Symposium to examine problems with interventions in acute stroke care

Wednesday’s symposium on “Problems with Interventions in Acute Stroke: 7 Little Things” from 1:30–3 p.m. Wednesday in Davidson Ballroom A will address unanswered questions in endovascular therapy for acute stroke, covering efficacy, safety and the role of recanalization.

“This is a timely session because a recent Dutch study presented at the 2014 World Stroke Conference suggested that endovascular therapy for acute stroke is safe and effective for patients with acute ischemic stroke caused by an intracranial arterial anterior-circulation occlusion when given within six hours of stroke onset,” said session co-moderator Tudor G. Jovin, MD, associate professor of neurology and neurosurgery and director of the Stroke Institute and the Center for Neuroendovascular Therapy at the University of Pittsburgh.

His co-moderator is Peter Schellinger, MD, PhD, FAHA, Johannes Wesling Clinic, Minden, Germany. The results of that study conflict with a recent Italian study presented at the 2013 International Stroke Conference showing no benefit to endovascular therapy when given in addition to or instead of tPA.

Two other recent trials scheduled to be presented at the ISC 2015 evaluating endovascular interventions were halted after interim analyses showed overwhelming efficacy of endovascular therapy for acute ischemic stroke, Jovin said. “This session will provide a great opportunity for speakers to review the latest studies of endovascular therapy,” he said.

Joseph Broderick, MD, professor of neurology and director of the Neurosciences Institute at the University of Cincinnati, will talk about standardizing the procedures used in the treatment of acute stroke. Marc Ribó, MD, PhD, assistant professor of neurology at the Universitari Vall d‘Hebron in Barcelona, Spain, will discuss the importance of recanalization on treatment effects in acute stroke. “The quality of vessel recanalization is the main driver of good outcomes in patients who are treated with endovascular therapy,” Jovin said. “Partial recanalization is not good enough. We need to achieve complete recanalization and do it very quickly.”

Werner Hacke, MD, PhD, professor and chair of neurology at the University of Heidelberg, Germany, will examine safety issues related to interventions in acute stroke. “All the acute stroke interventions have potential complications. Dr. Hacke has been the leader of many intravenous thrombolytic trials and other types of trials in stroke,” Jovin said.

Rishi Gupta, MD, director of neurocritical care at Wellstar Health System in Marietta, Ga., will talk about standardizing the procedures used in the treatment of acute stroke.

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Uncover the future of AIS treatment.

TODAY IN HALL B!

11:10 AM - 11:22 AM

ESCAPE:
Endovascular treatment for Small Core and Anterior circulation Proximal occlusion with Emphasis on minimizing CT to recanalization times

Michael D Hill, MD
University of Calgary
Calgary, AB, Canada

11:22 AM - 11:34 AM

EXTEND-IA:
Endovascular Therapy After Intravenous t-PA Versus t-PA Alone For Ischemic Stroke Using CT Perfusion Imaging Selection

Bruce Campbell, MD
Royal Melbourne Hospital
Melbourne, Australia

11:34 AM - 11:46 AM

MR CLEAN:
Multi center Randomized Clinical trial of Endovascular treatment for Acute ischemic stroke in the Netherlands

Yvo Roos, MD
University of Amsterdam
Amsterdam, Netherlands

11:46 AM - 11:58 AM

SWIFT PRIME:
Solitaire™ FR With the Intention For Thrombectomy as Primary Endovascular Treatment for Acute Ischemic Stroke

Jeffrey L Saver, MD
University of California
Los Angeles, California
Session examines new advances in pediatric stroke
Vessel wall imaging future of stroke prediction

Understanding the nuances of the microvasculature of the brain and carotid artery — not the degree of arterial stenosis — is the future of predicting strokes, according to Thomas G. Brott, MD, professor of neurology at the Mayo Clinic in Jacksonville, Fla.

