



About Dr. Rothenberg:
Dr. Rothenberg focuses on interventional cardiology, specifically coronary artery disease and valvular heart disease.

Dr. Rothenberg completed a 6 year medical program at Lehigh University and the Medical College of Pennsylvania in 1989. He completed his medical internship and residency at Temple University Hospital in 1992, and completed a cardiology fellowship at Temple University Hospital in 1996. He has been at JFK Medical Center since 1999.

Perspectives on the ACIST CVi™ Contrast Delivery System: **Dr. Mark Rothenberg, MD, FACC**

*Medical Director, Cardiac Catheterization Laboratory
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Contrast delivery has been an important concern for Dr. Rothenberg since he began his interventional cardiology career over 20 years ago. Throughout his practice, many of his patients have been elderly with compromised renal function—thus at greater risk for CI-AKI.

As a proctor for transcatheter aortic valve replacement (TAVR), Dr. Rothenberg is also keenly interested in anything that helps advance this alternative to open heart surgery. We asked Dr. Rothenberg for his insights on the value ACIST CVi brings to his patients, clinicians and hospital systems.

Do you use CVi every time you perform a TAVR (also called TAVI)?

CVi is in four of my five hospitals. Of those four that have CVi, it's used for all coronary cases in all of the rooms. I use CVi for TAVR; my partner uses CVi for our peripheral cases. We adopted CVi years ago and my practice partners and I wouldn't think of not using it whenever it's available to us.

Why did those four hospitals implement CVi?

Hospital administration leadership was able to see from the studies that CVi delivers significant measurable benefits, from patient and staff safety to contrast savings and improvement in turnover time.

Of those benefits, which do you think are most important?

That's hard to say, it's such a great device in so many ways. As a proctor, I appreciate that CVi helps mitigate challenges that can be part of performing TAVR. For example, there are times when your first aortogram doesn't reveal the aortic sinuses as well as you would like. With CVi, it just takes a puff of contrast to know all you need to know.

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You can inject under pressure, which is important because a lot of cases involve high-flow coronary arteries. There's no need to turn multiple stopcocks, as there is with the manifold system. CVi simply gives you far more confidence in minimizing the amount of contrast you need.

In terms of benefits for my patients, hands down it's the protection CVi delivers against CI-AKI. That's invaluable.

Why isn't CVi in that fifth location?

That hospital has not made the evolution from manifold. It's more difficult to perform cases at that site (they don't do TAVRs there). It reminds me what life was like before CVi—all the chronic hand soreness that comes from using a manual system every day.

When I proctor for TAVR, I'm relieved when I see the ACIST CVi. It's increasingly the standard. In fact, for one of the hospitals that uses CVi, it started in one cath lab. It didn't take long to get it in three more cath labs, the hybrid OR and the interventional radiology suite.

What would most surprise someone who hasn't used CVi?

How easy it is to use and adopt. There's really no learning curve in using it. The staff requires some training to ensure efficient setup so there's no downtime. But each site gets up to speed fast. You have to get it in your hands to believe how intuitive it is.

With two decades of experience, what changes have you seen in your field?

I used to feel like a golfer, working alone for the benefit of my patients. Now it's like I'm a baseball player - part of an important team made up of other players, medical device reps and cath lab staff, all working together and sharing perspectives to bring value to each procedure.

I feel fortunate to be in interventional cardiology. It's constantly evolving. CVi has helped every step of the way to make TAVR and other procedures safer for patients, safer and easier for the cath lab (or hybrid) team and me, and more economically viable than the alternative for the hospitals.