

Heart Place

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Asheville
Cardiology
Associates, P.A.



Asheville Cardiovascular
& Thoracic Surgeons, P.A.

Regional EDs Adopt RACE

RACE, the state initiative for Reperfusion in Acute MI in Carolina Emergency Departments, is well underway in Western North Carolina. Physicians from every hospital ED have met with the regional RACE physicians and program coordinator, and each hospital now has a designated RACE team. This statewide collaboration works to ensure that all AMI patients receive the systematic interventions recommended by American College of Cardiology/American Heart Association guidelines. Each regional hospital has developed individual protocols for ST elevated MI patients to streamline treatment and transfer decisions, and to reduce response times.

Mission a Top 100 Heart Hospital Again

For the fifth year in a row, Mission was named a Top 100 Heart Hospital by the Solucient Cardiovascular Benchmarks for Success Program. Mission is the only hospital in the Carolinas to be designated this year.

Inside: Statin Therapy Valve Surgery



Brian Asbill, MD
Cardiologist
Asheville Cardiology Associates

STATIN THERAPY

“It cannot be emphasized enough that statins are extremely safe and generally under-utilized in the patient with cardiovascular disease. Numerous trials have demonstrated both their safety and efficacy. They will continue to serve as the cornerstone of our treatment regimen for years to come. With luck, new and innovative therapies for HDL raising, such as CETP inhibitors, will further enhance our medical arsenal.”



Alan Johnson, MD
Cardiovascular/Thoracic Surgery
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VALVE REPAIR

“Heart valve surgery has rapidly evolved since the first valve replacement in the 1950s. Today we can offer corrective surgery with little post-operative compromise in the quality of life or limitations to an active lifestyle. We are able to tailor a valve procedure to the needs and specific limitations affecting a patient, providing good durability and quality of life with low risk.”

Significantly Reduces Mortality

The value of statin therapy in reducing cardiovascular morbidity and mortality from atherosclerotic vascular disease has been repeatedly and consistently demonstrated in clinical trials. Intensive LDL reduction is shown to result in improved cardiovascular outcomes. Nonetheless, increasingly aggressive guidelines and patient compliance issues make lipid management a challenge for the physician.

At Asheville Cardiology Associates, we have established a Lipid Clinic to target the high-risk patient with a difficult-to-treat lipid profile and/or intolerance to medications. This focused approach to treatment has resulted in high compliance and greater success in achieving goal LDL and HDL levels, and should be adaptable to your practice.

OTHER THERAPY GOALS

We vigorously pursue the latest (2004) guidelines from the National Cholesterol Education Program (NCEP) developed by the National Heart, Lung, and Blood Institute. (See targets at right below.)

- For most dyslipidemias: Low density lipoprotein (LDL) reduction using therapeutic lifestyle changes (diet and exercise) and, in almost all cases, LDL-lowering drug therapy.
- For patients with triglycerides greater than 200 mg/dL: Achieve the non-HDL target (total cholesterol-HDL).
- For high-risk patients with low HDL levels (<40 for men and <50 for women): Drug therapy to raise HDL levels should also be considered. (See right.)
- For very high-risk patients with established vascular disease and who are diabetic, smoke, or have multiple poorly controlled risk factors: Target an LDL of <70 mg/dL. At these low levels, we are beginning to see for the first time, regression of atherosclerotic plaques in coronary arteries and improvement in hard clinical outcomes.

To achieve these targets, we place many patients on multiple drug regimens.

RAISING HDL LEVELS

Now that we have more potent statins and combination drug therapy allowing us to reach these lower LDL goals, more attention and research dollars are being invested in non-LDL cholesterol management, particularly in the treatment of low

HDL. Low HDL is actually a more powerful predictor of coronary heart disease risk than elevated LDL levels, but has historically been difficult to treat. Available and promising options include:

- Non-pharmacologic interventions: weight loss, exercise, and smoking cessation.
- Niacin: The most effective agent for raising HDL, but the side effect of flushing has limited its use.
- Fibrates: Also effective and may raise HDL by up to 30 to 35% in some patients.
- Future pharmacologic options: cholesteryl ester transfer protein (CETP) inhibitors, peroxisome proliferation-activated receptor (PPAR) agonists, and HDL-mimetic peptides.

Development of the most promising CETP inhibitor and the one that was closest to being clinically available—torcetrapib—was halted in December by Pfizer due to adverse cardiovascular events. This was surprising and disappointing given the promise that the drug showed during its earlier stages of development.

