Issue 17
January 2025

the bulletin

Society for Cardiothoracic Surgery
in Great Britain and Ireland

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the bulletin
Society for Cardiothoracic Surgery in Great Britain and Ireland

In this issue ...

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From the Editor

Dionisios Stavroulias, Publishing Secretary, SCTS

A new year's curtain opens always with reinvigorated hopes and recurrent fears. A quarter of century is already behind us; hopefully it is not "too late to awaken" as Slavoj Zizek argues in his last book, although the ongoing wars around us give him some credit.

I always feel the true year begins every September and in January we only challenge ourselves against the ongoing plans of our lives. Are we doing better? Are we moving forward as a cardiothoracic society? Yes, I think so. At least this is my optimistic perception reading this edition's articles.

In the president's report by Narain Moorjani, there is a detailed overview of the exciting changes taking place within our specialty at a pace that even the Bulletin just about manages to keep up with. This was the last report by Narain, as president of the SCTS, and I would like to personally thank him for his hard work, his dedication, his continuous support of our Bulletin, and above all his ethos.

Embrace the change with the unrelenting innovation that permeates our specialty invites us, our Honorary Secretary Rana Sayeed, with his latest report which reminds us of the six CQC principles on the subject. Be aware though that the latter can have both beneficial and some undesired consequences.

Well, if you wish to improve something, you need to be able to measure it first, and hence Doug West argues why thoracic surgeons should engage with NCIP dashboards in his well-written article. This is going to be "a tool for team and personal reflection", as he explains, without a public release or national report. It will be helpful for quality improvement activities too. His article is well combined with the audit sub-committee report by Uday Trivedi, who highlights again the importance for all cardiac units in participating in the Quality Assurance Process (QAP).

Break the barriers, real or perceived, by the medical students when they attempt to enroll in a career in cardiothoracic surgery. I agree with the message that arises from the survey led from the INSINC committee; especially the real financial obstacle many students face. I am just cautious we may end up defining "barriers" as the skills that are admittedly required to become a cardiothoracic surgeon, nicely listed in the start of their article.

Phenomenal ongoing work from Debbie Harrington and Elizabeth Belcher on the Education front. The fighting spirit to offer so many high quality opportunities for training to NTNs and TADs is unique on their watch.

> **"Are we doing better? Are we moving forward as a cardiothoracic society? Yes, I think so. At least this is my optimistic perception reading this edition's articles."**

Karen Redmond's report on thoracic surgery presents a plethora of exciting news; pectus patients affected in their daily activities can expect to be offered surgery on the NHS thanks to both our national MDT and the RESTORE trial which has successfully enrolled its first patients. The thoracic trauma working group, the data working group, and the NCIP portal are all positive expressions of our thoracic subcommittees' hard work.

Manoj Kuduvalli's report on adult cardiac surgery piqued my interest with regards to the pathway that is under construction for the management of chronic aortic dissection. The engagement with NICE to establish guidelines on the three cardiac conditions he mentions (stable angina, TAVI for aortic incompetence, and VA ECMO) is very positive.

Working in a major trauma centre myself, I enjoyed reading the findings of the Trauma Survey led by Priyad Ariyaratnam and Rory Beattie. It is significant that 57% of the respondents are not satisfied with their chest trauma protocols or that conservative chest injuries are managed by thoracic surgeons in 77% of the hospitals that participated in this survey. I hope the SCTS Chest Trauma Working Group will succeed in producing national guidelines as requested by our colleagues.

What a fascinating piece of writing by David Clarke, a gem of pure history of our cardiothoracic specialty. Reading about the challenges that those surgeons faced back in time, you spontaneously wonder whether we sometimes complain too easily or too often about our working conditions. I identified myself with his closing quotation which I often mention too.

Concluding this editorial with a personal view; I am all for innovation, and when better should one reflect on such matters other than when the new year starts? If I may, however, let's conserve undisturbed some, even if very few, core principles of our medical ethics: our rapport, our relationship with our patients, must be protected by technological temptations that act as proxies. No AI, or any type of robot should replace our physical presence by the bed of our patients. The benefits from this human-towards-human approach are well documented. Our outcomes confirm this aspect too. They just heal better, faster, and happier.

"The future of any society depends on the solid residue of conservative sentiment, which forms the ballast to every innovation, and the equilibrating process that makes innovation possible." Roger Scruton

Happy New Year all and enjoy your reading!

Please send any comments to my email: **dionisios.stavroulias@ouh.nhs.uk** ■

From the President

Narain Moorjani, SCTS President, Consultant Cardiac Surgeon, Royal Papworth Hospital, Cambridge

As we enter 2025, it is exciting to see the progress that has been made over the past year in cardiothoracic surgery, despite the challenging environment around us. At the most recent SCTS BORS meeting, it was a real pleasure to hear about the different initiatives being introduced in the cardiothoracic surgical units around the country to improve the quality of care that is being delivered. This was epitomised by Nisha Bhudia and Rosalie Magboo for their Prevention of Atrial Fibrillation after Cardiac Surgery project, as inaugural winners of the SCTS Quality Improvement and Patient Safety Awards, and the INSINC Medical Student Committee for their Widening Participation and Outreach programme, as winners of the inaugural SCTS EDI Awards.

Over the past six months, the SCTS has also made great progress in developing its research portfolio. Following on from the great success of the SCTS Research-led Priority Setting Partnerships in Adult Cardiac Surgery and Congenital Cardiac Surgery, the Society is proud to announce that it has secured funding for a Priority Setting Partnership in Thoracic Surgery through the James Lind Alliance. This really exciting initiative will define the priorities for the thoracic research community for the next 5-10 years and enable the funding bodies to support the crucial projects that have the potential to directly influence the clinical care we deliver. The SCTS Research sub-committee is also continuing to support the development of and recruitment to a number of large multi-centre prospective randomised controlled trials, working in collaboration with other professional cardiothoracic surgical societies in Europe and North America, to help define surgical practice for the future and ensure that we can clearly demonstrate the benefits of cardiothoracic surgical intervention. As before, we would encourage all members of the cardiothoracic surgical community to contribute to these trials to ensure that the specialty evolves.

The society has also made great strides developing its programme of outcome monitoring for cardiothoracic surgery. The SCTS Adult Cardiac Surgery Database allows units to review their own data in terms of monitoring both mortality and morbidity outcomes but also benchmarking their results to the national averages at a granular level for the different cardiac surgical operations, as well as the overall unit outcomes. It will also provide an exciting opportunity for the Society to develop nationally driven audit projects to allow us to determine current national cardiac surgical practice and additionally to identify best practice and improve the care that we offer to patients undergoing surgery. In thoracic surgery, the SCTS are in the process of developing a thoracic surgery dataset that will provide meaningful outcome measures to augment the current information available from the Thoracic Surgery Returns. In parallel, the National Consultant Information Programme (NCIP) has been launched by NHS England to give thoracic surgery consultants an opportunity to review their clinical practice, with the opportunity to benchmark their activity and outcomes to both local and national results.

"It is exciting to see the progress that has been made over the past year in cardiothoracic surgery, despite the challenging environment around us. At the most recent SCTS BORS meeting, it was a real pleasure to hear about the different initiatives being introduced in the cardiothoracic surgical units around the country to improve the quality of care that is being delivered."

As ever, the SCTS Education team have been working hard to deliver their phenomenal programme of training courses and international travelling fellowships for all practitioners caring for patients undergoing cardiothoracic surgery. The team are to be congratulated for their flexibility and agility, at a time when obtaining resources to deliver these educational initiatives is becoming increasingly challenging.

As part of our Equality, Diversity & Inclusion (EDI) strategy, we have continued to expand the Widening Participation and Outreach Programme to reduce the barriers that potential entrants may face when considering a career in cardiothoracic surgery. As well as the recently launched medical student mentorship programme and the

Some of the SCTS Executive members at the recent Executive Committee Meeting on 18th October 2024 at the Royal College of Surgeons, London

ever-expanding portfolio of enhanced work experience placements, the SCTS Student Engagement event was held in Cambridge last November. It was a real pleasure to hear so many inspirational talks to motivate the enthusiastic medical students who will be the future of our specialty. The SCTS EDI Sub-committee have also produced a short video for medical schools, to promote the initiatives that it has introduced to develop a diverse workforce and an inclusive environment in the specialty, to encourage those from all backgrounds, irrespective of race, gender or socioeconomic background, into the specialty to ensure that cardiothoracic surgery remains a vibrant and exciting specialty for the future.

With a view to the future, and given the current environmental challenges we face as a society, the SCTS has its first Sustainability in Cardiothoracic Surgery Conference planned for January 2025, with keynote speeches from the leaders in the field and partners from industry, as we strive to become more sustainable and contribute to the changing world around us. The SCTS has also been working hard with the Royal College of Surgeons and other key stakeholders to write best practice guidance for surgical teams to develop the knowledge and skills needed to disseminate sustainable models of care in all our Units.

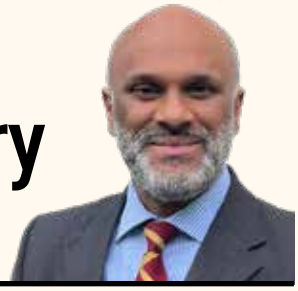
By the time this edition of the Bulletin is published, the 2025 SCTS Annual Meeting will only be a few weeks away. We look forward to welcoming you all to Edinburgh. The Meeting team have been developing what I am sure will be an amazing conference, with our special guest Sir Clive Woodward set to inspire us during the Presidential Plenary. We would encourage all those who haven't yet booked tickets to attend and bring members of your extended multi-disciplinary team with you. Last year over 1200 delegates attended and we are hoping to see even more of you this year.

In my last couple of months as President, I wanted to thank the membership of the Society for all their support during my time with the SCTS over the past 12 years. It has been a real privilege and honour to have been given the opportunity to serve all of you and to continue the great work of all my predecessors.

I wanted to express my immense gratitude to the SCTS Executive, sub-committee members, BORS representatives, educational course directors and faculty, and especially the membership for their incredible help on delivering the projects and initiatives that the SCTS have set up. I am also eternally thankful to the SCTS administration staff who work tirelessly behind the scenes to make the SCTS run so efficiently. In particular, I wanted to express my sincerest thanks to Emma Piotrowski, Sri Rathinam and Rana Sayeed, who have done so much to support my time in office.

I would also like to congratulate Enoch Akowuah on his recent election as the President Elect and would like to wish them, Aman Coonar and all SCTS all the best, as I am sure they will do a great job to strengthen cardiothoracic surgery for the future. ■

Innovation and the Past, Present, and Future of Cardiothoracic surgery



Rana Sayeed, Honorary Secretary, Consultant Cardiac Surgeon, John Radcliffe Hospital, Oxford

Like many surgeons of his generation, Professor John Leigh Collis (1911–2003), a former Honorary Secretary and President of the Society, is an example of how to adapt to a changing specialty. After the Second World War, he had a busy practice as a chest surgeon, establishing a network of sanatoria and travelling across the West Midlands to perform thoracoplasties for tuberculosis. The arrival of antibiotics – after the first published randomised clinical trial – reduced the need for surgery and changed thoracic surgical practice: cancer and cardiac surgery became the new horizons. He was a pioneering cardiac surgeon, undertaking a series of mitral valvotomies and describing a technique to repair ischaemic ventricular septal rupture. His BMJ obituary describes that 'the ingenious improvisation of an instrument from a sharpened dessert spoon and a piece of wire gauze enabled him to be one of the first to remove a tumour from within the cavity of the left atrium.' He eventually specialised in oesophageal surgery, and his registrars recall his use of fine stainless steel wire to suture oesophagogastric anastomoses and the consequent 'trial by wire' for his assistants.

Innovation means introducing new ideas, techniques, methods, or products, and all surgeons need to be innovative against the background of continual changes in healthcare – alternative treatments, new technologies, and organisational reforms. Collis was a great innovator, establishing new clinical networks and services for TB, taking on and developing novel techniques in the nascent specialty of cardiac surgery, describing his eponymous procedures in oesophageal surgery, and successfully charting a career through an evolving specialty.

Recent innovations have had both beneficial and detrimental effects on cardiothoracic surgery – surgeons, the wider cardiothoracic workforce, and our patients. The rise of PCI and trans-catheter heart valves has challenged cardiac surgery to establish the true benefit of different interventional options through rigorous clinical trials to identify the best treatment. Neoadjuvant immune-oncology therapy and Lung Health Checks will transform the current and future practice of thoracic surgery. The introduction of the Acute Aortic Dissection Pathway Toolkit and regional aortic dissection networks will improve outcomes for patients, although staffing and other challenges remain to be resolved; the Safe and Sustainable proposals for children's heart services failed to achieve meaningful service improvements. The widespread availability of video-conferencing has facilitated remote patient consultation, increased attendance at local and regional MDTSs, and (too many) clinical management meetings.

Further innovations – diagnostics, interventional technologies, digital and artificial intelligence – will transform cardiothoracic surgery and drive improvements in the delivery of care and clinical outcomes, but adopting innovative techniques and care models can be slow within an individual hospital and across the country. The CQC recently published six principles essential to improve innovation – both the invention of new techniques, services, and models of care and the adoption of these new inventions – based on literature reviews, CQC reports, and engagement with many healthcare organisations[1]:

- Develop and deploy innovations with the people that will use them
- Develop a culture where innovation can happen
- Support your people
- Adopt the best ideas and share your learning
- Focus on outcomes and impact
- Be flexible when managing change

These principles apply to local hospitals as much as national organisations. The fourth principle, adopting the best ideas and sharing learning, underlies the recently established SCTS Quality Improvement & Patient Safety and Equality, Diversity & Inclusion Awards at last year's Board of Representatives meeting and the upcoming Sustainability Awards. The guidance highlights that implementing and spreading innovation are often more critical to improving outcomes than developing an invention or technique. Innovative technologies and models of care may need to be adapted to local circumstances; a successful solution from one institution may not resolve another's differing challenges.

As part of its *Future of Surgery* programme, the RCS promotes innovation for surgeons at all careers stages through its Innovation Hub[2]. The Hub offers resources and practical support to surgeons to combine innovation with their surgical practice and training with the aim of creating and adopting world-class innovations in surgery.

All surgeons and other cardiothoracic practitioners need to be involved in some aspect of innovation to deliver future improvements in cardiothoracic surgical care and better outcomes, either as innovators developing new technologies and models of care or as part of multi-professional teams adapting and implementing innovations in their unit or region.

Good luck in your endeavours to shape the future of the specialty but remember that not all innovations succeed: I regret that I cannot ask for a Collis spoon for my next myxoma. ■

There have been several new senior appointments within the SCTS Executive and its sub-committees ...
Babu Naidu has been appointed RCS-SCTS Cardiothoracic Surgical Specialty Lead to succeed Gavin Murphy. The SSL links the Surgical Trials Centres and national clinical research networks to support the development of multicentre clinical trials within cardiothoracic surgery. Nizar Asadi has been elected SCTS Cardiothoracic Dean, replacing Neil Roberts, to represent the interests of trainees on the SCTS Executive, the SAC, and the Intercollegiate Specialty Examination Board. Finally, we are delighted to welcome Justin Nowell and Stephan Schueler as Consultant Trustees who will take office after the Annual Meeting in March 2025 to replace Manoj Purohit and Vipin Zamvar, whose three-year terms of office will end.

We look forward to working with our new officers to advance the work of the SCTS and thank Gavin, Neil, Manoj, and Vipin for their valuable contributions to the SCTS and the specialty. ■

[1] https://www.cqc.org.uk/publications/themed-work/enabling-innovation-adoption-health-social-care-developing-shared-view
[2] https://www.rcseng.ac.uk/standards-and-research/future-of-surgery/innovation-hub/

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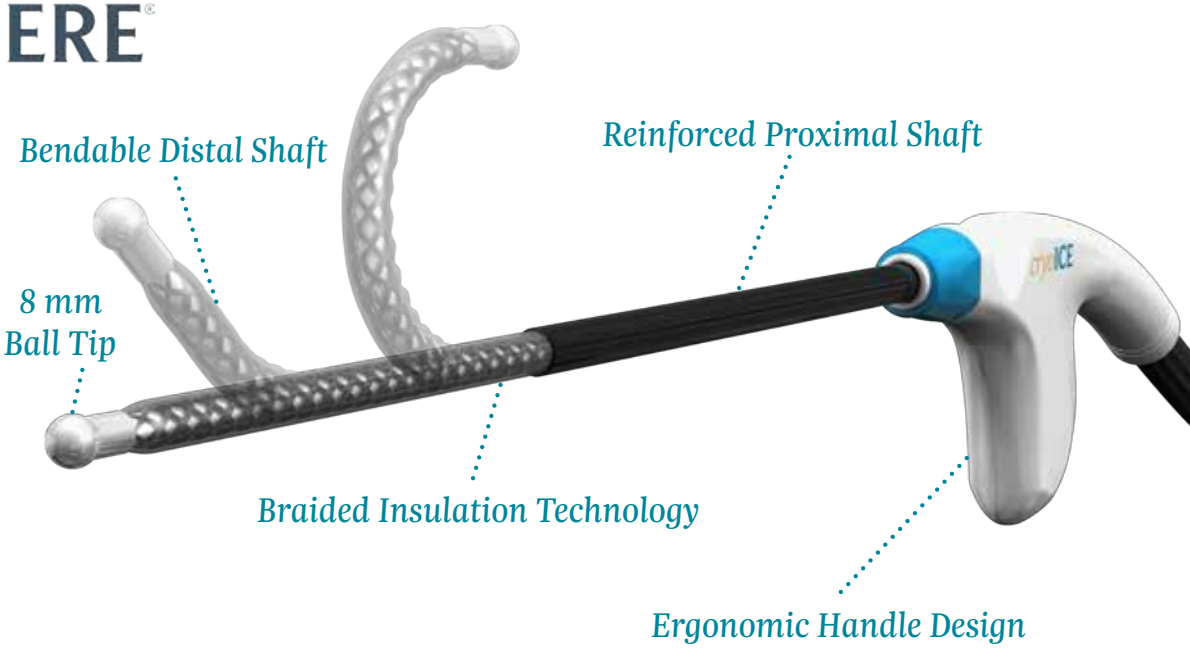

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SCTS Meetings Report

Making Cardiothoracic Surgery Great

Nisha Bhudia, SCTS NAHP Meeting Lead, Lead Pharmacist, Critical Care and Anaesthesia, Royal Brompton and Harefield Hospitals

Sunil Bhudia, SCTS Meeting Secretary, Consultant Cardiac Surgeon, Royal Brompton and Harefield Hospitals

We are at that point of the year when the preparation for our SCTS Annual Meeting 2025 is in full flow. Our meeting will be in Edinburgh from 16th to 18th March 2025. The team, Carol Tan, Nisha Bhudia, Rosalie Magboo, Gianluca Lucchese, Emma Piotrowski, Paulina Sapinska, and Sunil Bhudia attended site visits in September and January and will be putting together an exciting programme. We have explored some new ideas that will be introduced and persisting with our traditional model.

There are three exciting plenary sessions that will include Presidential Plenary, Equality, Diversity & Inclusion Plenary, and combined Research with Education Plenary highlighting how to make cardiothoracic surgery great.

The Presidential Plenary on Monday 17th March 2025 will feature our **President Narain Moorjani** and **Sir Clive Woodward**. Sir Clive has made remarkable contributions to rugby and sports management. As Head Coach he led England to their memorable 2003 Rugby World Cup victory in Australia. His career reflects the dedication to excellence in both sports and business. He will be talking to us about teamship and striving for excellence.

We are very excited to welcome **Prof Yolonda L Colson**. She became the 103rd President of the American Association for Thoracic Surgery (AATS) and notably the first female President of the Association. She is currently the Chief for the Division of Thoracic Surgery at Massachusetts General Hospital, the Hermes C. Grillo Professor in the Field of Thoracic Surgery, and Professor of Surgery at Harvard Medical School. She has a specific clinical interest in increasing and improving the identification and treatment of lung cancer in the operating room for lung cancer treatment, and in understanding the unique differences of lung cancer in women.

A great line-up of experts from around the world and United Kingdom will be addressing various sessions which include Prof Gebrine El Khoury, Pedro Catarino, Prof Nuria Novoa Valentín, Prof Luca Vricella, Prof Irene Lie, Dr Hatem Soliman, Prof Mark Radford, Mark Bowers, and Prof Lis Neubeck.

For the University Day on Sunday 16th March 2025, we have put together an excellent educational day. This includes our traditional lectures and opinions from world renowned experts in thoracic surgery, cardiac surgery, congenital surgery, transplant surgery, team working, civility and looking to the future. There are exciting sessions planned on research equity in cardiac surgery and translating research into practice.

We are introducing wetlab sessions that individuals can book into to learn procedures and tips and tricks from experts. In addition, we will facilitate walk-in wetlab and dry skills lab stations to share, learn and build on surgical skills through the day for all. New introduction will be wetlab and dedicated lectures in the congenital cardiac surgery stream. Experts will discuss Ross procedure with tips and tricks in the wetlab.

The wetlabs will be complemented with various simulators for cardiac and thoracic surgery that will give us flavour of how to practise and train in the future for complex procedures.

We have planned for exciting keynote speakers that will provide insight on topics to include building new skills for NAHP, implementation of new innovative tools in the NHS and exciting session on how civility saves lives in the NHS.

