OFFICIAL NEWSLETTER OF SLCC

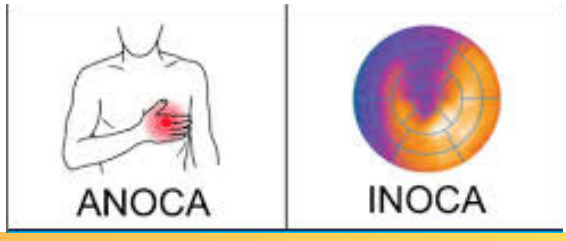
FEBRUARY 2025

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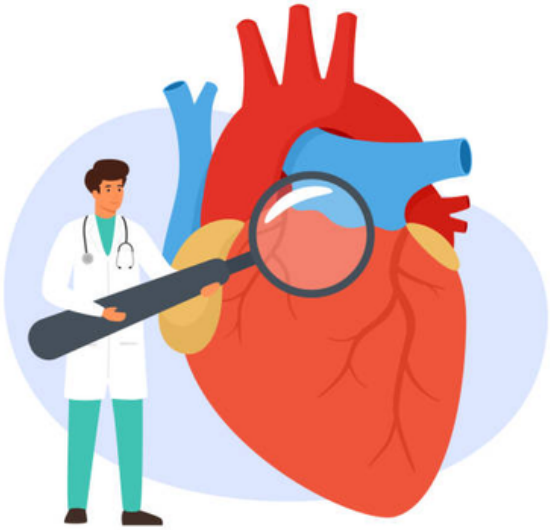
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BIT Summit



Review Article



Cardiology Quiz

Editorial



Dear Colleagues,

February has been a significant month for our cardiology community, marked by inspiring events and valuable insights. A key highlight was the BIT Summit in Bangladesh, where some of our skilled cardiologists presented their innovative research. These events serve as a testament to our collective efforts in advancing the field of cardiology and enhancing patient care.
This issue of our newsletter is packed with exciting content! We feature a compelling case report, providing a fascinating glimpse into diagnostic challenges and management strategies. Additionally, our review article offers an in-depth look at the ESC guidelines , ensuring you stay updated on the latest advancements in the field.

To keep your skills sharp, don't miss the cardiology quizzes included in this edition. They are designed to challenge your knowledge and encourage critical thinking, making for a fun way to engage with the material.

Looking forward, we have several upcoming events that you won't want to miss. We encourage all members to participate and share your expertise.

We also invite you to contribute to next month's newsletter! Whether it's a case study, an article on a recent breakthrough, or any other relevant topic, your submissions are essential for creating a rich resource for our community.

Thank you for your dedication to cardiology. Together, we can continue to push the boundaries of our field.

Editorial desk - faslurcard@yahoo.com

SLCC NEWS

15th BIT SUMMIT : BANGLA INTERVENTIONAL THERAPEUTICS 2025

Dr Samapath Withanawasam, Dr Sandamali Premaratne and Dr Upul Wickramarachchi participated at the recently concluded Bangla Interventional Therapeutics (BIT) conference held in Dhaka, Bangladesh. SLCC at the BIT was a dedicated session to SLCC which consisted of three talks, Intervention in Pregnancy and Peri partum period, PCI complications – loss of devices and management and Drug coated balloons – when and why?. In addition, the participants contributed actively to the conference as panelists and moderators of numerous sessions cementing the bond between the SLCC and the Cardiology community of Bangladesh.




15th BIT SUMMIT
Bangla Interventional Therapeutics
2025


BIT
Bangla Interventional Therapeutics


15th BIT SUMMIT
Bangla Interventional Therapeutics
2025




PCI Complications – Loss of Devices and Management
Dr. Sandunali Premarathe
MBBS, MD
Consultant Cardiologist
Teaching Hospital of Kurunegala
Sri Lanka



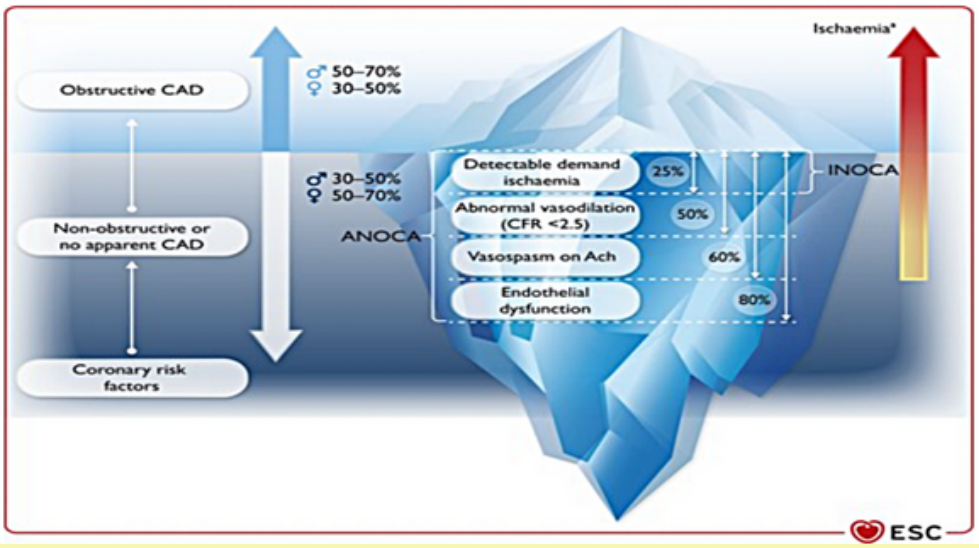

15th BIT SUMMIT
Bangla Interventional Therapeutics
2025


15th BIT SUMMIT

REVIEW ARTICLE

INSIGHTS INTO THE NEW CONCEPTS OF ANOCA / INOCA (extract from ESC 2024)

Angina and ischaemia in patients with non-obstructive coronary arteries (ANOCA/INOCA) are more prevalent in women (around 50% to 70%) compared to men (30% to 50%) who are referred for invasive coronary angiography (ICA). The disparity between myocardial oxygen demand and blood supply, leading to angina and ischaemia in conditions like ANOCA/INOCA, may result from coronary microvascular dysfunction (CMD) and/or epicardial coronary artery spasm. Unfortunately, these conditions are often not accurately diagnosed, resulting in a lack of tailored treatments for affected patients. As a result, many continue to suffer from recurrent angina, experience a poor quality of life, face frequent hospitalizations, undergo unnecessary repeat coronary angiograms, and encounter negative cardiovascular outcomes both in the short and long term.



