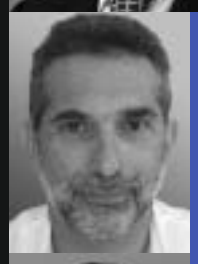
IR congress news

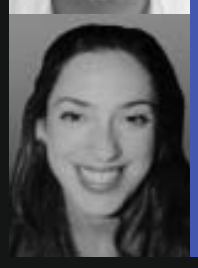
Welcome to the 2007 CIRSE meeting, Welcome to Athens!

Andy Adam
CIRSE 2007
Gold Medallist

Johannes Lammer
CIRSE President



Elias Brountzos
Meeting Chairman



Katerina Malagari
Meeting
Co-Chairwoman

Dimitrios Kelekis
Honorary
Meeting Chairman

CIRSE 2007 - Athens
Saturday, September 8, 2007

Welcome to CIRSE 2007

Join us for the Opening Concert and a spectacular show!

16:00, Room A (Trianti Hall)

CIRSE Awards

CIRSE 2007, Europe's most comprehensive meeting for minimally invasive therapy, will be officially inaugurated with a ceremony honouring this year's CIRSE laureates. We are happy to announce that former CIRSE president Professor Andy Adam will receive the CIRSE Gold Medal for outstanding achievements in Interventional Radiology. One of CIRSE's founding fathers, Professor Dimitris A. Kelekis, will join the ranks of Distinguished CIRSE Fellows. The same honour will go to Klemens H. Barth, who is a Professor of Radiology at Georgetown University. Dr. Thomas Rand and Dr. Jan Šochman will receive the CVIR Editor's Medal.

Opening Show

Don't miss the Opening Ceremony of CIRSE 2007, featuring an outstanding dance and percussion show performed by the Greek national ballet and the drummers of the Olympic Games 2004.

Cocktail Reception

The CIRSE 2007 Opening Ceremony and Concert will be followed by a cocktail reception in the exhibition area of the Megaron Centre. We would like to invite all congress delegates to join us for this event, which will be the perfect opportunity to meet old colleagues and make new friends.

The Drummers of the Olympic Games 2004 will perform for CIRSE

Interventional Radiology represents the most challenging, dynamic and innovative specialty in today's medicine. Our practice offers the least invasive, most efficient treatment in a vast variety of diseases, both in elective and emergency situations. The development of Interventional Radiology is continuing, as intense research in technology and medicine are providing ever new methods of treatment. We are confident that CIRSE 2007 will address your needs whether you are seeking to solidify your skills in Interventional Radiology or update your knowledge on the cutting edge of our specialty. Mike Lee and the other members of the Programme Planning Committee have compiled an exciting programme featuring 39 Special Sessions, 8 Foundation Courses, 45 Workshops, 11 Hands-on Workshops, 27 Free Paper Sessions and 17 Satellite Symposia, among others.
It goes without saying that the 5,000 year old city of Athens offers numerous attractions. The Acropolis with its monumental temples, the city's numerous museums and archaeological sites, the historical centre and the beautiful coastline with its countless sandy beaches will offer you a multitude of possibilities for entertainment and recreation.
Last but lost least we have made our best to organize a compelling social programme, taking advantage of Athens' extraordinary entertainment possibilities.

We wish you a pleasant stay in Athens and hope that CIRSE will be an unforgettable experience.

Elias Brountzos
Meeting Chairman
Katerina Malagari
Meeting Co-Chairwoman
Dimitrios Kelekis
Honorary Meeting Chairman

Dear Fellow Interventionalists,

Michael J. Lee
Chairman of the
Scientific Programme Committee

Welcome to Athens, who's cultural legacy to the World is incalculable. During the reign of Pericles (ca. 495 BC – 429 BC), which is also referred to as the Golden Age, Athens became the intellectual and cultural centre of the world, producing intellectuals like Socrates, Plato, Aristotle, Sophocles and Euripides, just to name a few. Numerous historic sights like the Parthenon conceptualize Greek democracy and appear as witnesses of an exceptional cultural apogee. Moreover, Athens is of course famous for the holding of the first modern Olympic Games in 1896 and for holding the latest Olympic Games in 2004. It is indeed a historic city and I am glad you have decided to join us here for another exciting CIRSE meeting.

I am delighted to announce that this year the CIRSE Programme has changed format, so that delegates can follow a particular of six main themes right through the meeting, including vascular intervention, transcatheter embolisation, non-vascular intervention, interventional oncology, clinical practice development and a basic education theme. The congress programme is designed so that attendees can follow one of these themes with little or no overlap. Importantly, for our juniors, the basic educational theme running through the meeting comprises eight foundation courses, divided into two main topics: peripheral vascular disease and transcatheter embolisation. There are also three basic workshops on embolisation technique to build on the knowledge gained during the corresponding foundation course. For the first time, there will be an optional online test after the foundation course as part of the e-learning initiative.

The good clinical practice course will continue this year with the theme of basic medical statistics. This is a must for those who wish to understand basic statistics used in IR research. As with last year, there will be a number of interactive case sessions, which have proved to be very popular.

All in all, the programme continues to develop and I hope you will agree that there will be something for everyone at CIRSE 2007. I am also looking forward to the social events organised by Professor Elias Brountzos and the local organising committee.

I look forward to a fantastic CIRSE 2007.

Michael J. Lee
Chairman of the
Scientific Programme Committee

EPOS Awards

The Electronic Presentation Online System (EPOS), first developed by the European Congress of Radiology and kindly made available to CIRSE, has set new standards in the medical meeting industry. It currently comprises more than 6,500 exhibits, allowing much greater flexibility and better communication than traditional scientific exhibits.

CIRSE is happy to announce that the 2007 EPOS awards were granted to the following presentations:

Magna Cum Laude
Comparison of late in-stent stenosis and vessel wall inflammation in Cypher® Select™, Taxus® Express™, and Polyzene®-F nanocoated cobalt chromium stents in a porcine coronary artery model

Authors:
B.A. Radeleff, U. Stampfl, R. Lopez-Benitez, S. Stampfl, H. Thierjung, C. Sommer, I. Berger, G. Kauffmann, G. M. Richter; Department for Diagnostic Radiology, University Hospital Heidelberg, Heidelberg, Germany

Cum Laude
Physician radiation exposure during CT fluoroscopy (CTF) guided procedures: bicentric prospective study on 160 consecutive patients

Authors:
H. Brat[1], T. Bouziane[2], M. Bricoult[3], D. Delhaye[1]; 1 Radiology Department, CH Hornu-Frameries, Hornu, Belgium, 2 Radiology Department, Clinique Notre Dame, Tournai, Belgium, 3 AV Controlatom, Vilvoorde, Belgium

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Closure Devices: Which device where

Stefan Müller-Hülsbeck
Vice Chairman, Department of Radiology
University Hospitals Schleswig-Holstein
Kiel, Germany

Don't miss it !
Closure devices: which device where
Workshop 506
Saturday, September 8, 14:30-15:30
Room H

Since Interventional Radiologists began the practice of percutaneous entry into the arterial system with the Seldinger technique in the early fifties (1), closure of the puncture site has been problematic in some cases; it is an unglamorous and sometimes time-consuming part of the procedure. Compression over the puncture site followed by bed rest (2-4) is still considered to be the gold standard to achieve haemostasis. In the 1990ies, percutaneous arterial closure devices were introduced. They made haemostasis possible within some moments with minimal or no compression and were even successful with continued anticoagulation (5-8). In spite of the permanent trend towards miniaturization of the arterial access site, arterial closure devices today are still an issue and more so than in previous years. They allow patient's mobilization within hours and have made a complete percutaneous approach possible for several endovascular procedures (9,10). The time to obtain haemostasis after sheath removal and closure device application is reduced from 18 to 4 minutes (5-8) and the length of patient immobility drops from 18 to 4 hours (5, 8, 11), without any significant increase in complication rates (5-14).

I must point out that the devices currently available are only fit for groin access, meaning that the common femoral artery is punctured either in retrograde or antegrade fashion. Today's devices are not suitable for brachial, popliteal or other access site closure (except Pads). When having a closer look at the devices currently available, we can distinguish two groups: active and passive closure devices. Active closure means that the artery is closed by suture, collagens, a bio absorbable anchor, a Nitinol clip or other (The Closer™, Vasoseal™, Angio-Seal™, Starclose™, etc.); passive closure includes wound dressing pads and compression systems used in order to reduce manual compression time (Clo-SurPAD™, Chito-Seal™, FemoStop™, etc.).

