the bulletin

Society for Cardiothoracic Surgery
in Great Britain and Ireland

July 2013

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Report from The President

James Roxburgh

The past is a foreign country; they do things differently there.

Safe and Sustainable is definitely in the past and whilst we can learn from it we should not dwell upon its demise. We move on.

When I joined the ACHD review panel it became very clear to me that the separation of the care of the congenital cardiac patient into paediatric and adult congenital was going to place constraints upon the review. As someone who is neither a congenital surgeon nor involved in the Safe and Sustainable review I could not understand the logic behind it but we had to play the hand we were dealt. It was therefore not a surprise when the Independent Reconfiguration Panel made it very clear that they felt that this was a fundamental flaw:

> *The proposals for children's services are undermined by the lack of co-ordination with the review of adult services. The opportunity must be taken to address the criticism of separate reviews by bringing them together to ensure the best possible services for patients.*

Sustainability is perhaps even more of an issue now than it was when Bruce Keogh wrote to the Secretary of State for Health over 5 years ago. The Independent Reconfiguration Panel acknowledged this in Recommendation Two of their report stating:

> *Patients should receive congenital heart surgery and interventional cardiology from teams with at least four full-time consultant congenital heart surgeons and appropriate numbers of other specialist staff to sustain a comprehensive range of interventions, round the clock care, training and research.*

Safety is a minimum standard and should not be confused with quality. A seat on a budget airline is safe and so is a first class flat-bed flight on BA but there is vast difference in quality. Although the juxtaposition of safe and sustainable rolled off the tongue it missed the point. Safety is not an endpoint in the delivery of high quality care but simply one of its many markers and we must aim for sustainable high quality care.

Safety is a minimum standard and should not be confused with quality.

There are many people who feel that to start the whole process over again facing the prospect of political involvement and legal impediments is simply too daunting a prospect. I have sat on the ACHD panel for 18 months and I can assure you that starting over again is not something I relish; but start again we must. What we must not do is to worry about the the potential political and legal challenges at the end and in so doing dilute our standards to avoid conflict. Down that road lies mediocrity and not excellence.

It is estimated that that £6 million has been spent on the Safe and Sustainable review and more will be spent before the final recommendations are published. If we are prepared to spend this much on producing standards for a sustainable high class congenital cardiac service we must not skimp on its implementation. Mergers and re-organisation in the NHS is often seen as a way to save money and whilst this may be true in the long term it requires investment in the short term. Poorly funded and poorly managed re-organisation of services is worse than no re-organisation at all.

The politicians on both sides have made it as clear as politicians ever do that they accept that the "status quo" is not acceptable and no one has disagreed with Lord Ribeiro who stated "Our recommendations are not a panacea for doing nothing" or "going back over all the ground in the last five years". This whole situation must be resolved quickly both in terms of determining new standards of care for the patient with a congenital cardiac condition and in their implementation. The delays and uncertainty has, not to put to too fine a point upon it, caused major problems for all those involved. This is why both BCCA and SCTS have asked Bruce Keogh to allow us to be involved with NHS England's work to deliver the next step in the process.

Brutus:

There is a tide in the affairs of men,
Which, taken at the flood, leads on to fortune:
Omitted, all the voyages of their life
Is bound in shallows and miseries.
On such a full sea we are now afloat,
And we must take the current when it serves,
Or lose our ventures.

Julius Caesar Act 4 Scene 3.

I rest my case.

James Roxburgh

Honorary Secretary's Report

Simon Kendall

I take on this role with significant trepidation. The three honorary secretaries that I was fortunate to work with – Bruce Keogh, James Roxburgh and Graham Cooper - achieved so much in their tenure. Their commitment to the role and the leadership they displayed was exemplary, and I will do my utmost to live up to their standards.

I have recently been out of the operating theatre with a fractured scaphoid – a dog ran out in front of my bike and 52 year olds don't bounce on tarmac. At work everyone was very concerned but I reassured them the dog was OK. I have had to guiltily watch my colleagues filling the empty lists as they continued to take on all the challenging cases that are referred to us. All I could do was offer to do clinics, MDTs (and there were many), ward rounds, assess in-house referrals and continue with the role of clinical director.

As you can imagine it didn't feel like the same job, and at the end of the day there was still some (significant actually) energy left. It reminded me how tough major surgery is – thoracic, congenital, cardiac. We will all have different stresses and tolerances – but if you haven't performed major surgery then it must be impossible to imagine what it's like.

Isn't that why professional societies exist? – for us to share practice and experience? We have an empathy with each other, an innate understanding of what our jobs entail and we can gain knowledge and resilience from each other's support. From this foundation we go on to develop our portfolios – and in the SCTS we have done a remarkable amount in a relatively short space of time. We have moved from being an inward looking exclusive group of surgeons to an outward looking inclusive group –

We care about patient outcomes and we accurately measure them -

- We continue to help the next generation of surgeons to be ready for their consultancy –
- We work with Surgical Care Practitioners / Specialist nurses to develop the specialty
- We will share ideas and plans with ACTA to improve patient care
- We continue to work with the Society of Clinical Perfusionists
- We will listen more and more to our patients and their representatives to maintain our focus

Sadly the NHS is not an easy, nor a particularly supportive environment at present. The country has lived and spent beyond it means. And to some extent the western world has extended health care beyond the physiological and financial reserve of the population – which is relying more and more on medicine to maintain its health, rather than individuals, families and communities focussing on a healthy lifestyle.

There is a lack of money to fund developments – both on an institutional level and on a personal level where money is being withdrawn from our pensions, our job plans and excellence awards.

Difficult times.

These challenges need to be focussed through the Society. Indeed there is so much work to do we have formed three sub committees in Cardiac Thoracic and Congenital surgery to allocate tasks. These sub committees are responsible to the executive and have the following remit:

- To ensure there is sensible monitoring of performance and outcomes for patients and colleagues
- To ensure sound commissioning through the CRGs (clinical reference groups)
- To review the job plans of new and replacement consultant posts
- Ensuring appropriate involvement with NICE guidelines and technology review
- To ensure that we are working with the SAC to help trainees be appropriately prepared for their consultant roles

And along with the Education Secretaries and the Meeting Secretary we will continue to deliver excellent post graduate education.

Throughout my tenure I will work with the President and the executive to coordinate and facilitate all these pieces of work – for the benefit of our patients and our profession.

To some extent the western world has extended health care beyond the physiological and financial reserve of the population

Stentless aortic valve and aortic root

Nigel Drury

The second Stentless Aortic Valve and Aortic Root Replacement course was held on 15th December 2012 at the West Midlands Surgical Training Centre at the University Hospital, Coventry.

This intensive one day course is aimed at intermediate (ST4-6) level and was developed in response to the growing need for cardiothoracic trainees to train on realistic anatomical models. The use of human cadavers enables delegates to learn new skills and develop techniques in a safe environment which effectively simulates a clinical operation.

The day was almost entirely hands-on, with one cadaveric thorax per delegate and a very low delegate-to-trainer ratio. Experienced Consultant trainers provided frequent assistance and feedback on operative techniques whilst the overhead cameras enabled each procedure to be recorded. The Surgical Training Centre is a state-of-the-art facility which provides an excellent learning environment for simulated operative training. As a ST5 with limited first operator experience in aortic root surgery, the course was a thoroughly enjoyable experience and has improved both my operative skills and confidence, with additional feedback on performance provided as simulated Procedure Based Assessments on the ISCP. It also refreshed my knowledge of aortic root anatomy and provided an understanding of the indications for stentless aortic valve replacement.

The course was convened by Mr Jitendra Parmar, Consultant Cardiothoracic Surgeon in Coventry with faculty from across the West Midlands and was heavily sponsored by industry; with a delegate cost of under £300, I also felt that it provided excellent value for money.

The next course will be scheduled for later this year with further information available via www.cardiothoracicskills.co.uk

State of the art facilities at West Midlands Surgical Training Centre

UK Early Mitral Trial

Summary Protocol December 2012

Simon Ray
Consultant Cardiologist/ Honorary Professor of Cardiology, UHSM

South Manchester University Hospitals NHS
NHS Trust

3rd December 2012

Dear Colleagues

We are writing to you to ask whether you would be willing to consider taking part in a UK based clinical trial randomising patients with severe primary mitral regurgitation to early surgery or watchful waiting according to current guidelines. A summary of the proposed protocol is attached.

We believe that this is potentially a very important trial that could have a significant influence on cardiological and surgical practice and which the UK is uniquely positioned to carry out. The protocol has been approved by the Society of Cardiothoracic Surgeons and the British Heart Valve Society and we are now looking for expressions of interest from Centres who may with to take part. The full requirements for participation in this trial are outline in the accompanying summary protocol.

We would be grateful if you could let us know whether you would like to participate by e-mailing me at simon.ray@uhsm.nhs.uk and we will be happy to answer any further questions that you may have.

Best wishes

Simon Ray
Consultant Cardiologist/Honorary Professor of Cardiology
UHSM

Ben Bridgewater
Consultant Cardiac Surgeon / Honorary Professor of Cardiac Surgery
UHSM

Steve Livesey
Consultant Cardiac Surgeon
Southampton General Hospital

Proposal

We propose a randomised controlled trial of early surgery against guideline triggered surgery for patients with severe primary mitral regurgitation due to mitral prolapse or flail leaflet. The null hypothesis is that early surgery carries no advantage over a conventional watch and wait approach.

3.1 Patient Selection

Patients will be selected at participating centres on the basis of the following criteria:

3.1.1 Inclusion criteria:

- Severe mitral regurgitation on the bass of ASE/EAE criteria due to mitral prolapse or flail leaflet
- Valve anatomically suitable for repair – MDT decision
- LVEF>60%, PAP pressure at rest <50mmHg
- LVESD< 4.5cm
- Sinus rhythm
- Asymptomatic during daily life
- Aged 18-75

3.1.2 Exclusion criteria

- Previous myocardial infarction
- Symptomatic coronary disease requiring intervention (asymptomatic disease discovered during work up is not an exclusion)
- Other valve disease of more than mild degree
- Any significant co-morbidity impacting on the risk of surgery

Patients will reviewed by a trial MDT to confirm their suitability for inclusion.

Subject to informed consent patients will be randomised on a 1:1 basis to mitral valve repair or a watchful waiting approach. Coronary angiography will be performed as required in patients randomised to surgery after they have consented.

3.2 Baseline Investigation:

Baseline investigations will be performed on all randomised patients as follows:

- Echocardiography: full study to include 3D assessment wherever feasible
- Biomarkers: BNP
- CMR: LV volumes and mass (where available)
- Functional assessment
- QoL assessment

continued overleaf

UK Early Mitral Trial Summary Protocol December 2012

3.3 Watchful waiting

Patients randomised to watchful waiting will be followed up by their cardiologist according to ESC guidelines at 6 monthly intervals with at least annual echocardiography (see below). The decision to refer for surgery will be made by the referring cardiologist on the basis of current ESC guidelines.

