Is on-pump better than off-pump for coronary artery bypass surgery? Page 10

Message from the President

The first months of 2011 have been very busy ones for EACTS. We are preparing the programme for the forthcoming annual meeting in Lisbon 1-5 October. Abstract submission closed on 1 April and we are encouraged by the number and quality of abstracts received. A total of 1188 abstracts are now with our reviewers who have the task of reading and rating all abstracts prior to the programme committee meeting which will be held in May. This Annual Meeting is a very special one for the EACTS as it marks our 25th Anniversary. Since EACTS was founded in 1986 we have grown both in number and stature. EACTS held its first scientific meeting in Vienna in 1987 when EACTS had 288 members from 27 European countries, with 420 delegates attending the annual meeting. Twenty-five years later, we have grown into the largest professional cardio-thoracic association in Europe with 2945 members, from 101 countries. Our annual meeting is attended by over 4000 physicians and 1500 exhibitors. We are now the largest Cardio-Thoracic meeting in the world.

In this second issue of EACTS News we have an interview with the Association’s first President, Professor Francis Fontan, who will share his memories of the founding of our Association and his thoughts for the future. We will also look forward to the Lisbon Programme and I would like to take the opportunity to invite you all to celebrate this 25th Anniversary with us at a special Anniversary Party on Tuesday evening 4 October. You will read more about this in this issue of EACTS News. This edition features the SURTAVI Trial with one of its investigators Professor Rudiger Lange. The Big Question in this issue is "which procedure results in better outcomes: off-pump or on-pump for CABG?" Patrick Klein, Robert Klautz and Stephan Jacobs debate this hot topic.

The domains have been active in the early months of 2011. Franca Melli and Ralph Schmid organised the successful Robotic Course in Cardio-Thoracic Surgery in Strasbourg. The Vascular Domain organised a stimulating course in Open and Endovascular Aortic Therapy in Windsor. Juan Comas in co-operation with the Association for European Paediatric Cardiology (EAPC) organised a multidisciplinary course on The Right Ventricular Outflow Tract Management from Neonates to Adults: An Interdisciplinary View" in Palma. I congratulate all the organizers for their hard work. It was a great pleasure for me to join Pascal Vouhé and representatives of the National Societies to discuss the future training of cardio-thoracic surgeons.

It is my pleasure to send you the second issue of EACTS News. I hope it stimulates the debate concerning topical issues in cardio-thoracic surgery and I hope that you will enjoy reading it.

Ottavio Alfieri, MD, PhD President

Save the date

Join the 25th EACTS Anniversary Party in Lisbon on Tuesday evening 4 October 2011!

To celebrate the 25th Anniversary of the EACTS, we plan a special Anniversary Party on Tuesday 4th October, to replace the traditional gala dinner. The aim is to create a welcoming and informal atmosphere in elegant surroundings where you can relax and enjoy the company of colleagues both old and new and from all continents. An interesting and varied programme of entertainment and music is planned which will appeal to all tastes. The highlight of the evening will no doubt be the Cardio-Thoracic Surgeons Band, led by Volkmar Falk. A buffet dinner will be served. Further information at www.eacts.org

Which LVAD has the lowest published stroke and thrombosis rates?

View compelling data and superior outcomes at www.VADParadigm.com

Minimizing risk of stroke and thrombosis: Advances in LVAD design

Presented by Steve Reichenbach, PhD, Thoratec Corporation
An interview with Francis Fontan

The leading founding father of the European Association for Cardio-Thoracic Surgery

Since the European Association for Cardio-Thoracic Surgery (EACTS) was founded 25 years ago, it has grown into the largest professional cardio-thoracic association in Europe, with 2,500+ members from over 70 countries across the world. EACTS News was delighted to interview the Association’s leading ‘founding father’ Professor Francis Fontan who recounts how the foundations of the EACTS were laid in various airport meetings throughout Europe, his memories of the first meeting and why the annual meeting is now the largest cardio-thoracic meeting in the world.

“I had been thinking about the idea of trying to create a European association or society to represent cardiothoracic surgery and it had occurred to me and others that although national societies existed, the specialty of cardiothoracic surgery in Europe was not sufficiently represented,” began Fontan. “The idea matured in 1984/85 when I was on my way back from the American Association for Thoracic Surgery meeting and I thought why are the best European papers presented outside Europe to be recognized by the scientific community in meetings where many of us could not go for geographical reasons and financial constraints? So I decided to try and convince my colleagues to create the Association.”

Airports

He contacted his good friends, Hans Huysmans and Marko Turina, and their enthusiastic response coupled with the positive responses from other friends and colleagues encouraged him further. What followed was a series of meetings in airports across Europe. At the first meeting held on 1 March 1986 at Amsterdam airport, Fontan invited 11 colleagues and discussed the formation of a new scientific organisation of cardio-thoracic surgery for Europe.

“When we met in Amsterdam, we didn’t know how we could begin to think and work together and there was also a little embarrassment that day, for some as they were meeting each other for the very first time,” he commented. “I was soon aware that my belief was unanimous among the group and it became our firm conviction that an Association should be created. After a second meeting was held in Frankfurt on 12 April that same year, the decision to found the Association was taken on 17 May 1986 in Paris, and the Council was set up. “What was extremely important at the beginning was the hardwork and belief of the founding council. They possessed tremendous intellectual and personal qualities, and totally devoted to the EACTS, its aims and ambitions,” added Fontan.

“We were 12 people and we decided to have 11 seats on the council. Of the 11 to serve on the council, five were officers and six were councillors. The first question was who would serve as President? And they all said I should be president, but I was reluctant, I didn’t help to found the Association just to be its President. But, they all agreed and said it must be me.”

The first EACTS Council

The founding council members of the EACTS were: Francis Fontan (President), Kevyan Moghissi (Vice-President), Marko Turina (Secretary-General), Ingolf Vogt-Moykopf (Treasurer), Hans Borst, (Editor of the European Journal of Cardio-Thoracic Surgery (EJCTS), Louis Couraud (Councillor), David Wheatley (Councillor), Hans Huysmans (Councillor), Bjarne Semb (Councillor), Ramiro Rivera (Councillor) and Muniruo Cotrufo (Councillor).

From the outset, it was agreed on a “fair proportion” of cardiac and thoracic surgeons, with the president being a cardiac surgeon serving for two years, followed by thoracic surgeon for one year. The council had the world’s largest assembly of cardio-thoracic surgeons.

“What are two great memories of that meeting. The first is when I was to open the meeting in the first scientific session to explain to the delegates how we had created the meeting. I came from my hotel in a taxi and arrived in time to take my slides presentation room. I am in the room for five minutes and suddenly I cannot find my slides anywhere. I take a taxi back to the hotel panicking because this is the first meeting and I am due to make a very important speech and I have no slides. Thankfully, five minutes before the start of my talk, we found the slides in the speaker ready room. It would not have strongly supported by industry. “For the first time, cardiothoracic surgeons throughout Europe had the chance to meet in the same place; there were also many people from non-European countries present. It was not a great financial success, but at least we didn’t lose money,” Fontan remembered.

The next meeting took place in the following year in Dr Fontan’s home town of Bordeaux, France, and attracted twice as many delegates. Since then, the meeting has grown year by year, so that the 24th meeting held last year in Geneva, Switzerland, attracted more than 3800 attendees, making it the second EACTS meeting was held in Frankfurt on 12 April that same year, the decision to found the Association was taken on 17 May 1986 in Paris, and the Council was set up. “What was extremely important at the beginning was the hardwork and belief of the founding council. They possessed tremendous intellectual and personal qualities, and totally devoted to the EACTS, its aims and ambitions,” added Fontan.

