

IEPR Newsletter

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Joseph Winterman, RN

Angina Center
Evansville, IN Site 109

In this issue:

Pages 3-5
Publications &
Presentations

Page 7
Clinical Tips
Did you know?

Page 8-9
IEPR Data
Outcomes

IEPR
Medical
Director
Georgiann
Linnemeier, MD

IEPR
Coordinating
Center

Sheryl Kelsey, PhD
Lisa Kennard, PhD
Nichole Dwyer, BA
Brad Wulffkuhle, BS

IEPR
127 Parran Hall
130 DeSoto St.
Pittsburgh, PA 15261
Tel: 412 624 3764
Fax: 412 624 5592



Santa gets ready for EECPC.



Joe flanked by Deann (left) and Brenda (right), both are EECPC therapists for the Angina Center.

I am the Clinical Director of the Angina Center of Evansville, a division of Ohio Valley Heart Care, a 17-physician practice. I developed and set-up this EECPC Clinic in August of 2000 in coordination with my medical director, Ralph Millsaps, MD. To date, we have treated approximately 80 patients with a great deal of success.

My wife Lisa and I have been married 29 years, in spite of being high school sweethearts here in Evansville, IN. We have three children. Sam, 26, is an electrician. Jessica, 24, is newly married. She is returning to school to become an RN, after receiving a B.S. in English and a B.S. in German. Ben, 21, our 6'5" baby, is in the School of Business at St. Louis University, considering a career in music production. Lisa and I, with an almost empty nest, enjoy traveling and Indiana University basketball. I also enjoy occasionally drowning a few crickets on the end of a hook. Each year, for about 12 years now, from late November through December, my alter ego appears as a big man in a red suit. I visit the children of friends and family to be sure they have been good and to learn what they want for Christmas. Nothing compares to seeing the look in their eyes when Santa has come to their home just to see them. And let me not forget our second family of a Bassett Hound, Goliath and a Chow mix, Annie.

I became a registered nurse in 1978 after graduating from St. Elizabeth Hospital School of Nursing in Lafayette, IN, (the last existing Diploma school in Indiana). I also spent 3 years in Bloomington at Indiana University as a Political Science major. I began my nursing career at St. Mary's Medical Center (Evansville, IN), as a 'float'. After having had a taste of floor nursing in orthopedics, medical, surgical, etc., I quickly gravitated to a 24 bed ICU where cardiac patients were easily my favorites. There were so many pieces to the puzzle of what to do to get them better; every day was a new challenge with new procedures, therapies, and medicines to learn. During the 23 years in the ICU as a staff nurse, I shunned several offers of promotions, as I continued to enjoy patient contact and knew several of my bosses that missed that part of nursing. In that 23 years, I became proficient with Swan/Ganz, Continuous Venovenous Hemodiafiltration, Left Ventricular Assist Device, post-op Cardiovascular patients, Advanced Cardiac Life Support, and I knew Intra Aorta Balloon Pump's as well as anyone around. This is probably why EECPC is so logical to me. Eventually, the need for the adrenaline rush, such as when

a CODE BLUE is called, fades. Luckily, for me, Dr. Millsaps, whom I had known for 20 years, recognized my need and desire to get out of ICU, and offered me this job. I now have the opportunity to care for very sick people without the day-to-day stress of frequent life and death decisions. I am also allowed the luxury of helping my patients with some of the problems they face in the health care system when they don't know what questions to ask, much less who to ask. Another important part of my job is the education of both lay-people and professionals in regard to EECP. I have been able to challenge many of my skeptics (MDs) to allow me to treat a patient whom they have no other options to offer. If the patient shows improvement, they send more people to me. If they don't, they haven't lost anything. When we first started, the nearest treatment center was over 150 miles in any direction. There are now 5 other treatment centers within 50 miles of ours. I know this is a result of The Angina Center pioneering EECP in this part of the country.

I recently organized a workshop for EECP Therapists in Indianapolis, IN. The workshop was focused on and for the people that run the machines on a day-to-day basis. The workshop was an opportunity to share tricks of the trade and helped set up a network of friends among therapists. With the help of Vasomedical, Inc. and CardioDynamics (BioZ), it was a wild success. Future workshops like this one will be done in conjunction with the International EECP Therapists Association (IETA). If you are not currently a member of IETA, please join as many opportunities will become available as time goes on.

