

Updates in STEMI Management

In January 2008, restructured guidelines for the treatment of acute ST-elevation myocardial infarction (STEMI) reinforced the vital nature of reducing ischemia time via reperfusion.

The new guiding principles, published in the *Journal of the American College of Cardiology* and the American Heart Association's *Circulation*, named primary percutaneous coronary intervention (PCI) as the preferred method of restoring blood flow in STEMI patients and sanctioned a door-to-balloon maximum of 90 minutes from EMS arrival as the gold standard. When rescue PCI is not feasible within 90 minutes and there are no contraindications, the recommended action is fibrinolytic therapy

administered within 30 minutes of EMS arrival or patient self-transport to an emergency department.

"Any measures that can be taken to shorten the time between STEMI and revascularization in a cardiac catheterization lab are beneficial," says Stephen Mester, MD, cardiologist, Brandon Regional Hospital. "An environment fostering teamwork is fundamental to accomplishing recommended D2B times. In addition, technology has evolved to accommodate transmission of EKGs from emergency transport personnel in the field to the hospital by means of Bluetooth technology, saving valuable time before the patient even arrives at the facility. With the continued advancement of technological developments, such options will be attainable at more and more facilities in the future."

DRUG THERAPIES

New recommendations advocate anticoagulation therapy be administered for at least 48 hours after thrombolytics, and in some cases, during inpatient care. Guidelines specify usage recommendations for unfractionated heparin (UFH), enoxaparin, bivalirudin, and fondaparinux. Morphine sulfate is recommended for pain management in STEMI patients.

Additionally, due to an increased risk of subsequent infarction, hypertension, heart failure, myocardial rupture, and mortality, the new guidelines advocate that patients presenting with STEMI who are on regimens of (1) NSAIDs

(aspirin excluded) and (2) nonselective and selective COX-2 agents should suspend use of these medications.

The guidelines also recommend that:

- patients who do not show signs of heart failure, low output state, increased risk for cardiogenic shock, nor contraindications to beta blockers receive beta blockers within 24 hours
- beta blockers be used as a secondary prevention in patients with early contraindications within the first 24 hours of STEMI
- beta blocker therapy be administered to patients with moderate or severe left ventricular failure

THE POWER OF PREVENTION

While following STEMI treatment guidelines has been proven to greatly enhance outcomes, the first line of defense against STEMI involves proactive primary care. Continual monitoring of patient health and identification of STEMI risk factors are essential, and primary care physicians are perfectly positioned to impart this information and provide screening.

"It's always better to avert STEMI rather than to have to manage it," says Dr. Mester. "Assessing the risk of patients in a primary care setting, including the management of weight and diabetes, and encouraging patients to employ healthy lifestyle choices can aid in prolonging the onset of STEMI events."

For more information or to refer a patient, please contact the Heart & Vascular Center at Brandon Regional Hospital by calling (813) 571-5108 or visit www.brandonhospital.com.



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Contributing Factors to Postoperative Mitral Valve Repair Success



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When compared to mitral valve replacement, valve repair procedures for mitral regurgitation (MR) provide the advantage of less morbidity and mortality perioperatively, mitral vascular-ventricular apparatus preservation, increased ventricular function maintenance, no long-term reliance on anticoagulation medications, increased durability, and a decreased need for a second procedure.

Due to the significant, progressive nature of severe mitral valve regurgitation and an association with poor outcomes, particularly a marked incidence of premature death; heart failure; decreased rate of 10-year survival; and an increase in sudden death, the American College of Cardiology and the American Heart Association now recommend that even asymptomatic patients with MR undergo corrective surgery.

“Not so long ago, mitral valve surgery used to be a ‘wait-and-see’ procedure,” says Brad Bufkin, MD, cardiothoracic surgeon, Brandon Regional Hospital. “Today, cardiologists recognize the severity of MR and are recommending valve repair surgery sooner and for more patients.”

Typically, prompt surgery provides patients with more significantly improved survival than with other medical treatment and later surgical intervention. Approximately 40,000 Americans now undergo mitral valve replacement or repair annually, with the majority of these procedures

performed on an arrested heart with cardiopulmonary bypass.

INNOVATIONS IN SAFETY AND IMAGING

Advancements in myocardial protection during cardiopulmonary bypass and intraoperative echocardiography have enhanced the surgeon’s capabilities for corrective mitral valve surgery, and transesophageal and epicardial echocardiography now make it possible for the surgeon to optimize results. While mitral valve repair is still considered one of the more challenging cardiac procedures, the transference of operative information to the surgical team in real time makes it possible for surgeons to analyze the physiological abnormality of the underlying valve structure, the functioning mechanism, and the pathologic process, and then use this information as an intraoperative safety net.

