Congress Interviews

EMJ is delighted to present this exclusive interview series from EuroPCR 2026, featuring insights from EuroPCR Course Directors Thomas Cuisset and Nicolas Dumonteil, alongside Salvatore Brugaletta, Editor-in-Chief of PCRonline and PCR Board member. These interviews delve into the future of interventional cardiology, exploring advances in structural heart interventions, imaging, AI, complex PCI, and continuous education, while highlighting the innovations and collaborative approaches shaping patient care worldwide.

Featuring: Salvatore Brugaletta, Thomas Cuisset, and Nicolas Dumonteil

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Salvatore Brugaletta

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> **We want to understand how AI can help us in real-world decision-making and patient care**

Q1 As Editor-in-Chief of PCRonline and a member of the PCR Board, how do you see educational needs in interventional cardiology changing, and how did the EuroPCR 2026 Congress adapt to meet them?

That is a very important question because it is something we ask ourselves every year when we begin planning EuroPCR. To me, there are two main changes.

The first is the growing interest in structural procedures. Years ago, this was just beginning, but now we see more and more interventional cardiologists coming to EuroPCR specifically to learn about structural interventions.

The second major topic is AI. This year, AI was introduced much more broadly throughout EuroPCR, and I think many of us are very interested in understanding how AI can actually be applied in daily clinical practice, not just theoretically, but practically. We want to understand how AI can help us in real-world decision-making and patient care.

Q2 Imaging has become increasingly central to decision-making in percutaneous coronary intervention (PCI). How do you see the integration of CT, intravascular ultrasound (IVUS), optical coherence tomography (OCT), and physiology reshaping the way operators approach complex coronary disease?

Imaging and physiology are fundamental. If we look back at coronary stents themselves, I think we have more or less reached the top in terms of device performance: there is not much more improvement to be made there. What we can improve is understanding when a stent should be implanted using physiology, and how we can implant it better in order to improve patient outcomes.

CT is extremely important for procedural planning, while IVUS and OCT are essential during PCI itself. Every interventional cardiologist should know not only how to use these technologies, but also how to take full advantage of them. It is not enough to simply open the box and use the pressure wire or imaging catheter: you need to understand how to extract the maximum value from these techniques.

This was highlighted by recent studies such as CHIP and OPTIMAL, presented at the American College of Cardiology (ACC) 2026 Scientific Sessions, which showed that simply using imaging is not always enough if you are not fully leveraging the information it provides.

At EuroPCR this year, there were again many small group sessions focused on imaging techniques, with greater emphasis on CT planning. I believe this is the future. Every operator should understand how to integrate these techniques into daily practice.

Q3 At EuroPCR 2025, there was significant focus on vulnerable plaque and myocardial infarction with non-obstructive coronary arteries. Do you think interventional cardiology is moving beyond simply treating obstructive disease towards a more preventive and mechanistic approach?

Yes, I do think so. With myocardial infarction with non-obstructive coronary arteries, imaging can help clinicians make the diagnosis, but for me, the more important evolving topic is vulnerable plaque. We are becoming increasingly interested not only in preventive drug therapies but also in whether preventive treatment of plaque, for example, with stenting or other interventional strategies guided by physiology or OCT, may help reduce future vulnerable events.

