

# *the* **bulletin**



Society for Cardiothoracic Surgery  
in Great Britain and Ireland

July 2012

## ***Annual Meeting 2012 - Report***

***Thoracic Surgical Audit***

***Valve Repair Fellowship***

***The Fate of Abstracts***

***St George's Valve Technology Symposium***

***Ethicon Fellowship Report***

***The State of ECOM***

***Sinister Trainers or Trainees?***

[www.scts.org](http://www.scts.org)

[www.sctsltd.co.uk](http://www.sctsltd.co.uk)



Society for Cardiothoracic Surgery  
in Great Britain and Ireland

# the bulletin

July 2012

## Contents

|  |    |
|--|----|
| Report from The President                | 2  |
| Honorary Secretary's Report              | 4  |
| Annual Meeting Report                    | 5  |
| Thoracic Surgical Audit                  | 7  |
| Valve Repair Fellowship                  | 8  |
| St George's Valve Technology Symposium   | 10 |
| Nursing Representative's Report          | 11 |
| The Fate of Abstracts                    | 14 |
| Ethicon Fellowship Report                | 15 |
| Sinister Trainers, or sinister trainees? | 16 |
| Current Status of Adult ECMO in the UK   | 18 |
| Forthcoming Events                       | 21 |
| New Appointments                         | 22 |
| Crossword                                | 23 |



Society for Cardiothoracic Surgery in Great Britain and Ireland

The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London WC2A 3PE

Tel: +44 (0) 20 7869 6893 Fax: +44 (0) 20 7869 6890

Email: [sctsadmin@scts.org](mailto:sctsadmin@scts.org)

[www.scts.org](http://www.scts.org)



Edited by Vipin Zamvar  
Publishing Secretary

Contact: [zamvarv@hotmail.com](mailto:zamvarv@hotmail.com)

# Report from The President

James Roxburgh



**I first sat on the Executive as the Senior Registrar representative nearly 20 years ago. At that time the President only served for one year and the culmination of his Presidency was the annual meeting held at a venue of his choosing, often the President's home town. My recollection is that the Executive had little dealings with external agencies and that without e-mail everything was done at a much more gentlemanly pace.**

It is now over 10 years since the Executive made the momentous decision to take over the running of the Annual meeting. I was an elected Trustee at this time and understandably the Annual meeting took up a lot of our time, but for the first time we were in total control of our financial future. It was also about this time that the role of the President changed. It became clear that if SCTS was to move forward and engage with the Department of Health, the Royal Colleges and become an asset for its members the President needed had to have a longer-term perspective. It was simply not possible to function on a 12-month cycle. It did not even cross anyone's mind that we should also consider the patients, the press and the politicians! We now have a patient's representative as a valued member of the Executive, we have excellent access to senior politicians and we actively engage with the press. We are fighting above our weight and our recent dealings with NICE have shown us the power of the patient coupled with reasoned professional argument. However we must not stand still and rest upon our laurels. The changes facing both cardiothoracic surgery and the current financial climate are two significant pressures we must face up to.

## Annual Meeting

Over the last few years we have regarded the Annual Meeting as a cash cow to fund a range of our activities but this has, to some

extent, been a financial illusion. We are now in a position where the Annual Meeting is self-funding and any surplus is a real one but it will often be much smaller than we have come to expect. We rely on the generous support of our corporate colleagues to make the University and the Annual Meeting the outstanding events they have become, but we cannot keep going to the same "well" for all our financial needs. I have felt for some time that we need to be more creative when looking for future sources of funding for our Society. I am very pleased that we have obtained £50,000 from the GMC to support the development of thoracic audit over the next 3 years. This is the first time the GMC have made such significant donation and it was, in part, due to our proven ability to deliver major projects such the cardiac and thoracic Blue Books and the Public Portal.

At the recent Executive we discussed 2 proposals from professional fund raising companies. Malcolm Dalrymple-Hay and I have had preliminary discussions with senior executives from both companies and what is abundantly clear is that there are funds out there and if we are to tap into them we need professional help. This is a big step for us and not one SCTS should take lightly but I feel strongly that we must consider it. Whatever the outcome the Executive will have to decide upon our financial priorities for the next few years to ensure we use the funds we have, however limited they may be, to the best effect. I would therefore ask all members to e-mail me with their views on what our future financial priorities should be. We need to have a coordinated approach to obtaining new funds and that can only happen if we have an overall view of what will get us the "most bangs for our bucks".

## Paediatric Review

It was our Society that initiated the paediatric review process when the then President, Sir Bruce Keogh, wrote to the Department of Health; no one was more surprised than Bruce when it landed on his desk as the new Medical Director of the NHS! As everyone knows the Safe & Sustainable review will finally make an announcement on July 4th but the ACHD review has only just published the draft standards for public consultation. Although I was aware of the S&S review it was not until I was involved in the ACHD process that I truly understood the problems associated with looking at congenital cardiac surgery as 2 distinct entities (Paediatric and ACHD) rather than the totality of the speciality. However we are where we are and there is no going back! David Anderson, Chuck Mclean and I felt from the outset that our involvement in the ACHD process must be as representatives of the whole speciality. A congenital sub-committee was set up within the Executive and the draft

*The Executive will have to decide upon our financial priorities for the next few years to ensure we use the funds we have, however limited, to the best effect. I would therefore ask all members to e-mail me with their views on what our future financial priorities should be.*

*continued overleaf*

## President's Report continued

standards were discussed at a constructive session held at the Annual meeting. The final closing date for this phase of the public consultation is July 27th, so please avail yourselves of this opportunity to contribute.

I am very pleased to welcome our new patient representative, Mike Fisher, to the Executive. The role of the patient representative has been invaluable to the Society and it has not just been in understanding the patient's perspective but also helping us see to the broader picture. Mike was, until his retirement, Director of Strategy for Bass-Charrington and so I am sure his wide experience will be of great benefit to us. The appointment was a difficult one as we had an embarrassment of riches and Mike is already working with the other short-listed candidates to set up a Patient Representatives Group. I look forward to working with him over the next 2 years to build on the excellent work that was done by David Geldard.

### Out-of-hours

One of David Taggart's Presidential objectives was to "explore mechanisms to ensure safer surgery out-of-hours". Marjan Jahangiri has worked with ACTA to produce Guidelines for the Safe Practice of Cardiac Surgery and these formed the basis of a very popular session in Manchester. Following the publication by Dr Foster on the increased mortality at weekends and the drive by the Dept. of Health these guidelines are very timely. We have shown that mortality in cardiac surgery is not affected by the day of admission or of operation but this does not belittle the considerable difficulties in undertaking high-risk and complex surgery with inexperienced assistants. By the time this is published the guidelines will have been signed-off ACTA & SCTS and will circulate to all members in late July. The Academy of Royal Colleges is taking soundings from all medical and surgical specialities and we have already submitted a response. However this will continue to be a major issue for some time to come.

### Moving on

I think the time has come for cardiac surgery to move the spotlight away from surgeon specific mortality and towards unit based outcome measures. The mortality for elective 1st time CABG is now under 1% and thus for 99% of patients it is the quality of their survival that is important. In addition the difference in mortalities between surgeons and units is moving to the situation where it is of statistical interest rather than of practical importance. Although we have shown we are responsible when it comes to self-monitoring we cannot abandon surgeon-specific mortality. However I believe we have the moral high ground and by developing more relevant outcome measures we can focus on what is more important for surgeons and patients. The new e-reports that have been developed by Ben Bridgewater are the first step in this direction.

We are the Society for Cardiothoracic Surgery in Great Britain & Ireland and it is important that we do not forget this. A few years ago many felt, with some justification, that thoracic surgery was the poorer relation of cardiac surgery but we have worked hard to ensure it is an equal partnership. It has been said that SCTS has not fully grasped the effect that devolved health care has had on how we can support all our members. At the recent Executive I proposed wide ranging changes to make us more efficient and responsive as a Society and these will be discussed in detail over the coming months. We must consider how we respond to the needs of those who work under devolved healthcare. I hope all unit representatives will be able to attend later in the year when we will have a chance to discuss all these issues in detail. Such changes are not easy or quick but I can assure you that you will be kept informed and welcome your input.

Finally I would like to thank the Executive for the hard work they will be doing over the next 2 years and say how much I am looking forward to working for our Society. As always please feel to contact me [james.roxburgh@gstt.nhs.uk](mailto:james.roxburgh@gstt.nhs.uk)

# Honorary Secretary's Report

Graham Cooper



**Obtaining £50,000 from the General Medical Council to set up and run the National Thoracic Database for two years is the culmination of a long journey to fund a thoracic database. It is a significant achievement. It clearly shows belief in SCTS and our commitment to medical professionalism. For the GMC it represents an opportunity to show their willingness to work with the profession in their role of promoting proper standards in the practice of medicine. Our obligation to the GMC for the funding is simply to provide them with an annual report on progress. We have a written agreement that running the database, all data within it and any outputs from it are the sole responsibility of SCTS. The database will use the already agreed SCTS thoracic dataset and we hope it will go live in early 2013. The database will be run by Dendrite. Units that do not have an existing database or database support will be able to upload data on a case by case basis. Those that have an existing in-house database will be able to upload data as a periodic bulk upload should they prefer. We will keep you informed as the project progresses, Richard Page is leading this and he and I are happy to answer any queries you may have at this stage.**

The thoracic sub-committee was established in late 2009 and has been a great success, last year a congenital sub-committee was formed and your Executive agreed last month to form an adult cardiac sub-committee as well. The details of the membership and terms of reference of this new sub-committee and the 2 existing ones are being drawn up for approval at the Executive in September. Simon Kendall is leading this work and he or James Roxburgh are keen to receive your comments.

