



AMERICAN ASSOCIATION OF CARDIOLOGISTS OF INDIAN ORIGIN

OCTOBER 2004 • Debasish Roychoudhury, M.D., Editor

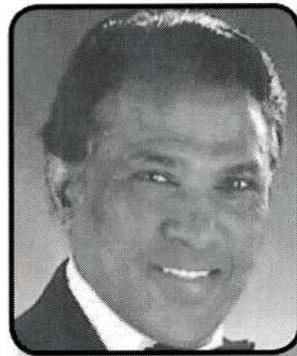
Message from the President of AACIO Dayan Naik, MD, FACC

It is with great pride that I have accepted the Presidency of the AACIO on July 1, 2004 for a period of two years. During my tenure I would like to improve the membership of the organization, conduct various cardiology meetings and develop a comprehensive program for the cardiology fellows of Indian origin in the United States.

It is also my desire to develop a cohesive relationship with the various pharmaceutical companies and business institutions to make the AACIO financially strong. We are also moving toward developing a combined program with the American College of Cardiology. On behalf of the AACIO Executive Committee and the Board members I would like to extend an invitation to all of you to attend the dinner meeting during the AHA Convention at the Hotel Monteleone, 214 Rue Royale in New Orleans. Please extend the invitation to one of your colleagues and cardiology fellows of Indian origin. Your participation in this program will serve to strengthen the AACIO.

I also urge those of you who are not members of the organization to log onto www.AACIO.org > Membership, to join.

I would also like to thank the Executive Committee and the Board members for their support. Our deep appreciation is extended to Sanofi Aventis and Astra Zenca for their generosity in sponsoring this dinner program.

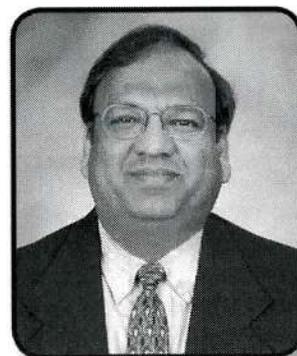


Dr. Prakash Deedwania To Be Honored By AACIO

It has been decided to honor Prakash C. Deedwania, M.D. at the AACIO meeting Sunday November 7th, 2004. Dr. Deedwania is Professor of Medicine at the University of California, San Francisco (UCSF), School of Medicine. Dr. Deedwania is Chief of the Cardiology Division for the UCSF Program, Fresno. He is also Director of Cardiovascular Research for the UCSF Fresno-Central San Joaquin Valley Medical Education Program and a Clinical Professor of Medicine at Stanford University, Palo Alto.

Widely published, Dr. Deedwania has authored or coauthored well over 300 publications, including refereed journal articles, book chapters, and abstracts. Dr. Deedwania has been an invited speaker for numerous national and international meetings. He is a faculty member of the National Lipid Education Council, National Diabetes Education Initiative, and is a founding member of the Vascular Biology Working Group. He has also served as an external expert reviewer for the National Heart, Lung, and Blood Institute. He has been a visiting professor at many prestigious medical universities in the U.S. and abroad. He is a regular invited Guest Faculty at Cardiac Society of India and Association of Physicians of India.

Dr. Deedwania has also started and just completed the first prospective randomized trial ever conducted (the IRIS trial) in Asian Indians living in USA and Canada. The results from IRIS study would not only provide pivotal data regarding the distribution of various lipid and lipoprotein levels and emerging risk factors in South Asians living in North America but this study would set a stage for future clinical trials for Indians in USA.



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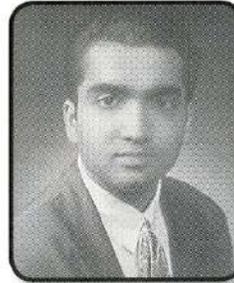
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Dr. Deedwania is the immediate past president of the International Society of Holter Monitoring and Non-invasive Cardiology (ISHNE). He is a member of the writing groups for the ACC/AHA Practice Guidelines on Ambulatory ECG Monitoring and Practice Guidelines on Chronic Stable Angina. Dr. Deedwania is currently President of the California Chapter of the American Society of Hypertension.

