本會成立宗旨：

以非營利為目的之社會團體，以結合國內外熱心人士從事血脂異常及其相關疾病之衛生教育、學術研究、疾病預防及臨床服務等工作為宗旨。

本會成立目標：

- 舉辦衛教活動
- 推動學術研究
- 舉辦學術演講及討論會
- 參與國際相關組織及活動
- 結合熱心人士及團體以推動血脂異常之防治工作
- 其他與章程所訂宗旨及任務相關事項

委員會成員名單：

理 事 長：陳文鍾

常務理事：陳茂元、許勝雄

理　　事：陳明豐、葉宏一、陳肇文、林幸榮、胡啟民
殷偉賢、王國陽、李源德、王宗道、李啟明

常務監事：廖朝崧

監　　事：王水深、林中生

秘 書 長：吳造中

秘書(聯絡人)：陳素文

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【協辦單位】：台中榮民總醫院、高雄醫學大學附設中和紀念醫院、財團法人祺華教育基金會

台灣血脂衛教協會 *Taiwan Association of Lipid Educators*

2014 下半年度北、中、南學術研討會暨第二屆第二次會員大會

Holistic Care for the Patients with Cardiovascular Diseases: Controversies and Issues in 2014 (Part II)

【台中】：103 年 11 月 23 日 (星期日) 08:55 ~ 17:05

台中榮民總醫院 - 研究大樓一樓 - 第二會場

Time	Topic	Speaker	Moderator
08:55-09:00	Opening Remarks		陳茂元 教授
09:00-09:30	Comprehensive Lipid Management in T2DM	高醫 林宗憲 教授	
09:30-10:00	HDL, Atherosclerosis, and Emerging Therapies	中榮 林維文 醫師	
10:00-10:30	Statin Induced Diabetes and Its Clinical Implications	中榮 黃金隆 主任	
10:30-10:50	Discussion		
10:50-11:10	***Coffee Break***		
11:10-11:40	Treatment of Dyslipidaemia in Patient with Multiple Risk Factor	中山 蔡青峰 醫師	陳茂元 教授
11:40-12:10	A Comparison of Ezetimibe/Simvastatin versus Simvastatin Monotherapy on Cardiovascular Outcomes After Acute Coronary Syndromes: What is IMPROVE-IT Telling Us?	馬偕 葉宏一 教授	
12:10-12:40	Beyond Lipid Goal, What Should We Concern for Hyperlipidemic Patients?	中榮 李奕德 醫師	
12:40-13:00	Discussion		
13:00-14:00	***Lunch***（敬備餐盒）		
14:00-14:30	Practical Consideration for the Use of Oral Anticoagulants in Patients with Atrial Fibrillation: An Asian Perspective	彰基 張永明 醫師	陳文鍾 理事長
14:30-15:00	Unforgettable Minorities: Management of Familial Hypercholesterolemia	北榮 常敏之 教授	
15:00-15:20	Discussion		
15:20-15:40	***Coffee Break***		
15:40-16:10	Glycemic Control: Balance between Glucose Lowering and CV Benefits	中榮 謝育整 醫師	
16:10-16:40	The Importance of Home BP in Clinical Practice	彰基 夏建勳 醫師	
16:40-17:00	Discussion		
17:00-17:05	Closing Remarks		

***停車資訊：當天（次）停車優惠 會員50元。**

《最終節目表依大會公告爲準》

台灣血脂衛教協會 *Taiwan Association of Lipid Educators*

2014 下半年度北、中、南學術研討會暨第二屆第二次會員大會

Holistic Care for the Patients with Cardiovascular Diseases: Controversies and Issues in 2014 (Part II)

【高雄】：103 年 11 月 30 日 (星期日) 08:55-16:05

高雄醫學大學附設中和紀念醫院 - 高醫啓川大樓六樓 - 第一會議室

Time	Topic	Speaker	Moderator
08:55-09:00	Opening Remarks		許勝雄 院長
09:00-09:30	Current Treatment of Mixed Dyslipidemia	高榮 賴奇正 醫師	
09:30-10:00	Comprehensive Lipid Management in T2DM	奇美 田凱仁 醫師	
10:00-10:20	Discussion		
10:20-10:40	***Coffee Break***		
10:40-11:10	Statin Induced Diabetes and Its Clinical Implications	中山 蘇峻弘 醫師	吳造中 教授
11:10-11:40	A Comparison of Ezetimibe/Simvastatin versus Simvastatin Monotherapy on Cardiovascular Outcomes After Acute Coronary Syndromes: What is IMPROVE-IT Telling Us?	馬偕 葉宏一 教授	
11:40-12:00	Discussion		
12:00-13:00	***Lunch***（敬備餐盒）		
13:00-13:30	Unforgettable Minorities: Management of Familial Hypercholesterolemia	高榮 邱寬饒 副教授	王國陽 主任
13:30-14:00	Practical Consideration for the Use of Oral Anticoagulants in Patients with Atrial Fibrillation: An Asian Perspective	成大 劉秉彥 副教授	
14:00-14:20	Discussion		
14:20-14:40	***Coffee Break***		
14:40-15:10	Are Outcome Trials Needed for The Hypoglycemic Agents?	高醫 林宗憲 教授	賴文德 院長
15:10-15:40	The Importance of Home BP in Clinical Practice	高長 鄭正一 副教授	
15:40-16:00	Discussion		
16:00-16:05	Closing Remarks		

《最終節目表依大會公告爲準》

【台北】：103 年 12 月 20 日 (星期六) 13:55-17:10

國立台灣大學公共衛生學院公衛大樓二樓 -201 會議室

Time	Topic	Speaker	Moderator
13:55-14:00	Opening Remarks		吳造中 教授
14:00-14:30	Role of RHYTHM CONTROL in AF Management	馬偕 李應湘 醫師	
14:30-15:00	How Can We Improve ACS Care Based on Latest Evidence?	亞東 李任光 醫師	
15:00-15 :20	Discussion		
15:20-15:40	***Coffee Break***		
15:40-15:45	**Which NOAC is Better for Our Daily Practice?**		殷偉賢 主任
15:45-16:10	**Debate - FIIa Antagonist**	高醫 林宗憲 教授	
16:10-16:35	**Debate - FXa Antagonist**	成大 李貽恆 教授	
16:35-16:55	**Q&A from the Moderator and Audience**		
16:55-17:00	**Rebuttal - FIIa Antagonist**	高醫 林宗憲 教授	
17:00-17:05	**Rebuttal - FXa Antagonist**	成大 李貽恆 教授	
17:05-17:10	Closing Remarks		

【台北】：103 年 12 月 21 日 (星期日) 08:55-16:15

國立台灣大學公共衛生學院公衛大樓二樓 -201 會議室

Time	Topic	Speaker	Moderator
08:55-09:05	會員大會		陳文鍾 理事長
09:05-09:10	Opening Remarks		
09:10-09:40	Current Treatment of Mixed Dyslipidemia	新光 賴史明 主任	廖朝崧 教授
09:40-10:10	Comprehensive Lipid Management in T2DM	亞東 邱昱偉 醫師	
10:10-10:30	Discussion		
10:30-10:50	***Coffee Break***		
10:50-11:20	A Comparison of Ezetimibe/Simvastatin versus Simvastatin Monotherapy on Cardiovascular Outcomes After Acute Coronary Syndromes: What is IMPROVE-IT Telling Us?	馬偕 葉宏一 教授	林幸榮 教授
11:20-11:50	Beyond Lipid Goal, What Should We Concern for Hyperlipidemic Patients?	台大 王治元 副教授	
11:50-12:10	Discussion		
12:10-13:10	***Lunch***（敬備餐盒）		
13:10-13:40	Statin Induced Diabetes and Its Clinical Implications	台大 吳卓鍇 醫師	陳肇文 教授
13:40-14:10	The Importance of Home BP in Clinical Practice	新光 徐國基 教授	
14:10-14:30	Discussion		
14:30-14:50	***Coffee Break***		
14:50-15:20	Glycemic Control: Balance between Glucose Lowering and CV Benefits	北榮 黃柏勳 副教授	胡啓民 教授
15:20-15:50	New Armamentarium in T2DM Treatment: SGLT2 Inhibitor	彰基 謝明家 副院長	
15:50-16:10	Discussion		
16:10-16:15	Closing Remarks		王水深 教授

《最終節目表依大會公告爲準》

理事長的話

各位同好：

有鑑於心血管疾病為國人十大死因之第二位，而心血管疾病相關知識、診斷及治療之研究日新月異，推陳出新。本會之宗旨包括推動專業人員之繼續教育，實有必要針對近期發表之相關學術論述與爭議，舉辦心血管全人照護研討會，以釐清相關之觀念。