“We were 12 people and we decided to have 11 seats on the council. Of the 11 to serve on the council, five were officers and six were councillors. The first question was who would serve as President? And they all said I should be president, but I was reluctant, I didn’t help to found the Association just to be its President. But, they all agreed and said it must be me.”

The first EACTS Council

The founding council members of the EACTS were: Francis Fontan (President), Kevyan Moghissi (Vice-President), Marko Turina (Secretary-General), Ingolf Vogt-Moykopf (Treasurer), Hans Borst, (Editor of the European Journal of Cardio-Thoracic Surgery (EJCTS), Louis Couraud (Councillor), David Wheatley (Councillor), Hans Huysmans (Councillor), Bjarne Semb (Councillor), Ramiro Rivera (Councillor) and Muniruo Cotrufo (Councillor).

From the outset, it was agreed on a “fair proportion” of cardiac and thoracic surgeons, with the president being a cardiac surgeon serving for two years, followed by thoracic surgeon for one year. The council had the world’s largest assembly of cardio-thoracic surgeons.

“What are two great memories of that meeting. The first is when I was to open the meeting in the first scientific session to explain to the delegates how we had created the meeting. I came from my hotel in a taxi and arrived in time to take my slides presentation room. I am in the room for five minutes and suddenly I cannot find my slides anywhere. I take a taxi back to the hotel panicking because this is the first meeting and I am due to make a very important speech and I have no slides. Thankfully, five minutes before the start of my talk, we found the slides in the speaker ready room. It would not have said much for the organisation, if the President had lost his presentation,” Fontan remembers. “The second memory was the day after the first meeting in Vienna has finished, my wife and I went for a very relaxing walk in Vienna and I enjoyed it so much because we proved the meeting could be successfully organised, apart from my missing slides!”

Francis Fontan Prize

Such is the debt the Association owes to Fontan, the EACTS funds the Francis Fontan Prize that is awarded to a medical doctor in specialty training in cardiac or cardio-thoracic surgery. The amount awarded is €30,000 and covers the costs of one year’s stay at a major European department or any other European research facility. Previous recipients have included physicians from Europe and elsewhere, including a US citizen and others from China and India.

“I remember receiving a phone call from the EACTS President saying that the Association had decided to create a prize called the Fontan Prize and as the founding father of the Association, they would like to name it after me. I said to him ‘Isn’t it normal that you wait until someone has died until you name something after them? Shouldn’t we wait until I die?’ But it was decided it was best not to wait!”

The one thing that has surprised Fontan is how both the meeting and the Association have have become one of the largest in the world. “We did not think at the time it would become so large, but I think the reason EACTS has grown is because new people came in with new ideas. One fundamental change was the creation of the domains because this brought about new developments, as well as brings new personnel into the Association,” concluded Fontan. “All this was achieved because of the intelligence of our successors; councillors and officers. If the EACTS continues to do this, it will keep its position as leader of the cardiac field.”

Additional reading:
Setting new benchmarks in transcatheter valve delivery

New and improved delivery systems engineered for:
- enhanced procedural control
- predictable and precise valve placement

For professional use. For additional information, indications, contraindications, warnings, precautions and adverse events, please refer to the instructions for use provided with the products. Edwards, Ascendra 2 and Edwards NovaFlex are trademarks of Edwards Lifesciences Corporation. Edwards Lifesciences, the stylized Fibro, and CoreValve-Edwards are trademarks of Edwards Lifesciences Corporation and are registered in the United States Patent and Trademark Office. © 2011 Edwards Lifesciences SA. All rights reserved. E1823/SH/11/THV

Edwards Lifesciences, S.A., Rue de l’Etat 76, 1966, Nyon, Switzerland, +41 22 787 43 00

Paris, USA, Nyon, Switzerland, Tokyo, Japan, Singapore, Singapore, Sao Paulo, Brazil
Nurses, nurse practitioners and other allied health professionals at EACTS 2011

EACTS organized the first Post Graduate course for nurses, nurse practitioners and other allied health professionals during the 24th Annual Meeting in Geneva in 2010. The course was very well received by those who attended and the feedback was extremely positive. As the care of our patients is becoming more and more complex the role of specialized nurses will become an integral part of the team effort involved in patient care. The EACTS has decided to organize the symposium again during the 25th Annual Meeting in Lisbon on 2 October 2011.

Nurses and nurse practitioners are presented with a two-day programme which includes Techno College on Saturday and a Post Graduate course on Sunday. The topics included in the postgraduate course will be transplantation, assist devices, developments in wound care, the role for nurses in the implementation of clinical guidelines, nurses/nurse practitioner’s role developments, and guidance on writing a scientific article.

This year we are offering nurses and nurse practitioners the opportunity to submit an abstract. Submission is through the EACTS User Area (Abstract section). The deadline for submissions is 15 May 2011. Suggestions for topics that you would like to see included in the nurses programme can be sent to Rianne Kalkman: RianneK@eacts.co.uk. A more detailed programme will be published on the EACTS website in June.

Successful course on Open and Endovascular Aortic Therapy

This year the EACTS Vascular Course took place for the third time and was organized for the first time in Windsor on 16-18 March. Attendees came from a variety of countries including India and Mexico. The organisers feel that this fact underlines the attractiveness of the EACTS Educational Program and the efforts to its continuous improvement.

There were three days of fruitful dialogues between participants and faculty which we felt was very important as a format with lots of time for discussion was the aim of the course. As such both participants and faculty were able to gain contralateral insights from one another including individual needs during training, the loco-regional variety of treatment options offered as well as the most recent insights into new technology and its clinical application further accompanied by a thorough understanding of what should be recommended for the armamentarium of the cardiovascular surgeon today.

Over the three days, the course was broken into eight sessions. The morning of the first day covered the natural course of thoracic aortic disease, molecular mechanisms of atherosclerotic lesion development and plaque rupture, as well as imaging modalities in aortic disease (Computed Tomography, Magnetic Resonance imaging, Transesophageal echocardiography, Transthoracic echocardiography and Intravascular Ultrasound). In the afternoon, the sessions were concentrated on cardiopulmonary bypass principles of aortic surgery, including cannulation techniques, perfusion options and temperature management, as well as brain, heart and visceral organ protection.

The second day of the course examined the indications and techniques when treating the aortic valve and ascending aorta and included presentations on the replacement of the aortic root (mechanical composite graft), biological aortic root replacement, valve sparing operations (David- and Yacoub procedures) and bicuspid aortic valve (reconstruction and replacement). In addition, Robert Bonser, Ernst Weingang and Roberto Di Bartolomeo, outlined the indications and techniques for conventional arch surgery (partial-, hemic- or total arch replacement), hybrid aortic arch repair (case selection, pre-operative work-up, surgical technique, stent-graft selection) and extended aortic arch repair (Elephant trunk and Frozen elephant trunk).

There was also a specific emphasis on the basic requirements for endovascular aortic repair including the technical skills for endovascular procedures, open and percutaneous access for endovascular aortic repair and device selection in endovascular aortic repair. For the session on aortic dissection, attendees assessed the treatment algorithm for acute type A aortic dissection as well as examining the fate of the false lumen after repair for acute type A aortic dissection. This was followed by looking at the treatment options for acute type B aortic dissections and the pitfalls in endovascular repair of type B aortic dissection.