Thus far, my association with EECP therapy has been very rewarding. When first introduced to EECP by Dr. Millsaps, I truly thought the stress of his job had finally pushed him over the edge. I asked, "Do you really believe you can decrease angina symptoms by pumping on a person's legs?" I was sure he would come to his senses once faced with the absurdity of this notion. He gave me some literature and told me of the www.eecp.com website. I started reading, and again, with my background in IABP's, I had to admit, it did make sense. I know the national average is about an 80% success rate, but there are only a handful of patients we haven't helped to some degree. What continues to surprise me are the few patients that admit only minimal improvement at the end of 35 treatments, contact me a month or so later and brag about how they are a "whole lot better than even when I first got finished. Do you think it was the EECP?" An integral part of our treatments is the education we provide while we have a "captive" audience. We don't lecture, but we do go over the importance of diet, smoking, knowing what medications he or she is on and what they are for, what CHF is, what causes angina, the importance of exercise, and (my favorite) to be pro-active in their own health care. That is, don't walk out of the doctor's office without knowing why he/she didn't do anything at all. It is unusual for our patients to have a visit with their cardiologist in our building and not come up to our department to say hi.

The Angina Center of Evansville provides EECP in a private practice. We have two MC2s and currently treat about 11 patients a day. If we try to do our capacity of 12, we don't have buffer days for illness of our patients. We generally have about a 4-6 week waiting list to get started. I am very lucky to have two technicians (one part-time and one full-time) Deann Johns and Brenda Still, both EMTs, who are not only proponents of EECP, but are good at what they do. Both have the gift of being good listeners and can carry on conversations with the same people day in and day out. We provide our patients with as much comfort as possible. A custom vinyl-covered egg-crate pad, personal fan table-side, plenty of pillows, TV/VCR with wireless headphones, cassette tape player (books on tape), and each is made to feel as though they are our favorite patient. We have also added a firm foam wedge (about 6 inches elevation) behind their shoulders to give those with some breathing restrictions the feeling they aren't flat on their back. I have many success stories. One patient went from walking 2 city blocks and having angina to walking 2 miles with no angina. Another's goal was to be able to walk to the barn to see his horse and not have angina. He not only goes to the barn, but also rides and grooms his horse without angina. I have had a number of "professionals" question how this could possibly extend life expectancy. Some are really stunned when I answer, "it doesn't, it improves quality of life. Which would you prefer for yourself?" Perhaps the most common comment is the old "it's a placebo effect". I answer with documentation of studies showing increased perfusion and point out the patients are up and moving and then ask "what do you have to offer them with these results?" Many of our patients are happy to be able to take a shower, carry in the groceries, wash the dishes, or have sex, all without angina. Though I believe all surgical and medical modalities should be exhausted first, I have had a few patients tell me EECP helped them more than any medicine or surgery. We all look forward to the day we can start treating CHF patients. I think the experience I've had treating angina patients and the improvement in their lives and the lives of their families has proved as rewarding as the 'saves' made in the years I spent in the ICU. I love my job, and there are a lot of people in this world that can't say that.

American Journal of Cardiology

May 2002

A Comparison of Patients Undergoing Enhanced External Counterpulsation and Percutaneous Coronary Intervention for Stable Angina Pectoris
R Holubkov, E Kennard, J Foris, S Kelsey, O Soran, D Williams, D Holmes

June 2002

Relation of the Pattern of Diastolic Augmentation During a Course of Enhanced External Counterpulsation (EECP) to Clinical Benefit [from the International EECP Patient Registry (IEPR)]
M Lakshmi, E Kennard, S Kelsey, R Holubkov, A Michaels

In press: Congestive Heart Failure

July 2002

Enhanced External Counterpulsation as Treatment for Chronic Angina in Patients with Left Ventricular Dysfunction:
A Report from the International EECP Patient Registry (IEPR)
O Soran, E Kennard, S Kelsey, R Holubkov, J Strobeck, A Feldman

8th World Congress on Heart Failure

Washington, DC July 2002

Does Enhanced External Counterpulsation (EECP) Reduce the Refractory Angina Burden in Patients With Left Ventricular Dysfunction: - A 2 Years Follow-Up Study
O Soran, E Kennard, A Feldman

European Society of Cardiology

Berlin, Germany September 2002

Functional Status of Patients with Chronic Angina Treated with Enhanced External Counterpulsation
E Kennard, S Kelsey, G Linnemeier

European Association for the Study of Diabetes

Budapest, Hungary September 2002

Enhanced External Counterpulsation Provides Angina Relief in Diabetic Patients – a One Year Clinical Outcome Study from the International EECP Patient Registry
G Linnemeier, E Kennard, S Kelsey

Heart Failure Society of America

Boca Raton, FL September 2002

Diabetic Patients with Angina Undergoing Enhanced External Counterpulsation Therapy - The Effect of Low Ejection Fraction
G Linnemeier, E Kennard, S Kelsey

Do Women with Left Ventricular Dysfunction and Refractory Angina Respond as Well as Men to Enhanced External Counterpulsation?