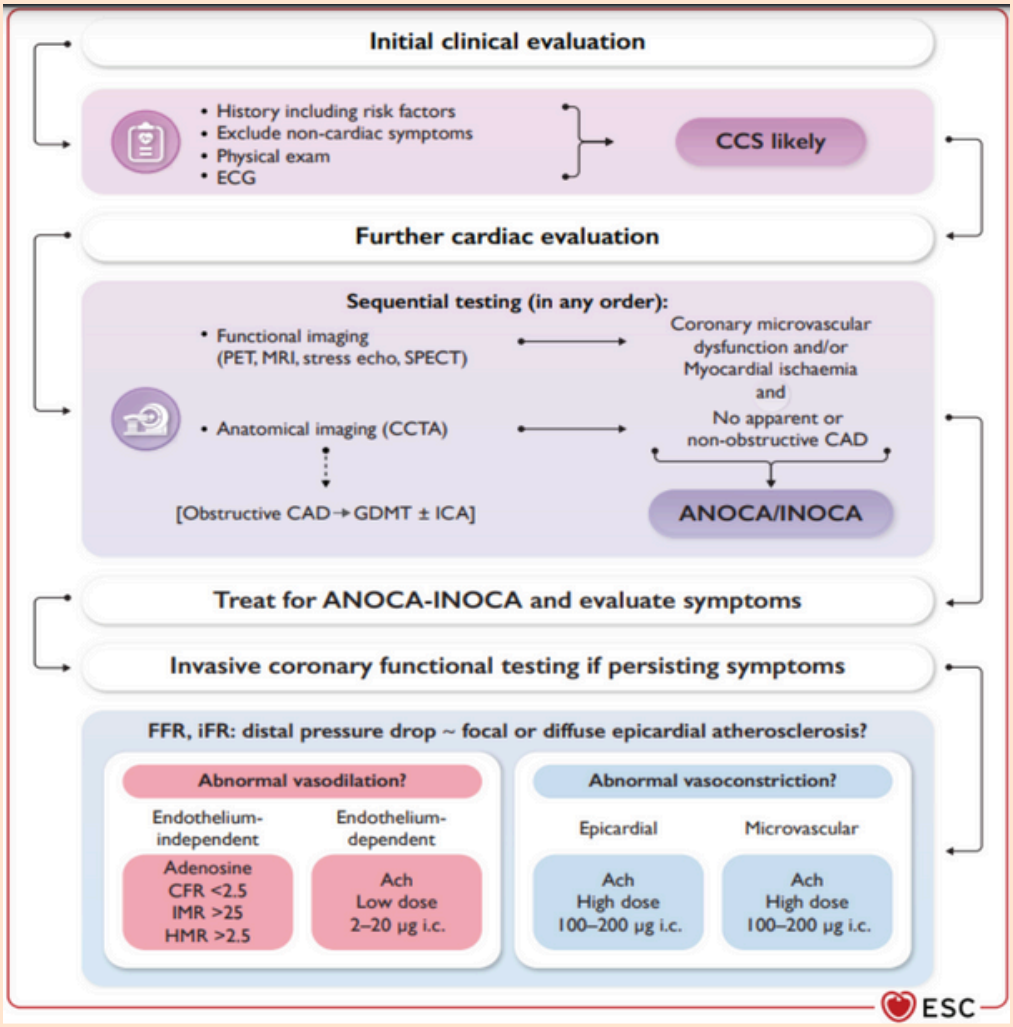
The figure above illustrates the prevalence of ANOCA and INOCA concerning different endotypes. Up to 70% of patients undergoing invasive coronary angiography (ICA) experience angina with non-obstructive coronary arteries, with 25% showing documented ischaemia (INOCA). Among those tested with acetylcholine (Ach), 80% demonstrate endothelial dysfunction, 60% have microvascular angina or vasospastic angina, and 50% exhibit impaired coronary flow reserve (CFR) and/or increased microvascular resistance. This helps to emphasize the importance of testing not only patients with INOCA but also all individuals with ANOCA in order to identify the specific endotype and ensure that appropriate treatment can be started.

Functional imaging is recommended as the initial test when assessing myocardial ischaemia, viability, or microvascular disease. These ischaemia detection tests have a stronger ability to confirm the presence of disease compared to coronary computed tomography angiography (CCTA) and are advisable in cases where there is a moderate to high probability (>15-85%) of obstructive coronary artery disease (CAD).

Further invasive evaluations may be warranted in patients suspected of having ANOCA/INOCA, if invasive coronary angiography and coronary pressure assessment reveal no significant epicardial coronary artery disease. This can include measurements of the index of microcirculatory resistance (IMR), coronary flow reserve (CFR), and, if indicated, invasive vasoreactivity testing using acetylcholine (Ach) or ergonovine as part of a comprehensive invasive coronary functional testing (ICFT) approach.

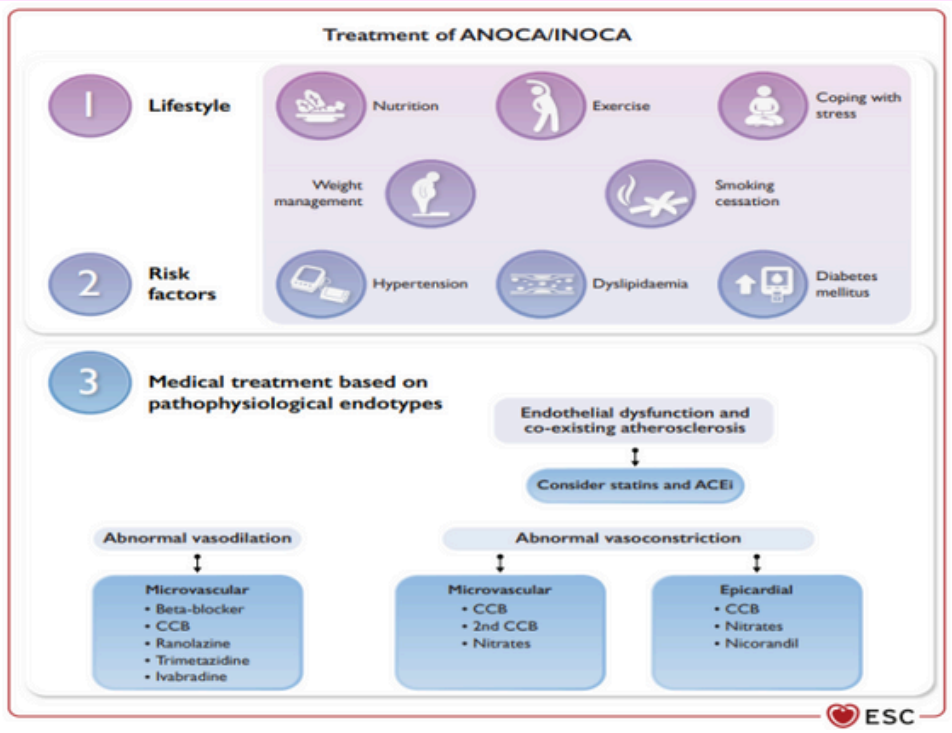
The debate over which modality to select as a first-line test has largely concentrated on detecting obstructive epicardial stenoses, often overlooking the significant prevalence of non-obstructive coronary disease and ANOCA/INOCA, particularly in female patients. Choosing a first-line test should focus on evaluating both the anatomical severity and the functional impact of coronary disease, regardless of whether it is obstructive. In this context, PET-CT should be considered more often and made more widely available, as it effectively combines calcium scoring with precise, operator-independent detection of myocardial ischaemia and coronary microvascular dysfunction (CMD), all while delivering a low dose of radiation.

Another valuable test for the non-invasive diagnosis of ANOCA/INOCA is the sequential or combined anatomical and functional testing. Additionally, using combined tests, such as CCTA and PET, can enhance prognostic assessment for patients with chronic coronary syndrome (CCS).
In the absence of obstructive CAD on CCTA or ICA, the detection of myocardial ischaemia through functional imaging, should always prompt clinical suspicion of ANOCA/INOCA. The diagnosis of ANOCA/INOCA relies solely on invasive functional assessments of the coronary microcirculation, as no method currently allows for direct in vivo visualization of this microcirculation in humans. Several non-invasive and invasive tests have been developed to evaluate coronary microvascular function, as shown in the figure below.



Non-invasive tests such as stress echocardiography, PET, perfusion CCTA, and cardiac magnetic resonance (CMR) facilitate the diagnosis of ANOCA/INOCA by assessing coronary flow reserve (CFR).

Management should prioritize a patient-centered, multidisciplinary care approach. The figure below presents an algorithm for the therapeutic management of ANOCA/INOCA.



Recommendations on the diagnosis and management of ANOCA/INOCA

Recommendations	Class[a]	Level[b]
Diagnosis of ANOCA/INOCA endotypes		
In persistently symptomatic patients despite medical treatment with suspected ANOCA/INOCA (i.e. anginal symptoms with normal coronary arteries or non-obstructive lesions at non-invasive imaging, or intermediate stenoses with normal FFR/iFR at coronary arteriography) and poor quality of life, invasive coronary functional testing is recommended to identify potentially treatable endotypes and to improve symptoms and quality of life, considering patient choices and preferences.	I	B
In persistently symptomatic patients with documented or suspected ANOCA/INOCA, transthoracic Doppler of the LAD, stress echocardiography, CMR, and PET may be considered for the non-invasive assessment of coronary/myocardial flow reserve	IIb	B
Management of ANOCA/INOCA		
In symptomatic patients with ANOCA/INOCA, medical therapy based on coronary functional test results should be considered to improve symptoms and quality of life.	IIa	A
For the management of endothelial dysfunction, ACE-I should be considered for symptom control.	IIa	B
For the management of microvascular angina associated with reduced coronary/myocardial blood flow reserve, antianginal medications aiming at preventing demand myocardial ischaemia should be considered for symptom control.	IIa	B

KEY MESSAGES

- The need for improved diagnosis and treatment strategies for patients with ANOCA/INOCA is underscored by the condition's significant prevalence and its association with major adverse cardiovascular events (MACE).
- Patients with suspected ANOCA/INOCA who remain symptomatic and do not respond to guideline-directed medical therapy (GDMT) should undergo invasive coronary functional testing to identify the underlying endotypes.
- Characterizing endotypes is essential for guiding the appropriate medical therapy for patients with ANOCA/INOCA.