With atherosclerotic vascular disease accounting for one-third of deaths annually, effective management of dyslipidemia is imperative. My colleagues and I are always available for telephone consultation.

Call (828) 225-4611.

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NCEP Guidelines for LDL reduction (2004):

LDL-C (mg/dL)

RISK CATEGORY	GOAL	INITIATION LEVEL FOR TLC	CONSIDERATION LEVEL FOR DRUG THERAPY
High risk: CHD or CHD risk equivalents (10-yr risk >20%)	<100 (optional: <70)	≥100	≥100 (<100: consider drug options)
Moderately high risk: 2+ risk factors (10-yr risk 10-20%)	<130 (optional: <100)	≥130	≥130 (100-129: consider drug options)
Moderate risk: 2+ risk factors (10-yr risk <10%)	<130	≥130	≥160
Lower risk: 0-1 risk factor	<160	≥160	≥190 (160-189: LDL-C-lowering drug optional)

Valve Repair:

the Optimal Choice for Good Patient Outcomes

The ability of a skilled cardiac surgeon to repair diseased valves has improved dramatically in the last decade. For most patients, successful repair of the native valve—rather than replacement—is now possible and is certainly the treatment of choice. Repair provides good durability at low risk, with little post-operative compromise in the quality of life or limitations to an active lifestyle. It frees patients from a lifetime of anticoagulant therapy. However, repair remains far more challenging than replacement.

MITRAL VALVE SUCCESS RATES

At Mission, we are able to repair (versus replace) 90 percent of cases of mitral valve regurgitation, including patients with significant co-morbidities, with good and durable results. Even with ischemic mitral insufficiency, new repair techniques used at Mission allow good success. We believe repair offers:

- Freedom from re-operation in degenerative valve disease: 90 to 95% at 10 years
- Freedom from re-operation in ischemic MR: >90% at 5 years

AORTIC VALVE DISEASE OPTIONS

Aortic valve disease is being repaired at Mission in some subsets such as aortic insufficiency in connective tissue disease (Marfan's syndrome, for example) with an approach known as the **David procedure**. The operation is complex and not offered at many cardiac surgery centers. It preserves the patient's healthy valve while replacing the dilated aortic root responsible for the valvular insufficiency, dramatically reducing risk of dissection in the Marfan's patient. Current results with the David procedure are:

- Mortality in elective cases: 1 to 2% (>10% in acute type A dissection)
- 10-year survival: 96%
- Late AI (3-4+) = 10% at 8 years

In younger aortic valve disease patients who have a normal pulmonic valve and do not have a connective tissue disease, the **Ross procedure** offers dramatic relief. The diseased aortic valve is excised along with the aortic root, and the patient's own pulmonic valve is transposed into the aortic position. The pulmonary outflow tract defect is then closed with a cadaver homograft pulmonic valve or a stentless bioprostheses. This operation is the only option allowing growth of the neo-aortic valve, no transvalvular gradient, and no thromboembolism risk (thus no Coumadin).

- Ross procedure at Mission: 99% operative survival (30 days). (198 patients out of 200).
- International Ross Registry data: 80% 10-year survival and 75 to 85% freedom from autograft replacement at 19 years

ADVANCES IN VALVE REPLACEMENT

Replacement will always be required for some patients. Fortunately, a vast amount of research has led to significant improvement in prosthetic valves. Biologic valves are less likely than their mechanical counterpart to cause clotting, embolism, and stroke, and do not require long-term anticoagulation, thus avoiding the complications of Coumadin therapy. Today's biologic valves are far more durable and much improved in design and function.

In referring your patient for valve surgery, the hospital's ratio of repair to replacement should be determined, as well as its outcomes. This data is readily available from Mission. Please call if we can be of assistance.

Alan M. Johnson, MD

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Access Cardiovascular Surgeons and Cardiologists in Asheville

Cardiologists and cardiovascular surgeons on the medical staff at Mission Hospitals are available to physicians in the region for telephone consultations, referrals, and consultative care for referred patients as well as for scheduling urgent office appointments. Mission cardiovascular surgeons and cardiologists remain in contact with patients' referring physicians through direct letters and telephone calls to ensure that referring physicians share in their patients' consultative care. Patients are returned to their physicians' care as soon as clinically warranted.

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Adult outreach clinics are offered in Marion, Spruce Pine, Brevard, and Highlands.
Pediatric outreach clinics are held in Murphy and Sylva.

Visit www.avlcard.com, the official site of ACA, which offers a variety of clinical resources for physicians as well as ACA practice information.



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For more information about Mission Hospitals and its physicians, please call or visit www.missionhospitals.org.

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