HEART CARE NEWS

We lead with heart

NORTHSIDE HOSPITAL HEART INSTITUTE

Spring 2025 | Vol. 4 Issue 2

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Northside Hospital Heart Institute Expands State-of-the-Art Technology

Northside Hospital Heart Institute is significantly enhancing patient care across the Atlanta region through the strategic implementation of cutting-edge cardiac technologies. These advancements include tricuspid transcatheter edge-to-edge repair (TEER), pulsed field ablation (PFA) systems with or without electro-anatomical mapping for atrial fibrillation (AFib) treatment, and cardiac positron emission tomography/computed tomography (PET/CT) scanning.

The introduction of these innovative technologies has been met with considerable excitement by Northside staff. February 2025 marked the launch of two key advancements. At Northside Hospital Gwinnett, Dr. Fredy El Sakr and the Structural Heart Team successfully performed their first TEER procedure utilizing the Abbott TriClip. This minimally invasive TEER procedure offers significant benefits compared to traditional open-heart surgery, including expedited recovery, often allowing patients to return home the next day with minimal limitations, reduced postoperative discomfort, and a decreased risk of complications. Concurrently, Dr. Hyo Jin "Kevin" Song and his team at Northside Hospital Forsyth conducted the inaugural mapping and ablation procedure using the latest iteration of the CARTO 3 System from Biosense Webster, Inc. This advanced system provides improved signal clarity, location-independent annotation, and integrated artificial intelligence to optimize procedural workflow.

Further expanding its AFib treatment capabilities, Northside Hospital Heart Institute introduced PFA technology in the fall of 2024. Dr. Alok Gambhir and his team successfully performed a PFA procedure using the Medtronic PulseSelect System. Employing pulsed electric fields for ablation offers a more selective approach to treating AFib, minimizing potential damage to surrounding tissues.

Complementing these advancements, cardiac PET/CT scanning provides a sophisticated myocardial perfusion imaging technique to evaluate blood flow to the heart, assessing perfusion both at rest and during stress. This technology is invaluable in the diagnosis of coronary artery disease. Cardiac PET/CT scans offer several advantages, including superior image resolution, low radiation exposure, efficient examination times, and the ability to differentiate between damaged and viable myocardial tissue. Building upon its availability at the Northside Hospital Gwinnett and Forsyth campuses, cardiac PET/CT services will also be accessible at Northside/Barfield Imaging and Northside/Holly Springs Imaging starting in the summer of 2025.

As Northside Hospital continues to expand its state-of-the-art cardiac care options, the successful implementation of these new technologies marks a step forward in providing innovative, patient-centered treatment for patients with heart diseases.

The first Afib ablation using the Carto J&J technology (Dr. Hyo Jin "Kevin" Song and team)

Cardiac PET/CT Scan

In This Issue

Clinical Trials and Research

Sponsor	Study/Protocol Number and Study Title	NCT Identifier
Conformal Medical, Inc.	**C-541; 21-101 ||** An Evaluation of the Safety and Effectiveness of the Conformal CLAAS System for Left Atrial Appendage Occlusion (CONFORM)	NCT05147792

Study Design

Objective 1: To evaluate the safety and effectiveness of the CLAAS device by demonstrating non-inferiority to currently marketed LAAO systems in subjects with non-valvular atrial fibrillation.

Objective 2: To demonstrate the safety of a post-procedure pharmacologic antiplatelet regimen that consists of DAPT alone without concomitant anticoagulation therapy.

Objective 3: To demonstrate the ability to safely deliver the CLAAS device using a conscious sedation protocol without general anesthesia. To investigate this objective, a separate sub-study will be conducted after recruitment of the RCT is complete at select, qualified sites based on the experience demonstrated in the RCT.