GAPS IN EVIDENCE

- The diagnosis of ANOCA/INOCA and its various endotypes primarily relies on invasive coronary functional testing. Additional research is necessary to improve and evaluate non-invasive diagnostic imaging techniques for coronary microvascular dysfunction (CMD). Both existing and emerging non-invasive imaging methods should be calibrated against invasive testing to enable the interchangeable use of their measurements.
- The role of antithrombotic therapy in patients with chronic coronary syndrome (CCS) and ANOCA/INOCA has yet to be defined.
- Since the medical therapy for ANOCA/INOCA is mainly empirical, there is a pressing need for prospective randomized clinical trials to assess the efficacy of antianginal treatments in improving symptoms and outcomes for the different endotypes.

From the editorial desk

Dr. M.B.Faslur Rahuman,
Consultant Cardiologist.

CASE REPORT

"Preferential attack on cardiac conduction system"- A peculiar presentation of an age old foe

Stephen, NLG1; Senarath, MLS1; Senevirathna, SMRM1; Sampath, K; Amarasinghe, RMMK1; Wickeremasinghe, RDSS1; Vas Goonewardane, APN1
1- Department of Cardiology, Teaching hospital, Polonnaruwa.

Abstract

Acute Rheumatic fever is an autoimmune disease with a plethora of effects on multiple organ systems. Rheumatic carditis deserves special attention because it is easily treatable preventing long term morbidity and mortality attached to it. 15 year old boy presents with day 7 fever and constitutional symptoms. He presents with dizziness and ECG shows severe bradycardia due to complete heart block. Over the next few days classical fleeting type oligoathritis ensues and acute rheumatic fever (RF) diagnosis is made where he is successfully managed with oral Penicillin and high dose aspirin. ECHO at diagnosis and at three weeks appear to be not suggestive of valvular damage. Yet due to the peculiar presentation he is kept on strict bed rest till recovery from raised inflammatory markers and then put on secondary prophylaxis with IM Benzathine penicillin. Early diagnosis, antibiotic directed streptococcal eradication and regular- highly compliant prophylaxis are the pillars of contemporary RF management.

Keywords: Acute rheumatic fever, complete heart block, Myocarditis

Introduction

Acute Rheumatic Fever (RF) has been considered as a delayed autoimmune reaction to Group A Beta Hemolytic streptococcal infection (GAS). It generates a systemic inflammation involving heart, joints, skin and central nervous system. Global age-standardized mortality due to rheumatic heart disease decreased by 47% from 1990 to 2015, but large differences were observed across regions. In 2015, the highest prevalence of rheumatic heart disease were observed in Oceania, South Asia, and Central sub-Saharan Africa (1). World heart foundation (WHF) strategic goal is a 25% reduction in premature deaths from RF and RHD among individuals aged <25 years by the year 2025(2).

Cardiac involvement is classically a pancarditis but most of the importance lies with valvulitis. This is because valvular damage is the disease component which results in long term morbidity. Cardiac conduction abnormalities vary from ectopics, non-sustained ventricular tachycardia (NSVT), 1st degree atrioventricular block (AVB) to rarely complete AVB (6). Diagnosis is predominantly clinical and image based using revised Duckett Jones criteria with antecedent streptococcal infection evidence.

Case Report

15year old boy presented with fever, flu like symptoms and dizziness for 1 week duration. Inquiry was negative for recent similar upper respiratory infection or suppurative skin lesions. Only noteworthy past medical history was bronchial asthma which was in long term remission. On examination his blood pressure was 110/70mmHg and heart rate (HR) was a regular 30/min. Except for having high fever (101F) other system examination was normal. This amount of bradycardia in the background of fever was rather puzzling.

12 lead ECG showed complete atrioventricular (AVB). Isoprenaline infusion was started as a bridge therapy. Following septic screening empirical intravenous antibiotics (Coamoxyclav) was started. His echocardiogram showed normal valvular function with preserved bi-ventricular function. No pericardial effusion or rheumatic valvular lesions were noted. His ECHO was overall negative for WHO rheumatic carditis criteria of both “probable” and “definite” categories.

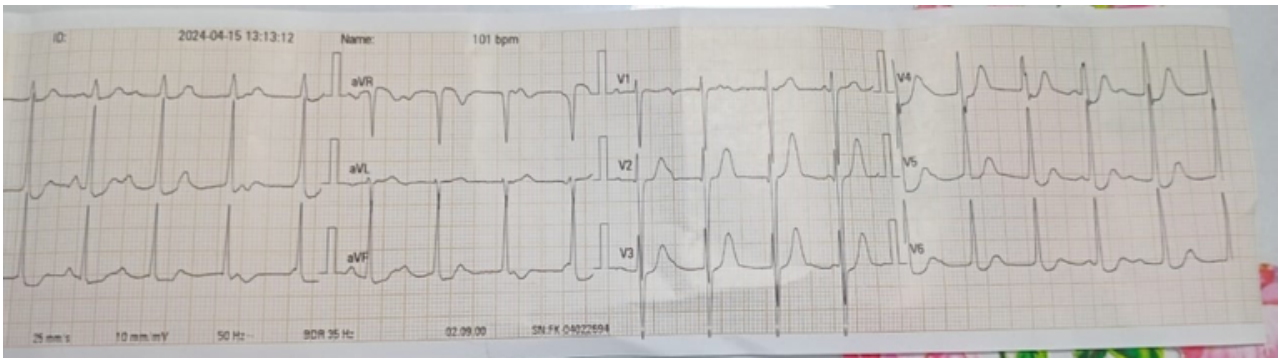


Figure1- CHB with faster nodal escape



Figure2- CHB with long ventricular standstill periods

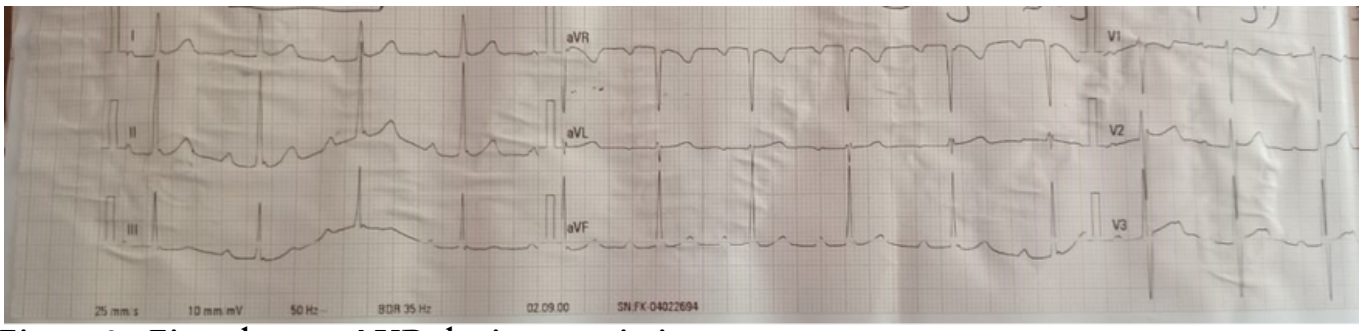


Figure3- First degree AVB during remission

From day 2 of admission, he developed a migratory type polyarthralgia involving hips, knees, ankle and finally shoulder joint over a few days. His blood cultures, urine cultures and Procalcitonin were negative. White blood cells – 10 x 103, Platelets 359 x 103 , CRP 57mg/L, ESR 77, Troponin 196(<20), Anti-Nuclear Antibodies and Rheumatoid Factor were negative. Anti-Streptolysin O Titer was 800IU/L (<200). As per revised Duckett Jones criteria the diagnosis of acute RF was made.

