

# DailyNews

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## Scientific Sessions combines world's best science with networking opportunities

**A**t a time when traveling is inconvenient, in an age where it's easy to flip open your computer and virtually be anywhere, organizers of the American Heart Association's Scientific Sessions get it. They can't merely host their annual scientific meeting, even though it's well established as the premier gathering of cardiovascular thought leaders in the U.S.

They need to put together a program compelling enough for doctors, researchers and other healthcare professionals to set aside four days from their usual activities to be present in Chicago. They need to create an experience in which the value truly comes from being here in person.

That is exactly the reason Robert Harrington, MD, FAHA, FACC, FESC, is smiling.

This is the second Scientific Sessions he's overseen, and his 10th straight as part of the Committee on Scientific Sessions Program. He is proud of how the event has adapted and evolved, and prouder still of everything being offered in 2014, especially the tweaks and changes in response to suggestions from convention-goers and AHA staff and volunteer leaders. He's confident the program will enhance Sessions' reputation.

"Going to a meeting like Sessions is about more than gathering data," said Harrington, chair of the Department of Medicine at the Stanford University School of Medicine. "It's about the personal interactions. That's where ideas come from. You ask a question or probe a data point or you hear someone make a comment and the light bulb goes off for you. We want to make sure that human element remains a vibrant part of this conference."



SCIENTIFIC SESSIONS continued on page 17

## AHA, CHF join forces to fund research into heart defects

The American Heart Association and The Children's Heart Foundation are committing at least \$2.5 million in a two-year collaboration to fund research that will help children and adults with congenital heart defects.

The Children's Heart Foundation is a national nonprofit with 15 chapters in the United States. "Our mission is to fund the most promising research to advance the diagnosis, treatment and prevention of congenital heart defects," said William Foley, the organization's executive director.

Since it was founded in 1996, the CHF has funded more than \$6.3 million of research in congenital heart defects.

The new AHA/CHF Congenital Heart Disease Research Award will support investigators doing innovative basic, clinical, population or translational research projects on congenital heart defects. Such research is urgently needed. Each year close to 40,000 U.S. babies — or 1 percent of all live births — have a congenital heart defect. About 1.3 million adults live with congenital heart defects in the United States.

The AHA will match these amounts dollar for dollar, so in the next two years at least \$2.5 million in CHD research will be funded

through this collaboration.

Both the AHA and CHF will advertise, promote and brand the new award, and the AHA will coordinate the peer-review of research proposals. The AHA will give CHF a list of meritorious, fundable applications in rank order and without regard of geographic location. Then the CHF Medical Advisory Board will choose those that best fit with CHF's mission.

In addition to providing a matching contribution, the AHA will also distribute funds to the awardee's institution and collect annual progress and expenditure reports.

The AHA and CHF are also working on a program of collaborative support for parents of children with CHD. The details of

that should be finalized by early 2015.

"We've worked hard

for two years to make this happen and will evaluate it over the next two years," Foley said. "We'd love it if it succeeds and we do this for the next 20 years." To learn more about this research award, including submission deadlines, visit [my.americanheart.org/research](http://my.americanheart.org/research). To learn more about the Children's Heart Foundation, visit [childrensheartfoundation.org](http://childrensheartfoundation.org). ▼



## Mission Engagement Forum gives glimpse into AHA's future

The first time Shelley Stingley stood on the Scientific Sessions floor, she learned how the 12-lead ECG helps people having the most serious heart attack.

The second time, she discovered robotic cardiac catheterization equipment.

Another time, she observed an automated device that performs CPR compressions when placed on a person's chest.

"Seeing the new technologies on the floor was very insightful to a new foundation and what things we might be able to do in rural America with technology," said Stingley, who as program director for the Rural Healthcare Program of the Leona M. and Harry B. Helmsley Charitable Trust looks for projects to invest in that can help save lives and improve the delivery of healthcare in rural areas.

Stingley will be back this week as one of more than 100 American Heart Association honored guests who will peek behind the curtain of the world's premier cardiovascular gathering by participating in the Mission Engagement Forum.

In addition to seeing the latest technology, Mission Engagement Forum

participants will talk one-on-one with scientists about topics such as the genetic link to high cholesterol and heart disease. They will also dine with top thought leaders who will discuss how the AHA is accelerating science and advancing children's health. And they will meet with foundation and private funders who help the association fight heart disease and stroke.

"I've learned a lot from other funders and from listening to speakers, especially at honored guest day when they have survivors come talk," Stingley said. "There, you see the personal effects of what the American Heart Association does and what private funding can do to help people live longer."

The Helmsley Charitable Trust has awarded more than \$30 million in grants to Mission: Lifeline, which the AHA created to help people experiencing ST-elevation myocardial infarction (STEMI). Each year, more than 200,000 Americans



Shelley Stingley

experience STEMI — the deadliest kind of heart attack — but don't receive appropriate treatment within the recommended time.

Every ambulance in South Dakota, North Dakota, Minnesota, Wyoming, Nebraska and Montana is equipped with 12-lead ECGs to help determine

if someone is having a STEMI and needs to get to a hospital with a cardiac catheterization lab so doctors can insert a stent to open an artery.

"It's a long way from a rural person's home to a place that they can get a stent," Stingley said. "It could be two hours by land, so they would need to call an air ambulance to move them directly to a hospital that can give them that lifesaving care." ▼

## TODAY AT SESSIONS

Don't miss today's highlighted presentations and events. For a complete schedule, see the Final Program or view it online at [scientificsessions.org](http://scientificsessions.org).

### 9 a.m.–Noon

*Early Career: Opening General Session*

Room S100ab

### 9:30–10:30 a.m.

*2014 Awards for Lifetime Achievement in Cardiac Resuscitation Science and Trauma Resuscitation Science*

Lakeside Hall D1

### 10:30–11:30 a.m.

*ReSS Best of the Best Oral Abstract Presentations and Presentation of the Best Abstract Awards for Cardiac and Trauma Resuscitation Science*

Lakeside Hall D1

### 1:30–2:45 p.m.

*ReSS Best Original Resuscitation Science Oral Abstract Presentations*

Lakeside Hall D1

### 2:15–3:30 p.m.

*Samuel A. Levine Young Clinical Investigator Award Finalists*

Room S406a

### 3:45–5 p.m.

*Laennec Young Clinician Award Finalists*

Room S406a

### 5–6:30 p.m.

*Early Career Reception*

Grand Concourse Lobby

### 4:45–6:15 p.m.

*ReSS Best Original Resuscitation Science Poster Session and Reception*

Lakeside Ballroom E354

## SCIENTIFIC SESSIONS

BY THE NUMBERS

**Five days** of comprehensive, unparalleled education

More than **17,000** attendees

Global presence from more than **100** countries

**880** sessions, including  
**560** original research sessions  
and **316** invited sessions

More than **5,000** presentations

**1,000** invited faculty **4,000** abstract presentations; all from the world's leaders in cardiovascular thought

Science and Technology Hall (exhibits) will be open Sunday through Tuesday with more than **200** exhibitors showcasing the latest cardiovascular technology and resources.

**1.5 million** medical professionals who participate virtually in lectures and discussions about basic, translational, clinical and population science

# HIGHLIGHTS FROM THE PROGRAM CHAIR

By Robert Harrington, MD, FAHA, FACC, Committee on Scientific Sessions Program Chair

## Welcome to Chicago for the

American Heart Association's Scientific Sessions 2014! On behalf of the Committee on Scientific Sessions Program and AHA staff who have put together this year's program, we are excited to have you at the "center stage" of the cardiovascular science world for the next five days.

Planning this year's program began shortly after last year's meeting in Dallas and involved the commitment of dozens of volunteer leaders representing AHA Councils and Science Committees. Feedback was solicited through formal surveys and through informal discussions and networking. Many great ideas and innovations emerged and have been incorporated into this year's meeting.

The future of Scientific Sessions was also explored and extensively reviewed by a large group of volunteers representing a multitude of clinical and scientific disciplines and expertise, and staff, at the Sessions Summit.

While much of the thinking and many of the innovations proposed during the Summit will be instituted in 2015 and

beyond, we've added several creative enhancements to programming and logistics that should make Sessions an outstanding experience. I will mention these in upcoming issues of the *Daily News*.

As in prior years, Saturday's focus is the Early Career (EC) attendee. The Councils were intimately involved in the creation of Saturday's programming by constructing sessions that are both informative and interactive. The morning sessions are broad to appeal to a large group of EC attendees, from clinical trainees to science graduate students and postdoctoral fellows.

AHA President Elliott Antman, MD, FAHA, will provide an introduction to science opportunities within the AHA during a special morning presentation. Other topics include writing scientific papers, submitting papers to a journal, constructing a grant and how to take advantage of mentorship. These topics should appeal to any attendee look-



Robert Harrington, MD, FAHA, FACC

ing for advice and insights into general academic and professional development issues. These sessions will have both didactic and interactive panel presentations — lots of chances to engage!

In the afternoon sessions, the Councils have planned activities designed to highlight opportunities in their clinical and scientific

areas. There's a nice mix of career advice, professional development and scientific counsel. Like the morning sessions, these sessions will emphasize engagement, discussion and networking. Opportunities to get involved as a science volunteer with the AHA will be discussed and explained.

Finally, late in the afternoon, there's an Early Career Reception. Come meet your colleagues and network with EC attendees from around the globe. After that, don't forget the Council Dinners Saturday night. What a first day! ▼

## EARLY CAREER PROGRAM SATURDAY, NOV. 15

SESSION NUMBER	SESSION TITLE	LOCATION	TIME
EC.21	PVD FIT—Welcome Remarks and Session 1: Steps to a Successful Career	Room S406b	8–9:25 a.m.
EC.01	Early Career Opening General Session: Developing the Skills Needed to Succeed for All Disciplines Part I	Room S100ab	9–10 a.m.
EC.22	PVD FIT—Session 2: Venous Disease	Room S406b	9:25–11:20 a.m.
EC.02	Early Career Opening General Session: Developing the Skills Needed to Succeed for All Disciplines Part II	Room S100ab	10–11 a.m.
EC.03	Early Career Opening General Session: Developing the Skills Needed to Succeed for All Disciplines Part III	Room S100ab	11 a.m.–Noon
EC.23	PVD FIT—Session 3: Diseases of the Aorta and Major Branches	Room S406b	11:20 a.m.–12:30 p.m.
EC.05	Considering Electrophysiology as a Specialty—Part I <i>Planned by the Council on Clinical Cardiology</i>	Room S501	1–1:45 p.m.
EC.20	Joint AHA/Heart Failure Society of America Session: Career Opportunities and Program Building in Heart Failure	Room S402	1–2:30 p.m.
EC.09	The Path to a Successful Career in Cardiovascular Sciences—Part I <i>Planned by the Council on Basic Cardiovascular Sciences</i>	Room S503	1–2:45 p.m.
EC.11	Keys to Early Career Success in Pediatric Cardiology <i>Planned by the Council on Cardiovascular Disease in the Young</i>	Room S404a	1–3 p.m.
EC.15	Career Development <i>Planned by the Councils on Functional Genomics and Translational Biology and Clinical Cardiology</i>	Room S404bcd	1–3 p.m.
EC.04	Emerging Researchers from 3CPR Council: How to Build a Road Map for Your Career in Cardiopulmonary, Critical Care, Perioperative and Resuscitation Research <i>Planned by the Council on Cardiopulmonary, Critical Care, Perioperative and Resuscitation</i>	Room S401bcd	1–3 p.m.
EC.06	My Story: A Panel Discussion on the Different Types of EP Career Options—Part II <i>Planned by the Council on Clinical Cardiology</i>	Room S501	1:45–3 p.m.
EC.25	PVD FIT—Session 4: Carotid Artery Disease	Room S406b	1:45–3:20 p.m.
EC.08	Keys to Success in Contemporary Nursing Science <i>Planned by the Council on Cardiovascular and Stroke Nursing</i>	Room S502	1–5 p.m.
EC.13	Interventional Cardiology	Room S403	1–5 p.m.
EC.17	Imaging Boot Camp <i>Planned by the Council on Cardiovascular Radiology and Intervention</i>	Room S505	1–5 p.m.
EC.14.gc	Team Science, Big Data Research and Finding a Job: A Primer for Early Career Epidemiology and Outcomes Investigators <i>Planned by the Councils on Epidemiology and Prevention, Lifestyle and Cardiometabolic Health and Quality of Care and Outcomes Research</i>	Room S504	1–5 p.m.
EC.010	The Path to a Successful Career in Cardiovascular Sciences—Part II <i>Planned by the Council on Basic Cardiovascular Sciences</i>	Room S503	3–4:45 p.m.
EC.16	Developing Your Niche in Cardiovascular Surgery and Anesthesia <i>Planned by the Council on Cardiovascular Surgery and Anesthesia</i>	Room S401a	3–4:45 p.m.
EC.12	How to Navigate the Omics World <i>Planned by the Council on Functional Genomics and Translational Biology</i>	Room S404bcd	3–5 p.m.
EC.07	Early Career EP Clinical Session—Part III <i>Planned by the Council on Clinical Cardiology</i>	Room S501	3:15–5 p.m.
EC.26	PVD FIT—Session 5: Lower Extremity Peripheral Artery Disease	Room S406b	3:20–5:20 p.m.

# Expect big things, new twists at your AHA scientific events

**W**ith changes ranging from enhanced science exchange, expanded use of technology, new networking opportunities, clustering of programming, and a bit of fun, Scientific Sessions 2014 is delivering in response to your suggestions.

The changes are among those being implemented as a result of the Association's Meetings Initiative. In June, more than 100 AHA volunteer leaders met with AHA staff leadership to discuss ways to transform the AHA's meetings and professional education offerings.

"We want people to have a robust, meaningful experience, and that can't happen if you just come into a meeting and digest fact after fact and lecture after lecture," said Clyde Yancy, MD, Chair of AHA's Meetings Initiative Steering Committee. "We need to process the information at the time that it is delivered and feel engaged in the process of conveying the information."

Yancy, the chief of the Division of Medicine-Cardiology and Magerstadt Professor for Northwestern University Feinberg School of Medicine, said it's about more than just information delivery.

"In addition to science and clinical medicine, it's also about the experience," he said. "If the experience is relevant and meaningful, then it's more likely the information will be retained."

Several initiatives have already been implemented for Sessions 2014:

**New ways of presenting science will enhance learning.** "Next Best

Thing in Cardiovascular Science (at Lightning Speed)" session will offer rapid-fire presentations highlighting cutting-edge and future cardiac predictions: Wednesday, Nov. 19, 9–10:15 a.m. The Arrhythmia Research Summit will be highly interactive and designed for a lively exchange of ideas. Rapid-fire presentations and discussions on the newest findings in arrhythmia mechanisms, diagnosis, and management. The target audience: Clinicians, basic scientists, biomedical engineers and outcomes experts.

