Healthy Heart

Volume-6 | Issue-72 | November 5, 2015

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Honorary Editor :
Dr. Ajay Naik

From the Desk of Hon. Editor:

Dear Friends,

Wishing you and your family a Very Happy Diwali and Prosperous New Year.

The Arrhythmia and Heart Failure Management program at CCC, CIMS has grown from strength to strength over the past decade. The entire credit for the same goes to the faith that you have shown in our ability and care.

*I recently analyzed our **procedural data over past 14 years** and am conveying the same to you for your perusal.*

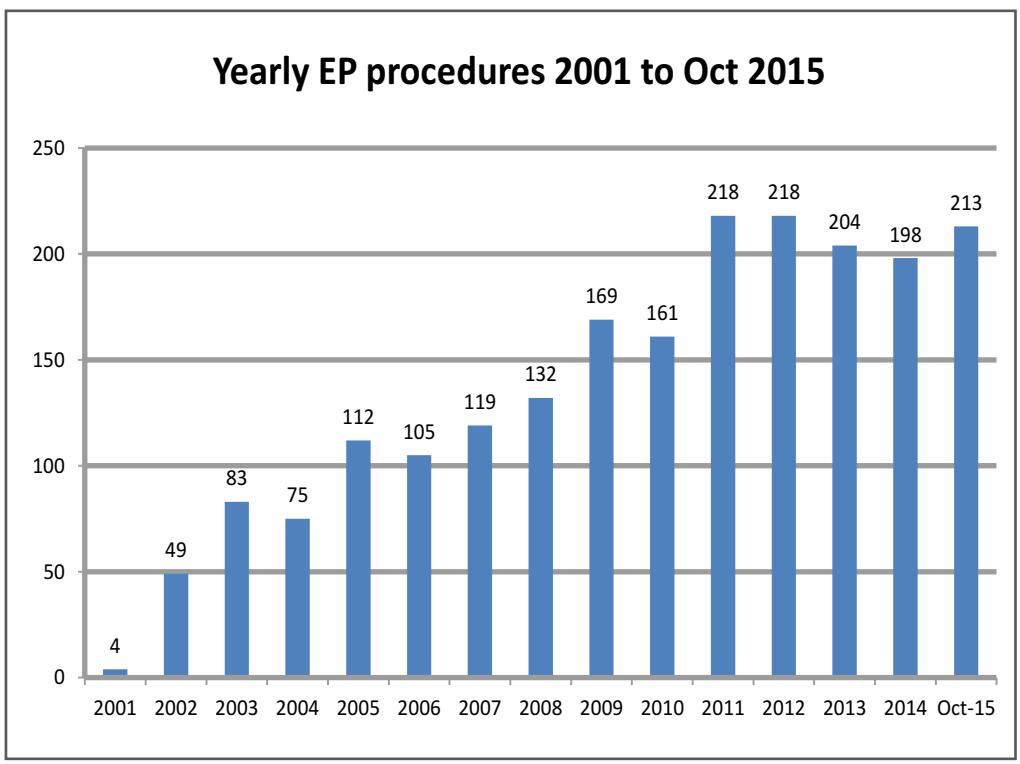
I am sure that our relationship will continue to flourish in the future with the common goal of best patient care.

- Dr. Ajay Naik

Trends of EPRFA therapy for arrhythmias at a single operator large volume center (CCC, CIMS) in Western India

Clinical and Interventional management of arrhythmias is linked to availability of advanced skills; physician and community awareness guided by availability of dedicated Electrophysiologist. The trend of Electrophysiology study (EPS) and Radiofrequency ablation (RFA) procedures was studied in a single operator driven EP program over 14 years at CCC Group, the leading Cardiology group of Western India.

The operator managed personal database of EP study and RF ablations over 14 years from 2001 to October 2015 was studied. The volume of procedures as well as



nature of arrhythmias managed were analyzed. These represented procedures performed by a single operator as part of the CCC group. The procedures had been performed at 6 hospitals over this period by the Electrophysiologist, generally restricted to less than 3 centers at any given time period.

