NEWSLETTER OF THE FRIENDS OF THE ISRAEL HEART SOCIETY

Editor's Note: Welcome to the Winter 2014 FIHS Newsletter. As we usher in the New Year 2015 we celebrate innovation of the Israeli and American spirit that has made these countries great.

This issue will include its usual features- a message from our President, Jeff Goldberger, announcements of Cardiology Meetings, and recently published research from Israel. We will bring the latest in Israeli innovation.

In addition, we will bring the readership follow-up to a political letter published in The Lancet critical of Israel, and the response of the Friends of the Israel Heart Society's response which was published online at The Lancet.

In a first, we will highlight 4 different articles from Israeli heart centers that appeared in worldwide Cardiology Journals. Of note, 2 of the articles are coauthored by Arie Steinvil, one of the winners of last year's FIHS Meltzer Award (one of the articles is of the abstract he presented last year). We are helping to raise the next generation!! Grants do help!

The FIHS has decided to send American cardiology fellows to meetings in Israel. We announce our first efforts- 2 fellows will be sent to present posters at the 62nd Annual Meeting of the Israel Heart Society, again in Tel Aviv in April (right after Passover). We would like the word to get to prospective attendees to email their poster ideas to the editor, and 2 lucky winners will win a sponsored trip to Israel for the meeting (my email is jackstroh@usa.net).

Please note- description of new technology in our Newsletter does not constitute an endorsement. We just want to give our readership a sense of the vast scope of Israeli ingenuity in the fields of Cardiology.

Remember, this Newsletter and Society belong to you, the membership. We look forward to enhancing this Society and the connections that we hope to foster between Israeli and non-Israeli cardiologists and their institutions. Please feel free to email us with questions, answers, comments, criticisms, or just to tell us to keep working harder!

Our immediate goal is to try to grow our membership and participation to include any and all cardiologists and fellows from around the world who would be interested in supporting this bridging relationship. If you know of any cardiologists or cardiology fellows who we can contact, please email me (my email is jackstroh@usa.net).

Message from the President

Thank you to all our Friends for your support for the Friends of the Israel Heart Society in 2014. I can confidently say that your help, support, and friendship are felt and appreciated by the Israel Heart Society. Current events also reemphasize the existential importance of our organization. You will recall this past summer that in addition to the physical warfare in the Middle East, we were all shocked to see the publication of the Open Letter for the People in Gaza in the Lancet in July 2014. While this has engendered many discussions, responses, and debates, perhaps the most important event that followed this was the visit by Dr. Horton, the editor of Lancet, to Israel – his first! He accepted an invitation to visit Rambam Medical Center. Per his description, it was an enlightening experience for him. You can read the editorial response he wrote following his visit in this newsletter (other articles, i.e. in the Jerusalem Post, are also available online). Through our collective and continued efforts, we hope that this renewed understanding will have an impact on the dialogue affecting our academic colleagues in Israel.

It seems like 2015 has started off no better with the recent attacks in Paris. The sheer outpouring of support in the French community and from leaders worldwide has been heartening. We can be certain that these issues, both in the general community and in the medical community, will not dissipate in the near future. However, the bonds that we

form in standing up to these physical and mental attacks are important and necessary. To that end, we are extremely grateful to our to our Silver, Gold, and Platinum sponsors for 2014 who are listed on page 24 (as of the publication date of this newsletter – a final list will appear in our next newsletter).

We also want to use this opportunity to ask you to help with our membership drive. I am struck by the number of people I meet who are would-be supporters but had not yet heard of the organization. We still need your help reaching out to the large number of cardiac care specialists who are (or might be) interested in the activities of the Friends of the Israel Heart Society, but who we have NOT YET reached. Please consider forwarding this newsletter to ten colleagues who you feel might be interested – new members can get on our mailing list either by signing up via our website http://www.friendsihs.org/index.html or by emailing me at j-goldberger@northwestern.edu.

Please note the various upcoming scientific meetings that will be taking place in Israel. These meetings are high caliber and provide a wonderful opportunity to combine professional enlightenment with a visit to Israel.

FIHS Heart Beats! If you have personal and/or academic milestones you would like to share with the FIHS membership, please submit these to Jack Stroh at jackstroh@usa.net. This is a wonderful opportunity for our members to share news.

Finally, a few notes of gratitude. I want to thank Josh Hartman for all his efforts on the FIHS website and Jack Stroh for his efforts at maintaining the high quality and informativeness of the FIHS newsletter.

Please plan to join us at our reception at the American College of Cardiology meetings in San Diego on March 15, 2015.

NEWSLETTER OF THE FRIENDS OF THE ISRAEL HEART SOCIETY

With best wishes for a great 2015,

Jeff Goldberger, M.D., M.B.A.

President, Friends of the Israel Heart Society

Meetings

As mentioned above, the Friends of the Israel Heart Society is embarking on a new project starting 2015. Just as we have sponsored through the Meltzer Award 2 Israeli cardiology fellows to present their research at the annual American College of Cardiology meeting in the USA, we will be sending 2 American cardiology fellows to Israeli meetings. The first is the Annual Conference of the Israel Heart Society.

