

# Rhode Island Chapter of the American College of Cardiology

"THE MISSION OF THE RHODE ISLAND CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY IS TO BE AN ADVOCATE FOR ACCESSIBLE, HIGHEST QUALITY, COST EFFECTIVE CARDIOVASCULAR CARE FOR THE PEOPLE OF RHODE ISLAND AND TO ACTIVELY SUPPORT CARDIOLOGISTS IN THEIR EFFORTS TO ACHIEVE THESE GOALS."

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## Second Annual Chapter Meeting ACC Trustee to Keynote

**M**ichael J. Wolk, MD, ACC Treasurer and Board of Trustees member, will keynote the Second Annual Chapter Meeting on Wednesday October 18<sup>th</sup> at the Metacomet Country Club. Dr. Wolk is an attending physician at New York Hospital and a Clinical Professor of Medicine at Cornell University

Dr. Wolk chaired the ACC Task Force for the Twenty First Century. This group developed a three year plan that carefully matches the College's operating and investment funds with its strategic needs and it is the first time the College has ever developed a multiyear strategic fiscal plan which sets a model for the College in the new millennium. This plan is about investing in the future and directing College resources into specific activities which will benefit individual members and includes advocacy, membership services, clinical practice and education.

Invitations will be mailed the first week of September and, as with the First Annual Meeting, there will be no charge for chapter members.



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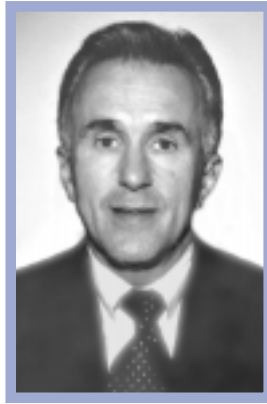
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# The President's Message: Strong Membership Shows Supports for Chapter's Mission

The Rhode Island Chapter has 110 members as of the May census. As Chapter President, it is gratifying that over 87% of eligible Chapter members have paid their dues. This ranks among the highest of all chapters. This support is not taken for granted and I believe it is a reflection of your desire to support the mission of the Chapter.

The ACC is committed to the concept of universal health care. In June, I was invited to participate in the "ACC's Uninsured and Health System Reform Summit". This summit was chaired by Drs. Bellereller and Garson. Several trustees, governors and other ACC members were invited. These principles will be refined and feedback sought from ACC members. Further discussion will take place at the fall Governor's meeting in September and sent to the Board of Trustees for discussion and approval in November.

It is astounding that we have over 44 million uninsured Americans. This represents 18% of the population under age 65. Eight in 10 of the uninsured are workers or their dependents. The average annual cost of a family health insurance policy is almost \$6,000. In Rhode Island many citizens have benefited from the RiteCare program. This has spelled the difference for many workers and their families who could not otherwise afford health care. Unfortunately, it has placed a



strain on the state government which is presently being addressed. Hopefully, the principles which the ACC proposes will help build a

coalition which will lead to meaningful legislative reform and funding.

In July, I was appointed to an ACC writing group to address the principles by which prescription drugs are changed to OTC (over-the-counter) status. This was a response to Merck's request to allow the sale of Lovastatin without a prescription. The FDA has subsequently ruled against this change.

It is generally true that when medications previously available only by prescription are changed to an over-the-counter status, the price drops and it becomes readily available to consumers. The drugs which have transitioned from prescription only to over-the-counter status are those used to treat certain symptoms. For example, ibuprofen for pain and cimetidine for ulcer symptoms are

two drugs which have achieved over-the-counter status with the expected reduced cost and increased availability following. It is important to note that the patient judges the effectiveness of this therapy by its relief of symptoms.

The concept of making cholesterol lowering medications available as OTC drugs signifies a change in

We adhere to the principle that patients need professional advice and treatment to achieve the desired "wellness goals".

principle since an elevated cholesterol level is not associated with symptoms. The manufacturers had proposed a low dose for patients with elevated cholesterol with no evidence of vascular disease. The available data argued in favor of the safety of this dose but should not diminish the importance of the physician-patient relationship in risk factor reduction.

