Victoria Heart Institute FOUNDATION

CV Research Victoria

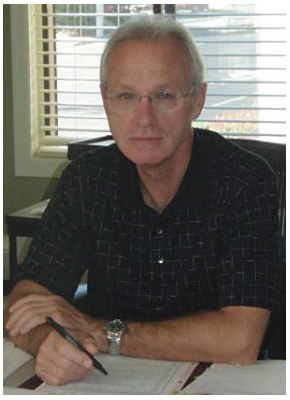
March 2007

Featured Trials:

CENTAURUS
CRESCENDO
CURRENT/OASIS 7
IMPROVE-IT

Contents:

Research Director Message



Dr. W. Peter Klinke
Research Director VHIF

Recently, I attended an evening CME event chaired by Dr. Walter Chow, which dealt with the issues around COX-2 Inhibitors (COXIBS) in family practice. The session included talks from a rheumatologist, gastroenterologist and a cardiologist.

The rheumatologist emphasized the prevalence and disability of osteoarthritis. Many of these patients will require treatment with either a non-selective NSAID or a COX-2 Inhibitor.

The gastroenterologist told us that the COX-2 drugs do indeed reduce GI bleeding, which is in the range of 2-4% per year with the use of non-selective NSAIDs.

The cardiologist reminded us of the possible adverse cardiac effects of these drugs, although risk/benefit decisions arise every day in individual patients.

The transformation of arachidonic acid to prostoglandins is catalyzed by cycolooxygenase (COX), which exists in two forms COX-1 and COX-2. COX-2 inhibition mediates the anti-inflammatory effects of NSAIDS; whereas COX-1 inhibition is responsible for adverse GI events such as bleeding.

It therefore was reasonable to believe that inhibiting COX-2 selectively would result in the same anti-inflammatory benefits of non-selective NSAIDS with fewer gastrointestinal side effects.

In 1995, the first generation of COXIBS (Celecoxib and Refecoxib) entered clinical trials. By 2000, these drugs dominated the market for prescription NSAIDS, although now there is serious dispute about the cardiovascular safety of all COXIBS.

Despite numerous studies on COX-2 Inhibitors that have emerged, drawing conclusions about their cardiovascular effects has been complicated by conflicting results, under powered clinical trials, the lack of placebo groups, and the use of post-hoc and non-specified analyses. We are still in need of randomized controlled trials that are well designed and adequately powered to determine the cardiovascular effects of these drugs.

Are all COXIBS the same? It appears not. At our current state of knowledge, different degrees of risk are associated with different COXIBS, which may be related to the degree of COX-2 selectivity of each drug or certain moieties within its chemical structure. Unfortunately, there are no trials that have made a head-to-head comparison of COXIBS to substantiate this.

Should the cardiac risk profile of a patient affect our decision to use a COXIB? For patients with known coronary disease or multiple risk factors, it would be prudent to avoid a COXIB. For young or low risk individuals, the answer is less clear at this time.

Is there a benefit to adding aspirin when prescribing a COXIB to a patient with a high cardiovascular risk profile? Clinical trials do not give us an answer and the only trials that looked at this, showed that ASA did not lower cardiovascular events. What is clear is that the use of ASA with a COXIB eliminates the gastrointestinal safety advantage of COXIBS over non-selective NSAIDS.

The use of ASA and NSAIDS in cardiac patients can also be problematic since some NSAIDS can blunt the anti-platelet effect of ASA by binding to COX-1. Giving ASA two hours before the NSAID is recommended. This type of interaction becomes irrelevant when ASA is combined with a COXIB because COX-2 is not expressed in platelets.

Finally we lack definitive trials about where the various non-selective NSAIDS, the presumed alternative to COXIBS, stand in terms of cardiovascular safety. Observational studies however have not shown any significant cardiac effects from non-selective NSAIDS use.

In spite of thousands of lawsuits initiated against the makers of COXIBS, we still do not know if there is an increase in cardiac events in all or many of the patients prescribed these drugs.

If you are looking for the right answer, it helps if you ask the right question!!