If you know of fellows that would like to submit their research for consideration, please have them forward the abstracts/outlines ASAP to jackstroh@usa.net.

This is a great opportunity for young investigators to gain worldly experience and exposure. Please see below for details regarding these specific meetings.

The 11th Meeting of the Myocardial and Pericardial Diseases Working Group of the European Society of Cardiology

February 4-6, 2015

Dan Tel Aviv Hotel (new location)

http://cardio.pwizard.com/

Program tracks-

Amyloidosis
Cardiooncology
Genetics
Echocardiography
Magnetic resonance imaging
Biomarkers
Arrhythmology
Metabolic cardiomyopathies
Pericardial diseases
Arrhythmogenic right ventricular dysplasia
The Role Of Systemic Inflammation In Myocardial Disease
Athlete heart
Genetic testing in cardiomyopathies
Modifying Disease Progression In Hcm
Myocarditis
Diabetic cardiomyopathy
Dilated cardiomyopathy and heart failure
ICDs
Atrial fibrillation in a patient with cardiomyopathy
Innovations In Heart Failure Therapy
Basic Science
Other

The 62st Annual Conference of the Israel Heart Society in Association with the Israel Society of Cardiothoracic Surgery

April 13-14, 2015

David Intercontinental Convention Center, Tel Aviv

http://2015.en.israelheart.com/

Guest Lecturers

Dan Atar

Vice President, European Society of Cardiology, Norway

Elliott Antman

President, American Heart Association, USA

Jeroen J. Bax

President Elect, European Society of Cardiology, The Netherlands

Ioan M. Coman

Past President, Romanian Society of Cardiology, Romania

Jeffery J. Goldberger

President, Friends of the Israel Heart Society, USA

Fausto J. Pinto

President, European Society of Cardiology, Portugal

Patrick T. O'Gara

President, American College of Cardiology, USA

Kim Allan Williams

President Elect, American College of Cardiology, USA

There will be Joint Sessions with the following

European Society of Cardiology (ESC)

American College of Cardiology (ACC)

American Heart Association (AHA)

L'Association Franco-Israe`lienne de Cardiologie (AFICARDIO)

The Lancet Controversy-Update

On July 23, 2014 in the middle of the recent Operation Defensive Shield, The Lancet published a letter from Manduca, et. al. (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61044-8/fulltext) which was felt by many to be politically biased against the State of Israel. Our Society received a request from our sister Israel Heart Society to respond. The following is the text of our response as published online in The Lancet on August 7, 2014. We are republishing our letter, and the after will include an updated article from HAARETZ.

(http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61303-9/fulltext)

Israel—Gaza conflict

Jeffrey J Goldberger [a], Richard L Popp [b], Douglas P Zipes [c], on behalf of 43 signatories

As a humanitarian physician community, we grieve the loss of innocent lives. War is anathema to our moral and medical sensibilities, but nevertheless remains a reality of the present global political landscape, particularly in the Middle East where ongoing internecine struggles exist between different ideologies, killing or displacing thousands of innocent people. Before addressing the inflammatory propaganda promulgated by Paola Manduca and colleagues,[1] we unequivocally state that we hope

for the day when "nation shall not lift the sword against nation, neither shall they learn war anymore" (Isaiah 2:4).

To reuse Manduca and colleagues' comments, their letter "has insulted our humanity, intelligence, and dignity and our professional ethics".[1] They claim to represent facts, but instead obscure their description of human suffering in Gaza with inflammatory falsehoods, deliberately misleading the reader. The aim of our letter is not to refute their many factual errors, but to promote a balanced humanitarian approach that all who are truly concerned about protecting human health and lives can adopt.

No compassionate human can deny the unfortunate situation in Gaza. Yet, an immense amount of energy, ingenuity, and resources, costing hundreds of millions of dollars, were invested to accumulate thousands of missiles and build sophisticated terror tunnels into Israel to expressly commit acts of terror against Israeli civilians. Had these resources and efforts promoted the social and economic welfare of the residents of Gaza, there might be no current war, no casualties, and a much better living situation in Gaza. The unfortunate choice made by Hamas to invest these resources in terrorism has caused and aggravated suffering in Gaza.

A master clinician differentiates symptoms from the underlying diagnosis. Similarly, to properly address the present situation in Gaza requires a detailed understanding of the need for Gaza's residents to establish a thriving social and economic infrastructure and the need to ensure security for Israel. A time for rebuilding will be after this war. Re-accumulation of missiles and rebuilding tunnels will inevitably lead to another round of bloodshed. The good people of Gaza and the global humanitarian community must unite to mandate a Palestinian leadership that pursues a path of peace and prosperity, one that will focus their resources and energy to build a civic infrastructure that benefits its people and promotes a peaceful coexistence so that innocent civilians, on both sides of the border, can live without fear of constant attack.