Brott is co-moderator of “Cerebrovascular Vessel Wall Imaging: State of the Art” from 1:30–3 p.m. Wednesday in Davidson Ballroom B. His co-moderator is Yongjun Wang, MD, department of neurology at Beijing Tiantan Hospital, Capital Medical University.

Stroke prediction in the 21st century was characterized by an emphasis on carotid and intracranial vascular disease and the degree of narrowing of the arteries, said Brott, but an increasing number of clinical trials have recognized limitations to this approach. In several studies among patients with asymptomatic disease, there was no correlation between the extent of stenosis and subsequent risk of stroke, he explained.

This will be reviewed in-depth during the session by Martin M. Brown, MD, professor of stroke medicine at the Institute of Neurology, University College London, in “Shortcomings of Stenosis as a Predictor for Stroke and the Need for Vessel Wall Imaging: Lessons from Randomized Clinical Trials.”

Other speakers will cover a variety of approaches to vessel wall imaging, including MRI screening, ultrasound, computed tomography and molecular examination of blood vessel walls.

“Such approaches to examination of the blood vessel wall as a means of predicting stroke are purely 21st century strategies and dependent on 21st century tools,” Brott said.

The technology, as compared to measures of arterial stenosis, looks below the surface of the plaque, revealing characteristics of lipids, hemorrhage, and plaque irregularities and other features, and how these features might result in stroke or predict plaque progression. Vessel wall imaging may also help predict how contemporary medical therapies may affect plaque progression or remission, Brott said.

All session speakers have expertise in extracranial and intracranial vessel wall characteristics. Chun Yuan, PhD, professor of radiology and bioengineering and co-director of the vascular imaging laboratory at the University of Washington in Seattle, will discuss “Techniques of Carotid and Intracranial Vessel Wall Imaging.” Thomas S. Hatsuokami, MD, professor of surgery and co-director of the vascular imaging laboratory at the University of Washington in Seattle, will present “Potential Applications for Carotid Vessel Wall Imaging.” David Mikulis, MD, professor and co-director of medical imaging research at the University of Toronto, will present “Potential Applications for Intracranial Vessel Wall Imaging.”

Brott said the session is important to all physicians who treat carotid artery disease or intracranial disease.

“Understanding the blood vessel wall over the next decade will become key in terms of predicting who will have a stroke and who will not; which medical approach is best; and which interventional approach might be best in preventing a stroke,” Brott said. “We are only beginning to develop the techniques needed to look very closely at the microvasculature. The hope is that over the next 10 to 20 years, our methods will be up to the challenge of learning about the microvasculature of the brain where so many of the answers lie.”

Poster Tours: Sessions kick off today

SC 2015 offers two types of poster sessions: professor-led poster tours and one-on-one individual Q&A poster presentations. Choose from 10 Professor-Led Poster Tours from 5:15–6:15 p.m. Wednesday in Hall D. Expert moderators will lead these tours, which are organized by category; they provide a short presentation and Q&A with each of the poster authors in that section. To take part, simply review the poster Abstracts section of the Final Program (page 50). Decide which section/category of posters you would like to attend. Then, at 5:10 p.m., arrive at the correspondingly numbered “Section” sign for your selected section/category.

During the Regular Poster Sessions, poster presenters will be at their posters for informal Q&As with attendees from 6:15–6:45 p.m. Wednesday in Hall D. These one-on-one posters are not a part of the earlier Professor-Led Poster Tours. To see the posters featured in Wednesday’s Regular Poster Sessions, go to page 57 of the Poster Abstracts section of the Final Program. Posters also will be available for viewing in the Poster Hall (Hall D) from 8:00 a.m. – 6:45 p.m. Wednesday and Thursday. See Thursday’s Stroke News for details on Thursday’s Professor-Led Poster Tours and Regular Poster Sessions. Please see page 49 of the Final Program for the Poster Hall map.

Watch for these Unofficial Satellite Events

Exhibitors, universities, nonprofit organizations and industry supporters will offer several independently organized learning opportunities — Unofficial Satellite Events and Expert Theaters — during ISC 2015.

