The Official Annual Congress of the European Association of Percutaneous Cardiovascular Interventions—the EuroPCR course—was held in Paris from 20 May to 23 May 2014. This was the 25th anniversary of what is now known as EuroPCR and reaffirmed the course as the leading Congress in the field of percutaneous cardiovascular medicine with an attendance of 12 257 participants. It is noteworthy that 39 National Societies of the European Society of Cardiology community were represented at EuroPCR this year, with a dedicated area to showcase their achievements. Overall, the course comprised 513 sessions with 51 h of live case transmissions from 17 centres in Europe, Canada, Japan, and Kuwait.

Ten sessions were dedicated to the presentation of 48 late-breaking clinical trials, including first reports of randomized controlled trials, large-scale registries and updates of clinical trials.

In the field of coronary interventions, important data were presented by Dr Valgimigli from a pooled patient-level analysis of five trials including 4896 patients randomly allocated to everolimus-eluting stents or bare metal stents. In this analysis, everolimus-eluting stents were associated with a marked clinical benefit compared with eluting stents or bare metal stents. In this analysis, everolimus-eluting Xience stent with durable polymer coating in terms of target-lesion failure at the 1-year follow-up. This was not limited to a reduction in the risk of the prevention of restenosis, but extended to a marked clinical benefit compared with bare metal stents during 2 years of follow-up. This was not limited to a reduction in the risk of the prevention of restenosis, but extended to a marked clinical benefit compared with bare metal stents during 2 years of follow-up. This was not limited to a reduction in the risk of ischaemic events, including stent thrombosis, myocardial infarction, and cardiac mortality.

The primary end-point results of the CENTURY II randomized trial were presented by Prof. Wijns and simultaneously published online in the European Heart Journal. In this all-comer trial, the new-generation, thin-strut, sirolimus-eluting Ultimaster stent, with biodegradable polymer coating was shown to be non-inferior to the everolimus-eluting Xience stent with durable polymer coating in terms of target-lesion failure at the 1-year follow-up. Finally, the OCTAVIA intracoronary imaging study was presented by Dr Guagliumi, with interesting data on the mechanisms of atherothrombosis in the setting of acute myocardial infarction in women and men.

Moving on to the field of transcatheter aortic valve interventions, Dr Webb presented for the first time the 30-day outcomes from the SAPIEN 3 trial. In this study, the newest iteration of the SAPIEN heart valve prosthesis with an outer skirt to mitigate paravalvular leaks not only showed remarkable clinical outcomes with a very low rate of mortality and stroke but, importantly, an exceptionally low rate of paravalvular aortic regurgitation. Dr Moellmann presented promising results on the ACURATE neo transfemoral TAVI device at 30 days. Moreover, Dr Tuzcu presented the initial results of the US feasibility trials of the Direct Flow Medical valve. Finally, Dr Duncan reported the long-term 5-year outcomes of transcatheter aortic valve interventions in high-risk patients within the UK TAVI registry.

Concerning mitral interventions, two first-in-man studies were presented on the Fortis valve and the Tiara bio-prosthesis, presented by Dr Bapat and Dr Cheung, respectively. These reports reflect the fact that transcatheter mitral valve replacement has entered the clinical arena with important studies to evaluate this new technology to be followed in the next few years. On the topic of transcatheter mitral repair, Dr Maisano reported a feasibility study on a ‘surgical-like’ device for percutaneous mitral valve direct annuloplasty. It is likely that transcatheter mitral valve replacement and repair will play complementary roles and future studies will address which patients will benefit from these interventions.

In addition to late-breaking science, EuroPCR 2014 included a large number of educational sessions. The educational theme this year was ‘Personalized Medicine’, with the intention of placing the individual patient at the centre of decision-making, and to provide guidance on how results from clinical trials performed in highly selected patient populations may influence the care of individual patients. Of note, interventional cardiovascular medicine is inclusive by definition as it encompasses prevention, diagnosis and integrated care of multiple, interrelated disease conditions. The theme of Personalized Medicine represented an important thread running throughout the educational component of the EuroPCR 2014 course.