We also encourage the medical community to cultivate a humanitarianism that transcends

politics, propaganda, and meaningless rhetoric. Our physician community should focus our collective conscience on promoting health, safety, and security for all. Even as the conflict continues, Israel has set up a field hospital with health-care workers who are devoted to caring for the injured from Gaza. In addition to providing humanitarian aid and support, we can and should promote peace to prevent the unfortunate consequences of war. Finally, as a community devoted to scientific integrity, truth, and compassion, let us make sure we inoculate ourselves against the forces that demean these ideals.

Jeffrey J. Goldberger, MD

Northwestern University

Joseph S. Alpert, MD

University of Arizona

Charles Antzelevitch, PhD

Masonic Medical Research Laboratory

Jeffrey S. Borer, MD

State University of New York Downstate Medical Center

Michael H. Davidson, MD

The University of Chicago Pritzker School of Medicine

Steven B. Feinstein, MD

Rush University Medical Center

Richard L. Popp, MD

Stanford University

Dan J. Fintel, MD

Northwestern University

Douglas P. Zipes, MD

Indiana University

Gary Gershony, MD

John Muir Health and Cardiovascular Institute

On behalf of:

Susan Sirota, MD

Pediatrust Pediatric Partners

Bradley H. Strauss MD, PhD

University of Toronto

Jack A. Stroh, MD

Rutgers-Robert Wood Johnson Medical School

Ari Weinreb, MD, PhD

University of California, Los Angeles

Giora Weisz, MD

Columbia University Medical Center

Michael J. Wolk, MD

Weill Medical College of Cornell University

In Israel, Lancet editor regrets publishing open letter on Gaza

Dr. Richard Horton, editor of the British medical journal, made a statement Thursday during Grand Rounds at the Rambam Medical Center in Haifa saying that he will publish a retraction.

By JTA in Haaretz | Oct. 3, 2014 | 4:20 AM |

JTA - The editor of the British medical journal The Lancet, which ran an open letter accusing Israel of a "massacre" in Gaza, said on a visit to Israel that he will publish a retraction.

Dr. Richard Horton made a statement Thursday during Grand Rounds at the Rambam Medical Center in Haifa, which he also visited earlier in the week.

Horton reportedly said during his statement that he "deeply, deeply regrets" publishing the letter to the people of Gaza in The Lancet during this summer's conflict in Gaza between Israel andHamas. Several dozen physicians from the West signed the letter, which also accused Israel of "cruel" and "vicious war crimes." Physicians, researchers and Israeli officials decried the letter.

NGO Monitor last week unearthed evidence tying two of the letters' authors to support for white supremacist David Duke.

During his statement at Rambam on Thursday, Horton reportedly condemned the contributors to The Lancet who promote explicitly anti-Semitic materials, expressed a new understanding of Israeli realities including the complexities of the Arab-Israel conflict, and pledged a new relationship with Israel.

He also invited Israelis to "tell the Israeli health story" in The Lancet, in parallel to the Palestinians'.

Following Horton's remarks, NGO Monitor, a Jerusalem-based research institute which monitors non-governmental organizations, said in a statement that it is "urgent that the July 2014 "An Open Letter for the People of Gaza" be removed from The Lancet's website and a formal retraction and apology be published prominently, both on the website and the next hard copy issue."

NGO Monitor also called on The Lancet to "undertake positive initiatives to accurately inform the medical community of Israel's contributions to medicine, as well as the close cooperation that takes place between different sectors of the population."

http://www.haaretz.com/news/diplomacy-defense/1.618899

Here in his own words in The Lancet-

Offline: People to people

http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)61782-7.pdf

Last week was a turning point in the sometimes angry debate that followed publication of a letter from Paola Manduca and colleagues during the recent war in Gaza and southern Israel. Among the many responses we received, one quite different letter stood out. Professor Karl Skorecki, Director of the Rappaport Research Institute at Technion and Director of Medical Research and Development at the Rambam Health Care Campus in Haifa, wrote to invite me to Israel "because of the intense interest that the editorial leadership of *The Lancet* has attracted, focusing on issues of medical professional responsibility and accountability for the tragic loss of life and human suffering of Gaza civilians including children". I visited Rambam last week thanks to the hospitality— and courage—of Prof Skorecki, Prof Rafael Beyar (Director-General of the Rambam Health Care Campus), and Prof A Mark Clarfield (Director, Medical School for International Health, Ben-Gurion University). At Rambam I saw an inspiring model of partnership between Jews and Arabs in a part of Israel where 40% of the population is Arab. I saw Rambam offering an open hand, gladly grasped by families from Gaza, the West Bank, and Syria, who were living with life-threatening health-care needs. I saw Rambam as one example of a vision for a peaceful and productive future between peoples, which I learned

exists throughout Israel's hospitals. I also met Israel's Minister of Health, Yael German, who not only endorsed this visit but also welcomed future collaboration. Out of this exchange has emerged an extraordinary opportunity.

