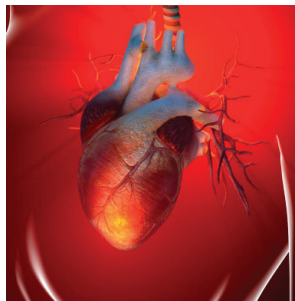


Video Presentation

Heart Congress 2019 & Cardiac Surgery 2019



Joint event on

10th WORLD HEART CONGRESS
&
6th International Congress on
CARDIOLOGY AND CARDIAC SURGERY
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Hypertension risk from iron brake particulate matter

William J Rowe

Medical University of Ohio, USA

Of 12 moon walkers, James Irwin on day after return from Apollo 15 mission, showed extraordinary bicycle (B) stress test (ST) hypertension (275/125) after 3 minutes exercise; supervising > 5000 maximum treadmill ST, author never witnessed ST- blood pressure approaching this level. Symptom-limited maximum B stress test showed "cyanotic fingernails"; possibly venous blood trapped peripherally, supporting author's "Apollo 15 Space Syndrome," postulating that severe fingertip pain during space walks, triggered by plasma fluid, trapped distally; mechanism could be related to endothelial dysfunction, providing "silent ischemia" warning. Neil Armstrong returned to Earth with severe diastolic hypertension (160/135), consistent with ischemic left ventricular dysfunction; 50 mm increase in comparison with resting BP 110/85. With inhalation of lunar dust, brought into habitat on space suit, with high lunar iron (I) this dust inhalation, along with reduced (R) space flight- transferrin, R antioxidant, calcium (Ca) blocker - magnesium, conducive to severe

oxidative stress, Ca overload with potential endothelial injuries. Using moon walker studies as example, my recent editorials show that I dust, released from brakes, with over 90% of brakes made of I, is a major hypertension factor and may also contribute to myocardial infarctions.

Biography

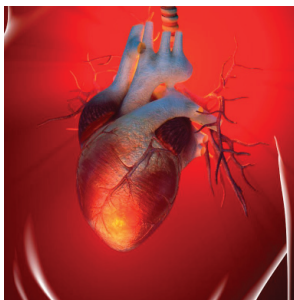
William J Rowe is a board certified specialist in Internal Medicine. He received his M.D. at the University of Cincinnati and was in private practice in Toledo, Ohio for 34 years. During that time he supervised over 5000 symptom - limited maximum hospital-based treadmill stress tests. He studied 3 world class extraordinary endurance athletes and published their exercise-related magnesium deficiencies. This triggered a 20 year pursuit of the cardiovascular complications of Space flight. He has published in LANCET that extraordinary, unremitting endurance exercise can injure a perfectly normal heart. Of only 4 space syndromes, he has published 2: "The Apollo 15 Space Syndrome" and "Neil Armstrong Syndrome." All his publications are posted on his website (HYPERLINK "<http://www.femsinspace.com>" www.femsinspace.com).

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 Notes:

e-Poster

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Caseous calcification of the mitral annulus. Report of a case

Juan Francisco Pérez Salúm

EACVI - HIT Ambassador, Paraguay

Male, 60 years old, hypertensive, dyslipidemic treated with atorvastatin 20 mg daily. He consumes losartan 50 mg every 12 hours. He was smoker of 10 packages year until 3 years before the examination. He does not have hospitalizations or previous surgeries. He denies symptoms. The patient came to our center to undergo a transthoracic echocardiogram control, in the context of his arterial hypertension.

On the echocardiography we found a severe concentric hypertrophy, mild dilation of the left atrium, mild central mitral valve insufficiency. A rounded echodense image with a regular surface of up to 2.22 cm by 1.75 cm was observed, anchored to the posterior ring of the mitral valve and extending to the posterior leaflet, which due to its characteristics is compatible with caseous calcification of the mitral annulus.

According to Deluca et. Al, the prevalence of caseous calcification of the mitral annulus is very low (0.06-0.07%); up to 0.6% of patients with mitral ring calcification.