**Improved technology will help attendees manage content and navigate Scientific Sessions.** A new Conference Notes iPad app in select rooms lets attendees automatically load faculty slides when they enter a lecture venue, take notes on key slides and archive them for later, thereby getting more from the content, not just during the presentations but after the conference too. And a new smartphone app will help attendees navigate the convention center, listen to live audio streaming from educational sessions while on the go, browse the Science & Technology Hall's offerings and generally stay connected.

**ePoster Workstations** located throughout the convention center allow viewing of poster content closer to the meeting rooms.

**Enhanced poster hall will provide more interaction for poster presenters.** eAbstracts sessions will be presented in a mini-theater environment, with a mini-theater in each core where attendees can view must-see science of the day presented with moderator-led discussions which

promise to be highly interactive and lively. Seating areas within each mini-theater will also serve as networking areas.

Also in the poster hall, Poster Professors will make their teaching rounds to meet each author to drive increased interaction and robust discussion.

**Getting the audience closer to faculty and other presenters in the plenary room will encourage discussions.** It's a way of making a big meeting feel more intimate, Yancy said. Audiovisual materials displayed before and after presentations will focus on more science and more relevant content.

**More fun.** Attendees can personalize their conference experience with "Art of the Heart." The interactive exhibit lets attendees wave their arms to electronically "paint" a heart on an 11-foot canvas. Take your creation home to share with family, friends and patients.

**Expanded networking opportunities.** The AHA Science Subcommittee – Collaboration Station will be a chance for attendees to meet with Council and subcommittee chairs to learn more about the Councils' science subcommittees' work and volunteer opportunities and make professional connections in an informal setting. It's located in the Exhibit Hall. In addition, all abstract submitters for Scientific Sessions 2014 are invited to attend the Abstract Submitters Reception (Tuesday, Nov. 18 from 10–10:45 a.m. in the Science & Technology Hall, South Hall A1) to take advantage of this additional networking event. ▼

## MEMBER SPOTLIGHT

**Sarah M. Perman, MD, MSCE**

*Assistant Professor of Emergency Medicine, University of Colorado School of Medicine*



**How long have you been an AHA/ASA Professional Member?**

I joined the AHA in 2010 as an emergency medicine resident interested in the field of resuscitation. I continued my membership through fellowship and now as an emergency medicine attending.

**Why did you join?**

I was very interested in resuscitation science and knew the AHA was committed to the field. The AHA offers tremendous assistance to young investigators, by way of mentorship, committee work and project support. I also recognized that resuscitation science is a multidisciplinary field. I knew the AHA would afford me the opportunity to meet other investigators outside of my specialty, emergency medicine, and in fields of medicine such as neurology, cardiology and critical care.

**Are you involved in AHA councils?**

Since becoming a Professional Member, I have joined the Council on Cardiopulmonary, Critical Care, Perioperative and Resuscitation (3CPR). I recently joined the Early Career Committee of the 3CPR Council and am working with other young investigators to increase our presence in the AHA as well as establish programmatic support to assist other young investigators.

**What do you enjoy most about these roles?**

Being a member of the Early Career Committee has provided excellent opportunities to network with other early career scientists, to establish new collaborations and to work collectively to create programming for other young researchers at this year's Scientific Sessions. We are a new group with many new ideas, so stay tuned!

**How else are you involved with the AHA?**

I continue to credential as an AHA instructor and am involved in the education and training of residents/medical students in advanced cardiovascular life support and advanced cardiovascular care.

**Why is membership valuable to you?**

Membership in the AHA allows young investigators like myself the opportunity to establish collaborations with other researchers and to seek national mentors who are experts in their field. The AHA also has great programming and support for young researchers at the early career meetings. Finally, the AHA has various funding mechanisms to support early career investigators.

**What message would you like to convey to your colleagues about being an AHA member?**

The AHA is an avenue for early career investigators to learn the latest science, establish collaborations and gain national mentorship from experts in the field of resuscitation. Without the AHA, I would not have had the opportunities I have had to present my science, meet leaders in the field of resuscitation and collaborate with other young investigators. ▼

## CAREER PROGRESSION

### MARK RUEL, MD, MPH, FAHA

Mark Ruel was a cardiac surgery resident considering his fellowship focus in 1999 when his chief of cardiology suggested he attend Scientific Sessions.

The size and scope of the conference made a lasting impression that has kept him coming back each year.

"It was so exciting to see, at one time, the latest in basic scientific discovery shoulder-to-shoulder with the latest in clinical trials," said Ruel, MD, MPH, FAHA, chairman of the Division of Cardiac Surgery at the University of Ottawa and chief of cardiac surgery at the University of Ottawa Heart Institute.

At the time, Ruel was focused on angiogenesis. But his experience at Scientific Sessions was the "catalyst" to him shifting to minimally invasive surgery and translational research training at Harvard Medical School.

Ruel credits Frank Sellke, MD, FAHA, vice chair of the Scientific Sessions Program Committee and his professional mentor, for getting him more involved in the AHA.

Ruel started as an early career

Each day in this spot, we will profile an investigator at a different career stage, from early career to distinguished veteran.

member in 2002, the same year he was a finalist for the Young Investigator Award.

In 2008, he served on the Council on Cardiovascular Surgery and Anesthesia's Leadership Committee. He was a team leader for surgical cell and regenerative therapies and surgery for coronary artery disease, and has been actively involved in its program committee.

He's currently CVSA program chair and guest editor of the Cardiovascular Surgery Supplement of *Circulation*.

"With increased involvement, there was also increased relevance to my practice, my research and my career," Ruel said. "It is such a great way to stay in touch with all aspects of science as they pertain to my career of surgeon-investigator, with all the latest ranging from lipid management recommendations for our patients down to a new protein involved in modulating the regenerative response in the heart."

Sessions' programming offers the best science available in his field, Ruel said.

"The level of science and the level of relevance that goes on in the meetings is unmatched, even by our own surgical associations," he said. The programming is also for everyone — no matter the stage of your career, he said. "As a lab director and translational investigator, it's the only meeting I can go to with my lab students where there's as much for them as there is for me."

The breadth of programming also provides opportunities to see issues from different perspectives — potentially sparking a new way of thinking, Ruel said. He recalled an "a-ha" moment after sitting in a seemingly unrelated presentation about how stem cells transfer to the fetus during pregnancy.

"I called my co-researcher at the lab right away about what I heard there," Ruel said. "I was amazed at the mechanism at work." ▼



# Mission: Lifeline expanding care

**M**any of the more than half a million people in the United States who have an ST-elevation myocardial infarction, out-of-hospital cardiac arrest or both every year don't always get the appropriate treatment within recommended timeframes.

But Mission: Lifeline®, created by the American Heart Association to remedy these inconsistencies, now covers 65 percent of the country.

"Mission: Lifeline fills the critical gap between the public and emergency medical services and hospitals," said James Jollis, MD, a cardiologist and professor of medicine and radiology at Duke University Hospital. "We've known what to do for 30 years. We haven't had the processes, measurements, leadership and coordination to put it in place. Each part of the health system focused on its own job, but there hasn't been this overarching vision to link the pieces together."

For example, many of the more than 15,000 EMS agencies in the country aren't well-coordinated, are poorly funded by local taxes and have uneven services, especially in rural areas. Despite this, they continue to provide heroic responses, even in challenging circumstances.

"The last, and probably the biggest challenge, is that most of the time the coordination between medical services and hospitals is minimal," said Jollis, an American Heart Association volunteer.

With Mission: Lifeline, the community, EMS providers and the health system are integrated and work seamlessly. The specific types and timetables of care help medical personnel interacting with patients use the same playbook. Each year, nearly 250,000 Americans experience STEMI, the deadliest form of heart attack, characterized by a completely closed artery. Through Mission: Lifeline, we're working to change these facts:

- Thirty percent of STEMI patients don't receive percutaneous coronary intervention or thrombolytic therapy.
- Of those who receive PCI, only 40

percent are treated within the recommended 90 minutes for first medical contact-to-device.

- Of those who receive thrombolytic therapy, fewer than half are treated within the recommended 30 minutes for door-to-needle.
  - Seventy percent of patients who aren't eligible for thrombolytic therapy don't receive PCI, the only other option to restore blood flow to blocked arteries.
- The program's three levels of



James Jollis, MD



involvement — participation, recognition and accreditation — help hospital and EMS teams provide quality care and raise awareness.

Since the American Heart Association recently launched its Mission: Lifeline EMS

Recognition program, 209 agencies have been recognized for excellence in STEMI care. To qualify, agencies obtained 75 percent or better on at least two of three criteria.

Jollis hopes the next step for Mission: Lifeline is to expand to stroke.

"Now, we can take some of our relationships and models from heart care and augment stroke care," he said. "Our long-term goal is to make this our standard of care. Basically, no matter where you live, you should get the same care. Where you live should not determine whether you live." ▼

PAID

**IN THE TREATMENT OF ACUTE CORONARY SYNDROME**

# DECISIONS TODAY CAN IMPACT A LIFE

**BRILINTA CAN HELP BEYOND 30 DAYS, BEYOND THE HOSPITAL, BETTER EFFICACY THAN CLOPIDOGREL**

**AT 30 DAYS, BRILINTA plus aspirin reduced the primary composite end point of cardiovascular (CV) death, myocardial infarction (MI),\* or stroke by 12% RRR<sup>1</sup> (ARR<sup>2</sup> 0.6%) vs clopidogrel plus aspirin.<sup>§1,2</sup>**

**AT 12 MONTHS, BRILINTA plus aspirin significantly reduced the primary composite end point by 16% RRR (ARR 1.9%) vs clopidogrel plus aspirin. The difference between treatments was driven by CV death and MI with no difference in stroke.<sup>§1</sup>**

**IMPORTANT SAFETY INFORMATION ABOUT BRILINTA**  
**WARNING: (A) BLEEDING RISK, (B) ASPIRIN DOSE AND BRILINTA EFFECTIVENESS**

**A. BLEEDING RISK**

- BRILINTA, like other antiplatelet agents, can cause significant, sometimes fatal, bleeding
- Do not use BRILINTA in patients with active pathological bleeding or a history of intracranial hemorrhage
- Do not start BRILINTA in patients planned to undergo urgent coronary artery bypass graft surgery (CABG). When possible, discontinue BRILINTA at least 5 days prior to any surgery
- Suspect bleeding in any patient who is hypotensive and has recently undergone coronary angiography, percutaneous coronary intervention (PCI), CABG, or other surgical procedures in the setting of BRILINTA
- If possible, manage bleeding without discontinuing BRILINTA. Stopping BRILINTA increases the risk of subsequent cardiovascular events

**B. ASPIRIN DOSE AND BRILINTA EFFECTIVENESS**

- Maintenance doses of aspirin above 100 mg reduce the effectiveness of BRILINTA and should be avoided. After any initial dose, use with aspirin 75 mg - 100 mg per day

**CONTRAINDICATIONS**

- BRILINTA is contraindicated in patients with a history of intracranial hemorrhage and active pathological bleeding such as peptic ulcer or intracranial hemorrhage. BRILINTA is contraindicated in patients with severe hepatic impairment because of a probable increase in exposure; it has not been studied in these patients. Severe hepatic impairment increases the risk of bleeding because of reduced synthesis of coagulation proteins. BRILINTA is also contraindicated in patients with hypersensitivity (eg, angioedema) to ticagrelor or any component of the product



ACCELERATING SCIENCE FOR EXTRAORDINARY IMPACT

## Join us for our Annual Awardee Group Photo at Scientific Sessions

- Photo taken with AHA President Elliott Antman, MD, FAHA and the other officers
- Monday, November 17 at 1:30
- S100 Lobby
- Participants will receive a special lapel pin!



Research Awardees from Scientific Sessions 2013 in Dallas, TX.

# Heart failure program measures hospitals' performance

**G**regg Fonarow, MD, FAHA, FACC, a longtime American Heart Association volunteer, knows the value of hospitals having advanced certification for heart failure programs.

"Heart failure is one of the most common reasons people are hospitalized, and there's a big risk of re-hospitalization within 30 days of discharge," said Fonarow, director of University of California at Los Angeles's Cardiomyopathy Center and co-director of UCLA's Preventative Cardiology Program. "There's an intense national focus on improving how we manage the care of patients with heart failure so that they transition better from the hospital to home care and we reduce their risk for re-hospitalization."

In 2011, the American Heart Association and The Joint Commission launched the Advanced Certification in Heart Failure for Joint Commission-accredited hospitals. To become certified and display the American Heart Association's Heart-Check Mark and The Joint Commission's seal, hospitals must meet or exceed Get With The Guidelines<sup>®</sup>-Heart Failure and Joint Commission criteria.

Get With The Guidelines<sup>®</sup>-Heart Failure program recently reached a new milestone: touching the lives of more than 1 million patients. The in-hospital program is designed to boost compliance with scientifically based heart failure treatment guidelines, improving patient outcomes. Adherence to the program has led to reductions in 30-day hospital readmissions.

## Exceeding expectations

The criteria for hospitals to receive Advanced Certification in Heart Failure include:

- Design and operate a heart failure-focused program.
- Staff qualified medical professionals.
- Individualize care to meet patients' needs.
- Involve patients in their hospital care.
- Coordinate patients' care after they leave the hospital.
- Collect hospital's heart failure treatment performance data.
- Use data to assess and continually improve quality of care for heart failure patients.
- Participate in the Get With The Guidelines<sup>®</sup>-Heart Failure quality improvement program at an award-winning level of performance.

- Provide inpatient and outpatient treatment as well as support for the transition from the hospital to home.
- "What's novel about this certification program is that it looks at a hospital's performance," Fonarow said. "Older programs required hospitals to provide data, but that didn't mean that there was quality care taking place. This program requires a certain level of quality to be matched or exceeded. It's a very meaningful certification program. It's been a real honor working with the American Heart Association and to see how this program has had a collective impact on the care of heart failure patients." Learn how your hospital can improve care for heart failure patients through Get With The Guidelines<sup>®</sup>-Heart Failure at [Heart.org/QualityHF](http://Heart.org/QualityHF) or through Advanced Certification in Heart Failure at [Heart.org/Certification](http://Heart.org/Certification). ▼

ADVERTISEMENT



## PROVEN SUPERIOR TO CLOPIDOGREL IN REDUCING CV DEATH AT 12 MONTHS

CV death secondary end point: RRR with BRILINTA plus aspirin was 21% (ARR 1.1%) vs clopidogrel plus aspirin<sup>§1</sup>

### INDICATIONS

BRILINTA is indicated to reduce the rate of thrombotic cardiovascular (CV) events in patients with acute coronary syndrome (ACS) (unstable angina, non-ST-elevation myocardial infarction, or ST-elevation myocardial infarction). BRILINTA has been shown to reduce the rate of a combined end point of CV death, myocardial infarction (MI), or stroke compared to clopidogrel. The difference between treatments was driven by CV death and MI with no difference in stroke. In patients treated with PCI, it also reduces the rate of stent thrombosis.