- **Roll-In Phase:** To ensure adequate implant experience, up to 3 subjects per investigational site may be implanted with the CLAAS device prior to initiation of the randomized phase of the trial.
- **Randomized Controlled Trial:** A prospective, unblinded, randomized, multicenter, active control trial to evaluate the safety and effectiveness of the CLAAS System by demonstrating non-inferiority against standard of care, commercially available LAAO devices.
- **Conscious Sedation Single-Arm Sub-Study:** A prospective single-arm trial evaluating a conscious sedation protocol. The sub-study will evaluate the safety and performance of the CLAAS device using conscious sedation in comparison with the device delivery safety and performance observed in the CLAAS arm of the RCT.

Biosense Webster, Inc.	**C-563; BWI202303 (OMNY-AF) ||** Assessment of Safety and Effectiveness in Treatment Management of Paroxysmal Atrial Fibrillation with the BWI Pulsed Field Ablation System with OMNYPULSE Catheter	NCT05971693

Study Design

- Prospective, single-arm, multicenter, clinical evaluation of the BWI OMNYPULSE™ PFA Platform to demonstrate safety and long-term effectiveness of the system for the treatment of PAF comparing to corresponding performance goals.
- The study will include two sequential phases:
  - **Pilot Phase**: to assess acute safety of the investigational devices including evaluation of neurologic symptoms and/or cerebral lesions.
  - **Pivotal Phase:** to evaluate the safety and effectiveness of the investigational devices. The Pivotal Phase will enroll subjects in the Roll-In and Main phases.
- All subjects will undergo study ablation procedure using the OMNYPULSE™ PFA Platform, followed by a 3-month blanking period and a 9-month evaluation period.

Abbott Medical Devices	**C-581; ABT-CIP-10523 (CRD-1064) ||** Amulet 2 Left Atrial Appendage Occluder (Amulet 2 device) VERITAS Study	NCT06707688

Study Design

- Prospective, single-arm, multicenter, investigational study of the Amulet 2 device
- The study will enroll and treat subjects who undergo an Amulet 2 implant attempt.
- Clinical sites will follow all subjects until completion of the 2-year visit
- Subjects who undergo an Amulet 2 implant attempt but do not receive the device are followed for 7 days for adverse events and then exited from the study
- Study visits will occur at baseline, implant, pre-discharge, 45 days, 6 months, 12 months, and 24 months.

BWI=Biosense Webster; CLAAS= Conformal Left Atrial Appendage System; DAPT=dual antiplatelet therapy; LAAO=left atrial appendage occlusion; PAF=paroxysmal atrial fibrillation; PFA=pulsed field ablation; RCT=randomized controlled trial

To learn more about Clinical Trials at Northside Hospital, visit our Clinical Research page or call 404-303-3355.

In the News: Updates for Clinicians

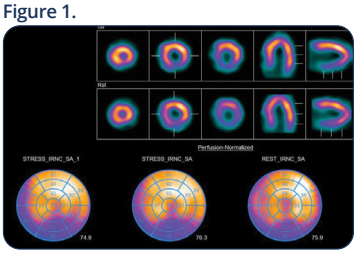
Multimodal Imaging Enhances Cardiac Risk Stratification in Bone Marrow Transplant Recipients with Myelodysplastic Syndrome to Improve Outcomes

By Lalitha C. Medepalli, MD

Multimodal imaging plays a key role in understanding and managing cardiovascular diseases. Echocardiography, myocardial perfusion imaging, cardiac computed tomography, cardiac magnetic resonance imaging and nuclear cardiology are some of the imaging methods utilized. A case was presented to emphasize the importance of cardiac imaging for patients undergoing hematopoietic stem cell transplantation (HSCT) to establish pre-treatment cardiovascular risk stratification and to highlight the need for providers to utilize these imaging techniques to improve patient outcomes post-transplant.[1]

The case presented involved a 74-year-old male with myelodysplastic syndrome (MDS) and a history of significant cardiovascular risk factors. Despite his cardiovascular involvement, he was asymptomatic (e.g., no chest pain, dizziness, dyspnea, etc.). He had progressive anemia that was refractory to erythropoiesis-stimulating agents, relying on red blood cell and platelet transfusions, and his MDS was categorized as intermediate risk. Multimodal cardiac imaging techniques were required to diagnose triple-vessel coronary artery disease, which considerably increased his risk for post-HSCT complications, including cardiac arrythmias, myocardial infarction and heart failure. He underwent cardiac catheterization, which deemed the patient a high-risk candidate for HSCT without pre-procedural optimization and ultimately led to coronary artery bypass grafting (CABG). Two months post-CABG, the cardio-oncology team would re-evaluate the patient's cardiac risk prior to HSCT (Figure 1: TTE Bull's eye strain imaging with a normal triplane endocardial peak systolic average global longitudinal strain of -18.50% but with a regional strain abnormality).