There is no "magic bullet" which protects the patient from developing cardiovascular disease and the physician-patient relationship can recognize and treat multiple risk factors and reinforce collateral measures such as nonsmoking, diet

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# ACC Survey Results

In 1999, the College conducted several intensive efforts to identify the advocacy needs of members and their satisfaction with current advocacy efforts. Through over 200 face to face interviews, over 150 phone interviews and through written surveys, members told us the following:

- A. Changes in health care delivery. Members greatest concerns revolve around changes in health care delivery and its impact on patient care. Concerns include:
- declining standards of patient care
  - managed care medicine's emphasis on cost over care
  - attacks on physician autonomy
  - eroded respect of the physician specialist
  - decreased physician reimbursement
  - decreased insurance benefits for patients
  - increased billing and documentation demands

- B. Awareness of ACC's advocacy efforts. Members generally have limited awareness of the full scope of ACC advocacy efforts. They do not blame the College for the problems with health care delivery and reimbursement, but they do want the College to do much more to advocate for change.
- C. Importance of ACC chapters. Members believe strengthening the state chapters would address both the needs for more effective advocacy and for bridging the leadership-membership gap. It was suggested that the local governors solicit members on a regular basis to gather feedback about key concerns.
- D. Importance of state/local advocacy. Members believe it is at the state and local level that ACC can have the greatest impact in terms of fighting adverse legislation, passing important regulations, negotiating with third-party payers, etc.

- E. Importance of speaking with one voice. Similarly, they suggest it is through more active participation at the state level and better communication from the membership up through the national leadership that ACC can act a more as a unified, cohesive member organization.
- F. Advocate for quality health care. Respondents urged the College to advocate more strenuously on behalf of quality health care, with increasing numbers urging the College to form a Political Action Committee (PAC) or take other more active roles.

Specific actions that members want the College to take include the following:

Take every opportunity to inform the membership about specific College lobbying efforts directed to ameliorating the negative aspects of managed care.

Offer sessions at the Annual Scientific Session which inform cardiologists about proven strategies for dealing with HMOs, HCFA, and other aspects of the managed care environment.

Offer sessions at the Annual Scientific Session and elsewhere targeted specifically to practicing physicians to give them better practice management knowledge, skills and tools.

Expand the ACC Web site to similarly provide practice management support and tools electronically.

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## THE PRESIDENT'S MESSAGE *continued from page 2*

modification and hypertension detection and treatment. Physicians support, reduced cost and availability of drugs as it leads to improved compliance but we also adhere to the principle that patients need professional advice and treatment to achieve the desired "wellness goals". To do otherwise is a disservice to the patient.

See you in October at the Annual Meeting.

# Clinical Briefs from *Journal Watch Cardiology*

*Journal Watch Cardiology has graciously allowed us to reproduce selected articles from their publication that we feel are of special interest.*

## **C-Reactive Protein and Cardiovascular Risk**

Recent studies have highlighted the importance of inflammation in the pathogenesis of atherosclerosis, and some have emphasized the prognostic significance of plasma markers for inflammation. To assess the association between such markers and cardiovascular risk, these researchers designed a prospective, nested case-control study that involved participants in the Women's Health Study. (The 2 lead authors of the present study are named as co-inventors on a pending patent application for a method of measuring levels of inflammatory proteins in coronary artery disease prediction.)

Among 28,263 postmenopausal women with no previous history of cardiovascular disease or cancer, 122 died from coronary heart disease, suffered nonfatal MIs or strokes, or underwent coronary revascularization procedures during a mean follow-up of 3 years. Then, each case patient was matched with 2 control women of the same age and smoking status. Investigators performed high-sensitivity measures of C-reactive protein (CRP), serum amyloid A, interleukin-6, soluble intercellular adhesion molecule type 1, homocysteine, and several lipids and lipoproteins.

Multivariate analysis (adjusted for other plasma markers, body-mass index, history of hypertension, history of diabetes, and parental history of MI) revealed that the only independent predictors of cardiovascular risk were CRP as measured by a high-sensitivity test (relative risk, 1.5; 95% CI, 1.1-2.1) and the ratio of total cholesterol to HDL cholesterol (RR, 1.4; CI, 1.1-1.9).