O Soran, E Kennard, A Feldman

Enhanced External Counterpulsation Provides Angina Relief in Diabetic Patients Who Are Not Candidates for Coronary Revascularization – a Six-Month Clinical Outcome Study from the International EECP Patient Registry

G Linnemeier, ED Kennard, S. Kelsey

Background: Many diabetic patients with anginal symptoms are poor candidates for coronary revascularization procedures. Enhanced external counterpulsation (EECP) is a noninvasive analogue of the intra-aortic balloon pump designed to increase myocardial perfusion pressure and decrease cardiac workload. EECP has been demonstrated to be safe and effective in treating angina in a wide range of patients. We examined the efficacy of EECP for patients with diabetes mellitus (DM) who were not candidates for coronary revascularization.

Methods: The International EECP Patient Registry (IEPR) enrolls consecutive patients undergoing EECP for chronic angina. We analyzed demographic and clinical outcome data from 899 patients with DM from 66 sites who were not revascularization candidates by referring physician's assessment.

Results: The mean age of patients with DM who were not revascularization candidates was 66 ± 10 years, and 69% were male. The duration of coronary artery disease was 10 ± 8 years, 67% had prior percutaneous intervention (PCI), 72% had prior coronary artery bypass surgery (CABG), and 42% had a history of congestive heart failure (CHF). Angina symptoms were severe - with 88% of patients classified as Canadian Cardiovascular Society (CCS) Class III or IV. Most patients (81%) were able to complete a course of therapy with a mean of 34 ± 11 treatment hours. Immediately after EECP, 70% of patients decreased at least one angina class, and 70% of patients were classified as no angina or CCS Class I or II. Mean angina class pre-treatment was 3.2 ± 0.7 , and post-treatment 1.9 ± 1.2 ($p < 0.001$). At six months follow-up, angina status remained improved in 79% of patients, with a mean angina class of 1.7 ± 1.3 ($p < 0.01$). Episodes of angina were also significantly reduced with patients reporting on average 11 episodes/week pre-EECP, and only 3 episodes/week post-EECP ($p < 0.001$), and 4.0 ± 7.8 episodes/week at six months ($p < 0.001$).

Conclusions: The management of coronary artery disease (CAD) in patients with diabetes mellitus (DM) continues to pose a challenge. EECP offers an effective antianginal effect for patients with DM who are not candidates for coronary revascularization. Although these patients have a significant disease profile, most patients achieved symptomatic improvement, which was maintained at six months.

Enhanced External Counterpulsation Provides Relief from Severe Angina in Diabetic Patients - a Six-Month Clinical Outcome Study from the International EECP Patient Registry

G Linnemeier, E Kennard, W Lawson

Background: Many diabetic patients (D) experience severe anginal symptoms despite optimum medical management, yet many are poor candidates for revascularization due to higher procedural morbidity and mortality and recurrent events. Enhanced external counterpulsation (EECP) is a noninvasive analogue of the intra-aortic balloon pump, designed to increase myocardial perfusion and decrease cardiac workload, that has been demonstrated to be safe and effective in treating angina. The long-term effectiveness of EECP for treatment of severe angina in diabetic patients is unknown.

Methods: Patients enrolled in the IEPR who had Canadian Cardiovascular Society (CCS) angina class III or IV were studied. 706 were D and 920 were non-diabetic patients (ND). EECP was given 1-2 hours daily to each group with similar total treatment hours (mean, 34 hours) and completion rates. Patients were followed for six months post-treatment to determine clinical outcome.

Results: D differed significantly from ND in age (65.5 vs 67.3 years), female gender (30.6% vs 21.9%), history of congestive heart failure (38.1% vs 26.3%), and noncardiac vascular disease (37.3% vs 23.9%), all $p < 0.001$. Most patients in both groups were not candidates for revascularization (80.8% for D vs 77.0% for ND, $p = NS$). All patients were highly symptomatic reporting > 10 episodes of angina/week, and requiring 9-10 nitroglycerin (NTG)/week. At completion of treatment, 73.6% of D and 78.8% of ND ($p < 0.05$) had their CCS angina class reduced by 1 class. NTG use was decreased by 39% in D and 46% in ND. Of patients responding at six months, 78.6% of D and 81.2% of ND ($p = NS$) reported maintenance of angina improvement. During the follow-up period, D experienced a higher rate of congestive heart failure (7.2% vs 3.4%, $p < 0.001$), and higher mortality (5.7% vs 2.7%, $p < 0.01$) than ND.