The outer diameter of active closure devices ranges from 6 French to 10 French. All active devices are available in 6F to close a puncture site up to 7F. For 8F or more only a limited number of devices are available. At our institution the protocol for using vascular closure devices consists of the following recommendations and guidelines:

- Diagnostic angiography, 4F or 5F access (retrograde and antegrade): manual compression
- Interventional angiography, 5F to 7F access (retrograde and antegrade): Angio-Seal™ 6F or others (Fig. 1)
- Interventional angiography, 8F to 9F access(retrograde and antegrade): Angio-Seal™ 8F or others
- Endovascular aortic repair (EVAR) , 9F to 24F access (retrograde): two Closer™ 6F according to the "Kiel technique"9

An innovative concept for the extended use of active closure devices is total endovascular aortic repair without the groin cut being done by a surgeon. This concept is represented by the Kiel technique (Fig. 2) which was modified from Torsello et al.'s approach (17) and developed for total percutaneous aortic repair (TPAR). It uses two Closer™ devices which are implanted one after the other in a 90° rotation, maintaining guidewire access after retrograde common femoral artery access (proximal to the origin of the profunda femoris artery) at the beginning of TPAR. In a second step a 9F sheath is reinserted. Afterwards the 24F sheath or a prosthesis delivery catheter is inserted. A sufficient incision of the skin prior to this manoeuvre is of outmost importance. When TPAR is completed, heparin given during the endovascular procedure should be neutralized. Later the preformed knots of the two sutures are cinched down by using knot pushers to finish the procedure (9).

We recommend limited or no use of active arterial closure devices in young adults. Their use should be completely avoided in children and women after UFE due to high and severe complication rates (18). However, when using active closure devices in typical cardiovascular patients, the technical success rates range from 92.6% to 97%, whereas the major complication rate varies between 2% and 4.9% in large case series (19). Even "magic" pads reach a high technical success rate (95%). However the major haematoma incidence is 6.7% (20).

Comparing currently available devices, one can conclude that "no individual device is clearly superior (19)". Technical success and complication rate clearly depend on the operator's skills and experience with the specific active arterial closure devices and the specific device's learning curve.

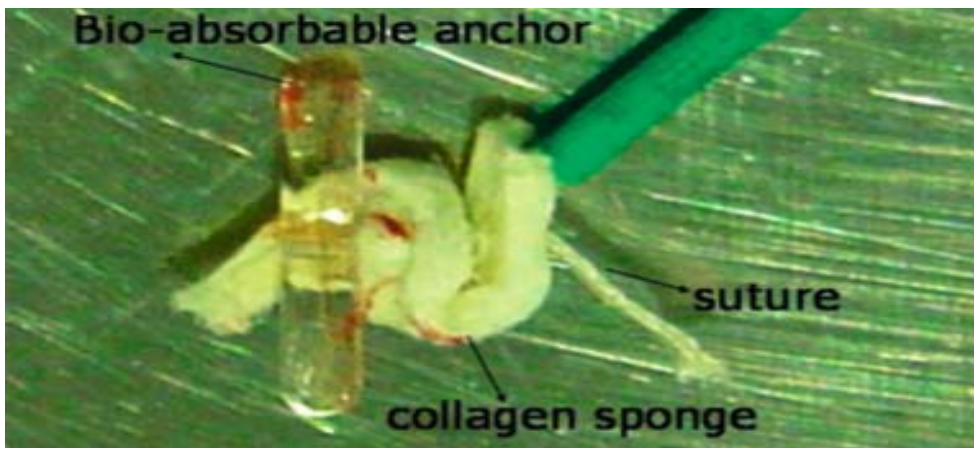

Fig. 1: Active closure device Angioseal™ activated ex vivo presenting three device components like bio-absorbable anchor, collagen sponge and suture

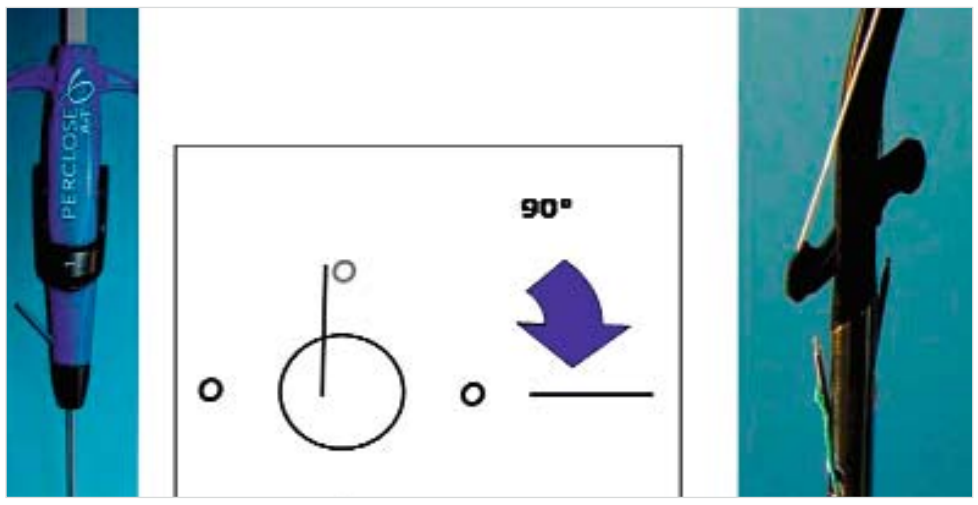

Fig. 2a

Fig. 2b

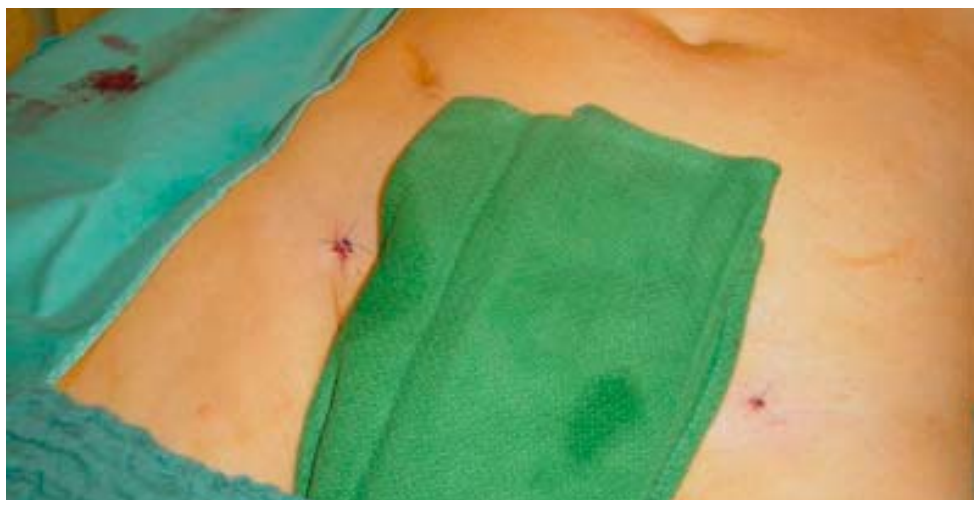

Fig. 2c

Fig. 2: Total percutaneous endovascular aortic repair (TPAR). (a) Schematic drawing indication needles (small circles) of two Closer™ devices which were implanted one after the other in a 90° rotation; the magnification presents the activated needles capturing the suture (b) Impression of TPAR after placement of a 22F sheath. Note the two sutures fixed by two clamps. (c) Photograph after completing the procedure.

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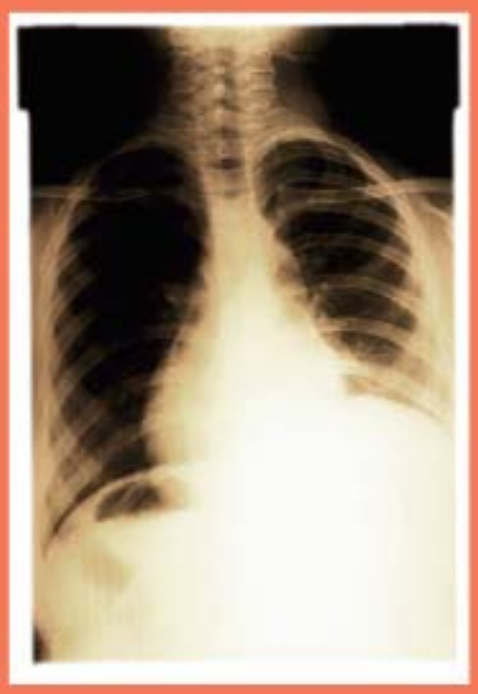

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Filter, flow reversal or nothing?