*But first, some reflections. At a moment of unbearable human destruction in Gaza, the unintended outcome of the Manduca et al letter was an extreme polarisation of already divided positions. This schism helped no one and I certainly regret that result. I have seen for myself that what was written in the Manduca et al letter does not describe the full reality. I was later horrified to discover that two co-authors of the letter had forwarded a vile and offensive video. The clearly anti-Semitic worldview expressed in that video is abhorrent and deserves universal condemnation. There are lessons to learn. For example, in the case of the Manduca et al letter, important interests should have been declared earlier. Also, although political determinants of health are real, there are reasons to be vigilant about how these are discussed. Here is our proposal for new guidance to help us in these rare circumstances—"Editors will, from time to time, be faced with submissions that lie at the difficult intersection of medicine and politics. Health and health care do have political determinants and editors should not shy away from those. But politics, by its very nature, can be disruptive and divisive, with many different points-of-view held. While taking strong editorial positions on issues of relevance to health is sometimes necessary, editors should always pause, reflect, and consult before publishing any manuscript that might unnecessarily polarise, or foster or worsen political division."

What is the opportunity? First, we have to make a conscious choice. Either one can let residual anger prevail and entrench existing divisions still further—a position that has too often scarred relations in the Middle East. Or one can use this moment to nurture something positive and long lasting, which I firmly intend to do. As one American correspondent wrote to me recently, "the answer to speech we do not like is more speech, not the silencing of writers (or editors) whose opinions we disagree with". That is why *The Lancet* opposes all forms of boycott. I have proposed to Prof Skorecki that, together with *The Lancet*, we initiate

a new partnership to publish a Series on Israel's health and medical research system, its strengths and challenges, and prospects for its future. The response has been positive, planning for this Series has started, and we will follow up in meetings that will begin upon my return to Israel in January, 2015. My visit to Israel had many moving moments. Sitting between a Rabbi and an Imam, who were working to foster peaceful coexistence between their communities, in a room adjacent to the El-Jazzar mosque in Acre, northern Israel, I asked how I should approach our future involvement in the region. The answer was clear: "Work with Palestinians, work with Israelis, and encourage both communities to work together. War is not the answer." The greatest threat our plans now face is cynicism and a refusal to believe that people, and the world, can be different.

Richard Horton

richard.horton@lancet.com

Research #1

Pulmonary arterial capacitance in patients with heart failure and reactive pulmonary hypertension.

Dragu R[1], Rispler S, Habib M, Sholy H, Hammerman H, Galie N, Aronson D.

[1]Department of Cardiology, Rambam Health Care Campus and the Ruth and Bruce Rappaport Faculty of Medicine, Technion, Israel Institute of Technology, Haifa, Israel; and [2]Institute of Cardiology, S. Orsola-Malpighi Hospital and the University of Bologna, Bologna, Italy

Eur J Heart Fail. 2014 Nov 11. doi: 10.1002/ejhf.192.

http://www.ncbi.nlm.nih.gov/pubmed/25388783

Abstract

AIMS:

Reactive pulmonary hypertension (PH) is a severe form of PH

(HF). Given the structural and functional abnormalities in the pulmonary vasculature that occur in reactive PH, we hypothesized that pulmonary artery capacitance (PAC) may be profoundly affected, with implications for clinical outcome.

METHODS AND RESULTS:
We studied 393 HF patients of whom 124 (32%) were classified as having passive PH and 140 (36%) as having reactive PH, and 91 patients with pulmonary arterial hypertension (PAH). Mean PAC was highest in patients without PH (4.5 ± 2.1 mL/mmHg), followed by the passive PH group (2.8 ± 1.4 mL/mmHg) and was lowest in those with reactive PH (1.8 ± 0.7 mL/mmHg) (P = 0.0001). PAC and pulmonary vascular resistance (PVR) fitted well to a hyperbolic inverse relationship (PAC = 0.25/PVR, R^2 = 0.70), with reactive PH patients dispersed almost predominantly on the flat part of the curve where a reduction in PVR is associated with a small improvement in PAC. Elevated PCWP was associated with a significant lowering of PAC for any PVR (P = 0.036). During a median follow-up of 31 months, both reactive PH [hazard ratio (HR) 2.59, 95% confidence interval (CI) 1.14-4.46, P = 0.02] and reduced PAC (HR 0.72 per 1 mL/mmHg increase, 95% CI 0.59-0.88, P = 0.001) were independent predictors of mortality.

CONCLUSIONS:
The development of reactive PH is associated with a marked reduction in PAC. PAC is a strong independent haemodynamic marker of mortality in HF and may contribute to the increased mortality associated with reactive PH.

