Canadian Cardiovascular Congress

Co-hosted by the
Canadian Cardiovascular Society and the
Heart and Stroke Foundation of Canada

PLEASE PLAN TO ATTEND

SUNDAY, October 26

12:00 - 13:30 Workshop
THE CHALLENGES OF INTEGRATING PALLIATIVE CARE INTO HEART FAILURE CARE (Room 714 A)

12:00 - 14:00 CANADIAN JOURNAL OF CARDIOLOGY SYMPOSIUM
Risk Prediction in Cardiovascular Disease - Current Status and Future Challenges (Room 716 AB)

14:00 - 16:00 CCC OPENING CEREMONIES AND HSFC LECTURE
The Gender Gap in Cardiovascular Disease
(Hall F, Level 800)

16:30 - 18:00 JOINT CCS/ACC SYMPOSIUM - HOT TOPICS IN CCS HEART FAILURE (Room 716 AB)

16:30 - 18:00 MEET-THE-EXPERTS SESSION
Primary PCI: Treatment Delays, Adjunctive Therapies and Optimal Care Before, During and Immediately After the Procedure (Room 714 B)

SATURDAY, October 25

"Reshaping the Future of Atrial Fibrillation Management"
Saturday, October 25, 14:30-16:30, Room 718 AB

"Management of High-risk Patients:
Recent Advances and Clinical Implications"
Saturday, October 25, 18:00-21:00, Room 701 AB

SUNDAY, October 26

"The CV Show: Expert Insights into Atherosclerotic Vulnerability in the Vulnerable Patient"
Sunday, October 26, 7:00-9:00, Room 718 AB

"New Concepts in Acute Coronary Syndromes:
Beyond 2000 (XIV)"
Sunday, October 26, 8:00-12:00, Hall G (Level 800)

"Fourth Annual Medical Debate in Lipid Management—
Meeting the Challenge of Evolving Evidence"
Sunday, October 26, 10:00-12:00, Room 718 A

"Managing Cardiovascular and Metabolic Challenges:
Treatment Strategies for Cardiovascular Risk Reduction"
Sunday, October 26, 18:00-21:00, Room 701 AB

MONDAY, October 27

"Improving Outcomes with Antiplatelet Therapy: Practical Applications from New Research"
Monday, October 27, 7:00-9:00, Room 701 AB

WEDNESDAY, October 29

"Expert Opinion: Current Issues in Cardiology"
Wednesday, October 29, 7:00-9:00, Room 701 AB

Medical Education Network

INFO-*Cardio*, the official newspaper of the CCC, is made possible through collaboration of industry partners.

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INFO CARDIO

REGISTRATION ISSUE
Saturday / Sunday Edition
13th Anniversary of the Official Newspaper of the Annual Canadian Cardiovascular Congress
October 25-29, 2008 / Toronto, Ontario

Welcome to Toronto!

HSFC lecture: excess CVD mortality in women

There is an excess of 50,000 deaths from cardiovascular disease (CVD) each year among US women compared to men, an alarming fact which must give members of the CVD community pause.

"We have made progress in this disease," acknowledges Dr. Susan Bennett, Director, Women's Heart Program, George Washington University Hospital, and this year's Heart and Stroke Foundation of Canada lecturer. Dr. Bennett is addressing a key theme at this year's Congress—CVD in women. Unfortunately, men seem to have gained the "lion's share" of these benefits, as disproportionate numbers of women with the same disease seem to be stalled along that line of progress.

Dr. Susan Bennett

For example, 38% of women who survive their first myocardial infarction (MI) die within one year of the index event compared with 25% of men. Almost twice as many women at 35% who survive their first MI will have another within six years compared with 18% of men, and more than twice as many women at 46% who survive their heart attack will be disabled with heart failure within six years vs. 22% of men. Women are also almost twice as likely to die as men following bypass surgery.

Gender differences may be unavoidable—women are older when they develop CVD; they experience more diabetes and heart failure—but it may also reflect the fact that women with CVD are not treated as aggressively as men.

