Medtronic Industrial Spot
10:30 - 11:30 Auditorium

Medtronic Industrial Spot
13:45 - 14:15 Auditorium

Medtronic
Engineering the extraordinary

DON'T MISS

NATIONAL LIVE TRANSMISSION

WED, 08 JUN 2022

09:00 - 10:00 Great Hall
A case of cryoballoon- guided PVI
Supported by: **Medtronic**

12:15 - 13:15 Great Hall
Smouha University Hospital
TAVI case
Supported by: **Medtronic**

16:15 - 17:15 Great Hall
Smouha University Hospital
CTO- Retrograde case
Supported by: **Abbott Vascular**

THU, 09 JUN 2022

10:00 - 11:00 Great Hall
International Cardiac Center
DynamX Bioadaptor - The Next Advancement in Coronary Intervention
Supported by: **Elixir Médical Corporation**
Elbahey Trading

INTERNATIONAL LIVE TRANSMISSION

WED, 08 JUN 2022

10:30 - 11:00 Great Hall
Fortis Escorts Heart and Research Center India
Onyx Case
Supported by: **Medtronic**

14:00 - 15:00 Great Hall
Humanitas Research Hospital Italy
(DES+DCB) treatment of diffuse disease

THU, 09 JUN 2022

13:45 - 14:45 Great Hall
Leipzig Heart Institute Germany
Transfemoral TAVI with commissural alignment

MOBILE APPLICATION

Download on the App Store

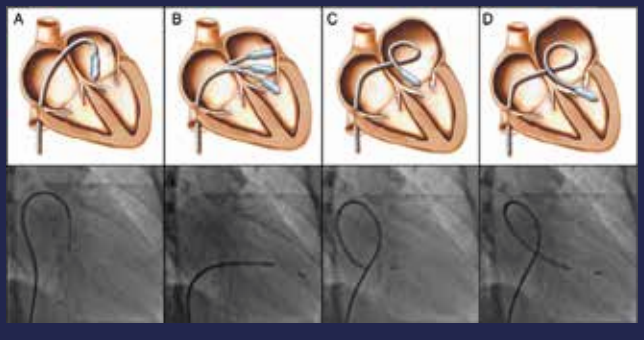
GET IT ON Google Play

#CardioAlex

MEET OUR INTERNATIONAL SPEAKERS

ANTONIS PANTAZIS	UK
HOSSAM EL GENDI	UK
JULIA GRAPSA	UK
OMER GOKTEKIN	TURKEY
KHALID TAMMAM	KSA
CHRISTIAN SCHLENSAK	GERMANY
OMAR GALA	KSA
GIUSEPPE MANCIA	ITALY
WAEL ABOSHOKKA	UAE
IMAD SHEIBAN	ITALY
THOMAS LUSCHER	UK
ALDO PIETRO MAGGIONI	ITALY
EWA JANKOWSKA	POLAND
GIUSEPPE ROSANO	UK
CHRISTOPH NABER	GERMANY
ANTOINETTE NEYLON	FRANCE
SAMIH LAWAND	KSA
DENNIS CALNON	USA
RANDALL THOMPSON	USA
RAMESH DAGGUBATI	USA
ALEXANDRA LANSKY	USA
EMAD AZI	USA
MICHEAL HEINEINZ	USA
SHIBU MATHEW	GERMANY
PETER AZIZ	USA
FRANK ING	USA
MATTEO CAMELI	ITALY
WILLIAM ZOGB	USA
SHERIF NAGUEH	USA
GREGG STONE	USA
MOHAMED JEILAN	KENYA
AHMED HASSANEIN	USA
GEORGE VETROVEC	USA
THOMAS HOVASSE	FRANCE
LUCY SAFI	USA
GIANLUIGI SAVARESE	SWEDEN
GREGORY THOMAS	USA
STEPHAN ACHENBACH	GERMANY

LATEST ADVANCES IN PERCUTANEOUS BALLOON MITRAL VALVULOPLASTY (PBMV)



