



Pedro M. Moreno, M.D., Joins Cardiac Catheterization Team

We are delighted to welcome Pedro R. Moreno, M.D., to the faculty as an interventional cardiologist in the cardiac catheterization laboratories.

A world-renowned expert in high-risk atherosclerosis, Dr. Moreno has been a pioneer for over a decade in the understanding of the role of inflammation in acute coronary syndromes. In 1993, he was the first to describe the role of macrophages in patients with unstable angina and acute myocardial infarction, and established the correlation between macrophages and tissue factor. His work revealed that inflammation plays dual roles in human atherosclerosis, contributing to both plaque rupture and coronary thrombosis.

Dr. Moreno has also investigated the vascular biology of restenosis following percutaneous coronary interventions. Combining clinical, radiographic and tissue-based techniques, he explored the role of macrophages in restenosis after coronary intervention in patients with unstable angina. Through analysis of coronary tissue obtained from patients who developed restenosis after stent deployment, he documented increased macrophage content in coronary tissue as an early event in restenosis, establishing the link between inflammation and

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SPORTIF-III Trial Results Presented at ACC Meetings in Chicago

Jonathan L. Halperin, M.D.

The main results of the SPORTIF-III trial—Stroke Prevention Using the Oral Direct Thrombin Inhibitor Ximelagatran in Patients with Nonvalvular Atrial Fibrillation—were presented at the annual scientific sessions of the American College of Cardiology in April to a great deal of media attention.

Atrial fibrillation is a major cause of preventable ischemic stroke, and both its prevalence and the associated risk of thromboembolism rise with age. In fact, more than half the strokes affecting people with atrial fibrillation occur among those over 75 years old.

Multiple studies have demonstrated that adjusted-dose warfarin provides highly effective prophylaxis against ischemic stroke. In a meta-analysis of six randomized trials, the relative risk reduction was 62 percent compared with placebo.

Although warfarin is associated with low rates of bleeding in these trials, the incidence of intracranial hemorrhage in elderly patients is substantial.

Anticoagulation with warfarin also entails variability resulting from interactions with foods and other medications, requiring frequent blood-test monitoring and dose adjustments. These limitations contribute to the under-treatment of patients with atrial fibrillation at greatest risk and create a need for easily

administered, safer alternatives.

Ximelagatran is the first in a class of oral direct thrombin inhibitors under investigation as an anticoagulant for prevention and treatment of thromboembolism. The pharmacokinetic profile of ximelagatran is stable and predictable, with a rapid onset of action, a relatively wide therapeutic margin and a low potential for food and drug interactions. Unlike warfarin, routine coagulation monitoring and dose adjustment are not necessary.

The SPORTIF program includes two long-term Phase III clinical trials comparing the safety and efficacy of ximelagatran with warfarin in patients with atrial fibrillation at high risk for ischemic stroke. SPORTIF-III involved 3,407 patients randomized at 259 sites in 23 countries in Europe, Asia and Australasia. The protocol is identical to the North American SPORTIF-V trial, except that the latter involves double-blind treatment. Patients were randomized to receive warfarin, dose-adjusted to maintain INR between two and three based on monthly measurements of prothrombin time, or ximelagatran in a fixed dose of 36 mg twice daily.

Eligibility was based upon current clinical indications for anticoagulation. Treatment was administered open-label with regular screening for stroke symp-

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smooth muscle cell proliferation. These findings formed an important part of the rationale for such therapies as anti-inflammatory and antiproliferative drug-eluting stents, which are now employed in clinical practice.

Currently, Dr. Moreno's research team is studying interactions between the medial and adventitial layers of the arterial wall in advanced human atherosclerosis. Their observations about the relationship between vascular inflammation and rupture of the internal elastic lamina are regarded as major advances in the field, providing new insights into the biology of complex lesions. His studies of macrophage migration in the coronary plaques of patients with diabetes mellitus have yielded an important breakthrough in understanding the role of neovascular microangiopathy in diabetic atherogenesis. These vessels within the diabetic plaque, first described by pathologists early in the 20th century, are associated with a high incidence of intraplaque hemorrhage and dramatic degrees of macrophage and T-lymphocyte infiltration. The latest information gained from these studies will be presented in November at the annual scientific sessions of the American Heart Association in Orlando, Florida.