The modified Jones criteria (2015)

LR populations

Major criteria	Minor criteria
1. Carditis Clinical and/or subclinical	1. Polyarthalgia
2. Arthritis Polyarthritis only	2. Fever (≥38.5°C)
3. Chorea	3. ESR ≥ 60 mm/h and/or CRP ≥3.0 mg/dL
4. Subcutaneous nodules	4. Prolonged PR interval after accounting for age variability
5. Erythema marginatum	

Moderate risk to HR populations

Major criteria	Minor criteria
1. Carditis Clinical and/or subclinical	1. Monoarthralgia
2. Arthritis Monoarthritis or polyarthritis Polyarthralgia	2. Fever (≥38°C)
3. Chorea	3. ESR ≥30 mm/h and/or CRP ≥3.0 mg/dL
4. Subcutaneous nodules	4. Prolonged PR interval after accounting for age variability
5. Erythema marginatum	

CRP, C-reactive protein; *ESR*, erythrocyte sedimentation rate.
For all patient populations with evidence of preceding Group A streptococcal infection.
Diagnosis of initial ARF: 2 major manifestations or 1 major plus 2 minor manifestations.

Figure 4- Revised Duckett-Jones RF criteria

Oral penicillin 250mg bid was given for two weeks. After starting on high dose Aspirin (50mg/kg/day) in four divided doses along with penicillin, his symptoms and AVB recovered gradually over the next week. He did not need steroids according to his clinical response and ECHO findings. The fever subsided in D5 of admission and inflammatory markers improved satisfactorily by D10. Patient was kept in strict bed rest for a week and gradually mobilized thereafter. Aspirin was tailed off over a three week regime.

Repeat ECHO at 3 weeks from admission showed no definite evidence of rheumatic valvular involvement except a mild mitral regurgitation. Still he was explained the necessity of being on secondary prophylaxis of once a month IM Penicillin 1.2M units prophylaxis till age of 25(10 years from incident) years minimum.

Conclusion

Cardiac conduction system involvement has been reported as a feature of acute rheumatic carditis, with involvement ranging from first degree atrio-ventricular (AV) block (72.5%), second degree AV block (2.6%) and rarely complete AV block (0.6%) based on previous case reports(7). First degree AVB is the only ECG marker which is applied in Duckett Jones criteria too. When it occurs complete AVB in acute RF is often transient and reverts over the course of acute illness like in our case. Temporarily pacing should be considered if the patient is hemodynamically unstable or symptomatic.

Amongst registry data of Northern Australia in patients with severe RHD at diagnosis, 50% had proceeded to valve surgery by 2 years, and 10% were dead within 6 years(3). This shows the importance of secondary and tertiary prevention strategies during RHD management. Monthly IM Benzathine Penicillin until 10 years from incident or 21 years(whichever is longer) is the single most time tested strategy for preventing RF related deaths and valve surgery due to re-infection. As our patient was diagnosed to have rheumatic carditis without residual structural changes on ECHO criteria the recommended duration of secondary prophylaxis would be till 25 years of age. There has been a dilemma with regards to echocardiographic screening for rheumatic carditis in asymptomatic populations (4). The natural history of screening-detected RHD is not benign. Progression of borderline cases to severe RHD demonstrates the need for monitoring and individualized consideration of prophylaxis. Obviously this strategy depends on local prevalence of disease and available infrastructure (5).

Ideally acute rheumatic carditis patients should be referred to tertiary cardiac centers with facilities for high dependency observation, departmental ECHO and proper clinic setup dedicated for RF/RHD follow up.

	Morphological changes	Pathological valvular insufficiency
Mitral valve RHD	Thickening of the anterior mitral valve leaflet (≥3 mm, age-specific)	It should be observed in two different views
	Thickening of the chordae tendineae	Insufficiency jet length should be ≥2 cm in at least one view
	Reduced leaflet mobility	The velocity in one complete envelope should be ≥3 m/s
	Extensive mobility of the leaflet tip during systole	Insufficiency jet should be pansystolic in at least one envelope
Aortic valve RHD	Irregular or focal consolidation	It should be observed in two different views
	Coaptation defect	Insufficiency jet length should be ≥1 cm in at least one view
	Reduced leaflet mobility	Velocity should be ≥3 m/s in early diastole
	Prolapse	Insufficiency jet should be pandiastolic in at least one envelope
Definite RHD (A, B, C, or D)		
A. Pathological MR and presence of at least two morphological features of RHD of the mitral valve		
B. Mitral stenosis (mean pressure gradient ≥4 mmHg)		
C. Pathological AI, and presence of at least two morphological features of RHD of the aortic valve		
D. Concomitant presence of borderline rheumatic involvement of both mitral and aortic valves		
Borderline RHD (A, B or C)		
A. Presence of at least two morphological features of rheumatic involvement of the mitral valve without pathological MS or MR		
B. Pathological MR		
C. Pathological AI		

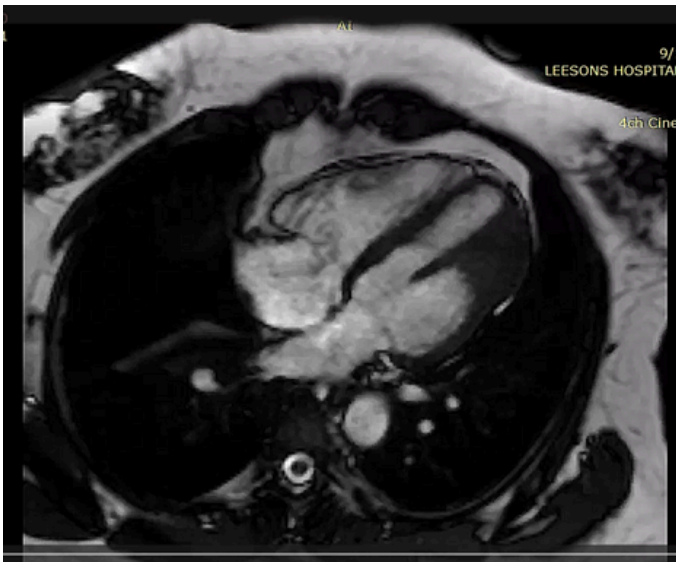
AI: Aortic insufficiency; MR: Mitral regurgitation; MS: Mitral stenosis.

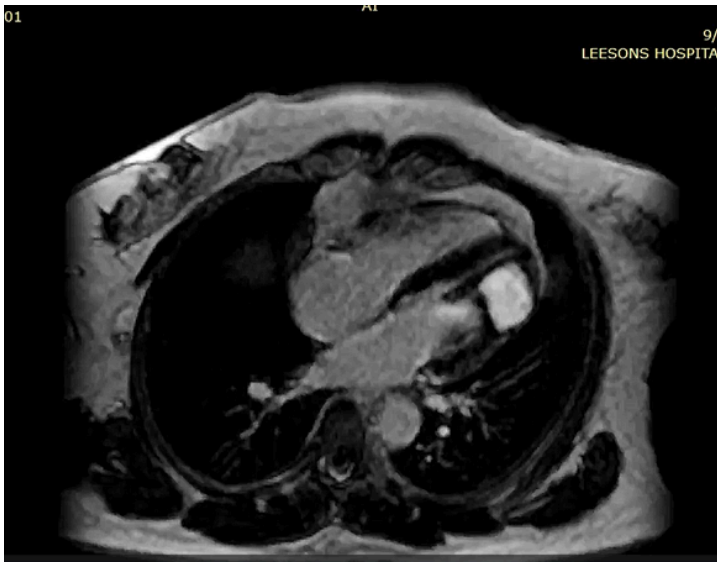
Figure5- WHO ECHO criteria for RHD diagnosis

