I would like to thank those who have already submitted proposals for next year’s meeting. With the submission deadline upon us, I encourage you to SUBMIT IDEAS for satellite symposia and/or invited plenary speakers NOW! Your input into this process will be very valuable to the Scientific Program Committee: the majority of the invited scientific content for the Annual Meeting will stem from proposals submitted by ISHLT Members and Scientific Councils.

If you have ideas not yet fully developed, you are encouraged to consult directly with one of the Education Committee Representatives listed below. These committee members will be able to provide guidance regarding educational areas identified as priorities for the Annual Meeting, in order to increase the likelihood of your ideas/proposal being accepted for inclusion in next year’s program.

Education Committee Members:
(website: http://www.ishlt.org/boardsAndCommittees/education.asp):

Chris Wigfield, Committee Chair, cwigfield@lumc.edu
Marilia Cascalho, BSTR Council, marilia@umich.edu
David Baran, HFTM Council, dbaran@sbhcsm.com
Amparo Sole, ID Council, sole_amp@gva.es
Matthew Petty, NHSAH Council, mpetty1@fairview.org
Dylan Miller, PATH Council, dylan.miller@imail.org
Debra Dodd, PEDS Council, debra.dodd@vanderbilt.edu
Haifa Lyster, PHARM Council, h.lyster@rbht.nhs.uk
Dana McGlothlin, PH Council, mcglothl@medicine.ucsf.edu
Kevin Chan, PULM TX Council, kevichan@umich.edu

If you have a fully developed symposium idea, including title, summary, and suggested speakers and session chairs, please use one of the forms available on the Future Meetings page of the ISHLT website (http://www.ishlt.org/meetings/futureMeetings.asp) and submit...
The BSTR Council is now off and running. Inspired by the vision of Lori West, the Council underwent a full structural overhaul last year under the guidance of Lori West and Jim George. We now have liaisons and contacts with all of the major divisions of the ISHLT. We hope that with this structure, we can be much more responsive to the needs and goals of the Society, and assure the place of basic and translational sciences within this organization.

Newly formed, our main accomplishments have been to envision projects that we feel would benefit the society, obtain consensus within our ranks as to the best way to proceed with them, and to obtain board endorsement for proceeding with their implementation. During our next year, we will focus on three major projects:

1. A Career Development Center is being created with plans to be online by the next ISHLT Annual Meeting. Within this career center, we plan to provide a listing of labs within the ISHLT that could provide opportunities for students, post-docs, residents and fellows to pursue research training. Members of the society with labs wishing to participate should contact me at kgandy@mac.com. Suggested content for the laboratory listing will soon be posted on the BSTR website. Similarly, we plan to evaluate the potential of this site to pair trainees with mentors.

2. We intend to aid the ISHLT Grants and Awards Program with revision of the grant application process. For starters, the CVs in all future grants will be submitted in the standard NIH format, an effort that we feel will benefit all as it will facilitate comparisons of CVs of individuals from across an international spectrum. We are also in the process of discussing options for the applications to be submitted in an electronic format.

3. Finally, we have begun our efforts to join with TTS and ESOT under the guidance of the I2C2 in a collaborative effort to support a biannual meeting.

We feel that these types of efforts will enhance our organization’s efforts to support, interact with, and be a part of the top-level basic and translational science within the field.

In summary, our newly formed council is energetic and has a number of goals which we think are critical to the ISHLT mission. Please join us.

Disclosure statement: The author has no relevant financial relationships to disclose.
VINCENT’S NONSENSE

It’s official—all thoughts now are aimed at Montreal, Canada. Even remnants of my first memory of Montreal have been resurrected from the Pediatric Council Report entitled, Who’s on First? (Do you remember the Abbott and Costello routine?) As a mere little boy and his dirty face, all I knew of Montreal was the Montreal Expos and one of its first players, Rusty Staub, because I had the baseball card. Little did I know they were the first Major League Baseball franchise outside the United States. However, I did know their nickname was derived from the World’s Fair in 1967 in Montreal, the Expo, (later take note of the 1853 World’s Fair in New York City) and who can forget Nadia Comaneci’s perfect 10s in the 1976 Summer Olympics in Montreal.

