Conclusions
Use of distal protection device during angioplasty in AMI reduces the total procedural time with better and faster optimal blood flow and myocardial perfusion grade.

Use of distal protection device is effective in reducing the risk of intra-procedural embolization and no-reflow incidences, simultaneously reducing administration of intra-coronary vasodilators and glycoprotein IIb/IIIa inhibitors.

Implantation of coronary sinus Reducer stent was safe and feasible in patients with refractory angina pectoris and carries no immediate or long-term complications.

Preliminary clinical improvement observed with the coronary sinus Reducer stent presents a novel effective tool in treatment of refractory angina patient and supports further evaluation of clinical efficacy of the stent in such patients.

Implantation of the device for non-invasive measurement of pulmonary artery pressure is safe, feasible and likely efficacious in monitoring and treating patients with CHF.

In CHF patients, nocturnal rise in pulmonary artery pressure (both systolic and diastolic) may be responsible for the worsening of these patients' symptoms at night or early morning. Non-invasive measurements by the implantable device may assist the daily monitoring of these patients including their nocturnal changes and adjustment of therapy.
Pulmonary artery (PA) pressure and more importantly, PA Diastolic pressure show significant rise following exercise in CHF patients limiting their exercise capacity. This increase in PA pressure may be secondary to either ischemia or Left ventricular dysfunction or both. Management of these patients should be tailored to avoid this exertional rise in PA diastolic pressure either by avoiding ischemia or by improving left ventricular dysfunction.

Loading metoprolol XL (MXL) in CHF patients using the recommended MERIT-HF protocol was associated with minor insignificant changes in PAP. However, not all patients may tolerate beta-blocker well, which supports the recommendation for slow and careful uptitration of MXL in patients with CHF. Use of the device may help identifying beta-blocker intolerance in certain patients.

Slow and careful uptitration of MXL upto 200 mg/d may prevent this nocturnal rise as evident from the non-invasive frequent monitoring by the implantable device.

Metoprolol XL treatment in CHF patients produce a slight insignificant increase in systolic PAP at baseline and after exercise (with decrease in peak exercise systemic BP and HR) but improve the exercise capacity in selected patients. This supports the recommendation for slow and careful uptitration of MXL in CHF patients.

Management of CHF patients and titration of therapy using non-invasive hemodynamic monitoring may show clinical improvements.