



Society for Cardiothoracic Surgery
in Great Britain and Ireland

the **bulletin**

December 2012

Venous External Support Trial

Expanding TAVI

***Cardiothoracic Surgery Training
- time for a change?***

Thoracic Surgical Audit

***Brighton 2013 -
Annual Meeting, SCTS University
& Cardiothoracic Forum***

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the bulletin



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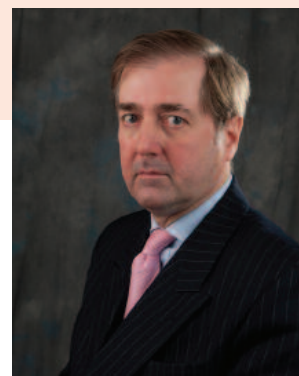
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Designed & produced by CPL Associates, London

Report from The President

James Roxburgh



Tiger Woods to borrow second hand clubs from Rory Mcllroy next season.

Well, this is never going to happen but this is, in effect, what money saving in the NHS is leading to. In an era when our results as cardiac and thoracic surgeons are under increasing scrutiny it is somewhat bizarre that managers think that the instruments we use are not that important. In procedures which require a high degree of hand-eye coordination having the correct instruments is vital. Having a needle holder you are comfortable with is just as important as finding a putter that suits your particular style and probably costs about the same. All too often surgeons are compared to pilots when it comes to analysing the “near miss” but perhaps we should also consider how important it is to be in the correct mindset, or “in the zone” as sports psychologists would say, when it comes to operating. It is bad enough to have to work with old and inefficient operating lights and poorly functioning air-conditioning but to be forced to use fine instruments that just do not “feel right” is certainly not the way to start an operation that is going to be the object of more public scrutiny than almost anything else in the NHS. We were asked by one member if SCTS had a policy on providing newly appointed surgeons with their own instruments and the answer was a simple “No”. The reason was that we never thought this would be an issue, but it now it appears it is. Churchill said, “Give us the tools and we will finish the job” - cardiothoracic surgeons are already delivering outstanding results and it is not unreasonable to ask for the tools to allow us to continue to do this.

Damburst of data

Many journalists, politicians and patients feel that the medical profession has built a dam of obfuscation to control the release of outcome data into the public domain. The Cabinet Office initiative on data transparency, the ever present Freedom of Information Act, the continued pressure from organisations like Dr Foster and the insatiable appetite of the Press has put some serious cracks in this dam. In a recent interview Bruce Keogh was questioned at length by the BBC about the releases of surgical outcome and is quoted on the BBC website:

Sir Bruce says he wants to roll out publication of individual surgeons’ results in England to help drive clinical outcomes.

“It forces you, if you know your results are going to be out in the public domain, to concentrate on your own performance and data [and] to seek help from colleagues.”

“It encourages you to really consider whether you are operating on the right patients and doing the right operation at the right time.”

The dam is now about to break and by this time next year the release of outcome data will. I am sure, be in full flood. Although it will new experience for cardiac surgeons not to be the only ones in the spotlight we must not let the Politicians and the

Press hijack what is a complicated issue. To do so will be a great disservice to patients and doctors alike. We have learnt many lessons over the last 10 years of data collection and release but above all we know that surgeons can collect, collate and publish their own outcome data but we need a properly funded infrastructure to do this. Central to this infrastructure is the involvement of patient groups to help us provide data in a constructive and meaningful way. The Data Transparency Program means that data from government funded audits such as those for Angioplasty, Myocardial Infarcts and Lung Cancer as well as all Cardiac surgery can, and will, be made available to third parties such as Dr Foster, CHKS and others yet unknown. There are many obvious problems with this and previous third party publications have caused concern within the medical profession. I have represented SCTS on a group looking into this for the Government, the matter is due to be discussed by the RCS Council (England) in mid-December. However this is not something we can stop, and in truth, nor should we but we can to our best to make it redundant. My view throughout this process has been that if we present the outcome data in a professional and meaningful way then these organisations will either want to work with us or move onto other specialties. It is unlikely that the new Thoracic audit would be subject to requests under the Data Transparency Program as there is agreement that only data from established audits would be required to make their data available. An established audit is one that has been through 2 or 3 complete audit cycles and since the Thoracic Audit only starts in April next year it is likely that it will be 2016 - 2017 before the audit is deemed mature.

Cardiothoracic surgeons are already delivering outstanding results and it is not unreasonable to ask for the tools to allow us to continue to do this

The Thoracic Audit, funded by the GMC to the tune of £50,000 for the next 3 years is now nearing completion. Richard Page and the Thoracic Subcommittee have worked hard to get to the final testing stage ahead of target and all will be revealed at the Annual Meeting in Brighton. We have also obtained funding from HQUIP to pay for the hosting of the Cardiac Surgery

continued overleaf

President's Report continued

Outcomes data on our own website following the decision by CQC to withdraw funding. I am sure many of you will have seen the article in the Daily Telegraph highlighting the problems we have had. We aim to publish by the end of January to coincide with the publication of other data initiatives such as the Blue Book on-line.

Speciality needs

Many of you will be aware that the Thoracic Subcommittee was set up several years ago to enable better representation of thoracic surgery within SCTS and it has been an undoubted success. This has allowed Thoracic surgeons to not only deal with the day-to-day issues of Thoracic surgery but also develop the bigger issues. I have felt for some time now that this is the model for both congenital and adult cardiac surgery and indeed a "shadow" subcommittee for congenital surgery was set up when the ACHD revue was started in September 2012. In July this year the Executive agreed to formalise this and, in addition, set up one for adult cardiac surgery. Simon Kendal has led on drawing up the bye-laws and will be asking for expressions of interest from members who wish to serve on these committees. Each committee of 7 will be composed of the relevant elected trustees, a senior Executive Officer, a data lead and the balance will be invited members. So if you feel you have something to contribute to your specialty but do not feel able or wish to serve on the Executive this might be just what you have been looking for!

ACHD Review

Safe and Sustainable goes on! The implementation committee was set up earlier in the year with Leslie Hamilton and David Barron representing SCTS. However the S&S review has been referred to the Independent Reconfiguration Committee, chaired by Lord Ribeiro, and the IRP will report in late February 2013. It is important to note that this is the first time a national service has been referred to this body. There is also a judicial review that is also due to be heard in February 2013. The ACHD review is nearing the end of the standards setting process and I expect that the assessment questionnaires will go out in February/March next year. This will then follow the same path as the S&S review. This whole process has already lasted 2 Presidential terms of office and is likely to see off another 2! Whatever the rights and wrongs of the whole process it has caused a lot of uncertainty for both patients and those who

deliver their care. When the final decisions are made I can only hope that they will be backed by more than enough financial support and responsible management. The NHS has a record of falling at the last hurdle when it comes to implementing mergers and service rationalisation.

