Groups commit to improve CT surgery education

Over the past several years, the specialty of cardiothoracic surgery has experienced a continued decline in enrollment in CT residency training programs. If left unchecked, the result of this decline in qualified residents, combined with the aging of the US population, will be a serious deficit of CT surgeons and restricted access for patients with cardiovascular and thoracic disease. In fact, demand for surgeons currently exceeds the supply, a trend which is predicted to worsen significantly over the next 15 years.

The leaders of the American Association for Thoracic Surgery (AATS), American Board of Thoracic Surgery (ABTS), Society of Thoracic Surgeons (STS), and Thoracic Surgery Foundation for Research and Education (TSFRE) are responding to this crisis by joining forces to create and fund a Joint Council on Thoracic Surgery Education (JCTSE) with the express purpose of changing the current training paradigm and coordinating all thoracic surgery education in the United States.

“Less than 75 percent of CT residency slots have been filled in the last four years, and in 2007 the ABTS examination failure rate was the highest on record,” explained D. Craig Miller, M.D., President of AATS. “A large part of the problem is negative perceptions among medical students regarding the field of cardiothoracic surgery — it takes too long, the job market is saturated, reimbursement is low, and the scope of practice is limited mostly to open surgical procedures, not the exciting high-tech interventional procedures being performed by other specialties.”

The four organizations along with leaders of every major cardiothoracic surgical organization in the US met for two separate strategic retreats in 2007 to address current cardiothoracic surgery training and education in the United States. The outcome of these meetings was the creation of a Memorandum of Understanding (MOU) between the organizations and the development of a job description for an individual Surgical Director of Education to coordinate these efforts and work with the specialty organizations, training programs, and certification organizations.

“In a recent AAMC report, commissioned by AATS and STS, it was concluded that the United States is currently facing a shortage of cardiothoracic surgeons that will grow more severe within the next fifteen years,” said W. Randolph Chitwood, Jr., M.D., President of STS. “The evidence is clear that based on population projections and current CT surgical workforce data, we will not have enough qualified and well-trained cardiothoracic surgeons to treat the growing elderly population that will need CT surgical care.”

It was agreed that the current educational paradigm to train cardiothoracic surgeons needs to change. The leaders of these organizations joined forces to create the JCTSE to coordinate these efforts and work with the specialty organizations, training programs, and certification organizations.

Global CTS leader reviews past, looks to future

Develooping and advancing the field of cardiothoracic surgery has never been easy, and cardiothoracic surgeons must continue to be resourceful and enterprising into the future. This is the message Honored Speaker Marko I. Turina, M.D., will deliver during his lecture Tuesday at 11:40 a.m. during the Plenary Session on “50 Years of Cardiothoracic Surgery through the Looking Glass and What the Future Holds.”

“It takes courage, discipline and a significant amount of hard work to achieve progress in our field,” said Dr. Turina, a world-renowned cardiothoracic surgery leader. “Our pioneers did not have it easy, as it might look now. It’s important to remember that the development of our profession was very much influenced (and still is) by socioeconomic factors.”

Dr. Turina will address how cardiothoracic surgery arrived where it is today and how its development was not a straightforward process but “a tedious development, interspersed with setbacks.”

Dr. Turina is a past president of the European Association for Cardiothoracic Surgery (EACTS) and a former editor of the European Journal of Cardiothoracic Surgery. He is presently the editor of the MUltimode Manual of Cardiothoracic Surgery, a new internet-based collection of surgical procedures. He is a member of the Austrian, German, British and French cardiothoracic surgery societies.

“From the lecture, I hope the audience takes away the understanding that we must again take initiative in the field of cardiothoracic surgery,” Dr. Turina noted. “We must listen carefully to the changed needs of our patients and lead progress in the field of minimally invasive, percutaneous and transcatheter technologies, notably in the field of valvular and endo-aortic surgery.”
The Epicor™ Cardiac Ablation System uses HIFU to precisely and evenly deposit energy through varying thicknesses of tissue. A functional and flexible system, Epicor system gives surgeons the control to create multiple left atrium lesion patterns, including a full classic box lesion and a line to the mitral annulus – entirely epicardially, on a beating heart. The result is a safe, effective and reproducible approach to epicardial and off-pump cardiac tissue ablation.

