



Wait Time for Interventional Cardiology Services at the New Brunswick Heart Centre (NBHC)

In the last issue of the NBHC HeartBeat (Fall 2006), we provided an overview of the NBHC cardiac triage process along with the tools used to objectively triage those patients referred for interventional cardiology services. The addition of a third cardiac catheterization laboratory located at the NB Heart Centre has significantly reduced the wait time for access to interventional cardiology services in New Brunswick (NB). Wait time data are currently being collected and reported by the NBHC access coordination personnel. In this issue, we share with our readers the wait time statistics from October 2005 to the end of March 2007. Note that these statistics are also available on the NBHC website along with the detailed explanations for each column and rows. Go to www.ahsc.health.nb.ca/Programs/NBHC/stats.shtml.

We invite you to explore table 1 where information pertaining to wait times for access to interventional cardiology services is displayed. In order to compare our information with other major Canadian heart centers, the data currently collected at the NB Heart Centre is compiled in the same manner as the Cardiac Care Network of Ontario (CCNO). An additional row has been added to table 1 which contains the wait time data for cardiac catheterization from the CCNO for the month of October, November, and December 2006. You will note that the wait time for access to interventional cardiology services in NB is

comparable, and in some categories is superior to the centers in Ontario.

Here is an example of the impact of the third lab on wait time: an otherwise healthy 50 year old woman with an electrically positive stress test at a moderate workload (7 Mets) would be categorized as an elective referral for cardiac catheterization. If this woman had been referred to the NBHC in February 2006, she would have waited a median of 59 days (or two months) on the outpatient list before her appointment/procedure. Some patients in this category, for that time period waited up to 452 days or longer for their procedure. In comparison, were the same patient referred to us today, she would only wait 10 days for her appointment. This improvement of service delivery has markedly decreased the anxiety levels of patients at home and of referring physicians at the office.

NBHC personnel are committed to ensure that patients in the Province of New Brunswick continue to access services within recommended guidelines. Based on the current information, healthcare providers in our small and geographically dispersed Province can proudly boast that access to interventional cardiology services is as good as, or better than in our Canadian capital Province. For questions or comments you may contact us by e-mail at nbhc@reg2.health.nb.ca.

Table 1: NB Heart Centre Cardiac Triage Wait Time from October 2005 to March 2007

Date Range	Monthly Average Number of Cases	Recommended Maximal Wait Time (RMWT)								
		Emergency + Urgent 0-7 days			Semi-Urgent 8-28 days			Elective 29-84 days (CCNO), 120 days (NBHC)		
		Median Wait (days)	90th Percentile Wait (days)	Cath Within RMWT	Median Wait (days)	90th Percentile Wait (days)	Cath Within RMWT	Median Wait (days)	90th Percentile Wait (days)	Cath Within RMWT
Oct-Dec 2005	249.3	1	6	90.6%	7	27	77.8%	50	187	52.8%
Jan-Mar 2006	292.6	2	8	86.6%	13	27	89.6%	59	452	39%
Apr-June 2006*	343.3	1	5	95.7%	8	23	97.8%	36	244	68.7%
July-Sept 2006	276	1	4	99.2%	5	13	100%	12	48	97.3%
Oct-Dec 2006	295.3	1	5	97.6%	5	10	100%	10	22	99.3%
Jan-Mar 2007	307	1	4	98.3%	5	14	100%	10	28	100%

Cardiac Care Network of Ontario Cardiac Cath Statistics: www.ccn.on.ca										
Oct-Dec 2006	4,759	1	4	88%	7	22	70%	11	26	99%

*3rd Cardiac Cath Lab opened on April 21, 2006

We need your Feedback:

Welcome to the fourth issue of the *New Brunswick Heart Centre HeartBeat*. Since the creation of this newsletter, we have used it to communicate the various activities occurring at the NB Heart Centre. We would like to hear from you. We are particularly interested in our reader's perception of the content of the newsletter. Are we meeting your needs? Are there topics related to cardiovascular disease you would like to read about? Are you interested in submitting an article to the newsletter? Please let us know how we can best utilize this medium to meet your needs.