References:
1) Watkins DA, Johnson CO, Colquhoun SM, Karthikeyan G, Beaton A, Bukhman G, Forouzanfar MH, Longenecker CT, Mayosi BM, Mensah GA, et al. Global, regional, and national burden of rheumatic heart disease, 1990- 2015. N Engl J Med. 2017; 377:713–722. doi: 10.1056/NEJMoa1603693
2) Remenyi B, Carapetis J, Wyber R, Taubert K, Mayosi BM; World Heart Federation. Position statement of the World Heart Federation on the prevention and control of rheumatic heart disease. Nat Rev Cardiol. 2013; 10:284–292. doi: 10.1038/nrcardio.2013.34
3) Cannon J, Roberts K, Milne C, Carapetis JR. Rheumatic heart disease severity, progression and outcomes: a multi-state model. J Am Heart Assoc. 2017;6:e003498. doi: 10.1161/JAHA.116.003498
4) Engelman D, Wheaton GR, Mataika RL, Kado JH, Colquhoun SM, Remenyi B, Steer AC. Screening-detected rheumatic heart disease can progress to severe disease. Heart Asia. 2016; 8:67–73. doi: 10.1136/heartasia-2016-010847
5) Reményi B, Wilson N, Steer a, Ferreira B, Kado J, Kumar K, Lawrenson J, Maguire G, Marijon E, Mirabel M, et al. World Heart Federation criteria for echocardiographic diagnosis of rheumatic heart disease: an evidence-based guideline. Nat Rev Cardiol. 2012; 9:297–309. doi: 10.1038/nrcardio.2012.7
6) Umapathy S, Saxena A. Acute rheumatic fever presenting as complete heart block: report of an adolescent case and review of literature. BMJ Case Rep. 2018 Feb 11;2018:bcr2017223792. doi: 10.1136/bcr-2017-223792. PMID: 29440244; PMCID: PMC5836695.
7) Clarke M, Keith JD. Atrioventricular conduction in acute rheumatic fever. British Heart Journal. May 1972;34(5):472-479.

CMR QUIZ

45 years old lady came with mild exertional dyspnea. 2D echo found to have inferior lateral wall thickened unusually.





What is the diagnosis?

1. Thrombus
2. Myocardial scar
3. Myxoma
4. Cardiac fibroma
5. Localized effusion

ANSWER

4. Cardiac Fibroma

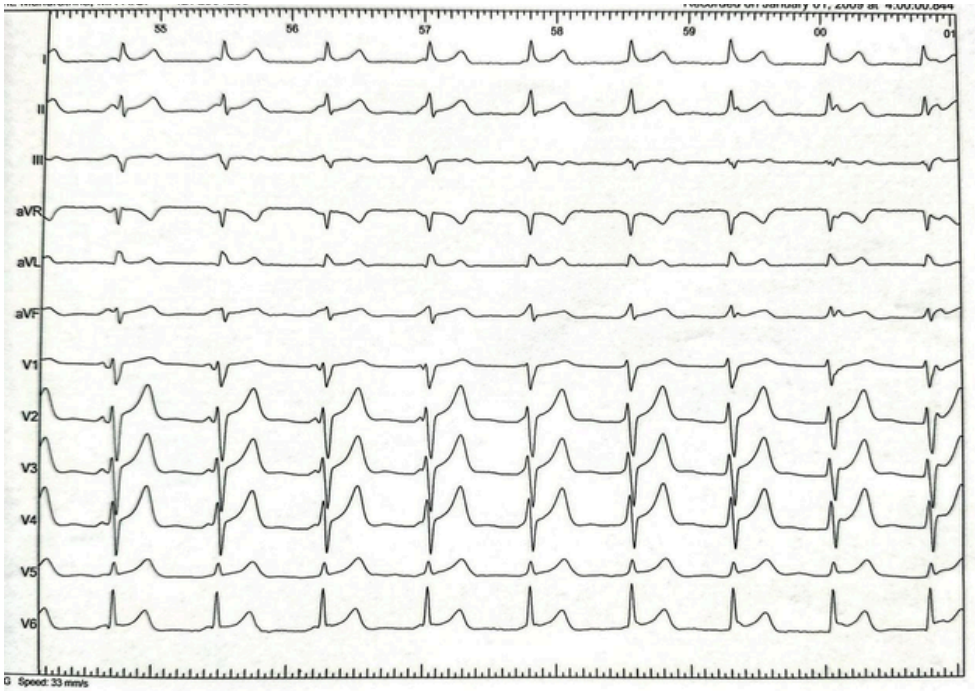
CMR shows well defined mass origination from lateral myocardium and late gadolinium enhancement (LGE) images show very well defined margins with LGE. These CMR features are diagnostic of cardiac fibroma, benign tumor of myocardial origin.

Incidence - Cardiac fibroma is extremely rare in adults, with most cases occurring in children, making its incidence in the adult population very low; often reported as less than 1% of cases.

Thanks to Dr. Wasantha Kapuwatta, Cardiac Imaging Fellow, Bournemouth UK, for this CMR quiz.

ECG QUIZ

Patient presented with palpitations.



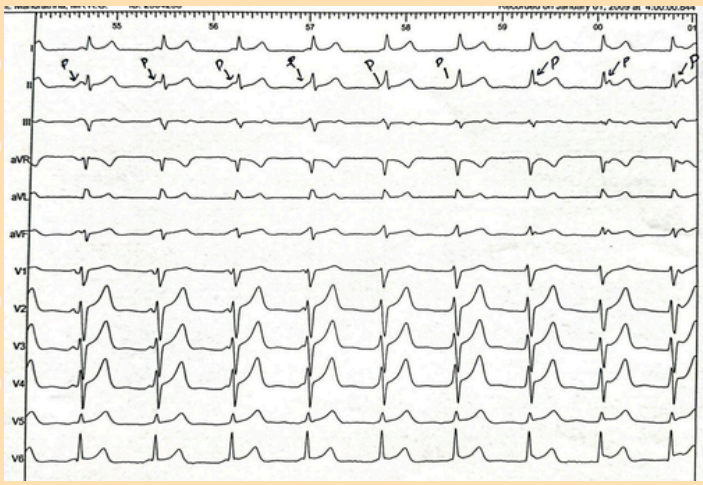
What is the diagnosis based on the ECG?

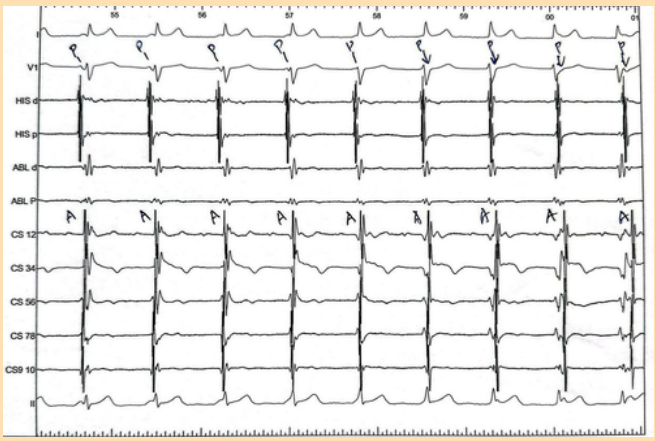
1. WPW right sided accessory pathway
2. WPW left sided accessory pathway
3. Complete heart block
4. Junctional rhythm
5. Idioventricular rhythm

ANSWER

4. Junctional rhythm.

P waves can be seen marching through. In the intra cardiac tracing one can decipher the P waves with the corresponding A signals in the intracardiac catheter signal.



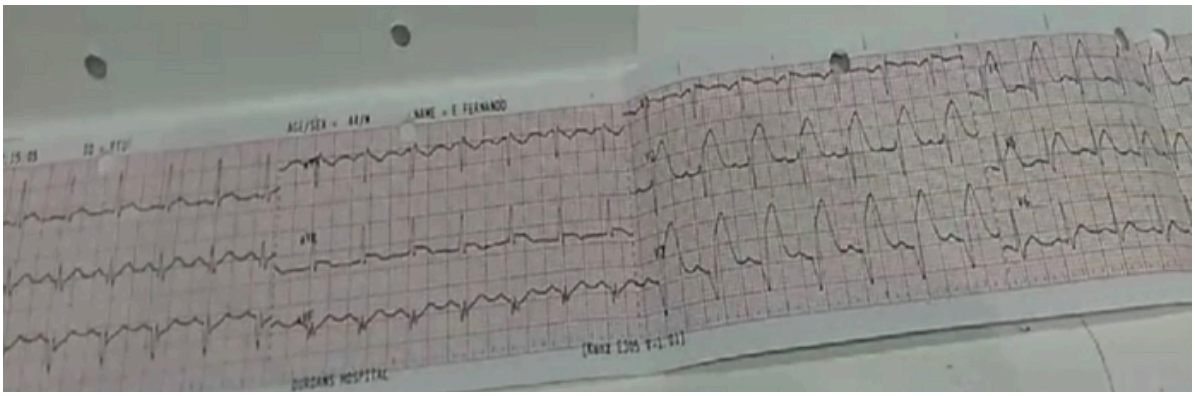


Thanks to Dr. Suresh Kottegoda, Consultant Cardiac Electrophysiologist, Sri Jayawardenapura Teaching Hospital, for this ECG Quiz.