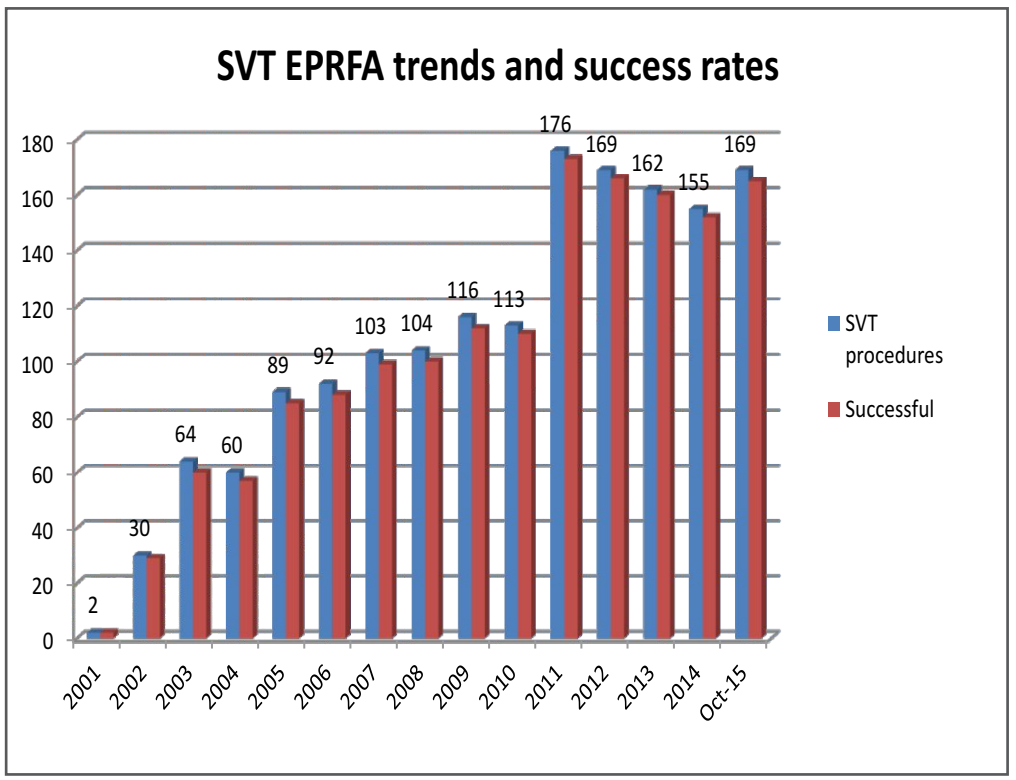
2060 EP studies were performed, that included 345 diagnostic procedures and 1715 therapeutic RF ablation procedures.

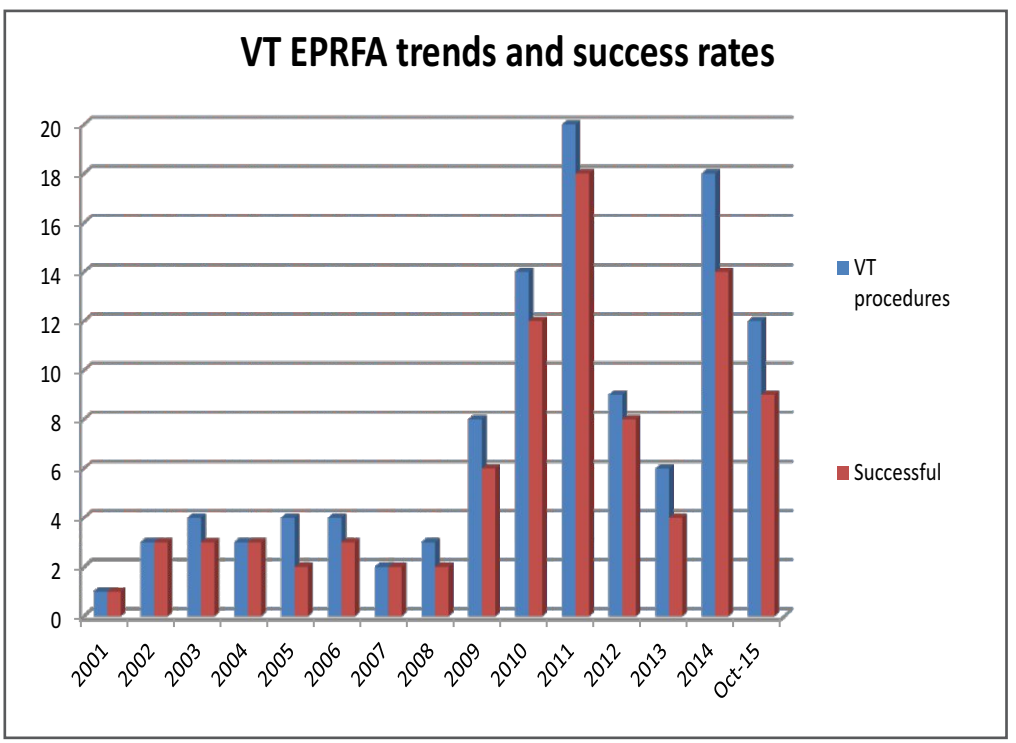
Of the RF ablation procedures, 1604 procedures (93.5%) were performed for Supraventricular Tachycardia (SVT) and 111 procedures (6.5%) for Ventricular Tachycardia (VT).