Overall, the blend of live cases, educational, and scientific sessions represents the very essence of EuroPCR, making it a unique course in interventional cardiovascular medicine.
Pan-African Society of Cardiology (PASCAR) is an organization (established in 1981) of physicians from across Africa involved in the prevention and treatment of cardiovascular disease. The founders of PASCAR were concerned by the lack of progress in the diagnosis and effective treatment of cardiovascular disease across Africa. Africa does offer unique challenges, but with achievable objectives and a long-term strategy, a positive impact can be made on the disease.

Pan-African Society of Cardiology has recently appointed George Nel to assist the society with an office and management infrastructure. This allows the Governing Council to focus on identifying key issues, brainstorm novel solutions, and design appropriate programmes to combat cardiovascular disease across the continent. The PASCAR office focuses on liaising with stakeholders and on the successful implementation of priority programmes. The number of additional resources required is determined by the specific programme and they are funded by third parties with mutual interest.

Pan-African Society of Cardiology is forming working relationships with other organizations and departments with a similar mandate and focus in Africa. For more information contact PASCAR at george@medsoc.co.za or www.pascar.org.

It is important to understand the unique challenges faced in Africa and, as such, the PASCAR Governing Council consists of a core group of committed individuals with extraordinary knowledge of the African cardiovascular environment and passion to make a difference.

Pan-African Society of Cardiology National Council (Dakar, Senegal, May 2013): left to right—Back row: Dr Anastase Dzudie, Cameroon, Assistant Secretary General (Central Africa); Dr Harun Otieno, Kenya, Assistant Secretary General (East); Dr Saad Subahi, Sudan, Vice-President (North); Prof. Elijah Ogola, Kenya, Vice-President (East); Dr Awad Mohamed, Sudan, Assistant Secretary General (North); Prof. Serigne Ba, Senegal, Vice-President (West); Prof. Samuel Kingue, Cameroon, Vice-President (Central); Prof. Johan Brink, South Africa, Assistant Secretary General (South). Front row: Prof. Toure Ali Ibrahim, Niger, Assistant Secretary General (West); Dr Ana-olga Mocumbi, Mozambique, Vice-President (South); Prof.

Bongani Mayosi, South Africa, President; Prof. Karen Sliwa-Hahnle, South Africa, Treasurer; Dr Benedict Anisiuba, Nigeria, Secretary General. Not in picture—Prof. Paul Brink, South Africa (Editor—Cardiovascular Journal of Africa)

In addition to our geographically aligned structures (North, East, South, and West Africa), PASCAR Task Forces bring together representatives from key cardiovascular subspecialties such as interventional cardiology and lifestyle risk modification, and allied catheterization laboratory professionals. Prof. Bongani Mayosi has stated that PASCAR will actively engage with Africa north of the Sahara, to become an active contributing region in PASCAR. This has culminated in the PASCAR 2015 Congress being awarded to the Tunisian Society of Cardiology and Cardiovascular Surgery. The PASCAR 2015 programme will address all aspects of cardiology that are relevant to Africa.

Pan-African Society of Cardiology is currently involved in the following programmes.

‘Cardiac Pacing Services for every African country’

There are three potential barriers to the establishment of an effective cardiac pacing service in Africa

- cost of pacemakers;
- lack of insertion facilities; and
- absence of clinical expertise.

The high cost of new pacemaker devices may be overcome by the reuse of pacemakers, a practice that has been demonstrated to be safe and cost-effective. Pacing requires the availability of X-ray equipment with fluoroscopic capabilities and aseptic conditions, which are available in many hospitals in sub-Saharan Africa and in almost all academic centres.

It is not necessary for the procedure to be carried out in a dedicated catheterization laboratory, a facility that is not available in the majority of African countries.

Finally, the lack of trained doctors in pacemaker implantation and non-physician clinicians (or nurses) in supportive care is the only significant barrier to the establishment of cardiac pacing in many countries in the region.

African Fellowships in Cardiac Pacing and Clinical Cardiology address the lack of expertise through a 6-month intensive training programme at high-volume pacemaker implanting and training centres such as University of Cape Town, South Africa. Some North African countries could also provide such training facilities. The first unit under this programme should be operational in Sierra Leone from mid-2015.
‘PASCAR brings together Medical Experts from across Africa to Forge a Path to Eliminate Rheumatic Heart Disease’

A historic assembly took place in early 2014 at the Zambezi Sun, Livingstone, Zambia, bringing together Africa’s leading experts in rheumatic heart disease (RHD) to design a roadmap for the control and elimination of the disease in Africa. The second Pan-African ‘Stop Rheumatic Heart Disease ASAP in Africa’ Continental Congress was held under the auspices of the PASCAR and in partnership with Novartis, and included cardiac specialists from 30 countries in Africa as well as representatives from the World Health Organization (WHO) and the World Heart Federation (WHF).