Thursday

7-10 p.m. The Solitaire™ Stent Thrombectomy Device for the Treatment of Acute Ischemic Stroke: An Analysis of the Results From Three Randomized Studies

Omni Hotel Nashville, Legends Ballroom

Sponsored and supported by Covidien

Professor-Led Poster Tours

5:15–6:15 p.m. Posters W MP1–W MP120

1. Acute Endovascular Treatment

Moderated Poster Tour

2. Acute Neuroimaging

Moderated Poster Tour

3. Acute Nonendovascular Treatment

Moderated Poster Tour

4. Aneurysm & SAH and Other Neurocritical Management

Moderated Poster Tour

5. Basic and Preclinical Neuroscience of Stroke Recovery & Clinical Rehabilitation and Recovery

Moderated Poster Tour

6. Community/Risk Factors

Moderated Poster Tour I

7. Emergency Care/Systems

Moderated Poster Tour I

8. Experimental Mechanisms and Models

Moderated Poster Tour I

9. Health Services, Quality Improvement, and Patient-Centered Outcomes

Moderated Poster Tour I

10. Intracerebral Hemorrhage

Moderated Poster Tour

Regular Poster Sessions

6:15–6:45 p.m. Posters W P1–W P426

These posters are not included in the 5:15 p.m. Professor-Led Poster Tour Session at left.

1. Acute Endovascular Treatment Posters I

2. Acute Neuroimaging Posters I

3. Acute Nonendovascular Treatment Posters I

4. Aneurysm Posters I

5. Basic and Preclinical Neuroscience of Stroke Recovery Posters I

6. Cerebral Large Artery Disease Posters I

7. Clinical Rehabilitation and Recovery Posters I

8. Community/Risk Factors Posters I

9. Diagnosis of Stroke Etiology Posters I

10. Emergency Care/Systems Posters I

11. Experimental Mechanisms and Models Posters I

12. Health Services, Quality Improvement, and Patient-Centered Outcomes Posters I

13. In-hospital Treatment Posters I

14. Intracerebral Hemorrhage Posters I

15. Nursing Posters I

16. Preventive Strategies Posters I

17. Vascular Biology in Health and Disease Posters I

18. Vascular Malformations Posters I

19. Late-Breaking Science Posters I

ISC 2016 award nominations

AHA Members can submit nominations for the ISC 2016 Feinberg, Willis and Sherman Awards:

• Nomination Period Opens: Wednesday, Feb. 11, 2015

• Nomination Period Closes: Wednesday, July 8, 2015

Go to strokeconference.org/awardsandlectures for more information.
Important Safety Information

CLEVIPREX® (clevidipine) Injectable Emulsion is contraindicated in patients with:

- Allergies to soybeans, soy products, eggs, or egg products;
- Defective lipid metabolism seen in conditions such as pathologic hyperlipemia, lipoid nephrosis, or acute pancreatitis if it is accompanied by hyperlipidemia; and
- Severe aortic stenosis.

CLEVIPREX® is intended for intravenous use. Use aseptic technique and discard any unused product within 12 hours of stopper puncture.

Hypotension and reflex tachycardia are potential consequences of rapid upward titration of CLEVIPREX®. If either occurs, decrease the dose of CLEVIPREX®.

There is limited experience with short-duration therapy with beta-blockers as a treatment for CLEVIPREX®-induced tachycardia. Beta-blocker use for this purpose is not recommended.

CLEVIPREX® contains approximately 0.2 g of lipid per mL (2.0 kcal). Lipid intake restrictions may be necessary for patients with significant disorders of lipid metabolism.

Dihydropyridine calcium channel blockers can produce negative inotropic effects and exacerbate heart failure. Monitor heart failure patients carefully.

CLEVIPREX® is not a beta-blocker, does not reduce heart rate, and gives no protection against the effects of abrupt beta-blocker withdrawal. Beta-blockers should be withdrawn only after a gradual reduction in dose.