RHEUMATIC HEART DISEASE IS A CHRONIC MANIFESTATION OF RHEUMATIC CARDITIS, WHICH OCCURS IN 60% TO 90% OF CASES OF RHEUMATIC FEVER. ALTHOUGH ALL OF THE CARDIAC VALVES MAY BE INVOLVED BY THIS RHEUMATIC PROCESS, THE MITRAL VALVE IS INVOLVED MOST PROMINENTLY. THE ENDOCARDIAL LESION MOST OFTEN LEAVES PERMANENT SEQUELA RESULTING IN VALVULAR REGURGITATION, STENOSIS, OR BOTH. STENOSIS OF THIS VALVE OCCURS FROM LEAFLET THICKENING, COMMISSURAL FUSION, AND CHORDAL SHORTENING/FUSION.

BEFORE THE ADVENT OF PBMV, MOST PATIENTS WITH SYMPTOMATIC MS WERE TREATED WITH SURGICAL MITRAL COMMISSUROTOMY. IN COMPARISON TO SURGICAL MITRAL COMMISSUROTOMY, PBMV HAS SHOWN EQUAL OR BETTER SUCCESS RATES AND COMPARABLE RESTENOSIS RATES. RANDOMIZED TRIALS COMPARING PBMV TO CLOSED COMMISSUROTOMY HAVE SHOWN THAT PBMV IS SUPERIOR TO CLOSED COMMISSUROTOMY, PROVIDING A LARGER VALVE AREA AND BETTER LONG-TERM DURABILITY.

LOCK ET AL IN INDIA FIRST REPORTED THE USE OF A CYLINDRICAL BALLOON FOR MITRAL VALVULOPLASTY.

SUBSEQUENTLY, THE IDEA OF A DOUBLE-BALLOON TECHNIQUE WAS INTRODUCED FROM SAUDI ARABIA AS

A POTENTIAL ALTERNATIVE METHOD FOR BALLOON COMMISSUROTOMY. THE DOUBLE-BALLOON TECHNIQUE REQUIRES THAT 2 GUIDEWIRES BE POSITIONED IN THE LEFT VENTRICULAR APEX, THROUGH WHICH 2 FLOATING BALLOON CATHETERS ARE THEN ADVANCED ACROSS THE MITRAL VALVE ORIFICE. ALTHOUGH THE DOUBLE-BALLOON TECHNIQUE IS SURELY EFFECTIVE, IT IS MORE TECHNICALLY DEMANDING AND THUS OFTEN REQUIRES A LONGER PROCEDURE TIME, WHICH MAY LEAD TO INADVERTENT COMPLICATIONS. THE GUIDEWIRE POSITIONED IN THE LEFT VENTRICULAR APEX SOMETIMES INDUCES PERFORATION OF THE APEX, LEADING TO CARDIAC TAMPONADE. IN FACT, PBMV USING A SINGLE INOUE BALLOON YIELDS EQUIVALENT EFFICACY WHEN COMPARED WITH THE DOUBLE-BALLOON TECHNIQUE AND WITH LOWER PROCEDURAL RISKS. TODAY, THEREFORE, INOUE'S SINGLE-BALLOON TECHNIQUE HAS BECOME THE MOST POPULAR METHOD FOR PERFORMING PBMV IN MOST PARTS OF THE WORLD.

WIFI
GET YOUR USERNAME & PASSWORD

NOVARTIS

SCIENTIFIC PROGRAM ACCREDITATION

"CardioAlex.22 - Program" is accredited by **THE EUROPEAN BOARD FOR ACCREDITATION IN CARDIOLOGY (EBAC)** For **"20"** Hours

