EACTS News
European Association For Cardio-Thoracic Surgery
July 2011 **Issue 3**

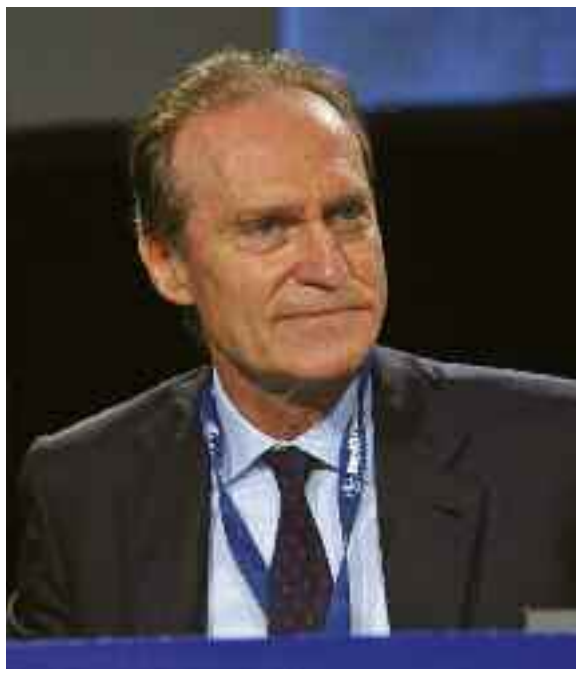
The Big Question: Tricuspid valve – Ring or no ring? Page 8-9

In this issue…

Presidential update

Dear member,
My term as EACTS President nears its end, and so this is my final President's Column. It has been an exciting year. The EACTS had a number of productive meetings with other professional organizations.

The meeting with representatives of the National Societies, to discuss the future training of cardiothoracic surgeons in Europe was extremely successful in identifying the needs of the future. Council members together with representatives of the National Societies are continuing to work on this project and produce a European Statement on Cardio-Thoracic Training and Education.



Our collaboration with the European Society for Cardiology resulted in the joint publication of practical guidelines on myocardial revascularization. These guidelines are intended to serve as an unbiased clinical guide for cardiothoracic surgeons and cardiologists. We continue to work together with the ESC on creating guidelines on the Management of Valvular Heart Disease.

The Hannes Meyer Cardiothoracic Surgery Research and Training Symposium organized by EACTS International Co-operation Committee (ICC) in Bloemfontein, South Africa for the second time was a great success. Participants especially valued the wetlab session on closed mitral valvotomy and the off-pump training course in CABG surgery. In this issue of *EACTS News* you will learn more about the work of the ICC. In this issue you will also find reports on other successful EACTS courses, the Robotic Course organized by the Thoracic Domain and the Right Ventricular Outflow Tract Management from Neonates to Adults: An Interdisciplinary View in Palma de Majorca Course organized by the Congenital Domain in co-operation with AEPC.

The Annual Meeting is only a few weeks away. All domains have worked very hard to produce an outstanding scientific offering. The Annual Meeting provides a unique opportunity to discuss the latest developments in our specialty and for meeting friends and colleagues. In this issue we have noted some associated highlights that shouldn't be missed.

As I mentioned my term comes to an end in Lisbon. It has been an honour to represent you as President of the EACTS since last September and I am grateful for the opportunity to have worked so closely with so many of you on so many issues facing our association this past year. This past year has demonstrated that a team of well-organized cardiothoracic surgeons working together with our staff members in the Windsor, Freiburg and Rotterdam offices can effectively meet the many challenges of an increasingly complex health care environment. Everything we have achieved is due directly to the energetic and dedicated teamwork of both volunteer membership and EACTS staff. Thanks to all of you who have contributed so vitally to the organization during this past year.

I look forward to see you all in Lisbon!

Ottavio Alfieri, MD, PhD
President

The EXCEL trial

Peter Kappetein
Secretary General, EACTS

A new clinical trial, EXCEL (Evaluation of Xience Prime versus Coronary Artery Bypass Surgery for Effectiveness of Left Main Revascularization), will compare drug-eluting stents to coronary artery bypass graft surgery in patients with left main coronary artery disease,

While the SYNTAX trial suggested that percutaneous coronary intervention (PCI) with drug-eluting stents may be safe and effective in selected patients with left main coronary artery disease, the trial was not powered specifically to address this set of patients. Since the SYNTAX trial, advances have been made in drug-eluting stent technology, PCI procedural guidance, bypass surgery techniques and optimal medical therapies.

The primary endpoint is the composite incidence of death, myocardial infarction (MI) or stroke at a median follow-up duration of three years, powered for sequential non-inferiority and superiority testing. The major secondary endpoint is the composite incidence of death, MI, stroke or unplanned repeat revascularization. Measures of cost-effectiveness and quality of life at several time points also constitute important secondary endpoints. All patients will be followed for a total of five years.

The global trial, will be academically organized and run by four principal investigators (including two cardiac surgeons and two interventional cardiologists), along with many other physician scientists. Patients will be enrolled from the United States, Canada, Europe, South America (Brazil and Argentina), and South Korea. The EXCEL trial has started enrollment and is expected to complete it in December 2012.

During the EACTS Annual Meeting in Lisbon there will be a conference to update the investigators on Monday morning 3 October at 7am in the congress venue.

The European School: Thoracic education

The history of education is the history of teaching and of learning, and the history of what might be described as the curricula. Education has taken place in most communities since earliest times as each generation has sought to pass on cultural and social values, traditions, morality, religion, knowledge and skills to the next generation. As the customs and knowledge of ancient civilizations became more complex, many skills would have been learned from an experienced person on the job, a mentor. Historically, surgical training has followed an apprenticeship model. Universal education has been a recent development, not occurring in many countries until after 1850 CE. Nowadays, formal education consists of systematic instruction, teaching and training by professional teachers.

Above and below: EACTS Academy; Hands-on thoracoscopic workshop in Thessaloniki, 2011

It is generally accepted that medical education is unfit for the millennium. Professional conservatism, inertia, and poor leadership have left it struggling to cope with rapidly changing health care systems. Some universities have adopted new educational programs, but globally they are a minority and their experiences have mostly not been evaluated or well disseminated. There are too many educational programs at all levels usually boring and only few train doctors, both new and established, to acquire the skills that the new trends in health care demand.

More emphasis has been placed on quantity than quality, despite the fact that ever more credence is being given to the role of continuing medical education in maintaining professional standards.

Moreover, effective mentoring has a valuable role in the development of surgeons at various levels and is frequently perceived vital in achieving career success. However, the formal role of mentoring and learner support in surgical training remains non-existent, while modern education needs to be "vaccinated" with the "deontology" of the profession in all fields.

One should not forget that today the new trends in professional training are small individualized modules – programs that offer the necessary specialization and the update in the latest evolutions. Also, motivating doctors to improve their performance and adopt continuous learning as a way of life is very important. The fact that most current models of continued medical education fall well short of the ideal has fostered the conceptually broader paradigm of continued professional development. While continuing medical education is largely designed to plug supposed gaps in knowledge, continuing professional development is rooted in self directed reflection.

Taking into account all the above, we decided to offer a totally different course in Thoracic Surgery within the European School, which is system based learning and focusing on advances on specific subjects, principally based on interaction between students and experts.

With a proportion of students/tutors 3:1, which is an international novelty during this one week course, students are involved with their teachers who are experts in their fields. They can start in that way building their career abroad by developing communication in different levels with their tutors, especially in informal occasions, and exchange ideas with the other students coming from different countries representing diverse health care systems. Tutors and students work close together for a week, teach and learn from each other, and develop relationships and collaboration that could last life-long promoting the medical science and the quality of medical care.

This year two courses are based on lung and mediastinum emphasizing all recent achievements in surgery, oncology and molecular biology.

In the earlier times we used to address the School to residents, but nowdays we extend it to "junior" surgeons along with organized visits to centers of excellence in their fields. Enrino Rendina in Rome was the first to accept a group of young surgeons at his department presenting the area of his expertise in practice and teaching along with Thoracic Surgery, Organisation and Leadership in our specialty.

Apart from the theoretical sessions, a two–day hands-on Thoracoscopic Workshop is organized for the third time in Thessaloniki next year becoming more and more international, where one can practice in thoracoscopic surgery in an animal lab promoting his surgical skills under the supervision of experienced tutors.

Among our future plans is to have participants feedback in order to create a network of collaboration and support which might be very useful to its members on different levels.

In conclusion, the University and the surgical training today offers knowledge, we offer more than that, such as experienced surgeons, well known in their specialty who can satisfy all educational needs.

EACTS educators strive to advance your knowledge and medical skills to help you provide the best care to your patients. Few academic institutions offer such vast experience and extensive commitment to your success.

Join us and meet the soul of the profession!

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

Editor in Chief
Pieter Kappetein

Managing Editor
Owen Haskins
owen.haskins@e-dendrite.com

Features Editor
Peter Myall
peter.myall@e-dendrite.com

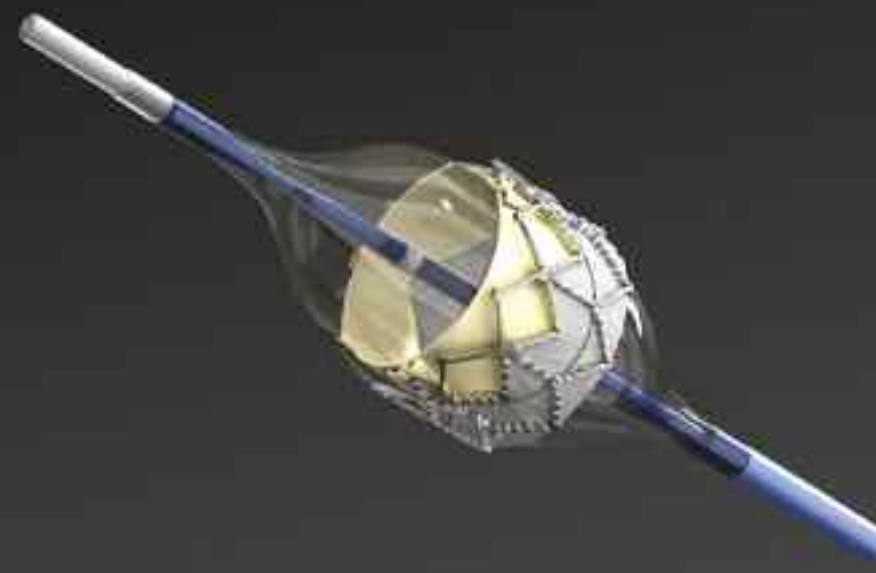
Journalist
Khan Johnson-Evans

Design and layout
Peter Williams
williams_peter@me.com

Publisher
Dendrite Clinical Systems

Head Office
The Hub
Station Road
Henley-on-Thames,
RG9 1AY, United Kingdom
Tel +44 (0) 1491 411 288
Fax +44 (0) 1491 411 399
Website www.e-dendrite.com

EDWARDS
NovaFlex
Transfemoral Delivery System



EDWARDS
Ascendra2
Transapical Delivery System

Setting new benchmarks in transcatheter valve delivery

New and improved delivery systems engineered for:

- enhanced procedural control
- predictable and precise valve placement

Edwards Lifesciences, S.A. | Route de l'Etraz 70 | 1260 Nyon | Switzerland | 41 22 787 43 00
Irvine, USA | Nyon, Switzerland | Tokyo, Japan | Singapore, Singapore | São Paulo, Brazil

Edwards

First European joint EACTS and AEPC Course

Right Ventricle Outflow Tract Management from Neonates to Adults: An Interdisciplinary View Palma de Mallorca (Spain) from 11–12 March

George Sarris and
Juan V Comas

A pioneering initiative of the Congenital Domain of the the European Association for Cardio-Thoracic Surgery (EACTS), namely, the first Postgraduate Course organized jointly with the Association of European Pediatric Cardiology (AEPC),entitled "RightVentricular Outflow Tract Management from Neonates toAdults: An Interdisciplinary View", took place in Palma de Mallorca (Spain) from 11-12 March 2011.

The meeting's rich two – day program focused on the numerous unsettled issues regarding management of the problematic RVOT, a common theme in many congenital heart defects, including but not limited to Tetralogy of Fallot. The goal was to bring together the knowledge, perspective and skills of many related disciplines in exploring questions such as optimal means of palliation of RVOT obstruction, techniques of RVOT reconstruction at the time of primary surgical repair, prevention of late complications, indications and techniques of percutaneous or surgical re-intervention, postoperative care, and training.

The faculty included both surgeons an cardiologists, members of AEPC and EACTS, renowned for their expertise in this field. The course's systematic and comprehensive approach covered allaspects of Right Ventricular Outflow Tract Management-from Neonates to Adults, including basic knowledge (embryology, anatomy, physiology, evaluation), primary surgery, reoperations and percutaneous options. A series of lectures focused on areas of special interest and innovative techniques.

A highlight of the course was the exploration of strategies to prevent long term RVOT complications by careful selection of timing and technique of initial surgical repair. Emphasis was given on the optimal preservation of RVOT structure and function, including that of the pulmonary valve, at the time of repair. Transatrial – transpulmonary repair, which avoids a right ventriculotomy, with minimal or even no incision of the pulmonary valve annulus emerges as a preferred technique. Other approaches presented included reconstruction of pulmonary valve function with pericardial, homograft, or PTFE monocusp valves or native pulmonary valve cusp augmentation. Innovative approaches for managing the RVOT in rare lesions, such as TOF with absent pulmonary valve and various valved conduits were also discussed.