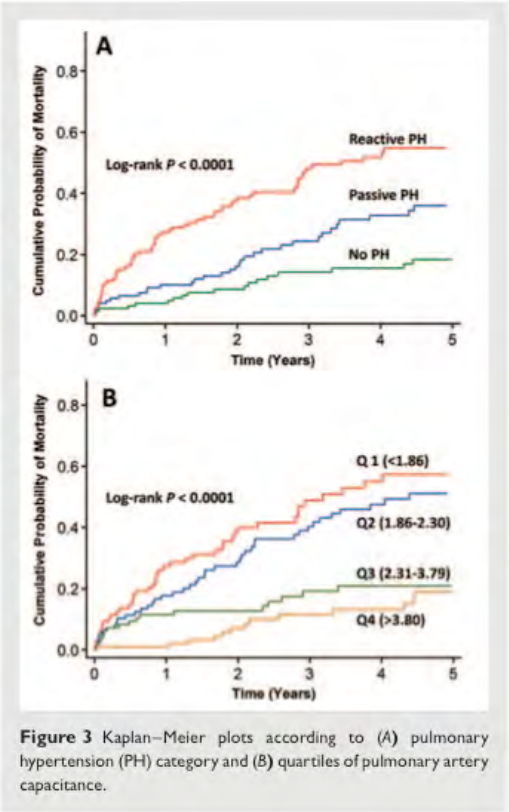

Figure 3 Kaplan–Meier plots according to (*A*) pulmonary hypertension (PH) category and (*B*) quartiles of pulmonary artery capacitance.

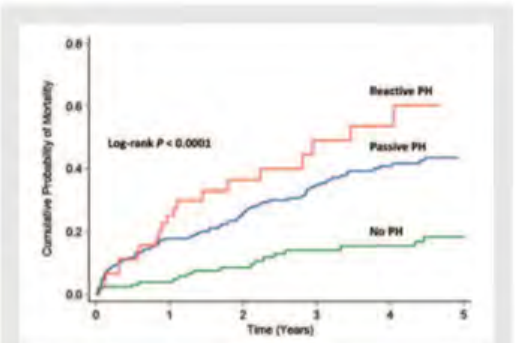

Figure 4 Kaplan–Meier plots according to pulmonary hypertension (PH) category with reactive PH defined based on diastolic pressure difference (defined as diastolic pulmonary artery pressure − mean PCWP) ≥7 mmHg.

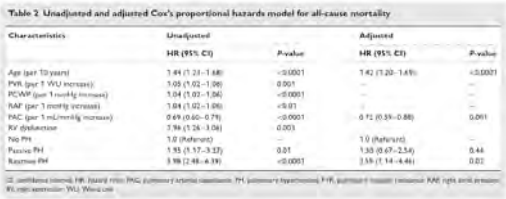

Table 2 Unadjusted and adjusted Cox's proportional hazards model for all-cause mortality

Characteristics	Unadjusted		Adjusted	
	HR (95% CI)	P-value	HR (95% CI)	P-value
Age (per 10 years)	1.44 (1.21–1.68)	<0.0001	1.42 (1.20–1.67)	<0.0001
PVR (per 1 WU increase)	1.05 (1.02–1.08)	0.001	–	–
PCWP (per 1 mmHg increase)	1.04 (1.02–1.06)	<0.0001	–	–
RAP (per 1 mmHg increase)	1.04 (1.02–1.06)	<0.01	–	–
PAC (per 1 mL/mmHg increase)	0.69 (0.60–0.79)	<0.0001	0.72 (0.59–0.88)	0.001
RV dysfunction	1.94 (1.26–3.06)	0.003	–	–
No PH	1.0 (Reference)	–	1.0 (Reference)	–
Passive PH	1.93 (1.17–3.32)	0.01	1.30 (0.67–2.54)	0.44
Reactive PH	3.98 (2.48–6.39)	<0.0001	3.59 (1.74–7.46)	0.01

(CI, confidence interval; HR, hazard ratio; PAC, pulmonary arterial capacitance; PH, pulmonary hypertension; PVR, pulmonary vascular resistance; RAP, right atrial pressure; RV, right ventricular; WU, Wood unit)

Research #2

Comparison of early and late outcomes of TAVI alone compared to TAVI plus PCI in aortic stenosis patients with and without coronary artery disease.

Abramowitz Y[1], Banai S, Katz G, Steinvil A, Arbel Y, Havakuk O, Halkin A, Ben-Gal Y, Keren G, Finkelstein A.

[1]Department of Cardiology, The Tel-Aviv Medical Center, Tel-Aviv, Israel[2]Sackler Faculty of Medicine, Tel-Aviv University, Tel Aviv, Israel
[3]Cardiothoracic Surgery, The Tel-Aviv Medical Center, Tel-Aviv, Israel

Catheterization and Cardiovascular Interventions 83:649–654 (2014)

http://www.ncbi.nlm.nih.gov/pubmed/24532332

Abstract

OBJECTIVES:
To assess the safety and effectiveness of performing percutaneous coronary intervention (PCI) before transcatheter aortic valve implantation (TAVI).

