A message from the President

Dear EACTS members,

As president and as former editor I am proud to inform you that the European Journal for Cardio-Thoracic Surgery (EJCTS) has reached an impact factor of 2.550 and I want certainly to congratulate the current editor, Friedhelm Beyersdorf, and the staff of the editorial office with this achievement. As mentioned in the previous newsletter the EJCTS will celebrate its 25th anniversary this year. A quarter of a century is a milestone! And what is better way to celebrate this milestone than to do that with an increased impact factor. In the next edition of EACTS News you will learn more about 25 years of EJCTS.

In this issue of EACTS News you will find reports on the EACTS courses. All these courses were organized for the first time at our EACTS House in Windsor. Fully equipped with the latest audio-visual and videoconferencing facilities, wired and wireless network, as well as wet lab facilities EACTS House is a perfect venue for our courses.

Also in this issue we have an interview with cardiologist Patrick Serruys, best known from his work in interventional cardiology and particularly in the restoration of vascular function. During the ESC Annual Meeting in Munich this August Prof Serruys was awarded with the ESC Gold Medal for his contribution to medicine. Reading this interview you will find his answer to the question, “Does the cardiologist still needs the surgeon”. Collaboration between our two specialties is necessary to find treatment and cure for cardiovascular diseases. One hand cannot do without the other. Therefore the ESC and the EACTS create joint guidelines to work and produce joint guidelines on the treatment of cardiovascular diseases. The latest EACTS-ESC guidelines on the management of valvular heart disease will be presented duringour Annual Meeting in October in Barcelona and are already available online (www.EJCTS.org).

This leads me to the following item of this issue of EACTS News: the scientific programme of the 26th EACTS Annual Meeting in Barcelona. The Annual Meeting is only a few weeks away and the four EACTS domains have worked very hard to produce a wide range of educational formats presenting the latest and the best information on new technologies and techniques in cardio-thoracic surgery. You will find more details on the scientific programme further in this issue. Another important joint initiative is the development of a European Training Programme. Together with representatives of the national societies, the EACTS has identified the needs of the future training of cardio-thoracic surgeons in Europe and is developing a European Statement on Cardio-Thoracic Training and Education. A first draft will be presented during the EACTS Annual Meeting in Barcelona. This is already issue six of EACTS News. I hope you enjoy reading our newsletter as much as I do. Three times a year we try to offer you a variety of topics to keep you informed about the latest developments in our association and in cardio-thoracic surgery. Since EACTS News is made for our members, we would welcome any suggestions and ideas that you may have for our newsletter.

See you soon in Barcelona!

Ludwig von Segesser
MD, FECTS, FACS, FESC
President EACTS
Twenty interested scholars, from as far away as Russia and Korea, convened in the new EACTS headquarters in Windsor on Monday morning March 26. A warm welcome and a cold refreshment disguised a non-expected technical assessment at the start. This was the first step of an unhabitual master class based on the principles of the science of learning. All scholars were challenged to perform an anastomosis on a low fidelity simulator. Two video cameras anonymously observed the technical handling during the 15 minute interval given for this assessment.

This unhabitual master class was embedded in a scientific project, to study induced technical and cognitive learning progress, focused on coronary surgery and data interpretation. It is therefore logical that the previous technical torture was followed by an even more cruel knowledge assessment. Multiple choice questions were chosen to sharpen the attention of the scholars on the coming subjects. All scholars were hit in the face by the difficult, nevertheless crucial questions, pertinent for the daily care of patients and the correct interpretation of scientific publications. An identical technical and knowledge assessment closed the master class at the end of the week. In a later step, as well the graft and the grafted vessel as the videotaping will become the evidence for the validation of this performance using the FANN OSATS. The analysis of the data will allow the study of the technical and knowledge progress within that week, separately and in parallel.

The daily program was evenly balanced with four hours of intellectual interaction and four hours of low fidelity simulation. It usually ended with a splendid dinner in one of the fine restaurants of Windsor. Some closed the exhaustive days with a minor liquid imbalance. The knowledge and technical educational processes were deconstructed before the course and deposited in documents, power points and PDF files that guided the class. At several moments during the course the scholars were given the opportunity to direct the subjects for the following days according to their interests and needs. The interaction was structurally embedded in the lectures; in addition at any given moment questions and answers were raised by the scholars. Sometimes the planned paths were left for some challenging explorations. The age and experience variability within the group of scholars added interesting perspectives and enriched the whole group.

The last day the induced knowledge was applied in the critical reading of a series of well known manuscripts, identifying hidden limitations and destabilising some scholars in their unspoil belief of scientific publications. Tired but satisfied faces closed the week as a closed group of friends, having gone through a scientific process and study, usually reserved for the animal lab.

Vascular Course

Martin Czerny
Chair, EACTS Vascular Domain

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Advanced Module Coronary Surgery

Windsor 26–30 March

Rectification

In "The Big Question" section in issue 5 (pages 14–15) of the EACTS News newsletter, we incorrectly reported that Professor Hans Sievers was not in favour of the Ross procedure and that Professor Ad Bogers was in favour of the procedure. The publishers of EACTS News would like to apologise to both authors for this misrepresentation and for any embarrassment caused. This was an error on the part of the publishers and we acknowledge that Professor Hans Sievers is absolutely in favour of the Ross operation.

EACTS Executive Secretariat

Publishing by
Dendrite Clinical Systems
Managing Editor
Owen Haskins
owen.haskins@dendrite.com

Features Editor
Peter Myall
peter.myall@dendrite.com
Designer
Peter Williams
williams.editions.com
Industry Liaison
Martin Twycross
martin.twycross@dendrite.com

Managing Director
Peter Walton
peter.walton@dendrite.com
Dendrite Clinical Systems
Heat Office
Thirloe
Station Road
Horley-on-Thames
Oxfordshire
P012 5AY
United Kingdom
Phone: +44 1491 411 288

Published by
Dendrite Clinical Systems
Managing Editor
Owen Haskins
owen.haskins@dendrite.com

Editor in Chief
Peter Kappetein
Editor
Rianne Kaukman
rianne.kaukman@eacts.co.uk
Published by
Dendrite Clinical Systems
Managing Editor
Owen Haskins
owen.haskins@dendrite.com

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EDWARDS TRANSCATHETER HEART VALVE PROGRAM

Advancing TAVI. Changing Lives.