Back to the matter at hand, this month’s featured articles: A Year in Review from the Pathology, Mechanical Circulatory Support, Basic Science and Translational Research Councils as well as a little help from Paul Simon for the Pharmacy and Pharmacology Council. Also, if you look carefully at this dot . . < it is actually two dots in the grand scheme of things. Simply reminding us Where We’ve Been and Where We’re Headed are the reports from the Junior Faculty and the Infectious Disease Councils. It is important for all of us to take note where we have been, where we are, and where we are headed. It helps us remain focused on our mission—for us it’s important and huge; however, for the world in time and in space it may be hardly noticeable. Don’t forget to prioritize. Maybe it is better to chase Zebras and Horses as cleverly presented by the Pulmonary Hypertension Council Report or what about Who’s Who in the Pulmonary Council Report. Of course our creative Nursing, Health Sciences and Allied Health Council Report has us looking at the Silver Screen and finally there is the Heart Failure and Transplant Medicine Council with a Post-Game Wrap Up.

Allow me to shift gears and give you a little secret to success. I employ the strategy of surrounding myself with successful people, to secure my success. I am completely encircled by all of you, members, delegates, reporters, writers, International Correspondents Board, associated and our venerable senior editors of your Links e-Newsletter. Of course let’s not forget our Managing Editor, Susie Newton. The success of our Society, our Journal and this Newsletter comes from within, you and all of us. You should all have a part in it and feel quite proud of it.

Another attempt at my own personal success is to surround myself with great literary works. By using a simple strategy from my favorite writer which could make me a bit of a donkey of myself is to tell you I am a ‘Twainiac’. At the risk of getting a little American-centric this year, I will share with you my familiarity and interpretations of our beloved Mark Twain. He was not just an American, he was International and very successful with his writings and lectures across the globe. Studying and understanding great writers like Mark Twain will only open our minds to improve ourselves and help us achieve that success we are all searching for. It will get a bit Twainiacal this year, but I hope and expect many of you will share you special personal and human interests for our future issues. For this issue, I leave you with a major key to success … No Success Without Failure.

Vincent Valentine, MD
Links Editor
HEART FAILURE AND TRANSPLANT MEDICINE COUNCIL: POST GAME WRAP-UP

David P Nelson, MD
HFTM Council Communications Liaison

HFTM Council website: http://www.ishlt.org/councils/heart.asp

Let’s dive right in to the exciting season highlights and great plays made by members of your top-ranked HFTM Council.

PRAGUE
Meeting highlights, kindly provided on a very short notice by Dr David Feldman, are provided below.

1) Wednesday AMR session hosted by Drs Kobashigawa and Glanville was an excellent mini-symposium which was interactive and informative.
2) The session Wednesday morning led by Drs Frigerio and Shah featured a session that included Drs. Taylor, Hunt, Starling and McManus discussing future practical and molecular approaches to assess our patients for rejection.
3) A session chaired by Drs. Smedira and Moazami on cardiogenic shock before and after heart transplantation covered mechanical support ideas utilizing ECMO and the total artificial heart to bridge our patients to transplant or recovery from acute rejection.
4) Later that morning there was an excellent translational science session on complement, plasma cells and B-cell immunity hosted by Drs Mohanakumar and Berry which included case presentations along with basic science explanations.
5) The poster sessions were well attended Wednesday, Thursday and Friday afternoons.
6) Thursday morning had an excellent session on transition from mechanical support to transplant and thereafter long-term management. This session was chaired by Drs. Uber and Zuckermann and also included a panel discussion of various aspects of patient care. In a parallel session, Drs. Johnson and Vega hosted a thoughtful discussion on complications and risk factors in cardiac transplantation.
7) An important ID-focused session on both heart and lung transplant was hosted by Drs Hannan and Verschueren.
8) The results of the CARGO 2 Allomap trial were presented.
9) An excellent “part II” basic science session hosted by Drs West and Lemstrom highlighted the importance of MHC induced autoimmunity and Non-HLA microarray analysis.
10) The mini-oral session on Thursday afternoon by Drs Starling and Gandy was thoughtful and provocative.
11) As a follow-up to Wednesday there was an additional “experts” session hosted by Dr Mehra on “difficult cases”.
12) Late Thursday for those die-hard attendees there was an excellent basic science session hosted by Drs Goldberg and Epailly on “back to the basics”.
13) On Friday morning Drs. Mancini and Mirabet hosted a session on the follow-up of some of our
most recent large clinical trials and their application in clinical practice.