This type of calcification is described as a chronic

degenerative process of greater frequency in elderly patients, with chronic renal disease, women and hypertensive patients. It most often begins in the basal zone of the posterior mitral valve and it may extend to the entire annulus.

The caseous material is composed of a calcified cover and inside it a mixture of calcium, fatty acids and cholesterol. Caseous calcification of the mitral annulus can be confused with abscesses and tumors. It is essential to make a good correlation with the clinic, in order to avoid unnecessary surgeries.

Biography

Juan Francisco Pérez Salúm is a doctor in Medicine and Surgery from the National University of Asunción. He is Specialist in Clinical Cardiology and Images in Cardiology. Completed his PhD in Health Administration and Master in Transoesophageal Echocardiography and Management of Hospital Centers. He is an Ambassador in Paraguay of EACVI -HIT (Heart Imagers of Tomorrow - European Association of Cardiovascular Imaging). He also worked as a theatre actor. And a writer in his free times.

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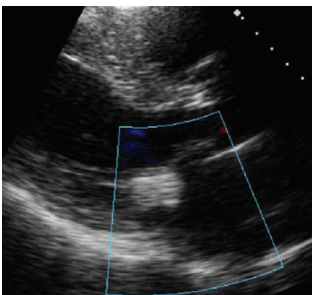


Fig1: Mass anchored to the posterior ring of the mitral valve

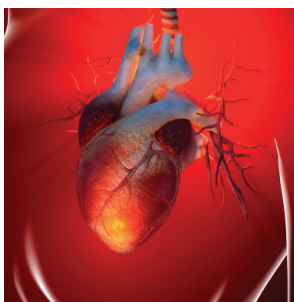


Fig. 2: Zoom of the mass

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"Life support-based comprehensive treatment regimen" in fulminant myocarditis treatments

Chen Chen, Dao Wen Wang

Tongji Hospital and Medical College, China

Fulminant myocarditis is caused majorly by the infection of various viruses. It arises quickly, progresses rapidly, and may lead to severe heart failure or circulatory failure presenting as hypotension and cardiogenic shock in a short time, and its mortality is up to 50-70%. The most importantly, there are no treatment options, and no treatment guidelines or expert consensus statement.

Here, we provide first expert consensus, Chinese Society of Cardiology Expert Consensus Statement on the Diagnosis and Treatment of Fulminant Myocarditis, based on the data of our recent registered clinical trial. In this statement, we described its clinical features and diagnostic criteria, and importantly, first time we described a new treatment regimen,

"life support-based comprehensive treatment regimen". This treatment regimen includes serious managements of nutrients and fluids, sufficient doses of glucocorticoid, immunoglobulin, antiviral reagents, continuous renal replacement therapy and life-support treatments including applications of mechanical respirators and circulatory support systems, intraaortic balloon pulsation (IABP) and extracorporeal membrane oxygenation (ECMO) as well as cardiac pacemaker if it is needed.

Our practice in multiple cardiac centers demonstrates this treatment can dramatically lower the mortality of the patients with fulminant myocarditis.

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Early identification of cognitive decline in metabolic syndrome**Galya Naydenova Atanasova**

Country Medical University of Pleven, Bulgaria

Background: Metabolic syndrome (MetS) may be a prodromal manifestation of vascular cognitive impairment. Diagnosing early stages of cerebrovascular pathology can lead to prevention and delay of the progression of pathological conditions such as vascular cognitive impairment.

Objective: The objective of the study was to investigate new biomarkers for early diagnosis of MetS and cognitive decline as a follow-up. A cardiological, neuropsychological and neurological study was conducted among 75 Bulgarian participants. Beta amyloid in the blood, procalcitonin (PCT), NT-proBNP as predictors of cognitive impairment in patients with metabolic syndrome were identified.