Partner with us to continue advancing valve science and building unrivaled clinical evidence as you transform the lives of patients.
In this issue we interview Professor Patrick Serruys, in which he discusses the evolution of cardioiology, the future of cardiovascular medicine and whether the cardiologist still needs the surgeon.

You have been involved in cardioiology for some 30 years, what has the most significant change?

The first thing to say is that I am an ex-internal medicine doctor and then I trained in cardioiology. At that time our primary function was to make a diagnosis and the surgeon was the one who would provide the solution to a coronary artery or valve problem, it was a very special relationship.

Our second function was to control the outcomes from surgery such as bypass, left ventricular function, angina, exercise testing and so on after surgery.

All this changed drastically in 1977 with the first angioplasty procedure. Suddenly, we were no longer internal medicine practitioners but interventional cardiologists, although the term did not exist at the time.

I remember when I was carrying out the first procedures in 1980, I had to go to the Royal Netherlands Academy of Arts and Sciences and explain to a panel of professionals including physicians, psychiatrists, poets, novelists, physicists and so on what interventional cardioiology was.

Our role was both diagnostic and therapeutic. I say therapeutic because we were able to “cure the disease” and this changed the psychology of a whole generation of ex-internists and cardiologists.

How did the surgeons react to the emergence of angioplasty?

I can only speak for myself, but when we started in Rotterdam, there was a waiting list of almost one year for cardiac surgery. I think it took me four months to find my first angioplasty patient. At the time the only balloon that existed was 4.2, so I had to find patients with single artery disease who had an artery of 4.2mm.

Initially, there was a gap of around three months between patients, at the same time the cardiologists were so busy and they thought that treating single vessel disease with angioplasty was just a small enterprise.

At first we could only start work late in the day, after 5pm, once the surgeons had finished their surgical programme as they remained on standby in case of complications. One day, when we decided to perform the procedure at 8am, it caused quite a stir.

But, step by step, our surgical colleagues began to recognise that in some patients with very simple lesions angioplasty was a valid treatment.

Of course it was not perfect, at the time we had some 30% rate of restenosis. I remember some three out of ten patients would require surgery and the surgeon would always say: “What have you done…. again?”

But over time, the number of patients being referred to surgery declined. I remember we used to only perform one case per day. I was working alone for a few weeks and performed five cases the first week, five cases the second week cases and in the third week I case each on Monday and Tuesday, all without surgery. This was a remarkable achievement. So I found excuses not to perform angioplasty on Wednesday, Thursday and Friday. I am superstitious and did not want to perform number 13.

So what lead to the adoption of angioplasty?

Angioplasty was still in its infancy and we were all still trying to master the technique. It was in 1982 that the first real advancement came with the first steeerable guidewire.

The second significant change came with the introduction of bare metal coronary stents and I performed the first procedure in the Netherlands in 1986. Of course, there were high rates of stent thrombosis and so the patients required anticoagulants, despite this, it was yet another step forward. Then along came drug-eluting stents, which reduced the incidence of thrombosis.

Has the Heart Team approach changed the relationship between cardiologists and surgeons?

Yes, in many institutions there were two systems of referral and very little communication between the surgeons and cardiologists.

The Heart Team approach means that they have to work together and co-sign an agreement on the course of treatment. They have to sit down and think carefully on the best course of actions for patient.

The concept is not new. When I first came to Rotterdam in 1976, we had discussions across the entire team. At the time all the patients went to surgery but everyone was allowed to voice their opinion and concerns.

For the SYNTAX study, I met with Friedrich Mohr to discuss a trial comparing surgery and drug-eluting stents in selected patients. Immediately he raised his fists, said he disagreed and did not want to do this kind of trial with cherry picking patient and he insisted that it must be an all-comers trial.

As there were no exclusion or inclusion criteria, the dialogue between the surgeon and interventional cardiologists became critical. Following a coronary angiogram, they had to decide what was responsible, even ethical, to stent the patient. This is the basis of the Heart Team approach.

The idea was to have a technical tool to look carefully at the angiography and comorbidity and surgeons and cardiologists would take the decision together. I believe this approach has made the two specialties listen to each other.

In the vessel, but you create a new vulnerable plaque is protected by tissue etc.

The calcium is still in the vessel, you create a new vessel and reconstruct a long segment, this would be great value in using this option as a method of revascularisation.

What are the biggest challenges facing interventional cardiologists and cardiac surgeons over the next decade?

Cardiac surgeons are not interested in angioplasty, they saw that as part of the domain of the interventionalist. However, this is not the case with TAVI, because it is an indication that requires the mastering of both surgical and interventional skills. Over time, the type of procedure both surgeons and interventionalists perform will be something different, but something that requires both surgical and interventional skills.

I have been impressed how quickly surgeons have embraced TAVI, perhaps we have finally seduced the surgeon.

The Heart Team concept has been recognised by the EACTS and European Society for Cardiology guidelines and guidelines from the United States. This is because it is Level 1 evidence-based medicine.

Following on from the success of the SYNTAX, PARTNER and the current SURTAVI and EXCEL trials, do you think the design of these trials is the future of trials design?

I believe so as I do not see another way to randomise patients. It is an interesting dynamic as when a patient is randomised, the surgeon and cardiologists are saying "I can do this procedure". However, there is also an element of doubt. We do not know if one procedure is better than the other.

Another important element is of course the SYNTAX Score, a tool to score complexity of coronary artery disease. For the EXCEL trial the FDA insisted that there should be exclusion criteria based on SYNTAX score 33. So, I believe this could now become a standard approach for all future trials.

Do you think the SYNTAX score will evolve over time like EUROSCORE?

Yes, in a recent study published in the journal EuroIntervention (2012 Aug), we report the Score is feasible, reproducible and may have a long-term prognostic role in patients with complex coronary disease undergoing surgical revascularisation. However, a validation of this scoring methodology is required.

Another development, which may allow SYNTAX Score to be reproduced in a more cost feasible way, is the development of the multislice CT scan. This will allow the Score to be given based on quantitative measurements and could open up a whole new world or diagnosis.

For example, a patient who presents with angina pectoris is given a multislice CT and is given a SYNTAX Score and their fractional flow reserve. So at the time of a procedure, the operator has all the information they need. I am very interested to see where this technology will go in the next five years.

Over the last 20 years we have seen the PCTA, bar-metal stenting, drug-eluting stenting and now bioabsorbable stents, what do you believe will be developed in the next decade?