14) Drs Rajagopalan and Eisen hosted a session about “the latest” in immunosuppression.

15) Part II of “bad bugs” was hosted by Drs Martin and Kusne. This session helped shed new light on commonly seen infectious problems.

16) A plenary session by Drs Kirklin and Corris later that afternoon was provocative and frankly entertaining.

17) Closing out the meeting on Saturday morning was a session that included an award ceremony and the integration of the new information technology and remote monitoring available to better care for our patients.

Since I wasn’t able to attend the meeting this year, I would like to include the most important take-home messages that you experienced at the Prague meeting (important abstracts, sessions, ideas, best place to grab a beer…), for inclusion in the next Links issue. Please feel free to email me your best highlights!

COUNCIL VICE CHAIR NEWS
Conduct of our Council’s annual business in Prague was limited by attendance and, as a consequence, a Council Chair-elect was not selected. Instead, two candidates were identified whose names will be forwarded to the membership for an electronic vote in the near future.

LINKS NEWSLETTER
Do you have any newsworthy reports or information related to our Council members, heart failure or heart transplantation? Please feel free to send them to me for inclusion in the monthly Links issues. Importantly, do not forget that the December Links will be HFTM Council focused, so ideas for that issue would be particularly valued and appreciated.

Our Chair, Dr D Brad Dyke, reports that there is a misperception that a PDF version of the Links is unavailable. PDF versions of the Links are available on the ISHLT website; there is a brief time lag between an issue’s online publication and its PDF postings.

UNOS
Dr Shelley Hall joined with fellow HFTM Council member, Dr David Nelson, UNOS Region 4 Councilor, in initiating a Regional Thoracic “pre-meeting” immediately preceding the May Region 4 meeting. Thoracic committee proposals were discussed and HLA lab attendees facilitated a discussion of Dr. Afzal Nikaein, et al’s recent publication in the Journal about VAD-associated antibodies (Journal of Heart and Lung Transplantation 2012; 31:443). Region 4 is the first region to join Region 5 in conducting Regional Thoracic meetings in conjunction with their full Regional Meeting.

HFTM Council and ISHLT board member, Dr Joe Rogers, has been named as the new Vice-Chair of the UNOS Thoracic Committee.

HRSA
The HFTM Council has worked this year with the Health Resources and Services Administration (HRSA) Donor Management Task Force (DMTF) to develop metrics for investigators designing donor management studies to use as outcome measures to assess short and long-term cardiac effects of investigational donor interventions. The DMTF was impressed with the Council’s progress on this project at its April Chicago meeting. After the Council Workgroup’s final product is approved by the Council’s Chair and ISHLT board, the DMTF will review and forward it to the UNOS Thoracic Committee for vetting. The Council’s DMTF Workgroup members are Drs Hannah Valantine, David Baran, Kiran Khush, Jeff Hosenpud, Richard Daly and Ram Kalya. I am the DMTF liaison and co-chair of one of the three DMTF committees. Kiran Khush is the Council’s other DMTF member and has played a particularly active role in metric development.

PEDIATRIC HEART INITIATIVE
Dr. Yuk Law, of the Pediatric Scientific Council, reports the formation of a Pediatric Heart Failure Workforce within the Pediatric Scientific Council to provide an organizational platform to develop initiatives supporting pediatric cardiologists. Because of the prominent role pediatric cardiologists can play in donor management, a joint effort between this new work force and the HRSA Donor Management Task Force is being explored.

NBA
ISHLT headquarters is in Texas and I am in Oklahoma, so we in Region 4 would like to extend our sympathy to all of you whose NBA seasons are over. GO OKLAHOMA THUNDER!

And that’s a wrap!