Evaluation of late complications and delineation of criteria for reintervention were discussed in detail, and significant consensus on the great utility of CMRI in this context was reached. Important information regarding the development and pathophysiology of late (after early surgical repair) life threatening ventricular arrhythmias was presented, and guidelines for preoperative electrophysiologic studies, possible ablation of these arrhythmias by catheter or intraoperative techniques and indications for AICD placement were presented.

Regarding pulmonary valve replacement, surgical techniques and options, including bioprosthetic valves and homograft or heterograft valved conduits were presented. Special emphasis was given to the available percutaneous options, their indications, criteria of applicability and early results. Future innovations under development in this area were presented. An important emerging new strategy favors the use of a bioprosthetic valve at first reoperation for pulmonary valve replacement, as this is felt to create an optimal and very safe "landing zone" for a future percutaneous valve deployment, when the inevitable bioprosthetic failure occurs.

Important sessions were also included on intensive care management of patients with RVOT dysfunction or after intervention, focusing on optimal management of the right but also of the frequently comorbid left ventricle. A special session on training attracted great interest by all, including senior staff, juniors, and trainees.

The final interactive session of the course brought all of the information and expertise together in the discussion of case presentations, with major and active participation of a large audience of surgeons, cardiologists, interventional cardiologists, anesthesiologists, intensivists andnurses in the field of pediatric cardiology. At the end, the audience enthusiastically requested that such joint multidisciplinary courses be repeated in the future.

The leadership of the also AEPC expressed their satisfaction with this first joint course:

"I wanted to add my personal thanks to you for organizing such an excellent meeting. I enjoyed it very much and it sets a good example to others about how educational meetings between surgeons and cardiologists should be run.
Shak Qureshi"
President, AEPC

"Thank you for organizing the Palma meeting. The program was excellent thanks to expert speakers. You created an atmosphere that facilitated active discussions. Several delegates, juniors and experts, have thanked for the meeting and have told that they earlier have not seen so many surgeons and cardiologists discussing together.
The joint-meetings between EACTS and AEPC should definitely get repeated in the future.
Eero Jokinen"
Secreatary General of the AEPC

2nd EACTS Robotic Course Level II in Cardio-Thoracic Surgery

February 23-26, 2011
IRCAD Strasbourg (France)

Franca MA Melfi
Director of Robotic Multidisciplinary Center
University Hospital of Pisa, Italy

Franca Melfi (front row, centre left) and attendees of the 2nd EACTS Robotic Course Level II in Cardio-Thoracic Surgery

The second Robotics Course (Level II) was held on 22 February at IRCAD in Strasbourg.

The course provided skill training and familiarization with this new technology to cover important clinical aspects relating to the use of robot system in cardio-thoracic surgery. Lectures in this area focused on the development of this new technique covering technical aspects. The course provided an overview on the rapid development of the surgical robot system in the field of cardiac and thoracic surgery including didactic sessions, hands-on cadaver and large animal models. The use of this new technology in the labs, under the tutelage of faculty experts, gave a great opportunity to all delegates to learn practical information to perform complex surgical procedures such as robotic revascularization, MVR, major lung resections, thymectomy , oesofagectomy,

A highly qualified international panel of experts took part in the meeting, which was aimed at discussing procedural steps, complications and management of robotic procedures in the field of cardio-thoracic surgery. They gave valuable information in terms of indications and technical surgical sequences guaranteeing a high quality of the course. Operating room configuration, system set-up, port placement, instrumentation as well as pre-, intra- operative techniques using the robotic surgical system were well illustrated. The 4-day course drew residents from the United States, Netherlands, Singapore, Greece, Ireland , Italy, Belgium , Iran, Switzerland, Portugal, Finland, Czech Republic, Spain. All skilled surgeons in conventional cardiothoracic surgery (open and or MIS), benefited from the expertise of 13 speakers from different institutions :

- Franca MA Melfi MD, Director of Robotic Multidisciplinary Center AOUP- University of Pisa (Italy);
- Ralph A. Schmid MD, PhD University Hospital of Berne (Switzerland);
- Federico Rea MD, PhD University of Padua (Italy);
- Jens C. Ruckert MD, H Charite' Berlin (Germany);
- Giulia Veronesi MD, IEO (European Oncological Institute) Milan (Italy);
- Kemp H. Kernstine MD, PhD City of Hope National Medical Center and Beckman, Duarte (USA);
- Thierry A Folliguet MD, FACS Institute Mutualiste Montsouris Paris (France);
- Roberto P Casula MD, Ph.D Imperial College Healthcare NHS Trust,St. Mary's Hospital, London (UK).
- Marco Taurchini,MDGeneral Thorac Surgery,Hosp. Forli' (Italy)
- Frank Van Praet M.D O.L. Vrouw Ziekenhuis, Aalst (Belgium)
- Nikolaos Bonaros,MD Ass Prof Innsbruck Medical University Innsbruck (Austria)
- Mark Dylewski, M.D. Medical Director General Thoracic Surgery and Robotic Surgery Baptist Health of South Florida Miami
- David Douglas Intuitive Clinical Technician IRCAD – Strasbourg (France)
- L. Wiley Nifong, MD Director of Robotic Surgery East Caroline Heart Institute Brody School of Medicine Greenville NC USA

By the end of the training Level 2 Programme all participants were able to:

- Understand basic features and potential benefits of the robotic surgical system
- Articulate patient selection, patient positioning, surgical techniques, indications and contraindications;
- Interpret up-to-date literature on surgical outcomes and techniques in robotic surgery;
- Apply the principles in order to be a safe and efficient robotic surgeon.

During the next 25th EACTS Annual meeting in Lisbon, 1-5 October 2011, an interview in addition to a questionnaire, will be evaluated by the Faculty. This is an important prerequisite to access the Robotic Level 3 Course which will be held in Pisa (Italy), at Robotic Multidisciplinary Center of AOUP-University of Pisa. This Robotic Level 3 Course includes integrated system training, live procedure-observation, as well as training at the console of the new da Vinci System Si (Intuitive Surgical, Inc.,Mountain View, CA).

The dual console capability facilitates teaching and enables surgeons to collaborate during surgery.

In addition this feature allows surgeons to exchange and coordinate control of the instrument arms and the endoscopic camera.

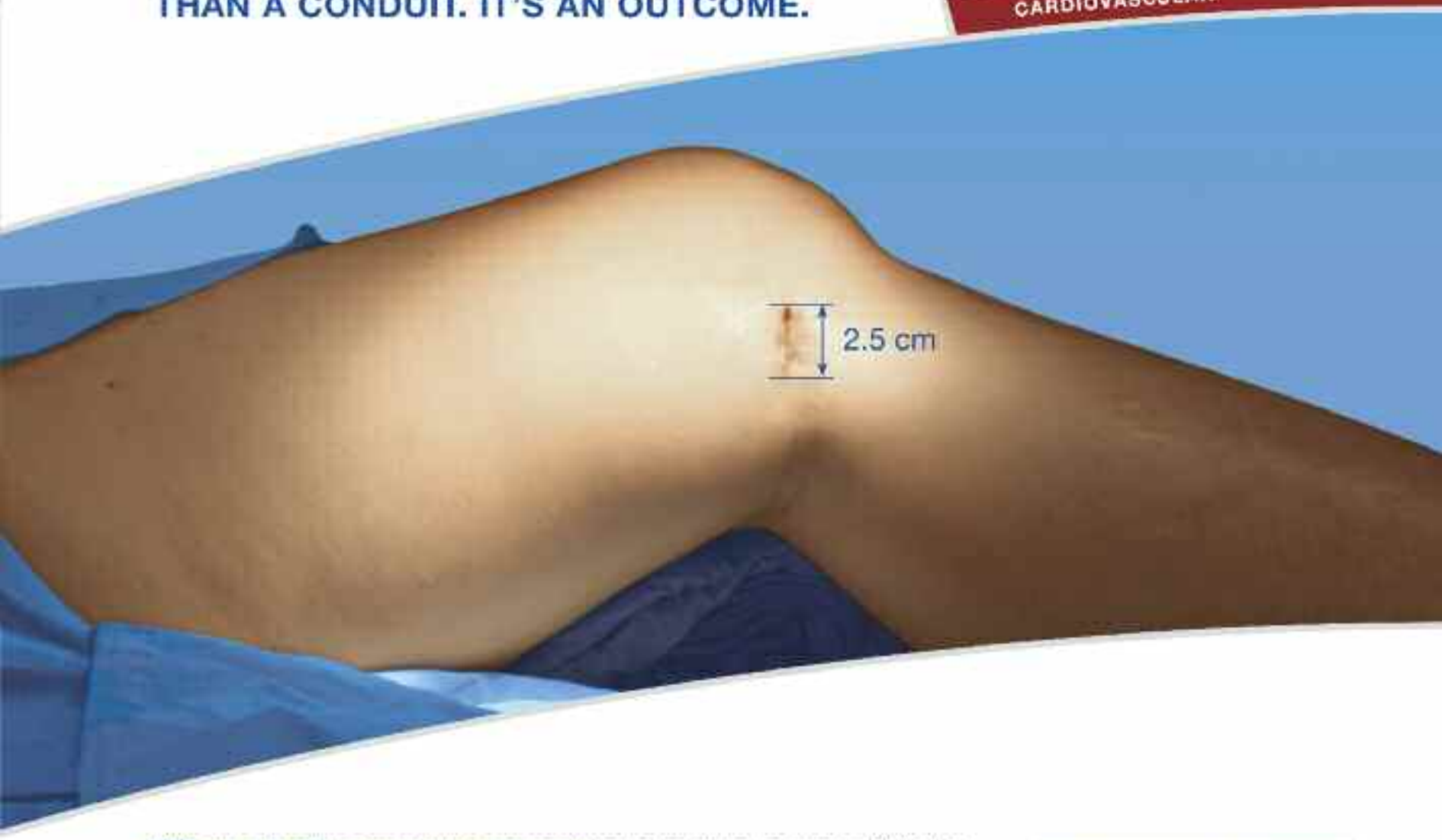
A successfully completed Level 2 course with a structured curriculum and appropriate documentation of training, is required.

The complete program with 3 Level course will give a great opportunity to train surgeons in the field of high-technology applied to cardiothoracic surgery and EACTS plays an important role in this task

MAQUET
GETINGE GROUP

IN VESSEL HARVESTING, IT'S MORE THAN A CONDUIT. IT'S AN OUTCOME.

CARDIOVASCULAR



With over one million procedures performed, endoscopic vessel harvesting (EVH) offers enhanced clinical value over traditional open harvest or bridging methods, including:[1]

- Reduced infections and wound complications
- Reduced postoperative pain
- Reduced time to ambulation
- Reduced hospital length of stay and readmissions for wound care
- Improved cosmesis and patient satisfaction

New VASOVIEW HEMOPRO 2 EVH System

Recent data from over 16,000 patients studied show why your patients can trust this procedure. It provides substantial short term benefits as well as comparable long-term results with respect to morbidity, mortality and revascularization rates.[2, 3,4]

Visit MAQUET at EACTS Exhibit Booth #2.24, or stop by our EVH Clinical Suite Exhibit Booth #2.01 to learn more about our latest technology advancements and how they can improve your practice.

1 Million VASOVIEW

1. Allen KB, et al. Endoscopic Vascular Harvest in Coronary Artery Bypass Grafting Surgery: A Consensus Statement of the International Society of Minimally Invasive Cardiothoracic Surgery (ISMICS) 2005. Innovations: Technology & Techniques in Cardiothoracic & Vascular Surgery. Winter 2005; 1:51-60.
2. Dacey LJ, Braxton JH, Kramer RS, Schmoker JD, Charlesworth DC, et al. Long-Term Outcomes of Endoscopic Vein Harvesting After Coronary Bypass Grafting. Circulation 2011;123:147-153.
3. Niv Ad, Harry L, Hunt G, Massimiano P, Lee J, Rhee J, Collazo L. The impact of endoscopic vein harvesting on outcome of first time Coronary Artery Bypass grafting surgery. ISMICS 2010.
4. Ouzounian M, Hassan A, Buth KJ, MacPherson C, Ali IM, Hirsch GM, Ali IS. Impact of endoscopic versus open saphenous vein harvest techniques on outcomes after coronary artery bypass grafting. Ann Thorac Surg. 2010;89:403-408.

MAQUET Cardiovascular LLC 170 Baytech Drive, San Jose, CA 95134 Phone: +1 (408) 835-8800 Fax: +1 (408) 835-8801

MAQUET EVH: Uncompromising performance. Proven outcomes.

www.maquet.com

INTERNATIONAL CO-OPERATION COMMITTEE

An introduction to the ICC

The main objective of the EACTS is "to advance education in the field of cardio-thoracic surgery. The annual meeting and the scientific journals are the means by which the Association fulfils this aim. In addition, the EACTS International Co-operation Committee (ICC) provides opportunities for cardio-thoracic surgical education in all countries outside of Europe. EACTS News discussed the work of the ICC with the former and current Chairs of the Committee, Marko Turina and Paul Sergeant.

Marko Turina

Paul Sergeant

The ICC is really a continuation of the former Eastern European Committee, which was created by Hans Borst at the time he was Editor in Chief of the European Journal of Cardio-Thoracic Surgery, said Professor Turina, who explained that the Committee was established to help and assist Eastern European colleagues who did not have the ability and opportunities to travel. "As a result, scholarships were organised to enable them to travel. That was really the beginning of international co-operation."

