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Q1 As the European Society of Cardiology (ESC) Congress 2026 draws to a close, which aspects of the scientific programme do you feel resonated most strongly with delegates, and, from your conversations with colleagues throughout the congress, what has emerged as the key priorities and challenges facing cardiovascular medicine today?

What stands out to me is the increasing focus on moving from innovation to implementation. We have extraordinary new evidence, new technologies, and increasingly sophisticated ways of identifying cardiovascular risk, but the real challenge is how we translate all of this into better outcomes for patients.

AI has clearly been an important theme, particularly in its potential to support imaging, ECG interpretation, risk prediction, and clinical decision-making. But the discussion is becoming more mature. The question is no longer whether we can use AI, but where it adds genuine clinical value, how we validate it, and how we integrate it safely into routine care.

At the same time, prevention remains fundamental. We are treating cardiovascular disease more effectively, but its global burden remains enormous. Earlier prevention, better implementation of evidence-based therapies, multimorbidity, ageing populations, and inequalities in access to care are recurring challenges.

For me, one of the strongest messages from this congress is that the future will depend not

only on scientific discovery, but on our ability to implement innovation at scale and make it accessible to our patients.

Q2 What does the ESC Congress 2026 represent for you personally, and why do you believe it remains such an important event for the global cardiovascular community?

For me, the ESC Congress is much more than a scientific meeting. It is where science, education, collaboration, and professional relationships come together.

You can read a clinical trial or a guideline anywhere, but at the congress you have the opportunity to discuss the implications directly with the people who generated the evidence, hear different perspectives, and understand how colleagues are translating that evidence into clinical practice in very different healthcare systems.

It is also one of the few places where the whole cardiovascular community meets. We tend to become increasingly specialised, but our patients are not divided into subspecialties. The congress reminds us of the importance of maintaining a broad cardiovascular perspective.

Personally, it is also an opportunity to reconnect with colleagues from around the world, develop new collaborations, and, importantly, engage with younger clinicians and researchers. That combination of science, people, and international collaboration is what continues to make the ESC Congress unique.

Q3 Beyond the ESC Congress 2026, what should the cardiovascular community be prioritising to continue improving outcomes for patients worldwide?

I would highlight three priorities: prevention, implementation, and equity.

We already know how to prevent or treat a substantial proportion of cardiovascular disease, but many patients around the world still do not receive evidence-based interventions. Generating new evidence is essential, but ensuring that existing evidence reaches patients is equally important.

We also need to move towards more personalised care. Better phenotyping, imaging, biomarkers, genetics, and digital technologies can help us identify who is truly at risk and tailor prevention and treatment accordingly. Technology should simplify care rather than make it more complex.

Finally, we need to think globally. Cardiovascular disease remains the leading cause of

mortality worldwide, but access to diagnostics, therapies, and specialised care varies enormously. The next major improvement in cardiovascular outcomes will come not only from discovering new treatments, but from ensuring that effective cardiovascular care can be delivered to patients wherever they live.

Q4 You have been a leading figure in cardio-oncology for many years. What initially inspired your interest in the intersection between cardiovascular disease and cancer care?

What attracted me to cardio-oncology was a very practical clinical problem. We were increasingly seeing patients whose cancer treatment was successful, but whose cardiovascular disease or cardiovascular toxicity was becoming an important limitation to treatment and, in some cases, to long-term survival. It became clear to me that cardiology could make a real difference in the cancer journey.

The objective should never simply be to identify cardiotoxicity. Our role is to help patients receive the best possible cancer treatment as safely as possible. That requires understanding cardiovascular risk before treatment, detecting complications early, treating them effectively, and avoiding unnecessary interruption of effective cancer therapies. That concept has remained central to my view of cardio-oncology. It is not cardiology occurring alongside oncology. It is cardiovascular medicine integrated into cancer care, with oncologists, haematologists, radiation oncologists, cardiologists, nurses, and many other professionals working towards the same goal.

Q5 Cardio-oncology has become one of the fastest-growing areas within cardiovascular medicine. As chair of the ESC Cardio-Oncology Council, what do you see as the most important developments in the field over the past decade?

The most important change has been the transition from a reactive model to a proactive one. Ten years ago, cardio-oncology was largely about managing left ventricular dysfunction after cancer therapy. Today, we assess cardiovascular risk before treatment, develop personalised surveillance strategies, identify toxicity earlier, and try to prevent cardiovascular complications, while maintaining effective cancer therapy. The field has also expanded enormously. We now deal not only with cancer therapy-related cardiac dysfunction, but with myocarditis, vascular toxicity, hypertension, arrhythmias, thrombosis, metabolic complications, radiation-associated disease, and the long-term cardiovascular health of cancer survivors.



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Another major development has been the creation of multidisciplinary teams, dedicated cardio-oncology services, and, importantly, international clinical guidance. The 2022 ESC Cardio-Oncology Guidelines provided a common framework and language for the field. Perhaps the biggest evolution, however, is conceptual: cardiovascular health is increasingly recognised as an integral part of cancer care rather than a separate problem.