BRILINTA has been studied in ACS in combination with aspirin. Maintenance doses of aspirin >100 mg decreased the effectiveness of BRILINTA. Avoid maintenance doses of aspirin >100 mg daily.

\*Excluding silent MI. †RRR=relative risk reduction. ‡ARR=absolute risk reduction. §The PLATO study compared BRILINTA (180-mg loading dose, 90 mg twice daily thereafter) and clopidogrel (300-mg to 600-mg loading dose, 75 mg daily thereafter) for the prevention of CV events in 18,624 patients with ACS (UA, NSTEMI, STEMI). Patients were treated for at least 6 months and up to 12 months. BRILINTA and clopidogrel were studied with aspirin and other standard therapies.

¶PLATO used the following bleeding severity categorization: **Major Bleed-Fatal/Life threatening.** Any one of the following: fatal; intracranial; intrapericardial bleed with cardiac tamponade; hypovolemic shock or severe hypotension due to bleeding and requiring pressors or surgery; clinically overt or apparent bleeding associated with a decrease in hemoglobin (Hb) of more than 5 g/dL; transfusion of 4 or more units (whole blood or packed red blood cells [PRBCs]) for bleeding. **Major Bleed-Other.** Any one of the following: significantly disabling (eg, intraocular with permanent vision loss); clinically overt or apparent bleeding associated with a decrease in Hb of 3 g/dL; transfusion of 2 to 3 units (whole blood or PRBCs) for bleeding. **Minor Bleed.** Requires medical intervention to stop or treat bleeding (eg, epistaxis requiring visit to medical facility for packing).

### ADVERSE REACTIONS

- The most commonly observed adverse reactions associated with the use of BRILINTA vs clopidogrel were Total Major Bleeding (11.6% vs 11.2%) and dyspnea (14% vs 8%)
- In clinical studies, BRILINTA has been shown to increase the occurrence of Holter-detected bradyarrhythmias. PLATO excluded patients at increased risk of bradycardic events. Consider the risks and benefits of treatment

**Please see Brief Summary of Prescribing Information, including Boxed WARNINGS, on the adjacent pages.**

References: 1. BRILINTA Prescribing Information, AstraZeneca. 2. Data on file, 1755503, AstraZeneca.

**HELP MAKE AN IMPACT WITH BRILINTA**

**BLEEDING AT 12 MONTHS, there was no significant difference in Total Major Bleeding (which includes Fatal and Life-threatening bleeding) for BRILINTA plus aspirin vs clopidogrel plus aspirin (11.6% vs 11.2%).**

**There was a somewhat greater risk of Non-CABG-related Major plus Minor Bleeding for BRILINTA plus aspirin vs clopidogrel plus aspirin (8.7% vs 7.0%) and Non-CABG-related Major Bleeding (4.5% vs 3.8%), respectively.**

**PLATO trial did not show an advantage for BRILINTA compared with clopidogrel for CABG-related Bleeding (Total Major 85.8% vs 86.9% and Fatal/Life-threatening 48.1% vs 47.9%, respectively).<sup>||1</sup>**

### WARNINGS AND PRECAUTIONS

- Moderate Hepatic Impairment: Consider the risks and benefits of treatment, noting the probable increase in exposure to ticagrelor
- Premature discontinuation increases the risk of MI, stent thrombosis, and death
- Dyspnea was reported in 14% of patients treated with BRILINTA and in 8% of patients taking clopidogrel. Dyspnea resulting from BRILINTA is self-limiting. Rule out other causes
- BRILINTA is metabolized by CYP3A4/5. Avoid use with strong CYP3A inhibitors and potent CYP3A inducers. Avoid simvastatin and lovastatin doses >40 mg
- Monitor digoxin levels with initiation of, or any change in, BRILINTA therapy

# History of heart disease puts a mom on a mission

**P**aula Chavez used to struggle like some of the students in the exercise classes she teaches. At 32, she wore a size 16, was at least 50 pounds overweight, had high cholesterol and was at high risk for heart disease.

“I was hiding in my house,” said the 36-year-old mother of three who is an American Heart Association Go Red For Women volunteer. “The weight just crept up on me as I became busy with the kids. I wouldn’t eat all day, and then at the end of the day I was starving and would eat a lot at night while watching TV. I didn’t even want to look in a mirror. I felt hopeless.”

Chavez, who is Colombian, lives and teaches fitness in Union, New Jersey. She grew up on a diet of fried foods, red

meat, breads and soda. Both grandfathers, her grandmother and her father died of heart attacks.

When her doctor wanted to put her on medication for high cholesterol because she was also at high risk for heart disease, Chavez knew she had to make changes.

“I saw what happened to my family, and I wanted to be a good example to my kids,” she said.

Change came gradually. “I didn’t do everything all at once,” Chavez said. “I started doing some aerobic workouts early



Paula Chavez

time, but we got the whole family involved.” As her children grew, so did Chavez’s strength — physical and emotional. “I



gained muscle and this inner strength; I found somebody I had inside of me that I didn’t know I had,” she said.

To encourage others, Chavez became a certified fitness

instructor and online fitness coach. She launched “Sweaty Selfies” on Facebook and Instagram to encourage women to share pictures of themselves after exercising, and to share their journeys on social media.

Chavez lets mothers know about the dangers of heart disease while empowering them to make positive changes. “I tell moms to take care of themselves,” she said. “I tell them daily exercise and eating right is going to make them feel a lot better. Your kids are watching. By taking care of yourself, you take care of your kids.” ▼

## BRILINTA® (ticagrelor) Tablets

**WARNING: (A) BLEEDING RISK and (B) ASPIRIN DOSE AND BRILINTA EFFECTIVENESS**  
See full prescribing information for complete boxed warning

### A. BLEEDING RISK

- BRILINTA, like other antiplatelet agents, can cause significant, sometimes fatal bleeding [see WARNINGS AND PRECAUTIONS and ADVERSE REACTIONS].
- Do not use BRILINTA in patients with active pathological bleeding or a history of intracranial hemorrhage [see CONTRAINDICATIONS].
- Do not start BRILINTA in patients planned to undergo urgent coronary artery bypass graft surgery (CABG). When possible, discontinue BRILINTA at least 5 days prior to any surgery [see WARNINGS AND PRECAUTIONS].
- Suspect bleeding in any patient who is hypotensive and has recently undergone coronary angiography, percutaneous coronary intervention (PCI), CABG, or other surgery [see WARNINGS AND PRECAUTIONS].
- If possible, manage bleeding without discontinuing BRILINTA. Stopping BRILINTA increases the risk of subsequent cardiovascular events [see WARNINGS AND PRECAUTIONS].

### B. ASPIRIN DOSE AND BRILINTA EFFECTIVENESS

- Maintenance doses of aspirin above 100 mg reduce the effectiveness of BRILINTA and should be avoided [see WARNINGS AND PRECAUTIONS and CLINICAL STUDIES (14) in full Prescribing Information].

### BRIEF SUMMARY of PRESCRIBING INFORMATION:

For full Prescribing Information, see package insert.

### INDICATIONS AND USAGE

#### Acute Coronary Syndromes

BRILINTA is a P2Y<sub>12</sub> platelet inhibitor indicated to reduce the rate of thrombotic cardiovascular events in patients with acute coronary syndrome (ACS) (unstable angina, non-ST elevation myocardial infarction, or ST elevation myocardial infarction). BRILINTA has been shown to reduce the rate of a combined endpoint of cardiovascular death, myocardial infarction or stroke compared to clopidogrel. The difference between treatments was driven by CV death and MI with no difference in stroke. In patients treated with PCI, it also reduces the rate of stent thrombosis [see Clinical Studies (14) in full Prescribing Information]. BRILINTA has been studied in ACS in combination with aspirin. Maintenance doses of aspirin above 100 mg decreased the effectiveness of BRILINTA. Avoid maintenance doses of aspirin above 100 mg daily [see Warnings and Precautions and Clinical Studies (14) in full Prescribing Information].

#### DOSE AND ADMINISTRATION

Initiate BRILINTA treatment with a 180 mg (two 90 mg tablets) loading dose and continue treatment with 90 mg twice daily. After the initial loading dose of aspirin (usually 325 mg), use BRILINTA with a daily maintenance dose of aspirin of 75-100 mg. ACS patients who have received a loading dose of clopidogrel may be started on BRILINTA. BRILINTA can be administered with or without food. A patient who misses a dose of BRILINTA should take one 90 mg tablet (their next dose) at its scheduled time.

#### CONTRAINDICATIONS

**History of Intracranial Hemorrhage** BRILINTA is contraindicated in patients with a history of intracranial hemorrhage (ICH) because of a high risk of recurrent ICH in this population [see Clinical Studies (14) in full Prescribing Information].

**Active Bleeding** BRILINTA is contraindicated in patients with active pathological bleeding such as peptic ulcer or intracranial hemorrhage [see Warnings and Precautions (5.1) and Adverse Reactions (6.1) in full Prescribing Information].

**Severe Hepatic Impairment** BRILINTA is contraindicated in patients with severe hepatic impairment because of a probable increase in exposure, and it has not been studied in these patients. Severe hepatic impairment increases the risk of bleeding because of reduced synthesis of coagulation proteins [see Clinical Pharmacology (12.3) in full Prescribing Information].

**Hypersensitivity** BRILINTA is contraindicated in patients with hypersensitivity (e.g. angioedema) to ticagrelor or any component of the product [see Adverse Reactions (6.1) in full Prescribing Information].

#### WARNINGS AND PRECAUTIONS

##### General Risk of Bleeding

Drugs that inhibit platelet function including BRILINTA increase the risk of bleeding. BRILINTA increased the overall risk of bleeding (Major + Minor) to a somewhat greater extent than did clopidogrel. The increase was seen for non-CABG-related bleeding, but not for CABG-related bleeding. Fatal and life-threatening bleeding rates were not increased [see Adverse Reactions (6.1) in full Prescribing Information]. In general, risk factors for bleeding include older age, a history of bleeding disorders, performance of percutaneous invasive procedures and concomitant use of medications that increase the risk of bleeding (e.g., anticoagulant and fibrinolytic therapy, higher doses of aspirin, and chronic nonsteroidal anti-inflammatory drugs [NSAIDs]). When possible, discontinue BRILINTA five days prior to surgery. Suspect bleeding in any patient who is hypotensive and has recently undergone coronary angiography, PCI, CABG, or other surgical procedures, even if the patient does not have any signs of bleeding. If possible, manage bleeding without discontinuing BRILINTA. Stopping BRILINTA increases the risk of subsequent cardiovascular events [see Warnings and Precautions (5.5) and Adverse Reactions (6.1) in full Prescribing Information].

**Concomitant Aspirin Maintenance Dose** In PLATO, use of BRILINTA with maintenance doses of aspirin above 100 mg decreased the effectiveness of BRILINTA. Therefore, after the initial loading dose of aspirin (usually 325 mg), use BRILINTA with a maintenance dose of aspirin of 75-100 mg [see Dosage and Administration and Clinical Studies (14) in full Prescribing Information].

**Moderate Hepatic Impairment** BRILINTA has not been studied in patients with moderate hepatic impairment. Consider the risks and benefits of treatment, noting the probable increase in exposure to ticagrelor.

**Dyspnea** In PLATO, dyspnea was reported in 14% of patients treated with BRILINTA and in 8% of patients taking clopidogrel. Dyspnea was usually mild to moderate in intensity and often resolved during continued treatment, but occasionally required discontinuation (0.9% of patients taking BRILINTA versus 0.1% of patients taking clopidogrel). If a patient develops new, prolonged, or worsened dyspnea during treatment with BRILINTA, exclude underlying diseases that may require treatment. If dyspnea is determined to be related to BRILINTA, no specific treatment is required; continue BRILINTA without interruption. In the case of intolerable dyspnea requiring discontinuation of BRILINTA, consider prescribing another antiplatelet agent. In a substudy, 199 patients from PLATO underwent pulmonary function testing irrespective of whether they reported dyspnea. There was no significant difference between treatment groups for FEV<sub>1</sub>. There was no indication of an adverse effect on pulmonary function assessed after one month or after at least 6 months of chronic treatment.

**Discontinuation of BRILINTA** Avoid interruption of BRILINTA treatment. If BRILINTA must be temporarily discontinued (e.g., to treat bleeding or for elective surgery), restart it as soon as possible. Discontinuation of BRILINTA will increase the risk of myocardial infarction, stent thrombosis, and death.

**Strong Inhibitors of Cytochrome CYP3A** Ticagrelor is metabolized by CYP3A4/5. Avoid use with strong CYP3A inhibitors, such as atazanavir, clarithromycin, indinavir, itraconazole, ketoconazole, nefazodone, nelfinavir, ritonavir, saquinavir, telithromycin and voriconazole [see Drug Interactions (7.1) and Clinical Pharmacology (12.3) in full Prescribing Information].

**Cytochrome CYP3A Potent Inducers** Avoid use with potent CYP3A inducers, such as rifampin, dexamethasone, phenytoin, carbamazepine, and phenobarbital [see Drug Interactions (7.2) and Clinical Pharmacology (12.3) in full Prescribing Information].

#### ADVERSE REACTIONS

##### Clinical Trials Experience

The following adverse reactions are also discussed elsewhere in the labeling:

- Dyspnea [see Warnings and Precautions (5.4) in full Prescribing Information]

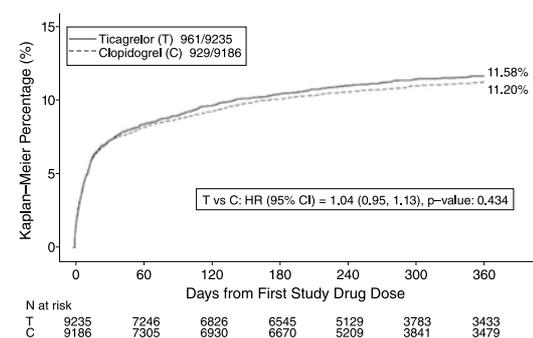
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. BRILINTA has been evaluated for safety in more than 10000 patients, including more than 3000 patients treated for more than 1 year.

