Writing a textbook is no easy task. Indeed, it is oftentimes described as a labor of love, something that your passion must push forward lest you lose steam halfway through. Now at the culmination of what started almost 2 years ago, I will tell you that this is true. The desire to simply finish what has been started is not nearly enough; an author has to really want a book to be not only completed but also worthy of the time, effort, and inspiration that designed it. So what kept me going? I have often wondered how I came to this point in my career, where I care so deeply about a single disease that I would want to become instrumental in its course. It is, I think, an interesting story and one that I will now share with you. In doing so, perhaps you will understand a little bit of why I created this book and the void I was hoping to fill.

I first heard the term \textit{hypertrophic cardiomyopathy} (HCM) in 1994 as part of my second-year cardiovascular pathophysiology course at Brown University Medical School. What was clear to me within just a few short weeks was that this was a remarkable disease. Not only was the physiology impossibly intricate, but the diverse symptomatology, differential age at presentation from childhood to the elderly, and genetic and social aspects as well as the diagnostic and therapeutic challenges made this disease uniquely appealing. To be clear, at the time, there was little in terms of treatment and only a relatively rudimentary understanding of diagnosis, physiology, and genetics. But that was part of what fascinated me—the feeling that despite years of progress, we remained in some ways at the beginning.

My next memory of HCM is from 1998 during internal medicine residency at Cornell Medical Center/New York Presbyterian Hospital in Manhattan. A senior resident was presenting a case during morning conference, and it turned out to be one of HCM. As he went around the room, I remember being able to articulate the underlying etiology of dynamic outflow tract obstruction, something I was quite proud of. He went on to describe the potential management options. At the time, dual-chamber pacing to reduce outflow tract obstruction was a leading concept having first been reported formally in 1992. In addition, he described a novel percutaneous approach to eliminating obstruction, alcohol septal ablation, which in early studies had been shown to mimic results of surgical septal myectomy. A few things stood out in my mind at this time. First, it appeared that HCM was extremely rare, this being the first case that we had seen during my 2 years of residency. Second, it seemed that neither surgical myectomy nor alcohol septal ablation was being performed with any regularity. And third, the disease was still fascinating to me—something I wanted to learn more about.

My own inroads into the management of HCM started in fellowship training at the University of Pennsylvania. Believe it or not, I went there initially to become a heart failure and transplant specialist. My interest in hemodynamics, physiology, and heart failure in particular was paramount up until the point that I stepped into the cardiac catheterization laboratory. As it turns out, I like to use my hands and soon realized that the hemodynamic and heart failure concepts I so loved were right there at the cath table. So it was that in 2000, I saw my first alcohol septal ablation performed by one of my mentors, Dr. John Hirshfeld. Here was a patient suffering from severe heart failure, unable to walk one block on a flat level without significant dyspnea.
Despite high-dose medications and unable to climb a flight of stairs without fear of passing out. The procedure went smoothly, and 3 days later the patient was transformed. His heart failure was vastly improved. It was surreal, and I have never forgotten.

Four years later, I graduated fellowship and took my first job as a faculty interventionalist back at my residency program, Cornell. My goals were to be an academic interventional cardiologist focusing on drug-eluting stents while becoming as good a clinician as I could. As it were, though, most academic institutions like their faculty to develop niches—areas of expertise that they could call their own, master, and develop. So it was that a patient presented to the emergency room with severe hypertrophic cardiomyopathy refractory to multiple and high-dose medications. Moreover, this patient had already undergone surgical myectomy 4 years prior, but the area of maximal septal-valve contact was clearly missed. His gradients were almost 300 mmHg with provocation, 100 mmHg resting, and the patient described ongoing severe symptoms that only worsened after surgery. This was my first alcohol septal ablation patient. Ten years later, I count him as not only a patient but a longtime friend, someone whose life has vastly improved due to my efforts.

Over the next few years, I became first the local and then the regional HCM expert. I read all the relevant original articles, all the reviews, and became intimately involved in every aspect of the disease from presentation to diagnosis and management. After moving to Winthrop University Hospital in 2006 as Director of the Cardiac Catheterization Laboratory, I created the HCM treatment center. What started as a handful of patients has now grown to almost 500. Over time, the Center has grown to include all aspects of diagnosis including cardiac MRI and genetics, electrophysiology, family screening, original research, randomized controlled trials, pediatrics, surgery, and alcohol septal ablation. We are now reaching into the community to raise awareness in high schools and impact statewide legislation. With all this, our national presence has grown with presentations at national meetings, live proctoring courses (Fig. 1), numerous grand rounds, as well as a biannual patient-centered regional conference.