You can contact us by e-mail: nbhc@reg2.health.nb.ca, by phone at (506) 648-7782, or by fax at (506) 648-6110.

Mark your calendar for the following Upcoming events:

- Canadian Lipid Nurses Network Conference, May 25, 2007**
 Ramada Crystal Palace, Moncton, NB. For more information call: (506) 648-6201 Register at: www.ahsc.health.nb.ca/Programs/NBHC/Brochure%20English.pdf
- NBHC Cardiovascular Symposium Saint John Regional Hospital September 20 to 22, 2007**
 For information call (506) 648-7285
- Canadian Cardiovascular Congress Quebec City, October 20 to 24, 2007**
 For more information go to: www.cardiocongress.org/english/index.html

If you wish to advertise an upcoming activity occurring in your area, contact us at: nbhc@reg2.health.nb.ca

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**New Brunswick
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To our readers:

In this newsletter the acronym "NBHC" refers to the "New Brunswick Heart Centre".

In French, the acronym "CCNB" refers to "Centre cardiaque du Nouveau-Brunswick", not to be mistaken for "Collège communautaire du Nouveau-Brunswick."

Low molecular weight heparin use in special populations

By Dr. Trudy Arbo and Dr. Vernon Paddock

Low molecular weight heparins (LMWH) are widely used as the anticoagulant of choice for the management of acute coronary syndrome, myocardial infarction and venous thromboembolism. Its ease of administration, predictable anticoagulation effect and minimal need for monitoring has made it a preferable choice over

it readily available to clinicians for closer evaluation.

In obese patients, the intravascular volume does not have a linear relationship with total body weight. It is hypothesized that using total body weight in obese patients may lead to overdosing and potentially increased risk of bleeding complications. Unfortunately, most large

Table 1: Empiric dosing of enoxaparin based on renal function*

CrCl (mL/min)	Loading dose	Maintenance Dose	Anti-Xa levels
≥ 60 mL/min	1 mg/kg	1 mg/kg q12h	NONE
30-60 mL/min	1 mg/kg	0.75 mg/kg q12h	Pre and 4 hour post anti-XA levels with third dose. If therapeutic no further levels needed.
<30 mL/min NOTE: Enoxaparin not recommended for CrCl less than 30 mL/min, suggest to use unfractionated heparin	1 mg/kg	1 mg/kg q24h OR 0.5 mg/kg q12h	Pre and post 4 hour anti-Xa levels with third dose.

*Adapted from Kruse et al.¹

CrCl: creatinine clearance [(140-age)/wt x 1.2] / Scr (x 0.85 for females)

unfractionated heparin (UFH) in many circumstances. However, there are serious concerns with its use in special populations such as patients with obesity, renal impairment and in the elderly.

There is little evidence in the cardiac literature to support the use of low molecular weight heparin in patients with a creatinine clearance of less than 30 mL/min or in patients with a body mass index (BMI) of greater than 30 kg/m². These patients are traditionally excluded from clinical trials involving LMWH or are treated with unfractionated heparin. In thrombolytic trials, patients over the age of 75 are given a reduced dose of LMWH or encouraged to use UFH as the anticoagulation of choice due to an increased risk of bleeding complications.