Marko Turina, a past president of the Association, became Chair of the Committee in 2003 and realised that the Committee would have to change to reflect the changing political climate and the committee was subsequently renamed the International Co-operation Committee. "We were not really interested in a programme that would organise travel for a few colleagues. We really wanted to encapsulate and utilise the 'transfer of knowledge' techniques. So we selected leading experts in our field and organised symposia in the countries of the former Eastern Europe. The first symposia were held in Prague (Czech Republic) and Krakow (Poland), and later in Moscow (Russia).

We offered teaching courses, advanced techniques in cardio-thoracic surgery and we invited prominent surgeons to attend the session, provide lectures and perform the techniques/operation which were transmitted to the auditorium so people could see the procedure and ask questions directly to the operator afterwards," added Marko Turina.

"The second format which is also very popular is Applied Science, in which we teach surgeons the basic scientific techniques. We have found that there is a knowledge gap as some surgeons are not well-trained in analysing materials and submitting an abstract or paper, and we provide them with skills necessary.

In addition, the ICC also organised teaching courses jointly with the Saudi Heart Association in Riyadh. Overtime, this has extended to numerous countries including Syria, Iran, and in 2010, for the first time we extended our co-operation to China and India. "I believe it is particularly important to reach out to isolated countries such as Iran, as the people are appreciative and welcome their European colleagues and eagerly embrace our teaching methods and techniques," added Professor Turina.

> "We have found that there is a knowledge gap as some surgeons are not well-trained in analysing materials and submitting an abstract or paper, and we provide them with skills necessary."
>
> Marko Turina

Paul Sergeant, outlined the other major activities of the ICC committee namely the awarding of scholarships and visiting fellowships

Over the years, the ICC has grown and now allocates 30 scholarships annually for the European School for cardio-thoracic education, as well as allocating ten visiting scholarships for surgeons who at a higher level of training wish to visit a particular institution in Western Europe.

Scholarships at European School

The ICC has widened its focus over the years. At the beginning, the ICC addressed cardio-surgical demands for training for scholars coming from Eastern European Countries," said Paul Sergeant whereas we now address cardio-thoracic surgical education in all countries outside of Europe.

The European School is a week of intensive training in courses that are given by experts in their respective fields. There are three or four prominent mentors and this enables one-to-one supervision and contact with attendees allowing effective mentoring of surgeons in training.

Application for scholarships is through the EACTS website and is open to any scholar. The ICC covers the fee and accommodation at the European School value approximately €2000. It is impossible for the ICC committee to set criteria on age or qualification, due to the variability between countries added Professor Sergeant

> "The intention of the position statement is to explain which activities can be undertaken by the Committee and which activities are out of our scope."
>
> Paul Sergeant

Visiting fellowships

The ICC offers visiting fellowships to give the opportunity to surgeons who have already completed or are about to complete their training, to go to an institution of their choice and spend a couple of weeks observing, sometimes assisting, to further their education and experience. "The fellowships give credibility to the scholars in applying for a visiting fellow position and it helps the scholar to pay for travel and lodging," added Sergeant. "Nearly all organisations appreciate these visits. I myself have had many of these scholars in the past and the discussions with them have enriched me considerably."

Teaching courses

Paul Sergeant stated that the ICC will continue to provide teaching courses and clinical courses on specific subjects. "We propose to countries and local organizers complete basic science courses covering all aspects of creation and distribution of knowledge," explained Professor Sergeant.

In September 2008, the ICC issued a 'position statement' outlining the aims of the ICC and their international activities. "At the time we had too many people applying for assistance and help. We felt that many people were mistaking the ICC as a body that provided free surgical care, equipment and financed healthcare in some countries," said Professor Turina. "Therefore, we felt we had to make a very clear statement outlining our role and emphasizing that this was not our duty or responsibility and that it was impossible for us to do this."

"The intention of the position statement is to explain which activities can be undertaken by the Committee and which activities are out of our scope. The EACTS and its ICC committee does not want to compete with non-governmental organizations," explained Professor Sergeant. "Neither does it want or have the ability to organise full time, year round educational or clinical projects."

The future

"In the future, I think we will try to extend our activities. Of course we are always wary of the changing political landscape and prior to the upheaval in the Middle East and North Africa we had plans for programmes in some Arab countries. We also had plans to provide courses in Sudan, but again, this was postponed due to political events," said Professor Turina. "So, we are limited in where and what we can do, but the plan is to extend a similar programme of high-level teaching, both in science and advanced techniques, to Asia.

Both Professor Turina and Professor Sergeant urged members to attend the open session of the ICC at the annual meeting and make proposals and suggestions, give their opinion about courses, and also if they wish, apply to work on the Committee.

"I would also like to thank the Niarchos Foundation," concluded Professor Turina. "Who continue to be extremely generous with their support of the ICC and the work we undertake."

EACTS News

Applications
If you are interested in applying for a visiting fellowship, scholarship or attending teaching courses please contact the EACTS or visit the Associations website:

EACTS Executive Secretariat
3 Park Street
Windsor, Berkshire SL4 1LU, UK
Tel: +44 1753 832166
Fax: +44 1753 620407
Email: info@eacts.co.uk

www.eacts.org/content/international-co-operation

the big

Tricuspid valve:

Michele De Bonis, MD
Department of Cardiac Surgery,
San Raffaele University Hospital, Milan, Italy

Ring

In patients with left sided valve disease, functional tricuspid regurgitation (TR) occurs mainly from right ventricular dilatation, enlargement and distortion of the tricuspid annulus and tethering of the tricuspid leaflets[1-3]. Tricuspid annular dilatation has always been the primary target of the surgical treatment of secondary TR[4] and has usually been corrected by two main surgical methods: the ring annuloplasty and the suture annuloplasty (mostly De Vega and Kay techniques). Either method does not consistently eliminate functional TR. The recurrence rate of significant tricuspid insufficiency after tricuspid annuloplasty is around 8-15% already one month after surgery[5,6] and has been attributed to several factors including the severity of preoperative TR[5-7], pulmonary hypertension[7], presence of pacemakers[5], left ventricular (LV) dysfunction[5], increased LV remodeling[6], severe tethering of the tricuspid leaflets and, particularly important, the use of suture rather than ring annuloplasty[5,6,8-10]. Indeed most of the published studies, both randomized and observational, have demonstrated that ring annuloplasty repairs are more durable than suture annuloplasty, particularly in patients with severe tricuspid annular dilation or pulmonary hypertension[5,6,8-14] (Table 1).

A randomized study of 159 patients comparing Carpentier ring annuloplasty with De Vega suture annuloplasty demonstrated a significantly higher rate of moderate or severe TR in the suture annuloplasty group at 45 months (De Vega, 34%; Carpentier, 10%; p< 0.01)[8].

Matsuyama et al.[9] reported by three years recurrence of 3+ or 4+ TR in 45% of patients in the De Vega group compared with 6% of patients in the ring group (p = 0.027).

Among the different types of prosthetic rings, the semirigid or rigid ones (either standard or 3-dimensional) have been associated with the best results and the least increase across time of recurrent tricuspid insufficiency. In two large series published by the Cleveland Clinic group, the degree of postoperative 3+ or 4+ TR remained stable across time with the Carpentier-Edwards ring (12% at five years and 17 % at eight years) and rose constantly with the De Vega procedure reaching the overall rate of 24% at five years[6] and 33% at eight years[5].

Besides being more durable, ring repairs provide also better long-term survival and event-free survival up to 15 years after surgery compared to suture annuloplasty[12]. This is not surprising considering that moderate and severe TR is an important predictor of late mortality independent of ventricular function and pulmonary artery pressure[15].

In contrast with the above reported data favouring ring procedures, it is certainly possible to find in the literature a number of series reporting early and late satisfactory results with both De Vega and Kay suture annuloplasty[16-20]. Most of these studies have been published in the late eighties and nineties and have major limitations including the use of freedom from reoperation as marker of outcome and a very limited number of echocardiographic controls with only a minority of the study patients, randomly selected, investigated at follow-up by color doppler echocardiography. An exception in this scenario is the study by Ghanta and co-workers[7] which enrolled 237 patients and used echo data to show that bicuspidization (Kay repair) and ring annuloplasty were equally effective and durable at reducing TR up to three years postoperatively (TR recurrence was 31% in the ring group and 25% in the "bicuspidization" one, P=0.18).

However, in this retrospective study, patients treated with a ring had lower ejection fraction and more severe TR compared to those who received a bicuspidization procedure. Although a propensity matching was used to control for this discrepancy, this bias towards using a ring for worse patients might have influenced the results. In addition a longer follow-up should be waited considering that recurrence of TR may require many years to become evident after the initial repair.

> We believe that compelling evidences have been accumulated in the recent years showing that prosthetic ring annuloplasty represents the most effective and durable method to treat severe TR, particularly in presence of severe annular dilatation and pulmonary hypertension

In conclusion we believe that compelling evidences have been accumulated in the recent years showing that prosthetic ring annuloplasty represents the most effective and durable method to treat severe TR, particularly in presence of severe annular dilatation and pulmonary hypertension. In these circumstances suture annuloplasty should be avoided. Conversely, in the early stage of functional TR, when initial annular dilatation is responsible for mild to moderate degree of tricuspid insufficiency, it cannot be excluded that "no ring procedures" might still play a role including the modified De Vega repair, with pledgets between every suture, which seems to lower the risk of suture dehiscence[21]. Further studies, possibly randomized, are necessary to clarify this issue.

Table 1. Some of the most important studies comparing ring versus suture tricuspid annuloplasty

Author	Year	n. of pts	Annuloplasty technique	Mean Fw-up (years)	TR recurrence	P
Rivera[8]	1985	76	Ring (CE)	5.3	10%	<0.01
		83	De Vega		34%	
Matsuyama[9]	2001	17	Ring (CE)	3.3	6%	0.02
		28	De Vega		45%	
McCarthy[5]	2004	139	Ring (CE)	8	17%	0.06
		116	De Vega		33%	
Tang[12]	2006	209	Ring (CE/FB/D)	5.7	30%	0.003
		493	De Vega		36%	
Ghanta[7]	2007	80	Ring (FB/CE/CA)	3	17%	0.18
		157	Kay repair		14%	
Roshanali[10]	2009	53	Ring (CE)	1	14%	<0.05
		52	De Vega		28%	
Navia[6]	2010	584	Ring (CE/MC3)	5	12%	Not reported
		129	De Vega		24%	

C-E: Carpentier Edwards semirigid ring; MC3 : Edwards MC3 Annuloplasty System 3 dimensional ring;
FB: Cosgrove Edwards Flexible Band; D: Duran Band (Medtronic).

