

Cardiac Monitor

Welcome New Physicians!



Handel Robinson, MD, is a vascular surgeon joining Mercy Medical Group from University of Miami Miller School of Medicine where he was an Assistant Professor of Surgery in the division of Vascular and Endovascular Surgery. Dr. Robinson is a graduate of Emory University School of Medicine, Atlanta, Georgia.



Punit K. Sarna, MD, is a cardiologist who will be working in the Elk Grove/Big Horn office. Dr. Sarna is a graduate of the University of Southern California Keck School of Medicine, completing his internship and residency at Santa Clara Medical Center. Dr. Sarna is board certified in Cardiac Echocardiography.

Referral Resources

CHAMP®	916.564.2880
Cardiac Rehabilitation	
Mercy General Hospital	916.453.4521
Mercy San Juan	916.537.5296
Sierra Nevada Memorial	530.274.6103
Woodland Memorial	530.662.3961
	<i>ext. 4531</i>
Pulmonary Rehab./Smoking Cessation	
Mercy General Hospital	916.453.4268
Mercy San Juan	916.537.5299
Sierra Nevada Memorial	530.274.6084
Woodland Memorial	530.662.3961
	<i>ext. 4531</i>
Cardiac Education Forum & Support Group	916.453.4521
Heart Shaped Community	916.733.6245
Adv. Heart Disease Clinic	916.453.4768



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WINTER 2017 / FOR PHYSICIANS

New Treatments for Atrial Fibrillation

Atrial fibrillation (AF) is the most common type of irregular heartbeat, affecting an estimated three million Americans. With the aging population, that number is expected to rise to more than 12 million by 2030. AF is becoming the most common reason for hospital visits, surpassing heart failure and heart attack.

The growing prevalence is concerning given that one out of every six ischemic strokes is believed to be related to AF, and a stroke related to AF tends to result in greater disability. These facts have led to increased urgency in the search for more effective treatment options.

Existing Treatment and Care Challenges

The standard of treatment for AF is medication, followed by ablation therapy if indicated; however, the risk of stroke remains a concern. “There is no clear evidence that treatment such as catheter ablation alone can effectively reduce the risk of stroke,” explains Dr. Arash Aryana, Dignity Health Heart and Vascular Institute Electrophysiologist. “Typically those patients then end up on anticoagulants, which is the mainstay in stroke prevention for AF patients.”

For many patients, regulating anticoagulation therapy is challenging. Anticoagulation therapy involves frequent monitoring, dietary restrictions, knowledge of drug interaction, and a risk of bleeding.

As new and innovative therapies have been developed, Dignity Health Heart and Vascular Institute is implementing these effective treatments to reduce stroke risk by offering two new procedures for those living with persistent, permanent AF.

Epicardial/Endocardial Ablation Combination Procedures

For patients who have permanent, persistent AF with structural heart disease, Dignity Health Heart and Vascular Institute is among a few providers to offer a planned, staged approach utilizes the best of the surgical- and catheter-based approach. This procedure involves both Epicardial (surgical) and Endocardial (catheter) ablation. Candidates include patients who have: lived

(Continued on page 3)

Understanding Types of AF

Treatment for atrial fibrillation (AF) is typically dependent on the type of AF.

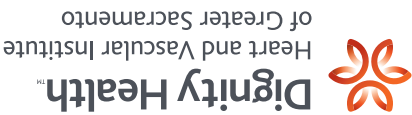
Paroxysmal Atrial Fibrillation:
In paroxysmal AF, the faulty electrical signals and rapid heart rate begin suddenly and then stop on their own. Symptoms usually resolve in less than 24 hours, although they may last up to a week.

Persistent Atrial Fibrillation:
Persistent AF is a condition in which the abnormal heart rhythm continues for more than a week. It may stop on its own, or it can be stopped with treatment.

Both paroxysmal and persistent AF may become more frequent and, over time, may result in Permanent AF.

Patients diagnosed with AF should be evaluated by a cardiologist and/or electrophysiologist.

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Mercy Medical Group Launches AF Study

Dr. P. Gearoid O’Neill

Mercy Medical Group Electrophysiology Department is starting a new research study, SYMPPLICITY-AF (PI: P. Gearoid O’Neill, MD.) The study’s purpose is to investigate the contribution of renal artery denervation (RDN) in preventing atrial fibrillation (AF) recurrence in hypertensive subjects with paroxysmal or persistent AF who are scheduled for pulmonary vein isolation (PVI) with cryoablation.

In previous studies, therapeutic renal denervation has been shown to be an effective means of reducing elevated sympathetic nervous system activity

which is a common and key factor in disease states such as hypertension, heart failure and atrial fibrillation.

Qualified subjects with paroxysmal or persistent AF, systolic blood pressure >140 mmHg treated with at least one anti-hypertensive medication, renal arteries without significant stenosis or aneurysm and adequate length for ablation treatment and no prior renal angioplasty or stenting, eGFR ≥ 30 mL/min/1.73m2, no previous left-sided AF ablation, and no implanted pacemaker, ICD or CRT-D device will be randomized 1:1 to either RDN treatment with the investigational

Symplcity Spyral™ RF renal ablation catheter or to control, no RDN.