In my last article for the Bulletin I talked about how we needed to look at longer term financial planning for the Society. We cannot keep going to the same companies for funding as this is not an expanding area and they are under increasing financial pressures themselves. We are very grateful for their support but if we are to grow we need to look to the wider world and to this end we have commissioned a report from a group of professional fundraisers. The report will be delivered to the Executive in late December and will be debated at the February Executive and there will be a detailed presentation at the Annual Meeting.

Thanks

This will be Graham Cooper's last Bulletin as Hon.Secretary and I would like to say how much I have valued his friendship, advice and common sense over the last 9 years we have worked together on the Executive. He put his heart and soul into the new post of Meeting Secretary and his hard work and bold imagination laid the foundations for the outstanding meetings we have come to expect. His editorship of our societies most recent publication Modern Medical Professionalism and in particular his work on Explaining Divergence produced a landmark publication for any medical association and one that is highly regarded within the Colleges and the Department of Health. He is an organiser "par excellence" working tirelessly for the Thoracic Subcommittee but above all he has kept a multitude of projects on track with his usual brand of common sense and good humour. Graham can be justly proud of his contribution and we should be immensely grateful for his hard work. He'll be back...

Robert "Bob" Bonser was the first Senior Registrar I worked with when I started at the London Chest. I will be forever grateful for the kindness he showed me as a completely inexperienced RSO thrown into the deep end working for the irascible duo of John Wright and Pat Magee! Bob's clinical workload and his academic output was legendary and his contribution to cardiac surgery, and in particular aortic surgery, was immense. The simple plaque in St Paul's Cathedral commemorating the life of Sir Christopher Wren reads, in part, "Lector si monumentum requiris circumspecte - Reader, if you seek his monument, look around you". Visit the cardiac unit in Birmingham and you will do just that - it is a monument to his enthusiasm and dedication to the speciality he loved. He will be sorely missed.

*When the final decisions are made
I can only hope that they will be
backed by more than enough
financial support and responsible
management.*

Honorary Secretary's Report

Graham Cooper



In my first Bulletin article as Honorary Secretary I wrote that 'In order to be trod upon you have to be lying down'. I wrote this in the context of rising to the challenge posed by revalidation. Five years later, as I write my last article for the Bulletin as Honorary Secretary, revalidation is here. SCTS has played an important role in shaping this. What appeared threatening five years ago looks commonplace now. It is noteworthy that all the surgical specialties have some form of post-operative mortality in their clinical outcomes and that we are no longer the sole professional voice calling for transparency about clinical outcomes.

It has not always been easy standing up. However, adhering to two core values; putting patients first and demonstrating professionalism has helped keep perspective. These values will need to remain at the front of our thinking for the next five years and further as we respond to the significant pressures that the NHS faces.

There is an increasing lack of trust in the ability of the NHS to consistently provide a reasonable standard of care. This pressure will be increased by the publication of The Mid Staffordshire NHS Foundation Trust Public Inquiry report early next year. It is likely that the upholding of professional standards will be called into question.

Mike Fisher, our new patient representative, has the experience and strength of purpose to invigorate our commitment to put patients first. Demonstrating professionalism requires complex and stratified thinking. As a membership organisation, SCTS has to balance consensus and accountability to its members with the responsibility of leading the specialty and the stated aim of 'advancing science in the field of cardiothoracic surgery for the benefit of the public'. This tension has to be recognised as a potential conflict of interest.

This conflict must be acknowledged and addressed if we are to retain the confidence of our patients. This can only be achieved by:

- by being overt about the standards of care they can expect
- by being transparent about how we meet these standards
- by benchmarking outcomes to drive quality improvement

This is clearly not always easy or comfortable. Nevertheless it remains essential if SCTS is to remain relevant and continue to maintain trust.

There are many strands that make up SCTS in 2012; the Annual Meeting, SCTS University, nursing, surgical care practitioners, education, trainees, scholarships, Blue Books, Lilac Books, databases, thoracic and cardiac, commissioning, medical students but above all patients. Mike Fisher's concept of a patient network to provide support for patients and ensure that their voice is our voice is our most important initiative for the next five years.

It has been a privilege being your Honorary Secretary, those who have supported me provided advice and where necessary, challenge are too numerous to name but I am immensely grateful to them all. I have no doubt that SCTS will remain standing and will continue to influence rather than react.

Graham Cooper, Honorary Secretary
graham.cooper@sth.nhs.uk

Congratulations

- 1) Of the four shortlisted surgeons for the Leonardo Da Vinci prize for excellence in training, three (Sunil Ohri, Marjan Jahangiri, and Simon Kendall) were from the UK. At the recent EACTS meeting in Barcelona, the prize was awarded to Simon Kendall. Congratulations to all three.
- 2) Rajesh Pala has been elected to the Council of the Royal College of Surgeons of Edinburgh. Congratulations.

David Taggart

Prof Taggart is an advisor
to VGS and is the PI for
the VEST Trial

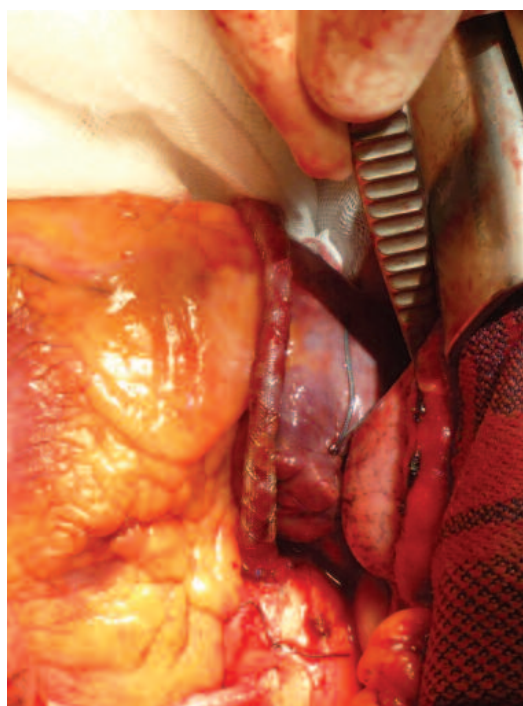
The Venous External Support Trial (VEST)

Coronary artery disease (CAD) remains the leading cause of death in developed countries and recent studies such as SYNTAX and FEEDOM have confirmed that CABG remains the gold standard treatment in terms of survival and freedom from myocardial infarction and the need for repeat revascularization.