Patients who receive prolonged CLEVIPREX® infusions and are not transitioned to other antihypertensive therapies should be monitored for the possibility of rebound hypertension for at least 8 hours after the infusion is stopped.

There is no information to guide use of CLEVIPREX® in treating hypertension associated with pheochromocytoma.

Most common adverse reactions for CLEVIPREX® (>2%) are headache, nausea, and vomiting.

Please see Full Prescribing Information available at booth.
ISC 2015 abstract categories

- Acute Endovascular Treatment
- Acute Neuroimaging
- Acute Nonendovascular Treatment
- Aneurysm
- Basic and Preclinical Neuroscience of Stroke Recovery
- Cerebral Large Artery Disease
- Clinical Rehabilitation and Recovery
- Community/Risk Factors
- Diagnosis of Stroke Etiology
- Emergency Care/Systems
- Experimental Mechanisms and Models
- Health Services, Quality Improvement, and Patient-Centered Outcomes
- In-Hospital Treatment
- Intracerebral Hemorrhage
- Nursing
- Pediatric Stroke
- Preventive Strategies
- SAH and Other Neurocritical Management
- Vascular Biology in Health and Disease
- Vascular Cognitive Impairment
- Vascular Malformations
- Late-Breaking Science

Educational luncheons scheduled

Four educational luncheons will take place during the International Stroke Conference.

Wednesday
- Fellow and Early Career Luncheon: Developing Successful Career Paths in Stroke, 12:10–1:30 p.m. in Room 102
- Nursing and Rehabilitation Professionals Luncheon, 12:10–1:30 p.m. in Room 103

Thursday
- Fellow and Early Career/Stroke Leader Roundtable Luncheon, 12:10–1:30 p.m. in Room 102
- Advance Practice Providers’ Luncheon, 12:10–1:30 p.m. in Room 105; please note, this lunch is sold out.

International attendees

International attendees may obtain an attendance verification form at one of the self-service terminals in Registration, located in the Hall C Lobby, Level 3.

Claim your CME/CE credit

You have two ways to complete your conference evaluation and claim your CME/CE credits for the conference, pre-conference symposia and/or nursing symposium.

1. Stop by the Communication Center, which is located in the Hall B Lobby, Level 3 of the Music City Center.
2. Visit learn.heart.org from any computer with Internet connection.

You should claim your CME/CE credit within 30 days of conference completion. CME/CE credit will NOT be available after July 31, 2015.

ACUTE STROKE

continued from page 7

“We will discuss how standardization of the way endovascular stroke procedures are performed will lead to better outcomes,” Jovin said. “It’s important to fine tune the way the procedures are administered so we can make better sense of the data on outcomes and improve those outcomes.”

Jeffrey L. Saver, MD, director of stroke and vascular neurology services at the Ronald Reagan Medical Center of the University of California at Los Angeles, will look at standardization of efficacy and bleeding endpoints in trials of acute stroke.

“The definitions of endpoints and safety points are not uniform or standardized in stroke trials, and that hinders our ability to compare the results of various trials,” Jovin said. “It’s important to standardize endpoints when we design trials so we speak the same language.”

Martin Köhrmann, MD, from the department of neurology at the University Hospital Erlangen, Germany, will discuss the logistics of stroke care, including which specialists should perform the procedures and how quickly the interventions should be initiated in the hospital.

Finally, Raul G. Nogueira, MD, associate professor of neurology, neurosurgery and radiology at Emory University School of Medicine in Atlanta, will examine the economic implications of acute stroke care.

“We utilize devices and an infrastructure that are quite expensive. The question is whether the expense of the procedures is justified in terms of outcomes.”

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Experts to debate selection and transport of stroke patients for endovascular therapy

Two debates — on where to triage and evaluate acute stroke patients for endovascular therapy, and the other on where to transport stroke patients with suspected large-vessel occlusions for endovascular therapy — will be featured in “Selection for Endovascular Therapy in the Ambulance or Angio Suite: Is It Possible?” Thursday from 7–8:30 a.m. in Davidson Ballroom A.