There will be improvements in the pharmacological treatment and I can see some type of new treatment of coronary artery disease, where treatment will be pharmacological rather than surgical or interventional. That will be a good development. I think overtissue, molecular biology will be at the forefront of coronary artery disease.

Of course, the big enemy is calcification of the necrotic core and at the moment there is no other option that performing bypass. But in the future it could be possible to the refurbish the calcified tube?

We have had some positive results from bioabsorbable stent studies and perhaps this is paving the way for some kind of template for tissue engineering. The calcium is still in the vessel, but you create a new smooth muscle cell, fibroic tissue etc.

The great value of bypass is that you go distally to the vessel and the vulnerable plaque is protected by the bypass concept. If you can pave a vessel and reconstruct a long segment, there could be great value in using this option as a method of revascularisation.
Hospital and database installations
Our innovative system has become the preferred clinical governance tool at over 250 major hospitals throughout the world.

National and international databases and registries
Our registries are empowering professional societies, hospitals, clinical departments and clinicians with their own data, allowing them to make informed decisions leading to improved outcomes for patients.
The workshop was organized by the cooperation of the Departments of Thoracic Surgery of Marmara University and Dokuz Eylül University Medical Faculties together with the EACTS, Turkish Society of Thoracic Surgery and Sociedade Brasileira de Cirurgia Toracica. Congenital and acquired chest wall diseases such as pectus deformities, chest wall tumors and sternal dehiscence were discussed and debated on the basis diagnosis and treatment, by the 31 invited faculty and 117 registered participants from the USA, Latin America, Africa, Middle East, Asia and various countries in Europe. The workshop started on Friday morning on the 22 June 2012 with the registration of the participants. The first session was chaired by Dr Kalliopi Athanassiadi and Dr Bedrettin Yildizeli. Dr Mustafa Yuksel welcomed the participants and Dr Hasan Fevzi Batirel, the dean of the Marmara University Medical Faculty, gave an opening speech. Dr Andre Hebra followed him with his speech on the history of pectus surgery. Dr Jose Ribas Milanez de Campos, one of the founders of CWIG talked about the history of the CWIG.

The following session was Live Surgery from the OR, where four operations – 2 MIRPE and 2 MIRPC – were transmitted live to the conference hall. The session was moderated by Dr Campos in the conference hall and by Dr Marcelo Martinez-Ferro in the OR. Two patients with pectus excavatum deformity were operated on, one of them by Dr Hans Pilegaard and the other one by Dr Yuksel. Following the first operation, Dr Pilegaard gave a speech on the basic principals of MIRPE. Two patients with pectus carinatum deformity were operated on also by Dr Yuksel. The operations were completed successfully, and had been interactively contributed by the participants as well.

Following the lunch break six studies were presented (by Dr Sergio Sesia, Dr Akin Balci, Dr Marcelo Martinez-Ferro, Dr Murat Oncel, Dr Marko Kostic, and Dr Ivan Schewitz) on the Mini Symposium session chaired by Dr Patricio Varela and Dr Frank-Martin Haecker. The video presentation session was chaired by Dr Hyunik Park and Dr Sina Ercan, where Dr Vladimir Kuzmichev, Dr Schewitz, Dr Hebra, Dr Haecker, Dr Park and Dr P. Varela presented their videos on their own experiences on pectus surgery.

The last session of the day was chaired by Dr Hebra and Dr Volkan Kara. Dr Ferro gave a speech on his Dynamic Compression System for pectus carinatum. Dr Marlos de Souza Coelho shared his experience on open surgical correction of pectus deformities. Following him Dr Horacio Abramson gave a speech on his own technique of minimally invasive repair of pectus carinatum. Then, Dr Hebra gave a striking speech on mortality due to surgical repair of pectus deformities. Dr P. Varela followed him with his speech on his own technique of thoracoscopic cartilage resections for the correction of pectus deformities. At the end of the session Dr Sungsoo Lee presented his own study on bracing therapy for pectus carinatum.

After this last session the participants enjoyed a selection of local wine and various cheese at the opening cocktail of the workshop.

In the evening, a dinner for the invited faculty was held at Temenye Fish Restaurant in Pendik Marina.
On the second day, at the first session on chest wall resection and reconstruction, chaired by Dr Athanassiadi and Dr Levent Elbeyli, the first speaker was Dr Cosimo Lequaglie. He gave a speech on his experience on chest wall resection – reconstruction. Following him Dr Jean-Marie Wihlm gave a speech on the 2012 trends for chest wall resection – reconstruction. The last speaker of the session was Dr Gonzalo Varela sharing his own experience on the same subject. At the end of the session Dr Korkut Bostanci presented a Jeune's Syndrome case who was treated by bilateral thoracic expansion surgery and the case was discussed by the participants.

The next session was chaired by Dr Schewitz and Dr Sedat Gurkok. The first speaker was Dr Mehmet Bayramicli and he spoke about his experience on the surgical correction of Poland’s Syndrome. Following him Dr Gurkok gave his speech on modified open surgery for pectus deformities. The last lecturer of the session was Dr Athanassiadi and she shared her experience on chest wall resection and reconstruction with the participants. Following her three studies from Italy were presented by Dr Stefano Sanna and Dr Andrea Dell’Amore.

In the afternoon the first session was chaired by Dr Campos and Dr Ilgaz Dogusoy. Dr Ludwig Lampl lectured on modern strategies in sternal dehiscence treatment. Following him four studies were presented by Dr Federico Tacconi, Dr Hamidreza Davari, Dr I.K. Leval and Dr A. Gouzubayuyk.

The fourth session of the day was chaired by Dr G. Varela and Dr Ahmet Basoglu. Dr Pilegaard lectured on his technique of minimally invasive repair of pectus excavatum and Dr Yuksel lectured on his technique of minimally invasive repair of pectus carinatum. At the end of the session Dr Bostanci presented two challenging cases and the cases were discussed by the participants interactively. Then Dr Pilegaard also presented various cases to be debated by the participants.

The following video presentation session was chaired by Dr Lampl and Dr Akin Balci. Dr Abramson was the first speaker and he gave a speech on the technical aspects related to the Nuss Procedure. Afterwards Dr Campos presented various challenging cases. Following him Dr Wihlm lectured on his technique of correcting the costal flaring. The last speaker of the session was Dr Ferro and he gave a speech on the algorithm of the treatment of pectus carinatum.