Methods: Clinical, anthropometric, biochemical, neuropsychological, cognitive and statistical data processing. Plasma amyloid beta (A β) levels, procalcitonin, NT-proBNP in MetS were investigated in participants with MetS and in group of healthy people.

Results: In the present study, plasma levels of A β 42 and A β 40 were found to be reduced in MetS participants. Procalcitonin concentration was significantly higher in males than in females. NT-proBNP was significantly higher in females than in males ($p < 0.001$). Regression analysis showed a positive relationship between NT-proBNP and systolic blood pressure ($p < 0.001$) and fasting blood glucose ($p < 0.05$). An inverse relation between NT-proBNP and diastolic blood pressure, waist circumference, triglycerides, HDL- and LDL cholesterol was found.

Conclusions: There was a positive association between PCT levels, decreased levels of A β 42 and A β 40, as well as elevated NT-proBNP and cognitive impairment in people with MetC. A concentration of NT-proBNP of 60 pg / ml or greater could be an indicator of metabolic abnormalities and early cognitive decline.

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Assessment of vascular stiffness and relation to cardiovascular risk factors in patients with SLE**Moataz Taha**

Cairo university, Egypt

Statement of the Problem: Cardiovascular disease is a major cause of morbidity and mortality in SLE patients. Accurate risk stratification would require a simple, non-invasive index integrating all traditional and emerging risk factors. Vascular stiffness fulfills these requirements and has better predictive value for cardiovascular events than traditional risk factors in hypertensives and patients with coronary artery disease. Our aim was to determine whether arterial stiffness is increased in SLE patients compared to healthy controls.

Clinical Practice: Patients were recruited from Rheumatology department of Cairo University while the study done in Cardiology department. This study included 100 subjects divided into 50 SLE patients and 50 age- and gender-matched healthy individuals. All individuals underwent standard clinical evaluation. Assessment of aortic stiffness was performed by calculation of aortic elastic indices using M-mode transthoracic echocardiography (TTE). Endothelial function was assessed using brachial flow mediated dilation (FMD). Carotid duplex ultrasound was performed to measure quality arterial stiffness (QAS) parameters using

Esaote MyLab 60. We calculated carotid-femoral pulse wave velocity (cf-PWV) as the carotid-femoral travel distance divided by the transit time ($\Delta L/\Delta t$).

Results : SLE patients had higher median aortic stiffness index (SI) and lower strain and distensibility, compared to controls. SLE patients had significantly impaired FMD compared to controls. Regarding QAS parameters, SLE patients had significantly lower median carotid distension, distensibility coefficient, and compliance coefficient, with higher median carotid SI, carotid pulse wave velocity (PWV), and augmentation index (AI). SLE patients had a higher median cf-PWV 6.5 m/sec (4.8 – 11.8), compared to a median of 4.6 m/sec (3.8 – 6.9) in controls.

Conclusion & Significance: SLE patients have significantly impaired FMD and increased arterial stiffness compared to healthy controls. SLE is an independent cardiovascular risk factor. SLE duration is an important predictor of arterial stiffness. These findings emphasize the need for early diagnosis of SLE and aggressive risk factors modification.

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The evaluation of left atrium as a heart failure evolution predictor in patients with Arterial Hypertension

Huseynova K Q, Ibrahimov F S, Shakhuseynov S H, Sadichova M N

Ministry of Health of Azerbaijan Republic, Azerbaijan

About 50 Arterial Hypertension patients with developed Heart Failure were examined: left atrium ECG and Echocardiogram changes were estimated comparatively in dynamics. It is well known, that in patients with Arterial Hypertension developed changes of the Left Ventricle End-Diastolic pressure manifest not only in the Left Ventricle but in Left Atrium also. So that diastolic dysfunction and systolic dysfunction both increase the loading of the Left Atrium. By the cause of the Left Atrium muscle weakness comparatively with Left Ventricle muscle, it manifests firstly by functional and structure disturbances of the Left Atrium. We investigated these disturbances in patients with Arterial Hypertension by evaluation of their Electrocardiogram and Echocardiogram indices in dynamics. Ongoing research

