Cath Lab Digest

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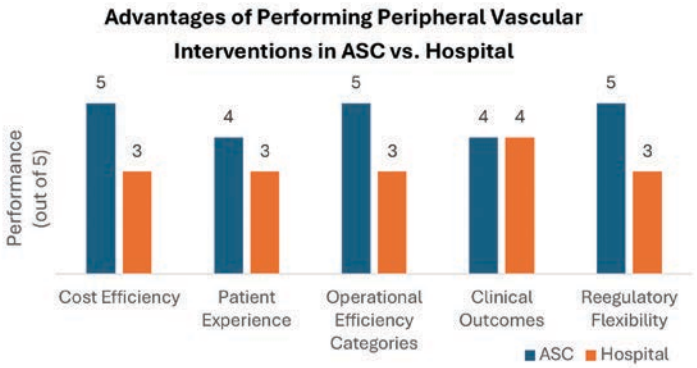

OUTPATIENT SETTINGS

Peripheral Vision: Evaluating Vascular Procedures in Ambulatory Surgery Center (ASC) Settings

Joyce Froetschel, Account Manager, Corazon

Navigating the delivery of patient care related to peripheral vascular procedures can be complex. While advancements in technology, improvements in patient outcomes, and expanding reimbursement have opened new opportunities, it's important to note that peripheral vascular procedures are typically adjunctive offerings within ambulatory surgery centers (ASCs) that already perform cardiac interventions. The establishment of an ASC dedicated exclusively to peripheral vascular procedures is relatively rare, as reimbursement rates tend to be slightly more favorable in physician-owned office-based labs (OBLs).

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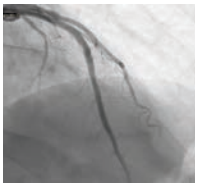
CASE REPORT

Advancing Coronary Intervention With Terumo's Takeru™ PTCA Balloon Dilatation Catheters: A Clinical Experience Across Complex Lesions and Intravascular Lithotripsy



Ghulam Mujtaba Ghumman, MD; Zaid Al-Jebaje, MD

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RADIATION SAFETY

Radiation Safety and Occupational Safety

James B. Hermiller, MD, FACC, MSCAI

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SCAI

Srihari S. Naidu, MD, MSCAI, Discusses SCAI and His Presidency Year

In this introduction to the 2025-2026 Society for Cardiovascular Angiography and Interventions (SCAI) President Srihari S. Naidu, MD, MSCAI, he shares what he most values about the Society, his goals in founding the Emerging Leaders Mentorship (ELM) program, and plans for the upcoming year.

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HMP Global

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Srihari S. Naidu, MD, MSCAI, Discusses SCAI and His Presidency Year

In this introduction to the 2025-2026 Society for Cardiovascular Angiography and Interventions (SCAI) President Srihari S. Naidu, MD, MSCAI, he shares what he most values about the Society, his goals in founding the Emerging Leaders Mentorship (ELM) program, and plans for the upcoming year.

Dr. Naidu also discusses his desire to educate further around cardiogenic shock, with a focus on what he has termed "door-to-lactate clearance". This measure centers on clearing lactate and improving perfusion in cardiogenic shock patients within 24 hours.

Dr. Naidu is a Professor of Medicine, New York Medical College, and System Director of the Cardiac Catheterization Laboratories and Hypertrophic Cardiomyopathy (HCM) National Center of Excellence at Westchester Medical Center in Valhalla, New York.

Dr. Naidu, can you tell us about your previous work and experience with SCAI?

First of all, thank you for having me. It's a pleasure and an honor to be here. I'm incredibly excited about stepping into the role of SCAI President. I think my journey has been a little unique, and I hope that helps me connect with a broad range of people across the field. That's something I'm hoping becomes a theme this year.

Like many of us, I trained in general cardiology and then interventional cardiology, and started my career in an academic medical center. But not long after, I moved out to Long Island. At the time, about 25 years ago, there weren't many large academic institutions in the area. So, on paper, it looked like I was leaving academics behind to focus solely on clinical work, and I was okay with that. The truth is most of our members are practicing clinicians. They take care of patients every day, and that's what we all came into this field to do, and we're proud of that.

What's unique about SCAI is that it recognizes you can do both: you can be a clinician and still make an academic impact. By "academic," I mean teaching, mentoring, publishing, building new programs, and moving the field forward. SCAI understands that everyone, regardless of where they practice, can contribute meaningfully. Early in my career, I reached out to SCAI because I wanted to get involved. There's often a perception that unless you're at one of a few major institutions, you won't have a seat at the table. But SCAI was different. There's less of a hierarchy. It embraces passion, drive, and the desire to make a difference, regardless of where you trained or where you worked.

Out of that experience came the Emerging Leader Mentorship (ELM) Program, which I helped found. Honestly, it was born out of the idea that if we always tap the same five or six institutions, we might be missing incredible people. We wanted to create a space where people could say, "*Pick me, give me a shot, and I'll show you what I can do.*" That first class was the beginning, and today nearly a hundred interventionalists have come through the program. To me, it speaks to what SCAI is about: taking chances, doing things differently, and growing alongside its members.

Over the last 20 years, and especially the past 10, SCAI has grown tremendously, not just in size, but in impact. Our publications and guidelines have expanded to where we're now leading in many critical areas, in procedures such as transcatheter aortic valve replacement, pulmonary embolism, patent foramen ovale closure, and of course, cardiogenic shock, which is something I'm personally passionate about.