Figure 1.



Although HSCT is potentially curative for many disorders including MDS, assessing and managing cardiovascular risk is crucial in improving outcomes, particularly for elderly patients and those with a history of cardiovascular disease. HSCT survivors' cardiovascular-related mortality is more than double that of the general population, highlighting the need for evaluation of risk factors that are attributed to adverse cardiovascular outcomes. The American Heart Association recommends a pre-HSCT assessment that includes four steps: [2]

- Initial risk stratification
- Exclusion of high-risk cardiovascular disease
- Assessment of cardiac reserve
- Optimization of cardiovascular reserve.

Patients should be involved in discussing options for appropriate pre-HSCT interventions along with the development of a cardiac monitoring plan to help reduce post-HSCT survivorship risks and improve cardiovascular outcomes.

References:

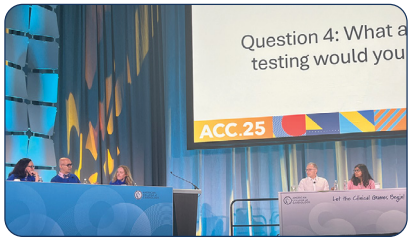
1. Khanal R, Cooper C, Medepalli LC, Holland HK, Vinjamaram S. Cardiac risk stratification in bone marrow transplant recipients with myelodysplastic syndrome: the role of multimodal imaging. *Cardiol Res Cardiovasc Med*. 2024;9:266. doi:https://doi.org/10.29011/2575-7083.100266.

2. Hayek SS, Zaha VG, Bogle C, et al. Cardiovascular Management of Patients Undergoing Hematopoietic Stem Cell Transplantation: From Pretransplantation to Survivorship: A Scientific Statement From the American Heart Association. *Circulation*. 2024;149(16):e1113-e1127. doi:ahajournals.org/doi/10.1161/CIR.0000000000001220.

ACC 2025 Annual Meeting Recap

The American College of Cardiology's (ACC) 74th Annual Scientific Session & Expo meeting took place in Chicago, Illinois, from March 29th through March 31st. Several Northside Hospital providers were involved in the discussions and presentations at this event as listed below.

Provider	Session	Role
Jason Grady, NRP	Who's in Danger: Cardiogenic Shock, the Patient, the System?	Co-Chair – Moderator
	Against the Odds: Breaking Down Barriers to Survival of Out-of-Hospital Cardiac Arrest – Role of a Multidisciplinary Team – Approach to Cardiac Arrest Syndrome	Speaker
Allison Dupont, MD	Cardiogenic Shock Teams and Technologies	Co-Chair – Moderator
	Against the Odds: Breaking Down Barriers to Survival of Out-of-Hospital Cardiac Arrest	Co-Chair – Moderator
Jeff Marshall, MD	Stemming the Tide: Non-Compete Agreements and State-Based Advocacy Strategies	Co-Chair – Moderator
Lee Padove, MD	Tackling Cardio-OB Myths: Battle of the Cardio-OB Team	Co-Chair
Parham Eshtehardi, MD	Tackling Cardio-OB Myths: Battle of the Cardio-OB Team	Team 1



Breaking Down Barriers to Survival of Out-of-Hospital Cardiac Arrest

By Jason Grady, NRP, AACC

Out-of-hospital cardiac arrest (OHCA) is the third leading cause of death in the U.S. and demands a coordinated, team-based approach to improve survival and neurological outcomes beyond the typical 10%. Cardiac arrest syndrome encompasses not only the resuscitation itself, but also post-resuscitation care, including brain injury, heart dysfunction, systemic inflammation and the underlying cause of the arrest. Care begins in the field with Emergency Medical Services (EMS), where rapid response, high-quality CPR and early defibrillation are critical. In the Emergency Department (ED), the focus shifts to stabilizing the patient, managing body temperature and identifying and treating the underlying cause. A smooth transition to cardiology and critical care teams enables ongoing cardiac and neurological support, coronary angiography with PCI, if indicated, and comprehensive post-arrest care.

