



October 2020 ISSUE

# CV Edge

The Official  
Publication of  
 **CACPR**  
Canadian Association of Cardiovascular  
Prevention and Rehabilitation

*Current Issues & Trends in  
Cardiovascular Disease Prevention & Rehabilitation*  
**Spring Conference Highlights**

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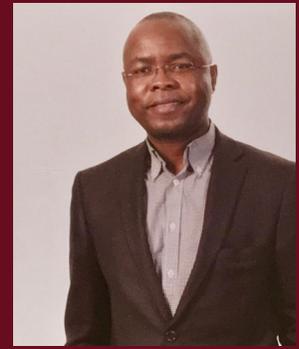
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# A Message from the Editor



*Dr. Warner Mampuya, MD PhD FRCPC*

Dear friends,

Last spring, as the Coronavirus was spreading and public health officials recommended against large gatherings of people, CACPR decided to convert a planned spring meeting in Toronto into a virtual gathering. The virtual conference was a huge undertaking by the CACPR on a short notice and was successfully accomplished.

This issue of CV Edge brings you the highlights of the CACPR Spring 2020 Annual Meeting held virtually on May 29th and June 5th, 2020.

The main theme of the conference was “Innovation in Prevention & Rehabilitation”.

In this highlight edition of CV Edge, we provide you with summaries of the presentations done during this 2-day virtual gathering. We hope that these summaries will refresh the memories of those of you who attended the conference, and give to those who did not attend a glance of the high quality content they missed.

One of the advantages of the virtual conference is that all the content is recorded and readily available for those who missed the conference or those who want to review it.

We encourage you to use this opportunity and enjoy those conferences in the comfort of your homes.

On behalf of the CACPR, we want to thank the organizing committee and all the speakers for their endeavor.

Next week, October 22nd and 23rd, we will be meeting for the fall conference. The theme of the conference is “Redesigning Cardiac Rehab: What is the new 'normal'?” We hope that you have registered and will attend this virtual event.

We thank you for your involvement with the CACPR to advance cardiac patient care.

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# A Word From the Conference Organizing Committee



*“The secret of change is to focus all of your energy not on fighting the old, but on building the new” - Socrates*

This year's Annual CACPR Spring conference theme was "**Innovation in Prevention & Rehabilitation**". In March 2020, worldwide 'change' and a new normal abruptly became the reality for all in response to the COVID-19 pandemic. As a planning committee, our team was committed to revising the 2-day onsite conference program to a completely virtual experience for our attendees. Our team ventured into new territory along with several other professional associations around the world to plan and deliver an interactive and exciting virtual conference program that would capture and meet our membership's learning needs. We're excited to share a brief conference overview and key indicators of success that may be of interest to our readership.

Day 1 of the CACPR virtual program featured a new highlight to Spring conference this year - the highly esteemed Dr. Terry Kavanagh Lecture Award. This year's award recipient, Dr. Scott Lear delivered a timely and highly informative presentation that focused on "Supporting Patients with Cardiovascular Disease at a Distance Using Technology". Dr. Lear's expertise and vast work in this specialty area has provided several CR programs with the necessary knowledge and tools to facilitate the transition of specific elements of patient care programming to a virtual format during the pandemic response. The afternoon sessions featured the exceptional progress and diligent work of the following committees: the CACPR clinical guidelines, the Registry and Quality Indicators, as well as the CACPR Position Statement on Optimal Risk Reduction Interventions. The day concluded with the Annual General Meeting led by Tracy Selway, our outgoing President who welcomed Dylan Chipperfield, the incoming President. We'd like to thank Tracy for her strong leadership, passion and commitment to this role over the past 3 years and extend a warm welcome to Dylan and look forward to his direction and guidance during his upcoming tenure.

# A Word From the Conference Organizing Committee

Day 2 featured captivating and interactive presentations from nutrition, exercise and rehabilitation experts across the country. The sessions spanned a number of timely topics including: 'Food for Thought' - the Mediterranean diet and brain-heart health, delivery of PAD patient programming, Cardiac Rehab and the heart failure model of care, the COVID-19 pandemic and implications for cardiac patient & community-based care, climate change and associated patient challenges, rehabilitation of the SCAD patient. Summaries of each session are included in this edition of CV Edge. A special thank you to our amazing and energetic Health Break facilitators from Toronto Rehab, Jessica Nooyen, Merrisa Martinuzzi and Lais Vanzella who kept everyone active and moving along with great music between session breaks.

