2025 POST-ESC HIGHLIGHT SYMPOSIUM

(高雄場)

時間: 114 年 10 月 4 日(星期六) 09:00-12:00

地點: 高雄漢來大飯店 15 樓會展廳 (高雄市前金區成功一路 266 號)

	Topic	Presenter	Moderator
09:00 – 09:05	Welcome Remarks		李貽恒
09:05 – 09:25	Hot Line and Late-Breaking Clinical Trials	林宗憲	李貽恒
09:25 – 09:45	Intervention cardiology	杜宗明	洪惠風
09:45 – 10:05	Prevention	王朝平	洪惠風
10:05 – 10:25	Panel Discussion		謝宜璋
10:25 – 10:35	Healthy Break		
10:35 – 10:55	Image	王俊力	洪明銳
10:55 – 11:15	Hypertension	劉俞旻	王宗道
11:15 – 11:35	Heart Failure	徐千彝	陳志成
11:35 – 11:55	Panel Discussion		賴文德
11:55 – 12:00	Closing Remarks		賴文德

林宗憲 醫師

專長
高血壓、心絞痛、心肌梗塞、心衰竭、心律不整、四肢動靜脈疾病診治、心臟及周邊血管超音波檢查、心導管及周邊血管介入性治療

現任職稱
高雄醫學大學附設中和紀念醫院副院長
高雄醫學大學附設中和紀念醫院運營管理部主任
高雄醫學大學附設中和紀念醫院心臟血管主治醫師
高雄醫學大學醫學系教授
高雄醫學大學臨床醫學研究所合聘教授

學歷
高雄醫學大學醫學系學士
高雄醫學大學臨床醫學研究所碩士
高雄醫學大學臨床醫學研究所博士

專科執照與學會
內科醫學會專科醫師及指導醫師
心臟學會專科醫師及指導醫師
重症醫學會及重症專科醫師
介入性心臟血管醫學會

經歷
高雄醫學大學附設中和紀念醫院實習醫師
高雄醫學大學附設中和紀念醫院內科住院醫師
高雄醫學大學附設中和紀念醫院心臟內科總住院醫師
高雄醫學大學附設中和紀念醫院心導管室主任
高雄醫學大學附設中和紀念醫院心臟血管內科加護病房主任
高雄醫學大學附設中和紀念醫院心功能室主任
高雄醫學大學附設中和紀念醫院行政管理中心主任
高雄醫學大學附設中和紀念醫院心臟血管內科主任
高雄醫學大學附設中和紀念醫院院長室醫務秘書
高雄醫學大學附設中和紀念醫院醫品病安管理中心主任
高雄醫學大學教師發展中心臨床技能組組長

杜宗明 醫師

現任

- 亞東紀念醫院 心導管室主任
- 亞東紀念醫院心臟血管內科專任主治醫師
- 致理科技大學兼任助理教授

主治項目

- 三高（高血壓，高血脂，糖尿病）治療
- 冠狀動脈心臟病診斷治療(心導管及支架置放手術)
- 瓣膜性心臟病診斷及治療
- 心衰竭診斷及治療
- 急重症照顧

學歷

- 國防醫學院醫學系

經歷

- 住院醫師：國軍新竹醫院內科部、國軍松山總醫院內科部
- 總醫師：三軍總醫院心臟內科、國軍松山總醫院內科部
- 主治醫師：曾任國軍松山總醫院急診醫學科、曾任三軍總醫院心臟內科、曾任國軍松山總醫院內科部
- 空軍司令部內科醫官
- 三軍總醫院心臟內科研究員
- 國防醫學院臨床講師
- 經國管理學院兼任講師
- 致理科技大學兼任講師
- 教育部部訂助理教授
- 心臟專科指導醫師
- 中華民國心臟醫學會專科醫師
- 重症專科指導醫師,一般醫學專科指導醫師,一般醫學導師
- 中華民國內科專科指導醫師
- OSCE 台灣醫學教育學會考官
- 中華民國內科專科醫師,心臟血管介入專科醫師

王朝平

義大癌治療醫院 內科部 副部長

專長：

介入性心導管檢查及治療(含冠狀動脈氣球擴張術、血管支架置放術、先天性心臟病檢查、周邊血管硬化阻塞與血管廔管阻塞之導管治療)、永久人工心律調節器置放術、心臟超音波檢查 (含經胸前，經食道及即時 3-D 立體心臟超音波)冠狀動脈疾病治療、心臟衰竭治療、瓣膜性心臟病治療、心臟預防醫學治療(含高血壓、高血脂、代謝性症候群)、週邊血管硬化診斷及治療、 昏厥診斷及治療、各種急慢性心臟血管疾病治療