Barriers such as protocol variability, limited access to resources and poor communication can hinder effective prognostication and coordinated care. Standardized education and reporting, consistent processes and stronger interdisciplinary teamwork are essential to overcoming these challenges. Community efforts (e.g., widespread CPR training, AED access and public education) are also vital. A system-wide approach is key to improving both survival and recovery for OHCA patients. We can change these outcomes together, and everyone involved — EMS, ED, cardiology, and critical care — must share the same goal: complete neurological recovery.

Heart of the Matter 2025 Meeting Recap

Anticoagulation in the Pregnant Woman

By Michele D. Voeltz, MD

At the Heart of the Matter conference, I had the opportunity to present on the significance of anticoagulation in pregnant women. Physiological changes of pregnancy, including continuous changes in volume distribution, can affect the pharmacokinetics and ultimately the efficacy of medications, including anticoagulants. Not only is it important to understand pregnancy's effect on medication metabolism, but also the effect on the coagulation cascade (e.g., increased concentration of factors VII, VIII, X and vWF as well as fibrinogen[1]) that can remain until more than eight weeks postpartum and may warrant anticoagulation therapy.

The choice of anticoagulation agent and dosing schedule is dependent on the indication as well as the risk versus benefit of the medication to the mother and baby. Unfractionated heparin, low molecular weight heparin and warfarin are the most commonly used anticoagulants in pregnancy.

Indications for Anticoagulation in Pregnancy

- Thromboembolism
  - Pregnant women have up to 10-fold increase in risk
  - Prevalence 0.5-2/1000
  - VTE accounts for 9.3% of all maternal deaths
- Prosthetic heart valves
- Atrial fibrillation
- Left ventricular dysfunction
- History of recurrent fetal loss
- Inherited thrombotic disorders
  - Protein C/S deficiency
  - Inherited thrombophilias

The timing of anticoagulation discontinuation in preparation for delivery is vital and the cessation risk, anesthesia options and mode of delivery should be considered.

Reference:

1. Simcox LE, et al. *Breathe (Sheff)*. 2015;11(4):282-289.

Valvular Heart Disease in Pregnancy

By Parham Eshtehardi, MD

The presentation I prepared for the Heart of the Matter conference focused on valvular heart disease (VHD) in pregnancy, including hemodynamic changes, preconception counseling, risk assessment, specific regurgitant or stenotic lesions, valve interventions, labor & delivery (L&D) and post-partum follow-up. Physiologic hemodynamic changes of pregnancy including an increase in cardiac output, stroke volume and heart rate, as well as a decrease in systemic vascular resistance (SVR) can lead to cardiac decompensation and complications in women with VHD. I emphasized the importance of preconception counseling, clinical testing (e.g., echocardiographic assessment and exercise testing), risk assessment and monitoring to ensure these patients are well-informed prior to conception. Several risk assessments and prediction indices can be used along with guidance on the subsets of patients that should be advised against pregnancy altogether. Each regurgitant and stenotic lesion was discussed in detail along with options for preconception and post-conception interventions. The presentation concluded with key takeaways on VHD in pregnancy, which are provided on the next page.