Our 2020 Planning Committee was thrilled and inspired to witness the participation in this year's Spring conference especially considering the challenges that everyone has faced in the past number of months. We had record attendance numbers with 305 registrants on day 1 and 241 for day 2. We would like to acknowledge and thank Secretariat Central for their technical support during the conference. Thank you to everyone for your continued support and shared passion for learning. We look forward to seeing everyone virtually this October for the 2020 Fall Conference, "Redesigning Cardiac Rehab: What is the New Normal"? We are especially eager to see everyone in person one day soon when it is safe to do so. In the meantime, stay safe and keep up the incredible work you do everyday for our CACPR patient populations.

*Please stay tuned via our website, twitter, LinkedIn, or Facebook! Our regular webinar offerings will resume in the fall, and we are currently working with CCS for our fall conference. COVID has created some challenges affecting conference format, and more information is coming. Please 'Save the Dates' - they are **October 21-24, 2020**. We are underway with Spring Conference planning for 2021, and starting to plan for 2022. If you have suggestions for future speakers/ topics/ conferences, or you would like to participate in conference planning or hosting, please contact us at [cacpr@secretariatcentral.com](mailto:cacpr@secretariatcentral.com).*

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## Getting a Leg Up on PAD

*Sandra Black BSc (PT)*

Staff Physiotherapist,

Division of Cardiac Prevention and Rehabilitation,

University of Ottawa Heart Institute



**Bio:** *Sandra Black is a registered Physiotherapist having received her Bachelor's of Science from Queen's University. She is also a Certified Clinical Exercise Physiologist through ACSM. She has worked in the Division of Cardiac Prevention and Rehabilitation at the University of Ottawa Heart Institute for over 30 years. During the last 2.5 years with other team members, she has enjoyed the challenge of developing and supervising the Heart Institute's PAD Walking Rehabilitation Program. Other interests include alternative cardiac rehabilitation program delivery models and exercise training.*

It is estimated that up to 42% of individuals with coronary artery disease (CAD) also have peripheral artery disease (PAD). People diagnosed with PAD generally have poorer risk factor control compared to those with CAD. Cardiac rehabilitation programs are able to provide an interdisciplinary approach for the care and management of PAD clients.

Onsite supervised exercise programs are recommended based on randomized control trials and studies with long-term follow-up. Research supporting home-based exercise is more recent and has provided evidence in support of this approach. Two questions to assess if someone has typical claudication symptoms are “do your calf muscles hurt or ache when you walk?” and “does this calf pain go away when you stop walking?” The 6-minute walk test is utilized to assess claudication symptom onset and progression, requirement for rest breaks and overall distance walked.

The exercise program should be performed 3 to 4 times per week. The exercise session includes warm-up, exercise bouts ideally of 8 to 10 minutes duration and to an intensity of moderate claudication pain with rest breaks until claudication symptoms have resolved and then cool-down. The goal is at least 30 minutes of exercise training. Weight bearing exercise (walking or treadmill) is preferred. If someone is unable to walk for more than 2 to 4 minutes continuously, it is best to start with seated aerobic exercise (recumbent stepper, stationary bike, arm ergometer). Bouts of seated aerobic exercise can be alternated with shorter bouts of walking exercise.

Clients will improve in claudication onset threshold, physical capacity and mental health outcomes.

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## Beyond outcomes; expanding the role of cardiac rehabilitation in heart failure management

*Ashley Huitema, MD, FRCPC*



**Bio:** *Dr. Ashley Huitema is a member of the Division of Cardiology at St. Joseph's Healthcare London and London Health Sciences Centre. She is the incoming Co-Program Director for the Adult Cardiology Program at Western University and an Assistant Professor at Western. She completed her Internal Medicine and Cardiology training at Western and a fellowship in Cardiovascular Rehabilitation and Prevention at the Rumsey Cardiac Centre, part of the University Health Network at the University of Toronto. Dr. Huitema carries her passion for cardiac rehabilitation and secondary prevention forward into her current practice. Her research interests center around cardiac rehabilitation in special clinical populations, knowledge translation involving patient care and care delivery and heart failure management.*

Heart failure (HF) is a global epidemic with approximately 26 million people globally and more than 600,000 people in Canada living with this disease. Despite the availability of efficacious evidence-based medical therapy, patients still suffer from high rates of morbidity, including repeat hospitalizations, and death. The cost of treating HF worldwide is a significant burden and necessitates system planning for HF management that must consider patient complexity and the increasing prevalence of disease.