**Comment:** The results of this landmark study confirm the prognostic importance of C-reactive protein as a marker of inflammation, independent of information about cholesterol. The next step should be to determine the clinical usefulness of CRP testing from a public health perspective. —**HM Krumholz**

*Ridker PM et al. C-reactive protein and other markers of inflammation in the prediction of cardiovascular disease in women. N Engl J Med 2000 Mar 23; 342:836-43.*

## **Metoprolol for CHF**

The survival benefit of beta-blockade for patients with congestive heart failure has been demonstrated in multiple studies. To test this treatment's effect on other CHF outcomes, investigators at more than 300 U.S. and European sites followed 3991 patients with chronic NYHA class II to IV heart failure and ejection fractions of less than 40% for 1 year.

Patients were randomized to either placebo or once-daily metoprolol CR/XL (25 mg for class II, 12.5 mg for classes III and IV; titrated for 6 to 8 weeks to a target dose of 200 mg).

At baseline, about 90% of patients already were using diuretics and ACE inhibitors; almost two thirds were receiving digitalis. Incidences of the following combined endpoints were lower in the metoprolol group than in the placebo group: total mortality or all-cause hospitalization (risk reduction, 19%); total mortality or hospitalization due to CHF (RR, 31%); death or heart transplantation (RR, 32%); and cardiac death or nonfatal acute MI (RR, 39%).

In addition, metoprolol recipients spent fewer days in the hospital because of heart failure than did placebo recipients (3401 vs. 5303). Finally, quality of life, measured with a McMaster Overall Treatment Evaluation questionnaire, was significantly better among metoprolol recipients.

**Comment:** In this study, supported by the manufacturer of metoprolol CR/XL, patients with NYHA class II to IV heart failure benefited signifi-

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**THE RHODE ISLAND CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY GRATEFULLY ACKNOWLEDGES FINANCIAL SUPPORT FROM THE FOLLOWING CORPORATIONS:**

**GENENTECH, INC.  
GUIDANT CORPORATION  
MEDTRONIC, INC.  
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cantly from the addition of this beta-blocker to conventional therapy. This study adds to a growing body of research supporting beta-blockers as first-line therapy for mild and advanced CHF, and it provides more data about the safety of beta-blockade for very-high-risk patients. —KA Eagle

*Hjalmarson et al. for the MERIT-HF Study Group. Effects of controlled-release metoprolol on total mortality, hospitalizations, and well-being in patients with heart failure: The metoprolol CR/XL randomized intervention trial in congestive heart failure (MERIT-HF). JAMA 2000 Mar 8; 283:1295-302.*

#### **Amiodarone Beneficial for Atrial Fibrillation**

Despite the high prevalence of atrial fibrillation (AF), substantial controversy remains about the best treatment strategies for AF patients. To determine whether low dose amiodarone is more effective than sotalol or propafenone in preventing recurrences of AF, Canadian investigators conducted a multicenter, prospective, nonblinded trial of 403 patients who had suffered an episode of symptomatic AF within the preceding 6 months and had been prescribed long-term antiarrhythmic drug therapy during that period. Pa-

tients were randomized to amiodarone (201) or to either sotalol or propafenone (101 to each).

During a mean follow-up of 468 days, 35% of amiodarone recipients had at least 1 recurrence of AF, compared with 63% of those receiving sotalol or propafenone. Patients assigned to amiodarone had a 57% lower risk for recurrence than sotalol or propafenone recipients, whose recurrence rates were about the same. Mortality was similar across groups, but discontinuation rates were higher among those receiving sotalol or propafenone (46%) than among those receiving amiodarone (34%). Amiodarone treatment was discontinued because of pulmonary abnormalities in only 4 patients (2%).

**Comment:** The results of this important study indicate that amiodarone is much more effective than either sotalol or propafenone in preventing recurrence of atrial fibrillation. The substantial benefit conferred by amiodarone should make it a first-line option for AF patients. However, the short duration of follow-up in this study (about 15 months) leaves unresolved the question of how long-term use of amiodarone affects patients. —HM Krumholz

*Roy D et al. for the Canadian Trial of Atrial Fibrillation Investigators. Amiodarone to prevent recurrence of atrial fibrillation. N Engl J Med 2000 Mar 30; 342:913-20.*

#### **Aortic Valve Replacement for High-Risk Patients with Severe Aortic Stenosis**

Among patients with aortic stenosis, the risks of aortic valve replacement are greatest for those with left ventricular dysfunction and low transvalvular mean gradients. To study the acute and long-term results of aortic valve replacement in this high-risk group, Mayo Clinic investigators examined 52 patients (mean age, 71) with aortic stenosis who underwent the procedure over a 10-year period; all had left ventricular ejection fractions (LVEFs) of 35% or less and transvalvular mean gradients of less than 30 mm Hg.