We have been concerned that the publication of surgeon and unit specific results may lead to risk aversion and so lead to some deserving patients being turned down for surgery. The key safeguard against risk averse behaviour is adequate risk adjustment for case mix. At the Annual Business Meeting this year, Ben Bridgewater presented data that showed that the modified logistic EuroSCORE did not adequately risk stratify for emergency and salvage adult cardiac cases. The proposition that these cases are excluded from surgeon and unit specific analyses was accepted by the meeting. This will be implemented immediately. We will continue to monitor the outcomes of emergency and salvage cases this data will however, be excluded from the data used to analyses individual surgeons and units outcomes.

We also discussed benchmarking mortality rates by hospital and surgeon at the Annual Business Meeting. As the results of surgery have improved so much over recent years, the original logistic EuroSCORE is not an adequate risk stratification model any longer. This has led to the modification of the EuroSCORE. The original EuroSCORE being recalibrated based on mortality rates between 2004 and 2007 as the benchmark. With further improvements in mortality, this modification is now also not an adequate model. We therefore agreed at this years Annual Business Meeting that we should introduce true contemporary benchmarking, whereby units and surgeons would be compared

against the mortality rates of their peers during the time period under consideration, after making appropriate adjustments for case mix. Thus for the period 2008 to 2011, the logistic EuroSCORE will be calibrated against the mortality for the same period. We also recognised that this system of recalibration to achieve adequate risk stratification was becoming increasingly complex and potentially confusing. We therefore agreed to conduct an analysis of the adequacy of EuroSCORE 2 as an accurate risk prediction model based on the SCTS database. Ben Bridgewater has carried out this analysis. This showed that EuroSCORE 2 is a reasonable predictor of overall mortality. In June, therefore the Executive agreed that from April 2013 we will use EuroSCORE 2 as the risk stratification model for benchmarking adult cardiac surgery. A separate analysis found that EuroSCORE 2 was, like the original EuroSCORE, an inadequate risk model for emergency and salvage cases. These will therefore remain excluded from unit and surgeon specific analyses from April 2013. To allow you time to make any necessary adjustments for using EuroSCORE 2 we will continue to use the contemporary recalibration of the original EuroSCORE until April 2013. Details of the change to EuroSCORE 2 will follow but in the meantime please contact Ben Bridgewater or myself if you have any questions.

John Pepper's term as Education Secretary has ended and we are grateful for his hard work in taking the Education sub-committee forward. Chris Munsch is his replacement and we can expect further significant progress in this key area. Sunil Ohri's term as Communication Secretary has also ended and again we are grateful for all his hard work, especially with Leon Hadjinikolaou in getting the new website on-line. We will be replacing Sunil but are considering the scope and remit of the role before putting out an advert. If you have views on this I would be pleased to hear them. David McCormack and Mick Murphy are out two new trainee representatives replacing Betsy Evans.

We are delighted to have appointed Mike Fisher as our next patient representative. We received twelve applications for the post and drew up a shortlist of four. It was a difficult task choosing one above the others and Mike has formed a patient representative board with the other shortlisted candidates, Ken Timmis, Reg Denby and David Gregson. This promises to strengthen our patient involvement and therefore our Organisation. Mike is keen to establish a network with patient representatives in units and will be contacting Unit Representatives in the the near future.

The prospects for SCTS look stronger than ever....now if we could only influence the weather.....

Best wishes

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

## Annual Meeting and SCTS University 2012

Ian Wilson



# Report on the 1st Joint Meeting SCTS & ACTA

MANCHESTER CONFERENCE CENTRE –  
April 18th – 20th 2012

The inaugural joint SCTS /ACTA meeting held in Manchester this year reflected the enormous strides that the specialty has made in delivering a multidisciplinary approach to the management of cardiothoracic surgical patients.

The SCTS meeting organisers group were joined by Donna Greenhalgh and Niall O’Keeffe, consultant anaesthetists based in Manchester; this increased breadth of experience, knowledge and views resulted in a vibrant exchange of ideas that facilitated the development of an innovative meeting programme.

On behalf of both groups of the organising committee we would like to take the opportunity to thank all participants in the meeting for their contributions. The entire programme attracted a record number of delegates, with over 1,000 attendees.

The SCTS/ ACTA University programme was composed of 10 Educational Streams and 9 Lunch Box sessions; this interactive educational environment was delivered by a wealth of international and national faculty generating a dynamic, interactive environment.

Over 600 participants attended the day, creating a tremendous energy at the start of the inaugural SCTS / ACTA annual meeting. The society is indebted to the entire faculty for their contributions. This year was the first occasion that streaming of some of the educational material has allowed later publication of the sessions on-line via the SCTS University web site. This material is currently undergoing editing and will shortly be released for viewing.

Session evaluation was diligently completed by a high percentage of attendees; educational objectives were achieved for an overwhelming majority of delegates.

At conclusion of the SCTS/ ACTA University the Exhibition Hall was opened allowing recognition of the enormous



Society for  
Cardiothoracic  
Surgery  
in Great Britain  
and Ireland



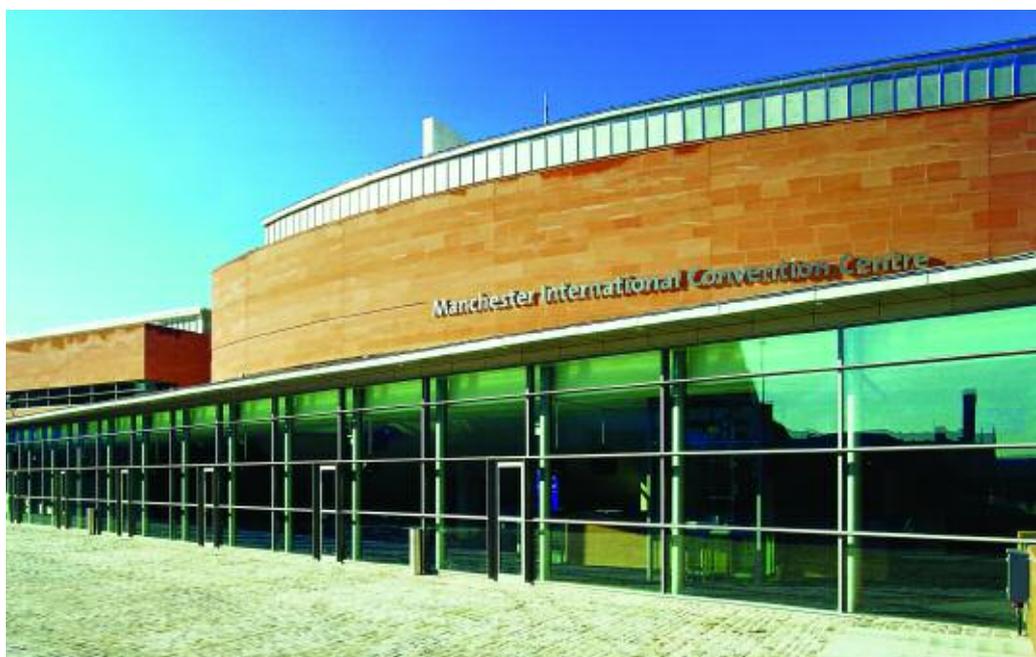
Association of  
Cardiothoracic  
Anaesthetists

corporate contribution that has been made in the progressive development of the meeting. The lively atmosphere generated in the Hall was further augmented by music provided by **Chris Satur and his North Staffordshire University Orchestra**, which allowed delegates to unwind, whilst corporate groups had the opportunity to renew old acquaintances and create new contacts.

The SCTS / ACTA meeting on the following two days proved to be a great success. Attendees appreciated Simon Kendall’s vision of increased delegate and content diversity.

*continued overleaf*

*There was a huge majority from all groups requesting future joint meetings. These are now tabled for every third year.*



Annual Meeting 2012 MANCHESTER CENTRAL – April 18th – 20th 2012



## SCTS & ACTA 2012 *continued*

There was considerable interest generated this year from a wide range of cardiothoracic related disciplines over the course of the event. The multidisciplinary nature of the meeting engendered a positive educational environment with sharing of cross discipline knowledge and experience. More than 74% of attendees responding to the post-meeting evaluation questionnaire stated that they were strongly in favour of the joint meeting, with 16% equivocal. Lessons have been learned following this initial joint meeting but overall the consensus was that this was a successful venture; there was a huge majority from all groups requesting future joint meetings. These are now tabled for every third year.

This year's meeting included an increased number of multidimensional parallel sessions, and also a series of vibrant multidisciplinary interactive plenary sessions attended by a wide spectrum of clinicians from across the specialty.

Stimulating debates covering the multifaceted approaches to patient management, changes in the National Health Service delivery, contemporary areas of specialty development and advances in both leadership and medical education, resulted in an enormously interactive environment with a frank exchange of views.

Great credit should go to **Simon Kendall**, **Donna Greenhalgh** and **Niall O'Keefe** for developing such an insightful programme.

**The Patients Forum** was well attended, and it was fitting that the sessions carried David Geldard's name, in memory of his enormous contribution to cardiothoracic surgery over the years that he was associated with the society.