Sumaira Macdonald
Consultant Vascular Radiologist and
Honorary Clinical Senior Lecturer
Freeman Hospital Newcastle-Upon-Tyne
United Kingdom

Don't miss it !
Carotid artery stenting: What's new?
Special Session 202
Saturday, September 8, 10:00-11:00
Room C (Skalkota Hall)

Background
Any carotid intervention, be that endarterectomy (CEA) or carotid stenting (CAS) has prophylactic intent, aiming to achieve survival free of ipsilateral ischemic stroke and ischemic stroke related death. To date there is limited level-1 evidence to support the contention that CAS prevents stroke in the longer term, but what is self-evident is that the therapeutic efficacy of any carotid intervention relies on minimising the procedural risk of stroke. Thirty-day outcomes for CAS within the recent, prematurely stopped randomised trials EVA3S and to a lesser extent SPACE have refocused attention on the safety of CAS.

The use of cerebral protection devices is intended to improve the safety profile of CAS. There is as yet no level-I evidence to support the use of protection devices, but their use is intuitive. Filters are the most commonly used device currently and the flow reversal system (Gore Neuroprotection System; WL Gore, Flagstaff, Arizona) is now available following modification of the original Parodi Anti-Embolism System.

Rationale for the use of cerebral protection during CAS
Assessment of procedural microembolic load on transcranial Doppler (TCD) reveals that carotid angioplasty is eight times more emboligenic than CEA (1). Emboli may be detected in more than 90% of CAS treatment episodes and each stage of carotid stenting incurs a microembolic penalty (2, 3). Control of this embolic burden seems imperative.

The Influence of filters and flow reversal on procedural macroemboli
Théron's concept of distal control using balloon occlusion during carotid angioplasty was revolutionary and paved the way for an explosion in cerebral protection devices. Many preliminary papers reported early experiences of each type of device (distal balloon occlusion, filtration, proximal balloon occlusion, flow reversal) providing level III and IV evidence for the capture of macroemboli. Debris including fibrin, cholesterol clefts, red and white cell aggregates and organised thrombus was retrieved from earlier generation filters (4). It was thought that this material was likely to have been liberated by the endovascular manipulation of the carotid bifurcation plaque with subsequent entrapment rather than forming on the filter device in-situ, although this remains unproven. The reported mean size of trapped particles for all evaluated protection devices ranged from 4-5043 microns and the numbers captured ranged from 12-34,000 particles.

Visible debris may be present in 169 of 279 filters (60%) evaluated during contemporary protected CAS (5). This would imply that despite a number of technical advances that have occurred since the inception of rudimentary carotid angioplasty, there may still be a substantial macroembolic penalty (Fig. 1).

The influenece of filters and flow reversal on procedural microemboli
Although ex-vivo work on the prototype of the NeuroShieldTM (now EmboShieldTM, Abbott Vascular, Abbott Park, Illinois, US) suggested that 88% of the liberated embolic burden during carotid angioplasty was trapped, the in-vivo capture rate is not known (6). Particles smaller than the pore size of the available devices (currently 60-140 microns) may pass unhindered to the brain due to filter through- and periflow. Supporting evidence for this comes from ex-vivo work analysing carotid angioplasty and liberated microemboli i.e. particles <60 microns, which were analysed using a Coulter technique (7). Guide wire passage alone generated 40,000 microemboli, although emboli were generated at each procedural stage and a substantial number of emboli less than 60 microns were produced. These may evade capture by currently available filters, but may be controlled by alternative protection strategies.

A preliminary non-randomised prospective study evaluated flow reversal during CAS in thirty patients (15 symptomatic with >70% stenoses and 15 asymptomatic with >80% stenoses) (8). The Gore Neuroprotection System comprising balloon occlusion of the common carotid artery (CCA) and external carotid artery (ECA) and establishment of an arteriovenous shunt from access-site femoral artery to femoral vein with an interposed blood filter was used. Flow reversal could satisfactorily be established in 28 of 30 patients of whom 27 were tolerant of this system. TCD recorded a complete absence of microembolic signals (MES).

Transcranial Doppler monitoring of transcervical carotid stenting with flow reversal achieved by means of a common carotid to jugular venous shunt again demonstrated absence of detectable emboli in a recent evaluation (9). Whilst flow reversal may eliminate MES on procedural TCD it may not be tolerated in a subset of patients. TCD findings when filters are employed are quite different.

A Dutch clinical single-centre prospective analysis of microembolic signals on procedural TCD for unprotected CAS and filter-protected CAS recently reported (10). Patients were divided into three groups: 161 patients treated before filters had become available (group 1), 151 patients treated with filters (group 2), and 197 patients treated without filters after these devices had become available (group 3). The authors concluded that carotid angioplasty and stent placement yielded more microemboli in patients treated with filters than in unprotected procedures. However, the infrequent occurrence of cerebral sequelae did not allow comprehensive statistical comparison between groups. A randomised trial comparing filter-protected and unprotected CAS in 30 patients demonstrated significantly more microemboli (total load plus particulate elements) when filters were used (11), (Figure 2).

A novel multi-frequency TCD machine, capable of differentiating gaseous and particulate emboli was utilised to evaluate the embolic burden of filter-protected CAS (12). The filters used were the Accunet (now Abbott Vascular) and the FilterWire EX (Boston Scientific, Warren, New Jersey). During contrast injections without the protection device, 1,013 emboli were detected with 28% of these being solid. With the deployment of the filter, 8,636 emboli were found with 40% classifying as solid (p<0.001). During stenting and angioplasty with the protection device, 7,395 emboli with 42% solids were detected (p,0.001). Finally, injection of contrast after the procedure, with the protection device still deployed, yielded 1,241 emboli with 31% solids. The authors concluded that microembolisation frequently occurs during filter-protected CAS.

The phenomenon of ongoing microembolisation with a filter in place was elegantly described by Schonholz as "controlled embolisation" (13). The clinical impact of microembolisation remains unclear.

Summary
- Carotid stenting generates macro- and microemboli
- All protection devices are capable of the entrapment of macroemboli
- Macroembolisation still occurs despite a number of technical advances (low profile, rapid exchange dedicated carotid systems and dual antiplatelet regimes) and poses a significant threat to the brain
- Filters may allow the passage of substantial numbers of microemboli because of filter-through flow and peri-flow
- Filters may be associated with more microemboli on TCD than during unprotected stenting
- The clinical relevance of microembolisation remains unclear
- Flow reversal may abolish all MES on procedural TCD, but a small number of patients may not tolerate the system
- There is as yet no clinical level-1 evidence to support the use of protection devices, but level-III and level-IV evidence suggest benefit
- The pragmatic response would be to routinely use protection, accepting that all available devices have a trade-off

Fig. 1: Contemporary image elegantly displaying entrapped macroembolus in a SpideRx™ filter, Ev3 Europe, 75008 Paris, France. This debris is of such a size as to pose a considerable threat to the ipsilateral middle cerebral artery (MCA) and may cause devastating stroke if it embolised to the brain

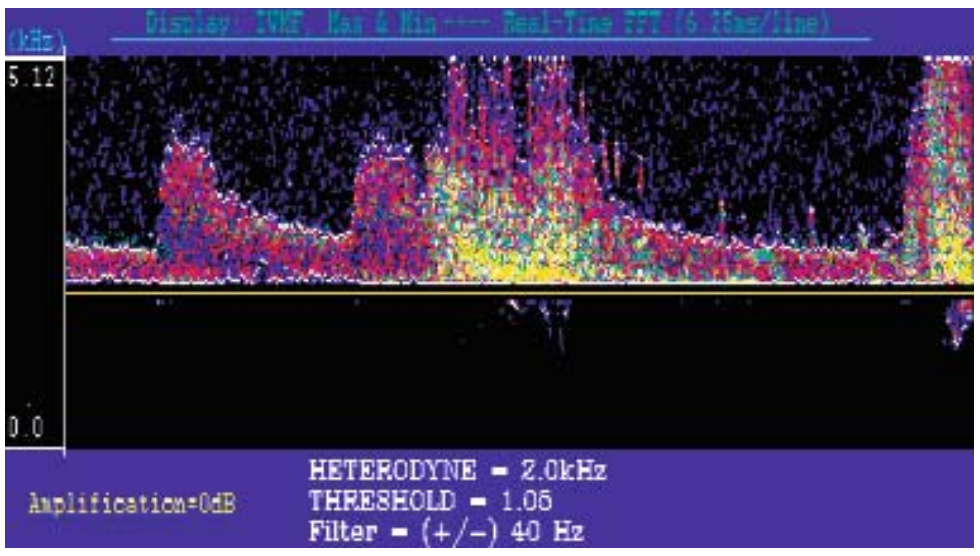

Fig. 2: Showers of microemboli on TCD of the ipsilateral MCA with a filter in place during stent deployment

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Advertorial

Access to medical expertise made easy to provide decision support for high-end interventional practice

After demonstrations or workshops with hands-on where you rarely get the hand at, it can become frustrating when looking at your patient situation to evaluate the best treatment. Leveraging on the latest web technologies deployed in the clinical research field, a new company, decidemedical inc., is building a tool that will bring together in an intelligent answer/response workflow physicians looking for support and experts ready to help them. When asked about the strategy and goal of the company, the CEO replied: «we're focusing on enhancing new practices adoption to ultimately improve patient care by making sure the physician could confidently evaluate all options.»