Conclusion: EECP is an effective, non-invasive treatment option for patients with diabetes and symptomatic coronary artery disease (CAD). The adverse events seen in this population were not unexpected given their clinical characteristics. The benefits of EECP are sustained in most patients at six-month follow-up, assisting the physician in treating the challenging diabetic patient with severe CAD.

The Incidence of Repeat Enhanced External Counterpulsation in Patients With Refractory Angina Who are not Candidates for Invasive Revascularization: Results from the International EECP Patient Registry

O Soran, AD Michaels, L. Kennard, S Kelsey, AM Feldman

Purpose: Enhanced external counterpulsation (EECP) is safe and effective treatment for patients with refractory angina despite maximal medical therapy and surgical or percutaneous revascularization. However, there is no published data on the repeat EECP rate in the long-term follow up in such patients. We examined the efficacy and the repeat EECP rate for patients who are not candidates for invasive revascularization.

Methods: The International EECP patient registry (IEPR) tracks the short- and long term outcomes of patients undergoing EECP for chronic angina. To date 5000 patients have been enrolled from over 90 international centers. We analyzed demographics and clinical outcome data from 1363 patients with refractory angina who are not candidates for invasive revascularization. We compared immediate and one year clinical outcomes and repeat EECP rate at one year follow up.

Results: The mean age was 66±11 years, with a predominant male gender (75.5%) and white race (94%), 67.6% had prior MI, 32.6% had history of heart failure, 87.1% had prior percutaneous intervention or CABG, and none of them were candidates for further invasive intervention. Cardiac risk factors included: Diabetes mellitus 42.8%, hypertension 69.4%, hyperlipidemia 77.1%, smoking 66.2%, family history of CAD 75.4%, and non-cardiac vascular disease 30.3%. Mean EF was 45.61%, 81.4% had multivessel disease, 86.0% had Class III-IV or unstable angina, and nitroglycerin usage was 70.5%. Immediately after EECP patients had a significant reduction in angina, 73.4% of patients decreased at least one angina class, with a mean reduction of 7 angina episodes a week and over half of patients initially using nitroglycerin had discontinued its use. One-year follow-up was complete for 78% of patients and of these 76% reported either class 1-2 or no angina, and had maintained the same or lower angina class compared to immediately post-EECP. The mortality rate was 5% reflecting the severity of disease in these patients. 15% had returned for a repeat course of EECP.

Conclusion: EECP is an effective treatment in refractory angina patients whose coronary arteries are unamenable to further invasive revascularization. More importantly improvements have been maintained at 1-year follow-up with a low repeat EECP rate.

Does a History of Congestive Heart Failure Influence the Effectiveness of Enhanced External Counterpulsation for the Treatment of Angina in Patients with Diabetes? - A One-Year Clinical Outcome Study from the International EECP Patient Registry

G Linnemeier, E Kennard, M Rutter, R Nesto

In patients with diabetes (DM), Enhanced External Counterpulsation (EECP) is safe, well tolerated and effective for the relief of angina. DM is associated with a 2-fold increase in the risk of congestive heart failure (CHF). The influence of CHF on effectiveness of EECP in patients with DM is unknown.

We examined outcome following EECP in 751 patients with DM, 267 (36%) of whom had a history of CHF. The proportion having undergone previous coronary angioplasty or bypass surgery, was high in groups with and without CHF (87% and 83%, p=NS). Those with CHF were more likely to be female (35% vs 26%, p<0.05), have a history of myocardial infarction (MI) (79% vs 59%, p<0.001), and be treated with ACE inhibitors (55% vs 35%, p<0.001), angiotensin receptor blockers (17% vs 10%, p<0.01), or lipid lowering medication. Those with CHF had reduced mean left ventricular ejection fraction (40% vs 51%, p<0.001), had longer duration coronary disease (10.6 yrs vs 8.9 yrs, p<0.001), were less likely to complete the standard 35 hours of EECP treatment (77% vs 85%, p<0.01) and were more likely to report a clinical exacerbation of CHF during the treatment period (8% vs 0.4%, p<0.001). On completion of EECP, both groups achieved similar reductions in angina severity (reduction 1 or more angina classes: 68 % vs 72 %, p=NS), frequency (mean reduction weekly episodes: 6.3 vs 7.0, p=NS), and nitroglycerin use. At one year (data available in 80% of patients), maintenance of angina improvement was similar in both groups (81% vs 77%, p=NS). However, in keeping with previous studies, those with DM and CHF were more likely to report a clinical exacerbation of CHF (18% vs 5%, p<0.001), MI (9% vs 4%, p<0.01) or death (14% vs 3%, p<0.001).