Disclosure statement: The author has no conflicts of interest to disclose.
NEWS FROM THE ID COUNCIL: WHERE WE’VE BEEN AND WHERE WE’RE GOING

Michele Estabrook and Macé Schuurmans
ID Council Communications Liaisons


Accomplishments over the past year:

The ID Council has remained extremely active and productive in the past year. Drs. Erik Verschuuren and Lara Danziger-Isakov collaborated with the Program Committee to bring exciting content to the ISHLT Academy and the Annual Meeting including discussion of multi-drug resistance, donor infections and travel medicine. In the fall, we organized a response to the proposed PHS Guidelines on high-risk donor screening on behalf of the Society. Dr. Stanley Martin has generously contributed monthly to LINKS. Several projects were hatched including a survey of MCS infection prevention practices led by member Dr. Shimon Kusne (watch your in-boxes!!), a systems-based guide to infectious complications led by Drs. Amparo Sole and Fernanda Silveira and a Fungal working group led by Dr. Shahid Husain.

Now to the future where it takes a village:

• The ID Council will be developing infection related variables to be considered for IMACS, the ISHLT sponsored device registry. Dr. Margaret Hannan is leading this collaboration.
• The ISHLT Registries and Databases Committee has agreed to consider adding ID variables and the council will begin to develop event-based, prospective events such as bacteremia, pneumonia, and CMV for consideration.
• The newly proposed MCS guidelines were posted on the ISHLT website and have been reviewed for ID content. Dr. Stan Martin will be responding on behalf of the ID Council.
• Drs. Amparo Sole & Fernanda Silveira have created an exciting proposal for a “What to do if” clinical scenario publication that could be distributed to clinicians working in cardiothoracic transplantation. This handbook will guide the clinician on how to approach certain ID situations in this population.
• Dr. Shahid Husain is spearheading the fungal prophylaxis workgroup that will perform an in-depth analysis of literature to help establish consensus on this very important yet, heterogeneous topic.
• ISHLT will have a presence at ICAAC. The first-ever Pre-meeting Symposium on Transplant ID at ICAAC will be co-sponsored by the ISHLT ID Council with Drs. Lara Danziger-Isakov and Shahid Husain as invited speakers.
• The ID Council welcomes submission for symposia for the upcoming 2013 meeting ideally with details on topics, speakers, time frame and chairs.

We are pleased to announce the new ID Council representatives:

Chair Lara Danziger-Isakov
Vice Chair Fernanda Silveira
Past Chair Martha Mooney
Program Committee Erik Verschuuren & Stan Martin
Education Committee Amparo Sole
I2C2 Committee Martha Mooney
Registries & Databases Paolo Sole and Shahid Husain
Standards & Guidelines Stan Martin
Board of Directors Liaison Joe Rogers
Communications/LINKS Michele Estabrook & Macé Schuurmans
Basic Science Liaison Orla Morrissey
Junior Faculty Liaison Me-Linh Luong

Disclosure Statement: The authors have no disclosures.
JFTC YEAR IN REVIEW: WHERE HAVE WE BEEN AND WHERE ARE WE GOING

Christina Migliore, MD
JFTC Communications Liaison

JFT Council website: http://www.ishlt.org/councils/junior.asp

The JFT Council (http://www.ishlt.org/councils/junior.asp) was created 5 years ago and included only a handful of members. Our size has increased to over 200 members with a quarter of its members from outside the US. The goal of the Council has always been to tap into the enthusiasm of junior faculty and trainees and make them an integral part of the society.

2011 has been one of our most productive years! The JFTC was the main focus of the March Issue of the ISHLT’s Links Newsletter. Several members of the council contributed exceptional articles. The issue spotlighted two events our Council is extremely proud to have sponsored:

1. the Mentor Luncheon, organized by Ramesh Emani, hosted about 40 mentees and 10 invited faculty at the ISHLT Annual Meeting in Prague.
2. the Mentorship Program, organized by our incoming JFTC chair, Pali Shah, now has over 150 faculty mentor volunteers!

These and other events at the 2012 ISHLT conference have helped to welcome younger faculty and trainees to the conference as well as to bring some new members to the Society.

Also at the annual scientific meeting, for the third straight year, the JFTC sponsored the Clinical Case Dilemmas in Thoracic Transplantation symposium. 150 abstracts were submitted, 6 were selected for oral presentations and 50 were selected for poster presentation. Congratulations to Erin Albers whose case presentation was selected for the Best Presentation Award during the symposium.