The last session of the workshop was chaired by Dr Yuksel and Dr Bostanci. The first presenter was Dr Sadashige Uemura and he presented his study on advanced Nuss procedure for adults. Following him Dr Hakan Ozalper presented his study on the effects of the pectus bar on the mammarian arteries. Afterwards Dr Murat Bezer lectured on the relationship of pectus deformities and scoliosis. The last speaker of the workshop was Dr Park and he gave an speech on his own techniques for complex pectus deformities (press-molding andpectoplasty).

Therefore, the two day workshop which had been held in high academic level and included complex academic debates had succeeded to an end. It was announced by Dr Yuksel at the closing speech of the workshop, that in 2013 there would be two CWIG Meetings, one in Seoul, South Korea on 14–15 June, and one in Buenos Aires, Argentina on 27–28 September, and all the participants were invited to these meetings.

At night a Gala Dinner at Cercle D’Orient was organised for the participants to enjoy the Turkish food by the Marmara Sea.

In addition, we sincerely thank to everyone who had taken part in any aspect of this workshop as well as the Topkon Company which undertook the responsibility of the organisation and to Tasarimmed, Seres – MedXpert, BioMet, Synthes, and KLS Martin companies for their financial and moral support.
Adult Cardiac Domain programme

This year we are following the overarching theme of the meeting which is quality improvement programmes or QUIP for short. All health care systems are at bursting point from the economic viewpoint and in parts of Europe this is especially poignant right now.

Targeting the most appropriate operation towards the correct patient is a priority but needs careful analysis of the widening options available. We shall be exploring the data from established operations as well as teasing out the information from evolving minimal invasive and wire-based interventions. We have introduced some joint sessions across the domains, notably a session on infection of the cardiovascular system with the aortic domain and a session on myocardial rejuvenation with the congenital domain.

In coronary artery surgery we shall be looking at Syntax at five years, investigating how best we can optimise the delivery of coronary surgery and relating Syntax scores to graft patency. There are new developments in antiplatelet therapy which will be discussed in a special session.

Dealing with end-stage heart failure is an increasing occupation in many units so we have sessions on VADs and the total artificial heart, ECMO and the difficult problem of preventing and treating right ventricular failure. There is a state of the art review of heart transplantation.

Much of the new activity is taking place in transcutaneous valve implantation and so we have devoted four sessions to TAVI and a further four sessions to minimal invasive mitral repair including the mitra-clip. There is a session on hybrid approaches which will be controversial. Further sessions include in-depth analysis of aortic valve sparing operations, review of multiple valve procedures and the decision making, as well as a review of different approaches to the aortic root.

Long term studies are now emerging which indicate the dangers of inappropriate use of blood products and its effect on patients’ outcome and so we have a session entitled “blood matters”. Finally and most importantly, we will review the current valve guidelines and seek to refine risk assessment for all cardiac surgery both for mortality and morbidity.

We hope this programme will promote argument and discussion to enable us all to treat our patients to the very best of our ability.

EACTS Programme Committee

The programme at this year’s EACTS Annual Meeting is the result of months of hard work and dedication by the EACTS Programme Committee and reviewers.

“This year’s programme is one of the most comprehensive to be held at our Annual Meeting,” said Professor Pieter Kappetein, EACTS Secretary General. “The programme continues to improve each year and this is due to the expertise and commitment of the Committee and reviewers. I would like to thank all members and reviewers for all their hard work.”

MY SIMULATOR

Rafael Sadaba Chairman of the Session
Paul Sergeant Chairman of the Jury

The EACTS in collaboration with Ethicon has organized, last year in Lisboa, a contest to build a low fidelity for anastomotic simulation. Dr Arroyo from Valladolid was selected as the 2011 winner by an international jury. He received the 3,000 Euro award and his submission has been transformed into a product.

The 2012 simulation building contest involves the creation of a low fidelity simulator for mitral valve repair. Several brilliant submissions have already been submitted.

If you want to learn about this contest, find out what the future plans are with the Arroyo project, participate in the evaluation and criticism (only positive) of the 2012 submissions and finally learn more about future plans in simulation training, please come to the MY SIMULATOR session on Tuesday noon at the next EACTS meeting in Barcelona.

EACTS Programme Committee

Members of the EACTS Programme Committee

Rafael Sadaba, Chairman of the Session
Paul Sergeant, Chairman of the Jury

SUBMIT YOUR IDEA by October 20th to participate...

To view more information on the EACTS 2012 ETHICON CARDIOVASCULAR SIMULATION AWARD, please visit www.eacts.org/residents/aspx
### Vascular Simulation Courses

**TEVAR Simulation Workshop**

*08:30–10:30 Monday 29 and Tuesday 30 October*

**Room Vallvidrera, 14th Floor**

**Hotel AC Barcelona Forum**

**Objectives:**

After the course, participants will be able to describe the rationale for performing TEVAR and list the procedural steps of the implantation of a Valiant Captivia stent-graft for a thoracic aortic aneurysm and/or rupture.

**Participant Profile:**

Surgeons interested in understanding the endovascular treatment of the thoracic aorta with the Medtronic Valiant Captivia stent-graft with no/limited experience in this field.

**Objectives:**

You will perform a variety of different EVAR focused anatomies utilising the simulator for an introduction to EVAR. You will be able to perform an EVAR on a variety of different anatomies with 2 or 3 part graft systems.

**Logistics:**

Slots of 1 hour for 3 registered Annual Meeting delegates at a time. Registration on a first-come, first-served basis via the Information Desk in the main registration foyer area.

**Mentice Simulation Course**

*08:30–17:00 Monday 29 October*

**Room Montjuic, 3rd Floor**

**Hotel AC Barcelona Forum**

**Objectives:**

Utilising the endovascular Mentice VIST-Lab simulator for an introduction to EVAR. You will perform a variety of different EVAR focused anatomies utilising the real devices in a safe and controlled environment.

The course aims to be predominantly practical. After a brief introduction, the participants will be using individual Mac computers to go through the course and practice all the concepts explained.

**Objectives:**

The objective of the course is to teach the participants how to:

- Import images from a CT scan
- View one or multiple series of images from a study
- Navigate through the most important commands and toolbars
- Customize toolbars
- Use the main analysis and measurement tools
- Precisely perform the measurements with the MultiPlanar Reconstruction Display (MPR) and 3D Volume Rendering
- Export images, videos or DICOM files

**Logistics:**

The course is restricted to 25 registered Annual Meeting delegates.

