

Sea Changes in Cardiology Practice Predicted

With technological advances, primary caregivers will manage increasingly complex cardiology patients.

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NEW ORLEANS — In coming years, technologic advances will allow primary care physicians to function more and more like cardiologists—and to take over some aspects of traditional cardiology practice, Douglas P. Zipes, M.D., predicted at the annual meeting of the Heart Rhythm Society.

This turf reconfiguration will likely come about due to looming technologic advances, including genomic screening for susceptibility to sudden cardiac death, non-invasive mapping of the heart to pinpoint the site of ventricular tachycardia or accessory pathways, noninvasive autonomic imaging of sympathetic enervation of the heart, and vagal imaging of the ventricle.

The primary care physician caring for a patient with, say, chest pain, will be able to order these noninvasive tests much like ordering a chest x-ray. Armed with the results and with detailed practice guidelines, this physician will probably be able to manage an increasing number of patients without need for cardiology referral, according to Dr. Zipes, former president of the Heart Rhythm Society and the American College of Cardiology.

"In the future, this may well affect the

whole paradigm of how we take care of patients. We've seen some of this already in cardiovascular surgery, as we the interventional cardiologists or electrophysiologists have usurped the cardiothoracic surgeons by our use of catheters for electrophysiologic studies and stenting," said Dr. Zipes, distinguished professor emeritus of medicine, Indiana University, Indianapolis.

Cardiologists needn't worry, though; they have job security well into the indefinite future. That's because with the aging of the American population, the prevalence of three major forms of cardiovascular disease—atrial fibrillation, heart failure, and sudden cardiac arrest—is expected to at least double in the next 25 years. There will be plenty of work for all, he continued.

Among his other provocative predictions for arrhythmia management over the next 5-10 years, and in some cases beyond, were:

► **A fork in the road for implantable cardioverter defibrillators.** For years, ICDs have been growing more complex. That

will continue. Some will soon be capable of monitoring comorbid conditions such as heart failure, diabetes, and atrial fibrillation. But payer pressures will force device manufacturers to also offer very simple bare-bones ICDs.

"We're at a branch point with implantable devices. In the future, one size will no longer fit all." Dr. Zipes said.

► **More remote patient management.**

All of the major implantable device manufacturers have developed their own proprietary systems for remote patient monitoring and de-

vice reprogramming. "I call this the outpatient coronary care unit, where we'll be able to manage arrhythmic conditions and comorbidities and have access to continuous monitoring data."

► **Noninvasive arrhythmia ablation.** Gynecologists have blazed the trail here. The Food and Drug Administration-approved Exablate 2000 employs MRI together with focused ultrasound for noninvasive surgical ablation of uterine fibroids. Something similar will surely be developed for ablation of arrhythmogenic foci in patients at risk for sudden cardiac death.

► **The biologic pacemaker.** This sort of cell-based therapy faces numerous hur-

dles, both political and scientific, but it's coming eventually for survivors of sudden cardiac arrest.

► **Novel neurostimulation-based antiarrhythmic therapies.** Dr. Zipes and his associates recently documented a major reduction in ischemic ventricular arrhythmias with thoracic spinal cord stimulation in dogs with healed MI and superimposed heart failure.

Thoracic spinal cord stimulation applied by a device implanted next to the spinal column is already FDA approved for treatment of chronic refractory back pain. It's also under active investigation for refractory angina, an application where it shows considerable promise. The Indiana investigators reasoned that modulation of spinal cord activity could also curb ventricular arrhythmias.

And indeed it did. They showed in the dog model that this kind of spinal cord stimulation increased vagal and reduced sympathetic activity to the heart.

Similarly, Dr. Zipes and his associates recently analyzed the cardiac electrophysiologic effects of intrathecal clonidine, another novel therapy for chronic pain. Clonidine is an α_2 -agonist that works centrally and at the spinal cord level to reduce sympathetic activity. The investigators showed intrathecal clonidine also decreased sympathetic activity to the myocardium, significantly reducing in ischemia-related ventricular arrhythmias in dogs. ■

The 'outpatient coronary care unit' will allow us 'to manage arrhythmic conditions and comorbidities and have access to continuous monitoring data.'

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