Supporting the community

Every congress comes with its round of physicians doing their best to approach a speaker or a recognized expert to seek information and help on cases for which they have to carry some documentation throughout the event.

With the technology ever evolving, this picture is slowly fading out in favour of other means of communication, but the stress remains the same for those who must answer: missing or irrelevant information, poor quality documents, and other issues makes it very challenging to give an honest and weighted answer.

These direct exchanges between renowned experts in a specific field and physicians looking for advices to help their patients about the selection of the best treatment is becoming key as new treatment options and techniques arise ever more quickly.

In order to take up this challenge, decidemedical's team is developing a platform to set a standard for patient information exchange in daily practice. This enthusiastic team, coming from the clinical research field and with all the experience and rigorousness required there, is focusing on providing decision support in high-end interventional practices. The company is building a network of physicians recognized by their peers as experts in their field of practice, and accepting to provide other physicians with the required time and effort to support them. This network of medical experts will be directly accessible through a web-based managed platform, using a wizard that will accompany physician in qualifying the case for which they seek support.

decidemedical has put together an innovative process that enables the industry to sponsor physician requests while guaranteeing the neutrality of decidemedical and its experts' network. Reports on real-life cases will be edited and distributed freely to the member of decidemedical community.

decidemedical's team is now looking forward to the start of its service on October 1st, 2007 and is eager to get feedback from the community.

How it works

decidemedical medical experts' community is available to providing advice on treatment options and techniques. Contacting an expert through the decidemedical service is as easy as one, two, three...

1. The physician uses the decidemedical website to select an expert and submit a case. He pays for the service using a voucher. This voucher is either sponsored by Healthcare Corporation or purchased by the physician on decidemedical's website.
2. The medical expert and the physician use decidemedical's online patient information system and communication tools to discuss about the eligibility and the relevant treatment techniques.
3. The medical expert uses decidemedical's online imaging tools and response wizard to provide the physician with scientifically based advices.

A complete patient file

For optimal patient evaluation, decidemedical system enables the physician and expert to exchange and evaluate cases using a standard web-browser. In addition to standard patient data, decidemedical technology enables to handle medical images via a professional web-based imaging workstation, and to scan paper documents using an original fax-to-database technology.

A new era in surveillance

The effort decidemedical is putting together with its system is going further beyond providing medical expertise to physician worldwide. With its target of opening this service to new practices and procedures on a quarterly basis, the company is willing to build a network of over two hundred recognized experts within the next two years. At that time, decidemedical is aiming to get about thirty practices and procedures available in many different clinical fields.

Watching permanently the process, decidemedical will analyze cases and create controversy or consensus events on the fly, bringing together key opinion leaders in online conferences accessible to the decidemedical community. The results of case analysis will also enable decidemedical to provide interesting cases as examples for the community, and have them commented in online video clip by experts.

In addition, to make the most of this information, the company is partnering with ultimate leaders in data mining technology companies. Although a limited number of data collected for each case to reduce and a limited number of cases per practice, these new data-mining technologies will be able to provide the community with extremely relevant information and will help increase safety and innovation in patient care.

Starting at the Cirse in Athens

decidemedical has chosen to launch its service this year at the Cirse. decidemedical is a US based company, providing its service worldwide through its website. Located in New Jersey, it can be reached through its website contact form www.decidemedical.com, or at info@decidemedical.com. If you have interest in proposing a new field of expertise, do not hesitate, the guys at decidemedical are very friendly and open!

They joined the network already

Spine Interventions
Pr. Afshin Gangi, Strasbourg, France
"Beside being an expert in the field of vertebroplasty on decidemedical platform, I will certainly be a user of this service for difficult cases in other fields"

Liver tumor
Pr. Ricardo Lencioni, Pisa, Italy
"With the fast development of technological solutions in Interventional Radiology, our community needs an easy access to a high quality expertise. Liver tumor treatment is a vast domain where technical challenges require a tool such as decidemedical platform."

Vascular Interventions
Pr. Marc Sapoval, Paris, France
"This service is the kind of help I have dreamed about for a long time. This will definitely help the medical technology innovation spread faster by making the medical communication easier. I am enthused helping building expertise in the field of vascular interventions"

Advertorial

Abbott Vascular Crossroads Institutes in Europe, Asia Pacific, and Africa

Focused on Improving Care for Patients with Cardiac and Vascular Disease

Abbott announced the launch of the Crossroads Institute for cardiac and vascular medical education at the EuroPCR 2007 meeting in May 2007 in Barcelona. Headquartered in Brussels, Belgium, and with established facilities in Tokyo, Japan and Johannesburg, South Africa, the Crossroads Institute features a teaching faculty of more than 100 worldwide experts focused on providing the latest in medical education to advance the treatment of patients with cardiac and vascular disease.

Formerly the Guidant Institute for Therapy Advancement, the newly named Crossroads Institute, a medical education initiative from Abbott Vascular, offers more than 70 courses on cardiac and vascular treatment developed and led by participating faculty members, with 50 of the courses CME-accredited. Featuring discussion forums with physician experts, the Crossroads Institute offers high-touch teaching methodologies with virtual simulators and a virtual in-house catheterization lab to help physicians learn the latest in cardiac and vascular treatment methodologies. In addition, the Crossroads Institute offers live case broadcasts from neighboring hospitals, to bring real-time catheterization lab events into forums for discussion, which are moderated by world-renowned cardiac and vascular disease treatment experts.

"The Crossroads Institute represents a best in class medical education facility, from which healthcare professionals at all levels across Europe can benefit," said Professor Jean Marco, M.D., course director for the Crossroads Institute. "To date, more than 12,000 physicians have participated in educational programs at the Crossroads Institute. A key element to the programs is providing physicians with treatment strategies that will ultimately improve patient care."

The medical education program at the Crossroads Institute is led by Professor Jean Marco of the Centre Cardio-thoracique in Monaco and Dr. Luc Stockx of the Ziekenhuis Oost-Limburg in Belgium, who developed an educational program to offer healthcare professionals patient-focused training on the latest subjects and techniques in cardiac and vascular care.

"With peer-to-peer interaction and hands-on experience with state of the art technology, the mission of the Crossroads Institute is to provide healthcare professionals with unbiased training that makes patient care a first priority," said Dr. Stockx, course director for the Crossroads Institute.

About the Crossroads Institute

Providing leadership in interventional medical education since 2000, the Crossroads Institute was the first medical learning institute of its kind established in the world to advance the open exchange of information about cardiac and vascular care in order to help healthcare professionals improve the treatment of cardiac and vascular disease. The Crossroads Institute is a world class medical education facility funded by Abbott and headquartered in Brussels, Belgium with offices in Tokyo, Japan and Johannesburg, South Africa.

For more information about The Crossroads Institute, phone +32-2-714-14-65 or visit www.crossroads-institute.com.

About Abbott Vascular

Abbott Vascular, a division of Abbott, is one of the world's leading vascular care businesses. Abbott Vascular is uniquely focused on advancing the treatment of vascular disease and improving patient care by combining the latest medical device innovations with world-class pharmaceuticals, investing in research and development, and advancing medicine through training and education.

Headquartered in Northern California, Abbott Vascular offers a comprehensive portfolio of vessel closure, endovascular and coronary products that are recognized internationally for their safety and effectiveness in treating patients with vascular disease.

About Abbott

Abbott is a global, broad-based health care company devoted to the discovery, development, manufacture and marketing of pharmaceuticals and medical products, including nutritionals, devices and diagnostics. The company employs 65,000 people and markets its products in more than 130 countries.