In these patients with DM, many of whom had undergone a previous revascularization procedure, EECP was effective in the treatment of angina in those with and without a history of CHF. EECP extends treatment options for angina in this high risk population.

Society for
Cardiac
Angiography
and
Intervention
Seattle,
Washington
May 2002

American
Diabetes
Association
San
Francisco,
California
June 2002

A friendly reminder about data form submission

It is important that all forms be submitted in a timely manner. The following forms must be submitted for each new patient:

- Screening log entry – fax the current log sheet every Friday whether or not a new patient has been enrolled. Simply draw a line under the last entry, date, and initial before faxing.
- Pre-EECP form – submit within one week of the first day of treatment
- Pre DASI form – submit within one week of the first day of treatment

The continuation form must be faxed in at the 35th hour if the patient is to receive more than 35 hours of therapy.

At completion of EECP treatment, the following must be received within one week of the last day of treatment:

- Post-EECP form
- Post DASI form

IEPR pre-EECP and post-EECP forms are being received without the DASI forms. The functional status form is an essential part of the IEPR data collection, and should be completed and faxed at the same time as the PRE and POST forms. If the patient refuses to continue participation or cannot be contacted for completion of the post-DASI form, send in a blank form indicating the patient is lost to follow-up and provide a brief written explanation on the form.

As detailed in the Manual of Operations for IEPR – Phase 2, forms will not be entered into the database unless the patient has been entered on the Screening Log, the Screening Log has been received, all the data forms for the time point have been received and the dates on all forms match. If any of these criteria for completion have not been met, the forms will not be recorded as received on your monthly compliance report.

We appreciate your continued support of the IEPR. Please contact Nichole Dwyer at 412-624-3764 or email at dwyer@edc.pitt.edu if you have any questions.

Clinical Tips

CLINICAL TIPS

Gladware disposable storage containers (6 1/2" square size) work well to protect lower quadrant kidney transplants and stomas. The rounded edges are non-traumatic, while the rigid sides provide a protective housing. Cover the area to be shielded with a thin piece of foam, then position the plastic container over the foam.

Joanne Giordano, LPN, Secretary of IETA
EECP Supervisor, Cardiology & Medicine Associates, Vero Beach, FL

Louanne Tempich, LPN, RCVT, President of IETA, EECP Supervisor of the EECP Center of Pittsburgh, tells us that in the Emergency Department's in Canada, Ativan (Lorazepam) 0.5mg is given sub-lingually to patients that present with anxiety and tachycardia. Within 5 minutes of administration, the patient is usually calmer and the heart rate is decreased. Permission of the medical director must be obtained before this can be used pre-EECP, but it's something to keep in mind for those patients that come to treatment anxious and have a rapid heart rate.

DID YOU KNOW?

Eight million women in the United States are afflicted with heart disease. Heart attacks are the biggest killers of American women, striking some 440,000 each year with 250,000 fatalities - more than stroke, lung cancer and breast cancer combined.

Women indicate they are twice as frightened of breast cancer, which in 1998 killed one in 28, as they are of heart attacks, which killed one in 5.