AACIO Young Investigator Awards



Dr. Dipan J. Shah

The abstracts of Dr. Vishal Gupta (work done while at the University of Alabama at Birmingham, Birmingham, Alabama) and Dr. Dipan J. Shah (Duke Cardiovascular Magnetic Resonance Center, Durham, NC and Northwestern University Feinberg School of Medicine, Chicago, Illinois) were selected for the AACIO Young Investigator Award and were presented at the AACIO Meeting held during the ACC meeting in New Orleans, Louisiana in March 2004. Both received a plaque and a check for \$1000.00. Dr. Gupta received the Dr. Krishna Ramaswamy Young Investigator's Award and presented an abstract on the "Atrial Septal Defects in a Large Population of Ischemic Stroke Patients: Age Distribution, Gender and Race" and Dr. Shah received the Dr. Madhukar Deshmukh Young Investigator's Award and presented his abstract on "Contrast MRI Predicts Reverse Remodeling and Contractile Improvement in Akinetic Thinned Myocardium".



Dr. Vishal Gupta

Dr. Navin C. Nanda Honored

Dr. Navin C. Nanda, Professor of Medicine and Director of the Heart Station/Echocardiography at the University of Alabama at Birmingham was recently honored by the NRI Medical College and General Hospital in China Kakani, Guntur Dist., Andhra Pradesh, India who named their Echocardiography Laboratories as "Navin Nanda Echocardiography Laboratories" in honor of Dr. Nanda's pioneering contributions to the field of echocardiography.



Also in March 2004, the Government of the United Arab Emirates and the Emirates Society of Cardiology designated Dr. Navin Nanda as the "Echocardiographer of the Millennium" for his pioneering lifetime contributions to the advancement of cardiology.

The Predilection To Overspend

I recently met with an elderly Indian physician who had been in the USA several months visiting his sons, who are both doctors. He is an intelligent man, well informed and well read. His curiosity about all things American was great, and his questions to me searching and cogent. I, in turn, asked him about his impressions of the American medical system.

He told me that the most consistent American trait, in his opinion, was never to do anything in a simple and inexpensive manner when it could also be done in a more complicated and expensive way. He called this tendency "overspend". This unexpected comment, as startling as it was apparently paradoxical, he proceeded to amplify with the following observations:

The system whereby patients are investigated or worked-up here is very American, different from the British or European systems. American medical students are trained to believe that every patient should have a full battery of tests according to the presenting symptoms. The tests might range from simple biochemical or radiologic ones to invasive procedures or imaging tests using multimillion-dollar CT or MRI equipment. A workup comprising many tests is the fate of most patients who deliver themselves up into the hands of an internist or specialty physician trained in this system. The patient has to run the gauntlet of all these tests, unless he lacks adequate insurance. Every new biochemical, radiologic or electrocardiographic procedure may reveal some deviation from the norm, sometimes important but more often irrelevant or trifling in significance. The watchful eye of the clinician then seizes on such "abnormality" to order a new test.

Should the patient question the necessity of these further investigations, he is told that these tests are advisable because theoretically there are various conditions to be excluded. What he may not be told is that there are medico-legal reasons, lawsuits that the physician needs to avoid at all costs. The financial costs and the risk or stress of putting a patient through an array of tests to diagnose a very few or uncommon treatable abnormalities (likelihood 2% or less) are seldom considered in a litigious society, with third-party payers footing most of the bill.

Along with advances in medical science, the number of new tests being added to the diagnostic repertoire far exceeds the number of established tests that are discarded as obsolete. The medical equipment and biochemical industry continues to expand. Each company wants to increase its share of the market, because that is the American way. This means, of course, enhanced medical costs and incremental revenues for manufacturers, physicians and hospitals.

Some diagnostic procedures are undoubtedly essential for patient management, but with respect to others, the truly useful yield of data is meager, if not tiny. For very large outlays in health care dollars, there is often a very small gain in really applicable diagnostic information. Witness the millions of dollars spent every week in the USA, to exclude a cardiac cause of stroke, syncope or dizziness in very elderly patients, even when no clinical clues point to the heart.