**TEVAR Pre-Case Planning Course with Osirix**

*08:30–17:00 Monday 29 October*

**Room Montjuic, 3rd Floor**

**Hotel AC Barcelona Forum**

**Objectives:**

The purpose of this course is to teach the participants how to perform the case planning of a TEVAR procedure. This will include all the concepts needed for analysis and pre-case planning is planning to fail. Before entering the Operating Room, an analysis of the case is mandatory to properly understand the pathology and choose the optimal treatment. This course aims to provide an understanding of the use of Osirix for the analysis of the pathologies of the Thoracic Aorta and the planning of potential treatments. Osirix is becoming a reference environment of another technique might be used in place of another technique.

The objective of the course is to teach the participants how to:

1. Describe the methods used to perform valve sparing root replacement
2. Explain the reasons that one technique might be used in place of another
3. Perform the techniques in a wetlab environment

**Learning objectives**

At the end of this wetlab, the candidate will be able to:

1. Describe the methods used to perform valve sparing root replacement
2. Explain the reasons that one technique might be used in place of another
3. Perform the techniques in a wetlab environment

### Advanced Techniques Wetlabs

**Acquired Cardiac Disease**

**Valve Sparing Root Replacement**

*Room 122/123, Senior Stream*

**Learning objectives**

At the end of this wetlab, the candidate will be able to:

1. Describe the methods used to repair the mitral valve using GoreTex neochords and a mitral ring
2. Explain the reasons that one technique might be used in place of another
3. Perform the techniques in a wetlab environment

### Logistics

- Export images, videos or DICOM files
- Navigate through the most important commands and toolbars
- Customize toolbars
- Use the main analysis and measurement tools
- Precisely perform the measurements with the MultiPlanar Reconstruction Display (MPR) and 3D Volume Rendering
- Export images, videos or DICOM files

**Advanced Wetlabs**

- **Mitral Valve Repair using GoreTex chords**
- **Room 122/123, Senior Stream**

**Learning objectives**

At the end of this wetlab, the candidate will be able to:

1. Describe the methods used to repair the mitral valve using GoreTex neochords and a mitral ring
2. Explain the reasons that one technique might be used in place of another
3. Perform the techniques in a wetlab environment

**Convenient Heart Disease**

**Operating Techniques**

*Room 129/130*

**Chest Wall**

**Room 127/128**

**Learning objectives**

At the end of this wetlab, the candidate will be able to:

1. Describe the methods used to repair the mitral valve using GoreTex neochords and a mitral ring
2. Explain the reasons that one technique might be used in place of another
3. Perform the techniques in a wetlab environment

**Thoracic Disease**

**Chest Wall**

**Room 127/128**

**Chest wall resection and reconstruction – demonstration of various techniques including an introduction to the various devices/materials that are currently available**

Delegates will have an opportunity to observe various airway stitching techniques on sheep trachea staplers/sealants/stents and energy devices. Delegates will have an opportunity to fire staplers and insert stents etc.

Registration on a first-come, first-served basis via the Information Desk in the main registration foyer area.

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*MediaFIT – The new Dismountable Generation of Forceps for Mediastinoscopy*
### EACTS 2012 – 26th Annual Meeting: At a glance timetable

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<th>Time</th>
<th>Session 1</th>
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<tr>
<td>13:00</td>
<td><strong>Thoracic Surgery</strong></td>
<td><strong>Heart Failure</strong></td>
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<td>14:00</td>
<td>Medical and surgical intervention and management of cardiac arrhythmias in congenital heart disease</td>
<td>Minimal invasive repairs</td>
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<td>15:00</td>
<td>Aortic valve repair in childhood</td>
<td>Case reports - worst case scenarios</td>
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<td>Cardiac assist</td>
<td>Empyema - difficult cases</td>
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<td>Controversies of open and endovascular approaches</td>
<td>Thoracic Vascular Trauma</td>
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<td>Update on valves</td>
<td>Left heart failure</td>
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<td><strong>Innovations in patient care</strong></td>
<td><strong>Hands-on sessions with industry and surgeons</strong></td>
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<td>Exposition Open</td>
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### Lunch
- Aspects of valve repair
- The front door approach: the role of the surgeon in selecting the best patient-specific access route (ends 15:45)
- Elephant Trunk: Conventional and Frozen
- Break
- Contemporary approaches in acute and chronic type B aortic dissection (ends 17:30)
- Minimal invasive Aortic Valve Repair
- Euroscore II: refining risk assessment
- Research in cardiothoracic surgery (WtV 11:00-12:00, abstract session) 
- Visit Exhibits
- Thoracic oncology III
- Thoracic non-oncology I

### Satellite Symposia
- Residents’ Luncheon: Minimally invasive cardiothoracic surgery
- Lunch
- Multiple Valves
- Late Breaking I

### Visit Exhibits
- Thoracic oncology III
- Thoracic non-oncology I

### Other interest
- Residents’ Luncheon: Minimally invasive cardiothoracic surgery
- Lunch
- Multiple Valves
- Late Breaking I

### Exhibition Open
- Minimal invasive Aortic Valve Repair
- Euroscore II: refining risk assessment
- Visit Exhibits
- Thoracic oncology III
- Thoracic non-oncology I

### Session 4
- Understanding the univentricular circulation (ends 17:30)
- Outcomes of arterial revascularisation
- Aortic diagnostics from a different point of view (ends 17:30)
- Decision making
- LVAD management
- Endocarditis

### Break
- How durable is TAVI
- Unanswered questions in right ventricular failure
- PASCat
- Teach the teacher
- The patients getting sicker, what do I do next?
- Pulmonary Embolism
- Thoracic non-oncology II

### Session 5
-国会式
- Other interest
- General

### Hands-on sessions with industry and surgeons
- Minimal invasive repairs
- Mitral valve surgery

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Raising standards in training

In this issue EACTS News speaks to Professor Alfred Kocher, Department of Cardiac Surgery, General Hospital Vienna, Austria, who was the first recipient of the EACTS Leonardo da Vinci Award for Training Excellence.

The Training and Manpower Committee of EACTS established the Leonardo Da Vinci Award for Training Excellence to identify the best cardiothoracic trainer in Europe, as nominated by the trainees. The Association believes that by recognising and rewarding excellence in training, a trainer model can be established and the attributes that make a good cardiothoracic surgical teacher will be defined.