In the Nurses' Health Study, for example, only 3% of the entire cohort had all of their CVD risk factors "lined up" and at target, as Dr. Bennett points out. It has also been shown that decision-making seems to be slower when women present to the emergency with symptoms suggestive of an MI and they undergo the necessary tests somewhat later than men. "Once they get to the cardiac catheterization laboratory, they get reasonably good care," Dr. Bennett observes, "but mortality rates among women are still far higher than they are for men."

It is unclear whether women respond as well to CV medications known to help prevent events as men, or whether they are at greater risk for adverse events. Aspirin, for example, does not appear to confer the same degree of protection against subsequent events in women as it does in men, while the GP IIb/IIIa inhibitors, a boon in acute coronary care syndromes, may similarly not benefit women as much as men, and may in fact pose a greater risk for women than for men.

Physicians themselves are also implicated in the perpetuation of this gender gap. As Dr. Bennett observes, "Gender plays a huge role in how we think and a lot of it is unconscious." In her opinion, physicians frequently underestimate a woman's risk for CVD and their perception of women being at low risk leads to inaction: uncontrolled hypertension, high cholesterol levels and lifestyle changes that are not emphasized enough.

Moreover, clinical trials still under-represent women to a considerable degree. In Tsang et al.'s study to be reported here (Abstract 980), women represented 29% of randomized controlled trials (RCTs) in coronary artery disease, 25% of those in heart failure, 34% of RCTs in arrhythmias and 61% in prevention trials. When results are in and a new drug or device is deemed advantageous, results may not apply to women because they typically make up such a minority of the clinical trial population that no solid conclusions could be drawn, as Dr. Bennett suggested.

"Not all drugs work the same in men and women but we don't know enough about these differences to exploit their advantages or disadvantages," Dr. Bennett remarked. "We need to change how we think about this because gender is here to stay." ❑

2008 Congress bigger, better, greener than ever

A bigger and better-than-ever Congress is anticipated this year, with expectations that some 4,000 delegates will register for the 2008 premier cardiovascular congress in Canada.

"We now have 19 participating member societies at the Congress, with groups ranging from specialty societies such as the Canadian Heart Rhythm Society to the Association des cardiologues du Québec," reveals CCS CEO Ann Ferguson, "and all of the members have contributed to the programming and have a presence at the meeting." Listening to delegate feedback in part explains the ongoing popularity of the CCC. In response to delegates' requests for more interactive sessions, the program has boosted the number of workshops and interactive sessions to some 28 in total.

The program also features sessions called "Clinical Connections" where relevant science is interpreted by experts as it applies to clinical practice. Delegates are also encouraged to participate in the many satellite symposia (some 18 in all) sponsored by industry and which can be counted on for the high quality of the science presented by experts in their field as well as their clinical applicability.

Ann Ferguson

The CCC is also proud to "go green" this year, not only by providing 100% on-line registration capacity, but also by offering a "mixed-source" final program (stamped by the FSC) from well-managed forests, controlled sources and recycled wood or fibre. Here at this year's meeting venue, the Metro Toronto Convention Centre already offers green services such as expanded paper recycling, biodegradable dishware, Bullfrog Power from renewable energy resources, a green roof, food bank donations, and geothermal heating and cooling systems.

Of course, the Community Forum and the CCS booth itself will again provide delegates from different member societies a cozy place to meet and mingle and talk about professional and private issues—and obtain access to the Internet—within the Forum itself. "There is a lot of connecting going on, about things that are important to a person's professional career and for which you need help and guidance," remarks Ferguson. "So it's a great meeting point; it allows young trainees to meet a mentor and it's a great opportunity for the young and the more experienced to highlight their work. Plus it's nice to see a face in the crowd you know." ❑

Access to Care Workshop: acknowledging improvements in CV care delivery

Dr. Blair O'Neill

Ontario, Nova Scotia and Alberta will be singled out as key provinces where significant improvements in delivery of cardiovascular care have been made in the "Access to Care" workshop spearheaded by Dr. Blair O'Neill, Dalhousie University.