Day three began with a look at the descending and thoracoabdominal aorta and look at the pathomechanisms and treatment options for traumatic aortic rupture. This was followed by a study of neuroprotection in thoracoabdominal aortic repair (including cerebrospinal fluid drainage, somatosensory evoked potential and transcranial motor evoked potentials), as well as an assessment of surgical techniques in thoracoabdominal aortic replacement and of the hybrid approach in thoracoabdominal aortic aneurysm. The final session of the course covered the natural course of abdominal aortic aneurysms and assessed the limitations of both open and endovascular repair and asked which was currently the treatment of choice.

The organisers would like to thank the participants, faculty and EACTS staff for their support in making this course again a success and do look forward to next year.
Introducing the Trifecta™ Valve from St. Jude Medical

We wanted to call it the Perfecta, but our lawyers wouldn’t let us...
EACTS and National Societies discuss future training

A group of motivated European cardio-thoracic surgeons met in the picturesque surroundings of a traditional English garden overlooking the river Thames to discuss the future of cardio-thoracic training in Europe in the coming years against a background of changing therapeutic options, new technology and restrictions of the EWTD.

The meeting with national societies, the ESCVS and the ESTS was organized by the EACTS, where several National Societies were represented at the meeting.

Plenary sessions were alternated with break-out groups which examined the European Board for Thoracic and Cardiovascular Surgery, the Board Examination the role of the UEMS. It became clear from the fruitful discussions in the breakouts that the participants shared common concerns.

Key messages from participants was the need for harmonization of cardio-thoracic training and education programmes in Europe and in particular the need for a set of minimum standards in training programmes. Participants also considered that imaging, minimal invasive and catheter based techniques should be included in training programmes in the future.

In the next phase the group will examine the various European training programmes and work on a guidelines document on training. Participants were also urged to appoint national society members to participate in an active way in the Cardio-Thoracic Section of UEMS.

Other items for discussion included the implementation of Clinical Guidelines and role of the European Databases in quality control and benchmarking.

Also discussed were the content of the EACTS 25th Annual Meeting, the implementation of Clinical Guidelines and the European Databases.

The next meeting will be organized during the 25th EACTS Annual Meeting in Lisbon.

For further information please contact Rianne Kalkman: RianneK@eacts.co.uk

EACTS attends 22nd Scientific Session of the Saudi Heart Association

The European Association for Cardio-Thoracic Surgery (EACTS) participated for the second time in the Annual Meeting of the Saudi Heart Association. The 22nd Scientific Session of the Saudi Heart Association (SHA22) was held in Riyadh, Saudi Arabia from 21-24 February 2011 at the King Faisal Hall, Intercontinental Hotel. The Saudi Heart Association also welcomed participation from European Society of Cardiology, Association of Thoracic and Cardiovascular Surgeons of Asia, American College of Cardiology, Gulf Heart Association, Arab Association of Cardiothoracic Surgery, Canadian Cardiovascular Society and World Heart Federation.

The meeting attracted some 1,500 participants and is one of the largest meetings in the region. The meeting includes all specialties in cardiac care offering sessions in cardiology, interventional cardiology, cardiac surgery both adult and paediatric, imaging and perfusion in five parallels.

The EACTS had a major role in the meeting, with two full days of sessions that were highly attended by participants from all over the world. The ESC also organised a whole one day programme which included the highlights of the ESC 2010 in Stockholm and ESC guidelines.

In addition to the joint session, the European Association of Cardiothoracic Surgery and Saudi Heart Association had a business meeting with a wide range of issues being discussed, databases, guidelines and future joint sessions.

Dr. Hani Najm, President of the SHA and a member of the EACTS, stated that he was proud to have invited the EACTS speakers to participate in the SHA22, and that having world renowned cardiac surgeons share their knowledge with colleagues and people of Saudi Arabia contributed greatly to the strength of the scientific session. It is the aim of the Saudi Heart Association to continue to expand and foster collaboration with different major international heart associations.
they did however, recommend that we show you *this*:

Introducing the next-generation pericardial tissue heart valve – Trifecta™. The unique valve design consists of externally mounted tissue, which allows leaflets to open more fully and efficiently. This results in larger EOAs and single-digit mean gradients at six months.¹ Through outstanding performance in all three key areas of hemodynamics, durability² and implantability, the Trifecta valve performs more like a natural heart valve.

2. Data on File, St. Jude Medical.
The 25th Annual Meeting returns to Lisbon for a third time.

In the 25 years since the first annual meeting was held in Vienna in 1987 (when 132 abstracts, 90 Oral, 18 Posters and 14 Films) were presented over two and a half days the annual meeting has developed significantly. It is now over four and half days and continues to evolve to meet the needs of today’s surgeons. In addition to new science we offer a wider range of session types to better educate the practitioners of the future in the wider environment which reflects the multi-disciplinary care of patients.

The 25th Annual Meeting will include as usual Techno-college, Post Graduate courses, Advanced Technologies, New Science and Focus Sessions. In addition this year we will present a new session type called Professional Challenges. Professional Challenge sessions will address a single issue, combining keynote lectures, videos, new science and learning from experience, bringing together in one session the state of the art, clinical practice and complications. Each of our four specialty domains will present programmes in each area.

The Domain of Acquired Cardiac Disease plan an extensive range of sessions and this list gives a flavour of what can be expected.

Techno College - Saturday 1 October
- Aortic Surgery
- Transcatheter Aortic Valve Implantation
- Mitral Valve Surgery

PostGraduate Course - Sunday 2 October
- Update on Syntax
- Interpretation of Guidelines
- Recent Trials in Cardiovascular Disease
- The Great Debate – Surgery is the best treatment for left main stem disease

Monday and Tuesday 3 & 4 October
- Professional Challenges
- Wire Skills
- Total Atrial Grafting
- Focus Sessions
- Heart Team at work
- Training for transcatheter aortic valve implantation
- Surgery for Heart Failure 1
- Surgery for Heart Failure 2
- Functional MRI
- Antiplatelet therapy
- Perfusion Problems & Opportunities
- New Perspectives in Functional Tricuspid Regurgitation
- Grantsmanship

Advanced Techniques – Wednesday 5 October
- Transcatheter aortic valve implantation - the gold standard for the treatment of aortic valve stenosis
- Controversies Adult Cardiac Surgery: Aortic Valve and Root Surgery
- Minimally Invasive Therapies for Atrial Fibrillation
- Master of Valve Repair
- The role of the Ross Operation on the surgical menu

In addition there will be a range of wet lab courses.

Abstract Submission 2011
The abstract submission is now closed. We are happy to report that we received a total of 1188 abstracts. It is now the task of our reviewers to read and rate all the abstracts prior to the programme committee meeting which will be held in May.

Abstract Reviewers 2011
The Council and Programme Committee extend their thanks and appreciation to all those members who will diligently read and rate all the submitted abstracts.

Eduardo da Cruz
Martin Czerny
Graham Cooper
Paola Ciricco
Jerry Brun
William Brann
Thierry Carrel
Filip Cseke
Manuel Antunes
Raimundo Aescio
Emile Bacha
Jean Bacht
Rimantas Benedis
Benjamin Bidstrup
Ozcan Birim
Johannes Bonatti
Philippe Bonhoeffer
Robert Bonser
Michael Borgor
Jerry Brown
William Brann
Ian Brade
Philip Cseke
Filip Cseke
Manuel Antunes
Raimundo Aescio
Emile Bacha
Jean Bacht
Rimantas Benedis
Benjamin Bidstrup
Ozcan Birim
Johannes Bonatti
Philippe Bonhoeffer
Robert Bonser
Michael Borgor
Jerry Brown
William Brann

25th Annual Meeting, 1–5 October 2011, Lisbon, Portugal

In the next two issues of EACTS News, we will be focusing on this year’s programme from the Annual Meeting in Lisbon. To begin the programme overview, we talked to Thoracic Domain Chair, Paul Van Schil, who outlined some of the highlights planned for the Thoracic programme.

