Interview with Carlo Di Mario

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IDK: How did you decide to become a cardiologist and more specifically, an interventional cardiologist?

CDM: In my 4th year of medical school, I started attending the Department of Cardiology of the University of Padua, which was at that time led by the charismatic Director Professor Sergio Dalla Volta. His lectures were inspiring, among the best I ever heard, revealing the flamboyant personality of the former pupil of Sodi Pallares in Mexico City who spent long periods in Harvard, Boston. He spoke 10 languages (but not Turkish, I am afraid). The department was at the forefront of cardiology, in which novel techniques such as echocardiography were practiced with one of the largest congenital heart disease practices, with a Cardiac Surgery run by a co-worker of DeBackey, Professor Gallucci, a master in coronary surgery and aortic pathology. I remember asking him in 1979, two years after the first angioplasty in Zurich, what he thought of this new technique. He was cautious but encouraging, saying that there was space for a minimally invasive technique in the early phases of diseases or as palliation in inoperable patients. Despite this surgical opening, I had almost finished my cardiology fellowship before the first angioplasty was performed in Padua, and I could fulfill my dream only two years after the completion of my fellowship when I was accepted for a 6-month research internship at the Thoraxcentre of Rotterdam under Professor Serruys. My projects at the time were focused on aortic balloon valvuloplasty, a technique recently introduced by Cribier, and coronary sinus retroperfusion, which was considered a possible solution in acute myocardial infarction at a time when very few ventured into primary angioplasty. It was an exciting time, with the first stent implanted by Sigwart, my predecessor at the Brompton, in Lausanne; the first intravascular ultrasound (IVUS) pilot work by Yock and Tobis; the first Radi pressure wire tested by Emmanuelson in a sabbatical year in Rotterdam; and the introduction of many technical advances from Rotablator to laser. I discussed my PhD thesis on IVUS imaging and Doppler in 1993, while I was practicing in the very busy Catheterisation Laboratory of Rotterdam.

IDK: Can you tell us a bit about your path from Italy to London?

CDM: Although I loved working in Rotterdam, family reasons suggested a return to Italy. I visited Columbus Clinic in 1994, curious to see in practice at work Dr Colombo. This eccentric Italian cardiologist was stenting without post-operative warfarin and trusted the efficacy of IVUS to fully expand stents. It was an eye-opening experience. He had just returned from the United States and had brought back the practical approach of Hartzler to complex angioplasty completed by a truly innovative technique of stenting. I was amazed by the difference between the cautious stent deployment that was routinely practiced, attentive to avoid deformation with post-dilatation, and his aggressive work with the Chubby balloon, which was built for him by Schneider, guided by repeated IVUS passes. I was accepted to join his practice, and the year after we visited the place where new techniques were tested, from the new stent designs that replaced the Palmaz–Schatz and Gianturco–Roubin stents to the Igaki–Tamai biodegradable stents to the Jomed Graftmaster, carotid filters, and the Perclose. I enjoyed a great professional relationship with Colombo, but I felt that it was time to look around and move on to a more independent role. I was somewhat surprised that the most appealing offer, after some exploratory visits in the United States and Canada, came from the "conservative" UK. It took me time, with seven visits to the center, to get convinced that it was a good idea, and it still was hard to get into a very different system from the rest of Europe. However, almost 15 years later, I can say that it was the right choice.

IDK: And about your presidency of the European Association of Percutaneous Cardiovascular Interventions (EAPCI)?

CDM: I started presenting abstracts to the European Society of Cardiology in 1984, and I was always present for every annual congress except, paradoxically, the year I became FESC, when I was on call and asked colleagues to present my work. My first