comparing ECG and Echocardiogram changes gave us the opportunity to reveal Left Atrium ECG disturbances relatively earlier than Echocardiogram structural changes. Many times when we revealed ECG signs of Left Atrium enlargement and loading, we did not observe any changes of the Echocardiogram indices at the early period. Performed investigations in Arterial Hypertension patients with Heart Failure give the possibility to observe appropriate ECG changes firstly. These changes may be the early predictor of the possible developing Heart Failure in such patients, moreover it makes possible an optimal Arterial Hypertension management retarding and delaying the origin of the Heart Failure.

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ECP – A simple, non-invasive solution to the complex problem of CAD and Heart Failure (New hope for CAD & HF Patients)

Anupam Shrivastav

Heart Care, India

Modern life-style is responsible to increasing number of CAD patients worldwide. Coronary Heart Disease has come out as the biggest killer of human population in past 2-3 decades. CAD / CHD, is basically a systemic disease in which a part or parts of myocardium do not get proper blood supply through coronaries, due to blockages or narrowing of the vessels. Surprisingly, in spite of the large number of morbidity & mortality caused by this disease, the measures to check or reverse the disease process are either not sufficient or not in the proper direction.

Initially CABG, then due to high morbidity and mortality followed by so many post surgical complications, focus was shifted towards balloon Angioplasty, BM Stents, DES/ Medicated Stents, but due to higher rates of restenosis & other complications, now DEB (Drug Eluting Balloon) & bio absorbable stents are highlighted.

But, we must hold all this & think are we going towards right direction?

Now in 21st Century External Counter Pulsation (ECP) has come into light as the first Non-invasive, Non-pharmacological USFDA approved treatment modality, which is performed without hospitalization as an outdoor procedure, without any anesthesia, without any risk, without any peri or post procedure complications and without pain. Patients treated with ECP therapy, in various trials and in thousands of ECP centers all over the world, all the 'ECP Experts' have demonstrated marked improvement in all aspects in terms of functional angina class, increased exercise tolerance, and a reduction in nitroglycerin use also in all kind of myocardial perfusion assessment like MPI

scan by SPECT, Stress ECG and PET scan. These benefits have been demonstrated in terms of increased myocardial perfusion & enhancement in LVEF, remain durable in many patients from 5 to even 12 years after treatment. ECP has come out as a proven non-invasive treatment modality for Stable CAD & Heart Failure patients. It fulfills all the criteria for a successful CAD / LV dysfunction treatment as defined by ACC/AHA in their published Guidelines. By this unique treatment, presently we are treating patients of CAD/ LVF/ CHF those who are either Unfit or Unwilling for Invasive or surgical revascularization.

ECP is a very good choice, also when it remains a big confusion in the mind of treating consultant, whether, to send any particular patient for PCI or not. Similarly patient who developed re-stenosis or re-blockages after Stent implantation, then ECP remains very good option to save that patient from the risk and complications of CABG. In post CABG cases, ECP is the safest option and provides very good all round symptomatic relief & hemodynamic improvement. ECP remains the only treatment option for those CAD patients who are having diffuse or micro-vascular disease including Diabetics & women.

ECP treatment provides numerous all round benefits including even Non-cardiac improvements to all the cardiac patients.

Now, it is the right time to change our mind-set for the benefits of CAD patient community and provide them the best & safest treatment available in present days, i.e. ECP, which provide lot of all round benefits and no harm.

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Impact of integrated / direct 6 years DNB CVTS residency in the filling of CVTS seats at the national board counseling? Review of 6 years Indian data. Is it time for medical council of India to follow suit

S Sanathkumar

Apollo Speciality Hospitals, India

In developing countries, the Cardiothoracic training courses have intensified over the last decade and continues to do so with revamped protocols.