The Canadian Cardiovascular Society has already published benchmarks for access to care along the continuum-of-care spectrum from symptom onset to rehabilitation. "We think we've had tremendous success with our benchmarks," Dr. O'Neill told INFO-*Cardio*, "but we would like to see them adopted by each and every province."

In a recent rating of which province best serves the Canadian healthcare consumer, Ontario emerged as the clear winner, leading by a large margin in the successful provision of primary care. It also ranked first for the level of service provided and placed above average for medical outcomes. British Columbia came in second in the same survey, but when it comes to the delivery of cardiovascular care, Nova Scotia has made major progress meeting CCS benchmarks, confirmed Dr. O'Neill. Alberta, too, has been involved in a very ambitious project to use navigators in the regional districts throughout the province to improve access to cardiovascular services.

Innovative strategies implemented by each province will be discussed by various speakers so as to serve as examples for others to follow suit. For example, the Cardiac Care Network in Ontario has offered the rest of the country a model of how to stratify patients according to need for interventions such as cardiac surgery and cardiac catheterization.

It has also provided patients with alternative centres with shorter waitlists if the jurisdiction they are in has a longer wait time, added Dr. O'Neill. Nova Scotia in turn has had a measure of success in achieving its benchmarks and in the transparency of their reporting along with moving significant numbers of patients through referral processes.

"The focus of the workshop is to identify best practices across the country and use them as examples in other districts so that other districts can adopt the same measures and improve their own benchmarks," stated Dr. O'Neill. ❑

Aboriginal Heart Health: holistic and Western medicine for women at risk

Think "heart" when a woman of Aboriginal origin or descent presents with symptoms a healthcare professional might otherwise attribute to indigestion or a hiatus hernia because of her youth.

"One of the themes of this year's Congress is women and cardiovascular disease," Denise Newton-Mathur, RN, Assistant Professor of Nursing, Laurentian University, Sudbury, tells INFO-*Cardio*. Newton-Mathur herself is an Odawa/Ojibwe Métis.

Unfortunately, few if any other cultural group rivals the risk that Aboriginal women have for gestational diabetes, type 2 diabetes, and premature heart disease as a consequence of both. Contributing factors are legion and highly nuanced but they begin with a genetic predisposition to diabetes. Whether they are First Nation, Métis or Inuit, Aboriginal people are more likely than most to inherit the so-called "thrifty gene" that predisposes them to store more fat from fewer calories than those without the gene. As a consequence, results from the Inuit Health Survey to be presented during the Congress are fairly predictable: almost half of some 929 participants without cardiovascular disease (mean age 32.4 years) at the time of the survey had a BMI in excess of 30/kg/m^2. Aboriginal women also tend to start reproduction early and may have multiple births in their young lifetime. During each of these pregnancies, they are at increased risk for gestational diabetes, a well-known precursor for type 2 diabetes in subsequent years.

Compounding their risk are socioeconomic factors as young mothers on social assistance try to feed their children—and themselves—on very little money. "The cost of living in many Aboriginal communities, especially those in northern and remote areas, is extremely high," as Newton-Mathur observes, "and a lot of the time, the only food you can afford to feed your children (and yourself) is Kraft dinner and Klik" (canned luncheon meat). Small wonder that exhortations from public health officials to eschew junk food are met with incredulous responses.

There is also a profound disconnect between what Aboriginal people need to help them stay the course of a prescribed regimen and what Western medicine historically has offered them. As Newton-Mathur explains, the Aboriginal model of holistic health—referred to as "the Medicine Wheel"—involves balance in all things mental, emotional, physical and spiritual. The Western model concentrates on the physical: this is what you have; this is what you have to do to take care of it. This is not sufficient for Aboriginal patients, as it neglects elements Aboriginal people feel are necessary for their journey towards better health. "When you are treating Aboriginal people, you can't just talk about the disease, you have to address all four aspects of the Medicine Wheel with them," Newton-Mathur stresses.