**Bleeding** PLATO used the following bleeding severity categorization:

- **Major bleed – fatal/life-threatening.** Any one of the following: fatal; intracranial; intrapericardial bleed with cardiac tamponade; hypovolemic shock or severe hypotension due to bleeding and requiring pressors or surgery; clinically overt or apparent bleeding associated with a decrease in hemoglobin (Hb) of more than 5 g/dL; transfusion of 4 or more units (whole blood or packed red blood cells (PRBCs)) for bleeding.
- **Major bleed – other.** Any one of the following: significantly disabling (e.g., intraocular with permanent vision loss); clinically overt or apparent bleeding associated with a decrease in Hb of 3 g/dL; transfusion of 2-3 units (whole blood or PRBCs) for bleeding.
- **Minor bleed.** Requires medical intervention to stop or treat bleeding (e.g., epistaxis requiring visit to medical facility for packing).
- **Minimal bleed.** All others (e.g., bruising, bleeding gums, oozing from injection sites, etc.) not requiring intervention or treatment.

Figure 1 shows major bleeding events over time. Many events are early, at a time of coronary angiography, PCI, CABG, and other procedures, but the risk persists during later use of antiplatelet therapy.

Figure 1 Kaplan-Meier estimate of time to first PLATO-defined ‘Total Major’ bleeding event



Annualized rates of bleeding are summarized in Table 1 below. About half of the bleeding events were in the first 30 days.

Table 1 Non-CABG related bleeds (KM%)

	BRILINTA N=9235	Clopidogrel N=9186
Total (Major + Minor)	8.7	7.0
Major	4.5	3.8
Fatal/Life-threatening	2.1	1.9
Fatal	0.2	0.2
Intracranial (Fatal/Life-threatening)	0.3	0.2

As shown in Table 1, BRILINTA was associated with a somewhat greater risk of non-CABG bleeding than was clopidogrel. No baseline demographic factor altered the relative risk of bleeding with BRILINTA compared to clopidogrel. In PLATO, 1584 patients underwent CABG surgery. The percentages of those patients who bled are shown in Table 2. Rates were very high but similar for BRILINTA and clopidogrel.

## Gold Standard Boards boost volunteer participation

Thirty-three AHA local governing bodies this year earned the Gold Standard Boards for strengthening and improving health, revenue and volunteerism goals at affiliates across the country.

Another 33 — out of 112 nationwide — earned the Silver Standard Board designation and 16 received Bronze.

“The leadership of our boards is essential to the success of the American Heart Association, because our board members are the ones who make meaningful, enduring connections with the people who live in the communities they serve,” said Elliott Antman, MD, FAHA, president of the American Heart Association and professor of medicine and associate dean for clinical/translational research at Harvard Medical School in Boston, Massachusetts.

Ideally, boards should include at least 25

percent physicians or medical professionals, 25 percent philanthropists, heart disease or stroke survivors, or members of health-related companies and 50 percent from the corporate world. Typically, board presidents are physicians who can serve as AHA spokespeople, while chairs are from the corporate world.

“I want to thank our outstanding boards for so selflessly contributing their time, their passion and their immense talent,” Antman said. “Their extraordinary efforts are vital to our mission of building healthier lives, free of cardiovascular diseases and stroke.”

To achieve Gold Standard designation, a local board has to meet 14 of 16 criteria. This shows they’re following best practices to generate revenue, sustain volunteer leadership and make a health impact in the community.

The AHA started the Gold Standards Board

initiative three years ago to help dramatically ramp up volunteer efforts to meet its 2020 Impact Goal: to improve the cardiovascular health of all Americans by 20 percent while reducing deaths from cardiovascular diseases and stroke by 20 percent.

About 1,900 members serve on 112 local boards, up from 105 boards when the program started. They work with staff members at local offices on fundraising activities such as Heart Ball and advocate on state policy issues to help get patient care guidelines into local hospitals.

Boards are asked to get 14 of Top 25 companies in the affiliate’s market to participate in fundraising efforts such as Heart Walk or Go Red For Women luncheons. Top 25 companies can take part in health initiatives like National Wear Red Day, American Heart Month or American Stroke Month activities or conduct CPR education or training. ▼

## A-TRAC program accepting applications

The American Heart Association’s Tobacco Regulation and Addiction Center is accepting grant applications for pilot funding for the 2014-15 fiscal year.

Applicants accepted for the one- to two-year fellowships will pursue research projects to expand knowledge needed for effective tobacco product regulation.

“Last year six applications were received, and four will be funded,” said Aruni Bhatnagar, co-director of the center and professor of medicine and biochemistry and molecular biology at the University of Louisville in Kentucky.

The amount of fellowship salary support is commensurate with the level of training.

In FY 2013, the U.S. Food and Drug Administration and the National Institutes of Health partnered to award about \$53 million to fund tobacco-related research. The money was used to create 14 Tobacco Centers of Regulatory Science (TCORS) at institutions nationwide. The centers’ goal is to generate research to inform the regulation of tobacco products to protect public health and train the next generation of tobacco regulatory scientists.

The AHA will receive about \$4 million per year in 2013-18 to fund its A-TRAC program — putting it at the forefront of tobacco research.

TCORS brings together investigators from across the country to develop and evaluate tobacco product regulations. Each TCORS application identified a targeted research goal; when combined, the various sites will increase knowledge across the full spectrum of basic and applied research on tobacco and addiction.

The A-TRAC will support multidisciplinary research programs and increase understanding of cardiovascular effects. (Other TCORS sites may address such areas as cancer and pulmonary disease.)

The AHA’s program will:

- Assess the effects of tobacco products on cardiovascular health and disease.
- Examine communication and marketing approaches related to the use, distribution and sale of tobacco products.
- Create intervention strategies to help the general and minority populations stop using tobacco products.

In studying tobacco products, the A-TRAC will pair cardiologists, cardiovascular scientists and toxicologists with investigators experienced in tobacco research.

Program results will help the FDA regulate the manufacture, distribution and marketing of tobacco products to help protect public health and reduce tobacco-related disease, disability and death.

With e-cigarettes, lozenges and other types of tobacco products being developed and marketed in recent years, new knowledge is needed to safeguard public health, Bhatnagar said.

“The FDA needs a lot of specific science to implement effective regulations,” he said.

Applications for pilot funding for eligible A-TRAC projects for the September 2014-August 2015 cycle are being accepted. Qualified applicants include pre-doctoral/post-doctoral PhD candidates, cardiovascular fellows, early-career faculty and established faculty interested in career redirection. Applications are welcome from a wide array of disciplines, including toxicology, pharmacology, public health, nursing, medicine, communications, etc.

To learn about the application process, visit the A-TRAC home page and view the program description. All applications must be submitted using Grants@Heart.

For more information about A-TRAC, visit Anshula Kesh or call (214) 706-1031. ▼

### ADVERTISEMENT

BRILINTA® (ticagrelor) Tablets

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Table 2 CABG bleeds (KM%)

	Patients with CABG	
	BRILINTA N=770	Clopidogrel N=814
Total Major	85.8	86.9
Fatal/Life-threatening	48.1	47.9
Fatal	0.9	1.1

Although the platelet inhibition effect of BRILINTA has a faster offset than clopidogrel in *in vitro* tests and BRILINTA is a reversibly binding P2Y<sub>12</sub> inhibitor, PLATO did not show an advantage of BRILINTA compared to clopidogrel for CABG-related bleeding. When antiplatelet therapy was stopped 5 days before CABG, major bleeding occurred in 75% of BRILINTA treated patients and 79% on clopidogrel. No data exist with BRILINTA regarding a hemostatic benefit of platelet transfusions.

**Drug Discontinuation** In PLATO, the rate of study drug discontinuation attributed to adverse reactions was 7.4% for BRILINTA and 5.4% for clopidogrel. Bleeding caused permanent discontinuation of study drug in 2.3% of BRILINTA patients and 1.0% of clopidogrel patients. Dyspnea led to study drug discontinuation in 0.9% of BRILINTA and 0.1% of clopidogrel patients.

**Common Adverse Events** A variety of non-hemorrhagic adverse events occurred in PLATO at rates of 3% or more. These are shown in Table 3. In the absence of a placebo control, whether these are drug related cannot be determined in most cases, except where they are more common on BRILINTA or clearly related to the drug’s pharmacologic effect (dyspnea).

Table 3 Percentage of patients reporting non-hemorrhagic adverse events at least 3% or more in either group

	BRILINTA N=9235	Clopidogrel N=9186
Dyspnea <sup>1</sup>	13.8	7.8
Headache	6.5	5.8
Cough	4.9	4.6
Dizziness	4.5	3.9
Nausea	4.3	3.8
Atrial fibrillation	4.2	4.6
Hypertension	3.8	4.0
Non-cardiac chest pain	3.7	3.3
Diarrhea	3.7	3.3
Back pain	3.6	3.3
Hypotension	3.2	3.3
Fatigue	3.2	3.2
Chest pain	3.1	3.5

<sup>1</sup> Includes: dyspnea, dyspnea exertional, dyspnea at rest, nocturnal dyspnea, dyspnea paroxysmal nocturnal

**Bradycardia** In clinical studies BRILINTA has been shown to increase the occurrence of Holter-detected bradycardias (including ventricular pauses). PLATO excluded patients at increased risk of bradycardic events (e.g., patients who have sick sinus syndrome, 2nd or 3rd degree AV block, or bradycardic-related syncope and not protected with a pacemaker). In PLATO, syncope, pre-syncope and loss of consciousness were reported by 1.7% and 1.5% of BRILINTA and clopidogrel patients, respectively. In a Holter substudy of about 3000 patients in PLATO, more patients had ventricular pauses with BRILINTA (6.0%) than with clopidogrel (3.5%) in the acute phase; rates were 2.2% and 1.6% respectively after 1 month.

**Gynecomastia** In PLATO, gynecomastia was reported by 0.23% of men on BRILINTA and 0.05% on clopidogrel. Other sex-hormonal adverse reactions, including sex organ malignancies, did not differ between the two treatment groups in PLATO.

**Lab abnormalities** Serum Uric Acid: Serum uric acid levels increased approximately 0.6 mg/dL from baseline on BRILINTA and approximately 0.2 mg/dL on clopidogrel in PLATO. The difference disappeared within 30 days of discontinuing treatment. Reports of gout did not differ between treatment groups in PLATO (0.6% in each group). Serum Creatinine: In PLATO, a >50% increase in serum creatinine levels was observed in 7.4% of patients receiving BRILINTA compared to 5.9% of patients receiving clopidogrel. The increases typically did not progress with ongoing treatment and often decreased with continued therapy. Evidence of reversibility upon discontinuation was observed even in those with the greatest on treatment increases. Treatment groups in PLATO did not differ for renal-related serious adverse events such as acute renal failure, chronic renal failure, toxic nephropathy, or oliguria.

### Postmarketing Experience

The following adverse reactions have been identified during post-approval use of BRILINTA. Because these reactions are reported voluntarily from a population of an unknown size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

**Immune system disorders** – Hypersensitivity reactions including angioedema [see Contraindications (4.4) in full Prescribing Information].

### DRUG INTERACTIONS

**Effects of other drugs** Ticagrelor is predominantly metabolized by CYP3A4 and to a lesser extent by CYP3A5. Ticagrelor is also a p-glycoprotein (P-gp) substrate.

**CYP3A inhibitors** [see Warnings and Precautions and Clinical Pharmacology (12.3) in full Prescribing Information].

**CYP3A inducers** [see Warnings and Precautions and Clinical Pharmacology (12.3) in full Prescribing Information].

**Aspirin** Use of BRILINTA with aspirin maintenance doses above 100 mg reduced the effectiveness of BRILINTA [see Warnings and Precautions and Clinical Studies (14) in full Prescribing Information].

**Effect of BRILINTA on other drugs** Ticagrelor is an inhibitor of CYP3A4/5 and the P-glycoprotein transporter.

**Simvastatin, lovastatin** BRILINTA will result in higher serum concentrations of simvastatin and lovastatin because these drugs are metabolized by CYP3A4. Avoid simvastatin and lovastatin doses greater than 40 mg [see Clinical Pharmacology (12.3) in full Prescribing Information].

**Digoxin** Digoxin: Because of inhibition of the P-glycoprotein transporter, monitor digoxin levels with initiation of or any change in BRILINTA therapy [see Clinical Pharmacology (12.3) in full Prescribing Information].

**Other Concomitant Therapy** BRILINTA can be administered with unfractionated or low-molecular-weight heparin, GPIIb/IIIa inhibitors, proton pump inhibitors, beta-blockers, angiotensin converting enzyme inhibitors, and angiotensin receptor blockers.

### USE IN SPECIFIC POPULATIONS

**Pregnancy** Pregnancy Category C: There are no adequate and well-controlled studies of BRILINTA use in pregnant women. In animal studies, ticagrelor caused structural abnormalities at maternal doses about 5 to 7 times the maximum recommended human dose (MRHD) based on body surface area. BRILINTA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. In reproductive toxicology studies, pregnant rats received ticagrelor during organogenesis at doses from 20 to 300 mg/kg/day. The lowest dose was approximately the same as the MRHD of 90 mg twice daily for a 60 kg human on a mg/m<sup>2</sup> basis. Adverse outcomes in offspring occurred at doses of 300 mg/kg/day (16.5 times the MRHD on a mg/m<sup>2</sup> basis) and included supernumerary liver lobe and ribs, incomplete ossification of sternbrae, displaced articulation of pelvis, and misshapen/misaligned sternbrae. When pregnant rabbits received ticagrelor during organogenesis at doses from 21 to 63 mg/kg/day, fetuses exposed to the highest maternal dose of 63 mg/kg/day (6.8 times the MRHD on a mg/m<sup>2</sup> basis) had delayed gall bladder development and incomplete ossification of the hyoid, pubis and sternbrae occurred. In a prenatal/postnatal study, pregnant rats received ticagrelor at doses of 10 to 180 mg/kg/day during late gestation and lactation. Pup death and effects on pup growth were observed at 180 mg/kg/day (approximately 10 times the MRHD on a mg/m<sup>2</sup> basis). Relatively minor effects such as delays in pinna unfolding and eye opening occurred at doses of 10 and 60 mg/kg (approximately one-half and 3.2 times the MRHD on a mg/m<sup>2</sup> basis).

**Nursing Mothers** It is not known whether ticagrelor or its active metabolites are excreted in human milk. Ticagrelor is excreted in rat milk. Because many drugs are excreted in human milk, and because of the potential for serious adverse reactions in nursing infants from BRILINTA, a decision should be made whether to discontinue nursing or to discontinue drug, taking into account the importance of the drug to the mother.

**Pediatric Use** The safety and effectiveness of BRILINTA in pediatric patients have not been established.

**Geriatric Use** In PLATO, 43% of patients were ≥65 years of age and 15% were ≥75 years of age. The relative risk of bleeding was similar in both treatment and age groups. No overall differences in safety or effectiveness were observed between these patients and younger patients. While this clinical experience has not identified differences in responses between the elderly and younger patients, greater sensitivity of some older individuals cannot be ruled out.