The welcome reception will start at 5pm on Sunday, for delegates and exhibitors to mark the opening of the exhibition for the Monday and Tuesday.

On Monday and Tuesday, together with the three plenary sessions, there will be abstracts driven sessions. We have had a record number of over 520 abstracts submitted this year. The quality of these abstracts is of very high standard. Through the year the Meeting's Team, in collaboration with the NAHP Team, have participated in teaching sessions on how to submit a high-quality abstract. We are very grateful to the membership for reviewing these high number of abstracts and scoring them.

The cardiothoracic trainees have an increasing contribution and will have a trainees' forum. They will get updates from the educationalist.

The SCTS INSINC Committee, the student group, will be welcoming medical students to give them a flavour of cardiothoracic surgery. Together with the entire cardiothoracic community we can inspire these medical students to a career in cardiothoracic surgery. The best abstract from the students will be awarded the Patrick G. Magee Student Prize.

There are various other prestigious prizes to be awarded. These include Ronald Edwards Medal (best scientific oral presentation), John Parker Medal (best clinical presentation), Bob Bonser Aortic Surgery Prize, Society Thoracic Medal (best thoracic presentation), BASO Prize (best oncology presentation), Best Operative Movie Prize, Best NAHP Cardiothoracic Forum Presentation, and Best Poster.

Importantly, we will be welcoming you all to Edinburgh to enjoy meeting and mingling with experts, colleagues and friends not only at the annual meeting but also during the pub quiz organised by the team and the Annual Gala dinner, which will be in the impressive setting of the National Museum of Scotland. We plan to offer our dinner guests an evening to remember with bag pipers, clan warriors and entertainment from the world's favourite ceilidh band 'Whisky Kiss'. Tickets can be bought at registration, which opened on the 1st December 2024. Early bird registration rates end on 31st January 2025.

This is a journey for all of us to make cardiothoracic surgery great. ■

SIR CLIVE WOODWARD

BIOGRAPHY

Sport

- England's 2003 Rugby World Cup Winning Head Coach
- Director of Sport Team GB: London 2012, Vancouver 2010, Beijing 2008
- Longest serving member of IOC Entourage Committee 2012 - present
- Director of Sport, Apex 2100 International Ski Academy

Business

- Rank Xerox, Graduate Trainee 1978 – 1988
- Sales Finance & Leasing, Owner / Founder 1988 – 1997
- Hive Learning, Owner / Founder 2012 – 2020

Sir Clive Woodward is known for his remarkable contributions to rugby and sports management. As Head Coach, he led England to their memorable 2003 Rugby World Cup victory in Australia. Clive, a former England International and British & Irish Lion player, as Head Coach guided the team from being sixth in the world to the top-ranked team, securing every major trophy along the way.

In 2006, Clive joined the British Olympic Association as Team GB's Director of Sport. He collaborated in close partnership with all stakeholders in British Sport, supporting national coaches and athletes at the Beijing and Vancouver Olympics, as well as delivering Team GB's most successful Olympic games of the modern era at London 2012.

Clive's career extends beyond sports and is one of the very few people who have worked at highest levels in sport and business. He started with Rank Xerox as a graduate trainee, eventually becoming Sales Director in Sydney. He then ventured into entrepreneurship, running his own IT leasing and finance company. Clive's innovative spirit led him to found Hive Learning, a digital learning platform that he led to global prominence before his departure in 2020.

Today, Clive continues to shape the future of sports as the Director of Sport at Apex 2100, an elite International Ski Academy in Tignes, in the French Alps. At this world-class high-performance academy, Clive inspires young, aspiring athletes, guiding them to achieve their dreams in Alpine skiing. Sir Clive Woodward's career reflects his dedication to excellence in both sports and business.

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Trainee Representative: Michelle Lee
Trust Appointed Doctors Leads: Anas Boulemden (Cardiac), Mohammad Hawari (Thoracic)
Student Leads: Jason Ali (Cardiac), Shilajit Ghosh (Thoracic)
Accreditation Lead: Shafi Mussa
Communication Lead: Vivek Srivastava
Website Development Lead: Christopher Horton

Research

Co-Chairs: Mahmoud Loubani, TBC
Executive Co-Chair: Sunil Bhudia
Adult Cardiac Surgery: Gianluca Lucchese
Thoracic Surgery: Babu Naidu
Congenital Cardiac Surgery: Attilio Lotto
NAHP Representatives: Rosalie Magboo, Zainab Khanbhai, Hemangi Chavan, Nisha Bhudia
Trainee Representative: TBC
Medical Student Leads: Niraj Kumar, Gokul Raj Krishna
Co-opted Members: Rana Sayeed (National Cardiac Surgery Trials Prog Steering Comm Rep.) (Cardiothoracic SSL), Babu Naidu, Luke Rogers (aSSL), Ricky Vaja (aSSL), Akshay Patel (aSSL), Jacie Law (aSSL), Ann Cheng (aSSL), Brianda Ripoll (aSSL), Moslem Abdelghafar (aSSL), Hind Elhassan (aSSL)

Professional Standards

Co-Chair: Sarah Murray
Executive Co-Chair: Indu Deglurkar
NAHP Lead: Amanda Walthew
Appointed Member: Attilio Lotto

Training

Trainee Rep (Senior): Bassem Gadallah
Trainee Rep (Junior): Walid Mohamed
Education Trainee Rep: Michelle Lee

Meetings

Meeting Secretary: Sunil Bhudia
Executive Co-Chair: Sri Rathinam
Deputy Secretary: Carol Tan
Associate Secretary: Gianluca Lucchese
NAHP Meeting Leads: Nisha Bhudia, Rosalie Magboo (Associate Lead)
Conference Organisers: Tilly Mitchell / Paulina Sapinska, Emma Piotrowski

Innovation

Co-Chair: Vasileios Tentzeris
Executive Co-Chair: Rana Sayeed
Appointed Members: Ishtiaq Ahmed, Alex Cale, Massimo Caputo, Roberto Casula, Ranjit Deshpande, Joel Dunning, Hazem Fallouh, Rafael Guerrero, Shyam Kolvekar, Kelvin Lau, Nicolas Nikolaidis, Karen Redmond, Stephan Schueler
Trainee Representatives: Joshil Lodhia, Bassem Gadallah, Walid Mohamed
NAHP Representatives: Una Ahearn, Amanda Walthew
Lay Representative: Sarah Murray

Equality, Diversity & Inclusion

Co-Chair: TBC
Executive Co-Chair: Narain Moorjani
Appointed Members: Giovanni Mariscalco, Rashmi Birla, Cecilia Pompili, Nicole Asemota, Nikhil Sahdev, Shagorika Talukder, Ahmed Abbas, Chiemezie Okorocha, Hanad Ahmed, Aswani Pillai, Ramanjit Kaur, Charlie Bailie, Adam Borrer, Samuel Burton, Jeevan Francis, Sathyan Gnanalingham, Anoop Sumal

Nursing & Allied Health Professionals (NAHP)

Co-Chair: Amanda Walthew
Executive Co-Chair: Sri Rathinam
Regional Tutors: Libby Nolan, Michael Martin, Namita Thomas, Yi Wang
Cardiac Lead: Ana Alves
Thoracic Lead: TBC
Audit Lead: Hemangi Chavan
Transplantation Lead: Emma Matthews
Innovation Lead: Una Ahearn
Membership Lead: TBC
Communication Lead: Jeni Palima
Pharmacy Lead: Nisha Bhudia
Critical Care Lead: Matthew Petty
Perfusion Lead: Lisa Carson
Physiotherapist Lead: Zoe Barrett-Brown
Research Lead: Zainab Khanbhai
Physician Associate Lead: Ramanjit Kaur
Surgical Care Practitioner Lead: ACTSCP President – Nisha Nair

Women in Cardiothoracic Surgery (WICTS)

Co-Chair: Ralitsa Baranowski
Executive Co-Chair: Narain Moorjani
Cardiac Surgery Rep. (Scotland): Rashmi Birla
Trainee CT Surgery Rep (Wales): Rhian Allen
Trainee CT Surgery Rep (England): Georgia Layton
Trainee Academic CT Surgery Rep: Nicole Asemota
Thoracic Surgery Rep: Leanne Ashrafian
Research CT Surgery Rep: Laura Clark
Core Surgical Trainee Rep: Alice Copperwheat
Medical Student Reps: Augusta Paulikaite, Heen Shamaz

Communications

Co-Chair: Sri Rathinam
Executive Co-Chair: Rana Sayeed
SCTS Website: Clinton Lloyd
Bulletin Editor: Dionisios Stavroulias
NAHP Representative: Jeni Palima
Consultant Living Text Book Co-Leads: Bilal Kirmani, Jeremy Smelt
Perfusionist Representative: Lee Clark
Education Website Development Lead: Christopher Horton
Trainee Members: Hanad Ahmed, Raisa Bushra, Maria Comanici, Francesca Gatta, Georgia Layton, Rohith Govindraj

Patient Safety Working Group

Co-Chair: Andrew Parry
Deputy Chair: Vanessa Rogers
Executive Co-Chair: Sri Rathinam
Appointed Members: Ismail Vokshi, Ruhina Alam, Jane Dickson, Jody Stafford, Branko Mimic, Sarah Murray

Sustainability in CT Surgery Working Group

Co-Chair: Sridhar Rathinam
Appointed Members: Christopher Efthymiou, Fathima Mubarak, Kudzayi Kutywayo, Bhuvaneswari Krishnamoorthy, Philip Hartley, Joy Edlin, Nader Moawad, Khurum Mazhar, Vanessa Rogers

Society for Cardiothoracic Surgery
in Great Britain and Ireland

SCTS ANNUAL MEETING 2025

Sunday 16th - Tuesday 18th March

REGISTRATION OPEN

Edinburgh
International Conference Centre

www.scts.org

SCAN ME

SCTS Annual Meeting 2025
16th-18th March

International and National Guests

Yolonda Colson, Nuria Novoa Valentín, Rene Petersen, Carlos Galvez, Patrick Forde, Marco Di Eusanio, Gebrine El Khoury, Pedro Catarino, Martin Czerny, Tom Verbelen, Mattia Glauber, Ruggero De Paulis, Oleksandr Babliak, Irene Lie, Sigrid Sandner, Mark Radford, Mark Bowers, Hatem Soliman

SCTS University

Cardiac & Thoracic Surgery Educational Sessions by International and National Leading Expert
Neoadjuvant versus Peri-operative chemo-immunotherapy for lung cancer
Improving Quality in Thoracic Surgery
Evidence based and contemporary management of pleural disease
NAHP Research
Thoracic and Cardiac Skills station and wetlabs

Main Meeting Programme

Presidential Plenary featuring Sir Clive Woodward address on Teamship
Scientific Abstracts and Keynote lectures
Industry Exhibition & Symposiums
Late breaking trial launch announcements

CT Nurse & Allied Health Professional Forum

Sharing best-practice in NAHP - led services
Learning differently and thinking outside the box to escape the coffin
Innovative research-based project implementation in the NHS
Working together to enhance patient care pathways
Embracing new skills and digital health care era

Social Events

Sunday 16th March – Welcome Reception in Exhibition Hall
Sunday 16th March – Pub Quiz at Kimpton Charlotte Square Hotel – The Cellar
Monday 17th March – SCTS Gala Dinner at National Museum of Scotland

Up to 18 CPD points
Registration is now open

Early bird discounted rates until 31st January 2025
To register or view the detailed programme
please visit www.scts.org

SCAN ME

SCTS Nurses and Allied Health Professional Update

Amanda Walthew, NAHP co-chair 2024–2027
Lead Advanced Clinical Practitioner, Liverpool Heart and Chest NHS Foundation Trust

This is my first report as the SCTS nursing and allied professional co-chair. It is an honour to lead and support the nursing and allied health professional team and I must thank my predecessor Dr Bhuvana Krishnamoorthy for her hard work and support as NAHP co-chair over the past few years and for her transitional guidance over the past few months.

For those who haven't met me yet, I am the lead surgical advanced clinical practitioner at Liverpool Heart and Chest Hospital with almost thirty years of cardiothoracic nursing experience under my belt. I am passionate and driven in relation to providing the best services and care for our patients and staff and will bring my knowledge and skills to the NAHP team and our members of the society.

Our NHS nurses and allied health professionals encounter significant challenges on a day-to-day basis; including staffing shortages, increased patient demand, and the emotional toll of high-pressure environments. Additionally, there are persistent disparities across Great Britain and Ireland in access to training and development opportunities, which can hinder career progression and job satisfaction. These challenges not only affect the well-being of staff but can also compromise the quality of patient care. Our NAHP team at the SCTS aim to break down these barriers by collaboration with our wider cardiothoracic teams, providing education and support in development of services. Our nurses and allied health professionals are pivotal in improving patient outcomes, they are the backbone of the National Health service, and we must support, encourage, and lead them to success.

The SCTS Nursing & Allied Health Professional committee was established to increase the Nursing & AHP profile within the cardiothoracic surgical speciality, the cardiothoracic arena and among the general NAHP community. The main aims are to improve the communication between our cardiothoracic centres across Great Britain and Ireland, specifically Nurses, Surgical Care Practitioners and AHP's. By promoting and sharing service changes, developments, innovation, and sharing new ways of working, we can all be the best! The SCTS NAHP committee take an active role in supporting workforce change, eroding the division of the delivery of care.

National NAHP leads advertisements:

I must thank all our members for their continued support and the current amazing subcommittee leads who have given their time and goodwill in their involvement in meetings and for providing educational support. Finding people with the right drive, skills, knowledge, and attitude can be an onerous task but once it comes to fruition it is magical.

We currently have openings for new national leads which are still vacant. If you are a leader, driven and want to help please apply for one of the following openings. Current leads have been extended until March 2025 so please contact us if you are interested.

Role availabilities for 2025:

- Thoracic lead
- Perfusion lead
- Pharmacy lead
- ODP lead
- Research lead
- Physiotherapy lead
- Innovation lead
- Transplant lead
- Education co-lead

Contact **Amanda.walthew@lhch.nhs.uk** for more information.

New lead appointments

NAHP Cardiac Lead – Ana Alves

Ana is a qualified Nurse with over 10 years of diverse experience in surgical, medical, and critical care settings. She began her advanced practice training in 2018 at Guy's and St Thomas' Hospital, specialising in cardiac surgery. Since then, she has progressed to become a fully qualified Advanced Clinical Practitioner and currently serves as the Lead ACP for Cardiac Surgery. With a robust background and a deep commitment to advancing nursing standards, Ana has been instrumental in shaping advanced clinical practice within her speciality. She is a passionate advocate for the role of Nurses and Allied Healthcare Professionals (NAHPs), leveraging her strong leadership skills to build a highly skilled team in the adult cardiac surgery department. Her innovative efforts have significantly enhanced the integration and effectiveness of NAHPs, driving improvements in both patient care and professional standards. She will be a great asset to the NAHP team.

NAHP Critical Care Lead – Matt Petty

Matt has worked on cardiothoracic ICU for over twenty years and been the lead nurse for Critical Care at Royal Papworth Hospital since 2020. He is interested in anything and everything critical care – Cardiac Surgery, ERAS, mechanical

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devices, ECMO, transplantation, ventilation, renal failure, post ICU follow up, whether this is clinical skills, teaching, or research. He believes that advanced skills can only be developed on strong foundations of good care and clinical knowledge. I also have a passion for those conditions not normally associated with Cardiothoracic ICU – spinal cord injuries, neuro protection, septic shock. He will be a great addition to the NAHP team.

NAHP Research

I must thank our SCTS Research NAHP team for their hard work over the past twelve months. Lead Hemangi Chavan and the team Nisha Bhudia and Rosalie Magboo. The University research day at the 2024 Annual Meeting was well received. They have also continued the research mentorship programme and the supported associate principal investigator scheme. We are still supporting two randomised controlled trials for the scheme: (1) (SLIMCARD trial) and (2) Wound Imaging Software and Digital platform to detect and prioritise non-healing surgical wounds (WISDOM study). Please contact Rosalie Magboo: **Rosalie.renamagboo@nhs.net** or visit **https://www.nihr.ac.uk/health-and-care-professionals/training/associate-principal-investigator-scheme.htm** for more details.

Amazing achievement

Nisha Bhudia and Rosalie Magboo have been leading the national quality improvement project on prevention of Atrial Fibrillation after Cardiac Surgery (AFACS). They were awarded the winner of the Quality Improvement and Safety awards and presented with the certificate at the BORs meeting in September 2024. The Quality Improvement and Patient Safety Awards were launched by SCTS in 2024 where the awards aim to recognise innovative initiatives that have been demonstrated to improve the safety or quality of care delivered to patients undergoing cardiothoracic surgery.

The Quality Improvement Project (QIP) is being implemented at 15 hospital sites across the UK to help change the practice and embed AF prevention bundle into standard practice to potentially reduce AFACS. It is aimed to reduce AFACS with the emphasis on early betablocker (re) administration postoperatively and establish that beta blockers (BBs) can be administered safely with small doses of noradrenaline. The QI project ensures that embedding the use of AF prevention bundle into standard practice achieves patient benefit. This quality improvement project encourages the multidisciplinary team to work together throughout the patient pathway by doing simple things well and working towards safety, quality, and effectiveness to improve patient care without compromising patient safety. If any to the centres not already taking part in this national QIP and interested to implement this in their centre do contact Nisha Bhudia (**n.bhudia1@nhs.net**) or Rosalie Magboo (**rosalie.renamagboo@nhs.net**).

The project was also presented at EACTS in Lisbon and awarded the best presentation during the nurse and nurse physician postgraduate Education Course in October 2024 – what an amazing achievement for the NHAP research team.

Education

NAHP Education Lead – Kathryn Hewitt

Our education lead Kathryn Hewitt has worked tirelessly in setting up and ensuring monthly webinars in relation to the cardiothoracic surgical speciality are provided to our members, however uptake is variable. The sessions are amazing and free to members so please attend if you can and share with your teams. We are planning some face-to-face cardiothoracic teaching this year so look out for the advertisement. It will be a great opportunity to learn and network. We have given two fantastic international fellowship awards this year worth £2000 each which is amazing. Charlotte Bartlett, advanced nurse practitioner from Southampton and Ramanjit Kaur physician associate Oxford have both been successful and will be visiting The Mayo clinic in Minnesota. We look forward to their presentations of their experiences in the future.

NAHP core focus areas for 2025

- team structure, recruitment, and succession planning
- research
- website development for NAHPs
- increasing NAHP membership
- education
- increasing NAHP membership to have more amazing NAHPs in our society

If you have colleagues interested in the SCTS and they are keen to become involved within the workforce please encourage them to contact us. The current fee (NAHP) is a one off £10 admin fee and £30 per annum, please share with your teams. ■

SAC Chair Report

Timothy Jones, Chair of the Cardiothoracic Specialty Advisory Committee, Consultant Paediatric Cardiac Surgeon, Birmingham Children's Hospital

Cardiothoracic surgery is a diverse, challenging, demanding and rewarding career. To be a safe and competent surgeon requires a combination of intellectual rigour, as well as a high standard of manual dexterity supported by generic professional behaviours as expected of a doctor. Such skills develop with exposure, practice, feedback and experience which can only come from providing our trainees with the appropriate opportunities and environment.

Since August 2021, surgical training has become outcomes based. The curriculum is structured on achieving competencies in the core capabilities required of consultants in their daily practice. Across all surgical specialties these capabilities have been identified as:

- Manages an out-patient clinic
- Manages the unselected emergency take
- Manages ward rounds and the on-going care of in-patients
- Manages an operating list
- Manages multi-disciplinary working

For cardiothoracic surgery, due to the nature of our work we added two additional capabilities required for practice as a day one consultant:

- Manages patients within the critical care area
- Assesses surgical outcomes both at a personal and unit level

It is vital we provide our trainees with exposure, in a supervised setting with appropriate feedback and assessment, to all these components of clinical practice.

Following the COVID pandemic all surgical specialties experienced a significant decline in elective surgical activity documented by trainees. For most specialties, there is progressive recovery in elective surgical activity but cardiothoracic surgery is the exception and trainees elective surgical activity has now plateaued at approximately 25% less than pre pandemic levels. The reasons for the reduction in overall cardiothoracic surgical activity are well rehearsed and multifactorial. The reduction in opportunity is deeply concerning for our trainees and consultant of the future.

All trainees should have a minimum of two full days (four sessions) and ideally three or more full days (six sessions) in the operating room per week. Recent national training surveys identify a proportion of our trainees continue to receive less than two days per week in theatre.