Another American example of "overspend" is the system whereby high school students select (and are selected) by undergraduate colleges, undergraduate students apply for graduate colleges, medical students are matched to residencies and hospital residents matched to specialty positions for fellowships. In each of these situations, the candidate sends in applications to a large number of institutions, visits many of them, is called for interviews by several (one to ten or more) and then is finally matched by a computer which achieves an electronic compromise between the choices of the candidate and of the institution. This process, which in the abstract appears reasonable, is in reality often complicated by heads of recruiting departments making deals with unofficially favored candidates, or by crafty string pulling by other influential personages, which is even more unofficial. Each candidate makes up to five or ten trips by car or plane in connection with this cumbersome and extravagant application process, even before he starts attending the institute he joins. The number of medical residents applying for Cardiology Fellowships has increased so greatly in recent years that currently (2004-2005) there are a hundred applicants for each slot in many cardiology programs in the USA, and not only in the most prestigious ones. Scrutinizing 300 to 500 applications,

corresponding with the applicants, filing the data and letters of recommendation of each separately, will take up myriads of clerical and administrative man-hours. How much more simple and economical is the Canadian system, where only one form is filled out in which the candidate states his preferences as to institution, in numerical order of choice. A central office or clearinghouse, which has all the data on his past academic performance, assigns the candidate to an institution commensurate with his past record and considering his choices. There is little scope for machination or clout, but he gets the university or college he deserves with tremendous savings of time and money for both the candidate and the institution.

"Overspend, overtest, overapply – superabundance of everything but common sense and thrift", said the elderly Indian physician. He said all this at a dinner party where all present were Indian doctors and their wives, all American citizens. The conversation dealt with the usual topics, local medical politics, general American politics and business aspects of their medical practice. Nobody paid any attention to what the wise old man had said.

Ivan A. D'Cruz, M.D., F.R.C.P.
Professor of Medicine
University of Tennessee Health Science Center
Cardiologist, Memphis VA Medical Center

FUTURE CARDIOLOGY/ECHOCARDIOGRAPHY CONFERENCES

November 6, 2004 • 14th Annual Conference in Echocardiography: Case Students and Recent Advances in Echocardiography. New Orleans Hilton Riverside Hotel, 2 Poydras Street, New Orleans, Louisiana. Conference Director: Dr. Navin C. Nanda. Conference Co-Director: Drs. Julius Gardin, Natesa Pandian and David Sahn.

December 31, 2004 • Joint International Conference of International Academy of Cardiovascular Sciences and International Society for Heart Research (JIC-2005) is being held in Ahmedabad December 31st 2004 to January 2nd, 2005. Dr Keyur Parikh, respectable member of AACIO is the organizing secretary of this program. He has personally extended his invitation to all fellow AACIO members to attend this meeting. You may download the registration forms from the website www.indianheart.com.

March 5, 2005 • 21st Annual International Conference on Recent Advances in Echocardiography, Orlando, Florida. Conference Director: Dr. Navin C. Nanda. Held just prior to the American College of Cardiology meetings.

September 15-17 • 2005 IX World Congress of Echocardiography and Vascular Ultrasound, Marrakesh, Morocco. Under the patronage of His Majesty King Mohammed VI, King of Morocco. Congress President: Prof. Ahmed Bennis. Contact email: iscu2005@albine-conseil.fr.

High Prevalence of Stroke in Asian Indians Living in the US

A study published in the October 1, 2004 issue of the American Journal of Cardiology has found a high prevalence of diabetes mellitus in Asian Indians living in the USA. A total of 1046 Asian Indians living in and around the Atlanta, Georgia metropolitan area were surveyed during religious and social gatherings at Bochasanwasi Shri Akshar Purushottam Swaminarayan Sanstha (BAPS) temple. The overall prevalence of diabetes was found to be very high at 18.3% (22.5% in men and 13.6% in women).