Fortunately, the Aboriginal model of holistic health is now being incorporated into some health care clinics for Aboriginal people and care is beginning to be provided by not only Western health care practitioners but by traditional healers as well. "Traditional healers look at not only what is going on physically, they also look at everything holistically and try to bring all of the elements back into balance," observes Newton-Mathur. ❑

Extending the CCC experience beyond the meeting a key priority for the CCS

Extending the experience of the Canadian Cardiovascular Congress (CCC) beyond the meeting itself has become a key priority for the Canadian Cardiovascular Society (CCS), in recognition that too much work goes into the meeting each year for it to be forgotten after only a few days.

"We estimate that we put in hundreds if not thousands of hours of work into preparing the meeting and abstracts and presenting it all, and it would be a shame if all that work just lasted for four days," states CCS incoming President Dr. Charles Kerr, University of British Columbia. So a "very high priority" for the CCS has been to try to re-package as much material as possible that was central to the meeting into other formats and venues so that it is available to members after the meeting.

For example, Dr. Kerr foresees ongoing enhancement of the CCS Web site as a vital portal for physicians to access educational resources. "We'd also like to have interactive sessions out of the congress available for viewing all year round," he added.

Dr. Charles Kerr

There are of course other whole areas of knowledge transfer that the CCS also organizes, but the Congress is the single most important event, as members of the CCS are aware, because it is the ideal venue to meet, plan and share professional concerns as well as research interests.

The CCS has not traditionally been involved in advocacy, as Dr. Kerr pointed out. Now, however, he would like to see the CCS strengthen their position in three principal areas. Among these are wait lists and access to care, now under the able mantleship of CCS Vice-Present Dr. Blair O'Neill, Dalhousie University. The CCS has already developed standards for access to care which have been implemented well in some parts of the country: the real challenge is to effectively apply these in all regions of Canada—a task that may seem Herculean but which is one of the key goals for the new CCS President.

The other main area where the CCS sees itself playing an advocacy role is in human resources. Outgoing CCS President Dr. Lyall Higginson, Royal Jubilee Hospital, Victoria, has a profound interest in this area and Dr. Kerr will be soliciting his help for the critical task of making sure not just cardiologists and cardiovascular surgeons receive adequate training but also in securing more permanent funding for subspecialists such as interventionalists, electrophysiologists, perfusion technologists and cardiovascular nurses. "We need funding and training at all levels," he emphasized, "and we need to advocate for more training positions." As Dr. Kerr points out, the CCS was instrumental in the development of the Heart Health Strategy. (Please note that there will be no update on the Heart Health Strategy at the CCC this year because of the federal elections.) Both Dr. Higginson and Dr. Eldon Smith, University of Calgary, have been stalwarts behind this extremely important platform right from the start, as Dr. Kerr indicated, and work will continue on it once the elections are over and government positions are confirmed.

"The Heart Health Strategy is not just about the delivery of health care, it's about prevention of cardiovascular disease, end-of-life issues and Aboriginal issues. It's a very broad-spectrum initiative and the CCS can play a role in identifying key individuals who may help with this collaborative initiative and advocate on its behalf," Dr. Kerr stated. ❑

Joint CCS/ACC Symposium: comprehensive heart failure management

All that needs to be addressed in the comprehensive management of heart failure is promised for delegates attending the joint Canadian Cardiovascular Congress (CCS)/American College of Cardiology (ACC) symposium.

Dr. James Young, Chair, Department of Medicine, Cleveland Clinic Foundation, Ohio, will update delegates on new medications that may better address hyponatremia in heart failure, as well as drugs that act on new pharmacologic targets now in the pipeline. There is also the brave new device world, novel mechanical circulatory support devices and ventricular assist devices in particular, that help stabilize patients hemodynamically until they are able to undergo transplantation, or even "destination devices" that are permanently inserted.

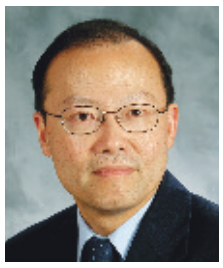
"There is also controversy about disease management programs as they relate to heart failure, in that they probably don't work," Dr. Young told INFO-*Cardio*. He suggests this may have more to do with the way clinical trials are designed, as they may well be confounded by issues such as patient selection and outcomes trialists choose to measure. "It's the same rubric with virtually every sort of clinical trial, not just the ones in heart failure," Dr. Young observes, "but since some studies do show the programs impact outcomes, we need to take a closer look at this."