There have been a few smaller, retrospective trials evaluating the pharmacokinetics of enoxaparin, the LMWH of choice in cardiovascular medicine, in patients with impaired renal function. Kruse et al¹, developed and implemented a dosing protocol for patients with a creatinine clearance between 30-60 mL/min and less than 30 mL/min (table 1). The enoxaparin product monograph indicates the dose should be reduced by 50% in patients with creatinine clearance of less than 30 ml/min but have not published their data or made

randomized controlled trials have used total body weight without ceiling doses, but have only a small number of patients weighing greater than 100kg enrolled in

NB Heart Centre Cardiac Surgery Research Program



By Dr. Craig Brown, Cardiac Surgeon and Carole Dubé-Roy, Research Nurse

The Department of Cardiac Surgery at the New Brunswick Heart Centre (NBHC) employs a three-pronged approach to cardiovascular research. Through the utilization of, and participation in the *Society of Thoracic Surgery National Database*, the NBHC joins with other centers across Canada and the United States in clinical research projects.

their trials. Currently, the Canadian product monograph for enoxaparin recommends dosing to a maximum of 100 mg if given twice daily (i.e. 100 mg BID). This may result in underdosing of patients weighing greater than 100 kg, however, if total body weight is used, we may be exposing them to an increased risk of bleeding. Consideration should be given to use unfractionated heparin as anticoagulant of choice in these patients as we are able to monitor the amount of anticoagulation with some degree of certainty based on the activated partial thromboplastin time (aPTT).

What about anti-Xa levels?

There is debate whether anti-Xa levels correlate to clinical outcomes and if monitoring them in clinical practice is useful in special populations. The other question is whether we should monitor trough or peak levels. In general, trough levels are used to monitor LMWH in patients with renal impairment as we are concerned with accumulation. Peak levels are monitored in our obese patient population, to ensure adequate anticoagulation, however there is no steadfast rule. To add to the confusion, levels may vary depending on the type of LMWH used and the dosing interval (daily versus q12h). Most dosing strategies adjust the LMWH dose according to peak anti-Xa levels.

In general peak levels should be measured 4 hours post third dose. The target peak anti-Xa level for the therapeutic dose of enoxaparin is 0.5-1.0 IU/mL. There is an increased risk of bleeding associated with a peak greater than 1.0 for twice daily dosing regimens. It is important to note for once daily dosing regimens the target anti-Xa level varies depending on the LMWH used. Trough levels should be drawn just prior to the third dose. The target trough levels for enoxaparin 1 mg/kg BID is 0.2-0.3 IU/mL.

What are we doing at the NB Heart Centre?

At the NB Heart Centre, we are recommending all patients with a calculated creatinine clearance of less than 30 mL/min use unfractionated heparin as the anticoagulant of choice. In patients weighing greater than 100 kg, unfractionated heparin should be considered. However, in the elderly patient population, the evidence is less clearly defined. Other factors should be considered such as relative risk of bleeding complications, concomitant medical conditions and practitioner preference to help determine which agent would be the best choice for anticoagulation. When thrombolytics are used in patients greater than 75 years old, unfractionated heparin should be initiated. If enoxaparin is to be

used, no IV bolus should be given and a lower maintenance dose is required.

We are currently evaluating a dosing strategy for enoxaparin in patients with a creatinine clearance between 30 and 60 mL/min, based on the Kruse et al¹ protocol, and should be completed by the end of April 2007.

References:

1. Kruse et al. Retrospective evaluation of a pharmacokinetic program for adjusting enoxaparin in renal impairment. *American Heart Journal* 2004;148 (4):582-9.
2. The seventh ACCP Conference on Antithrombotic and thrombolytic Therapy. *CHEST* 2004;126:188-203
3. Enoxaparin product monograph
4. Neely JL, Carlson SS, Lenhart SE. Tinzaparin sodium: A low molecular weight heparin. *AM J Health-Syst Pharm* 2002; 59:1426-36.
5. Chow SL, Zammit K, et al. Correlation of antifactor Xa concentrations with renal function in patients on enoxaparin. *Journal of Clinical Pharmacology* 2003;23:586-590.
6. Duplaga BA, Rivers CW, et al. Dosing and monitoring of LMWH in special populations. *Pharmacotherapy* 2001;21(2):218-234
7. Lim W, Daentali F, et al. Meta-analysis: low-molecular weight heparin and bleeding in patients with severe renal insufficiency. *Ann Intern Med* 2006; 144(9): 673-84.
8. Montalescot G, Collet JP et al. Anti-Xa Activity relates to survival and efficacy in unselected acute coronary syndrome patients treated with enoxaparin. *Circulation* 2004; 110:392-398.