學經歷：

高雄醫學大學畢業

義大醫院心臟內科主治醫師

前高雄長庚醫院心臟內科主治醫師

中華民國心臟學會專科醫師

台灣介入性心臟血管醫學會會員

義守大學生物技術暨化學工程研究所博士

教育部部定教授

義守大學醫學院學士後醫學系專任教授

王俊力醫師

心臟超音波、心衰竭治療、一般心臟學

- 現職
  - 林口長庚心臟內科系副系主任
  - 心臟內科教授級主治醫師
  - 長庚大學醫學系教授
- 學歷
  - 台北醫學大學醫學系
- 經歷
  - 美國明尼蘇達州梅約醫院（MAYO Clinic）研究員
  - 日本神戶市立中央市民病院進修
  - 林口長庚心臟內科系非侵襲性心血管中心主任
  - 林口長庚心臟內一科主治醫師
  - 林口長庚心臟內一科住院醫師
  - 林口長庚內科部住院醫師
- 學會與認證
  - 超音波專業醫師
  - 中華民國心臟學會專科指導醫師
  - 中華民國心臟學會專科醫師
  - 內科專科醫師

劉俞旻 醫師

- **現職**

新竹馬偕紀念醫院內科部主任(2025~迄今)
新竹馬偕紀念醫院心臟內科主任(2025~迄今)
新竹馬偕紀念醫院心血管中心主任(2025~迄今)
馬偕醫學院醫學系兼任助理教授 (2019-迄今)
新竹馬偕紀念醫院心臟內科主治醫師 (2007-迄今)

主要學歷

醫學博士 | 2000 | 法蒂瑪醫學院-醫學系
哲學博士 | 2019 | 國立清華大學-生物資訊與結構生物研究所
學士 | 1997 | 英屬哥倫比亞大學 (UBC)主修: 細胞生物與基因

主要經歷

新竹馬偕紀念醫院內科部副主任(202407~202506)
新竹馬偕紀念醫院醫學研究科主任 (2018-202406)
中華民國內科專科指導醫師
中華民國心臟內科專科指導醫師
台灣心血管介入專科醫師
清華大學醫學科學系/先進光源科技學位學程合聘助理教授
糖尿病共同照護網成員
台北馬偕醫院心臟內科總醫師
台北馬偕醫院內科住院醫師
中華民國公職醫師高考合格
美國醫師 USMLE STEP 1&2 考試及格
美國麻省總醫院 (MGH) 訪問學生

其他相關

獲獎/榮譽:

歐洲心臟學會 (ESC)院士(2024~迄今)
亞太心臟學會 (APSC) 最佳論文獎 2019
歐洲心臟學會 (ESC) 最佳論文獎 2016

會員:

台灣內科醫學會會員
中華民國心臟學會會員
中華民國醫用超音波學會會員
臺灣介入性心臟血管醫學會會員

徐千彝 醫師

現職：

- 臺北醫學大學附設醫院心臟內科專任主治醫師
- 臺北醫學大學附設醫院研究部副主任
- 臺北醫學大學醫學院醫學系專任副教授
- 教育部部定副教授

學歷：

- 國立陽明大學醫學系學士
- 國立陽明大學臨床醫學研究所博士

經歷：

- 臺北榮民總醫院內科部住院醫師
- 臺北榮民總醫院心臟內科住院總醫師
- 臺北榮民總醫院心臟內科主治醫師
- 美國加州大學聖地牙哥分校(UCSD)心血管實驗室進修醫師
- 臺北榮總玉里分院內科部主治醫師