References

1. Mikami T., Kudo T, Sakurai T, Sakamoto S, Tanabe Y, Yasuda H. Mechanisms for development of functional tricuspid regurgitation determined by pulsed Doppler and two-dimensional echocardiography. Am J Cardiol 1984;53:160–163.
2. Ton-Nu TT, Levine RA, Handschumacher MD, Dorer DJ, Yosefy C, Fan D, Hua L, Jiang L, Hung J. Geometric determinants of functional tricuspid regurgitation: insights from 3-dimensional echocardiography. Circulation 2006; 114:143–149.
3. Sukmawan R, Watanabe N, Ogasawara Y, Yamaura Y, Yamamoto K, Wada N, Kume T, Okura H, Yoshida K. Geometric changes of tricuspid valve tenting in tricuspid regurgitation secondary to pulmonary hypertension quantified by novel system with transthoracic real-time 3-dimensional echocardiography. J Am Soc Echocardiogr 2007;20:470–476.
4. Carpentier A, Deloche A, Hanania G, Forman J, Sellier P, Piwnica A, Dubost C, McGoon DC. Surgical management of acquired tricuspid valve disease. J Thorac Cardiovasc Surg 1974;67:53–65.
5. McCarthy PM, Bhudia SK, Rajeswaran J, Hoercher KJ, Lytle BW, Cosgrove DM, Blackstone EH. Tricuspid valve repair: durability and risk factors for failure. J Thorac Cardiovasc Surg 2004;127:674-85.
6. Navia JL, Nowicki ER, Blackstone EH, Brozzi NA, Nento DE, Atik FA, Rajeswaran J, Gillinov AM, Svensson LG, Lytle BW. Surgical management of secondary tricuspid valve regurgitation: annulus, commissure, or leaflet procedure? J Thorac Cardiovasc Surg 2010;139(6):1473-1482.
7. Ghanta RK, Chen R, Narayanasamy N, McGurk S, Lipsitz S, Chen FY, Cohn LH. Suture bicuspidization of the tricuspid valve versus ring annuloplasty for repair of functional tricuspid regurgitation: midterm results of 237 consecutive patients. J Thorac Cardiovasc Surg. 2007;133(1):117-26.
8. Rivera R, Duran E, Ajuria M..Carpentier's flexible ring versus De Vega's annuloplasty. A prospective randomized study. J Thorac Cardiovasc Surg. 1985;89(2):196-203.
9. Matsuyama K, Matsumoto M, Sugita T, Nishizawa J, Tokuda Y, Matsuo T, Ueda Y. De Vega annuloplasty and Carpentier-Edwards ring annuloplasty for secondary tricuspid regurgitation. J Heart Valve Dis. 2001;10(4):520-4.
10. Roshanali F, Saidi B, Mandegar MH, Yousefnia MA, Alaeddini F. Echocardiographic approach to the decision-making process for tricuspid valve repair. J Thorac Cardiovasc Surg. 2010;139(6):1483-7.
11. Anyanwu AC, Chikwe J, Adams DH, Tricuspid valve repair for treatment and prevention of secondary tricuspid regurgitation in patients undergoing mitral valve surgery. Curr Cardiol Rep 2008;10:110–117.
12. Tang GH, David TE, Singh SK, Maganti MD, Armstrong S, Borger MA.Tricuspid valve repair with an annuloplasty ring results in improved long-term outcomes. Circulation. 2006; 114(1 Suppl):I577-81.
13. Yada I, Tani K, Shimono T, Shikano K, Okabe M, Kusagawa M. Preoperative evaluation and surgical treatment for tricuspid regurgitation associated with acquired valvular heart disease. The Kay-Boyd method vs the Carpentier-Edwards ring method. J Cardiovasc Surg (Torino)1990;31:771–777.
14. Konishi Y, Tatsuta N, Minami K, Matsuda K, Yamazato A, Chiba Y, Nishiwaki N, Shimada I, Nakayama S, Fujita S, et al. Comparative study of Kay-Boyd's, DeVega's and Carpentier's annuloplasty in the management of functional tricuspid regurgitation. Jpn Circ J 1983; 47:1167–1172.
15. Nath J, Foster E, Heidenreich PA. Impact of tricuspid regurgitation on long-term survival. J Am Coll Cardiol 2004;43:405-409.
16. Nakano S, Kawashima Y, Hirose H, Matsuda H, Shimazaki Y, Taniguchi K, Kawamoto T, Watanabe S, Sakaki S. Evaluation of long-term results of bicuspidalization annuloplasty for functional tricuspid regurgitation. A seventeen-year experience with 133 consecutive patients. J Thorac Cardiovasc Surg 1988;95:340–345.
17. Katircioglu SF, Yamak B, Ulus AT, Ozsoyler I, Yildiz U, Mavitas B, Birincioglu L, Tasdemir O. Treatment of functional tricuspid regurgitation by bicuspidalization annuloplasty during mitral valve surgery. J Heart Valve Dis 1997;6:631–635.
18. Chidambaram M, Abdulali SA, Baliga BG, Ionescu MI. Long-term results of DeVega tricuspid annuloplasty. Ann Thorac Surg 1987;43:185–188.
19. Abe T, Tukamoto M, Yanagiya M, Morikawa M, Watanabe N, Komatsu S. De Vega's annuloplasty for acquired tricuspid disease: early and late results in 110 patients. Ann Thorac Surg 1989;48:670–676.
20. Morishita A, Kitamura M, Noji S, Aomi S, Endo M, Koyanagi H. Long-term results after De Vega's tricuspid annuloplasty. J Cardiovasc Surg (Torino) 2002;43:773–777.
21. Antunes MJ, Girdwood RW. Tricuspid annuloplasty: a modified technique. Ann Thorac Surg 1983; 35:676–678.

question

Manuel J Antunes,
Department of Cardiothoracic Surgery, University Hospital, Coimbra, Portugal

ring or no ring

No ring

The use of mechanical prostheses in the tricuspid position in multi-valvular procedures has been associated not only with increased mortality but also with a higher incidence of thrombotic complications. Although thrombolytic therapy has, in recent years, been successfully applied in the treatment of thrombosis of tricuspid mechanical prostheses, it remains a very serious and often lethal problem. Several reports indicate that by five years only about 35–45% of the patients were alive free from reoperation after tricuspid valve replacement.[1]

On the other hand, bioprostheses degenerate earlier rather than later, depending on the age of the patient, requiring repeat surgery which carries a. significantly higher mortality than in the primary operation. Although percutaneous valve-in-valve implantation may alter this situation, it is too soon to predict outcomes.

But it appears that only exceptionally does the tricuspid valve need to be replaced as a first procedure, because the valve tolerates well a less than perfect repair, with less than moderate regurgitation or stenosis, in contrast to what happens with left-side heart valves where total competence is of primordial importance. Hence, most people agree that annuloplasty is the surgery of choice.

In the early 1970s, Deloche et al,[2] from Carpentier's group, showed that dilatation of the tricuspid annulus occurs essentially in the mural portion of the annulus, corresponding to the anterior and posterior leaflets, and DeVega[3] developed the procedure that bares his name, which consists of plication of the posterior and anterior portions of the annulus, preserving the septal portion, with a double continuous suture (Figure 1).

The De Vega procedure has since been used in tens of thousands of cases throughout the world and it appears to be safe and efficacious. The guitar-string syndrome, resulting from sutures tearing and pulling out of the tissues was the main complication associated with this procedure. In order to avoid it, in 1987 we described a modification of the De Vega annuloplasty which consisted of the interposition of Teflon pledgets in each bite of the suture (Figure 2).[4]

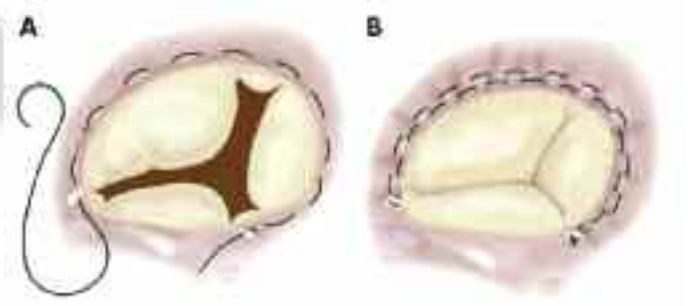


Figure 1

Several total or partial tricuspid annuloplasties were described, including the bicuspidization method which consists of a tight reduction of the posterior annulus segment only,[5] but the DeVega annuloplasty or its modifications have gained wider acceptance. In these situations, the valve is usually made mildly stenotic, but it has been emphasised that tricuspid stenosis is usually well tolerated by the patient.[6] It is technically easy and reproducible, even by relatively inexperienced surgeons.

The routine use of an annuloplasty ring has been considered superior and recommended by many groups.[7,8] However, in our experience, the implantation of a ring is specifically indicated when there is organic involvement of the tricuspid valve, usually with stenosis, where a commissurotomy is also necessary. In these circumstances, because remodelling of the annulus is probably essential, we prefer the Carpentier-Edwards ring.[9]

> The modified DeVega tricuspid annuloplasty proved to be a safe and efficacious procedure for the management of secondary tricuspid regurgitation.

Somewhat different is the problem of late appearing tricuspid regurgitation, especially if an annuloplasty had already been performed in a previous operation, but If it had not been done previously, annuloplasty is, again, preferable to valve replacement. In these cases, however, greater tendency for deformity of the whole valve mechanism, rather than isolated annular dilatation, and dilatation and dysfunction of the right ventricle may dictate more extended use of a prosthetic ring.[10,11]

Results

In our experience, the modified DeVega tricuspid annuloplasty proved to be a safe and efficacious procedure for the management of secondary tricuspid regurgitation. In our view, it should be used in all patients with more than mild "functional" regurgitation, when operating on the left-side valves, especially the mitral.

We have followed this policy for more than three decades and close to one thousand patients with encouraging results, and we have observed a low rate of late reoperations. In this period, only a hand full of patients required primary tricuspid valve replacement. A Carpentier ring was used in approximately 10% of the cases. The operative mortality is only slightly higher than in patients without tricuspid valve surgery, but the excess mortality is related to the pathology and not the procedure itself. No case of dehiscence of the annuloplasty suture was identified. Others have also reported excellent long-term results with this and other suture-annuloplasty techniques.12

On the other hand, reoperation for late TR, whether isolated or in conjunction with repeat surgery of another valve, has an operative risk which is higher than that which occurs after other redo valve surgery and may reach 10–20%, although much lower mortality rates have recently been reported.

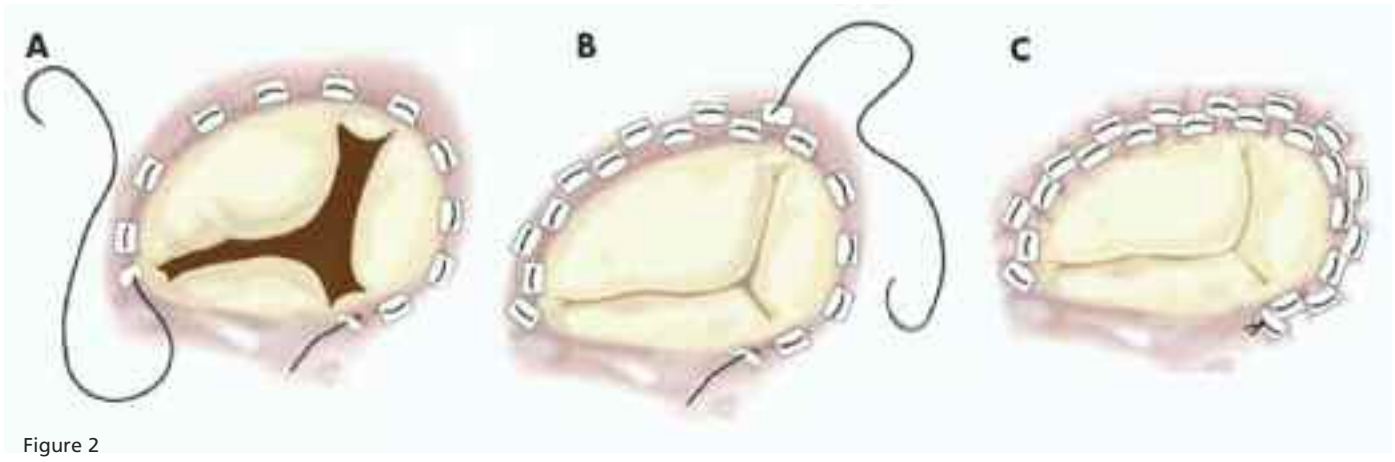


Figure 2

References

1. Reed GE, Boyd AD, Spencer FC, Engelman RM, Isom OW, Cunningham JN Jr.. Operative management of tricuspid regurgitation. Circulation 1976;54(suppl 3):96–8.
2. Deloche A, Guerinon J, Fabiani JN, Morillo F, Caramanian M, Carpentier A, Maurice P, Dubost C. Anatomical study of rheumatic tricuspid valve diseases: application to the study of various valvuloplasties. Ann Chir Thorac Cardiovasc 1973;12:343–9.
3. DeVega NG. La anuloplastia selective, reguable y permanente. Rev Esp Cardiol 1972;25:6–9.
4. Antunes MJ, Girdwood RW. Segmental tricuspid annuloplasty: a modified technique. Ann Thorac Surg 1983;35:676–8.
5. Kay JH, Maselli-Campagna G, Tsuji KK. Surgical treatment of tricuspid insufficiency. Ann Surg 1965;162:53-58.
6. Barlow JB. Aspects of mitral and tricuspid regurgitation. J Cardiol 1991;21:3–33.
7. McCarthy PM, Bhudia SK, Rajeswaran J, Hoercher KJa, Lytle BW, Cosgrove DM, Blackstone EH. Tricuspid valve repair: durability and risk factors for failure (see also discussion). J Thorac Cardiovasc Surg 2004;127:674–85.
8. Tang GHL, David TE, Singh SK, Maganti MD, Armstrong S, Borger MA. Tricuspid valve repair with an annuloplasty ring results in improved long-term outcomes. Circulation. 2006;114:I-577 – I-581
9. Antunes MJ. DeVega annuloplasty of the tricuspid valve. Operative Techniques in Thoracic and Cardiovascular Surgery 2003;8:169–76.
10. Xiao X, Huang H, Zhang J, Wu RB, He JG, Lu C, Li ZM. Surgical treatment of late tricuspid regurgitation after left cardiac valve replacement. Heart Lung Circ 2004;13:65–9.
11. Park CK, Park PW, Sung K, Lee YT, Kim WS, Jun T. Early and midterm outcomes for tricuspid valve surgery after left-sided valve surgery. Ann Thorac Surg 2009;88:1216-23
12. Ghanta RK, Chen R, Narayanasamy N, McGurk S, Lipsitz S, Chen FY, Cohn LH. Suture bicuspidization of the tricuspid valve versus ring annuloplasty for repair of functional tricuspid regurgitation: Midterm results of 237 consecutive patients. J Thorac Cardiovasc Surg 2007;133:117-26

RESIDENT'S COMMITTEE

Residents at EACTS

***EACTS News* discusses the role of residents within the Association with the Resident's representative, Peyman Sardari Nia, who outlines his role and responsibilities as well as looking forward to this year's Resident's programme in Lisbon.**

The Council of EACTS is composed of members of different committees and the EACTS Resident's Representative on the Council is a member of the Surgical Training & Manpower Committee.

The Resident's Representative was recently granted full rights (including voting) and according to Sardari Nia, this underlines the important role and function residents perform within the Association. "The residents represent the next generation of cardio-thoracic surgeons and it is crucial we, as an Association, have in place the mechanisms and channels for residents to express their views and opinion, as well as promoting, at the highest level, their participation in the decision-making process," he commented.

There are several issues of concern to residents particularly training programmes and European Working Time Directive (EWTD). Every European country currently has its own training programme and some countries have different training pathways. "Ideally, we would like to have the same curriculum in each European country, based on the same standards, and ultimately the same certification. This will allow surgeons to be trained to the same educational and scientific quality throughout Europe, which is very important for patient care. Equally, it will also facilitate manpower and migration," said Sardari Nia.

