



Canadian Cardiovascular Congress

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Key Leaders in CV Medicine Share Their Expertise Across Multiple Symposia

Toronto - This year, Canadian Cardiovascular Congress hosted some 17 satellite symposia, all featuring key leaders in cardiovascular (CV) medicine who shared their considerable knowledge and expertise with attendees. Among the topics explored by successive experts were CV risk prediction and protection, especially among high-risk patients; screening patients for vulnerable plaque; attenuating cardiometabolic risk; addressing care gaps in acute coronary syndromes; new treatment options for atrial fibrillation and atrial flutter; new and improved antiplatelet strategies as well as drug-eluting stents; and clinical practice implications for controlled trials between ACE inhibitors and the angiotensin II receptor blockers. A summary from some of these symposia follows.

Toronto – Cette année, le Congrès canadien sur la santé cardiovasculaire a été le carrefour de 17 symposiums satellites, auxquels ont participé des sommités en médecine cardiovasculaire qui ont transmis aux congressistes leur savoir et leur expérience considérables. Ces experts ont exploré plusieurs questions d'actualité : prédiction du risque CV et protection, surtout chez les sujets à risque élevé; dépistage des plaques vulnérables; diminution du risque cardiométabolique; lacunes thérapeutiques à combler dans les syndromes coronariens aigus; nouvelles options de traitement dans la fibrillation et le flutter auriculaires; stratégies antiplaquettaires nouvelles et améliorées, et tuteurs médicamenteux; et retombées sur la pratique clinique d'essais comparatifs sur les inhibiteurs de l'ECA et les antagonistes des récepteurs de l'angiotensine II. Un tour d'horizon de quelques-uns de ces symposiums vous est présenté dans les lignes qui suivent.

By Pam Harrison

Among patients at the highest risk for cardiovascular (CV) events are those with chronic kidney disease (CKD) and diabetes. Indeed, experts argued that the presence of CKD should not prevent physicians from using primary prevention strategies, including intensification of a lipid-lowering regimen, to reduce the otherwise high CV disease (CVD) risk in this patient group. However, as pointed out during the same symposium, many patients need to have their LDL-C levels lowered very substantially and a more aggressive approach using low-dose statin combined with ezetimibe will reduce LDL-C by approximately 50%. The combination in turn can reduce LDL-C levels by 55% to 69%.

Screening patients for the presence of vulnerable plaque may allow physicians to initiate life-saving interventions before rupture occurs. Quantitative coronary angiographic studies have demonstrated that those who progress on QCA fare worse clinically, while findings from ASTEROID showed that treatment with rosuvastatin induced disease regression as assessed by intravascular ultrasound. The soon-to-be announced results from JUPITER, a novel trial in that patients with optimal lipid levels but elevated hsCRP also received rosuvastatin, may represent a paradigm shift in how patients are managed if results are positive, especially given that patients in JUPITER would not have been candidates for lipid-lowering therapy based on current guidelines.

Whether or not patients assessed as having an elevated cardiometabolic risk should be treated with lifestyle changes or lifestyle changes plus pharmacotherapy is still to be debated on Wednesday morning. Positive lifestyle changes come close to addressing the constellation of risk factors that determine cardiometabolic risk, most notably abdominal obesity, and a strong argument can be made to support behavioural change as a key strategy. On the other hand, pharmacotherapy with the cannabinoid receptor type 1 rimonabant helps reduce abdominal obesity and it also has favourable effects on metabolic abnormalities. Thus, the combination of lifestyle changes plus CB₁ receptor antagonism may offer a more potent strategy to reduce cardiometabolic risk. Importantly, there is evidence that the same intervention may help normalize total atheroma volume in addition to shifting metabolic parameters in a more favourable direction.

Many issues are yet to be resolved in the optimal management of ACS patients, but consensus advocates dual antiplatelet therapy, ideally in all ACS patients. Whether higher loading doses accompanied by higher maintenance doses of clopidogrel will achieve rapid and more complete platelet inhibition than standard doses is under investigation. In the meantime, alternative antiplatelet agents are emerging, with recent results suggesting that the new investigational thienopyridine

prasugrel does achieve more rapid and complete inhibition of platelet function than clopidogrel, although bleeding risk with prasugrel was higher than for clopidogrel in patients overall. Other investigational antiplatelet agents include AZD6140, a direct, reversible P2Y₁₂ inhibitor currently being explored in a large-scale trial involving NSTEMI-ACS patients undergoing PCI, as well as a PAR-1 and a TP receptor antagonist.

Paradigm Shift

Until now, no antiarrhythmic agent has been shown to improve clinical outcomes for patients with atrial fibrillation (AF) and flutter. A landmark trial with an investigational multi-channel antiarrhythmic agent, dronedarone, may result in a paradigm shift in how practitioners approach these common rhythm disturbances, as for the first time, active therapy was shown to reduce hard clinical end points, including CV mortality, arrhythmic death and stroke, relative to placebo and it was well tolerated. These findings are obviously meaningful for patients, for whom symptoms and quality of life, as well as risk for morbid events, are clearly more relevant than any reduction of AF documented by ECG.

Questions about drug-eluting stents (ES) seem to have been addressed with further analyses of available data but there are still differences in event rates when comparing different DES among them. In one large randomized trial comparing sirolimus-eluting stents and zotarolimus-eluting stents, investigators documented significantly higher rates of restenosis in patients receiving a zotarolimus-eluting stent in addition to stent thrombosis compared with those who received a sirolimus-eluting stent. Data from a Danish registry also suggest that there is a higher risk for all-cause mortality and a strong trend toward higher cardiac mortality with the zotarolimus-eluting stent. Other researchers have reported the rates of restenosis were higher among patients who received a zotarolimus-eluting stent compared with those who received a rapamycin-eluting stent.

Finally, a large-scale randomized trial in CAD patients or those with diabetes showed that outcomes were virtually indistinguishable between the telmisartan arm and the ramipril arm, but the ARB was better tolerated than the ACE inhibitor. Importantly, there was no added benefit in terms of protection against the primary end point in patients who received a combination of the two agents, although there was no significant increase in adverse events in the combination arm relative to ramipril alone. □



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in Edmonton!**

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à Edmonton !**

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1-877-230-4CME (4263)

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