The Cardiothoracic Forum was similarly well attended, achieving record attendance, and a lively atmosphere. As Tara Bartley hands over the reins to Christina Bannister the place of the Cardiothoracic Forum as a central focus within both the society and the SCTS meeting has never been more prominent, and is a reflection of the enormous success that has Tara achieved.

It was of note that the annual dinner was also extremely well attended, and even hosted a band, with some members seen to take to the dance floor. A first for the SCTS meeting.

The first joint SCTS / ACTA meeting threw up some challenges in its development, but was ultimately very well received, and seen as a significant advance in the iteration of the SCTS society meeting.

**Isabelle Ferner** and **Tilly Mitchell** have worked tirelessly to deliver the meeting as a finished article. No task or change appeared too big for them to embrace, and the success of the meeting is largely down to their professionalism.

**Simon Kendall** now stands down as meeting secretary; his contribution to the progressive development of the meeting has been enormous, and he will certainly be a tough act to follow.

## Prize Winners 2012

### Ronald Edwards Medal – S Stoica

The Ross operation for patients with congenital heart disease: 11-year trends and results from the UK national database

### John Parker Medal – B Nguyen

Activation of leukocytes during surgery with Cardiopulmonary Bypass is attenuated by sulforaphane in a porcine model: a novel therapeutic strategy

### Society Thoracic Prize – N J Acosta Canon

Repair of pectus excavatum does not improve early chest wall function

### Pat Magee Student Poster Prize – N Papalexopoulos

Successful treatment of failing biological prosthesis due to 'stent creep' with transcatheter aortic valve implantation: A Case Series

### BASO Prize – A Sharkey

Analysis of Potential Quality Outcome Measures for Lung Cancer

Surgery Across a Cancer Network

### Ethicon Cardiothoracic Forum Best Presentation

#### 1. J Broughton

Radial artery harvesting; what can go wrong?

#### 2. D Southey

The impact of the Cardiothoracic Ward Nurse Practitioner upon cardiothoracic patient care

### Ethicon Cardiothoracic Forum Best Poster

#### 1. A Eden

Key Performance Indicators: A Physiotherapy Departments performance for patients following cardiothoracic surgery and cardiology in-patients

#### 2. P Agostini

Exploration of patient physical activity level following thoracotomy and lung resection

# Thoracic Surgical Audit

Richard Page



**This year has seen the production of the second SCTS Blue Book on Thoracic Surgical Activity and Outcomes, published in electronic form in November 2011, and available via the SCTS website.**

The report shows a dramatic increase in virtually all areas of thoracic surgical activity throughout the UK and Ireland, especially with regard to lung resections for primary cancer. Undoubtedly this is a direct result of an increase in the number of consultant surgeons contributing to thoracic surgery. Information on surgical treatment of lung cancer patients is described in more detail, both from the twelve units who have contributed to the SCTS Thoracic Surgical Database over recent years, and also from separate data available from the National Lung Cancer Audit via the LUCADA database. Both data streams show that the resection rate for lung cancer is increasing. Other recently published data from the Thames Cancer Registry shows that a high resection rate leads to more cures for patients. This information shows that the efforts made by the wider lung cancer team and especially thoracic surgeons are now making an impact in ensuring that the treatment of lung cancer in the UK and Ireland is able to approach the standard set by the best units in Europe and North America.

Unfortunately the majority of thoracic surgical units have poorly developed facilities for data collection on their activity and outcomes. The Thoracic Surgical Register has been a wonderful tool over the years but its accuracy and usefulness is becoming vulnerable to criticism based on the lack of ability of the Register to be patient specific. As many members will already be aware it is excellent news that the General Medical Council have agreed to fund a fully functional thoracic surgical database for SCTS members. Discussions are already underway with Dendrite Clinical Systems to run an on-line facility for immediate entry of data on all thoracic surgical operations, as well as receive uploads from those units with an existing data collection infrastructure. Our dataset for this project has been discussed and agreed many times over the years, which means that the development and implementation of the database should be achieved towards the end of the current financial year. I will be writing to thoracic audit leads as things develop with more information but look forward to another major leap forward for the SCTS thoracic surgical project with this initiative. The credit for this will go to all thoracic surgeons, especially the SCTS thoracic audit leads who I know have worked hard over the years to make sure things like the Blue Book happen. Please, as always, do not hesitate to contact me with any queries you have over any aspect of thoracic audit.

Specialised commissioning for thoracic surgery is in the early embryonic stages, with the newly formed Clinical Reference Group for thoracic surgery having just been created and which I will chair. Although there is a lot of negativity throughout the country regarding what many see as a repeat of a failed experiment of the early 1990's, there is also an opportunity to make sure patients requiring thoracic surgery have access to only the best and most comprehensive forms of management for their problems. It is incumbent on the profession of thoracic surgery to guide the commissioning process so excellence rather than mediocrity can be achieved. I will need help within the CRG to achieve this and I am grateful to all for the offers of help I have already received.

*The report shows a dramatic increase in virtually all areas of thoracic surgical activity throughout the UK and Ireland, especially with regard to lung resections for primary cancer.*

Hunaid A Vohra

## Ethicon Scholar

## Valve Repair Fellowship

## Saint-Luc University Hospital, Brussels

## The inspiration

It was in June 2010 that I attended the Brussels Valve Symposium. I was utterly overwhelmed by the intensity and the quality of surgery performed by Professor Gebrine ElKhoury over this 2-day course. Four 'live' aortic valve repair cases are shown daily and observed by around 130 delegates from more than 30 countries. Professor ElKhoury also performs a vast number of mitral valve repairs with almost 400 valve operations performed annually at this centre.

To undertake a valve repair fellowship at this centre seemed to be an ambitious desire. At the end of the course, I personally approached Professor ElKhoury and expressed my interest to spend a period of Fellowship with him. I was told to send my CV to his secretary and join the waiting list!

## The provision and the hurdle

In the early half of 2011, the Ethicon Scholarships (£50,000 each) were advertised by the SCTS. These awards were for a designated period of 6 months for individuals who have obtained their FRCS(CT) but have not yet secured a consultant post. The principles were that there would be ample operating opportunity, full involvement in pre-operative evaluation and post-operative care, an educational agreement and the post should be supernumerary. Also, the positions had to be taken up before the end of 2011.

This sounded like the ideal opportunity and the timing could not have been any better. Obviously, these scholarships generated huge interest amongst the senior trainees. In the meantime, I received confirmation from Brussels that I would be accepted if I was supported by the Ethicon Scholarship..... I felt as if my whole career relied on being successful in the interview.

When the Panel Chair (Professor John Pepper) called me on the day following the interviews, I was delighted to hear that I was successful. A UK mentor was also nominated (in my case, Mr Steve Livesey).

## Mais il ya un probleme

There was one thing however, that needed attention - My French! The hospital was in the French part of Brussels. As 'Bonjour' was the only French word I knew at the time I actively arranged lessons. I rented a room with a Belgian family which was a 15 minute tram journey from the hospital. The retired airhostess grandmother in the family spoke fluent English and taught even better French, so my French improved rapidly.

## The fellowship

My day in the hospital started with a ward round at 0730 hours followed by Professor ElKhoury's theatre, Monday to Friday.

From the outset, the Fellows set up cases. Although the in-house speciality is Aortic Valve Repairs and the David operation (3-4 cases/week), the Ross-in-Valsalva operation, Homografts, Mitral/Tricuspid Repairs and Redos were commonly performed. I performed David operations, Mitral and Tricuspid Repairs as the primary surgeon under the supervision of Professor ElKhoury.

The rest of the staff surgeons including Professor Noirhomme and Professor Glineur are very friendly and supportive. Various techniques of AV repairs are performed which include cusp plication, resuspension, resection, patching, decalcification, commissural reconstruction, annuloplasty and re-implantation. Apart from the standard mitral valve repair techniques, other techniques commonly performed are annular decalcification and patching, commissural reconstruction and tricuspid autograft insertion. Around 20% of the work is less-invasive and the department has also acquired a robot which is used to perform robotically-assisted mitral repairs.



*I personally approached Professor ElKhoury and expressed my interest to spend a period of Fellowship with him. I was told to send my CV to his secretary and join the waiting list!*

## Valve Repair Fellowship continued

Every year in January, the Mitral Congress is also held which generates interest similar to the Brussels Valve Symposium. Here, I was given the opportunity to give 2 lectures on various techniques of mitral valve repair. For Fellows interested in presenting and writing papers, there is always ample opportunity to generate new hypotheses and retrieve data from the in-house database which is robust and up-to-date. Also, the majority of operations are recorded on video and all Fellows are encouraged to edit the videos for learning and presenting purposes. During my stay there, two in-house wetlabs on porcine hearts (aortic and mitral) were also organised where Fellows were taught the more complex techniques of repair by Professor ElKhoury himself.

### The ambience

The city of Brussels itself is known for its fine food and cafe culture. 'Gaufre de Liège-Luikse wafel' (Belgian waffle with caramelized sugar) is certainly something that I will remember. The establishment as the Cultural Capital of Europe since in 2000 has paved the way for renewed life to historic buildings. Landmarks like Grand Place-Grote Markt, Parc du Cinquanteaire-Jubelpark, Atomium and the Palais de Justice are relaxing after a day in the operating theatre.