Regarding the EWTD, a recent survey undertaken by the Committee and published in the *Interactive CardioVascular and Thoracic Surgery* (Sabada et al: 2010;11:243-246) revealed that the vast majority of residents believe that the 48 hour resulted in insufficient time allocation for their training requirements. The survey also revealed that some 60% of residents were not really satisfied with their training programme.

"Of course, EACTS can only offer itself in an advisory and conciliatory role, but cannot change national curriculums", explained Sardari Nia. Subsequently, earlier this year, the EACTS organised a meeting with the national societies, the ESCVS and the ESTS to discuss the role of the European Board for Thoracic and Cardiovascular Surgery, the Board Examination the role of the UEMS and the harmonisation of cardio-thoracic training and education programmes in Europe. Members of the Surgical Training & Manpower Committee were present, and they were able to represent the views and vision of residents and express opinions concerning the proposal of a common curriculum. "It was decided that the EACTS will publish guidelines that will set out the basis of a European-wide curriculum on training, which is a very important development, especially for Residents."

Peyman Sardari Nia

Residents meeting in Lisbon

The Resident's Committee, the Surgical Training & Manpower Committee, is responsible for putting together the Resident's programme for the Annual Meeting. "Traditionally there are three people responsible, myself, the Chair of the Resident's Committee Rafa Sabada and Mathias Siepe (the previous Resident's representative on the EACTS Council)," he added. "The resident's programme has developed substantially in the last few years, previously it was outside the main EACTS programme but since last year it has been incorporated into the main programme.

The title for this year resident's meeting is "Future of Cardio-Thoracic Surgery: How to be trained and master the minimal invasive techniques," and this subject was chosen to demonstrate the changing nature of cardio-thoracic surgery. "We cannot expect to use the same surgical procedures we have used for the past 40 years. Cardio-thoracic surgery is changing and we must adapt to these changes and adopt new techniques and technologies. I believe that the future of our specialty will be dependent on our ability to lead innovation and to teach the young generation the minimal invasive techniques."

The session consists of four lectures that will cover the history of minimal invasive techniques in cardiothoracic, future perspectives and new developments of minimal invasive techniques, cardiothoracic training and place of minimal invasive techniques and the survival of cardiothoracic specialty: training and innovation.

EACTS Residents special luncheon

This year we will be having a special luncheon meeting next to the regular session. The luncheon consists of seven tables and each table has its own subject, we hope that young surgeons will find meeting their peers stimulating, so residents will be take part in roundtable discussions with prominent surgeons and the idea is to create an environment for informal discussion, one-to-one tuition and also to develop and foster networking.

Annals of Thoracic Surgery

The STS, with an educational grant from Maquet, are pleased to offer EACTS trainee members and trainee applicant members (who have paid their subscription by 1 July) the Annals of Thoracic Surgery in print and online from August 2011 until July 2012.

Course of minimal invasive techniques in adult cardiac surgery

Organiser: **EACTS – Surgical Training and Manpower Committee**
Venue: **St Antonius Hospital, Nieuwegein, Netherlands**
Dates: **13-15 February 2012**
Length: **2.5 days**
Subjects: **Heartport, TAVI, mini-maze, mini-AVR and TEVAR**
Focus: **Technical aspects, how to do it?**
Target audience: **Residents in advanced stage of training and young surgeons**

Cardiothoracic surgery is a relatively young specialty dependent on developments and innovations in the field of related specialties. The success of our specialty is based on the consistency and safety of conventional techniques developed in the past four decades.

Although the incidence and prevalence of cardiovascular and pulmonary diseases increased substantially during the past decades, the share of our specialty in treatment of these diseases did not substantially increase. There are four possible factors for this. Firstly, the conservative view that the boundaries of surgical specialty are defined by the surgeon' knife, and this view could be why we lost the opportunity in the percutaneous treatment of ischemic heart disease. Secondly, investment in the field of research cardiology and pneumology is greater than the device industry. Thirdly, our cautious approach in embracing new developments and techniques preferring consistent, safe conventional techniques with known long-term results. And finally our failure to incorporate the new developments and techniques in the basic training program.

It would be naïve to think that techniques that have been developed over 30 years ago will continue to compete effectively with new developments and treatments evolving in the future. The survival and growth of our specialty will depend on our ability to lead innovation and research in the field of cardiovascular and lung diseases, and our ability to take the lead in training future practitioners in minimal invasive techniques.

With the guidance of the Acquired Cardiac Disease Domain, the Surgical Training and Manpower committee of EACTS has created an advanced level of the curriculum offered at the European School on minimal invasive techniques in adult cardiac surgery. The course will focus on technical aspects of minimal invasive or minimal access techniques and aims to teach the participants how to do and start such a program at their institutions.

The venue of the course is St Antonius Hospital in Nieuwegein, Netherlands. The department of cardiothoracic surgery at St Antonius is the largest cardiothoracic department in the Benelux with high volume of all the available minimal invasive techniques at one venue. The course length is 2.5 days and it is designed for residents in advanced stage of training and young surgeons. During the course there are going to be case demonstrations of each technique with technical aspects presented by local surgeons and invited faculty through live-in-a-box and live-presentations. The maximum number of participants is set to be 100 and the full program and registration will be available during the EACTS Annual Meeting in Lisbon.

Peyman Sardari Nia, MD, PhD
Course Coordinator

EACTS News

Residents' views
If you would like to comment on any of the aspects concerning training and education, *EACTS News* would be delighted to publish your views.

Please send your comments to:
communications@e-dendrite.com.
We will publish as many of your comments as possible.

1st European Cardio-Thoracic Resident's Luncheon

Tuesday 4 October 2011
12:45 – 14:00

Register on site

This year the first resident luncheon will be organized at 25th EACTS annual meeting. The luncheon consists of seven tables with prominent cardiothoracic surgeons having lunch with residents and talking informally about specific subjects. The residents who would like to attend the luncheon have to register on site in Lisbon. The residents have to indicate three tables of choice and must be registered for attendance of annual meeting.

Congenital table
Invited Surgeons:
Prof. Pascal Vouhé *Paris*
Juan V. Comas *Madrid*

Thoracic Table
Invited Surgeons:
Philippe G Dartevelle *Paris*
Erino A. Rendina *Rome*

Mitral Valve table
Invited Surgeons:
Ottavio Alfieri *Milan*
Hugo K Vanermen *Aalst*

Extensive Aortic Surgery table
Invited Surgeons:
Marc A.A.M. Schepens *Brugge*
Roberto Di Bartolomeo *Bologna*
Thorsten C.W. Wahlers *Koln*

Editors table
Invited Surgeons:
Friedhelm Beyersdorf *Editor: EJCTS*
L Henry Edmunds Jr , *Editor: Ann Thorac Surg*
Lawrence H Cohn *Editor: JCTVS*

Minimal Invasive Aortic Valve Surgery table
Invited Surgeons:
A.Pieter Kappetein *Rotterdam*
Alaaddin Yilmaz, *Nieuwegein*
Francesco Maisano, *Milan*

Revascularisation table
Invited Surgeons:
Paul Sergeant *Leuven*
David P. Taggart *Oxford*
Rugero De Paulis *Rome*

EACTS is grateful to St. Jude Medical for it's educational grant in support of this programme

ST. JUDE MEDICAL

European Cardio-Thoracic Resident's meeting 2011

25th TEAMWORK
25th EACTS Annual Meeting
1-5 October 2011
Lisbon, Portugal
EACTS

Future of Cardio-Thoracic Surgery:

How to be trained and master the minimal invasive techniques

Tuesday 4 October
15:30–17:00 during the EACTS Annual Conference main programme

Chairs: Peyman Sardari Nia – Nieuwegein; Matthias Siepe – Freiburg

History of minimal invasive techniques in cardio-thoracic surgery
Roberto Lorusso – Brescia

Future perspectives and new developments of minimal invasive techniques
Volkmar Falk – Zurich

Cardio-thoracic training and place of minimal invasive techniques
A Pieter Kappetein – Rotterdam

Survival of cardio-thoracic specialty: training and innovation
J Rafael Sadaba – Pamplona

EACTS is grateful to St. Jude Medical for it's educational grant in support of this programme

ST. JUDE MEDICAL

25TH ANNUAL MEETING JOIN US IN LISBON

An invitation to help celebrate the 25th Annual Meeting of the EACTS

Dear Friends and Colleagues,

We are delighted to invite you to Lisbon for the world's leading cardiothoracic surgery event. The EACTS Annual Meeting offers you the opportunity to network with peers and connect with world-class faculty. Every member of the cardiothoracic community should take advantage of this year's dynamic and engaging programme to learn the latest technologies and techniques in cardiothoracic surgery.

Improving the care of patients with cardiothoracic diseases is one of the world's biggest challenges and the guiding mission of the European Association for Cardio-Thoracic Surgery. The 2011 scientific programme will further this goal by bringing together all professionals involved in cardiothoracic surgery, from surgeons and other clinical practitioners to basic scientists, epidemiologists, nurses, technicians, health care industry, care opinion leaders and policy makers.

Our programme will contain the variety and quality you have come to expect from the EACTS and our aim is to constantly develop and improve it to accommodate changing need and demand. As it is our 25th Anniversary Annual Meeting our annual meeting has a special theme this year: 'Teamwork'. It goes without saying that not only a surgeon is needed for improving the care of patients with cardiothoracic diseases but a whole team of healthcare professionals from cardiologists, radiologists and other clinical practitioners to nurses, technicians and scientists. Teamwork sessions will be found throughout the whole programme. We also organize for the second time the Postgraduate Course for nurses, nurse practitioners and physician assistants on the Sunday. Techno College will be as always on the Saturday and our Thoracic, Cardiac, Vascular and Congenital Postgraduate Courses on the Sunday. New this year will be our Professional Challenges Sessions. During these sessions one specific topic will be highlighted by video presentation, abstracts, keynote lectures and "learning from experience" cases.

On Wednesday morning we organize the Advanced Techniques sessions including wet-lab sessions.

Last but not least I want your special attention for our 25th Anniversary Party on Tuesday evening. Since the EACTS was founded 25 years ago the Annual Meeting is now the largest cardiothoracic meeting in the world. We could not have done this without the help of you, our members and of course the EACTS Staff. To mark this Silver Jubilee and to thank you all for volunteering throughout these years we have planned a special Anniversary Party where you can relax and enjoy the company of friends and colleagues from around the globe in an informal atmosphere and in the elegant surroundings of the Convento do Beato. This event will be very different from the formal dinner that we had in the past on the Tuesday evening. The highlight of the evening will be that EACTS 'House' Band will play until the wee hours.

Join us in Lisbon, looking forward to welcoming you all!

A Pieter Kappetein, MD, PhD

Secretary General

Postgraduate Course... Professional Challenges... Advanced Techniques

Adult cardiac – this year's highlights

In this issue, *EACTS News* continues the preview of this year's EACTS meeting in Lisbon. We begin by featuring an interview with Professor John Pepper, London UK, who outlines the highlights from the Adult Cardiac programme.

"This year, the Postgraduate Course begins with a four year results from the SYNTAX trial, probably one of the most important clinical trials in cardiac surgery," said Pepper. "This will be followed by an examination of interpretation of guidelines for coronary bypass surgery, because guidelines have been so important an affect every day clinical practice."

He explained that the 'science' behind the guidelines would look at how the guidelines were constructed and who was involved in their development (ie cardiologists, cardiac surgeons, etc). This to present a balance of the evidence to physicians and surgeons, but also provide patients with sufficient knowledge to make an informed opinion when they are facing possible intervention (whether this is percutaneous and surgical).

Cardiac surgery trials

"We will then have a review of some of the most important clinical trials in cardiovascular disease, such as the ADVANCE (HeartWare device) bridge-to-transplant trial, one of the first to report on a 2nd generation device. Importantly, we will also look at the STICH trial, which produced a result that many surgeons did not expect," explained Pepper. "This trial illustrates the problems with setting up a clinical trial in surgery." The final trials under the microscope will be the PARTNER trial, both the A and B cohorts. "The results from PARTNER showed astoundingly good outcomes of those patients who received transcatheter aortic valve implantation (TAVI) with almost no 'learning curve'. So, rather like STICH, there are lessons and implications from both trials in how to establish and run cardiac surgery trials." The session will conclude with a discussion of the TAVI European Registries.

'Heart Team' approach

Monday's programme will be focused around specially designed sessions and begin with how the 'Heart Team' approach seeks to inform participants of how a multi-disciplinary meeting in ischaemic heart disease actually works in practice. "We will also be looking at the EXCEL trial, which is the successor to SYNTAX. Whereas the latter excluded left main stem disease, the EXCEL trial will look specifically at stenting versus surgery for left main stem disease. So we will be hosting a debate and looking at the arguments on both sides, which we hope will be informative and assist participants in making informed decisions." There will be three or four case presentations, with live discussion of decision making based on presented angiograms, echo, Magnetic Resonance Imaging and a panel will discuss the merits of percutaneous or surgical intervention in the light of the current guidelines and comorbidities. "Essentially, we are going to try and see how PARTNER A and B works in practice."

> So we will be hosting a debate and looking at the arguments on both sides, which we hope will be informative and assist participants in making informed decisions… essentially, we are going to try and see how PARTNER A and B works in practice
>
> JOHN PEPPER

Another session will look at the future training and how young cardiac surgeons can become fully-involved in transcatheter valve implantation, which incorporates a combination of conventional surgical and endovascular skills.