To support trainees and trainers in improving trainees' time and experience in the operating room the SAC has been working with the SCTS, JCTS, Royal Colleges and NHS in developing the following initiatives:

- ***All cases should be training cases*** – if for whatever reason the trainee is not the first surgeon operator there is still an abundance of education in every case we do. Operative planning, set up, conduct and management including unexpected complications are as important as stitching an anastomosis. Performing the entire operation from skin to skin is ideal but may not be appropriate for a trainee, but there will be some parts of the surgery the trainee can do. Trainees, make sure you are in the operating room even if not first surgeon, a lot can be learnt from watching and assisting an experienced surgeon deal with complex cases and complications.
- ***Differential rotas*** – in the last edition of *The Bulletin*, Mahmoud Loubani and Shahzad Raja published on behalf of the SAC a paper on the use of differential rotas to maximise trainees time in the operating room especially for Phase 3 trainees.
- ***eLogbook*** – working with the eLogbook team, Josh Lodhia has developed improved metrics for both trainees and trainers to record and monitor their training activity. This will provide trainees with the ability to compare their progress with peers as well as national averages. Trainers and Regional Training Program Directors will be able to see who is delivering operative training so we can support and recognise the work.
- ***NHS cases in independent sector*** – all NHS cases whether undertaken in a NHS or independent ('private') facility as routine or waiting list initiatives are training cases. This is a directive from the Royal Colleges of Surgery, NHS and JCST.
- ***ARCP outcomes*** – we are working to standardise ARCP panels, processes and outcomes. Each transition from Phase 1 to Phase 2 to Phase 3 will prompt a very careful review of progression regarding competencies as well as operative experience. The use of targeted training and non-standard Outcomes such as an Outcome 3 is not a punitive measure but one to ensure a trainee achieves objectives and progress. Ravi De Silva is leading on analysing the current length of training and use of ARCP Outcomes to better understand the reason a trainee may not progress.
- ***SCTS Education and National Online Training Program*** – the portfolio of SCTS Education courses have been realigned to the current curriculum thanks to the continued work by Elizabeth Belcher and Debbie Harrington. NHSE and HEE have funded a National Online Training Program (NOTP) platform to provide instant access to on line educational resources and eLearning. Mike Shackcloth as NOTP Director and Georgia Layton, our NOTP Fellow, have developed a curriculum aligned national, virtual teaching program for cardiothoracic surgery. This means national trainees and trust appointed doctors can access core teaching without leaving the workplace meaning face-to-face regional teaching and SCTS Education courses can focus on delivering technical hands on training via simulation.
- ***Simulation*** – the role out of simulation for all trainees was delivered by Sri Rathinam. Dheeraj Mehta has taken over form Sri as SAC Simulation Lead and we are looking at ways of promoting simulation locally, regionally and nationally to provide trainees with core skills so they can capitalise on time in the operating room.
- ***National Training Surveys*** – Shahzad Rafa continues to dedicate a lot of time and effort into delivering Quality Assurance of Training on behalf of the SAC and JCST. We continue to monitor and respond to the JCST and GMC National Training Surveys. But we need better completion by both trainees and trainers to provide more meaningful data for us to act upon. To this end we have refined and focussed the JCST Cardiothoracic Survey questions and urge all trainees to complete the survey following each placement.

Whilst we are working to improve operative exposure and training, we recognise ultimately it is down to you – the trainers and trainees. We are very grateful and thank all those who spend the time and effort deliver operative training. We urge all trainers and trainees to use the above initiatives to ensure we improve and maximise operative exposure and training.

If you require any further information or want to discuss any of the above, please do not hesitate to contact either me, Bassam Gadallah or Walid Mohamed, our trainee representatives on the SAC. ■

 # no operative training today, no surgeons tomorrow

Audit Sub-Committee Report

Uday Trivedi, SCTS Audit Lead,
Consultant Cardiac Surgeon, University Hospitals Sussex NHS Foundation Trust

It has been nearly five years since we started the process of moving away from surgeon-specific to unit-level outcomes and from only mortality to wider morbidity and patient pathway measures in adult cardiac surgery. During these five years, numerous presentations have been made to make members aware of these changes and the importance of having a transparent process of quality assurance that the SCTS can demonstrate to the public and other stakeholders.

It is important that all units participate in the Quality Assurance Process (QAP) because as a profession we are being allowed to police ourselves. We have negotiated to only report outcomes on a unit level and that this will be the only type of information in the public domain from the SCTS. The rationale for this has been outlined in previous reports, and at the Annual and BORS meetings. Many units have embraced the vision and are participating in completing the quarterly Quality Assurance Form and uploading data to the SCTS dashboard project. However, a significant minority are not fully on board, and it is vital that all units participate in the QAP. The SCTS needs to demonstrate that ALL units are actively taking part in local and national quality processes (hence the need for a quarterly completion of the form), otherwise we risk returning to previous systems of outcome monitoring and public scrutiny.

> "It is important that all units participate in the Quality Assurance Process (QAP) because as a profession we are being allowed to police ourselves. We have negotiated to only report outcomes on a unit level and that this will be the only type of information in the public domain from the SCTS."

It has been agreed that the cardiac BORS representative for each unit would complete the Quality Assurance Form. This form must be completed every quarter and email reminders are sent out to remind individuals to fill in the form. Once it has been completed for the first time, the subsequent time required to fill in the form is less than a few minutes as the previous answers are pre-populated into the form. The crucial point about this form is that it asks each unit to declare that they have reviewed their outcomes (death, new renal injury, permanent stroke, return to theatre for bleeding and deep sternal wound infection) each quarter. This response is part of the assurance process by which the SCTS can objectively record that each unit has good clinical governance in place.

There have been reasons why some forms are not completed, such as when the BORS representative has changed in the unit, but the SCTS has not been notified. The reminder emails only go out to the names we have on our database. Equally, if the BORS representative is not an SCTS member, this can cause issues, but if it is known then it is an easy fix to give that person access to fill in the form.

Given the importance of the quarterly form completion, the SCTS Executive has agreed that we will publish completion rates for each unit on the SCTS website. This will provide the transparency and assurance that is required for a self-policing profession.

With regard to the SCTS Dashboard, it has been developed as a benchmarking tool and in the future, it will be a data source for audits etc. This database is anonymised and does not contain patient identifiers. However, the SCTS (with University Hospitals Bristol & Weston) as data controllers need to have a data sharing agreement (DSA) in place with each Trust prior to any data being uploaded to the dashboard. We are aware that there have been issues at local levels, and to date, we have 20 units who have signed a DSA. Where units have had issues with local information governance teams, we have been able to resolve their queries and get the DSA signed off. If you are experiencing such problems, please get in touch with either Emma or myself.

NICOR continues to perform the outcomes analysis and it is to be congratulated for getting the 2021-2024 analysis done in the shortest time frame ever. NICOR is obligated to conduct the outcome analysis on both individual surgeon and unit levels. It can be reported that there were no alarm (old-fashioned 3SD) outliers either at an individual or unit level.

On the congenital audit front, we all wish to thank Carin van Doorn for all her hard work with the congenital audit and the Blue Book. She has stepped down and Serban Stoica has been appointed as the lead for congenital surgery. Carin will continue to oversee the Blue Book project. The role of the deputy audit lead will be shared by Branko Mimic and Phil Botha. The congenital surgeons are continuing to work to establish a database and dashboard similar to the adult dashboard, and currently exploring funding options as well as engaging with other stakeholders within the congenital fraternity. Anybody wishing to get more details of the proposed initiative should get in touch with Serban.

The Thoracic audit has been in a state of flux since the loss of LCCOP. Rammohan Kandadai is overseeing the creation of a new audit programme in thoracic surgery which is more fit for purpose given the degree of sub-specialism in the modern era. We hope to have more details at next year's annual meeting. ■

The SCTS Annual Dinner 2025

Monday 17th March
19:00 - 00:00
National Museum of Scotland

Tickets include welcome drink, 3 course meal, wine, entertainment & dance

Tickets £80 available online when registering for the Annual Meeting

Dress code: Formal evening attire

The National Museum of Scotland
Chambers Street, Edinburgh, EH1 1JF

www.scts.org

SCTS Education Secretaries Report

Debbie Harrington, SCTS Co-Education Secretary,
Consultant Cardiac Surgeon, Liverpool Heart and Chest Hospital

Elizabeth Belcher, SCTS Co-Education Secretary,
Consultant Thoracic Surgeon, Oxford University Hospitals NHS Foundation Trust

The Education Subcommittee welcomes Shilajit Ghosh (Shilli), Consultant Thoracic Surgeon at the University Hospital of North Midlands, as the new SCTS Student Education Thoracic Lead. Farah Bhatti has demitted as SCTS Student Education co-lead, and we would like to thank Farah for all her work over the years. Farah contributed to expanding the student committee and its reach via widening participation and mentorship. Shilli will co-lead SCTS Student Education with Jason Ali after a move to advertise these roles as separate cardiac and thoracic appointments. The Education Subcommittee would like to thank Prakash Punjabi and Shahzad Raja as they demit their Consultant SCTS Education roles. We are grateful to our subcommittee members, course directors, and faculty in all our education streams, who continue to provide excellent training opportunities.

Industrial Partnerships

SCTS Education would like to thank our industry partners for their generosity and support in these challenging financial times. SCTS Brand Partnerships are held with Ethicon, Acumed, Aquilant, Artivion, Atricure, Ambu, Edwards, Intuitive, Getinge, LeMaitre, Medtronic Thoracic, Pulmonx, Serb, Storz and Transmedics.

Funding of courses has become increasingly challenging due to increased costs and compliance constraints relating to non-technical courses. In 2025, we will amalgamate the ST2 courses into one and shorten courses, facilitated by the reduced requirement for didactic course teaching by the launching of the National Online Curriculum Webinar Series. Delegates are asked to fund accommodation for some UK courses.

Fellowship Awards

SCTS Education is delighted to announce Heart Research UK Travelling Fellowships for 2024. These five awards totalled £40,000 and were awarded to Gareth Hooks, Azar Hussain, Nader Moawad, Luke Rogers, and Charlene Tennyson. The Aortic Centre Trust Michael Warburg Fellowship for 2024 of £20,000 was awarded to Robert Fleck. We are grateful to both charities for their ongoing support of SCTS members. Their generosity is invaluable to these awardees travelling to the US, Canada and Australia. We encourage potential applicants to plan Fellowships as soon as possible. Applications for all Fellowships must be detailed regarding the proposed project plan and include support from their current institution and fellowship centre. Details of projected costs and the subsequent benefit to the NHS are also vital to a successful application.

NAHP Travelling Fellowships for 2024 of £2,500 each were awarded to Charlotte Bartlett, Thoracic ANP at Southampton and Reema Kaur, PA, at Oxford University Hospitals NHS Foundation Trust, both of whom will travel to the Mayo Clinic.

SCTS and RCS Edinburgh Post-CCT Fellowships in Cardiothoracic Surgery

SCTS and RCS Edinburgh Post-CCT Fellowships have been developed to provide high-quality, high-prestige and quality-assured training in complex cardiothoracic surgery. This is a service requirement, and independent practice at this level is beyond that required for CCT. Jennifer Williams has been appointed to the Barts Robotic Thoracic Surgery Post-CCT Fellowship, and George Gradinariu has been appointed to the Liverpool Complex Aortic Surgery Post-CCT Fellowship. Fellowships are also available at Barts Aortic Centre and the Bristol Heart Institute. Applicants should have been admitted to the Cardiothoracic Surgery Specialist Register of the GMC or the Medical Council in Ireland or comply with the certification requirements. Posts are also open to consultants within two years of appointment.

NTN Portfolio

The ST2.1 Phase 1 Essential Skills Course in Cardiothoracic Surgery ran in Nottingham in September. The ST4.1 Phase 2 Core Cardiac Surgery Course, the ST1 Phase 1 Introduction to Cardiothoracic Surgery Course, and the ST7.2 Phase 3 Leadership and Professional Course ran at Ashorne Hill during the autumn. We are grateful to all course directors and faculty who worked to deliver these courses, led by Mahmoud Loubani and Mike Shackcloth. There is an expectation that all SCTS member national trainees will attend courses appropriate to their year of training, which are aligned with the current curriculum.

TAD Education

In line with the SCTS strategy of increasing equality of opportunity, we continue to improve access to education for our Trust Appointed Doctors. In October, the Ethicon-funded TAD Curriculum Review Course was run at their Pinewood facility with excellent feedback. The TAD Cardiothoracic Surgery Update and Wetlab ran in September at Ashorne Hill. This course runs as a subspeciality course, divided into cardiac and thoracic streams. The Portfolio Route (previously CESR) Course ran in November as a one-day

review for senior TADs who plan to enter the specialist register via this route. All TADs sitting the JCIE May 2025 diet, who are SCTS members, can access a place on the Revision and Viva Course. We have developed this strategy to minimise differential outcomes. In addition, we will continue offering TAD trainees places in as many of our NTN courses as possible in 2025. We thank Anas Boulemden and Mohammad Hawari, who lead the TAD Portfolio.

NAHP Education

The NAHP portfolio goes from strength to strength under the leadership of Kathryn Hewitt, whose weekly webinars have received fantastic feedback. We look forward to continuing this collaboration with Kathryn in 2025 and hope to announce further courses, including face-to-face events, soon.

INSINC

INSINC Insight, a work experience programme, completed a successful round of work experience placements at Edinburgh, Cambridge, Leicester and Bristol. The INSINC Insight Scheme has been awarded first place for the SCTS Equality, Diversity & Inclusion Award 2024. The widening participation program is complete, and a near-peer mentoring program linking young doctors and students is underway. The INSINC Student Engagement event was held at the University of Cambridge in November. The launch of an INSINC Journal Club is planned. We are grateful to Jason Ali and all the medical students who lead and run the INSINC program.

Lastly, we would like to express our gratitude to our fantastic administration team, Mara Banuta, aided by Taet Chesterton, without whom SCTS Education would not exist. Please let them know if your contact details or level of training change so that we can update our records accordingly and ensure you are appropriately invited to SCTS Education events. (**Education@scts.org**).

We wish everyone a healthy and happy 2025 and look forward to welcoming you to SCTS Education events. ■

Course	Location	Date
ST3.2 Phase 1: Non-operative technical skills for surgeons (NOTSS)	Bristol Simulation Centre	TBC
SCTS Viva Course for FRCS CTh	Virtual & Ashorne Hill	4th – 7th March 2025
ST5.2 Phase 2: Cardiothoracic Intensive Care and Critical Conditions Course	Ashorne Hill	28th – 29th April 2025
ST3.1 Phase 1: Operative Cardiothoracic Surgery Course	Medizin im Grunen	8th – 9th May 2025
SCTS Harefield Core Thoracic Organ Transplantation Course	STaR Centre, Harefield	29th – 30th May 2025
ST5.1 Phase 2: Cardiothoracic Surgery Sub-speciality Course	TBC	5th – 6th June 2025
ST4.2 Phase 2: Core Thoracic Surgery course	The Johnson & Johnson Institute, Pinewood Campus	9th – 11th June 2025
TAD Cardiothoracic Surgery Update and Wetlab Course	The Johnson & Johnson Institute, Pinewood Campus	12th – 13th June 2025
ST7.1 Phase 3: Cardiothoracic Pre-consultant Course	Keele Anatomy & Surgical Training Centre	25th – 26th June 2025

Adult Cardiac Sub-Committee Report

**Manoj Kuduvalli, SCTS Adult Cardiac Surgery Co-Chair,
Consultant Cardiac Surgeon, Liverpool Heart and Chest Hospital**

Management of chronic aortic dissection

SCTS has been asked to engage with NHSE along with the Vascular and Cardiology societies to develop a pathway for elective management of patients of patients with chronic dissection, with a broader scope to include identifying at risk individuals (family screening where appropriate) and managing patients with incidental finding of aortic aneurysms, for example, through a Targeted Lung Health Check CT scan. This work is in the initial stages, and different workstreams are being formed to feed into a comprehensive guidance document.

Engagement with NICE

SCTS, via the ACSSC has engaged with NICE as stakeholders on various guidance and technology assessments.

- Decision making aid for stable angina
- TAVI for Aortic Incompetence
- Venoarterioal Extracorporeal Membrane Oxygenation (VA ECMO)

Ring-fencing resources (ward and CCA beds) for elective cardiac surgery

SCTS, with input from the ACSSC, published a letter of support for ring-fencing resources for elective cardiac surgery, particularly focusing on critical care beds. This was published working alongside colleagues from ACTACC.

Other areas of engagement

- Working with SCTS Research to recruit to large multi-centre research trials to help further demonstrate the efficacy of surgical intervention.
- The SCTS is working with cardiologists and the Faculty of Dental Surgery at the Royal College of Surgeons of England to produce a position statement to encourage adherence to the updated ESC guidance, advocating antibiotic prophylaxis for those at high risk of infective endocarditis undergoing invasive dental procedures.
- The ACSSC continues to engage with NHS England to promote the excellent surgical outcomes of cardiac surgery achieved in United Kingdom & Ireland. The SCTS is also lobbying the government through the Royal College of Surgeons to increase funding and resources to support initiatives to tackle the waiting lists and backlog.
- Review of cardiac surgery service specification for Wales.
- Ongoing development of guidance documents for Mitral valve surgery, provision of post-Cardiotomy ECMO and SAVR vs TAVI. ■

Thoracic Surgery Sub-Committee Report

**Karen Redmond, SCTS Thoracic Surgery Sub-committee Co-Chair,
Consultant Thoracic & Lung Transplant Surgeon, Mater Misericordiae University Hospital, Dublin**

It has been a productive year for the Thoracic Subcommittee. The terms of reference for all members has been revised. We are making excellent progress with a number of working groups in place.

The Pectus Working Group has supported the publication of guidelines, collaborated with NHS England, participated in a national MDT and has helped to deliver on successful target recruitment rates for the RESTORE trial. Protocols have been put in place for CPET testing, CT parameters and echo assessment. A standards document in relation to surgery supports the RESTORE trial and the three commissioned surgical sites for England. The Pectus Working Group are working towards establishing standards for non-surgical care programmes providing treatment using such devices as braces and vacuum bells. We are working closely with our BAPS representatives to hopefully establish a referral network that will streamline activity from paediatric through to adult patients.

We have nearly achieved our funding target in relation to establishing a priority setting partnership (PSP) with the James Lind Alliance. The aim is to over one year work with key stakeholders in our speciality to prioritise key areas of research. We would like to thank sponsors who have supported this initiative so far. If additional funding is required we may consider crowd source funding. We look forward to providing feedback to our membership as this project develops to the next stage.

A Thoracic Trauma Working Group has just been established. If members have an interest in participating please contact Rory Beattie, our Deputy Co-Chair.

The Data Working Group have been exploring all options in relation to a new database. The plan is to bring together a minimum bespoke data set to cover all subspecialty topics within the Thoracic Surgery remit. We hope this database can submit to other registries as required. If any members have an interest in being involved in defining the data sets please contact Kandadai Rammohan.

The NCIP portal is due to go live for members within the UK in England. Doug West is leading on this and has communicated back to the SCTS around NCIP efforts. As part of his previous GIRFT quality role, he is also establishing pleural sepsis guidelines akin to previous guidelines published for airway and pneumothorax.

NICE are looking at expert feedback in relation to their ongoing evidence based review of the role of robotics in the speciality. We have representation on this group.

Discussions are ongoing in relation to what the job plan should be for a Thoracic Surgeon. A draft of the job plan will be submitted to members for their thoughts. I feel particularly strongly about delivering on a job plan that allows for a safe and sustainable workload, for example every unit should have an on-call frequency of 1:6, no more. There is a lot of work to be done in this area.

The Thoracic Subcommittee are supporting the annual meeting and the ACTACC SCTS meeting in November 2025. The Scottish ESTS bid is awaiting a final decision.

We hope to set up an Airway Working Group to regionalise airway activity and training. We also need a patient information and charities representative. Please email me if you wish to get involved.

There is a lot of activity going on within the Thoracic Subcommittee as we drive forward with multiple areas in our effort to support members and their patients within the specialty. ■

Communications Committee Report

Sri Rathinam, SCTS Communication Secretary,
Consultant Thoracic Surgeon, Glenfield Hospital, Leicester

The communications committee comes into the third year of its existence with me writing my final report as communication secretary, after an exciting three years at the helm as Co-Chair of this committee. The communications committee has made steady progress since the last bulletin, it was only possible with our committee members' enthusiasm who give their valuable time.

We thank the SCTS Administration team for their hard work in delivering our various projects.

Bulletin

The Bulletin, under Dio as Editor, steps into the second issue and has his vision and style incorporated in it. We have adopted an ecofriendly and sustainable model of only printing limited numbers for members who have opted in to receiving printed copies.

From the Chest

There are many stories to tell and share, we urge colleagues to share their experiences and local history, inspirations and lessons learnt for the wider membership. I believe sharing our challenges and how we overcame them is an integral part of inspiring the next generation. Please share your stories and creations with us.

Website

The website has improved over the years with content updates from some committees. Our focus for the first quarter is to have a communication lead for the four clinical sub specialties who will update content both for professionals as well as the public.

We are in the process of having all the 'Life time achievement awardees' on the website as inspirational role models for our members.

Executive Report

The executive report of the activities of the SCTS committees will have reached you by now. We thank all the committee chairs and members for their hard work.

BORS report and Unit Engagement

The unit engagement programme has been deferred due to various challenges least of it being units members finding suitable time to spare amongst all the clinical demands. We will commence Unit engagements from January to gain insight from various units and to the challenges and how SCTS can help and support them. BORS report and BORS meeting recordings are available in the website. We thank all the BORS members for submitting unit data.

Social Media

We have a pool of keen members within the communications committee, who will be the SCTS Ambassadors in social media increasing our web presence. We request members to tag SCTS in their social media posts. The SCTS social media policy has been written and approved and circulated to members.

SCTS Abstracts and Perspectives

SCTS Annual Meeting abstracts are published in JTCS. There are discussions with the meetings team to choose talks from SCTS University for prospective Perspectives Monologue in JTCS.

The communications sub-committee is exploring the option of having a collaborative arrangement with JTCS as our journal.