Featured Trials

The CENTAURUS Trial

Study Snapshot	CENTAURUS
Patient Condition:	Acute Coronary Syndrome (ACS)
Official Title:	Comparison of the Effects Noted in The ApoB/ApoA-I Ratio Using Rosuvastatin and Atorvastatin in Patients With Acute Coronary Syndrome
Intervention:	Drug: Rosuvastatin, Drug: Atorvastatin
Study Phase:	Phase III
Study Design:	Treatment, Randomized, Double-Blind, Active Control, Parallel Assignment, Safety/Efficacy Study
Expected Enrollment:	1160 study patients
Victoria Enrollment:	3 study patients
Principal Investigator:	Peter Klinke, M.D.
Co-Investigator:	Anthony Della Siega, M.D.
Co-Investigator:	David Hilton, M.D.
Co-Investigator:	David Kinloch, M.D.
Co-Investigator:	Eric Fretz, M.D.
Co-Investigator:	Elizabeth Swiggum, M.D.
Sub-Investigator:	Reginald Smith, Pharm. D.
VHIF Coordinators	Jody Joval, RN, Liza MacRae, RN, Sheryll Sorensen, RN, Liz Reimer, RN
Sponsor:	AstraZeneca
Study Progress:	Start 2006 — End 2008

Purpose

Patients with a diagnosis of acute coronary syndrome (ACS) and atherosclerosis with high levels of lipids are usually treated with statin medications. High levels of lipids can increase the risk of atherosclerosis in ACS patients. Statins lower the lipid levels in the bloodstream.

The effectiveness of statin medications on the biological marker ApoB/ApoA-1 ratio (a marker considered to be one of the strongest predictors of serious cardiovascular problems) have not been confirmed.

The purpose of the CENTAURUS trial is to determine if the statin medication, rosuvastatin, is effective in treating ACS by decreasing the ApoB/ApoA-1 ratio, and if so, how it compares to another statin medication, atorvastatin.

The study will also assess whether the commencement of statin treatment prior to hospital discharge (within 48 hours following the onset of the first ACS symptoms) is beneficial.

Study Status

The CENTAURUS trial is currently enrolling at numerous sites in Belgium, France, Hungary, Ireland, Italy, Portugal, Spain, and Canada. As of February 2007, three patients enrolled into the CENTAURUS study are from Victoria.

How It Happens In Victoria

- Potential study patients meeting inclusion criteria and after consultation and consent, receive study medication prior to their scheduled percutaneous coronary intervention (PCI). Before discharge from the hospital, study patients undergo a physical exam and receive dietary and medication counseling.
- Study patients are seen at VHIF one month and three months after hospital discharge. Patients will undergo physical exams, blood samples, and an ECG.

Knowledge Gained

Patients with ACS are at particularly high risk for myocardial infarction and death. Recent clinical studies have shown that the utilization of statins can decrease the risk of cardiac events in patients suffering from ACS.

The National Cholesterol Education Program Adult Treatment Panel III Guidelines (NCEP ATP III) have recommended that patients admitted with a major coronary event should be considered for treatment with statin on discharge from the hospital. Recent studies have shown that higher doses of statin drugs will produce a greater benefit in reducing coronary events following discharge than standard doses of statin drugs. However, these trials randomized patients a number of days after the onset of the ACS. The primary objective of this study is to compare the efficacy of rosuvastatin versus atorvastatin in reducing ApoB/ApoA-I ratio at three-months in ACS patients receiving study treatment.

The CRESCENDO Study

Purpose

The primary objective of the CRESENDO study is to determine if the investigational medication, rimonabant, is effective at reducing the risk of myocardial infarction (MI), stroke, and death in patients with abdominal obesity and at increased risk for cardiovascular events.

Study Status

CRESCENDO is a very large study with an expected enrollment of 17,000 study patients. There are research sites in over thirty-five countries participating in the CRESCENDO study, including the U.S., Australia, Belgium, Brazil, U.K., Finland, Malaysia, to name a few. Enrollment in Victoria will begin in March 2007.

How It Happens In Victoria

- Following consultation and consent at the VHIF office, study patients will be asked to provide a history, a physical exam will be done, an ECG will be done and a blood sample will be taken for testing.
- Study patients will start on the study medication and will visit VHIF at 1, 3 and 6-months, and then every six months to the end of the 48-month study for a physical exam, a review of medications, a blood sample, and heart rate and blood pressure measurements. Telephone follow-ups will be conducted every three months during the course of the study period.