(continued on page 5)

Heart of the Matter 2025 Meeting Recap (continued)

Key Takeaways (continued)

- Hemodynamic changes of pregnancy can result in cardiac decompensation in women with severe VHD.
- Stenotic lesions are not as well tolerated in pregnancy compared with regurgitant lesions.
- Women with VHD should have a preconception risk assessment and counseling.
- Transthoracic echo is essential before conception to assess valve function, ventricular function and pulmonary pressures.
- For severe symptomatic VHD, percutaneous interventions or surgery may be necessary, but these are high-risk procedures and should be performed in specialized centers.
- Pregnancy in women with mechanical valves is high-risk, with significant maternal and fetal morbidity/mortality.
- Women with moderate or high-risk VHD (stage C/D) should be referred to a center with experience in pregnancy and heart disease.
- Women with VHD should have a detailed delivery plan, including a multidisciplinary team to manage potential complications.
- Vaginal delivery with appropriate analgesia/anesthesia and minimization of Valsalva maneuver is preferred in women with VHD.

Hypertensive Disorders of Pregnancy

By An Young, MD, MPH

In early March, I had the privilege of presenting an update on hypertensive disorders of pregnancy (HDP) at the Heart of the Matter conference. This article provides an overview of the key takeaways. HDP complicates approximately 10-15% of pregnancies, are the most common reason for postpartum hospitalization and are responsible for 16% of maternal deaths globally. Potential adverse consequences of maternal hypertension (defined as a systolic blood pressure [SBP] of ≥140 mm Hg and/or diastolic blood pressure [DBP] ≥90 mm Hg) include placental abruption, eclampsia, preterm birth, small for gestational age, and maternal stroke. Labetalol, extended-release nifedipine, methyldopa, and hydralazine comprise first-line antihypertensive options for non-severe hypertension.

Severe hypertension during pregnancy, defined as a SBP ≥160 mm Hg and/or a DBP ≥110 mm Hg or severe preeclampsia (HTN + end organ involvement), is an emergency requiring urgent control. Management of preeclampsia includes rigorous monitoring, administration of antihypertensives, seizure prophylaxis with magnesium, and coordination of delivery timing.

Blood pressure is highest 5-10 days postpartum due to the administration of intravenous fluids, and mobilization of fluids continue after delivery. Therefore, it is also important to monitor blood pressure closely peripartum. HDP is associated with long-term risk of diverse cardiovascular diseases (e.g., coronary artery disease, heart failure, ischemic heart disease), and close postpartum screening (consisting of yearly blood pressure check and regular lipid panel and diabetes check) is warranted.

Aortic Disease in Pregnancy

By Lee Padove, MD

Over the last 17 years, Northside Hospital has hosted a multispecialty conference on cardio obstetrics called the Heart of the Matter. The speakers for this conference included world experts along with Northside Hospital specialists. This last spring, the conference included my presentation on aortic disease in pregnancy. Some of the emphasis of this topic was in identifying obstetric patients either with known aortic disease or at risk and determining possible preventative strategies. Although aortic dissection is rare, the risk is heightened in pregnancy and patient counseling as to the risk along with birth control, medications, imaging, prophylactic surgery and labor management is necessary. It is estimated that nearly 20% of patients with thoracic aortic aneurysm and dissection (TAAD) syndrome have a family history of the disease. There are two categories of heritable thoracic aortic disease: syndromic disorders (part of a genetic syndrome usually with some other degree of identifiable physical abnormalities) and non-syndromic disorders.

One of the most quoted guides to risk stratification in pregnancy is modified World Health Organization (mWHO).

Heritable Thoracic Aortic Disease

Syndromic Disorders	Non-Syndromic Disorders
• Marfan Syndrome	• Familial TAAD
• Loeys-Dietz Syndrome	• *ACTA2, MYH11, PRKG1, MYLK*
• Vascular Ehlers-Danlos Syndrome (vEDS)	
• Turner Syndrome	

It is a risk classification that identifies the risk of maternal complications a patient may face based on the type of cardiac diagnosis.[1] Although, it was developed a few years back and there have been changes in our knowledge base, it provides a good starting point for risk stratification. The cohorts consist of I, II, II-III, III, and IV, where classification I poses no significant additional risk of morbidity and mortality compared to the general population, versus classification IV, where pregnancy is not recommended. Patients with TAAD should receive multidisciplinary cardio-obstetrics counseling, continual cardio-obstetrics team monitoring throughout pregnancy and delivery and aorta imaging peripartum to ensure optimal outcomes for both mother and baby.[2]

References:

1. van Hagen IM, Roos-Hesselink JW. *Heart.* 2020;106(23):1853-1861.
2. Crousillat D, et al. *J Am Coll Cardiol.* 2023;82(9):817-827.