Is valve surgery safe in patients over 80? What are the results of coronary bypass surgery performed without the heart lung machine? These and other questions have been topics for cooperative studies at the NBHC. Some of these studies are confined to New Brunswick. Two ongoing investigations relate to mitral valve repair and to surgical ablation for atrial fibrillation. In addition, the Department of Cardiac Surgery has participated in several multicentre trials of devices or drugs in the hopes of making cardiac surgery safer and more successful.

Currently, we are focusing on the following five research initiatives:

1. Perioperative Myocardial Infarction	Enrollment has begun
2. Perioperative Heart Function	Enrollment to begin
3. Wound Healing	1st Phase Completed, 2nd Pending
4. Valve Anticoagulation	Planning Phase
5. Surgical Site Infections	Submitted for grant approval

Finally, the NBHC Cardiac Surgery Research Program receives requests from industry to evaluate new heart valves and their implantation techniques. Three valve registries/studies are currently underway.

1. Mechanical Valve Implant Registry	Enrollment Phase
2. Tissue Valve Performance Registry	Enrollment Phase
3. Tissue Valve Observational Study	Enrollment Phase

Many of these research projects require extended follow-up of patients after their discharge from hospital. It must be emphasized that the success of these research projects depends on patient and family commitments to the studies and, when applicable, the aid of the Telehealth Department of Atlantic Health Sciences Corporation.

The NBHC Cardiac Surgery Research Program could not function without the dedication of fluently bilingual research nurses with several years of cardiac surgical experience. These nurses work under the supervision of Carole Dubé-Roy whose work experience in cardiac surgery, Telehealth, and research has been an asset to this program. Carole also sits on the New Brunswick executive committee of the Canadian Council of Cardiovascular Nurses in the capacity of research chairperson.

For further information about this program you may contact us via the NBHC e-mail: nbhc@reg2.health.nb.ca.

Telehealth Utilization at the NBHC – Postoperative Cardiac Surgery Follow-up Clinic

By Krisan Palmer and Francine Bordage

The New Brunswick Heart Centre (NBHC) utilizes various Telehealth applications in the delivery of tertiary cardiology services. In the last issue of the *NBHC HeartBeat*, focus was placed on the Telehealth application commonly referred to as the *Home Monitoring Program*. In this issue of the newsletter, we bring your attention to the Telehealth application referred to as *Postoperative Cardiac Surgery Follow-up Clinic*.

Patients who undergo cardiac surgery at the NBHC are seen in follow-up by the cardiac surgeon six to eight weeks post discharge from hospital. During this visit the patient is assessed for any untoward problems related to the cardiac surgical procedure and both the patient and family member(s) have an opportunity to have their questions answered and concerns (if any) alleviated.

Prior to the introduction of Telehealth, all patients would return to the NBHC in Saint John to be seen in the ambulatory clinic for follow-up. Following a research and development project carried out

In the picture, Dr. Craig Brown, Cardiac Surgeon at the NBHC, is assisted by Cindy Nugent (Telehealth Nurse) in conducting a post op clinic assessment via Telehealth.

in 1998 by the Atlantic Health Sciences Corporation and the NBHC in partnership with all of the NB Regional Health Authorities, it was determined that those follow-up visits could safely be carried out via a Telehealth application. The technology utilized for these virtual visits allow for a fully interactive, real time clinical assessment. "Clinically validated electronic stethoscopes with exceptional diagnostic quality audio, coupled with the transmission of echocardiograms via a 512 ISDN connection make these clinics easily sustainable" (www.ahsc.health.nb.ca/Programs/Telehealth/telecardiology.shtml)

Presently the Telehealth devices required for the follow-up clinic assessment are located in each of New Brunswick's health regions and in two health care facilities in Prince Edward Island. The clinics are conducted on a weekly

basis allowing patients to have their follow-up appointments closer to home. The patients travel to their local regional hospital where specially trained registered nurses assist them in the fully interactive real time clinical assessment with the cardiac surgeon located at the NBHC. The AHSC Telehealth department is responsible for coordinating the interactive visit with the regional facilities. The Telehealth clinicians and clerical support personnel are responsible for scheduling and conducting the clinics to ensure that all run smoothly.