Knowledge Gained

The investigational drug rimonabant has recently been studied in several large clinical trials. It was associated with significant weight loss and decrease weight circumference compared to placebo. Other effects seen in some of the trials were a significant increase in HDL-

cholesterol and decreases in triglycerides, and in small, dense atherogenic LDL particles, and in C-reactive protein. Insulin sensitivity was also improved in patients. These effects were maintained over 2 years with continued treatment.

Rimonabant may decrease weight and waist circumference, and it may improve other conditions that increase the risk of heart attack and stroke. The CRESCENDO study will provide further data to demonstrate the effectiveness of rimonabant at lowering the chance of MI, stroke, or death.

Study Snapshot	CRESCENDO
Patient Condition:	**Cardiovascular Disease**
Official Title:	Randomized, Multinational, Multicenter, Double-Blind, Placebo-Controlled, Two-Arm Parallel Group Trial of Rimonabant 20 Mg OD for Reducing the Risk of Major Cardiovascular Events in Abdominally Obese Patients With Clustering Risk Factors
Intervention:	Drug: SR141716 Rimonabant
Study Phase:	Phase III
Study Design:	Treatment, Randomized, Double-Blind, Placebo Control, Parallel Assignment, Efficacy Study
Expected Enrollment:	17,000 study patients world-wide
Victoria Enrollment:	0 (not yet enrolling), expecting 20 study patients
Principal Investigator:	Peter Klinke, MD
Co-Investigator:	Anthony Della Siega, MD
Co-Investigator:	David Hilton, MD
Co-Investigator:	David Kinloch, MD
Co-Investigator:	Eric Fretz, MD
VHIF Coordinator	Noreen Lounsbury, BN, Lynn Mitchell, RN
Sponsor:	Sanofi-Aventis
Study Progress:	Start: Dec 2005 — End: 2010

The CURRENT Oasis 7 Trial

Study Snapshot	CURRENT/OASIS 7
Patient Condition:	**Acute Coronary Syndrome, Unstable Angina**
Official Title:	Clopidogrel Optimal Loading Dose Usage to Reduce Recurrent EveNTs/Optimal Antiplatelet Strategy for InterventionS
Intervention:	Drug: SR25990C
Study Phase:	Phase III
Study Design:	Treatment, Randomized, Double-Blind, Dose Comparison, Factorial Assignment, Efficacy Study
Expected Enrollment:	14,000 study patients world-wide
Victoria Enrollment:	0 study patients
Principal Investigator:	W. Peter Klinke, M.D.
Co-Investigator:	Anthony Della Siega, M.D.
Co-Investigator:	J. David Hilton, M.D.
Co-Investigator:	David Kinloch, M.D.
Co-Investigator:	Eric Fretz, M.D.
Co-Investigator:	Richard Mildenberger, M.D.
Co-Investigator:	Malcolm Williams, M.D.
Sub-Investigator:	Reginald Smith, Pharm D.
VHIF Coordinator	Jody Joval, RN, Sheryll Sorensen, RN, Lisa MacRae, RN, Liz Reimer, RN
Sponsor:	Sanofi-Aventis, Bristol-Myers Squibb
Study Progress:	Start: 2006 — End: 2009

Purpose

The purpose of the CURRENT Oasis 7 research study is to evaluate whether a higher dosage of clopidogrel with aspirin decreases the risk of ischemic complications for patients who have undergone a percutaneous coronary intervention (PCI).

Study Status

The CURRENT Oasis 7 trial is a very large research study with a planned enrolment of 14,000 participants from 800 study sites worldwide. Patient enrollment in Victoria will begin in early 2007.

How it Will Happen in Victoria

- Potential study patients have a diagnosis of ACS and are eligible for PCI within 24 hours of randomization.
- Following consultation and consent, study patients will undergo a physical exam, ECG, and blood testing, and if study inclusion criteria have been met, study patients will then be randomized to either a standard dose group or to a high dose group.
- Study patients receive study medication for approximately thirty days and are seen in follow-up at the VHIF office for dietary counseling, to provide a blood sample, vital signs, a physical exam and medications review.

Knowledge Gained

Information gathered from the CURRENT Oasis 7 study will answer the question as to whether or not higher doses of clopidogrel and/or higher doses of aspirin are beneficial, while at the same time addressing the significant concern regarding bleeding complications with the various combinations of high and low dose aspiring and clopidogrel.