專科證書：

- 醫師證書
- 內科專科醫師證書
- 中華民國心臟學會專科醫師證書
- 臺灣介入性心臟血管醫學會專科醫師證書

Hot Line and Late-Breaking Clinical Trials

林宗憲

Many clinical trials are presented in the “Hot-Line sessions” of European Society of Cardiology scientific conference this year. Studies, including DANISH and REM-HF for the efficacy of implantable cardioverter defibrillator in heart failure patients were presented and discussed. Strategies of dual antiplatelet treatment (DAPT) and platelet function monitoring (ANTARCTIC) challenged the current concept of DAPT treatment. Management for hyperlipidemia is still a hot topic in this year. Study from Japan (IJ-PROPER) argued the effect of ezetimibe on acute coronary event. ESCAPE trial investigated the effect of alirocumab, a PCK9 inhibitor, on the frequency of lipoprotein apheresis in a randomized phase 3 setting. CE-MARC 2 trial investigated the diagnostic accuracy for coronary artery disease by various image modality, including MR and SPECT and presented in the meeting. The choice of anti-platelet agents and its effects in patients without stenting were discussed in EROSION and PRAGUE-18 trials. ENSURE-AF study reported the effects of edoxaban vs. enoxaparin/warfarin in subjects undergoing cardioversion of atrial fibrillation. These results of clinical trials update the concept and provide information on treatment strategies on patients with cardiovascular diseases.

Intervention cardiology

杜宗明

Topic 1: POIES-2 trial: Aspirin in patients undergoing noncardiac surgery

Perioperative aspirin not prevent death or MI, but increase risk of major bleeding

Topic 2: POIES-2 trial: Clonidine in patients undergoing noncardiac surgery

Clonidine not reduce post-operative MI or death, but increase clinically important hypotension

Topic 3: ALECARDIO trial: Effect of Aleglitazar on cardiovascular outcome after acute coronary syndrome in patients with type 2 diabetes mellitus

Aleglitazar not decrease the risk of cardiac mortality, MI, or stroke in type 2 DM patient with recent MI, but increase risk of heart failure, renal dysfunction, bone fracture, GI hemorrhage, and hypoglycemia

Topic 4: GIPS-III trial: Glycometabolic intervention in patients presenting with ST-segment elevation myocardial infarction

In patients without diabetes, metformin 500mg 2dd, started directly after PCI and continued for 4 months does not preserve left ventricular ejection fraction after STEMI as compared to placebo

Topic 5: CHOICE trial: A randomized comparison of self-expandable and balloon-expandable prostheses in patients undergoing transfemoral transcatheter aortic valve replacement

Balloon-expandable valve had greater rate of device success than self-expandable valve

Topic 6: STS/ACC TVR registry: One year outcomes from the STS/ESC trascatheter valve therapy(TVT) registry

Multivariable model

Death: age, male gender, severe COPD, ESRD, access site, STS PROM

Stroke: female gender

Prevention

王朝平

Abstract:

More and more evidences indicated environmental pollutions are important risk factors affecting cardiovascular diseases (CVDs). Among these, urban air pollution shared the greatest contribution in the association with human diseases, which is not confined to illness and also involves a higher impact on CVDs morbidity and mortality.

The mechanisms linking air pollution and cardiovascular diseases are proposed in the scientific statement from the American Heart Association by Brook et al., and our previous studies may add support for these mechanisms, including those on inflammation and pro-coagulation, decreased heart rate variability, increased oxidative stress, increased aortic pulse wave velocity, decreased left ventricular (LV) dP/dt max, and increased systemic vascular resistance.

We have provided evidence that exposure to air pollution may decrease pulse pressure in the general population. Short- term exposure to PM2.5 contributes to pulse pressure narrowing along with cardiac and vasomotor dysfunctions in office workers with non-dipper of blood pressure at night. Moreover, in middle-aged adults, the intima-media thickness of the carotid artery and inflammation indices in terms of blood leukocyte and monocyte are associated with the individual's exposure to air pollution of PM2.5 absorbent, PM10, NO2, and NOx as derived from long-term air pollution exposure estimated by land-use regression models of the European Study of Cohorts for Air Pollution Effects. These studies provide supporting evidence of an increased risk of subclinical cardiovascular health following long-term air pollution exposure in Asia.

Air quality in Asia has deteriorated significantly in recent decades because of rapid industrialization, urbanization, and motorization. How to cope with these issues and critical conditions, searching for possible solutions are anticipated.

Imaging

王俊力

Exercise echocardiography is usually performed to detect reduced LV systolic and/or diastolic reserve capacity in the setting of coronary disease or diastolic dysfunction, as patients with diastolic dysfunction may have a similar hemodynamic profile (in terms of cardiac output and filling pressure) at rest as healthy individuals who have normal diastolic function.

Diastolic stress testing is indicated when resting echocardiography does not explain the symptoms of heart failure or dyspnea, especially with exertion. The most appropriate patient population for diastolic exercise testing is the group of patients with grade 1 diastolic dysfunction, which indicates delayed myocardial relaxation and normal LA mean pressure at rest.