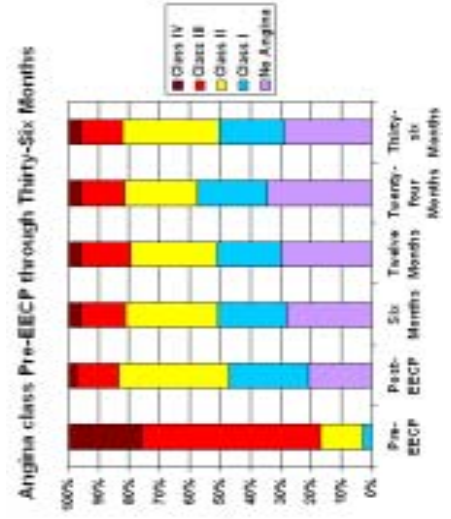
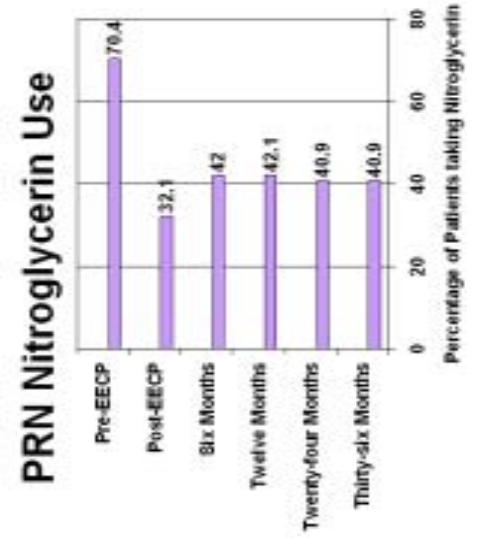
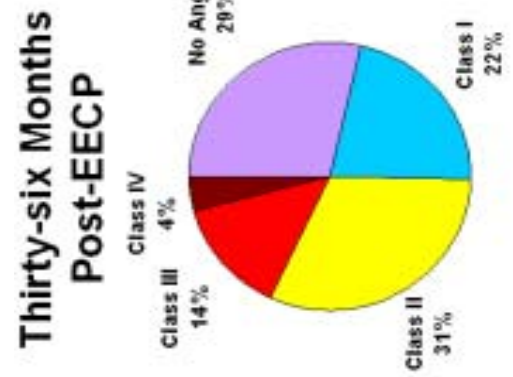
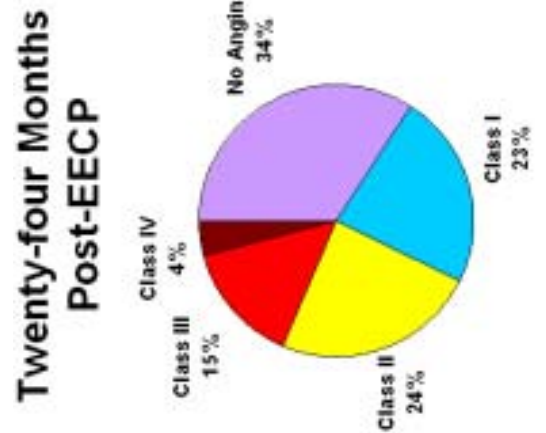
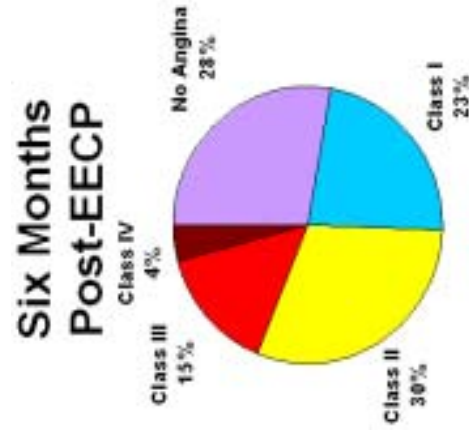
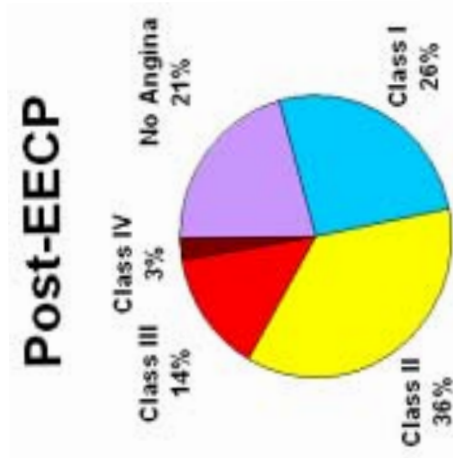
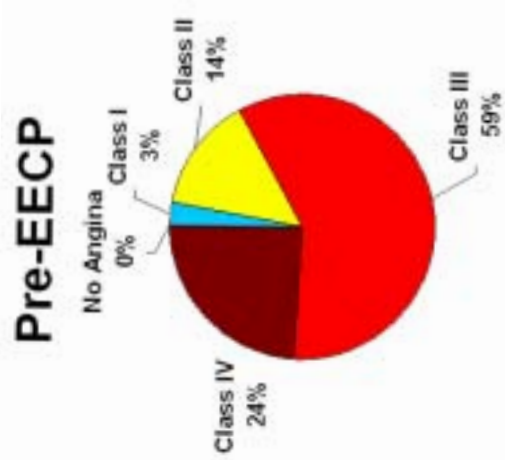
Symptoms of heart attack in women can be far more subtle than the chest-crushing pain common to men. Women may experience nausea, breathlessness or exhaustion, only mild chest discomfort, inexplicable jaw or back pain, or abdominal pain that is easily mistaken for indigestion. Or they may feel nothing at all. Studies show that up to 45% of female heart attacks go unnoticed or unreported. Two-thirds of women who die from heart attacks have no warning symptoms of any kind.
FORTUNE, November 22, 1999

The clinical manifestations of CAD occur approximately 10 years later in women than in men. Despite the later onset, women rapidly catch up with men in CAD prevalence and mortality. Since 1984, the number of cardiovascular disease deaths in women has exceeded that in men by more than 50,000 per year.