There is at least a 30-year history of engaging HF patients in cardiac rehabilitation (CR) as an integral part of their management plan. Multiple high-quality studies have shown that CR is safe and efficacious for patients with HF, even for those with significant functional limitations. Consistent evidence shows reduced hospitalizations, improved functional capacity and higher levels of health-related quality of life for HF patients. Despite the convincing safety and efficacy data low referral, use and adherence rates for CR persist. Greater effort is required to ensure HF patients are assessed for eligibility and referred to CR programs.

Integration of HF management into regional development and administration of CR services could be accomplished through use of a Spoke-Hub-Node (SHN) model of care. This model represents a collaborative organization of care that works with the primary care sector, which is highly integrated with community-based multidisciplinary teams of health care professionals and also with specialty care. CR could be seen as a chronic disease framework within this model to optimize evidence-based medication adherence and achievement of focused quality indicator standards for HF patients.

## “Virtual Reality”

### Cardiac Rehab & Covid-19

*David Bewick, MD, FRCPC*



**Bio:** *Associate Professor, Director of Health and Wellness & Heart Function FRCP, FACP, FACC*

**Title:** *“The new “virtual reality” : the challenges and practical approach of delivering cardiac rehab during and after Covid-19*

The COVID-19 pandemic resulted in the suspension of numerous cardiac rehabilitation (CR) services across Canada with the implementation of physical distancing recommendations. The traditional model of medically supervised, center-based cardiac rehab (CBCR) was challenged with the cataclysmic shutdown of CR programs.

Virtual cardiac rehab (VCR) offered an alternative and innovative solution but had new challenges encompassing resources, connectivity and a different format for a staff-patient interaction.

VCR principles must ensure both patient and staff safety from exposure to COVID-19, seamlessly provide a CR program during a pandemic and ensure the needs are met of at-risk patients in rural communities, the economically disadvantaged and elderly.

For centers initiating VCR, the program must be basic, safe and timely rather than complex and comprehensive. One should incorporate educational handouts, phone assessments and utilize if feasible, electronic technologies including tablets, smart phones and videoconferencing.

A core tenet for CR is a symptom-limited exercise treadmill study which may not be available. Risk stratification and an exercise prescription will potentially require innovative solutions with a greater emphasis on clinical assessment and to explore alternate methods of functional capacity assessment. (eg.6-minute walk test) The exercise prescription should initially be conservative and begin at a low intensity. It is mandatory patients are educated on concerning symptoms and signs with review by the CR team before recommending progressing to a more advanced exercise level.

All CR centers will have to plan for a future “ebb and flow” with varying degrees of care disruption due to the COVID-19 by incorporating a hybrid model of CBCR and VCR.



## How to exercise safely in an increasingly hot climate: Can patients with cardiovascular disease handle the heat?

*Daniel Gagnon, PhD*



**Bio:** *Daniel Gagnon is Assistant Professor of kinesiology at Université de Montréal and Researcher at the Cardiovascular Prevention and Rehabilitation Centre (ÉPIC) of the Montreal Heart Institute. He obtained his PhD in kinesiology from the University of Ottawa. His PhD work examined sex-differences in temperature regulation during exercise in the heat. Daniel subsequently undertook a postdoctoral fellowship at the Institute for Exercise and Environmental Medicine in Dallas, Texas, during which he studied the impact of age on the cardiovascular responses to heat exposure. In 2016, Daniel setup the Human Integrative Physiology Laboratory at Centre ÉPIC. His research programme examines the human physiological adaptations to heat exposure and their implications for cardiovascular health. His research is supported by the Montreal Heart Institute Foundation, the Fonds de Recherche du Québec – Santé, the Canada Foundation for Innovation, the Natural Sciences and Engineering Research Council of Canada, the National Health and Medical Research Council of Australia, and the Heart and Stroke Foundation of Canada.*

Exercise is a cornerstone of cardiovascular disease prevention and outdoor exercise is an easily accessible means for individuals to achieve an active lifestyle. Due to climate change, it is likely that outdoor exercise will be more often performed during periods of hot weather. Individuals with cardiovascular disease represent a vulnerable population during periods of hot weather. This begs the question of whether it is safe for these individuals to exercise outdoors when it is hot.