Committee Positions

By the time this issue arrives, the Executive would have appointed a new Communications Secretary to succeed me and replenished the committee members as well. We wish the new team all the very best in taking this committee to greater heights.

"To effectively communicate, we must realise that we are all different in the way we perceive the world and use this understanding as a guide to our communication with others."
– Tony Robbins, author, speaker, coach

The SCTS communication team has set agendas and tried various methods to reach out to our members. As members, we request you to reach out to colleagues who are not members to bring them to our society.

For me personally, it has been a great honour and privilege to serve as your Communications Secretary for the last three years. I thank the committee members for their hard work and dedication and wish my successor all the very best. ■

Intercollegiate Specialty Board in Cardiothoracic Surgery

Sri Rathinam, Chair, Intercollegiate Specialty Board for Cardiothoracic Surgery JCIE, Consultant Thoracic Surgeon, Glenfield Hospital, Leicester

The exam board membership is complete with representatives from all stake holders.

Mr Sridhar Rathinam	Chair
Miss Juliet King	Leader, Panel of Question Writers [S2]
Miss Elizabeth Belcher	Leader, Panel of Question Writers [S1]
Mr Rana Sayeed	JSCFE Lead
Mr Steven Rooney	RCSEd
Professor Farah Bhatti	RCSEng
Mr Vincent Young	RCSI
Mr Manoj Kuduvalli	RCPSGlas
Mr Tim Jones	SAC Chair
Vacancy	SCTS
Mr Narain Moorjani	SCTS
Ms Rebecca Weedle	Trainee Representative
Mrs Claire-Digance Fisher	Specialty Manager

The board will be seeking representation from SCTS as Neil Roberts has demitted office as SCTS Cardiothoracic Dean and Narain Moorjani will demit office when he steps down as President. We thank both for their contribution to the Cardiothoracic Board.

Panel of Examiners

The panel of examiners is in a better shape, with the big recruitment drive having increased the examiner pool with more thoracic examiners, female examiners, and examiners from all four nations and Republic of Ireland. Special efforts have been made to recruit more female examiners to reflect our trainees.

Belfast Examinations

We have recently conducted the 5th diet of the new format examinations with patient volunteers and subspecialty vivas in Belfast. The host examiner was Mr Mark Jones who delivered the local patient volunteers, support team and instruments; a big thank you to Mark and Rory Beattie who supported him and all the juniors who helped with the exam.

The McCormack Medal – 2024

Daniel Sitaranjan of the East of England Cardiothoracic programme been awarded the McCormack Medal by the Intercollegiate Specialty Board in Cardiothoracic Surgery for the most outstanding performance at the Intercollegiate Specialty Examinations in Cardiothoracic Surgery held during 2024.

This medal was originally created in 1982 in the memory of Mr R J M McCormack, former Vice President of the Royal College of Surgeons of Edinburgh, and is awarded annually to the candidate attaining the highest mark in the Intercollegiate Specialty Examination in Cardiothoracic Surgery.

Waiting Lists for Section 2

With the new format examinations and chosen specialty interest, we now have waiting lists for Section 2 examinations particularly for cardiac themed trainees. JCIE will offer the place on a first come first basis at the time of submission of application. Applications from NTNs and TADs will be maintained in a common list. We urge all candidates to take their exams at the earliest opportunity so that the exams don't impact on consultant posts and fellowship plans.

We are working with the secretariat towards solutions to increase the number of candidates in each diet.

Standard Setting and Question Writing

The examiner role not only includes examining, it also includes a standard setting process and question writing; a big thank you to all the examiners who give away their valuable time in making this happen. It is the examiner pool who ensures the standard of the exam. A big thank you to Elizabeth Belcher and Juliet King who led the Question writing groups and Mark Jones who supported Juliet with the cardiac questions.

Joint Surgical Colleges Fellowship Examination

The JCIE is exploring options regarding the future of the JSCFE examinations with various options to support the candidates. Candidates who have passed the section 1 of JSCFE can now appear for the JCIE exam if they have worked in the UK or Ireland for one year. The Dubai diet was cancelled due to low numbers with various alternate options explored for 2025.

Future Exams

The next examination will be held in Blackpool, hosted by Prof Nidal Bittar and Mr Manoj Purohit on the 20th-22nd May 2025.

The following diets of the Section 2 will be held in 21st-23rd October 2025 in London and Stoke-on-Trent in May 2026.

New Examiners

We are grateful to all the new examiners who have made important contributions to the examinations.

We welcome experienced surgeons and trainers who have completed five years of substantive posts and are in good standing, to consider joining the court of examiners. There will be a lead time of 12-24 months before you will examine, as your application will be assessed by the board. You will then be invited to the examiner training following which you will observe an exam before formally examining in a diet.

Opportunities in the Cardiothoracic Board

Elizabeth Belcher will be demitting office as Section 1 QWG lead and I will be demitting office as Board Chair in May 2025, both posts will be advertised by JCIE soon. We encourage colleagues to consider and apply for the posts. ■

APROTININ *10,000 KIU/ml Injection BP*

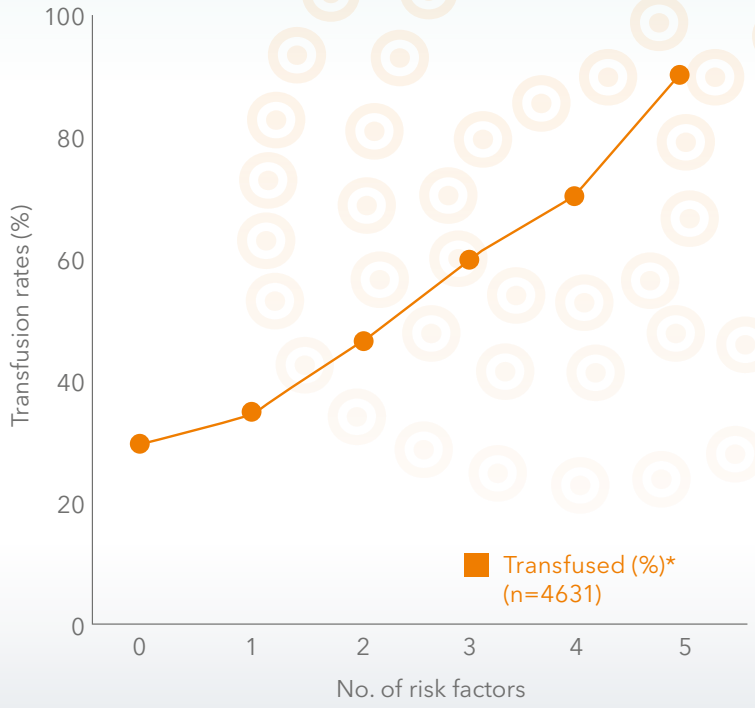
Aprotinin is indicated for prophylactic use to reduce blood loss and blood transfusion in adult patients at high risk of major blood loss undergoing isolated cardiopulmonary bypass graft surgery. Aprotinin should only be used after careful consideration of the benefits and risks, and consideration that alternative treatments are available.[1]

Scan this QR code for aprotinin prescribing and adverse event reporting information

Red blood cell transfusion is the single factor most reliably associated with increased risk of post-operative morbidity and mortality[2]

- Blood loss requiring transfusion remains a risk in cardiac surgery, despite the use of blood-sparing agents and blood management techniques[3-5]
- The graph below shows how multiple patient risk factors compound to increase the risk of transfusions during CABG surgery[6,7]

Risk Factors for Tranfusion in iCABG Patients:



Regardless of volume of blood loss, when patient risk factors are compounded, transfusion rates increase[6]

In a recent study of patients undergoing scheduled coronary artery surgery, a set of pre-defined risk factors were applied.[6]

- Age >70 years
- Female
- Low molecular weight heparin or antiplatelet therapy <5 days pre-operatively
- Estimated Glomerular Filtration Rate <60mL/min
- Insulin dependent diabetes mellitus

Scan the QR code or visit our website at aprotinin.co.uk to see what other HCPs think of aprotinin and for other useful resources

Adapted from Myles PS *et al.* 2017[1,2]
*Any transfusion up until hospital discharge

References:
1. Aprotinin 10,000 KIU/ml Injection BP Summary of Product Characteristics. Available at www.medicines.org.uk. Accessed November 2024.
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5. Gombotz H *et al.* The second Austrian benchmark study for blood use in elective surgery: results and practice change. Transfusion 2014;54:2646-57
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7. Supplement to: Myles PS *et al.* Tranexamic Acid in Patients Undergoing Coronary-Artery Surgery. N Engl J Med 2017;376:136-48.

NORDIC PHARMA

UK-TRA-2400036 | October 2024

Trainee Report

Bassem Gadallah, ST6 Northwest Deanery, Wythenshawe Hospital, Manchester
Walid Mohamed, Cardiac Surgery Registrar (StR), University Hospital Southampton

As our term as NTN Representatives and Co-Chairs of the National Trainee Committee for Cardiothoracic Surgery (NTCCTS) approaches its end in March 2025, we would like to express our gratitude to our fellow NTNs for their support in electing us into this role, their invaluable feedback on training-related issues or personal concerns and their engagement with us at various events. The training pathway is a long and winding road full of inevitable ups and downs, with various aids and obstacles making this journey easier for some and more difficult for others. We hope that our work in this role has provided a strong voice for trainees to speak up when their training is not going to plan and remember they are never alone in their journey. The election process to the roles will be advertised soon, and we look forward to welcoming and supporting the next NTN Representatives in continuing the strong advocacy for trainees at a national scale.

> **"The training pathway is a long and winding road full of inevitable ups and downs, with various aids and obstacles making this journey easier for some and more difficult for others."**

This year marks our fifth **SCTS Annual Trainee Meeting** which will take place on 16th March 2025 at the SCTS Annual Meeting in Edinburgh. We will be delighted to share an update on the work done by the NTN Representatives and NTCCTS over the past year to represent trainees with the invited NTNs and TPDs.

The event also includes updates from SCTS SAC and Executive Committee members, discussions on training-related issues with an opportunity to ask questions and a session where trainees share their fellowship experiences and resources.

The **SCTS Annual Trainer Awards**, awarded to cardiac consultant, thoracic consultant and NTN trainers who the committee votes on, will also be given out at the event. Nominations for the awards will open shortly, so please look out for our announcement on WhatsApp and SCTS communication channels.

The **SCTS Annual Trainee Dinner**, generously funded by AtriCure, has been a staple of our Annual Meeting day since 2022, with over 60 NTNs attending last year's event. We are currently planning this year's dinner (venue details will be announced soon), and look forward to seeing you all in Edinburgh for a fun night out!

We are pleased to announce we are recruiting very soon for the following ten vacancies on the NTCCTS:

- Foundation Doctor Representative
- Core-Level Doctor Representative
- Communications Officer
- ST1 Representative
- ST2 Representative
- ST3 Representative
- ST4 Representative
- ST5 Representative
- ST7+ Representative
- Cardiac Surgery Committee Representative

This is a fantastic opportunity to join our expanding committee and help make an impact on training at a national scale. Please keep an eye out for the advert details which will be shared soon.

Maintaining communication with NTNs is a vital part of our role, and we are working on updating the NTCCTS website and SoMe platforms to work on expanding the committee's reach and collaboration with other societies. Our NTN WhatsApp groups (with NTNs grouped by ST year from ST1-ST7) have proved useful in advertising educational opportunities, communicating news/information from the SCTS and SAC and generally allowing more effective networking amongst trainees. We have worked with the SCTS Education Subcommittee to establish a system to update this database and WhatsApp groups every year to account for new ST1/ST4 entrants and any changes in circumstances for NTNs.

The updated **"Guide to Cardiothoracic Surgery Deaneries"** will be published very soon on the Oriel, Wessex national recruitment and SCTS websites. This includes a prospectus from each deanery/region with an overview of the training programme to help guide NTN recruitment applicants and ST1 starters. Our excellent **"ST1 Welcome Guide"** for those starting their training programme is also available on the same platforms, and we urge NTNs to share these guides with national recruitment applicants or anyone interested in the specialty within their regions.

The NTCCTS is working on other projects to bring exciting opportunities to trainees, including fellowship grants and advising on rota patterns to improve theatre opportunities.

We are keen to hear from all trainees about any training-related matters (that can then be discussed at the relevant SCTS committee) or any project-related ideas or suggestions. Please get in touch via WhatsApp or email **ntccts@gmail.com**.

We look forward to seeing you all at the next SCTS Annual Meeting! ■

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[1]Compared to 12 mm SureForm staplers.

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The Intuitive Surgical 8 mm SureForm 30 Staplers, 8 mm SureForm 30 Reloads, and accessories are intended to be used with a compatible da Vinci Surgical System for resection, transection of vasculature and tissue, and/or creation of anastomoses in General, Thoracic, Gynecologic, Urologic, and Pediatric Surgery.

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MAT03819 v2 EU 12/2024

2024 Highlights: INSINC Student Committee's Year in Review and Future Initiatives

Heen Shamaz, SCTS INSINC Lead
Emma McEwen, SCTS INSINC Events Lead
Jason Ali, SCTS Student Education Lead, Locum Consultant Cardiothoracic Surgeon, Royal Papworth Hospital, Cambridge

As we look back on 2024, the INSINC Student Committee celebrates a year of growth, innovation, and commitment to widening access to cardiothoracic surgery. From expanded work experience placements and a new mentorship program to improved resources for medical students, this year's initiatives reflect our dedication to supporting students in their journey toward a career in cardiothoracic surgery.

INSIGHT Widening Participation Work Experience Placements

Following on from successful work experience placements which offered week-long hospital-based placements for sixth form students intending to apply to medicine, we expanded this scheme to two new centres: Edinburgh and Cambridge. This year, we hosted 20 students across four centres (Edinburgh, Cambridge, Bristol, and Leicester).

In Cambridge, the work experience placements were enriched with targeted tutorials and support for medical school applications, including sessions on personal statement writing, mock multiple mini-interviews (MMIs), and medical ethics. In Edinburgh, students also received individualised personal statement feedback and had the opportunity to observe clinical care in a range of settings, including ward, intensive care, and the operating theatre with robotic surgeries. Over 2023-24, we offered 32 placements and hope to expand to further cardiothoracic centres in the coming years. If any centres are keen to consider hosting students through this scheme next year, please contact Mr Jason Ali **jason.ali@nhs.net**.

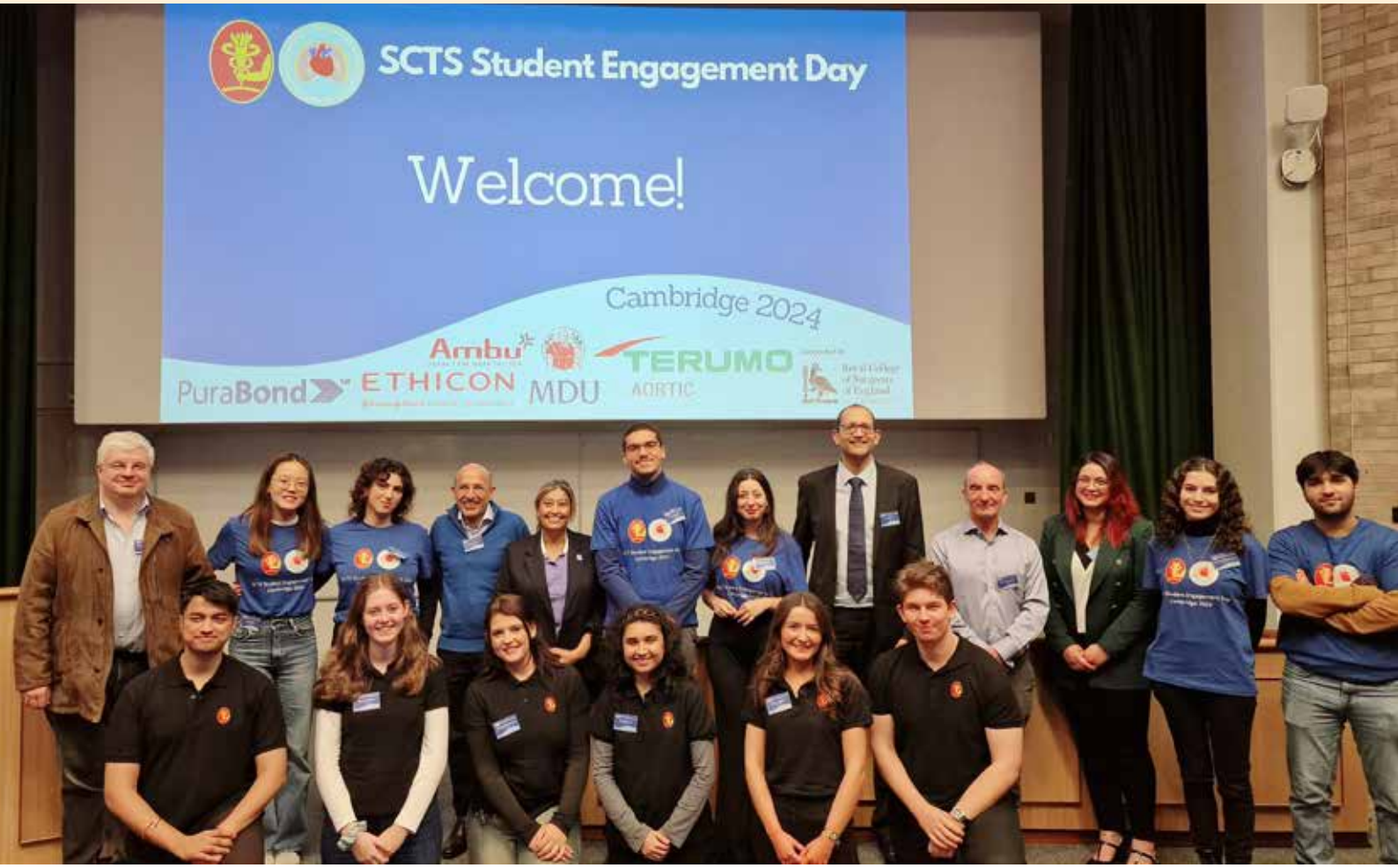
Additionally, we are very grateful to receive the 2024 SCTS EDI award. This award recognizes the work of the current and the previous INSINC committees (2021-23) in organising week long virtual lectures and in-person work experience placements in 2023 and 2024.

Medical Student Mentorship Scheme

In August 2024, we launched the first iteration of our medical student mentorship scheme. These mentorship pairings aim to connect medical students interested in pursuing cardiothoracic surgery training with cardiothoracic surgery registrars and fellows. We hope through these connections, students are able to access personalised advice on preparing an application portfolio, research projects, and obtain insight into the day-to-day life as a trainee. We also hosted a virtual mentorship event in November 2024 with distinguished speakers including Mr Narain Moorjani, Prof Mahmoud Loubani, Mr Jason Ali, and Lucy Vere (Head of Learning and Organisational Development at Hull University Teaching Hospitals). This was a well-attended event with 200 students which covered SCTS' EDI strategy and projects on widening participation, the need for mentorship, and principles of mentoring from both mentees' and mentors' perspectives. Given the success of the mentorship scheme thus far, we plan to re-open applications in the spring, with matches being made for the next academic year in August 2025.

Regional Publicity Leads

Following a competitive application process this summer, we have recruited our next cohort of regional publicity leads who help advertise INSINC's events to their medical school locally. A big thank you to everyone who applied; we were truly impressed by the high quality of applications this year! Through this scheme, we hope to continue to enhance student awareness and engagement with the specialty. We're thrilled to have representation from more than two-thirds of medical schools across the UK and Ireland, which is a notable increase from last year. We can't wait to see some of our regional publicity leads at SCTS 2025 in Edinburgh, where we'll announce our winner of the Regional Publicity Lead of the Year award!



Elective and Foundation Jobs Repository

The SCTS INSINC website is currently being revamped with sections to detail our new projects. Recognising that electives during medical school can be tricky to organise, as part of this update, we will also be launching an elective repository. This is a document detailing all cardiothoracic surgery centres in the UK and Ireland and links to applying for medical student electives at their affiliated hospitals. For final year medical students looking ahead to foundation/intern jobs, we have also put together a spreadsheet of all foundation year jobs across the UK and Ireland which include cardiothoracic surgery.

Cambridge Student Engagement Day

This year's SCTS Student Engagement Day was hosted by the University of Cambridge. It was attended by 106 students. The day began with a series of talks from distinguished faculty, including Prof Farah Bhatti, Miss Hassiba Smail, Mr Richard Steyn, and Mr David Jenkins. There was also an abstract competition, followed by hands-on workshops, including basic suturing, coronary anastomosis, and VATS and bronchoscopy.

Further Updates and Things to Watch For

1. **Journal Club** – In November, we launched our inaugural Cardiothoracic Surgery Journal Club, led by Prof Bhuvana Bibleraaj, Dr Marcus Taylor, and our very own Joshua Halyckyj-Smith. Aiming to make research more accessible to medical students, we will meet monthly to explore an aspect of research and discuss a landmark paper. For the latest updates and details on how to sign up, please check our social media and the SCTS newsletter.

2. **Equality, Diversity & Inclusion (EDI) Survey** – This survey launched in March 2023 with aims to identify medical students' perceived barriers to a career in cardiothoracic surgery.