Despite strong evidence of an additional survival benefit of bilateral internal mammary arteries (BIMA) over a single internal mammary artery (SIMA) only around 5-10% of patients receive BIMA or additional arterial grafts. The Saphenous Vein Grafts (SVG) is still the most commonly used conduit because of its abundance, ease of harvest and 'user friendliness'. However its main disadvantage is its relatively poor long term patency compared to IMA grafts with graft failure in as many as 20% of veins within the first year and in as many as 50% at 10 years and with further significant disease in half of the remaining patent grafts (in comparison to perfect patencies of 90%-95% of IMA grafts). SVG failure can result in major adverse clinical sequelae (including myocardial infarction, re-interventions and death).

Diffuse neo-intimal tissue proliferation, the origin of vein graft disease, develops in 75% of grafts within one year of implantation. This occurs because the vein graft is exposed to a "new" mechanical environment in the arterial circulation, with relatively high pressures and shear stress. In the first few weeks, shear induced remodeling leads to luminal enlargement followed by a later phase typified by wall tension induced

remodeling leading to wall thickening (intimal hyperplasia) and stiffening. It is also believed that luminal irregularities of the native vein and including its valves are additional triggers for aggressive focal intimal hyperplasia further increasing the risk of vein graft failure.



Using an external stent to prevent vein graft dilation and mitigate luminal irregularities and wall tension has been hypothesized to reduce intimal hyperplasia and consequently vein graft failure. However, previous attempts at external stenting of vein grafts have failed for a variety of reasons. VGS *FLUENT*, a novel external support device for SVG's, is a cobalt chrome braid, with a unique combination of different types of wires which provide it with axial plasticity (ie can lengthen to cover the entire length of a vein graft) and radial elasticity (makes the vein graft crush and kink resistant while providing beneficial biomechanical properties by reducing wall tension and the diameter mismatch with the host artery). The stent maintains its position without any additional fixation such as using glue and can be applied in less than a minute.

A CABG study in sheep demonstrated the *FLUENT*'s safety along with excellent efficacy in reducing intimal hyperplasia, preventing vein graft dilation/ deformation and eliminating thrombus formation. Following these successful animal studies the *FLUENT* has been evaluated in a randomized controlled study (*Venous External Support Trial*) in the UK which recruited 30 patients in Oxford and Brompton/Harefield who in addition to an IMA graft to the LAD, required vein grafts to the Right Coronary Artery and the Circumflex Artery. Patients were randomized for one vein graft to receive the stent and the other to act as a control. Patients are now undergoing 12 months angiography, IVUS and OCT to compare the experimental and control grafts' patency, lumen uniformity and plaque volume (intimal and medial hyperplasia). If VEST successfully reproduces the findings in the sheep model the VEST inVESTigators plan to undertake a multicentre trial in Europe, including several UK centres. If the stent is successful in significantly reducing intimal hyperplasia it will undoubtedly become a 'game changer'.

If VEST successfully reproduces the findings the inVESTigators plan to undertake a multicentre trial in Europe, including several UK centres. If the stent is successful in significantly reducing intimal hyperplasia it will undoubtedly become a 'game changer'.

Expanding TAVI

to lower risk younger patients using different access routes

Marjan Jahangiri



In several units worldwide, TAVI is no longer experimental and has become routine practice for treatment of high risk elderly patients. The overall results from reported registries and limited trials show a mortality of 5 – 10% at best, on par with figures published in the 6th National Cardiac Surgical database 2008 for surgery on octogenarians. On the basis of this, many clinicians advocate expanding TAVI to lower risk younger patients. I have a problem with this in that non-inferiority seems to have become gospel and the way forward. Furthermore, the forthcoming trials are mainly designed with intellectual and financial assistance of the industry.

The overall mortality of at best 5 -10% , vascular access complications of up to 25% (10% requiring intervention), stroke rate of up to 10%, pacemaker implantation of 20% and paravalvular and central aortic regurgitation of another 20% following TAVI should be noted. The proponents of TAVI (incidentally, I AM definitely one) propose cure of the paravalvular or central aortic regurgitation using balloon valvuloplasty following insertion of TAVI valve or insertion of a second (valve – in – valve). The effect of the latter on the integrity and longevity of the TAVI valve is not known. Regarding management of paravalvular leak, there seems to be a dichotomy in the cardiology and cardiac surgical community: after an AVR, if a red blood cell moves in the wrong direction, an urgent message is sent from the echo lab to the surgical team, whereas, with TAVI, moderate paravalvular leak is happily accepted.

In terms of selection of patients and justification for TAVI, diagnosis of porcelain aorta warrants attention. In TAVI cohorts this is as high as 10% and much higher than what the surgical community has experienced with AVR. Is it perhaps an over diagnosis?

Trans aortic approach to TAVI is gaining popularity due to less manipulation around the arterial tree, direct access to the valve and familiar approach by surgeons. But what about the latest approach of trans carotid? The advocates are using the (“non-inferiority”) argument for the application of this approach.

I am an advocate of TAVI, working in one of the main centres for this procedure in the UK and believe that our trainees have to become proficient in performing the procedure. However, unless the results and outcomes can match surgery to some extent, TAVI should not be expanded to younger/ lower risk patients. Our duty is to ensure reporting accurate risk factors and outcomes of TAVI and AVR to UK national database and with the developing practice, we must not base the evidence on non-inferiority.

Marjan Jahangiri

Professor of Cardiac Surgery

St. George's Hospital, University of London

2nd Medtronic Marlow Meeting

Friday 8th February / Saturday 9th February 2013



Neil Moat and his co-chairmen Mo Bhabra, Simon Davies, David Hildick-Smith & Uday Trivedi invite you to the **2nd Medtronic Marlow meeting.**

This meeting is dedicated to Cardiac Surgeons interested and /or involved in TAVI

Information, agenda and registration are **online**

www.medtronicmarlowmeeting2013.com

The **Compleat Angler**
Marlow Bridge,
Marlow
Buckinghamshire
SL7 1RG (SatNav SL7 1RH)



Training in Cardiothoracic Surgery

– is it time for a change?

Steve Livesey
Chairman,
Cardiothoracic SAC

Despite assurances to the contrary many trainees in the current era feel that they are less well trained and less experienced than were their trainers at a similar stage of their careers.