“The debates will evaluate the effectiveness of endovascular therapy and how to improve outcomes in acute stroke patients,” said Category Chair Tudor G. Jovin, MD, associate professor of neurology and neurosurgery and director of the Stroke Institute and the Center for Neuroradiology and Neuroradiology at the University of Pittsburgh Medical Center.

Co-moderators for this session are Xabier Urra, MD, PhD, neurologist at the Hospital Clinic of Barcelona, Spain, and Rüdiger von Kummer MD, PhD, professor of diagnostic radiology and neuroradiology and chief of neuroradiology at the Technical University of Dresden, Germany.

For the first debate, one speaker will address triage and evaluation of stroke patients in the ambulance while two other speakers will argue that the time to reperfusion can be shortened by others means.

Albert J. Yoo, MD, a diagnostic radiologist at the Massachusetts General Hospital, Boston, will argue that the emergency department is the established and safest place to select the appropriate candidates for endovascular therapy. He will also assert that the best way to reduce time to reperfusion is to refine and shorten the imaging studies currently used to evaluate and select patients.

David S. Liebeskind, MD, a vascular neurologist at the University of California at Los Angeles Medical Center, will contend that bypassing emergency department assessments and obtaining the necessary information to select patients for reperfusion in the angiography suite is the most efficient way to reperfuse the brain.

Heinrich J. Audert, MD, head of neurology at the Charité Benjamin Franklin Hospital in Berlin, will discuss evaluating stroke patients in the ambulance.

“We know that there is some delay between the time the patient reaches the hospital door and the time to reperfusion,” Jovin said. That delay is due to emergency department assessments and imaging studies and transport time to the angiography suite.

In addition to severity of stroke symptoms (NIH stroke scale score), there are several critical elements in the decision-making process that deem a patient suitable for mechanical embolectomy. They are: absence of hemorrhage, proof of large vessel occlusion, and extent of irreversibly damaged brain (core) in relationship to the entire brain territory at risk of dying without timely reperfusion.

“The latter three elements only currently can be obtained through brain imaging studies, and the performance of which incurs long delays,” Jovin said. “The time interval from arrival to hospital to procedure start is in the 90 minute-range even at the best hospitals. Many will argue that these times are too long and that we should model ourselves along the cardiology model of 60 minutes for door-to-balloon time.”

In the second debate, Andrew D. Demchuk, MD, director of the stroke program and chair of acute care and emergency services at the University of Calgary, Alberta, will maintain that the best way to get stroke patients with suspected large-vessel occlusion to the appropriate therapy is to transport the patient directly to the closest primary stroke center.

The current system of stroke care is set up as a hub-and-spoke system, Jovin said. The ambulance takes the patient to the spoke, i.e., a community hospital stroke center that evaluates the patient, and if the patient is a candidate for endovascular therapy, triages the patient to the hub, i.e., a stroke center with endovascular capabilities.

“One of the justifications for this approach is that patients will receive intravenous tPA faster because the spoke hospitals are generally located closest to where the stroke patient is picked up by the ambulance,” he said. “However, a significant proportion of patients with large-vessel occlusion do not respond to IV tPA, and endovascular therapy has been proven to be beneficial in a time-dependent fashion. Therefore, transfer to a local center and from there to an endovascular center could negatively affect outcomes due to the inherent delay incurred with this approach.”

Natalia Pezé de la Ossa, MD, from the stroke unit in the department of neurosciences at the Hospital Universitari Germans Trias i Pujol in Barcelona, Spain, will argue that not all patients with severe acute stroke should be transported directly to a stroke center with endovascular capabilities.

IMPROVING STROKE continued from page 1

Spiegel is co-moderator for “Improving Stroke Care for Women” from 3:30–5 p.m. Wednesday in room 209. The session is designed to draw attention to the need for improved stroke care for women and to recent guidelines from the World Stroke Organization that point the way to improving stroke care for women.