3. **Cardiothoracic Surgery Training Pathway Teaching Series** – Following a successful six-part webinar series in 2024, we have relaunched the CTS training pathway webinars on MedAll, covering information for medical students and foundation year doctors on building a surgical portfolio, surgical membership exams, person specifications ("the matrix"), and more. Registration links are shared on our social media and in the SCTS newsletter.

4. **Applications for the INSINC Committee (2025-27)** – As our time in INSINC is coming to an end, we look forward to welcoming applications to be on the next committee. If this is something you are interested in, please follow our social media as well as the SCTS weekly newsletter for details of when the applications will be opening.

5. **SCTS Annual Meeting 2025** – Building on the success of last year's SCTS Annual Meeting in Newport, our next Student Day will be held at the SCTS Annual Meeting 2025 in Edinburgh. This will also mark our time to handover to the next committee. We are planning for a very exciting day and look forward to seeing you there! ■

From the Italian University Classrooms of Bologna to the Heart of St. Thomas' Hospital in London: A Medical Students' Unforgettable Leap into the World of Cardiac Surgery

Gabriele Ciampaglia and Anna Sofia Bottecchi,
3rd year medical students, Alma Mater Studiorum, University of Bologna, Italy

As medical students, one of the earliest concepts we learn is that human life depends on a beating heart. Conversely, the moment of death is marked by a flat line on the electrocardiogram.

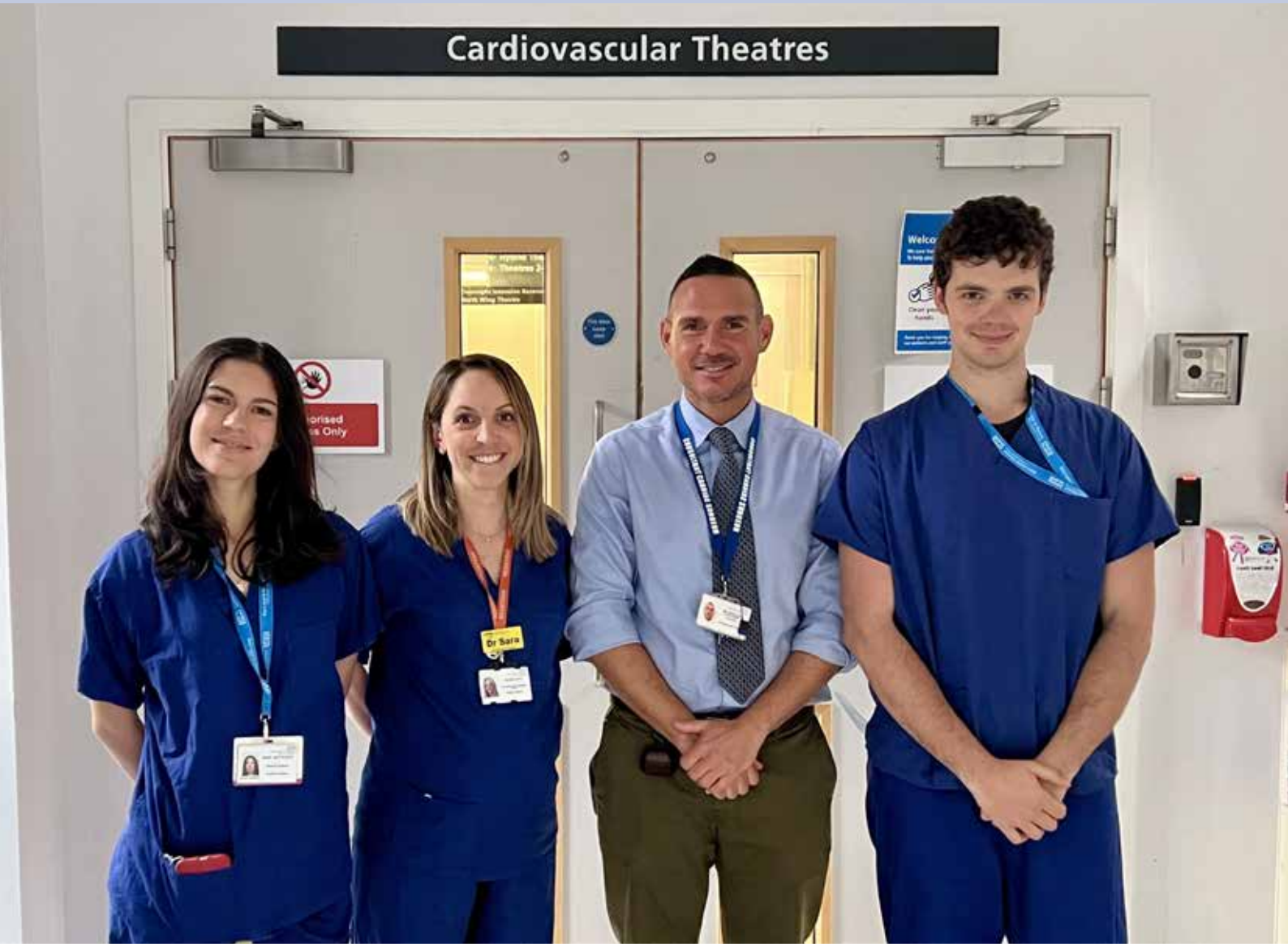
The heart, in many ways, is viewed as a perfect machine governed by intricate mechanical and electrophysiological laws. Studying these systems is so fascinating that what might otherwise seem like a struggle becomes a remarkable pleasure for medical students. Yet, reading about the heart in textbooks or observing images on a screen is worlds apart from the breath-taking experience of seeing a real heart beating inside a living body during surgery. Our time in the Cardiac Surgery Department at St. Thomas' Hospital in London was truly an unforgettable experience that has shaped our future not only from a medical perspective but also on a deeply human and emotional level.

Our journey began on July 29, 2024, with a perfect British morning – cloudy skies and a cool breeze – greeting us as we stepped out of Westminster Underground Station. Our eyes were first drawn to Big Ben, but soon after, an immense building across the Thames captured our attention: St. Thomas' Hospital, a modern structure equipped with cutting-edge technology, whose history is rooted almost one thousand years back.

When Miss Volpi opened the door at the second floor with her badge, and we could read the big black sign "Cardiovascular Theatres", it was indeed the start of four extremely captivating weeks of observership and the first time for us in a Cardiac Theatre. In the operating room, one of the first aspects that captured our attention was the perfect synergic mechanism thanks to which every member of the staff works with the final aim of ensuring the best possible outcome for the patient. Starting from the surgeons, never had we seen people endowed with so much precision and concentration for such an extended period of time. Their hands work tirelessly and, at the same time, they are able to make decisions of the utmost importance on the surgical procedure according to the variable anatomy of each patient. Next to them, the anaesthetists meticulously control the vital parameters, take care of the ventilation, administer drugs and perform transoesophageal echocardiogram to assess the results of each surgery. Moreover, the perfusionist played a vital role in controlling the heart-lung machine, a testament to the marvels of modern science and technology. The scrupulous work of the surgical care practitioners, scrub nurses, and the rest of the staff was equally crucial. A key takeaway from our experience was that efficient teamwork is essential not only for successful surgical outcomes but also for creating a functional and supportive working environment based on cooperation and mutual respect.

> **One of the most valuable lessons we learned was: "At first, you admire a surgeon for their ability to suture, but later you realize the true challenge is making the right decision at the right time."**

The first operation we observed was a septal myectomy, a procedure that had only occupied merely a paragraph of our medical textbook. As the bright surgical lamps shone over the operating table, and the heart-lung machine hummed nearby, we were reminded of how this procedure is used in hypertrophic obstructive cardiomyopathy. Mr Lucchese, was incredibly fast and precise. While administering cardioplegia, it was the first time we saw the ECG going completely flat at the isoelectric line, and it was even more astonishing to admire that wonderful organ completely paralysed while it should have been



working restlessly, beating since the fifth week of gestation until the moment of death.

Time flew by, and on our second day, something unexpected occurred: one of the operating theatres was put on hold for a heart explant. Unfortunately, the heart was deemed too hypertrophic for transplantation, and only the liver was harvested. The emotional weight of that surgery was palpable. Immediately following this, we observed a coronary artery bypass, a procedure we had studied extensively at university but had never seen in real life. The massive appearance of the liver of the previous operation was opposed by the millimetric size of the coronaries, so small that the distance between each stitch was almost impossible to see for our naked eye. Watching the delicate and intricate process of restoring blood flow to the heart was a profound learning experience.

One of the most valuable lessons we learned was: "At first, you admire a surgeon for their ability to suture, but later you realize the true challenge is making the right decision at the right time." Our experience also allowed us to witness congenital heart surgeries, including an arterial switch in a 11-day old baby. Although we understood the theory behind the procedure, seeing such a tiny baby on the table was emotionally overwhelming. His heart was stopped, and the surgeons skilfully completed the complex operation. During the procedure, we couldn't help but thinking that the surgical team was donating the chance of living a long and healthy life to this baby. How amazing can this be? And how much will his parents be relieved after having alleviated such an heavy burden?

The human side of cardiac surgery became even more apparent during our time in the pre-operative clinic. Here, patients face difficult decisions – whether to undergo invasive surgery or surrender to their condition. These conversations were handled with empathy and respect, and the Registrar explained the risks and benefits of each option. None of them refused the treatment, even after hearing the most feared words "mortality and stroke risk of one to two percent", demonstrating both their will to fight for life and their deep trust in the surgical team.

In conclusion, the magic part of heart surgery lies in how the structures are profoundly altered, sometimes even disrupted, in a way that at half way though the operation everything seems out of place: the aorta is cut, the coronary arteries disconnected from their sinuses, the heart is not beating, the right atrium is opened and so on. However, at the end, similarly to solving a puzzle, the surgeons reconstruct the anatomy and restore normal physiology with precision and expertise.

We are deeply grateful to the entire Cardiothoracic Team at St. Thomas' Hospital for welcoming us, patiently explaining complex concepts, and offering us this incredibly formative and fulfilling elective. Now, having seen the finish line of years of study and training, we eagerly look forward to continuing our journey to becoming compassionate, skilled doctors. ■

A Journey of Inspiration: A Senior Medical Student's Experience in Cardiac Surgery

Essam Eldien Abuobaida Banaga, Senior Medical Student,
The Faculty of Medicine National Ribat University, Khartoum, Sudan

As a senior medical student, the world of medicine has opened countless doors for me, each leading to a myriad of specialties and pathways. Yet, as I embarked on my clinical rotations, one path stood out above the rest: cardiothoracic surgery. My recent experience in the operating room during a mitral valve repair surgery solidified my commitment to this demanding yet rewarding field.

The patient was a 62-year-old man, who had been battling severe mitral valve regurgitation for years. His condition had deteriorated rapidly over the past few months, leading to debilitating symptoms such as shortness of breath, fatigue, and fluid retention. By the time he was admitted for surgery, he was critically ill, teetering on the brink of heart failure. The gravity of his situation was palpable; the surgical team understood that we were not just performing a routine procedure but were instead fighting for this man's life.

The day of the surgery was filled with a mixture of anxiety and anticipation. As I donned my scrubs and prepared to assist in the operating room, I felt a surge of adrenaline. I had studied the intricacies of the heart and the complexities of mitral valve repair during my medical education, but nothing could compare to witnessing it firsthand. The attending surgeons welcomed me into the sterile environment, emphasizing the importance of teamwork and precision in such high-stakes situations.

As the surgical team gathered around the patient, I could see the worry etched on his face. The anesthesiologist administered medication to ease his anxiety, and soon he was asleep, oblivious to the life-altering procedure that lay ahead. With the patient stabilized on the operating table, we began the intricate process of accessing his heart.

The surgery itself was a symphony of collaboration. Each member of the team played a crucial role, from the lead surgeon meticulously dissecting tissue to the perfusionist monitoring blood flow through the heart-lung machine. I assisted by handing instruments and observing every delicate maneuver. As I watched the surgeons repair the mitral valve, I marveled at their skill and precision. The valve was reconstructed using sutures and a ring to provide support, ensuring that it would function properly once the heart resumed its normal rhythm.

After several hours in the operating room, we successfully completed the procedure. As we closed the chest, I felt a wave of relief wash over me. We had done our part, but I knew that the next few hours would be critical for his recovery. The team carefully monitored him in the intensive care unit (ICU), where I had the opportunity to witness firsthand how resilient the human body can be.

In the days following surgery, the transformation was nothing short of miraculous. Initially still groggy from anesthesia and battling discomfort, he gradually regained consciousness and began to respond to our questions. His determination to recover became evident as he worked with physical therapists to sit up and take his first steps post-surgery. Each small victory was celebrated, and I found myself inspired by his strength and resolve.

Witnessing the patient's journey from critical illness to recovery reaffirmed my passion for cardiothoracic surgery. It became clear to me that this specialty is not just about technical skills; it is about restoring life and hope to patients who are often at their most vulnerable. Each day brought new challenges, but also new opportunities to make a meaningful impact in someone's life.

However, I also learned that this path is not without its demands. The work of a cardiothoracic surgeon requires immense dedication, resilience, and an unwavering commitment to patient care. Long hours in the operating room can be grueling, and the emotional toll of dealing with critically ill patients can weigh heavily on even the most seasoned practitioners. Yet, despite these challenges, I discovered that every moment spent in this field is worth it when you see a patient regain their health and vitality.

As I continued my rotation in cardiothoracic surgery, I encountered various cases that further fueled my desire to specialize in this area. From coronary artery bypass grafting to lung resections, each procedure presented unique challenges and learning opportunities. The complexity of each case demanded not only technical proficiency but also critical thinking and adaptability – skills that I eagerly sought to develop.

Moreover, I was struck by the camaraderie within the surgical team. Surgeons, nurses, anesthesiologists, and other healthcare professionals worked seamlessly together, united by a shared goal: saving lives. This sense of teamwork fostered an environment where knowledge was freely exchanged and where mentorship thrived. I found myself inspired not only by the procedures but also by the people who dedicated their lives to this noble profession. In conclusion, my experience in the patient's mitral valve repair surgery was transformative – both for him and for me. It served as a powerful reminder of why I chose medicine in the first place: to make a difference in people's lives. As I continue my journey toward becoming a cardiothoracic surgeon, I carry with me the lessons learned from this experience: that resilience exists within us all, that teamwork is essential in healthcare, and that every life saved is a testament to our collective efforts as healers.

With each passing day in this field, I am reminded that while the road ahead may be demanding, it is also filled with profound rewards – rewards that make every challenge worthwhile. ■

A Collaborative Path Forward: A Thoracic Surgery Strategy Day

Hannah Jesani, ST5 Cardiothoracic surgery trainee, West Midlands
Ashvini Menon, Consultant Thoracic surgeon, Queen Elizabeth Hospital, Birmingham
Prof Babu Naidu, Consultant Thoracic surgeon, Queen Elizabeth Hospital, Birmingham

On 19th June 2024, the thoracic surgery department at the Queen Elizabeth Hospital Birmingham hosted a departmental strategy day at the Edgbaston Park Hotel.

This initiative invited all members of the thoracic surgery team inclusive of the ward nurses, healthcare assistants, physiotherapists, theatre team, administrative team, managers, consultant surgeons, anaesthetists, thoracic surgical registrars, thoracic advanced care practitioners, research nurses and core trainees. Staff engagement was overwhelming with over 50 people in attendance for the day. The mission was to collaborate and focus on enhancing patient care through innovative and research driven peri-operative services supported by a well-trained, well-resourced, and cohesive team.

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Those usually behind surgical gowns and behind desks were unveiled and we were able to voice freely outside of the work environment. We were able to understand individuals' backgrounds, challenges and ideas for improvement. Collaborative brainstorming where no idea was restricted was used throughout the day. This provided an opportunity for members to contribute their insights, working towards a unified vision for the department's future for enhanced patient care.

We began by dividing into teams discussing our challenges (niggles), valuable points (nuggets), aspects that would be 'nice if…', and those definite 'no no's' for what we would envisage for the department. There was a broad range of topics for dialogue and an abundance of valued aspects about the department as well as improvements. Many themes were common amongst all the groups and sharing these allowed us to relate to one another and recognise common goals. Valued aspects included approachability and respect of all staff members, the team's passion for the speciality, mentorship for skill development, thoracic surgical expertise and a collaborative MDT environment.

These discussions led to a list of aims, objectives and ideas of solutions to how we can achieve our goals. Measurable key performance indicators were also identified to assess progress which will be monitored. Aims included addressing staff shortages and training through recruitment open days, well-being initiatives, continued educational mentorship with flexible

working patterns to allow this and a comprehensive thoracic induction training programme. We discussed improving the flow of the peri-operative pathway as well as updating and enhancing the accessibility of patient education programmes. We proposed gaining space to allow a 'one-stop clinic' including pre-operative assessment, research nurse review, occupational therapy assessment to enhance discharge planning, and our high-risk anaesthetic clinic. From a thoracic surgery trainee perspective, the most beneficial element of this day was gaining an understanding for each subset of the department's complexities and struggles. It allowed trainees to express adversities in training and how the wider team can mitigate such challenges to help encourage an environment for learning and development.

We recommend all thoracic surgery departments invest in organising strategy days. We also suggest these days recur on a yearly basis to ensure progress, implementation and momentum. These sessions give empowerment to staff at all levels to help shape the focus and future for the department. It is accepted that there may not be straightforward or immediate solutions to some challenges. However, by promoting an open dialogue and fostering a culture of innovation and collaboration this can lead to tangible improvements in staff satisfaction and patient care. Staff who attended expressed they felt a renewed sense of purpose and encouragement. Reflection is a vital component of our daily practice and the ability to do this as a whole department proved invaluable so we can work together for our patients and team. ■

Cardiac Surgery in Birmingham – the Early Days

David Clarke, retired consultant, Queen Elizabeth Hospital, Birmingham

My time as a registrar with the cardiothoracic unit at the Queen Elizabeth Hospital in Birmingham in 1960 was the most exciting and demanding time of my ninety-four years. The first operation on cardiopulmonary bypass was a year before that – Birmingham was one of the first units in the country to start an open heart programme.

Professor A L d'Abreu (Pon) – my chief – had visited the USA and seen the pioneering work being done at Minneapolis and the Mayo Clinic. He realised that this was going to be the next step forward. However, his commitments would have made it impossible for him to initiate an open heart surgery program so he took the unprecedented step of delegating the task to his senior registrar, Leon Abrams with the admonition 'Make a mess of this, Abe, and you'll be finished and it won't do me much good either'. He couldn't have chosen better. Leon Abrams was a highly intelligent, dexterous surgeon, with an eye for detail and a fascination with mechanical devices. He drove himself and his team relentlessly.

Funding was only a few thousand pounds which had to cover the salaries of two technicians, animal trials, and building the monitoring equipment. There was not enough money to buy one of the pump oxygenators on the market so they constructed a Lillehie deWal bubble oxygenator. The only bought component was the pump; it had oscillating fingers which milked blood along tubing. After each use it had to be disassembled, cleaned, coated in silicone and sterilised, so it was possible to perform only one or two operations per week. Another disadvantage was that the output of the machine was not enough to sustain life in an adult, so our practice was limited to children, usually with ventricular septal defects or Fallots Tetralogy. Mortality was high. Heart block was a problem as this was before the relationship of the conducting tissue to the VSD was established. Losing one of these little patients was always distressing. Later we changed to the Rygg/Kyssgaard bubble oxygenator and could operate on adults.

Two remarkable men operated the pump. Ray Lightwood had worked for an electrical firm but resigned when he was transferred to weapons development. He assembled all the monitoring electronics which used pens on reams of paper, recording BP, ECG, EEG and central venous pressure. He later developed the couple inductive pacemaker. Joseph Fejfar had been a theatre orderly with a talent for handling any mechanical device. He constructed the Lillihie bubble oxygenator. A cardiology registrar was also part of the team.

It was amazing that such a disparate crew could work together so effectively, but they did. The culture shock for me, coming from general surgery to a discipline where I was expected to be familiar with new surgical techniques, cardiology, fluid mechanics and unfamiliar anatomy, was profound.

There were very few intensive care units in 1960. Sick patients were moved to the end of the ward behind screens. Our ward sister, Marion Simpson, converted a small sideward into a two bed ICU and compiled a loose leaf book on intensive care nursing which was used all over the country. Monitoring was primitive. Blood loss was measured in drainage bottles, blood pressure was taken with a cuff sphygmomanometer and CVP was taken with a water manometer in a neck vein. Readings were taken every fifteen minutes. There was also a device which bleeped with every heart beat. If an electrode fell off, the first instinct was to reopen the wound to get the heart started; No external cardiac compression then!

There were five main theatres at the Queen Elizabeth but no time had been allocated for open heart surgery. This had to be tacked onto the end of d'Abreu's list. It was not unusual for the registrar to spend the day assisting at say, a closed mitral valvotomy and a couple of lung resections and then starting the bypass surgery in the evening. It usually finished in the small hours of the morning, and the rest of the night was spent at the bedside in the ICU. Such working conditions would not be tolerated today but we accepted the chronic fatigue and stress as necessary evils. The excitement and fascination of the work kept us going and we were getting a lot of experience. I completed my training with d'Abreu, Leigh Collis and Abrams in Birmingham, and Sir Thomas Holmes Sellers at Harefield before being made a consultant at the Queen Elizabeth in 1969.