Translating experimental studies of plaque morphology from coronary arterial and aortic specimens *in vitro* to the rabbit atherosclerotic model, Dr. Moreno and his colleagues developed a near-infrared spectroscopic catheter that is now undergoing investigation in human subjects. Furthermore, the models of vulnerable atherosclerotic plaques created in swine and hypercholesterolemic rabbits form a substrate in which to evaluate a variety of novel adjunctive therapies. These

extraordinary contributions prompted the Vulnerable Plaque Organization to present its most prestigious awards to Dr. Moreno's research team in 2002 and 2003.

Dr. Moreno earned his medical degree from Javeriana University in Bogota, Colombia. After completing his training in internal medicine and cardiology, he joined the experimental cardiovascular laboratory at Harvard Medical School as a research fellow during Dr. Fuster's tenure as Chief of Cardiology at Massachusetts General Hospital. After additional training in interventional cardiology at the Brigham and Women's Hospital and Massachusetts General Hospital, Dr. Moreno joined the faculty at the University of Kentucky in 1997 and served as director of the cardiac catheterization laboratory at the VA Medical Center in Lexington until July 2003.

He has been honored by the Chilean Society of Cardiology, the Venezuelan Society of Cardiology, the Colombian Society of Cardiology and the Dominican Republic Society of Cardiology, and is frequently sought as an expert reviewer for the American Heart Association and for several scientific journals, including the *Annals of Internal Medicine*, *Circulation*, the *Journal of the American College of Cardiology*, the *American Journal of Cardiology*, the *American Heart Journal*, and the *European Heart Journal*.

Dr. Moreno's achievements and expertise complement those of the staff in Mount Sinai's cardiac catheterization laboratories, which under the direction of Dr. Samin K. Sharma are already recognized as the best in New York State.

SPORTIF-III Trial Results

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toms and multiple levels of blinded endpoint assessment, including evaluation by local study-affiliated neurologists and review of all detected events by a Central Adjudication Committee. The protocol stipulated a minimum per-patient exposure of 12 months, an aggregate follow-up of more than 4,000 patient-years, and accumulation of at least 80 primary events.

The primary analysis compared the combined rate of all strokes (ischemic or hemorrhagic) and systemic thromboembolic events based on intention-to-treat in patients assigned to ximelagatran with those assigned to warfarin. A confirmatory efficacy analysis involved the same endpoints, but considered the treatment actually received. Adverse events were also compared between the two groups.

The well-established efficacy of warfarin made a placebo control unethical. Hence, the objective was to evaluate whether ximelagatran was at least as effective as warfarin, within a pre-specified margin of two percent for the difference in rates of primary events. This is distinguished from the conventional superiority trial design or a comparison based on proving equivalence to an active control.

Key demographic features, including the duration and pattern of atrial fibrillation, were similar to cohorts of patients enrolled in previous trials of antithrombotic therapy and were evenly distributed between the two treatment groups. Randomized patients were predominantly white males; their mean age was 70 years. There was a history of stroke or transient ischemic attack in about a quarter of the cohort, hypertension in over two-thirds, and heart failure or left ventricular systolic dysfunction in about a third. Almost 70 percent of the cohort had more than one risk factor for thromboembolism.

The intensity of warfarin anticoagulation was assiduously maintained throughout the study. The mean INR was 2.5 across all measurements. INR values fell within the intended therapeutic range for 66 percent of the entire duration of exposure, and values were within the extended range of 1.8 to 3.2 over 80 percent of the time, a rate much better than in most published literature or experience in clinical practice.

Patient follow-up was completed after 4,941 patient-years of exposure, a mean follow-up of 17 months per patient. There were 56 primary events in the warfarin group, an annual rate of 2.3 percent; 40 occurred in the ximelagatran group, 1.6 percent per year. The relative risk reduction of 29 percent and absolute risk reduction of 0.7 percent per year reflect achievement of the primary objective and confirm the non-inferiority of ximelagatran to warfarin for this indication. By on-treatment analysis, the rate of primary events was 2.2 percent per year in the warfarin group and 1.3 percent per year in the ximelagatran group, an absolute risk reduction of 0.9 percent per year and relative risk reduction of 41 percent. These event rate differences were statistically significant.