The blame for this is usually laid at the door of the European Working Time Regulations, but before you move on to the next article, please give me a chance; this is not going to be an essay telling you how adherence to the ISCP and a competency based training will make everything alright. They are both excellent principles, **BUT WE COULD DO SO MUCH BETTER.**

We have done our best within in the constraints of a system that is woefully outdated. The benefits to the “trainee” of the “system” under which I grew up were lots of exposure to clinical material, lots of opportunity to perform the common operations, plenty of time out-of-hours to make our own decisions and more than enough opportunity to learn from our mistakes. Well times have changed and although some useful analogies are often drawn between the airline industry and surgical training – this was how we used to train fighter pilots during the Second World War! In more stable times, a different approach is used. To extend the analogy further (with thanks to Paul Sergeant), consider the pilot landing a modern fighter jet on an aircraft carrier. He is landing an aircraft worth £30m, loaded with fuel and munitions onto a hundred metre landing strip on an aircraft carrier worth the best part of £1bn with 1000 people on board. Yet after an appropriately structured training and appropriate assessments he is deemed competent to do this in his early twenties.

These analogies can be taken too far but I think there is an important lesson to be drawn from this. If you want to train a valuable national resource, the most appropriate way to do that is to design a bespoke programme focussing on the desired outcome of training. So the fighter pilot’s training progresses

through various different types of aircraft using advanced simulation where necessary until final training on the aircraft his/her employers want him/her to fly. They do not learn to be fighter pilots by sitting in the co-pilots seat flying tourists to the Costa Brava.

So what can we learn from this in the NHS. Firstly, we should recognise that to work most efficiently, the NHS must design its systems to deliver the service that the country requires. That means redesigning the staffing models of hospitals to deliver healthcare, and to deliver it more efficiently. It means having appropriately trained staff delivering all aspects of healthcare and in many instances these people will not be doctors. So a cardiothoracic unit would have, for example, nurse practitioners with advanced skills delivering the majority of the ward based medical care, but they would not be working in isolation. They would require ready access to, and the support of appropriately trained and experienced medical staff to ensure safe passage along the patient journey. But these doctors do not need to be trainee cardiothoracic surgeons; Trust doctors are much more appropriate for these support roles. This may seem harsh if you are a Trust grade doctor (and more on that later) but if the NHS wants to be serious about designing systems to deliver high quality outcomes it cannot continue to rely on itinerant junior doctors to deliver such a large chunk of the care patients receive whilst in hospital. So staffing rotas must be designed that allow the wards, theatres, ITU and outpatients to function fully and efficiently without any reliance on doctors in training at all. So, the prime focus of a cardiothoracic unit would be to deliver the highest quality care possible in the most efficient manner. And that is surely what patients would want. I am sure it’s what the NHS Medical Director and the Secretary of State would want too.

So back to training; where does training fit in to this structure? Well, just as we should design our system of healthcare to deliver the best possible outcomes, we should design our systems of training to do the same. To do this we need to make some radical changes.

Firstly, trainees should be supernumerary. That is, we do not require them to be there for the service to run; if they are there, then it’s a bonus.



We have done our best within in the constraints of a system that is woefully outdated. If you want to train a valuable national resource, the most appropriate way to do that is to design a bespoke programme focussing on the desired outcome of training.

Training in Cardiothoracic Surgery Continued

Secondly, not everyone wanting to be a cardiothoracic surgeon will be able to be one. Selection processes must continue to be robust, but selection on to a programme should not guarantee CCT in that specialty. We must be able to move individuals out of cardiothoracic training at an early stage if we do not feel they are suited to the specialty. I would set the bar quite high, for example in cardiac surgery a trainee must be able to safely construct a distal coronary anastomosis, on a patient, by the end of their first year of training. If they have the manual dexterity required, they will be able to do this given the appropriate access to training in simulated environments and on patients. If not, then they would not be able to continue in the programme. Postgraduate Deans would need to understand this and a satisfactory process would need to be developed for moving trainees who were felt to be in the wrong specialty; and very importantly, trainers would also need to understand their responsibilities to the trainee.

Thirdly, if service is service and training is training, then we should mix the two as little as possible. This means that surgical trainers will need to have some operating lists that are focussed on training and some that are focussed on delivering the service.

Fourthly, freeing the trainee up from the requirements of the service would allow us to design a much better training programme; The Dutch model has much to recommend it. In a six-year training programme, the first year is spent in the generality of cardiothoracic surgery. So they are taught the principles of operating by cardiothoracic surgeons, not general or orthopaedic surgeons. It is at the end of this year that the decision is made as to whether or not the trainee is to continue in the specialty. After the first year the trainee has two years out of cardiothoracic surgery as such learning relevant aspects of surgery in general and then specific modules in ITU, cardiac catheter lab skills, respiratory medicine, cardiology etc. I see this as a vital aspect of a modern training programme and this can only be done if trainees are supernumerary. They return to cardiothoracic surgery for their final three years, initially in the generality of the specialty and then pursuing their special interest.

A scheme such as this would allow us to produce high quality surgeons who are well trained across the breadth and depth of their specialty. They would be well equipped to develop in the newer areas of our specialty such as VATS resections, over the wire device implantation and minimally invasive cardiac surgery.

It would also significantly shorten the time required to train from the current ten-plus years after qualification to eight and produce the focussed surgeons we need to become the leaders of the future.

Steve Livesey

Chairman,

Cardiothoracic SAC

Thoracic Surgical Audit

Richard Page

As many members will already be aware it is excellent news that earlier this year the General Medical Council agreed to fund a fully functional thoracic surgical database for SCTS members.

Over the last few months I have been working closely with Dendrite Clinical Systems to develop this and by the time the Bulletin is published I am optimistic that there will be a product available to all SCTS members by the start of the next financial year, for use either individually or in conjunction with their hospital audit departments.

The database will take the form of a secure on-line facility for immediate entry of data on all thoracic surgical operations in line with the SCTS dataset. This includes the parameters used for calculation of the Thoracoscore risk-prediction tool although one of the long-term ambitions of the projects is to develop a risk model more specific to thoracic surgical practice with the UK and Ireland. Patient, individual surgeon and hospital details will be anonymised at the point of data submission into the database to ensure maximum confidentiality and security of the information to be collected. After the data is entered Dendrite will work closely with colleagues to ensure thoracic surgical Units receive regular reports of their activity and outcomes for both the hospital and

I am optimistic that there will be a product available to all SCTS members by the start of the next financial year

individual surgeons. This will allow SCTS members to have the information they require to achieve revalidation and relicensing.

In parallel to this work Dendrite will work with those Units who already have mature pre-existing data collection facilities to enable uploads of data as a contribution to the regular Thoracic Surgical Blue Books.

I will be writing to thoracic audit leads as things develop with more information but look forward to another major leap forward for the SCTS thoracic surgical project with this initiative. Please, as always, do not hesitate to contact me with any queries you have over any aspect of thoracic audit.