BACKGROUND:
The presence of coronary artery disease (CAD) negatively impact procedural outcomes and long-term survival after (TAVI). The management of obstructive CAD before TAVI is not yet well established.

METHODS:
Patients with severe symptomatic aortic stenosis (AS) (n = 249) that underwent TAVI were divided into two groups: patients with CAD (subdivided to patients treated with TAVI alone and to patients that underwent PCI before TAVI) and patients with isolated AS. Procedural endpoints, device success and adverse events were considered according to the Valve Academic

Research Consortium (VARC) definitions.

RESULTS:
Of a cohort of 249 consecutive patients with mean age of 83.2 ± 5.5 years, 83 patients with AS + CAD were treated with TAVI alone, 61 patients with AS + CAD underwent PCI before TAVI and 105 patients underwent TAVI for isolated AS. The mean duration of follow-up was 17 months (range: 6-36 months). Despite a significantly higher logistic EuroScore of the AS+CAD group compared to the AS alone group (30.1 vs. 21.1 P < 0. 001), the overall VARC-adjudicated endpoints did not differ between the groups. All-cause mortality at 30-days was 1.6% for patients with AS+CAD treated with PCI compared to 2.9% for patients with AS alone (P = 1).

CONCLUSIONS:
Performing PCI before TAVI in high-risk elderly patients with significant CAD and severe AS is feasible and safe. This combined treatment approach did not increase the periprocedural risk for complications or the all-cause mortality.

TABLE II. Thirty-Day Outcome

	Group 1 AS+CAD (n = 144)	Group 2 AS alone (n = 105)	P Value	Group 1A NO PCI (n = 83)	Group 1B PCI (n = 61)	P Value
Average days in hospital	8.4	7.7	0.25	8.3	8.6	0.8
All-cause mortality	3 (2.1%)	3 (2.9%)	0.7	2 (2.4%)	1 (1.6%)	1
MI	0 (0%)	0 (0%)		0 (0%)	0 (0%)	
Tamponade	2 (1.4%)	1 (1%)	1	0 (0%)	2 (3.3%)	0.18
Cardiogenic shock	2 (1.4%)	1 (1%)	1	1 (1.2%)	1 (1.6%)	1
Respiratory failure	4 (2.8%)	2 (1.9%)	1	3 (3.6%)	1 (1.6%)	0.64
CVA	4 (2.8%)	1 (1%)	0.4	2 (2.4%)	2 (3.3%)	1
Major bleeding	3 (2.1%)	1 (1%)	0.64	1 (1.2%)	2 (3.3%)	0.57
Major vascular complication	5 (3.5%)	3 (2.9%)	1	2 (2.4%)	3 (4.9%)	0.65
Minor vascular complication	13 (9%)	12 (11.4%)	0.53	4 (4.8%)	9 (14.8%)	0.07
Renal dialysis	0 (0%)	0 (0%)		0 (0%)	0 (0%)	
Sepsis	4 (2.8%)	0 (0%)	0.14	1 (1.2%)	3 (4.9%)	0.31
Permanent pacemaker	35 (24.3 %)	24 (22.9%)	0.88	22 (26.5 %)	13 (21.3 %)	0.56
Combined safety end point	10 (6.9%)	7 (6.7%)	1	5 (6 %)	5 (8.2%)	0.74
Average NYHA class	1.25	1.31	0.46	1.17	1.37	0.06

AS, aortic stenosis; CVA, cerebrovascular accident; MI, myocardial infarction; NYHA, New-York Heart Association; PCI, percutaneous coronary intervention; TAVI, transcatheter aortic valve implantation.

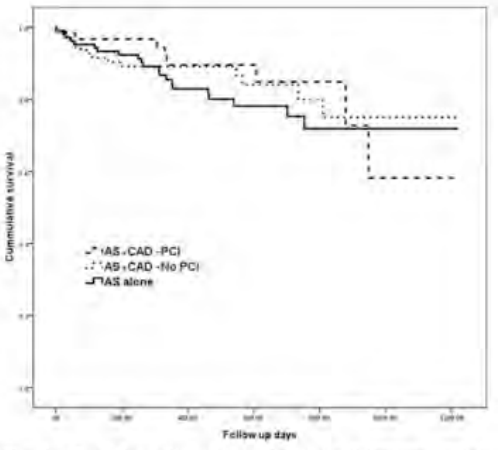

Fig. 1. Overall survival during the study follow-up period. Caption: Kaplan-Meier curves for overall survival in group 1B: AS+CAD –PCI (top curve), group 1A: AS+CAD -No PCI (middle curve) and group 2: AS alone (bottom curve) up to 3 years (*P* = 0.68, log-rank test).