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encounter with the group of Interventional Cardiology, at that time called Working Group on Coronary Circulation, was in 1996. I saw an opportunity to join the expertise of the various European groups and prepare a manuscript on definitions and interpretation of IVUS, and I stood up proposing to create a task force to work on it. I was told that it was too early, and when I insisted to have the proposal voted on, I was badly defeated. In the same meeting, Bernhard Meier proposed to change the name of WG into Interventional Cardiology, and his proposal was also turned down! The year after the new secretary contacted me and asked me to enter the Nucleus of WG leading, Task Force I proposed. It was not much hard work to write the document but to have 20 people agreeing on the various points (thank God the internet had started to be popular because there was no money for meetings), and when the document was finished, it was carefully scrutinized to make sure that it was not in conflict with existing guidelines. We published the document in the European Heart Journal before the Americans, but I still noticed in the years after that the Mintz paper was the one most frequently quoted by Europeans, despite many similarities. If I was smart, that experience could have been sufficient, but I felt that it was a natural role for a person who had practiced in three European countries to facilitate integration, and after several initiatives on the definition of a common training path for interventional cardiology in Europe, I started the slow growth from the treasurer to the secretary elect, and the working group increased from few hundred to 2000 members, organizing courses and with the highest number of abstracts submitted to the annual congresses and 10 sessions directly organized. When it was proposed that we become an association, joining forces with EuroPCR Congress and having EuroIntervention as official journal, I supported the pr oposal, agreeing to postpone my presidency for 3 years to have William Wijns, a non-elected member from EuroPCR, in charge of the transition period. It was not an easy relationship between the "democratic" WG component and the historical group around Jean Marco organizing the congress. Many projects I had in mind when I became President in 2009 are still in the pipeline (the training platform based on our curriculum has just been implemented, the European integrated database as a platform for large observational studies and to facilitate strategy trials has been dropped for PCI and produced results only for structural interventions such as TAVI and the MitraClip). This August, I will leave my last EAPCI role, Chairman of the EORP Transcatheter Valve Registry with the transition from the pilot to the long-term phase, when we hope to welcome Turkish contribution. It has been a titanic work to lead this big multifaceted association with very limited support for years, neglecting the opportunity to spend time to prepare new articles with my fellows, to spend hours in front of the computer to answer requests, to write the monthly President's page on EuroIntervention, and to ensure that the various projects were running, but I do not regret it. Eventually, we will see a powerful Interventional Association within the European Society of Cardiology truly leading the largest interventional world congress and one of the most respected journals and organizing training, designing, and conducting trials, ensuring that the progress of interventions in countries where angioplasty, stent, and valve implantation have started.

IDK: What fueled your interest into chronic total occlusions?

It still is the main reason of the failure of PCI and a big driver for the referral of patients to surgery. I remember spending hours with Patrick Serruys and Jaap Hamburger to open chronic occlusions using laser wires and dual injection and finishing the work with ultrasound-guided stenting, something other centers adopted only 10 or 20 years after. When I was offered the opportunity to work on a larger patient group at San Raffaele, I focused on these complex cases, and my first move in London was to invite Dr Katoh, the real inventor of the retrograde approach and of many devices that have transformed and greatly facilitated the technique. In 2006, when the retrograde approach was practiced by a handful of centers and the success rate was 60–70% on average with only easy occlusions approached, with Reifart, Werner, Sianos, Galassi, Escaned, and others, we founded the European CTO Club. Many European centers have now reached 80–90% success, and the annual congress of this group has become a must for all dedicated operators. I am very pleased to see Turkey at the forefront with Ömer Göktekin chairing the local organizing committee for the next course in Istanbul, where I hope to see all the interventionalists of Turkey.

IDK: I am sure that many interventionalists from Turkey are looking forward to attend this meeting.

Anyone in the hospital is aware of your incredibly long working hours that, a lot of the time, span from the early morning till late midnight; how do you maintain your motivation; and how do you manage with such pressure?

I was lucky, enjoying good health, and doing some daily physical activity cycling back and forth from my house to the hospital, no matter the weather, which is always unpredictable in London. Having young fellows sharing long hours around you also gives great motivation.

IDK: Are you able to find some spare time, and if so, do you have any hobbies during this time?

I ran the London Marathon soon after my arrival here, the classical mistake you make when you approach your 50s and you want to show you are still young. Now I prefer long cycle rides or walks through the English countryside, full of places of stunning natural beauty. I even took a full week holiday this summer and went to Scotland. I needed the emptiness of that grand landscape to recharge.

IDK: You have also worked alongside a few fellows from Turkey, from that it would be interesting to know your opinions.

All the Turkish fellows I had were excellent. Ömer Göktekin was my first fellow at the Brompton and came for electrophysiology more than interventions. I am pleased that I managed to interest him in interventions because he proved to have great natural gifts. I was really impressed seeing the new center he managed to create in Istanbul and the complexity of cases he presents in courses around the world. More recently, Dr Kadriye Kilickesmez and you joined our group. You are an ideal partner to work with, always respectful and attentive, but you immediately sense when you are not doing your best or when you are trying to cut corners. It is amazing to see that after 1 ½ years, you have published so well and have become a speaker presenting at congresses and specialized imaging courses.

IDK: Thank you very much for the kind words. If you could give any advice to young interventional cardiologists, what would that be?

Don't be too eager to do one case after another as soon as you have learned how to insert a wire and a balloon. Training should mean that you watch and assist more than you do. It is very difficult to learn more when you are an established independent operator. You will then have your chance to do 1000 cases. Take your time when you are young, travel abroad, learn the way other operators and centers use, and then develop your own style and update it with the progress of materials and techniques.

IDK: If you could look back in time would there be anything you would change in your career, or indeed any advice you would give yourself?

CDM: Spend more time with your children; they grow too fast, and they do not know that the time of their birth often coincides with the most critical period of their father or mother's career. You will regret to have missed the opportunity when it is too late.

Thank you very much for this wonderful interview and opportunity.