The use of Telehealth technologies require that health care professionals be educated in the



Looking Back on a Productive and Successful Year

Improving the Health and Wellness of our New Brunswick Communities through Exposure to Novel Cardiovascular Devices and Treatments

In the premiere issue of the *NBHC HeartBeat*, the NB Heart Centre Research Initiative (NBHCRI/Initiative) was featured as an innovative approach to conducting cardiovascular research at our institution. As reported, a consortium of like-minded cardiologists decided to work collectively to elicit and conduct high quality clinical trials that would enhance the knowledge base and scope of care provided at the Atlantic Health Sciences Corporation (AHSC).

Since its inception, the Initiative has been networking with leading national and international cardiovascular researchers and the pharmaceutical industry to attract the most beneficial clinical trials to our New Brunswick community. "It is important that our provincial population be provided with the option to participate

in clinical trials and our site must ensure we are included in those trials that answer important scientific questions." said Dr. Sohrab Lutchmedial, Medical Director of the Initiative. "The outcomes of the trials we selected will decide the future of patient care delivery. The Initiative's participation in these endeavors ensures that New Brunswick's voice is heard by health care decision makers."

The group's effort has received a positive response from both patients and partners. Cardiac patients appreciated the level of contact received when participating in a study with comments such as: "Being in a research study and visiting the hospital for study examinations provides me with the regular contact with a study nurse and cardiologist that I might otherwise not get."

"The participation commitment shown by the patient population has been

noted by the pharmaceutical industry as a positive factor for AHSC's reputation as research institute." said Fabia Fitzgerald, Manager of NBHCRI. "When deciding which sites will participate in trials, the site sponsor regularly reviews both patient and staff commitment. AHSC continues to rate very high in both of these categories which leads to being viewed as a preferred partner in research trials."

Having the group work together has been very successful with each interventional cardiologist currently leading a productive clinical trial. As a result, our research site has been recognized as a leading site in Canada for recruitment and quality data. The researchers at the Initiative have received several invitations to speak on their success rates with both recruitment and retention of study patients.

In March 2006, the department



utilization of the equipment in performing advanced clinical assessment. In June 2006, an educational activity was organized by the AHSC Telehealth Coordinator Krisan Palmer and took place at the Saint John Regional Hospital. Health care professionals from New Brunswick and Prince Edward Island were given an opportunity to examine the processes involved in the cardiac surgery follow-up clinics. During the day, the participants were provided with an overview of the scheduling process, the proper use of Telehealth equipment (such as microphone usage and camera positioning), a session on videoconferencing etiquette (such as interview dialogue), and what is required to create an ideal Telehealth assessment condition. Other activities included a mock patient presentation, a home Telehealth demonstration, sternal assessment, as well as a proper heart and lung assessment using the electronic stethoscope.

For further information about this program you may contact us by e-mail at: nbhc@reg2.health.nb.ca

successfully completed a Health Canada Inspection. "While having to experience an inspection can be stressful, it was a great learning experience for everyone and verified that we are operating a solid department", Fitzgerald said

It has been a rewarding experience as we continue to grow our department including additional interested researchers. We are grateful to our dedicated staff of research coordinators who are often seen working late in the evening along side the nursing staff to ensure our trial patients are comfortable. "We are most grateful to our New Brunswick research patients who dedicate their time to make a valuable contribution to the treatment of heart disease. Better healthcare requires better knowledge of the causes of disease, the progression of disease and the response of disease to intervention" said Lutchmedial. "We look forward to another year full of new and interesting challenges in the field of clinical research."