Research #3

Prevalence and Predictors of Carotid Artery Stenosis in Patients With Severe Aortic Stenosis Undergoing Transcatheter Aortic Valve

Implantation

Arie Steinvil,[1,2]* MD MHA, Eran Leshem-Rubinow,[1,2] MD MHA, Yigal Abramowitz,[1,2] MD, Yacov Shacham,[1,2] MD, Yaron Arbel,[1,2] MD, Shmuel Banai,[1,2] MD,

Natan M. Bornstein,[1,2] MD, Ariel Finkelstein,[1,2] MD, and Amir Halkin,[1,2] MD

[1]Departments of Cardiology and Neurology, Tel-Aviv Medical Center, Tel-Aviv, Israel[2]Sackler Faculty of Medicine, Tel-Aviv University, Tel Aviv, Israel

Catheter Cardiovasc Interv. 2014 Nov 15;84(6):1007-12

http://www.ncbi.nlm.nih.gov/pubmed/24975558

Objectives:

Our aim was to analyze the prevalence and predictors of Carotid artery stenosis (CAS) in patients undergoing transcatheter aortic valve implantation (TAVI).

Background:

CAS is associated with the risk of periprocedural stroke in patients undergoing cardiac surgery. However, little is known about the prevalence of and clinical significance of CAS in the setting of TAVI.

Methods:

Consecutive patients undergoing a carotid Doppler study the day before TAVI were followed prospectively. CAS was defined in accordance with current practice guidelines. Logistic regression models were used to identify independent correlates of CAS. Results: The study included 171 patients (age 8266, male gender 47%). Carotid atherosclerosis (CA, defined as any carotid plaque) was present in 164 (96%) of patients, and CAS (peak systolic velocity [PSV] ≥125 cm/ sec; ≥50% diameter stenosis) in 57 (33%) patients. Severe CAS (PSV≥230 cm/sec; ≥70% stenosis, or near occlusion) was found in 15 (9%) patients. By multivariate analysis, smoking and a higher Euroscore independently predicted the presence of CAS. Patients in the present TAVI cohort had a significantly higher prevalence of both unilateral and bilateral CAS≥50% than those in a previously reported cohort (n=494 patients, age≥70) undergoing clinically driven coronary angiography (33% vs. 20%, OR=1.9, P=0.001; and, 13% vs. 6%, OR=2.3, P=0.003, respectively). CAS was not independently associated with 30-day mortality or stroke rates.

Conclusions:

The prevalence of CAS in patients undergoing TAVI is high, exceeding that observed in patients undergoing catheterization for coronary indications. The impact of CAS on clinical outcomes following TAVI merits further research.

TABLE III. Prevalence of Carotid Artery Stenosis and Atherosclerosis Among Study Patients and Reference Populations

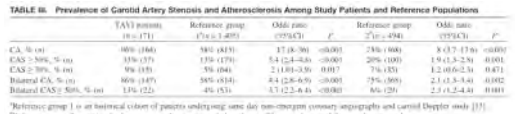

TABLE IV. Thirty-Day Adverse Event Rates

Event	Total (n=171)	CAS <50% (n=114)	CAS ≥50% (n=57)	P value
Death, n (%)	8 (5)	6 (5)	2 (4)	0.72
MI, n (%)	0	0	0	NA
Stroke, n (%)	1 (<1)	1 (1)	0	0.99
Vascular complications, n (%)	38 (22)	27 (24)	11 (19)	0.56
Major, n (%)	19 (11)	15 (13)	4 (7)	0.31
Minor, n (%)	19 (11)	12 (11)	7 (12)	0.79
Permanent pacemaker, n (%)	30 (18)	23 (20)	7 (12)	0.21

Abbreviations: CA, carotid atherosclerosis; CAS, carotid artery stenosis; MI, myocardial infarction.

Research #4

Response to Prasugrel and Levels of Circulating Reticulated Platelets in Patients With ST-Segment Elevation Myocardial Infarction

Leor Perl, MD*; Hila Lerman-Shivek, BPharm*; Eldad Rechavia, MD*; Muthiah Vaduganathan, MD, MPH‡; Dorit Leshem-Lev, PhD§; Noa Zemer-Wassercug, MD*; Oshrat Dadush, MSc§; Pablo Codner, MD*; Tamir Bental, MD*; Alexander Battler, MD*; Ran Kornowski, MD*; Eli I. Lev, MD*

* Cardiology Department, Rabin Medical Center, Petah-Tikva, Israel, and the Sackler Faculty of Medicine, Tel-Aviv University, Tel-Aviv, Israel
‡ Department of Medicine, Massachusetts General Hospital, Harvard Medical School, Boston, Massachusetts
§ The Felsenstein Medical Research Institute, Rabin Medical Center, Petah-Tikva, Israel

This study was financially supported by the Grant for Young Investigators, Rabin Medical Center (Dr. Perl).

J Am Coll Cardiol. 2014;63(6):513-517.

http://dx.doi.org/10.1016/j.jacc.2013.07.110

Objectives
The aim of this study was to determine whether response to Prasugrel is associated with the proportion of circulating reticulated platelets (RPs) in patients with ST-segment elevation myocardial infarction (STEMI).