Liverpool Heart and Chest Hospital 
NHS Foundation Trust

Liverpool Aortic Surgery Symposium V New Frontiers

For further information please contact:
Lorraine Richardson, L.R. Associates
mobile: 077111 32946
email: lorrainerichardson1@btinternet.com
www.aorticaneurysm.org.uk

First Announcement
24th - 25th May 2013

Arena and Convention Centre, Monarch's Quay, Liverpool L3 4XF

SCTS University & SCTS Annual Meeting

Ian Wilson

Brighton International Centre 17-19th March 2013

Abstract submissions for next year's Annual Meeting are high, and an array of International Faculty are in place, to provide an exciting educational opportunity on the south coast in March 3103.

Tirone David, Toronto General Hospital, **Ed Verrier**, University of Washington, **Jim O'Connor**, University of Maryland, and **John Elefteriades**, Yale University School of Medicine, head up a trans-Atlantic faculty to augment a tremendous European faculty.

The European faculty include: **Ottavio Alfieri**, **Pieter Kappetein**, **Hans Kristian Pilegaard**, **Philippe Dartevelle**, **Jean-Marie Wihlm**, **Thomas Pascal**, **Jean-Louis Vanoverschelde**, **Philippe Kolh**, **Alec Vahanian** and **Renee Peterson**.

The SCTS University on the 17th March 2013 will include:

Educational Streams

- A Masterclass in Aortic Regurgitation Surgery
- Mitral Valve Repair Surgery: Greater Understanding allows Prediction of Pitfalls
- Contemporary Coronary Artery Revascularisation: An Evolving Multidisciplinary Field
- Heart Failure Surgery
- Thoracic Trauma
- Thoracic Surgery: Pushing the Boundaries
- Debates and Controversies in Thoracic Surgery
- Minimally Invasive Thoracic Surgery
- A Masterclass in Atrial Switch Surgery
- Perfusion for Minimally Invasive Surgery

Lunch Box Sessions

- Intraoperative Imaging in CABG Surgery: Important Adjuncts of Unnecessary Expense
- State of the Art Thoracic Aortic Aneurysm Surgery
- MitraClip – It's Role in Contemporary Clinical Practice
- Choosing the Optimal Valve Prosthesis
- Chest Wall Reconstruction
- Advances in Interventional Management of Emphysema
- Congenital Surgery Lunch Box
- Clinical Perfusion Lunch Box

continued overleaf



The meeting will be vibrant and educational; we hope you will join us in Brighton, and participate in all aspects of the conference.



SCTS University and SCTS Annual Meeting

continued

Brighton International Centre 17-19th March 2013

The SCTS University day will be followed by the opening of the Exhibition Hall and the Annual Trainees Meeting.

On 18th March 2013 the Annual Meeting opens with a dynamic Plenary Session, and this energy will be continued throughout the meeting with a cocktail of abstracts, key-note lectures, and an insight in to the New NHS, with information on how these changes will influence our working practices.

The key-note Tudor Edwards Memorial Lecture will be delivered by Bill Walker on Minimally Invasive Thoracic Surgery, whilst Philippe Kolh and David Taggart will debate the Impact of the ESC / EACTS CABG guidelines on working practices across the UK.

A Thoracic Trauma Session will analyse the changes in trauma care delivery in the UK and with the recent release of the ESC / EACTS guidelines in valve surgery, the co-authors of these guidelines will debate their potential importance in the delivery of valve surgery over the next decade.

The Congenital Heart Surgery sessions will be on the 18th March 2013 and will include the Management of Ebstein's Anomaly, Neonatal Physiology, and Management of a Borderline Left Ventricle.

The Cardiothoracic Forum looks strong, and we encourage all SCTS members to facilitate attendance of the CT forum members, thereby further advancing the multidisciplinary nature of our specialty.

The Annual Business Meeting will be at the end of the day on the 18th March.

The Annual Dinner will have a seaside theme and offers the opportunity to catch up with colleagues in a friendly atmosphere, which will offer good food and drink, and the potential for a degree of light-hearted banter.

Sessions: On the 19th March 2013 the Annual Meeting continues with sessions including:

- Aortic Valve Surgery:
The Present and the Future
- Bleeding in Cardiothoracic Surgery,
- Enhanced Recovery in Thoracic Surgery,
- Advanced Heart and Lung Failure Surgery,
- Thoracic Oncology
- An innovative Fixing Heart and Protecting Minds session.

The Board of Representatives Meeting will be in the afternoon of the 19th March 2013.

The meeting will offer a huge opportunity to interact with world authorities in cardiothoracic surgery and allows SCTS members to benefit from these exchanges.

The programme will be available on an SCTS Annual Meeting App, and all SCTS University sessions will be available via video streaming to attendees.

The meeting will be vibrant and educational; join us in Brighton, and participate in all aspects of the conference.

Ian Wilson

continued overleaf



SCTS University and SCTS Annual Meeting continued

Cardiothoracic Forum

Brighton International Centre
17-19th March 2013

Open access to all aspects of the SCTS meeting

Opening Remarks

Andrea Spyropoulos – RCN President of the RCN

Plenary Sessions

Main Plenary Speaker: Professor Brian Toft OBE, Professor in Patient Safety

Specific Sessions with Plenary Speakers

Advanced Nurse Practitioner Session:

Anne Baileff, Director of Programmes: Advanced Clinical + Expert Practice.
Independent Nurse Prescribing: Safety Issues

Thoracic Session: National Lung Cancer Forum for Nurses

Practical Industry Session for Nurses and Allied Health Professionals

Scientific Papers presented by Nurses, Allied Health Professionals and Medical colleagues

Joint Sessions

Joint Plenary sessions with the main scientific meeting including presentation of UK Activity Data

Joint sessions with the Patient Forum and ACSA –
Association of Cardiothoracic Surgical Assistants

Annual Dinner

at The Grand Hotel, Brighton

for Nurses and Allied Health Professionals to attend.
Half Price tickets for the First 30 Nursing and Allied Health Professional Applications.

The Forum invites Nurses, Surgical Care Practitioners, Physiotherapists, Pharmacists and other Allied Health Professionals to register.

www.scts.org

'Safety Matters'



Obituary

Professor Hugh Bentall

Professor Hugh Bentall, who has died aged 92, became, on April 17 1953, the first British surgeon to carry out an open-heart operation when, with Bill Cleland, he operated on a 30-year-old woman with a blocked aortic valve.

The procedure was made possible by the newly-developed heart-lung machine, before the advent of which there was no means of cutting into the heart without killing the patient. Operations had thus been limited to procedures on the intact beating heart, for example widening the mitral valve with a dilator.