Key Mentions from GEMSA

The Georgia Emergency Medical Services Association (GEMSA) Conference and Awards occurred March 26-28, 2025. Among the presenters were two Northside Hospital Forsyth providers, Dr. Jon Allen and Alex Hodson. Dr. Jon Allen serves as an emergency department physician at Northside Hospital Cherokee and as the medical director for several major EMS partners, including Cherokee County Fire & Emergency Services, Forsyth County Fire Department and Pickens County Fire Rescue. Dr. Allen shared his identified "pearls" for organizational leadership within the emergency medical services setting. Alex Hodson serves as the Critical Care Advanced Practice Provider supervisor for the Northside Forsyth intensive care unit (ICU). She presented on the importance of EMS's relationships with hospitals and the impact of EMS on a patient's overall outcome, including the ICU stay. Alex also discussed her past partnership with Forsyth County Fire Department, training many ICU nurses and personnel on high-performance cardiopulmonary resuscitation (CPR), pit-crew style resuscitation, and effective use of mechanical CPR devices. She shared that EMS professionals are true experts in rapid resuscitation during acute cardiac arrest.

The Dr. J. Jeffrey Marshall Excellence in Emergency Cardiac Care award, established in 2020 and named after the chief of Northside Hospital Cardiovascular Institute, was also presented at GEMSA. It recognizes individuals or organizations in Georgia for outstanding emergency cardiac care. Ericka Jackson and Hezekiah Garner received this award for their swift, skilled response to a critical vehicle accident. Through rapid assessment, timely CPR, defibrillation, and advanced cardiac care interventions, they were able to save a patient's life. They were able to stabilize the patient and regain a pulse through their ability to adapt, apply defibrillation, and manage the patient's airway. The patient was later discharged with no lasting deficiencies, a testament to the life-saving impact of their work.

Alex Hodson


Dr. Jon Allen

Left to right: Michael Johnson – Director, Georgia State Office of EMS; Ericka Jackson – Paramedic; Hezekiah Garner – AEMT; Dr. Jeff Marshall

Left to right: Dr. Jeff Marshall; Ericka Jackson – Paramedic; Reilly Campbell – Cardiac Arrest Survivor; Hezekiah Garner – AEMT; Jason Grady, NRP

Emergency Cardiovascular Care Conference (EC3) Presentation Highlight

The Incredible Journey to Change STEMI Management Worldwide

By Cindy Grines, MD

At the 2025 Emergency Cardiovascular Care Conference (EC3), I had the pleasure of presenting my personal endeavor to change management of STEMI's (ST-elevation myocardial infarction) worldwide and the many struggles along the way. Observations in the cardiac catheterization lab years ago helped to develop a better understanding of STEMIs and challenges including that streptokinase failed the majority of the time. Tissue plasminogen activator (tPA) did a better job reperfusing the vessels, but the rate of intracranial bleeding was high. We found it difficult to wait for the 60- and 90-minute angiograms required per tPA protocols, when wiring and ballooning occluded coronaries arteries could be performed very quickly. However, percutaneous coronary intervention (PCI) results after thrombolytics were suboptimal; and made us question whether the blame was on angioplasty or thrombolytics.

In 1993, we published the first randomized trial comparing primary angioplasty with thrombolytic therapy for acute myocardial infarction (AMI). Our results proved that primary percutaneous coronary intervention (PCI) reduced combined nonfatal reinfarction or death and reduced intracranial hemorrhage compared to tPA. Over the years, additional studies confirmed that primary PCI was superior to thrombolytic therapy and, due to this finding, the role of triaging patients to specialized heart-attack centers became crucial. To improve access to this life saving treatment, we performed trials that proved EMS transfer to a PCI center or performing PCI in centers without surgical back up were safe and effective. The Stent PAMI trial randomized patients to receive heparin-coated stents versus PTCA and showed that stenting reducing reocclusion, recurrent ischemia and restenosis. There was much debate over the risk of discharging STEMI patients without monitoring in the critical care unit (CCU) or without performing pre-discharge non-invasive testing, but our studies demonstrated the safety and cost saving of avoiding both in low-risk STEMI patients. Key takeaways from this presentation are listed below.