Staffing levels compared badly with today. Cardiothoracic surgery in the West Midlands was divided between Birmingham and Coventry. Three Birmingham surgeons had a catchment population of 2.5 million. Keith Roberts had started open heart surgery at the Childrens' Hospital, I covered adult surgery at the QEH and Abrams divided his time between the two. We also covered chest trauma for the Birmingham area. One of the most appealing aspects of our speciality was its variety. Closed mitral valvotomy and repair of atrial septal defects using moderate hypothermia were still practised; they were safer than cardiopulmonary bypass. There was still plenty of pulmonary and oesophageal surgery but with the increasing demand for cardiac surgery this gradually reduced. When I started coronary bypass grafting the demand became even greater so that by the time of my retirement in 1990 I was doing little else.

It was a privilege to work in this demanding speciality but, as Pon d'Abreu once remarked, "I'm a lucky man; they pay me for doing what I love.". ■

Chest Trauma in the United Kingdom and Ireland: The SCTS Trauma Survey and Establishment of the SCTS Chest Trauma Working Group

Priyad Ariyaratnam, Consultant Thoracic Surgeon, Derriford Hospital, Plymouth
Rory Beattie, Consultant Thoracic Surgeon, Royal Victoria Hospital, Belfast

Introduction to Chest Trauma

Trauma remains the most common cause of mortality in those under 50 years of age in the United Kingdom and Ireland. Chest trauma, in particular, accounts for around 15-30% of trauma admissions and is associated with a significant in-hospital mortality and long-term morbidity.

In the last 15 years, NHS England have introduced the concept of Major Trauma Centres (MTCs) which are tertiary referral centres for complex trauma patients with the intention of improving outcomes. However not all thoracic surgery units are part of MTCs: with some forming part of local trauma networks (Major Trauma Units-MTUs) whilst others do not deal with acute trauma at all.

There is currently very little national guidance in how thoracic trauma should be delivered in the UK. Given this lack of national guidance, NHS Trusts have deferred guidance to local expertise.

Although local guidance is important, it can give way to variations in the quality of thoracic trauma delivery which can impact not only on outcomes in chest trauma but how elective thoracic care is delivered with competition of resources.

National SCTS Chest Trauma Survey

We conducted a survey of thoracic trauma service delivery in the UK as a starting point to discern variations in practice.

22 thoracic surgery centres replied to the survey. All of these centres managed patients with thoracic trauma to some degree although 2 centres (9.5%) only managed chest trauma patients that specifically needed thoracic operations.

73% of Thoracic Units belonged to MTCs, 9% belonged to MTUs and 18% belonged to neither.

64% of Thoracic Units had clearly written protocols for the management of chest trauma patients whilst 36% did not. Of those that did have a written protocol, 57% were not satisfied with the protocol.

Conservative (non-operated) chest injuries were managed by thoracic surgeons in 77% of centres and by orthopaedic/general surgeons in 23% of centres.

For those thoracic centres that managed conservative chest trauma, the following were the criteria used for admission to thoracic surgery:

- Isolated Chest Injuries – 27%
- Chest trauma fulfilling a minimum Chest Score on a defined Scoring system – 38%
- Chest trauma requiring a local anaesthetic infusion – 63%
- Those with specific defined chest injuries (e.g. patients requiring a chest drain) – 75%

With regard to the delivery of chest trauma services, 68% of centres felt that thoracic injuries were dealt with in a timely manner from admission to the emergency department. 68% centres felt that the hospital had a satisfactory and clear pain relief protocol for chest injury patients such as a chest trauma bundle and appropriate escalation from oral pain relief to IV pain relief and regional anaesthesia (e.g. erector spinae blocks).

Despite Major Trauma Wards (where polytrauma patients are managed) being a defining criteria of MTCs, only 75% of MTCs had a Major Trauma Ward (MTW). 68% of centres felt that the MTW had insufficient capacity for the volume of polytrauma admissions with chest injuries and so many of these admissions came to a thoracic ward.

"The initial aims of this group would be to evaluate current local guidelines and scientific evidence for the management of chest trauma to identify areas of good practice that can be extrapolated to national guidelines."

In those centres where thoracic wards looked after polytrauma patients, 76% agreed that there was a timely review by the other relevant trauma specialties on their ward. 73% of centres felt there was adequate physiotherapy cover for chest trauma patients when admitted to their ward. Only 36% centres had a dedicated ortho-geriatrician to advise on the management of elderly trauma patients admitted to the thoracic ward.

With regard to the impact of trauma admissions on other thoracic services: 81% of centres felt there were significant delays in getting complex polytrauma patients discharged from a thoracic ward once the thoracic injuries had been managed successfully/resolved. 59% of centres felt this had a negative impact on their elective services as trauma patients were put on the same ward as elective thoracic surgery admissions.

Finally, 95% (21/22) of centres wanted national guidance either from the SCTS or the NHS bodies in how chest trauma services should be delivered.

Next steps

There are many examples of good practice in how chest trauma is delivered in thoracic surgical centres in the UK and Ireland. However, clearly our survey has raised concerns in how best to deliver trauma services with the limited infrastructures and resources units have. Furthermore, participants overwhelmingly wanted national guidance on how best to (a) manage specific chest trauma injuries, (b) complex polytrauma patients who have chest injuries and (c) develop criteria for consultation/admission under thoracic surgery.

We felt the best way to begin addressing some of these issues, was the establishment of a Chest Trauma Working Group for the SCTS. The initial aims of this group would be to evaluate current local guidelines and scientific evidence for the management of chest trauma to identify areas of good practice that can be extrapolated to national guidelines.

The working group would not be limited to cardiothoracic surgeons but would actively liaise with allied professionals in trauma care (other medical specialities such as emergency medicine, anaesthesia/pain specialists and orthopaedic surgery; allied healthcare professionals such as nurses, advanced care practitioners and physiotherapists; as well as data management teams such as the National Major Trauma Registry) with the overall objective of improving outcomes from chest trauma nationally whilst efficiently managing limited resources in thoracic surgery services.

For those who would like to be involved in the Chest Trauma Working Group, please forward your expression of interest to either Mr Rory Beattie (**rorybeattie84@googlemail.com**) or Mr Priyad Ariyaratnam (**p.ariyaratnam@nhs.net**). ■

Congenital Cardiac Surgery Training in the UK: the Role of Wet-Labs in Teaching Surgical Skills

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A. Lotto, Congenital Cardiac Surgeon, Alder Hey's Children Hospital

Congenital cardiac surgery (CCS) is considered by many as one of the most fascinating and competitive surgical specialty. In recent years, we have witnessed a shortage of congenital cardiac surgeons. Nevertheless, training in such specialty remains complex and lengthy, with limited opportunities for hands-on experience in clinical posts. To this purpose, in 2022 the SCTS Education Group established the Congenital Cardiac Wetlab, a yearly highly specific course designed for aspiring congenital cardiac surgeons. Its program includes a congenitally-oriented workshop on anatomical specimens, alongside simulated operations on pig and piglet hearts across two days. Although delegates' surgical experience varies in relation to their background level of expertise, the procedures performed during the course remain complex; these include Ross procedure, Ross-Konno, Hypoplastic aortic arch reconstruction, Aortic annular enlargement and Norwood procedure.

As part of the course evaluation, we ran an anonymous questionnaire as an adjunct to the official SCTS feedback forms, to evaluate the impact such course has on trainees' aspirations to succeed in CCS in the United Kingdom (UK). The data was collated for each year of running the course.
Most delegates were male, and in the age groups 25-28 and 31-34. Majority of candidates were Cardiothoracic NTNs in ST3 to ST6 level, alongside a small number represented by surgeons pursuing a CESR root, with uniform attendance from 11 Deaneries. The overall results are impressive. All candidates agreed the course improved both their theoretical knowledge and technical skills. This was demonstrated by subjective self-evaluated competencies for the

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SCTS Congenital Cardiac Surgery Wetlab - Mr Mohamed Nassar assisting a delegate, whilst providing one-to-one feedback

operations practised during the course. More importantly, the entire cohort of attendees agreed the wet lab was able to provide an insight into CCS, which was not available in their current job role. Lastly and foremost, the workshop allowed networking with experts of the field across different centres, as well as the creation of a CCS community in the UK, which these young surgeons felt proudly part of.

These are some of the comments provided by the delegates in both the official feedback and subsequent survey: "super anatomical and morphological demonstration"; "excellent hands-on sessions"; "the best SCTS course I've been on"; "large number of hearts and equipment"; "every single step of the surgical procedures was shown, and every single error corrected"; "nice meet up with colleagues".


SCTS Congenital Cardiac Surgery Wetlab - Prof Attilio Lotto assisting a delegate, whilst providing one-to-one feedback

"This initiative not only attracts junior doctors, cardiothoracic trainees and fellows across the country, but improves our understanding of congenital heart diseases and allows to perform complex congenital heart operations."

It is evident that SCTS Education greatly succeeded in delivering an exceptionally appreciated course. This initiative not only attracts junior doctors, cardiothoracic trainees and fellows across the country, but improves our understanding of congenital heart diseases and allows to perform complex congenital heart operations. Finally, it increases our motivation to continue in such specialty and makes us feel part of a community. ■


SCTS Congenital Cardiac Surgery Wetlab, Leamington Spa

Breaking Barriers in Cardiothoracic Surgery: Insights from the Medical Student Survey on Equality, Diversity & Inclusion

Alexander Reynolds, Swansea University Medical School, Wales, SCTS INSINC EDI lead 2021–2023
Joshua Halyckyj-Smith, Wythenshawe Hospital, Manchester University NHS Foundation Trust, Manchester, SCTS INSINC EDI lead 2023–Present
Jason Ali, Royal Papworth Hospital NHS Foundation Trust, Cambridge, INSINC lead
INSINC committee members 2021–2025, SCTS EDI committee members

Cardiothoracic surgery (CTS) is a demanding and rewarding field, yet many aspiring junior doctors face perceived barriers within the specialty that discourage application. As the former and current EDI leads of SCTS INSINC (Inspiring Students in Cardiothoracic Surgery), we believe that all medical students should have the confidence to fully engage in early exposure to CTS, regardless of their background, socio-economic status, or protected characteristics. A diverse and inclusive CTS community will ultimately drive excellence in patient care, recruiting the most appropriate candidates and reflecting the diverse patient population we serve. As Professor Farah Bhatti instilled during INSINC's inception, quoting Mary Church Terrell, we must "lift as we climb." Our survey revealed three main barriers that deter students from pursuing CTS: financial costs, negative experiences in the operating theatre, and gender disparities.

Background

Our Equality, Diversity & Inclusion (EDI) survey was first conceived by the 2020-2023 INSINC committee, developed by Alexander Reynolds under the leadership of Ms Karen Booth and Professor Farah Bhatti and with assistance from the EDI committee under the leadership of Professor Indu Deglurkar. The survey aimed to identify perceived barriers to a career in CTS, exploring circumstances before medical school, initial career interests, and attitudes toward the surgical field overall. It was launched in March 2023 during the Pat Magee Session of the SCTS Annual Meeting in Birmingham and promoted via social media to capture a broad and representative student perspective.

Financial Barriers and Proposed Solutions

Financial challenges were frequently noted among self-funding students. The high costs of building a competitive CTS portfolio – such as attending surgical courses, electives, and conferences – place additional strain on students, particularly those without nearby cardiothoracic units who face added travel and accommodation expenses. To alleviate this financial burden, we are working towards securing funding that can be awarded to support students gaining experience in cardiothoracic surgery. For example, we will soon be launching an elective bursary to help support travel and accommodation costs for students interested in CTS. In return, recipients would share reflections on their experiences, inspiring further applicants and broadening interest in CTS. Additionally, we plan to publish a guide listing key contacts at CTS units, connecting students with mentors and supportive contacts across the country.

Negative Theatre Experiences and Proposed Solutions

A significant portion of students reported negative experiences in the operating theatre. Common issues included feeling ignored, witnessing hostility or unprofessional conduct, and a lack of orientation to the theatre environment. These factors can dissuade students from pursuing a surgical specialty. To address this, we propose creating an "orientation booklet" for cardiothoracic units, offering students pre-insight into the theatre environment and expected etiquette before they begin. By orienting students to both the theatre and the technical aspects of common CTS procedures, we hope they can engage more confidently with the team and explore the technical details of operations in greater depth.

Gender Disparity and Proposed Solutions

Gender disparity remains a significant perceived barrier to pursuing CTS, with fewer female role models in the specialty (females comprise 10% - 15% of UK consultants). This disparity can lead some female students to associate CTS with negative experiences as a female trainee or consultant. INSINC supports initiatives to make the field more inclusive for female students, in collaboration with the Women in Cardiothoracic Surgery (WICTS) committee. WICTS organizes events, publications, and a support network to address gender inequity in CTS. We encourage all surgeons to engage with WICTS resources and promote their availability to female students.

Conclusion

The SCTS INSINC, EDI, and WICTS committees share a common goal of equalizing opportunities in cardiothoracic surgery. We are committed to reducing perceived and unnecessary barriers, fostering an inclusive environment, and ensuring that all medical students, irrespective of background, can aspire to a career in CTS. By promoting interventions that address both circumstances and experiences among potential future trainees, we aim to secure a promising future for both the specialty and the patient population it serves.

Acknowledgements

Special thanks to our SCTS EDI and INSINC committee members. ■

The First Ever International Cardiology and Cardiothoracic Conference in Iraq

Prof Mahmoud Loubani, Consultant Cardiothoracic Surgeon, Castle Hill Hospital, Hull
Ahmed Abbas, Honorary Cardiac Surgeon, AlKafeel Specialty Hospital, Karbala-Iraq

On January the 15th, at 13:35 Baghdad time, I replied to an offer of collaboration from Syed Ali Naqvi, an interventional cardiologist from Hull, via LinkedIn. This LinkedIn message ignited the spark of the first ever international Cardiothoracic conference in Iraq. The discussion of the conference idea between myself and Dr Naqvi has ended up with establishing a team led by Professor Mahmoud Loubani as the cardiac surgery lead and Mr Joel Dunning as the thoracic surgery lead.

The preparations for this historical event started as a series of Zoom meetings between the UK and Iraqi teams to draw the road map for the conference and the post conference activities. The UK team included cardiologists from Manchester Foundation Trust, Kings College Hospital, Castle Hill Hospital and Imperial College Foundation Trust. We succeeded to invite teams from the Czech Republic under the leadership of Mr Viktor Zlocha, the Cardiothoracic lead at the university hospitals of Pilsen, and a team from Budapest under the leadership of Dr Levente Molnar a TAVI operator at Semmelweis University Hospital, in addition to Professor Arshad Quyyumi a cardiologist from the US. The team from Iraq included adult and congenital Cardiothoracic surgeons from Baghdad, Mid-Euphrates Cardiothoracic society, south of Iraq and Kurdistan (northern Iraq). The conference venue chosen was the University of Warith Al-Anbiyaa in Karbala, situated 1 hour drive south of Baghdad. The venue is remarkable for the mix of modern and historical architect.

The Day one of the conference started with the opening ceremony followed by keynote speakers and a glimpse on the history of the Cardiothoracic surgery in Iraq followed by the exhibition hall visit with a large number of pharmaceutical and device companies' representatives. Day one ended with a gala dinner at the Master of Regents City in Karbala.

On day two, the main day, the conference started with the combined Cardiology and Cardiothoracic sessions where debatable topics like TAVR Vs SAVR, CABG vs PCI for Left Main Stem Disease and AF Surgery vs catheter ablation were interactively discussed. The day then split into cardiothoracic and cardiology sessions covering the main areas of interest. The audience ranged from consultants, trainees, nurses and medical students. The conference closed by 7 pm mainly due to the plethora of cardiology discussions; we the surgeons, were succinct and finished by 4pm!

The day after the conference, the UK team delivered the CALS and REACT courses to Cardiothoracic surgeons and cardiology team in Zein El-Abedin Hospital. The two courses were led by Prof Mahmoud Loubani, Mr Joel Dunning, Mr Syed Suhail Qadri and Dr Ali Naqvi. They were extremely enjoyable and appreciated by the delegates.

The other guests and speakers not delivering the courses were taken on an exciting trip to the ruins of ancient Babylon. This proved to be an unforgettable tour and included a secret visit Saddam's Palace, which was not open to the public. The group then headed to the best ice cream shop in the Iraq and bought one Kilo of ice cream before heading back to Karbala for a dinner in the University gardens hosted by the President of Warith Al-Anbiyaa University.

On day three, the team headed to Najaf Cardiac Centre, which is the largest cardiac centre in Mid-Euphrates where we visited the Cath Labs and theatres. This visit has opened the gate for future collaboration and networking in the field of cardiology and cardiothoracic surgery. Prof Loubani and Mr Dunning did an MDT session during the visit. We then went to Imam Ali Holy Shrine and had some sight seeing with wonderful views of the sunset over the sea of Najaf. On our way back to Karbala, we had to stop next to Iraqi falafel and shawarma restaurants (Prof Loubani insisted and took the risk), the whole team had both falafel and shawarma and despite the cheap price this was the best part of the journey.

This great support from the UK team has meant a lot to our country, particularly to the Iraqi cardiothoracic society. The feedback was phenomenal, and you can sense the eagerness to collaborate and network with the UK on clinical, academic and business partnership levels. ■

OOPT in Minimally Invasive Cardiac Surgery at King's College Hospital, London

Mayooran Nithiananthan, ST7 Cardiac Surgery Trainee, East Midlands

The landscape of cardiac surgical training is evolving, with a growing focus on specialised areas such as minimally invasive cardiac surgery (MiCS), robotic surgery, and aortic surgeries. Trainees now need to acquire expertise in these emerging technologies to enhance their prospects of securing consultant positions in the future. They are permitted to take time out of their training programs for various reasons, including research, additional training, or personal development.

I am a trainee from the East Midlands with a specialised interest in MiCS. To achieve my future goals, I decided to undertake an Out of Programme (OOP) training year at King's College Hospital, London. My main aim was to explore all aspects of MiCS comprehensively. King's College Hospital was one of the pioneering centres in the UK to establish a MiCS program more than 15 years ago. King's has a team of dedicated, highly specialised surgeons, including Mr Ranjit Deshpande, Mr Max Baghai, and Mr Habib Khan, who perform MiCS regularly.

During my OOP training, I was primarily attached to Mr Ranjit Deshpande, where I had the opportunity to observe, assist, and perform MiCS procedures. These included minimally invasive mitral and tricuspid surgeries, Minimally Invasive Direct Coronary Artery Bypass (MIDCAB), and mini sternotomy AVR/ascending aortic surgeries. Additionally, I was particularly impressed by the intricate redo mitral surgeries performed via a right thoracotomy approach.

Over a six-month period, I was involved in more than 40 MiCS cases. Under Mr Deshpande's supervision, I gained experience in femoral cannulation, thoracotomy access for mini mitral procedures, mini-sternotomy AVR, and off-pump coronary anastomosis for MIDCAB. Alongside my MiCS cases, I also performed some interesting open cases under Mr Deshpande's supervision, including open mitral repairs, triple valve replacement, and total arterial CABG using bilateral mammary arteries.

As a trainee, case numbers matter – a concept I often compare to the "run rate" in cricket. King's has excellent trainers performing a wide range of operations. In the final five months of my training, I was attached to Mr Donald Whitaker, a

Multivessel MIDCAB Lecture, by Mr. Piroze Davierwala

BISMICS 2023, London

Setting up a FET procedure

Cricket at Oval

Talk at theatre practitioner's study day

renowned trainer who guided me through numerous cardiac pump cases and thoracic procedures, including decortications, VATS bullectomies, lung biopsies, and my personal favourite, rib fracture fixation. King's, being one of the busiest trauma centres in London, also exposed me to numerous challenging trauma cases.

Beyond the operating room, I had opportunities to review new patients, assess their suitability for MiCS, and discuss cases in Pan-London MDTs. This allowed me to meet and discuss cases with prominent figures in the field. During this year, I also published a few articles, contributed to a book chapter, attended and presented at national meetings, and served as faculty for various courses. One of my personal achievements was passing the FRCS Section 1 exam, which presented its own unique challenge.

Although it was a busy year at King's, I learned a great deal from many senior surgeons, both in operative and non-operative skills. One of the highlights was observing two senior surgeons collaborate on a challenging redo MiCS case, resulting in a successful outcome. The "two-operator" approach, widely used in the aviation industry to reduce cognitive burden and provide peer-to-peer support, was inspiring to see applied in surgery.

Being based in London offered a vibrant social life as well. We attended a cricket match at The Oval to watch England vs. Sri Lanka and participated in various educational activities for London trainees, which greatly helped in preparing for my FRCS exams. I am incredibly grateful to Mr Ranjit Deshpande, Mr Donald Whitaker, and Mr Habib Khan for providing me with an excellent training year at King's. Special thanks to Prof. Prakash Punjabi and Mr Kamran Baig, the joint TPDs for the London training program, for accommodating me as an OOP trainee.

Cardiac surgery is evolving, and minimally invasive techniques are here to stay. As trainees, we should aim to incorporate MiCS into our training years. While some advocate for pursuing MiCS as a post-CCT fellowship, I personally believe that engaging in MiCS early in training provides a solid foundation and opens future career pathways. A year of training outside your program can be invaluable, helping you learn new techniques, refine skills, and, most importantly, achieve self-realisation of your position and progress. This experience will undoubtedly contribute to my growth as a seasoned surgeon in the years to come. ■

Demitted Roles

Thank you to the following for the time and commitment they gave to their roles ...