Of the SVT procedures, 1558 were successful ablations (success rate 97.07%).

Of the VT procedures, 90 were successful ablations (success rate 81.08%).

The number of arrhythmia interventions increases with increasing awareness, education and knowledge in physicians and community with availability of higher skills in the form of Electrophysiologist. The nature and complexity of arrhythmia interventions has shown a progressive rise over the period in the Western India geographical region.





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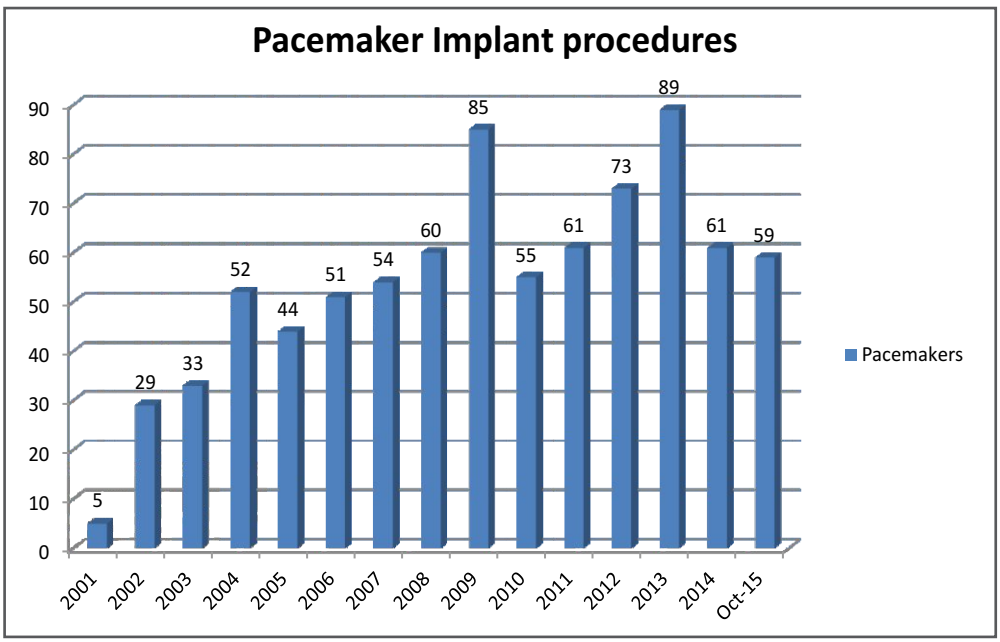
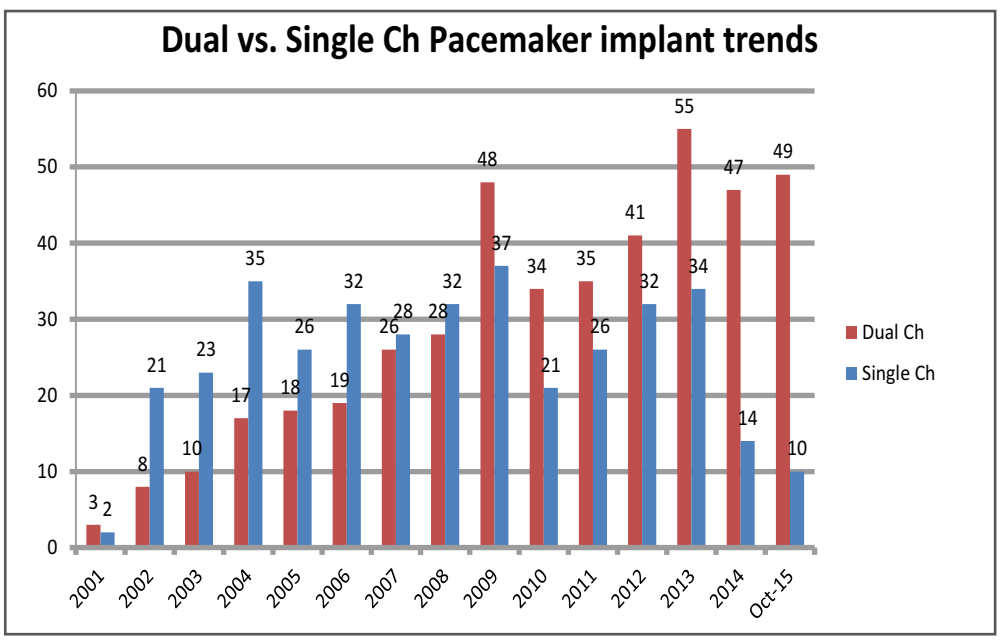
Electrophysiologist driven CIED (Device) implant trends over 14 years at tertiary care cardiology program (CCC, CIMS) in Western India