“We had a meeting last year in Paris to decide which topics would be most important for the forthcoming year, taking into account the programme for last year,” said Van Schil. “There are approximately ten people involved and we make everybody responsible for one part of the programme. The programme is divided so they can have control of that particular area. The Postgraduate Course and Techno-College is decided by the people on the thoracic domain, so they are invited lectures.”

Last year, the thoracic Techno-College focused on training in thoracic surgery and specific methods to improve surgical outcome in oncology. This year’s thoracic Techno-College programme will examine new techniques utilising the transcervical approach in thoracic surgery.

“The programme will examine tumours of thoracic inlet, laryngotracheal surgery and staging of lung cancer, as well as compare minimally-invasive and invasive techniques for lung cancer staging,”

...continued from the Thoracic Programme

The abstract submission is now closed. We are happy to report that we received a total of 1188 abstracts. It is now the task of our reviewers to read and rate all the abstracts prior to the programme committee meeting which will be held in May.

Abstract Reviewers 2011
The Council and Programme Committee extend their thanks and appreciation to all those members who will diligently read and rate all the submitted abstracts.

Ottavio Alfieri
Manuel Antunes
Raimundo Aescio
Emile Bacha
Jean Bacht
Rimantas Benedis
Benjamin Bidstrup
Ozcan Birim
Johannes Bonatti
Philippe Bonhoeffer
Robert Bonser
Michael Borgor
Jerry Brown
William Brann
Ian Brade
Philip Cseke
Filip Cseke
Manuel Antunes
Raimundo Aescio
Emile Bacha
Jean Bacht
Rimantas Benedis
Benjamin Bidstrup
Ozcan Birim
Johannes Bonatti
Philippe Bonhoeffer
Robert Bonser
Michael Borgor
Jerry Brown
William Brann

Arrhythmia 37
Assisted Circulation – Artificial Heart 34
Cardiac General 130
Coronary/CABG 33
Congenital 120
Coronary/CABG 160
Esophagus 7
Experimental 53
Thoracic Non-oncologic 47
Thoracic Oncologic 76

Paul Sergeant
Malaksh Shrestha
Francesco Sisciari
Hans-Henrik Severs
Johan Siggren
Miguel Sousa Uva
Dagan Subotic
Shirinchi Takamato
Johanna J.M. Takkenberg
Omke Testen
Matthias Theilmann
Pascal Thomas
Wouter Van Leeuwen
Gonzalo Varela
Herbert Vetter
Ulrich Van Oppell
Pascal Voukh
Alexander Wayberth
Thomas Walther
Ernst Weigang
Olaf Wendler
Daniel Werdt
David Wheatley
Georg Wieshaelter
Jean-Marie Wihlm
Jens Wirppermann
Douglas Wood
Ludic Zarrini
Marian Zembala
Andrea Zulin

Prevising Lisbon 2011 - the thoracic Programme

25th Annual Meeting, 1–5 October 2011, Lisbon, Portugal
EACTS 2011
Ethicon Cardiovascular Simulation Award

EACTS, in partnership with Ethicon, is proud to announce the first EACTS Ethicon Cardiovascular Simulation Award.

The Contest is to create a Simulator which replicates for training purposes Coronary Anastomoses.

Development Criteria of the Simulator:

Low Fidelity
Cost Effective
Reusable
Portable/Flat Pack assembly

The projects will be submitted under the form of a transportable self-construction package. It will have a graphical description of its building process and a textual description of the materials used.

The award will be presented during the 25th EACTS annual meeting. An educational grant of 3000 € will be given to the winning team/person and the award simulator will be manufactured and used throughout Europe for training.

Contest opened to all residents and trainees.

Deadline for Submission: 1st of September 2011
For questions or submission, e-mail info@eacts.co.uk
For more information, visit www.eacts.org/content/residents
Why we shouldn’t operate off-pump routinely…

Coronary artery bypass surgery has proven to be a highly effective and durable treatment of anginal complaints due to coronary artery disease and can improve survival in selected groups of patients. Traditional coronary artery bypass surgery is performed using extracorporeal circulation and aortic cross-clamping. Since the 1980s interest grew to perform bypass surgery on the beating heart and a number of local myocardial stabilizers emerged to facilitate this. Advocates of “off-pump” bypass surgery or OPCAB postulated that OPCAB would reduce peri- and postoperative complications associated with the use of extracorporeal circulation and aortic cross-clamping, namely: stroke, neurocognitive disorders, depression of myocardial function and generalized inflammatory response.

Moreover, this could allegedly be accomplished without compromising the number and quality of coronary anastomoses. While conceptually these postulates seem justified, evidence to support them is still lacking. Also, concerns have raised whether indeed the same number and quality of anastomoses can be performed. The Veterans Affairs Randomized On/Off Bypass (ROOBY) study group published their results in 2009. They randomized more than 2,000 patients scheduled for urgent or elective CABG to either off-pump and on-pump procedures and they found no difference in the rate of the 30-day composite outcome. Especially, neither the incidence of stroke nor the outcome of neuropsychological testing and the incidence of renal failure requiring dialysis was found to be different. More worrisome, the rate of one-year composite outcome was significantly higher for off-pump than on-pump CABG (9.9% and 7.4%, p=0.04, for respectively OPCAB and CABG), with fewer grafts constructed compared to planned in the off-pump group and reduced one-year overall patency. This was entirely attributable to the saphenous vein graft patency and not to the Left Internal Mammary Artery (LIMA) to Left Anterior Descending (LAD) anastomosis. Although hampered by several limitations (mainly low risk and male patients, high conversion rate in the OPCAB group which may be indicative of limited experience in OPCAB surgery), the ROOBY trial constitutes a large and relatively well conducted randomized controlled trial.

It is true that there is no evidence that the number of grafts is directly related to outcome. To the contrary, the results from the SYNTAX-trial imply that the completeness of revascularization was not related to age of 4.5 year in a retrospective review of more than 6,000 consecutively operated patients. These results are confirmed by Hueb et al. who found no difference between OPCAB and CABG regarding a composite endpoint (death, myocardial infarction, further revascularization or stroke) at five-years follow-up. Also they found that the number of grafts per patient was significantly higher in the CABG group then in the OPCAB group. A meta-analysis by Takagi et al. of OPCAB versus on-pump CABG (12 randomized trials, 4,326 patients) even demonstrated a statistically significant increase in mid-term all-cause mortality by a factor of 1.37 with off-pump relative to on-pump CABG. In deed, there are also numerous studies which show the opposite. It seems likely that experience is a major factor in achieving high quality revascularization. This becomes an even more important issue as proof is accumulating that complete arterial revascularization has a far more dramatic impact on late outcome, than the use or non-use of ECC. Complete arterial revascularization is technically more demanding and may justify the use of ECC, specifically to improve long-term outcome.

On the other hand, the prospect of an OPCAB procedure using a complete “no-touch” aorta principle, thus abolishing a side-biting clamp, combined with total arterial revascularization might be an excellent strategy in patients with a calcified or atheromatous aorta. These patients have a higher risk for stroke during conventional CABG and may benefit from OPCAB. The development of a stroke-risk score might be helpful in this respect.

To conclude, we feel that all evidence indicates that we shouldn’t perform off-pump CABG routinely. However, OPCAB might be an excellent treatment option for a selected group of patients who have an increased risk of stroke.