本會歷年在台北、台中、高雄舉辦之相關研討會均得到相當大的迴響與佳評，因此本會每半年舉辦一次，以孚知識進展之時效性與普及性。爰此，本會於2014年11月23日於台中榮民總醫院，11月30日於高雄醫學大學附設中和紀念醫院及12月20–21日台北國立台灣大學公共衛生學院，再次舉辦心血管疾病照護相關議題之整合性學術研討會，歡迎各位同好踴躍參加，共襄盛舉。

理事長

陳文鍾

申請網路會員

申請入會方式：

1. 歡迎線上【台灣血脂衛教協會 http://www.lipid.com.tw/】【醫療專業人員】-【註冊 - 報名完成。
2. 填寫下列報名表後撕下，研討會後交給櫃檯服務人員或填寫後傳真至：(02) 2321-7485。
3. 來電告知秘書處聯繫 (02)-2312-3456 分機 88558，並請提供：姓名、連絡電話、e-mail。

會員可享：

1. 協會研討會活動日期、課程節目表通知及學分申請。（以 e-mail 通知為主，如需郵寄請提供收件地址）。
2. 協會【醫療專業人員】網站資料下載、閱覽專業新知。
3. 2015 年新書出版會員獨享優惠折扣。

****

台灣血脂衛教協會入會申請表

姓　　名	
醫事編號 或 ID 後 4 碼 (必填)	
手機、電話	
E - M A I L	
收件地址	□□□□

（請務必正楷填寫，以避免無法辨識）**回傳專線：(02) 2321-7485**

簡　　歷

姓名：林宗憲 教授

現職：

2001.8-　心臟血管內科主治醫師

2006.8-　高雄醫學大學醫學系助理教授

學歷：

1989-1996　高雄醫學大學醫學系

1999-2002　高雄醫學大學臨床醫學研究所碩士

2003-2007　高雄醫學大學臨床醫學研究所博士

經歷：

高雄醫學大學附設醫院實習醫師

高雄醫學大學附設醫院內科住院醫師

高雄醫學大學附設醫院心臟內科總住院醫師

高雄醫學大學附設醫院心臟血管內科主治醫師

專科執照與學會：

內科醫學會及內科專科醫師及指導醫師

心臟血管內科醫學會,心臟血管內科專科醫師及指導醫師

重症醫學會及重症專科醫師

介入性心臟血管醫學會

醫用超音波醫學會

專長：

高血壓、高血脂、心絞痛、心肌梗塞、心衰竭、心率不整

四肢動靜脈疾病診治、心臟及週邊血管超音波檢查、心導管及週邊血管介入性治療

Comprehensive Lipid Management in T2DM

林宗憲 教授

CURRICULUM VITAE

NAME: Wei-Wen Lin MD, PhD（林維文）

Medical Department, Chung Shan Medical University, Medical Degree
Life Science Department, Tung-Hai University, PHD
Attending Physician, Cardiovascular center, Taichung Veteran Hospital
Assistant Professor of Life Science Department, Tung-Hai University
中山醫學大學 醫學系畢業
東海大學 生命科學系博士班畢業
台中榮民總醫院 心臟血管中心主治醫師
教育部定助理教授

EDUCATION:

1986/07/01-1992/06/30	Medical Student, Chung Shan Medical College, Taichung, Taiwan
1992/07/01-1994/06/30	Internship, Chung Shan University H, Taichung, Taiwan
2003/07/01-2007/11/30	PH. D, Life Science Department, Tung-Hai University, Taichung, Taiwan
2007/12/1-2008/12/31	Visiting Scholar, University of Connecticut, Regenerative Medicine Center, Connecticut, USA
2009/09/01-2009/11/30	Visiting Scholar, Berlin Heart Center, Berlin, German

EMPLOYMENT RECORD:

1994/07/01-1997/06/30	Resident, Internal Medicine, Veterans General Hospital, Taichung
1997/07/01-2001/06/30	Fellow, Adult Cardiology, Cardiovascular center, Veterans General Hospital, Taichung
2001/07/01-present	Attending Cardiologist, Adult Cardiology, Cardiovascular center, Veterans General Hospital, Taichung

BOARD CERTIFICATION:

1997/12	The Society of Internal Medicine, Taiwan (M4767)
2000/10	The Society of Emergency Medicine and Critical Care
2000/12	The Republic of China Society of Cardiology, Adult (S758)

RESEARCH INTEREST:

1. Molecular mechanism of atherosclerosis, reverse cholesterol transport
2. Echocardiography, non-invasive hemodynamic evaluation of heart function
3. Embryonic stem cell and therapeutic cloning research
4. Cardiac Catheterization, precutaneous coronary intervention

HDL, Atherosclerosis, and Emerging Therapies

林維文 醫師

高密度脂蛋白 (HDL-C) 擁有幾個重要角色：首要爲膽固醇逆運送 (reverse cholesterol transport)，其他角色包含抗氧化、抗血栓、抗發炎、血管內皮功能維護等，藉著排除膽固除、抑制 LDL 氧化、減少發炎反應等機轉，HDL-C 可有效預防動脈粥狀硬化的病程。在膽固醇逆運送中，HDL 顆粒可以由 Apo-A1 逐漸演變爲 Nascent HDL、HDL3c、HDL3b、HDL3a、HDL2a、HDL2b。顆粒將因爲逐漸載滿膽固醇而逐漸飽滿變大，將堆積在周邊組織的膽固醇運送回肝臟，進而由膽汁排除。而這個過程中需要許多不同蛋白與代謝酵素的協助，例如 ABCA-1、LCAT、CETP 等等，若這些蛋白與酵素缺乏將造成不同疾病。藉由了解 HDL-C 合成與分解，有助於我們認識 HDL-C 的品質與功能的關聯，並重新評估合適的治療藥物。

研究指出 HDL-C 過低的病患會有較多的心血管疾病事件，也會有較高的動脈粥狀硬化風險。但提昇 HDL-C 是否就能有效改善疾病事件與風險？目前看來，HDL-C 提升藥物的研究結果仍有爭議，包含 CETP inhibitors 類用藥臨床研究 (Illuminate、Dal-outcome) 顯示，雖然均提升了 HDL-C 濃度，但沒有顯著臨床改善效果；而 niacin 類用藥的臨床研究結果分歧。如此引發我們思考究竟這些藥物所提升的 HDL-C，是否具有心血管保護功能？

簡　　歷

姓名：黃金隆 醫師

主治專長：
心臟血管疾病、心衰竭、心律不整

專業經驗：
電氣生理學、心律調節器置放 (PPM、CRT)

重要經歷 / 進修訓練：
心臟血管中心 主治醫師
台中榮總心臟血管中心 心臟衰竭科主任
中華民國心臟衰竭委員會委員 (民國 99 年 8 月 - 迄今)
中華民國電生理暨節律器委員會委員 (民國 99 年 8 月 - 民國 101 年 7 月)
中華民國心律醫學會秘書長 (民國 100 年 2 月 - 民國 102 年 3 月)

學歷：
中山醫學大學醫學系
國立陽明大學臨床醫學研究所醫學博士

專科證照：
中華民國內科醫學會專科醫師
中華民國心臟醫學會專科醫師暨指導醫師
中華民國重症醫學會專科醫師

教師資格：
國立陽明大學醫學院部定副教授
國立國防醫學大學醫學院臨床副教授

研究興趣：
心臟病、心臟衰竭、心律不整、電生理學

進行中之計劃：
2012 年院內計畫「心衰竭患者接受心臟同步化節律器治療後心臟電氣及機械再塑性的臨床差異性探討」2011-2014 年國科會計畫「以豬模式研究造成腦神經刺激的電極特性」。

Statin Induced Diabetes and Its Clinical Implications

Jin-Long Huang, MD, PhD
Cardiovascular center of Taichung Veterans General Hospital

Statins are one of the most commonly used drugs in the world based on their potential to prevent adverse cardiovascular events. These cholesterol-lowering drugs received a US FDA warning, in February 2012, regarding increased risk of incident diabetes and impaired glycemic control in patients who already have diabetes Mellitus (DM). The possible association of diabetes with statin therapy has started a wave of discussion in the medical community. A number of meta-analyses conducted in recent years have demonstrated that the association is real although causality has not been proved yet. Individual statins differ with respect to their diabetogenic property; women and elderly persons appear to be at increased risk. Various aspects of statin's effect on glycemic control remain to be explored. In West of Scotland Coronary Prevention Study (WOSCOPS), development of type 2 DM was found to decrease in pravastatin-treated patients. Some studies showed no changes or decrease in fasting sugar/ HbA1c in the CAPITAIN /PAPAGO-T/J-PREDICT studies, novel effects of pitavastatin on glucose homeostasis were observed in these three cohorts of patients with metabolic syndrome, DM or impaired glucose intolerance, independent of its efficacy in reducing levels of lipoproteins. As further research in this area continues, physicians might still take some precautions to make risk benefit ratio more favorable for the patients.