Radiofrequency ablation workshops to show latest developments in technology and new treatment strategies

Interview with Riccardo Lencioni
Professor at the Department of Radiology
University of Pisa, Italy and
Chairman of the first European Conference on Interventional Oncology
ECIO 2008

In order to cater to the growing number of interventionists involved in oncologic interventions, this year's CIRSE meeting will feature another series of hands-on workshops dedicated to radiofrequency (RF) ablation. The programme will feature both, basic and advanced workshops to meet the different needs of beginners and of those who already have experience and want to enhance and refine their practice.

"There is an ever increasing demand for education and training in Interventional Oncology" says the well-know expert Professor Riccardo Lencioni, who has been in charge – along with Dr. Thierry De Baere and Prof. N. Kelekis – of the organization of the workshops. "This year, CIRSE has a special track dedicated entirely to Interventional Oncology, including special sessions, workshops, interactive case discussions and hands-on workshops". According to Professor Lencioni, hands-on workshops offer a unique opportunity to become familiar with the latest development in technology. "The progress of RF ablation devices is continuous, every year there is something new on show" says Professor Lencioni. "Technology now provides Interventional Radiologists a full line of devices capable of ablating a variety of lesions from one to seven centimetres in diameter. It is of utmost importance to be aware of the latest advances and to become familiar with the entire armamentarium to make the best choice when treating a case".

One recently launched device is the UniBlate, manufactured by AngioDynamics – RITA Medical Systems. The UniBlate features a single, 17 gauge cannula electrode with a scalable active tip length of 1 to 2.5 centimetres (Fig. 1). This novel feature allows the physician to perform multiple ablations with the same electrode; the physician can adjust the length of the active electrode to ablate areas between 1 and 3 centimetres in length and 1 and 2.5 centimetres in diameter, reducing the need to switch electrodes during a multiple ablation procedure. "The single needle design also provides an added level of safety when treating small tumours located in critical anatomical areas, where deployment of a multi-tined electrode array may be technically challenging" says Professor Lencioni.

Advanced workshops will also focus on new treatment strategies, such as the combination of RF ablation and the intra-arterial administration of drug-eluting beads (DC Bead, Biocompatibles), a technique named "DEB-enhanced RF ablation" by its inventor, Professor Riccardo Lencioni. "Chemoembolization is widely used to increase the effect of RF ablation when treating large liver tumours" says Professor Lencioni "Following the promising results reported in phase I/II studies with the use of doxorubicin eluting beads in the treatment of hepatocellular carcinoma, we have successfully developed a combination treatment that includes RF ablation followed by intra-arterial DEB administration for the treatment of large tumours refractory to standard RF ablation".

In fact, previous experimental work in animal tumour models demonstrated a significant dose-dependent increase in RF ablation-induced coagulation necrosis associated with the administration of doxorubicin. Professor Lencioni's clinical trial is the first one to prove such a synergy in human cancers. In his pilot study, DEB-enhanced RF ablation induced a high rate of sustained complete response in tumours resistant to standard RF treatment and was extremely well tolerated by the patients. The results are impressive: the mean increase in necrosis following DEB administration was 61%, leading to total or subtotal ablation of tumour masses of up to 7 cm in diameter (Fig. 2). After a mean follow-up period of 1 year, 10 of 20 treated patients were completely free of disease, and in 9 of 20 patients tumour growth was controlled by repeated interventions. Although only one of 20 patients died because of tumour progression, Professor Lencioni believes further investigation is warranted to fully explore the clinical benefit associated with this new therapeutic approach.

Don't miss it !

New tumour ablation modalities
Special Session 2903
Wednesday, September 12, 10:00-11:00
Room B (Mitropoulos Hall)

Fig. 1: UniBlate RF ablation device (AngioDynamics – RITA Medical Systems)

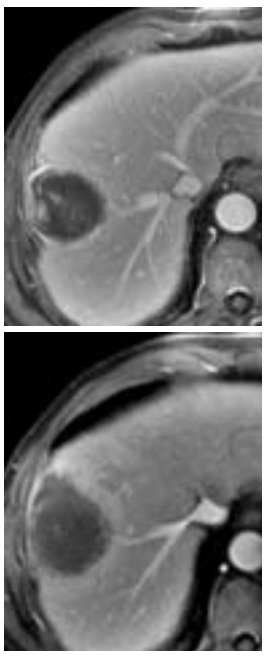


Fig. 2: Large hepatocellular carcinoma in subcapsular location shows partial ablation after standard RF ablation (a). Following intra-arterial administration of doxorubicin eluting beads (DC Bead, Biocompatibles), there is a clear-cut increase in the volume of necrosis, which results in complete tumor ablation (b)

Advertorial

Experience with 2nd generation AORFIX™ Endovascular Stent Graft

Dr Mark Fillinger
Dartmouth-Hitchcock Medical Center, Vascular Surgery, Lebanon, USA

The Aorfix™ stent graft has been in clinical use for over two years and recently achieved a milestone in the product's US trial, Pythagoras, when Dr Mark Fillinger implanted the 2nd generation Aorfix™ into a patient with an 80° neck angle. This was the first time that the 2nd generation Aorfix™ had been used in the US and is believed to be the first severely angled neck to have been treated in a stent graft clinical trial in the US.

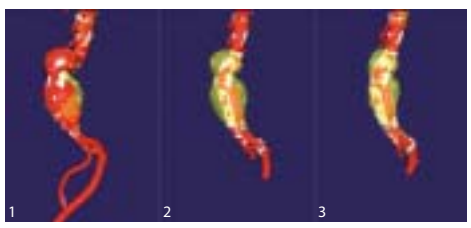
Dr Fillinger is the Principle Investigator for Pythagoras but his interest in Aorfix™ is wider than its well known success in angled necks.

"When I first handled the Aorfix™, I was intrigued by the hybrid design approach. It had much of the flexibility of the Ancure device, which was useful on many occasions, but the ring stents and modular design help control the implant much better during deployment. The implant felt conformable and likely to handle irregular anatomies, conical necks and changes in morphology"

To date, Dr Fillinger has placed 4 Aorfix™ and has found positioning the mouth to be precise. The proximal end of the graft is controlled throughout its deployment by being attached to its delivery system by two thin, semi-flexible rods. These stabilize the mouth during delivery and can be left attached to the graft throughout its deployment, detachment becoming necessary when the delivery system is removed. These rods are essential in preventing the graft from toppling or jumping down when it is deployed.

Aorfix™ was the subject of the European Arbiter study where it achieved aneurysm shrinkage in 60% of cases at six months and 83% of cases at 2 years. The device integrity and fixation is maintained during sac shrinkage. The inherent flexibility of the Aorfix™ design enables it to move with the anatomy of the vessel and thus remain patent throughout. To date in the US, the Pythagoras study has 4 patients to have reached 6 month or more follow-up; two are Dr Fillingers and of these he says, "I was pleased to see volume reduction of 20% at 6 months in one case and 24% at 12 months in the other. I understand that fellow investigators' patients have also shown shrinkage at 6 months. In terms of sac shrinkage, this equals the best devices available and I hope to see these early indicators confirmed at the end of the study."

1. 04-Mar-2006 Pre-op *2. 24-May-2006 Post-op*
3. 19-Oct-2006 Post-op *4. 23-Apr-2006 Post-op*



1. 18-Jul-2006 Pre-op *2. 19-Oct-2006 Post-op*
3. 20-Mar-2007 Post-op

Dr Fillinger is applying techniques he developed with previous stent grafts to the deployment of Aorfix™. "The most important thing with this graft is to start the deployment 30 or 40 mm above the renals to get the orientation and symmetry of the implant right before we pull it down to the renal landing zone.

Rotation of flexible delivery systems usually works best when they are being pulled slowly distally.

"The techniques we learned from other systems also work with Aorfix™; narrow access vessels can be dilated with a large sheath and core, followed by gentle but continuous pressure on the delivery system itself.

I sometimes find the Meier wire is helpful in tortuous necks because it has a long semi stiff tip which you can pull back into the delivery system. The Aorfix™ Gen 2 delivery system has a flexible core and this technique helps it to align itself in angled vessels."

Precision deployment is aided by the rotating ratchet handle of the delivery system.

Designed to deploy the mouth of the implant in 12 distinct clicks, the ratchet permits controlled, considered placement which is very different from 'pull and pray' systems.

Aorfix™ employs four pairs of hooks to provide active fixation of the proximal end. Lombard engineers achieved high levels of fixation with the hooks, avoiding the need for a suprarenal component. They found that suprarenal designs usually involved rigid components that crossed the renal arteries, limiting those implants' ability to tolerate peri-renal angulation.