There was no significant difference between treatments in rates of hemorrhagic stroke, fatal bleeding or other major bleeding. Major bleeding was associated with a decrease in hemoglobin of 2 g/dl or required transfusion, or involved a critical anatomical site. When minor hemorrhages were counted as well, there was significantly less bleeding among patients randomised to ximelagatran. All-cause mortality rates were the same in both treatment groups.

Elevations of serum transaminase enzymes above three times the upper limit of normal were observed in 6.5 percent of patients in the ximelagatran group, typically between two and six months af

ter initiation of treatment. These enzymes returned toward baseline in all cases, either spontaneously or after cessation of treatment.

The net clinical benefit of treatment with anticoagulant medication can be evaluated in a number of ways. By the end of treatment, the combined rates of the primary events, major bleeding and death were 6.1 percent per year with warfarin and 4.6 percent per year with ximelagatran, a statistically significant reduction favoring ximelagatran.

SPORTIF-III is the largest clinical trial involving antithrombotic therapy in patients with atrial fibrillation undertaken to date and the first to evaluate the safety and efficacy of an oral direct thrombin inhibitor for prevention of thromboembolism. Ximelagatran, administered orally in a fixed dose without titration or monitoring of anticoagulation intensity, was at least as effective as adjusted-dose warfarin when judged on the basis of intention-to-treat, and superior in the on-treatment analysis. Increased serum transaminase enzymes were observed during the first six months of treatment in 6.5 percent of patients treated with ximelagatran, but there were fewer bleeding complications than with warfarin.

The SPORTIF studies are a culmination of more than a decade of drug development research, the work of hundreds of investigators and the willingness of thousands of patients to participate in randomized trials with the goal of finding an antithrombotic agent that is safer or easier to tolerate than warfarin. This advance has the potential to extend treatment more widely across the population at risk and bring us closer to the goal of preventing thousands of strokes. The ongoing double blind SPORTIF-V trial will provide additional experience with ximelagatran in a similar population.

Cardiovascular Genetics Program

The Zena and Michael A. Wiener Cardiovascular Institute co-sponsors the Cardiovascular Genetics Program which offers state-of-the-art diagnostic evaluation and counseling for individuals and families with genetic cardiovascular disorders. The primary physicians in this program are Mark Lieb, M.D. (Adult Cardiology), Judy Willner, M.D. (Clinical Genetics), and Bruce Gelb, M.D. (Pediatric Cardiology).

These physicians specialize in evaluating patients with diseases of the aorta (Marfan's and Ehlers-Danlos syndromes and annulo-aortic ectasia), cardiomyopathy (including familial forms of dilated and hypertrophic cardiomyopathy and right ventricular dysplasia), and channelopathies (including the long-QT syndrome and Brugada syndrome). Muscular dystrophies that affect the heart (e.g., myotonic dystrophy and carriers of the gene for Duchenne muscular dystrophy) are also appropriate referring diagnoses. Services include access to DNA-based testing, where applicable, and identification or evaluation of family members at risk.

Physicians wishing to refer patients or discuss cases with program physicians are encouraged to contact the program's coordinating nurse practitioner, Arzellra Walters, CPNP, at 212-241-9461.

Communicating about Patients Under HIPAA

By Shari Engels, Esq.

The federal privacy regulations (the Privacy Rule) issued under the Health Insurance Portability and Accountability Act of 1996, now known by all as HIPAA, required compliance starting April 14, 2003. This article is intended to provide a brief overview of how providers' communications about patients are (and are not) affected by the new regulations.

The Privacy Rule: General Principles

HIPAA regulates "covered entities," a term defined to include virtually all healthcare providers, health plans and healthcare clearinghouses. The Privacy Rule placed new restrictions on the way covered entities use and disclose "protected health information" (PHI), which is defined very broadly to include information transmitted or maintained in any form—electronic, written or oral.

PHI encompasses information, whether created or received, that identifies (or risks being used to identify) an individual and that relates to:

- the individual's past, present or future physical or mental health or condition;
- the healthcare services that the individual has received;
- the individual's past, present or future payments for those services.

Treatment, Payment and Healthcare Operations

Under the Privacy Rule, covered entities may use and disclose PHI for "treatment, payment and healthcare operations" without obtaining patient consent or authorization, and may also do so under certain exceptional circumstances such as public health reporting.

All other use and disclosure of PHI, *including for research*, requires the individual's written authorization.

