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## Q1 Looking back on the European Society of Cardiology (ESC) Congress 2026, what were the most important scientific messages or breakthroughs that emerged from this year's meeting?

I think the new guidelines were probably the biggest headline of all. For example, in the heart failure guidelines, we had very important changes, such as the removal of the category of heart failure with mildly reduced ejection fraction. We now have just two categories of heart failure, and I think this is going to simplify clinical practice.

It was also the first time that we had guidelines on cardiovascular disease and chronic kidney disease, which are extremely important in my opinion. In addition, we saw the first ESC guidelines on cardiac rehabilitation.

The Fifth Universal Definition of Myocardial Infarction, of which I was also a task force member, offers a completely new view of the definition of myocardial infarction and should help simplify clinical practice. Overall, I think the guidelines were the major scientific highlight of the Congress.

## Q2 Was there a specific presentation, late-breaking trial, or discussion at the ESC Congress 2026 that you believe has the potential to change clinical practice in the near future?

I think the majority of the late-breaking trials presented have the potential to influence practice, but one that stood out to me was the REACT trial.<sup>1</sup>

The study showed that silent atherosclerosis was present in almost 60% of apparently healthy participants, including individuals at a very early age. I think this will change the way we understand primary prevention and encourage us to address prevention in younger populations.

It may also change how we screen for atherosclerosis. Rather than relying only on traditional methods such as blood tests and blood pressure measurements, imaging tools such as ultrasound may play a larger role in identifying disease. I think this study will probably change how we practise prevention in the future.

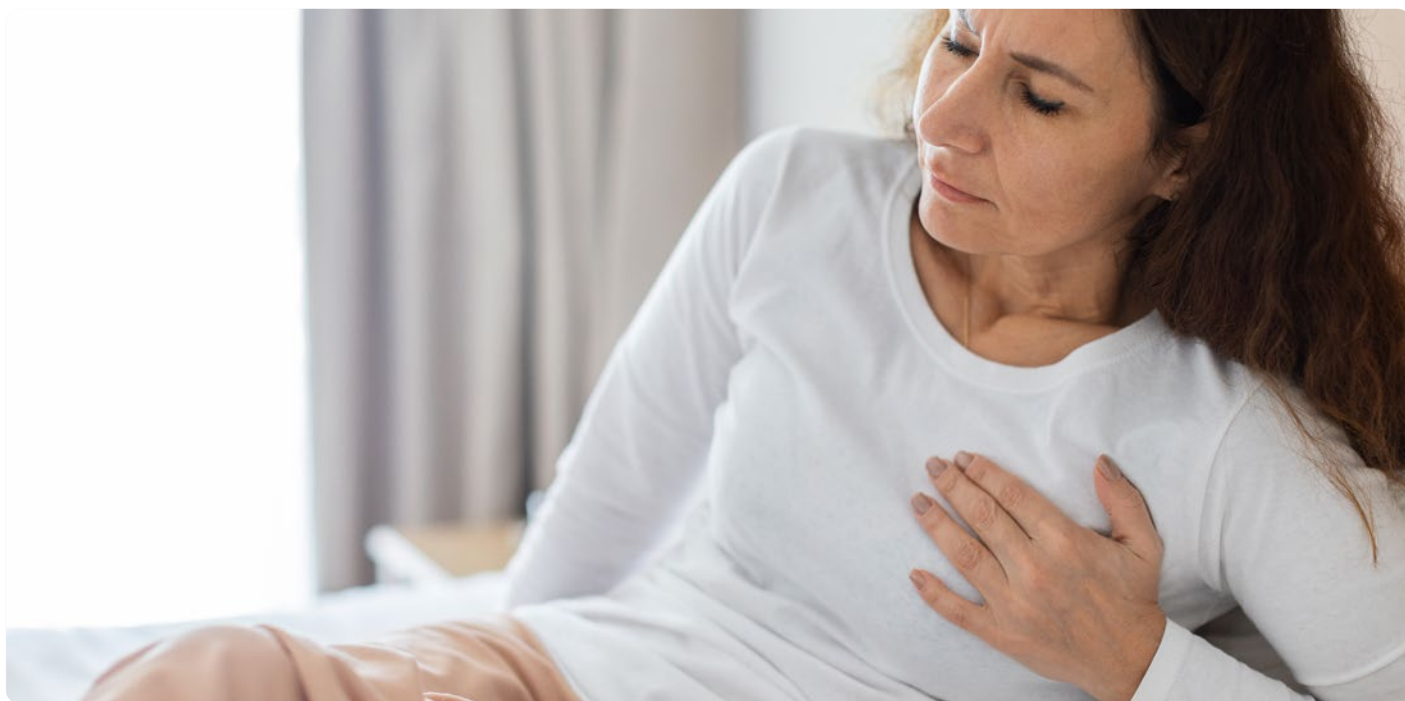
## Q3 You are Chair of the ESC Gender Task Force (2024–2026); what sparked your interest in women's cardiovascular health?