Mean preoperative data were: LVEF, 26%; aortic valve gradient, 23 mm Hg; and aortic valve area, 0.7 cm<sup>2</sup>. Thirty-two patients (62%) also underwent coronary artery bypass surgery. Of the 52 patients, 11 (21%) died within 30 days of aortic valve replacement.

According to multivariate analysis, smaller aortic prosthesis size was the only predictor of hospital mortality.

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During a median 1.5-year follow-up, 10 more patients died; the overall 3-year survival rate was 62%. Among those patients surviving surgery, 77% had improved by at least 1 NYHA functional class at follow-up. Of the 93% of 30-day survivors for whom LVEF was assessed postoperatively, 74% improved (mean LVEF increase, 8%); LVEF improvement was significantly greater among women than among men.

**Comment:** These results support the contention that patients with severe aortic stenosis should not be denied aortic valve replacement regardless of age, severity of left ventricular dysfunction, or presence of a low transvalvular gradient. Although the perioperative mortality rate was significant in this study, more than 70% of patients experienced marked improvements in symptoms and ejection fractions. —H Calkins

*Connolly HM et al. Severe aortic stenosis with low transvalvular gradient and severe left ventricular dysfunction: Results of aortic valve replacement in 52 patients. Circulation 2000 Apr 25; 101:1940-6.*

#### **Beta-Radiation for In-Stent Restenosis**

Intracoronary radiation with a Gamma-emitter has been shown to reduce recurrent restenosis in stented patients. Beta-radiation reduces restenosis after balloon angioplasty but has not been evaluated previously in stented patients.

The Washington Radiation for In-Stent restenosis Trial (Beta-WRIST)

is a prospective registry designed to test intracoronary catheter-based radiation treatment with the Beta-emitter 90-yttrium for the prevention of recurrent in-stent restenosis. Fifty treated patients were compared with the control group from a previous Gamma-radiation trial (see *Circulation* 2000; 101:2165).

The radiation source was a flexible wire that was delivered through a centering balloon and that remained across the lesion after successful primary therapy with balloon or laser angioplasty, rotational atherectomy, or stent placement.

The dwell time was calculated to ensure delivery of 20.6 Gy. Within 6 months, 17 treated patients (34%) experienced adverse cardiovascular events, including late thrombosis with MI (5 patients) and target-vessel revascularization (17).

Angiographic follow-up on 42 patients revealed border restenosis in 22% and in-lesion restenosis in 34%. The rates for revascularization and restenosis were significantly lower among treated patients than among controls.

**Comment:** The results of this registry demonstrate the feasibility of Beta-radiation for in-stent restenosis and suggest that this treatment may be effective for patients, at least by comparison with historical controls. Nevertheless, the findings will need to be corroborated in a prospective, randomized trial. Finally, the high rate of late thrombosis (with 22% of patients receiving additional stents) is of concern. —HC Herrmann

*Waksman R et al. Intracoronary Beta-radiation therapy inhibits recurrence of in-stent restenosis. Circulation 2000 Apr 25; 101:1895-8.*

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Waltham, MA 02451-1413*

## RIACC Chapter Website Hits

The chapter website had 313 and 383 hits respectively in May and June. The average session duration is approximately 6 minutes.

The website provides information regarding the Rhode Island Chapter and serves as a link to the ACC, RI Department of Health and other useful websites. Future development will include a patient education section. You can visit this website at **RIACC.org**.

# State and National ACC News Briefs

**A health care initiative in Massachusetts** is headed toward a voter referendum this November. The initiative would compel a managed care patient's bill of rights and a requirement that the state move toward a system of universal health care. It would guarantee a patient's choice of provider and second opinions, create prohibitions on incentives to deny care and require health plans to spend 90 percent of revenue on health care services. Meanwhile, legislators are now in conference for the third consecutive year in order to fashion a managed care bill. The Senate conferees, generally tougher on the managed care industry, now appear willing to relinquish a right-to-sue provision.

