Keynote Forum
September 18, 2017

Heart Diseases 2017

Annual Conference on

HEART DISEASES

September 18-19, 2017 | Toronto, Canada

William E Feeman

Bowling Green Study, USA

Enhanced prediction of the population at risk of atherothrombotic disease

Introduction: The holy grail of the prevention of atherothrombotic disease (ATD) lies with the prediction of the population at risk of ATD. Many different risk predictors have been advocated, but none universally accepted. The author presents his risk predictor based on the characteristics of those who have developed some form of clinical ATD during the 4November 1974-4November2003 time frame.

Purpose: Following the precepts of the Framingham Heart Study, the author has analyzed the constellation of ATD risk factors that characterize the ATD population and has generated a predictive tool that accurately characterizes that population.

Methods: The author has examined his patient population database and separated out those who developed some form of clinical ATD during the study timeframe, compared with those who did not.

Results: The population who developed ATD is characterized by cigarette smoking, dyslipidemia, and (often) hypertension, with some contribution from uncontrolled diabetes. ATD patients are defined by an abnormal lipid ratio, as defined by the Cholesterol Retention Fraction (CRF, defined as [LDL-HDL]/LDL) with/without cigarette smoking and/or hypertension. This is best seen in a risk factor graph with the CRF on the ordinate and systolic blood pressure (SBP). The graph is characterized by a threshold line with CRF-SBP co-ordinates (0,74,100) and (0.49,140), above which lie the CRF-SBP plots of 93% of all of the ATD patients (710 patients) in the author's practice (See Figure.1). Fine tuning of risk prediction is done by stratification by cigarette smoking status, and the outcomes of the ATD patients are given in Table I. Additional risk stratification is done by stratifying CRF vs SBP and CRF by LDL-cholesterol. Any therapy that brings the CRF-SBP plot below the threshold line results in plaque stabilization/regression in a minimum average of 76% of cases.

Conclusions: The population at risk of ATD is predictable and hence preventable.

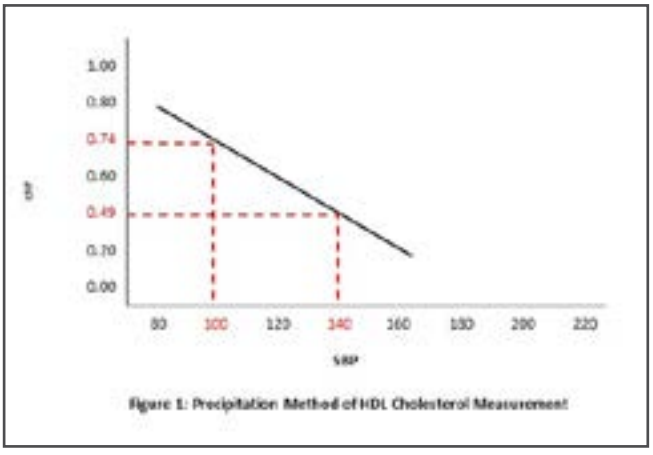

Figure 1: Precipitation Method of HDL Cholesterol Measurement

Notes:

Table I
ATD w/r to ASR Line
1974-2003

			Above ASR Line			Below ASR Line		
Sex	Average Age of		+	Past	-	+	Past	-
Male								
		Total Patients	126	130	86	20	14	8
	ATD Onset	Total Patient Years	6659	8536	5913	1174	1041	623
		Ave. Age of ATD Onset	53	66	69	59	74	78
		Total Patients	38	41	32	6	5	1
	MSD Onset	Total Patient Years	2363	2983	2522	382	402	78
		Ave Age of MSD Onset	62	73	79	64	80	78
		Total Patients	49	64	47	12	11	4
	Death	Total Patient Years	3153	4780	3805	815	879	374
		Ave Age of Death	64	75	81	68	80	94
Female								
		Total Patients	65	56	137	18	15	34
	ATD Onset	Total Patient Years	3852	3908	9955	1145	1003	2543
		Ave. Age of ATD Onset	59	70	73	64	67	75
		Total Patients	22	24	49	6	7	16
	MSD Onset	Total Patient Years	1534	1800	3931	440	532	1283
		Ave. Age of MSD Onset	70	75	80	73	76	80
		Total Patients	26	23	79	9	7	23
	Death	Total Patient Years	1830	1824	6542	650	533	1941
		Ave. Age of Death	70	79	83	72	76	84

ATD means Atherothrombotic Disease
"+" means Current Cigarette Smoker
"Past" means Former Cigarette Smoker
"-" means Never Cigarette Smoker
MSD means Multiple System Disorder
ASR Line means Angiographic Stabilization/Regression Line