Q6 What are some of the biggest challenges clinicians face when balancing effective cancer treatment with the prevention and management of cardiovascular complications?

The most difficult decisions are rarely simply cardiovascular decisions. They are about balancing two competing risks: the risk associated with cardiovascular toxicity and the risk of compromising effective cancer treatment. We have to be very careful not to create cardiotoxicity anxiety that leads to unnecessary interruption or modification of life-saving cancer therapies. This is why risk stratification and multidisciplinary decision-making are so important. A mild change in an imaging parameter does not have the same significance in every patient, and cardiovascular abnormalities need to be interpreted in the context of the cancer prognosis, the treatment options available, and the patient's baseline cardiovascular risk. Another challenge is the evidence base. Oncology evolves extremely rapidly, and cardiovascular evidence often comes later. We therefore need stronger prospective studies and randomised trials specifically addressing cardiovascular prevention and management in patients with cancer.

Ultimately, successful cardio-oncology means protecting the cardiovascular system while enabling, rather than limiting, optimal cancer therapy.

We increasingly need to understand cardiovascular disease across the entire cancer continuum, sometimes decades after treatment

Q7 Since co-chairing the 2022 ESC Guidelines on cardio-oncology, how have you seen those recommendations influence clinical practice across Europe and beyond?

I think one of the most important contributions of the guidelines has been to provide a common framework for clinicians who were already facing these patients but often without standardised pathways. They reinforced several key concepts: baseline cardiovascular risk assessment, risk-adapted surveillance, multidisciplinary management, and the importance of avoiding unnecessary interruptions to cancer treatment. They also helped establish common definitions for cardiovascular toxicities and practical approaches to increasingly complex scenarios, including immune checkpoint inhibitor toxicity. What has been particularly rewarding is seeing the guidelines being used not only in specialised cardio-oncology centres, but also to develop local pathways, educational programmes, and referral networks in many different countries.

However, publishing guidelines is only the beginning. The next challenge is implementation. We need to understand which recommendations are being adopted, where the barriers are,

and how we can create models of cardio-oncology care that are effective but also realistic and scalable across very different healthcare systems.

Q8 What areas of research in cardio-oncology do you find are currently generating the most excitement and have the greatest potential to improve patient outcomes?

There are several very exciting areas, but I think the next major advance will come from better personalisation of cardiovascular care.

We need to identify more accurately which patients are genuinely at risk, who needs intensive cardiovascular surveillance, and who can be monitored less frequently. Combining clinical information with imaging, biomarkers, and potentially digital and AI-based tools could make surveillance much more precise and efficient.

There is also enormous interest in the cardiovascular effects of newer cancer therapies, particularly immunotherapies and cellular therapies, where we are still learning about mechanisms, early diagnosis, and optimal treatment.

Long-term survivorship is another important area. As cancer survival improves, we increasingly need to understand cardiovascular disease across the entire cancer continuum, sometimes decades after treatment.

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Furthermore, we urgently need more prospective and randomised evidence. Cardio-oncology has generated an extraordinary amount of observational research. The next step is proving which strategies have clinically meaningful outcomes.

Q9 How can cardiologists, oncologists, and other allied HCPs work more effectively together to ensure patients receive truly integrated care?

Cardio-oncology works best when the cardiologist is not simply consulted after a complication occurs, but is integrated into the cancer pathway from the beginning when cardiovascular risk is relevant. That does not mean that every patient with cancer needs to see a cardio-oncologist. We need clear pathways that identify which patients can be managed

within oncology, which require cardiovascular assessment, and which need specialised cardio-oncology care. Communication is essential. Shared protocols, rapid referral pathways, and multidisciplinary discussion of complex cases can prevent both delays in cancer treatment and unnecessary cardiovascular investigations. Nurses and allied HCPs are also fundamental. Prevention, patient education, blood pressure management, treatment adherence, exercise, and survivorship care cannot depend exclusively on physicians.

Ultimately, integrated care is not about putting different specialists in the same building. It is about creating a system in which they make coordinated decisions around the needs and priorities of the same patient.

Q10 If you could leave the ESC Congress 2026 attendees with one key message about the future of cardiology, or more specifically cardio-oncology, what would it be?

My key message would be that cardiovascular care must increasingly follow the patient rather than the disease. Our patients are older, have more comorbidities, and are receiving increasingly complex treatments. Cancer and cardiovascular disease are two of the major health challenges of our time, and they frequently coexist. In cardio-oncology, our ambition should, therefore, go beyond preventing cardiotoxicity. We should aim to optimise cardiovascular health across the entire cancer journey, from diagnosis and treatment through to long-term survivorship.

And there is one principle I would particularly emphasise: cardio-oncology should enable effective cancer treatment, not become a barrier to it.