Featured Trials (continued)

The IMPROVE-IT Trial

Study Snapshot	IMPROVE-IT
Patient Condition:	**Hypercholesterolemia, Acute Coronary Syndrome**
Official Title:	Study to Establish the Clinical Benefit/Safety of Vytorin (Ezetimibe/Simvastatin Tablet) vs Simvastatin in Subjects With Acute Coronary Syndrome (IMProved Reduction of Outcomes: Vytorin Efficacy International Trial – IMPROVE IT)
Intervention:	Drug: ezetimibe/simvastatin combination 10 mg/40 mg (VYTORIN), Drug: simvastatin 40 mg (ZOCOR)
Study Phase:	Phase III
Study Design:	Treatment, Randomized, Double-Blind, Active Control, Parallel Assignment, Safety/Efficacy Study
Expected Enrollment:	10,000 study patients
Victoria Enrollment:	25 study patients
Principal Investigator:	W. Peter Klinke, M.D.
Co-Investigator:	J. David Hilton, M.D.
Co-Investigator:	R. David Kinloch, M.D.
Co-Investigator:	Anthony J. Della Siega, M.D.
Sub-Investigator:	Reginald E. Smith, Pharm. D.
VHIF Coordinator	Liza MacRae, RN, Sheryll Sorensen, RN, Liz Reimer, RN, Jody Joval, RN
Sponsor:	Merck/Schering-Plough Research Institute and Merck & Co.
Study Progress:	Start 2006 — End 2010

Purpose
The purpose of the IMPROVE-IT trial is to compare two drugs, ezetimibe and simvastatin in combination, and simvastatin alone, to determine the effectiveness of each of these drugs in lowering LDL-C (bad cholesterol) levels.

Study Status
The IMPROVE-IT trial is a large multi-nation research study recruiting through 500 sites in twenty-one countries. In Canada, study sites include Victoria, New Westminster, Edmonton, Scarborough, Granby, and Sainte-Foy. Twenty-five study patients are currently enrolled in the IMPROVE-IT trial in Victoria.

How It Will Happen In Victoria
- Following consultation, consent, and assessment of eligibility, study patients are randomized (assigned by chance) to either of two groups receiving study medication (ezetimibe and simvastatin in combination, or simvastatin alone).
- Study patients are seen in follow-up at the VHIF office at one month and three months after beginning the study, and then once every four months where study patients undergo a physical exam, a review of medications, and a blood test.

Knowledge Gained
Persons with a history of coronary artery disease (CAD) and acute coronary syndrome (ACS) may also have a high level of LDL-C. The combination of these conditions may increase the chances for unstable angina or a heart attack.

The IMPROVE-IT trial will provide further insight into whether having a lower LDL-C level makes it less likely that persons with CAD will develop unstable angina and heart attacks.

Clinical Trials In-Process at the VHIF

Clinical trials research conducted through VHIF focus on treatments for cardiovascular patients.

All clinical trials conducted through VHIF must first be approved by the Clinical Research Ethics Board (CREB) of the Vancouver Island Health Authority (VIHA).

Twenty-six research trials are underway through VHIF as at March 2007.

	Enrolling Study	Patient Diagnosis
1	APPRAISE-1	Acute Coronary Syndrome (ACS)
2	BEAUTIFUL & Echo Sub study	Coronary Artery Disease (CAD) and Congestive Heart Failure (CHF)
3	CENTAURUS	ACS
4	CURRENT/OASIS 7	ACS
5	CRESCENDO	CAD & abdominal obesity
6	EarlyACS	ACS
7	EQUINOX	Deep Vein Thrombosis (DVT)
8	EVEREST-II	Valvular Heart Disease (VHD)
9	FREEDOM	Diabetes, CAD
10	IMPROVE-IT	ACS
11	MEND CABG II	Coronary Artery Bypass Grafting (CABG)
12	OPTIMAL CARE	Anticoagulation Therapy
13	PLATO	ACS
14	PROTECT	CHF
15	SERP 1	ACS
16	SNAPIST-III	CAD
17	SOX	Peripheral Vascular Disease (PVD)
18	VIA	ACS
19	ZESCA	ACS

	No Longer Enrolling, Study Patients in Follow-Up:	
20	AGENT4	Inoperable-CAD
21	ASTRONOMER	VHD
22	C-CIRUS	CAD
23	ERASE	ACS
24	IPRESERVE	CHF
25	OAT	CAD
26	STRADIVARIUS	CAD

Acknowledgement

VICTORIA FOUNDATION

CONNECTING PEOPLE WHO CARE WITH CAUSES THAT MATTER

VHIF wishes to recognize their contribution and express appreciation to the Victoria Foundation for their support of cardiovascular research in Victoria.