RECENT PUBLICATIONS AND PRESENTATIONS BY MEMBERS

Uncommon Case of Refractory and Repetitive Stent Thrombosis Requiring Emergency CABG to the Rescue with Potent Antithrombotic Therapy Onboard

44-year-old male presented with acute chest pain of 2 hours duration.
ECG was indicative of an acute Anterior STEMI.



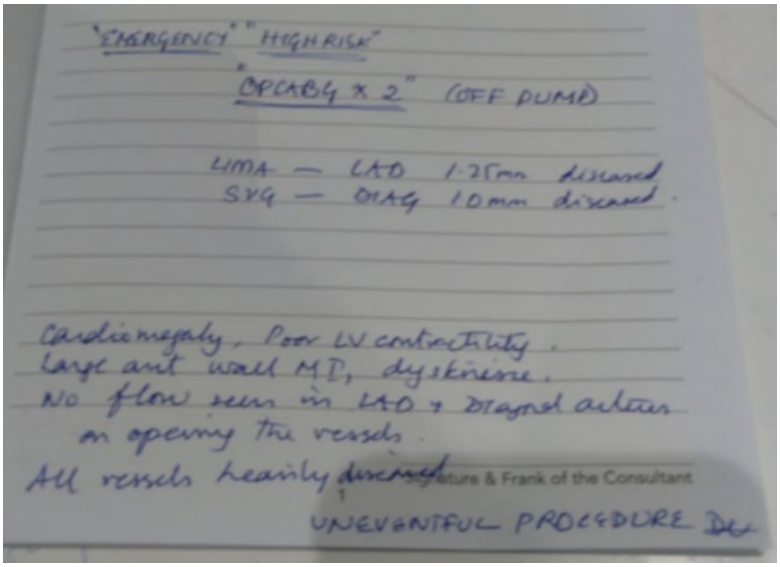
- He was taken for primary PCI on admission after pre-loading with Aspirin and Ticagrelor.
- Coronary angiogram revealed single vessel disease with a sub-totally occluded LAD.
- Primary PCI to mid LAD was done with 2.5x49mm Angiolite DES which was post dilated with 2.75x12mm and 3x12mm non-compliant balloons with good angiographic outcome.
- Within 10 minutes of completion of procedure the patient became hemodynamically unstable.
- Repeat angiography confirmed hyperacute stent thrombosis and repeat coronary intervention was done with ongoing Chest compressions to open the blocked LAD stent. Patient was loaded with Intracoronary and intravenous Abciximab (10mg in total) plus IV Heparin to achieve an ACT over 300 seconds.
- Patient regained hemodynamic stability which stood only for 30 min before blood pressure dropping again with evidence of repeat stent thrombosis.



- Patient was treated with another top-up dose with 5mg of Intra-coronary Abciximab plus additional bolus of heparin. Repeat ACT was over 500 seconds.
- Further post dilatation was done with 3x12mm balloon to establish stent patency.
- Patient developed repeated episodes of stent thrombosis despite similar attempts to keep the stent patent over the next 4 to 5 hours.

- An acute hypersensitivity response to stent material was suspected and patient was referred for emergency CABG after final post dilatation having achieved good immediate angiographic outcome with TIMI 3 flow.

- There was no flow in the LAD and diagonal at the time of grafting.



- He received LIMA to LAD and SVG to D1. Intra-operative blood loss was not excessive and

- He made a smooth post-operative recovery and was discharged on Day 10, post MI (18.09.2024). There was moderate LV dysfunction with EF of 35% to 40% at discharge, probably with an element of myocardial stunning. Repeat echocardiogram is planned in 6 weeks.

- Follow up echocardiogram done 2 weeks after the STEMI confirmed recovered LV systolic Function with a EF of 55%.

- Thrombophilia screening revealed weakly positive lupus anticoagulant and deficiency of Protein S (down at 40% of reference range value).

Discussion :

It was an extremely unusual case of stent thrombosis where repeated episodes thrombus formation continued to happen despite treatment of therapeutic doses of Ticagrelor, Abciximab and heparin. While the possibility of stent mal-apposition of cannot be excluded without the use of IVUS, acute hypersensitivity of the patient to the stent material was felt to be the most likely cause. Underlying thrombophilia too may have contributed. On the other hand CABG appear to be an effective bailout option when indicated even when the patient has been treated with potent antithrombotic therapy.

Operators : Dr. Amila Walawwatta and Dr. Niroshan Lokunarangoda.
Presented by Dr. Amila Walawwata, Consultant Cardiologist, CSTH at the Singapore LIVE 2025 Conference.

ACADEMIC CALENDAR 2025

Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Acute Cardiac Care Proficiency Program for Medical Officers	**Back to basics teaching programme-** March 1st & 2nd		**Cardiology updates - Lectures:** (dates to be confirmed)	**ECG Workshop:** (dates to be confirmed)		**Annual Academic Sessions :** August 1st to 5th	**CT and MRI workshop:** (Date to be confirmed)			
Senior Registrars' Program: weekly	**Heart Failure Seminar :** March 23rd					**Regional Cardiology Updates: Kurunegala :** (date to be confirmed)				

We kindly request contributions from the cardiology community in the scope of the following topics:



Review articles on

- **The importance of research, audits and ethics.**
- **Revolutionizing the referral system between institutions.**
- **Strategies to address waiting lists for cardiac catheter interventions and surgeries.**
- **Identifying and overcoming pitfalls in prescription patterns to improve patient care.**
- **Sharing of facilities and duties within the system and healthcare professionals to uplift healthcare in a resource-poor setting.**
- **Prevention of non-communicable diseases.**

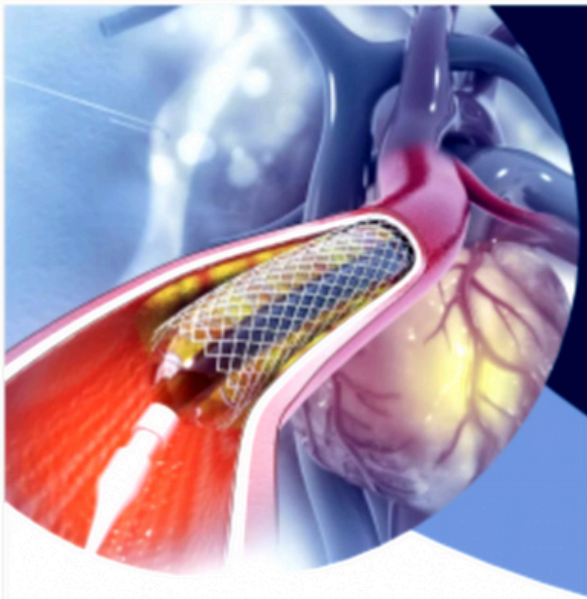
Case reports mainly within the interventional field and also in general cardiology.

Quizzes on ECG, Echo-cardiograghy, CT, MRI, and intervention procedures such as angiograms and PCI.

Your contributions will help foster collaboration and knowledge-sharing within our field.