Overall, this was an amazing Fellowship for all those interested in Valve Reconstruction. It may seem to be an onerous task for those reaching the end of their training as it requires a bit of organising and working in a completely new environment but leaves one with a legacy for an entire lifetime. The experience can inspire and revolutionise one's approach to valve reconstruction in day-to-day practice. Additionally, it paves the way for broader avenues of future collaboration for innovation in this ever-changing speciality.

I would like to take this opportunity to thank SCTS and Ethicon for the grant of the Scholarship and Professor ElKhoury and his team for the privilege of the Fellowship. If anyone would like more info, please do not hesitate to contact me on [hunaidvohra@yahoo.co.uk](mailto:hunaidvohra@yahoo.co.uk)



Getting to know the robot

# St George's Valve Technology Symposium

*Marjan Jahangiri*

**The St .George's Valve Technology Symposium took place on 14 and 15 April. It was in it's eighth year and was held in association with Charing Cross Symposium for the first time. The emphasis was to review current controversies in the field of aortic and valvular heart surgery in an 'intimate' forum allowing for discussion between delegates and speakers of all levels of expertise.**

The first day was devoted to management of the diseases of the aorta, including endovascular and hybrid procedures. The presentations were delivered by cardiac and vascular surgeons, igniting lively debates. Furthermore, neurological sequelae and methods of prevention of neurological complications and operative aspects were reviewed.

The second day was devoted to management of valvular heart disease, in particular aortic valve. Novel imaging modalities and their application to surgery were discussed in detail. Minimally invasive aortic valve replacement and transcatheter aortic valve implantation (TAVI) were discussed with results from the latest trials and registries.

In addition, the value of trials was presented, aiming to raise awareness of some of the significant limitations of this in modern cardiac surgery. This was particularly important since we are in an era of introducing and establishing new modalities of treatment in cardiac surgery which can change the face we practice for many years to come.

There were mannequins for practicing wire required skills and TAVI. The valve conference attracted 250 national and international delegates and the overall Charing Cross Symposium attracted 3800 delegates.

We hope to see you in 2013.

Marjan Jahangiri



# Nursing Representative Report

*Cnhristina Bannister*  
Nurse Representative

**I would like to begin by thanking Tara Bartley for all the hard work, effort and leadership she has put into the role of Nursing Representative and start by highlighting a few of her achievements.**

Throughout her six year term of office Tara has completely altered the way in which nurses and Allied Health Professionals link into the Society. She has changed the face of the Cardiothoracic Forum at the Annual Meeting from a small number of nursing presentations in 2006 to this year; a two day event encompassing plenary sessions from Members of Parliament, members of the RCN, previously including the President, and other Fellows, and specialist nurses from around the world. These are interspersed by a large number of papers presented from nurses, allied health professionals, medical trainees and students.

Alongside the Forum, Tara has been fundamental in creating the SCTS Advanced Cardiothoracic Course at Heartlands Hospital, Birmingham and continues to be part of the faculty. She also continues as a faculty member of CALS courses both in the Lake District and in cardiothoracic units around the country.

Throughout her term of office she has worked with the Education Sub-committee to create a joint RCS & SCTS Cardiothoracic Advanced Examination and will continue to give her expertise to help push this project through to its completion.

Tara has presented for the Society at many national and international Conferences and last year was integral in forming the first nursing forum at EACTS, which we hope to continue and grow.



*Tara's knowledge of nursing issues both generically and within the cardiothoracic domain has enabled her to lead on a number of pieces of work looking at workforce planning, and she has influenced the way cardiothoracic nurses and allied health professionals work for the future.*

Tara's knowledge of nursing issues both generically and within the cardiothoracic domain has enabled her to lead on a number of pieces of work looking at workforce planning, and she has influenced the way cardiothoracic nurses and allied health professionals work for the future. As a Fellow of the RCN, Tara will be able to take the knowledge gained from her experiences within the cardiothoracic community and help shape nursing practices across the board in the future.

On a personal note I would like to thank Tara for all the support she has given me throughout the past year working as her Deputy, many colleagues have asked me how I feel stepping into her shoes, daunted is one I might say. However I have had an excellent role model to watch throughout the past few years at meetings and events, and if I can continue with the same support network and enthusiasm for the post as she has had then I'm sure I will be able to move the nursing and allied health professional agenda forward.

## Cardiothoracic Forum at the 2012 Annual Meeting

**This year's annual meeting was held at Manchester Central Conference Centre and we had a good number of nurses and allied health professionals attending, an increase from last year. This was due in some part to the use of a 'buy five get one free' policy which enabled units to send more nurses and allied health professionals to the meeting.**

The Ethicon Cardiothoracic Forum room was dedicated to **David Geldard, MBE** who passed away last year. David worked extremely hard as patient representative for the Society and will be sadly missed. The Forum amalgamated the patients' forum for this year within its programme and we welcomed at least 25 cardiothoracic patients to share the Thursday with us.

We started the programme in this vein, having our first plenary session delivered by **Tony Nash**, a British bobsledder who won a Gold medal in the two man bob during the Winter Olympics at Innsbruck in 1964. Tony, a past cardiac surgical patient himself, talked about the concept of teamwork and success and gave a fascinating insight into the preparation, planning and dedication that goes into being a leader in a sporting field – concepts that we can transfer to the area of medicine and nursing.

This was followed by a group of talks begun by **Mr Eric Lim, Dr Kathryn Fogg and Judy Cotterill**, surgeon, anaesthetist and nurse, giving their perspectives surrounding the issues of patient partnership in decision making. The quartet of talks was completed by Baroness Billingham who gave a very insightful and entertaining presentation not only in relation to her previous thoracic surgery, but to health care in general and the impact of the British Government to tennis.

*continued overleaf*

## Nursing Report *continued*

On the Friday, the Forum had plenary sessions from **Dame Gill Oliver**, a RCN Fellow who discussed her experiences 'From the Ward to the Board' and **Janet Davies**, FRCN who presented the RCN's work defining the 'Principles of Nursing Practice', a major undertaking looking at the image of nursing and standards of care provided.

Our International speaker was **Jill Engel**, Director of Advanced Practice for the Duke Heart Centre at Duke University Hospital, USA. Jill has been instrumental in implementing an Advanced Nurse Practitioner workforce within the cardiothoracic department at the Duke Heart Centre and shared with us all how those roles are carried out, and the underlying educational framework that runs alongside.

Our final speaker returned to the concept of patient and professional inter-working that ran throughout the forum. **Stevie Caffrey** gave a heartrending account of her experiences in needing an LVAD following the birth of her baby. She had a number of the audience in tears as she told, with the help of **Shishir Kore**, Specialist Nurse in Organ Retrieval and Ventricular Assist Device Co-ordinator, her story from the birth of her baby to workup and implantation of the LVAD, through to going home with the LVAD in place and subsequent removal. Her comments made us all deeply consider the impact we have on peoples' lives and how correct information giving and support is crucial to a good outcome.

Throughout the two days we also had thirty presentations given from a variety of nurses and allied health professionals, as well as from medical students and doctors. Congratulations to all presenters whose work went to creating an excellent two day Forum.

**The Ethicon Cardiothoracic Forum Best Paper** with a £200 Award was shared between **J. Broughton, S. Kendall, T. Tiyenga and J. Ferguson** from James Cook University Hospital, Middlesbrough; *Radial artery harvesting, what can go wrong*; and **D. Southey, H. Luckraz, E. Lengyel, J. Gunn, K. Raybould, S. Sherwood**, H. Flavell, J.S. Billing and W. Pugsley from New Cross Hospital, Wolverhampton; *The impact of the cardiothoracic ward nurse practitioner upon cardiothoracic patient care*.

The '**Ethicon Cardiothoracic Forum Best Poster**' which received a book token from Wisepress was also shared between **A. Eden** from Papworth Hospital NHS Foundation Trust, Cambridge; *Key Performance Indicators: A Physiotherapy Departments performance for patients following cardiothoracic surgery and cardiology in-patients*; and **P. Agostini, H. Cieslik, B. Naidu, P. Rajesh, R. Steyn, E. Bishay, M. Kalkat and S. Singh** from Heart of England NHS Foundation Trust, Birmingham and Coventry University; *Exploration of patient physical activity level following thoracotomy and lung resection*. Congratulations to you all.

The **2013 Annual Meeting** is to be held in Brighton and I look forward to seeing many of our nursing and allied health professional colleagues there. Abstract submission will open later in the year and I encourage you all to submit papers highlighting the quality of research and projects that is being created at the moment.

*Stevie Caffrey gave a heartrending account of her experiences in needing an LVAD following the birth of her baby. Her comments made us all deeply consider the impact we have on peoples' lives and how correct information giving and support is crucial to a good outcome.*

### Other news from Nursing and Allied Health Professionals

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

### Joint RCS & SCTS Cardiothoracic Advanced Examination

Work continues around this venture with the establishment of a syllabus, examination and Q&A process being created. This is still ongoing but moving forward well.

### University Hospitals Coventry and Warwickshire Cardiothoracic Team Projects Presentation Day

I was invited to attend a presentation day in Coventry which was extremely interesting. I gave a presentation on behalf of the Society in regards to nursing and allied health professionals' involvement, and encouraged anyone to join. Papers presented looked at inter-hospital transfers, the use of patient diaries in CICU, ward attenders, pre and post operative physiotherapy services and the management of AF post cardiac surgery. I spent a very valuable afternoon networking with the staff in Coventry and thank them for this opportunity.