All study subjects will have a standard PVI ablation using a cryoballoon, and if randomized to the RDN arm of the study, will have treatment of their bilateral renal arteries during the same procedure. Before leaving the EP Lab a Reveal LINQ monitor will also be implanted in all study subjects (provided at no cost to the subject) for continuous cardiac rhythm monitoring post procedure. Study subjects will be followed for approximately 18-months post-ablation.

News for Antithrombotic Therapy

By James Palmieri, PharmD

Current guidelines* recommend antithrombotic therapy (AT) to prevent thromboembolism in most patients with atrial fibrillation. However, a variety of patient-centric issues dictate how, and even whether, to anticoagulate these patients. Shared decision making between patient and provider increases the likelihood that AT will be successful.

In his article,** Dr. Andrew Freeman reminds us of the variety of patient issues that govern the choices for AT. Things to take into consideration in addition to thromboembolic risk include cost, transportation issues, language and cultural barriers, health beliefs, frailty, renal and hepatic function and concomitant drug therapy, among others. The guidelines are only the beginning of the story.

As with evidence-based guidelines that recommend clinical decision making, Dr. Freeman makes the point that our clinical training and judgment should only guide the patient choices to be made and that it is a shared decision between patient and provider that will lead to the best possible outcome. For those patients who are ambivalent, education of the pros and cons of treatment delivered in a language that the patient understands is essential, as are goal setting, motivational interviewing, and a patient-specific monitoring mechanism.

In one view, it may seem that the pendulum is beginning to swing away from a reliance on guidelines to provide target indicators for successful outcomes. In fact, consensus guidelines remain an important starting point for patient-centered care. The patient-centered approach is an evolution in population-based medical management that encourages patient self-management and patient-provider communication, and promotes success.

*Journal of the American College of Cardiology. 2014; 64:2246-80.

** American College of Cardiology, Latest in Cardiology. “Patient-Centered Anticoagulation: Are You Getting the Best Results?” By Andrew M. Freeman, MD, FACC (October 3, 2013), (accessed 7/24/16)

Cardiac Rehab: Class 1 Indication

Medicare has revised its criteria for referral to Cardiac Cardiac Rehabilitation, making it a Class I indication for Myocardial Infarction; PCI; CABG; chronic stable angina; and chronic systolic heart failure.

Criteria for coverage of cardiac rehab for heart failure includes:

- Left ventricular ejection fraction < 35%
- NYHA class II-IV symptoms despite being on optimal heart failure therapy for at least 6 weeks
- Stable: no recent or planned major cardiovascular hospitalizations or procedures

American Association of Cardiovascular and Pulmonary Rehabilitation reports that cardiac rehab benefits include reduced mortality; reduced readmission rates; and improved quality of life.

Atrial Fibrillation Treatments (continued from first page)

with AF for many years; structural heart disease; enlarged or growing left atrium (>4.5 cm); failed other AF treatments; persistent, long-standing persistent, or permanent AF.

This planned, staged approach starts with the surgeon using a minimally invasive approach to perform an epicardial ablation to the back wall of the left atrium. The patient is then monitored to determine if the ablation resolved the AF. If not, the next step is for the electrophysiologist to perform an endocardial ablation via via catheter to eliminate any remaining abnormal electrical impulses.

Most patients experience normal heart rhythm following this planned, staged approach and are able to stop taking some daily medications.

The Epicardial/Endocardial Combination procedure combines the best techniques of both cardiac surgeon and electrophysiologist, with a minimally invasive approach that allows for shorter hospital stay and quicker recovery time.

Watchman Procedure

Finding an AFib treatment that can eliminate the need for anticoagulation therapy has long been a priority. Looking ahead to the near future, the Watchman® Left Atrial Appendage (LAA) Closure Technology device offers a viable AFib treatment option with excellent potential for stroke prevention (comparable to warfarin). With an implant success rate of 95%, Watchman is the only FDA-approved LAA closure device that safely and effectively reduces stroke risk in patients long-term.

The Watchman is a catheter-delivered implant designed to close the left atrial appendage. The umbrella-like device is permanently placed in the opening of the LAA to prevent blood clots from exiting and entering the bloodstream, reducing the risk of stroke and, over time, allowing patients to stop taking anticoagulants. In clinical trials, 92% of patients were able to stop taking warfarin at 45 days and 99% stopped at one year after the Watchman procedure.

The Watchman is performed under local or general anesthesia in the cardiac/hybrid catheterization lab. The procedure takes about an hour and requires an overnight hospital stay.

The Watchman device is indicated for AF patients who:

- Are at increased risk for stroke and systemic embolism based on CHADS2 or CHA2DS2-VASc scores and are recommended for anticoagulation therapy;
- Are deemed by their physicians to be suitable for warfarin; and
- Have an appropriate rationale to seek a non-pharmacologic alternative to warfarin, taking into account the safety and effectiveness of the device compared to warfarin.

Physicians Travel the World in 2016

Dignity Health Heart and Vascular Institute physicians traveled the globe in 2016, seeking to educate themselves and, often, helping to train others on the latest innovations in heart care. Dr. Arash Aryana presented original research on VT ablation in Brazil (pictured top, far right). Dr. Michael Chang (middle photo, second from left) served as a proctor for a team of physicians in Japan learning the TAVR procedure. Dr. Frank Slachman (bottom photo in blue gown), visited several cities in China, educating physicians on valve repair and replacement.