Please forward your submissions to the editorial desk - faslurcard@yahoo.com

Visit our website slcc.lk



Back to Basics 2025

Interventional Cardiology

A Structured Basic Teaching Program in Cardiology for Cardiologists and Cardiology Trainees
Organized jointly by Sri Lanka College of Cardiology
& Cardiology Unit National Hospital Kandy

Annual series of the "Back to Basics" program (since 2015)
Focused on Interventional Cardiology for day-to-day practice
Ideal platform for revising basics, sharing experiences, and enhancing knowledge

Course Directors:
Dr. Z. Jamaldeen, Consultant Cardiologist
Dr. K. Suntharesan, Consultant Cardiologist

Special Features

- CD presentation session on Interventional Cardiology and Prizes for the best three CD presentations

Facilities

- Accommodation for Faculty and Senior Registrars in Cardiology under Local Training
- Common transport from Cardiology Unit, NHSL Colombo, to Grand Kandyan Hotel, Kandy, on 1st March and return on 2nd March

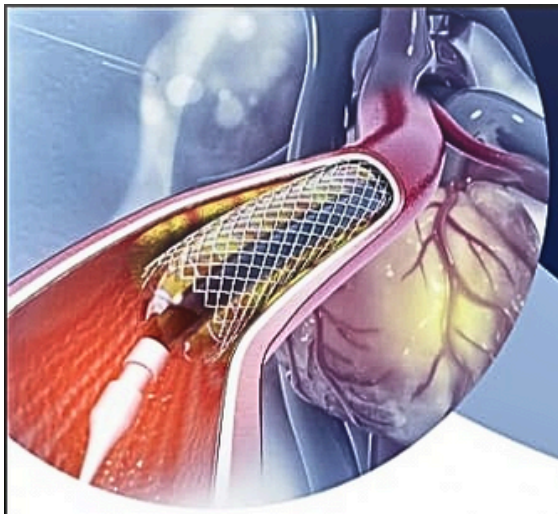
For Further Information look out for the upcoming flyer and notices.

1-2 March 2025
Grand Kandyan Hotel Kandy

Cardiology Unit
NATIONAL HOSPITAL - KANDY

For Inquries

0719950468
cardiologyru18@gmail.com



Back to Basics 2025

Interventional Cardiology

Day 01: 1st March 2025

8.00-8.30: Registration
8.30-8.40: Lighting of Oil Lamp and National Anthem
8.40-8.50: Welcome Address:
Dr. K. Suntharesan
8.50-9.00: President SLCC Address:
Dr. Sampath Withanawasam

Session A
9.00-9.25: Preparation for Cardiac Cath and Radiation Safety:
Dr. Sandamali Premaratne
9.25-9.50: Cardiac Imaging to understand Cardiac Catheterization:
Dr. Wasantha Kapuwatta
9.50- 10.15: Vascular Access Radial vs. Femoral and Its Complications :
Dr. Suneth Karunaratne
10.15- 10.40: Hemodynamic Assessment of Cardiac Catheterization :
Dr. Duminda Samarasinghe
10.40-11.00: Discussion 1

11.00- 11.15: Tea and visiting trade exhibition

Session B
11.15-11.40: Guide wires and Catheters:
Dr. Ruwan Munasinghe
11.40-12.05: Stents and Balloons :
Dr. Nawshard Ali
12.05-12.30: Overview of PCI Indications and Techniques: Provisional Vs. Bifurcation :
Dr. Disna Amarathunga
12.30-12.55: Physiology Guided Interventions: Role of FFR and IFR:
Dr. Thilina Jayasekara
12.55-1.15: Discussion 2

1.15-2.00: Lunch and visiting trade exhibition

2.00- 2.30: Plenary 1
Imaging in Cath Lab: Basics of IVUS and OCT: Dr. Prakash Priyadharshan

2.30- 3.10: Plenary 2
HCM and Ablation:
Dr. Vas Goonewardane

Session C
3.10-3.35: Basics of Percutaneous Intervention in MR
Dr. Roshan Paranamana
3.35-4.00: How to take Challenges in PTMC?
Dr. Bhathiya Ranasinghe
4.00-4.10: Discussion 3

4.10-4.25: Tea and visiting trade exhibition

Session D
4.25-4.50: Basics and Challenges in Treating Calcified Lesions : Rotational Atherectomy and Lithotripsy:
Dr. Sanjeewa Rajapakse
4.50-5.15: Chronic Total Occlusion (CTO) Interventions: When and How to attempt? :
Dr. Tanya Pereira
5.15-5.25: Discussion 4

8.00: Gala Dinner

Consultants:
Rs. 5000/=

Cardiology Trainees:
Rs. 3500/=

Registration will be closed on
15th of February 2025

REGISTER NOW

Day 02: 2nd March 2025

Session E
8.30-8.55: Revascularization and Management of PCI Complications, Perforations/Dissections and Stent Thrombosis:
Dr. Sampath Withanawasam
8.55-9.20: No Reflow and Slow Flow:
Dr. Wasanthi Rathnayake
9.20-9.30: Discussion 5

Session F
9.30-9.55: Antiplatelets Therapy in PCI: Basics and Update :
Dr. Arulkumar Jegavanthan
9.55-10.20: Anticoagulation in PCI: Heparin, Bivalirudin and Alternatives:
Dr. Nawshad Junaideen
10.20-10.30: Discussion 6

10.30-10.45: Tea and visiting trade exhibition

Session G
10.45-11.10: LMCA Techniques and Intervention:
Dr. Vajira Senaratne
11.10-11.35:Basics in TAVI:
Dr. Chandrike Ponnamperuma
11.35-12.00:
DCB- Why, When and How ?:
Dr. Upul Wickramarachchi
12.00-12.25:
Contrast Induced Nephropathy:
Dr. Lakshman Bandara
12.25-12.45: Discussion 7

12.45-1.45: Let's discuss your patient
CD Session
1.45-1.50: Vote of Thanks:
Dr. Z. Jamaldeen

1.50: Lunch

1-2 March 2025
Grand Kandyan Hotel Kandy

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Course Directors:
Dr. Z. Jamaldeen, Consultant Cardiologist
Dr. K. Suntharesan, Consultant Cardiologist

Organized jointly by Sri Lanka College of Cardiology & Cardiology Unit National Hospital Kandy


Second annual
Cricket encounter
Gents T20 and Ladies matches
SLCC
Cardiology
SLCoSHH
Venereologists
Angampitiya Grounds, Kotte
16th March 2025 | 8.30 am onwards
Come, Cheer and Live the fun!

Sri Lanka College of Cardiology
Annual Academic Sessions 2025
CALL FOR SUBMISSION OF FREE PAPERS

The Sri Lanka College of Cardiology
Invites submissions for free papers
to be presented during the
25th Annual Academic Sessions of the SLCC
3-5th August 2025 at Cinnamon Life hotel, Colombo.

- These should be based on original work by the author related to the field of Cardiovascular Disease.
- The mode of presentation will be either as an oral presentation or as a poster presentation. (Please indicate your preference in the application)
- For author guidelines and more information on submissions, please visit our website http://www.slcc.lk

CLOSING DATE: 30 th April 2025, 4:00 PM

Please note that submissions should be emailed to **editor@slcc.lk**
on or before the closing date.

For more information please contact
Editor, Sri Lanka College of Cardiology
No.06, Wijerama Mawatha, Colombo 07, Sri Lanka.
Tel: +94112699684
Email: editor@slcc.lk

Sri Lanka College of Cardiology
Annual Academic Sessions 2025
CALL FOR APPLICATIONS FOR
PRAMOD RANATUNGA RESEARCH AWARD 2025
The Sri Lanka College of Cardiology

Invites submissions for the above research award to be presented during the
25 th Annual Academic Sessions of the SLCC
3-5 th August 2025 at Cinnamon Life hotel, Colombo.

- This should be based on original work by the author related to the field of Cardiovascular Disease.
- Three printed copies of the abstract, as well as full paper along with a soft copy (MS Word), should be submitted to the address below on or before the closing date. (Abstracts only will not be considered)
- The selected submission will be published in the conference book and will receive the research award at the Annual Sessions 2024, which includes a cash award of Rs.100,000/- (Rupees One Hundred Thousand) and a medal of recognition. The awardee should make an electronic (PowerPoint) presentation of his / her research topic at the Conference.
- The final decision regarding the award will be made by the council of the SLCC on the recommendation of the review panel.

CLOSING DATE: 30 th April 2025, 4:00 PM

For more information please contact:
Editor, Sri Lanka College of Cardiology
No.06, Wijerama Mawatha, Colombo 07, Sri Lanka.
Tel: +94112699684 Email: editor@slcc.lk
Please note that submissions should be emailed to editor@slcc.lk on or before the closing date.