Victoria Foundation recently provided a grant to support both a gene-therapy research trial, and an original research project designed to evaluate the safety and efficacy of same-day discharge for selected heart patients undergoing radial approach percutaneous coronary interventions.

Dr. Andrew Small, VHIF Cardiovascular Fellow, is leading the same-day discharge research project.

The Victoria Foundation supports projects that enhance the quality of life in local communities. Their website is: www.victoriafoundation.bc.ca

Clinical Vignette:

CARDIAC RESYNCHRONISATION THERAPY OVERVIEW

Dimitrios Lypourlis, MD
Electrophysiology Fellow,
Royal Jubilee Hospital,
Victoria, B.C.

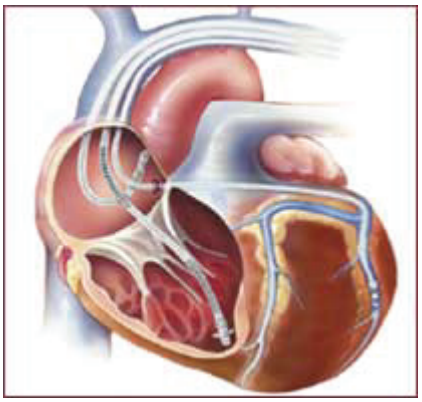
Cardiac resynchronization therapy (CRT) has been shown to be an effective therapy in selected patients with advanced drug-refractory heart failure (HF). The primary substrate of CRT is a failing heart with discoordinate contraction that is due to electrical timing delay rather than fixed functional defects as with myocardial infarction. The major property identifying such a heart has been a widened QRS complex- particularly with LBBB morphology. This occurs in about 25% of all HF subjects, and is associated with a nearly 1.7-fold higher risk of both worsened failure and sudden cardiac death (SCD)

Currently implantation criteria for CRT devices are as follows:

- Stable and optimized medical regimen
- NYHA functional class III or IV
- QRS duration > 120 msec
- LVEF< 35%

It can not be overemphasized that CRT is not and should not be considered as an alternative to medical optimization, but rather viewed as an adjunctive form of therapy.

Early clinical trials demonstrated clinical efficacy of CRT for improving symptoms and reducing re-hospitalization rates for HF. The COMPANION study reported in mid-



2004 was the largest study that provided data on mortality, but also compared treatment with CRT devices alone versus CRT devices combined with an ICD. For the principal endpoint - reduction in all-cause mortality combined with re-hospitalisation for worsened HF, both CRT and CRT-D provide significant and nearly identical improvements, with a risk reduction of 24%. The effect though on all-cause mortality alone reached statistical significance in the CRT-D group (reduction 36%, p = 0.004) but not in the CRT alone group (borderline significant, p = 0.06). Subsequently the CARE-HF trial reported in 2005 and which did not have an ICD arm, found CRT to reduce all-cause mortality by more than 30% (p<0.002), although this effect did not appear until 12 months after implantation and became increasingly prominent over time.

One ongoing issue is how to best target CRT to HF patients so that those most likely to benefit are appropriately treated. In all studies, 25%-40% of patients receiving CRT are non-responders, however this number may in fact be larger because of the significant placebo effect seen in device trials. Potential reasons for this observation include:

- Cardiac dyssynchrony is but one of the components contributing to the LV dysfunction and the associated symptoms
- The selected patients may have not been correctly identified as candidates based on the current criteria
- The therapy may not have been adequately instituted

Mechanical synchrony may be in the normal range in HF patients despite having a wide QRS complex, while on the other hand, about 30% of patients with a narrow QRS and HF may have clinically significant mechanical dyssynchrony. Moreover it has been shown that patients with a similar extent of mechanical dyssynchrony respond favorably to CRT regardless of QRS duration.

