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reliable manner. For example, ventricular pacemakers were not approved because they saved lives, but rather because they demonstrated the ability to initiate a signal that would effectively induce a contractile response in the presence of a block in the normal electromechanical signaling pathway. In some cases, the value of individual devices has come after, rather than before the approval of the device. One example is P1: Yet to Come Preface biventricular pacing, first approved on the basis of early studies demonstrating that resynchronization of the heart could improve heart failure symptoms, exercise tolerance, and quality of life in patients with heart failure. The role of resynchronization therapy in improving both survival and the combined endpoint of survival and hospitalization for worsening heart failure came in subsequent Phase IV studies. However, studies of resynchronization were surprising as they demonstrated that a device could actually enhance cardiac remodeling, alter the molecular biology of the heart, and improve survival. Another important difference between drugs and devices is that an individual physician can administer a drug to their patient. However, the use of a device often requires the collaboration of a multidisciplinary team. For example, the placement of an internal cardioverter defibrillator requires the collaboration of a cardiologist or internist, an electrophysiologist, and occasionally a surgeon specializing in the thoroscopic placement of leads on the epicardium of the heart. For other devices, there may only be a single physician at an institution that can implant a specific device. For example, some percutaneous devices require skills in transseptal procedures—a technology around which only some interventional cardiologists are skilled and one that requires the collaboration of heart failure specialists and interventionalists. Similarly, valve replacement or repair can be a critical feature in the treatment of a patient with heart failure—but one that also requires a multidisciplinary team approach to the patient. The various chapters in this text can be subdivided based on the role of the device in the care of patients with heart failure. The first five chapters detail a group of devices that are chronically implanted to either improve cardiac function or increase survival Cardiac Resynchronization Therapy and Implantable Cardioverter-Defibrillator Therapy, provide online and real-time monitoring of cardiac function Chronic Implantable Monitoring, or new implantable devices that may have the ability to improve cardiac function or delay maladaptive cardiac remodeling Impulse Therapy and Cardiac Restraint. The final group of chapters provides a discussion of invasive technologies—both surgical and nonsurgical—that can provide urgent or chronic support in patients with severe left ventricular dysfunction, including Revascularization for Left Ventricular Dysfunction, the use of Minimally Invasive Treatment for Mitral Valve Disease, Percutaneous Mechanical Assist Devices in patients with acute cardiac decompensation or as a support device during high-risk revascularization, the use of Left Ventricular Assist Devices as a bridge to transplantation or a bridge to recovery, and the use of Counterpulsation and Ultrafiltration in patients with both acute and chronic heart failure. The treatment of patients with heart failure is a continuously moving target as new devices are being developed. In this text we have focused on those technologies that in some cases are available at most hospitals that have programs in electrophysiology and cardiac surgery as well as new technologies that are available or undergoing late-stage investigation at quaternary hospitals with surgical and medical heart failure programs. With the increasing number of options available to physicians, there will be an increasing need to identify the right intervention for the right patient. Thus, we have tried to provide guidelines within each chapter that will help to define those patients that will be benefited the most by each of these different therapies. However, decisions regarding each of these new therapeutic options will in many cases be based on the presentation and needs of each individual patient. Unlike drug therapy where practice guidelines have defined both the list of optimal medications and the target therapeutic levels for heart failure medications, we will see that the use of device therapy is far less clear. Hopefully, future studies will better define the effectiveness of these various therapies and more clearly define their role in the care of heart failure patients.

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