Single chamber Permanent pacemaker therapy for symptomatic bradycardia has been the basic **CIED (Cardiovascular Implantable Electronic Device)** implant performed by Cardiologists. Progression to **Dual chamber pacemakers, ICD and CRT implantation** is usually linked to availability of advanced skills; Physician and community awareness, education by dedicated Electrophysiologists. The trends of device implant nature and volumes were studied in a single operator driven EP program over 14 years at CCC, CIMS, Ahmedabad.

The operator managed personal database of CIED implants over 14 years from 2001 to 2015 was studied. The volumes of device implants as well as nature of devices were analyzed. These represented implants by a single operator as part of CCC group. The implants had been performed at 6 hospitals over this period by the Electrophysiologist, generally restricted to less than 3 centers at any given time period.

811 permanent pacemaker implantations were performed, that included 373 single chamber and 438 dual chamber pacemaker implants. Initial years had a majority of single chamber pacemaker implants, the crossover to majority dual chamber pacemakers occurred in 2009.

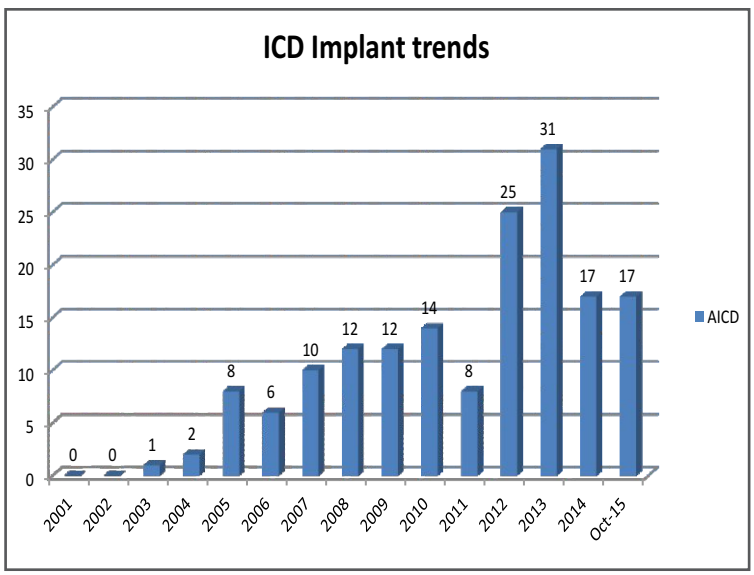


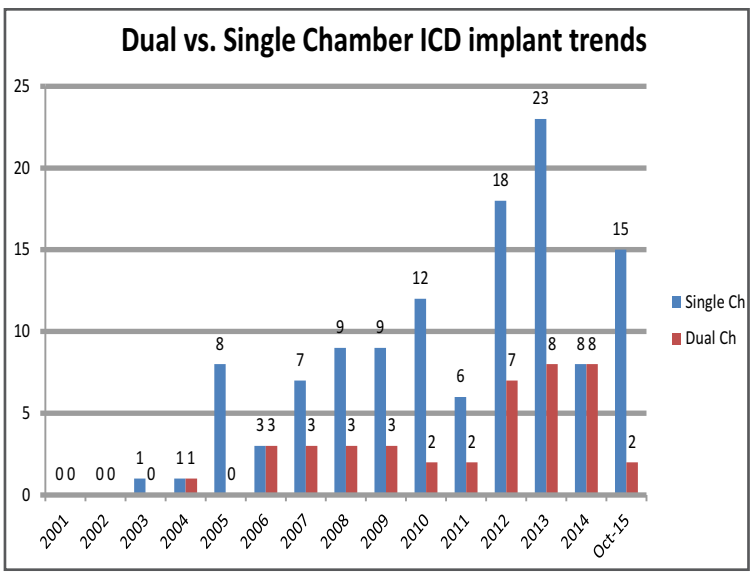


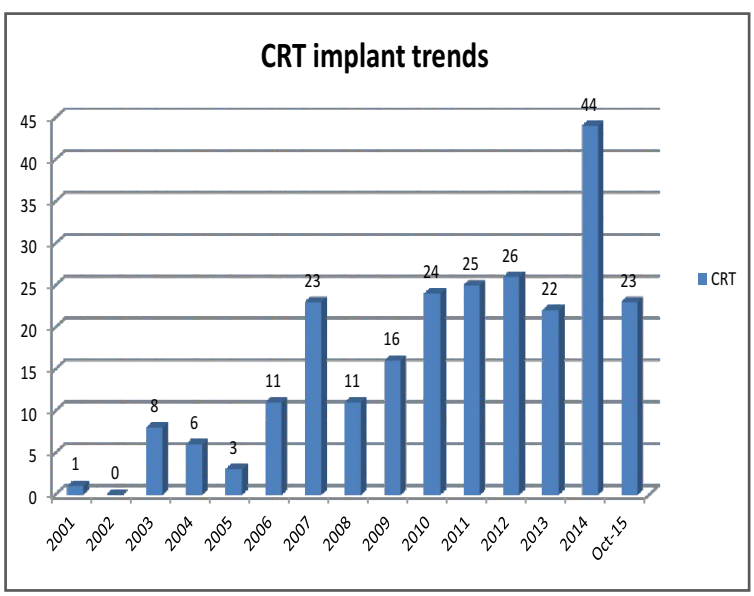
247 CRT implants were performed, of which 170 were CRTP and 77 were CRTD devices.

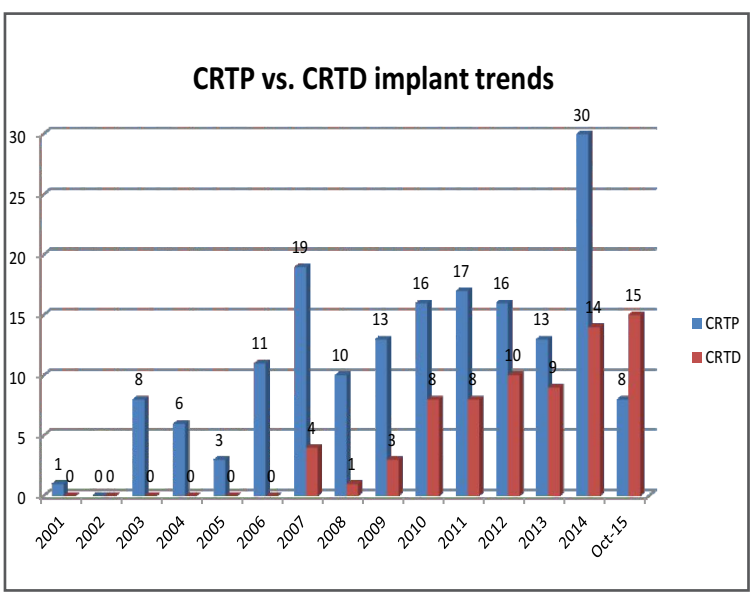
163 ICD implants were performed, of which 120 were single chamber and 43 were dual chamber devices.

The complexity and number of CIED implants increases with dissemination of education, knowledge and awareness in Physicians ancmunity with availability of higher skills in the form of Electrophysiologist. The nature and volume of CIEDs have shown a progressive rise over the period in the Western India geographical region.