簡　　歷

基本資料：

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886-4-24739595　ext 34709、32527

現任：

中山醫學大學醫學系 副主任

中山醫學大學醫學系 部定副教授

中山醫學大學附設醫院 內科部 教學研究 副主任

中山醫學大學附設醫院心臟內科 主治醫師

中山醫學大學附設醫院臨床技能中心 執行長

主要學歷：

臺灣大學 藥學士

成功大學 學士後醫學士

中山醫學大學 臨床醫學研究所醫學博士

美國印第安那普渡大學 Krannert 心臟中心研究員

主要經歷：

中山醫學大學醫學系 部定副教授 (現任)

中山醫學大學附設醫院 心臟內科主治醫師 (現任)

臺北榮民總醫院 內科住院醫師

臺北榮民總醫院 心臟內科總住院醫師/心臟電氣生理研究室研究員

專長：

心臟電氣生理學及心律不整

心臟血管醫學 (包含高血壓學)

臨床藥理學 (心臟血管藥物)

Treatment of Dyslipidemia in Patient with Multiple Risk Factors

蔡青峰 副教授
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心臟疾病、腦血管疾病、糖尿病、高血壓等疾病都跟高血脂有關，這四種疾病危害台灣好幾萬人寶貴生命，受害對象多數爲中老年人，千萬不可讓高血脂在血管中造成傷害，侵襲人類健康。而在去年八月台灣高血脂治療的健保規範也已放寬，我們所熟知的心血管疾病建議降至 100 mg/dL 以下，也同時納入了糖尿病病人合併高血脂建議降至 100 mg/dL 以下，除此之外非高風險病患，如有危險因子，如 1. 高血壓 2. 男性≧ 45 歲，女性≧ 55 歲或停經者 3. 有早發性冠心病家族史 (男性≦ 55 歲，女性≦ 65 歲) 4. HDL-C<40mg/dL 5. 吸菸。而今年九月美國國家脂質協會（NLA）也依據幾項危險因子而建議治療目標值，建議醫生和患者設定膽固醇的目標，著眼於患者的風險和危險因素，建議考慮到每個病人的獨特的醫療和個人的歷史，需要採取多方面的辦法來預防和治療帳號；那強大的病人提供商之間的關係是至關重要的，實現長期成功地預防心腦血管疾病。因此在極高風險患者如 ASCVD 及糖尿病患建議將 LDL-C 降至 70mg/dL 以下，其目標值與歐洲指南的血脂治療目標是一致的，而多重風險的病患其 LDL-C 均建議降至 100mg/dL 以下，其說明目前很多的實證醫學證據顯示積極的血脂控制能大幅降低心血管的風險。而血脂控制方面可由許多方法來安全地降低血液中的膽固醇，包括改進的飲食和鍛煉習慣和幾種藥物，已被證明，以減少在高風險的個體的心血管風險，且在史他汀類藥物有最支持的證據如 Rosuvastatin 於台灣上市有 5 毫克及 10 毫克，相較低的劑量而高效能就能達到血脂治療目標，根據 2008 年一項台灣本土性的研究顯示高風險病患這組，使用 Rosuvastatin 10 毫克其治療目標 LDL-C 100mg/dL 可達 80% 以上，這也呼應了血脂實證醫學證據顯示，積極的血脂控制能大幅降低心血管的風險的好處。

簡　　歷

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榮譽榜：

1996　Overseas Research Student's Awards (英國)
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1998, 2000　行政院國家科學委員會甲種研究獎
1999　青年醫師研究獎 (Young Investigator Award), (中華民國心臟學會)
2002　吳大猷先生紀念獎 (行政院國家科學委員會)
2011　傑出研究獎 (中華民國血脂及動脈硬化學會)

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7/1991~現在　台北馬偕紀念醫院心臟內科主治醫師
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7/2006~現在　台灣老人急重症基金會執行長
8/2006~現在　台北醫學大學兼任教授
10/2012~現在　中華民國血脂及動脈硬化學會秘書長
2/2011~現在　International Journal of Gerontology 主編
2/2012~現在　Biomarker Research 編輯委員
9/2008~現在　馬偕醫護管理專科學校董事

研究主題：

隙連結
血管醫學
心律不整之病生理
新穎診斷治療工具

研究成果：

已發表一百五十多篇研究論文於國際SCI醫學期刊，包括 Circulation, Circulation Research, ACS Nano, Arteriosclerosis,Thrombosis and Vascular Biology, Cardiovascular Research… 等。研究成果爲心臟學教科書 Braunwald's Heart Disease, the eighth and ninth edition 所引用。

A Comparison of Ezetimibe/Simvastatin versus Simvastatin Monotherapy on Cardiovascular Outcomes After Acute Coronary Syndromes: What is IMPROVE-IT Telling Us?

Yeh, Hung-I[1,2]

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The American Heart Association has announced that the trial will be presented by Chris Cannon on November 17 at 11:51 AM (central time) in Chicago at the group's annual scientific sessions. IMPROVE-IT compared the effect on cardiovascular outcomes of the statin simvastatin with Vytorin (the combination of simvastatin and ezetimibe, manufactured by Merck) in more than 18,000 patients with acute coronary syndromes.

Background: The IMProved Reduction of Outcomes: Vytorin Efficacy International Trial (IMPROVE-IT) is evaluating the potential benefit for reduction in major cardiovascular (CV) events from the addition of *ezetimibe* versus placebo to 40 mg/d of *simvastatin* therapy in patients who present with acute coronary syndromes and have low-density lipoprotein cholesterol (LDL-C) ≤125 mg/dL.

Methods: The primary composite end point is CV death, nonfatal myocardial infarction (MI), nonfatal stroke, rehospitalization for unstable angina (UA), and coronary revascularization (≥30 days postrandomization). The simvastatin monotherapy arm's LDL-C target is <70 mg/dL. *Ezetimibe* was assumed to further lower LDL-C by 15 mg/dL and produce an estimated ~8% to 9% treatment effect. The targeted number of events is 5,250.

Results: We enrolled 18,144 patients with either ST-segment elevation MI (STEMI, n = 5,192) or UA/non–ST-segment elevation MI (UA/NSTEMI, n = 12,952) from October 2005 to July 2010. Western Europe (40%) and North America (38%) were the leading enrolling regions. The STEMI cohort was younger and had a higher percentage of patients naive to lipid-lowering treatment compared with the UA/NSTEMI cohort. The UA/NSTEMI group had a higher prevalence of diabetes, hypertension, and prior MI. Median LDL-C at entry was 100 mg/dL for STEMI and 93 mg/dL for UA/NSTEMI patients.

Conclusions: This trial is evaluating LDL-C lowering beyond previously targeted LDL-C levels. The results depend on achieving the desired separation of LDL-C with *ezetimibe* and on the assumption that *ezetimibe's* lowering of LDL-C will have similar event reduction efficacy as the LDL-C lowering from a statin. The results could affect future therapies and guidelines.

IMPROVE-IT may have important implications beyond our understanding of ezetimibe. It is widely believed that the trial will provide a significant contribution to the debate about the reliability of surrogate endpoints in general and the independent importance of lowering LDL cholesterol in particular.

簡　　歷

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84年　國立陽明大學醫學系畢業
87年　中華民國內科專科醫師考試合格
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94年　中山醫學大學醫學研究所碩士
98年　中山醫學大學醫學研究所博士

經歷：

84-86年　嘉義榮民醫院內科住院醫師
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91年　台中榮民總醫院內分泌暨新陳代謝科主治醫師
91-93年　中山醫學大學附設醫院內分泌暨新陳代謝科主治醫師
98-99年　美國加州 Cedars-Sinai Medical Center 進修一年
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台中榮民總醫院內分泌暨新陳代謝科主治醫師
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Beyond Lipid Goal, What We Should Concern for Hyperlipidemia Patients?