Dr. Peter Liu, Heart & Stroke/Polo Chair Professor of Medicine, University of Toronto, will turn his attention to the challenging problems physicians face in the diagnosis and management of diastolic dysfunction. "We always thought systolic heart failure was the dominant form of heart failure, but now with the aging population, diastolic heart failure or heart failure with small hearts is becoming the dominant form," he explained. Unfortunately, there is little information about either the diagnosis or the treatment of diastolic heart failure, and consequently, it is likely unrecognized to a significant degree, he added.

At least physicians are aware of the major causes of diastolic heart failure—age, diabetes and hypertension key among them. Especially in the context of diabetes, diastolic heart failure is a "high-risk situation," as Dr. Liu indicates, and if patients sustain a myocardial infarction, "they end up with worse outcomes and more renal failure as well." Treatment strategies for diastolic heart failure are similarly more challenging than they are for systolic heart failure, "which is why it is important for us to look at the pathophysiology of diastolic heart failure that may help us treat it better," Dr. Liu stated.

Dr. Marc Pfeffer, Professor of Medicine, Harvard Medical School, Boston, will examine the relationship between heart failure and chronic kidney disease (CKD). As discussed by Dr. Dirk J. van Veldhuisen, University of Groningen, The Netherlands, during a heart failure session at the European Society of Cardiology meeting in 2006, heart failure can lead to renal dysfunction. Conversely, severe renal disease can cause end-organ damage, left ventricular hypertrophy (LVH) in particular; often, the two morbidities occur together. For example, as Cheung et al. reported (*Kidney Int* 2004;65(6):2380-9), 40% of one group of hemodialysis patients had heart failure. In advanced heart failure, another group reported that the mortality risk in those with a glomerular filtration rate (GFR) of <44 mL/min/1.73 m^2 was dramatically higher than it was for patients with a GFR between 59 and 76 mL/min/1.73 m^2 or higher (Hillege et al. *Circulation* 2000;102(2):203-10). Even patients with mild heart failure and impaired renal function have a greater risk of death over time than those whose kidney function is better preserved (Smilde et al. *Am J Cardiol* 2004;94(2):240-3).

Dr. Heather Ross



Dr. Peter Liu

In a study under lead author Dr. Hans Hillege, also from the University of Groningen, Dr. Pfeffer and colleagues reported CKD increased mortality risk, cardiovascular death and hospitalization for worsening heart failure for those with both a reduced and a preserved left ventricular ejection fraction (LVEF) (*Circulation* 2006;113:671-8). Using data from the CHARM study, investigators found that reduced GFR and LVEF were both significant independent predictors of worse outcomes at a median follow-up of 34 months, and that the risk for cardiovascular death or hospitalization for worsening heart failure, as well as for all-cause mortality, increased significantly once GFR fell below 60 mL/min/1.73 m^2.

Dr. Heather Ross, Associate Professor of Medicine, University of Toronto, will address the urgent need for physicians to attend to end-of-life directives with their heart failure patients, as prognosis in advanced disease is grim. As Dr. Ross related to INFO-*Cardio*, approximately half a million Canadians have heart failure at any given time, while about 10% of the heart failure population has advanced disease. "This means that approximately 50,000 Canadians have advanced heart failure across the country," she noted. With a generous estimate of 200 heart transplants being carried out each year in these patients and insertion of mechanical devices in perhaps another 50, "49,750 patients with advanced heart failure have no opportunity for life-saving interventions and in that group of patients, mortality at six months is 50%," she reports.

Most patients with advanced heart failure are not eligible for any potentially life-saving interventions. Consequently, the majority of this patient population will die from it soon. Unless physicians choose to skip critical elements of patient care, they have no alternative but to address issues surrounding end-of-life care, including advanced-care directives. For these directives, several elements must be considered. Firstly, patients need to identify a substitute decision-maker so that the he or she can direct the patient's care when they themselves are no longer capable.