Role	Name
SCTS Education Consultant Co-leads	Prakash Punjabi/Shahzad Raja
SCTS Transplantation Co-Chair	Rajamiyer Venkateswaran
SCTS EDI Co-Chair	Indu Deglurkar
SCTS Research Co-Chair	Eric Lim
Cardiothoracic Dean	Neil Roberts
RCS-SCTS Cardiothoracic Surgical Specialty Lead	Gavin Murphy

New Roles Congratulations to the following ...

Role	Name
SCTS President-elect	Enoch Akowuah (commencing after completion of Annual Meeting March 2025)
SCTS Elected Trustee	Justin Nowell (commencing after completion of Annual Meeting March 2025)
SCTS Elected Trustee	Stephan Schueler (commencing after completion of Annual Meeting March 2025)
SCTS Co-Deputy Congenital Cardiac Surgery Audit Leads	Phil Botha/Branko Mimic
SCTS Student Education Thoracic Lead	Shilajit Ghosh
RCS-SCTS Cardiothoracic Surgical Specialty Lead	Babu Naidu
Cardiothoracic Dean	Nizar Asadi

Cardiothoracic Surgery Curriculum Taster Programme in Congenital Cardiac Surgery

Jean-Luc Duval and Ali Ansaripour,
NTN Cardiothoracic Surgery Trainees, Oxford Deanery

The UK Cardiothoracic Surgery Curriculum is designed to provide broad foundational training with structured pathways for trainees to gain early exposure to specialised fields. The Specialty Advisory Committee (SAC) recently introduced taster programmes in areas like Congenital Cardiac Surgery and Transplantation & Mechanical Circulatory Support. These two-week placements specifically target National Training Number (NTN) trainees, allowing them to explore these subspecialties early on, aiding career decision-making and skill development.

During our ST2 training year, we undertook the congenital cardiac taster at Birmingham Children's Hospital, which was an invaluable experience. The ability to arrange a bespoke experience in Birmingham allowed us to choose the congenital experience that worked for us and provided us with the necessary experience, not within our deanery. Our experiences highlight the breadth of training offered and underscore the value of this initiative for early-stage trainees.

Arranging and Timing the Taster Programme

Arranging a taster programme requires early discussions with your Training Programme Director (TPD) and Assigned Educational Supervisor (AES). Securing their approval for study leave is essential. TPDs and AESs often have valuable contacts with centres offering taster placements, which can help you identify the best supervisors and locations for a meaningful experience. Additionally, they can guide you towards available deanery funding options to support travel and accommodation expenses during the programme.

Early planning ensures rotas are covered, minimising any impact on your colleagues and patient care. Timing is key; these tasters are ideally suited to ST1 or ST2 trainees, providing early exposure to subspecialties, although they can be undertaken at any point in training. You might consider arranging the taster during a non-cardiothoracic rotation, which allows you to gain this experience without losing cardiothoracic training opportunities. Also, consider the availability of supervisors at the host centre. Arranging your taster around their schedule ensures you receive the full benefit of their mentorship and maximises your learning during the placement.

Why We Chose Congenital Surgery

We both have been lucky to work within transplant units during our foundation programmes, gaining familiarity with transplantation but had limited exposure to congenital cardiac surgery. The congenital taster offered an opportunity to gain insights into a unique field essential for any cardiothoracic surgeon. Congenital cardiac surgery requires a deep understanding of complex developmental anatomy and physiology, skills that translate well to adult practice. Moreover, cardiac surgeons are increasingly encountering adult patients with congenital pathologies, many with prior cardiac operation, making this experience highly relevant.

Arranging the placement at Birmingham Children's Hospital was straightforward, thanks to the experienced human resources (HR) team and responsive

"Congenital cardiac surgery requires a deep understanding of complex developmental anatomy and physiology, skills that translate well to adult practice. Moreover, cardiac surgeons are increasingly encountering adult patients with congenital pathologies, many with prior cardiac operation, making this experience highly relevant."

clinical staff, who managed all necessary paperwork efficiently. The Heart Unit at Birmingham Children's Hospital is a leading centre for congenital cardiac care performing over 450 surgeries per year and acts as a supra-regional service for several complex cardiac procedures including hypoplastic left heart syndrome, neonatal surgery, and congenitally corrected transposition of the great arteries. This high volume and variety made it an ideal setting for a taster placement.

Overview of the Two-Week Programme at Birmingham Children's Hospital

We were welcomed by a supportive team, including senior registrars, clinical fellows, consultants, specialist nurses, and other allied healthcare professionals. Their guidance helped us integrate quickly, allowing us to make the most of the learning opportunities.

The two-week programme was structured to maximise exposure across all aspects of congenital care. Each day started early with ICU rounds, followed by theatre time, outpatient clinics, multidisciplinary team meetings, and departmental teaching sessions, providing a holistic view of congenital cardiac surgery.

The programme's structured approach allowed us to gain substantial clinical exposure in a short period. We had the opportunity to participate in and observe several complex surgeries, including ASD and VSD repairs, atrioventricular valvular repairs, and tetralogy of Fallot corrections. We also witnessed, and even scrubbed in, other advanced procedures such as hypoplastic arch repairs and, notably, the various staged procedures involved in treating hypoplastic left heart syndrome at different ages. We had the privilege of following these patients through their post operative course on the ICU and sometimes attend out-of-hours together with the on-call fellow or registrar.

In addition to operative experience, outpatient clinics and MDT discussions provided insights into long-term patient management and collaborative decision-making in congenital care. We also benefited from discussions with consultants and senior registrars, which provided clarity on training pathways and career options within congenital surgery. The placement allowed us to explore potential future rotations and further training opportunities.

Leave and funding

Since the taster programme is a part of the Cardiothoracic Surgery Curriculum, you are eligible to apply for study leave and access the associated budget through Health Education England (HEE) and your deanery. However, as the study budget is limited and needs to cover other essential courses, e.g. ATLS, it is important to plan your applications strategically.

Beyond the HEE study budget, there may also be additional funding sources available at the departmental or local level to help cover expenses such as travel and accommodation. It's worth discussing these options with your TPD, who can advise on any local funding opportunities that might help to alleviate the financial burden and make the most of this valuable opportunity.

Conclusion

The SAC's introduction of taster placements in Congenital Cardiac Surgery and Cardiac Transplantation is a welcomed addition to the Cardiothoracic Surgery Curriculum. This opportunity enables early-stage trainees to explore subspecialties in a supportive environment. The congenital taster programme at Birmingham Children's Hospital exemplifies the value of these placements, offering trainees structured mentorship, exposure to complex cases, and a holistic view of the field.

To any NTNs considering this experience, we would highly recommend taking advantage of this opportunity. The skills and insights gained are invaluable, broadening clinical understanding and enhancing practical skills that will benefit any future career in cardiothoracic surgery. By taking advantage of these taster programmes, trainees not only gain exposure to sub-specialties within our field but also develop competencies that strengthen their broader practice, ultimately contributing to the development of well-rounded cardiothoracic surgeons in the UK. Your TPDs and AESs are the best first point of contact, so contact them early to discuss these opportunities. ■

Comment from Tim Jones, SAC Chair, Cardiothoracic Surgery

It's good to read Jean-Luc and Ali's experience of the Taster Program and the positive benefits they gained from it. We would encourage all trainees to consider such a placement.

The Taster Program was initiated to provide all trainees with the opportunity of spending 1 – 2 weeks observing in either a congenital cardiac unit and or a cardiothoracic transplant unit. Whilst a knowledge of both subspecialties is part of the curriculum, we have responded to feedback from trainees many don't get exposure to either sub speciality and this may negatively impact on their subsequent career choice.

Jean-Luc and Ali have outlined how to access the Taster Program. It is important to discuss early with your training program director (TPD) and for all TPDs and AES's to raise the possibility with Phase 1 trainees.

For those trainees who enjoyed the Taster Program and want to spend further time training in either sub speciality the SAC has also introduced 3–6-month sub speciality training placements in congenital and or translation. These can be undertaken in region or out of region. They can either be accredited towards training time or used as additional training time by undertaking them as either an OOPE (out of program for experience) or an OOPP (out of program pause). Undertaking an OOPE or OOPP will extend overall training time, but it will provide valuable experience and training and may help you decide on either sub speciality as a future career.

Please discuss any of the above with your TPD or contact me directly for any further information.

tim.jones9@nhs.net ■

Cardiac team at the IV Leeds Aortic Course: Mr Ahmed Omran (candidate), Miss Brianda Ripoll (cardiac trainee, case presenter), Miss Betsy Evans (Leeds Aortic Course founder and faculty), Mr Walid Elmahdy (Course director and faculty), Mr Yama Haqzad (faculty), Mr Alex O'Neill (Artivion representative)

The 4th Leeds Aortic Course

Brianda Ripoll, Run-through trainee ST5, Yorkshire and the Humber

The national aortic calendar has a date saved for the Leeds Aortic Course since 2020. On the 17th and 18th of June 2024, at the Division of Anatomy of Leeds Institute of Medical Education, Cardiac and Vascular surgeons reunited for the 4th edition of the Leeds Aortic Course, sponsored by Leeds Hospital charity from the Vascular Surgery Research Fund.

Leeds Aortic Course is the only running course in the United Kingdom bringing together vascular and cardiac surgeons to think tank and practise multiple pathologies and techniques of the aortic organ. The course is divided in two days: Day 1 focuses on the proximal aorta, and Day 2 on the thoracoabdominal aorta. Both days count with extensive surgical practice on Thiel cadavers. Each specimen is allocated to a minimum of two trainees combining vascular and cardiac background across the country. Each table has dedicated national faculty from both specialties.

During day one, the course directors Mr Walid Elmahdy (Cardiac and Aortic Surgery, LTHT) and Mrs Nonica Maftei (Vascular Surgery, LTHT) introduced the course. The Aortovascular team initiative in Leeds, started by Miss Betsy Evans (Cardiac Surgery, LTHT) is unique in the United Kingdom for its dedicated team of excellent professionals working on complex aortic cases since inception. The Leeds Aortic Course is the evolution of this initiative and successful collaboration.

Mr Elmahdy then proceeded to explain cardiopulmonary bypass access for proximal aortic surgery, the principle of aortic root replacement and aortic arch vessels debranching, deployment of Frozen Elephant Trunk (FET) and Ascyrus Medical Dissection Stent (AMDS) with the media and logistic support of Mr Alex O'Neill, Artivion representative. This served as introduction for the first cadaveric session where candidates could practice axillary, femoral, and carotid dissection, followed by aortic root replacement with the help of both cardiac and vascular faculty including Miss Betsy Evans (LTHT), Mr Mohamed Osman (Harefield Hospital), Mr Ahmed Nassef (LTHT), Mrs Nonica Maftei (LTHT) and Mr Gabriele Maritati (Ospedale dei Castelli Hospital, Rome) and Mr Yama Haqzad (LTHT).

Mr Walid Elmahdy, course director of the Leeds Aortic Course


Miss Betsy Evans, founding faculty of the Leeds Aortic Course

During lunch break, candidates could practice different endovascular approaches including TAVI, TEVAR and handle models of FET and AMDS provided by Artivion and Medtronic.

Day one continued with the outstanding master class of arch surgery for Type A / non-A non-B aortic dissection by Mr Ulrich Rosendahl (Lead Aortic Surgeon, Royal Brompton Hospital, London), and a short case discussion session by Mr Yama Haqzad (Locum consultant, LTHT) and Miss Brianda Ripoll (Cardiac trainee, LTHT) showcasing the most challenging and successful complex aortic hybrid cases of Leeds Aortovascular service.

The second cadaveric session of the day provided direct hands-on practice for deployment of both AMDS and FET and performed total arched replacement and debranching.

Closing day one, Dr Amit Chawla (Consultant Anaesthetist St Thomas's Hospital, London) gave an in-depth view of the anaesthetic and critical care challenges in complex aortic surgery.

Both candidates and faculty enjoyed dinner at the Thai Edge restaurant where they could network, share experiences and anecdotes, and establish a bridge between specialties outside work.

Day two focused on the thoraco-abdominal aorta, with the kickstart of the international master class on TAAA open repair of Mr Gabriele Maritati, followed by the first cadaveric session.

During this session, with the expert help and teachings of Mrs Nonica Maftei, Mr Ahmed Nassef, Mr Tom Wallace and Mrs Jenny Robson (Vascular Surgery, LTHT), Mrs Rachel Bell (Vascular, Freeman Hospital, Newcastle) and Mr Maritati taught the control of descending thoracic aorta and retroperitoneal aorta. This practice included left thoracotomy and abdominal approach, lombotomy approach, aortic replacement in all its choices (supra/juxta and infra/renal) for all types of TAAA and left renal re vascularisation procedures to facilitate hybrid repairs.

During the lunch break of day two candidates had at its reach different simulation and models demonstrations provided by Artivion and Medtronic.

The day swiftly continued to the up-to-date, excellent masterclass on aortic infections and explants by Mr Morad Sallam (Consultant aortic surgeon, Guy's and St Thomas's Hospital, London), moderated by Mr Nassef, Mrs Maftei, Mr Wallace and Professor SV Homer (Vascular Surgery, LTHT) that led to an excellent discussion on suspected versus confirmed infections and the future perspectives on current trends and guidelines.

Dr Sapna Puppala (Interventional Radiology, LTHT) took over with a cutting edge, cinematic session on aortic imaging and challenging case presentations that brought together vascular and cardiac specialists as well as anaesthetists to an exciting discussion that we can see in our hybrid theatre. Miss Rachel Bell (Vascular Surgery, Freeman Hospital, Newcastle) displayed a series of complex cases that were debated by the panel.

The second vascular cadaveric session of the day continued with the help of the Leeds cardiac and vascular team and led by Mr Gabriele Maritati, Mr Morad Sallam and Mrs Bell. Candidates went through

"Leeds Aortic Course is the only running course in the United Kingdom bringing together vascular and cardiac surgeons to think tank and practise multiple pathologies and techniques of the aortic organ."

>>

Transperitoneal (TP) approaches to the abdominal aorta. Midline incision, Mattoux and Cattel-Braasch manoeuvres, emergency/elective supra-coeliac/supra-renal clamping; juxta/para-renal aortic repair, and visceral/renal revascularisation.

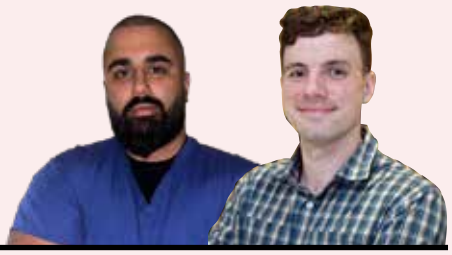
Mr Maritati closed the lecture session of the course on his experience at the OR for complex AAA.

This 4th edition of the Leeds Aortic course continues offering the only course in the UK that brings together cardiac, vascular surgeons and trainees to discuss needs, strategic steps, milestones, and practice together advanced surgeries on Thiel cadavers with the supervision of high yield national and international faculty. We look forward to continuing offering this excellent course and provide a rounded exposure to Aortic Surgery from our high-quality aortic service in the West Yorkshire. The 5th edition of the Leeds Aortic Course will be held on the 7th and 8th of July, 2025. Join us! ■

IV Leeds Aortic Cadaveric course during implantation of Frozen Elephant Trunk

Successfully Applying for a National Training Number in Cardio-Thoracic Surgery

Fadi Al-Zubaidi, ST1, Oxford
Harry Smith, ST1, London



In recent years, the ST1 cardio-thoracic surgical training program has emerged as the most competitive medical specialty in the United Kingdom. Whilst the number of available training positions have remained stable, the number of candidates applying has surged dramatically. In the latest application cycle, 408 candidates applied for just 9 posts, marking an unprecedented application ratio. For medical students and junior doctors aspiring to enter the specialty, this challenge can feel overwhelming. However, while the path may be daunting, we seek to provide some reassurance and share insights from our own journeys, having recently been appointed as ST1 trainees in August.

The Matrix: Blue Pill or Red Pill

For those determined to embark upon a career in this specialty, the first step is to familiarise yourself with the ST1 application matrix. Released annually in October, this scoring system delineates the criteria used for shortlisting candidates for interviews. Much like Neo's choice between the red pill and the blue pill in The Matrix, prospective applicants must decide whether to embrace the challenging reality of the application process or remain in the familiarity of the status quo. Although the scoring criteria may evolve from year to year, certain themes consistently emerge including academic prizes, publications, audits, postgraduate certifications, and achievements outside of medicine.

Our advice? Print out the scoring matrix, meticulously review each domain, and assess your achievements with ruthless honesty. Only claim points for accomplishments that meet the criteria with undeniable evidence. If you lack documentation, begin gathering it immediately – whether it's a letter from an audit department or a certificate from a conference. The sooner you compile your evidence, the smoother your application process will be.

The Right Environment

Whilst some well-prepared candidates are able to secure a training number straight out of foundation training, many applicants require additional experience before succeeding at cardio-thoracic national selection. Our paths into this specialty were remarkably similar.

After completing cardio-thoracic placements during our Foundation programmes, we sought further experience at a high-volume cardio-thoracic surgical unit and secured positions at Royal Papworth Hospital. From the outset, we made a conscious decision to collaborate in developing our portfolios, maximising our learning opportunities, and preparing for specialty applications. Although the competitive landscape may tempt one to take an isolated approach, our experiences demonstrate that a collegiate outlook can be incredibly effective and make the process significantly less stressful, if not enjoyable.

Our first year was spent as Core Trainees on the wards, where we gained invaluable experience in managing common cardiac and thoracic surgical patients, honing our operative skills, and building robust networks with supportive mentors. This immersion not only confirmed our passion for the specialty, but also served as a constant reminder of our ultimate goal: securing a training number. The clinical scenarios we encountered regularly prepared us for interviews and equipped us with a solid foundation of clinical experience. Despite a very fruitful first year, we found ourselves just shy of the shortlisting cut-off for interviews.

In light of this setback, the relationships we had built at the unit proved beneficial and helped us to secure medical education roles at Royal Papworth Hospital. This not only enhanced our skills in medical education, but also afforded us the time to pursue academic projects, prepare for the MRCS exams, complete higher degrees, and strengthen various aspects of our portfolios. The contrast between our first and second years highlighted the tension between invaluable clinical experience in a demanding ward setting and the opportunity to refine our portfolios in a more relaxed environment.

Ultimately, the path you choose after foundation training is personal, and success can be achieved through various routes. Familiarise yourself with the person specification, gain clarity on how long you can work in the specialty or related fields as a non-trainee before time runs out, and chart a course that effectively addresses the gaps in your experience.

> **"For those determined to embark upon a career in this specialty, the first step is to familiarise yourself with the ST1 application matrix. Released annually in October, this scoring system delineates the criteria used for shortlisting candidates for interviews."**

Mentorship

The importance of supportive mentors cannot be overstated when navigating the application and interview process. The encouragement we received from senior mentors after our initial setbacks fueled our determination and focused our approach. Seeking input from recently appointed national trainees proved invaluable in enhancing our chances of securing interviews.

Preparing for the interviews was undeniably daunting. For any prospective interviewee, attending the free national interview course generously organized by Mr. Kamran Baig and his faculty is essential. In our experience, this event was an excellent opportunity to connect with like-minded candidates, receive invaluable feedback from a diverse group of trainees and consultants, and lay the groundwork for effective preparation. We also arranged numerous mock interviews with trainees and consultants, which were pivotal in our readiness. We cannot thank enough all those seniors who dedicated their time to support us.

Portfolio Submission

A pragmatic approach to your portfolio is a crucial component of the ST1 application process. The best advice we received was to adopt the perspective of the reviewer, ensuring that your evidence is irrefutable, and to critically evaluate your own submissions. There should be no ambiguity regarding whether the evidence you provide meets the criteria in the ST1 matrix; your evidence must be bulletproof. Carefully follow the published instructions on how to display your evidence to avoid any unexpected disappointments.

Pragmatism

The time constraints of the application process mean that achieving every point in the matrix is unrealistic – and perhaps that is a blessing. No applicant possesses all the points across every domain. We recommend taking a broad approach, aiming to score across multiple domains. Consider what you can realistically accomplish in the time available, whether that involves completing another exam, obtaining a postgraduate certificate, or delivering a presentation. If you are pursuing a higher degree, finishing it early could prove advantageous. Leverage every opportunity to your benefit and think creatively about how one project can address multiple criteria – an audit presented nationally, for instance, may lead to an award, scoring points for an audit, a national presentation and a prize.

Persistence

Both of us applied twice – once during our F3 year and again in our F4 year. Initially, we did not secure interviews, but after considerable effort and resilience, we ultimately obtained our training numbers. The key takeaway is that with hard work, a supportive network and determination, it is possible to make incremental progress each day that brings you closer to your goal. Good luck! ■

NCIP Dashboards: Coming Soon to Thoracic Surgery

Doug West, NCIP Thoracic Surgery Clinical Lead, Thoracic Surgeon, Bristol

The National Consultant Information Programme (NCIP) is a free online portal – part of the Getting It Right First Time (GIRFT) programme – giving consultant surgeons, medical directors, responsible officers and specialty clinical leads a single point of access to locally and nationally benchmarked data covering activity and outcomes. With NCIP rolling out in thoracic surgery this winter, Doug West talks us through the development of the programme in our subspecialty.