"Treatment" includes:

- the provision of healthcare services;
- the coordination or management of

healthcare and related services between one or more healthcare providers or a healthcare provider and a third party;

- consultation between healthcare providers relating to a patient;
- the referral of a patient from one healthcare provider to another.

"Payment" includes:

- billing and collection activities;
- eligibility determinations;
- other activities undertaken by providers to obtain reimbursement for the provision of health care.

"Healthcare operations" includes:

- quality assessment and improvement activities;
- credentialing and training of healthcare professionals;
- compliance programs;
- and certain other activities.

To use or disclose PHI for treatment, payment or health care operations, HIPAA requires only that by the date of first service delivery after April 14, 2003, the patient be provided with a copy of the notice of privacy practices and that a good faith effort be made to obtain the patient's acknowledgement of receipt of the notice (or, if unsuccessful, that the reason for the failure to obtain it be documented).

The HIPAA regulations do not preempt more stringent state laws, however, and therefore if patient consent was required pre-HIPAA under New York State law (e.g., with respect to HIV-related information), it continues to be required. Subject to these requirements, members of Mount Sinai's medical staff may use and disclose PHI *for treatment and payment purposes* within The Mount Sinai Hospital and Mount Sinai School of Medicine, including the faculty practices, as well as outside of Mount Sinai.

Mount Sinai and Its Medical Staff

The Mount Sinai Hospital and Mount Sinai School of Medicine are covered entities under HIPAA. In addition, the private practices of physicians on Mount Sinai's medical staff are covered entities if they submit health information electronically in connection with any transaction covered by HIPAA.

Under HIPAA, Mount Sinai and its medical staff are also part of an "organized health care arrangement" (OHCA), which is defined as a clinically integrated care setting in which individuals typically receive care from more than one provider.

In addition to being able to use and disclose PHI for purposes of treatment and payment, members of an OHCA may disclose PHI to each other for any health-care operations activities *of the OHCA* and may use a joint notice of privacy practices. If one member of the OHCA provides the notice of privacy practices to an individual, it satisfies the notice requirement for all members of the OHCA.

Mount Sinai uses a joint notice of privacy practices that covers the use and disclosure of PHI in connection with all services (hospital and physician) provided to inpatients and outpatients at Mount Sinai. However, voluntary physicians do need to provide patients with their own separate notice of privacy practices when seeing those patients outside of Mount Sinai in their private offices.

Minimum Necessary Rule

Generally, covered entities are required to take reasonable steps to release only the amount of PHI necessary to accomplish the intended purpose. This minimum necessary rule does *not* apply to treatment. It does apply, however, for purposes of payment and healthcare operations. Thus, when PHI is used during grand rounds or case confer-

ences, for example, patient names and other clearly identifying information should be removed.

Communicating PHI in Practice

Although the Privacy Rule has changed many aspects of how PHI may be used and disclosed, healthcare providers retain the ability to communicate freely with each other for purposes of treating patients.

For example, if a cardiologist who is a member of the medical staff of Mount Sinai (either as an employed or a voluntary physician) refers a patient to the Cardiac Catheterization Lab at Mount Sinai, the cardiologist may then request a copy of the cath lab results without obtaining patient authorization under HIPAA. (Under New York State law, there would be implied consent by the patient to disclose the cath result to the referring cardiologist.)

Beyond Privacy: Upcoming Compliance Issues
Compliance with HIPAA regulations does not end with the Privacy Rule. By October 16, 2003, all covered entities must also comply with the HIPAA transaction and code set standards—a system of standardized computer transactions for medical payments and related inquiries regarding health insurance.

In addition, the final security standards (the Security Rule), published last February, require compliance by April 20, 2005 with the administrative, technical and physical safeguards required by the Security Rule to protect the confidentiality, integrity and availability of PHI in electronic form.

HIPAA compliance is an ongoing challenge.

36th Annual New York Cardiovascular Symposium

December 19-21, 2003
The New York Hilton

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Cardiology Training at the Turn of the 21st Century

by Eric H. Stern, M.D.

Things have certainly changed since I was a fellow (1979-1981). I say this from the perspective of serving for almost 6 years as the Associate Program Director.

Training used to last a mere twenty-four months but expanded several years ago to the present 36-month curriculum. Today, there are more procedures to learn, each with technical and cognitive component, and there is a formal research requirement. Fellows interested in basic science now spend two or more years in the laboratory in addition to two years of clinical training. Others participate in clinical trials and many write review articles, book chapters, and the like.