During exercise, at least 80% of metabolic rate is converted into heat that must be exchanged with the environment to avoid dangerous increases in internal body temperature. Heat exchange between the body and the environment occurs through dry heat exchange and evaporative heat loss. When exercise is performed in ambient temperatures that are equal to or greater than  $\sim 35^{\circ}\text{C}$ , the body depends entirely upon the evaporation of sweat to regulate internal body temperature. The threshold ambient temperature at which exercise may be dangerous for health can be estimated based on exercise intensity (which determines heat production by the body) and the maximum evaporative capacity of the body. Individuals with cardiovascular disease who perform outdoor exercise in Canadian hot weather are unlikely to be at greater risk of heat illness when exercise is performed according to secondary prevention guidelines. However, exercise in hot weather will result in greater cardiovascular strain as heart rate for a given intensity is greater when exercise is performed in the heat.



## CACPR Position Statement on Optimal Risk Reduction Interventions

*Carolyn Baer MD FRCPC*



**Bio:** *Carolyn Baer is a general internist in Moncton, New Brunswick. She was previously the director of Cardiac Rehabilitation at the Moncton Hospital and past president of CACPR. She is the chair of the Advanced Training Modules Committee for CACPR and a member of the Position Statement committee. She also sits on the education committee of the Canadian Women's Heart Health Alliance.*

Hypercholesterolemia is a well-known risk factor for the development of major adverse cardiovascular events (MACE). Statins are considered the first line therapy for hypercholesterolemia. Though generally effective, many patients experience statin intolerance or still have uncontrolled levels of LDL cholesterol (residual risk) while on maximal statin doses. The CACPR position statement will provide recommendations for managing residual risk through the use of PCSK9i in cardiovascular rehabilitation (CR). There are currently 2 PCSK9i molecules available in Canada, Alirocumab and Evolocumab, with outcome trials for both showing improved MACE.

The position statement consists of a rapid review of current guidelines, a literature scan of PCSK9i in the CV rehab context, and committee consensus on key elements for inclusion. The focus will be on recommendations for whom to use PCSK9i in, prescription details, monitoring, and general considerations for use. Provisional results from 26 documents identified the following patients to be targets of PCSK9i use: Patients with familial hypercholesterolemia (FH); Patients with statin intolerance and Patients with cardiovascular diseases / risk factors with residual risk despite statin use. PCSK9i are a third line therapy for LDL-lowering after statins, ezetimibe and lifestyle changes. Not all the documents had a recommendation on dose. There was no clear consensus on long term monitoring but the key element is to track LDL cholesterol. Considerations about price, cost-effectiveness, and provincial availability are key consideration for healthcare practitioners and patients. The position statement is in its final steps and it is expected that it will be available in the Fall of 2020.

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## Supporting Patients with Cardiovascular Disease at a Distance Using Technology

*Scott Lear, PhD*

Professor  
Department of Faculty of Health Sciences  
SFU



### **Objectives:**

1. To provide an overview of the evidence supporting technology for use in patients with cardiovascular disease
2. To understand the challenges and benefits for the implementation of technology in patient care programs

In March 2020, cardiac rehabilitation (CR) outpatient programs closed due to the coronavirus pandemic. While some programs turned to technology to connect with patients, many were unable to. The discontinuation of CR services could have long-term implications for increased poor outcomes. Of note, even prior to the pandemic, less than 25% of eligible patients attended CR with lack of accessibility being the greatest barrier. The technology to support virtual CR has been available for more than a decade but uptake has been slow to this point with concerns of security and privacy, lack of sustainable funding models and a culture focused on face-to-face care being the prominent barriers. Over the past 15 years, my research team has developed and evaluated virtual CR programs. In our randomized trial in patients from northern British Columbia with cardiovascular disease, virtual CR (remote heart rate monitoring, patient chat sessions and data exchange) resulted in increased exercise capacity, decreased LDL-C and improved diet quality. These improvements were sustained in the year following the program. There was also a 40% non-significant reduction in cardiac events and ER visits. The virtual CR program was implemented in the Fraser Health Authority at which time we overcame many of the institutional barriers. In a two-year period, 87 patients were enrolled and 73 completed. The average wait time was 1/6 of the standard hospital-based CR program. Over 90% of patients found it beneficial and would recommend it to others with convenience of time and no travel being highly rated. The cost per patient was 3/4 of the standard program. Virtual CR is an effective means at increasing access to CR and is a timely solution during the pandemic.