3.4 Surgery

Patients randomised to surgery will undergo mitral valve repair within two months of enrolment. Criteria for surgical centres are detailed below.

3.5 Follow up protocol

Patients will be followed up for 5 years from randomisation. Patients randomised to surgery will be followed up at 3 months post operatively and then both groups will reviewed according to a standard protocol:

- 3 month post surgical review
  - Clinical assessment and ECG
- 6 monthly review
  - Clinical assessment
  - QoL
  - Echocardiography
  - ECG
  - Biomarkers
- Follow up at 5 years
  - Standard review investigations
  - Additional investigations at 5 years CMR, functional assessment

Biomarkers, echocardiographic and CMR images will be analysed by a central core lab. Patients randomised to watchful waiting who subsequently require surgery will remain in the trial and will be followed up according to the standard protocol.

3.6 Primary end point:

Composite of total mortality, stroke, hospitalisation for heart failure, permanent atrial fibrillation

3.7 Secondary end points:

Cardiovascular mortality, LVEF, exercise tolerance, quality of life, health economic outcomes, requirement for redo mitral valve repair, mitral valve replacement

3.8 Additional analyses

Biomarkers, echocardiographic and CMR parameters, surgical complications

3.9 Sample size calculations

We assume an event free survival of 60% in the watchful waiting group and 5 year follow up with 80% power at conventional 5% significance. If surgery improves event free survival to 80% (50% reduction in events) we would require 86 patients in each group (172 overall) and if surgery improves event free survival to 75% (37.5% reduction in events) we would require 155 in each group (310 overall). The more conservative estimate will be used – so 155 in each group

4.0 Criteria for Recruiting Centres

Individual surgeons will be selected to take part in the trial on the basis of:

- Subspecialisation in mitral valve repair
- Surgeons will be asked to submit evidence of mitral repair practice and experience for consideration by the steering committee alongside review of the SCTS data analysis on the basis of volume, repair rates for degenerative disease and mortality for isolated mitral valve repair.

Each surgeon and centre wishing to participate will be approved by the steering committee. Each recruiting centre will have a cardiologist responsible for investigating and following all patients entered into the trial. Criteria for centre participation will be:

- Cardiac surgeon accredited by the steering committee
- Cardiologist with expertise in valve disease
- Access to all required investigations

Trainees Report

David J. McCormack & Mick Murphy

We have been trainee representatives for just over a year. Much has happened in the specialty related to training during this period. Communication of information to trainees has been streamlined through monthly newsletters and a new trainee website (www.tscts.org). Feedback on either of these is always welcomed.

Specialty Training Introductory Course

Based on the TSDA Boot Camp the inaugural **Specialty Trainee Introductory Course** was held in October 2012. All newly appointed ST3 Trainees were invited. An experienced and talented faculty donated their time to ensure fundamental concepts and skills were covered over 3 days of intensive tuition. Feedback from the course was very encouraging and has helped in the development of the 2013 iteration (to which ST1s will be invited also). Generous funding and support from **Sorin** and **WetLab** meant that the course could be delivered free of charge to delegates (with accommodation and sustenance provided). Special mention should be given to Susannah Love who was instrumental in envisaging and setting up the course.

National Selections 2013

The 2013 round of national selections were held in Southampton on 4th and 5th February. Selections for ST1 run-through and ST3 posts were carried out in overlapping sessions. We were invited to attend and participate. From our perspective, the ST1 candidates were of an impressively high standard in terms of portfolio, performance at interview and practical assessment. Eight ST1 run-through posts and 16 ST3 posts were awarded. We anticipate that in the future there will be a progressive trend towards recruitment at ST1 level. We welcome the new NTNs to training and look forward to seeing them at the 2013 Specialty Trainee Introductory course.

Annual Trainee Forum

There was an excellent attendance of over 100 people at the annual trainee forum. Invited presentations ranged between optimising foundation training to Post-CCT considerations and covered all levels of training. Trainees were invited to send questions for the panel electronically prior to the meeting to ensure comprehensive answers were forthcoming. This seemed to work well and with some wine enhanced impromptu interrogation, all questions were answered. A key point of discussion was the consideration of quantified operative requirements in training. Strong arguments were made for and against and ultimately it was agreed that a separate session would be held in the 2014 annual meeting with the intention of forming a unified trainee position statement. The trainee meal was kindly supported by CardioSolutions and allowed a good opportunity to relax socially with trainees from throughout the Great Britain and Ireland.

Association of Surgeons in Training (ASiT)

Involvement in ASiT council meetings has highlighted to us the good work that this pan-surgical specialty group does. Whilst cardiothoracic representation at the annual ASiT meeting is usually low, this year represented a noticeable improvement with 28 abstracts submitted. Furthermore, ASiT demonstrated their commitment to encouraging cardiothoracic involvement by facilitating a preconference Cardiac Surgery WetLab. Supported by **Sorin** and **WetLab**, medical students and foundation doctors were guided through the principles of cardiopulmonary bypass, evidence for cardiac surgery and essential practical skills by a dedicated and experienced faculty. The course received strongly positive feedback and we intend to repeat it in future years.

CardioThoracic Research Collaborative (CTRC)

Over the last year the CTRC has continued to grow under the guidance of Claire Burdette and Aaron Ranasinghe. New members continue to join the group and numerous multicentre research projects are in progress. Work from the group has been presented at the Annual SCTS Meeting, the Royal College of Surgeons Cardiothoracic Research Day and at the Annual ASiT Meeting. Those who would like to be involved should visit www.CTRC-UK.com.

SCTS Fellowships (funded by Ethicon)

Ethicon continues to generously support these excellent awards. This year's awards will cover fellowships in the breath of the specialty (thoracic, congenital and two adult cardiac). We would advise all trainees to think about fellowships in their ST4/5 years and prepare strong applications for this funding in the latter part of their training.

The future

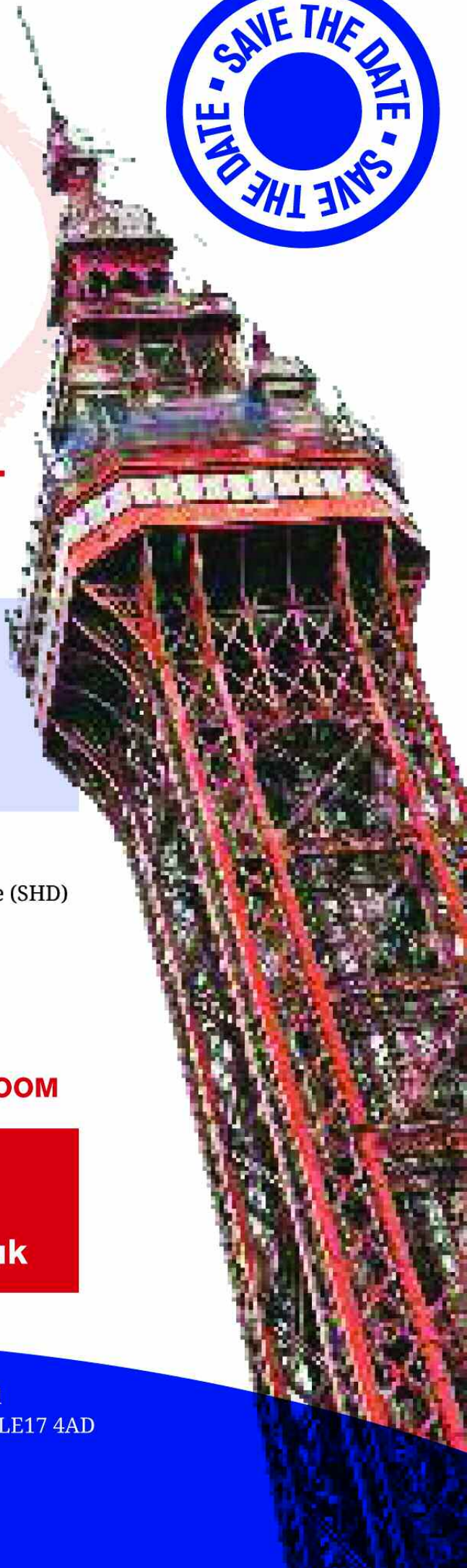
We look forward to working with you to enhance all aspects of training. Please feel free to contact us if there are any questions or suggestions.

Specialty Training Introductory Course 2012

SAVE THE DATE • SAVE THE DATE •

5th DAVID SHARPE MEMORIAL SYMPOSIUM

INNOVATIVE MANAGEMENT OF STRUCTURAL HEART DISEASE



ONE HEART, ONE TEAM CONCEPT

Joint Cardiology, Cardiac Surgery and Cardiac Anaesthetic Meeting

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ORGANISED BY:	The Lancashire Cardiac Centre, Blackpool Teaching Hospital NHS Foundation Trust

International Expert Faculty addressing:

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- Percutaneous Valve Interventions
- Multidisciplinary Atrial Fibrillation Management
- Hybrid Interventions for SHD and AF

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SCTS University & Annual Meeting 2013

Ian Wilson
& Jonathan Hyde

The SCTS Annual Meeting 2013 was greeted by choppy seas in the English Channel during Conference Build-day, but as the International and National faculty arrived, and strong delegate numbers descended upon Brighton, the seas calmed and the sun shone.

The SCTS meeting organising group made the decision, early in the cycle of the 2013 meeting development, that creation of an SCTS Meeting App would facilitate presentation of the diverse content within the programme. Jonathan Hyde led this initiative and presented the inaugural SCTS Meeting App in a style that allowed easy access to the full extent of the programme.

The App was complimented by production of a hard copy, pocket sized, "Shortened Programme."

This was the first year that the Abstract Book had not been produced. General consensus was very positive, although some missed the old style. There may have been an age divide to the opinions amongst SCTS members, but on balance, now that there is a gap on the bookcase of members after the 2012 Abstract Book, the initiative should now continue, and develop to incorporate all the instant media availability. Plans are being developed for 2014; members who have specific knowledge in the area, and ideas about potential areas of advancement should contact the organising team.

Abstracts

More than 300 abstracts were submitted for oral presentation, and 30 movies were also forwarded for consideration. Themed sessions were constructed by the Programme Committee, with the content of these sessions complimented by Invited Key Note lectures. Enormous appreciation is due to the Lead abstract reviewers and the abstract review teams for their time in contributing to programme design.

The International Faculty was very strong on the cardiac, thoracic and congenital sides of the specialty. Participation included both Key Note Addresses, and considerable interaction with active discussion in both the SCTS University and the SCTS Main Meeting.