# Nursing Report *continued*

## Update on Current Issues

This year saw the appointment of a new **Chief Nursing Officer, Jane Cummings**. She will be focussing on quality improvements in patient safety and patient experience, and we look forward to participating in work that makes a difference to our patients and colleagues by improving the care we provide and being empowered as a clinician to do this.

The **Nursing Quality Care Forum** is currently setting out its proposed future focus and priorities to the Prime Minister and the Secretary of State for Health, and new phases of consultation and research will begin. Throughout, 'the forum remains committed to delivering the fundamental elements of good care – compassion, dignity, respect and safety – and supports the adoption of best practice'.

Tara was present at the RCN Congress in Harrogate in May, this was well attended and Health Ministers from all political party's gave an address and took questions. A number of important nursing issues were debated including the changes in undergraduate nurse training and the role of mentors in the clinical environment. Discussion also took place with regards to the current turbulence within the NMC, and how it sees itself being able to be a strong regulatory body.

In a plenary session from **Dr Peter Carter**, he highlighted the problems nurses have in working within a health service striving to make multi-billion pound cuts, saying nurses were spread too thinly and many were at breaking point. He went on to say that this painted an indisputable picture that the NHS is suffering and identified that down-banding and diluted skill mix were measures that Trusts were taking to save money, adding that this will add to the pressures faced by many working on the frontline.

We have been fortunate in Cardiothoracic surgery that specialist nursing knowledge and skills have been recognised and maintained so far, however the pressures upon Trusts continues to impact upon us. The SCTS early on identified issues related to staffing the unit, looking specifically at the dwindling number of junior doctors due to EWTG and a reduced number of training posts, and instigated a move towards the implementation of Advanced Nurse Practitioners across the specialty. As members of the Society we must continue to lead the way by acting as effective role models to all members of staff, promoting education and providing quality research based clinical care for our patients. As the NMC continue to be unable to agree an acceptable definition of Advanced Practice as a professional qualification that can sit on the NMC register, we must push forward with the innovations that we have created. Through the work of the SCTS Education sub-committee the ANP examination has the potential to become a framework for future work to achieve this outcome.

To finish this years' **International Nurses Day** highlighted outstanding practice through the use of social media. By using Twitter and Facebook Health Ministers and celebrities were able to join nurses and contribute to the ongoing celebrations with raised awareness for the day. By harnessing these methods too, we may be able to reach out to more members of our speciality and enhance the care we provide and the knowledge and skills gained.

If any of your colleagues would like to become an associate member of the Society or would like to add their names to the SCTS Allied Health Professionals database so they can receive the emails that are sent out then please forward their name, address and title to me at [Christina.Bannister@uhs.nhs.uk](mailto:Christina.Bannister@uhs.nhs.uk) or [chrisiebannister71@gmail.com](mailto:chrisiebannister71@gmail.com) or direct to Tilly Mitchell at [tilly@scts.org](mailto:tilly@scts.org)

**Chris Bannister, Nursing Representative**

# The Fate of Abstracts

The fate of abstracts presented at annual meetings of the Society for Cardiothoracic Surgery in Great Britain and Ireland from 1993 to 2007

The full version of this article was published in the European Journal of Cardiothoracic Surgery, 2012

*Nigel E Drury,  
Georgios Maniakis-Grivas,  
Vanessa J.C. Rogers,  
Lynne K Williams,  
Domenico Pagano,  
Antonio E. Martin-Ucar.*

## Abstracts

**Although the presentation of original research to learned societies is valuable, the target should be publication in a peer-reviewed journal. Therefore, the strength of a meeting may be assessed by the rate of the subsequent publication of papers from the presented abstracts. We conducted an analysis of abstracts presented at consecutive annual meetings of the Society for Cardiothoracic Surgery (SCTS) in Great Britain and Ireland over a 15-year period.**

Abstract books and other documentation from the 1993–2007 meetings were reviewed; abstracts from other major Cardiothoracic Surgery meetings held in 2007 were also reviewed. Medline was searched to identify the peer-reviewed publications arising from each work presented. For abstracts presented at SCTS in 2003–07, the factors potentially associated with publication were analysed by logistic regression. If no publications were identified, authors were contacted through a standardized email questionnaire to ascertain its status and reasons for non-publication.

Over the 15-year period, 909 abstracts were presented at the SCTS meetings. The rate of publication rose from ~30% in the mid-1990s to consistently >60% from recent meetings, with a high of 81.3% from 2006. However, in comparison with other Cardiothoracic Surgery meetings in 2007, the chance of subsequent publication from SCTS (66.7%) was lower than from the European Association for Cardio-Thoracic Surgery (75.0%), the American Association for Thoracic Surgery (83.9%) and The Society of Thoracic Surgeons (72.5%) meetings. For abstracts presented at the last five SCTS meetings, publication was most commonly in a speciality journal (56.3%) and the median time for publication was 15 months (range ~24 to 63 months) with 14 papers published prior to presentation at the meeting.

On regression analysis, the only factor associated with publication was the study design comparing randomized trials and systematic reviews with other types of study ( $P < 0.01$ ). Of the 90 unpublished abstracts, 48 (53.3%) authors replied to an email questionnaire revealing that 41 (85.4%) were never submitted for publication. The most common reasons given were low priority (29.6%) and low likelihood of acceptance (24.1%). In recent years, the annual meeting of the Society has become a forum for the presentation of high-quality research that usually withstands peer-review, most commonly in a speciality journal.

The rate of publication has increased to consistently >60%, although those that remain unpublished are generally never submitted. This compares favourably with national meetings of other surgical societies, although it is lower than other major cardiothoracic meetings which have an affiliated journal. At a time when it has been suggested that medical research in the UK is in decline, cardiothoracic surgery appears to be thriving.

*At a time when it has been suggested that medical research in the UK is in decline, cardiothoracic surgery appears to be thriving*

# Ethicon Fellowship Report

*Deborah Harrington  
Liverpool Heart  
and Chest Hospital,  
November 2011- April 2012*

**In 2011, thanks to a generous donation from Ethicon, four six month scholarships were awarded by the SCTS to senior trainees who had completed the FRCS C-Th exam but had not yet obtained a Consultant post. There were several Fellowships suggested or candidates could build their own programme. The Scholarships were awarded by competitive interview conducted by the SCTS and SAC. I was lucky to be one of the grateful recipients.**

I chose to undertake my Fellowship with the Thoracic Aortic Aneurysm Service at the Liverpool Heart and Chest Hospital (LHCH). The Aortic team is led by Mr Aung Oo, and also comprises Mr Manoj Kuduvalli and Mr Mark Field. They undertake 150-180 thoracic aortic cases per year including all aspects of major aortic surgery from root replacement to thoracoabdominal aortic replacement, and also perform TEVAR jointly with local vascular surgeons and interventional radiologists, as well as TAVI with interventional cardiologists. The three surgeons each have a conventional cardiac and an aortic operating list per week, and they were the first unit in the country to set up a dedicated aortic on call rota for emergencies such as acute aortic dissection. There is a weekly aneurysm clinic and monthly aortic MDT meeting held jointly with vascular surgeons and interventional radiologists. The service also has a dedicated aortic nurse practitioner, the first of its kind in the country, who helps with management of in-patients and coordinates care of out-patients, and a monthly patient support group.

My background is that I was a senior West Midlands trainee, with a research MD on cerebral protection in aortic arch surgery and considerable previous exposure to major aortic surgery with Professor Bonser in Birmingham. I recently also spent a year Out of Programme in Middlesbrough, supervised by Mr Simon Kendall, and was independently operating in the majority of conventional cardiac cases prior to commencing my Fellowship.

I wanted to count the Fellowship towards my training and did manage to obtain prospective approval from the GMC for this but the process involved was a complex administrative one which resulted in a month's delay in commencing the Fellowship.

My priority during the Fellowship was to be first operator at as many procedures as possible beginning with aortic root replacement. I have now progressed to performing aortic root replacement independently including the use of hypothermic circulatory arrest with an open distal anastomosis. I have also assisted at many more complex aortic procedures and have performed components of thoracoabdominal aortic replacement including opening, closing, thoracic and abdominal mobilisation and anastomoses. I regularly perform axillary and femoral cannulation for cardiopulmonary bypass and have gained familiarity with left heart bypass, spinal cord and visceral protective strategies as well as practical use of my cerebral protection strategy knowledge. I have also had exposure to TEVAR and TAVI.

Each week I attend the aneurysm clinic which includes seeing new patients as well as follow ups. Where possible I assess all referrals to the aneurysm service, including elective, urgent and emergency patients, and as I am supernumerary and not on a rota, I am available to operate out of hours. The unit receives approximately 90 urgent/emergency aortic referrals per year which generally involves reviewing a CT scan and either giving advice or transferring a patient, assessing them, planning and helping to deliver the appropriate treatment.

During my Fellowship I have also analysed the Liverpool results for repair of acute type A aortic dissection, which demonstrate a reduction in mortality rates from 29.6% to 10.6% since the introduction of the subspecialised aortic on call rota. I was privileged to be able to present this work at the Houston Aortic Symposium in March this year, where I also met Professor Hazim Safi, who has a longstanding collaboration with LHCH, and I plan to visit him and his team later in the year. I also presented the data at the SCTS/ACTA meeting in Manchester in April, and was fortunate to be able to attend the New York Aortic Symposium where our results were displayed as a presentation on demand.