Experience Control. AATS booth 1013
Adult cardiac symposium focuses on aneurysms, valve repair

The general rule for aortic aneurysms is that they are silent and unpredictable. Exceptions to this rule are the syndromic aneurysms, particularly associated with Marfan’s Syndrome. Addressing syndromic aneurysms was Duke Cameron, M.D., of Johns Hopkins University, Baltimore, with his presentation “Surgical Implications and Indications in MFS and Other Syndromic Patients,” during Sunday’s AATS/STS Adult Cardiac Surgery Symposium.

“The genetic syndrome offers an exception to this rule because they have a recognizable phenotype,” Dr. Cameron said. “The patient’s disease can be recognized before the aneurysm is apparent and allows us the opportunity to intervene before an aortic catastrophe.”

With Marfan Syndrome (MFS), aortic rupture and dissection are the major cause of premature death and on average shorten lifespan in these patients by a third, according to Dr. Cameron. Preventing aortic rupture by beta blockade and prophylactic aortic root replacement has been a major factor in improving longevity in patients with MFS. In this respect, prophylactic aortic root replacement is usually indicated when the sinus diameter exceeds 5.5-5.5 cm, though thoracic surgeons may wish to operate sooner if there is strong family history of aortic rupturedissection or if size increases and aortic regurgitation worsens.

With 2 percent of the general population having bicuspid aortic valve (BAV) syndrome, it is clearly the most common aneurysm syndrome where 30 percent of these patients experience a marked enlargement of the ascending aorta, according to Dr. Cameron. Enlargement to 5.5-5.5 cm is the point at which thoracic surgeons operate in BAV patients, and the two procedural choices include aortic valve replacement and root replacement.

Addressing the when and how of surgical issues was John A. Elefteriades, M.D., Yale University School of Medicine, New Haven, Conn., during his presentation “Thoracic Aortic Aneurysms: When is Intervention (Open or Stent-Grafted) Indicated?” The medical literature is replete with references on how to perform aortic operations but scant on when these operations should be performed.

“One of my main messages is that we should try to avoid an irrational exuberance in attacking aneurysm disease,” Dr. Elefteriades said. “We must be certain that our intervention is founded on evidence-based criteria in patients truly at risk from their aneurysm.”

When should thoracic surgeons intervene? The aneurysmal thoracic aorta should be resected before it reaches a critical 6 cm dimension in patients who do not have many comorbidities. In his presentation, Dr. Elefteriades recommended resection when the aorta reaches 5.5 cm, which provides a safe margin before rupture or dissection occurs. For MFS patients or those with an aneurysm-positive family history, Dr. Elefteriades recommends a threshold of 5 cm as an appropriate time to operate.

Surgical intervention is clearly indicated in cases of rupture or acute aortic dissection, with ascending dissection requiring urgent operation and descending dissection calling for a more complication-specific approach. Aneurysm symptomatic states include pain indicative of unexplained rupture, compression of adjacent organs (trachea, esophagus or left main stem bronchus) and significant aortic insufficiency in conjunction with ascending aortic aneurysm. Another feature calling for surgery is marked aortic enlargement, defined as more than 3 cm in growth.

“What we are talking about is how we can prevent virulent lesions from turning into real catastrophes with rupture and dissection,” Dr. Elefteriades said.

The symposium included additional discussions on aortic dissections, mitral valve controversies, percutaneous aortic valve replacements, and an update on contemporary cardiovascular imaging.

PET scans offer an effective means to stage lung cancer, depending on adequate instrumentation, nuclear medicine radiologist experience and a patience with false negatives.

This is the observation presented during the AATS/STS General Thoracic Surgery Symposium by Carolyn E. Reed, M.D., of the Medical University of South Carolina, Charleston, S.C., during her presentation “PET Scans—When Should We Rely on them in the Staging of NSCLC?”

“It is a single, non-invasive test that gives us reasonable, cancer-specific imaging. There have been several studies to show that the impact of PET is that it can decrease the percentage of futile thoracotomies”

In one clinical trial — PLUS — PET scanning incorporated into conventional lung cancer work-up led to a 50 percent relative reduction in futile thoracotomies and prevented cancer work-up led to a 50 percent relative reduction in futile thoracotomies and prevented cancer work-up led to a 50 percent relative reduction in futile thoracotomies and prevented cancer work-up led to a 50 percent relative reduction in futile thoracotomies.