On Tuesday there will be a focus on 'Professional Challenges' with specific attention on 'Total Arterial Grafting'. "We will be looking at the reasons behind the disparity between science, which suggests that total arterial grafting is the best treatment for surgical coronary disease and the practice, which shows it is rarely utilised. We hope to establish why this is the case."

There will also be two session on 'Surgery for Heart Failure', the first will examine the merits of left ventricular assist devices, destination therapy with mechanical support, new micropumps, as well as bridge to transplant. In addition, the second session will look at new developments in the treatment of advanced heart failure and the arrhythmia aspects of surgery (atrial fibrillation and ventricular tachycardia), as well as the role of short term support in acute heart failure (ECMO).

Tuesday will also see a company-sponsored session on antiplatelet therapy examining platelet function and antiplatelet therapy in acute coronary syndrome, and tips and tricks when operating under antiplatelet therapy. In addition, participants will also have the chance to look at new developments in extra-corporeal circulation such as mini cardiopulmonary bypass, long term oxygenators and portable systems.

There will also be a dedicated session for academic cardiac surgery research that will highlight how to write an academic paper, how to apply for grants, how to get European grants, encompassing the whole range of academic cardiac surgery.

Controversies

Wednesday's programme will concentrate on the conventional aortic valve surgery and aortic valve and root surgery. There will be an examination of classical aortic valve replacement surgery, aortic valve endocarditis, aortic root in bicuspid valves, aortic valve in acute aortic dissection type A, as well as new technologies in aortic valve replacement. "And finally, there will be an overview of the worldwide experience with the Ross operation detailing different surgical techniques, to enable participants to define indications and contra-indications for the Ross procedure, compare the Ross procedure with other options on the surgical menu and, ultimately define the requirements for optimal clinical application of the Ross procedure," concluded Pepper.

EACTS

European Association for Cardio-Thoracic Surgery

25TH ANNUAL MEETING
JOIN US IN LISBON

Previewing – Techno-College

Innovations of the future in Lisbon

Professor Volkmar Falk discusses some of the key presentations and highlighted the technological advances at this year's Techno-College event…

"The aim of the Techno-College is to make participants aware of what is new in the specialty, a technique or a device and focus on a disease area. Last year, there was a specific focus on atrial fibrillation, this year the focus will be on aortic stenosis," Falk explained. "We feel that this is a hot topic due to the widespread application of catheter-based procedures in recent years and an increase in devices with numerous advantageous and disadvantages."

Along with presentations featuring sutureless, the session will also feature a video presentation of a new transcatheter valve (developed by St Jude Medical), which will be the first time this device has been presented. In addition, there will also be an examination of new access devices with a live demonstration of a new expandable sheath that could expand the indication for the transfemoral aortic valve implantation. "As in recent years, we will also show developments in a preclinical stage and what is in the pipeline."

According to Falk, one of the highlights will be Dr Galadja's presentation on transapical endoscopic mitral repair approach and he added that he would be very interested to see what participants thought of the technique. "It is certainly something that deserves attention and discussion," he added.

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. In particular, the winner will demonstrate a technological breakthrough in an area related to thoracic and cardiovascular.

"Over the year's we have seen an increase in the Techno-College Award and I think it is because it is fundamentally different as it is open to industry submissions and it is not limited to technology," commented Falk. "So it could be a new procedure, device, implant, software or administration skill."

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 1st October 2011, where the prize, €5,000, will also be awarded. ***Submissions will close on 1 August 2011.***

Volkmar Falk

Previewing – the Congenital Programme

Techno-College to Fontan controversies

***EACTS News* talked to Congenital Domain Chair, Juan Comas, who outlined some of the highlights planned for this year's Congenital programme**

"The Congenital Domain was established three years ago," said Dr Comas. "Previously the Techno-College programme was dominated by the Adult Cardiac and Thoracic Domains, and we felt it was important for the Congenital Domain to have a presence within the Techno-College."

This year, the Congenital Techno-College programme will concentrating on innovation and new ways of closing interventrical holes. Dr Comas explained that traditionally, the cardiac surgeon performed an open procedure to close the defect. Today, interventional cardiologists are also performing many procedures to close these defects. Therefore, to reflect these changes in treatment paradigms, we have invited both cardiac surgeons, interventional cardiologists and anaesthesiologists to discuss the merits and limitations of open and interventional procedure. "Dr Fengwe (Linyi, China) will outline off-pump perventricular closure of ventricular septal defects (VSDs) and Dr Tsang (London, UK) will assess whether surgery is still the gold standard for VSD closures. The afternoon session will concentrate on the advances in fetal treatments with a review of interventional and surgical procedures, as well as improving outcomes for heart hypoplasia. By including these differing specialists we are endorsing the whole multidisciplinary approach and are referring to this year's special theme 'Teamwork'."

The Congenital Postgraduate Course reflects the multidisciplinary nature of patient care in congenital heart surgery. The programme will examine the technical detail of myocardial protection and leakage. "One of the great pioneers of our specialty is Roger Mee (Royal Melbourne Children's Hospital, Australia), and he was asked last year at a meeting to recognise his achievements, why he had such good results? He answered that is was not because he was a great surgeon, but because he had anaesthesiologists, intensive care units, nurses and others around him and this helps achieve practice efficacy and practice efficiency for the whole of healthcare."

The second session will look at the pathology of the interrupted aortic arch in association with other major malfunctions (eg. truncus), as well as a video session where the audience are asked to vote anonymously on neonatal Ross procedures.

Professional Challenges

This year the Congenital programme will include a 'Professionals Challenges' session. The objective on this session will be to understand the different surgical options for patients with this pathology and understand the current controversies and complications. The session is comprised of a video and an abstract session, and a keynote lecture by Dr Tom Spray (Phildelphia, US). Then there will be a cases session focused on learning from experience and will examine when one needs to go back to the operating room or the cath lab depending on what type of procedure is required, and a two part lecture from a surgeon and cardiologist entitled, 'What to expect'. The afternoon session will consist of two abstract sessions.

The Tuesday morning will also be different.

In Lisbon, there will be another joint session with a focus on extracardiac Fontan controversies. As this is the 25th Annual Meeting of the EACTS, Tuesday will finish with an historic lecture of how EACTS has helped to contribute to the treatment of congenital heart disease. Wednesday's programme will be an interactive discussion on congenital ventricular assist devices for neonates, infants and children.

EACTS
European Association for Cardio-Thoracic Surgery

25TH ANNUAL MEETING
JOIN US IN LISBON

Previewing Lisbon 2011 – the Vascular programme

Acute aortic dissection to complex aortic disease

EACTS News continues to preview the 25th Annual Meeting and we discussed the Vascular programme with Domain Chair, Martin Grabenwöger, who outlined some of the highlights planned for this year's programme…

"The EACTS structure of Domains was established by Paul Sergeant three years ago and I was the first Vascular Domain Chair, the meeting in Lisbon will be my last as chair of the domain," said Grabenwöger. "Over the last three years, I have seen a change in the professionalism of the EACTS and we have also been able to establish EACTS Vascular Courses. It has been a very enjoyable experience."

He explained that the process creating a programme begins in almost as soon as the annual meeting finishes, with the Domain Chairs meeting in November 2010. This year, the Vascular Domain programme will have two parts; invited speakers and abstracts presentations. The abstracts are assessed and marked, and then assigned to a relevant session. "We received over 90 abstracts concerning aortic disease specifically for the vascular domain. The quality of the abstracts is improving every year," he added. "Obviously, we include the abstracts that receive high marks but abstracts that fit together so there is a theme or subject central to each session."

This year's programme highlights include sessions on the acute aortic dissection type A and a focus on complex aortic disease, where one has to treat the ascending, the arch and the descending aorta. "So participants in the session will be able to watch and comment on videos of these procedures. This will be followed by a keynote lecture and five abstract presentations that will fit to this topic, but may offer different solutions," commented Grabenwöger. "There are different ways to treat the same pathology. So we hope that video presentations, keynote speakers and abstracts will raise many talking points and further discussion."

Professional challenges

The Vascular Domain programme on the Monday will this year feature a special focus session on acute aortic dissection type A. "This is a very important topic in emergency surgery as the majority of the patients who present with this condition will die if they are not treated surgically within the first 24 hours," he explained. "There is a lack of evidence concerning acute aortic dissection type A because there are no prospective randomised trials available. We in the Domain believe the problem is because people are using different methods, for example for cannulation, so these differences will be highlighted in this Professional Challenges session."

Grabenwöger then explained the benefits of working within EACTS and how the structure of the EACTS Domains has gathered together the experts in their fields who not only work on the programme for the annual meeting, but also, in cooperation with the European Society of Cardiology, form a Taskforce on the use of stent grafting for aortic aneurysms. Together, the society and association will be researching and writing a manuscript for stent grafting. "In addition, Ernst Weigang has established the European Registry of Aortic Disease (EuRADa) that we hope will collect much need standardised information on patients with aortic diseases that will aid in the treatment of patients with aortic disease. EuRADa is supported by the Vascular Domain and the EACTS Council. The collection of data and establishing guidelines are valuable roles the Domains within the EACTS can perform.

Nurses Course at the 25th Annual Meting of the EACTS

Vital team members: Nurses, nurse practitioners, physician assistants

Post-graduate Course: Sunday 2nd October

Leslie Hamilton
Consultant Cardiothoracic Surgeon
Programme Chair Postgraduate Course Nurses

The theme of this, the 25th annual EACTS meeting, is "Teamwork". It seems obvious therefore that a specific programme should be organised during the Postgraduate day (Sunday) to explore in depth, the vital contribution made by the members of the team from a nursing background.

This is a rapidly expanding area of practice and their value is becoming increasingly obvious. Having skilled, knowledgeable nurses who have developed their roles and are permanent members of the team is of great benefit in providing continuity of care. This contrasts with trying to maintain a service workforce based on doctors in training with unpredictable levels of experience who come to the department for a variable period of time for surgical training.

The programme for the day extends over six sessions. The aim is to cover general themes of advanced nursing practice and includes presentations by nurses on specific projects. The challenges of wound care are addressed and issues around transplantation will be explored (including LVADs and ex-vivo lung perfusion). Advances in our specialty will be considered (hybrid revascularisation and TAVI) and we will discuss research and publication. The day will finish with a discussion of the EACTS Guidelines on Resuscitation in the ICU and will include a live demonstration of the protocol.

We would ask that you encourage your nursing colleagues to attend and specifically support them in obtaining funding. In doing so you will both encourage your team and help make this day a success.

Come and join the party!

We shall be celebrating our 25th Anniversary at one of Lisbon's most remarkable and historical buildings – the Convento do Beato. Within the various wings of this 15th Century convent, recognized over the years for its magnificient construction, we will provide you with a variety of culinary and musical delights!

In the main Cloiser Hall we will celebrate the decade in which the Association was founded - the 80's – by showcasing some of the most famous stage musicals from that period. Our performers will sing and dance their way through internationally renowned hit stage musicals such as Les Miserables and Cats. The programme on the main stage will culminate in a performance by our EACTS 'house' band, made up of our own group of surgeons. The band will perform some well known cover songs, enticing everyone onto the dance floor.

In the more tranquil setting of the Library, our soloists will perform a range of classical music and operatic arias written by European composers, and in the Upper Foyer area we will celebrate the best traditional and folk music and dance that Europe has to offer.

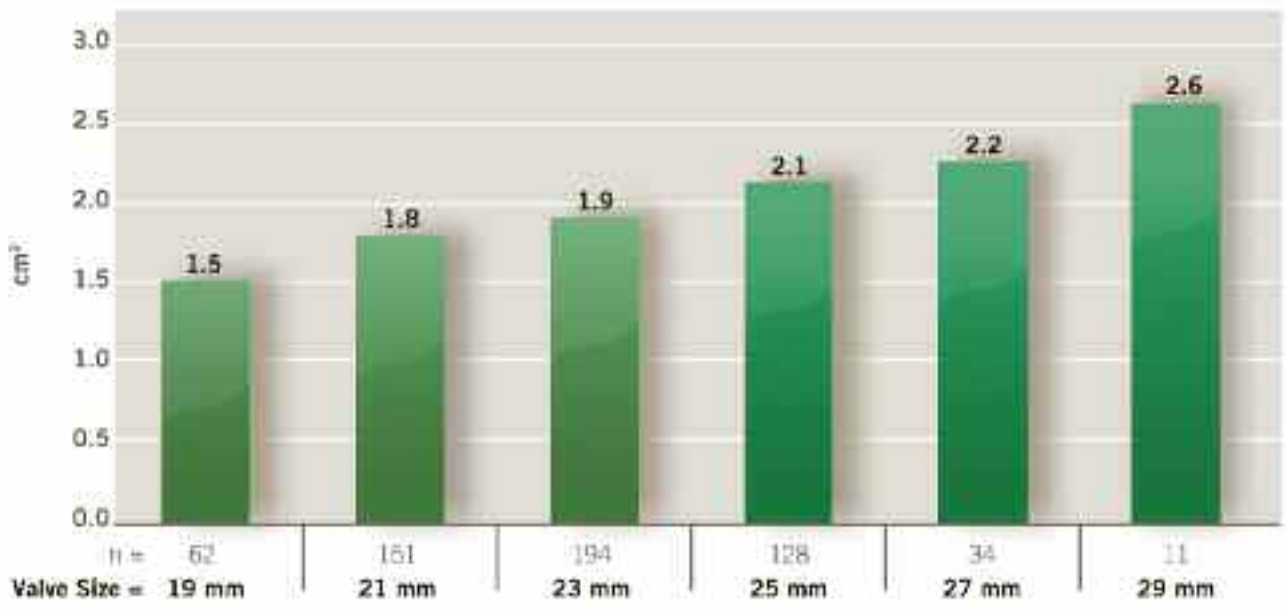
For those of you seeking even more excitement, we plan to run an EACTS casino where you will have the opportunity to join your colleagues for a flutter on the gaming tables.