**Hepatic Impairment** BRILINTA has not been studied in the patients with moderate or severe hepatic impairment. Ticagrelor is metabolized by the liver and impaired hepatic function can increase risks for bleeding and other adverse events. Hence, BRILINTA is contraindicated for use in patients with severe hepatic impairment and its use should be considered carefully in patients with moderate hepatic impairment. No dosage adjustment is needed in patients with mild hepatic impairment [see Contraindications, Warnings and Precautions, and Clinical Pharmacology (12.3) in full Prescribing Information].

**Renal Impairment** No dosage adjustment is needed in patients with renal impairment. Patients receiving dialysis have not been studied [see Clinical Pharmacology (12.3) in full Prescribing Information].

### OVERDOSAGE

There is currently no known treatment to reverse the effects of BRILINTA, and ticagrelor is not expected to be dialyzable. Treatment of overdose should follow local standard medical practice. Bleeding is the expected pharmacologic effect of overdosing. If bleeding occurs, appropriate supportive measures should be taken. Other effects of overdose may include gastrointestinal effects (nausea, vomiting, diarrhea) or ventricular pauses. Monitor the ECG.

### NONCLINICAL TOXICOLOGY

#### Carcinogenesis, Mutagenesis, Impairment of Fertility

[see section (13.1) in full Prescribing Information]

#### PATIENT COUNSELING INFORMATION

[see section (17) in full Prescribing Information]

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AstraZeneca

# AHA launches effort to reduce Americans' sodium intake

**S**alt is everywhere — and the American Heart Association says it's time for you and your patients to take notice.

In the campaign, "I love you salt, but you're breaking my heart," the AHA is showing Americans that too much sodium can hurt their health. The association is also encouraging them to cut back on salt and to become advocates for reducing sodium in the food supply. Reducing Americans' sodium intake is part of the association's 2020 Impact Goal to improve the cardiovascular health of all Americans by 20 percent while reducing deaths from cardiovascular diseases and stroke by 20 percent.

The campaign's website, [heart.org/sodium](http://heart.org/sodium), went live over the summer after consumer research showed that 97 percent of American adults cannot estimate or greatly underestimate their sodium intake. On average, Americans eat more than 3,400 milligrams of sodium a day, more than double the amount recommended by the AHA.

"The big picture is that elevated blood pressure is the leading preventable cause of death worldwide," said Dr. Lawrence Appel, chair of the Council on Lifestyle and Cardiometabolic Health, chair of the AHA's Sodium Advisory Task Force and professor of medicine at Johns Hopkins University School of Medicine.

One-third of American adults have high blood pressure, and excess sodium intake is



a major contributing factor. About 90 percent of American adults are expected to develop high blood pressure at some point during their lifetimes.

On the website, visitors are urged to join AHA's movement to reduce sodium by taking a pledge to reduce their sodium consumption. They can get tips, share stories, comment on a blog from a registered dietitian and upload photos to show how they are

reducing sodium. Those who take the pledge will be added to AHA's list of supporters and tapped to take future actions to spur change to reduce sodium in the food supply.

The AHA hopes visitors will share via email and social media a one-minute video featuring "Salt man" — a man dressed in white spandex with "SALT" emblazoned across his chest — who shows how salt sneaks into packaged and restaurant foods.

Approximately 75 percent of the sodium consumed by Americans is added to processed, prepackaged and restaurant foods.

In addition to striving for personal behavior change, the AHA wants to build advocates to influence food manufacturers and policy makers about the food supply.

If the food industry reduced sodium by 50 percent in the top 50 foods that contribute to Americans' sodium intake, and then reduced sodium in other

foods by 10 percent, it could result in 80 percent of the population reaching intermediate sodium goals (2,300 mg sodium/day) and 40 percent achieving ideal sodium intake (1,500 mg sodium/day), according to modeling commissioned by the AHA and presented at its June 2013 Sodium Conference.

## How can you help?

- Sign the pledge to reduce the sodium you eat, then share it on social media and encourage your patients to sign it too.
- Watch and share the 1-minute video, "Don't Let Salt Sneak Up On You" at [heart.org/sodium](http://heart.org/sodium).
- Share the website [heart.org/sodium](http://heart.org/sodium) with your patients. ▼

## Advocates push Congress to support Medical research

When Heather Vaclav recently visited Washington, D.C., she wanted lawmakers to know that making medical research a federal priority would pay off big.

"What keeps me alive today — my heart monitors, the EKG tests, my medications, all of that — is because of medical research," said the 24-year-old from Birmingham, Alabama. "And if and when in 20 or 30 years, the time comes that I need aortic valve replacement, the procedure that could save my life probably hasn't even been invented yet."

Vaclav was born with a heart murmur, but didn't experience complications until she was a teenager and fainted in gym class. She was diagnosed with aortic stenosis.



Heather Vaclav

Thankfully, medication, a healthy lifestyle and regular checkups with her cardiologist stabilized her condition, allowing Vaclav to avoid surgery and enjoy high school and college. By 23, her condition was downgraded to aortic insufficiency, a milder form of stenosis.

As an American Heart Association You're the Cure volunteer, Vaclav went to Capitol Hill in September to explain to lawmakers that heart disease isn't just an older person's disease, and that research is needed not just for lifesaving therapies but for developing preventive measures as well.

"The AHA and You're the Cure brings the patients' and survivors' voice to these issues," said Vaclav, who met with Republican U.S. Senator Richard Shelby of Alabama and other leaders in Congress. "Visiting Capitol Hill allows lawmakers to see who is affected by medical research."

"Just three years ago, the Food and Drug Association approved a minimally invasive procedure for aortic valve replacement. So think about what the future might hold for patients with aortic stenosis."

## AHA funding innovations to transform medicine

**T**he American Heart Association is bridging the funding gap to get technologies from laboratories to patients' bedsides with its Science & Technology Accelerator Program.

Started in 2011 with a \$1 million donation, Science & Technology Accelerator identifies the most transformational innovations to help meet its 2020 Impact Goal to decrease death from heart attack and stroke 20 percent by 2020.

Many basic scientific research projects further along in development lack funding to attract private equity or industry support — leaving technologies that could transform the way medicine is practiced languishing, or ultimately dying.

"We want to run that second leg of the funding relay," said Charles Huntington, Jr., chairman of the Accelerator Program Committee that chooses the projects.

Joining Huntington on the panel is what he calls an "all-star list" of volunteer advisers with expertise in cardiology, law, venture capital, regulatory matters, intellectual property and commercialization.

"We're making a modest investment into technology that we have great faith in, in terms of promise getting this to the patients," said Huntington, senior vice president and investment officer at Huntington Kraus Financial Group of Wells Fargo Advisors. "We're trying to effect change in as many patients' lives as possible."

The American Heart Association is a "trusted member" of the investment

spectrum that's filled with many impartial parties, Huntington said. He would ultimately like investors to support the accelerator program's projects much like they follow billionaire investment guru Warren Buffett.

"I would love for the American Heart Association to have that same reputation five years from now where if the American Heart Association invests in it, everyone is breaking down the door to find out what have they [AHA] invested in and how can we invest in it next," Huntington said.

The accelerator's investment money comes from donors. All return on investment goes back into the program to help propel more innovations to market.

So far, with its limited funding, the accelerator program has invested in one project a year:

- CytoVas is aimed at creating a revolutionary diagnostic test for assessing the health of the lining of blood vessels. The spinoff from the University of Pennsylvania's School of Medicine's Vascular Health Profile (VHP) blood test would identify the marathon runner likely to suffer sudden death in his next race, and determine the efficacy of any cardiovascular preventive therapy in time to make changes if necessary.
- BioKier is a joint venture involving a promising treatment for Type 2 diabetes patients. BioKier is developing a potentially once-a-day oral treatment that would mimic the effects of intestinal bypass surgery for morbidly obese Type 2 diabetics, whose glucose numbers normalize after



surgery, before they've lost even a pound.

The capsule carries the nontoxic, natural dietary substances intact from mouth to colon without releasing them, similar to what happens when the route from mouth to colon is shortened surgically. The compounds then bind with receptors and dramatically increases insulin production and decreases insulin resistance.

- The latest investment involves expanding ePRISM's technology to permit its use without integrating into each hospital's system. This would dramatically increase the number of acute ischemic stroke patients receiving tPA in time to reduce long-term disabilities. ePRISM technology could also be used on smartphones and tablets. ▼

# Program aimed at preventing obesity in young kids

**R**educing childhood obesity by helping early care and education centers create healthier environments is the aim of Healthy Way to Grow, a joint effort of the American Heart Association and the nonprofit children's health system Nemours.

The year-old program, funded by the William G. McGowan Charitable Fund, helps centers develop wellness policies that incorporate good nutrition and effective levels of physical activity.

"The more we learn about obesity, the more it's clear that prevention really is the key," said Stephen R. Daniels, MD, PhD, president of the American Heart Association Southwest Affiliate and a member of the Healthy Way to Grow expert panel. "Obesity is hard to treat once it occurs."

Because prevention works best when started early, the program targets children from birth to

age 5. Ninety-seven percent of the participating centers serve pre-school age children, but many also serve toddlers and infants.

Meals or snacks are served in 95 percent of the 115 centers in Chicago; Rochester, New York; Denver; Kansas City; Reno, Nevada; and Scranton/Wilkes Barre, Pennsylvania. This makes early care and education centers an important place to intervene, as children get a large portion of their daily nutrition in these settings.

Environmental factors affecting obesity, including types of food and play, are addressed at each site.

"The hope is that this extends to their homes," said Daniels, professor of pediatrics and chairman of the Department of Pediatrics at the University of Colorado School of Medicine and pediatrician-in-chief at Children's Hospital Colorado. "If things are being modeled well in

the day care, that may be helpful for parents."

Fewer than half the centers initially met best practice standards for portable play equipment and indoor-outdoor play areas and spaces, according to baseline data. About one-fourth of the centers rarely or never provided educational information to families about nutrition and physical activity.

Initial evaluation data this fall will provide a snapshot of changes made at the centers in the program's first year, with the goal of expanding in the future.

Some care providers are reducing sedentary entertainment time, such as television and video watching, and replacing it with physical activity, Daniels said.

The AHA recommends 60 minutes per day of moderate to vigorous activity for children. Dietary changes include eliminating

sugar-sweetened beverages and emphasizing fruits and vegetables.

At first, some center directors were concerned about how much they could accomplish, given their facilities and other challenges such as adopting a wellness plan in a society where obesity is prevalent, Daniels said.

"In some ways, it's easier to go with the flow, with the way the rest of the world is looking at things," he said.

Almost one-fourth of U.S. preschool children ages 2 to 5 are overweight or obese, which can lead to increased risk for cardiovascular disease later in life.

Six centers have achieved the Bronze level of national program recognition for taking significant steps toward best practices in nutrition, physical activity, screen time and infant feeding. ▼

## NFL PLAY 60 app gets kids moving

**A** mobile app from the American Heart Association and the National Football League that encourages physical activity among kids through their smartphones is quickly catching on.

"We are very excited that the app has received such a positive response from kids and educators," said Anna Isaacson, vice president of social responsibility for the NFL. "To reach this age group, we thought a fun, interactive app that gets kids up and moving was the perfect way to expand our PLAY 60 efforts with the American Heart Association."

The app encourages kids to be active and help get their 60 minutes of activity while playing the downloadable game. It requires players to move as they compete in an "endless runner" game and uses gyroscope technology to track the movements of the person holding the device. The character runs, turns and jumps on screen as the player accumulates points.

The app, available on newer-generation Apple products and Android, is an extension of the NFL PLAY 60 program that combats child obesity by encouraging kids to be active for 60 minutes a day. The app also provides other ideas for staying active.

Targeting children ages 6 to 12, the game features colorful animated characters and city street scenes. Navigating the game on a smart phone or tablet involves running and jumping over obstacles as the player hears encouragement such as, "It starts with you. Let's move those feet."

"Our app is unique as it asks the user to stand up and move in order to compete and excel in the game," Isaacson said.

Players can earn digital coins and redeem them for team gear to be worn by their game avatar. NFL power-ups multiply players' points and American Heart Association hearts make the character "invincible."

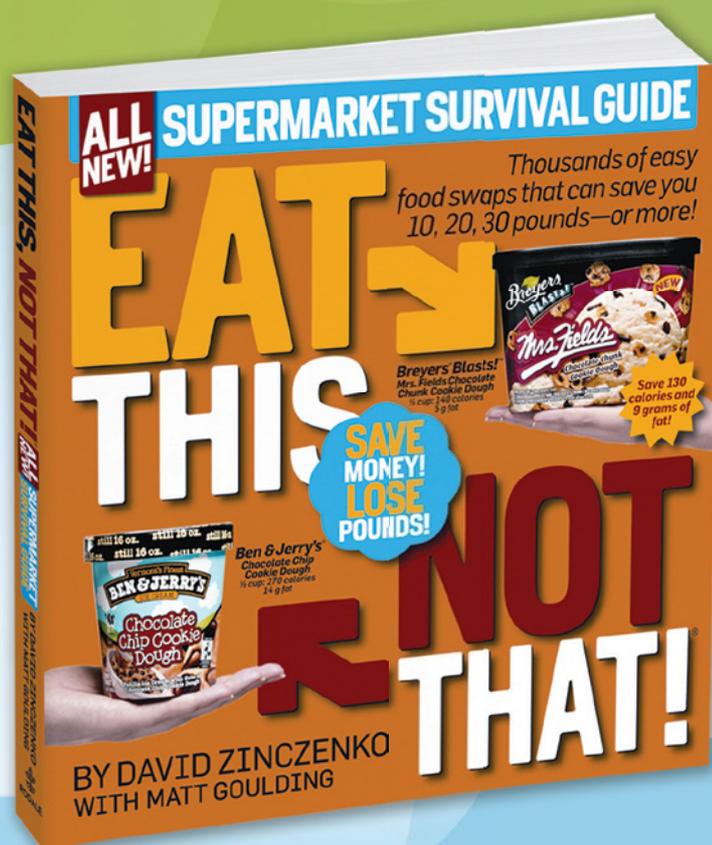
During breaks, the game provides health facts — such as food serving size and nutrition labels — to supplement the physical activity.

Since its debut in February, the app has been downloaded more than 525,000 times, making it the American Heart Association's most downloaded app to date. In the iTunes store, it has ranked No. 1 in Kids for iPhone and No. 1 in Health and Fitness for iPad. ▼

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## Health eHeart study collecting big data

Health eHeart, a pioneering digital research study of cardiovascular disease, is featured at this year's Scientific Sessions.

The large scale, long-term, fully electronic heart study gathers dense data using everyday digital and mobile technology, including smartphone apps and wireless devices such as home blood pressure or blood sugar monitors — even digital scales.