Cardiovascular disease remains the number one killer of both women and men, but the situation is particularly concerning for women because they remain underrepresented, undertreated, and underdiagnosed.

I think that reality is what first caught my attention and motivated my interest in this area.

## Q4 Throughout your mandate, what progress have you witnessed in advancing awareness of sex and gender differences in cardiovascular disease?

I think we had a unique opportunity during the last few years, because two very important political initiatives were launched



by the EU: the Safe Hearts Plan and the new Gender Equality Strategy 2026–2030.

Both initiatives place considerable emphasis on sex and gender in cardiovascular health. The ESC worked closely with policymakers during their development, and I think this represents a huge step forward. I have a feeling that we are finally moving from discussion towards action, and I am very optimistic about these strategies.

Within the task force itself, we have also developed several important projects. One significant achievement was changing the ESC topic list to include a dedicated category for sex and gender in cardiovascular health. Previously, women's health was grouped under 'special populations', but now it has its own dedicated topic area.

We have also curated a collection of articles focused on sex and gender in cardiovascular health. In addition, we are planning a series of webinars on the topic and a major women's heart health programme that will be

announced soon. The task force has been very active, and several initiatives are close to launch. Additionally, the task force has monitored the implementation of the ESC gender policy across the whole ESC very closely.

### **Q5** Were there any sessions or research findings at the ESC Congress 2026 that highlighted important developments in women's cardiovascular health or gender-sensitive medicine?

There were several activities dedicated to sex and gender in cardiovascular health. For example, this year we had a dedicated Young Investigator Award focused on women's health, as well as clinical case sessions on cardiovascular disease in women.

We also organised a joint session with the WHO on women's cardiovascular health.

More broadly, what I found most encouraging was that clinical trials are becoming increasingly inclusive. We are seeing more

balanced representation of women and men, as well as more sex-disaggregated data being reported. To me, this is very important because it demonstrates that we are beginning to move from simply discussing these issues to taking meaningful action.

**“Additionally, the task force has monitored the implementation of the ESC gender policy across the whole ESC very closely.”**

### **Q6** How can clinicians better integrate sex-and-gender-specific considerations into everyday cardiovascular care?

If I had to highlight one thing, it would be awareness.

Awareness needs to exist across the entire chain. It starts with the general population, including

young girls who may not realise that factors such as early menarche can be associated with increased cardiovascular risk. It extends to general practitioners, cardiovascular professionals, and policymakers.

Awareness at every level is important, but especially among cardiovascular professionals.

**Q7** From a research perspective, where do you believe the greatest opportunities lie for improving our understanding of sex and gender differences in cardiovascular disease over the next decade?

I think there are two main priorities.

The first is increasing the equal representation of women/females and men/males in research studies. This is essential.

The second is supporting more sex-specific research topics. This requires dedicated funding, potentially from the EU and other funding bodies, such as philanthropic ones, to investigate issues that are unique to women/females. One particularly important area is the study of sex-specific cardiovascular risk factors and their impact on cardiovascular health.

**Q8** The ESC has placed increasing emphasis on diversity, inclusion, and equitable healthcare. How do you see these priorities influencing the future direction of the Society?

I am very pleased to announce that, in the new mandate that began this week, the ESC has established the new Committee on Gender, Diversity, and Inclusivity.

Our president is very supportive of this topic, and we are looking

forward to beginning our work. I believe this demonstrates the importance the ESC is placing on diversity, equity, and inclusion moving forward.