All cardiothoracic trainees in every European country were invited to nominate their trainer for the Leonardo Da Vinci Award and asked to submit a piece of reflective writing indicating why the trainer deserves to win.

“I saw emails referring to the EACTS Leonardo Da Vinci Award for Training Excellence, but I did not really know what it represented. Then I received a couple of emails from residents who suggested that they would like to nominate me for the award,” said Kocher. “At first I did not take much notice, however after four or five emails I began to give this serious consideration and said to my residents that if they felt that I am a good trainer, please feel free to nominate me.”

As the nomination progressed, it was not just the residents who endorsed the nomination but also his peers (an anaesthetologist, a nurse and a resident who had nominated him). The nomination was also endorsed by the Director of the Department of Cardiac Surgery and the Director of the Department of Surgery at the General Hospital in Vienna. Kocher added that it was “very humbling” to receive such support from different colleagues.

“I was overwhelmed that I received this prestigious prize, I think it is an excellent idea and I hope it can be used as a first step to build an integrated common curriculum in Europe for cardiac surgery,” he said. “The award was presented like an Oscar night celebration. I could not believe I would win the award given the quality of the competition. Mattia Glauber from Italy and Sam Nashef from the UK are both very esteemed cardiac surgeons in Europe. I was deeply honoured to win the award.”

Providing opportunities

He explained that the Leonardo Da Vinci Award is one way in which cardiac surgeons can underline the importance of training, particularly in Europe. Having spent time in Stanford and Columbia University/New York in the US, Vienna, Innsbruck and Poland he acknowledged there are significant differences in how surgical departments structure their training. While he was quick to emphasise that there is no over-arching concept of how residents should be trained, he stressed that the curriculums should be integrated.

“In the UK and the US they have established similar awards for a number of years. I believe that it is vital that we have a similar award in Europe because the problem is we have no master plan for training cardiothoracic surgeons across Europe,” he said. “I think it is important that we try and develop an integrated training fellowship across Europe, similar to fellowships offered in the US.”

Experience

“To be a cardiac surgeon you must have certain skills and attributes such as dexterity, patient care, a sound knowledge base and so on. But the most important aspect is gaining experience and having the opportunities to perform surgery, he said. “A surgical colleague of mine spent 12 years in the cardiac surgery department without performing one single open heart case on his own. Now he is re-training as a gynaecologist. So we need to give residents the opportunity, otherwise they will never learn. Practice does not make perfect, practice only makes permanent.”

He explained that a crucial aspect of teaching is teacher guidance and added that if trainees do not have guidance then they will practice incorrectly for a very long time. The key, said Kocher, is supervision.

“However, before you can gain the experience, you need the knowledge. It is not learning by doing, but learning by learning. I recommend to all my trainees to read cardiac surgical text books first so they have a sound knowledge base.”

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He believes that it is important that every person in the operating room learns from the procedure. A pre-operation briefing takes place the day before the operation and he and his trainees talk about the patient, the condition and the planned procedure. They then have a de-briefing session after the procedure and they answer any questions the resident may have. He explained that not all operations proceed as intended and this session is an opportunity for the trainees to ask why the surgeons did not carry out the procedure as planned.

“In the operating theatre is where residents learn the process of decision-making. A text book can inform you of many things, but it cannot help to make decision in theatre. So in the de-brief we explain why we made certain decisions and why we chose a certain course of action.”

Another important skill that trainees must develop is patient care and Kocher stresses to the residents the importance of keeping the patient informed about the operation, both pre- and post-operation, and allows the patient to ask any questions.

“I also give patients for their phone numbers and dial it immediately so I can call them after the operation and tell them how well the operation went, when they can leave hospital and so on. The simple things can sometimes be the most important to the patient.”

Influences

Kocher said he has developed many of his teaching attributes from two of the great influences on his career, Professor Laufer, who is Head of the Department of Cardiac Surgery and Professor Wolner, former Head of the Department of Surgery in Vienna.

“I was fortunate to make good friends with both Professor Laufer and Wolner. Not only are they both great surgeons, although Wolner has now retired, but they are both extremely generous,” he said. “In 1988 when I first announced that I intended to go to Columbia University in New York, some people in the hospital said it was impossible due to the number of the residents. Professor Wolner said that it was important that I went to New York, broadened my research and experience, and gave his agreement. Now I tell my residents to broaden their research and experience at every opportunity.”

Teach the Teacher Course

A “Teach the Teacher” session will be presented during the Annual Meeting in Barcelona on Tuesday 30 October. The course will examine the supervision of training and look at the evidence for training assessments, as well as hear from a trainee who will discuss their experiences.

The session will be moderated by John Pepper and Jos Maesens from Maastricht. Dr Maesens will inform participants of how training is organised and supervised in the Netherlands. Among the various interesting topics, there will be a lively debate on the motion “This house believes that we can train cardiac surgeons within the rules of EWTD.” Paul Sergeant will support the motion with Andre Simon opposing it.

“It is important that we as teachers learn how to teach and that trainees also see how we teach. In years to come they will be next teachers,” said Kocher. “This is why I am fully supportive of such initiatives.”

Alfred Kocher
26th EACTS Annual Meeting
Barcelona, Spain
27th - 31st October 2012

To find out more or to register for the event visit: www.eacts.org

Raising Standards through Education and Training
Peyman Sardari Nia MD, PhD

On behalf of Surgical Training and Manpower Committee

I am honored and pleased to announce the training track programme for the annual meeting in Barcelona. In 2008 the STMP committee was in charge of organizing a single session called “the resident’s meeting” outside the main program of the annual meeting. Today the STMP committee has a full program dedicated to training and novel techniques.

The STMP represents young surgeons and residents, the future of our specialty and we embrace the future with all its fullness. We believe that training, research and innovation are the foundations of our practice and future of our specialty. We believe that excellence in training, research and innovation should be recognised, pursued and applauded. And we do this by awarding each year different prizes for research (young investigators awards), for training (Leonardo da Vinci award for excellence in surgical training) and for innovation (simulation award). We organise courses on new procedures, and have set out new initiatives for the coming years, such as a minimal invasive course in adult cardiac surgery and wetlab training.