EBAC®

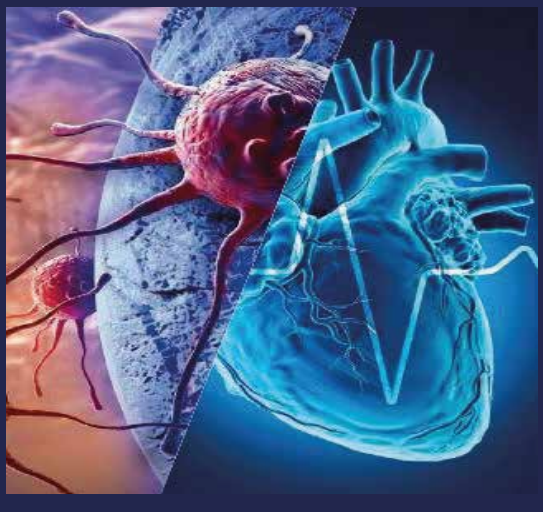
TAVI, ALEXANDRIA UNIVERSITY EXPERIENCE

Degenerative aortic valve stenosis has an increasing prevalence nowadays due to the increased awareness, advancement in our imaging modalities and treatment strategies. It is the most common valvular lesion in Europe according to the latest surveys and clinical studies. It carries significant CV morbidity and mortality, especially in elderly patients with a high burden of CV risk factors and other comorbidities.

TAVI offers a safe and effective option nowadays in the elderly or high surgical risk populations with severe aortic stenosis with ongoing innovations in valve design, implantation techniques,vascular access closure options and imaging modalities, along with accumulating experience and clinical data. Hence, TAVI was approved as a class I recommendation in "low risk "patients
with some concerns about the long-term outcomes, which are currently being tackled in every aspect of the daily practice.

TAVI gained popularity in our practice in the Egyptian cardiac centers after the provision of the latest devices through the Egyptian United Pay Agency (U.P.A.) and the accumulation of experience in the leading centers in our country. Alexandria university has started its TAVI program for more than one year, completing a series of twenty successful cases under the supervision of certified proctors in the field of TAVI. Our program commenced with a series of lectures, workshops and hands-on training sessions before proceeding into operating our first case.

The establishment of a multi-disciplinary team was crucial before starting this elegant program, combining multiple subspecialties such as: cardiac structural interventionists, cardiac imagers, cardiac anesthesiologists, cardio-thoracic surgeons and vascular surgeons. This approach refines our practice, predicts complications and improves our outcome. Initiating a TAVI program mandates continuous data collection to establish a local registry enabling continuous clinical auditing and promoting research to improve our practice and outcomes. Finally, we hope to expand our program to offer a large number of indicated patients the latest evidence-based practice interventions to reduce the disease burden in our community



Cardio-oncology is neither the science nor the practice of treating heart tumors, rather an emerging multidisciplinary field that focuses on the cardiovascular management (prevention, diagnosis and treatment) of patients with cancer.

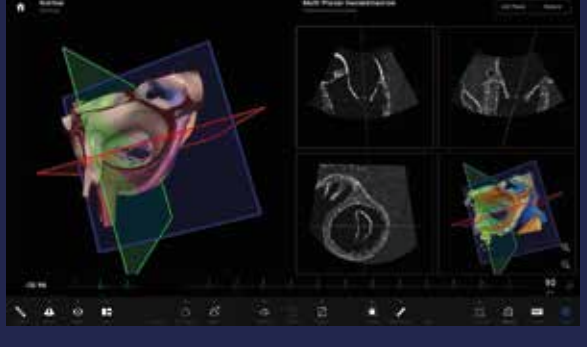
The core objective of the cardio-oncology discipline is to ensure that "the cancer patient of today does not become the heart patient of tomorrow."

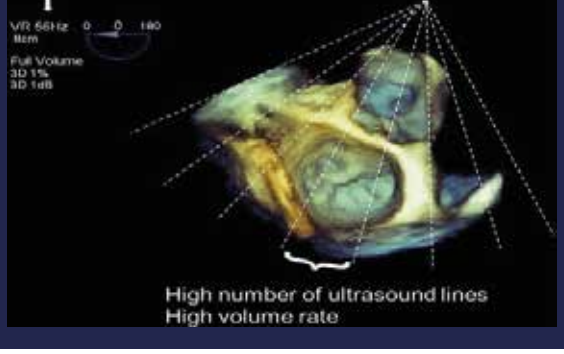
This year, we are focusing on this emerging subspecialty with dedicated lectures & talks.