The 6 year integrated superspeciality courses is making inroads nowadays for the right and several reasons. It takes in applicants into the long rigorous module who are confident about their ambition straightaway after the undergraduation.

There is no wastage of time involong the bridge between speciality and superspeciality which may take months-years.

There is no deviation as grads come out in flying colours as a superspecialist in contrary to the 3 + 3 years where people often get carried away,confused and diverted away from their dream after the 3 year surgical course.

We aim to find out whether it has inspired more prospective applicants into the stream in terms of choice at counseling over the last 6 years and compare it with the conventional 3 years model. Final data was compared with the recently concluded superspecialty counseling results.

National board of education website was accessed and counseling data from year 2012 through 2017 was taken for both DNB(Diplomate of National Board) CVTS(Cardiothoracic and Vascular surgery) 3 and 6 years residency seats. Filling rate for the above mentioned years was taken for DNB CVTS 3, 6 years stream and compared. Average filling rate for both streams was compared again with MCh(Master of Chirurgiae) CVTS course vacancy rate obtained from NEET superspecialty counseling held in 2017.

The average filling rate for DNB 6 years course was 98.2% while it was 22.28% for DNB 3 years course from 2012 till 2017. As for MCh CVTS course, filling rate was 29.37% for the year 2017.

The reception for direct 6 years DNB CVTS course is better among prospective applicants when compared with conventional 3 years model and MCI can consider introduction of direct 6 years MCh CVTS course.

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Complex coronary artery stenting- Double bifurcation lesion intervention

Balbir Pachar, Shekhar Kunal

SMS Medical College, India

Coronary intervention in case of acute coronary syndrome is best, easy and prompt approach for revascularization. It maintains the perfusion of myofibrils and thereby reverses all electrical and mechanical sequel of ischemia. There are different types of stentotic lesion which are revealed only after coronary angiography. These lesions range from simple to complex and the patient of course maybe stable or hemodynamically unstable, imparting challenge in either way. In this case the patient in his 80's, established case of CAD, presented with acute coronary syndrome, hemodynamically unstable, systolic blood pressure is 90 mmhg, on inotropic support, LVEF 20-25%, immediately shifted in cath lab for catheterization. Angiography reveals left main + DVD. Calcified distal left main 60%, ostial LAD 90% and ostial LCx 80% stenosed.

Immediately decided for interventions. LMCA hooked and both vessels were wired, ballooned. When Proximal LAD opened, there is another bifurcation lesion noted (main branch 80%, and ostial large D1 80%). So first distal bifurcation was tackled and then the left main bifurcation was tackled successfully with TIMI 3 flow in both major arteries. Subsequently patient improved and discharged on 5th day. There is a situation during cardiac catheterization when interventional cardiologist has to weigh the favorable outcome of procedure against the patient's factor i.e. age, low EF and high risk for cardiac surgeries. In this case, interventional outcome seems to be better against patients' factor.

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Cardiovascular Nursing**Jasmin Debora S**

DR NTR University of Health, India

Cardiovascular nursing is a branch of Medical surgical Nursing in which a specialized registered nurse will provide care to patients suffering from various cardiovascular conditions such as a spectrum of coronary artery diseases (Angina, Myocardial Infarction, Cardiac dysrhythmias, Ischemic heart disease), Cardiomyopathy, Rheumatic heart disease, Heart failure, Hypertension, Congenital heart disease, peripheral arterial and Venous disorders in collaboration with Cardiologist. The scope of this branch is extended to clinical practice at CCU, ICU, CTICU, Thoracic recovery rooms, Cardiac catheterization, peripheral vascular catheterization, OT, cardiac Rehabilitation centers, cardiac medical and Surgical Wards, cardiovascular ICU's. These Nurses need to be competent in Hemodynamic monitoring, cardiac remodeling, vascular and cardiac monitoring, cardiac, respiratory and vascular Assessments, Stress test evaluation, Post-operative care in surgical units, Medication administration by continuous intravenous drip and infusions, ventilatory care, ECG rhythm analysis. All cardiovascular nurses must have BLS, ACLS and Cardiac rehabilitation certification. Most cardiovascular clinical nurse specialists (CNSs) work in healing facilities. They look after fundamentally