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**Fig. 1** (a) Dr. Naidu with select faculty and participants from the first Annual Alcohol Septal Ablation Live Proctoring Course in 2014. (b) Dr. Naidu addresses the audience. (c) Dr. Naidu and Co-Director of the Live Course, Dr. George Hanzel, perform an alcohol septal ablation. (d) Dr. Michael Fifer (right) teaches from the viewing area.
So where does this book come in? No one reads books anymore, I was once told—and to some extent, they are correct. But HCM is different, I think. In 2009, I was asked to serve on the first official American College of Cardiology (ACC)/American Heart Association (AHA) guideline on the diagnosis and management of HCM—I was to be the official representative of the Society for Cardiovascular Angiography and Interventions (SCAI). Although chosen to represent an interventional society, I brought all my insights as a medical director of a busy HCM program contributing as much as possible on all aspects. This was a transformative process for me. Working alongside luminaries such as guideline chair Dr. Bernard Gersh, I realized that those on the committee were part of a larger mission to (a) make sure our combined wisdom makes it to paper, (b) help physicians realize that HCM management is difficult and time consuming and should thus be done alongside an HCM Center of Excellence, and (c) make sure the recommendations we are writing are practical enough to be followed. Two years later, I was very proud of the group’s efforts and culminating document. But something was missing.

It struck me at that point that there was no vehicle other than these newly created guidelines to explain why we do what we do for patients with this disease. We explained what to do and made dozens of formal recommendations, but the “why” and the “how” were limited—necessarily so as most were consensus driven. That’s when I realized that books are still necessary for rare diseases. This is the way we put down in words what our experience has taught us. This is the way we can teach others. This is how we can grow the understanding, appeal, and impact of appropriately treating these patients and their families. This is where the details come. A book could be a blueprint not only for treating patients in a comprehensive yet practical way but also for creating and sustaining a Center of Excellence—and in doing so sustaining the optimal yet dynamic management of a rare disease.

This textbook is constructed purposefully to do this. After the foreword and this preface, we travel back in time to rediscover HCM, dive into the pathology, and tease out the nuances of diagnosis from echocardiography to cardiac MRI. A treat for the reader, Dr. Eugene Braunwald provides his firsthand account of encountering HCM. We discuss management including medications, pacemakers and defibrillators, and invasive septal reduction therapy—both surgical myectomy and alcohol septal ablation. Chapters on genetics, family screening, lifestyle concerns, and athletic screening are added given the ongoing controversies and differences of opinion on many of these. Advanced management including imaging, heart failure, and transplantation are also discussed in detail.

The chapters are meant to be practical, with each one starting off with key points of knowledge and ending with clinical pearls—the tiny morsels of information that only the experts have known about. The practical approach continues with dedicated chapters on creating a Center of Excellence and on case-based reviews and discussions. This last chapter takes you through the management of actual patients, showing over decades the nuances to diagnosis and management and the sometimes abrupt changes in the course of their diseases that necessitate correspondingly abrupt modifications in treatment. Through it all, the reader not only understands the dogma of HCM care as depicted in the guidelines but also the stuff between the cracks—the knowledge that not only separates the student from the teacher but the teacher from the master.

I would be remiss if I did not credit several individuals for making sure that HCM—the disease—was not “lost” after its discovery over 50 years ago and then for rapidly raising awareness and helping develop treatment options over the past two decades. Perhaps the two most influential would be Dr. Eugene Braunwald (Fig. 2) and Dr. Barry Maron. While the former helped describe the first cases and delineate the underlying pathophysiology, the latter took the disease in—like it was part of his family—and shepherded its rise and acceptance as well as the growth of other physicians with similar passion. As a result, there are now many HCM experts throughout the world with unique expertise that ranges from pathophysiology to medical therapy, genetics to imaging, alcohol septal ablation to surgery, and electrophysiology to transplantation. And patient-centered groups have also arisen right alongside providing that
much-needed patient voice and drive for advocacy. Together, we form a very strong community tied by our deep passion for this disease and the patients and families that are affected by it—in essence, we are each other’s extended family.

This book would not have been possible without several people who have inspired and supported me over the years. To my parents and sister, who quietly told me I could do anything and always stood by me even when I was my own worst enemy; to Vartan Gregorian, whose leadership style I think rubbed off on me; to John Hirshfeld, Howard Herrmann, Robert Wilensky, Daniel Kolansky, and Mariell Jessup, who inspired me to reach higher, focus, and be impactful in everything I do; to Kevin Marzo and Michael Niederman, who took a chance on me and let me fly; to Garry Schwall, who supported my interest in HCM right from the beginning; to Nicole Goldman, who keeps me on track with my patients; to Nina Naidu, who told me not just that I could do this but that I should; and to my son, Kiran Naidu, who makes me happy every single moment of my life and lets me take the time to enjoy it. This book is for all of you. And I thank you.

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