The Minister of Health of Zambia gave the opening address, welcoming the 50 delegates from over 30 countries across Africa, from Cape Town to Cairo.

Prof. Bongani Mayosi, a leading advocate for patients with RHD globally stated, ‘This is the time to scale up our efforts if we are to realise the elimination of rheumatic heart disease in Africa in our lifetime’.

‘Despite its high prevalence, for a very long time, rheumatic heart disease has been a neglected disease in Africa, but this is slowly changing’, said Dr John Musuku, paediatric cardiologist at the University Teaching Hospital in Lusaka, Zambia. Under the auspices of PASCAR and in partnership with Novartis, Dr Musuku is leading a broad effort in Zambia to measure the prevalence of RHD in school children and to form a new electronic patient registry. The other delegates are working in all areas of Africa, leading important new research in RHD as well as the genetic epidemiology of RHD—the REMEDY study and the Genetics of Rheumatic Heart Disease Network (RHDGen) represent the start of a new era in ground-breaking RHD research in Africa.

Pan-African Society of Cardiology Task Force on Hypertension

Pan-African Society of Cardiology embarked on a process to write, disseminate, implement, and monitor a very practical guideline for the management of hypertension (HTN) in Africa. Hypertension is the most common single-risk factor for cardiovascular-related events and deaths worldwide. Over the last years, a substantial number of publications have highlighted the growing evidence of HTN as a largely underdiagnosed and undertreated disease associated with poverty and ignorance, leading to complications such as stroke, renal disease, and heart failure.

Recently, under the patronage of the Senegalese President, PASCAR as the leading continental organization, has engaged and adopted the ‘The 10 Best Buys’ to combat heart disease, diabetes, and stroke in Africa with HTN management as the first priority. Pan-African Society of Cardiology has taken a real measurement of the condition and the challenges but also the opportunities that exist in developing a credible preventive programme with the following elements:

- Clinical and very practical guidelines that answer specific questions related to HTN in Africa.
- Implementation plan with the use of the World Health Organisation-Africa policy.
- Monitoring, evaluation, and regular revision.

Pan-African Society of Cardiology Educational Collaboration in Catheter Laboratories of Africa

The South African Allied Group Society, ISCAP (The Interventional Society of Cath Lab Allied Professionals) donated a complimentary copy of their recently published Cardiac Catheterisation Training Manual to every cath lab unit in Africa. This will be the first of hopefully much more collaboration in this cardiac environment.

Pan-African Society of Cardiology Task Force on Nutrition and Cardiovascular Diseases

This new initiative was launched in June 2014 and will consist of a situational analysis on Nutrition and CVD in Africa as well as stakeholders’ consultation and systematic reviews of published data (including data meta-analysis). The task force will issue stakeholders consultation report, peer-reviewed publications, guidelines on
lifestyle management to reduce CVD risk in Africa and a Handbook on Nutrition and CVD in Africa. Evidence will be gathered from a cross-country project and a multi-country school-based pro-

gramme, with eventual communication through the PASCAR website, social media, and a satellite symposium in Tunisia, September 2015.

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First evidence for shockless atrial fibrillation treatment

Cardiac optogenetics achieve defibrillation without the pain of electric shocks

The first evidence for a shockless treatment for atrial fibrillation (AF) was presented at Frontiers in CardioVascular Biology 2014 in Barcelona, Spain.

Electric shocks are the quickest way to bring AF patients back to normal sinus rhythm and prevent symptoms and complications. But shocks are very painful and require anaesthesia, which comes with its own possible adverse effects.

Atrial fibrillation usually progresses from a paroxysmal form, in which episodes of AF last from several minutes up to 7 days, to a persistent and eventually a chronic form. People with the latter are in AF 24 h a day, 7 days a week, and shock treatment no longer works. Dr Brian O. Bingen, first author, said: ‘AF causes structural changes to the atrium which make patients more prone to subsequent induction of AF. That’s another reason to get patients back into sinus rhythm as soon as possible’.