The council has started 2012 under our new workforce leadership:

Chair: Pali Shah
Vice Chair: Jen Cowger
Secretary: Manreet Kanwar
Program Committee: Lorriana Leard and Jen Cowger

We have several initiatives on the horizon including the development of a job posting website and as well as the pairing of the society’s junior members with senior member to write articles and teaching slide sets in conjunction with the Education Committee, ISHLT Academy and the Journal for Heart and Lung Transplantation.

In gearing up for the 2013 scientific meeting in Montreal, the council will be working on the possible addition of a multidisciplinary panel of experts and work on presenting unknown cases with an interactive discussion. The council would also like to continue its work with the program committee to pair JFTC members with senior moderators for select sessions to foster development of these critical academic skills. We have and continue to encourage our members to join and develop international proposals with the various councils in the Society.

Lastly, the JFTC would like to thank our previous fearless leader, Dan Dilling, as he closed his term as our council chair and communications liaison this year. Your endless efforts as our spokesman have been greatly appreciated.

The council has received wonderful feedback from new members on the breadth of opportunities available for junior members and we hope to make 2012-2013 even better!

Disclosure statement: The author has no conflicts of interest to disclose.
Current Trends

With the introduction of continuous flow (CF) devices, mechanical circulatory support (MCS) volumes have been rapidly growing worldwide. There also has been a trend toward earlier patient referral for MCS, with a 65% reduction in INTERMACS profile 1 patients being implanted over the past 5 years. Device intention at implant has become increasingly hazy, with 40% of patients having an indeterminate strategy at implantation. Nevertheless, it has been destination therapy with CF devices which has driven most of the growth in implants. Outcomes continue to improve in the LVAD patients, with an overall 1-year survival between 80 and 90% with the CF pumps.\(^1,2\)

Update on Devices in Trials

In the U.S., the HeartWare HVAD was approved by a vote of 9 to 2 as BTT by the FDA Circulatory Systems Device Advisory Committee. The FDA is still in the process of finalizing the review of the PMA. In addition, HeartWare has completed a 450-patient enrollment for ENDURANCE, its prospective, randomized DT trial. Newer miniaturized products, such as the Circulite Synergy, are being developed which are implanted off-bypass and via less invasive operative approaches. The Synergy device is presently undergoing CE Mark Trials in Europe.

Emerging Surgical Issues

As long-term survival continues to improve, increasing focus has been placed on early and late complications that have important ramifications for intraoperative and postoperative management, such as aortic insufficiency (AI), RV dysfunction and TR, and driveline infection.

An area of continuing controversy is how to manage AI intraoperatively and postoperatively. In patients with significant AI recognized intraoperatively, most clinicians agree that the aortic valve should be addressed in some fashion. Goda et al. demonstrated that aortic valve procedures can be performed at the time of VAD implantation with acceptable results.\(^3\) However, which procedure should be performed is more controversial. Options range from central coaptation (Park’s stitch) to complete valve closure to aortic valve replacement with a tissue valve.

Late de novo AI after VAD implantation is a worrisome development. In a study by Toda et al, patients who develop late AI have a worse overall prognosis.\(^4\) Two postoperative factors were associated with the development of AI in this study: >2+ MR and no aortic valve opening at 1 month. Moreover, failure of the aortic valve to open at least intermittently while on MCS is considered a risk factor for the development of aortic root thrombus and gastrointestinal arteriovenous malformations. Therefore, many centers have been striving to maintain intermittent aortic valve opening in their LVAD patients. For late AI, interesting emerging options include percutaneous closure\(^5\) or TAVI.\(^6\)