Peter Phillips, President of Lombard Medical in the US added, "To date we have implanted 17 devices in our US trial with very high accuracy and excellent technical success. We use M2S models and analyses for all of our planning and it is clear that good quality CTs reconstructed with standardized 3D modeling techniques aid our outcomes significantly. In Europe, Lombard now offers a planning service based on its in-house Terarecon system and I strongly recommend that clinicians work with our sizing experts to plan their cases with the detail these systems provide."

Lombard Medical Breakfast Satellite Symposium
Sun 9th Sept, 08:00 - 08:20, Room E
6th Month-3yr Follow-up Data Of The Aorfix™ Endovascular AAA Stent Graft
Presenter: Prof M Szczerbo-Trojanowska, University Hospital, Lublin, Poland
Moderator: Mr Jan Macierewicz, UK
www.lombardmedical.com

STATINS – beyond the oculostenotic reflex

Christoph Kopp
Department for Angiology and Cardiology
University Hospital AKH
Vienna, Austria

Over the last years we - as an interventional community – have learned from several randomized controlled trials that statin therapy in patients with established cardiovascular disease not only reduces recurrent major adverse cardiovascular events and slows the progression of the disease, but also improves the short and long-term results after endovascular intervention, limiting the need for re-intervention. However, several epidemiologic trials showed an under-use of statins, even in patients with recent myocardial infarction or stroke.

Today statins, a class of 3-hydroxy-3-methylglutaryl-coenzyme A (HMG-CoA) reductase inhibitors, which act by decreasing cholesterol synthesis and by increasing "low density lipoprotein" (LDL) - catabolism via increased LDL receptor activity, play a central role in best medical treatment of patients with clinically manifest atherosclerosis. Evidence for the beneficial effect of this group of lipid lowering drugs in cardiovascular disease dates back to the Scandinavian Simvastatin Survival Study (4S trial), a multi centre, double-blind, randomized, placebo-controlled trial with simvastatin (20-40mg daily) in 4,444 patients (3,617 men and 827 women) aged between 35 and 70 years with established coronary artery disease and a mean cholesterol level of 261mg/dl at the study entry.

In this study simvastatin caused a highly significant reduction (37%) in the risk of death and morbidity in patients with coronary heart disease (CHD) followed for a median of 5.4 years. The study could also provide evidence for a beneficial effect of simvastatin on fatal und nonfatal cerebrovascular events.

The Cholesterol and Recurrent Events (CARE) study, a double – blind trial in 4,159 patients (3,583 men and 576 women) lasting for 5 years, demonstrated that the benefit of cholesterol – lowering therapy by pravastatin (40mg) extends to the majority of patients with CHD and an only moderately elevated LDL - cholesterol level (mean LDL 139mg/dl). In this cohort of patients the frequency of stroke was reduced by 31%.

The Long – Term Intervention with Pravastatin in Ischemic Disease (LIPID), a double – blind, randomized trial, compared the effect of pravastatin (40mg daily) with those of placebo over a mean follow-up period of 6.1 years in 9,014 patients (7,498 men and 1,516 women) who were 31 to 75 years of age with a median LDL - cholesterol level of 150mg/dl. The study showed a 24% relative risk reduction (RRR) of death from CHD and a 22% relative risk reduction from all cause mortality in the pravastatin group. The relative stroke risk was reduced by 19%.

The "Heart Protection Study" extended our knowledge about the effect of statins to an even broader population. During a five year period, 20,536 patients (aged 40 to 80 years) with CHD, other occlusive arterial disease or diabetes were randomly allocated to receive 40mg simvastatin daily or placebo.

There was a highly significant reduction of approximately 25% regarding the primary combined endpoint of non - fatal MI or coronary death, of non – fatal or fatal stroke and of coronary and non – coronary revascularisation therapy. Due to the large number of patients included, this study demonstrated substantial benefit not only in patients with manifest CHD, but also in those with cerebrovascular disease (CVD), peripheral arterial disease or diabetes.

Enhanced LDL- lowering beyond that obtained with standard doses of statins may further reduce CVD events. Current guidelines for cholesterol management in patients with advanced atherosclerotic cardiovascular disease set an LDL-C goal of <100mg/dL. Findings from the heart protection study (HPS) strongly suggested that high risk patients with a baseline level of LDL-C <100mg/dL will still benefit when LDL-C levels are reduced to well below 100mg/dL by drug therapy.

The Pravastatin or Atorvastatin Evaluation and Infection Therapy (PROVE-IT) trial, testing a high dose of statin that reduced LDL-C levels to 62mg/dL and comparing it to a standard dose that reduced levels to 92.5 mg/dL, showed a 16% reduction in CVD events with the high dose of statin. On the basis of the results from the HPS and the PROVE-IT trials, the National Cholesterol Education Programme proposed that an LDL-C goal of <70mg/dL is a therapeutic option in high-risk patients with advanced atherosclerotic CVD.

The extremely low rates of myopathy and the increase in liver enzymes found in these trials confirmed the safety of statins. Thus, the muscle or liver enzymes do not need to be measured routinely in most patients.

In addition to the lipid lowering effect different pleitropic effects of statins on inflammation, plaque volume and plaque stability were described. C-reactive protein CRP, an acute phase protein elevated in symptomatic as well as asymptomatic advanced atherosclerosis is lowered with statin therapy, which may account for plaque volume regression over a broad range of LDL-lowering, as demonstrated by the REVERSAL study. This study included 655 patients stratified to either pravastatin 40mg or atorvastatin 80mg daily. Plaque volume was measured by coronary intravascular ultrasound at baseline and after 18 months of therapy. High dose statin reduced plaque volume and thus the progression of the disease.

In randomized trials with 3 year follow-up, cholesterol lowering by statins has been shown to reduce the progression of carotid atherosclerosis defined by intima – media thickness in patients with cholesterol levels (>6 mmol/L) before treatment. Surprisingly, even in patients with cholesterol levels <6mmol/L, statins reduced the development of carotid atherosclerosis when followed up over a period of 4 years, eluding to the potent, non – lipid, pleotropic effects of statins.

In conclusion, statin therapy is a safe and effective therapeutic measure for patients with established atherosclerosis at high cardiovascular risk.

Don't miss it !
Atherosclerotic plaque
Statins and other drugs -
what is the evidence for treatment
Special Session 102
Saturday, September 8, 8:30-9:30
Room C (Skalkota Hall)

References:
1. MRC/BHF Heart Protection Study of cholesterol lowering with simvastatin in 20,536 high-risk individuals: a randomised placebo-controlled trial. Lancet, 2002. 360(9326): p. 7-22.
2. Cannon, C.P., et al., Intensive versus moderate lipid lowering with statins after acute coronary syndromes. N Engl J Med, 2004. 350(15): p. 1495-504.
3. Dichtl, W., et al., HMG-CoA reductase inhibitors regulate inflammatory transcription factors in human endothelial and vascular smooth muscle cells. Arterioscler Thromb Vasc Biol, 2003. 23(1): p. 58-63.
4. Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) final report. Circulation, 2002. 106(25): p. 3143-421.
5. Todd, P.A. and K.L. Goa, Simvastatin. A review of its pharmacological properties and therapeutic potential in hypercholesterolaemia. Drugs, 1990. 40(4): p. 583-607.

Interview with Dr. Antonio Laudani
President of the Cardiac Assist & InterVascular divisions

Antonio Laudani
President of the Cardiac Assist
& InterVascular divisions

1. Datascope is a new player in Interventional Radiology. What kind of company is Datascope?

Datascope is an innovative company that entered the market more than 42 years ago with an innovative patient monitoring system (PM). Subsequently, many other products followed.
DSCP is the worldwide leader in counterpulsation (CA) and is well-known in the Vascular Surgery field with its full range of Vascular Grafts and Patches.
Datascope's most recent achievement was entering the endovascular field, with Sorin peripheral products, which are now becoming an important part of our company's diversified portfolio of products.
There will be many more new and exciting products in the future.

2. There are several different divisions within the company. What is your role?

I have two roles within the company. My first role is that of President of both Cardiac Assist and InterVascular Inc. Division, my second role is that of Vice-President of the EMEA business. My main objective as President is to redefine our business strategy by incorporating both divisions while at the same time providing full support to EMEA to help business growth in Europe, Middle East & Africa.

3. What were the reasons for Datascope-InterVascular, as a producer of grafts & patches to enter into the endovascular market?

We have been very successful in manufacturing & marketing our grafts and patches for a number of years. We carefully monitored the changes that were progressively taking place, from an open vascular surgery techniques to the minimally invasive technology of the endovascular market.
I believe it would have been foolish to ignore these important changes and developments that were taking place which is why we decided to change our strategy by entering the Endovascular market with its new innovative technology and start to move away from the traditional polyester grafts & patches.
I strongly believe that the future lies with the Endovascular technology market.

