The first large national cardiology meeting I attended was the American Heart Association Scientific Sessions in 1973. I was awed with the content and spectacle of the convention. Over the years, these national (and now international) meetings have evolved both for better and for worse.

The major cardiology meetings continue to be stunning in breadth of subject matter and depth of expertise. They bring together at one place and time almost all the leading authorities and pioneering researchers in nearly every area of cardiovascular medicine. Important research findings are presented by the responsible investigators to their peers. State-of-the-Art reviews of every facet of cardiovascular disease are presented at levels appropriate for experts and for novices. The material is presented in multiple formats to accommodate the varying preferences of the attendees.

The medical presentations are accompanied by an all-encompassing industrial exhibit. Equipment for invasive and noninvasive procedures, the entire spectrum of pharmacologic agents, and medical textbooks and journals are all on display. It provides the ideal venue for those about to purchase equipment and those seeking to keep up with new technology. The industrial exhibits also provide much of the spectacle of the meeting. The glitz of the booths, the visuals presented on boards and screens, the countless company representatives eager to discuss every facet of their products all contribute to the sense of a space-age medical bazaar.

As cardiovascular medicine and surgery have grown, so has the size of the major meetings, somewhat to the detriment of the program. It used to be possible to move between sessions in different rooms, even between individual abstracts. The meetings are now so large and spread out that you need to be well conditioned just to get from one end of the convention to the other. With rare exception, it is usually easier to choose a session and remain in the room the entire time. This can be frustrating since there are so many important and interesting sessions occurring simultaneously. The meetings used to provide an opportunity to catch up with colleagues and see old friends. You can no longer rely on bumping into people in the hall. The crowds and the distances at the meetings have made them feel more impersonal.

Another change in the national meetings has been the increasing emphasis on public relations. Tabloids are distributed on a daily basis extolling the important presentations which have been made and highlighting those which are to come. Television monitors present this same information in the hallways of the convention center and in our hotel rooms, and once even in the buses that transported us. The findings presented at the meeting receive prominent coverage in the national press and television. As one of my colleagues remarked “the meetings are like one big press conference.” It is easy to get the impression that receiving media attention has now become one of the principle goals of the meeting and one of the major criteria of success for the participants.

The prominence of media highlights is expressed to some degree in the phenomenon of Late-Breaking Clinical Trials (LBCTs). No one could argue with the fact that promptly releasing data that could impact clinical care is preferable to waiting months before the next major meeting. However, LBCTs seem to have taken on a life of their own. The designation of “late-breaking” has come to convey a sense of importance and credibility in and of itself. The trials that are presented receive prominent media coverage. Prestigious journals jockey to obtain submission of LBCT manuscripts, with letters of solicitation and direct contacts from the editorial office offering special expedited processing. The epitome of the achievement for late-breaking phenomenon is simultaneous publication (in print or online) at the time of presentation. Given the attention and importance accorded to these trials, one wonders if investigators might not be incented to time completion of their analysis just so that it can be designated as “late-breaking.”

There are several aspects of the late-breaking phenomenon that raise concern. Given that the results of LBCTs are generally not known at the time they are selected for presentation, it is not surprising that the findings neither are always definitive nor provide the basis to alter clinical care. (For this year’s American College of Cardiology meeting, abstracts received in January were required to provide a strong promissory note that the results would be available, but not the results themselves). Therefore, the data presented may be preliminary or incomplete. However, the preliminary nature of the findings is frequently lost in the fanfare surrounding the presentation, and results are often disseminated online and in the media with an air of finality. Second, even when the data analysis is complete, the process of external peer review has not occurred. Clearly, peer
review is important not only in assuring accuracy, but also in enhancing the analysis and presentation of the data. As a final concern, expedited analysis and review may not provide sufficient time to identify all of the issues, nuances, and implications of the data by either the authors or the reviewers. The Letters to the Editor section offers evidence of issues identified even after the findings appear in print. In sum, LBCTs carry the danger of presenting preliminary results with the aura of great importance and credibility, and disseminating them widely to the profession and the public in the absence of standard peer-review scrutiny.

Several steps would seem to be in order to avoid the potential dangers of LBCTs. First, investigators should be prohibited from presenting preliminary data, even if it requires withdrawing the presentation from the program. Second, transmission of findings to the profession and public should be done cautiously and with emphasis on the lack of a full peer-review. The release of the text and graphics of the presentation conveys a finality that usually does not exist. Third, it is my opinion that the medical and non-medical community would usually be better served by avoiding a rush to publication and allowing some time for reflection by the authors, reviewers, and cardiovascular community in general. Finally, it seems to me that we would do well to rethink the emphasis and exposure given to LBCTs by our major meetings.

I have not missed attending a national meeting since 1973, and with any luck I will not miss any in the foreseeable future. For all of their imperfections, they provide something unavailable in any other venue. In terms of the national meeting itself, its limitations (size, impersonality, glitz) appear to be inextricably linked to its unique values (diversity, expertise, exposure to products). I guess you have to take the good with the bad. However, I do believe it would serve us well to temper the emphasis on the media and press conferences. Regarding LBCTs, it is my view that we are on a problematic course. I urge the major cardiology societies to seriously consider the refinements suggested within this paper. The potential impact of important clinical trials on patient care is too great to risk for an exaggerated sense of significance and urgency.

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