Women who survive a myocardial infarction, have a greater risk of chronic heart failure in part because of the greater prevalence of diabetes mellitus, hypertension, and advanced age at presentation.
The American Journal of Managed Care, October, 2001.

For more information on heart disease in women:
WomenHeart - the national coalition for women with heart disease
202-728-7199 or www.womenheart.org

Did you know...?



EECP Therapy: Duration of Clinical Benefit

The International EECP Patient Registry (IEPR) database was frozen on 02/05/02. Post-EECP, Six month, Twelve month, twenty-four month and thirty-six month data reflect patients who completed the prescribed course of EECP treatment and for whom follow-up information was available.

Patient Demographics

Mean age	66.7 years
Age >65	59.5%
Male gender	75.4%

Medical History:

Duration of CAD	10.9 years
Prior PCI/CABG	86.0%
Prior MI	68.1%
CHF	32.4%
Diabetes	42.0%

	Pre-EECP (N=4894) %	Post-EECP (N=3829) %	6 months (N=2873) %	12 months (N=1995) %	24 months (N=842) %	36 months (N=134) %
No angina	-	20.9	27.9	29.9	34.2	28.9
Class I	2.7	26.1	22.6	21.0	23.1	21.9
Class II	14.2	36.4	30.5	28.5	24.1	32.0
Class III	59.1	14.0	14.9	16.6	14.5	14.1
Class IV	24.1	2.6	4.1	4.1	4.1	4.1
Improved by >= 1 class		82.8				
Improved by >= 2 classes		44.5				
No increase in angina since Post-EECP			79.6	75.6	76.1	70.3
prn Nitro use	70.4	32.1	42.0	42.1	40.9	40.9

IEPR-1

Follow-Up Form Compliance

Six Months	88%	One Year	80%
Two Years	71%	Three Years	49%

We are very short of our goal of 95% compliance!

Let's make an extra effort to get follow-up completed and sent in! The credibility of the Registry data depends on a >90% compliance rate for follow-up!

DASI participants: 90% of post forms have been received, and six month forms are due.

Diabetes ancillary study participants: Only 182 patients have been enrolled since this study began in June 2001. Some extra effort will be needed to reach the goal of 500 within IEPR 2.

IEPR-2

Total sites enrolling: 68

Total patients enrolled as of July 1, 2002: 597

Data Outcomes

IEPR-1 Compliance

IEPR-2 Update

IEPR CONTEST

CONTEST

- WHY?** We need to improve the follow-up compliance for IEPR-1
- ELIGIBILITY?** All sites with < 90% follow-up compliance at 2 and 3 years as of July 1st, 2002
- THE WINNERS?** All sites that improve follow-up compliance to > 90% by August 15th, 2002.
- THE PRIZE?** Something special for each successful center **AND**
- ALL** prize winners will be entered in to a **grand prize** drawing which will reward the winner with an **ALL expenses paid trip to the AMERICAN HEART ASSOCIATION MEETING in Chicago, IL in November 2002!**



So contact those patients and get your forms in! GOOD LUCK!

As always, please contact Nichole Dwyer at 412-624-3764 if you have any questions.

Thank you for your continued support of the IEPR!

The IEPR has Global Span

How the IEPR is Truly International Georgiann Linnemeier, MD

As the Medical Director of the International EECPP Patient Registry, I find the depth and breadth of our clinical experience fascinating. Some coordinators and providers may not realize the level of international experience we have represented in the Registry.

We now have 17 international sites including Beaumont Hospital in Dublin, Ireland, The Medkar Center in Ankara, Turkey, two sites in the United Kingdom (Hull and London), as well as sites in Aruba, the Bahamas, Israel, and Colombia. These centers have enrolled a total of 266 patients in the IEPR-1. (With good one and two-year follow-up compliance, I might add).

With the support of these centers, as well as those in the United States, we have had the opportunity to present to both national and international meetings. This year alone there have been presentations on EECPP at the British Cardiac Society, the European Association for the Study of Diabetes, the European Society of Cardiology, the 8th World Congress on Heart Failure, and the 2nd European Conference on Management of Coronary Heart Disease.