The photo displays those in attendance during the Telehealth educational session on June 22, 2006. From left to right: 1st row: Marie-Reine Poirier (R6), Pam Gallagher (R3), Andrée Banville (R1-Beauséjour). 2nd row: Patsy Burke (R3), June McNaughton (R5), Krisan Palmer, Telehealth Coordinator AHSC (R2), Janice Connell, Administrative Assistant Telehealth (R2), Carole Ruest (R4). 3rd row: Diane Robert-Bujold (R5), Annette Haché (R6), Shawn Thorne (R3), Shelley Musgrave (R1-South East), Brenda Duplessie (R7), Cindy Nugent, (R2), and Anne Desjardins (R4). Absent: Kim Bowness (Summerside-PEI).

Access Coordinator for the NB Heart Centre



Céline Michaud
Access Coordinator

We, at the NBHC are happy to announce the appointment of Céline Michaud in the role of Access Coordinator. Céline obtained her nursing diploma in 1978 from Collège Saint Louis-Maillet in Edmundston and is currently enrolled in the BN program with the Université de Moncton. Her experience in cardiology began at the Saint John General Hospital in the Coronary Care Unit. Certified as an Exercise Specialist with the American College of Sports Medicine in the USA & Canada, she worked as Coordinator of the Cardiac Rehabilitation program at the Edmundston Regional Hospital from 1997 to 2000. Céline joined the Cardiovascular Health and Wellness program of the NB Heart Centre in 2005 where her expertise was utilized in both cardiac rehabilitation and the heart function clinic. "Both Céline's clinical and linguistic expertise will be an asset to the access coordination team of the NB Heart Centre program" says Francine Bordage, Administrative director.

Clinical Pharmacist for the NB Heart Centre



Trudy Arbo
PharmD, B.Sc.
Pharm, BCPS, ACPR

In September 2006, Trudy Arbo joined the NB Heart Centre team in the role of Clinical Pharmacy Practice

Leader. Trudy completed her pharmacy

undergraduate degree at the University of Alberta in 1999. In 2000, she completed a hospital pharmacy residency at the Ottawa Hospital and worked as a critical care pharmacist at the Civic Campus until moving to beautiful British Columbia in 2003. Trudy completed her doctorate of pharmacy through Idaho State University in 2005 and accepted a position with the Renal Program at the Fraser Health Authority as Clinical Pharmacy Specialist. In 2006, Trudy and her husband decided to venture to the east coast of Canada to be closer to family and as a result she joined the New Brunswick Heart Centre. "The move to Saint John has been wonderful and I couldn't be happier. Although I am still relatively new to my position, my colleagues in the pharmacy department and throughout the Heart Centre have made me feel very welcome and an important part of their team" says Trudy. Since her arrival in September 2006, Trudy has been busy getting acquainted with the clinicians and has already spearheaded several initiatives such as: Plavix coverage for those patient unable to pay for this medication post stent insertion, revamping the cardiac Heparin protocol, and the initiation of a research project relating to sternal infection in post cardiac surgery patients to only name a few. More recently Trudy has initiated a review of all patient education material in use at the NBHC.

"In the short time Trudy has been working in the program she has proven to be a great addition to our team" says Dr. Vernon Paddock, Medical Director.

Clopidogrel (Plavix®) Drug Coverage in New Brunswick

By Dr. Trudy Arbo
and Dr. Vernon Paddock

Clopidogrel (Plavix®) is used as an anti-platelet agent in cardiac angioplasty and cardiac stenting procedures to prevent stent thrombosis. It also has a role in the management of acute coronary syndrome.