Speaker Biography

William E. Feeman Jr., MD, is a Physician on staff at Wood County Hospital, and in private practice, both in Bowling Green, Ohio. He attended undergraduate school at Ohio State University (1961-1966) and became interested in a career in medicine during that time; prior to his decision to enter medicine he planned to have a career in astronomy. He attended undergraduate medical school at Ohio State University, earning Bachelor of Science in physiology (1961-1966) and medical school at Ohio State University (1966-1970); where he developed an interest in the primary and secondary prevention of atherothrombotic disease. Over the last 26 plus years, he has spent his professional life in medicine perfecting a tool to predict the population at risk of atherothrombotic disease e and to guide therapy to maximally stabilize/reverse that disease if extant. Thus he has founded the Bowling Green Study of the Primary and Secondary Prevention of Atherothrombotic Disease (BGS) to which he is the principal investigator. This study terminated on 4 November 2003. Dr. Feeman has had six major articles published in various science/medical journal. He has had numerous letters to the editor published in various medical journals. All publications relate to the primary and second prevention of atherothromboitc disease. He has presented data at a number of annual scientific assemblies of the American Academy of Family Physicians and at a number of national and international symposia in atherothrombotic disease. Dr. Feeman is the founder of the Association for the Prevention of Atherothrombotic Disease in Northwest Ohio to facilitate the spread of knowledge about this disease.

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Nirankar Singh Neki

Government Medical College, India

Clopidogrel resistance-Current issues

Antiplatelets are mainly used in the prevention and management of atherothrombotic complications. Current ACC/AHA/ESC guidelines suggest dual antiplatelet therapy (combining aspirin & clopidogrel) for patients having acute coronary syndromes or undergoing PCI. But in spite of administration of dual antiplatelet therapy, some patients develop recurrent cardiovascular ischemic events especially stent thrombosis which is a serious clinical problem. Clopidogrel is an effective inhibitor of platelet activation and aggregation due to selective and irreversible blockade of the P2Y2 receptors. The mechanism of clopidogrel resistance remains incompletely defined but there are certain clinical, cellular and genetic factors including polymorphisms responsible for therapeutic failure. The prevalence of clopidogrel nonresponse varies from 4% to 30% 24 hours after administration. Currently there is no standardized or widely accepted definition of clopidogrel resistance. This presentation is focussed on the methods used to identify patients with clopidogrel resistance, the underlying mechanisms, metabolism, clinical significance and current therapeutic strategies to overcome clopidogrel resistance.

Speaker Biography

Nirankar Singh Neki, MBBS, MD(Internal Medicine) is working as Professor and Head of Medicine unit 2 at Govt. Medical College Amritsar, India. He has teaching experience of 30 years as undergraduate teacher and 28 years as postgraduate teacher. He has an entry in the Limca Book of Records of 2015 for being the recipient of four Fellowships of the Royal College of Physicians (Edinbourgh, Glasgow, Ireland and London). In total he has 38 fellowship awards with different institutes. He is receipient of FACC(USA),FAHA(USA), FESC, FACP(USA),and holds name in cardiology .Dr. Neki holds 13 different Oration Awards and has been a named author in 365 scientific publications, including book chapters. He is also Editor in Chief, Senior Editor, Editor, Section Editor, and Associate Editor of more than 13 national and international medical journals. Dr. Neki has been a Visiting Professor at James Cook University Hospital in Durham, UK and at the University of Manitoba's Institute of Cardiovascular Sciences at St. Boniface Hospital &Research Centre, Winnipeg, Canada.

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Nicholas Ruggiero II

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TAVR 2017: Supporting data and future directions

Transcatheter Aortic Valve Replacement (TAVR), first performed by Dr. Cribier in 2002, has become the management of choice for patients with aortic stenosis who are considered high risk or inoperable. Current data illustrates that TAVR is equivalent to surgical aortic valve replacement (SAVR) in patients considered intermediate risk and may even be superior in specific patient populations. Ongoing trials evaluating this modality in low risk patients, asymptomatic patients as well as longitudinal data looking at valve durability will determine whether it will become the gold standard in all patient populations. In this lecture I will review the current supporting data and discuss what is on the horizon for TAVR.

Speaker Biography

Nicholas J. Ruggiero II, was born and raised in Wilkes-Barre, PA. He graduated summa cum laude from King's College in Wilkes Barre, PA majoring in Biology and minoring in Molecular Genetics. He then attended Jefferson Medical College where he graduated Magna Cum Laude. He was recruited back to Jefferson to begin his own section as the director of structural heart disease and non-coronary interventions. He developed the transcatheter aortic valve replacement (TAVR) program, mitraclip program, is director of the Jefferson Heart Institute vascular laboratory and is the associate program director of the Cardiology fellowship. He has published over 40 peer reviewed papers, authored numerous book chapters and abstracts, edited multiple textbooks, delivered multiple lectures at national and international meetings, served on many national and international committees and is on the editorial board of multiple journals. He is a fellow of many medical societies and is currently at the rank of associate professor at the Sidney Kimmel Medical College.

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