Flavio Ribichini

Originally from Argentina, Flavio Ribichini (head of the Cardiovascular Interventions Unit of the University of Verona, Italy) moved to Italy to see “more of the world” and decided to climb the Alps. He speaks to Cardiovascular News about being involved in the first use of primary angioplasty in Italy and how his belief in the “learning-teaching continuum” informs his clinical practice.

Why did you decide to become a doctor and why, in particular, did you decide to specialise in interventional cardiology?

Although this path is not genetically transmitted, it is certainly highly congenital. Indeed, as in most cases, my father, who was a pathologist, wanted me to be a doctor. I remember him having long conversations with his friends and colleagues—and a dermatologist, a lab technician and a nurse—into the deep hours of the night. I understood the importance and the meaning of these conversations (and in the subregional north-east Argentina close to Paraguay and Brazil) to take care of indigenous people with, and returning days later covered with dust, joy and pride. My kids see me leaving home to go with a helmet, a back pack and the motorcycle and although this is much less romantic than what my father was doing. I perceive that they feel the same sense of pride that I felt when I saw my father.

I really liked most of the clinical branches of medicine but at a certain point I had the impression that cardiology was the simplest, the most intuitive and logical, and nothing could be clearer than thinking on the consequences of an uncorrected artery and the potentials of opening it. Then, when you see that with a local anaesthesia and special catheters you can see the heart and vessels, and the patient is standing some hours later, there is no way back. At this point it is difficult to imagine something more fascinating and attractive than doing interventional cardiology.

Who have been your career mentors?

When I started studying at the University of Turin, I met Professor Gian Piero Buonaiuto—director of the Department of Medicine—at the time. He taught me that “the most difficult task for a young researcher doing his best is to learn how to be forgiven for his mistakes”. I did not understand his words at that time, but he was telling me all about the “adults of the professional world”.

William J. Wein and his colleagues Bernd De Breeje and Guy Huydecoper, in Aalst (Belgium) where I was a research fellow, have also been mentors to me. They taught me how to take the most of a research project and William provided me with the best example I have ever seen of “how to be” and showed me that “to be a good doctor, you must be a good person”.

Back in Italy, my current director Corrado Vassanelli gave the opportunity to run a cash lab and get into the academic world, a position that is very difficult to obtain for a foreigner in Italy. Under a technical point of view, when I perceive that something is “simply impossible”, I invite Euglio Garcia to my lab, and he “simply” shows me how to do it. I hope to be able to learn at least some of his tricks and experience to pass them on to future generations.

Why did you decide to move to Europe for your cardiovascular training and why did you decide to stay and work in Italy?

Argentina is a wonderful country and I love it, but I decided to leave at the age of 23 despite having a lovely family, a good job, and fantastic friends because I needed to know more about the world outside. I grew up during the total repression of a military dictatorship. Everything was forbidden and all around us was depicted as being “dangerous and bad”. I felt the need to escape from that abusive and authoritarian state to meet different people, to leave behind all the self that I had seen and heard. When I arrived in Italy, I went to Turin where some friends of my father helped me to start my career. I used to praise Santa Maddalena, the marvellous spectacle of the Alps all around the city. They were so close that I almost felt the smell of the snow. I decided to stay in Turin to study cardiology and to climb mountains in the mountains.

In your view, are there major differences in how interventional cardiology is practised in Europe compared to how it is practised in Latin America?

The level of healthcare in Argentina has always been excellent, following the American model of learning and training. However, in my opinion, the main differences are the organization of the health system and the access to complex care. In Latin America, medicine at a high complexity level, such as interventional cardiology, is mostly granted by private institutions. Public hospitals receive weaker budgets every year and hardly grant basic specialist interventions. Interventions are executed by a businesswoman (often a colleague) and are paid for services. Patients have to pay for healthcare either directly or through a certain kind of insurance. This creates obvious differences in the kind of medical care that is provided to the population. In Europe, and particularly in Italy, healthcare is seen as a basic human right and we offer all the population the same treatment, from primary to more primary coronary intervention cardiology (PCI), to a transcatheter valve implantation or a heart transplantation. This base the patient’s nationality, race, religion, social or economic state.