“One in five women will have a stroke while in men it is one in six,” said co-moderator Valeria Caso, PhD, associate professor in neurology at the University of Perugia, Italy. “Life expectancy is growing, which means we will have even more women with stroke compared to men.”

The primary risk factors for stroke are similar in both sexes, Caso noted, including hypertension, smoking and obesity. Pregnancy and oral contraceptives add to the risk of stroke for women but also multiply opportunities for stroke prevention.

“We want physicians to recognize that preventive measures can be taken during pregnancy — things like attention to blood pressure and high risk conditions for thromboembolism,” said Category Chair Walter Kernan, MD, professor of medicine at Yale School of Medicine in New Haven, Connecticut. “A pregnant woman at risk for stroke presents a huge opportunity for prevention. Physicians should also recognize that oral contraceptives may be harmful in women with additional risk factors, such as hypertension or smoking.”

Women are not at increased risk for stroke compared to men in any age group, Kernan noted. But because women tend to live longer than men, their lifetime risk of stroke is higher.

“Stroke physicians are finding themselves caring for, in women, a group of older patients who are more likely to have significant comorbidities that need to be factored into their care,” he said. “The main purpose for this session is to give clinicians the skills they need to provide more thoughtful, timely and intelligent care of women with stroke. There are distinct challenges in caring for women.”

One challenge is that risk factors can change dramatically over a woman’s lifetime. Before menopause, women tend to have much lower rates of hypertension, which lessens their risk of stroke. But postmenopausal women have higher rates of hypertension than men. A second challenge is a relative paucity of women in clinical trials. The deficit of women in early carotid endarterectomy trials continues to cloud the usefulness of the procedure.

“All of us walking into the room of a patient with stroke or at risk for stroke need to understand the specific challenges when the patient happens to be a woman,” he said. “We need to negotiate those challenges thoughtfully and in light of the best available science.”

Reference


Warnings/Precautions

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Patients with a Reveal® Insetable Cardiac Monitor should avoid sources of electromagnetic interference, such as cellular phones, computer monitors, etc., as this may adversely affect the performance of the device.

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Visit Wolters Kluwer (booth #228) or AHA/ASA HeadQuarters (booth #136) in the Science & Technology Hall for more information.
Science & Technology Exhibit Hall: Explore this must-see destination

The Science & Technology Exhibit Hall returns to ISC 2015 with a unique blend of innovative equipment, supplies and services. Nowhere else can you take in such offerings at one place at one time.

Visit with representatives from more than 100 companies from 10 a.m. – 4 p.m. Wednesday and Thursday. Any time you need to get connected, just stop by one of the Wi-Fi hotspots, located in the Stryker WIFI-Charging Lounge.

Be sure to check out the American Heart Association/American Stroke Association’s HeadQuarters, located in Booth 136, where you can:
• Network with your colleagues in the relaxing atmosphere of the Member Circle and power up your smart devices (for AHA/ASA Members only).
• Take in several presentations in the Theater. Visit Booth 636 for a detailed schedule.

AHA/ASA HeadQuarters, Booth 136

Wednesday
10:30–11:30 a.m. Stroke Journal webinar
Immunology of Stroke
Kyra Becker, MD

11:30 a.m.–12:05 p.m. My AFib Experience
Heather Simpson, manager, Health Initiatives, Patient & Healthcare Innovations

12:15–1 p.m. AFib Jeopardy
Steve Dentel
Can your team keep pace with the competition? Test your knowledge and play AFib Jeopardy. This is a team competition.

Teams can be made up of three to four players. Prizes will be awarded to the winning team.
E-mail kristen.wade@heart.org to reserve your spot to play.

1–2 p.m. QI International Consortium for Health Outcomes (ICHOM)
ICHOM assembled an international working group of 17 international experts, including patient advocates, vascular neurologists, registry experts, epidemiologists and rehabilitation specialists. Using a modified Delphi-method, the working group developed a Standard Set of outcomes for stroke patients that we believe should be measured in all adults with new stroke as a crucial part of the mission to improve the value we provide to stroke patients.