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與全球的趨勢相似，心臟血管疾病仍是越沉重的社會負擔。心臟血管疾病主因爲動脈硬化 (atherosclerosis)，其中以冠狀動脈、腦血管、周邊血管影響最大，對糖尿病造成相當的罹病率、死亡率，也增加了許多醫療花費。根據過去許多大型研究，提供了許多新的治療原則與方針；而且可使用的治療藥物也比以前有更多選擇與更多優勢。因此正確地瞭解糖尿病病患的風險評估及治療目標，能提供我們更多的依據去預防心臟血管疾病。

膽固醇與其他危險因子的風險累積的評估治療是面對像糖尿病這類高風險病患所必須強調的。尤其低密度膽固醇的下降更應該注意。藥物治療方面，目前有數種有效的降血脂肪藥物。在大型治療性試驗中都發現 HMG CoA reductase inhibitor (statin) 藥物對預防心臟血管疾病效果明顯。近期治療原則與方針也偏向於使用 statin 藥物的探討。

針對預防心臟血管疾病的介入，亦須同時兼顧安全性，才能更掌握到治療時所必要注意的重點。除此之外，醫療團隊需要針對病患的需求，提供有關治療或修正心臟血管疾病危險因子的技巧、管道及訊息，建立適合的飲食、運動建議，適當藥物治療。設定及達成病患治療目標。

簡　　歷

基本資料：

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學歷：

June 1994	高雄醫學院 醫學士
Sep. 2010 ~ June 2012	中山醫學大學 醫學研究所 碩士班

經歷：

1994/7-1997/12	彰化基督教醫院內科部 住院醫師
1997/7-2000/11	彰化基督教醫院心臟內科臨床研究醫師
2000/12-迄今	彰化基督教醫院心臟內科主治醫師
2010/07-迄今	彰化基督教醫院心臟內科病房主任

專科學會：

中華民國 內科醫學會 會員

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Practical Consideration for the Use of Oral Anticoagulants in Patients with Atrial Fibrillation: An Asian Perspective

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經歷：

2010-現任　台北榮總心導管中心主任
2011-現任　國立陽明大學內科教授

榮譽：

1995　美國心臟學會青年醫師獎
1997　美國貝勒醫學院內科最佳論文獎
1999　國軍退除役官兵輔導委員會年度研究發展報告
「轉殖TGFβ接受器基因對小白鼠心臟之影響」特優獎
2000　榮民總醫院教學優良醫師獎
2008　血脂及動脈硬化學會最佳論文獎
2008　榮民總醫院教學優良醫師獎

專科學會：

2003-目前　中華民國血脂及動脈硬化學會常務理事
2014-目前　台灣介入性心臟血管醫學會常務理事暨甄審委員會主任委員
2012-目前　中華民國心臟學會監事暨介入心臟學委員會主任委員

Current Management of Familial Hypercholesterolemia

常敏之 醫師

Familial hypercholesterolemia (FH) is a genetic disorder of lipid metabolism that is characterized by a significant elevation in levels of low-density lipoprotein cholesterol (LDL-C), and premature coronary heart disease (CHD). The etiology of FH includes known mutations in the gene of the LDL receptor, *LDLR*; the gene of apolipoprotein B, *APOB*; and the proprotein convertase subtilisin/kexin type 9 gene, *PCSK9*. Diagnosis of FH relies on five criteria: family history, clinical history of premature CHD, physical examination for xanthomas and corneal arcus, very high LDL cholesterol on repeated measurements, and/or a causative mutation detected by molecular genetics. Early identification and aggressive treatment of FH in individual patients, as well as screening of all first-degree relatives, are recommended to minimize the risk for premature CHD. Patient should receive moderate to high intensity of statins as initial treatment, statin-based combination therapy, or adjunctive therapies. Furthermore, patients with FH who have additional risk factors for, or existing, cardiovascular disease or those with an inadequate response to initial statin therapy should have access to higher doses of the most efficacious statins; statins used in combination with other LDL-C-lowering agents should also be supported by formularies; additional treatments, such as LDL-C apheresis or novel therapies, may also be required to achieve acceptable LDL-C levels. Newer treatment approaches include lomitapide and mipomersen, which were approved by the FDA for patients with homogzygous FH. Other novel treatments currently in development include *PCSK9* inhibitors and cholesteryl ester transfer protein inhibitor. The efficacy and safety of these novel FH treatments await larger prospective clinical investigation.

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Glycemic Control: Balance between Glucose Lowering and CV Benefits

謝育整 醫師

近年來對於糖尿病治療的藥物研發有長足的進步，然而也有一些有爭議的地方，例如是否需將糖尿病病人的糖化血色素 (HbA1c) 積極地降到 6.5% 以下及糖尿病病人服用降血糖藥物是否會增加心血管事件等。流行病學的資料顯示，台灣地區糖尿病的盛行率逐年上升，目前約爲 6%，而在 40 歲以下以及 80 歲以上的族群其增加的幅度比其他年齡層顯著，至於發生率方面，在 40 歲以下的男性族群有顯著增加的趨勢。

糖尿病患者若血糖控制不佳，會引發大血管病變，例如缺血性心臟病、冠狀動脈疾病、急性冠心症、缺血性腦梗塞和周邊血管疾病等；以及小血管病變，包括視網膜病變、腎病變和神經相關病變等。心血管疾病是糖尿病患者最常見的死因[3]，相較於正常族群，會增加 2 到 4 倍的風險[4]，還有研究發現，有糖尿病但沒有過去心肌梗塞或冠狀動脈心臟病病史的病人，未來死於冠狀動脈心臟病的風險，並不小於先前有心肌梗塞或冠狀動脈心臟病病史但沒有糖尿病的病人，特別是在女性方面[5,6]。

另一方面來說，嚴格血糖控制，經由 DCCT/DEIT 研究證實，對於第一型糖尿病可以減少小血管病變的進展並且有持久效果；經由日本的 Kumamoto 研究以及英國的 UKPDS 研究也證實對第二型糖尿病有類似效果，稱之爲“延續效應”(legacy effect)，亦即所謂代謝記憶 (metabolic memory) 的效應。在大血管病變方面，嚴格血糖控制，經由 DCCT/DEIT 後續研究顯示在第一型糖尿病可以顯著減少心血管事件並具有“延續效應”；然而在第二型糖尿病方面，UKPDS 早期研究雖顯示不能顯著減少大血管病變，但後續長期追蹤研究顯示較佳的血糖控制仍然可以減少心血管事件以及心肌梗塞，不過隨後的 ACCORD, ADVANCE，以及 VADT 研究卻顯示嚴格血糖控制並不能顯著減少主要心血管事件，甚至可能因爲低血糖而造成死亡率的增加。至於在糖尿病的監控方面，HbA1c 提供了三個月平均血糖值的估計，每增加 1% 的 HbA1c 會加 18% 的心血管事件風險；而每減少 1% 的 HbA1c 會減少 14% 的心肌梗塞、21% 的糖尿病死亡以及 37% 的小血管併發症風險。但 HbA1c 正常並不能完全排除糖尿病或糖尿病前期 (Prediabetes)。從加拿大的整合分析的資料顯示，空腹血糖值與口服葡萄糖耐受試驗 2 小時血糖值，都是發生心血管風險的危險因子，而來自歐洲的 DECODE 研究也顯示[24,25]，口服葡萄糖耐受試驗 2 小時血糖值越高，死亡率越高，比空腹血糖值更能有效預測心血管疾病死亡率。日本的 Funagata 糖尿病研究顯示，葡萄糖耐受不良患者死於心血管疾病的風險較高，但空腹血糖值正常或偏高族群則相當；而國人的金山社區心臟血管疾病追蹤研究則顯示，空腹血糖值和口服葡萄糖耐受試驗 2 小時血糖值，均與心血管疾病有顯著相關且預測能力相當。

至今只有有限的研究顯示降血糖藥物能減少冠狀動脈疾病，其中最經典的研究是英國的 UKPDS 研究，使用雙胍類 (Biguanides) ，磺醯尿素類 (Sulfonylurea) 與胰島素 (Insulin) 在長期追蹤的研究中發現可降低心血管疾病發生率。新一代藥物中 Thiazolidinedione (TZD) 類衍生物在心血管疾病的角色最受爭議，上市後 Rosiglitazone 即因會伴隨增加心血管疾病而下市。阿爾發葡萄糖苷酶抑制劑 (α-glucosidase inhibitors) 對於心血管的臨床預後尚無一致性的結論，需要更多資料來佐證。DPP-4 抑制劑 (Dipeptidyl Peptidase-IV Inhibitors) 與第 1 型類昇糖素胜肽 (GLP-1) 是最近研發的藥物，近期小型的研究顯示 DPP-4 與 GLP-1 可能能夠改善一些心血管疾病的監測指標 (surrogate markers) 。近期 ACCORD 與 VADT 研究都不支持要將 HbA1c 降至 6.5% 以下，這些積極降血糖的研究都發現，病人心血管疾病沒下降，但低血糖的危險性與死亡率會上升。血糖控制應該以病人爲中心的方式 (A Patient-Centered Approach) ，著重個別化的治療 (individualization of treatment)；因此以心臟科醫師的立場處方降血糖藥物，就降低心血管疾病的目的來看，對高心血管風險或已經確診心血管疾病的糖尿病病人，採取傳統標準治療至 HbA1C < 7% 即可。藥物的建議使用仍然是以雙胍類爲首選，至於 DPP-4 抑制劑與 GLP-1 類對心血管疾病是否有所助益，可能須看未來幾年的研究而定了。

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The Importance of Home BP in Clinical Practice

Home BP Monitoring Using a Telemonitoring System is Effective for Controlling BP in a Remote Island in Japan.