My Fellowship has been a fantastic experience and an excellent subspecialist training opportunity. I cannot speak highly enough of my supervisors in Liverpool who have very quickly enabled me to progress and trained at every opportunity. As a consequence, I plan to extend my Fellowship by a further six months, supported directly by LHCH, to continue my subspecialty training.

## Acknowledgements

I would like to thank Ethicon, Siobhan Brennan in particular, and the Society for Cardiothoracic Surgery for providing me with this fantastic opportunity. I would also like to thank everyone at the Liverpool Heart and Chest Hospital for making me feel at home and part of the team, and in particular Messrs Oo, Kuduvalli and Field for their support and commitment to training in their subspecialty. Thanks to Professor Pepper, my mentor for this post, and Tim Graham, whose ongoing support managed to guide me through the administrative complexities of ensuring training recognition. Thanks to all my long suffering family and friends who continue to support me despite often being dropped at a moment's notice, and finally thanks to Professor Bonser without whom I would not have been inspired to enter this complex and challenging but highly rewarding subspecialty.



# Sinister trainers or sinister trainees?

Simon Kendall

**90 – 95 % of the population is right handed – this figure is slightly greater in the older generation due to the Victorian prejudice to convert left handers to right handers at an early age and this was still being practiced in the sixties.**

So it's not surprising that our world is geared for right handers. If you're right handed you just take it for granted that: screws tighten clockwise so you can use your more powerful arm muscles; can openers are set up for you; scissors are designed for you; cheque books have the stubs on the left; and writing left to right so you don't smudge your ink are just some examples.

And this is only fair with only 5 -10% of us being left handed – and in the middle ages we were branded as sinister because the right handers supposed we were possessed by the devil.

It couldn't possibly happen that surgery could adopt such outdated misconceptions?

The discovery of general anaesthesia gave surgeons open access to the human body and so surgery has largely been developed in just the last 100 years – and during a time when the 'civilised world' was trying to eradicate left handedness. As a result surgery has been largely developed by right handers and the side the surgeon stands, the instruments they use and the techniques that have been developed are good for right handers.

The SCTS now has a few members that have come out – that have owned up they really are left handed and would prefer to operate with their dominant hand. Some of the very clever ones are AC/DC and confuse their team using both hands with equal dexterity. There used to be secret meetings but now you might see small groups of left handers sharing stories of their struggle for acceptance.

*In the middle ages we left-handers were branded as sinister because the right-handers supposed we were possessed by the devil*

Seriously though – the experience of the left handed trainee is fairly predictable and this article describes some of the problems and possible solutions.

First of all their first exposure to surgery may well be in FY or Core training. They will get the opportunity to cut a suture or do some stitching by a generous senior trainee or consultant – and as they hold the instrument in their left hand there will be a pause followed by 'Oh – you're left handed are you?'

This is the start for the left handed trainee to receive advice from the right handers – anecdotally these are the usual pearls of wisdom –

**'Have you considered a change of career? Give up surgery?'**

**'How's your right hand? Can you change hands?'**

And in cardiac surgery – **'You'll have to change sides and operate from the left'**

The surgical trainee will often encounter such advice in foundation year posts or core training, often from more senior trainees. The danger is that they will take such advice seriously and not receive the appropriate mentorship at this critical stage in their training – and if they do adjust their technique to right handed manoeuvres it can become even more difficult to retrain at a later stage in left handed techniques.

## A RIGHT HANDED WORLD

It is very reasonable that where the vast majority are right handed that surgical instruments are right handed.

Scissors naturally favour the right-handed surgeon – the left-handed surgeon needs to put their thumb into the ring on the handle and actively pull the handle towards the axis of the hinge to assist tight apposition of the blades.

The ratchet on needle holders and surgical clamps (ie mosquito clips, Roberts, vascular clamps etc) favours the right handed surgeon as the upper ratchet is on the left side. This allows opening of the clamp to be done with a pushing action by the thumb / palm of the right handed surgeon, whereas as the left handed surgeon has to insert their thumb into the ring and pull the upper ratchet towards their hand – a more cumbersome movement.

## PALMING / LEFT HANDED NEEDLE HOLDERS

The technique of 'palming' ('palm grip', 'palm technique') with a needle holder allows the instrument to be rotated around its axis. This allows the needle to be rotated through the tissues causing less lateral stress and hence smaller needle holes and less chance of the needle shearing through the tissue. There is varied acceptance of the importance of this technique.

If palming is accepted as good practice the left handed surgeon needs left handed needle holders – these have the upper ratchet on the right side of the instrument and allows the left handed surgeon to open and close the needle holder without putting their thumb in the ring. If the thumb is in the ring of the handle it is almost impossible to rotate the needle holder on its true axis.

Left-handed needle holders present a significant problem for theatre staff. They require the purchase of a sufficient range and numbers of needle holders so that they are available every time a left-handed surgeon scrubs for a case. This will not happen unless sufficient support is provided by the consultant surgeons

*continued overleaf*

## Sinister trainers or sinister trainees?

in each surgical team, not only to purchase the equipment but also to ensure scrub staff are expected to provide the suitable instruments for the left handed trainee.

Ideally the left handed surgical trainee would have left handed needle holders from the start of their surgical training, so that they do not have to re learn the technique when they have access to the proper instruments.

The lack of left handed needle holders will further decrease the 'spontaneous' opportunities for the trainee, where the trainer will offer the trainee an opportunity, such as closing the aortotomy, but the trainee will not have the appropriate needle holder available. They then have the choice of declining the opportunity (appearing ungrateful and unenthusiastic) or struggling with right handed instruments.

### CARDIAC SURGERY

With the heart almost always to the left of the midline, surgery is performed standing on the patient's right side. There really is no need for the left handed surgeon to move to the left side of the patient. Indeed the direction of the LV outflow favours the left handed surgeon for AVRs and surgery on the aortic root.

The left handed cardiac surgeon does need 'elbow room' – and the bar over the patient's head needs to be just 'cranial to the cranium' to the slight frustration of the anaesthetist otherwise it is too cramped for good use of needle holders.

Left handed surgeons have to have some basic techniques that differ from the right handed surgeon – some slight differences in cannulation, sometimes reversing the anastomosis on top ends to clockwise, but in general the techniques are very similar to right handers.

Society in general is becoming more tolerant – and I'm not saying that left handedness can compare with the major prejudices that exist – but in Medicine there is more acceptance that surgery can be performed by left handers and should be encouraged rather than changed. Hopefully right handed trainers will become more aware what left handed trainees need – and these trainees would benefit from early exposure to a left handed trainer to get the essentials – and there is clearly potential for web based learning which doesn't exist as yet.

#### Simon Kendall

Left Handed Cardiothoracic Surgeon – and always indebted to the Right Handed John Wallwork, who moved mountains to get the left instruments in the right place.

### The loneliness of the left handed surgeon

BMJ 2004; 330 doi: 10.1136/bmj.330.7481.10-f  
Published 30 December 2004

### The left handed surgical trainee

BMJ 2008; 337 doi: 10.1136/bmj.a2883  
Published 16 December 2008

### Left-handed surgeons: are they left out?

Curr Surg. 2004 Nov-Dec;61(6):587-91.

# Current status of adult ECMO in the UK

David P Jenkins  
Papworth Hospital,  
Cambridge



**Extracorporeal membrane oxygenation (ECMO) can be used to support potentially reversible dysfunction of the heart, or lungs or both systems. Cannulae can be sited centrally at surgery or peripherally by percutaneous means, and the circuit is most easily understood as a prolonged form of cardiopulmonary bypass without a venous reservoir. Use of ECMO in the UK, and worldwide, has increased over the last few years secondary to improvements in the ECMO technology and the recent H1N1 influenza pandemics. The former has made ECMO support easier to use and the latter prompted the National Specialist Commissioning Team (NSCT) to reconfigure the provision of adult respiratory ECMO in the UK. In addition, although some clinicians remain sceptical, a number of important trials have been published in the last few years confirming the benefits of ECMO<sup>1,2</sup>.**

Originally in the UK adult respiratory ECMO was provided by a single commissioned centre at Glenfield Hospital, Leicester. This unit had developed an international reputation with a large experience and excellent results, but at the time of the first H1N1 influenza outbreak during the winter of 2009/10, and subsequently with a greater peak in incidence in 2010/2011, the demand for ECMO was greater than the UK bed capacity. It was widely reported in the press that a patient from Scotland was flown to the Karolinska hospital in Stockholm for ECMO support, but less commonly understood that the UK and Swedish ECMO services had a longstanding bed sharing agreement. NSCT responded by rapid commissioning of surge capacity at Papworth hospital and Brompton hospital and later by commissioning an organised expansion of ECMO providers to ensure equality of access. Following an extensive evaluation and competitive bidding process, the following five units were selected and commissioned to provide adult respiratory ECMO services: Guy's and St Thomas' hospitals, Papworth hospital, Royal Brompton hospital, University hospitals of Leicester, University hospital of South Manchester, with Aberdeen designated separately in Scotland. There is now an organised referral pathway based on the intensive care networks.

Cardiac ECMO, as a temporary support to 'bridge' to heart transplantation (an alternative to temporary ventricular assist) is also commissioned by NSCT at the UK cardiothoracic transplantation units: Freeman hospital in Newcastle, Golden Jubilee hospital in Glasgow, Harefield hospital, Papworth hospital, Queen Elizabeth hospital Birmingham, and University hospital of South Manchester.