References:

The Value of OPCAB

Standardized OPCAB has been proven to be as safe as conventional on-pump surgery and meta-analyses of randomized controlled trials in low-risk patients display comparable results for both approaches with regards to mortality, myocardial infarction, and need for repeat revascularization at one and two years. They also demonstrate OPCAB to be associated with reduction of stroke, wound infection, renal and respiratory complications. Moreover OPCAB reduces the need for transfusion and inotropic support as well as the ventilation time, the length of hospital stay and in-hospital and one-year direct costs.

These data were confirmed recently in a large meta-analysis including 35 propensity score analyses with a total of 123,137 patients. This analysis found an overall odds ratio less than one for all outcome parameters in favour of OPCAB. These results were significant for most of the evaluated outcome parameters, in particular mortality suggesting OPCAB might be the superior technique when compared to on-pump surgery (Table 1).

In contrast, the recent ROOBY trial showed a 30% risk increase for the occurrence of the primary composite endpoint including death, myocardial infarction and need for repeat
In better outcomes – pump for CABG?

Stephan Jacobs

Leitender Arzt Herzchirurgie, Klinik für Herz- und Gefäßchirurgie, Universitätspital Zürich, Switzerland

Revascularization after OPCAB8. However, this prospective randomized multcenter trial displayed several major limitations as more than 70% of the evaluated patients were excluded due to clinical reservations of surgeons who were accepted to take part in the study after they had performed only OPCAB procedures. This lack of experience was also highlighted by the up to ten-fold higher need for conversion to on-pump (12%) as compared to specialized OPCAB centres that report conversion rates ranging from 1–3%. More than 50% of OPCAB patients received transfusions versus only 30% reported in previous randomized trials10 and only 30% reported in previous randomized trials7. Moreover, this prospective randomized multcenter trial aiming for more than 5000 high-risk patients with an inclusion criterion of a EuroScore >5 in parallel, there is the German Off-Pump Coronary Artery Bypass in Elderly Study (GOPCABE), a multcenter trial randomly assigning 2000 patients older than 75 years to undergo either OPCAB or on-pump.

Complete Revascularization A current standardized OPCAB approach does not come at the cost of less complete revascularization which has been reported to be a significant predictor for the long-term outcome11. Recent studies demonstrated feasibility of complete revascularization in OPCAB even in patients presenting with multi-vessel disease12.

Conclusion Current data demonstrate that OPCAB is a safe alternative to on-pump CABG, with similar outcomes for low-risk patients, and superior outcomes in high-risk patients. It can be safely implemented into clinical routine and although technically demanding, it does not come at cost of incomplete revascularization when standardized performed in high-volume OPCAB centres. The combination with total arteral grafting may constitute the current ‘standard of care’ to effectively reduce stroke and major neurological complications.

Table 1: The beneficial effect was highly significant for the outcomes mortality, stroke, renal failure, and RBC transfusion; significant for wound infection, prolonged ventilation, intra-aortic balloon pump support and isostropic support (adapted from Kuss et al., JTCVS 2010)

<table>
<thead>
<tr>
<th>Response</th>
<th>Number of studies (patients)</th>
<th>OR (95% CI)</th>
<th>P value</th>
<th>REM</th>
<th>homogeneity</th>
<th>P value (%)</th>
<th>OR (95% CI)</th>
<th>P value</th>
<th>FEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>28 (100,066)</td>
<td>0.69 (0.60-0.75)</td>
<td>P &lt; 0.001</td>
<td>.18</td>
<td>0.71</td>
<td>0.60 (0.56-0.66)</td>
<td>P &lt; 0.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td>22 (55,290)</td>
<td>0.42 (0.30-0.54)</td>
<td>P &lt; 0.001</td>
<td>.16</td>
<td>0.71</td>
<td>0.49 (0.41-0.58)</td>
<td>P &lt; 0.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>14 (35,951)</td>
<td>0.97 (0.73-1.30)</td>
<td>P = .06</td>
<td>.02</td>
<td>0.71</td>
<td>0.32 (0.25-0.40)</td>
<td>P &lt; 0.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>11 (29,343)</td>
<td>0.92 (0.80-1.05)</td>
<td>P = .20</td>
<td>.01</td>
<td>0.71</td>
<td>0.59 (0.52-0.67)</td>
<td>P &lt; 0.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Renal failure</td>
<td>17 (38,866)</td>
<td>0.60 (0.51-0.70)</td>
<td>P &lt; .01</td>
<td>.21</td>
<td>0.71</td>
<td>0.59 (0.53-0.66)</td>
<td>P &lt; 0.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Inotropic support</td>
<td>7 (6,153)</td>
<td>0.59 (0.39-0.93)</td>
<td>P &lt; 0.001</td>
<td>.82</td>
<td>0.71</td>
<td>0.65 (0.56-0.75)</td>
<td>P &lt; 0.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>RBC transfusion</td>
<td>8 (16,685)</td>
<td>0.36 (0.25-0.54)</td>
<td>P &lt; 0.001</td>
<td>.91</td>
<td>0.71</td>
<td>0.49 (0.40-0.56)</td>
<td>P &lt; 0.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Wound infection</td>
<td>13 (33,030)</td>
<td>0.59 (0.45-0.77)</td>
<td>P &lt; 0.001</td>
<td>.97</td>
<td>0.71</td>
<td>0.59 (0.54-0.77)</td>
<td>P &lt; 0.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Reoperation for bleeding</td>
<td>14 (39,480)</td>
<td>0.76 (0.57-1.02)</td>
<td>P = .06</td>
<td>.01</td>
<td>0.71</td>
<td>0.59 (0.59-0.81)</td>
<td>P &lt; 0.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>IABP support</td>
<td>7 (9,703)</td>
<td>0.60 (0.41-0.89)</td>
<td>P = .01</td>
<td>.18</td>
<td>0.71</td>
<td>0.57 (0.43-0.76)</td>
<td>P &lt; 0.001</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Prolonged ventilation</td>
<td>6 (8,675)</td>
<td>0.71 (0.56-0.89)</td>
<td>P = .02</td>
<td>.32</td>
<td>0.71</td>
<td>0.74 (0.61-0.90)</td>
<td>P = .002</td>
<td>.001</td>
<td></td>
</tr>
</tbody>
</table>
Clinical review: Radial artery grafts versus saphenous vein grafts in coronary artery bypass surgery; a randomized trial

Dr Jos Bekkers
Erasmus University Medical Center, Rotterdam, The Netherlands

In coronary artery bypass surgery (CABG) the use of the left internal mammary artery (LIMA) as the preferred graft for the anterior descending artery (LAD) is undisputed. In the recent ESC/ACOTS guidelines on myocardial revascularization arterial grafting of the LAD is an IA recommendation. In this guideline complete arterial revascularization to non-LAD coronary systems is recommended for patients with a reasonable life expectancy. Several arterial grafts may be used as a second arterial graft: the right internal mammary artery, the radial artery or the right gastroepiploic artery. Whether or not complete arterial grafting has a survival benefit in CABG patients is still a matter of debate. And furthermore, which of potential arterial grafts yields the best possible long-term patency rate is less clear. In their recent publication “Radial artery grafts versus saphenous vein grafts in coronary artery bypass surgery; a randomized trial”, JAMA 2011;305(2):167-174, Goldman and colleagues report on a multi-center, randomized controlled trial comparing the 1-year patency rate of radial artery grafts versus saphenous vein grafts. In this well-conducted study a total of 733 first-time CABG patients were included. These patients were recruited from 6148 patients initially assessed, therefore 12.3% of all assessed patients were included. 3270 patients were excluded for medical reasons, 2086 patients were excluded for non-medical reasons. Of the latter group 1087 patients were excluded by physician preference. It is not clear what preferences led to more than 50% of eligible patients not participating in the study and to what potential bias in the study group this might have led. Patients were almost exclusively (99%) male. Patients were randomized to receive a saphenous vein graft (n=367) or a radial artery (n=366). Pre-operatively and prior to randomization the surgeons decided which vessel was the most suitable to receive the graft to be studied. The target vessel for the study grafts was the circumflex artery in 57% of patients, the right coronary artery in 29% and the LAD in 14%. The primary end point of the study was angiographic graft patency one year after CABG. Secondary end points were myocardial infarction, stroke, repeat revascularization and death.