"You're also looking at a living will," Dr. Ross explains, "and together with the substitute decision-maker, patients also need to communicate this plan within their family and to the health care team so that they don't end up receiving care they wouldn't have wanted." It must be noted that the majority of palliative care right now is devoted to cancer patients. Yet as Dr. Ross observes, cancer only accounts for about 25% of the deaths in Canada, indicating a very large care gap that governments will need to address as a growing number of aging patients develop heart failure.

Dr. Ross concludes that there is a "critical need for communication and education" between physicians and patients, as in her own experience, patients frequently do not remember they have had an end-of-life discussion with their physician even when discussions have been documented—"a clear signal that some of the messages are not being heard," Dr. Ross confirms. ❑

THE Heart

Truth campaign: take CV risk to heart and wear red!

The Heart Truth campaign comes to the Congress this year dressed in symbolic red, a reminder that women need to take their personal risk for heart disease more seriously.

With the meeting this year being dedicated to cardiovascular disease (CVD) in women, The Heart Truth campaign, led by the Heart and Stroke Foundation of Canada (HSFC), fits in perfectly. The campaign is aimed at educating women about their risk for heart disease as well as warning signs of a myocardial infarction and stroke. Healthcare providers are also invited to become "Heart Truth champions" and educate women and other healthcare professionals in their community about heart health risks in women.

As the HSFC notes, one in three women in Canada will die of heart disease and stroke, more than all cancers combined. Yet many women are unaware that they are at personal risk for heart disease and stroke, a terrible oversight as women as well as men can reduce their risk for CVD by as much as 80% with lifestyle changes alone. The red dress is the national symbol of the Heart Truth campaign, a sign of women's courage and passion as they empower themselves and spread the word to raise awareness about the importance of heart health.

During the meeting, delegates will find signs of the Heart Truth campaign in many places, including the following:

A Red Dress display area in the Community Forum will showcase dresses created by top Canadian designs and modelled by Canadian celebrities.

Heart Truth champions Dr. Beth Abramson, Dr. Sonia Anand, Dr. Karen Humphries, Sally Brown (CEO of the HSFC) and Bobbe Wood (President and CEO, Heart and Stroke Foundation of British Columbia and Yukon) will deliver information presentations at the Red Dress display. Some of the same participants will lead the workshop entitled "The Heart Truth: Cardiovascular Disease Is a Woman's Disease (Too)."

The HSFC has invited 500 people to its public event which has a Heart Truth theme. Monday, October 27, is Wear Red Day at the Congress. There will be a Heart Truth table at the Convention Centre where people may make a donation to the campaign in exchange for a red tie or a pashmina, a Red Dress pin or mug.

The Toronto Fun Night has a Wear Red theme and will invite attendees to share the heart truth in their communities. ❑

Have-a-Heart Bursary program brings talented recipients to Toronto

Fifteen talented young recipients will be making their way to Toronto from across the country to indulge in as much cardiovascular science as they wish, thanks to the Canadian Cardiovascular Society Academy (CCSA) Have-a-Heart Bursary program.

"The Academy is a charity whose membership is the same as the membership of the CCS, it's just administratively separate from the CCS," Dr. Robert Howard, University of Toronto, explained to INFO-*Cardio*. Their mission is to promote education among young people interested in a career in the cardiovascular sciences, he added. For example, applicants may already be in an undergraduate program at university or they may have just started to do research in a Masters program. Applicants must submit a formal application to the Have-a-Heart Bursary program accompanied by their CV and reference letters.

Out of 50 to 70 applicants each year, 15 are ultimately selected and are invited to attend the CCC, all expenses paid. "They meet each other, of course, and spend time together and exchange experiences, and we introduce them to mentors—staff scientists or clinicians—who might be relevant to them as well," relates Dr. Howard. The Academy also keeps track of bursary recipients once they return to their respective studies. Fortunately, many do go on to have a career in cardiovascular medicine—"so we think the program works and it's enormously popular," he notes.

Like all charities, the Academy is now moving into fundraising activities and hoping that interested CCS members will consider making a donation so that they can keep the program going. (In fact, anyone who is interested can go to the CCS Web site and click on the Academy button and make a donation on-line). Depending on where the meeting is held, the program costs the Academy between $30,000 and $35,000 a year.