In the early 1950s Professor Ian Aird, under whom Bentall worked at the Royal Postgraduate Medical School at Hammersmith Hospital, had the idea of creating an artificial heart and lung that would operate as a bypass outside the body and take over the vital job of pumping and oxygenating the blood. With his support Denis Melrose, a lecturer (later Professor) at the school, set about designing a machine that would enable the surgeon to operate on a bloodless (though still beating) organ and repair defects such as holes in the heart. In collaboration with the medical instrument firm New Electronic Products (NEP), Melrose developed a machine which became known as the Melrose-NEP heart-lung machine.

Bentall and Cleland carried out the first operation using the machine on a human in Britain. It was a complete success; 25 years later the patient was still in good health. Within four years Bentall and his colleagues were routinely carrying out open-heart surgery on a variety of patients, and the apparatus was being introduced into other hospitals across the country and around the world.

Hugh Henry Bentall was born at Worthing, Sussex, on April 2 1920. After Seaford College, he studied at St Bartholomew's Hospital, London, graduating in 1942.

Bentall's first post was in general surgery under Ivor Lewis at the North Middlesex Hospital, where he assisted with the first successful pulmonary embolectomy (the surgical removal of clotted blood blocking blood circulation to the lungs) and the first anatomical correction of oesophageal atresia (a congenital defect affecting the alimentary tract) in Britain. He then became Chief Resident at the London Chest Hospital, doing thoracic surgery, until he joined the Royal Navy in 1945. He served in a naval hospital and then in Empire Clyde — the only hospital ship in the British Pacific Fleet during the war.

After demobilisation in 1947 he taught anatomy at the Charing Cross Hospital Medical School until 1950, when he joined the Royal Postgraduate Medical School at Hammersmith Hospital as chief assistant to Aird, doing general and thoracic surgery and research to develop cardiac surgery.



The development of open-heart surgery excited interest around the world, and in April 1959, with Denis Melrose, Bill Cleland and other members of the Hammersmith cardiac team, he accepted an invitation to travel to Moscow to demonstrate the new technique to Russian surgeons at the Institute of Cardiovascular Surgery in Leninsky Prospekt. After travelling on the Soviet Ship Baltika with half a ton of

equipment, the team carried out five open-heart operations, on adults and children, watched by more than 200 surgeons from across the Soviet Union. This was probably the first time that a group of foreign doctors had actually worked in the Soviet Union, and the visit was well covered in the British press, making the front page of The Daily Telegraph.

In 1962 Bentall and his team appeared in the first episode of the classic BBC documentary series, *Your Life in Their Hands*, in which he performed an operation to repair a hole in the heart. Three years later Bentall was appointed the first Professor of Cardiac Surgery in Britain, at the Royal Postgraduate Medical School.

In 1966 he operated on a young man with severe aortic valve regurgitation (the leaking of the aortic valve of the heart) and an aortic aneurysm (a swelling of the aorta). These are common problems in patients with Marfan Syndrome, and he successfully devised and performed a combined procedure whereby the valve and the ascending aorta were replaced in a single operation. The basic procedure, known as the Bentall Operation, is now used worldwide to treat Marfan patients.

Until his retirement in 1985 Bentall continued to work on a wide range of surgically treatable heart disease, latterly concentrating on the investigation and treatment of Woolf-Parkinson-White Syndrome (a disorder of the conduction system of the heart). After retiring from active surgery he returned to teaching anatomy one day a week at the Royal Free Hospital Medical School, until 1989.

Bentall enjoyed boating and antique horology, especially long-case clock mechanical repairs, for which he took weekly lessons from the head of horology at the Greenwich Observatory.

Hugh Bentall's wife, Jean, died earlier this year; he is survived by their three sons and one daughter.

Professor Hugh Bentall, born April 28 1920, died September 9 2012

Obituary courtesy of the Daily Telegraph

We remember

Frank Ashton

Frank Ashton, Consultant Thoracic Surgeon at Queen Elizabeth Hospital, Birmingham and previously Professor of Surgery at Queen Elizabeth/Birmingham University, passed away on 13 November, 2012 at the age of 87.

Bob Bonser

Bob Bonser, Consultant Cardiac Surgeon, at Queen Elizabeth Hospital, Birmingham, passed away in October 2012.

The Ionescu Scholarship

Once again we are happy to be able to offer a £10,000 travelling fellowship generously sponsored by Marian and Christina Ionescu. The details (right) outline the information we require by way of applications for this scholarship that is predominantly open to newer consultants.

The deadline for applications is **14th February 2013**.

For more details contact the Society office at sctsadmin@scts.org.uk

Applicants to provide information based on the following:

- Name
- Date of Appointment to consultant post
- Unit at which appointment is
- Membership of SCTS - essential
- Purpose of your visit
- Location
- A detailed essay of the use to which you would put the funds if you were to be successful.
- The benefits it will bring to UK Cardiac surgery.
- Would you be willing to make a presentation at the Annual Scientific Meeting regarding the project?
- You would need to provide an estimate of travelling expenses (they would need to be calculated based on economy travel etc), hotel costs, incidentals etc.
- Are you receiving or have you sought funds from other sources?

New Appointments

Name	Hospital	Specialty	Starting Date
Mr Uday Dandekar	University Hospital Coventry and Warwickshire NHS Trust	Cardiac	June 2012
Mr Nawwar Attar	Golden Jubilee National Hospital	Cardiac/Transplant	Aug 2012
Mr Aiman Alzetani	Southampton General Hospital	Thoracic	Sept 2012
Mr Kelvin Lim	Royal Infirmary of Edinburgh	Cardiac	Dec 2012
Mr Bari Murtuza	Freeman Hospital, Newcastle	Paediatric Cardiothoracic	Jan 2013

Other Appointments

Name	Hospital	Starting	Appointment
Manoj Puroit	Victoria Hospital, Blackpool	February 2011	Associate Specialist Cardiothoracic Surgery

Diary of Forthcoming Events

Contact details for courses at
The Royal College of Surgeons of
England, 35-43 Lincolns Inn Fields,
London WC2A 3PE
Tel: +44 (0)20 7869 6300
Fax: +44(0)20 7869 6320

Date: 8 - 9 JANUARY 2013
Meeting: **Intermediate Cardiac Surgery**
Town: London, UK
Venue: The Royal College of Surgeons of England
Contact: Education Department, RCS
Email: education@rcseng.ac.uk
Web: www.rcseng.ac.uk/education/courses/
intermediate-cardiac-surgery

Tel: 1 805 541-3118
Email: info@crefmeeting.com
Web: www.crefmeeting.com/

Date: 26 - 27 JANUARY 2013
Meeting: **STS/AATS Tech-Con 2013**
Town: Los Angeles, CA, USA
Venue: Los Angeles Convention Center
Contact: Kelley Stefko, Senior Manager, Education
The Society of Thoracic Surgeons
633 N. Saint Clair Street, Suite 2320
Chicago, Illinois 60611-3658
Tel: 1 312 202-5825
Email: kstefko@sts.org
Web: www.sts.org/annualmeeting