夏建勳 醫師

ABSTRACT

The purpose of this study was to assess whether a home blood pressure (HBP) telemonitoring system could improve BP control and overcome the problems of HBP monitoring in a remote location. The authors enrolled 60 subjects and randomized them to either a Telemonitoring group or a Control group. The outcomes were changes in HBP level, adherence to HBP monitoring, and visual analog scale (VAS; score 0-100) as a measure of the motivation to perform HBP measurements. The reductions in morning systolic BP (-5.5±0.9 mm Hg vs 0.7±0.7 mm Hg, P<.001) and evening systolic BP (-4.6±1.0 mm Hg vs 1.0±1.1 mm Hg, P<.001) and the change in VAS (12.8±3.3 vs -1.6±2.2, P=.001) were significantly greater in the Telemonitoring group than in the Control group. The measure of the adherence to HBP monitoring tended to be better (P=.064) in the Telemonitoring group than in the Control group. These results indicate that an HBP telemonitoring system would be a beneficial healthcare measure in remote geographical locations.

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Current Treatment of Mixed Dyslipidemia

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ABSTRACT

Optimizing lipid profile remains a very critical strategy to improve clinical outcome in management of patients with mixed dyslipidemia. Low density lipoprotein-cholesterol (LDL-C) targeted therapy is strongly recommended by current guidelines for primary and secondary prevention of cardiovascular events. Statin therapy has been documented to effectively reduce LDL-C and improve cardiovascular outcome. On the other hand, the role of the non-statin lipid optimizing therapy alone or in combination on cardiovascular benefit remains inconsistent and needs to be clarified. The non-statin lipid optimizing agents are expected to additionally reduce residual cardiovascular risk and yield clinical benefit. A plenty of observational studies have established the association between the level of high-density lipoprotein-cholesterol (HDL-C) and cardiovascular risk. However, there is no interventional study so far to convincingly prove cardiovascular benefit in the new lipid optimizing agents, for example, cholesteryl ester transfer protein (CETP) inhibitors which dramatically augment the level of HDL-C but do not improve cardiovascular outcome. In addition, lowering level of triglyceride may not only provide potentially cardiovascular protection but also reduce the risk of biliary track disorder. Simply speaking, aggressive combination therapy for mixed dyslipidemia is the cornerstone to optimize lipid profile. This speech will provide remarkable results from a few reviews and original articles which investigate the association between clinical benefit and optimization of lipid profile.

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Comprehensive Lipid Management in T2DM

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Statin Induced Diabetes and Its Clinical Implications

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Extensive and consistent evidence supporting the use of statins for the prevention of ASCVD(atherosclerotic cardiovascular disease) in many higher risk primary and all secondary prevention individuals without NYHA class II-IV heart failure and who were not receiving hemodialysis. In the RCTs reviewed, initiation of moderate-intensity therapy (lowering LDL–C by approximately 30% to <50%), or high-intensity statin therapy (lowering LDL–C by approximately ≥50%), is a critical factor in reducing ASCVD events.

The increased risk of new-onset type 2 diabetes associated with statin treatment is now well established. Large metaanalyses of randomised controlled trials (RCTs) of statins have demonstrated increased risk of developing type 2 diabetes when statins are compared with placebo or standard care, and when more intensive statin reatment is compared with less intensive.

Nonetheless, one must remember that statins confer a substantial reduction in risk of cardiovascular disease (CVD) events in patients with and without established diabetes, so that the magnitude of CVD risk reduction for those eligible for statin treatment easily trumps any small increase in diabetes risk.

Statins are not the only class of drug used in CVD prevention that raises plasma glucose concentration. Thiazide diuretics, for example, are commonly prescribed to patients with diabetes and have been shown to cause hyperglycaemia, but the spotlight of negative publicity appears to have fallen disproportionately on statins. This is likely because of the overwhelming frequency with which statins are prescribed, and the growing concern among patients and physicians about their other adverse effects. The bad press seems imbalanced, however, given both the considerable benefits for individual population health that these drugs confer and their excellent safety record, particularly when compared with other widely prescribed drugs such as aspirin.

As mentioned above, no drug can be entirely free of adverse effects. However, the robustly demonstrated sizable benefits of statin treatment with minimal concomitant harm, and improved algorithms to handle statin intolerance should remain foremost in the minds of the clinician and the patient when they are considering using a statin.

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A Comparison of Ezetimibe/Simvastatin versus Simvastatin Monotherapy on Cardiovascular Outcomes After Acute Coronary Syndromes: What is IMPROVE-IT Telling Us?

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The American Heart Association has announced that the trial will be presented by Chris Cannon on November 17 at 11:51 AM (central time) in Chicago at the group's annual scientific sessions. IMPROVE-IT compared the effect on cardiovascular outcomes of the statin simvastatin with Vytorin (the combination of simvastatin and ezetimibe, manufactured by Merck) in more than 18,000 patients with acute coronary syndromes.

Background: The IMProved Reduction of Outcomes: Vytorin Efficacy International Trial (IMPROVE-IT) is evaluating the potential benefit for reduction in major cardiovascular (CV) events from the addition of *ezetimibe* versus placebo to 40 mg/d of *simvastatin* therapy in patients who present with acute coronary syndromes and have low-density lipoprotein cholesterol (LDL-C) ≤125 mg/dL.

Methods: The primary composite end point is CV death, nonfatal myocardial infarction (MI), nonfatal stroke, rehospitalization for unstable angina (UA), and coronary revascularization (≥30 days postrandomization). The simvastatin monotherapy arm's LDL-C target is <70 mg/dL. *Ezetimibe* was assumed to further lower LDL-C by 15 mg/dL and produce an estimated ~8% to 9% treatment effect. The targeted number of events is 5,250.

Results: We enrolled 18,144 patients with either ST-segment elevation MI (STEMI, n = 5,192) or UA/non–ST-segment elevation MI (UA/NSTEMI, n = 12,952) from October 2005 to July 2010. Western Europe (40%) and North America (38%) were the leading enrolling regions. The STEMI cohort was younger and had a higher percentage of patients naive to lipid-lowering treatment compared with the UA/NSTEMI cohort. The UA/NSTEMI group had a higher prevalence of diabetes, hypertension, and prior MI. Median LDL-C at entry was 100 mg/dL for STEMI and 93 mg/dL for UA/NSTEMI patients.

Conclusions: This trial is evaluating LDL-C lowering beyond previously targeted LDL-C levels. The results depend on achieving the desired separation of LDL-C with *ezetimibe* and on the assumption that *ezetimibe's* lowering of LDL-C will have similar event reduction efficacy as the LDL-C lowering from a statin. The results could affect future therapies and guidelines.

IMPROVE-IT may have important implications beyond our understanding of ezetimibe. It is widely believed that the trial will provide a significant contribution to the debate about the reliability of surrogate endpoints in general and the independent importance of lowering LDL cholesterol in particular.

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Current Diagnosis and Treatment of Familial Hypercholesterolemia

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Familial hypercholesterolemia (FH) is a genetic disorder of lipid metabolism that is characterized by a significant elevation in levels of low-density lipoprotein cholesterol (LDL-C), and patients are at very high risk for premature coronary heart disease (CHD). The etiology of FH includes known mutations in the gene of the LDL receptor, *LDLR*; the gene of apolipoprotein B, *apoB*; and the proprotein convertase subtilisin/kexin type 9 gene, *PCSK9*. Diagnosis of FH relies on five criteria: family history, clinical history of premature CHD, physical examination for xanthomas and corneal arcus, very high LDL cholesterol on repeated measurements, and/or a causative mutation detected by molecular genetics. Early identification and aggressive treatment of FH in individual patients, as well as screening of all first-degree relatives, are recommended to minimize the risk for premature CHD. Similar to patients with conventional hypercholesterolemia, patients with FH should receive statins as initial treatment, but patients with FH may require higher doses of statins, more potent statins, statin-based combination therapy, or adjunctive therapies. Patients with FH who have additional risk factors for, or existing, cardiovascular disease or those with an inadequate response to initial statin therapy should have access to higher doses of the most efficacious statins; statins used in combination with other LDL-C-lowering agents should also be supported by formularies; additional treatments, such as LDL-C apheresis or novel therapies, may also be required to achieve acceptable LDL-C levels. New treatment approaches include lomitapide and mipomersen, which were approved by the FDA approval for use in patients with homogzygous FH. Other novel treatments currently in development include *PCSK9* inhibitors and cholesteryl ester transfer protein inhibitor. The guidelines brought together leading experts in the FH Taiwan, we hope to convey the best information available for improving medical practice, for the prevention of premature CHD and finally relief to families affected by FH.