Participants track and share information on blood pressure, diet, weight, exercise and smoking status that's seamlessly fed into the study's protected data system.

"After signing an electronic consent, research subjects provide information during electronic visits on the Internet," said Elliott Antman, MD, FAHA, professor of medicine at Harvard Medical School, a senior physician in the Cardiovascular Division of the Brigham and Women's Hospital in Boston and AHA president. "They can also link their wireless sensors to allow real-time streaming of their physiologic measurements such as heart rate and rhythm to the database.

"Soon, biospecimen data will be added to the study," he said. "The software interface is being written to allow linkage to electronic medical records and correlation with outcome events." This linkage should be complete by the end of the year.

Researchers will use the "big data" to develop more robust algorithms for personalized pattern-based prediction and ultimately improve heart disease and stroke prevention.

Health eHeart is a new paradigm for conducting clinical research, possibly leading to larger trials that can be done faster, easier and at lower cost. It also leverages existing technology and encourages the development of new health technologies such as sensors. This will make it easier to validate data and translate it into better health.

"This is an example of a platform that is an innovative testing ground not only for new therapeutics but also disease management strategies," Antman said.

Three University of California, San Francisco faculty members, in collaboration with the American Heart Association, are leading the study:

- Jeffrey Olgin, MD, Galo-Chatterjee Distinguished Professor of Medicine and Chief of the Division of Cardiology
- Gregory Marcus, MD, MAS, Director of Clinical Research for the Division of Cardiology
- Mark Pletcher, MD, MPH, Director of Research Consultation of the Clinical and Translational Research Institute

and cardiovascular epidemiologist

"We (the American Heart Association) are referring subjects from our patient networks to the study and soon will be receiving data that allow us to track progress toward our goal of improving cardiovascular health," Antman said. "Shortly, we will be conducting randomized trials in this new research environment."

Health eHeart aims to sign up 1 million participants age 18 and older from around the world. Healthy people and those with CVD are encouraged to sign up. Since the study launched, more than 9,800 participants have signed up.

### For More Information

To learn more, see the Health eHeart booth at HeartQuarters and attend these study-related presentations:

"The PCORI Vision for New Big Data Networks," 9–10:15 a.m. Monday, Nov. 17, in S100c

"The Health eHeart Study: Using Big Data to Perform a Large, Internet-Based, Cardiovascular Cohort Study" (full sessions), 5:30–6:45 p.m. Monday in S100c

"How to Collaborate with Large Scale Cohorts and Genome Programs," 8–8:15 a.m. Tuesday, Nov. 18, in S100c

"Joint AHA/Heart Rhythm Society Session: Prevention of AF," 9–10:15 a.m. Tuesday in S402

# Online support available for survivors, caregivers, families

**H**eat disease and stroke patients, caregivers and families who need emotional support can visit a new online community to meet others, share stories and find and give support.

Users at [heart.org/supportnetwork](http://heart.org/supportnetwork) and [strokeassociation.org/supportnetwork](http://strokeassociation.org/supportnetwork) can read and post messages in monitored discussions, join a support group and find inspirational stories. The website is helping create meaningful volunteer roles while increasing knowledge, healthy behaviors and quality of life for patients and families.

"We need to spread the word to healthcare providers so they can inform their patients and the public that this important resource exists," said Lynne Braun, PhD, CNP, FAHA, a nurse practitioner in the Rush Heart Center for Women and a professor in the Department of Adult Health and Gerontological Nursing in the Rush College of Nursing in Chicago. "For those who do have heart disease, we know it can take not just a physical toll but also an emotional toll on people and their families."

Braun, a member of the AHA's Patient Support Volunteer Subgroup committee and a longtime AHA volunteer, notes that not all patients have access to in-person, hospital-based support groups.

"We're very excited about how this support network can grow and how we can connect perhaps hundreds or thousands of people," Braun said.

Studies have shown an increase in depression among heart disease patients. According to a 2008 AHA Science Advisory, depression is about three times more common in patients after an acute myocardial infarction than in the general community. Further, a study based on National Health Interview Survey data of 30,801 adults found the 12-month prevalence of major depression to be 9.3

percent in people with cardiac disease, compared with 4.8 percent of those with no comorbid medical illness.

Caregiving also can have profound emotional effects. One study published in *Stroke: Journal of the American Heart Association* found that the stress of caring for a disabled spouse appears to significantly raise the caregiver's risk of future stroke, especially among African-American men.

There are plans to promote the virtual support community in three pilot market sites — Nashville, St. Louis and Phoenix. The local field offices in each city are working through grassroots and volunteer tactics to engage virtual users and promote face-to-face support group interactions.

Larry Sadwin, a longtime AHA volunteer and past national chair who was first diagnosed with heart disease 32 years ago, emphasizes the value of connecting with fellow patients and caregivers, who can feel isolated.

"The ability to be able to put people in contact with one another is terribly important," Sadwin said.

On the site, users "will find everything from bloggers to chat rooms to recipes to anything that a patient or a caregiver might need to find support and encouragement."

Sadwin was a young father when he was diagnosed with heart disease. He struggled with the knowledge that his dad had died from a heart attack at 42.

"I had a marvelous cardiologist, but I do not believe his job was to provide emotional support," Sadwin said. "His job was to keep me alive."

He added: "It was not only impactful on me but certainly on my family — my kids were then 10 and 7. There was literally no place to go."

He said the AHA is a trusted resource.

"I am very confident that when I go to their website, what I'm seeing is unbiased and credible," Sadwin said. ▼

## AHA/ASA journals' impact continues to be a factor

**T**he 12 American Heart Association/American Stroke Association journals continue to advance innovation in the field and application of the latest science into clinical practice.

In today's publishing environment, a single metric does not evaluate the quality of scientific publications.

Science has many needs:

From speed of publication, to reach in academic, research, and healthcare institutions, to Open Access options. Here are some of the journals' latest metrics:

- Reach:** 12,494 institutions with access
- Reputation:** 5,339 papers published\*
- Recognition:** 46,103 cites\*
- Exposure:** 13.4 billion media impressions
- Discoverability:** 28 million online visitors
- App-peal:** More than 118,000 app downloads

"The AHA/ASA journals are taking the lead in looking at different metrics to determine prestige and quality of published articles. One of those metrics is an article-level metric, which can be useful in identifying trends, especially by article type," said Robert M. Carey, MD, MACP, FAHA, FRCPI, chair of the AHA Scientific Publishing Committee. "We already provide other metrics, such as the *Eigenfactor*® Score, and we are also looking at measures of quality beyond the Impact



Factor. We have been given a unique opportunity to reflect on our individual evaluation methods and be a catalyst for change."

To learn more about the next generation of evaluation metrics, including total cites, *Eigenfactor*® Score, *Article Influence*® Score and Altmetrics for each journal, visit [www.ahajournals.org/site/metrics](http://www.ahajournals.org/site/metrics).

During Scientific Sessions, stop by AHA HeartQuarters (booth 1059) or Wolters Kluwer (booth 973) in the Science & Technology Hall. You can also view AHA/ASA

journals' apps and other new features. Complimentary copies of the AHA's five print journals and information about all the journals are available.

Accessibility is another way the AHA/ASA journals reach the science community. For more information about Open Access publishing options, visit [www.ahajournals.org/site/openaccess](http://www.ahajournals.org/site/openaccess).

*JAMA*, the AHA/ASA's fully open access journal, represents the 16 AHA scientific councils. *JAMA* encourages submissions from AHA/ASA members about CPR, cardiovascular surgery, pediatric cardiology and congenital heart disease, prevention, genetics, cardiovascular nursing, and the kidney in cardiovascular disease. Members are eligible for discounted article publication charges. Pick up a free *JAMA* booklet with featured articles, information about authors and more at AHA HeartQuarters (booth 1059) and from Wiley (booth 1412). Also visit [jama.ahajournals.org](http://jama.ahajournals.org).

Many of the AHA/ASA journals have Facebook pages, tweets of the latest study results, connections via LinkedIn and blogs with readers about cases or recently published articles. For the latest, visit [www.ahajournals.org/site/socialmedia](http://www.ahajournals.org/site/socialmedia). ▼

\*2013 Journal Citation Reports® (Thomson Reuters, 2014).

### AHA/ASA journals

- *Arteriosclerosis, Thrombosis, and Vascular Biology*
- *Circulation*
- *Circulation Research*
- *Hypertension*
- *Stroke*
- *JAMA – Journal of the American Heart Association*
- *Circulation: Arrhythmia and Electrophysiology*
- *Circulation: Cardiovascular Genetics*
- *Circulation: Cardiovascular Imaging*
- *Circulation: Cardiovascular Interventions*
- *Circulation: Cardiovascular Quality and Outcomes*
- *Circulation: Heart Failure*

# Leading executives dedicated to employee health

**H**enry Kravis, KKR & Co. L.P.'s co-chairman and co-CEO, led a company-wide health screening with a 99 percent participation rate. Macy's Inc. chairman and CEO Terry Lundgren and his wife lead the company's annual 5K, insist on healthy food at meetings and take the stairs instead of the elevator.

So it was a natural fit when they joined with American Heart Association CEO Nancy Brown and 19 more CEOs to form the AHA CEO Roundtable, which engages employees to make simple behavior changes that can make a big difference on their health and well-being.

"Collectively, the member organizations involved in the CEO Roundtable employ more than 2 million individuals in the United States," Kravis said. "We have the opportunity to support these employees, and by extension their families — millions of additional people — with tools and resources designed to help them improve their health and well-being. If we can prove what works at our member companies, and expand evidence-based programs to the roughly 150 million people in our country's workforce, the impact of the CEO Roundtable will be enormous."

And it will only continue to grow — from the 150 million-strong workforce to their families and on to their communities.

Under the AHA's guidance, the group will devise pilot programs, test strategies and focus on measurable results. With "Life's Simple 7," they'll encourage employees to take simple steps — like being more active and monitoring blood pressure — that can make a big difference on their health. Research shows that people who meet the criteria for three to four of Life's Simple 7 cut their risk of heart-related death by more than half. And those who reach ideal cardiovascular wellness goals by 50 can expect to live another 40 years free from heart disease and stroke.

"The Roundtable is a group of forward-thinking CEOs with a common interest in helping our collective workforces be the healthiest they can be," Lundgren said. "Relative to other developed and even emerging economies, Americans, in general, don't take good care of themselves. Our philosophy is that by working closely together, our country's major employers can improve everyone's well-being."

"Leading by example, the AHA CEO Roundtable aims to transform the culture of the workplace to meaningfully engage employees. Just by taking simple steps, our worksites can promote an environment that encourages employees to dramatically reduce their risk of heart-related death and illness," Brown said. "Some of the country's most influential CEOs are ready to tackle this issue head-on, share best practices and identify cutting-edge programs to help get America heart-healthy."

The AHA released results in July from a survey by Nielsen (a CEO Roundtable member) showing that American workers tend to think they're healthier than they are. The survey of 2,004 employees showed that 74 percent report being in very good or good health, despite the fact that 42 percent have

been diagnosed with a chronic illness.

Among the other findings:

- Of those who participate in workplace health programs, 60 percent said they ate healthier, 41 percent lost weight and 23 percent saw cholesterol levels decrease.
- Fifty-five percent of employees believe it's important to see a CEO set a good personal health example.
- 69 percent of employees who feel supported to participate in workplace health programs report that those programs have a strong impact on job satisfaction.

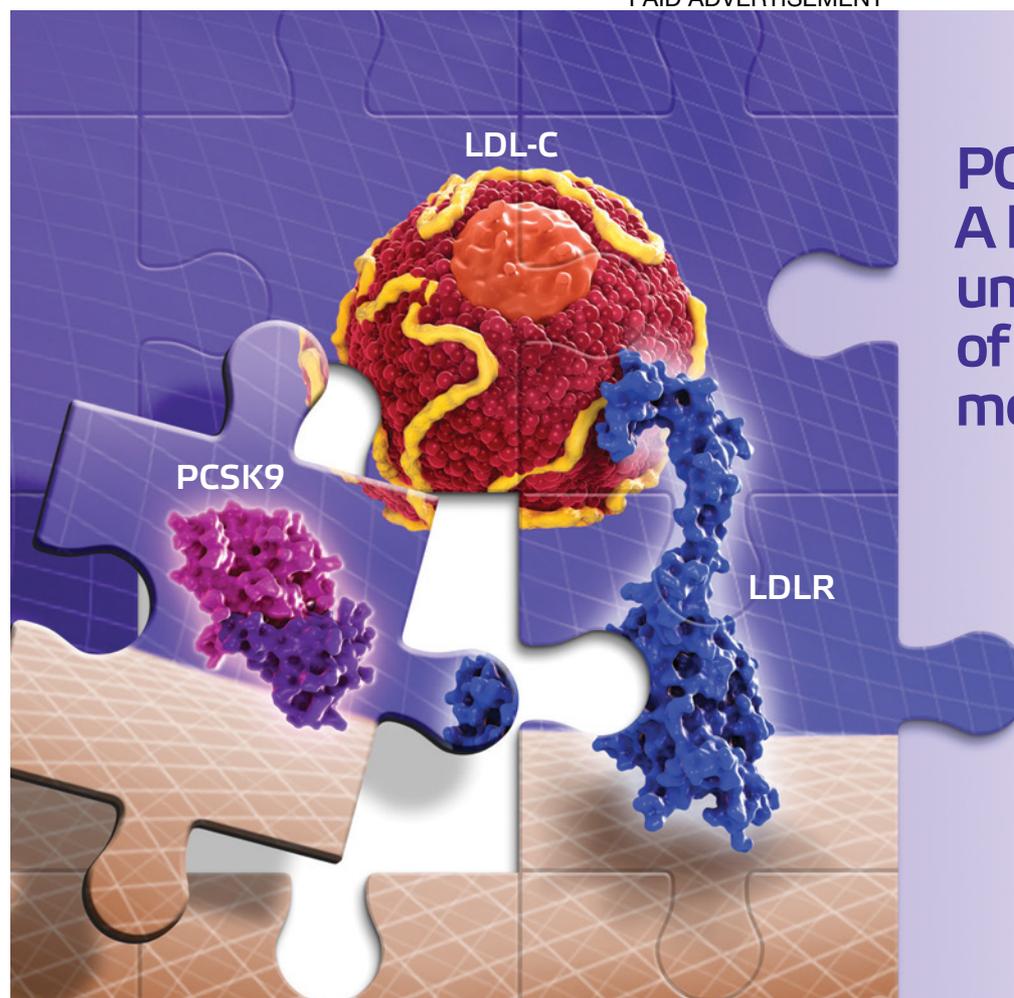
"The good news is workplace health programs make a huge impression on employee health awareness and satisfaction," said Uta Werner, executive vice president of product leadership at Nielsen and a lieutenant on the

CEO Roundtable. "Of employees who feel encouraged by senior management to participate in workplace health programs, 63 percent cite the availability of these programs as important to staying with their current employer."