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21st Year of Academics

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Program at a Glance

Day-1, January 8, 2016, Friday (Main Session)

- Introduction Session
- Coronary Artery Disease / Acute Coronary Syndrome
- Interventional Cardiology / Plenary Lectures
- Valvular Heart Disease / Hypertension / Lipids & Cardiovascular Risk Management
- Plenary Lectures
- Hypertension / Lipids & Cardiovascular Risk Management

Day-1, January 8, 2016, Friday (Satellite Session)

- Pharmacology & Therapeutics – I
- Pharmacology & Therapeutics – II
- Cardiology Guidelines (15 Points to Remember for Physicians)
- Echo & Cardiac Imaging

Day-2, January 9, 2016, Saturday (Main Session)

- Interactive ECGs / Arrhythmia
- Atrial Fibrillation / Arrhythmia
- Clinical Cases
- JIC Oration
- Structural / Imaging
- Live Case Session - Case Presentation

Day-2, January 9, 2016, Saturday (Satellite Session)

- Satellite Session-A
- Satellite Session-B
- Satellite Session-C
- Satellite Session-D

Day-2, January 9, 2016, Saturday - Tracks

- Ahmedabad Heart Failure Conclave (CVTS)
- Do's & Dont's in Critical Care Medicine Workshop
- Sleep Apnea Workshop

Day-3, January 10, 2016, Sunday - Tracks

- Internal Medicine/Clinical Cardiology
- Critical Care & Pulmonary
- Ahmedabad Heart Failure Conclave (CVTS)
- Trauma Care

International Faculty

Prof. Blasé Carabello	USA	Dr. Atul Mehta	USA
Dr. Bhavin Dalal	USA	Dr. Neil Mehta	USA
Prof. Uri Elkayam	USA	Dr. Navin Nanda	USA
Dr. Ramesh Gowda	USA	Dr. Ravi Ramani	USA
Dr. Ashit Jain	USA	Dr. Dipesh Shah	USA
Dr. Samir Kapadia	USA	Dr. Kris Vijay	USA

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Gift of a Lifetime --- Understanding Brain Dead Organ Donation

Understanding Death Before Donation

To understand organ donation and the shortage of organs for transplants, one needs to have a basic understanding of how people die and what impact it has on whether they can, in fact, be donors or not. Of the 2.2 million people who die in America each year, relatively few die under circumstances that make them medically eligible to be either organ donors or tissue donors.

Brain Death and Organ Donation

Most deceased organ donors are brain dead. They have suffered complete and irreversible loss of all brain function and are clinically and legally dead. Mechanical ventilation and medications keeps their heart beating and blood flowing to their organs.

In the U.S., less than one percent – about 15,000-20,000 – of all deaths are brain deaths. These are usually patients who suffer an injury to the brain resulting from a trauma, stroke or lack of oxygen and are rushed to the hospital, where doctors aggressively work to save their lives but cannot.

Brain Dead is Dead. There is No "Recovery"

Brain death can be confusing, particularly for families who are confronted with the sudden death of someone they love because a brain dead person on a ventilator can feel warm to the touch and can look "alive." The heart is still beating and the ventilator is pushing oxygen and air into the lungs making the person's chest rise and fall.

Brain death can be confusing for families who are confronted with the sudden death of someone they love.

When this happens, some families expect that the person they love can simply be kept on the ventilator in hope that their condition will improve. But to be brain dead is to be dead, and no improvement or recovery is possible. Defibrillators used to "shock" a heart may get it functioning again within the first several minutes after it stops. But there is no such method to jump-start or revive a brain that has been deprived of blood and whose cells have died.

How does brain death occur?

When the brain is injured, it responds in much the same way as an injury like a twisted ankle - it swells. Unlike the muscles and tissue of the ankle, however, the brain is in a confined space – the skull – and has no room to swell.

A head trauma, bleeding in the brain from a stroke or aneurysm, or prolonged cardiac arrest that deprives the brain of oxygen will cause the brain tissue to swell. The action of the brain swelling inside a closed space and the build-up of pressure is what can ultimately lead to brain death. As the brain swells inside the skull, it pushes downward toward the brain stem blocking all upward flow of blood. Depending on the type of injury, this may happen within minutes or over a period of days. Even while the heart is still beating and supplying blood to the rest of the body, blood that carries oxygen cannot reach the brain or the brain stem, which controls heart rate and breathing. The result is that the brain and the person dies.

Documenting Brain Death

Declaring someone brain dead involves no subjective or arbitrary judgments. Brain death is a clinical, measurable condition whose formal definition emerged after the President's Commission for the Study of Ethical Issues in Medicine embraced brain death in 1981, when Ronald Reagan was president.