The administrative aspects of training are now more onerous as well. The requirement that fellows maintain logs of procedures performed came just recently, as it was once assumed that competence could be acquired over two years. Until recently most procedural rotations had no formal curriculum, whereas today internal and external curricula set clear goals, specific for each level of training.

Board examinations were given every two years and there was no time limit on certification. Bedside diagnosis (history, physical examination, ECG, chest x-ray interpretation) was critical but was eroding in emphasis as technology advanced — no differently than in other fields of medicine. On-call duty was in-hospital (every five nights, sleep optional), with no Bell Commission or ACGME rules to restrict it.

Even after cardiac catheterization became a routine part of cardiology, interventional cardiology was the realm of pioneers. Coronary angiography was routinely accompanied by careful attention to hemodynamics. Today, fellows spend four months learning right and left heart catheterizations and coronary angiography in laboratories

far busier than those 20 years ago, and far more is accomplished today than documentation of anatomical lesions. Those training to perform diagnostic catheterizations independently require another four months and future interventionalists commit an entire year following clinical cardiology fellowship (and must pass an additional Board examination).

When I was a fellow, and two-dimensional images were rudimentary M-mode echocardiography was the rule. Doppler was in its infancy and color-Doppler was unknown. The portals of access were external (transesophageal and intravascular ultrasound were unavailable). The devices resembled instruments I had used as an engineering student. Today's fellows spend three months learning high-resolution digital echocardiographic image acquisition images for transthoracic, transesophageal and stress studies, and 3-dimensional imaging is around the corner. Volume has exploded and fellows are exposed to a wide spectrum of disease. Analogous to training in cardiac catheterization, fellows dedicate an extra 3-9 months to become eligible for certification of special competency.

Diagnostic electrophysiology studies were designed mainly to guide drug therapy and the only therapeutic procedure was pacemaker implantation. Dual-chamber pacemakers were less robust, external temporary pacemakers were unwieldy and implantable defibrillators were just a dream. The digital age brought 3-dimensional mapping of activation sequences, permitting accurate targeting for modification or ablation of tachycardia circuits or automatic foci. One or two years of training beyond basic fellowship are now needed to learn modern electrophysiology (and sit for yet another certifying examination).

Nuclear cardiology used thallium-101 for

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Cardiology Training

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perfusion and technetium-99m isotopes for gated blood pool and infarct imaging. Planar scans were the rule; no SPECT, PET, multiple heads, attenuation correction, 3-dimensional dynamic images. The basic two months of nuclear training can be supplemented by an additional 4-6 months (and an optional examination).

Despite the limited technologies available 20 years ago, we were powerless in many of the therapeutic arenas in which we are today successful. In the Coronary Care Unit, for example, I observed rather than changed the natural course of the acute coronary syndromes, and too stood often humbled as a patient succumbed to myocardial infarction.

The additional time spent in the clinical laboratories during current training in cardiology is related mainly to the variety and complexity of the procedures and interventions that are part of contemporary practice. I am concerned that procedural experience may be gained at the expense of bedside diagnostic and cognitive skills. Hemodynamics has become almost a sideline in the catheterization laboratory and

instead increasingly the focus of echocardiography.

To train cardiologists for the future, we now offer two programs: Our original program (now called the "Investigator Track") has rotations at Mount Sinai and the Bronx VA (as was the case when I was a fellow) and aims to produce "pluripotent" cardiologists for careers in basic science and clinical investigation as well as clinical practice. Our newer "Urban Community" program (see C:mail Volume IV, Number 3, April 2001) is directed toward training strong clinically-oriented cardiologists who will pursue careers in community-based practice. The rotations are at Mount Sinai, Elmhurst Hospital Center and Cabrini Medical Center. The two groups are together at Mount Sinai for conferences and procedural rotations.

As Niels Bohr said, "Prediction is very difficult, especially about the future." With each passing year we seem to attract ever-brighter fellows with a wide range of interests and talents. With Dr. Fuster's mentorship, our training programs offer tremendous opportunities to use and expand upon these gifts. And cardiology at Mount Sinai remains at the forefront of emerging science, in the biological research laboratories,

procedural areas and at the bedsides of patients with cardiovascular disease.