Diastolic stress testing is best performed with exercise and not using dobutamine as the administration of the drug does not simulate the day-to-day physiologic stress.

Hypertension

劉俞旻

In the past 5 years, key guidelines have been published regarding the treatment for hypertension in different countries and societies.

1) Hypertension and CVD prevention: Nature's randomized trial of blood pressure and cholesterol lowering. In this study, we discussed the effect of treatment for both hyperlipidemia and hypertension in hypertensive patients.

2) Lowering blood pressure: How low should we go? In this session of meeting, we discussed about a) Should guidelines aim for lower BP targets? SPRINT study b) Should SPRINT prompt guidelines to lower the systolic BP target to 120mmHg in high risk patients? c) BP measurement in SPRINT d) Unattended" BP measurement in SPRINT e) Never used before in a major outcome trial f) Results in lower BP values than usual measurement of BP in routine practice (estimated to be approximately -10mmHg g) More adverse events with lower SBP in some patients h) Maybe, a more realistic SBP target is <130mmHg in usual clinical practice

3) Optimal blood pressure lowering in coronary artery disease patients: blood pressure in CAD. In this session, we discussed about: a) Life long exposure to a 10mmHg lower SBP and 1mmol/L lower LDL-C may reduce CVD risk by almost 90% - irrespective of baseline levels. b) SPRINT suggested aiming to lower SBP to <120mmHg would reduce CVD and death but there is uncertainty about the actual BP levels achieved <130mmHg. c) Caution in lowering BP to 120/70mmHg in people with CAD.

4) More device-based treatments for hypertension. A) Pacemaker-mediated programmable hypertension control therapy. B) Sensitizing the baroreceptor to lower blood pressure in resistant hypertension

In conclusion, systolic BP and LDL-C are the major causes of CVD and modest reductions in both, over a lifetime, have the potential to prevent the development of CVD. Lively debate about whether BP should be lowered much further – with caution that over-aggressive BP lowering (<120/70mmHg) may increase CVD risk in people with CAD. we don't even achieve the existing BP target of <140/90mmHg in most patients.

HEART FAILURE

徐千彝

Reducing heart failure (HF) hospitalization length of stay (LOS) may reduce costs and prevent adverse hospital-related outcomes. Yet, premature discharge in a state of persistent congestion may counteract these benefits. A Canadian study showed that, among elderly HF patients discharged from hospital, a long LOS is associated with a higher risk of 30-day all-cause readmission and death. Short or long LOS during the index admission identifies a group who are at higher risk of 30-day CV and HF readmissions.

Management of elderly patients with acute HF may present differences from younger patients' regarding rates of prescription and dosing of in-hospital intravenous (IV) therapies as well as long-term HF life-saving medications. However, the effect of both IV and long-term HF medications administered in-hospital on the short-term outcome of elderly versus non-elderly AHF patients has not been addressed previously. Analysis from ALARM-HF registry revealed IV inotropes impose a deleterious effect on in-hospital mortality for both elderly and non-elderly patients with acute HF. Among long-term HF medications, ACE inhibitors and MRAs administered in-hospital consistently improve patients' in-hospital outcome irrespective of age.

The role of beta-blockers and their favorable prognostic implications in the setting of patients with heart failure (HF) and concomitant atrial fibrillation (AF) has been debated. EURObservational Research Programme on Atrial Fibrillation (EORP-AF) Pilot Registry revealed that, among AF patients, HF is common but beta-blockers non-use was evident in 22%, and was associated with a significant risk for all-cause death and cardiovascular death. Non-adherence to ESC guidelines by undertreatment with beta-blockers was associated with a two-fold higher risk of major adverse events.

Chemotherapy-induced cardiotoxicity is now recognized as one of the most feared side effects which has been reported in 50% of breast cancer patients up to twenty years later, of which the majority occurring post chemotherapy. Recent UK retrospective cohort study revealed that, among patients who had adequate follow up, 11% developed left ventricular systolic dysfunction during chemotherapy. They suggested that, despite the existence of guidelines to monitor cardiac function, only half of the patients studied in their cohort were monitored. Although left ventricular systolic dysfunction usually develops at later stages of cancer treatment, they found its occurrence even when chemotherapy is being delivered, which highlights the importance of surveillance to ensure early detection and management.