“With careful study of the multidimensional anatomy of the mitral valve using these

techniques, the surgeon has a better understanding of the relationships between the two leaflets and the subvalvular mitral apparatus,” Dr. Bufkin says. “All this information goes into a platform approach to the mitral valve, which is specific for each patient.”

The first step of mitral valve surgery is good exposure of the mitral valve, which today can involve minimally invasive techniques that might include a mini right thoracotomy approach, a lower mini sternotomy, or a xiphoid approach. Once the mitral valve has been exposed, a restoration of the normal anatomy is performed that involves minimal primary excision until the surgeon can assess all of the interrelationships of the tissue.

“When this is complete, my preference is to place the sutures before excision, as this gives the same overall architecture that would be present at the end of the procedure,” Dr. Bufkin says. “The limited but necessary valvular excision and the valvuloplasty of the posterior leaflet are performed either with or without cordal surgery.”

The valve is tested before a ring is placed to ensure the restoration of coaptation is complete.

POSTOPERATIVE COMPLICATIONS

While mitral valve repair has good long-term results, the procedure may be associated with several relatively rare complications that the surgeon must take steps to avoid:

- Obstruction of the left ventricle overflow can develop.
- The posterior leaflet remains too long postoperatively and causes the anterior leaflet to push in to the left ventricular outflow tract, which can be exacerbated by hypercontractility or hypovolemia.
- Persistent mitral regurgitation can occur if the leaflets in the left

ventricular space fail to coapt effectively.

- Mitral stenosis can develop following mitral valve repair if too small a ring is placed, which may require a full valve replacement to repair the condition.

“The overall complication rate of concomitant mitral surgery with another procedure is no greater than conventional cardiac surgery alone,” Dr. Bufkin says. “However, according to the Society of Thoracic Surgeons’ database, mitral valve replacement has a marginally higher rate of morbidity and mortality than mitral valve repair.”

SURGERY OF THE FUTURE

Technological advances will make it possible for more surgeons to perform mitral valve surgery and allow for the adoption of additional minimally invasive techniques. More importantly, however, is the larger opportunity for progress that exists with having the diagnostic capabilities to detect mitral valve pathology earlier. As a result, more patients will be able to have mitral valves repaired rather than replaced.

The natural history of severe mitral valve regurgitation is poor and carries a 10-year survival rate of 50 percent or less, but established world literature has documented that early repair of the mitral valve can result in the restoration of a patient to normal life expectancy.

“Very few procedures in medicine today can return patients to a normal, age-adjusted life expectancy,” Dr. Bufkin says. “The earlier the surgeon sees a patient and intervenes, the more likely we can repair the mitral valve and provide the patient with better long-term results.”

For more information or to refer a patient to the Heart & Vascular Center at Brandon Regional Hospital, call (813) 681-5551.

Nine HCA West and Central Florida Hospitals Earn AHA Awards

Congratulations to the HCA health professionals at nine HCA West and Central Florida Hospitals for saving more lives by optimizing care for coronary artery disease, heart failure, and stroke patients. Through participation in the American Heart Association’s Get With The Guidelines program, efforts to maximize continuing quality of life for patients and their families through improved outcomes and a reduction in recurring events are being recognized with Gold, Silver, and Bronze awards. The nine HCA West and Central Florida award recipients are:

Gold Sustained Performance Award:

Regional Medical Center Bayonet Point in Hudson

In recognition of sustained performance (two or more years) at 85 percent or higher adherence to all Get With The Guidelines performance measures.

Silver Annual Performance Awards:

St. Petersburg General Hospital in St. Petersburg, Blake Medical Center in Bradenton, and Doctors Hospital of Sarasota

In recognition of 12 months participation at 65 percent performance or higher adherence to all Get With The Guidelines performance measures.

Bronze Initial Performance Awards:

Central Florida Regional Hospital in Sanford, Northside Hospital and Tampa Bay Heart Institute in St. Petersburg, Osceola Regional Medical Center in Kissimmee, Brandon Regional Hospital in Brandon, Fawcett Memorial Hospital in Port Charlotte

In recognition of sustained performance for three months at 85 percent or higher adherence to all Get With The Guidelines performance measures.