The researchers devised a method of shockless defibrillation. They used optogenetics to genetically insert depolarizing ion channels into the heart that can be activated by light.

Dr Bingen said: ‘The theory was that we could just turn a light switch on and depolarise the entire myocardium without needing a shock. In theory, the patient could be given an implantable device with a mesh of light emitting diodes (LEDs) and when AF occurs you turn the light on and the AF stops’.

During arrhythmias there is subepicardial activity, but the heart is a complex three-dimensional structure and it is only possible to directly observe the epicardium. To see how their method worked subepicardially, the researchers developed two-dimensional (2D) hearts. They isolated cardiac muscle cells from the rat atrium, replanted them in a culture dish and allowed the cells to form intercellular connections, creating a 2D heart.

Atrial fibrillation was induced in 31 of these 2D hearts. The researchers used a lentivirus to insert a gene into the 2D hearts called calcium-translocating channelrhodopsin, which is a light-sensitive depolarizing channel.

Dr Bingen said: ‘Then it was just a matter of switching on the light and seeing what happened. We found that in all 31 of these 2D hearts we were able to achieve the 2D equivalent of cardioversion into sinus rhythm. The mechanism we saw was slightly different than the normal defibrillation but was equally effective’.

He continued: ‘We now have to test our method in the 3D setting. In that scenario we won’t be able to see the defibrillating mechanism in as much detail, but we hope that it will be possible to terminate AF in the complete heart. We will also test other types of light or energy sources that penetrate the body more deeply and could be applied externally, avoiding the need for an implanted device’. Dr Bingen concluded: ‘This is the first evidence of a shockless defibrillation. Our method of using optogenetics to defibrillate by light is completely painless and looks promising, but more research is needed before it can be applied in patients’.

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People’s corner: new appointment

Ulf Landmesser MD FESC

Ulf Landmesser, deputy chair of cardiology at the University Heart Center of the University Hospital Zurich and deputy editor of the European Heart Journal has been nominated by the faculty of the Charité Universitätsmedizin in Berlin as full Professor and Chairman of Cardiology, Charité-Universitätsmedizin Berlin (Campus Benjamin Franklin).

Ulf Landmesser studied medicine in Hannover and obtained his clinical training at the Medical School of Hannover under the leadership of the late Prof. Helmut Drexler. He moved in 2007 as consultant and later senior consultant in acute and interventional cardiology and professor of cardiology to the Department of Cardiology in Zurich, led by Prof. Thomas F. Lüscher.

Ulf Landmesser has had a major research interest in vascular biology of coronary disease, a topic he has pursued ever since he was trained by Prof. David Harrison at the Emory University School of Medicine in Atlanta, GA, USA. He has provided major contributions to the concept of HDL dysfunction and its role in patients with coronary disease or cardiovascular risk factors as well as progenitor cell dysfunction in the same patient population. Alterations of both the cardiovascular protective systems likely play an important role in the understanding of why several HDL-cholesterol-raising therapies have so far not yet yielded positive results. It is possible that a mere increase in plasma levels of the lipoprotein without improving its functional properties within the blood vessel wall may not translate into clinical benefit.

Similarly, his work on progenitor cells suggests that these mediators of cardiovascular regenerative and repair processes after myocardial infarction and other cardiovascular disease conditions are impaired in the presence of diabetes or heart failure. These findings again may explain why, so far, the current approaches of cardiac cell therapy have not yielded positive results in some patient populations.

Ulf Landmesser has also been and will remain a very active deputy editor of the European Heart Journal, acting as ‘editor-of-the-week’ together with Frank Ruschitzka and the editor-in-chief Thomas F. Lüscher, in addition to the handling of special areas of cardiology, such as prevention of coronary disease and translational cardiovascular science in particular.

Highlights from EuroPCR 2014

EuroPCR 2014, the Official Congress of the European Association of Percutaneous Coronary Intervention (EAPCI), took place at its Parisian home once more this May. A new feature included a pre-course Innovation day where developments in the MedTech space were presented in a structured format. The current and future European environment in 2018 surrounding device regulation were also described.