Lundgren said approaching employees in a strategic, systematic and data-driven manner — particularly when it comes to combating cardiovascular diseases — can help them help themselves. "This can make their lives happier, less stressful and more productive."

The CEOs on the Roundtable have committed to adopting the AHA's Impact Goal of improving the cardiovascular health of all Americans 20 percent by 2020. "The efforts of the CEO Roundtable and the access to so employees is a major catalyst to make a significant health impact," Brown said. ▼

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## PCSK9: A key piece in our understanding of LDL-C metabolism<sup>1,2</sup>

Sanofi and Regeneron are conducting research into the role of PCSK9 in LDL-C metabolism.



### Visit Booth 464 to learn more and attend Expert Lectures

November 16th 12:15-12:45 PM	Unmet Need: Low-Density Lipoprotein Cholesterol (LDL-C) and Its Relationship to Persistent CV Risk	Michael Koren, MD, FACC
November 16th 3:00-3:30 PM	PCSK9 Protein: Understanding Its Role in LDL-C Metabolism and PCSK9 Genetics	Alan S. Brown, MD, FACC, FAHA, FNLA
November 17th 1:00-1:30 PM	PCSK9 Protein: Understanding Its Role in LDL-C Metabolism	Keith C. Ferdinand, MD, FACC, FAHA
November 17th 3:15-3:45 PM	Unmet Need: Low-Density Lipoprotein Cholesterol (LDL-C) and Its Relationship to Persistent CV Risk	Michael Koren, MD, FACC
November 18th 12:15-12:45 PM	PCSK9 Genetics: Gain of Function and Loss of Function Mutations	Keith C. Ferdinand, MD, FACC, FAHA

LDL-C = low-density lipoprotein cholesterol; LDLR = low-density lipoprotein receptor; PCSK9 = proprotein convertase subtilisin/kexin type 9; CV = cardiovascular.

References: 1. Abifadel M, Varret M, Rabès J-P, et al. Mutations in PCSK9 cause autosomal dominant hypercholesterolemia. *Nat Genet.* 2003;34:154-156. 2. Lagace TA, Curtis DE, Garuti R, et al. Secreted PCSK9 decreases the number of LDL receptors in hepatocytes and in livers of parabiotic mice. *J Clin Invest.* 2006;116:2995-3005.

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## DailyNews

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# Professional Education Center offers medical education to healthcare professionals worldwide

The American Heart Association's Professional Education Center — the premier provider of continuing medical education — helps healthcare professionals navigate a changing landscape of licensing regulations on program transparency.

“The challenge in providing healthcare education is that we want experts to lead discussions on important content, but the experts may have conflicts based on funding for research or from other collaborations,” said Nancy Albert, PhD, FAHA, chair of the AHA's Professional Education Committee. “The AHA ensures that information presented in educational materials and oral presentations is evidence-based, with references, to reduce the risk of author biases.”

In September, the federal government launched its online Open Payments database as part of the Sunshine Act. The goal is to increase transparency of financial relationships between manufacturers of drugs, medical equipment or supplies, physicians and teaching hospitals.

“The federal rule has helped, but there are still many pockets where there can be bias in education,” said Albert, senior director of nursing research and innovation at the Cleveland Clinic. “Educators, no matter the education form or healthcare provider type, need to be honest in communicating potential or actual conflicts during the planning process, and ensure they prepare non-biased education materials.”

Six accrediting bodies have recognized the AHA as a provider of continuing education:

- American Nurses Credentialing Center (ANCC)
- Accreditation Council for Continuing Medical Education (ACCME)
- Commission on Dietetic Registration (CDR) for the Academy of Nutrition and Dietetics
- Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS)
- Accreditation Council for Pharmacy Education (ACPE)
- American National Standards Institute/ International Association for continuing Education & Training (ANSI/IACET)

“Being recognized as a provider of accredited education by these national organizations represents the AHA's commitment to education at the highest quality and standard,” Albert said. “We can ensure our members that the content is independent, free of commercial bias, and based on valid content.”

Albert said the AHA is ideally positioned to provide continuing education for other groups.

“We lead education programs ourselves, and we do it without bias and conflicts of interest, and our program information holds up as independent and trustworthy,” she said.

The AHA's Professional Education Center, a provider of continuing medical education for more than 50 years, is constantly evolving to provide the latest and best content in a variety of formats and uses social media to connect with users.

In 2013, the AHA had 163 accredited programs, an increase of 28 percent over 2011. The programs provided 744 accreditation hours for physicians, 683.5 for nurses and 481.75 for EMS professionals.

All AHA programs are offered worldwide and many are also available in Spanish.

“We're trying to meet learners' needs based on the way they learn best,” Albert said.

In addition to in-person, classroom-style lectures, healthcare professionals can use a variety of formats that cater to independent learners, including magazines that present bulleted information and interactive quizzes, live webcasts with time for discussion or video courses.

“The AHA does a beautiful job of not only putting together these programs and accrediting outside programs, but also being leaders in developing new programs that help healthcare providers do a better job of taking care of patients,” Albert said.

To learn more about the AHA's on-demand continuing medical education programs, including its Peer Review series and Non-valvular Atrial Fibrillation: 2014 Guidelines and Evidence-Based Practice, go to [learn.heart.org](http://learn.heart.org).

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## HEART FAILURE SHATTERS MILLIONS OF LIVES

Chronic heart failure is a growing crisis—with little improvement in hospitalization rates or mortality outcomes over the last 10 years.<sup>1,2</sup>

**LET'S WORK TOGETHER TO CHANGE THAT**



**VISIT BOOTH 417 TO LEARN MORE**

**References:** 1. Heidenreich PA, Albert NM, Allen LA, et al. Forecasting the impact of heart failure in the United States: a policy statement from the American Heart Association. *Circ Heart Fail.* 2013;6(3):606-619. 2. Go AS, Mozaffarian D, Roger VR, et al. Heart disease and stroke statistics—2014 update: a report from the American Heart Association. *Circulation.* 2014;129(3):e28-e292.

## Claiming CME/CE at Scientific Sessions

Healthcare professionals attending Scientific Sessions can claim and print CME/CE certificates.

- Sign in at [learn.heart.org](http://learn.heart.org) using your Professional Education Center (PEC) username and password. You can create an account if you don't have one.
- Find the courses you are registered for under the “Activities Catalog” tab or from the home page.
- Enter the authorization code you received with your attendee badge.
- Complete the evaluation.
- Claim your credit(s).
- International attendees can obtain their attendance verification certificate at the registration center. For a full list of conference accreditation statements and credit hours, visit [scientificsessions.org](http://scientificsessions.org).



# Attendees tout value of membership

The value of being one of the American Heart Association's more than 32,000 professional members resonated for Raina Merchant, MD, when she attended her first ReSuscitation Science Symposium as a medical student eight years ago.

"It was an incredible opportunity to interact with leaders in the field," Merchant said. "I was impressed with how the organization promoted mentorship and lots of opportunities to collaborate."

Merchant first served on the ECC Basic Life Support Working Group and gained a deeper appreciation for how levels of evidence impact patient care and how policy decisions are made in science. She's continued to participate on additional working groups and task forces for the 3CPR Council.

"It's been rewarding to have a role in interpreting science for the public," she said.

Her early career membership included networking with fellow junior investigators and access to mentorship and grants, "essentially having access to all the tools that you'll need early in your career," Merchant said.

Scientific Sessions attendees who join or renew as professional members of the AHA or American Stroke Association can save up to \$400 off registration and \$300 off other AHA scientific conferences. The promotion also includes a logoed black pullover.

Several levels of professional membership are available, including ones for students and early career members. Basic benefits for all professional members include:

- Discounted charges for accepted articles in the *Journal of the American Heart Association*, the AHA/ASA's open access journal. Members save \$500 with discount code.
- Waived application fees for the AHA research grant application
- Countless networking opportunities with like-minded professionals
- Priority registration and housing for Scientific Sessions and the International Stroke Conference
- Notification about AHA national and affiliate research funding opportunities and deadlines
- Notice about upcoming AHA scientific conferences and requests for abstracts
- Special opportunities to be a peer reviewer of manuscripts, research applications and abstracts for meetings
- Opportunities to apply for and receive council awards
- Unlimited access within the AHA's Professional Online Network
- *Connections* quarterly newsletter with council-specific information
- Inclusion in and access to the online AHA/ASA Professional Membership Directory
- Complimentary *You're the Cure Advocacy* e-newsletter
- Opportunities to help influence legislative policy and participate in advocacy programs
- AHA/ASA Professional Membership card, certificate and lapel pin
- Special briefing on legislative and regulatory issues to members who participate in AHA Lobby Day in Washington, D.C.



Raina Merchant, MD

Visit the HeartQuarters booth No. 1059 to learn more about the benefits of professional membership during the following exhibit hours:

11 a.m.–6 p.m. Sunday

10 a.m.–6 p.m. Monday

10 a.m.–2:30 p.m. Tuesday

Merchant, who is now an assistant professor in the University of Pennsylvania's Department of Emergency Medicine and a Robert Wood Johnson Clinical Scholar, has

recently been working with her local AHA office to promote heart-healthy living in the

community by improving CPR training. One project includes innovative social networking with a gaming component, reflecting the opportunities members have to "be creative and use new media tools to reach a broader

audience," she said.

"I'm working on so many great projects now that I never could have done without the American Heart Association's support," Merchant said. "At every level, everyone I've come in contact with, from the volunteers and the staff, are really passionate and great thinkers, always open to new ideas." ▼



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1. Mirabel M, Lung B, Baron G, et al. What are the characteristics of patients with severe, symptomatic, mitral regurgitation who are denied surgery? *Eur Heart J*. 2007;28(11):1358-1365.

## CPR training preparing future lifesavers

**A**s a pediatric cardiologist and electrophysiologist, Dianne Atkins, MD, knows firsthand that many of her young patients are at risk for sudden death, and that other children in the household could help save a life.

"Fear is often cited as a reason why people don't do CPR," said Atkins, a longtime American Heart Association volunteer and physician in Iowa City, Iowa. "I tell the kids taking our CPR classes, 'You can't make this worse.' In fact, I find the kids in junior and high schools are very motivated and want to help."

### A graduation requirement

Atkins is involved in the American Heart Association's CPR in Schools program to train future generations of lifesavers. In fact, since launching in 2011, more than 1 million high school students each year will be trained in CPR, ensuring generations to come will have these lifesaving skills. Twenty states currently require CPR training to graduate, and many other states are working on similar legislation this year.

More than 420,000 people have cardiac arrest outside of a hospital every year, with survival less than 11 percent — most likely because they don't receive timely CPR. When delivered right away, CPR doubles or triples survival rates.



Dianne Atkins, MD

Teaching students CPR could save thousands of lives, aligning with the American Heart Association's goals to reduce morbidity and premature death from cardiovascular diseases by 20 percent by 2020.

Most children have enough physical strength to perform the chest compressions needed for CPR starting in sixth or seventh grade. Mouth-to-mouth ventilation is no longer required of bystander CPR, although paramedics still perform it.

Teachers have a variety of options, but all students are required to get training that meets national emergency cardiac care guidelines for CPR and includes a psychomotor or hands on component within the training.

"The school environment presents a real opportunity," Atkins said. "Often the kids need to fulfill community service projects, and they are an eager group. They learn a lifesaving skill, they gain confidence and they know that they could help someone in need. It's a great program." ▼

## Gift to AHA provides lifetime income for Illinois couple

**J**ohn and Anita Casazza are passionate about the American Heart Association's work, especially its contributions to research.

John, 97, has survived multiple heart procedures in the past 22 years, including a quadruple bypass, angioplasty and replacement of his aortic valve with an artificial one. "John wouldn't be alive without research made possible by the American Heart Association," said Anita, 79.

The AHA has invested more than \$3.7 billion in research, funded 13 Nobel Prize winners and many lifesaving research advancements such as the first artificial heart valve, cholesterol-inhibiting drugs, heart transplantation, and CPR techniques and guidelines.

The Oak Brook, Illinois, couple was looking for a way to generate continuing income from the sale of a building when their attorney suggested they consider making a gift to charity that pays a guaranteed lifetime income and provides an immediate income tax deduction.

So in 2005, the Casazzas made the first of several charitable gift annuities to support the association's mission. Anita is a 22-year breast cancer survivor, so the couple also participates in a similar program with the American Cancer Society.



Anita and John Casazza

"Anytime we do well in the stock market, we invest more with the AHA because we feel the research is so important," Anita said.

In exchange for a gift of cash or appreciated assets, the association agrees to make fixed lifetime payments to up to two people. These payments are guaranteed by AHA reserves and assets.

Your payout rate is based on your age at the time of the gift and can be as high as 9 percent. A portion of those payments is tax-free. You'll also receive a charitable deduction for the value of your future gift.

If your gift is made with appreciated assets, you bypass some capital gains tax and the remainder of the tax is spread out across the payments for your lifetime.

Your payments start immediately, or you can receive a deferred payments at a future date.

To receive your personalized illustration of how a gift can pay you guaranteed lifetime income and provide a tax deduction, go to [www.americanheart.org/planyourlegacy.org](http://www.americanheart.org/planyourlegacy.org). ▼



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Learn more and register at the AHA Walking Challenge booth in the Grand Concourse Lobby of McCormick Place starting Saturday, Nov. 15 or at [scientificsessions.org/walkingchallenge](http://scientificsessions.org/walkingchallenge).

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## SCIENTIFIC SESSIONS

continued from page 1

“What we hear over and over is, ‘Talk to us. Engage us.’ Sessions is more than slides and people making presentations. People want to hear people talking about their areas of expertise. They want to ask questions. They want to hear how something changes their field. For the planning committee, these are things we’ve spent a lot of time thinking about.”

More than 17,000 attendees from more than 100 countries will gather here through Wednesday. Another 1.5 million professional attendees are expected to be involved virtually, absorbing groundbreaking insights, lectures from prestigious speakers and thought-provoking discussions about basic, translational, clinical and population science.

Harrington’s coordinating skills emerge as he breaks down this sprawling event. Asked about areas of emphasis of this year, he offered four points. Asked for examples of Sessions’ evolution in this year’s program, he offered three examples. The break-it-down approach makes sense considering the challenge of getting a grip on all the science packed into this event:

- More than 5,000 presentations
- More than 4,000 abstract presentations of original research
- 1,000 invited faculty
- A Science and Technology Hall open from Sunday to Tuesday and packed with more than 200 exhibitors showcasing the latest cardiovascular technology and resources

With programming spread across 26 programming tracks, there is clearly plenty for everyone. Harrington breaks it down into four areas of emphasis:

**The first area** is all about the Early Career professional.

The Early Career Lounge that was introduced last year is being expanded this year, setting the stage for more networking opportunities. For a second year, there’s an Early Career Day subcommittee of the CSSP led by a young faculty member. This fresh voice has helped shape what offerings are most sought by their peers. An Early Career reception to highlight networking and connections Saturday continues to grow as well.