Tirone David put in a phenomenal shift throughout the conference days, with considerable contributions delivered by Ottavio Alfieri, Miguel Congregado, Philippe Dartevelle, Jose da Silva, Roberto Di Bartolomeo, Gebrine El Khoury, Diego Gonzalez Rivas, Rune Haaverstad, Pieter Kappetein, Philippe Kolh, Gilbert Massard, Pablo Moreno de la Santa Barajas, Jim O'Connor, Rene Petersen, Hans Pilegaard, Dirk-Jan Slebos, Martin Strueber, Hanneke Takkenberg, Alec Vahanian, Arschang Valipour, Jean Louis Vanoverschelde, Ed Verrier, Jean-Marie Wihlm, and Mustafa Yuksel.

This diversely experienced faculty was augmented by a multidisciplinary national faculty, resulting in a series of contemporary cardiothoracic surgical educational opportunities.

University

Within the SCTS University and Main Meeting over 300 invited abstracts were presented, alongside 170 submitted and accepted abstracts. Two movie sessions were well attended, with considerable discussion and interaction from the invited international faculty.

There were over 650 attendees at this year's conference, which proved to be both exciting and informative. The Brighton conference centre has a layout that is somewhat sprawling and movement around the centre was facilitated by the very helpful Brighton staff, who were amiable and available. The SCTS meeting has benefited from the in-house organisational assistance of local medical students over many years, and recently has had the advantage of students who returned in subsequent years. This year Vikram Swaminathan and Ashley Newton led the team of medical student support impeccably, and the SCTS organising team would like to express their appreciation for four years industry.

An Image Gallery was launched this year, with the assistance of two dedicated local photography students. Photographs have been made available on the SCTS web site, and many more images are available. Requests for release of images for purchase can be made to Isabelle Ferner.

Abstract submission software was changed to Webges in 2013. The abstract submission appeared to work well, and was probably an advance for the meeting, but registration proved to be a less smooth transition in some specific areas of transaction. We have learnt from this experience and we trust that next year's will reflect increased familiarity and confidence with the software.

The SCTS Library was launched in January 2013, and now includes videos from both Manchester 2012, and Brighton 2013. These videos are predominately from the SCTS University, with more than 400 videos now available for continued education, covering the most contemporary review of cardiothoracic surgical topics by a hugely experienced international and national faculty within each sub-specialty area. The format of the SCTS University web site has improved with time and will develop

Brighton International Centre 17-19th March 2013

SCTS University Annual Meeting 2013 continued

further, but this resource is a major advance in SCTS education for all SCTS members. Currently the highest hits for the most popular 2012 video is 37,248, with the highest hits for the most popular video in 2013 presently recorded at 1,376.

The SCTS web site has been adjusted to ease navigation to the SCTS Meeting page and the SCTS University and Library pages. This reformatting will increase exposure to this fantastic educational resource, from which we can all benefit.

Prize winners from the 2013 were:

John Parker Medal	M Yates
Ronald Edwards Medal	E Teh
Thoracic Surgery Prize	R Jones
BASO Prize	M Smith
Best Cardiac Surgical Movie	N Nikolaidis
Best Thoracic Surgical Movie	L Socci
Bob Bonser Aortic Surgery Prize	R Attia
CT Forum Prize	J Cook
CT Forum 2nd Place	L Nolan
Presentation Prize	D Bleetman
Patrick Magee Student Poster Prize	G Walkden
Cardiac Poster Prize	H. Barrett
Thoracic Poster Prize	M. Schweigert

New Prizes were included in 2013; an Oscar was awarded to Enoch Akowuah for the most watched video from the SCTS University 2012, although his lead has subsequently been overturned. The inaugural Bob Bonser Aortic Prize was awarded to Rizwan Attia, and it was wonderful that Meena Bonser was able to attend the Bob Bonser Aortic Surgery session in the meeting.

The Annual Dinner was moved to the central night of the conference, after the successful experience of the ACTA / SCTS Annual dinner in 2012. The theme was seaside-based, respecting the local environs, and there was a record attendance of over 260 diners. This may have distracted from conference attendance on the Tuesday morning, and the organising group will have to consider how to respond to this; however the evening was a real success.

Although a conservative side of the cardiothoracic surgical psyche resulted in a slow engagement in the “Fun Fair” stalls, alcohol appeared to break down these inhibitions, with late night involvement in the fun of the fair. Testosterone was in abundance in the strength-events, equally shown by the both male and female members.

Cardiothoracic Forum attendance was high with considerable involvement from SCTS members. This fundamentally important collaboration underpins the SCTS and continued development is crucial to the ongoing progression of the society. Enormous credit should be given to both Tara Bartley and Chris Bannister for its development and continued progress.

Mike Fisher continues to develop the Patient’s Forum, and this year there was considerable collaboration with the main meeting and Cardiothoracic Forum. This association with our society is fundamental to both the SCTS and the SCTS meeting, and we would encourage continued dialogue with Mike and his team in growing this interaction across the country. Patients enthusiastic in engaging with the initiative should be encouraged to contact Mike Fisher who will be able to best channel their enthusiasm to the benefit of the society.

Isabelle Ferner and Tilly Mitchell are the engine room of the meeting, without whom members could not benefit from the educational opportunities offered. Association with world authorities in cardiothoracic surgery is humbling, but enormously beneficial to practices across the country, and further development can only benefit us all.

As we look forward to the SCTS Meeting in 2014, changes have been made to the dates, as a consequence of a clash with the Six Nations Rugby after match allocation in March 2013. Scotland is playing France on the proposed weekend of the SCTS Meeting, which was originally booked in 2009. The clash threatens the smooth running of the meeting, and certainly hotel accommodation will be at a premium on the Saturday night prior to the proposed SCTS University day. The Organization Team has taken the decision to move the dates to Monday 10th March 2014 – Wednesday 12th March 2014. The meeting will close at lunchtime on the Wednesday allowing time to travel back to base-hospitals on the Wednesday afternoon.

We hope that this minor change in dates will not be too great an inconvenience to you, and we look forward to greeting you in 2014 with a wonderful series of educational opportunities, augmented by fantastic Scottish hospitality.

Ian Wilson and Jonathan Hyde

Cardiothoracic Forum
at the Annual Meeting

Christina Bannister
SCTS Nursing & Allied Health
Professional Representative

We had an excellent CT Forum this year at the Brighton Conference Centre in March and once again we dedicated our room to David Geldard, previous SCTS Patient Representative. We had good representation from nurses, allied health professionals and patients from across the country and for the entire CT Forum, throughout Monday and Tuesday we listened to a number of plenary speeches and over 20 presentations from nurses, allied health professionals and doctors.

The audience selected the following papers as the **'Cardiothoracic Forum Best Paper',** the marks resulted in joint winners:

The Patient, The GP, The Primary Care Team: Their Relationship, Adherence to Treatment and the Implications for Research, Jo Cook, John Radcliffe Hospital, Oxford, UK

AND

Enhancing Safety in Cardiac Surgery: The Potential Impact of Human Factors Training, David Bleetman, Solihull, UK

AND

Patient Understanding and Experience of their Sternotomy and the Promotion of Wound Healing, Libby Nolan, S.Kivi, G.Hall, F.Bhatti, Morriston Hospital, Swansea, UK

Jo Cook's Paper also scored top marks for the 'SCTS Cardiothoracic Forum Best Poster' therefore Jo wins the overall prize with runner up prizes going to both David and Libby. I would like to congratulate the winners and also all presenters at the CT Forum.

Patient Safety

The CT Forum focussed on 'Patient Safety' and James Roxburgh, SCTS President and I began our opening session on Monday with a national RCN perspective given by the RCN President, Andrea Spyropoulos. Her words, as always, were an inspiration to all of us and kept us all up to date with the views of the RCN with regards to nursing issues currently. We thank her for opening the CT Forum and joining us to listen to the other presentations and for her presence at the annual dinner. We look forward to meeting with her again in Edinburgh.

Andrea's opening remarks were followed by the main plenary speech given by Professor Brian Toft, OBE. Professor Toft is a Professor of patient safety at Coventry University and visiting Professor of patient safety at Brighton and Sussex Medical School. He also holds many senior advisory positions within the National Patient Safety Agency, and the World Health Organisation. Professor Toft's presentation was not only hugely

informative but also very entertaining. He kept the audience intently listening whilst he explained concepts around patient safety issues and how human factors affect the way we interact with patients and vice versa. The presentation encouraged audience participation and we thank Professor Toft for his speech and his attendance at the meeting and annual dinner.

Hands-on

Monday afternoon saw a new departure for the CT Forum; we held a practical hands-on session for all participants. Kevin Austin and his team at Wetlab Ltd facilitated a fascinating session where nurses and allied health professionals were able to join in and try practical skills, many we have heard of and explain to patients but have never actually seen, or even tried ourselves. There was opportunity to practice cardiac and thoracic techniques on hearts and ribcages, for example, chest drain insertion and thoractomy, and we had a mitral valve station and coronary anatomy. I would like to thank all the clinicians that took the time to support us and come and teach and share with all the participants their knowledge and practical skills. We also had a number of company representatives present demonstrating their products and allowing nurses and allied health professionals to have a go and practice skills that they normally never do. We would like to thank Edwards Lifesciences, Cardiosolutions, Cardiologic, Maquet, Synthes and Rocket Medical for all their help and assistance.

Cardiothoracic Forum at SCTS 2013

continued

The session was a great success and I hope to build on this for our next meeting in Edinburgh.

Throughout Tuesday we had three main sessions looking at Thoracic Surgery, Cardiac Surgery and Advanced Clinical Practice. During the Thoracic session we had participation from Amy Bradley who came to tell us all about the work of the National Lung Cancer Forum for Nurses (NLCFN) especially in relation to the Thoracic Surgical Group (TSG). This was especially relevant to the thoracic nurses in the session who work closely with patients with lung cancer and need immense support.

Aortic valve session

Within our Cardiac surgical session, Mr Andy Chukwuemeka, not only chaired the session, but also gave us a hugely informative talk on less invasive approaches to the aortic valve. His in-depth knowledge provided a wealth of information, new and old, which was fascinating for all participants to hear. As the forum supports nurses and allied health professionals from all areas of care, wards, outpatients, theatres, his knowledge was useful for all to learn from and inform patients on their treatment options.

In our final session we had a change of plenary speech, and fortunately at the last minute Stephen Green from the National Cardiothoracic Benchmarking Collaborative (NCBC) stepped in to fill the slot. Stephen and I presented the specialist nurse data the NCBC obtained from their participating Trusts across the

country, which opened a great deal of discussion and sharing of practices. I would like to thank him greatly for participating at the last minute; I think he had about 48hrs to pull together the presentation.

I would like to again thank all plenary speakers, chairs, presenters and participants who without the CT Forum could not exist. Not only do we all learn from others at the Forum but the networking and shared working practice information that we all get is invaluable. I urge you all to encourage your colleagues in nursing and allied health professional specialities to attend next year's forum in Edinburgh.