Examinations are offered to document competency in many disciplines for which training is available beyond cardiology fellowship: among these are electrocardiography, echocardiography, and nuclear cardiology. Most candidates for careers involving these disciplines will choose to sit for these examinations. The continually expanding healthcare bureaucracy may demand it.

Some years ago, Dr. Fuster and Dr. Nash proposed avenues to provide internists with special training in areas we now consider the purview of cardiologists. There is renewed interest in their proposal, but it may still be too soon to say what will come of it, or to speculate on the effect this expansion of proficiency may have on the practice of cardiology. As in so much of medicine, combinations of reimbursement policies and patient expectations may ultimately dictate the outcome.

In all, it has been fascinating to watch the world change, and for me it is a privilege to carry on the vibrant traditions of teaching that I first encountered years ago at Mount Sinai.

CME Calendar of Events

Continuing medical education is a priority at the Cardiovascular Institute, and these sessions provide an opportunity for faculty and fellows to interact with visiting cardiologists. The institute sponsors nearly 50 lectures, conferences and academic rounds every month, and we invite you to share in these special educational events as often as you can. For information about conference locations or an updated schedule, please contact Ms. Imelda Samson at 212-241-7784 (imelda.samson@mountsinai.org).

2003-2004 Program Highlights: Cardiology Conferences

Visiting Professors

Nov. 17, 2003

Kanu Chatterjee, M.D.

University of California at San Francisco

Dec. 15, 2003

Andrew Marks M.D.

Columbia University

Jan. 26, 2004

Jeffrey Borer, M.D.

Weill-Cornell University School of Medicine

Feb. 23, 2004

Catherine Otto, M.D.

University of Washington, Seattle

Mar. 22, 2004

Warren M. Jackman, M.D.

University of Oklahoma

May 3, 2004

Joseph Loscalzo, M.D.

Boston University Medical Center

May 24, 2004

Kim Eagle, M.D.

University of Michigan Medical Center

June 21, 2004

Christopher Granger, M.D.

Duke University

Milestones

Academic Promotion Dr. Ira S. Nash, to Associate Professor of Medicine

Awards Dr. Barry D. Stimmel, the Mount Sinai School of Medicine 2003 Institute for Medical Education Lifetime Achievement in Teaching Award

To Dr. Valentin Fuster, the Gold Heart Award of the American Heart Association, its highest award

Also to Dr. Fuster, the Distinguished Career Award of the International Society on Thrombosis and Haemostasis, for contributions in the field of thrombosis

Appointments Dr. Pedro R. Moreno, to the staff of the cardiac catheterization laboratories and vascular biology research laboratories

Dr. Vivian M. Abascal, to the staff of the echocardiography laboratory

Born July 7, 2003, to Dr. Donald Haas and Lisa, a daughter, Julia Donna Haas, their third child.

New Beginnings

by Ram Gordon, M.D.

Every summer is a time of great transition in our hospitals. We say goodbye to colleagues who have finished training and welcome eager new physicians. Here are the comings and going within the Zena and Michael A. Wiener Cardiovascular Institute.

[Graduating Fellows – Investigator Track](#)

Anthony Aizer, M.D., has begun advanced training in electrophysiology at the Brigham & Women's Hospital in Boston.

Adam Rosenbluth, M.D., has joined his father in private practice at 912 Fifth Avenue. Adam, whose grandfather founded the Internal Medicine practice in 1937, is covering both internal medicine and cardiac patients and performing echocardiography, stress testing and stress echocardiography three days a week. On the other days, he is working with Drs. Henzlova and Goldman in non-invasive cardiology at Mount Sinai. Adam is thrilled to have his "dream job" and to remain an integral part of the Mount Sinai cardiology family while building his cardiology practice.

Daichi Shimbo, M.D., continued post-graduate research at Mount Sinai until joining the faculty at Columbia University in September.

[Graduating Fellows –](#)

[Urban Community Program](#)

Mehran Attari, M.D., has begun advanced training in electrophysiology at the Mount Sinai/St. Luke's Hospital in Milwaukee, Wisconsin.

Demetrius Bravidis, M.D., has joined Cardiology Associates of West Reading, Pennsylvania, a cardiology group associated with Reading Hospital & Medical Center.

Srinivas Attanti, M.D., has stayed on at Mount Sinai for advanced training in interventional cardiology.