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2014	Visiting scholar in Preclinical Image Lab of Notre Dame University, IN, USA (Prof. Matthew Leevy)
2014	Visiting scholar in Ronglih Liao's Cardiomyopathy Research Lab, Brigham and Women's Hospital, MA, USA
2024	Visiting scholar in Onco-cardiology team in Memorial Sloan-Kettering Cancer Center of New York, USA (Prof. Richard Steingart)

POSITION:

2000-present	Physician of Cardiology, Internal Medicine in National Cheng Kung University Hospital, Tainan, Taiwan
2006-2008	Postdoctoral Fellowship: Vascular Medicine Research Labs
2010-present	Clinical Associate Professor of Internal Medicine, National Cheng Kung University
2013-present	Faculty of Institute of Clinical Medicine, National Cheng Kung University

EXPERIENCES:

2012-2014	中華民國心臟學會副秘書長
2012-2014	成功大學醫學院內科學科研究委員會主委
2010-2014	中華民國心臟學會雜誌執行編輯
2010-2012	中華民國心臟學會研究委員會委員

Practical Consideration for the Use of Oral Anticoagulants in Patients with Atrial Fibrillation: An Asian Perspective

劉秉彥 副教授

簡　　歷

姓名：林宗憲 教授

現職：

2001.8-　心臟血管內科主治醫師

2006.8-　高雄醫學大學醫學系助理教授

學歷：

1989-1996　高雄醫學大學醫學系

1999-2002　高雄醫學大學臨床醫學研究所碩士

2003-2007　高雄醫學大學臨床醫學研究所博士

經歷：

高雄醫學大學附設醫院實習醫師

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高雄醫學大學附設醫院心臟內科總住院醫師

高雄醫學大學附設醫院心臟血管內科主治醫師

專科執照與學會：

內科醫學會及內科專科醫師及指導醫師

心臟血管內科醫學會,心臟血管內科專科醫師及指導醫師

重症醫學會及重症專科醫師

介入性心臟血管醫學會

醫用超音波醫學會

專長：

高血壓、高血脂、心絞痛、心肌梗塞、心衰竭、心率不整

四肢動靜脈疾病診治、心臟及週邊血管超音波檢查、心導管及週邊血管介入性治療

Are Outcome Trials Needed for The Hypoglycemic Agents?

林宗憲 教授

簡　　歷

基本資料：

姓名：鄭正一 副教授

生日：9月21日

學歷：

民國79年9月至民國86年6月　高雄醫學大學醫學系畢業

民國97年9月至民國99年8月　哈佛大學進修研究

民國95年9月至民國101年6月　長庚大學臨床醫學研究所博士班畢業

工作經歷：

民國86年7月至民國89年6月　高雄長庚醫院內科住院醫師

民國90年8月至民國92年7月　高雄長庚醫院心臟內科研究員

民國92年8月迄今　高雄長庚醫院心臟內科主治醫師，現任副教授級主治醫師

民國101年8月　長庚大學醫學院兼任助理教授迄今

專業證照：

民國89年12月　中華民國內科專科醫師 (內專醫字第005655號)

民國93年1月　中華民國心臟學會專科醫師 (92)中心專醫字第013號

民國96年11月　中華民國心臟學會心臟血管介入治療專科醫師，第0306號

民國99年4月　中華民國心臟學會專科指導醫師 (99)中心專指醫字第009號

得獎：

民國97年　中華民國心臟學會最佳論文第二名

民國101年　中華民國心臟學會最佳青年研究獎第一名

專長：

冠狀動脈介入治療，血管生物學

The Importance of Home BP on Clinical Practice

Cheng-I Cheng M.D. Ph.D.
Division of Cardiology, Department of Internal Medicine
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The accurate assessment and appropriate management of blood pressure (BP) is critical for management of hypertension in patients. Traditional office-based BP measurement has limitations that can be addressed, in part, through the use of home BP monitoring. Because BP readings are provided at specific time intervals throughout a 24-hour period, ambulatory BP (ABPM) represents a better picture of the normal fluctuations in BP levels associated with daily activities, including sleep. Blood pressure values obtained by 24-hour ABPM are a better predictor of cardiovascular risk than office-based BP measurements, and the technique can be used to discern white-coat hypertension and to evaluate masked, resistant, and pseudoresistant hypertension.Because ABPM is not reimbursed by insurance in Taiwan, self-measurement of home BP is an alternative to assess pressure control outside clinic. 2012 TSOC hypertension treatment guidelines suggest that patients should measure blood pressure twice a day – before sleep at night and after wake-up in the morning. The target of BP control should be below 135/85 mmHg for general hypertensive patients. Although measurement of home BP by patients leads to better BP control, the impact on long-term clinical cardiovascular benefit is under investigation. Herein, we will discuss why we should measure home BP and how patient measure home BP correctly.

CURRICULUM VITAE

PERSONAL INFORMATION:

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Primary department: Cardiovascular Medicine/ Internal Medicine

CAREER APPOINTMENT:

Attending Physician

since 2007/7	Cardiovascular Medicine, Mackay Memorial Hospital (MMH)
2008/8-2011/6	Cardiac Care Unit, MMH
2010/4-2011/6 & 2012/8-	Special Clinic for Cardiac Implantable Electronic Devices (CIED), MMH
2013/7-	Senior consultant cardiologist, MMH

EDUCATION AND POSTGRADUATE TRAINING:

1995/9-2002/6	Bachelor of medicine: Chung Shan Medical University
2000/7-2001/6	Clerkship: Changhua Christian Hospital
2001/7-2002/6	Internship: National Taiwan University Hospital
2002/8-2005/6	Residency of internal medicine: MMH
2005/7-2007/6	Fellowship of cardiology: MMH
2007/7-2009/6	Fellowship of interventional electrophysiology: MMH
2008/8-2009/7	Fellowship of critical care medicine: MMH, Tamsui Branch
2009/9-2009/11	Observer Fellowship of CIED: Chang Gung Memorial Hospital
2011/7/11-2012/7/10	Research Fellowship of Cardiovascular Diseases: Mayo Clinic, Rochester, MN, USA

BOARD CERTIFICATION:

’05-	Board of Internal Medicine
’06-‘12	Board of Geriatric Emergency and Critical Medicine
’07-	Board of Adult Cardiology
’08-	Board of Interventional Cardiology
’08-	Board of Ultrasonography in Cardiovascular System
’09-	Board of Cardiac Electrophysiology and Interventions
’09-	Board of Critical Care Medicine

Role of RHYTHM CONTROL in AF Management

李應湘 醫師

CURRICULUM VITAE

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CURRENT POSITION:

2014-present Attending Physician, Division of Cardiology, Department of Internal Medicine, National Taiwan University Hospital
2014-present Attending Physician, Telehealth Center, National Taiwan University Hospital
2011-present Adjunct Attending Physician, Department of Laboratory Medicine, National Taiwan University Hospital
2011-present Adjunct Lecturer, Department of Laboratory Medicine, National Taiwan University College of Medicine

EDUCATION:

2009-present PH.D. student, Group of Biomedical Electronics, Graduate Institute of Biomedical Electronics and Bioinformatics, College of Electrical Engineering & Computer Science, National Taiwan University
1996-2003 M.D., Department of Medicine, College of Medicine, National Taiwan University

WORKING EXPERIENCE:

2011-2014 Attending Physician, Department of Clinical Pathology, Far Eastern Memorial Hospital
2011-2014 Attending Physician, Division of Cardiology, Cardiovascular Center, Far Eastern Memorial Hospital
2008-2011 Resident, Department of Laboratory Medicine, National Taiwan University Hospital
2006-2008 Fellow, Division of Cardiology, Department of Internal medicine, National Taiwan University Hospital
2003-2008 Resident, Department of Internal Medicine, National Taiwan University Hospital

LICENSURES & CERTIFICATES:

2010-present Certificate of Intensivist
2010-present Certificate of Clinical Pathologist
2009-present Certificate of Interventional Cardiologist
2008-present Certificate of Adult Cardiologist
2006-present Certificate of Internist
2003-present Certificate of Physician

How Can We Improve ACS Care Based on Latest Evidence?

Jen-Kuang, Lee

Antiplatelet therapy prevents thrombotic events in patients with acute coronary syndrome; however, the ischemic benefits come at the price of bleeding. Determining who may benefit from more potent $P2Y_{12}$ inhibition is not straightforward. Clinical and genetic factors influence response, and the utility of testing platelet function or genomics remains an area of debate, as does the optimal duration of dual antiplatelet therapy in patients with coronary stents. The options for antithrombotic therapy in patients presenting with acute coronary syndromes are myriad. The treatment armamentarium has expanded in recent years to include oral antiplatelet agents. Patients may benefit from this array of treatments but only if they are incorporated into clinical practice and applied appropriately. Recently, updated guidelines for STE- or Non-ST ACS have been published and it provides more evidence and suggestion for healthcare professionals to adhere.