The primary finding of this study was an equal 1-year patency rate of 89% (95% CI 86%-93%) for the radial arteries and 89% (95% CI 85%-89%) for the saphenous vein grafts. There was no difference in graft patency between both groups for the different target vessels of the grafts. Further analysis revealed no influence of various other factors studied. These other factors included off-pump versus on-pump CABG, vessel to be bypassed (LAD versus non-LAD) and target vessel size. The incidence of 99% occlusion (“string sign”), or severe stenosis in radial arteries. In this study the angiographic 1-year patency of LIMA-grafts was 96%. There was no difference between the two study groups in the secondary end points studied.

The authors of the study conclude that there was no difference in angiographic patency between radial artery grafts and saphenous vein grafts in men. In this study the patency rate for the vein grafts was higher than reported in previous studies and higher than anticipated in the study design (expected patency rate of 83%), therefore the study may have been underpowered to detect a difference in graft patency between the groups. It might be that up to date medical treatment of post-CABG patients, including aspirin and statin treatment, yields a higher early vein graft patency than previously reported.

The authors realize, that the potential difference in graft patency between radial artery grafts and saphenous vein grafts might take more than one year of follow up to be apparent. Their final implications as possible.

SURTAVI trial to examine the role of TAVI in intermediate risk patients

It is hoped that the proposed SURTAVI trial will provide many answers to whether transcatheter aortic valve implantation (TAVI) could be an alternative for patients at intermediate risk for surgery. EACTS News discussed the trial with one of the investigators, Professor Ruediger Lange, Director of the Clinic for Cardiovascular Surgery at the German Heart Center, Munich, Germany, about its aim and possible implications for the future of TAVI.

“Current clinical practice dictates that this trial must take place. We have seen a shift in TAVI practice from high-risk surgical patients to intermediate risk patients,” said Lange. “Since this has become daily practice in many hospitals, it is the goal of the SURTAVI trial to provide evidence-based medicine to confirm this ‘daily practice’.”

Thus far, clinical trials (such as the PARTNER trial) and registries on transcatheter heart valves have only included patients who were inoperable or at high risk for surgery. The SURTAVI trial will be one of the first to investigate this technology in intermediate risk patients. “If the trial demonstrates the non-inferiority of TAVI treatment to surgery, it may result in benefits for the patient and the healthcare system. For example, the patient will not only avoid having their chest opened and being put on a heart lung machine, the intermediate risk population would also have a shorter hospital stay and a much quicker recovery time.”

Trial design

The trial will recruit approximately 1,000 to 1,200 patients who will be randomised to receive surgical aortic valve replacement or TAVI (approximately 500-600 patients in each group). Although details of the trial are currently under discussion, the primary endpoint will include all-cause mortality and major stroke. Secondary endpoints will include combined safety and efficacy endpoints based on VARC definitions, among others. The aim is to start enrolling patients in by the first quarter in 2012 in more than 40 clinical sites. The trial design is also undergoing pre-IDE evaluation by the FDA and the intention will be to include US clinical sites as well.

‘Heart Team’ approach

The SURTAVI trial will utilise the ‘Heart Team’ approach, pioneered in the SYNTAX trial and also incorporated in the PARTNER US trial. The heart team approach means that both the interventional cardiologist and the cardiac surgeon, together, both decide which patients can be randomised. “As a result, patients are not handpicked and importantly, the patient population is more representative,” he added.

The trial, which will utilise the CoreValve (Medtronic), could be expanded to the US, and it is believed the company will submit the SURTAVI trial protocol to the FDA for approval, in the hope that a US arm will be able to participate in the trial. “It is important that the trial provides a good evidence-base, that way we will know whether it is justified to implant a transcatheter valve in this group of patients,” concluded Lange.

Jos Bekkers

Members view

If you would like to comment on any of the aspects concerning training and education, express your opinion regarding the outcomes from the SYNTAX trial or discuss ESC/EACTS guidelines, EACTS News would be delighted to publish your views.

Please send your comments to: communications@edefinite.com. We will publish as many of your comments as possible.
A technological advance, the ACROBAT-i Stabilizer and Positioner from MAQUET was created to enhance visibility and control. Built on a foundation of proven excellence, the ACROBAT-i system combines sleek form with function:

- 180° side-to-side range of motion
- Vertical drop of stabilizer into the chest cavity
- Significantly lower profile mount and tubing management system for increased space in the working field

The exceptional maneuverability of ACROBAT-i gives you better access to even the most hard-to-reach vessels. Gain the confidence to deliver the clinical benefits of OPCAB to more patients.

FOR MORE INFORMATION about how to obtain the new ACROBAT-i Off-Pump System for your practice, please contact your local MAQUET sales representative.

www.maquet.com
MAQUET Cardiovascular LLC 170 Baytech Drive San Jose, CA 95134 USA Fax: +1 (888) 899-2974 Tel-Fax: +1 (888) 890-2974 Phone: +1 (408) 895-4900
The Leonardo Da Vinci Award for Training Excellence New for 2011

Teaching has to become more efficient, and at the same time highly effective to ensure the surgeons of tomorrow are well equipped. We are fully aware of the current pressures on the system introduced by the European Working Time Directive.

Teaching skills have never been formally recognised to the same extent as research and they are usually eclipsed by clinical acumen. The training and manpower committee of EACTS is proud to announce the Leonardo Da Vinci Award for Training Excellence to identify the best cardiothoracic trainer in Europe, as nominated by the trainees.

A good teacher is easy to recognise but hard to define. We are drawing on the experience of the Silver Scalpel Award in the UK and the Socrates Award for the STS society in America. The principal of the Leonardo Da Vinci Award for Training Excellence is:

1. Recognise and reward excellence in training
2. Establish a benchmark in the form of a trainer role model
3. To define the attributes that make a good cardiothoracic surgical teacher

All cardiothoracic trainees in every European country are invited to nominate their trainer for the Leonardo Da Vinci Award. Submission of the Leonardo Da Vinci Award for Training Excellence is through the EACTS User Area (Abstract section). The deadline for nominations is 15 May 2011.

The winner of the first Leonardo Da Vinci training award will be announced at the EACTS meeting in Lisbon in 2011.

The trainee is asked to submit a piece of reflective writing indicating why the trainer deserves the Leonardo Da Vinci Award. An advisory group will determine who is the best trainer in cardiothoracic surgery in a European country to be visited.

The Leonardo Da Vinci Award will be announced during the Annual Meeting.

How to apply

Applicants for The Francis Fontan Prize and the Thoracic Prize are requested to send in the following documents to the EACTS Executive Secretariat (at the address stated below):

- Curriculum vitae indicating:
  - Number and type of operations performed with and without senior assistance
  - Scientific publications and work in progress
  - An affidavit as to the proficiency of the applicant in English or in the language of the country to be visited

- Proposed plans for the prize year including the name of the department to be visited.