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## CACPR Cardiologica Registry: Interactive Virtual CR Quality Improvement

*Dr. Neville Suskin*  
London Health  
Sciences Centre



The Registry will facilitate patients meeting risk factor targets and enable evaluation within and between CR programs. Ideally, the Registry will be deployed as part of routine clinical workflow and produce clinically actionable information where clinical decision-making is taking place.

The Registry is hosted on its own Canadian virtual private cloud server and integrates seamlessly with the Cardiologica Patient Management System and the patient facing App. Within a CR program, users will have access to patient level data through the patient management system, where users can take advantage of a full suite of services including auto-generated patient intake and discharge summaries, highlighting whether patient's achieve risk factor targets.

Only aggregate data is available at the Registry interface, where CR programs' can compare their performance vs. guidelines and vs. the registry aggregate data as a whole. This way, personal health information can only be viewed by practitioners within a specific CR program. The data can be filtered by high-risk multimorbidity such as diabetes and peripheral vascular disease, to enable specific attention to those individuals.

The initial pilot phase of the Registry will begin in August 2020 and involve the CR programs already using the Cardiologica patient management system (Windsor, London, Toronto & Scarborough). Stay tuned for an update of the pilot at fall congress. This will be followed by a roll-out over the next 1-2 years to (hopefully) all CR programs in Canada, including those that do not use the Cardiologica Patient management system. Through unrestricted educational grants, the Registry will be made available to CACPR members free of charge.

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## Dietary Approaches to Sustain Brain and Heart Health

Carol Greenwood, PhD  
Senior Scientist,  
Rotman Research Institute Baycrest,  
Professor Emeritus,  
Dept. Nutritional Sciences,  
Univ Toronto



**Bio:** Carol Greenwood, a native born Montrealer, completed her graduate training at the University of Toronto and her post doctoral fellowship at MIT in Cambridge Massachusetts. She is currently a Senior Scientist at the Rotman Research Institute of Baycrest, Professor Emeritus in the Department of Nutritional Sciences, University of Toronto and Former Leader of the Nutrition, Exercise and Lifestyle Team in the Canadian Consortium for Neurodegeneration and Aging. Throughout her career, she has examined the relationship between diet and brain function, with a prolonged focus on lifelong dietary factors which modulate cognitive function. A primary focus of her research is aimed at understanding the mechanism(s) whereby midlife diet and type 2 diabetes mellitus contribute to cognitive decrements and ultimately elevate dementia risk. She actively collaborates with colleagues at the Rotman, Toronto Rehabilitation Institute, Sunnybrook Health Sciences Centre and other institutes to support multidisciplinary clinical studies spanning nutrition, exercise, cognitive psychology and neuroimaging.

Dementia is a progressive, heartbreaking deterioration of brain functioning, associated with aging. While there are different causes, the most common — Alzheimer's and vascular dementias — are now thought to be closely related to, and greatly impacted by, the same diet and lifestyle factors.

More and more research is linking Alzheimer's dementia to the same risk factors that cause heart disease, strokes, peripheral vascular disease, and vascular dementias: obesity, high blood pressure, high cholesterol, and diabetes. The evidence is substantial and studies show that people with these risk factors are significantly more likely to develop Alzheimer's disease. There's a very strong correlation between the heart health and the brain health. Evidence suggests the more we focus on heart health, the more we are helping our brain health as well. Some interventions like healthy diet and physical exercise play a huge role in lowering the risk factors of the disease and thus reducing the risk of cognitive impairment in older adults. As far as nutrition is concerned, the brain, like every tissue in our body, is reliant on healthy nutrition throughout its life span. It's important to recognize that the brain has its own needs for nutrition the same way that the heart and the muscles do. Baycrest scientists have led the development of the first

Canadian Brain Health Food Guide to help adults over 50 preserve their thinking and memory skills as they age. This Food Guide draws on the scientific evidence in terms of what diets seem to be best associated with retention of cognitive function and is very similar to the new Canadian food guide. Regular physical activity — any activity, for at least 150 minutes per week, is number one on the list of evidence-based actions you can take. Exercise clearly lowers the risk of dementia, even Alzheimer's.