CT Angiography Excellent for Ruling Out CAD

The *Journal of the American College of Cardiology* in 2007 published a study of 100 suspected coronary artery disease (CAD) patients with regular heartbeats that demonstrated the value of multislice computed tomography (MSCT) coronary studies in forecasting a cardiovascular event within a one-year range. Further, MSCT proved extremely effective for dismissing CAD.

MSCT scans detected the presence of calcified, noncalcified, and mixed plaques as evidence of CAD in 80 percent of the study participants. Patients with calcified or mixed plaques and/or plaques in the left main or left anterior descending coronary arteries experienced a higher incidence of cardiovascular events within a year of a CAD diagnosis. No such events occurred in the 20 subjects with normal MSCT scans.

“The 64-slice MDCT [multidetector computed tomography] scanner is an excellent tool in cardiac evaluation to rule out the presence of CAD, particularly in low or intermediate risk population,” says Hoshedar Tamboli, MD, interventional cardiologist, Brandon Regional Hospital. “MDCT has a negative predictive value of 98 to 99 percent. If a patient has a normal cardiac CT and calcium score, the patient does not have CAD.”

Two significant, multi-center studies presented at the 2007 American Heart Association and Radiological Society of North America scientific sessions further demonstrated that cardiac CT angiography possesses higher diagnostic accuracy for the detection and exclusion of obstructive CAD than any other noninvasive test to date.

“Cardiac CTA effectively stratifies patients at higher risk for adverse cardiovascular events and is safe and cost effective,” says Dr. Tamboli. “It can aid in diagnosing disorders such as congenital heart disease and pericardial diseases,

and the exclusion of life-threatening conditions like pulmonary embolisms and aortic dissection. Cardiothoracic surgeons often implement it prior to CABG to assess anatomy and for surgical planning, and electrophysiologists utilize it to evaluate patients prior to atrial fibrillation ablation and implantation of biventricular AICDs.”

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The advantages of a 64-slice CT scanner can be utilized at the following HCA West Florida facilities:

- Blake Medical Center
- Brandon Regional Hospital
- Central Florida Regional Hospital
- Northside Hospital & Tampa Bay Heart Institute
- Regional Medical Center Bayonet Point (coming 2009)

Cardiac Nursing Education at HCA West Florida Hospitals

As medical knowledge and technology continue to advance, the key to excellent health care lies in ongoing education for physicians and support staff. Continuing education is vital to keeping healthcare professionals current with the latest developments in medical practice—not only so they can maintain their licensure, but also to provide patients with optimal care.

In an effort to make continuing education more easily accessible to working nurses, the HCA West Florida Division has created and made accessible a series of continuing cardiovascular education videos. The 14-DVD series offers comprehensive teaching from leading cardiac and vascular surgeons, advanced registered nurse practitioners, and cardiologists at Brandon Regional Hospital, Osceola Regional Medical Center, and Tampa Bay Heart Institute at Largo Medical Center and Northside Hospital. The DVDs provide nurses with the opportunity to learn from the comfort of their own homes about the most current information on 14 different cardiovascular topics.

THE PROCESS

Currently, the cardiovascular continuing-education DVDs are available in the Education Departments at all of the HCA West Florida cardiac hospitals. Nurses may check them out free of charge, watch them at their convenience, and complete the accompanying paperwork to receive one unit of continuing education credit for each video. The program demonstrates HCA West Florida's commitment to quality and nursing education. The videos, designed to become part of the cardiac nurse teams' credentialing at each cardiovascular facility, may eventually be offered at all HCA West Florida hospitals.

For more information on the nursing cardiac education videos, e-mail Connie DeMilo at connie.demilo@hcabehcare.com.

Role of FEMALE GENDER in Cardiovascular Treatments, Risk Factors, and Lifestyle Choices

While significant progress has been made in promoting awareness of cardiovascular conditions prevalence among women, cardiovascular disease remains the leading cause of morbidity among American women, accounting for more than 40 percent of all deaths.

More assertive treatment for female patients with known cardiovascular risk factors has been advocated; however, a meta analysis of aggregated studies from 1970 to April 2008 identified in MEDLINE and Cochrane databases and published in the July 2, 2008 issue of *Journal of the American Medical Association*, identified that invasive treatment of non-ST-segment elevation acute coronary syndromes (NSTEMI), may not be advantageous to all women.