In the financially challenging world of medical innovation, dedicating a day to this area acknowledges the importance in addressing unmet clinical needs and provides an opportunity for networking between physicians, industry, inventors, and entrepreneurs. To coincide with this theme was the launch of an online device innovation data resource.

One of many devices that caught the eye was the OPTISENS pressure wire that uses fibre-optic technology allowing for guide wire-like properties. Fractional flow reserve measurement remains underused worldwide despite a wealth of clinical data. This product may be welcomed by those previously reluctant to use standard pressure wire equipment.

The opening day saw a number of late-breaking trials presented in conjunction with their publication in EuroIntervention. This synergy aims to help disseminate the data more widely.

In coronary intervention, the results of BABILON COBRA and TRYTON for bifurcation lesion PCI were presented. BABILON compared drug-coated balloons (DCBs) and T-stenting with bare metal stents (BMSs) against provisional stenting with drug-eluting stents (DESs). Therapy with DCBs proved inferior, driven by target vessel revascularization (TVR) and target lesion revascularization due to main branch restenosis at 24 months. The COBRA compared the biolimus-eluting AXXESS stent against everolimus DESs. The primary end-point of reduced percentage-uncovered struts per bifurcation segment as assessed by optical coherence tomography (OCT) at 9 months was not met. TRYTON is the largest randomized controlled trial (RCT) of a dedicated stent to date and presented negative results vs. a provisional strategy at TCT 2013.

At EuroPCR an additional hypothesis-generating post hoc analysis suggested benefit in side-branches > 2.55 mm. Although the trial failed to meet non-inferiority, the low TVR may lead to a drug-eluting version of the TRYTON. The sense left by these studies was that provisional stenting with DESs remains a robust strategy for bifurcation disease.

One-year non-randomized results (n = 443) of orbital atherectomy (ORBIT-2) continue to show favourable clinical results in severely calcified lesions. Despite no head-to-head study with conventional rotational atherectomy, these data support the use of this technology in this niche area.

ADEPT described favourable clinical results for the STENTYS self-expanding BMSs vs. DESs in elective saphenous vein graft intervention. Similarly APPOSITION IV evaluating a DES version against everolimus-eluting stents in primary percutaneous coronary intervention (PPCI) showed faster endothelialization without any difference in an underpowered study for major adverse cardiac events.
The potential for reduced dual antiplatelet therapy duration remains unexplored.

ROBUST evaluating systematic OCT-guidance of PPCI did not reveal any significant clinical outcome advantage compared with conventional clinical and angiographic guidance at 9 months but was underpowered. There was a trend towards better stent endothelial coverage in the OCT group and its routine use was found to be safe.

OCTAVIA (n = 140) comparing contemporary PPCI in predominately post-menopausal women and age-matched men demonstrated reassuringly no difference in clinical outcomes. The presence of eroded plaques in one-third of cases and greater delay in female clinical presentations compared with males were useful and important data to emerge. The CENTURY II (n = 1123) non-inferiority RCT, novel in design as it complied with both Japanese and EU regulatory bodies, confirmed no significant difference in standard angiographic end-points or safety end-points between the Ultimaster RCT, novel in design as it complied with both Japanese and EU regulatory bodies, confirmed no significant difference in standard angiographic end-points or safety end-points between the Ultimaster abluminal sirolimus-eluting stent with biodegradable polymer and the conventional everolimus-eluting stent at the one-year follow-up. An interesting observation with conventional end-point rates so low nowadays, due to the increased efficacy of all stent platforms, is that the future may see a move towards symptom and quality-of-life primary end-point outcomes.

A further theme of the congress was the translation of clinical trials into daily practice in order to go beyond just the scientific exposition of data or the opinions of key leaders in the field. Two platforms used to help promote this were the Great Debate and a series of ‘How does this affect my practice seminars’ covering the major intervention studies presented at the ESC Congress 2013: ACCOAST, PRAMI, and TASTE. It is envisaged that this approach will develop further in future congresses.

The Great Debate topic this year was entitled ‘Primary PCI for STEMI: an emergency’. Chaired very effectively, panellists from Poland, Italy, South Africa, and the UK argued their cases with respect to their individual practice in the setting of primary PCI. What emerged during a comprehensive discussion was a consensus on fundamentals such as speed to coronary intervention and the importance of myocardial reperfusion beyond just establishing coronary patency. What also emerged, however, were the differences in approach based upon local resources and interpretation of trial results.