簡　　歷

姓名：林宗憲 教授

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內科醫學會及內科專科醫師及指導醫師

心臟血管內科醫學會,心臟血管內科專科醫師及指導醫師

重症醫學會及重症專科醫師

介入性心臟血管醫學會

醫用超音波醫學會

專長：

高血壓、高血脂、心絞痛、心肌梗塞、心衰竭、心率不整

四肢動靜脈疾病診治、心臟及週邊血管超音波檢查、心導管及週邊血管介入性治療

Debate - FIIa Antagonist

林宗憲 教授

簡　　歷

姓名：李貽恆 教授

現職：
國立成功大學醫學院附設醫院心臟內科主治醫師
國立成功大學醫學院內科學科教授

學歷：
09/1981~ 06/1988　高雄醫學大學醫學系醫學士
09/1996~06/2000　國立成功大學醫學院基礎醫學研究所博士

經歷：
1990 年 9 月至 1995 年 8 月　國立台灣大學醫學院附設醫院內科部住院醫師
1995 年 8 月至 1996 年 8 月　國立成功大學醫學院附設醫院內科部主治醫師
1996 年 8 月至 2000 年 8 月　國立成功大學醫學系內科學科講師
2000 年 8 月至 2008 年 8 月　國立成功大學醫學系內科學科副教授
2008 年 8 月迄今　國立成功大學醫學系內科學科教授
中華民國心臟學會副秘書長
中華民國血脂及動脈硬化學會理事

研究主題：
動脈硬化的病態生理學
高血壓、高脂血症、冠狀動脈心臟病的分子遺傳研究
血管生物學

研究成果：
已發表七十多篇研究論文於國際 SCI 醫學期刊，包括 *Journal of the American College of Cardiology, European Heart Journal, Cardiovascular Research, Chest, American Journal of Cardiology, Thrombosis and Haemostasis* 等

Debate - FXa Antagonist

李貽恆 教授

簡　　歷

基本資料：

姓名：賴史明 主任

科別：內分泌糖尿病科

職稱：主治醫師

主治專長：

內分泌新陳代謝科疾病

病症參考：

糖尿病、甲狀腺疾病、高脂血症、其他內分泌疾病

現職：

新光吳火獅紀念醫院內分泌糖尿病科主治醫師

學歷：

1983年　　國立台灣大學醫學系畢業

1983年　　考試院高等考試優等及格

經歷：

1985-1988　台大醫院內科住院醫師

1988-1990　台大醫院內分泌新陳代謝科總住院醫師

1990-2000　台大醫院內科兼任主治醫師

1990-1992　羅東博愛醫院新陳代謝科暨實驗診斷科主任

1992-2005　新光吳火獅紀念醫院內分泌糖尿病科主任

2005-　　新光吳火獅紀念醫院內分泌糖尿病科主治醫師

1999-　　行政院衛生福利部全民健康保險爭議審議委員會醫療審查醫師

中華民國內科專科醫師甄審資格審查小組委員

專科證書：

中華民國內科專科醫師

中華民國內分泌新陳代謝科專科醫師

榮譽事蹟：

(一) 兩度獲選爲新光醫院內科部教學演講最佳講員

(二) 審訂譯作：

1. 糖尿病預防與治療 (輕舟出版社)
2. 糖尿病 Q&A (世茂出版社)
3. 血糖完全控制的最新療法 (新自然主義/幸福綠光股份有限公司)
4. 三酸甘油酯完全控制的最新療法 (新自然主義/幸福綠光股份有限公司)

Current Management of Mixed Dyslipidemia

賴史明 主任

在臨床上肥胖、代謝症候群、糖尿病患者經常併有混合型血脂異常，他們的血脂指標中總膽固醇 (TC)、低密度膽固醇 (LDL-C) 及三酸甘油脂 (TG) 偏高，而高密度膽固醇 (HDL-C) 偏低，針對這類病患，治療上有許多用藥選擇。其中 statins 類藥物治療主要是減少 LDL-C，無法有效改善 HDL-C、TG、non-HDL-C、ApoB 等目標，僅能降低有限的心血管風險，殘留的風險 (residual risk) 仍然存在。

爲了進一步改善殘留風險，除了考慮併用 fibrate 或 niacin 類藥物，陸續有藥物針對提升 HDL-C 的品質或數量，或 ApoA-I 等蛋白表現。目前這些非 statin 類藥物臨床研究結果具爭議，引發我們思考這類藥物是否能有效改善心血管事件的風險。在 2013 年加拿大 Clinical Practice Guideline、2014 年美國 ADA guideline 與 IAS guideline，仍持續肯定併用治療之臨床角色。

每日臨床工作中，該如何治療血脂異常病患？我們需要多方參考血脂治療指引與臨床文獻，評估合適且務實的臨床準則。

CURRICULUM VITAE

PERSONAL INFORMATION

Name: 邱昱偉 醫師（Chiu, Yu-Wei, M.D.）
Sex: Male
Date of Birth: January 28
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EDUCATION:

1999	Medical College, National Taiwan University, Taipei, Taiwan
2014	PhD of College of Medicine, Graduate Institute of Clinical Medicine, National Taiwan University, Taipei, Taiwan

MAJOR WORK:

1999-7-1-2002-6-30	Resident Physician, Department of Internal Medicine, National Taiwan University Hospital, Taipei
2002-7-1-2004-6-30	Fellowship training in Division of Cardiology, Department of Internal Medicine, National Taiwan University Hospital, Taipei
Since 2004-7	Attending Physician, Section of Cardiology, Cardiovascular Center, Far Eastern Memorial Hospital
2011-1-2013-9	Clinical Instructor, Far Eastern Memorial Hospital
Since 2013-9	Assistant Professor, Far Eastern Memorial Hospital and Yuan Zi University

BOARD OF CERTIFICATE:

1999	General License of Physician
2002	Specialist of Internal Medicine
2004	Specialist of Cardiology
2006	Specialist of Critical Care Medicine
2007	Specialist of Interventional Cardiology

Comprehensive Lipid Management in T2DM

邱昱偉 醫師

簡　　歷

姓名：葉宏一 教授

學歷：

09/1979 ~ 06/1986　台北醫學院醫學系 醫學士
10/1994 ~ 09/1997　英國倫敦帝國大學 (Imperial College London) 博士

榮譽榜：

1996　Overseas Research Student's Awards (英國)
1997　Professor Guy Scadding Prize for Outstanding PhD Thesis (英國)
1998, 2000　行政院國家科學委員會甲種研究獎
1999　青年醫師研究獎 (Young Investigator Award), (中華民國心臟學會)
2002　吳大猷先生紀念獎 (行政院國家科學委員會)
2011　傑出研究獎 (中華民國血脂及動脈硬化學會)

現職：

8/2009~現在　馬偕醫學院醫學系教授兼主任
7/1991~現在　台北馬偕紀念醫院心臟內科主治醫師
2/2011~現在　台灣老人急重症醫學會理事
5/2012~現在　中華民國心臟學會雜誌副主編
7/2006~現在　台灣老人急重症基金會執行長
8/2006~現在　台北醫學大學兼任教授
10/2012~現在　中華民國血脂及動脈硬化學會秘書長
2/2011~現在　International Journal of Gerontology 主編
2/2012~現在　Biomarker Research 編輯委員
9/2008~現在　馬偕醫護管理專科學校董事

研究主題：

隙連結
血管醫學
心律不整之病生理
新穎診斷治療工具

研究成果：

已發表一百五十多篇研究論文於國際SCI醫學期刊，包括 Circulation, Circulation Research, ACS Nano, Arteriosclerosis,Thrombosis and Vascular Biology, Cardiovascular Research…等。研究成果爲心臟學教科書 Braunwald's Heart Disease, the eighth and ninth edition 所引用。

A Comparison of Ezetimibe/Simvastatin versus Simvastatin Monotherapy on Cardiovascular Outcomes After Acute Coronary Syndromes: What is IMPROVE-IT Telling Us?

Yeh, Hung-I[1,2]

[1]*Division of Cardiology, Department of Internal Medicine, Mackay Memorial Hospital, Taipei, Taiwan*
[2]*Mackay Medical College, New Taipei City, Taiwan*

The American Heart Association has announced that the trial will be presented by Chris Cannon on November 17 at 11:51 AM (central time) in Chicago at the group's annual scientific sessions. IMPROVE-IT compared the effect on cardiovascular outcomes of the statin simvastatin with Vytorin (the combination of simvastatin and ezetimibe, manufactured by Merck) in more than 18,000 patients with acute coronary syndromes.

Background: The IMProved Reduction of Outcomes: Vytorin Efficacy International Trial (IMPROVE-IT) is evaluating the potential benefit for reduction in major cardiovascular (CV) events from the addition of *ezetimibe* versus placebo to 40 mg/d of *simvastatin* therapy in patients who present with acute coronary syndromes and have low-density lipoprotein cholesterol (LDL-C) ≤125 mg/dL.

Methods: The primary composite end point is CV death, nonfatal myocardial infarction (MI), nonfatal stroke, rehospitalization for unstable angina (UA), and coronary revascularization (≥30 days postrandomization). The simvastatin monotherapy arm's LDL-C target is <70 mg/dL. *Ezetimibe* was assumed to further lower LDL-C by 15 mg/dL and produce an estimated ~8% to 9% treatment effect. The targeted number of events is 5,250.