[Graduating Fellows – Electrophysiology](#)

David Harnick, M.D., has become a member of the voluntary staff of the Cardiovascular Institute at Mount Sinai and a part-time physician at St. Vincent's Medical Center in Manhattan.

Ajay Soodan, M.D., has joined the electrophysiology staff of the Baltimore Heart Center.

[Graduating Fellows – Interventional Angiography](#)

Johnny Lee, M.D., has joined the voluntary staff at The Mount Sinai Hospital with his partner, Dr. Tien H. Nguyen. Both Drs. Lee and Nguyen are interventional cardiologists, and their practice, *New York Heart Associates, P.C.*, is up and running in midtown Manhattan.

David Slovut, M.D., has joined Saint Mary's Duluth clinic in Duluth, Minnesota, where he will help start a peripheral vascular program, including peripheral vascular intervention.

Qaisra Saeed, M.D., has entered practice with Mount Sinai cardiology alumnus Dr. Abbas Shehadeh in northern New Jersey.

Chowdhury Ahsan, M.D., has joined the faculty at the University of California at Irvine as an interventional cardiologist.

[Graduating Fellows – Pulmonary Hypertension](#)

Roxana Sulica, M.D., has stayed on as Instructor of Medicine at Mount Sinai to continue her work in pulmonary hypertension.

Howard Van Dinh, M.D., has begun a cardiology fellowship at the University of California – Los Angeles.

And here are the incoming fellows:

[Investigator Track Program](#)

Eric Adler, M.D. — University of Washington

Nagib Chalfoun, M.D. — Hospital of the University of Pennsylvania

Andrew Einstein, M.D. — UMDNJ/ St. Peter's University Hospital

Anil Gehi, M.D. — University of California - San Francisco

Thomas Maddox, M.D. — University of Texas Southwestern

Anthony Shih, M.D. — Hospital of the University of Pennsylvania

[Urban Community Program](#)

Yan Li, M.D. — Lenox Hill Hospital

Steven Furer, M.D. — Montefiore Medical Center

Samantha Strong, M.D. — The Mount Sinai Medical Center

Geoffrey Webber, M.D. — New York University Downtown Hospital

[Electrophysiology](#)

Michael Manolios, M.D. — Baylor College of Medicine

Sunil Sinha, M.D. — University of Manitoba

[Interventional Cardiology](#)

Srinivas Attanti, M.D., — Mount Sinai School of Medicine/Elmhurst Hospital

Paul Lee, M.D., — University of Toronto

Prakash Krishnan, M.D., — Ochsner Clinic Foundation

Anshul Jain, M.D., — Alfred Hospital - Australia

We wish all the fellows who have graduated good luck, and we welcome our new fellows to the Cardiovascular Institute!

Cardiovascular Institute Telephone Numbers

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Ambulatory Care	Amrita Malik	241-5586
Cardiac Care Center	Nancy Rodenhausen	241-8095
Cardiac Health Program	Patty Brownstein, R.N.	241-8597
Cardiac Telemetry Unit	Ira S. Nash, M.D.	241-3282
Cardiothoracic Surgery	David H. Adams, M.D.	241-8181
Catheterization Laboratory	Samin K. Sharma, M.D.	241-5849
Coronary Care Unit	David A. Vorchheimer, M.D.	241-4040
Development	Stephanie Steel	373-4940
Echocardiography	Martin E. Goldman, M.D.	241-1719
Electrophysiology/Pacemakers	Davendra Mehta, M.D., Ph.D. Jorge L. Camunas, M.D.	241-6075 241-8181
Fellowship Training	Eric H. Stern, M.D.	241-4025
Heart Failure/Transplantation	Marrick L. Kukin, M.D. Alan Gass, M.D. Steven L. Lansman, M.D., Ph.D.	241-3161 241-5213 241-8181
Magnetic Resonance Imaging	Michael Poon, M.D. Zahi Fayad, Ph.D.	241-4461 241-6858
Nuclear Cardiology and Stress Testing	Milena J. Henzlova, M.D.	241-1718
Positron Emission Tomography	Josef Machac, M.D.	241-7888
Pediatric Cardiology	Ira A. Parness, M.D.	241-8662
To Transfer a Patient		1-800-TO SINAI
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Vascular Medicine	Jeffrey W. Olin, D.O.	241-6773
Vascular Surgery	Michael L. Marin, MD	241-7646
Women's CARE	Maryann McLaughlin, M.D.	241-3340

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