3 p.m. Hospital Accreditation — AHA/ASA & The Joint Commission
Does your hospital have what it takes? Test your knowledge in this interactive session about Primary Stroke Center Certification and Comprehensive Stroke Center Certification.

Thursday
10–10:30 a.m. Defining the New Support Network
Heather Simpson, Health Initiatives Manager, Patient & Healthcare Innovations
How we have entered the patient market arena to impact healthier choices and quality of life for patients, families and caregivers suffering from the effects of heart disease, stroke and congenital heart defect.

12:30–1 p.m. How to Claim CME/CE Credit for ISC 2015
Michelle Bruns, MLA, director, Professional Education
You have listened to the presentations, read the abstracts and participated in the discussion, now don’t forget about your continuing medical education credit. We will address when and how to claim your credit, expiration dates and more. A demonstration will be provided to show the process. Don’t leave your credit behind.

1–2 p.m. Stroke Journal webinar
Evaluation of Cryptogenic Stroke: Pursuit of Cause, Therapeutic Implications
J.R. Mohr, MD, MI, MD

Case Theaters, Booth 636

New to ISC 2015, the 30-minute Case Theaters begin at 3 p.m. on Wednesday and Thursday. Join our panel of experts for an interactive discussion and insight into the decision-making, technical aspects and management of common procedures, as well as highlights of areas of evolving innovation. Our case presentations aim to educate ISC membership with the best practices and educational pearls for both common and new procedures that are performed in patients during their day-to-day care around the world.

Wednesday
3–3:30 p.m.
Management of a Ruptured Complex Distal Aneurysm
Case Presenter: David Fiorella, MD, PhD, Stony Brook, N.Y.

Thursday
3–3:30 p.m.
Management of a Tandem Occlusion
Case Presenter: Tudor Jovin, MD, Pittsburgh

Collaboration Station
Council Science Subcommittees focus on targeted areas of content for AHA. This year we are highlighting the Stroke Council Science Subcommittees which include: Emergency Neurovascular Care Committee, Telestroke committee, Nursing and Rehabilitation Professionals, Quality and Outcome Committee, Rehabilitation and Recovery Committee, Stroke Statement Oversight Committee and the CVSN Stroke Nursing committee. Other committees AHA wide include: heart failure, interventional cardiology, acute cardiac care, imaging, cardiac rehab, electrophysiology, hypertension, molecular determinants of disease, social determinant of disease, prevention, obesity, diabetes, physical activity, nutrition, stroke and many more. Join us at the Collaboration Station for information and networking.

Expert Theater, Booth 636

Found in the Science & Technology Hall C, Booth 636, the Expert Theater feature targets educational programs as well as featured products and therapeutic treatments from industry supporters. Enjoy a complimentary lunch provided by the American Heart Association.

Wednesday
12:10–12:40 p.m.
Reducing the Risk of Thrombotic Events Across Multiple Indications: A Focus on Non-Valvular Atrial Fibrillation (NVAF)
Sponsored by Boehringer Ingelheim

Wednesday
1–2 p.m.
Physician-Patient Alliance Announces New Stroke VTE Safety Recommendations in Ischemic and Hemorrhagic Stroke Patients
Sponsored by Covidien

Thursday
12:10–12:40 p.m.
Cryptogenic Stroke and Atrial Fibrillation: How Hard Should We Be Looking?
Sponsored by Medtronic

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August 27-29, 2015
Hooman Valadi, Ph.D.