sick patients, and in addition, those recouping from cardiovascular strategies, for example, sidestep angioplasty, or pacemaker medical procedure. They even enable patients to recoup at home and provide care for baby boomers too. In addition to expert knowledge, cardiovascular nurses need to evaluate and implement evidence based practice with in culturally appropriate frame works. developing clinical research and cultural competencies and engaging in policy sphere which are crucial for improving CVD Outcomes.

Cardiovascular disease is a major contributor to global morbidity and Mortality; It is extremely costly and places a significant burden on individuals and communities. Cardiovascular nurses play a key role in combating the increasing burden of CVD, which is similar to their chronic diseases which accompanies the demographic and epidemiological transitions occurring worldwide. Keeping in view; WHO proposed core competencies that drive the curricula of cardiovascular nursing education such that they become effective agents in health care system. This ultimately enriches the preventive cardiovascular nurses.

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Coronary artery bypass surgery or interventional cardiology? Why not both? Let's go for hybrid coronary revascularization

Khalida Soomro

Hamdard University Hospital, Pakistan

The options for coronary artery disease have greatly expanded during the course of the last 2 1/2 decades with the advent of hybrid technology in the 1990s. Which implies using both interventional cardiology and cardiac surgery to offer the patients the best available treatments for CAD while minimizing the risks of the surgery, example can be a patient with a partial blockage in one coronary artery and a complete blockage in another. In this case, a combination revascularization approach might work best to restore blood flow to the heart muscle. Another beneficial approach can be a fixing associated heart rhythm abnormality involving catheter ablation or implantation of devices for brady-arrhythmias, Hybrid Cardiac Surgery a collaborative approach reduces risk

of complication, shorten recovery times and improve outcomes This fragmented approach to care is starting to change to a much-needed innovation in hospital design by set up including all the equipment needed for diagnostic imaging, minimally invasive procedures, and traditional surgery, the key requirement is productive collaboration of heart team comprising heart surgeons, cardiologists, electrophysiologists, by working together in the same space, at the same time. Although indications and patient selection of these procedures are still to be defined but high-risk patients have already been shown to benefit from hybrid approaches.

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Cardiovascular disease and its prevention

Purusharth Kumar Sharma

Rajasthan University, India

This is a condition which affects our heart. There are many types such as heart attack, heart failure, CAD, aortic disease, and many more. There are many other ways through which we can prevent this. So my research work is on that how we can manage these fatal diseases at their early stages so we can prevent the death of a patient or some ways to manage

this disease and I think these ways are very helpful to people and some techniques which a person can do at their level. If they get a heart attack and some medicine which has less side effect and more response.

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Rare case of iatrogenic aortocoronary dissection by diagnostic transradial cardiac catheterization

Amit Soni^{1,2}, Timur Maslov¹, Kenzhebek Bizhanov¹, Robert S Mvungi², Mustafa Bapumia²

¹National Scientific Centre of Surgery, Kazakhstan

²The Aga Khan Hospital, Tanzania

A combined, type A Aortic dissection with coronary artery dissection during diagnostic coronary angiography is an extremely rare, but a very critical complication with high mortality. During a coronary artery involvement as an entry point, it can be treated by sealing the dissection plane with a coronary stent. Extensive dissections may require a surgical intervention. Different factors that influence the management decision includes hemodynamically unstable patient, aortic injury mechanism, size, severity, direction

in which the dissection spreads, intimal flap presence, and preexisting atherosclerotic disease. We present a case of type A aortic dissection including dissection of ostium of right coronary artery (RCA) caused by a diagnostic coronary catheter. This iatrogenic aortic dissection required emergent coronary artery bypass graft (CABG) to RCA and surgical repair with supracoronary replacement of the ascending aorta.

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