RV dysfunction remains a difficult predicament confronting the MCS field. According to INTERMACS, the need for an RVAD in DT patients yields a 50% mortality rate at three months.\(^2\) To minimize RV dysfunction, it is critical to both appropriately select patients and optimize RV function perioperatively. For those patients requiring permanent biventricular support, options include pulsatile paracorporeal PVAD BiVADS or the TAH. However, small series using an HVAD for RV support have now been reported. Krabatsch et al (2011) have reported using the HVAD either as an RVAD\(^7\) or in a BIVAD configuration.\(^8\) However, implantation of the HVAD on the right side may require modifications to the outflow graft diameter.\(^8\) Lastly, percutaneous RVADs are under development which will allow a less invasive means to support the right ventricle in the near future.
LVAD implantation is a continuing area on controversy. Piacentino et al. found that patients with significant TR at LVAD implantation had a higher incidence of concomitant RVAD requirement, prolonged inotropic infusions, prolonged hospital stay, and worse survival.\(^9\) The same group, in a separate publication, showed that tricuspid valve procedures to address significant TR at the time of LVAD implantation improved overall survival.\(^10\) However, a study from Northwestern University could not demonstrate any clinical benefit from concomitant TVR.\(^11\) Furthermore, Maltais and colleagues demonstrated a more than four-fold increase in mortality in patients undergoing concomitant TVR during LVAD implantation.\(^12\) A group from Berlin showed similar survival in patients undergoing concomitant TVR at time of LVAD implantation as compared to primary BIVAD patients.\(^13\) Overall, it seems that the presence of severe TR is a marker for high risk, likely due to pulmonary hypertension and RV dysfunction, however which patients may benefit from such a procedure remains unclear.

Patients remain at risk for driveline infections throughout the duration of support, but with longer support times and patients implanted as destination therapy, there has been an increasing focus on mitigating this risk. Over the past year newer surgical approaches have been reported which try to address this challenge by changing the way the driveline exits the body. Instead of the having some of the velour exposed, several centers have adopted varied approaches that completely incorporate the velour portion of the driveline in the abdominal wall and ensure that the portion of the driveline that exits the skin is the silastic portion. Theoretically, the silastic portion allows an epithelialized track to form along the driveline. This would theoretically minimize the tissue disruption that occurs when velour-covered exit sites are exposed to torqueing or bending forces.\(^14\) Preliminary data from this change in driveline exit site strategy appears to be promising in decreasing the incidence of infections but more long-term data is needed.

**Improving Cost Effectiveness**

As the world economies deal with increasing healthcare costs in a challenging economic environment, it behooves the MCS community to demonstrate the cost-effectiveness of VAD therapy. Several publications have examined this issue, the most recent of which was published this year by Rogers et al.\(^3\) Comparing the cost-effectiveness data derived from the REMATCH trial to that of the HeartMate II DT trial, Rogers and colleagues showed a substantial improvement in cost-effectiveness. In present value dollars, the cost-effectiveness of DT has improved by 85%. Although the cost-effectiveness remains higher than the conventional threshold of $50-100K cost per QALY, the large improvement seen over a 7 year interval holds further promise for improving future cost-effectiveness.

**What’s Next?**

As outcomes continue to improve, emphasis will be placed on ameliorating the long-term morbidities of VAD therapy. Perhaps foremost among these will be efforts to create a totally implantable VAD with the help of transcutaneous energy transfer (TET) technology. It is clear that technological improvements will be necessary to allow the safe transmission of energy across the skin and to improve the capacitance of the charge so that less frequent charging episodes will be required. Two competing technologies—coil transfer and wireless electricity (wiricity)—are under development by different companies.

Efforts at miniaturization of VAD technology will continue, with the hope that VADs will be a viable option in the pediatric population as well as in the earlier class III HF patients. The REVIVE-IT trial is expected to begin enrolling soon. This multicenter trial will randomize patients with heart failure who are less sick to destination therapy with an HVAD versus optimal medical management. The ROADMAP is a multicenter nonrandomized observational trial of outcomes with a HeartMate II as destination therapy in an approved, but still less sick population, INTERMACS profiles 4-6.

**Disclosure Statement:** The authors have no conflicts of interest to report.

**References:**


NHSAH HITS THE SILVER SCREEN!

Annemarie Kaan
NHSAH Council Chair


It's GLITZY! It's GLAMOROUS! It's STAR-STUDDED! It's the NURSING, HEALTH SCIENCES AND ALLIED HEALTH COUNCIL REPORT! And this year, our Council is in the movies! That's right—symposia sessions and council meetings right there on the big screen...

2012 ISHLT ANNUAL MEETING
NURSING SESSIONS WEBINAR

COMING SOON!

... this summer to a computer screen near you!
Remember how you laughed when you heard about the development of our Google Group? How you cried when you saw that we were able to offer two unrestricted research grants to our members? How you were on the edge of your seats when you heard that some of our sessions would be recorded so that fans could watch from the comfort of their own homes? How excited you were when you had the opportunity to contribute to pulmonary hypertension and mechanical circulatory support guidelines?