Come join us and don't miss cardioncology sessions to learn about Alexandria university experience with this field.

Transesophageal Echocardiography has long been a key imaging modality for the evaluation of cardiac structures. The identification of detailed anatomical characteristics of the cardiac structures is essential to understand the mechanisms of the diseases and to select an optimal timing and guide intervention, however, conventional two-dimensional (2D) echocardiography has substantial limitations in assessing the complex anatomy of the complex cardiac anatomy. One of the main limitations is that 2D echocardiography can only show one acquisition plane which sometimes leads to misunderstanding of the disease. Recent developments allow the characterization of the complex anatomy of cardiac structures with great accuracy using three-dimensional (3D) echocardiographic images with great accuracy.

Don't miss the opportunity of learning from our experts in 2D & 3D TEE workshop in cardioalex 2022.





CLINICAL TRIALS

DUAL ANTIPLATELET THERAPY AFTER PCI IN PATIENTS AT HIGH BLEEDING RISK (MASTER-DAPT TRIAL)

Methods

One month after they had undergone implantation of a biodegradable-polymer sirolimus-eluting coronary stent, we randomly assigned patients at high bleeding risk to discontinue dual antiplatelet therapy immediately (abbreviated therapy) or to continue it for at least 2 additional months (standard therapy). The three ranked primary outcomes were net adverse clinical events (a composite of death from any cause, myocardial infarction, stroke, or major bleeding), major adverse cardiac or cerebral events (a composite of death from any cause, myocardial infarction, or stroke), and major or clinically relevant nonmajor bleeding; cumulative incidences were assessed at 335 days. The first two outcomes were assessed for noninferiority in the per-protocol population, and the third outcome for superiority in the intention-to-treat population.

RESULTS

Among the 4434 patients in the per-protocol population, net adverse clinical events occurred in 165 patients (7.5%) in the abbreviated-therapy group and in 172 (7.7%) in the standard-therapy group (difference, −0.23 percentage points; 95% confidence interval [CI], −1.80 to 1.33; P<0.001 for noninferiority). A total of 133 patients (6.1%) in the abbreviated-therapy group and 132 patients (5.9%) in the standard-therapy group had a major adverse cardiac or cerebral event (difference, 0.11 percentage points; 95% CI, −1.29 to 1.51; P=0.001 for noninferiority). Among the 4579 patients in the intention-to-treat population, major or clinically relevant nonmajor bleeding occurred in 148 patients (6.5%) in the abbreviated-therapy group and in 211 (9.4%) in the standard-therapy group (difference, −2.82 percentage points; 95% CI, −4.40 to −1.24; P<0.001 for superiority).

CONCLUSIONS

One month of dual antiplatelet therapy was noninferior to the continuation of therapy for at least 2 additional months with regard to the occurrence of net adverse clinical events and major adverse cardiac or cerebral events; abbreviated therapy also resulted in a lower incidence of major or clinically relevant nonmajor bleeding.

EMPAGLIFLOZIN IN HEART FAILURE WITH A PRESERVED EJECTION FRACTION(EMPEROR-PRESERVED TRIAL)

Methods

In this double-blind trial, we randomly assigned 5988 patients with class II–IV heart failure and an ejection fraction of more than 40% to receive empagliflozin (10 mg once daily) or placebo, in addition to usual therapy. The primary outcome was a composite of cardiovascular death or hospitalization for heart failure.