Cardiac ECMO support may also be provided for patients outside the above bridge indications, if there is an expectation of recovery, at any cardiothoracic hospital with sufficient

experience and available equipment, as an extension of standard care. In the latter case, the costs have to be met by the local centre or primary care trust. Potential reasons to use ECMO outside the commissioned services include post cardiac arrest as an extension of cardiopulmonary resuscitation or post-cardiotomy and inability to wean from cardiopulmonary bypass. Although survival following support in these situations is only 20-30%, mortality without support is 100%. It is the improvement and simplification of the technology that has precipitated the increased use of ECMO by non-specialists. The modern ECMO circuits are simplified and consist of a centrifugal pump head and low resistance membrane oxygenator. The heparin requirement is much lower and there are fewer bleeding complications. Once on support patients are often remarkably stable, and the heart and lungs can be rested to allow recovery while maintaining normal tissue oxygenation.

There are a number of courses available in the UK for those interested in increasing their experience of ECMO and an international organisation (ELSO) with lots of helpful online resources. It is likely that the use of ECMO will continue to expand and in the future cardiac surgeons, cardiologists and intensivists will be considering ECMO in the same way as we consider using intra aortic balloon pulsation today.

## References:

1. Peek GJ, Mugford M, Tiruvoipati R, Wilson A, Allen E, Thalanany MM, Hibbert CL, Truesdale A, Clemens F, Cooper N, Firmin RK, Elbourne D. Efficacy and economic assessment of conventional ventilatory support versus extracorporeal membrane oxygenation for severe adult respiratory failure (CESAR): a multicentre randomised controlled trial *Lancet*. 2009;374:1351-63.
2. Noah MA, Peek GJ, Finney SJ, Griffiths MJ, Harrison DA, Grieve R, Sadique MZ, Sekhon JS, McAuley DF, Firmin RK, Harvey C, Cordingley JJ, Price S, Vuylsteke A, Jenkins DP, Noble DW, Bloomfield R, Walsh TS, Perkins GD, Menon D, Taylor BL, Rowan KM. Referral to an extracorporeal membrane oxygenation center and mortality among patients with severe 2009 influenza A(H1N1). *JAMA*. 2011;306:1659-68.

## Links for resources:

[www.papworthhospital.nhs.uk/content.php?/education/papworth\\_ecmo](http://www.papworthhospital.nhs.uk/content.php?/education/papworth_ecmo)

[www.else.med.umich.edu/](http://www.else.med.umich.edu/)





# 2ND BRISTOL MINIMALLY INVASIVE Cardiac Surgery Workshop

- ♥ Trans-Catheter Mitral Procedures
- ♥ 3D-Imaging
- ♥ Sutureless AVR
- ♥ Aortic Access TAVI

**Friday 30th  
November 2012**  
Bristol Marriott  
Hotel Royal

**Organisers: George Asimakopoulos and Franco Ciulli**  
**Information: [MICSworkshop@gmail.com](mailto:MICSworkshop@gmail.com)**

Visit our website [www.acssuc2012.org](http://www.acssuc2012.org) for the latest course and registration updates!

7th ASIAN

# CARDIOTHORACIC SURGERY

## SPECIALTY UPDATE COURSE

22 – 24 NOV 2012

NATIONAL UNIVERSITY  
HOSPITAL SINGAPORE

Join us this November in Singapore for 3 days of first class educational experience.

This update course will benefit trainees, fully trained cardiothoracic surgeons, cardiothoracic and vascular nurses, perfusionists and all allied professionals involved in the care of cardiothoracic and vascular patients.

There will be outstanding trainers and speakers consisting of regional, UK and Hong Kong faculty.

Our course also features:

- Hands-on cardiac wetlab for aortic root enlargement, mitral valve repair and more (limited seats available on a first-come-first-served basis)
- Unique hands-on Chest Trauma workshop – first of its kind in Asia (Only few seats left!!)
- 2 days of intensive lecture-based symposium on topics pertinent to today's practice of cardiothoracic and vascular surgery.

Get your specialty update here in Singapore!

Organisers



**National University  
Heart Centre, Singapore**

**NUHS**  
National University  
Health System



# Diary of Forthcoming Events

Date: 17 - 18 July 2012  
 Meeting: **Aortic Valve Course 2012**  
 Town: Gloucester  
 Venue: The National Wetlab Centre  
 Faculty: Steve Rooney  
 Website: www.wetlab.co.uk

---

Date: 24 July 2012  
 Meeting: **45th Anniversary of the Ross Operation and 50th Anniversary of Homograft AVR**  
 Town: London, United Kingdom  
 Venue: The Royal College of Physicians  
 Contact: Sandra Wehr  
 Phone: +49 (0) 6182 94 666 28  
 Email: s.wehr@kelcon.de  
 Web: www.homograftat50.com

---

Date: 20 - 23 September 2012  
 Meeting: **Birmingham Review Course in Cardiothoracic Surgery**  
 Town: Birmingham  
 Venue: Heartlands Hospital  
 Contact: Lorraine Richardson  
 Phone: 01296 733 823  
 MOBILE: 077 111 32946  
 Email: lorrainerichardson1@btinternet.com  
 Web: www.birminghamreviewcourse.co.uk

---

Date: 24 - 25 September 2012  
 Meeting: **Dissection Course 2012**  
 Town: Gloucester  
 Venue: The National Wetlab Centre  
 Faculty: Graham Cooper, Ahmed Nassef  
 Web: www.wetlab.co.uk

---

Date: 24 - 25 September 2012  
 Meeting: **ESTS School of Thoracic Surgery (Practical Course in the Laboratory)**  
 Town: Paris, France  
 Venue: Covidien European Training Center  
 Contact: Sue Hesford  
 Phone: + 44 1392 430671  
 Fax: + 44 1392 430671  
 Email: sue@ests.org.uk  
 Web: www.estschool.org

---

Date: 19 - 20 October 2012  
 Meeting: **38th Congress on Perfusion**  
 Town: Reading  
 Venue: Hilton Hotel  
 Deadline: Call for Abstracts Submission deadline is 31st August 2012  
 Contact: Valerie Campbell  
 Tel: 020 7869 6891  
 Email: admin@sopgbi.freeserve.co.uk

---

Date: 21 - 23 October 2012  
 Meeting: **PAR Excellence 2012**  
 Town: Gloucester  
 Venue: The National Wetlab Centre  
 Website: www.wetlab.co.uk

---

Date: 26 October 2012  
 Meeting: **Essential Surgical Skills for Cardiologists**  
 Town: London  
 Venue: Royal College of Surgeons,  
 Contact: Jinna Sidhu  
 Tel: 020 7869 6303  
 Email: hsidhu@rcseng.ac.uk  
 Website: www.rcseng.ac.uk

---

Date: 27 - 31 October 2012  
 Meeting: **26th EACTS Annual Meeting**  
 Town: Barcelona Spain  
 Venue: Centre de Convencions Internacional de Barcelona  
 Contact: EACTS Executive Secretariat  
 Phone: +44 1753 832166  
 Fax: +44 1753 620407  
 Email: info@eacts.co.uk  
 Website: www.eacts.org

---

Date: 14 - 16 November 2012  
 Meeting: **Second International Joint Meeting on Thoracic Surgery Barcelona 2012**  
 Town: Barcelona, Spain  
 Auditorio Fomento de Trabajo  
 Deadline: Abstract submission deadline: 15 July 2012  
 Contact: Oriol Setó  
 Bonaire, 7 08301 Mataró (Barcelona/Spain)  
 Email: thoracic.surgery@actoserveis.com  
 web: www.mcspanamericanworkshop.com

---

## New Appointments

| <b>Name</b>                 | <b>Hospital</b>  | <b>Specialty</b> | <b>Starting Date</b> |
|-----------------------------|--|------------------|----------------------|
| <b>Jain Bhaskara Pillai</b> | University Hospital Of Coventry and Warwickshire NHS Trust | Adult Cardiac    | July 2011            |
| <b>Mr Mario Petrou</b>      | John Radcliffe Hospital, Oxford                            | Cardiac          | November 2011        |
| <b>Mr Reuben Jeganathan</b> | Royal Victoria Hospital, Belfast                           | Cardiothoracic   | January 2012         |
| <b>Mr Mo Asif</b>           | Golden Jubilee National Hospital                           | Thoracic         | February 2012        |
| <b>Mr Amal Bose</b>         | Victoria Hospital, Blackpool                               | Cardiac          | April 2012           |
| <b>Mr Ravi De Silva</b>     | John Radcliffe Hospital, Oxford                            | Cardiac          | April 2012           |
| <b>Mr Tony Walker</b>       | Victoria Hospital, Blackpool                               | Cardiac          | June 2012            |
| <b>Mr Michael Sabetai</b>   | St Thomas' Hospital, London                                | Cardiac          | July 2012            |
| <b>Mr Joel Dunning</b>      | James Cook University Hospital, Middlesbrough              | Cardiac/Thoracic | August 2012          |
| <b>Mr Ishtiaq Ahmed</b>     | Leeds General Infirmary                                    | Adult Cardiac    | September 2012       |
| <b>Ms Betsy Evans</b>       | Leeds General Infirmary                                    | Adult Cardiac    | September 2012       |

