The oblique view

We continue our series in which Consultant Interventionist Dr Michael Norell takes a sideways look at life in the cath lab…and beyond. In this column, he examines the similarities between the cath lab and televised popular sports.

This sporting life

Nursing an injured knee, I have had no choice recently but to become a spectator in all forms of competitive physical activity. This has meant putting 'on hold' jogging, skiing, occasional tennis and even rarer golf. Sadly, I have not been able to avoid standing for hours in a catheter lab, covered in lead and treating long segments of diffuse coronary disease by ingeniously reconstructing vessels with many millimetres of stainless steel.

Predictably, this has been frustrating. Nevertheless it has allowed more time to contemplate whether any similarities exist between modern cardiological practice and the popular sporting world, as brought to us particularly by television and radio.

Discussing an upcoming challenge, its anticipated difficulties and how they are to be overcome applies to both environments. A ruddy-faced, gum-chewing football manager, with the reputation of being the human equivalent to the mistral, assures us that the Chelsea strikers will be thwarted by his back four dropping deep (where is that exactly?) and using more width. Similarly, our colleagues (some of whom specialise in making simple angioplasty, complex) describe how two sequential trifurcation lesions will be addressed using a 9 French guiding catheter, six wires and enough simultaneous balloon/stent action for it to be described as not so much a "kiss" as an orgy.

Winter sports

At the time of writing, the Winter Olympics have begun in Turin and our TV screens are dominated by a bizarre montage of ice dancing, curling, speed skating (clearly a body-hugging Lycra suit is essential here) and, of course, the luge. How an Olympic event could ever have been devised that required simultaneous cross-country skiing and intermittent rifle shooting has never been explained. Why have mogul skiing and figure skating never been combined? (Oh! I've just learned – apparently they have.)

I am not so sure that the commentators are as clued up as we think, either. They keep up their usual monologue during the men's downhill . . . "Schultz then, from Austria, only 19 years of age, going out wide on the Sharpen-Cornen; he won't be happy with that!"

Or . . . "And Wolfgang Gluber, so clever at downhill that he is known as 'the fox', is going very well indeed. This is fast!" Surely, with such small time differences separating the top performers, the only way David Vine can tell that A is going faster than B is that the split time on his (and our) screen is 0.001 seconds better.

It is undoubtedly the 'post-event' debriefing that fails any reasonable expectation of contributing to the overall sum of human knowledge. Given the reported salaries of some individuals, we perhaps wrongly anticipate a bit more 'depth' – for instance, from a Formula One driver (who, let's face it, if he's got any sense, tries to go as fast as he can by putting his foot down), or a golfer (objective: get the ball in the hole in as few strokes as possible).

Tennis players are the most disappointing: "When he broke me at 4:3, I knew I had to work hard (surprise!). I've been practising my serve (good idea), and my ground strokes (good idea too, whatever they are), and I think that paid off". One is left only wondering who can don the most ridiculously designed baseball cap so that at least the sponsors will get something out of the after-match TV interview.

What might be the interventional cardiological equivalent of such earth-shattering revelations? We listen with caution to those who "talk the talk", awaiting confirmation that they can also "walk the walk". In angioplasty parlance, the equivalent adage has become: "They yak, they yak, but can they crack the plak?"

Plaque of the day

Scene: a sweat-soaked interventionist, his sterile gown bloody and undone, stands in front of a hoarding which sports various device company logos. No sooner has the Angioseal been deployed, than the interviewer steps forward and begins his interrogation.

"Well, Doctor, that certainly looked like hard work. I imagine you're pleased with the final result?"

"Yes, I knew that the combination of calcification, small calibre and diffuse disease was going to make it difficult. I had done a left

main bifurcation last week so I knew what to expect."

"Were you concerned when the right went down? Given his poor LV, he didn't tolerate it very well. What did you say to your assistant half-way through?"

"Well, obviously we had to reopen the right in a hurry, but it certainly looked better with the seven stents." (He wipes a speck of blood from his cheek and signs a drug chart thrust under his nose.) "We talked about how we should approach the left and made some changes; in particular, the balloon pump went in."

"It really was a case of three vessels. Did you feel that bringing out the Rotablator for the LAD proved to be a decisive moment?"

"Definitely; it really made the difference, and upsizing to 8 French as well gave us more options in the left main. After that the circumflex was straightforward with direct stents into each of the two marginals."

"You've got a bit of a break now to prepare for your next case. Are you going to make any changes?"

"Well, my trainee has got to go to clinic, so I'll be scrubbing with our staff nurse. We've got a graft case next so we'll switch the Rotablator for distal protection. Our covered stents have been suspended, so we'll go with a Filter Wire instead."

"Well, good luck with that! I'm sure you'll be relieved with the outcome of that last case given the widespread publication of individuals' results, together with your recent blip?"

"Sure. We know that Dr Foster is just around the corner but given adjustment for pre-procedural risk, I'm not too worried. Our surgeons had already turned him down so this was always going to be a tricky one. It really is a question of taking each case one at a time." He smiles, holding up a used balloon in one hand and a Filter Wire in the other. Unfortunately, the cameraman cannot focus sufficiently quickly to show the maker's name or logo, so a major commercial opportunity is lost.

"Thanks for your time, doc, and with that, back to the ward."

Next week's fixture

Such a seemingly bizarre scenario is not such a long way off: the panel or "faculty" discussion so often seen during "live" or recorded cases is in a similar vein. The only item missing might be a "Spot the stent" competition, in which members of the audience are asked to put crosses on an angiogram to identify the proximal and distal ends of the implanted device.

Well, it's time for my knee to get some physiotherapy while I sit back and watch the ski jumping. You have to be impressed: it is not enough to throw yourself into the air with two large planks on your feet, land with style and then come to an eventual stop without decimating the gathered spectators – you also have to remember to remove one of your skis and hold it up so that the maker's name is plainly visible. Now, I wonder if he could do that and stent the left main stem at the same time . . .?

Michael Norell
Consultant Interventional Cardiologist and PCI Programme Director
The Heart and Lung Centre, Wolverhampton, WV10 0QP.
(email: Michael.norell@rwh-tr.nhs.uk)