4. Datascope is currently distributing exclusively Carbofilm coated peripheral stents manufactured by Sorin Biomedica. Will this be the only product or do you plan to expand the existing portfolio of endovascular product range?

The Carbofilm coated stent is our first product and this is just the beginning.
We plan to develop new products in the near future to increase our portfolio and help us become more competitive in the Interventional Radiology market.
There is no immediate announcement with regards to new Endovascular products at present.

5. Are there other products you have for the interventionists?

Yes, we do have another product that has not been mentioned so far, Safeguard.
This is a very simple but innovative device that helps to reduce the active compression time following femoral arterial cannulation after an interventional procedure.
It is a noninvasive device beneficial to the medical staff in reducing the time to complete haemostasis and by increasing the patients comfort.

Advertorial

Abbott Vascular – A Pioneering Company with a Leading Portfolio

The recent acquisition and integration of Guidant and subsequent creation of the Abbott Vascular division, has created a vascular care leader with unsurpassed global reach by bringing together top expertise in R&D, manufacturing, and commercial execution to advance vascular care.

About Abbott Vascular
Abbott Vascular, a division of Abbott, is one of the world's leading vascular care businesses. Abbott Vascular is uniquely focused on advancing the treatment of vascular disease and improving patient care by combining the latest medical device innovations with world-class pharmaceuticals, as well as investing in research and development and advancing medicine through training and education. Headquartered in Northern California, Abbott Vascular offers a comprehensive portfolio of vessel closure, and endovascular and coronary products, which are recognised internationally for their safety, effectiveness and ease of use in treating patients with vascular disease.

Dedication to Service
Abbott Vascular is committed to offering the best service to its customers and end users, through ongoing physician training and support, as well as reimbursement initiatives for new and existing therapies. In addition, Abbott Vascular has a global team of around 1,000 representatives and clinical specialists devoted to providing personalised customer solutions.

Driving Innovation
In its relentless pursuit to drive innovation, Abbott places great emphasis in leading the creation of next-generation products by investing in and developing new technologies and products.

With highly experienced R&D, clinical and regulatory teams, Abbott Vascular is a pioneer in research on emerging technologies, including vulnerable plaque solutions, bioabsorbable stents, combination DES, and cell therapy.

The company is also at the forefront of advancing knowledge on vascular care through industry-leading investment in R&D and clinical trials.

Strong Leadership in Clinical Trials
Abbott Vascular's commitment and leadership in advancing vascular knowledge is reflected in pioneering trials such as SPIRIT Women, the first-ever clinical trial focusing on cardiovascular disease in women.

One of Abbott Vascular's latest studies is STRIDES, a single-arm clinical trial that seeks to evaluate the use of an everolimus-eluting, self-expanding stent system for the treatment of peripheral arterial disease. STRIDES has commenced enrollment with 100 patients at 15 European sites.

The STRIDES trial will evaluate the combination of a fracture-resistant, self-expanding stent system specifically designed to withstand normal leg movement, with the anti-proliferative drug everolimus as a longer-term treatment alternative for blockages in the superficial femoral artery (SFA).

What makes Abbott Vascular a global leader:

- A singular focus on the vascular marketplace and commitment to quality
- A strong portfolio of products designed to serve the broad needs of physicians and patients
- A strong focus and market leadership in R&D investment and commitment to expand market knowledge through clinical trials
- A strong emphasis on providing best-in-class educational and training support to physicians and associated healthcare providers

Education

Founded in 2000 and located in Brussels, Belgium, the Crossroads Institute for Cardiac and Vascular Education (formerly known as the Guidant Institute for Therapy Advancement) provides a real-world educational experience for healthcare professionals at all stages of their careers.

With an international faculty of over 70 expert physicians, the Crossroads Institute provides training on the latest developments in cardiovascular care in cooperation with major societies such as EBAC (European Board for Accreditation in Cardiology) and ESVS (European Society for Vascular Surgeons). Training programs cover various therapies such as carotid stenting and treatment of diabetic patients with CLI. Hands-on courses include working on close-to-reality flow models in an operational cath lab as well as VR simulation training. Discussion Forums for experienced physicians are provided on a regular basis.

Product Portfolio

Abbott Vascular offers a comprehensive range of vascular solutions with an advanced portfolio of carotid, peripheral and vessel closure products to assist physicians in a broad range of interventional procedures.

Peripheral Intervention Products
Abbott offers broad lines of self-expanding and balloon-expandable stents for treating peripheral arteries in iliac, SFA and infrapopliteal occlusive disease.

- The Absolute Self-Expanding Stent System for SFA has clinically proven superiority over the use of PTA alone, as well as fracture resistance [N Engl J Med 2006; 354:1879-88]. The established durability of the stent implant shall be leveraged in designing the SFA DES stent in future.

- The recently launched RX Herculink Elite is a cobalt chromium stent that boasts excellent radiopacity, low profile, high radial strength and outstanding stent flexibility. The Grip technology ensures excellent stent retention and sizing flexibility, as well as a safe procedure.

- The Omnilink stent has a multiple linked corrugated ring design and is one of the newer generation low-profile flexible balloon-expandable stents with good radial force used for the treatment of iliac arterial occlusive disease.
- The Xpert stent system has been specifically designed for small vessels. This self-expanding stent system is available in diameters from 3mm to 8mm, with excellent clinically-proven one-year results in limb salvage with CLI patients

Carotid Stents and Embolic Protection Devices

Abbott Vascular offers a full portfolio of carotid stents and embolic protection systems, giving the physician the power of choice in treating the patient:

- The RX ACCULINK Carotid Stent System is a widely-used, low profile, highly flexible and conformable carotid stent designed to provide easy and accurate stent placement in patients who have carotid stenosis and are at high risk for conventional surgery. It utilises rapid exchange (RX) technology so that a single operator can easily control the embolic protection device and stent delivery system during catheter manipulations.
- The RX ACCUNET Embolic Protection System is used by hundreds of physicians worldwide and features a dual strut filter basket and two different recovery catheter choices with a fixed wire design.
- The Xact Rapid Exchange Carotid Stent System offers accurate sizing, minimal foreshortening, high scaffolding, and high radial force at the lesion.

- The Emboshield PRO Embolic Protection Device is one of the latest embolic protection systems, based on bare wire technology with a highly visible filter and catheter tip to allow accurate and easier handling, a short filter parking length, and a highly visible retrieval tip.

Vessel closure
A pioneer in closure technologies, Abbott Vascular offers products designed to facilitate secure closure of the vascular access site after coronary and peripheral catheterisations. Clinicians use these products to help patients to ambulate safely and improve patient comfort.

- The StarClose Extravascular Closure System features an innovative Nitinol clip that is designed to promote the primary healing process to achieve a secure close of femoral artery access sites following diagnostic or interventional vascular procedures.
- The Prostar vascular closure device is a suture mediated closure device which offers early hemostasis, early ambulation and improved patient comfort to patients undergoing large hole closure. The Prostar is a time tested product indicated for 9 to 10F sheaths.

- The Proglide is the device of choice for secure reliable closure for those who prefer suture. Featuring monofilament prolene suture, the Proglide device can be used by a single operator with a short wire, and is our easiest Perclose ever.

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Additional information on Abbott Vascular, its products, clinical trials and news is available on the company's website abbottvascular.com.

Greek Mythology or Antiquity's Soap Operas

by Petra Mann
Cirse Office

There is barely anything in this world as beautiful and enriching as travelling. Also, there is barely anything as intellectually humbling. Who of us has not read an inscription on a statue thinking "King of the who?" or nodded knowingly at a tour guide's explanation without having the faintest idea what he was talking about. This feeling becomes especially excruciating in a country with a history as rich as the Greek. Having learned about Greek mythology in school adds a certain "I should know this" factor to the equation, which certainly doesn't help. You will be glad to hear that henceforth you shall not confuse Aphrodite with hermaphrodite or think that Achilles is a body part anymore. Ever so eager to help, we have put together a short summary of the most important Greek legends, a best of Greek gods, a top ten of the heroes and zeroes of Antiquity.

Zeus, king of gods and womanizer

It is not very commonly known that Zeus liked to relax from a hard day's work as super-god enjoying the company of Greece's finest ladies, preferably other people's wives. I guess most men were hard pressed to tell the father of gods to stay away from their wife…
So for all of you who like the juice gossip here is a list of some of his erotic adventures:

Danaë

Zeus came to her in the form of a shower, impregnating her with Perseus (too bad women nowadays do not have that excuse anymore).