Finally, if you just want to sit and take in the beautiful surroundings of this wonderful building, we will provide an area where you can relax and enjoy a quiet drink and a bite to eat in the company of friends and colleagues.

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, durability[2] and implantability, the Trifecta valve performs more like a natural heart valve.

Effective Orifice Area (EOA)



■ Trifecta™ [1]

1. St. Jude Medical, Trifecta 400 Late Patient Year Report, January 2010. Echo follow up at six months.
2. Data on File. St. Jude Medical.

ST. JUDE MEDICAL
MORE CONTROL. LESS RISK.

25TH ANNUAL MEETING OF THE EACTS -

SCIENTIFIC MEETING

Monday 3 October 2011:

Presidential Address: The beauty of the differences — Ottavio Alfieri, Milan:

Tuesday 4 October 2011

The Honoured Guest: Tissue specific adult stem cells — Piero Anversa, Boston

Domain of acquired cardiac disease

Monday 3 October 2011

Professional Challenges

Wire Skills: Part 1

Video 1: Transfemoral aortic valve replacement — F Maisano, Milan

Keynote lecture: Weird wires? — J Bavaria, Philadelphia

Imaging (Fluoroscopy, Intravascular ultrasound and intracardiac echocardiography — C DiMario, London

Guide wire/catheter nomenclature — L Lonn, Copenhagen

Arterial access and closure — C Di Mario, London

Trans septal approach — M Rigby, London

Wire Skills: Part II: Abstracts

Focus Sessions

Heart Team at Work

On-stage Syntax scoring will be demonstrated live. Indication for percutaneous coronary intervention (PCI) or coronary artery bypass graft (CABG) (or nothing will be discussed by the panel in the light of the current guidelines and co-morbidities 3/4 case presentations, with live discussion of decision making based on presented angiograms, echo, magnetic resonance imaging,

Functional Mitral Regurgitation

Understanding mitral regurgitation in heart failure – Do you? — M De Bonis, Milan

Imaging of functional mitral regurgitation — V Delgado, Leiden

Surgical repair – mitral and ventricular level — H J Schaefers, Homburg/Saar

Interventional treatment (MitraClip and beyond) — M Mack, Dallas

TAVI from inception to implantation

The Original Idea — L von Segesser, Lausanne
The Capital Investment — P Pouletty, Paris

The Animal Stage — N Borenstein, Paris
The R&D Accomplishment — S Delaloye, Ecublens

The Physician / R&D Collaboration — J Kempfert, Bad Nauheim

The Clinical Path to CE Mark — H Treede, Hamburg

TAVI in Perspective — T Walther, Bad Nauheim

Training for transcutaneous aortic valve replacement

Transcatheter valve implantation (TAVI) should be performed by surgeons

The Surgeon's View and The Cardiologists View

How did I train? The experience of three leading surgeons

Abstract Sessions:

Aortic Valve I; Coronary I: Heart Transplant I; Cardiac General I; Mitral Valves I, Assist I;: Mitral and Tricuspid Valves; Coronary II; TAVI I ; Cardiac General II; Experimental

Total Arterial Grafting: Part 1

Video and Keynote Lecture – No touch all arterial grafting — D Glineur, Louvain

Keynote lecture: Arterial grafting for everyone? — B Buxton, Victoria

Abstracts

Total Arterial Grafting: Part II

Video Arterial conduits in redo coronary artery surgery — G Tavilla, Nijmegen

Learning from Experience

Professional Challenges

Mitral Valve and beyond: Part I

Videos: Valve-in-ring implantation — R Klautz, Leiden; F Maisano, Milan; H Vanermen, Aalst

Abstracts

Mitral Valve and beyond: Part I

Transfemoral mitral valve-in-valve procedure: clinical experiences: — A Colombo, Milan; A.Vahanian, Paris

Abstracts

Percutaneous re-revalvulation of the tricuspid valve — M Gewillig, Leuven

New perspectives for the tricuspid valve — H Vanermen, Aalst

Focus Sessions

Antiplatelet therapy

Platelet function — J Carvalho de Sousa, Lisbon
Clopidogrel — N van Mieghem, Rotterdam

Prasugrel — P Smith, Durham
Ticagrelor — F Verheugt, Amsterdam

Antiplatelet therapy in stable coronary artery disease — M Heras, Barcelona

Antiplatelet therapy in unstable coronary artery disease — A P Kappetein, Rotterdam

Operating under antiplatelet therapy – Tips and tricks — M Sousa Uva, Lisbon

Postoperative use of ant platelet therapy (mono, double, tripple...) — F Verheugt, Amsterdam

Functional Tricuspid Regurgitation (TR): state of the art and new perspectives

Understanding functional TR: which implications

Anatomy, pathophysiology and assessment of functional TR — M Sarano, Rochester

Implications in tricuspid annuloplasty rings — M Jahangiri, London

Deciding about functional TR: timing of repair

Why so many MR patients with functional TR are still not treated? — R Klautz, Leiden

Which patients should be treated? — L van Herwerden, Utrecht

Treating functional TR: beyond daily practice

How to prevent progression of functional TR? — S Geidel, Hamburg

Is prophylactic annuloplasty for less than severe functional TR really necessary? — M Antunes, Coimbra

Tailoring the surgical approach to the stage of the disease — G Dreyfus, Monaco

Surgery for heart failure – Medical

Medical Therapy (Trial Update / Insight new guideline) — T McDonagh, London

Resynchronization Therapy — F Braunschwieg, Stockholm

Electrical Treatment Cardiac Resynchronisation Therapy (CRT); Atrial Fibrillation Ablation (AF); Ventricular Tachycardia (VT) — M Czesla, Stuttgart

Role of Short term support in acute heart failure extracorporeal membrane oxygenation — F Beyersdorf, Freiburg

Surgery for heart failure: MECC

Weaning from left ventricular assist device: How and when? — E Birks, London

Destination therapy with mechanical support — R Hetzer, Berlin

Micropumps — A Simon, London

Bridge to Transplant — M Morshuis, Bad Oeynhausen

Perfusion Problems & Opportunities

Mini cardiopulmonary bypass — J Mulholland, London
Long term oxygenators — F De Somers, Gent

Portable systems: A Philip, Regensburg – Extracorporeal Membrane Oxygenation Guidelines — C Benk, Freiburg

New ideas in Myocardial Protection — D Chambers, London

Abstract Sessions: TAVI II Mitral Valves II; Assist II; Aortic Valve II; Blood; Heart Transplant II; Aortic Valve III; TAVI III: Cardiopulmomary bypass; Arrhythmia

Wednesday 5 October 2011

Advanced Techniques

Controversies Adult Cardiac Surgery: Aortic Valve and Root Surgery

New Technologies in aortic valve replacement: The cardiologist's view — A Vahanian, Paris

Classical aortic valve replacement: Surgery, still the gold standard — G Berg, Glasgow

Aortic valve endocarditis: What to do — C Mestres, Barcelona

Aortic root in bicuspid valves: What to doR De Paulis, Rome

Aortic valve in acute aortic dissection type A: What to do — M Shrestha, Hannover

Minimally invasive aortic valve replacement — M Glauber, Massa

New Technologies in aortic valve replacement: Positive trend — T Folliguit, Paris

View from the medical industry: Aortic valve replacement — J McKenna, Vascutec, UK

View from the research: Aortic valve replacement: tissue engineered valves the future? — A Haverich, Hannover

Transcatheter Aortic Valve Implantation – The gold standard for the treatment of aortic valve stenosis

Implantability and short term complications — J Goiti, Bilbao

Haemodynamics and the relevance of aortic regurgitation — N Moat, London

Mid-term results, insights from the Partner trial — C Smith, New York

Next developments in technology. Surgical implications — V Falk, Zurich

Indications and patterns for referral for transcatheter aortic valve implantation in 2020 — A Vahanian, Paris

The future market for transcatheter aortic valve implantation — Philip Ebeling, VP, Research & Development, St Jude Medical

Minimally Invasive Therapies for Atrial Fibrillation

Surgical atrial fibrillation therapy in port-access surgery — M Czesla, Stuttgart

Isolated lone atrial fibrillation ablation through right minithoracotomy — G Nasso, Bari

Two-staged hybrid procedure for long-standing lone atrial fibrillation — B Gersak, Ljubljana

One-stage hybrid procedure for long-standing lone atrial fibrillation — M La Meir, Brussels

Minimally invasive left appendage management in patients with atrial fibrillation: — S Salzberg, Zurich

FULL DETAILS OF ALL PROGRAMMES AT WWW.EACTS.ORG
(PROGRAMMES SUBJECT TO CHANGE)

– SCIENTIFIC PROGRAMME – LISBON 2011

The role of the Ross Operation on the surgical menu

- Ross root replacement: indications, contra-indications and results – I El-Hamamsy, Montreal
- Video – Ross procedure root replacement – I El-Hamamsy, Montreal
- Video – Ross subcononary implantation technique – Hans Sievers, Luebeck
- Training requirements for the Ross procedure – W F Northrup III, Kennesaw
- Mechanical AVR: indications, contra-indications and results – H Körtke, Bad Oeynhausen
- Stentless bioprosthetic AVR: indications, contra-indications and results – R J M Klautz. Leiden
- Aortic valve repair: indications, contra-indications and results – H J Schäfers, Homburg/Saar
- Optimized decision making for prosthetic AV selection – J J M Takkenberg, Rotterdam
- Discussion: The surgical menu for aortic valve disease in (young) adults

Wet Labs

- Strategies to deal with Small Aortic Root
- Valve Sparing Root Surgery
- CABG anastomotic techniques

Domain of vascular disease

Monday 3 October 2011

Professional Challenges

Type A Aortic Dissection Part I

- Film: Acute Type A dissection
- Abstracts

Type A Aortic Dissection Part II

- Different cannulation sites in acute type A aortic dissection – C Mestres, Barcelona

Videos

- Carotid cannulation – P Urbanski, Bad Neustadt
- Direct aortic cannulation – K Kallenbach, Heidelberg
- Subclavian cannulation – S Folkman
- Direct axillary cannulation – D Pacini, Bologna
- Direct true lumen cannulation – L Conzelmannm Mainz
- Panel Discussion
- What have we learned so far from GERAADA concerning cannulation site and perfusion – E Weigang, Mainz

Focus Session

Neuroprotection

- Pharmacological protection – J Strauch, Bochum
- Perfusion and temperature management in type A aortic dissection (insights from GERAADA) – T Krueger, Tübingen
- Haemodynamic and brain monitoring in type A aortic dissection – R Bonser, Birmingham
- Monitoring and surgical aspects in thoraco-abdominal repair – M Schepens, Brugge
- Role of distal aortic perfusion – G Esposito, Bari
- Experimental aspects of spinal cord protection – C Etz, Leipzig
- Abstract Sessions: Acute and Chronic Ascending Aortic Disease

Tuesday 4 October 2011

Focus Session

Connective Tissue disease

- Hereditary Aortic syndromes – Y von Kodolitsch, Hamburg
- Pathological correlates of genetic aortic syndromes – O Leone, Bologna
- Indications for open surgery and surgical techniques – T Carrel, Berne
- The Thoraco-abdominal aorta in Marfan syndrome – M Schepens, Brugge
- Pharmacological treatment in connective tissue disease – J Pepper, London
- TEVAR in herdeditary aortopathy – M Funovics, Vienna

Abstract Sessions

- Complex Aortic Arch Pathology: Acute Type B Aortic Dissection; Descending Aorta

Wednesday 5 October 2011

Advanced Techniques

Novel Strategies for the Treatment of the Thoracic Aorta

- Functional imaging of the aorta – M Czerny, Berne/ E Weigang, Mainz
- Redo operations of the aortic root – M Di Eusanio, Bologna
- One, two or three vessel perfusion during selective antegrade cerebral perfusion – J Bachet, Abu Dhabi
- Novel surgical techniques in acute complicated type B aortic dissection – M Grabenwoger, Vienna
- Preventing paraplegia in thoracic endovascular aortic repair – EUREC II – M Czerny, Berne
- Thoracic endovascular aortic repair in thoracoabdominal aneurysm – Risk of endoleaks – M Funovics , Vienna
- Introduction to EURADA – E Weigang, Mainz

Domain of thoracic disease

Monday 3 October 2011

Abstract Sessions

- Lung Cancer; Mesothelioma, Lung Cancer and Rare Disorders; Esophagus and Mediastinum; Experimental

Tuesday 4 October 2011

Focus Session

Chest Wall

- Sternal reconstruction with cadaver bone (video) – F Rea, Padua
- Minimally invasive pectus excavatum repair – H Pilegaard, Copenhagen
- Minimally invasive pectus carinatum repair – M Yuksel, Istanbul
- Minimally invasive first rib resection – M C Ghefter, Sao Paulo
- Chest wall resection and reconstruction – C Deschamps, Rochester
- Sternal dehiscence – M Tocco, Rome
- Abstract Sessions: Minimally Invasive Techniques and Risk Factors; Non Oncology; Special Topics