Other news from Nursing and Allied Health Professionals

Advanced Course

This years' SCTS Advanced Cardiothoracic Course will take place again at Heartlands Hospital, Birmingham with the continued format of one thoracic day followed by a cardiac day. This is an excellent course and we recommend nurses and allied health professionals to attend. Once course dates have been confirmed we will inform all associate members.

Joint RCS & SCTS Cardiothoracic Advanced Examination

Work continues around this venture with the establishment of a syllabus, examination and Q&A process being created. This is still ongoing but moving forward well. Talks with the Royal College of Surgeons with regards for badging have slowed the process; however we are moving on to the goal of a national advanced examination for all cardiothoracic nurses.

Surgical Care Practitioner Update

Members of the SCTS attended the ACSA (Association of Cardiac Surgical Assistants) Annual Business Meeting this year in Brighton, to examine three main areas; registration, training & development – including discussions surrounding the continuation of the national exam which is seen as a clinical workplace standard; and role standardisation. An extremely lively discussion was held between Alistair Marshall, President of ACSA, all other members of ACSA present and the participants from the SCTS. The key theme was joint participation and close working between the two organisations to help and support members of ACSA who work within this speciality. As the Royal College of Surgeons are currently re-examining the National SCP Framework, and with the reduction in junior doctors hours from the European Working Time Directive, participation from the SCTS was seen as extremely important in supporting the role of the Surgical Care Practitioner in Cardiothoracics. We hope that our presence at the ACSA ABM signified our shared working principles and I look forward to working closely with Alistair to push these concepts forward.

EACTS

EACTS this year is being held at the Austria Centre in Vienna and the Postgraduate Nurses Day is planned for Sunday 6th October with the main themes being patient safety, development of allied professional roles and non surgical skills for surgical teams.

The EACTS Quality Improvement Programme (QUIP) programme still continues – looking in-depth at quality standards across Europe with the concept to bring together common aspects and setting a benchmark for establishing quality improvement. This involves a review of current nursing quality outcomes; the

continued overleaf

Other News continued

implementation of a quality pathway for patients, and a review of outcome measures, examining established protocols and practice guidelines.

For any nurses and allied health professionals that would be prepared to share good practice with our colleagues around Europe and get involved with the QUIP programme please contact Tara Bartley, Lead Nurse for QUIP at Tara.Bartley@uhb.nhs.uk

Update on Current Issues

The launch of NHS England at the beginning of this month marked a key milestone in the journey to transform and improve healthcare for all. Jane Cummings, the Chief Nursing Officer, stated that NHS England's overarching principle of placing patients at the centre of every decision gives all of us a great freedom to come up with innovative approaches to ensure staff and services deliver the highest standards of care, both today and tomorrow. Whether through delivering compassionate care on the frontline or providing sound clinical leadership, nurses and midwives have a fundamental role in embedding this patient-centered approach across all parts of the new health and social care system.

On NHS Change Day on 13 March 2013, Jane made a pledge along with senior nurses from all of the national organisations. Their pledge was to work with nurses, midwives and care staff across England to implement and embed the vision for Compassion in Practice and the 6C's for everyone being cared for every day. Within the new clinical commissioning groups, experienced clinical nurses are able to input their knowledge and experiences of caring for patients firsthand and can ensure that compassion is key to all parts of strategic planning. Through the implementation of the family and friends test across the country patients are now able to feedback their experience of their visit to a healthcare provider allowing change to occur and improvements in practice to encourage a vision of compassionate care.

The RCN Congress was held this year in Liverpool in April. Andrea Spyropoulos, President of the RCN, opened the meeting with a speech highlighting the importance of taking ownership in nursing and in the care we provide for every individual we care for. Within Congress a number of highly important issues were debated at length: unsafe staffing numbers was identified as an issue by a survey of charge nurses; within the survey 71% of the nurses asked said that they felt staffing levels were unsafe, reasons for this were recruitment freezes, lack of staff retention and posts that were permanently cut. Within the area of cardiothoracics, we need to ensure that staffing levels and subsequent high quality of care are maintained to the highest degree. Dr Peter Carter, RCN Chief Executive & General Secretary, stressed the urgent need for minimum nurse numbers enforced by law. Describing the Francis report as a "missed opportunity", he said the need for mandatory safe staffing levels has never been greater. "What we need above all else is feet on the ground, nurses at the bedside and in the community." Congress also examined the increasing burden of administrative work on nurses, it was identified that nurses spend an estimated 2.5 million hours a week on non-essential paperwork and clerical tasks - more than double the 2008 figure. By working together within the cardiothoracic community we need to learn from these figures and work together as a whole, sharing ideas and best working practices so that we can spend our time caring for patients and ensuring that we are not constantly 're-inventing the wheel' whilst we strive to improves the services we provide.

SCTS CT Forum Contacts

At the annual meeting this year we launched a SCTS CT Forum Facebook and Twitter page. The CT Forum is for all nurses and allied health professionals to belong to and I encourage you all to sign up to these pages and help us to communicate between all health care professionals working in the field of cardiothoracics, whether it be in outpatient departments, wards, intensive care, theatres or the community. We would like as many nurses and allied health professionals to join, to show that cardiothoracic health professionals have a voice and want to work together to improve the care provided for all patients.

The links for the pages are as follows, please pass these details on to as many nurses and allied health professionals that you all know and encourage everyone to participate.

Follow us at Twitter - @SCTS_CTForum

Join the Facebook Group - SCTS CT Forum

If any of your colleagues would like to become an associate member of the Society or would like to add their names to the SCTS Allied Health Professionals database so they can receive the emails that are sent out then please forward their name, address and title to me at Christina.Bannister@uhs.nhs.uk or chrissiebannister71@gmail.com or direct to Tilly Mitchell at tilly@scts.org

Chris Bannister

Nursing Representative

Ethicon Mitral Valve Scholarship

Ishtiaq Ahmed
PhD FRCS C-Th

I have just completed the most productive, enjoyable and rewarding 6 months of my cardiac surgical training to date. From January 1st 2012 I took up the position of the Ethicon Mitral Valve Scholar. This enabled me to become a supernumery fellow and tailor my learning needs to my subspecialty interest. My objectives were to expand my exposure as primary operator for mitral valve repair and also to learn minimal access cardiac surgical techniques. As mitral valve disease usually goes hand in hand with tricuspid disease and treatment of atrial fibrillation I wanted to also expand my operative expertise in these areas.

The Ethicon Scholarships were awarded by competitive interview in mid 2011. The plan was for these scholarships to provide a 'finishing school' of operative experience to senior trainees prior to taking on a consultant post.

The philosophy

Six months is not a long time. I wanted to maximize my primary operator exposure, while still working with leaders in this specialty. I took a three-pronged approach to tailor my experience to my learning objectives. I decided to be mentored by Mr Hunter in Middlesbrough, who has a large mitral repair practice and is the UK lead in minimal access repair, move on to Hugo Vanerman who was the pioneer of minimal access repair in the nineties, and then spend time with Professor Jean Francois Obadia, the lead minimal access mitral surgeon in France.

UK

I had previously spent time training with Mr Hunter in Middlesbrough, therefore I hit the ground running immediately. Now that I was supernumery I planned my week around the operating theatre sessions and was the primary operator for every mitral case. These sternotomy cases were usually complex cases, which could not be tackled by a minimal access route – including triple valve, ablation and revascularization. The stand-alone mitral cases were all via a minimal access route and we set off on the steep learning curve of breaking this procedure down into its separate components and becoming proficient in each part to start with.

I spent time in simulation laboratories in Switzerland, had opportunity to get to know the new devices such as the endoballoon occluders and long shafted instruments as well as getting used to operating via the scope. Mr Hunter and I shared the procedures initially and took a stepwise approach to gradually build up competencies in each component of the procedure. By the end of my time with Mr Hunter he was mentoring me through complete minimal access cases.

I had already had didactic TOE training, but during this attachment I had time to strengthen those skills – all vitally important when using endovascular techniques. This was done in theatre and also by using TOE simulation devices.

Now that I managed my own weekly timetable, my week was busier than it had ever been. I did not have to be influenced by service commitments. I made sure I was involved in every pre – op mitral consult, was in every mitral theatre, took care of the patients postoperatively, but also took opportunity of all the other educational opportunities in the unit. I had a dedicated transthoracic echo session of my own each week where I was performing TTE, attended the lunchtime echo meetings and MDTs (this has really been useful in correlating the 2D images into 3D correlates to plan my surgical strategy). I also took the chance to attend symposia such as Professor El Khoury's mitral symposium in Brussels and the comprehensive AF symposium hosted in Barcelona by Brugada and colleagues including James Cox.

Europe

I spent two blocks of time in Europe. The first was with the legendary Hugo Vanerman in Aalst. He has been performing minimal access mitral valve surgery since 1995! Since then he has gone from strength to strength, working closely with industry to develop technology to improve this procedure. Although I did not operate here I learned a tremendous amount from him in terms of technical tips and tricks, which complemented techniques I had already done in the UK and in addition he has an incredibly knowledgeable team around him. I learned a tremendous amount about the pitfalls of the

continued overleaf

Ethicon Mitral Valve Scholarship continued

procedure and how to avoid them from his chief perfusionist Geert, and also the latest echo techniques from his chief anesthesiologist.

Lyon was my final attachment. Hopital Louis Pradel is a large workhorse of a hospital with its cardiovascular services including transplant, complex aortic and mitral surgery and paediatrics. Professor Jean Francois Obadia is the lead mitral surgeon there and I effectively worked alongside him in his team. Lyon is the gastronomic capital of France and it was very easy to see why – even the hospital food was superb – so much so that every day stopped for 90 minutes at lunchtime so we could all sample the delights of the restaurant!

Every evening when I examined the list for the subsequent day it was like a Michelin star menu of mitral valve surgery. The volume of work was relentless – ischaemic mitral, Barlows, anterior leaflet pathology, posterior leaflet disease, rheumatic disease, endocarditis, stand alone thoracoscopic ablation. All approaches were taught to me - sternotomy trans-septal and via Sondergard's groove as well as minimal access. Professor Obadia's approach was slightly different to my previous experience – he did not use the endoballoon but used the Chitwood clamp instead. In addition I learned some novel techniques which I was not familiar with previously such as entirely percutaneous bypass and use of endovascular closure devices.

My French did get me through and I realized it had improved when I ended up one day giving commentary to the TV crew in French while they filmed his 1000th case – I even got a 10 second slot on French national TV explaining the concept and benefits of minimal access surgery!