RESULTS

Over a median of 26.2 months, a primary outcome event occurred in 415 of 2997 patients (13.8%) in the empagliflozin group and in 511 of 2991 patients (17.1%) in the placebo group (hazard ratio, 0.79; 95% confidence interval [CI], 0.69 to 0.90; P<0.001). This effect was mainly related to a lower risk of hospitalization for heart failure in the empagliflozin group. The effects of empagliflozin appeared consistent in patients with or without diabetes. The total number of hospitalizations for heart failure was lower in the empagliflozin group than in the placebo group (407 with empagliflozin and 541 with placebo; hazard ratio, 0.73; 95% CI, 0.61 to 0.88; P<0.001). Uncomplicated genital and urinary tract infections and hypotension were reported more frequently with empagliflozin.

CONCLUSIONS

Empagliflozin reduced the combined risk of cardiovascular death or hospitalization for heart failure in patients with heart failure and a preserved ejection fraction, regardless of the presence or absence of diabetes.

CLINICAL TRIALS

PREVENTION OF CARDIAC DYSFUNCTION DURING ADJUVANT BREAST CANCER THERAPY (PRADA TRIAL):

Extended Follow-Up of a 2×2 Factorial, Randomized, Placebo-Controlled, Double-Blind Clinical Trial of Candesartan and Metoprolol

Methods

In this 2×2 factorial, randomized, placebo-controlled, double-blind, single-center trial, patients with early breast cancer were assigned to concomitant treatment with candesartan cilexetil, metoprolol succinate, or matching placebos. Target doses were 32 and 100 mg, respectively. Study drugs were discontinued after adjuvant therapy. All 120 validly randomized patients were included in the intention-to-treat analysis. The primary outcome measure was change in LVEF assessed by cardiovascular magnetic resonance imaging from baseline to extended follow-up. Secondary outcome measures included changes in left ventricular volumes, echocardiographic peak global longitudinal strain, and circulating cardiac troponin concentrations.

RESULTS

A small decline in LVEF but no significant between-group differences were observed from baseline to extended follow-up, at a median of 23 months (interquartile range, 21 to 28 months) after randomization (candesartan, 1.7% [95% CI, 0.5 to 2.8]; no candesartan, 1.8% [95% CI, 0.6 to 3.0]; metoprolol, 1.6% [95% CI, 0.4 to 2.7]; no metoprolol, 1.9% [95% CI, 0.7 to 3.0]). Candesartan treatment during adjuvant therapy was associated with a significant reduction in left ventricular end-diastolic volume compared with the noncandesartan group (P=0.021) and attenuated decline in global longitudinal strain (P=0.046) at 2 years. No between-group differences in change in cardiac troponin I and T concentrations were observed.

CONCLUSIONS

Anthracycline-containing adjuvant therapy for early breast cancer was associated with a decline in LVEF during extended follow-up. Candesartan during adjuvant therapy did not prevent reduction in LVEF at 2 years, but was associated with modest reduction in left ventricular end-diastolic volume and preserved global longitudinal strain. These results suggest that a broadly administered cardioprotective approach may not be required in most patients with early breast cancer without preexisting cardiovascular disease.

SHUTTLE BUS SCHEDULE

WEDNESDAY - 8TH JUNE 2022

From Hotels		Hotels	Return Lines	Return lines Please check your hotel line number
Round 1	Round 2			
08:30 am	10:00 am	Windsor		
08:40 am	10:10 am	Metropole Cecil	1	
08:00 am	10:00 am	Sheraton Helnan Palestine Helnan Palace	2	
08:15 am	10:15 am	Hilton corniche Four seasons Romance Tolip Jewel Grand plaza Hilton green plaza	3 4 5	10 minutes after last session
07:30 am	10:00 am	Radisson Blu	6	
08:30 am	10:00 am	Grand Royal (Cherry Marisky)	7	

THURSDAY - 9TH JUNE 2022

From Hotels		Hotels	Return Lines	Return lines Please check your hotel line number
Round 1	Round 2			
08:30 am	10:00 am	Windsor		
08:40 am	10:10 am	Metropole Cecil	1	
08:00 am	10:00 am	Sheraton Helnan Palestine Helnan Palace	2	
08:15 am	10:15 am	Hilton corniche Four seasons Romance Tolip Jewel Grand plaza Hilton green plaza	3 4 5	10 minutes after last session
07:30 am	10:00 am	Radisson Blu	6	
08:30 am	10:00 am	Grand Royal (Cherry Marisky)	7	