On the research you have been involved with, which piece are you proudest of and why?

Certainly the development of primary angioplasty without surgery on site was one of the most exciting periods of my working life. We contributed, from a small city in the western Alps, to someon interventional cardiology in that it is quite difficult to implant a prosthesis in a coronary artery of a patient with very low cardiac output. The enthusiasm of my colleagues and the visionary support of the chief of this small division of cardiology, Professor Eugiano Uledghi, allowed me to be the protagonist of one of the most important changes of our interventional research.

The study of the mechanisms of restenosis and in particular, the dedication to the anti-inflammatory therapy with immune-suppressors helped me to enlarge my knowledge in the fields of vascular biology and gave me the chance to work on my most beloved “experimental human model”.

Dr Rana Vemani: I am aware of how lucky I have been to know her and work with her. Regarding your interventional studies it seems that you have been the top examiner in Italy for the EXCEL trial, a study that has compared surgery with PCI in patients with left main disease. What do you think of this new field of cell therapy? I think these are indicators of the high level that our research was achieved.

What are your current research interests?

I do believe that the next challenge for emergency vascular medicine will be the treatment of stroke. Despite such similarities with the treatment of acute myocardial infarction, stroke is medically easier to overcome. I think that stroke will be the protagonist of one of the intervention trials soon. We already use this approach from anterior communicating artery aneurysm, which is a collaborative group called, in fact, FRIENDS (Finalised research in endovascular strategies). We have done some nice work and we try to divulgate this new way of thinking among interventionalists to set up the framework for a change.

What has been your most memorable case and why?

Well, certainly the most compelling under an emotional point of view is the PCI I did to my father on the distal left anterior descending artery. I still remember the emotion when I asked him if he was ready for the procedure and he replied: “Yes, let’s do it”. I am happy every time I do it to the patient and every time I see the result. That is why I decided to remain in that field, and this makes you develop a different view of our job.

In our interventionalist’s world, learning is the product of experience. Teaching students makes this very clear, and when you begin to have your students, you begin to understand this feeling of something is “simply impossible”, I almost felt the smell of the snow. I decided to stay in Turin to study cardiology and also learn to climb mountains.

Outside of medicine, what are your hobbies and interests?

I like going trekking with my friend Luca and walking with my dogs. I run in the mountains in winter and on the Andes when my kids are older. My camera is one of my activities and my hobbies. I often take pictures of the mountains and I use it all year long regardless of the weather conditions and it gives me a lot of fun. Also, cooking is my most relaxing and funny activity at the end of the week, and I generally take care of the dinner with my wife and the kids, after they have done their homework. I like trying new recipes and tastes while sipping a good glass of wine.

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Working for the people in need is a privilege and turns true my ideal of being a doctor, and teaching in a university is more than what I had expected. But, the small size of this system in Italy is that you work for a “closed slimming” (which is the same irrespective of the quality or the quantity of the work you do), and that is the worst in Europe.

Indeed, if one were not in love with his job, one would immediately quit the Italian public system.

You were involved in publishing the first experience of primary PCI in Italy in 1993–1995. How has primary PCI evolved over the last 20 years?

When we started doing primary PCI in a small hospital without access to cardiac surgery on site (the closest cardiac surgery center was more than 100km away), we were criticized not only by clinicians, but also by most interventionalists from bigger and more important institutions. We were trying to follow the examples of the group of the Mid America Heart Institute in Kansas, and the Zwolle group in the Netherlands, but we were in Italy, and others judged it impossible. But, as always happens when something is right, primary PCI rapidly became the frontline treatment and now it has evolved to be performed worldwide as a routine intervention around the clock.

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What are your current research interests?

I do believe that the next challenge for emergency vascular medicine will be the treatment of stroke. Despite such similarities with the treatment of acute myocardial infarction, stroke is medically easier to overcome. I think that stroke will be the protagonist of one of the intervention trials soon. Slowly but steadily, I am working on this, as well as my best friends. We are dedicated to the diagnosis, and the treatment, of the “coronary leaving home in a coma” through a collaborative group called, in fact, FRIENDS (Finalised research in endovascular strategies). We have done some nice work and we try to divulgate this new way of thinking among interventionalists to set up the framework for a change.

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