Reflection

There are elements I will take from all the great teachers I have had, but one outstanding feature is the importance of teamwork and individual responsibility for quality. This is complex surgery with multiple facets. The initial learning curve is always a tricky time for every surgeon, as evidenced by the seminal paper by Mohr et al in 1998[1]. All of these facets need to be streamlined to get quality results. The great thing about having spent so much time with these three mentors is that I have been there through the easy cases and also the difficult ones and I realized I learned the most in the tricky cases. We all know new procedures are all associated with risk, however to minimize this I have gone out to get didactic training from the best in the business, to share experiences of cases, to learn the tricks and tips. I have realized that in surgery, even the experienced put all the checks in place every single time – selecting appropriate cases, how to avoid dissection, getting great exposure, important aspects when starting a new practice, avoiding problems when using the endoclamp – I hope to share some of these in the forthcoming UK MIS user group meeting.

The last 6 months of my training has been the most productive I have ever had. The Ethicon Scholarship was a complete 'game changer' for me. If I reflect on what I wanted to achieve – be primary operator for complex multivalve cases via sternotomy, increase my experience in AF surgery, learn all components of minimal access mitral valve surgery and start doing complete cases with a mentor, and importantly to learn this from three Grandmasters of mitral valve surgery – this scholarship ticked all the boxes. I am very much looking forward to taking these skills into my new post as a consultant in Leeds.

I am very grateful to Ethicon for this generous Scholarship and to the Society for administering it.

Ishtiaq Ahmed

PhD FRCS C-Th

ishtiaqmahmed@yahoo.co.uk

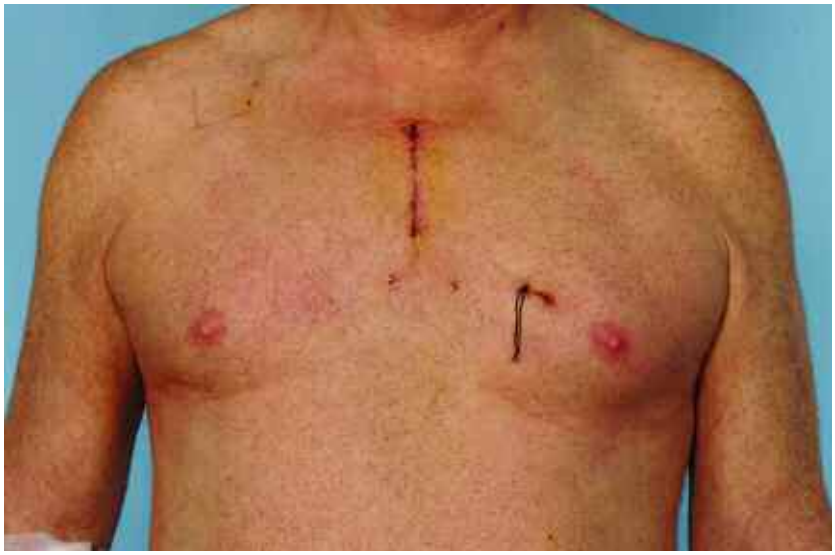
1. Mohr F et al. JTCVS 1998; 115: 567-74.

Middlesbrough Minimally Invasive Aortic Valve Replacement Course

Enoch Akowuah & Andrew Goodwin

Aortic valve replacement has seen many changes during the past 5 years with the advent of TAVI, sutureless valves and renewed interest in minimally invasive techniques.

Minimally invasive AVR, via an incision limited to the manubrium (sternotomy to the 2nd intercostal space), was introduced to Middlesbrough in late 2011 with over 100 procedures performed to date. With the growing interest in the technique we have developed a course that is intended for consultants who plan to adopt manubrium-limited minimally invasive aortic valve replacement.It runs over one and half days at James Cook University Hospital in Middlesbrough.



The aim of the course is to provide surgeons with the rationale behind the technique, the technical steps required, familiarity with the equipment needed, and the skills which have to be developed to allow successful adoption. These aims are achieved by participants spending time in the operating theatre observing a number of procedures by two different surgeons first hand. There is the opportunity to scrub for a procedure to be even 'closer to the action'. We also provide formal teaching on the 'tips and tricks' gleaned during the learning curve and a review of the results of the first 100 procedures. The course dinner provides an opportunity for further informal discussion.

One of the main features of the course is the availability of two consultants for the entire duration, one operating, and the other in theatre so that participants can feel free to ask questions throughout surgery.

One of the main features of the course is the availability of two consultants for the entire duration, one operating, and the other in theatre so that participants can feel free to ask questions throughout surgery. As part of the faculty, we have an experienced anaesthetist who has been involved in the program since its inception, and can answer questions relating to perioperative and post-operative anaesthetic care. Wherever possible, we encourage surgeons to attend with other members of their surgical team, particularly anaesthetic and perfusion staff, to facilitate easier adoption of the operation.

Five courses were held last year with ten consultant surgeons taking part. Feedback has been excellent and most participants have taken up manubrium limited minimally invasive aortic valve surgery since attending the course. The course has been accredited 12 CPD points by the SCTS.

We are grateful to our industry partners at Medtronic who have provided support for the course. If you are interested in attending please contact your local Medtronic representative.

Enoch Akowuah

Andrew Goodwin

British Heart Valve Society

Annual Meeting - 3rd October 2013
Wythenshawe Hospital, Manchester

To register online please visit: www.bhvs.org.uk

Members Fee £120

Non-members Fee £150

Students undertaking PhD £60

Venue:
Wythenshawe Hospital, Manchester

Starting at:
9.30 am

Registration:
8.30am onwards

Programme

Clinical dilemmas:		Chair:	**Mr Norman Briffa**
09.30 – 10.00	Surgery for functional mitral regurgitation		**Mr Peter Braidley**
10.00 – 10.30	How to manage the dilated aorta in the presence of valve disease		**Mr Mario Petrou**
Uncommon valve disease:		Chair:	**Prof John Chambers**
10.30 – 11.00	Iatrogenic valve disease (radiation, drugs)		**Dr Joseph Davar**
11.00 – 11.30	Rheumatic valve disease		**Dr Guy Lloyd**
11.30 – 12.00	Coffee		
Emerging valve technology:		Chair:	**Dr Patricia Lawford**
12.00 – 12.30	The ex-vivo porcine heart model		**Dr Jurgen de Hart**
12.30 – 13.00	Natural animal models of disease		**Prof Adrian Bosworth**
13.00 – 1400	Lunch		
14.00 – 14.30	**Annual general meeting**		
14.30 – 15.30	Young investigators	Moderators:	**Prof Simon Ray** **Dr Bernard Prendergast** **Prof John Chambers** **Dr Patricia Lawford**
15.30 – 16.30	Controversial cases in endocarditis: (Case-based discussions)	Chair:	**Prof Roger Hall**

Faculty

Prof Adrian Bosworth	Professor Royal Veterinary College, London
Mr Peter Braidley	Consultant Cardiac Surgeon, Northern General Hospital, Sheffield
Mr Norman Briffa	Consultant Cardiac Surgeon, Northern General Hospital, Sheffield
Prof John Chambers	Professor of Clinical Cardiology, Guy's and St Thomas' Hospitals
Dr Joseph Davar	Consultant Cardiologist, Royal Free Hospital, London and Senior Lecturer UCL
Prof Roger Hall	Professor of Clinical Cardiology
Dr Jurgen de Hart	
Dr Patricia Lawford	Senior Lecturer in Biomedical Engineering, Sheffield University
Dr Guy Lloyd	Consultant Cardiologist, Eastbourne Hospital, President BSE
Mr Mario Petrou	Consultant Cardiac Surgeon, John Radcliffe Hospital, Oxford
Dr Bernard Prendergast	Consultant Cardiologist, John Radcliffe Hospital, Oxford
Prof Simon Ray	Professor of Cardiology, Wythenshawe Hospital, Manchester

Why cardiothoracic surgeons must join the social media revolution

Norman Briffa
Cardiac Surgeon, Northern General Hospital, Sheffield

Health care systems around the world are under stress and are being reformed. New models of care are required for a rapidly aging population. Care that is currently hospital based must be transferred to the community. Cardiothoracic surgery provides treatments that may be very effective but remain very invasive and expensive.

The specialty lags behind general surgery, which has changed dramatically during the past 10 to 15 years. Many cardiac treatments, previously undertaken through open surgery, are now available with a catheter, carried out by cardiologists. Although percutaneous coronary intervention numbers remain stable, numbers of coronary artery bypass grafting operations, for many years staple fare for cardiac surgeons, are falling in both the United States and the United Kingdom. A revolution to reinvigorate and transform the specialty is required from within before it is seen to be punching increasingly above its weight.

The communications giant BT used to have a slogan, "We're Better Connected." These 3 words crystallize the transformative potential of social media to reinvigorate our specialty.

Since the early days of the Internet, e-mail has been the mainstay of electronic communication. Protocol industry changes, referred to as "web 2.0," have now made the ability to communicate and share any digital material instantaneously, possible. This is achieved through instant messaging and social media such as Twitter and Facebook. Browsers on desktop computers, smart phones, and touch-screen tablet devices have inbuilt sharing capabilities. It is now possible to share any digital content easily from any computer or smartphone with like-minded members of a connected community.

Twitter is a microblogging site that has been embraced by both celebrities and more significantly the arts and political classes. Such social media have radically changed the way business is done in the arts and politics worlds in the West. Medicine and particularly surgery has been late in adopting this technology. In recent months, medical educationalists and those who are involved in forming health policy have had a presence on Twitter. A junior doctor and a medical student have recently demonstrated the amazing potential of social media by starting the world's first Twitter-based journal club. Every Sunday evening, hundreds of medical professionals from all over the world discuss a nominated paper.

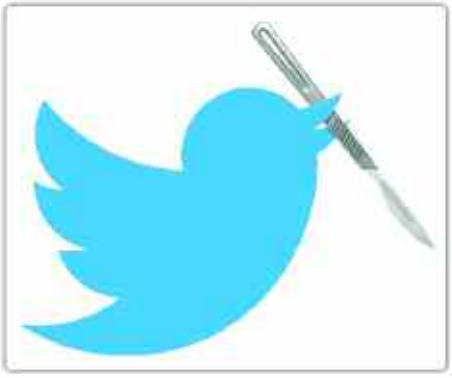
Associations and journals are also now sharing content on Twitter.

These are the tools that cardiothoracic surgeons around the world must use to bring about the required transformation. Sharing information from both within and importantly without the cardiothoracic bubble will be key. The instantaneous sharing of proceedings from meetings (not necessarily cardiothoracic) with surgeons from all over the world is now possible. The instant dissemination of the annual meeting of the Society of Cardiothoracic Surgery of GB and Ireland is possible with appropriate tags through Twitter.

It is up to all cardiothoracic surgeons and clinical staff the world over, both as individuals and as societies and associations, to make the effort to start this global movement. All should be encouraged to start blogs at free to use sites such as Blogger, WordPress, Posterous and Tumblr. The content should be shared through Twitter Google+ & Facebook. Like-minded folk will find each other, and soon an online community with the will to transform this specialty will be created.