## Other Appointments

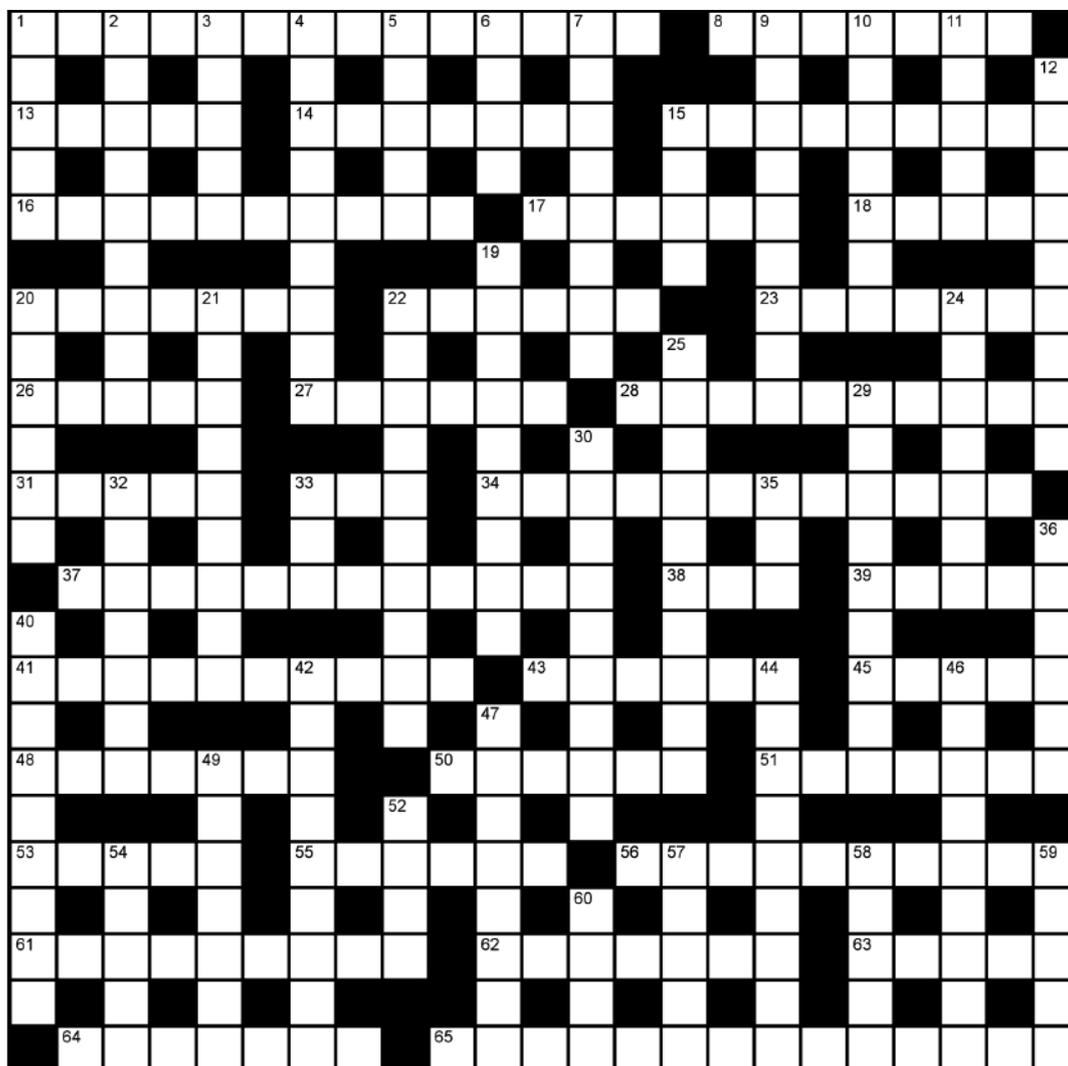
|                       |   |  |               |
|-----------------------|---|--|---------------|
| <b>Sing Yang Soon</b> | University Hospital of South Manchester | Locum Consultant<br>Cardiothoracic Surgeon | February 2012 |
| <b>Arvind Singh</b>   | Nottingham University Hospital          | Associate Specialist<br>Cardiac Surgery    | 2011          |



# the crossword



by Sam Nashef



Send your solution to:

Sam Nashef, Papworth  
Hospital, Cambridge CB23 3RE  
or fax to 01480 364744  
by 31 December 2012.

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

Last issue's solution overleaf

## Across

- 1/8/12 Planning exit, you ask high-tech light-hearted reference book (3,11,5,2,3,6)
- 13 The muscles of erection (5)
- 14 Walk back with unfinished clue to Arion's rescuer (7)
- 15 Game for a dance and a drink (9)
- 16 Red bits sprinkled with love, quiet in there (10)
- 17 Hollow in tree (6)
- 18 With difficulty, getting clue for sultan (5)
- 20 Gatekeeper in street, desperately keeping quiet (2,5)
- 22 Provided expression to relegate first to last (6)
- 23 "Altogether" translated to Latin (2,5)
- 26 Louis in Rome as soldier followed him in Paris (5)
- 27 State has no right to this region (6)
- 28 See 33 Down
- 31 Not at all pleasant for a family to lose leaders (5)
- 33 Spot the instrument (not half) (3)
- 34 Premeditated murder of the oaf or thug (12)
- 37 Helping, in a modest way, to convert lisp to normal (5,7)
- 38 Divine naked woman's top half ... (3)
- 39 ... is seen at junction (approximately) (5)
- 41 Not so funny to lose therapeutic ends coming out of hospital (10)
- 43 Sucker for nothing (6)
- 45 Bleat about greeting in Brazil (5)
- 48 Fun with lute should be (7)
- 50 Got suited (6)
- 51 Legend rewritten about right monster (7)
- 53 A doctor's hesitant expression on warning signal (5)
- 55 Heard where to find a filling that's not genetically modified (6)
- 56 Triumph of hope over experience to return stuff in anger, in anger (10)
- 61 Prince may be one that often makes the first move (5,4)
- 62 Firm stem (7)
- 63 Not one good open verse leads back to him (5)
- 64 See 20 Down
- 65 First atlas out to include 32 fjords won him an award (14)

Down clues overleaf

# the crossword

**Down**

- 1 Beat the short, short gown (5)
- 2 Typical EU fiasco for Australian growers (9)
- 3 Whiskey's drunken bloomer (5)
- 4 Rogue state in charge of body (9)
- 5 Stops deer changing sides (5)
- 6 Ex-chancellor's make-up (4)
- 7 Exceeds the agreed limit of cricket terms (4,4)
- 9 Rude ripple in bum is shot in the arm (5,4)
- 10 Most dangerous start to driving here is across the channel (7)
- 11 African is up first to express disapproval (5)
- 12 See 1 Across
- 15 See 49
- 19 Stay calm as standup comedian larks about, not terribly amused (4,5)
- 20/40/36/64 14's farewell to Jesus from the multitude? (2,4,3,6,3,3,3,4)
- 21 Central to strict cycle, pick treatment for depression (9)
- 22 Same about wrong ratio of an imaginary line (10)
- 24 Arsonist gets cruel punishment at hearing (7)
- 25 Star, perhaps Paul McCartney, fluid in audition (10)
- 29 Kit quietly replaced by item of furniture -that's fair (9)
- 30 Try a wig: any style is a departure (5,4)
- 32 Homer may be one who says footnote is included (7)
- 33/35/28 President of the BBC and the French TV with right coverage after strike carrier (6,10)
- 36 See 20
- 42 Spooner's baseball player at the restaurant (9)
- 44 Publication with earth a product here? (9)
- 46 Shrub that's hardy borders a garden that's informal (9)
- 47 Get stressed? Out of desserts? This will do it! (8)
- 49/15 Shoot missile, inclusive of 38's punishment (5,2,4)
- 52 Love prohibition in Scotland (4)
- 54 Judges reserve (5)
- 57 Keen on music, alternately out of tedium (5)
- 58 Fix hedge by trimming top (5)
- 59 Young partner for Max (5)
- 60 Where to have fun with blonde (4)

|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| C | H | I | C | K | E | N |   |   |   | C | R | O | S | S |   |   |
| O |   | Z |   | I | O |   | M |   | A | I |   | I |   |   |   |   |
| R | U | M | P | E | L | S | T | I | L | T | S | K | I | N |   |   |
| O | I |   | V |   | E |   | N |   | E |   | S |   | K |   |   |   |
| N | E | R | D |   |   | A | B | R | I | D | G | E |   |   |   |   |
| A |   |   |   | T |   | A | O |   | O | S |   | O |   |   |   |   |
| T | I | K | K | A |   |   | G | E | N | E | R | A | T | E | S |   |
| I |   | I |   | I |   |   | X |   |   | I |   | A |   | T |   |   |
| O | L | D | F | L | A | M | E | S |   | E | A | G | E | R |   |   |
| N |   | S |   | L | A |   | W |   | S |   |   |   |   | A |   |   |
|   |   |   | S | I | S | S | I | E | S |   | A | C | D | C |   |   |
| O |   | F |   | G |   | A |   | A |   | H |   | R |   | I |   |   |
| B | R | O | T | H | E | L | C | R | E | E | P | E | R | S |   |   |
| O |   | C |   | T |   | A |   | A |   | R |   | D |   | E |   |   |
| E | P | I | C | S |   |   |   |   |   | T | H | E | R | O | A | D |

Solution to last issue's crossword.

Last issue's winner: **Ted Brackenbury, Edinburgh**