Any of us who have taken their smart watch to the gym or on a run will know that data is essential if we want to improve our performance. Today's health service is awash with data and yet clinicians, who are often the staff most invested in improving outcomes, still struggle to access it. NCIP sets out to address this problem by creating usable, easy to access dashboards that summarise demographic, activity and outcomes data.

Before talking about what NCIP can do, it may be reassuring to talk about what it is not. Firstly, NCIP is not an audit. It is a tool for team and personal reflection; there is no public release or national report. Its first uses are likely to be for individual appraisal and revalidation, and to guide local audit and quality improvement activities. The project itself defines no audit standards, and it will identify no formal outliers. Secondly, it requires no new data collection. The current iteration of NCIP uses HES (Hospital Episode Statistics) data, although it is hoped that in time it will incorporate data from other sources such as theatre data. HES is the admitted patient care data already produced by all NHS hospitals in England.

NCIP's web-based portal summarises activity in an easily searchable and usable format. As much as possible, we have tried to approximate the procedure groups used in the Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS) returns.

Alongside activity will be contextual demographic and comorbidity data, but we have not formally risk adjusted outcomes. The outcomes reported include length of stay, acute kidney injury and mortality. NCIP will update quarterly, far more frequently than previous audit outputs like LCCOP.

NCIP will make benchmarking easy. Activity, comorbidity and outcomes will be reported alongside national data, and it will also be possible to directly compare with other units of similar characteristics. Having this data should empower surgical units to examine their activity, and plan evidence-based service improvements.

NCIP provides a unique opportunity to review NHS practice, helping support clinical quality and patient safety. Your trust submits your surgical data to NHS England, and this is used to produce dashboards in the NCIP portal. Making sure this data is recorded accurately is important for you and your patients. NCIP allows you to "drill down" to individual patient level, so correlation with hospital records should be possible. NCIP has produced a data quality guide that explains how to ensure activity is attributed accurately and clinical coding data reflects your surgical practice.

While we acknowledge the imperfections of HES and indeed all healthcare data, the potential benefit from teams having ready access to the data is a strong argument for its release – after all, who better to make the most effective use of this resource than clinicians themselves? SCTS members who have already helped us with their feedback during development have found it useful, and I trust that you will too.

More information on NCIP can be found on the NCIP webpage. To sign up for NCIP, email: **england.ncip@nhs.net** ■

"NCIP will make benchmarking easy. Activity, comorbidity and outcomes will be reported alongside national data, and it will also be possible to directly compare with other units of similar characteristics. Having this data should empower surgical units to examine their activity, and plan evidence-based service improvements."

HRUK SCTS Trainee Fellowships in Adult and Paediatric Cardiac Surgery (2022) The Hospital for Sick Children, Toronto

Joseph George, Congenital Cardiothoracic Surgery

My fellowship in The Hospital for Sick Children (SickKids) has been a significant milestone in my career, before I embark on practice as a consultant in the UK. I was able to learn a lot not only clinically and operatively, but also from a management and process improvement.

- A significant highlight has been the operation of the dedicated cardiac ICU, staffed by intensivists who are dual-certified in paediatric cardiology and paediatric intensive care, respiratory therapists dedicated to operating the mechanical ventilatory support, and the numerous non-nursing support staff who make sure equipment reaches the right person at the right time. The surgeon-intensivist relationship is a model of symbiosis.

- Being struck by the throughput and remarkably short length of stay (one of the shortest in the North American STS database), I learnt a lot about the journey behind making this happen. This included the pre-operative clinic where the patient undergoes all necessary appointments and tests in one sitting, routine regional anaesthesia and extubation on table, early removal of chest drains, and early engagement with the post-operative cardiology team.

- The close proximity of Toronto General Hospital (TGH), another world-renowned cardiac centre, to SickKids not only enables a seamless transition of care, but also close involvement in the care of ACHD patients. We would have regular lists with the occasional transplant for a congenital patient. As the congenital fellow, we would be involved in both retrieving from various North American sites, and implanting – a unique experience compared to the UK.

> **"Patients and staff benefitted from visibly large investments in infrastructure including human resources to deal with finer aspects of hospital admin, freeing up clinicians to focus on the decision-making and clinical care."**

- We undertook and prepared weekly and monthly 'performance rounds' focus on evaluating complications and successes on all post-operative patients. These reviews involve the whole heart centre including surgeons, cardiologists, intensivists, and nursing staff, who collaboratively analyse patient data to refine surgical techniques, enhance recovery protocols, and improve overall patient care.

- Patients and staff benefitted from visibly large investments in infrastructure including human resources to deal with finer aspects of hospital admin, freeing up clinicians to focus on the decision-making and clinical care. Sophistications in electronic health records, virtual meetings and collaborating digitally for patient care and research featured heavily in the day-to-day running of the heart centre – skills that will stand me in good stead as the NHS continues on its long overdue digital transformation programme.

- As well as being first operator for routine cases, I was able to train in minimally invasive approach (MIS) for atrial septal defects. The MIS programme was advanced, with procedures being undertaken for AV valve defects, re-operative surgery and encompassing a wide range of patients from infants to adults.

Overall, I had a fantastic time professionally. I cannot thank the SCTS and Heart Research UK enough because without the award, I would not have had the resources to support my family and benefit as much as I did from my fellowship. ■

Obituary:

Dr Yasser Hegazy 1961 – 2024

Cardiac Surgeon — a Legacy of Compassion and Service

On the 30th of October 2024, the NHS lost a dear colleague and cardiac surgeon following a short illness.

Dr Yasser Hegazy was born in Geneva, Switzerland, on the 24th of June 1961. As the son of an Egyptian diplomat, he travelled the world, enriching his cultural experience and broadening his perspective. At the early age of 12, he resolved to become a doctor, believing his purpose in life was to help others. By 20, he decided to become a cardiac surgeon after witnessing a cardiac surgery operation for the first time during an educational exchange as a third-year medical student. Yasser believed in having a clear life vision and pursued his with passion and enthusiasm.

In 1994, he was awarded his FRCS diploma and began his cardiothoracic training at St Thomas's Hospital in London. He then moved to Liverpool to work as a registrar at the Cardiothoracic Centre, now the Liverpool Heart & Chest Hospital, where two cardiac surgeons, Elaine Griffiths and Brian Fabri, left a profound impact on him, shaping his identity as a surgeon, refining his skills, and inspiring the professional excellence that defined his career.

From 1996 to 2010, Yasser helped develop the advancement of cardiac surgery in Egypt. As a consultant, he established the first cardiothoracic surgery units at the "International Medical Centre" and the "Galaa Central Hospital". He was appointed the editor-in-chief of the *Journal of the Egyptian Society of Cardiothoracic Surgery*. Yasser was twice elected to the board of the Egyptian Society of Cardiothoracic Surgery, serving for ten years as a benchmark for excellence in Egypt's cardiothoracic surgery field. Yasser treated underprivileged patients who had no access to medical care, often performing surgeries, sourcing equipment, and helping to finance the operations.

In 2005 Yasser ranged another significant surgical milestone and was entered onto the GMC Specialist Register for Cardiothoracic Surgery.

"Yasser contributed to research by reviewing doctoral theses, earning admiration by all as a true "gentleman" who treated everyone equally and prioritized patient care."

In 2010, Yasser returned to the UK, inspired by the NHS's mission to provide equitable healthcare. He worked in cardiothoracic surgery at the Aberdeen Royal Infirmary for five years, before moving to the Golden Jubilee Hospital in 2015 to join the Transplant and Cardiothoracic Retrieval Service, initially as a Speciality Doctor then in 2020 appointed as a Locum Consultant Cardiac and Retrieval Surgeon.

Yasser pursued further training in donor heart machine perfusion innovative technology, TransMedics Organ Care System (OCS), and was an integral member of the team that performed the first DBD OCS beating heart transplantation in Scotland 2017.

Yasser had a passion for mentoring the next generation of surgeons, shared his knowledge, enhanced their training. He also contributed to research by reviewing doctoral theses, earning admiration by all as a true "gentleman" who treated everyone equally and prioritized patient care.

Outside of work, Yasser loved playing the piano, having been trained by concert pianist, Olga Vasilieva, in Russia. He shared his passion for classical music with his colleagues and family, often performing at hospitals and home. He also enjoyed football, watching Premier League matches with his wife and playing with his children, even at 63 years old.

Yasser is survived by his wife, Marwa, his two children, Mohamed and Fatma. He was the heart of his family – a pillar of strength. Yasser's faith was also the cornerstone of his identity and was expressed through his actions, living a life of service and kindness.

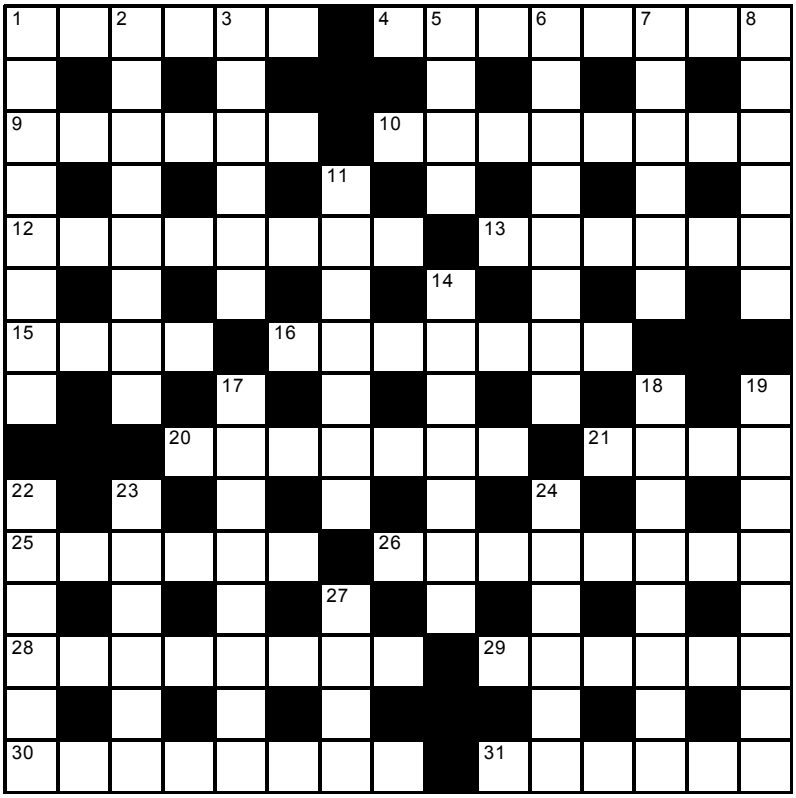
Yasser's impeccable manners, and charming humour left a lasting mark on all who knew him. His unwavering dedication to his family and cardiac surgery, compassion for his patients, reflect the very best of humanity and an unforgettable portrait of a life lived with purpose and grace. ■

New appointments August 2024 to January 2025 ...

Name	Hospital	Specialty/Role	Starting Date
John Hogan	Mater Misericordiae University Hospital, Dublin	Locum Consultant Thoracic Surgeon	July 2024
Mohammad Diab	University Hospital Southampton	Locum Consultant Thoracic Surgeon	August 2024
Stuart Grant	Wythenshawe Hospital, Manchester	Consultant Cardiac and Aortic Surgeon	September 2024
Prashant Mohite	Royal Papworth Hospital, Cambridge	Locum Consultant Transplant and Cardiac Surgeon	September 2024
Sara Tenconi	Wythenshawe Hospital, Manchester	Consultant Thoracic Surgeon	October 2024
Rhona Taberham	John Radcliffe Hospital, Oxford	Locum Consultant Thoracic Surgeon	October 2024
Sajiram Sarvananthan	John Radcliffe Hospital, Oxford	Locum Consultant Cardiac Surgeon	December 2024

Crossword

Set by Samer Nashef



Across

1 In case archbishop covers up investigation... (6)
4 ...press 'one' if worried to find the answer (8)
9 Expedient to be young with a lisp (6)
10 Drop iron? (8)
12 Persistently troubling relative, joint almost seized (8)
13 Straight in with one strike (6)
15 Appreciate speed (4)
16 Officer sounds a bit of a nut (7)
20 Appeared without a plan and decorated (7)
21 Spirit not one that's inherited (4)
25 Pretend backing league regularly is real (6)
26 Find recent leads go blue (8)
28 G12? (8)
29 Syndicate for clarinet not in fashion (6)
30 Doctor having a fatal accident (8)
31 Dynamism of topless 21 orgy (6)

Down

1/3 National Trust country house, perhaps in Dorset? (8,6)
2 Sufficient notice before match (8)
3 See 1
5 Prime Minister's garden (4)
6 Rover breaking into flat is forgiven (8)
7 Tidy million finally polished off (6)
8 Things that happen in Eastenders almost never return (6)
11 Game corner in series first half (7)
14 Senior finished pocketing money (7)
17 Time off for what is charged by museum (8)
18 Traitor act needed to break into trade secret (8)
19 People agree rationally (8)
22 Having a higher temperature, compiler's admitted to part of the hospital (6)
23 Film producer made us do it (6)
24 Stay with mother in control (6)
27 Once upon a time in the North (4)

Please email solutions by 28/03/25 to:

emma@scts.org ***or send to Emma Piotrowski, SCTS, 38-43, Lincoln's Inn Fields, London WC2A 3PE***

The winner will be randomly selected from successful solutions and will win either a bottle of 'fizz' or fine olive oil.

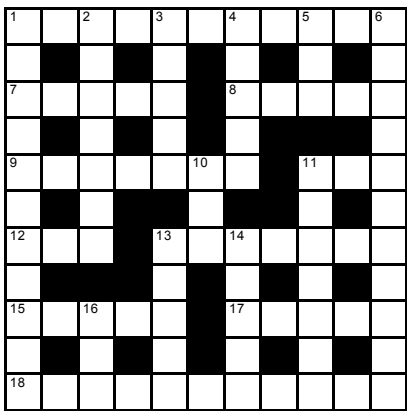
Congratulations to Jonathan Hyde for winning the August 2024 Bulletin crossword competition (right) who chose a bottle of fine oil as his prize.

S	T	R	E	S	S	E	D	■	R	A	D	I	O	S
H	■	O	■	O	■	L	■	■	■	B	■	M	■	W
R	E	M	I	N	D	E	R	■	S	A	V	A	G	E
I	■	A	■	G	■	G	■	B	■	N	■	G	■	E
L	A	N	D	S	C	A	P	E	■	D	R	I	F	T
L	■	S	■	■	■	N	■	E	■	O	■	N	■	E
■	■	■	P	S	S	T	■	S	I	N	G	E	R	S
P	■	D	■	T	■	■	■	■	■	E	■	D	■	T
A	N	I	M	A	L	S	■	S	O	D	A	■	■	■
S	■	S	■	T	■	A	■	E	■	■	■	T	■	L
S	C	A	L	E	■	C	O	A	S	T	L	I	N	E
A	■	G	■	M	■	K	■	S	■	H	■	B	■	G
G	A	R	D	E	N	■	L	I	F	E	T	I	M	E
E	■	E	■	N	■	■	■	D	■	R	■	A	■	N
S	H	E	E	T	S	■	R	E	V	E	R	S	E	D

Sudoku

	4		1			8		
	1			4	8			3
8	7						2	
			7		5		9	
					3	1		
2			5	6				1
						7		6
	6			9			8	

Quick Crossword



Across

1 Not alone (11)
7 Children's show (5)
8 One who gives (5)
9 Luxurious (7)
11 Asian sauce (3)
12 Very cold (3)
13 Dog (7)
15 Cherub (5)
17 Expression (5)
18 Type of olive oil (5,6)

Down

1 Rough (11)
2 100 years (7)
3 Deer (5)
4 Measure of performance (5)
5 Hotel (3)
6 Lech (5,3,3)
10 Sleep (3)
11 Yachting (7)
13 Saucy dance? (5)
14 Form of defence (5)
16 Intestine (3)

Over 300,000 patients have been treated with the INSPIRIS RESILIA valve globally

Celebrating a milestone in Heart Valve Surgery

We are thrilled to share a remarkable milestone: the successful implantation of 300,000 INSPIRIS RESILIA valves! As the world's most implanted surgical tissue valve, the **INSPIRIS RESILIA** valve is leading the way in innovation. This achievement would not have been possible without the unwavering dedication and exceptional skill of the cardiac surgeon community. Together, we have made a significant impact on the health and well-being of patients around the world.

Our Vision: Treating Many More Patients

At Edwards Lifesciences, we are driven by a passion to improve patient lives. As the leading global structural heart innovation company, we created INSPIRIS RESILIA valve on that vision, innovating on a foundation of the Carpentier-Edwards PERIMOUNT valve design and the familiar procedural experience of the Carpentier-Edwards PERIMOUNT Magna Ease valve.

Commitment to Clinical Evidence

Our commitment to generating scientifically backed evidence continues to support the INSPIRIS RESILIA valve. RESILIA tissue has been extensively studied since 2011[1] with the first RESILIA tissue valve implanted in July 2011. With now over **13 years of clinical experience**, RESILIA tissue has taken performance and durability to new heights transforming the tissue valve landscape.

Learn more about the growing base of evidence backing up RESILIA tissue performance

Learn more about our RESILIA tissue valves portfolio and join us in celebrating this incredible achievement. Thank you for your dedication and partnership in advancing cardiac care. Together, we are making a difference, one heart at a time.

Learn more at Edwards.com/gb/RESILIA

Testimonials from Cardiac Surgeons

Professor Olaf Wendler, consultant cardiothoracic surgeon at King's College Hospital, London, UK and Chair of the Heart, Vascular and Thoracic Institute at Cleveland Clinic London shares,

"The demonstrated long-term history of the Carpentier-Edwards PERIMOUNT valve, alongside the potential calcification delay of RESILIA tissue appeals to patients"

Mr Giovanni Mariscalco, head of Service for cardiac surgery and Lead Clinician for complex aortic surgery at Glenfield Hospital, Leicester, UK adds,

"I have implanted over 200 INSPIRIS RESILIA valves and I haven't had any unsatisfied patients"

Reference:

1. Final 5-year outcomes following aortic valve replacement with a RESILIA tissue bioprosthesis. Krzysztof Bartus, et al. *European Journal of Cardio-Thoracic Surgery,* Volume 59, Issue 2, February 2021

No clinical data are available to evaluate the long-term impact of RESILIA tissue in patients. Additional clinical data for up to 10 years of follow-up are being collected to monitor the long-term safety and performance of RESILIA tissue.

Medical device for professional use. For a listing of indications, contraindications, precautions, warnings, and potential adverse events, please refer to the Instructions for Use (consult eifu.edwards.com where applicable).

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Edwards

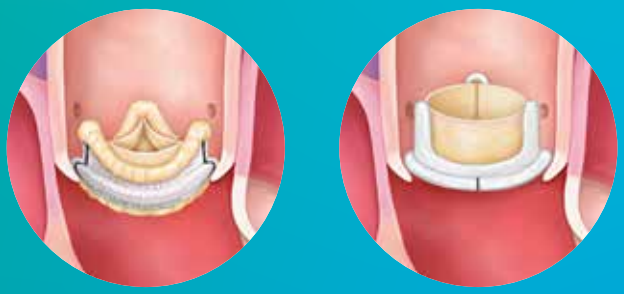
EPIC™ PLUS SUPRA
THE IDEAL VALVE OPTION FOR LIFETIME MANAGEMENT

No other valve has been expertly engineered with non-curtaining leaflets,* a low overall profile, and fracture-friendly stent with future interventions in mind.

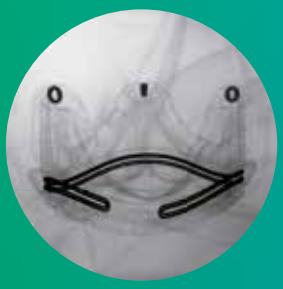
EPIC LEAFLETS DO NOT CURTAIN

Curtaining is a characteristic of pericardial leaflets where the leaflets form a curtain between stent posts that may present coronary obstruction risk (see right) or interaction with common suture affixation method.[1] In contrast, the leaflets of the Epic Plus Supra do not curtain and can mitigate coronary obstruction risk post-TAV-in-SAV.

For illustrative purposes only.
TAVI frame used is not meant to depict any specific valve.



Epic Plus Supra leaflet behavior vs. Inspiris‡



- Epic Plus Supra fractures at low pressures (8 atm)[2]
- Low profile stent posts[3]
- C-shape radiographic profile designed to facilitate expansion for future ViV

VALVE-IN-VALVE** SUCCESS[4]

>95%

Freedom From Valve Intervention 3-Years Post ViV

* Based on Abbott internal testing.
** The safety and effectiveness of valve-in-valve procedures in Epic Plus and Epic Plus Supra valves has not been established.

REFERENCES: 1. Technical report. Data on file at Abbott. 2. Allen, KB., Chhatriwalla, A., Cohen, DJ., et al. Bioprosthetic valve fracture to facilitate transcatheter valve-in-valve implantation. Ann Thorac Surg. 2017;104:1501-1508. 3. Epic Plus IFU 4. Fang, K. et al (2022, June) Three-year outcomes of Valve-in-valve intervention within the Epic™ Supra and Epic™ Mitral valves in a Medicare population. Poster presented at the TVT Annual meeting, Chicago.

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