Norman Briffa

Tweets as @chestcracker and blogs at www.chestcracker.blogspot.co.uk



Thoracic Endovascular Stenting in Aortic Pathology - Role of Cardiac Surgeons

Martin Yates, Jeremy Smelt, Marjan Jahangiri
Department of Cardiac Surgery, St. George's Hospital, London

The use of thoracic endovascular aortic repair (TEVAR) continues to increase both in the UK and USA. The use of TEVAR has trebled since approval by FDA in 2005 despite the fact that the incidence or diagnosis of aortic pathology has remained constant. In UK, TEVAR is in the exclusive domain of vascular surgeons.

With increasing number of patients undergoing TEVAR and now longer follow-up available, it is becoming apparent that in some cases, it does not prevent the growth of the aneurysm and is associated with up to 20% incidence of endoleaks. Treatment of a growing aneurysm or an enlarging arch haematoma with a failed stent in situ and endoleak are serious challenges for cardiovascular surgeons. In this latter cohort, if open repair was not considered at the outset, it is certainly more difficult at this stage. On the other hand, the risks and impact of repeat TEVAR (e.g. stent-in-stent) and associated extra-anatomic bypasses on quality of life particularly in younger patients are significant.

As cardiac surgeons we must ensure the appropriate use of this technology by both offering safe open repair of thoracic aortic pathology whilst facilitating TEVAR in those who benefit most.

Patients with complex thoracic aortic disease should be managed at a specialist centre offering multidisciplinary team working with input from cardiac and vascular surgeons and radiologists. Patients should be discussed at an aortic MDT meeting to ensure that all possible treatment options are considered and each patient receives optimal therapy based on current best evidence.

They should be included in lifelong follow-up at specialist centres, whether part of a clinical trial or a national registry.

The increasing complexity of these patients and the use of TEVAR will inevitably impact on training in aortic surgery. Trainees with an interest in aortic surgery should expect to spend time either as part of their rotation or as a fellowship in centres offering both open and endovascular intervention. The speciality as a whole must make provisions for such training both here and abroad in order that new consultants have the experience necessary to manage complex aortic conditions.

As a Society we must ensure that we set standards for management of complex aortic conditions and maintain appropriate skills to offer open surgery to those who require it, establish collaboration with vascular colleagues, whilst expanding our experience in the use of endovascular technology.

The increasing complexity of these patients and the use of TEVAR will inevitably impact on training in aortic surgery.

European Working Time Directive
Impact of full implementation

Balakrishnan Mahesh, Linda Sharples, Massimiliano Codispoti

Introduction: Impact on operative training in adult cardiac surgery

Surgical specialties have traditionally relied on the Halstedian apprenticeship-based system to transfer knowledge and technical skills, which in the past resulted in working hours exceeding 100/week. In 1993, the European Working Time Directive (EWTD) was introduced as a part of Health and Safety legislation in many European Countries[1], and in May 2000 it was modified to include trainee doctors within its remit[2]. The EWTD was implemented in full (average work <48hours/week) in the healthcare system in August 2009, and included in the definition of "working hours" any time spent by the trainee in hospital[2]. This led to a significant reduction in the number of hours available for training as well as the quality of patient care [3-8]. Since health care needs to be delivered around the clock, hospitals were forced to employ more trainees to staff EWTD-compliant rotas, with further dilution of operative opportunities. Evidence gathered in the United Kingdom (UK) shortly after the implementation of the EWTD suggested that high-volume cardiac units were better suited to meet trainees' requirements and expectations[9]. In fact, an earlier study from our Institution reported an increase in the proportion of training cases following the initial implementation of the EWTD[10].

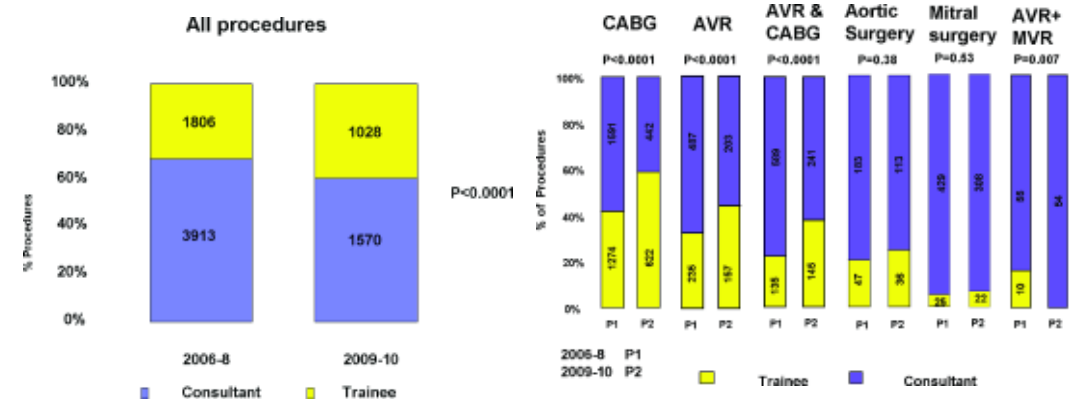
We conducted a study to examine the impact of the final reduction of trainees' working hours imposed by the full implementation of the EWTD on training in a single high-volume adult cardiac surgical practice.

Survey Results

Between January 2006 and August 2010, 6688 consecutive adult cardiac surgical procedures were considered for analysis. The outcome of interest was the binary marker of whether or not each case was a "training case", defined as a procedure performed by the trainee as the first surgeon. In 2009, 2 additional trainees were recruited to comply with reduction in working hours to 48/week imposed by the final phase of the EWTD, increasing trainee numbers from 7 to 9. Therefore, the study period was divided into 2 parts: pre-EWTD (Phase-1, January 2006 to December 2008: 4504 procedures) and post-EWTD (Phase-2, January 2009 to August 2010, 2184 procedures). This was the independent variable of primary interest in the study. Risk stratification of cases was undertaken using logistic EuroSCORE-I[11]. Data were prospectively collected in our hospital database and retrospectively analysed using Stata-11 (StataCorp, College Station, TX, USA). Continuous variables were expressed as means with standard deviation (SD) or as medians with interquartile range (IQR) and compared using Student's t-test or Mann—Whitney test, respectively, depending on the distribution of the data. Categorical variables were expressed as the number and percentage of the group and groups were compared using the c2 test. In order to assess the association between training and each of the independent variables, these were entered separately into a logistic regression model. Factors with p<0.1 were entered into a multivariable logistic regression as fixed effects, and results are presented as odds ratios (OR) with 95% confidence intervals.

Patients operated during the two periods were well matched in respect to all parameters, except the mean logistic Euroscore-I, which was significantly higher during Phase-2. During Phase-2, there was a significant increase (p<0.0001) in the proportion of elective operations performed outside routine working hours [Monday to Friday >5pm, weekend all day]. The proportion of aortic valve replacements and coronary artery bypass grafts (AVR+CABG), double valve replacements (aortic and mitral), mitral valve repairs/replacements, and aortic surgery had increased, while the proportion of isolated CABG had declined during phase-2 (table 2). This is reflected in the higher mean logistic Euroscore of the group of patients operated on during phase-2 (p<0.0001). Despite this, the proportion of training cases rose from 34.6% (1558/4504) during Phase-1 to 43.6% (953/2184) during Phase-2 (p<0.0001). A trainee had a 27% greater chance of performing a procedure after the full implementation of the EWTD. This is in sharp contrast to findings from other studies across a number of specialties including general surgery[6], orthopaedics[5] and paediatric anaesthesiology[3], all of which reported a marked reduction in the quantity and quality of training in technical and procedural skills. The paradoxical finding of our study can be at least partially explained by a strengthened resolve from the trainers to meet the requirements of the trainees and to adapt to the constraints imposed by the EWTD.

In the multivariate logistic regression model, significant positive predictors of training included consultant in charge, senior trainee, and procedures performed during phase-2, and significant negative predictors of training included surgery-type, logistic EuroSCORE-I, and out-of-hours' cases. EWTD emerged as an independent predictor of training, with implementation of EWTD having a favourable impact [OR 1.27 (1.1-1.47), p=0.001].



European Working Time Directive
Impact of full implementation

With regards to the proportion of cases performed by trainees at different stages of their progression, during Phase-1 senior trainees (years 5 and 6) performed 803 (17.8%) cases and other trainees (years 1-4) performed 755 (16.8%) cases; however, during phase-2, senior trainees performed 763 (34.9%) cases and other trainees performed 190 (8.7%) cases. Thus, with implementation of EWTD, senior trainees performed significantly greater proportion of cases ($p<0.0001$). A senior trainee had a 7.6 (6.54-8.83) times greater chance of performing a procedure than other trainees ($p<0.0001$). The drastic reduction in working hours imposed by the EWTD has hastened a certain paradigm-shift from the traditional apprenticeship-based methods towards a more structured approach to training, focused on the acquisition of key competences in the initial 4 years of training, for example, in coronary artery surgery, the acquisition of competence in sternotomy, conduit harvesting, cardiopulmonary-bypass establishment, proximal anastomosis and finally distal anastomosis, prior to performing an entire case. This could partially explain the apparent shift in performance of full cases by trainees towards the final 2 years of a 6-year training programme, thereby not exposing either the patient or the trainee to increased risk. There is a growing body of evidence suggesting that this more recently introduced type of modular approach to teaching and training is effective in transferring the knowledge and skills set necessary for independent practice[12-14].

Training procedures were more likely to be isolated CABG and were less likely to be combined, redo- or complex cardiac procedures. Out-of-hours cases were less likely to be performed by trainees [OR 0.53(0.37-0.76) p=0.001], reflecting the impact of service and cost-related pressures. Cases with higher Logistic EuroSCORE-I reflecting several co-morbidities were less likely to be performed by trainees [OR 0.96 (0.95-0.97), $p<0.0001$], possibly reflecting the attention to patient safety. We feel that these observations strengthen the case for taking many teachable components of operative training out of the pressured, at times stressful environment of the operating theatre and into simulation centres. In fact, there is growing evidence that such innovative educational methods increase trainees' and trainers' satisfaction as well as trainees' performance[15,16].

Conclusion

In conclusion, in our high-volume adult cardiac surgical practice, adequate training standards have been maintained, and even improved upon, despite the drastic reduction in working hours imposed by the EWTD and worsening risk profile of the patient population. Despite the challenges posed by the EWTD, such a commendable result is achievable only due to positive and renewed adaptive efforts from the trainers.

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Balakrishnan Mahesh, Massimiliano Codispoti (Papworth Hospital) & Linda Sharples (MRC Biostatistics Unit, Cambridge)

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McKenna's VATS Masterclass comes to Cardiff

M. Jenkins, P Vaughan, M. Kornaszewska
Department of Cardiothoracic Surgery, University Hospital of Wales, Cardiff

Video-Assisted Thoracic Surgery (VATS) has come a long way since Hans Christian Jacobaeus used a rigid cystoscope, with a candle as a light source over one hundred years ago to lyse intra-pleural adhesions.