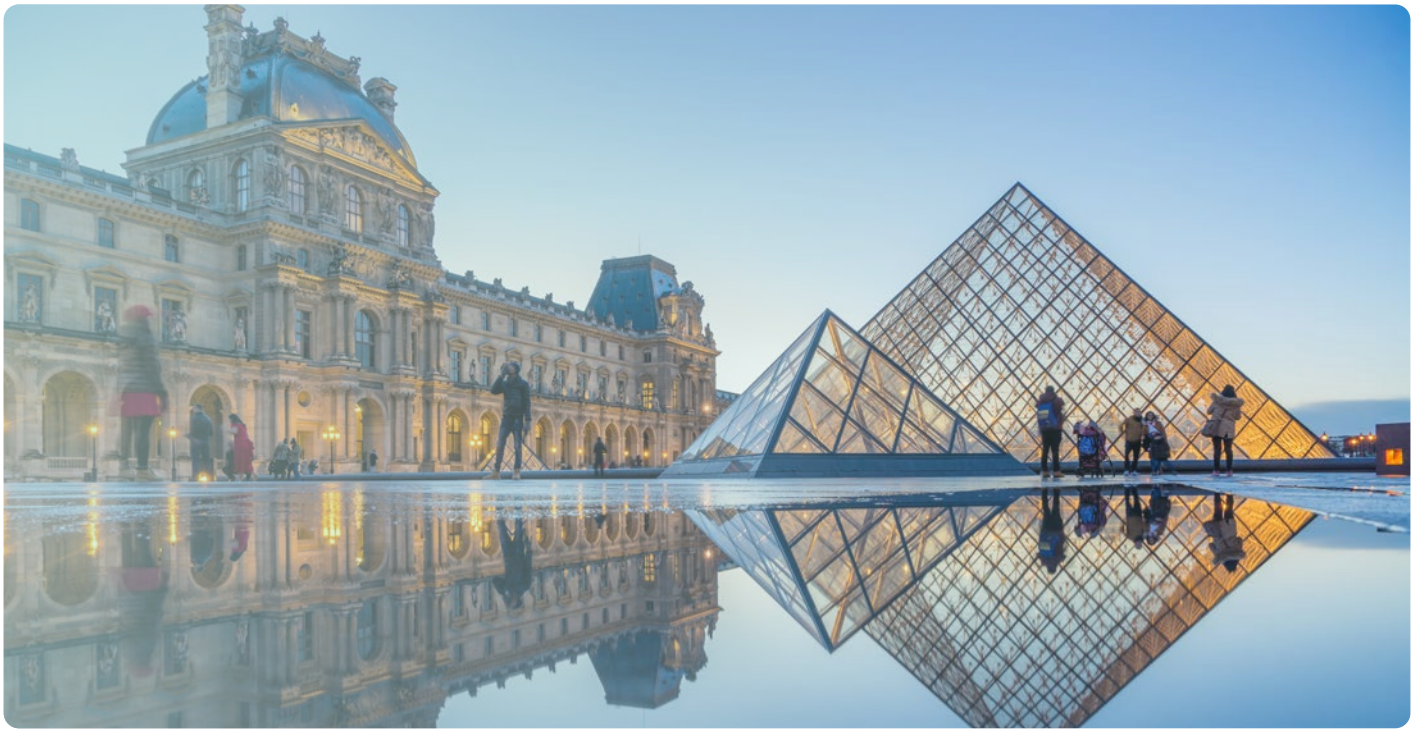
This year at EuroPCR, we had two dedicated sessions on vulnerable plaque. One focused on how to identify vulnerable plaque, while the other explored how to treat it. This field will become even more important over the next few years because several major studies are ongoing.

The COMBINE INTERVENE trial, for example, is expected to present results later this year, possibly at Transcatheter Cardiovascular Therapeutics (TCT) 2026, and additional studies will follow over the next 1–2 years. These trials may help us understand whether there is a clear role for interventional cardiologists in treating vulnerable plaque before events occur

Q4 Your recent work has explored OCT-guided PCI and advanced calcium visualisation techniques. Which imaging innovations do you believe are closest to changing routine clinical practice?

That is a difficult question because it is hard to select only one imaging modality.

When we talk about calcium assessment, I think most of us would agree that OCT is superior to IVUS in some aspects, particularly for measuring calcium



thickness. That does not mean IVUS is not useful in calcified lesions, but OCT provides additional detail, and calcium thickness measurements can directly influence procedural strategy.

CT also plays an important role in planning procedures, although it cannot be used in real time during PCI.

Another interesting development is 3D stent reconstruction using angiography-based imaging. After stent implantation, a 300-degree rotational acquisition can create a 3D image of the stent and the calcified plaque behind it. In the future, we may even be able to acquire this information before stenting, simply by positioning a balloon within the lesion. That could allow us to understand calcium length, arc, and thickness in much greater detail before intervention. Some interesting data on this were presented by Nicolas Amabile, Cardiovascular Institute Paris Sud (ICPS), Massy, France, during EuroPCR.

Overall, I would say that whatever imaging technique you use, the key is und erstanding it well and knowing how to use it properly.

Q5 Complex multivessel disease and high-risk PCI remain major challenges. In your view, what are the most important factors in improving outcomes for these increasingly fragile patients?

When we treat these patients, we must think about the patient as a whole, not just the lesion. The lesion belongs to a patient, and often both are high risk.

As the population ages, we are treating increasingly complex and fragile patients compared with 10 years ago. Education is therefore essential in understanding how to manage these cases.

For high-risk PCI, you need preparation and experience. You need a plan A and a plan B. These are not procedures that everyone can simply perform routinely. Teamwork within the catheterisation lab is also extremely important.

Operators need to understand all available devices: not only imaging tools for PCI optimisation, but also plaque-modification technologies such as intravascular lithotripsy, rotational atherectomy, orbital atherectomy, and others. In addition, it is crucial to understand when mechanical circulatory support is necessary.