Wednesday 5 October 2011

Advanced Techniques

Learning from Experience

Domain of congenital heart disease

Monday 3 October 2011

Professional Challenges

Hypoplastic left heart syndrome Part I

- Classical Norwood – W Gaynor, Philadelphia
- Modified Sano – D Barron, Birmingham
- Hybrid Procedure – R Pretre, Lausanne
- Abstracts
- Surgery for HLHS: – T Spray, Philadelphia

Hypoplastic left heart syndrome Part II

- Learning from experience
- Extreme form of hypoplastic left heart syndrome – C Schreiber, Munich
- One or two ventricles – L Galletti, Bergamo
- After Norwood: Surgical or Cath-lab revision – E Da Cruz, Denver
- Keynote Lecture: Treatment of HLHS What to expect – D Schranz, Giessen

Abstract Sessions

- Aortic Root / LVOT Right Ventricular Outflow Tract

Tuesday 4 October 2011

Focus Session

Fontan controversies

- Surgical view of controversies – W Brawn, Birmingham
- Cardiology view of controversies – F Berger
- **Panel Discussion:** B Maruszewski, Warsaw; J Fragata,Lisbon; M. Reddy, Stanford; Nico Blom, Marc Gewilling, Ornela Milanese, Dietmar Schranz
- Controversies: Optimal age; Management of pulmonary pulsative flow; Management of AV-valve regurgitation; Fenestration; Anticoagulation; Arrhythmia
- Abstracts

Abstract Sessions

- Domain Initiatives and Abstracts; Transposition of the great arteries: Mixed

Wednesday 5 October 2011

Advanced Techniques

Ventricular Assist Devices for neonates, infants, and : children, Interactive demonstration

- Theoretical Background
- Indications and contraindications for VADs – D L S Morales, Houston
- Review of centrifugal and roller pump technologies – C Haun, Sankt Augustin
- Developing Ventricular Assist Devices – B W Duncan, Houston
- Hands-on Practice and Troubleshooting

There will be 6 stations with different devices. The attendees will be in 6 groups that will rotate for a total of 30 minutes per station. Each station will offer a short lecture (5 minutes) about the device, followed by 25 minutes practice.

EACTS
European Association For Cardio-Thoracic Surgery

FULL DETAILS OF ALL PROGRAMMES AT WWW.EACTS.ORG
(PROGRAMMES SUBJECT TO CHANGE)

INTERNATIONAL CO-OPERATION COMMITTEE

Successful EACTS training course in Bloemfontein

The International Co-operation Committee (ICC) of EACTS co-organised a training course at the University of the Free State in Bloemfontein, South Africa held over two and a half days from 3–5 June 2011. This course, known as the Hannes Meyer Registrar Conference, is also supported by the Society of Cardiothoracic Surgeons of South Africa. Hannes Meyer was the founding head of the Cardiothoracic Surgery department at the UFS and also attended this year's course.

EACTS was represented by Professor Paul Sergeant, chairman of the ICC of EACTS, Professor Marko Turina, past –chairman of the ICC and Professor Charles Yanka from the Berlin Heart Institute. The program was jointly organised with Professor Francis Smit, head of the department of Cardiothoracic Surgery at the University of the Free State in Bloemfontein and also a member of the ICC of EACTS. A compliment of South African surgeons completed the faculty.

The course was attended by all heads of departments of training institutions (seven Universities) in South Africa, as well as registrars and perfusion technologists. In all, 10 delegates from six other African countries attended the course as well as 70 delegates from South African units. In addition 30 perfusionists attended the parallel perfusion course on 4 and 5 June.

The first day consisted of a research methodology session and a discussion of open mitral valvotomy, concluded with a successful wet-lab under the direction of Prof Yankah and heads of departments from South Africa.

The course also included a session on off-pump coronary artery surgery and its possible application in Africa. It also included two dry lab sessions on off pump CABG techniques conducted by Paul Sergeant.

Palliative paediatric surgical procedures (PA-banding and shunts), co-arctataion and PDA were discussed in the paediatric session. An approach to the surgical management of inflammatory lung disease was addressed in the thoracic session, and specific conditions were addressed in an interactive session.

Population studies were discussed and delegates developed basic protocols to hopefully conduct these studies at their own institutions.

Delegates from African countries, other than South Africa, discussed their programs and the challenges facing the development of cardiac surgical programs in Africa. The important role of a solid grounding in diagnostics (and echocardiography) as part of surgical training programs was emphasised. The extensive development of palliative and off pump cardiac surgery programs as a basis for the development of cardiac surgical programs in Africa was discussed during panel discussion in the paediatric and adult cardiac sessions.

> The extensive development of palliative and off pump cardiac surgery programs as a basis for the development of cardiac surgical programs in Africa was discussed

Left to right, Dr S M Mogaladi from Pretoria, Dr Paul Sergeant, Chairperson of the International Cooperation Committee of the European Association of Cardiothoracic Surgery (also immediate past president of EACTS) and Dr Richard Schulenburg from the UFS

A parallel session on perfusion was conducted on 4 June, and was attended by Mr Frank Merkle, chairman of the European Society for Cardiovascular Perfusionists current president of the European Board of Cardiovascular perfusionists (EBCP). The program included sessions on training programs for perfusionists, hemodynamic monitoring, including peri-operative TEE use. A session on coagulation and transfusion challenges in cardiac surgery including cell saving was well received. Wet –lab sessions were conducted on cell saving, mini- bypass systems and ECMO circuits on 5 June.

Left to right: Professors Charles Yankah, Francis Smit, Paul Sergeant, Hannes Meyer and Marko Turina.

Lectures are available on our departmental website at www.heartcentre.info.

We want to thank our sponsors Viking Medical, Philips and Ethicon.

EACTS Events in 2011–2012

1-5 October 2011
25th EACTS Annual Meeting
Lisbon, Portugal

24-26 November 2011
Multidisciplinary Teaching Course on Lung Cancer
Malaga, Spain
(jointly organised by ESTRO, ESMO, EACTS, ESTS, ESSO)

16-20 January 2012 (new date)
2nd Leadership Course for Cardiovascular and Thoracic Surgeons
Windsor, UK

8-9 February 2012
1st IACTS-EACTS Joint Workshop
Kolkata, India

13-15 February 2012
Course of Minimal Invasive Techniques in Adult Cardiac Surgery
Nieuwegein, The Netherlands

Key International Events in 2011

27-31 August
European Society of Cardiology Congress 2011
Paris, France
Contact: Congress Secretariat
Phone: (+33) 4 9294 7600
Fax: (+33) 4 9294 8629

7-11 November
Transcatheter Cardiovascular Therapeutics (TCT 2011)
San Francisco, US
Contact Cardiovascular Research Foundation
Phone: 646-434-4500
Email: info@crf.org

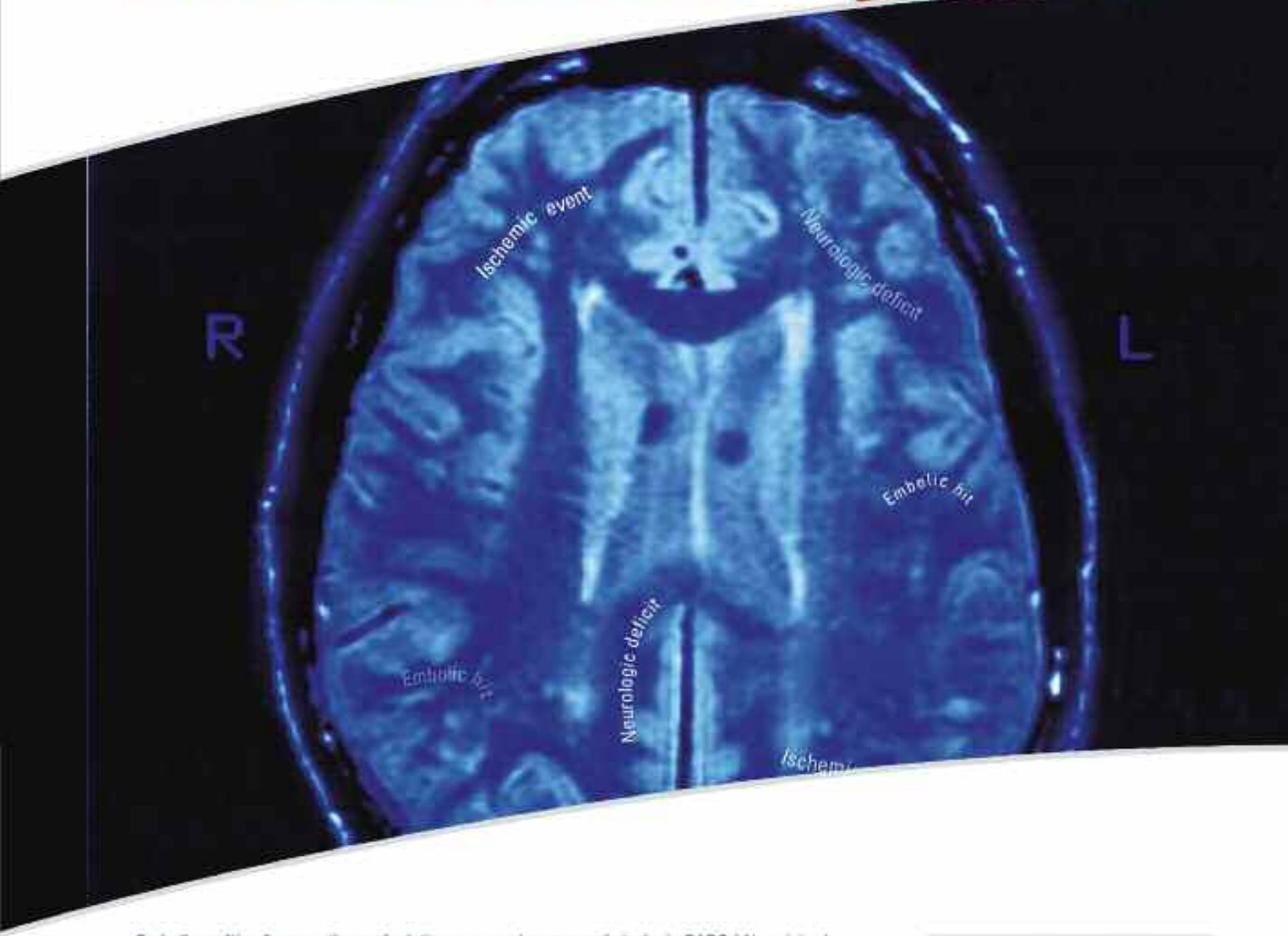
10-16 November
American Heart Association Scientific Sessions (AHA 2011)
Orlando, FL
Contact Conference Secretariat – AHA
Email: scientificconferences@heart.org

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

MAQUET
GETINGE GROUP

CARDIOVASCULAR

MINIMIZE RISK OF STROKE
MAXIMIZE CABG PATIENT OUTCOMES
CLAMPLESS BEATING HEART SURGERY



Emboli resulting from aortic manipulation are a major cause of stroke in CABG.[1] New data show that perioperative strokes can be minimized when surgeons utilize a fully clampless approach, consisting of off-pump revascularization with the HEARTSTRING Proximal Seal System.[2]

The unique HEARTSTRING device reduces the need for aortic manipulation and allows you to eliminate the need for a partial occlusion clamp, while easily and reliably hand-sewing your proximal grafts.

Additionally, the next generation ACROBAT-i System brings OPCAB to a new level by providing unparalleled ease of use, flexibility, and arm reach and strength. The increased range of motion and unobstructed surgical working space enable better access, especially for those hard-to-reach target vessels.

Visit MAQUET at EACTS Exhibit #2.24 to learn more about our innovative technologies and how to offer the benefits of clampless beating heart surgery to more of your patients.

HEARTSTRING Proximal Seal System

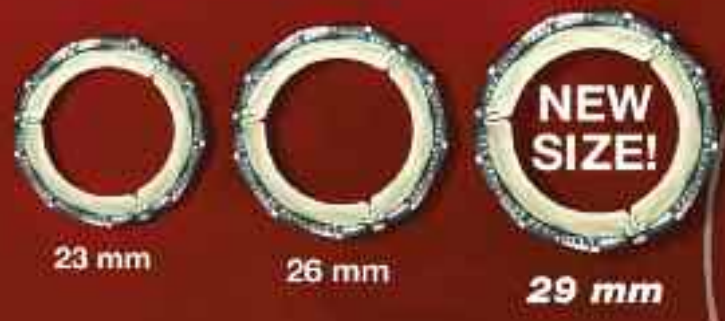
ACROBAT-i Off-Pump System, including Stabilizer, Positioner and Blower Mister

1. Royse AG, Royse CF. Epiaortic ultrasound assessment of the aorta in cardiac surgery. Best Pract Res Clin Anaesthesiol. 2009 Sep;23(3):335-41.
2. Filsoufi et al., Minimizing the risk of perioperative stroke by clampless off-pump bypass surgery: a retrospective observational analysis. Journal of Cardiothoracic Surgery 2010, 5:14

MAQUET Cardiovascular LLC 170 Baytech Drive, San Jose, CA 95134 Phone: +1 (408) 635-8500 Fax: +1 (408) 935-8801 www.maquet.com

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



Edwards Lifesciences S.A. | Route de l'Etraz 70 | 1260 Nyon | Switzerland | Phone 41.22.787.4300

Edwards