Background
Despite better pharmacodynamic

properties and clinical efficacy of Prasugrel compared with clopidogrel, antiplatelet responses to Prasugrel are not uniform. The mechanism of this variability in response is not clear. RPs, young hyperactive forms, are increased during situations of enhanced platelet turnover.

Methods

Patients with STEMI treated with primary percutaneous intervention (PCI) and Prasugrel were tested for platelet reactivity using purinergic receptor P2Y, G-protein coupled, 12 (P2Y12) assay and multiple electrode aggregometry (MEA). RP levels were determined using flow cytometry with thiazole orange staining. Tests were performed at 2 to 4 days and 30 days post-PCI. Platelet function was compared by varying levels of RPs, analyzed as continuous (regression analysis) and categorical (tertiles) variables.

Results

Sixty-two patients were included (mean age: 57.5 ± 8 years; 21.2% women; 27.7% diabetes). At the early time point, RP levels were strongly correlated with platelet reactivity when evaluated by the P2Y12 assay (Spearman's correlation coefficient: 0.55 for P2Y12 reaction units, –0.49 for percent inhibition) and MEA (Spearman's: 0.50). The upper tertile of RPs displayed higher platelet reactivity compared with the middle and lower tertiles, according to P2Y12 assay and MEA. Similar results with strong correlations between RP and platelet reactivity were noted at 30 days post-PCI.

Conclusions

The proportion of circulating RPs strongly correlates with response to Prasugrel in patients with STEMI treated with PCI. High levels of RPs are associated with increased platelet reactivity despite Prasugrel treatment.

Membership

This is also a reminder regarding membership dues for the Friends of the Israel Heart Society. The basic dues are **$50**. You can register through our website http://friendsihs.org/Register.html or send a check directly to:

Friends of the Israel Heart Society
8912 Little Elm Bend
Skokie, IL 60076

Please include your email address to assure you do not miss an issue!

We are particularly grateful to those who can be sponsors at any one of the levels indicated below so that we may continue and increase our support of creating a bridge between Israeli Cardiology and the rest of the World:

$250 Silver member

$500 Gold member

$1,000 Platinum member

$5,000 President's Club

Your support enables us to continue growing our programs, including the ACC meeting, support for Israeli fellows to attend the AHA/ACC meetings, and to grow other programs.

For those who are interested in directed donations, we have the following opportunities:

$500 Sponsor an issue of the FIHS newsletter

$1000 Partial sponsorship of an Israeli fellow to attend the AHA meeting

$1000 Partial sponsorship of an Israeli fellow to attend the ACC meeting

$2500 Sponsorship of an Israeli fellow to attend the AHA meeting

$2500 Sponsorship of an Israeli fellow to attend the ACC meeting

We would like to thank our Platinum, Gold, and Silver Members for their past and future support! Thanks to all!

Highlighting Joint Programs

This section highlights ongoing Interchange Programs taking place at American sites. Thanks to Board member Richard Popp for directing this program and allowing us to publicize it:

Feldman Family Foundation Visiting Professors Program

Stanford University School of Medicine, Palo Alto, California, USA

Program Director: Richard L. Popp, M.D.

Purpose: The aim of the professorship is to allow senior Israeli faculty physicians, in the mid-portion of their careers, to have sufficient time away from clinical duties to update their general skills and/or to acquire specialized knowledge that they will transmit to their colleagues and students on their return to Israel. Physicians from any field may apply. Each visiting professor will have a program tailored to his or her needs by the Program Director and a collaborating Stanford Faculty sponsor, who will ensure the quality of the visiting professor's day-to-day activities. The experience of living in the United States for 6 months is an additional aspect of the program. If you are a faculty member of an Israeli Medical School please contact Dr. Popp at rich.popp@gmail.com and he will give you the contact person's name at your program.

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I would also encourage Israeli programs to let our membership know about happenings and offers for training in Israel: Please email these to me at jackstroh@usa.net.

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Join us this year at ACC 2015 in San Diego!

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FIHS Heart Beats

None this issue. please send us your news for the Community!

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The FIHS has decided to send American cardiology fellows to meetings in Israel. We announce our first effort- the 62nd Annual Meeting of the Israel Heart Society, again in Tel Aviv in April (right after Passover).

If you know of fellows that would like to submit their research for consideration, please have them

forward the abstracts/outlines ASAP to jackstroh@usa.net.

This is a great opportunity for young investigators to gain worldly experience and exposure. Please see below for details regarding these specific meetings.

That's it for this issue of the newsletter of the Friends of Israel Heart Society. Special thanks as always to Mort Lebowitz MD and Batia Ziv for being our "eyes and ears on the ground" in Israel. Special thanks in America to our Society Administrators- Janice and Larry Brown!

Have any ideas to make this a better tool for our Society? Share them with us!

Tell your friends that we want them to join our mission to be a bridge between Israeli Cardiology and the world. If you have any questions, comment, criticisms (my favorites!) please email me at jackstroh@usa.net.

Happy, Healthy, and Peaceful New Year!!

Friends of the Israel Heart Society

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