During the forthcoming annual meeting in Barcelona you will have the opportunity of joining us for a number of activities. On Monday we will organize the “resident’s luncheon” for the second time. The subject and title of this year’s luncheon is “minimal invasive cardiothoracic surgery”. The luncheon consists of seven tables with each having been designated a specific subject within the minimal invasive techniques. Prominent surgeons with expertise in related techniques are invited for moderating at each table. Residents can register at the annual meeting on-site for attending the luncheon. Questions can be sent in advance and will be compiled in envelopes to be opened at tables to facilitate discussions and interactions.

Also on Monday we will have a new session titled “Research in cardiothoracic surgery: Work in progress abstract session”. Although there is enough room during our annual meetings to present data regarding the individual studies, les opportunity exists to discuss ongoing research projects. Therefore, we have introduced a new session for our young colleagues to present their preliminary results. We would like to create a forum during which the researchers could present projects that they are working on. The idea is to give an opportunity to innovative work and thinking, and create a medium whereby new ideas could be exchanged and new cooperation’s created. The focus is the project as whole, possible implications for our specialty and its future perspectives.

On Tuesday we have another new session with the title “The patients getting sicker, what do I do next?” In this interactive session, expert surgeons will present cardiac and thoracic cases with progressive complexity and complications. Together with the audience the subsequent decision-making process and evolution of complications will be explored and discussed. The aim of this session is simply bluntly an excursion through cardiothoracic disasters.

At noon on Tuesday you will have the opportunity to join us in the “My simulator” session. This is dedicated to low fidelity simulation. The “Valladolid simulator”, last year’s winner of the Ethicon simulation award, will be formally presented in its manufactured version, and this year’s candidates will present their low fidelity simulators for mitral valve surgery. An evaluating panel will announce this year’s winner at the end of the session.

On Wednesday we will have yet another new session titled “Live in-box minimal invasive cardiac symposium: How to do it?”. This session is fully dedicated to minimal invasive techniques in adult cardiac surgery. Live-in-box videos of different techniques are presented. The emphasis is on the technical aspects of each procedure and pitfalls related to these techniques. The aim of this session is to stimulate discussions, exchange ideas and give the young surgeons a stimulating introduction to these new developments.

As the representatives of the STMP committee hope that the proposed Training Track activities serve the young surgeons in training. Much energy was put into these innovative sessions and prominent faculty is involved in it. The format of the sessions and quality of the faculty might create a highly instructive atmosphere. We look forward to seeing you in Barcelona.
## Program

### Table 1: Minimal invasive mitral valve surgery
- Fredrich Mohr, Leipzig
- Thom De Kroon, Nieuwegein

### Table 2: Minimal invasive aortic valve surgery
- Mattia Glauber, Massa
- Marjan Jahangiri, London

### Table 3: Minimal invasive maze procedures
- Wim-Jan Van Boven, Amsterdam

### Table 4: Minimal invasive thoracic procedures
- William Walker, Edinburgh
- Paul Van Schil, Antwerp

### Table 5: Minimal invasive aortic surgery
- Martin Czerny, Bern

### Table 6: Minimal invasive revascularization procedures
- Jean-Luc Jansens, Brussels
- Anthony De Souza, London

### Table 7: Hybrid congenital procedures
- David Anderson, London
- Christian Schreiber, Munich

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The Luncheon is sponsored by an unrestricted educational grant from AtriCure.
Registration for the luncheon is only possible on site in the conference center.
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Please note, this offer is valid until 31st December 2012.


EACTS Session on Lateral Thinking

This year EACTS is introducing a new and special session on Lateral Thinking. The goal of this session is to get insights from all stakeholders from the cardiovascular arena, especially from experts involved in different fields of cardiac surgery, to put current practice in perspective. This session is meant to stimulate discussion, to initiate re-thinking and maybe to challenge the status quo.

During last year’s presidential address by Professor Alﬁeri, he highlighted the value of the Beauty of the Differences: “It means appreciation, respect, acceptance, and tolerance for different opinions, attitudes, and cultures. It means Open Mindness and therefore Potential of Growth”. He emphasised the fact that only with an open mind there is a potential for growth – which in his opinion also and especially counts for EACTS. Thus, in his presidential address the idea for this special session on Lateral Thinking was created.

This session is created to provide a platform for Open Mindness and thus to stimulate the Potential of Growth. In other words, the idea is to line up the biggest challenges in cardiac surgery as seen from all perspectives and all fields of interest. Valuable speakers will represent traditional and modern cardiac surgery, interventional cardiac medicine, cardiology, the younger generation, industry, entrepreneurship, venture capital, economics, alternative approaches and patients.

Each lecturer is asked to give insights into her/his special field of interest, motivations, goals, doubts, aims, biggest challenges and whatever is considered to be most important in order to stimulate further growth. Due to the special background of invited speakers, this diversity is meant to be the major advantage of this session. Each speaker is encouraged to make a strong and if necessary a provocative statement. The far goals could be to streamline ideas, establish efﬁcient cooperation, deﬁne the added value, create beneﬁts for stakeholders, initiate discussion and re-thinking, deﬁne new criteria, create a platform for ideas and, most important, identify the top priorities in the ﬁeld of cardiac medicine. It is our hope that at the end of the session, a clear picture will be depicted enabling a deeper understanding of this complex cardiovascular arena.

The session will not be conducted according to the usual presentation format. Each speaker is free to choose standard slides, videos, flipchart or free speech. Any interaction between speakers and audience is possible and the last part of the session will be an open discussion.

Finally, a vote will be conducted that will represent the opinions of all attendees reflecting the biggest challenges in contemporary cardiac surgery. The content and results of this session will then be documented and published.

We very much look forward to welcoming you to this new and special session.

Volkmar Falk & Joerg Seeburger [University of Zürich, Switzerland and the Heart Center Leipzig, Germany]

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www.eacts.org
Chairman of the ICC committee – what an exciting life

Tuesday morning, 7 February 2012. What can go wrong? Hundreds of e-mails have preceded this trip to Kolkata in India. Indeed the EACTS organises a meeting in collaboration with, and at the invitation of, the Indian Association of Cardiothoracic Surgery (IACTS). Kunal Sarkar was the interface and one cannot imagine a better organised and charming personality.

What can go wrong? Nothing, except maybe a visa. I had an unused single entry but valid India tourist visa for a cancelled September meeting. The Consular services mailed me that I needed a new one. I presented myself at the consulate and there they told me that the previous one was still valid and that I did not need a new one. Interesting! In fact they told me that I should not lie on a visa application. Lie? Indeed it stated tourist visa and in reality India has a possibility of a Congress visa. So a new Congress one? No finally it was decided to try with this one. I would see at Delhi International airport. The last days before departure, I heard that two EACTS seniors had their visa refused for all kind of issues and could not make it to Kolkata.

