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Personal series. . .

A 'pink salmon' returns to the River Arno

Interview with Professor Carlo Di Mario, Director, Structural Interventional Cardiology, Careggi University Hospital, after his return to Florence, Italy

River Arno with Ponte Vecchio

Carlo Di Mario © Bryan Wharton

Florence, Palazzo Vecchio (L) Cathedral (R)

More than a year has passed since our interview 'Carlo Di Mario moves from London to Florence'. People liked your story in which you made the comparison to salmons returning 'home' to the stream where they were born.

How is life back home?

Fishermen friends have told me that it is typical of the Pacific pink salmon to leave the ocean and to swim upstream through fast-flowing rivers to spawn in the freshwater streams where they were born. Only a small minority manage to return to their 'roots'. Fishermen's nets and hooks, dykes, hungry bears, and waterfalls intercept the rest. I confess that I also found many obstacles on my way, perhaps the biggest was the one I least expected, my lack of local knowledge. I took many wrong turns on my return journey, but I do not despair of reaching a quiet pond at the end.

What is the main difference between working in the UK and in Italy?

Both countries have health systems based on universal insurance, a concept I truly share. Good health is a necessity for every person and should not be a luxury for the wealthy few. However, especially in times of limited resources, this concept requires tough political decisions to select the main objectives. Political choices are required, but it is difficult to draw a line between the general indications left to voters and to the politicians they appoint, and the technical management that should be left to skilled administrators and competent doctors.

Can you give examples of different approaches between the two countries?

A transcatheter valve costs 7–8 times more than a surgical valve. However, the overall cost to society is lower for transaortic valve implantation (TAVI) than for a surgical aortic valve replacement (AVR) because patients go home after 2–4 days with no need for an intensive care unit stay or rehabilitation. Sadly, hospitals appear to be only interested in their local budget. When I quadrupled the number of TAVIs done in my new Division in Florence to more than 100, a number similar to the one I was performing in London, I did not see enthusiastic faces when it was announced at a recent Budget meeting.

So, England beats Italy 1:0. Anything better in Italy?

England has a truly inflexible system that makes it very difficult to introduce new drugs and devices into the practice of medicine. They have now halted the small three-centre registry of MitraClip implantation. I confess I was going to feel very uneasy if I had to stop the MitraClip programme 10 years after having started the first implantations in the UK. I think banning this new technology altogether from the UK is wrong. Even if the trial results in secondary regurgitation and heart failure will come up completely negative, you cannot deny a therapeutic option that works in patients with inoperable degenerative mitral valve regurgitation, an indication also accepted by the conservative US Food & Drug Administration. In Florence, on the contrary, I managed to introduce the MitraClip procedure and start new mitral treatments such as the CardioBand and trans-septal valve-in-valve and valve-in-ring implantations.

You made your name in coronary interventions. Have you now become only a valve specialist?

Most coronary interventions are now performed in patients with acute coronary syndromes. Careggi was one of the first centres in Italy to start primary angioplasty and remains a safe harbour for the almost 300 000 citizens of Northern Florence. However, we cannot live in the glory of the past and should accept that hospitals strategically distributed in a territory should cope with the local needs. In my view, tertiary referral hospitals should focus more on the more complex interventions such as, chronic total occlusions that have failed with conventional techniques. I think my greatest achievement last year has been in coronary interventions. I brought to Italy coronary lithoplasty, a technique addressing the growing number of severely calcified lesions almost impossible to expand well with balloons.

What is your next big project in Florence?

In addition to 10 beds in a normal ward or high dependency unit, I follow a very busy six bed unit of Cardiology Intensive Care, with many patients intubated, undergoing ultrafiltration or mechanical circulatory support. Last year, I was shocked to see some relatively young patients die with refractory heart failure after myocarditis or acute ischaemic events. Heart transplantation is not a readily available option for emergency cases. I hope co-operation with our cardiac surgeons will allow a prompt and more liberal use of implantable left ventricular assist devices, a costly, but unavoidable option in selected cases.

Is there a difference in the relationship with colleagues and the Hospital Administration?

I started my work in Florence by meeting individually with all 16 cardiologists working in my group, and I hold weekly meetings to discuss together difficult clinical cases and organisational problems. I think they found these small changes quite revolutionary in a place where, not so long ago, the Chief of Departments used to rule by diktats. It is easy enough to blame blind administrations for all the problems of hospitals. I understand that sometimes you need to force rules in a very complex environment that is difficult to govern. Still, hospitals are not chocolate factories or banks, and Managers should also understand this uniqueness and listen more to their medical staff. I think that this is true for Italy, the UK and probably also, to most other countries in Europe and the world.

Sounds quite reasonable and sensible. Finally, you claimed you were going back to do more work in education. Mission accomplished?

You should ask my medical students and cardiology fellows. I tried to start some didactical experiments asking students to prepare cases during their training in-hospital. They interviewed and examined patients, went through results of blood tests, watched non-invasive investigations, followed the patients in the operating room and the cath lab. They did a marvellous job in conveying this experience to their fellow students, a much better and much more practical way of teaching than any formal lesson I could prepare.

I shocked my Italian colleagues by starting monthly English-style Grand Rounds with the presentation of complications and deaths. It is human to forget and bury under the sand these experiences, but then you lose the opportunity to learn and allow others to learn from your mistakes. For this year, I have asked Italian and European colleagues to conclude these Grand Rounds with lectures on specific subjects. Prominent busy cardiologists from all over Europe accepted to spend 1 to 2 days teaching for no fee. I am not the only person who believes educating younger colleagues is a worthwhile mission!

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Conflict of interest: none declared.