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## CACPR Guideline update

Simon Bacon PhD, MSc, BSc



**Bio:** *Dr. Bacon's research deals with the impact of health behaviours and lifestyle (e.g., physical activity, diet, weight management, stress) on chronic diseases (e.g., obesity, cardiovascular disease, and chronic lung disease). He utilises multiple methodologies including epidemiological, psychophysiological, systematic review, and behavioural trials designs. Currently, Dr. Bacon is the CIHR SPOR Mentoring Chair in Innovative, Patient-Oriented, Behavioural Clinical Trials and a fellow of the Obesity Society, the Canadian Cardiovascular Society, and the Academy of Behavioral Medicine Research. Prior to joining Concordia he completed his postdoctoral studies at the Duke University Medical Center, McGill University, Hôpital du Sacré-Coeur de Montréal, and the Montreal Heart Institute. In addition to Concordia, Dr. Bacon is co-director of the Montreal Behavioural Medicine Centre ([www.mbmc-cmcm.ca](http://www.mbmc-cmcm.ca)), a researcher at the Centre intégré universitaire de santé et de services sociaux du Nord-de-l'Île-de-Montréal (CIUSSS-NIM: [ciusss-nordmtl.gouv.qc.ca/votre-ciusss/centres-de-recherche/](http://ciusss-nordmtl.gouv.qc.ca/votre-ciusss/centres-de-recherche/)), and co-leads the International Behavioural Trials Network ([www.IBTNetwork.org](http://www.IBTNetwork.org)).*

CACPR has had three editions of guidelines. The last edition published in 2009 includes around 165 recommendations. But given the massive new literature and new evidences in the area of cardiovascular rehabilitation and prevention, CACPR has decided to make new guidelines in the implementable format. An evidence-based recommendations task force has been created to undertake this massive work. In this task force, we have a broad representation of all the knowledge users across Canada. The 5 steps involved in the guidelines process include defining general priorities, working groups, evidence summaries, recommendation development and dissemination. The first three priorities are exercise, nutrition and general behavior change. The process is quite complex but we hope to come up with the new guidelines in a more implementable format as early as January 2021.

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## SCAD - epidemiology, clinical features and the importance of cardiac rehabilitation

*Thais Coutinho, MD*

Chief, Division of Cardiac Prevention and Rehabilitation  
Chair, Canadian Women's Heart Health Centre  
University of Ottawa Heart Institute  
Associate Professor of Medicine, University of Ottawa



**Bio:** *Dr. Thais Coutinho received her medical degree from the Universidade Federal do Rio de Janeiro, in Brazil, in 2004, and completed residency and fellowship training in Internal Medicine, Cardiology, Vascular Medicine, advanced Echocardiography and Research at the Mayo Clinic in Rochester, MN, in 2013.*

*Upon graduating, Dr. Coutinho joined the University of Ottawa Heart Institute as a Clinician-Scientist. In 2017, she was appointed Chief of the Division of Cardiac Prevention and Rehabilitation and Chair of the Canadian Women's Heart Health Centre. She is also an Associate Professor of Medicine at the University of Ottawa.*

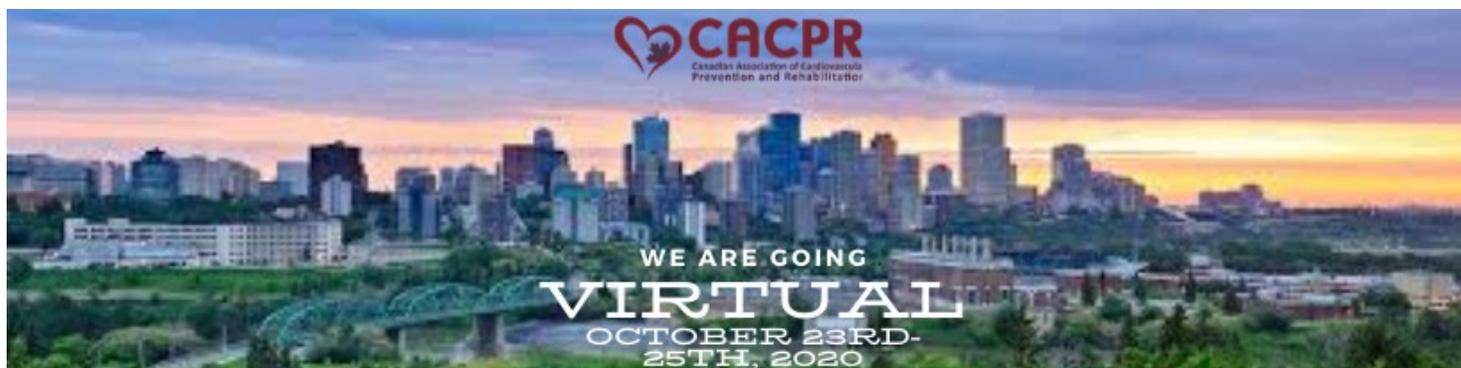
Spontaneous coronary artery dissection (SCAD) is defined as an epicardial coronary artery dissection that is not associated with atherosclerosis or trauma and not iatrogenic. This presentation gives contemporary insights into the causes, clinical course, treatment options, outcomes and associated conditions of SCAD and its rehabilitation strategies. The predominant mechanism of myocardial injury occurring as a result of SCAD is coronary artery obstruction caused by formation of an intramural hematoma or intimal disruption rather than atherosclerotic plaque rupture or intraluminal thrombus. SCAD has emerged as an important cause of acute coronary syndrome, myocardial infarction, and sudden death, particularly among young women and individuals with few conventional atherosclerotic risk factors. There is a need to increase the awareness of SCAD and its unique risk factors, associated conditions and different diagnostic, therapeutic, and prognostic implications compared with atherosclerotic coronary disease.