The New Brunswick Heart Centre (NBHC) has noticed an increase in the number of calls from patients and community pharmacies regarding drug coverage for clopidogrel. When ordered by the interventional cardiologists at the NBHC, the prescription is covered by the New Brunswick Formulary (see excerpt from the New Brunswick formulary). Initially, the prescription for clopidogrel is written for your patient for a specific duration based on the type of procedure that your patient had and other patient specific factors. The duration of therapy usually ranges from 30 days to 1 year. It is very important that the prescription be continued for the specified amount of time especially in patients who have received a drug eluting stent (DES) as they do not endothelialize the vessel until at least three months to one year and require

anti-platelet therapy to avoid stent thrombosis. If the Clopidogrel needs to be held or stopped for any reason please contact the Interventional Cardiology offices at (506) 648-6101 to discuss the risks and alternatives.

If a family physician or general practitioner writes a prescription for clopidogrel during this same time frame as the prescription written by the interventional cardiologist, it WILL NOT BE COVERED by the New Brunswick Formulary unless special authorization is applied for and approved. Therefore, we are asking that the full prescription issued by the interventional cardiologist be used until the refills are finished (i.e. after 1 year). Once the prescription for clopidogrel is completed, it may be continued at the discretion of the family physician or general practitioner; however, please note that as stated previously, special authorization must be applied for in order for the medication to be covered under the current New Brunswick Formulary.

If you have any questions or concerns regarding this issue, please feel free to contact Dr. Trudy Arbo by phone at (506) 649-2657 or Dr. Vernon Paddock at (506) 648-6101.

From the New Brunswick Formulary – Special Authorization Drug Criteria:

Clopidogrel (Plavix) Tablets 75mg

1. Secondary prevention of vascular ischemic events (myocardial infarction, stroke) in patients with a history of symptomatic atherosclerotic disease who have had treatment failure or are intolerant or allergic to ASA.
2. For the prevention of thrombosis post intracoronary stent implantation for a period of 28 days. Prescriptions written by invasive (interventional) cardiologists for this procedure do not require special authorization. The claims adjudication system will automatically recognize the NBPDP physician ID number of the cardiologists at the Atlantic Health Sciences Centre.
3. For the prevention of vascular ischemic events in patients who have been hospitalized with acute coronary syndrome (i.e. unstable angina or non-ST segment elevation myocardial infarction) in combination with ASA for a period of three months.



New Brunswick Heart Centre Foundation

Public and corporate philanthropy makes a significant difference in healthcare. Public donations help care providers to take on projects and services that are beyond the reach of regular government funding. Projects can involve everything from patient comforts to advanced medical technology, from leading edge research to cardiac forums and clinical trials. Donations are important.

The New Brunswick Heart Centre Foundation has been created to accept gifts directed to the cultivation of excellence at New Brunswick's Heart Centre. These gifts will result in enhanced cardiac care right here in New Brunswick . . . right away.

The latest equipment and technology helps attract and retain the best medical staff. Opportunities for research and drug trials are also related to the quality of the personnel and equipment. The Heart Centre's vision is to advance the reputation of the New Brunswick Heart Centre as a centre of excellence in Canada for cardiac care. But reputations are built on action. Our new Charitable Foundation is essential to this vision.

Donors with an interest in cardiac care have a place to direct their contributions. The Foundation will accept charitable donations, encourage estate gifts, promote the creation of endowments and conduct periodic campaigns and special events. Donations will be used entirely to support the New Brunswick Heart Centre. Gifts should be directed to:

**New Brunswick Heart Centre Foundation,
PO Box 2100, Saint John, NB E2L 4L2**

A donation to the New Brunswick Heart Centre Foundation will:

- Maintain advanced cardiac care right here in New Brunswick.
- Help attract and retain cardiac specialists.
- Help us keep pace with the latest in medical equipment and technology.

Yes, I support the New Brunswick Heart Centre.

Here is my donation of:

\$25 \$50 \$100 \$500 Other \$ _____

I have enclosed a cheque for NB Heart Centre Foundation

Charge my: Visa Mastercard

Name

Address

City

Postal Code

Card Number:

Expiry Date:

Signature:

Donation Reply to: New Brunswick Heart Centre Foundation,
PO Box 2100 Saint John, NB E2L 4L2