Alcmena

Zeus came to her in the shape of her husband. After Zeus spent the night with her, her husband was quite surprised to find her not too enthusiastic about his advances. She later gave birth to twins: Heracles being Zeus's offspring and the other baby her husband's (I know, I know, but you will simply have to put your medical knowledge aside when reading about Greek mythology).

Leda

Zeus turned into a swan to visit Leda, wife of King Tyndareus of Sparta, and fathered two children with her (I guess she must have been really, really lonely…).

Europa

In order to seduce Europa, Zeus turned himself into a bull and carried her over the Aegean Sea to Crete. I know what you are thinking right now: that guy needs some serious marriage counselling, but then again anything goes when you are the king of gods…

Io

Probably tired of having to go through all the trouble of disguising himself for the ladies, Zeus changed his strategy with beautiful Io, who he turned into a white cow. Being a little weary of his constant infidelities, his wife Hera asked Zeus to give the cow to her and sent a biting fly to plague her. Poor Io finally turned back into a woman, but still couldn't rid herself of Zeus, as she gave birth to his son Epaphus.

The bold and the beautiful – the Olympian Gods

Most of the Greek gods supposedly lived on Mount Olympus, located in Northern Greece, each one of them handling a different aspect of human life. After our short introduction to Zeus let's have a look at his brothers, Poseidon and Hades.

Legend has it that Zeus and his brothers drew lots to divide the world among them. Zeus was assigned the skies, making him king of the gods, Poseidon the oceans and seas (good luck handling that global warming!) and Hades the underworld (he must have picked the shortest straw).

Poseidon –

Do I smell fish?

Poseidon was not only the god of the seas and everything in or on it, but also (less commonly known) the god of earthquakes. Being Zeus's brother, Poseidon was quite a stallion himself, which, thinking about it, might be the reason why he was also worshipped as the god of horses. He was married to Amphitrite, one of the 50 (!) daughters of the god of rivers Nereus. Poseidon has a special relation to Athens, as he and Athena once got into a fight over which one of them would be the patron of the young and upcoming city. In his endeavour to suck up to the people of Athens, Poseidon gave them horses and a spring of salt water on the hill of the Acropolis. Athena on the other hand gave them olive trees. Since olives can be used for a lot of things, most importantly martinis, the people of Athens wisely opted for the olive trees, which is why Athens is called Athens and not Poseidonia.

Hades –

God of the underworld (and heavy metal bands)

Hades was the Greek god of the underworld, i.e. the land waaaay down under and therefore emperor of all former heavy metal band members and lawyers (just kidding, of course lawyers wouldn't even get in there). The gate of the underworld must have had a big "Beware of the dog" sign on it, as it was guarded by Cerberus, a cute little puppy with three heads that would shred anyone into pieces if he or she tried to make a run for it.

What is not very commonly known about Hades is that he was also the god of precious stones and metals, as these come out of the ground. This is probably why he drove a golden chariot, or as I like to call it: the first ever pimped ride.

Since meeting a nice girl in the underworld is not all that easy, Hades decided to resort to the good old pre-historic club-over-the-head method and simply kidnapped Persephone to drag her down to the underworld. Persephone just so happened to be the daughter of Demeter, the goddess of fertility, who decided to go on a strike to bring her daughter back (hence creating the first winter). When Hades finally returned Persephone to her mother, he gave her a pomegranate to eat. As the pomegranate was the food of the dead (comm'on, it's not that bad) and Persephone ate four seeds from it, she would henceforth have to return to the underworld for four months per year during which time her mother would stop working, winter would return and people would have to wear warm socks.

Apollo –

Antiquity's George Clooney

Apollo, the god of light, truth and healing was probably the most handsome one of the Olympian Gods. Since he was quite an athlete and the laurel tree the plant attributed to him, the winners of athletic competitions would receive a crown of laurels. Apollo also played the lyre, which is why music was another one of his domains and he is sometimes associated to the Muses (can you blame them?).

Hephaestus –

A guy with a great character

After Zeus had produced Athena by himself (again; medical knowledge was not that developed when these myths were created), Hera decided that she did not need her spouse to produce offspring either and created Hephaestus. Although extremely skilled, Hephaestus was, well, let's say he had a great personality, a really great one. Accounts vary from him being not so easy on the eye all the way to completely deformed. Nevertheless he did quite well for himself due to his extraordinary skills making armour and weaponry, which is also why he was known as the god of fire and the forge and the patron of craftsmen. Interestingly enough he was married to beautiful Aphrodite, hence creating the concept of a trophy wife.

Ares -

God of war and trouble makers

Ares, son of Zeus and Hera, was the god of war and therefore not the most popular kid on the block. Never shy to cause trouble he was also Aphrodite's lover. They had three children: Eros (Love), Deimus (Dread) and Phobus (Fear). Eros went on to become the god of sex (now that's a job), whereas his brothers Fear and Dread were obviously not quite as popular.

Artemis (Diana) –

The first tree hugger

Artemis, one of Zeus' offspring and Apollo's twin sister loved the outdoors and wild animals. In fact she loved them so much that she became the goddess of the hunt (there goes the logic of Antiquity again). Her symbol is the moon as opposed to her brother's sign the sun. She was also associated with women's monthly cycles, including PMS, I guess, which is probably why there are numerous accounts of her killing people in an attack of fury.

Dionysus –

God of parties and groupies man

Dionysus is well known as the god of wine and partying. His symbols were the grape vine and the ivy (I wonder if this is why a bunch of universities decided to call themselves Ivy League). Being the good time god Dionysus of course never lacked company. He travelled surrounded by an entourage of groupies called Maenads. He was also accompanied by satyrs, half men (on top) and half goats (down under) whose task was to dance around, drink and engage in all other groupie type of activities. Although he stood for many fun things, the ancients had mixed feelings about him, as he also stood for the crazy things people do when drunk (and for hangovers).

Don't miss it !
Film Interpretation Panel
Gods vs. Heroes
Monday, September 10, 15:00-16:00
Room A (Trianti Hall)

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Trianti Hall
(Entrance level)

MEET THE EXPERTS
Room located behind the
Boston Scientific Booth (Entrance level)

CLINICAL DAY
Room located behind the
Boston Scientific Booth (Entrance level)

Monday, 10 Sept, 2007

Clinical Insights from IR Frontiers

11:30 – 12:30 **Long-Term Results after Liver RFA with LeVeen Electrodes™: results of 500 patients**
Dr. J.R. Kachura, Canada

A Journey into SPACE provides an Interesting Outcome
Prof. M. Hartmann, Germany

Sunday, 9 Sept, 2007

09:30 – 10:30 **Developing your RAS Practice: The Nephrologists – Radiologists Interface**
M. Downes, UK - C. Farmer, UK

11:00 – 12:15 **Practical Inroads on a Cool Journey: CryoPlasty™ Clinical Case Reviews**
J.O. Balzer, Germany - B. Wiechmann, USA – M. Gargiulo, Italy

14:00 – 15:00 **Radiofrequency Ablation of Breast Tumors: modalities, clinical results, its place in breast conserving treatment?**
J. Palussière, France

16:00 – 17:00 **Techniques in Complex Embolization: The Art of Coiling**
J. Jackson, UK

Tuesday, 11 Sept, 2007

09:00 – 10:00 **NeuroRescue Techniques in Carotid Artery Stenting**
M. Hartmann, Germany

10:30 – 12:00 **Tips to Minimize Complications During CAS: Clinical Case Reviews**
N.J.W. Cheshire, UK – K. Mathias, Germany – C. Rabbia, Italy

13:30 – 14:30 **Reduction of complication rates using proximal Valved Venous Access Devices**
R. Reyes, Spain

Monday, 10 Sept, 2007

09:15 – 09:45 **BEACH: Carotid Stenting 2 year follow-up**
B.T. Katzen, USA

10:00 – 10:30 **PROTECT registry: Distal Protection in Lower Limbs**
S. Müller-Hülsbeck, Germany

10:45 – 11:15 **Below The Knee Chill: 365 days follow-up**
B.N. Wiechmann, USA

11:30 – 12:00 **RASCAL: Renal Artery Stenting and Cardiac Linkage**
M.-C. Monice, France

12:15 – 12:45 **Renaissance: Renal stenting 2 years clinical and DUS data**
K. Rocha-Singh, USA

13:00 – 13:30 **Prometheus trial: RF + Chemo vs. Chemo alone for patients with liver metastasis**
T. de Baere, France

13:45 – 14:15 **Studies and Registries: Use and Misuse**
M. Daridan, France

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