This year's recipients are: Ms. Stephanie Borris (Woodstock, ON); Ms. Delaine Cehols (Edmonton, AB); Ms. Maryam Elmi (Richmond, ON); Dr. Kristia Filion (Montreal, QC); Mr. Alon Hendel (Burnaby, BC): Dr. Mohamed Kodiha (Montreal, QC); Mr. David Lin (Richmond, BC); Mr. Cristian Linte (London, ON); Ms. Fang Liu (Montreal, QC); Ms. Christina Luong (Edmonton, AB); Mr. Madhur Nayan (Brossard, QC); Prof. Marlene Shehal (Ottawa, ON); Dr. Petsy So (Toronto, ON): Mr. James Thacke (Ottawa, ON); and Ms. Yan Zhang (Ottawa, ON).

Throng to be wooed, entertained on Toronto Night

Plan to be seduced by the Three Young Tenors as they kick off the CCC's Toronto Fun Night, to be held Monday evening starting at 7:30 pm at Heritage Court.

Recently graduated from the Glenn Gould School of Music, Royal Conservatory, Toronto, Michael Ciufo, Salvatore Gambino and Darrell Hicks debuted as the Three Young Tenors during their first year of studies when the school brought them together for a big fundraiser. "We were all from the same school, in the same year and (attended) the same classes and we are all friends and we just gelled," Ciufo told INFO-*Cardio*. Singing in their own distinct blend of voices, the group relies on largely classical selections taken from opera, operetta and traditional folks songs, he added.

Following their performance, delegates will be regaled with a selection of specialty dishes from different districts of Toronto which represent the diverse ethnicity of the city. After dinner, comedian Sean Cullen—recently featured on "Last Comic Standing"—will treat attendees to his novel style of stream of consciousness, mimicry and genuine musical talents.

Then the evening will get down with the Descendants featuring the CCS's own Dr. Heather Ross, lead singer of The Marginal Donors and a great asset to any band.

Get your tickets and get ready to rock!

Canadian Journal of Cardiology Symposium: focus on CVD risk prediction

Topical and relevant discussions on risk prediction in cardiovascular disease (CVD) will unfold during the *Canadian Journal of Cardiology* Symposium, co-sponsored by the CCS and the publishers of the journal, Pulsus Group Incorporated, and presented in co-operation with the Libin Cardiovascular Institute of Alberta, University of Calgary. The lineup of subjects to be covered is one that community cardiologists should recognize as pertinent to many patients seen in daily practice.

For example, Dr. Bruce McManus, University of British Columbia, will present an overview of biomarkers and their ability to predict the risk of an individual either developing CVD or, once developed, their risk of progression. Symposium co-chair Dr. Todd Anderson, University of Calgary, in turn will be examining endothelial dysfunction and its role as a surrogate marker for disease risk and prognosis, while Dr. Merril Knudtson, Libin Cardiovascular Institute of Alberta, will be looking at both predictors of risk for coronary artery disease as well as how to select the most appropriate treatment strategy.

Dr. Derek Exner, also of the Libin Institute, will address the risk of sudden cardiac death, a very definite challenge for cardiologists today and what they might learn from the electrocardiogram, patient history and analyses of rhythm disturbances. "We know that if you have a myocardial infarction, the mortality risk is relatively low per year, but of those who do die of their disease, about half die of sudden cardiac death due to arrhythmia, so this is a very topical issue," co-chair Dr. Eldon Smith, University of Calgary, told INFO-*Cardio*. "I think it will be an excellent symposium and highly applicable to daily practice for cardiologists." ❑

CCC 2008 INFO-*Cardio* is published by Medical Education Network Canada Inc. for the annual meeting of the Canadian Cardiovascular Congress. The purpose of INFO-*Cardio* is to promote events organized by the CCC, and to bring delegates closer together by fostering a sense of community spirit at the meeting. Your comments/suggestions are welcome. Contact us at mednet@mednet.ca or www.mednet.ca