Date: 27 - 28 FEBRUARY 2013
Meeting: **6th Advanced Video-Assisted Thoracoscopy and Thoracic Endoscopy Course**
Town: Leeds, UK
Venue: St James' University Hospital
Contact: Lorraine Richardson, L R Associates
58 Kiln Close, Calvert Green, Buckingham, MK18 2FD
Tel: +44 (0)1296 733 823
Fax: +44 (0)1296 733 823
Email: lorrainerichardson1@btinternet.com
Web: www.vatscourse.com

Date: 26 - 30 JANUARY 2013
Meeting: **STS 49th Annual Meeting**
Town: Los Angeles, CA, USA
Venue: Los Angeles Convention Center
Abstract submission deadline: 15 June 2012
Contact: Kelley Stefko, Senior Manager, Education
The Society of Thoracic Surgeons
633 N. Saint Clair Street, Suite 2320
Chicago, Illinois 60611-3658
Tel: 1 312 202-5825
Email: education@sts.org
Web: www.sts.org/annualmeeting or
www.sts.org/abstracts

Date: 27 FEBRUARY - 1 MARCH 2013
Meeting: **Hands-on Cardiac Morphology (Spring Edition)**
This 3 day course combines theory (lectures with video demonstrations) and hands-on examination of specimens covering the spectrum of congenital heart malformations.
Town: London, UK
Venue: Brompton Hospital
Contact: Carina Lim YP, Cardiac Morphology Unit, Brompton Hospital, Sydney Street, London SW3 6NP United Kingdom
Tel: +44 (0) 207 351 8751
Fax: +44 (0) 207 351 8230
Email: Morphology@rbht.nhs.uk
Web: www.cardiacmorphology.org/

Date: 1 - 2 FEBRUARY 2013
Meeting: **2013 Women's Career and Leadership Development Conference**
Town: Washington DC, USA
Venue: Heart House
Web: www.cardiosource.org/Lifelong-Learning-and-MOC/Education/Courses-and-Conferences/Conferences/2013/February-2013/WCLD-2013.aspx

Date: 4 - 8 MARCH 2013
Meeting: **Fundamentals in Cardiac Surgery: Part I**
Town: Windsor, UK
Venue: EACTS House
Contact: Louise McLeod, EACTS House, Madeira Walk Windsor, Berkshire, SL4 1EU
Tel: +44 1753 832166
Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 6 - 9 FEBRUARY 2013
Meeting: **33rd Annual Cardiothoracic Surgery Symposium (CREF 2013)**
Town: San Diego, CA, USA
Venue: Hilton San Diego Bayfront Hotel
Abstract submission deadline: 30 December 2012
Contact: CREF, 793-A East Foothill Blvd, PMB # 119, San Luis Obispo, CA 93405-1699

Date: 13 - 14 MARCH 2013
Meeting: **The Left Ventricular Outflow Tract Aortic Arch Surgery, Brain Development and Cerebral Protection**
Town: Windsor, UK
Venue: EACTS House
Contact: Louise McLeod, EACTS House, Madeira Walk, Windsor, Berkshire, SL4 1EU
Tel: +44 1753 832166
Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 17 MARCH 2013
 Meeting: **SCTS University 2013**
 Town: Brighton, UK
 Venue: The Brighton Centre
 Contact: Isabelle Ferner, 35-43 Lincoln's Inn Fields
 London, WC2A 3PE
 Tel: +44(0)20 7869 6893
 Fax: +44 (0)20 7869 6890
 Email: sctadmin@scts.org or tilly@scts.org
 Web: www.scts.org

Date: 18 - 19 MARCH 2013
 Meeting: **SCTS Annual Meeting & Cardiothoracic Forum**
 Town: Brighton, UK
 Venue: The Brighton Centre
 Contact: Isabelle Ferner, 35-43 Lincoln's Inn Fields
 London, WC2A 3PE
 Tel: +44(0)20 7869 6893
 Fax: +44 (0)20 7869 6890
 Email: sctadmin@scts.org or tilly@scts.org
 Web: www.scts.org

Date: 20 - 22 MARCH 2013
 Meeting: **Advanced Module: Open and Endovascular Aortic Therapy**
 Town: Windsor, UK
 Venue: EACTS House
 Contact: Louise McLeod, EACTS House, Madeira Walk,
 Windsor, Berkshire, SL4 1EU
 Tel: +44 1753 832166
 Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 8 - 12 APRIL 2013
 Meeting: **Thoracic Surgery Part I**
 Town: Windsor, UK
 Venue: EACTS House
 Contact: Louise McLeod, EACTS House, Madeira Walk,
 Windsor, Berkshire, SL4 1EU
 Tel: +44 1753 832166
 Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 16 - 17 APRIL 2013
 Meeting: **Teach the Teacher**
 Town: Windsor, UK
 Venue: EACTS House
 Contact: Louise McLeod, EACTS House, Madeira Walk,
 Windsor, Berkshire, SL4 1EU
 Tel: +44 1753 832166
 Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 24 - 26 APRIL 2013
 Meeting: **Leadership and Management Development for Cardiovascular and Thoracic Surgeons: Part II**
 Town: Windsor, UK
 Venue: EACTS House
 Contact: Louise McLeod, EACTS House, Madeira Walk,
 Windsor, Berkshire, SL4 1EU
 Tel: +44 1753 832166
 Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 17 - 22 MAY 2013
 Meeting: **2013 American Thoracic Society International Conference**
 Town: Philadelphia, PA, USA
 Venue: Philadelphia Convention Center
 Abstract submission deadline: 12 November 2012
 Contact: ATS International Conference Department
 Tel: 1 212 315-8652
 Email: conference@thoracic.org
 Web: <http://conference.thoracic.org/2013/>

Date: 25 - 29 MAY 2013
 Meeting: **21st European Conference on General Thoracic Surgery**
 Town: Birmingham, UK
 Contact: Sue Hesford, ESTS, PO Box 159, Exeter, UK EX2 5SH
 Tel: + 44 1392 430671
 Fax: + 44 1392 430671
 Email: sue@ests.org.uk

Date: 28 - 31 MAY 2013
 Meeting: **Module: Coronary Surgery with Special Focus on Off-Pump Coronary Artery Bypass Surgery**
 Town: Windsor, UK
 Venue: EACTS House
 Contact: Louise McLeod, EACTS House, Madeira Walk,
 Windsor, Berkshire, SL4 1EU
 Tel: +44 1753 832166
 Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