As always, I am grateful for the support of **all** the participating centers both national and international, and with everyone's support (and good follow-up compliance), we will, together, participate in the dissemination of important clinical experience with EECPP in the **real world**.



“Healing the World One Heart at a Time”

Dear Colleagues and Fellow EECP Therapists, The International EECP Therapists Association (IETA) is pleased to announce the creation of a Credentialing Board. The goal of this Board is to initiate the process and procedures necessary to develop and secure professional credentialing of EECP Therapists. This will serve to further enhance the visibility of EECP as a mainstream therapy for cardiovascular disease and to establish the professional standing of EECP Therapists in the medical community. The first meeting of the IETA Credentialing Board is planned for September 2002.

Credentialing Board Members include:

Debora Braverman, MD (IETA Medical Director), Vital Heart EECP Centers
Denise D'Ambrosia, FNP, Stony Brook University Hospital
Louanne Tempich, LPN, RCVT, EECP Center of Pittsburgh
Ellen Longmoore, CNMT, University of Virginia Medical Center
Michelle Cox, CMA
Gudrun Lang, RN, BSN, Vasomedical

A CONTEST

Be sure to log onto our website to learn about our upcoming contest. The details can be found under the “CUTTING EDGE”. The winner will be profiled on the IETA website! You must be an IETA member to participate.

To become a member of IETA please log on to our website: www.ietaonline.com complete the membership application, and return it to the address at the top along with the \$30.00 membership fee.

Don't forget that there is also telephone access to the IETA Board of Directors through the hotline number: 1-800-376-3321, ext. 140. Leave a message and a member of the Board will respond.

IETA Board of Directors:

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The Board of Directors thanks you for your continued support!

“The International EECP Therapists Association is a multidisciplinary organization of EECP therapists, united with one professional voice to set and uphold standards of excellence in the delivery of Enhanced External Counterpulsation (EECP)”

IETA

Heart Healthy Recipes



Heart Healthy Recipes!

Pasta with Grilled Chicken, White Beans and Mushrooms

2 chicken breasts
1 tablespoon olive oil
1/2 onion, chopped
8 ounces sliced mushrooms
1 cup white beans, cooked
2 tablespoons chopped garlic
1/4 cup chopped fresh basil
1/4 cup Parmesan cheese
12 ounce package of pasta (elbow,
rotelle, or shells)

Grill or broil the chicken breasts and shred into small pieces. In a large pan, saute the onion and mushrooms in the olive oil. Add white beans, garlic and fresh basil. Add the chicken and keep warm. Cook the pasta in water until al dente. Drain and add to the chicken mixture. Toss well. Serve immediately topped with parmesan cheese and pepper to taste.

Yield: 4 generous servings

Nutritional Analysis:

Calories	545
Fat (grams)	12
% calories from fat	20
% polyunsaturated	4
% saturated	5
% monounsaturated	11
Cholesterol (mgs)	120
Sodium (mgs)	170
Protein (gms)	35
Carbohydrate (gms)	74
Fiber (gms)	1

Diabetics or those on calorie-controlled diets may count one serving as: 4 starch, 2 vegetable and 2 meat servings

Strawberry Shortcake

Cake:

1 3/4 cups all-purpose flour
2 1/2 teaspoons double-acting baking powder
1/2 teaspoon salt
1 tablespoon sugar
2 tablespoons margarine
3/4 cup milk

Topping:

6 cups fresh strawberries
1 1/2 cup plain yogurt

Preheat oven to 450 degrees. Sift flour into a measuring cup. Resift flour along with baking powder, salt and sugar. Cut in margarine. Add the milk and stir lightly. Turn the dough onto a floured board. Knead for 1/2 minute. Pat to 1/4 inch thickness and cut into 6 pieces. Bake 10-12 minutes until golden. Place onto serving plate and top each with 1 cup of strawberries and two table-
spoons yogurt.

Yield: 6 servings

Nutritional Analysis:

Calories	250
Fat (gms)	5
% calories from fat	18
% polyunsaturated	7
% saturated	4
% monounsaturated	7
Cholesterol (mgs)	1
Sodium (mgs)	427
Protein (gms)	8
Carbohydrate (gms)	44
Fiber (gms)	5

Diabetics or those on calorie-controlled diets may count one serving as: 2 starch, 1 fruit, and 1 fat serving.



Next Issue:
Presentations from
European Society of Cardiology
and Heart Failure Society of America meetings