“Sessions has always had an emphasis on young people, but in the last couple of years, we’ve really stepped this up,” Harrington said. “Making Sessions better for them is very, very important to me. But I’ve found that others are equally passionate about it.”

**A second item** is embedding meetings within meetings. This includes continuing and improving the Resuscitation Science Symposium and the Cardiovascular and Stroke Nursing Clinical Symposium that have long been part of the event, plus a Global Congress on Big Data and — for the first time — a sub-specialty meeting, which will be devoted to arrhythmias.

“ReSS has been embedded for a long time and is very popular, but what we’re doing now is linking that meeting — which takes place Saturday and Sunday — to other activities that take place within the larger meeting,” Harrington said. “We’ve been growing our nursing meeting the last few years, and now we have a dedicated nursing track. We’re very pleased to highlight advances in nursing science in this way in addition to embedding these advances in the main program.”

Each year, Sessions offers a congress addressing a topic that is relevant to professionals from around the world. Last year, it was physical education and cardiovascular disease. This year’s aim is the timely topic of Big Data in cardiovascular science, with programs running daily through Tuesday.

“Big Data has become a fairly ubiquitous phase in society, so we’re just making it focused on cardiovascular medicine and science,”

Harrington said. “We have some amazing technology sessions, Basic Cardiovascular Sciences sessions, Clinical Research sessions ... pretty much everything surrounding Big Data. There are some really interesting topics around mobile tech, for example. There’s also e-health and health in the cloud. These are all things we never thought of having at Sessions three, four years ago.”

The Arrhythmia Research Summit is quite a new wrinkle, as it includes both a four-day meeting (Sunday through Wednesday) and a one-day event (Wednesday). Former AHA President Gordon Tomaselli, MD, FAHA, and other leaders in electrophysiology will play key roles in sessions devoted to cutting-edge research and therapeutic innovation.

**Harrington’s third area** of emphasis is the crux of the in-person experience: networking.

Time spent meeting colleagues and renewing acquaintances is priceless. Harrington has hired many people directly

and indirectly through contacts forged via Sessions. He tapped that same network for insights and opinions before he decided to leave his previous position as the director of the Duke Clinical Research Institute for Stanford.

By their nature, all meetings lend themselves to making connections, but it helps when the planners have baked such encounters into their plans. This goes well beyond the basic step of having lounges designated for Early Career professionals, FAHAs and speakers.

“We’ve tried to cluster communities within McCormick Place so you’re more likely to bump into people who share your interests — heart failure near EP near genomics near imaging — to help build that sense of community around the topic,” Harrington said. “At a meeting with nearly 20,000 people, we want you to feel as if you’re at a meeting with 500 to 2,000 of your closest friends. We’re trying to accommodate both

experiences, a large meeting and a small one. We want everyone to feel that Sessions is about them and their interests.”

**Harrington’s fourth point of emphasis** is Basic Cardiovascular Sciences. The anchor is a Monday night event focused on the Best of Basic Sciences and the Best of Basic Sciences posters. There also will be Late-Breaking Basic Sciences abstracts and a best of Basic Sciences abstracts.

“It is important to acknowledge that AHA is about science,” Harrington said. “And we want to engage people. This Monday evening reception will be another great opportunity to network and mingle all while viewing and discussing some of the hottest science from the large basic science community within AHA.”

Now, about that evolution of the Sessions agenda.

With Harrington stepping aside after a decade of planning, this could be viewed as

SESSIONS continued on page 19

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3:30 pm – 4:00 pm

Monday, November 17

10:45 am – 11:15 am

12:30 pm – 1:00 pm

Tuesday, November 18

10:45 am – 11:15 am

12:30 pm – 1:00 pm

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**Arrhythmia Research Summit**, Wednesday, Nov. 19, 7 AM–3:42 PM

- Rapid fire presentations and discussions on newest findings in arrhythmia mechanisms, diagnosis, and management
- Target audience: clinicians, basic scientists, biomedical engineers and outcomes experts
- *Highly interactive summit designed for lively exchange of ideas*

**Science subcommittees Hangout - Networking with light refreshments.**

- These 35 subcommittees focus on targeted areas of content for AHA
- Topics include: Heart Failure, Interventional Cardiology, Acute Cardiac Care, Imaging, Cardiac Rehab, Electrophysiology, Hypertension, Molecular Determinants of Disease, Social Determinant of Disease, Prevention, Obesity, Diabetes, Physical Activity, Nutrition, Stroke, and many more
- Members from these committees plan programming, author AHA science manuscripts, lead networking events, serve as content experts for AHA, etc

Come join and learn about the AHA Science Subcommittees.

## BIG NETWORKING

**Abstract Submitter Reception:** All abstract submitters for Scientific Sessions 2014 are invited to attend.

Tuesday, Nov. 18, 10–10:45 AM  
Science & Technology Hall, South Hall A1

**Enhanced Poster Hall**

- **eAbstracts** sessions are presented in theaters featured in each core poster community, highlighting the must-see science of the day. Moderators will lead lively discussions between the presenter and the audience
- **Poster Professors** will make rounds to meet each author for increased interaction and robust discussion

## BIG TECHNOLOGY

**Conference Notes Application**

- Follow slides and make notes in real time from your iPad
- Save important slides to revisit later
- Allows users to get more from the content, not just during the presentations but after the conference too

Piloted in four rooms onsite: Plenary (Hall B1), Special Sessions (S100ab & S106ab), Global Congress (S100c) and Cardiovascular Nursing Clinical Symposium (N427abc).

**Enhanced mobile app:** Navigate the meeting while onsite

- **Live audio streaming from educational sessions (listen while you are on the go)**
- Explore the 2014 Science & Technology Hall exhibitors
- Stay connected and connect with other attendees
- Upload photos of your Sessions experience to various social networks

**ePoster Workstations** located throughout the convention center allow viewing of poster content closer to the meeting rooms.

## JUST PLAIN COOL

**Art of the Heart** - Turn heart care into an art form at the Art of the Heart display, located in Booth 417. Using Microsoft Kinect technology, this unique exhibit allows you to create your own heart artwork — presented on an 11-foot, heart shaped canvas — simply by waving your arms. Share your newly created, one-of-a-kind masterpiece with others via an online gallery. You can even take your artwork home to share with your patients and colleagues and to remind yourself that heart care is an art form.

*Art of the Heart is supported by Novartis.*

**Exhibit Hall Member Activity**

Make your time in the Science and Technology Hall pay off in another big way. Check out AHA's Aisle After Magnificent Aisle membership activity. While visiting exhibitors, have your card punched for a chance to win prizes that are awarded daily!

*If you're not registered yet don't miss out on the big things happening this year!*

Visit **[scientificsessions.org](http://scientificsessions.org)** and register today!

**SESSIONS** continued from page 17

the legacy of his tenure. So it's little wonder that the first of the three items he noted was the expansion of opportunities for Early Career professionals.

Second is a new way of blending scientific advancement and networking. This also fits the you-have-to-be-there component, with the "there" being the Poster Hall.

"Of all the original abstracts submitted, 90 percent are now being presented as posters," Harrington said. "Everyone tells us they would like more engagement, more interaction, and we see the Poster Hall as a great forum to do that. We've worked to arrange the room in ways that drive people together."

In the Poster Hall last year, organizers successfully introduced "The Poster Professor," a way for a presenter to get quality feedback from a one-on-one visit with a senior member of their field. It was so well received that it's back and expanded this year, with a bevy of senior volunteers examining between 10 and 20 posters.

"They've been told that their 'job' is to engage that presenter in a conversation about their poster, their science," Harrington said. "The goal is to engage a young person and get them involved in what I'll call the culture of science — become accustomed to questions, criticism — and giving them a chance to show off a bit. They've worked hard, they deserve it. We also have worked hard on this concept. I think it's something that, when I look back on my tenure, I'll say it's one of the best things we did."

We've still only scratched the surface of all the offerings in this year's agenda. Here is a quick rundown of more highlights:

- Opening Session: At 1 p.m. Sunday, AHA President Elliott Antman, MD, FAHA, will present his Presidential Address, "Saving and Improving Lives in the Information Age." This will be followed by presentation of a series of awards and honors to leaders in our field.
- Late-Breaking Clinical Trials and Clinical Science Special Reports

Late-Breaking Clinical Trials are always among the most newsworthy elements of Sessions. The proliferation in submissions over the last five years prompted organizers to offer a secondary outlet, the Clinical Science Special Reports. They come from the same pool of submissions as the Late-Breakers, and are rigorously peer-reviewed and winnowed before being chosen.

Some of these presentations will have new twists, all fitting the overarching theme of "being here."

Since many presentations are going to appear in peer-reviewed literature, a recitation of the facts is somewhat redundant. The 15-minute presentation is being scaled back to about nine, with a few minutes for a commentary, then a panel discussion and a questions-and-answers session.

"This makes it more interactive, sort of poking and prodding to get to the core issues," Harrington said. "We're trying to make this something that is going to be helpful, useful, important to attendees." The other tweak is that in some sessions featuring multiple trials within similar realms, a single commentator will put it all into perspective, rather than pausing to discuss each.

- Learning At The Movies  
It only makes sense that this offering — probably the most interactive of all on the

Sessions agenda — is being expanded.

"Learning At The Movies" began in 2012, fittingly enough in Los Angeles, with the showing of taped cases. Videos can be stopped for discussion points, with a moderator or a panel discussing what's already happened and what could/should happen next.

In an effort to focus more on daily clinical practice issues, Harrington said there will be a "bigger, broader" rollout with sessions devoted to the catheterization lab, electrophysiology lab and the operating room, interventional cardiology, structural heart disease, coronary heart disease and more.

"We have a diverse set of presenters, moderators and panelists from around the globe," Harrington said.

Planners are proud to carry on the Sessions legacy.

After last year's event, organizers did

an immediate debrief and self-critique, then gathered feedback from a variety of sources. Then came the effort of putting those lessons into action. This included a small group of organizers meeting in Chicago for two days in December, then the entire CSSP met in January. And a Sessions Summit was held early in the summer.

"Everyone is creative, energetic and committed to making Sessions great," Harrington said.

Harrington said he's excited about this year's host city. He knows that being downtown means endless opportunities to take networking into an endless array of venues.

"With hotels up and down Michigan Avenue, attendees have a chance to walk around and experience the fabric of the city," he said. "It also helps that for people coming from around the world, they can get here relatively easily, seldom in more

than one stop. All in all, I think Chicago handles us very, very well."

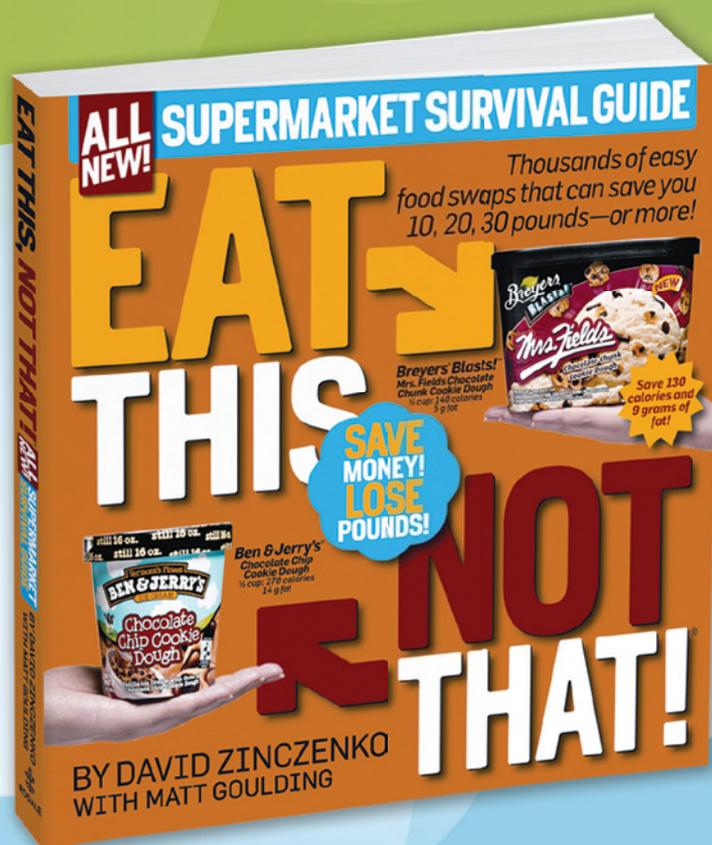
When Sessions ends, so will Harrington's tenure on the planning committee. It is bittersweet as he leaves behind a labor of love, but he knows it's time for others to have their turn. Frank Sellke, MD, FAHA, the Vice Chair of CSSP, will step up to lead the planning for 2015 in Orlando and 2016 in New Orleans.

"Scientific Sessions brings together very diverse people — from different backgrounds, different scientific interests, different cultures — into one place every November to discuss what we're all thinking about, which is how to better understand cardiovascular health and diseases and to take better care of patients, or prevent people from becoming patients," Harrington said. "I really believe passionately that we've put together a great forum and venue to do that." ▼

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## *Let the conversations flow.*

Amgen Cardiovascular invites you to visit Booth 1145 and AHA Cardiovascular Expert Theaters\* to learn about topics that add to the knowledge of CV patient care.

**Date:** November 16, 2014

**Time:** 11:15 AM - 12:00 PM

**Location:** Science & Technology Hall, Booth 174

**Title:** Focus on Patient Outcomes in the Management of Heart Failure: Considering the Emerging Role of Heart Rate

**Presenter:** Jeffrey Borer, MD

**Date:** November 17, 2014

**Time:** 12:00 PM - 12:45 PM

**Location:** Science & Technology Hall, Booth 174

**Title:** Who Is at Risk? Understanding the Current State of Dyslipidemia Treatment

**Presenter:** Matthew Roe, MD

**Date:** November 16, 2014

**Time:** 12:30 PM - 1:15 PM

**Location:** Science & Technology Hall, Booth 1725

**Title:** Prevalence and Management of Cholesterol, and the Role of PCSK9 in Cholesterol Homeostasis

**Presenter:** Peter Jones, MD

**Date:** November 17, 2014

**Time:** 12:00 PM - 12:45 PM

**Location:** Science & Technology Hall, Booth 1725

**Title:** Considering Heart Rate in Cardiovascular Disease: A Focus on Heart Failure

**Presenter:** Gregg Fonarow, MD

\* This event is not part of the official Scientific Sessions 2014 as planned by the AHA committee on Scientific Sessions Program.