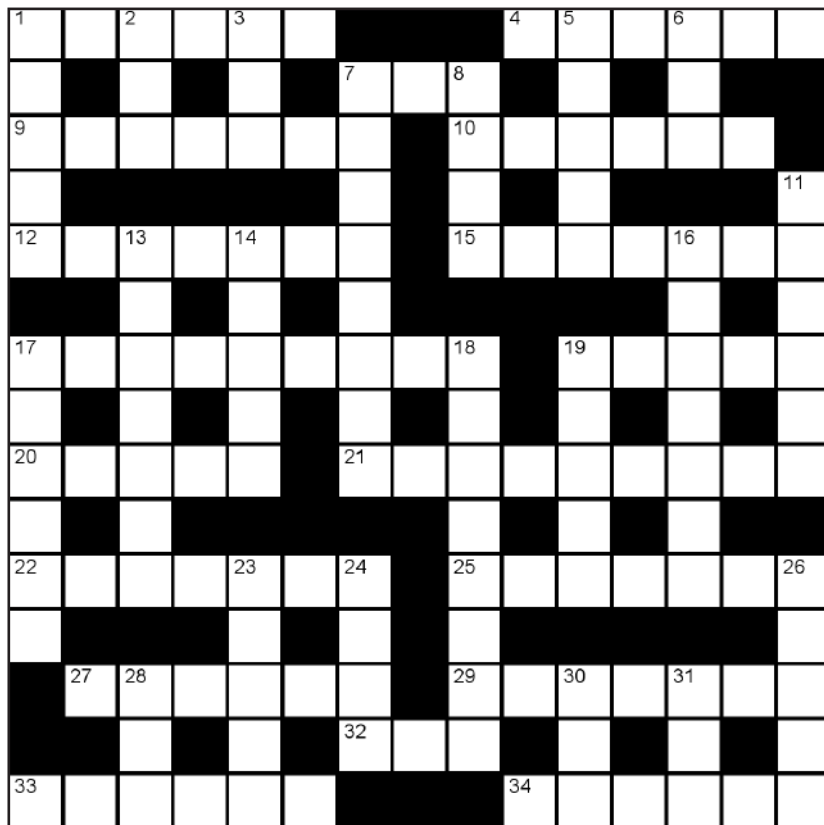
Date: 29 - 31 MAY 2013
 Meeting: **Hands-on Cardiac Morphology (Summer Edition)**
 - This 3 day course combines theory (lectures with video demonstrations) and hands-on examination of specimens covering the spectrum of congenital heart malformations.
 Town: London UK
 Venue: Brompton Hospital
 Contact: Carina Lim YP, Cardiac Morphology Unit,
 Brompton Hospital, Sydney Street, London SW3 6NP United Kingdom
 Tel: +44 (0) 207 351 8751
 Fax: +44 (0) 207 351 8230
 Email: Morphology@rbht.nhs.uk
 Web: www.rbht.nhs.uk/cardiacMorphology/

Date: 3 - 7 JUNE 2013
 Meeting: **Fundamentals in Cardiac Surgery: Part II**
 Town: Windsor, UK
 Venue: EACTS House
 Contact: Louise McLeod, EACTS House, Madeira Walk,
 Windsor, Berkshire, SL4 1EU
 Tel: +44 1753 832166
 Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

the crossword



by Sam Nashef

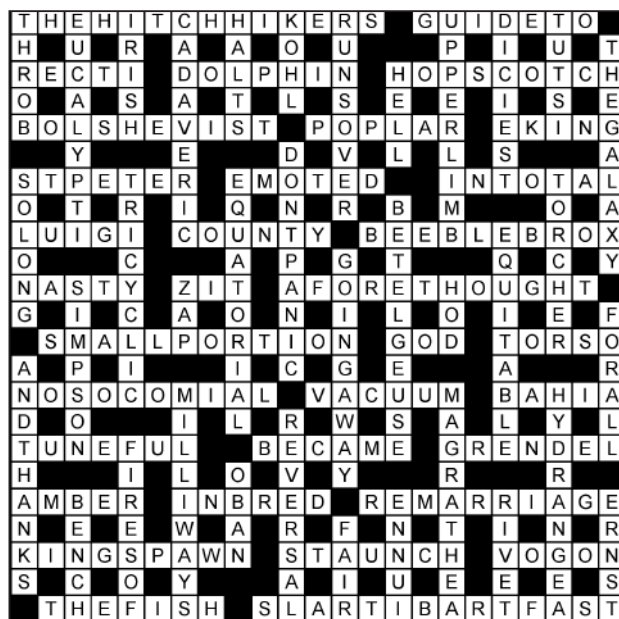


Send your solution by 31 July, 2013 to:

Sam Nashef, Papworth Hospital, Cambridge CB23 3RE or fax to 01480 364744

Solutions from areas over 10 miles from Cambridge will be given priority.

Last issue's solution



Marriage prospects are undefined

Across

- 1 Philosopher out of hospital (6)
- 4 Follow as an alternative (6)
- 7/32 Where plants are in terrible danger (6)
- 9 Join about 1 (7)
- 10 Cut, said lord (6)
- 12 March in formation (4,3)
- 15 Feature of hippo or mandrill (4,3)
- 17 Encourage one serving cocktails outside (9)
- 19 Fit, he may be (5)
- 20 Drunk table wine (5)
- 21 Line out gently, start out gently (9)
- 22 Blue alumnus with a view (7)
- 25 News: it's back, with a lot of noise and empty gestures (7)
- 27 US bum to speak easy where Francis came from (6)
- 29 Drive out previous beat (7)
- 32 See 7
- 33 Sausage in the car (6)
- 34 See 24 Down

Down

- 1 Stunner took exams again on the way up (5)
- 2 Love the longest river (almost) (3)
- 3 Some believe in this priest (3)
- 5 Is compiler having to leave friend? (5)
- 6/28 See nose put out of joint and relax (6)
- 7 Nan, 50, has a fit (5,3)
- 8 At first, reply so very politely (4)
- 11 Poles get doubtful and arrogant (6)
- 13 The sound of seals and birds (7)
- 14 Madame Antoinette's intended... (5)
- 16 ...to get wet and naughtily sit on me (7)
- 17 Degree has benefit for primate (6)
- 18 Next! (8)
- 19 The fashion of a secret rendezvous (5)
- 23 In the river, the Italian deportee (5)
- 24/34 Writer in debt, only to be restructured (4,6)
- 26 Strict violinist's bow? The other end! (5)
- 28 See 6
- 30/31 Everyone's favourite outside platform (6)

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23rd World Congress of the
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www.wsctscroatia2013.org

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