FOOD& BEVERAGE

WEDNESDAY 8TH of JUNE	
10:00 **Coffee Break1**	14:15 **Coffee Break 2**
14:00 **Learn & Lunch 1** - by invitation	16:15 **Learn & Lunch 2** - by invitation
17:15 **Lunch**	

THURSDAY 8TH of JUNE	
10:00 **Coffee Break1**	14:00 **Coffee Break 2**
13:45 **Learn & Lunch 1** - by invitation	15:30 **Learn & Lunch 2** - by invitation
17:15 **Lunch**	

ANSWER THE QUIZ& WIN GRAND PRIZES SCAN TO ANSWER

General recommendations for exercise and sports in healthy individuals

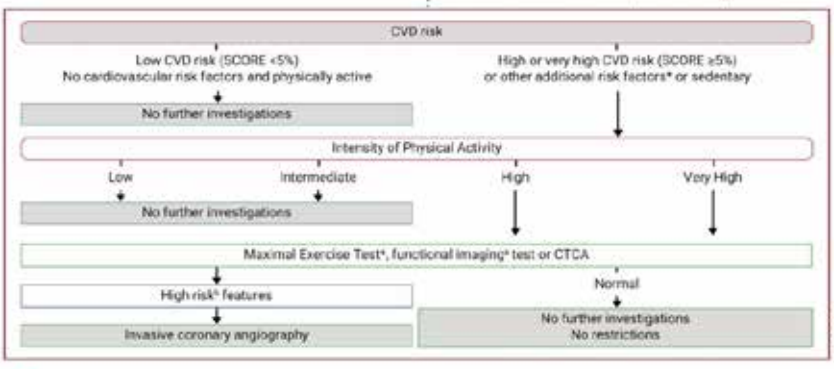
Recommendations	Class[a]	Level[b]
At least 150 min/week of moderate-intensity, or 75 min/week of vigorous-intensity aerobic exercise, or an equivalent combination thereof is recommended in all healthy adults.[113–118]	I	A
A gradual increase in aerobic exercise to 300 min/week of moderate-intensity, or 150 min/week of vigorous-intensity aerobic exercise, or an equivalent combination is recommended for additional benefits in healthy adults.[114,116]	I	A
Regular assessment and counselling to promote adherence and, if necessary, to support an increase in exercise volume over time are recommended.[119]	I	B
Multiple sessions of exercise spread throughout the week, i.e. on 4–5 days a week and preferably every day of the week, are recommended.[113,114]	I	B

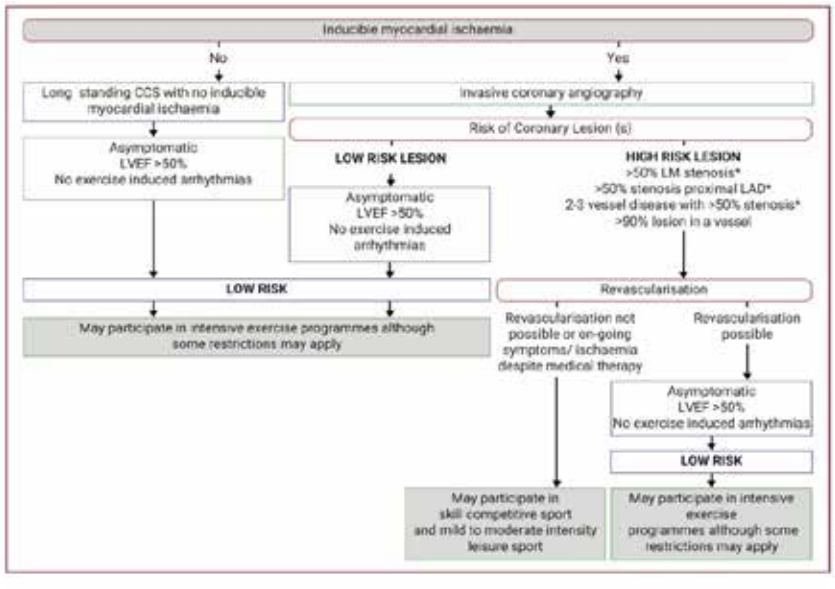
Recommendations for cardiovascular evaluation and regular exercise in healthy individuals aged >35 years

