Interventional cardiology and general cardiology: divided by a common speciality?*

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For a couple of years now, the annual meeting of the American College of Cardiology (ACC) consists of two separate meetings: the conventional ACC meeting and the SCAI-ACCi2 (Society for Cardiovascular Angiography and Interventions) meeting. The SCAI-ACCi2 meeting is specifically intended for interventional cardiologists and in order to attend the meeting one has to pay either a special entrance fee for this meeting or an additional fee to attend both meetings. Even Fellows of the ACC are not allowed into this dedicated interventional meeting (unless they pay the additional entrance fee). At the ACC.08 meeting in Chicago this year, the general cardiologist (ACC.08) could be recognised by a blue badge and the interventional cardiologist by a yellow badge (SCAI-ACCi2). Why two separate meetings? Why a structural separation between 'general' and 'interventional' cardiology.

First, who is an interventional cardiologist these days? The common view is that an interventional cardiologist performs percutaneous coronary interventions (PCI) primarily by putting stents into patients with stenosed coronary arteries, both in patients with an acute myocardial infarction (AMI) and on an elective basis. Over the last 30 years, PCI has dramatically improved patient care based on the major breakthroughs and tremendous advances in the field. Andreas Grüntzig and his followers have altered the landscape and horizon of our speciality for good. Primary PCI has become the mainstay of treating patients with AMI. However, the confinement of intervention to coronary pathology has become too narrow. Nowadays, cardiac interventions are also performed by electrophysiologists (implantable cardioverter defibrillators, radiofrequency ablation pro-

cedures), congenital cardiologists (balloon dilatation of narrowed valves and conduits, stenting of pulmonary vessel stenosis and aortic coarctation, percutaneous valve replacements, closure of patent foramen ovale and septal defects, ablation procedures) and echocardiologists (intravascular ultrasound (IVUS) and intracardiac echocardiography (ICE)). Some of these procedures are being performed solely by or in conjunction with interventional cardiologists or by interventional cardiologists in conjunction with cardiothoracic surgeons, such as the treatment of elderly patients with inoperable aortic valve stenosis who have become candidates for percutaneous valve procedures. Consequently, interventions in cardiology stretch much further than just treating coronary pathology.

The SCAI-ACCi2 meeting was predominantly focused on coronary artery disease, therefore dealing with a field that is much too restricted. In addition, having a separate meeting like this might give the wrong impression that non-interventionalists are not interested in the major advances in the field of cardiovascular interventions, i.e. one has created a meeting by interventionalists for interventionalists. The métier of PCI has become so distant from common cardiology practice that the feeling arises that the general cardiologist is indifferent to what is happening in the forefront of interventions; it has all become too technical. This assumption is far from the reality. In particular, the general cardiologist should be well informed on the major advances in the domain of intervention. General cardiologists should especially be able to follow the discussions on bare-metal stents versus drug-eluting stents, to become acquainted with advances in biodegradable stents, thrombus aspiration, vascular protection devices, stem cell therapy, carotid stenting, percutaneous left atrial appendage occlusion, percutaneous valve procedures etc, etc. On the other hand, having separate meetings might give the false signal that the interventional cardiologist is only marginally interested in general cardiology issues such

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* From George Bernard Shaw. *America and England are two countries divided by a common language.*

as advances in electrophysiology, congenital heart disease or myocardial imaging. For instance, in the era of integrated imaging, many invasive procedures are based on the results obtained from the use of imaging modalities. Image-guided intervention has become a key issue in optimal patient treatment and therefore the interventional cardiologist should be able to evaluate IVUS, ICE, scintigraphic, magnetic resonance and CT images.

In any case, by structurally separating interventional from general cardiology (or should we say invasive from noninvasive cardiology), thereby creating two types of cardiologists, we are entering a pathway in cardiology that is principally wrong. Such a pathway will be detrimental to the speciality of cardiology, to

the feeling of membership in a professional society, and finally to patient care. Cardiology is and has to remain one undivided speciality consisting of well-defined subspecialties but certainly no stand-alone superspecialties. I do sincerely hope that our own national society, the NVVC, will never engage in such a policy. In this respect, it is worthwhile to remember the words of William Boden, who stated that any cardiologist who actively treats a patient performs an intervention.¹ Or, putting it the other way around, aren't we all general cardiologists? ■

Reference

- 1 Yarlagadda RK, Boden WE. Are we all becoming "interventional" cardiologists? *J Am Coll Cardiol* 2002;**40**:1915-8.

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