In other imaging modalities are equally impressive in lung cancer detection and staging. Daniel L. Miller, M.D., of Emory University Clinic, Atlanta, addressed these modalities in his presentation on “Can Endobronchial Ultrasound (EBUS) and Esophageal Ultrasound (EUS) Fine Needle Aspiration (FNA) Replace Mediastinoscopy?”

“EBUS and EUS fine-needle nodal aspirations are superior to mediastinoscopy, which is effective for sampling lymph nodes in the tracheal, paratracheal and anterior subcarinal regions,” Dr. Miller said. “EUS is most effective for sampling lymph nodes in the posterior mediastinum (lymph node stations 7, 8 and 9), and EBUS is capable of visualizing all anterior lymph node and the majority of hilar lymph nodes.”

One 138-patient study at the Mayo Clinic, Jacksonville, demonstrated that the use of EUS or EBUS alone for diagnosing mediastinal lymphadenopathy resulted in low sensitivities under 70 percent.

The symposium continued with sessions on lung cancer management, esophageal cancer, and evolving concepts and techniques.
Congenital Symposium presents fresh perspectives

Sunday’s AATS/STS Congenital Heart Disease Symposium served up a unique mix of expertise and preliminary research, with 14 speakers giving presentations on subjects in which they’ve not previously published.

Symposium Chairman, Frank L. Hanley, M.D., specifically selected controversial topics with myriad opinions and/or surgical approaches to encourage discussion and debate.

Session I of the symposium began with two related presentations discussing the efficacy of septation in specific situations.

Vaughn A. Starnes, M.D., of the University of Southern California, presented “When I Use the Bidirectional Glenn in Septatable Hearts.”

Dr. Starnes said that the addition of bidirectional cavopulmonary anastomosis to a septatable heart with a normal left ventricle and a small or dysfunctional right ventricle is referred to as the one-and-one-half ventricle repair (1.5v).

While there is no clear proof that it is better than “a good Fontan (procedure),” Dr. Starnes said the reasons for performing the procedure are several.

“The advantages of a small pulsitile ventricle have been defined as the ability to increase cardiac output and maintain pulsatile flow in the pulmonary circulation. It gives the surgeon the flexibility to increase PVR without decreasing cardiac output and it is possible to maintain normal cardiac output with a low systemic venous pressure in the IVC,” he said.

“The low IVC pressure has the advantage of avoiding liver engorgement, ascites, peripheral edema and decreasing the incidence of protein-losing enteropathy. The potential to increase cardiac output readily without increasing the systemic pressure in the IVC may be the advantage of the 1.5v over the Fontan circulation.”

Dr. Starnes said that with increasing use of the 1.5v for very small right ventricles, at least there is the perception of an advantage of 1.5v over the Fontan circulation.

“In conclusion the 1.5v as a planned strategy maintains the benefits of separate pulmonary and systemic circulations including stabilization of CO in the face of changing PVR,” he said. “We will have to continue to look at this over time.”

Past AATS President Richard A. Jonas, M.D., of Children’s National Medical Center followed Dr. Starnes with “Fontan or Septation: When I Abandon Septation in Complex Lesions with Two Ventricles.”

Dr. Jonas said that the term septation is generally applied in the setting of a single ventricle with rudimentary ventricular septal development, thus making the statement “septation in the complex lesions with two ventricles” something of an oxymoron.

He pointed out that it is important to consider when the procedure is performed.

“You have to look at the era in which the Fontan was done,” Dr. Jonas said. “Every procedure before the lateral tunnel was invented should be thrown out of the equation.”

As the long-term results of the lateral tunnel and extracardiac Fontan procedures continue to improve, the threshold for shifting to a single track in the setting of a complex and non-ideal biventricular repair alternative has been lowered.

“Two ventricle options that subject the child and family to multiple surgical procedures and lengthy hospitalizations, as well as a limited cardiac output should be avoided,” he said.

The symposium continued with additional presentations featuring controversial congenital heart surgery issues and the cardiothoracic management of congenital heart disease.