Results: We enrolled 18,144 patients with either ST-segment elevation MI (STEMI, n = 5,192) or UA/non–ST-segment elevation MI (UA/NSTEMI, n = 12,952) from October 2005 to July 2010. Western Europe (40%) and North America (38%) were the leading enrolling regions. The STEMI cohort was younger and had a higher percentage of patients naive to lipid-lowering treatment compared with the UA/NSTEMI cohort. The UA/NSTEMI group had a higher prevalence of diabetes, hypertension, and prior MI. Median LDL-C at entry was 100 mg/dL for STEMI and 93 mg/dL for UA/NSTEMI patients.

Conclusions: This trial is evaluating LDL-C lowering beyond previously targeted LDL-C levels. The results depend on achieving the desired separation of LDL-C with *ezetimibe* and on the assumption that *ezetimibe's* lowering of LDL-C will have similar event reduction efficacy as the LDL-C lowering from a statin. The results could affect future therapies and guidelines.

IMPROVE-IT may have important implications beyond our understanding of ezetimibe. It is widely believed that the trial will provide a significant contribution to the debate about the reliability of surrogate endpoints in general and the independent importance of lowering LDL cholesterol in particular.

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POSTGRADUATE TRAINING:

Residencies:

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Fellowship:

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Attending & Administration:

1995-1997 Department of Internal Medicine, National Taiwan University Hospital
1996-2010 Department of Internal Medicine, National Taiwan University Hospital, Taiwan (Adjunct staff)
2001-2010 Chief of Endocrine and Metabolism, Far-Eastern Memorial Hospital (FEMH)
2006-2010 Chief of Department of Internal Medicine, FEMH
2007-2008 Chief of Center of Faculty Development (CFD), FEMH
2008-2010 Chief, Clinical Trial Center (CTC), FEMH

CURRENT POSITION:

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What are Optimal Treatment Targets for Dyslipidemia in Clinical Setting?

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Many large, randomized, controlled trials have proved that cholesterol-lowering therapy with 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors (statins) reduces the risk of mortality and/or cardiovascular events across a wide and various range of cholesterol levels whether patients have a history of coronary artery disease or not. That means that lipid-lowering therapy with statins reduces the risk of cardiovascular events. However, the optimal level of low-density lipoprotein (LDL) cholesterol is in debate. In previous comparison of two statin regimens of different lipid-lowering intensities for the prevention of cardiovascular events, intensive therapy with high-dose satins resulted in a median LDL cholesterol level of up to 62 mg/dl, as compared with a level of 95 mg/dl for standard-dose statins. The more intensive therapy had resulted in a much lower risk of mortality from any cause or major cardiac events than that did a moderate level of lipid lowering with the use of a standard dose of statins. We always could find more intensive lipid lowering significantly increased this clinical benefit for patients with hyperlipidemia and potentially cardiovascular disease. Previous reports indicated that intensive therapy with statins got a persistent beneficial effect on cardiac events due to lower LDL-cholesterol levels with a significant reduction in the risk of recurrent unstable angina and the need for revascularization. The reduction in clinical cardiac events with the more intensive lipid-lowering therapy was prominent as early as less than one month after the start of lipid-lowering therapy. It is very important to note that the safety and efficacy results were reported and monitored in various study population. We may even suggest that after once acute coronary syndrome in both diabetics and non-diabetics, the target LDL cholesterol level should be lower and concerned.

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Statin Induced Diabetes and Its Clinical Implications

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ABSTRACT

Recently, there are major changes focusing on the management of high blood cholesterol. First, the regulation of Taiwan National Health Insurance Bureau (TNHIB) has been adjusted. Doctors could prescribe statins under the coverage of health insurance for documented cardiovascular disease patients as long as their blood low density lipoprotein (LDL) level exceeded 100 mg/dL. The regulation were mainly changed according to the National Cholesterol Education Program released its Adult Treatment Panel III report in 2002. However, on November 12, 2013, updated guidelines for the treatment of high blood cholesterol levels were released by the American College of Cardiology–American Heart Association (ACC-AHA) Task Force on Practice Guidelines. Using the new approach, the expert panel identified four subgroups of patients for whom the benefit of statins clearly outweighs the risk. These groups are patients with 1. Clinically evident atherosclerotic cardiovascular disease, 2. Primary LDL cholesterol levels of at least 190 mg per deciliter, 3. Type 1 or type 2 diabetes and an LDL cholesterol level of 70 mg per deciliter or higher, or 4. a 10-year risk of atherosclerotic cardiovascular disease of at least 7.5%, according to the new, publicly available, pooled cohort equations, and an LDL cholesterol level of at least 70 mg per deciliter. The key points of the new guideline mainly eliminate of routine assessments of LDL cholesterol levels in patients receiving statin therapy, because target levels are no longer emphasized and the strategy of "the lower the better" is now doubtful. However, current guidelines also emphasize the importance of drug safety. In our current discussion, we are going to discuss how to improve statin therapy according to the revision of guidelines and TNHIB regulations. We will also discuss the benefit of pitavastatin, a statin which will not influence glucose metabolism and greatly reduced LDL level in the same time. We will also discuss about how this statin can reduce the occurrence of type 2 DM which is different from our traditional idea about statin use.

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The Importance of Home BP in Clinical Practice

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Hypertension is the most common risk for cardiovascular diseases. Although the availability of blood pressure (BP) lowering medications and public education, the control rate of hypertension is still poor. Self-measurement of BP at home offers specific advantages over conventional clinic measurement because it allows identifying patients with white-coat, masked, and sustained hypertension with readings taken under standardized home conditions, little measurement variability, and good reproducibility.

Home BP monitoring (HBPM) has emerged as a means of improving diagnostic accuracy, risk stratification, patient adherence, and therapeutic interventions. The definition of HBPM is an average of blood pressure >135/85 mmHg. HBPM is appealing to most patients. It can lead to better BP control by increasing awareness of hypertension and adherence to and persistence of drug treatment. HBPM may have greater prognostic value for risk of cardiovascular event than office BP. HBPM offers more extensive data than office BP measurement can provide, is less expensive, is widely available and convenient, and has been shown to improve patient compliance with treatment and BP control.

Home BP measurement is currently widely available to the general public because of the availability of affordable and reliably operating automatic devices. The importance of HBPM for comprehensive diagnosis of hypertensive conditions, patient risk stratification, and appropriate treatment selection should be more widely acknowledged and utilized.

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Glycemic Control: Balance between Glucose Lowering and CV Benefits

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ABSTRACT

The introduction of Incretin-based therapies represents a novel therapeutic strategy, since these drugs not only improve glycemia with minimal risk of hypoglycemia, but are also supposed to have other extraglycemic beneficial effects. These agents, which are effective in improving glucose control, could also have positive effects on the incidence of cardiovascular events. The aim of this lecture is to review the present literature about the updated concept of glycemia control in patients with diabetes mellitus, and also discuss the possible role of dipeptidyl peptidase 4 (DPP4) in cardiovascular districts, not only strictly correlated to its effect on glucagon-like peptide-1 (GLP-1) circulating levels, but also to what is known about possible cardiovascular actions. Certainly, DPP4 seems to exert many functions, both directly and indirectly, on cardiovascular districts, opening new possibilities of prevention and treatment of complications at this level, not only in patients affected by diabetes mellitus.

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New Armamentarium in T2DM Treatment: SGLT2 Inhibitor

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Type 2 diabetes is a complex multifactorial disease with multiple chronic complications, especially cardiovascular disease. Epidemiological studies and preliminary intervention studies have shown that fluctuated postprandial hyperglycemia is a direct and independent risk factor for cardiovascular disease. In fact, combined therapies with current different class of antihyperglycemic drugs still fail to achieve the target of HbA1c lower than 6.5% in the majority of diabetic patients. Risk of hypoglycemia and side effects of medications, such as edema and body weight gain, all impact the drug adherence. The ADA and EASD Position Statement has also emphasized the importance of tailoring regimens in the individual diabetic patients. Traditional antihyperglycemic therapies have very much focus on insulin resistance and inadequate insulin secretion. With the benefit of lesser episodes of hypoglycemia and no body weight gain, the role of incretin-based therapies including both DDP-4 inhibitors and GLP-1 receptor analogues are highly expected. Moreover, the blockade of glucose reabsorption from the proximal renal tubules, by target on sodium glucose cotransporter-2, has been recognized as a safe target of new therapy for type 2 diabetes. In this talk, I will overview the recent guidelines with regard to the management of type 2 diabetes. I will consider the variability in different classes of drugs, both in their ability to lower HbA1c but also their effects on hypoglycaemia, weight and risk benefit profile. In particular, I will focus on the contribution of the new class of SGLT-2 inhibitors to the treatment paradigm.