The examination of the data, conducted by the Thrombolysis in Myocardial Infarction Study Group at Brigham and Women's Hospital, was synthesized across eight randomized clinical trials comparing invasive and conservative treatment methods in patients with NSTEMI. The extracted data, compiled by observing 3,075 women and 7,075 men for 12 months of follow-up after a NSTEMI occurrence, examined gender-specific incidences of (1) death, (2) myocardial infarction (MI), and (3) rehospitalization with ACS, revealed that women with positive biomarkers who received invasive treatment had a significant 33 percent lower odds of incidences of death, MI, or being hospitalized for repeat ACS within 12 months, while women with negative biomarkers did not exhibit a significant improvement in outcomes based on invasive procedures.

Additionally, results for a study published in the May 2008 issue of *Journal of Women's Health* indicated women with known cardiovascular risk factors received less aggressive

care than men and concluded that more proactive measures should be implemented to ensure all cardiovascular patients are treated utilizing the standard secondary preventive methods.

PREPONDERANCE OF EVIDENCE

Vast amounts of clinical evidence from the landmark Nurses' Health Study established a baseline for examining the interlinked relationship between the lifestyle habits of women and their risk of cardiovascular disease. The latest findings from the ongoing study, updated at two-year intervals, continue to indicate that women's cardiovascular health risks were minimized in large percentage with alteration of lifestyle behaviors.

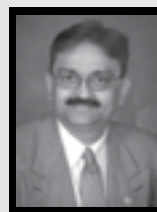
The January/February 2008 issue of the *American Journal of Lifestyle Medicine* found that 74 percent of cardiovascular disease cases, 82 percent of coronary heart disease cases, and 91 percent of diabetes cases in women could be prevented by adherence to regular physical activity, maintenance of a healthy weight, a balanced diet, abstinence from smoking, and minimal intake of alcohol. Incidence rates of cardiovascular conditions reduced in direct proportion with the number of protective factors in which the women engaged.

Therefore, emphasizing the significant impact that lifestyle changes can have on the cardiovascular health of women should be the foremost responsibility of physicians, according to Saurabh

Chokshi, MD, cardiologist, Brandon Regional Hospital.

"Because patients can greatly reduce their risks of developing cardiovascular disease through more healthful lifestyle habits, physicians have a responsibility to guide them toward those choices," says Dr. Chokshi. "We should routinely reiterate the importance of basic prevention methods, including smoking cessation, regular exercise, and a balanced, low-fat diet."

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Treatment for Atrial Fibrillation

Atrial fibrillation is the most commonly diagnosed symptomatic tachyarrhythmia in the United States, resulting in high morbidity and mortality rates as an underlying cause of thromboembolism and heart failure in some patients.



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“Atrial fibrillation is no longer considered a benign arrhythmia,” says Dilip Mathew, MD, electrophysiologist, Brandon Regional Hospital. “Of the 700,000 strokes occurring each year in the United States, 15 percent, or about 105,000, are related to atrial fibrillation. Those patients have a mortality rate of 30 to 35 percent, and 70 percent of them never recover from the stroke. Additionally, a-fib increases cardiovascular death rates, doubling it in men and tripling it in women.”

A-fib can occur in patients at any age, but it is more commonly diagnosed in those ages 50 or greater. The goal in treating all patients, regardless of age, is establishing long-term control of cardiac rate and rhythm. To accomplish this, physicians must focus on the cause and type of the disorder and determine how to achieve optimal outcomes for the patient. For many, that translates into long-term warfarin-free care.

“Coumadin is necessary in a-fib patients for the prevention of stroke, but many patients are motivated to come off it because it can be difficult to manage,” says Brad Bufkin, MD, cardiothoracic surgeon, Brandon Regional Hospital. “Some dietary restrictions apply, and patients typically must proactively restrict activities with potential to cause

trauma to help avoid bleeding complications.”

Although most of the 2.4 million Americans suffering from atrial fibrillation are treated first with medication, pharmacological therapies do not always demonstrate efficacy in controlling the disorder and characteristically have side effects that may negatively affect quality of life. Alternate approaches of electrophysiology and/or surgery are viable options in these instances.

“While drugs are straightforward and generally recommended as the first line of treatment for atrial fibrillation, non-drug approaches have been developed and improved in the last decade,” says Dr. Mathew. “A highly experienced cardiac surgeon can deliver excellent results: surgery brings greater than 80 percent long-term freedom from atrial fibrillation while drugs perform typically around 60 percent for the first year and approximately 20 percent for the second year. Ablation, a minimally invasive procedure where the pulmonary veins are essentially disconnected at their junction with the left atrium using different sources of energy, also boasts an 80 percent rate of long-term a-fib suppression if in paroxysmal stages. That success rate decreases significantly in chronic or persistent cases.”