**Q9** What are the priorities of the new Committee on Gender, Diversity, and Inclusivity?

I will be leading the committee, although we have not formally started our work yet and, of course, it will be a collaborative effort.

One of our first priorities will be understanding where the ESC currently stands regarding diversity, equity, and inclusion. Following that, we plan to redefine the existing ESC Gender Policy into a broader ESC Gender, Diversity, and Inclusivity Policy.

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We will also continue the programmes and projects initiated by the Gender Task Force, including the Women's Heart Health Programme, among others. These foundational actions will likely be among the first priorities of the new mandate before we move towards more specific projects and initiatives.

**Q10** What are the key priorities for the ESC beyond this year's Congress, and what developments should the cardiology community be watching for over the coming year?

One of the key priorities will be supporting the implementation of the EU Safe Hearts Plan.

The ESC is uniquely positioned to help ensure the plan is implemented at a national level because we work closely with national cardiac societies throughout Europe. As a result, I believe one of the ESC's major responsibilities and priorities over the coming years will be helping to coordinate and support the implementation of this important initiative.

**Q11** What are your current priorities at the Spanish National Centre for Cardiovascular Research (CNIC), Madrid, Spain?

Over the years, my research interests have shifted from acute cardiac care towards prevention because I believe prevention will play a key role in the future of cardiology.

We have made enormous advances in diagnosing and treating cardiovascular diseases, but there is still a great deal of work to do in prevention. At the CNIC, my current focus is on preventive cardiology, and I believe this will continue to be one of the most important areas for the future of the field.

**Q12** What aspect of prevention are you most excited about?

One area that particularly interests me is understanding how we identify atherosclerosis in younger people, how we reach these populations, and how we increase public awareness about cardiovascular risk.

“**More than 33,000 cardiovascular professionals came together at this year's Congress, which was a record attendance**”

We also need to understand how best to treat individuals once atherosclerosis is detected, particularly among younger patients.

I am also interested in how prevention strategies should be adapted for women/females. Hormonal status can play a major role in cardiovascular risk, prevention, diagnosis, and treatment decisions. We know that women/females often develop signs of atherosclerosis 5–10 years later than men, so an important question is how we should integrate these differences into routine clinical practice.

### **Q13** Having worked in Spain, Switzerland, and Germany, have you observed any notable differences in cardiovascular health and care?

I have not observed any major cardiovascular differences between populations beyond some general lifestyle observations.

For example, it seems to me that people in Spain tend to follow healthier lifestyles than those in Germany; in Germany there is a better work-life balance; and in Switzerland, people often place a strong emphasis on physical activity and balanced nutrition.

If I were to highlight one factor that may make a difference, it would probably be the Mediterranean diet. People also tend to spend more time outdoors, which may contribute to healthier lifestyles. However, these are

personal observations rather than scientific conclusions.

The health systems themselves are also quite different, which makes direct comparisons difficult.

In Spain, the public and private healthcare systems are largely separate. In Germany and Switzerland, the systems are more integrated. This influences how healthcare professionals practise, as physicians in Spain often work within one system or the other, whereas the structure is different in Germany and Switzerland.

The organisational differences are significant, although it is difficult to identify a single aspect that most directly influences cardiovascular care outcomes.

### **Q14** Finally, after reflecting on the ESC Congress 2026, what gives you the most optimism about the future of cardiovascular medicine?

AI was undoubtedly one of the major themes of the Congress, and we can see how rapidly it is becoming part of everyday medicine.

However, what gives me the greatest optimism is that, despite living in a digital world, more than 33,000 cardiovascular professionals came together at this year's Congress, which was a record attendance.

Seeing so many people committed to presenting research, learning from one another, and working

towards reducing the burden of cardiovascular disease is incredibly motivating. It may be a more emotional answer, but for me it is very powerful to see that, even in an increasingly digital age, thousands of professionals remain deeply committed to advancing cardiovascular medicine together.

#### **References**

1. Rigshospitalet. Detection of the prevalence of silent atherosclerosis across adult life - Phase I of REACT (DETECT). NCT06692127. <https://clinicaltrials.gov/study/NCT06692127>.