**Blue Cross and Blue Shield of Massachusetts (BCBSMA)** announced an end to its automatic downcoding policy, which was implemented in February 2000. After meeting with physicians and the leadership of the Massachusetts Medical Society, BCBSMA decided to focus on those physician outliers that account for one third of the claims billed with level five office visits and promised to scrutinize physician claims more carefully. In February, BCBSMA began automatically downcoding level five office visits billed with a minor or non-acute diagnosis codes. BCBSMA will now focus on the small number of physicians that account for a significant portion of the high level visits. A nurse will

contact each physician and discuss the office visit. If you are experiencing automatic downcoding policies by payers in your area contact the Practice Organization and Management Department at 800.253.4636.

## **The ACC's Ohio Chapter**

held its very first state legislative conference. They reported highly successful meetings with their legislators, measured by how receptive the lawmakers were to the issues presented to them. These issues included support for a strong prompt payment bill (soon to be introduced), two bills that include a mandatory point-of-service option (SB 163, HB 584) and opposition to a bill creating a physician profiling system (HB 475). In addition to legislative appointments, attendees had the opportunity to meet and exchange views with Ohio's Health Commissioner and three influential legislators from both the Senate and House health committees.

**A Food and Drug Administration (FDA) panel of experts** recommended against allowing Mevacor® or Pravachol® cholesterol-lowering 'statins', to be sold over-the-counter (OTC).

**HCFA is proposing a number of changes** in the Medicare physician fee schedule for 2001. HCFA estimates no net financial effect on cardiologists from these changes; however, the continued phase-in of practice expense changes will cause a three percent decline in the average

cardiologist's fees. Those declines will probably be offset by an estimated two percent increase for inflation and other factors. Payment changes will vary among procedures and cardiologists who have different practice profiles.

**The College is pursuing a legislative proposal** that would reduce projected cuts to overall cardiology practice expense payments by 1/3 by 2002. Frustrated with the lack of progress the Health Care Financing Administration has made in developing and refining practice expense relative values (PE RVUs), the College is working with nearly 30 medical specialty societies and other associations in seeking a halt in the current four-year transition to a Medicare resource-based relative value system for practice expenses.

## **The Massachusetts legislature**

(<http://www.magnet.state.ma.us/legis/legis.html>) unanimously approved legislation (H 4525) that would give physicians "wide latitude" in determining what constitutes "medical necessity" for their patients. The measure also contains significant consumer protections, creating a state HMO "watchdog" agency, mandating annual HMO report cards, creating an independent review process for patient appeals of HMO decisions and establishing a commission to study the state's uninsured.

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**In Rhode Island, Gov. Lincoln Almond** (R) signed legislation (<http://www.governor.state.ri.us>) that will allow the state to expand and stabilize its RIte Care program for low and middle-income Rhode Islanders (ten percent of the state's population). The measure puts into place reforms in the small employer health insurance market and strengthens financial accountability standards for health insurers in the state.

**United Healthcare (United) of Alabama** has moved to an all-products policy and is terminating contracts with Alabama physicians who participate only in its preferred provider organization. Six hundred specialists and 250 primary care physicians will have their contracts terminated on August 7, 2000, unless an agreement

can be reached. United has stated the use of all-products clauses, which require physicians to participate in all of their products as a condition of participation, are legal in Alabama and that United intends to enforce the use of the provision.

**Medtronic, Inc. has received approval** from the Food and Drug Administration for its Mosaic porcine bioprosthesis heart valve. The Mosaic valve is a reduced-profile valve that incorporates a flexible stent. Medtronic announced that the Mosaic valve will be commercially launched later this year. Medtronic's press release is available on their Web site at <http://www.medtronic.com/news/articles/20000801111209.html>.

**Save This Date:**  
2nd Annual Meeting of the  
RI Chapter of the ACC  
Wednesday,  
**October 18, 2000**  
Metacomet Country Club  
Keynote Speaker:  
**Michael J. Wolk, MD**  
National ACC Treasurer  
Chairman, ACC Task Force  
for the 21st Century  
**Look for your  
invitation in  
the mail!!**

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