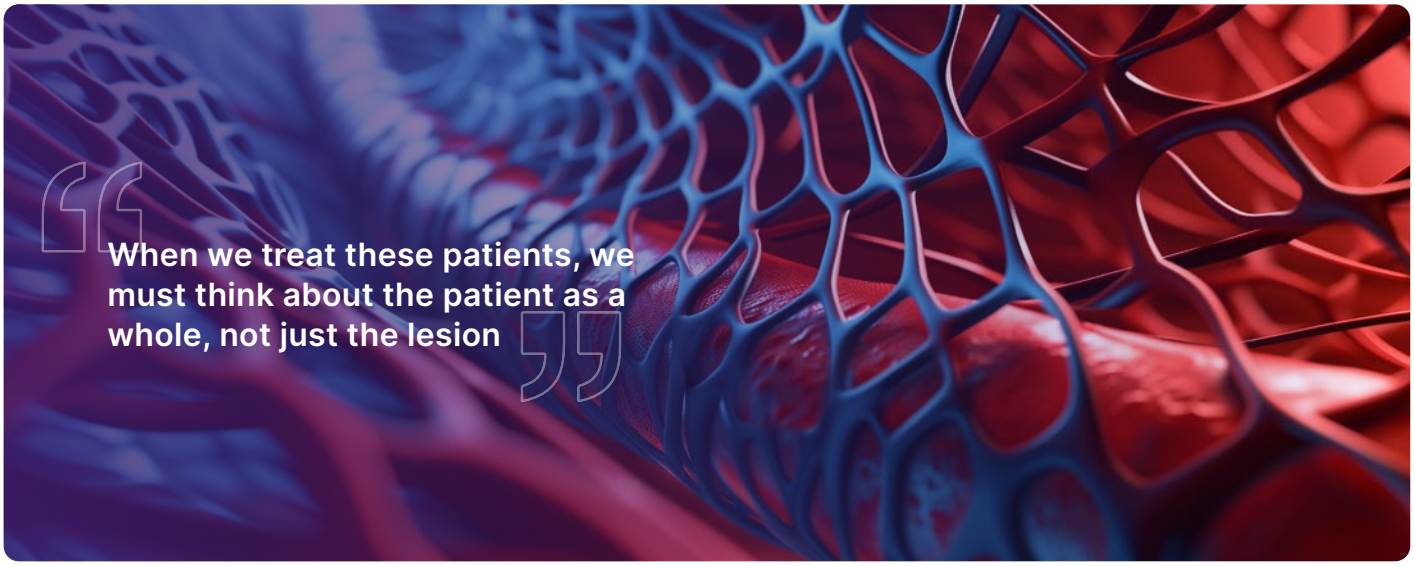
High-risk PCI will become an even bigger focus in the future because of the ageing population and the increasing number of elderly patients undergoing procedures such as transcatheter aortic valve implantation, often with multiple comorbidities and highly complex anatomy.

Q6 PCRonline has become a year-round educational platform rather than simply a meeting resource. How important is continuous digital education in a field evolving as rapidly as interventional cardiology?

Education is always the key.

Whether you organise a congress, a course, a symposium, or a webcast, the goal is always to educate others. Science does not belong to one individual: it belongs to everyone. It would be a mistake for someone to keep a specific technique or experience only to themselves instead of sharing it with the wider community.

That philosophy really is the foundation of PCR and PCRonline.



In addition to the congress itself, we now have educational journals, as well as textbooks and educational resources covering many different topics.

Another important development announced recently is an open access journal, where physicians around the world can share their experiences, regardless of whether they are based in Europe, Asia, or the USA.

The important thing is continuous education. Clinical practice may ultimately aim towards the same goal, but there are many different ways to approach it. Learning from different experiences allows physicians to choose the strategy that works best for their own hospital and clinical reality.

Q7 Looking back on EuroPCR 2026, what do you hope participants will take away from the meeting, not only scientifically, but also in terms of how they approach patient care and collaboration?

For me, the most important thing is always networking and returning home with the feeling that you have learned something new.

That learning may come from live cases, new devices, imaging techniques, poster sessions, or discussions with colleagues. What I appreciate most about EuroPCR is not one single technology or topic, but the overall feeling that when you leave the meeting, you go back to your hospital thinking, 'I learned something here, and now I will approach this differently'.

To me, that is the best possible takeaway from EuroPCR.

> **Science does not belong to one individual: it belongs to everyone**