SCAI is also making important moves in advocacy around reimbursement, education, and health equity. What's kept me connected to SCAI is that it has never lost sight of its members. Every decision starts with the question: How will this benefit the practicing interventionalist? Whether it's advancing innovation, improving reimbursement, reducing burnout, or increasing access to care, that member-centered focus has always been at the core.

At the end of the day, nearly everyone on the SCAI Board, myself included, still goes back to the hospital to take care of patients. That's who we are, and that's what keeps this organization grounded.

What are your plans for your presidential year?

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I'm genuinely excited to take on this role. Every president brings a unique perspective, and I think part of the opportunity lies in leaning into your strengths. My goal is to bring some new energy into SCAI, to show that no matter your background, if you care about this field, there is a place for you. If I can do it, others can too. SCAI is stronger when more people get involved, whether you're focused on academics, teaching, clinical care, or all three.

I want to bring the field back to a clear, actionable framework, what I'm calling "door-to-lactate clearance." Just like door-to-balloon time revolutionized STEMI care, I think we need one clear measure in shock care: clear the lactate within 24 hours.

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- **Wellness and Radiation Safety**

We've done a lot this past year around wellness and occupational safety, thanks to past SCAI president Dr. James Hermiller's leadership. He made a strong push to reduce orthopedic injuries and move cath labs toward lead-free environments. I plan to continue and broaden that work, not just to protect the body, but also the mind.

Burnout in our field is real. Between long hours, high-stakes cases, radiation exposure, and litigation stress, it adds up. We need to stop expecting people to brace for burnout. Instead, let's fix the system so burnout is less likely to happen in the first place. That's going to include expanding our wellness committee and tackling structural barriers that contribute to mental and emotional fatigue.

- **Advocacy and National Messaging**

SCAI is now large enough to push beyond traditional reimbursement issues and take a broader leadership role. We are at the forefront of treating cardiogenic shock, myocardial infarction, pulmonary embolism, and valve disease, largely through minimally invasive interventions. We need to be recognized nationally for that. That means engaging with hospital associations, payers, and other stakeholders to shape how interventional cardiology is viewed and valued.

- **Leadership Development: ELM Phase II**

One of our biggest initiatives will be expanding the Emerging Leader Mentorship (ELM) Program. The original goal was to identify and support future leaders early in their careers, and it has been very successful. But many professionals enter leadership through nontraditional paths or evolve later in their careers. We're designing ELM Phase II to support mid-career physicians, whether or not they were in the original program.

We want to offer targeted training in how to lead a department, run trials, become a hospital VP, or even a CEO. These are skills that allow us to thrive and make broader impact. And we want to recognize that leadership can come from many directions, not just the expected ones.

What are your goals for cardiogenic shock education?

This is a personal passion of mine. If you know my work, you probably associate me with hypertrophic cardiomyopathy and cardiogenic shock. And shock is absolutely in our wheelhouse. These patients come through the emergency department (ED) and end up in the cath lab, which means we are often the first responders. One of the things I'm going to emphasize this year is getting the field to re-center on what really matters in the first 24 hours of shock. We published the SCAI SHOCK classification system several years ago,[1] and since then, the field has evolved rapidly. There has been a lot of great work on staging, phenotypes, profiles, and device strategies. But honestly, it's also become more difficult and confusing for the people actually taking care of these patients. At the bedside, in the first hours, what you really need is a simple anchor. So what I'm saying is, focus on clearing the lactate. That's it.

Once you've recognized cardiogenic shock, whether that's in the ED, the cath lab, or the intensive care unit, if you can improve perfusion and get the lactate cleared in 24 hours, we know that the mortality goes down to probably about 20%. That's why I want to bring the field back to a clear, actionable framework, what I'm calling "door-to-lactate clearance." Just like door-to-balloon time revolutionized STEMI care, I think we need one clear measure in shock care: clear the lactate within 24 hours. Regardless of the approach, whether it's mechanical support, vasopressors, and/or fluids, the goal should be early perfusion recovery. If you do that, survival improves. It simplifies the target: lactate down in 24 hours = better outcomes. It's something every member of the team can rally around. You don't have to be a shock expert. You don't have to memorize five phenotypes or flow charts. Just: is the lactate going down?

We'll still explore phenotypes and individualized care, but this gives the team of cardiologists, intensivists, and nurses, a simple, unified goal in those first critical hours. I believe this could become the next standard in shock care.

Any final thoughts?

What I hope is that when members look at SCAI leadership, at the board, at the presidency, they see people who get it. People who know what the day-to-day looks like. People who understand the little things like juggling call, fighting for program support, building teams, dealing with burnout. I am sincere about working for SCAI and being just a regular member that works hard. I have a busy practice, and have evolved from coronary high-risk PCI to structural back down to coronary again, and done a lot of administrative work as well. I hope SCAI members see that we are here to represent them, and to advocate for, protect, and elevate their work. ■

REFERENCE

1. Naidu SS, Baran DA, Jentzer JC, et al. SCAI SHOCK stage classification expert consensus update: a review and incorporation of validation studies. *J Soc Cardiovasc Angiogr Interv*. 2022 Jan 30; 1(1): 100008. doi:10.1016/j.jscai.2021.100008