- A letter of support from the head of department which the applicant plans to visit.

- A recording of the applicant's head of department presenting with an affidavit that the applicant is suitable for the Prize and welcome to return to his department.

- A recording of the applicant's head of department presenting with an affidavit that the applicant is suitable for the Prize and welcome to return to his department.

The selection of the prize-winner is by a Prize Committee consisting of the President, Vice President and immediate past President of the Association. The winner of the Francis Fontan and the Thoracic Prize will be announced during the Annual Meeting.

On completion of the Prize-funded activities, the prize-winner is required to send a written report to the Secretary General presenting the knowledge and experience gained during the year including any published work. He/she should also report on the potential of disseminating new knowledge within the department with which he/she is working.

The deadline for submission of applications is 15 May.

On completion of the Prize-funded activities, the prize-winner is required to send a written report to the Secretary General presenting the knowledge and experience gained during the year including any published work. He/she should also report on the potential of disseminating new knowledge within the department with which he/she is working.

The deadline for submission of applications is 15 May.

EACTS Executive Secretariat, 3 Park Street, Windsor, Berkshire, SL4 1LU, UK
E-mail: info@eacts.co.uk

The Francis Fontan Prize

Available to Cardiac or Cardio-Thoracic Surgeons

The Francis Fontan Prize was instituted in honour of Professor Francis Fontan, founding father of The European Association for Cardio-Thoracic Surgery. The Prize is awarded to a medical doctor in specialty training in cardiac or cardio-thoracic surgery. It is not limited to European citizens.

The amount awarded is €30,000 and should cover the costs of one year's stay at a major European department or any other European research facility. The activities during this year are left to the discretion of the prize-winner and the head of the department visited, but should primarily involve fields such as research training, research activities, advanced clinical education and/or departmental management.

The Thoracic Prize

The Thoracic Prize was instituted in 2006 by the Council of the European Association for Cardio-Thoracic Surgery. The Prize is awarded to a medical doctor in specialty training in thoracic or cardio-thoracic surgery. It is not limited to European citizens.

The amount awarded is €30,000 and should cover the costs of one year's stay at a major European department or any other European research facility. The activities during this year are left to the discretion of the prize-winner and the head of the department visited, but should primarily involve fields such as research training, research activities, advanced clinical education and/or departmental management.

Techno-College Innovation Award

The Techno-College invites surgeons, engineers and individuals from companies active in the field of Thoracic and Cardiovascular Surgery to apply for The Techno-College Innovation Award. We are looking for technological breakthroughs in all areas related to thoracic and cardiovascular research in particular for new surgical methods or devices. Innovations can be in the form of patents, inventions, new products, ideas or services. The innovations should have the potential to change our standard practice and should go beyond marginal improvements in existing procedures or products.

The winner will be chosen on behalf of the EACTS by the members of the New Technology Committee and he/she will have the opportunity to present his/her work during the Annual Techno-College on Saturday 1 October 2011, where the prize, €5,000, will also be awarded.

Submission for the Techno-College Innovation Award is through the EACTS User Area (Abstract section). The deadline for submissions is 1 August 2011.

Previous Winners
2010 - Georg Nollert, Siemens AG
2009 - E M Boyle, PleuralFlow Catheter Systems
2008 - Jean-Marie Vogel, Pli propormed
2007 - Milo Simcha, Rehovot, Israel

George Nollert (left) (Techno-College winner 2010)
Pradeep Narayan (left) (Hans Borst Award winner 2010)
Awards and Prizes

**FRANCIS FONTAN PRIZE**
€ 30,000
Specialty training in cardiac or cardio-thoracic surgery.

**THORACIC PRIZE**
€ 30,000
Specialty training in thoracic or cardio-thoracic surgery.

**LEONARDO DA VINCI PRIZE FOR TRAINING EXCELLENCE**
Specialty training in thoracic or cardio-thoracic surgery.

**EACTS YOUNG INVESTIGATOR AWARDS**
Best manuscripts on topics of clinical or experimental research.
- Cardiac Young Investigator Awards
- Congenital Heart Disease Young Investigator Awards
- Thoracic Young Investigator Awards
- Alessandro Ricchi Transplant Services Foundation Award

**HANS G. BORST AWARD FOR THORACIC AORTIC SURGERY**
Stimulate advanced clinical or experimental research by young investigators.

**TECHNO-COLLEGE INNOVATION AWARD**
€ 5,000
Technological breakthroughs in new surgical methods or devices.

**C. WALTON LILLEHEI YOUNG INVESTIGATOR’S AWARD**
US $10,000
Implanting the St Jude Medical heart valve.

**ETHICON CARDIOVASCULAR SIMULATION AWARD**
€ 3,000
Creation of a Simulator which replicates for training purposes Coronary Anastomoses.

For more information please check our website, or download the pdf at www.eacts.org
In a cryptic crossword, the clue is in two parts. One part gives the definition of the answer, another part gives a different way of reaching the same answer. The parts of the clue are run together to further mislead the solver. For example, for the clue, “Planet’s broken heart (5)” the answer would be “Earth” (“Planet” = the definition, and “broken heart” implies an anagram is needed of “heart” = “earth”). Try the cryptic clues first, but if these are too difficult, the non-cryptic ones will help as both sets of clues have the same answers. Please use BLOCK CAPITALS and BLACK INK and complete your personal details.

**Compilations crossword** Fax back to +44 (0) 1491 411 377

Compiled by Sam Nashef, Papworth Hospital, UK. Entries must be received by 30 May 2011. The winner will be the first correct answer randomly selected by the Editor.

**Your name**

**Your email**

---

**Cryptic clues**

**Across**

9 Tall fruit salad helping 14 26 25 (15)
10 Starting the haematological results of many blood idiocynancies ... (7)
12 ... to end as mobile clot head somehow? (7)
13/25/27 Antihypertensive treatment, one for the very ill (9,7,4)
14/26 Learn poorly, miss organ malfunction (5,7)
15 Fussy person accepts new jewellery (7)
18 Some Arab’s cesspit needs drainage (7)
21 Monsters in the south, therefore come back (5)
23 One with no latitude line, stimulating the heart (9)
26/27 See 13
29 I left train at terminus, accepting scheme of operation (15)

**Down**

1 See 2
21/2 Romantic quality of cosmic powder (8)
3 Island relaxed with passion... (8)
5 ... for island swimwear... (6)
6 He cut points remarked with hesitation (6)
7 Aggression was evil once (8)
8 Bad luck in poor Ken’s joints... (8)
11 ... joint is something excruciating (5)
15 Prone to lose right gland (8)
16 Avengers deploying weapon of mass destruction (5,3)
17 Vehicle playing lyric 5 (8)
19 Like us, cooking with garlic (8)
20 He goes downhill: it’s more dangerous without central grip (5)
22 Uncommon to promote the last of surplus items (6)
24 Cause displeasure by not working on conclusion (6)
27 See 13 Across
28 Neat eruption here? (4)

---

**Non-cryptic clues**

**Across**

9 Treatment for 14/26 (15)
10 Clots... (7)
12 ... and how they may end up (7)
13/25/27 Part of hospital (9,7,4)
14/26 Anuria (5,7)
15 Jewellery (7)
18 Pus cavity (7)
21 Sheik-like creatures (5)
23 Describing dopamine (9)
25 See 13
26 See 14
29 19 grafting (15)

**Down**

1 See 2
2/1 Dreamy romanticism (8)
3 Australian island (8)
4 Two-piece (6)
5 And so on (2,6)
6 Hairdresser (6)
7 Rough use of force (8)
8 Metacarpal joints (8)
11 Door feature (5)
15 Gland (8)
16 Neurotoxin (5,3)
17 3-wheeler (8)
19 Non-medical! (8)
20 Sportsman (5)
22 Few and far between (6)
24 Insult (6)
27 See 13 Across
28 Volcano (4)

---

**Solution**

To competition crossword from issue 1, December 2010

Congratulations to David Luke, Dublin, Ireland who was the first correct answer randomly selected by the Editor.