Key Takeaways

Research from our group has revolutionized the management of STEMI patients worldwide, having proven:

- Primary PCI is superior to thrombolytics.
- Stenting reduces reocclusion and restenosis.
- STEMI patients can be safely transferred for primary PCI or treated with PCI at hospitals without surgical backup.
- Low-risk STEMI patients can skip the CCU and non-invasive testing and be safely discharged on day 3.
- IABP does not benefit high-risk STEMI patients.
- Importance of right heart function and multiple unstable plaques

Elevating the Patient Experience

Successful Rotapro Atherectomy

The cardiac catheterization lab at Northside Hospital Forsyth performed its first coronary atherectomy on April 21st with Dr. Christopher Leach and his team – it was a success. Northside Hospital Forsyth is the first site in our Northside Hospital system to perform coronary atherectomy without on-site surgical ("open-heart") backup. Coronary atherectomy is a percutaneous coronary intervention (PCI) procedure that is performed similarly to other PCI procedures (e.g., balloon angioplasty and stenting). This procedure is minimally invasive, and preparation and recovery is essentially the same as for a typical PCI. Atherectomy is commonly performed by either radial or femoral access and used to de-bulk heavily calcified blockages not initially responding to balloon PCI alone. In the past, atherectomy was viewed as a high-risk procedure, and depending on the circumstances, it still can be, but it is now more commonly used as another tool to treat blockages due to its safety and reliability. Northside Hospital Forsyth will soon start using a type of rotational atherectomy by Boston Scientific known as Rotapro, historically known as Rotablator. This device uses a small catheter-based, diamond-coated burr that rotates at high speeds to break down and remove plaque. Once the blockage has been debulked, it is generally more amenable to balloons and stents. Congratulations to Dr. Leach and his team for this incredible achievement that will continue to improve patient outcomes.

Team members were as follows, from left to right: Thao Luong, CVT, RCIS; Kristin McIntire, RN; Clay Doggett, RN, RCIS; Rachel Bryson, RN, RCIS; Karishma Patel, CVT, RCIS; Christopher Leach, MD.

Around Our Campuses and Community

Echocardiography: Adult Transesophageal Accreditation

In addition to the accreditation in adult transthoracic echocardiography, Northside Hospital Heart Institute is now accredited in transesophageal echocardiography examination (TEE) by the Intersocietal Accreditation Commission (IAC) at Northside Atlanta, Northside Cherokee, Northside Forsyth, Northside Duluth and Northside Gwinnett.

Provider Features and Recognitions

New Providers and Recognitions

Steven Anton, MD, is a non-invasive cardiologist who recently joined Northside Cardiovascular – Gainesville. To learn more, visit: northside.com/Anton-Steven.

Jason Grady, NRP, AACC, was inducted into the American College of Cardiology (ACC) as an Associate of the American College of Cardiology (AACC) and as a Fellow of the Society for Cardiovascular Angiography and Interventions (FSCAI).

Upcoming Education and Events

EDUCATION

2025 SCAI Shock National Meeting
September 18-20, 2025, @ the Tampa Marriott in Tampa, Florida

CLASSES

Built To Quit, Smoking and Tobacco Cessation Course
Next six-week session start date: July 8 2025
Weekly classes include the American Lung Association Freedom from Smoking curriculum.

BUILT TO QUIT
Resources to help you stop smoking and using tobacco

SPONSORED COMMUNITY EVENTS

2025 Atlanta Heart Walk
Benefiting the American Heart Association
September 27, 2025 @ 8 a.m. @ Atlantic Station in Atlanta

American Heart Association. Heart Walk.

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