Some panellists advocated a radial only strategy based on RIVAL and RIFLE; others preferred a hybrid strategy dependent on the level of operator experience, physical characteristics, and haemodynamic status. The concept of default stenting was also challenged based on the DEFER-STEMI study.

Antithrombotic therapies were debated with some panellists using bivalirudin and others conventional heparin and GP2b3a bailout. Bleeding was seen as more of a concern than stent thrombosis; however, the anticipated publication of HEAT-PPCI was acknowledged as a potential change in practice for those using bivalirudin.

Manual thrombectomy was scrutinized with some dissent among panellists, on the value of systematic thrombectomy based on the TASTE data, but it was acknowledged that the short-term outcome to headline that trial is likely to be premature and that the results of a larger TOTAL study together with 1-year outcomes are required.

Interestingly, there was a consensus that PRAMI would not lead to default multivessel index PPCI but may support a more aggressive approach to non-culprit lesions during the initial admission. Finally, alternative strategies to immediate PPCI were debated with geographical differences dictating the use of a pharmacoinvasive approach as supported by data from STREAM.

In the field of structural intervention the results of the SAPIEN 3 international multicentre registry (n = 150) continue to promote aortic valve implantation technology. Notably, SAPIEN 3 includes high- and intermediate-risk patients with 30-day outcomes among some of the best reported of any aortic device. Alongside these registries and the recent CORVALVE results, reducing stroke, post-procedural regurgitation and vascular complication rates, the impression was of a maturing aortic field. In addition, the first-in-man results from transapical FORTIS mitral valve implantations made on compassionate grounds were described as the beginning of a new journey in percutaneous mitral valve disease therapies. There was also an interesting session and case demonstration devoted to novel leadless pacing technology and its potential application in TAVI. Results from the Leadless II investigational device exemption (IDE) trial are eagerly awaited.

For peripheral interventions, less study data were presented. One area to receive attention was intervention for acute ischaemic stroke. Sessions devoted to this potentially practice-changing subject were well attended. Following the neutral results of last year’s randomized studies, progress has been slow. The PRAGUE-16 pilot RCT (n = 23) reported encouraging results with 48% achieving modified Rankin scale ≤2 after thrombectomy. This and a similarly small single-centre registry (n = 38) from Turkey may provide a renewed stimulus for larger-scale studies.

Renal denervation practitioners saw data on new catheter designs presented. One, the IBERIS catheter, is notable as the procedure is performed via the radial approach. The inability to assess anatomical and functional success of denervation at the time of the procedure remains a limitation common to all technologies, especially in the recent aftermath of the negative SYMPLICITY-HTN-III RCT. Data from this study have led to insecurity in the therapy but has not quashed interest; rather, it has stimulated research into the characteristics of responders and non-responders.

The results of the democratic EAPCI 2014-16 Board appointment process were announced during the Congress. Michael Haude (Germany) as president-elect, Andreas Baumbach (UK) as secretary, and Javier Escaned (Spain) as Treasurer were duly elected from 10 applicants and an impressive voting turnout from 1800 EAPCI members (53%). Together with the new President Stefan Windecker, these appointments represent a formidable team with which the EAPCI can deliver on its objectives. These include focusing more on young interventionalists, addressing gender differences in access to interventional care, improving educational standards and opportunities, strengthening scientific visibility, and supporting the expansion of structural interventions.

The Ethica award this year was awarded to Adnan Kastrati in recognition of his enormous contribution (>500 peer-reviewed publications) and impact in the field of coronary intervention. Supported on stage by members of the Intracoronary Stenting
and Antithrombotic Regimen team from Munich, his work on antithrombotic therapy for PCI has had a large influence on international guidance.

During the congress the EHJ held a Joint EuroIntervention/EHJ Symposium.

By the end of the meeting some 12,257 delegates had attended an enjoyable congress, now in its 25th year. Testament to the increased interactivity of the attendees and engaging atmosphere were the 200,000 questions posted via smartphones during sessions to be answered by panellists and opinion leaders.

Together with a broad array of online resources, this congress continues to invest in the education and the sharing of practice among the interventional community. For these reasons, it remains firmly placed in the calendar of practitioners caring for patients undergoing percutaneous interventional procedures.

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References


