HEART RX CAIRNS

The Murmur

What's new in Cardiology

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Dr Tim Carruthers
Consultant Cardiologist

Dr Greg Starmer
Interventional Cardiologist

Dr Shane Preston
Interventional Cardiologist

Dr Sam Hillier
Imaging & Consulting Cardiologist

Dr Ben Reeves
Paediatric Cardiologist

Dr Ram Saireddy
Interventional Cardiologist

PRACTISING

Clinical Cardiology

Transoesophageal Echocardiography

Echocardiography

Stress Echocardiography

Contrast Echocardiography

Dobutamine Stress Echocardiography

Stress Testing

Holter Monitoring

Event Monitoring

Ambulatory BP Monitoring

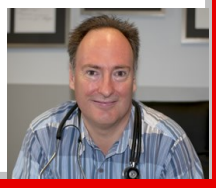
Pacemaker and Defibrillator Follow-up

I am delighted to announce that Dr Ram Saireddy has joined HeartRx and complements our existing services. Ram is an Interventional Cardiologist and is now working part time here at HeartRx, and also at the Cairns Hospital. He will be performing interventional procedures at the Cairns Private Hospital. Appointments for Ram are readily available and referrals are invited.

Our cardiologists have also commenced consulting in the Tablelands with monthly clinics being held at Atherton (Tablelands Specialist Clinic) and Mareeba (That's My Physio). Referrals for these clinics can be sent in the usual manner to HeartRx and our Reception staff will advise patients when the next Tablelands clinic is being held.

Thank you for your continued support.

Dr Tim Carruthers



Welcome to Dr Ramakrishna (Ram) Saireddy

Dr Ram Saireddy is an Interventional Cardiologist with his main interest being management of coronary artery disease and additional interest in structural heart disease management. Dr Saireddy is very experienced in performing coronary procedures such as angiography, fractional flow reserve, angioplasty, rotational atherectomy and optical coherence tomography via Radial and Femoral approaches. He has performed numerous balloon aortic valvuloplasties and has been part of the team performing trans-catheter aortic valve Implantations and MitraClip amongst other structural heart interventions.

Dr Saireddy graduated from India and then made his way to the UK. After obtaining MRCP, he moved to New Zealand where he completed Fellowship in Cardiology. He trained additionally for two years at The Prince Charles hospital in Brisbane, in intervention and structural cardiology.

HeartRx support staff

Front from left: Sarah (Typist), Claire (Enrolled Nurse), Alana (Echo Tech), Sara(Receptionist),

Back from left: Carolyn (Practice Manager), Marg (Registered Nurse), Linda (Typist/Enrolled Nurse), Heather (Receptionist)

Now consulting in Atherton and Mareeba!

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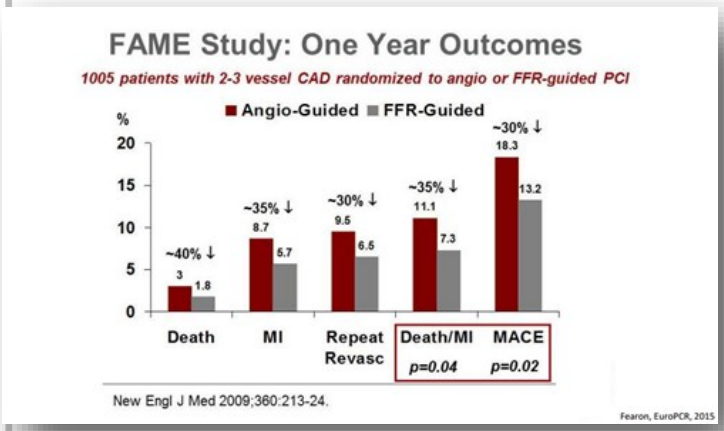
FFR - Fractional Flow Reserve – Pressure Wire Guided PCI

By Dr Tim Carruthers

It is rarely justified, I believe in today's world to just perform selective coronary angiography without also using FFR.

THE ORIGINAL FAME TRIAL

The original FAME (Fractional Flow Reserve (FFR) vs. Angiography in Multivessel Evaluation) Trial compared outcomes of patients whose treatment was guided by FFR to those whose treatment was only guided by visual angiography. Results from the landmark trial demonstrated improved clinical outcomes in patients with stable coronary artery disease and two or three vessel disease. The 12-month results published in the New England Journal of Medicine demonstrated that instances of major adverse cardiac events were reduced by 28 percent for patients whose treatment was guided by FFR rather than by standard visual angiography alone. Two-year results demonstrated that patients who received FFR-guided treatment continued to experience improved outcomes over time, including a 34 percent risk reduction in death or heart attack.



THE FAME II TRIAL

This trial examined the role of FFR in the treatment of stable coronary artery disease in one or more vessels. The trial compared clinical outcomes, safety and cost effectiveness of percutaneous coronary intervention (PCI) guided by FFR plus the best available medical therapy (MT) to MT alone. Trial results published in the New England Journal of Medicine revealed that patients with FFR-guided treatment plus medical therapy experienced superior outcomes to those treated with medical treatment alone. Further, the use of FFR helped reduce the relative risk of hospital re-admission with urgent revascularization by 86 percent. In January 2012, enrollment in the FAME II Trial was halted after an Independent Data Safety Monitoring Board (DSMB) found a highly statistically significant reduction in unplanned hospitalizations and urgent revascularizations in patients enrolled in the FFR guided PCI arm of the trial. The DSMB therefore deemed it unethical to continue to randomize patients into the arm of the trial receiving Medical Therapy alone.

Patients already enrolled in the trial continue to be followed, but no additional patients were added.

FFR AS STANDARD OF CARE

The positive outcomes of the original FAME trial resulted in the level of evidence for FFR to be upgraded to an "A" from a "B" by the American College of Cardiology/American Heart Association/ Society for Cardiovascular Angiography and Interventions. Level of evidence "A" is the highest level available, requiring the most clinical evidence and is awarded only when data is derived from multiple populations and multiple randomized clinical studies or meta-analyses. The benefits were also recognized in guidelines from the European Society of Cardiology/European Association for Cardio-Thoracic Surgery (ESC/EACTS) which included recommendations for the treatment of coronary artery disease that support measuring FFR before deciding to perform PCI or send the patient to surgery. The ESC guidelines gave FFR the highest recommendation possible: 1A.

FFR has demonstrated significant cost savings in various health care systems. In each country where an economic analysis was conducted, FFR was found to save resources while also improving clinical outcomes by increasing quality adjusted life years and reducing the number of cardiac events. In the U.S. health care system, there was a difference of about $2,000, or 14 percent, between total health care costs for the FFR-guided cohort and the group treated by angiography alone after one year. In Europe, the savings ranged from between 500€ and 900€ per patient. These lower health care costs were a result of reduced procedural costs, reduced follow-up costs for major adverse cardiac events and shorter hospital stays.

FFR reduces unnecessary potentially dangerous procedures. It is recognised around the world that there has been a problem with over-servicing of patients with PCI.