Recommendations	Class[a]	Level[b]
Among individuals with low to moderate CVD risk, the participation in all recreational sports should be considered without further CV evaluation.	IIa	C
Cardiac screening with family history, symptoms, physical examination, and 12-lead resting ECG should be considered for competitive athletes.	IIa	C
Clinical evaluation, including maximal exercise testing, should be considered for prognostic purposes in sedentary people and individuals with high or very high CV risk who intend to engage in intensive exercise programmes or competitive sports.	IIa	C
In selected individuals without known CAD who have very high CVD risk (e.g. SCORE>10%, strong family history, or familial hypercholesterolaemia) and want to engage in high- or very high-intensity exercise, risk assessment with a functional imaging test, coronary CCTA, or carotid or femoral artery ultrasound imaging may be considered.	IIb	B

Recommendations for exercise in ageing individuals

Recommendations	Class[a]	Level[b]
Among adults aged 65 years or older who are fit and have no health conditions that limit their mobility, moderate-intensity aerobic exercise for at least 150 min/week is recommended.[212,214,215]	I	A
In older adults at risk of falls, strength training exercises to improve balance and coordination on at least 2 days a week are recommended.[201,212,214,215]	I	B
A full clinical assessment including a maximal exercise test should be considered in sedentary adults aged 65 years or older who wish to participate in high-intensity activity.	IIa	C
Continuation of high- and very high-intensity activity, including competitive sports, may be considered in asymptomatic elderly athletes (master athletes) at low or moderate CV risk.	IIb	C





Recommendations for exercise in individuals with long-standing chronic coronary syndrome

Recommendations	Class[a]	Level[b]
Risk stratification for exercise-induced adverse events is recommended in individuals with established (long-standing) chronic coronary syndrome (CCS) prior to engaging in exercise.[233]	I	C
Regular follow-up and risk stratification of patients with CCS is recommended.[233]	I	B
It is recommended that individuals at high risk of an adverse event from CAD are managed according to the current Guidelines on CCS.[233]	I	C
Competitive or leisure sports activities (with some exceptions such as older athletes and sports with extreme CV demands) should be considered in individuals at low risk of exercise-induced adverse events (Table 11).[233]	IIa	C
Leisure-time exercise, below the angina and ischaemic thresholds, may be considered in individuals at high risk of exercise-induced adverse events (Table 11), including those with persisting ischaemia.[233]	IIb	C
Competitive sports are not recommended in individuals at high risk of exercise-induced adverse events or those with residual ischaemia, with the exception of individually recommended skill sports.[233]	III	C

GUIDE LINES

Recommendations for exercise prescription in heart failure with reduced or mid-range ejection fraction

Recommendations	Class[a]	Level[b]
Regular discussion about exercise participation and provision of an individualized exercise prescription is recommended in all individuals with heart failure.[260,261,285]	I	A
Exercise-based cardiac rehabilitation is recommended in all stable individuals to improve exercise capacity, quality of life, and to reduce the frequency of hospital readmission.[260,261,285]	I	A
Beyond annual cardiac assessment, clinical reassessment should be considered when the intensity of exercise is increased.	IIa	C
Motivational and psychological support and individualized recommendations on how to progress the amount and intensity of sports activities should be considered.	IIa	C
Low- to moderate-intensity recreational sporting activities and participation in structured exercise programmes may be considered in stable individuals.	IIb	C
High-intensity interval training programmes may be considered in low-risk patients who want to return to high-intensity aerobic and mixed endurance sports.	IIb	C