The electroencephalogram (EEG) of someone who is brain dead shows no electrical activity, and an injection of mild radioactive isotopes into the brain reveals the absolute absence of blood flow. People who are brain dead also have no gag response. Their pupils do not respond to light and

they do not blink when a swab is run across their eyeballs. They do not respond to pain, and in the absence of signals from the brain, their lungs have stopped working—only the ventilator keeps them "breathing."

When the brain is injured, it responds like other injuries—it swells. However, the brain is confined in the skull and has no room to swell. This leads to brain death.

To avoid even the smallest chance of mistake, most hospitals require that two physicians – sometimes hours apart – each conduct a range of tests in search of even the slightest indication of brain activity.

None of these physicians can have anything to do with organ donation and transplantation; they probably do not even know whether the patient is a would-be donor or how the family feels about donation. Physicians, however, often let family members watch as they perform some of these tests because the tests visually demonstrate that, appearances notwithstanding, the person they love is indeed dead.

No One "Pulls the Plug"

Once a person is declared brain dead, families are not asked to "pull the plug" or to take someone "off of life support" because such actions would be impossible: the person they love has already died.

Debates about whether to "pull the plug" or discontinue support on someone who is in a coma or in a persistent vegetative state have nothing to do with organ donation; such people still have brain function, and are not dead.

Organ and Tissue Donation after Cardiac Death

Typically when a person suffers a cardiac death, the heart stops beating. The vital organs quickly become unusable for transplantation. But their tissues – such as bone, skin, heart valves and corneas – can be donated within the first 24 hours of death.

However, in a return to where organ donation began 40 years ago, before the acceptance of brain death, some patients are becoming organ donors after suffering cardiac death. The medical community refers to this as "non-heart beating donation."

Some people with non-survivable injuries to the brain never become brain dead because they retain some minor brain stem function. If such individuals made the decision to be donors or their families are interested, organ donation may be an option.

The option of donating organs after cardiac death or "non-heart beating" donation may be presented to these families after it is clear that their loved one cannot survive. Donation in such cases entails taking the patient off the ventilator, typically in the operating room. Once the patient's heart stops beating, the physician declares the patient dead and organs can be removed.

Today, organ donation after cardiac death has increased the donation of life-saving organs – mostly kidneys and livers – by as much as 25 percent in a few areas of the country. Some experts estimate that it could increase the number of deceased-donor organs in the U.S. by thirty percent.

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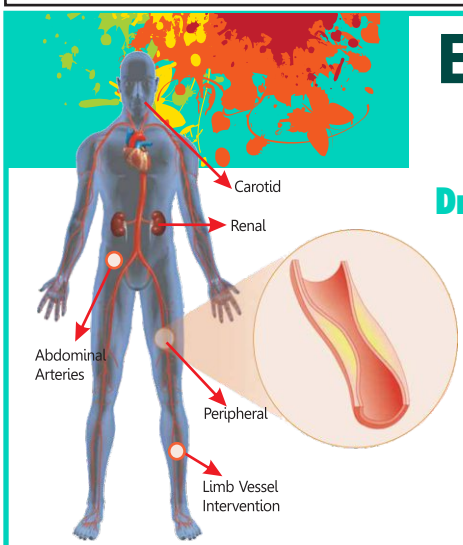

Endovascular Peripheral Workshop

with

Dr. Ashit Jain, Washington Hospital, USA
Dr. Ramesh Gowda, Mount Sinai Beth Israel & Brooklyn hospital, USA

January 7, 2016, Thursday

PATIENTS WHO ARE ELIGIBLE

- Carotid Artery Stenosis
- Renal Artery Stenosis
- Acute Limb Ischemia
- Critical Limb Ischemia
- Varicose Veins
- Dialysis Access Procedures
- Pulmonary Embolism
- Thoracic Outlet Syndrome
- Uterine Fibroids
- Vascular Malformations
- Venous Insufficiency and Venous Ulcers
- Claudication
- Femoropopliteal Disease
- Brachiocephalic Arterial Disease
- Venous Thromboembolic Disease
- Thoracic Abdominal Aortic Aneurysms
- Mesenteric Disease
- Catheter-Based Interventions for Failing Hemodialysis Accesses
- Infrapopliteal Peripheral Arterial Disease
- Intracranial Arterial Stenotic Disease
- Vertebral Arterial Disease

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Kindly refer your PVD, AAA patients for consultation (complimentary) and intervention.

Please contact any CIMS Cardiologist listed on front page

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