**CORONARY ARTERY**

**U W E L I E**

**S T R I C T 'SCALLOPS**

**B N U V C E E**

**L U N G M Y O C A R D I A L**

**R N T R I T**

**PS A L M B E A T N I K**

**T E C C G**

**M A C H I N E D Y L A N**

**E I A A N**

**INF A RCTION H I G H**

**T O K L G E L**

**D I S R E I L I T I C A L I C**

**T T N N N R O**

**B Y P A S S G R A F T I N G**

---

**Non-cryptic clues**

**Across**

1/6/29/30 Operation (8,6,8)
9 Stern (6)
10 Seafood (8)
11 See 26 Down
12/24 Heart attack (10,10)
13 I forgot to mention maltreated song (5)
15 Nonconformist to defeat the devil? Sounds like it (7)
19 See 26 Down
21 Poet after Bob and before Thomas (5)
24 See 12
26 Greeting said to be lofty (4)
27 Earl of Beaconsfield shows princess round the country (8)
28 Script is essential to merit a license (6)
29 See 1

**Down**

2 Much emotion expressed when tour bus breaks down at junction (8)
3 In the red shabby gown worn by compiler (5)
4 Fall of Man-U playing in Paris: you come in (6)
5 Agreed veto? The opposite! (3,4)
6 Salad: scary item at heart of menu (1,2,5)
7 Like bathroom, but led it astray (5)
8 You’re already seen this agent’s dine (6)
14 Field is clear, but avoid extremes (3)
16 Compiler extremely chilly indeed (3)
17 Elegant Kenneth’s birds (8)
18 Swelling with pride – leader follows group (8)
20 Fixing North in trouble (7)
22 Some spent it yearning for independent existence (6)
23 Perhaps gain an indication for 1, 6ac, 29, 30 (6)
25 Large vessel in the sea, or tanker (5)
26/11/19 Kit which may be used in 1,6ac,29,30 (5-4,7)

---

In a cryptic crossword, the clue is in two parts. One part gives the definition of the answer, another part gives a different way of reaching the same answer. The parts of the clue are run together to further mislead the solver. For example, for the clue, “Planet’s broken heart (5)” the answer would be “Earth” (“Planet” = the definition, and “broken heart” implies an anagram is needed of “heart” = “earth”). Try the cryptic clues first, but if these are too difficult, the non-cryptic ones will help as both sets of clues have the same answers. Please use BLOCK CAPITALS and BLACK INK and complete your personal details.
ANNUAL
25th MEETING: TEAMWORK

1-5 October 2011
Lisbon, Portugal

EACTS
EUROPEAN ASSOCIATION FOR CARDIO-THORACIC SURGERY
### Key International Events in 2011

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Association for Thoracic Surgery (AATS) 91st Annual Meeting 2011</td>
<td>7-11 May</td>
<td>Philadelphia, US</td>
<td>Phone: (+1) 978 927 8330</td>
</tr>
<tr>
<td>European Society of Cardiology Congress 2011</td>
<td>27-31 August</td>
<td>Paris, France</td>
<td>Fax: (+33) 4 9294 7600 Email: <a href="mailto:europcr@europa-organisation.com">europcr@europa-organisation.com</a></td>
</tr>
<tr>
<td>Transcatheter Cardiovascular Therapeutics (TCT 2011)</td>
<td>7-11 November</td>
<td>San Francisco, US</td>
<td>Phone: 646-434-4500 Email: <a href="mailto:info@crf.org">info@crf.org</a></td>
</tr>
<tr>
<td>American Heart Association Scientific Sessions (AHA 2011)</td>
<td>10-16 November</td>
<td>Orlando, FL</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>EuroPCR</td>
<td>17-20 May</td>
<td>Paris, France</td>
<td>Fax: +33 5 34 45 26 46 Email: <a href="mailto:europcr@europa-organisation.com">europcr@europa-organisation.com</a></td>
</tr>
<tr>
<td>European Society of Cardiology Congress 2011</td>
<td>27-31 August</td>
<td>Paris, France</td>
<td>Contact: Congress Secretariat Phone: (+33) 4 9294 7600 Fax: (+33) 4 9294 8629</td>
</tr>
<tr>
<td>European Heart Association Scientific Sessions (AHA 2011)</td>
<td>10-16 November</td>
<td>Orlando, FL</td>
<td></td>
</tr>
</tbody>
</table>

If you would like to list your events here please email the details to: communications@e-dendrite.com

### EACTS Events in 2011

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
<th>Location</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>25th EACTS Annual Meeting</td>
<td>1-5 October</td>
<td>Lisbon, Portugal</td>
<td></td>
</tr>
<tr>
<td>ESCTS Cardiac Course Level A</td>
<td>16-21 May</td>
<td>Bergamo, Italy</td>
<td></td>
</tr>
<tr>
<td>ESCTS Cardiac Course Level B</td>
<td>13-18 June</td>
<td>Bergamo, Italy</td>
<td></td>
</tr>
<tr>
<td>ESCTS Cardiac Course Level C</td>
<td>24-29 October</td>
<td>Bergamo, Italy</td>
<td></td>
</tr>
<tr>
<td>ESCTS Cardiac Course Level C</td>
<td>21-25 November</td>
<td>Bergamo, Italy</td>
<td></td>
</tr>
</tbody>
</table>

For information, contact:
EACTS Executive Secretariat
3 Park Street, Windsor, Berkshire
SL4 1 LU, UK
Phone: +44 1753 832166
Fax: +44 1753 620407
Email: info@eacts.co.uk
Web: www.eacts.org

ISMICS
Techniques, Technology & Innovation in CVT Surgery
ANNUAL SCIENTIFIC MEETING

6 Postgraduate Courses:
- Transcatheter Valves
- Minimally Invasive Valve Surgery
- OPCAB/Cardiac Imaging
- Thoracic Endovascular Aortic Repair (TEVAR)
- Atrial Fibrillation
- Thoracic

Defined Cardiac and Thoracic Tracks
International Residents & Fellow Program

Keynote Address:
James L. Cox, MD

www.ISMICS.ORG

Washington DC
8-11 June, 2011
The Mayflower Hotel
Washington DC
ANNUAL 25th MEETING: TEAMWORK

NURSES, NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

Deadline for abstracts 15 May 2011

EACTS
EUROPEAN ASSOCIATION FOR CARDIO-THORACIC SURGERY
Treat more patients **with confidence**

Treat more patients with the Edwards SAPIEN XT transcatheter aortic valve now available in three sizes to address the broadest annulus range

- 23 mm
- 26 mm
- **NEW SIZE!** 29 mm

For professional use. See instructions for use for full prescribing information, including indications, contraindications, warnings, precautions, and adverse events. Edwards and Edwards SAPIEN XT are trademarks of Edwards Lifesciences Corporation. Edwards Lifesciences and the stylized E logo are trademarks of Edwards Lifesciences Corporation and are registered in the United States Patent and Trademark Office. © 2011 Edwards Lifesciences Corporation. All rights reserved. 8850/02-11/THV.