Certain atrial fibrillation patients also experience additional cardiac problems, such as a leaking mitral valve,

that require heart surgery. In instances where correction is required for such additional issues, surgeons can address the atrial fibrillation disorder within one procedure.

“Patients with other forms of cardiovascular disease are at greater risk for atrial fibrillation,” says Dr. Bufkin. “Surgeons historically have been primarily responsible for treatment of patients who have atrial fibrillation along with another heart condition.”

SURGICAL APPROACH

Two surgical approaches are offered to atrial fibrillation patients by skilled cardiothoracic surgeons. First is a minimally invasive approach, which is performed using a scope instead of opening up the patient’s chest. In this method, the assistance of a heart and lung machine is unnecessary.

“With this minimally invasive procedure, we address atrial fibrillation in a similar way to how gallbladders are removed with a scope,” says Dr. Bufkin. “We are performing a pulmonary vein ablation procedure that may help patients with a form of intermittent a-fib.”

Another surgical approach is appropriate for the treatment of persistent forms of atrial fibrillation. Through a small incision made between the patient’s ribs, a surgeon opens into the right and left atria to perform a complete Maze procedure.

“This procedure allows us to take care of patients with more advanced and continuous atrial fibrillation,” says Dr. Bufkin. “However, the goal of both of these procedures is to close the left atrial appendage, which is the source of stroke for patients with atrial fibrillation. By closing the appendage, we hope to reduce or eliminate the risk of stroke in these patients.”

ELECTROPHYSIOLOGY APPROACH

From an electrophysiology standpoint, Dr. Mathew’s goals in the

management of patients with atrial fibrillation are to

(1) provide a broad understanding of the arrhythmia and its potential complications, and (2) discuss all treatment options with the patient, among them pharmacologic therapies, ablation, and surgery.

“As a specialist in atrial fibrillation, I present the patients with a broad overview of drug versus non-drug management of the disorder,” says Dr. Mathew. “Side effects of drugs can include lethal pro-arrhythmia, often requiring implantation of pacemakers or discontinuation. In addition, Coumadin is still required. The patient needs to be aware of these things.”

Over the past 10 years, studies have shown that atrial fibrillation is most often initiated by rapidly firing or trigger cells, which originate in the left atrium pulmonary vein junction (greater than 90 percent of the time), at least in its initial stage. Following these findings, percutaneous, transvenous procedures have been developed, which access the left atrium via a transeptal puncture.

EMERGING HYBRID TREATMENT

Recently, a local cardiac electrophysiologist and J. Crayton Pruitt, MD, cardiovascular and thoracic surgeon, Tampa Bay Heart Institute at Largo Medical Center in Largo, Florida, performed a hybrid electrophysiological/surgical operation at Largo. Through a combined effort, they were able to document the successful ablation of all pulmonary veins.

“The combined approach has promise because the electrophysiology techniques allow us to understand, during the course of the operation, how successful our ablations are at completing isolation of the pulmonary veins,” says Dr. Pruitt. “The type of testing the electrophysiologist can provide during surgery is extensive. In

this case, we found that after one application of the ablation device on the veins, one of the four veins was not completely isolated. We could find it and fix it.”

For more information or to refer a patient, contact the Heart & Vascular Center at Brandon Regional Hospital Heart by calling (813) 681-5551.



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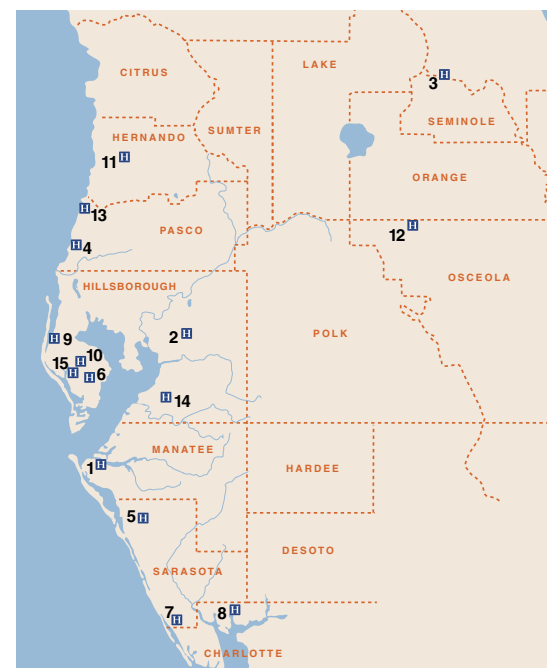
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