Tuesday Plenary Session addresses several leading CTS issues

Five outstanding scientific papers, the Address by the Honored Speaker and several awards will be presented during Tuesday’s Plenary Session from 9:00 to 11:40 a.m. in Ballroom 20A-C of the San Diego Convention Center.

An engaging paper presented on “Mid-Term Results of Endovascular Treatment of Acute and Chronic Aortic Dissection: The Talent Thoracic Retrospective Registry (TTR),” will address some unknowns about using stents as a therapeutic option for aortic dissection, particularly of the descending thoracic aorta.

“This particular paper will give us a lot more information on whether this is a good therapy or a bad one,” Dr. Kron said. “This paper will provide us some serious follow-up to an area that has been very controversial.”

Another paper addresses both sides of the question, “How Does the Use of PTFE Necthorder for Posterior Mitral Valve Prolapse (Loop Technique) Compare with Leaflet Resection?” This study compares traditional resection techniques of transferring normal chords from another part of the valve to using the relatively new procedure of constructing and implanting artificial chords.

“There are two opposing schools of thought,” Dr. Kron said. “Presenters will offer conclusions on which is better, where they are equivalent and where there are minor differences.”

The role of mechanical valve replacement in children will be the focus of “Mechanical Valves Versus Ross Procedure for Aortic Valve Replacement in Children: Propensity-Adjusted Comparison of Long-Term Outcomes.” Fewer risks are involved in the initial mechanical valve replacement surgery for children, but the required anticoagulation gives some cardiac surgeons pause. The alternative is the tougher, but the anticoagulation-free, Ross procedure.

“Does the decreased risk in the initial surgery for mechanical valves outweigh potential complications of anticoagulation? This paper explores the issue of whether our biases against anticoagulation are real,” Dr. Kron said. “The Ross procedure is a harder procedure and it has been used in kids with growth potential. However, there is a significant re-operation rate with the Ross procedure.”

The following presentations will also be given during Tuesday’s Plenary Scientific Session:

• Application of the Revised Lung Cancer Staging System (IASLC Staging Project) to a Cancer Center Population
• Selective Antegrade Cerebral Perfusion Via Right Axillary Artery Cannulation Reduces Morbidity and Mortality after Proximal Aortic Surgery
In addition to restructuring the residency training paradigm in the US, the JCTSE will address all levels of cardiothoracic surgical education, including graduate, postgraduate, and continuing education for practicing CT surgeons. The Surgical Director will help to develop postgraduate education with the AATS, STS and other organizations to meet the needs of the practicing CT surgeon, especially in the acquisition of new technology skills and expertise. The Surgical Director will be an ex-officio member of the ABTS, the ABTS Education Committee, the Education and Program Committees of the AATS, the STS Workforce on Clinical Education, Graduate Medical Education and the Annual Meeting, and the Education Committee of the TSFRE. “The coordination of postgraduate education among the organizations will certainly be a great benefit to the specialty,” stated Michael J. Mack, M.D., President of the TSFRE. “A major focus of the Foundation has always been education and we have worked with the STS and AATS in supporting their educational programs. The TSFRE is delighted to be an equal partner in the efforts of the JCTSE to enhance the education of our CT residents and practicing surgeons.”

The Surgical Director will also work with the ABTS to help diplomates meet the requirements for continuing Maintenance of Certification (MOC). “The Director will increase the availability of methods by which CT surgeons acquire new technical skills, partnering with the specialty societies and individually developed courses,” said Richard H. Feins, M.D., Chair of the ABTS. “All of these combined efforts will produce surgeons who are better prepared to take the board certification examination. By joining forces, we hope to maintain the same high-quality, well-trained CT surgeon to which we have become accustomed.”

Both the AATS and STS have established outreach programs focused on medical students and general surgery residents, as well. STS invites general surgery residents to its annual meeting and subsidizes their travel. AATS provides summer internships in CT surgery for first- and second-year medical students to spend eight weeks working in a CT surgery department.