What can go wrong on this beautiful Jet Airways plane that will bring me directly to Delhi? The plane leaves the gate and taxies to the runway. Is there an MD in the plane? I ask my Indian neighbour about malaria but he states that the cold season kills the females are dangerous. I lack some basic anatomy knowledge to identify a possible offender. I ask my Indian neighbour about malaria and he states that the cold season kills the bugs. Cold season, fine, yes it is winter, minor issue: the connection is in another terminal. A bus ride and one hour travel covers the five kilometres. So let us find a lounge. Minor issue: Indian law prevents you from entering the terminal building until two hours before departure. There goes the lounge! A metal chair helps me to sit down and relax until the gates open at 03:00. Inside I find two more softer chairs, bring them together and create a makeshift bed. Flight arrives finally at around 08:30 in Kolkata. A friendly driver weathered the storms of Indian traffic and brings me safely to the venue, where my first lecture is planned at around 11:00. The meeting is highly-attended, well-organised, following a strict timetable and the obligations follow nicely. In the evening a car weathered the same storm and brings Professor Turina and myself to an open-air party. We search for a calm table and wait for what is to come. The white tablecloth attracts a mosquito, I terminate its fatal attraction. There comes another one and, again, my ruthless behaviour ends that life. In no time there is carnage. Prof Turina asks me if the mosquito looks familiar? Well I never looked one right in the eyes but I focus my attention on the carnage. Could it be, yes, but which member of the family? The anopheles mosquito has 400 related families and I am most certainly no expert. In addition, as usual, only the females are dangerous. I lack some basic anatomy knowledge to identify a possible offender. I ask my Indian neighbour about malaria but he states that the cold season kills the bugs. Cold season, fine, yes it is winter, fine, but it is exceptionally 20°C outside, we are sitting next to a lake filled with non-flowing water and the animals looked in full battle condition. One look at Marko and we prefer to leave the most certainly splendid party to avoid some temperature problems in the coming days.

A couple more lectures, one more night and our return has started. Beautiful afternoon flight from Kolkata to Delhi. An arrival at 17:00 hours in Delhi. Next flight to Brussels at 03:00 in the morning. Yes, you guessed it, other terminal. From 18:00 hours till midnight a nice metal chair welcomes me outside of the international terminal. What can go wrong? Absolutely nothing, since the flight is a direct one to Brussels.

One hour into the flight, oh no! not again. Yes, a passenger, exhausted from extensive travel to Nepal, lost all pressure. A flat position with the legs elevated and some fluids bring him back to this world. Should we suggest landing the plane? Looking outside the window we are then flying over Pakistan, maybe no landing, next is Afghanistan, maybe no landing, next is Uzbekistan, next Kazakhstan. We find a business-class seat, recline the seat and allow the patient a normal night rest. Eight hours later we all land in Brussels, safe and sound with the same head position as at the start.

Yes, the car was still there in the parking lot and a short ride ended this uneventful trip of a chairman of the EACTS ICC committee. By the way, the IACTS organised a perfect meeting, elegant and efficient. We thank them for the spiritual and intellectual privilege.
CTSNet has commenced a major programme of improvements in 2012. You may already know www.ctsnet.org but you may be surprised to know how much interest we attract. We get one million visitors per year and over five million page views.

We already know that the most popular parts of our website include the ability to look up and search for colleagues all over the world including finding of their E-mail addresses, our ability to give you direct access to all the cardiothoracic journals via a single login to our website, the JANS (Journal and News Scan) and videos including regular interviews with the Giants of Cardiothoracic Surgery.

As we undergo a major programme of improvements, we are looking to improve the look and feel of the website. One major part of the upgrading will be the personal page. This is already a very popular part of the website but we want your homepage to be even better and potentially fit to be your own unique website. If you come to our stand in the exhibition area we will help you update your current homepage so that you can take advantage of the new upgrades as soon as they happen.

We also intend to help navigation round the website to videos, cases, and articles and also continue the very popular residents section. More and more we are also getting very high-quality submissions from our members. As the number of minimally invasive operations, conferences and events with live surgery or live presentations increases, we are encouraging people to get these together and instead of letting them go to waste, or appearing on local websites, we are happy to serve our community and to post this on CTSNet for the benefit of everyone.

CTSNet is an organisation run by full time surgeons and owned and managed by EACTS, the STS and the AATS. Our aim is to provide and disseminate the most up to date information possible for our members for their own education.

So if you have not seen the website for a while, either have a look at www.ctsnet.org or come along to our booth and see what changes we are making, or come and update your own webpage. In addition we would love to hear about any interesting videos you might have that you think people might learn from, so come along and we will put your operations on the world wide web!

Joel Dunning and Mark Ferguson
Interim Co-Editors in Chief

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CTSNet
THE CARDIO THORACIC SURGERY NETWORK

EACTS Events 2012

<table>
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<tr>
<th>Dates</th>
<th>Title</th>
<th>EACTS Domain</th>
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<tr>
<td>25 Oct</td>
<td>Deadline pre-registration 26th Annual Meeting</td>
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<td>12-16 Nov</td>
<td>Advanced Module: Heart failure: state of the art and future perspectives</td>
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<td>3rd EACTS Meeting on Cardiac and pulmonary regeneration</td>
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<td>Course for Industry partners: Basic knowledge in cardiothoracic surgery, statistics, etc</td>
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Course codes:
- Foundation Course
- Specialist Course
- Professional Development Course
- Co-sponsored Educational Activities

EACTS House
Madeira Walk
Windsor, SL4 1EU, UK
Tel: +44 (0) 1753 832 166
Email: info@eacts.co.uk
www.eacts.org

EJCTS/ICVTS/MMCTS Editorial Office
University Hospital Freiburg
Department of Cardiovascular Surgery
Hugstetter Str. 55
D-79106 Freiburg, Germany
Email: info@ejects.org

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Raising Standards Through Education and Training

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Rectification

In issue 5 of the EACTS News newsletter, we incorrectly quoted Jiri Nicovsky from Brno, Czech Republic, instead of Sonja Vanekova, Hradec Kralove, Czech Republic. The publishers of EACTS News would like to apologise to both Jiri Nicovsky and Sonja Vanekova for any embarrassment caused.

Mark Ferguson
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