In the latter half of the 20th Century, with the development of video endoscopy, endoscopic instruments and stapling devices, Thoracic surgeons applied the VATS approach to a wider range of procedures, as it had the advantage of reducing post-operative morbidity, in particular pain, but also reducing in-hospital stay and potentially accelerating recovery[1-3].

VATS lobectomy was first reported in 1992[4]. It can be a technically demanding procedure with a challenging learning curve. As a result the implementation of this technique has been slower than expected, with only 14% of lobectomies being performed by VATS in the UK in 2010.[5].

At the time of the first VATS lobectomies, all techniques were self-taught by experienced surgeons who had performed many open lobectomies. As the next generation of surgeons evolved, they learned techniques under supervision and therefore the development of training programmes and courses in VATS techniques came to fruition.

In June 2012, we were privileged to benefit from Dr McKenna's extensive experience when he led the Cardiff VATS Lobectomy Masterclass. This was held at WIMAT (The Welsh Institute for Minimal Access Therapy), in conjunction with Cardiff University School of Biosciences and University Hospital of Wales.

Amongst the pioneers of VATS lobectomy, Dr Robert McKenna Jr. is considered to be the Godfather of this procedure. Dr McKenna is the Clinical Chief of General Thoracic Surgery at Cedars Sinai Medical Center and Clinical Professor of Thoracic Surgery at University of California, Los Angeles. He promotes a minimally invasive technique and shares his wealth of expertise through training, meetings and courses. He has written more than 200 peer-reviewed journal articles, abstracts and book chapters on his specialty and is considered to be a world-leading authority on the subject. Dr McKenna has successfully performed more than 3000 VATS lobectomies, pneumonectomies, sleeve resections and segmentectomies.

Dr McKenna uses a systematic approach to VATS lobectomy, making it safe, feasible and resulting in a better patient experience with improved quality of life, compared to an open technique. Recent prospective database analysis has also shown the benefits of VATS lobectomies to include shorter length of stay, equivalent oncological outcomes, fewer adverse events and a reduced cost to the hospital[6,7].

The 2-day Cardiff course included lectures on VATS lobectomy techniques (including VATS port placement, different lobes and lymph node dissection) and a whole day of cadaveric workshop, set up with full VATS equipment to allow delegates to practise the methods described by Dr McKenna. The second day was a series of three live cases, performed by Dr McKenna assisted by the course conveners and faculty members.

The course itself allowed a hands-on approach to learning the anterior technique used by Dr McKenna for VATS lobectomy. Delegates had lectures with video footage of previous cases performed by Dr McKenna, and then took this knowledge away to the 'simulated' cadaveric VATS theatre and were able to perform VATS lobectomies under his expert supervision. The following day with live cases, Dr McKenna demonstrated his extensive expertise in VATS lobectomy, where he negotiated technically difficult cases. It was a very useful exercise in how to overcome challenging anatomy and how to cope with intra-operative difficulties without the need to convert to an open technique.

Overall, delegates were highly impressed with the course and took away techniques to practise and hone to improve their own VATS practice. The course will be repeated in this year, with the promise of further succeeding in expanding VATS lobectomy practice in the UK.

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Modern Management of Emphysema: A Masterclass in Endobronchial Valves in Cardiff

P. Vaughan, M. Jenkins, O Nawaytou, M. Kornaszewska
Department of Thoracic Surgery, University Hospital of Wales, Cardiff

The NETT trial[1] was a defining point in resectional Lung Volume Reduction Surgery (LVRS), identifying who would benefit most from the procedure. At the time, this was the biggest innovation for decades in the treatment of emphysema, and allowed surgeons to effectively deal with a selected group of previously untreatable patients with the severest form of the disease.

Since the NETT publication ten years ago however, there has been a revolution quietly gathering momentum - a less invasive alternative with reduced morbidity and mortality[2].

One-way valves placed bronchoscopically into lobar or segmental bronchi. Initial results were disappointing when compared to LVRS, in similar patient groups, and endobronchial valves (EBV's) were subsequently implanted almost exclusively for air leaks. More recently however, as result of a sub-group analysis from the VENT and EUROVENT trials[3,4], the development of CHARTIS to quantify collateral ventilation and emerging data[5] suggests patient selection has been refined considerably.

As a result more and more surgeons (as well as chest physicians) are realising the potential of these devices to give a lobar volume reduction effect.

On 13th November 2012, we were privileged to benefit from the UK's first "Modern Management of Emphysema" symposium. This was held at WIMAT (The Welsh Institute for Minimal Access Therapy), and featured a live link to the operating theatres at University Hospital of Wales. Delegates from all over the UK and Europe attended, and were rewarded with a faculty of surgeons and chest physicians from Cardiff, Leeds, Cambridge and Halle (Germany). This informative and educational day consisted of seminars during the morning with ample opportunities to discuss all aspects of endobronchial valves from patient selection, multi-disciplinary team (MDT) discussions, post-procedural follow-up, to a patients' experience of the procedure and how it changed his life.

There then followed a live link to the operating theatre, where delegates were privileged to watch and interact with the surgeons during the implantation of EBV's in two patients.

Overall, delegates were highly impressed with the course with everyone rating it as "excellent" or "very good". They particularly liked the "service requirements for EBV" and the "technical considerations" seminar and took away many tips and techniques. The course will be repeated in the near future, with the promise of further succeeding in expanding EBV implantation in the UK.

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The MME Faculty

Spacious facilities at WIMAT allowed lots of interaction between faculty and delegates

Specialist Surgical Group

at the Royal College of Surgeons of Edinburgh

Mr Pala B Rajesh
Royal College of Surgeons of Edinburgh

7 June 2013

Dear Members

I would like to take this opportunity to thank the Fellows of the Royal College of Surgeons of Edinburgh in our Society who cast their vote in my favour. I have been elected to the Council (November 2012-2017) for a tenure of 5 years.

The College wishes to engage with its members and fellows and seeks to be an advocate for the surgical profession. At the present time it is important for us to be involved and actively voice our opinions.

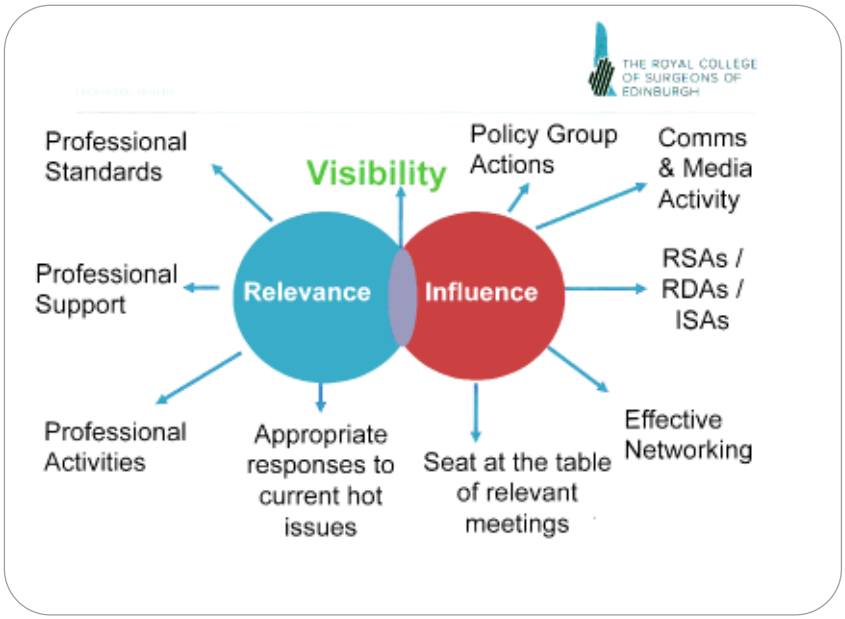
The College through its Surgical Specialist Groups requests information about each speciality. These groups act as an interface between the Regional Specialist Advisors and the Council of the College.

The relevance of the College:

- Professional standards
- Trusts/Employers
- Professional assistance – CDP, revalidation
- Communications and media activity

Please contact me if you have any queries, ideas or wish to engage with the College either to the Specialist Surgical Group or individually.

Mr Pala B Rajesh FRCS Ed (C-Th) FRCS(Eng)FETCS
Consultant Thoracic Surgeon
Chairman, Specialist Surgical Group (Cardiothoracic Surgery)
Member, Council, Royal College of Surgeons of Edinburgh



The Thoracic Surgical Register

Richard D. Page

The Thoracic Surgical Register for the year of activity 2010-2011 was published in April of this year.

Once again there has been an increase in all areas of activity, although the dramatic rise in the number of primary lung cancer resections which was seen between the years 2004 – 2010 has plateaued, with a total of 5423 resections being carried out for the year to March 2011. This is a 3% increase as compared with the previous year (5265 resections). Twelve per cent (12%) of lobectomies for primary cancer were carried out using VATS as opposed to open surgery, a slight fall from the figure of 13.8% for the previous year. This value varies significantly throughout the country from zero in units where no VATS lobectomies were recorded for primary cancer (13 out of 38 Units) to 59.3% in Oxford where the highest proportion of lobectomies were carried out using VATS techniques. It will be interesting to see how this activity develops over the next few years. Hopefully I will have the data for the full Register for the year 2011-12 in the near future; at the time of writing I am still awaiting returns from nine units.

The SCTS Thoracic Surgery Database has become available for all members since 1st April this year. It has been sponsored for the Society by the GMC with the intention of improving thoracic surgical data collection and helping thoracic surgeons provide information on their outcomes for the purposes of revalidation. Many thoracic surgeons work in hospitals where there are still no in-house methods for prospective data collection and the SCTS Database provides a system where this is now possible.

The Database takes the form of an on-line web-based product. It has been developed with Dendrite Clinical Systems Ltd and uses the same dataset agreed several years ago by the Society. Patient data is anonymised at entry and stored by Dendrite in a secure facility. Regular reports will made available for both individual surgeons and for the Units they work in. The data will be owned by the SCTS on behalf of its members but will be used for regular Society reports in the manner of previous Blue Books.

For those Units who do have existing in-house data collection facilities the new Database is designed to accept regular up-loads. I think it is very important that this is carried out on a regular basis ideally every three months, and that the process starts as soon as possible rather than leaving it to the end of the year. I know from our experience with the Liverpool database that some work was needed to iron out differences in the fields between the two systems. This isn't a problem to solve but it has been necessary to work closely with Dendrite for the last couple of months to make the up-loads accurate and easy to achieve. I would encourage all units to get in touch with Dendrite at the earliest opportunity to ensure that any upload issues are resolved sooner rather than later.

At the time of writing Dendrite has informed me that since 1st April when the Database became available, surgeons from 3 units (London-St George's, Norfolk/Norwich and the Freeman-Newcastle) have entered data on a total of 305 procedures and so far there have been no problems or concerns. A further 16 units have registered for either direct data entry or for the use of the upload facility.