SRI LANKA COLLEGE OF CARDIOLOGY
25th
ANNUAL ACADEMIC SESSIONS
2025
HEALTHY HEART FOR ALL : BRIDGING RESEARCH AND CLINICAL PRACTICE
For more informations
https://slcc.lk/
03-05 AUGUST 2025
Phone
+94 11 269 9684
e-Mail
presidentslha@gmail.com
Address
Wijerama House,
No. 6,
Wijerama Mawatha,
Colombo 7,
Sri Lanka
Sri Lanka
Cinnamon Life Hotel, Colombo

25TH ANNUAL ACADEMIC SESSIONS 2025 PROGRAMME

	04th August 2025- Day 01	
8.00-8.05	National Anthem	
8.05-8.10	Welcome Address	
8.10-8.30	Plenary 01- Rheumatic Heart Disease: A Continuing Challenge in Modern Cardiology	Dr. JC Mohan
8.30-9.30	Chronic Coronary Syndrome – (case based discussion – heart team approach) – Dr. WSS (moderator), Dr. Tom Johnson, Prof. Azfar Zaman, Prof. Divaka Perera, Dr. Peter O'Kane, Dr. Sanjeewa Rajapaksha	
8.30-8-35	*Case Presentation – Complex Coronary Lesions in CCS*	*Presenter - Dr. Sanjeewa Rajapaksha*
8.35-8.50	*Should I Offer PCI?*	*Dr. Tom Johnson*
8.50-9.05	*Is CABG a Better Option?*	*Dr. Catherine Sudarshan*
9.05 – 9.20	*Can I Manage This Patient Medically?*	*Prof. Divaka Perera*
9.20-9.30	*Panel Discussion*	
9.30-9.50	Plenary 02: Personalized Lipid Management: Tailoring Treatment to Patient Needs	Prof. Raman Puri
9.50-10.10	Plenary 03: Cardiogenic Shock: From Pathophysiology to Management	Dr. Trevor Richens
10.10-10.30	Tea Break	
	Opening of Trade Exhibition	Vice President
10.30-11.30	Symposium 01: Heart Failure	
10.30 – 10.42	*Heart Failure Treatment Tailor-Made: From Guidelines To Personalized Care*	*Dr. JC Mohan*
10.42 – 10.54	*The Interplay Of Heart And Kidney: Advances In Understanding And Management Of Cardiorenal Syndrome In Heart Failure*	*?Dr. Kaul*
10.54 – 11.06	*Place Of Device Therapy In Heart Failure*	*Dr. Mevan Wjietunga*
11.06 – 11.18	*Surgical Options In The Management Of End Stage Heart Failure*	*Dr. Catherine Sudarshan*
11.18 – 11.30	*Discussion*	
11.30-12.30	Symposium 02: Acute Coronary Syndrome	Prof Zaman, Dr. Mullasari, Dr. O'Kane,
11.30 – 11.45	*Advances In STEMI Management*	*Dr. Ajit Mullasari*
11.45 – 12.00	*Interpretation Of Cardiac Biomarkers In ACS*	*Prof. Azfar Zaman*
12.00 – 12.15	*Early Vs Delayed Invasive Strategy In NSTE - ACS – What Does The Evidence Say?*	*Dr. Peter O'Kane*
12.15 – 12.30	*Discussion*	
12.30-12.50	Plenary 04: CMR in cardiomyopathies	Dr. Kevin Roman
12.50-13.10	Plenary 05: Place Of CT In Coronary Artery Disease	Dr. Justin Carter
13.10 -14.00	Lunch Break	
14.00-15.00	Symposium 03: Preventive Cardiology	
14.00 – 14.12	*Impact of Environmental Pollution on Heart Health*	*Prof. D. Prabhakaran*
14.12 – 14.24	*Residual risk in ASCVD – current trends*	*Dr. Chandra Mani Adikari*
14.24 – 14.36	*A Guide To Pre-Sport Heart Screening*	*Dr. Justin Carter*
14.36 – 14.48	*Cardiac Rehabilitation: A Pathway To Recovery*	*Prof. Azfar Zaman*
14.48 – 15.00	*Discussion*	
15.00-15.30	Dr Thenabadu Memorial Oration	Dr. Naomali Amarasena
15.30-15.45	Tea Break	
15.45-16.45	Symposium 04: Cardiomyopathy	
15.45 – 16.00	*Decoding Cardiomyopathy: Insights Into Classification And Genetics Of Cardiomyopathy*	*Prof. Pascal Mckeown*
16.00 – 16.15	*Myocarditis: Challenges In Diagnosis And Management*	*Dr. Trevor Richens*
16.15 – 16.30	*Hypertrophic Cardiomyopathy: Advances In Diagnosis And Therapy*	*Prof. Pascal Mckeown*
16.30 – 16.45	*Discussion*	
16.45-17.45	Symposium 05: Atrial Fibrillation – A Case Based Discussion	Dr. Mevan Wijetunga, Dr. Narasimhan
16.45 – 17.00		
17.00 – 17.15		
17.15 – 17.30		
17.30 – 17.45	*Discussion*	
	End of the Day 01	

	05th August 2025- Day 02	
8.00-8.20	Plenary 06: What is new in ESC guidelines 2024	Dr. Naomali Amarasena
8.20-9.20	Symposium 06: Hypertension	ESC - online
8.20- 8.35	*Management of hypertension emergencies and urgencies*	
8.35 – 8.50	*HT In Special Populations*	
8.50 – 9.05	*Approach To A Patient With Resistant HT*	
9.05 – 9.20	*Discussion*	
9.20-10-20	Symposium 07: ACHD	
9.20 – 9.35	*Natural History Of Treated Complex Congenital Heart Disease*	*Dr. Elizabeth Orchard*
9.35 – 9.50	*Multimodality Imaging In ACHD*	*Dr. Kevin Roman*
9.50 – 10.05	*When To Intervene In ACHD*	*Dr. Trevor Richens*
10.05 – 10.20	*Discussion*	
10.20-10.35	Tea Break	
10.35-11.05	Dr Pramod Ranathunga Research award	
11.05-12.05	Symposium 08: Valvular heart disease	
11.05 – 11.20	*Use of clinical and imaging parameters in intervening in Aortic valvular disease*	*?Dr. Kaul*
11.20 – 11.35	*TAVR vs SAVR in contemporary aortic valvular disease management*	*Prof. Azfar Zaman*
11.35- 11.50	*Novel Approach to managing mitral regurgitation*	*Dr.Rob Smith*
11.50 – 12.05	*Discussion*	
12.05-12.25	Plenary 07: Aortopathy - Interventions In Aortic Disease	Dr. Kevin Roman
12.25-12.45	Pleanry 08: Cardio Oncology- Bridging Two Disciplines For Comprehensive Care ?best presentation from young cardiologists forum	Dr. Sivadasan?
12.45-13.35	Lunch	
13.35-14.35	Symposium 09: Pregnancy and Heart disease	
13.35 – 13.50	*Risk Stratification And Preconception Counselling: The Way Forward To Minimize Cardiac Morbidity And Mortality*	*Dr. Elizabeth Orchard*
13.50 – 14.05	*Management of valvular heart disease* *Management of Ischemic Heart Disease In Pregnancy*	*Dr. Vajira Senaratne*
14.05 – 14.20	*Navigating Heart Failure In Pregnancy: Challenges And Solutions*	*Dr. Elizabeth Orchard*
14.20 – 14.35	*Discussion*	
14.35-14.55	Plenary 09: The Role Of AI In Predicting And Preventing Cardiovascular Events	Dr. Upendra Kaul
14.55-15.15	Plenary 10: Inflammation and CV diseases – biomarkers and mechanisms	Dr. KeithChannon
15.15-15.35	Plenary 11: Dilemmas In The Management Of RV Failure	Dr. Trevor Richens
15.35-15-50	Tea break	
15.50-16.10	Plenary 12: antiplatelet and antithrombotic therapy after PCI	Dr. Elliot Smith
16.10-17.00	Quiz	Dr. Disna, Sunthar?
17.00 -17.05	Closing Remarks	
17.05-18.00	Awards and Certificates	
	End of the day 02	