Technical considerations may preclude successful delivery of the LV lead to an optimal pacing site. These include: inability to cannulate the coronary sinus, absent or inaccessible target veins, high left ventricular stimulation thresholds with as high as 20% loss of capture at 1 year (presumably related to the presence of scar on the epicardial surface of the heart underlying the target vein), and phrenic nerve stimulation or diaphragmatic capture. Furthermore, suboptimal programming of the device can have an impact on the derived benefit.

Currently the most utilized technique for interventricular (VV) optimization is tissue Doppler imaging and aortic velocity time integral. It is important to note though that there has yet to be a large study that prospectively demonstrates a clinical benefit of optimal VV timing programming compared to the simultaneous RV and LV pacing. Moreover echocardiographic optimization is time-consuming and costly and therefore only non-responders are typically optimized. A new optimization algorithm (Quick Opt Optimization, St Jude Medical) is a novel intracardiac electrogram-guided method to determine optimal atrioventricular and interventricular delays for CRT optimization at the push of a button. This is currently being prospectively evaluated in the FREEDOM trial and if it proves to be accurate it might replace echocardiographic optimization as the predominant form of optimization as the latter can be rather cumbersome.

Unresolved issues in CRT include its role in NYHA Class II heart failure and in combination with ICDs. The REVERSE trial is an ongoing prospective, randomized, double-blind, parallel study, designed to assess whether CRT combined with optimized medical therapy can attenuate progression of heart failure over at least 12 months, as compared to optimal medical therapy alone. Another unanswered question is should CRT be combined with ICD back-up? The RAFT trial is an ongoing trial that randomizes patients with moderate to severe HF symptoms (LVEF<30% and QRS>120 msec) to either ICD plus optimal medical therapy, or CRT/ICD plus optimal medical therapy, in a 1:1 randomization ratio. The objective is to determine if the addition of CRT to ICD and medical therapy will reduce total mortality and hospitalization for HF in advanced heart failure patients.

CRT has significantly contributed to the treatment of patients with HF. To further optimize individual benefit from CRT, identification of potential responders is needed. More research in areas of uncertainty is needed. Finally, economic considerations are important and the cost-effectiveness of CRT needs further study.

Recent Publications / Abstracts

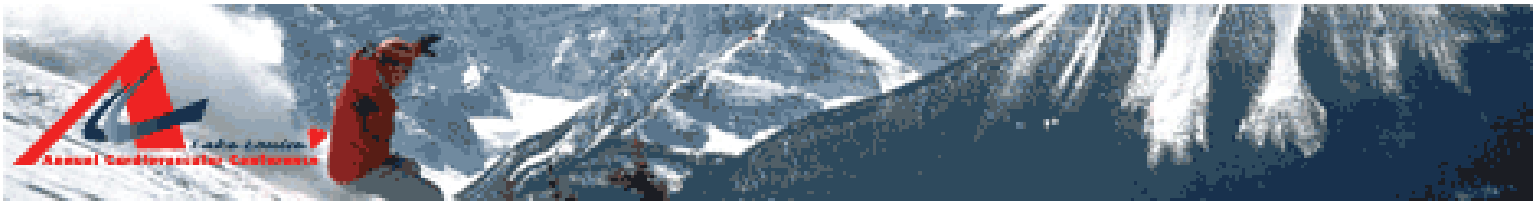
1. Karl Swedberg et al for the CHARM Investigators. Resource utilization and costs in the Candesartan in Heart failure: Assessment of Reduction in Mortality and morbidity (CHARM) programme. Eur Heart J. 2006; 27: 1447-1458.

2. Paul W. Armstrong et al for the APEXS AMI Investigators. Pexelizumab for Acute ST- Elevation Myocardial Infarction in Patients Undergoing Primary Percutaneous Coronary Intervention. JAMA. January 3, 2007 – Vol. 297, No. 1.

3. Kim Fox, Roberto Ferrari, Michal Tendera, Philippe Gabriel, Ian Ford on behalf of the BEAUTIFUL Steering Committee. Rationale and design of a randomized, double-blind, placebo-controlled trial of ivabradine in patients with stable coronary artery diessea and left ventricular systolic dysfunction: the morbidity-mortality EvAlUation of the If inhibitor ivabradine in patients with coronary disease and left ventricULar dysfunction (BEAUTIFUL) Study. AHJ. November 2006, Vol. 152, No. 5.