SCTS members will be aware of the recent agreement between the Royal College of Surgeons and the Department of Health that individual surgeons' outcomes from all specialities will published, as has happened for many years within cardiac surgery. Although these outcomes will be published within the current year, for thoracic surgery publication has been deferred until 2016. This deferment has been agreed largely because of the Society's track record of data collection and publication of patient outcomes, and the recent availability of the Thoracic Surgical Database. It is therefore our responsibility to see that the Database develops and builds on the Society's world class reputation for the collection and publication of surgical activity and outcomes.

As always please do not hesitate to get in touch with me directly if you have any questions. For specific enquiries regarding the database please contact Peter Walton and his colleagues at Dendrite Clinical Systems (peter.walton@e-dendrite.com)

Richard D. Page

Richard.page@lhch.nhs.uk

Many thoracic surgeons work in hospitals where there are still no in-house methods for prospective data collection and the SCTS Database provides a system where this is now possible.

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  or email Professor Sarah Jane George: socscardiology-msc@bristol.ac.uk

Starting: 9th September 2013

Congratulations

David Barron and David Jenkins were elected to the Executive.

Wish you a happy retirement

Ahmed Azzu has retired from the University Hospital of Wales, Cardiff. He worked as a Cardiac Surgeon at Cardiff from 1999 to 2013. Ex-Cardiff Cardiac trainees will always be grateful to him for his immense generosity with surgical training.

In Memory

Leon Abrams passed away after a long illness. He was 89. Leon, who was a cardiothoracic surgeon at the Queen Elizabeth and Childrens' Hospitals in Birmingham and was the second to perform surgery on bypass in this country and had made many notable contributions to the speciality.

New Appointments

Name	Hospital	Specialty	Starting Date
Mr Adam Szafranec	Nottingham City Hospital	Adult Cardiac	January 2013
Mr George Krasopoulos	Oxford Heart Centre	Cardiac	March 2013
Mr Steven Hunter	Northern General Hospital, Sheffield	Cardiac	April 2013
Ms Laura Socci	Northern General Hospital, Sheffield	Thoracic	April 2013
Miss Rashmi Yadav	Royal Brompton Hospital	Cardiothoracic	April 2013
Mr Vassilios Avolonitis	St Thomas' Hospital	Adult Cardiac	May 2013
Mr Martin Jarvis	Castle Hill Hospital	Adult Cardiac	May 2013
Mr Theo Velissaris	University Hospital Southampton	Cardiac	June 2013

Other Appointments

Mr Arvind Singh	Nottingham City Hospital	Locum Cardiac Consultant	January 2013
Mr Manoj Purohit	Blackpool Victoria Hospital	Locum Cardiothoracic Consultant	June 2013

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: 5 - 6 July 2013
Meeting: **Advanced Aortic and Mitral Valve Reconstructive Surgery**
Town: Windsor, United Kingdom
Venue: EACTS House
Contact: Louise McLeod
Madeira Walk, Windsor, Berkshire, SL4 1EU
Phone: +44 1753 832166
Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk
Web: www.eacts.org/academy/2013-programme.aspx

Date: 16 - 20 September 2013
Meeting: **Advanced Module: Valve Surgery, Including Trancatheter Heart Valves**
Town: Windsor, United Kingdom
Venue: EACTS House
Contact: Louise McLeod
Madeira Walk, Windsor, Berkshire, SL4 1EU
Phone: +44 1753 832166
Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 19 - 22 September 2013
Meeting: **Birmingham Review Course in Cardiothoracic Surgery**
Town: Windsor, United Kingdom
Venue: Education Centre, Birmingham Heartlands Hospital B9 5SS
Contact: L.R. Associates – Ms. L. Richardson
58, Kiln Close, Calvert Green,
Buckingham
MK18 2FD
Phone: 01296 733 823
Email: lorrainerichardson1@btinternet.com
Web: www.birminghamreviewcourse.co.uk

Date: 14 - 15 October 2013
Meeting: **ECMO**
Town: Windsor, United Kingdom
Venue: EACTS House
Contact: Louise McLeod
Madeira Walk, Windsor, Berkshire, SL4 1EU
Phone: +44 1753 832166
Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 21 - 25 October 2013
Meeting: **Advanced Module: Congenital Surgery**
Town: Windsor, United Kingdom
Venue: EACTS House
Contact: Louise McLeod
Madeira Walk, Windsor, Berkshire, SL4 1EU
Phone: +44 1753 832166
Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 4 - 8 November 2013
Town: Windsor, United Kingdom
Meeting: **Advanced Module: Heart Failure: State of the Art and Future Perspectives**
Venue: EACTS House
Contact: Louise McLeod
Madeira Walk, Windsor, Berkshire, SL4 1EU
Phone: +44 1753 832166
Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

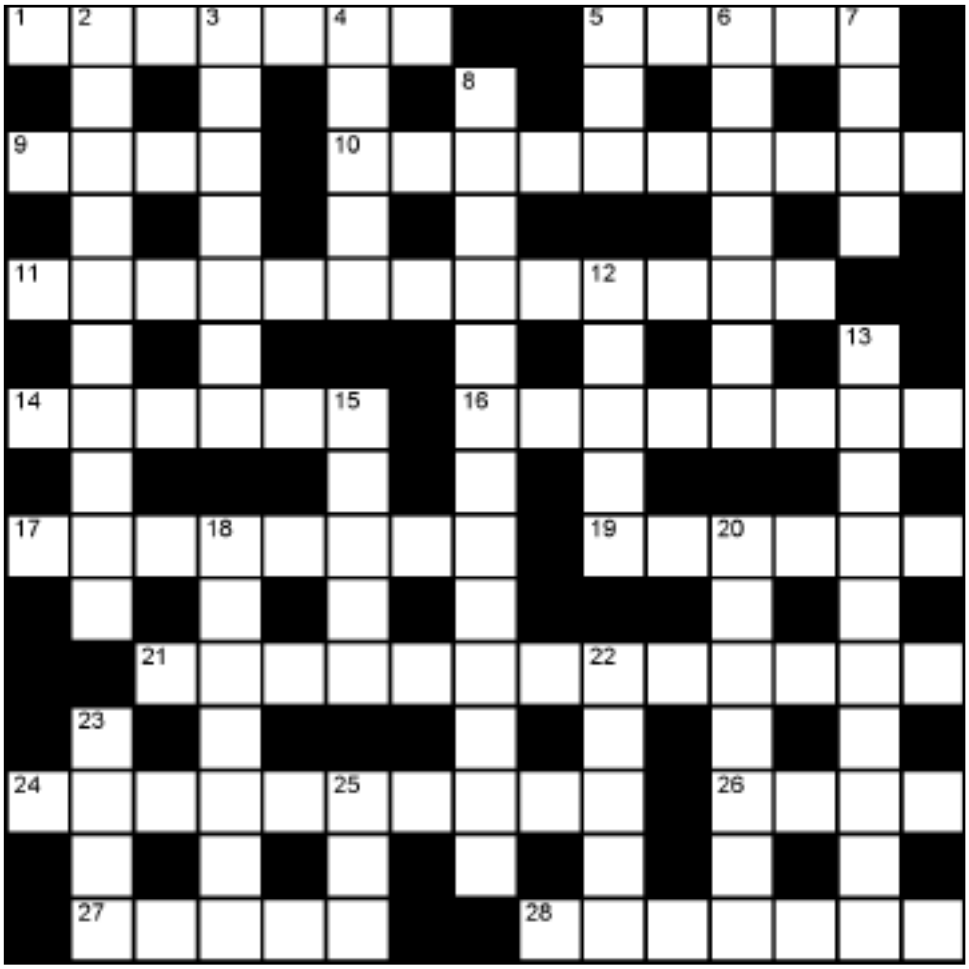
Date: 12 November 2013
Meeting: **Leadership and Management Development for Cardiovascular and Thoracic Surgeons: Part I with Part II to follow in 2014**
Town: Windsor, United Kingdom
Venue: EACTS House
Contact: Louise McLeod
Madeira Walk, Windsor, Berkshire, SL4 1EU
Phone: +44 1753 832166
Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 21 - 22 November 2013
Meeting: **Evidence Based Surgery**
Town: Windsor, United Kingdom
Venue: EACTS House
Contact: Louise McLeod
Madeira Walk, Windsor, Berkshire, SL4 1EU
Phone: +44 1753 832166
Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

Date: 3 - 6 December 2013
Meeting: **Thoracic Surgery Part II**
Town: Windsor, United Kingdom
Venue: EACTS House
Contact: Louise McLeod
Madeira Walk, Windsor, Berkshire, SL4 1EU
Phone: +44 1753 832166
Email: louise.mcleod@eacts.co.uk or info@eacts.co.uk

the crossword

by Sam Nashef



Send your solution by 31 December 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

Dear readers of the Bulletin,

Mr Brackenbury has won the champagne on so many occasions that the Editor is concerned about his hepatic function. In order to protect the health and safety of an important section of our readership (ie Ted), we recommend that other readers give him some serious competition.

Across

1/5A/2/14 Provided notes on zero nourishment in the plan, obey order to open 6, 15 (2,5,2,3,4,2,4,4,2)
9/28 The lady - too much depth to sort out (4,7)
10 Owner heard to support author (10)
11 Pat's to flash if playing doctors and nurses (8,5)
14 See 1
16 City rate set out by Lolitas (8)
17 Means to declare how old people are (8)
19 You old chaps neighbouring one Arab (6)
21 Most advanced country, frequently with card (5,2,3,3)
24 Prompts hugging deserter to encourage one with redeeming features (7,3)
26 Philosopher is not able to report (4)
27 Perverted black stuff in jelly (5)
28 See 9

Down

2 See 1 Across
3 Regularly ruin cheap pop by being miserable (7)
4 Bulletin putatively includes contribution (5)
5/25 Just depend on university qualification (6)
6/15 Romantic comedy on the 5th of January? (7,5)
7 Love is painful when rejected (4)
8 Rock 'n' roll song set, one by them? (7,6)
12 Corporation comes up with acronym, mutually exclusive of either side (5)
13 Stir at 9, perhaps, or 8 (10)
15 See 6
18 Get new skills in check, putting up painting (7)
20 Creature sounds little more than a pet... (7)
22 ... big one of which is somewhat anti-German (5)
23 Fold food (4)
25 See 5

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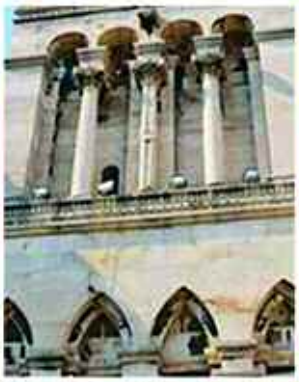




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World Society of Cardio-Thoracic Surgeons

12 - 15 September 2013, Le Méridien Lav, Split, Croatia

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