(212) 641-2477
Hooman Valadi is a board certified interventional cardiologist with an expertise in cerebrovascular disease. He is Dr. Valadi's primary research interest is thrombolysis and neuroprotection. Dr. Valadi has authored over 200 peer-reviewed publications on this topic. In addition, he has authored 3 books on the topic of stroke and stroke therapy. Dr. Valadi is a member of the American Heart Association, Society for Neuroscience, American Neurological Association, and American Stroke Association. Dr. Valadi is an associate editor for the journal Stroke and an editorial board member of Stroke: A Journal of Cerebral Circulation. Dr. Valadi is a member of the editorial board for the journal Thrombosis Research and a member of the editorial board for the journal Stroke: A Journal of Cerebral Circulation. Dr. Valadi is a member of the editorial board for the journal Stroke: A Journal of Cerebral Circulation. Dr. Valadi is a member of the editorial board for the journal Stroke: A Journal of Cerebral Circulation.
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When you’re in control, it’s amazing what you can capture.
The Mobile Stroke Unit (MSU) is a fully equipped ambulance vehicle that provides emergency medical care, and it’s a critical component of the Mobile Stroke Care System (MSCS), which is a network of services that allows patients to receive immediate treatment for stroke, even before arriving at a hospital. The MSCS includes MSUs, which can be deployed to stroke events at any time of day or night, and it uses advanced diagnostic and treatment technologies to provide the best possible care for patients with suspected stroke. The MSU is equipped with the latest technologies for the diagnosis and treatment of stroke, including the TeleStroke Network, which allows MSUs to connect with remote stroke specialists via video conferencing. This enables MSU medical staff to consult with stroke specialists in real-time, providing expert advice and guidance to make the best possible treatment decisions. By doing so, MSUs can significantly reduce the time it takes to diagnose and treat stroke patients, which can improve outcomes and save lives. So, if you ever find yourself in a situation where you need urgent medical care for a stroke patient, a Mobile Stroke Unit could be the critical link to saving a life.
have made a difference is the subject of “STAIRing Down the Barrel of a Loaded Research Gun: How Useful Are the STAIR Criteria 15 Years Later?” from 3:30–5 p.m. Wednesday in Davidson Ballroom A.

“The STAIR Criteria were developed as a means of improving the translatability of preclinical stroke research, but despite their good intent, the extent to which they are followed and really matter is debatable,” said session co-moderator Gregory Bix, MD, associate professor of anatomy and neurobiology at the University of Kentucky, Lexington. “The hard reality is that we still do not have very good new translatable stroke therapies.”

The STAIR Criteria was predicated on the fact that so many publications reported successful neuroprotection and infarct volume reduction — studies that were backed up by molecular and behavioral analysis — but these therapies were ultimately unsuccessful in humans, according to session co-moderator Farida Sohrabji, PhD, professor and associate chair of the department of neuroscience and experimental therapeutics at Texas A&M Health Science Center, College Station.

“Despite the decades of research, alteplase is still the only approved stroke treatment,” Sohrabji said.

The session will look at what the STAIR recommendations for designing preclinical stroke studies have meant for the field and afford discussion on their role going forward. It will include an introduction to the Multi-PART (Multicentre Preclinical Animal Research Team) international collaborative approach that builds off STAIR.

“This is a timely topic and we anticipate a lively discussion during the session, not just a boring overview of the guidelines,” Bix said.

“The point of the session is to discuss the real-world utility and impact of the preclinical STAIR Criteria.”

Session speakers are Ulrich Dirnagl, MD, coordinator for the clinical study team, German Center for Neurodegenerative Diseases, Charité—Universitätsmedizin Berlin; Louise McCullough, MD, professor of neurology and neuroscience at the University of Connecticut, Farmington; Gregory J. del Zoppo, MD, professor of medicine, University of Washington School of Medicine, Seattle; Thomas A. Kent, MD, chief of neurology at Michael E. DeBakey Veterans Affairs Medical Center, and director of stroke research and education and professor of neurology at Baylor College of Medicine, Houston; and I. Mhairi Macrae, MD, professor of neuroscience, University of Glasgow, Scotland.

“This is an important session for active preclinical researchers. It’ll provide an opportunity to compare their methods with those recommended by the guidelines, and to interact with the panel and discuss which recommendations have and have not been successfully incorporated,” Sohrabji said. “It is our hope that clinicians will also attend, so that we can gather their input regarding differences between the lab and the clinic.”
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