Due to their unique demographic, cardiovascular, and psychologic profile, experts recommend that patients with SCAD obtain tailored cardiac rehabilitation that acknowledges and targets the unique exercise, psychologic, and peer support needs of patients with SCAD, as well as increased education for health care providers, may be integral to promote patients in their recovery. The key points mentioned in this talk include:

- The differences in clinical characteristics of SCAD compared with atherosclerotic disease include: association with female sex, pregnancy, and physical and emotional stress triggers; concurrent systemic arteriopathies, particularly fibromuscular dysplasia; and high recurrence rates.
- SCAD represents 1% of all STEMIs and 19% of STEMIs in women age 50 or younger
- Most SCAD patients can be managed conservatively.
- Cardiac rehabilitation is safe and needed for SCAD patients

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# 2020 Fall Conference



## The Canadian Association of Cardiovascular Prevention and Rehabilitation's 2020 Fall Conference

### ***Redesigning Cardiac Rehab: What is the new 'normal'?***

The Canadian Association of Cardiac Prevention and Rehabilitation is pleased to announce that we have now opened the **2020 CACPR Annual Fall Conference** for registration! As many of you might already know, the Fall Conference is held in collaboration with the Canadian Cardiovascular Congress (CCC). This year the conference will be completely virtual! **For more information, and to register, [visit our website!](#)**

## Get your friends and colleagues to sign up for a CACPR Membership TODAY—Don't miss out!

CACPR is the National Body representing Cardiac Rehab programs in Canada, and has been incorporated since April 1991.

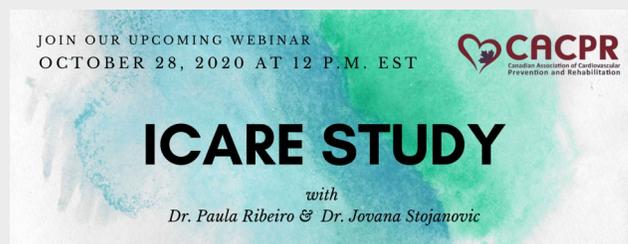
### ***Top 5 Member Benefits***

1. Liaise with like-minded professionals
2. Opportunities to shape CACPR and Clinical Practice
3. Discounts to attend CACPR Conferences
4. Access to CV Edge and JCRP
5. Access to CACPR Educational Webinars and Modules

### ***Who can join?***

Dietitians, Nutritionists, Physicians, Nurses, Pharmacists, Physiotherapists, Psychologists, Research Scientists, Exercise Rehab Professionals, Students and more!

**Sign up NOW!**



## ICARE STUDY

PRESENTED BY: DR. Paula Ribeiro & Dr. Jovana Stojanovic

Wednesday October 28, 2020 at 12:00 PM EST

Members receive a discounted rate! Sign up today for single webinars, or a yearly bundle!

**Register TODAY!**

## Advanced Training Modules

CACPR has now begun introducing Advanced Training Modules on numerous topics surrounding cardiovascular prevention and rehabilitation, with two modules now available!

Topics include:

- CV Risk Factors (*Available!*)
- Air Quality (*Available!*)
- Psychosocial
- Patient Management
- Nutrition
- Physical Activity



**Exclusive updates and discounts will be provided to members — *STAYTUNED!***

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