(Contact us at vhif@vhif.org for reprints)

ACC Lake Louise



The **23rd Annual Cardiovascular Conference at Lake Louise, March 11 – 15, 2007,** provided an outstanding scientific program, interactive workshops, topical satellites, and a special session presented by the Canadian Cardiovascular Society (CCS), entitled:""So You Think You Know How To Treat Patients With Heart Failure?"

Again this year, one of the presentations from ACC Lake Louise was recorded and is accessible on-line through www.acclakelouise.com. A number of presentations from this year, and from last year, are also available via this URL.

Appreciation to Pfizer, and Servier Canada, for sponsorship support of this newsletter

Cardiovascular Clinical Fellowships

A local television station recently broadcast a news story featuring the cardiovascular fellowship program at the Royal Jubilee Hospital in Victoria.

A video clip interview with two of our three current interventional cardiovascular fellows can be viewed on-line at: www.vhif.org/news.htm.

Dr. J. David Hilton, FRCP(C), FACC, is the Director of Fellowship Training.

VHIF Board of Directors Profile - Part 2

J. Michael Hutchison, QC
Director, Counsel to VHIF

Michael Hutchison received his Ll.B. from UBC in 1970; after having studied three years in chemistry and zoology and two years in the honours program in political science at the University of Victoria.

Hutchison articled with the Victoria law firm of Sullivan, Smith & Bigelow in 1971, and thereafter joined the firm, becoming a partner in 1974. He is now the sole remaining partner of that firm still in practice in the firm now known as Smith Hutchison.

Between 1971 and 1976, Hutchison worked almost exclusively in criminal law and thereafter branched into a civil practice, particularly in administrative law and commercial and intellectual property work as well as related civil litigation. He has been General Counsel to the Board of Examiners in Optometry for British Columbia since 1976. For several years after 1985, he was the external counsel to the University of Victoria, during which time he had extensive involvement with the University's administration of research involving human subjects.

Hutchison was appointed Queen's Counsel in 1985.

Hutchison was the founding Chairman appointed by the government of British Columbia to the Private Post Secondary Education commission for six years, the body which registered and oversaw more than 1200 private educational institutions in the province. From 1979 through 1989 he was a member and, during the last three years, Chairman of the Board of Governors of Camosun College. From 1977 to 1981, he spent two terms as an elected Trustee for School District 69 - Greater Victoria.

Hutchison played varsity rugby for the University of Victoria and UBC, following his university career with the James Bay Athletic Association and had selections to the Vancouver Island Rugby Union representative team the Crimson Tide. He has been Chairman of Selectors for the British Columbia Rugby Union and served a term as a vice president of the Canadian Rugby Union, during which time he worked with development of sports doping regulations in Canada.

Hutchison married Katy in 1998, combining families consisting of his son and daughter with Katy's twins. Since 1989, his firm has provided legal services to the VHIF on a voluntary basis and he became a member of the Board in 1991.

Having proven over the past seven years that he is not PGA tour material, he has recently lifted a 26 year absence from the squash courts. His cardiology friends are not certain whether to applaud or prepare.

VHIF Personnel

Director of Research:	Dr. W. Peter Klinke, MD, FRCP(C), FACC, FACP
Director, Interventional Cardiology Fellowship Training Program:	Dr. J. David Hilton, M.D., FRCP(C), FACC
Cardiovascular Fellows:	Dr. Jon Byrne
	Dr. Andrew Small
	Dr. Mark Spence
Thrombosis/Anticoagulation Research Fellow:	Amy Mailhot, RN, BSc
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Clinical Research Nurses:	Jody Joval, RN
	Liza MacRae, RN
	Lynn Mitchell, RN
	Liz Reimer, RN
	Sheryll Sorensen, RN
Clinical Support:	Catherine Graves
Business Manager:	Shawn Robinson, MBA
Accounting:	John Cantelon, BA
Regulatory Specialists / Administrative Support:	Kim Allen
	Sandi Allen

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Mission Statement

The Victoria Heart Institute Foundation is a non- profit, charitable organization dedicated to conducting and supporting cardiovascular research in Victoria.

With the knowledge we acquire in the etiology and management of cardiovascular disease from the results of clinical trials, we seek to improve the health status of cardiovascular patients in British Columbia.

Donations to VHIF are welcomed and will be acknowledged with a receipt for tax deduction purposes.