The prevalence of diabetes in those >20 years of age was 18.1%, in those >45 years of age was 21.6%, and in those >65 years of age was higher at 24.8%. There was no significant difference in the body mass index between those with and without diabetes mellitus. The prevalence of diabetes was higher in men compared with women ($p < 0.001$); however, among diabetic men and women, there were no significant differences in the prevalence of co-morbid conditions. As expected, myocardial infarction, hypertension coronary artery interventions, history of dialysis, hypercholesterolemia, and stroke showed significant associations with the presence of diabetes mellitus. Forward logistic regression showed that a family history of diabetes was the strongest independent predicting factor for diabetes. Age, male gender, myocardial infarction, and hypertension were also independent predictive factors for diabetes.

So far, no studies have examined the prevalence of diabetes mellitus in Asian Indian immigrants in the United States. The National Health and Nutrition Examination Survey (NHANES III) showed an overall crude diabetes prevalence of 5.3% in persons living in the United States aged >20 years of age. They found a higher prevalence of diabetes in Hispanics (9.3%) and blacks (8.2%) compared with whites (4.8%) in the >20 years age group. The prevalence of diabetes in Asian Indian immigrants >20 years of age in the current study was almost twice that of Hispanics and 4 times that of whites, as reported by NHANES III. In the current study, the overall prevalence of diabetes in Asian Indians >20 years was higher than all other racial groups in the United States. However, in the elderly age group, the prevalence of diabetes in Asian Indians was similar to the prevalence of diabetes in elderly Hispanics and elderly blacks. The prevalence of diabetes mellitus in Asian Indians >20 years of age in the current study is much higher than in Asian Indian immigrants in the United Kingdom, Singapore, Mauritius, Fiji, and South Africa where it has ranged from 6% to 15%.

A study performed by the Indian Council of Medical Research showed the overall prevalence of diabetes in India to be 1.73%; however, the prevalence varied from 2% in rural areas to up to 33% in urban areas. A study done by Ramachandran et al by sampling urban Indians aged >20 years in 6 major cities showed that the prevalence of diabetes in urban areas was 13.9% with a maximum prevalence seen in subjects aged between 60 and 69 years of age (29.1%). This study also showed a high prevalence of diabetes in the 60 to 69 years age group (32%) (Figure 1). The overall prevalence of diabetes in Asian Indians in the current study appears similar to the prevalence seen in urban India, supporting the view that populations undergoing acculturation changes from a traditional to a modern lifestyle have a higher prevalence of type 2 diabetes mellitus.

The authors of the study were Drs. Rajesh Venkataraman, Navin C. Nanda, and Gurpreet Baweja from Birmingham, Alabama and Naresh Parikh and Vishal Bhatia from Atlanta, Georgia. This study is the first attempt to assess the prevalence of diabetes mellitus and related conditions in Asian Indians living in the United States. Asian Indian immigrants now constitute 1% of the United States population numbering almost 2 million. They are one of the fastest growing ethnic minorities in this country.



American Association of Cardiologists of Indian Origin

**Cordially Invites You to the Fall
Dinner Meeting
Sunday, November 7th, 2004**

Hotel Monteleone 214 Royal Street
New Orleans, LA 70130-2201
(504) 523-3341
www.hotelmonteleone.com

R.S.V.P.

Please visit AACIO.ORG to reserve your seat.

There is no fee. Or contact:

Debasish Roychoudhury, M.D., Secretary, AACIO
193-49 Keno Avenue, Holliswood, NY 11423

Work: 718-881-4891

Fax: 718-881-0696

The Monteleone is on Royal Street just one block from
Canal Street (behind the New Orleans Marriott).

- 4:30-5:30 PM** — Executive Committee meeting in the Board Room
- 6:00-7:00 PM** — Registration and cocktails in the La Nouvelle Orleans Room
- 7:00-7:30 PM** — Welcome
- 7:30-8:15 PM** — Lecture Presentation - Endocannabinoid System and Metabolic Syndrome; Advances in the Management of Acute Coronary Syndromes
- 8:15-9:00 PM** — Awards
- 9:00 PM** — Dinner and Entertainment

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