The AATS, STS, ABTS, and TSFRE have indicated that they are committed to quality cardiothoracic surgical education at every level. Each of the organizations involved in the JCTSE has pledged major financial and administrative support of these initiatives. “American cardiovascular and thoracic surgery will emerge from this tumultuous time as a stronger, more vibrant specialty,” concluded Dr. Miller.
New products introduced in Exhibit Hall

CryoLife 523

In January 2008, CryoLife received 510(k) clearance for CryoValve® SG pulmonary human heart valve. The valve is processed using the SynerGraft technology designed to remove antigenic donor cells from the valve without compromising the collagen matrix. The heart valve is indicated for the replacement of damaged, damaged, malformed or malfunctioning native pulmonary valves.

Endwards Lifesciences 1001

Endwards Lifesciences offers new artificial and venous canalulae that are designed to reduce trauma, increase efficiency and provide a variety of cannulation options that address today’s more challenging surgical approach. Among these is the FemTrak™ femoral venous cannula and the OptiSite™ arterial cannula, which both have proprietary ultra-thin wall technology to optimize flow. The FemTrak™ femoral venous cannula is precision-designed with a metal ferrule to provide an abratic transition between the cannula and introducer, and features a tapered anti-dislodging tip that navigates through tortuous anatomy. The OptiSite™ arterial cannula features a dilator with a blunt tip configuration that provides flexibility in cannulation sites, a lock feature, and a vent plug.

Luna Innovations 239

The EDAC® QUANTIFIER (Emboli Detection and Classification) blood circuit monitor from Luna Innovations uses sophisticat-ed ultrasound technology to non-invasively count and measure gaseous emboli in the extraspinal blood circuit. Unlike traditional emboli detectors, the EDAC® QUANTIFIER detects microemboli that may otherwise go unnoticed. What was previously unknown is now precisely measurable. The EDAC® QUANTIFIER was recently FDA cleared and is CE mark pending.

SynCardia Systems 340

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Terumo Cardiovascular Systems

Terumo’s cardiac and vascular companies will display the Virtuoso™ Endoscopic Vein Harvesting System, Vascsuture™ Gelweave™ Graft Geometries range of gelatin seeded woven grafts, Duralene™ Left Ventricular Assist System (not available in the U.S.), cannulae and perfusion systems.

Intuitive Surgical 327

Intuitive Surgical, 9 a.m.–3:30 p.m., Doug Murphy, Saint Joseph’s Hospital, “Minimally Invasive Cardiovascular Surgery Utilizing Performance Enhancing Technology”

Medtronic 701

Medtronic, 9:15 a.m., Profile 3D Joseph Gorman, III, M.D., New Products

PEAK Surgical 1031

PEAK Surgical, 9:15 a.m and 3:30 p.m., Evaluation of PEAK Plasmablede Compared to Traditional Electrocautery and Ultrasonic Instruments. Kai Ihnken, M.D., Clinical Assistant Professor, Cardiothoracic Surgery, Stanford University School of Medicine, Stanford, CA

St. Jude Medical 1013

St. Jude Medical, 9:15-10:00 a.m., Pia Mykén, M.D. — “Two Decades Experience with the Biocor”

IN-BOOTH PRESENTATIONS

ESTECH 613 & 623

• Monday, 9:15-10:00 a.m., Dr. Ralf Krakor, director, Cardiovascular Services, Department of Cardiovascular and Thoracic Surgery, Stadttische Klinik, Hamburg, Germany — “Minimally Invasive Valve Surgery and Cardio Ablation Using the ESTECH LIV System and COBRA Adhere XL”

Peters Surgical 829

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Invited comment on the Sternal Talon
by Denton A. Cooley, MD, President and Surgeon-in-chief, The Texas Heart Institute, 2007

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Breakfast Symposium
Tuesday, May 13
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Learn about the potential for transit time flow measurement to deliver better CABG outcomes.

SHUTTLE BUS INFORMATION
Complimentary shuttle buses will be available throughout the event for all exhibitors. Shuttles will run from the San Diego Convention Center to the Marriott Marina Hotel (Waterfall Park), the Sheraton Hotel and the Hyatt Regency Hotel (Red Cars Harbor Drive).

Monday:
6:45 a.m. - 10:00 a.m.
4:00 p.m. - 6:00 p.m.

Tuesday:
6:45 a.m. - 10:00 a.m.
4:00 p.m. - 6:00 p.m.

Wednesday:
6:30 a.m. - 11:30 a.m.

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