Experience all those emotions AGAIN this year! Catch your breath as you discuss monthly hot topics on Google Groups! Let your emotions run wild as we connect with other councils and professional associations! Fire up your creative side and contribute to our educational slide sets for transplant nurses and allied health professionals! Fall in love with the prospect of being intimately involved with creating new guidelines!

Join us for a crazy, action packed “Hollywood” adventure!
The NHSAH – A Blockbuster of a Council!!

Not a member of the Nursing Council? You can join very easily by logging into the ISHLT Members Only website and updating your profile—you can join any of our 11 Councils, which are open to all Society members.

Disclosure statement: The author has no conflicts of interest to disclose.

RATTING LINKS
NEW LINKS IN THE LINKS!

This new page will provide pictures of ISHLT members’ children, grandchildren, great-grandchildren, nieces, nephews, etc ... Please consider this YOUR invitation to SEND IN your proud photos to share (susie.newton@ishlt.org).

Future ISHLT President

Please join us in congratulating ISHLT member, Fabienne Dobbels, PhD, on the birth of her beautiful baby boy, Arne (pictured right), who was born on January 10, 2012. She says he is growing fast and likes smiling a lot!

Dr. Dobbels is a member of the NHSAH Council and is the Council’s Registries & Databases Committee representative. She was not able to attend this year’s Annual Meeting in Prague (perhaps she was a bit preoccupied?), but we hope to see her—and little Arne—next year in Montreal!
**PATHOLOGY COUNCIL YEAR IN REVIEW**

James B Atkinson, III, MD, PhD
Pathology Council Communications Liaison

The Pathology Council under the outstanding leadership of Past Chair, Gerald J Berry, MD (Stanford University, CA), had an active year capped in Prague at the ISHLT meeting which likewise proved to be extremely productive and exhilarating for the members of the Pathology Council. Many members attended and actively participated in a host of pre-meeting symposia, concurrent sessions and concurrent symposia.

In addition, we held pre-meeting sessions for pathologists on Tuesday, April 17, on the subjects of cardiac and pulmonary antibody-mediated rejection. The morning session on cardiac antibody-mediated rejection brought together many of the members of the cardiac group from ISHLT 2010 Chicago and ISHLT 2011 San Diego. The topics included refinement of histopathological and immunophenotypic diagnostic criteria, and affirmation of the proposed grading scheme for antibody-mediated rejection. In the afternoon session, a group of pulmonary pathologists convened to discuss the results of the Pathology Council-sponsored survey of current practices for the diagnosis and reporting of pulmonary antibody-mediated rejection. This provided a platform to evaluate a host of technical, interpretative and reporting issues. Proposals for antibody selection, interpretative thresholds for C4d staining distribution and intensity, and uniform terminology for the reporting of biopsy results were reached by consensus from the discussion. A more detailed summary will follow (see below).

The Pathology Council for the coming year will be under the innovative leadership of its Chair, Patrick Bruneval, MD, Hopital European Georges Pompidou (Paris, France). The Council will focus on antibody-mediated rejection in lung transplantation. Specifically, the Council will:

- Publish the 2012 Pulmonary Antibody-Mediated Rejection Session at Prague
- Develop a digital image repository of antibody-mediated rejection cases
- Collaborate with the Pulmonary Council to develop a multidisciplinary approach to the diagnosis and management of antibody-mediated pulmonary rejection

**Disclosure statement:** The author has no conflicts of interest to disclose.

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**WHO’S ON FIRST? PEDIATRIC TRANSPLANT COUNCIL REPORT**

Melanie Everitt, MD
Pediatric Transplantation Council Chair

The countdown to the EURO 2012 Football Championship has begun and baseball season is in full swing, so I’d like to dedicate our Pediatric Council Report to the Boys of Summer by announcing the Pediatric Council’s starting lineup for 2012-2013. We are poised for a banner year, and the Council needs the enthusiasm and commitment of ALL of our members—no benchwarmers or sideliners, please.

First of all, congratulation goes to our Golden Glove Winner (a.k.a. Vice Chair) Marc Schecter (Houston, Texas). Dr. Schecter will be fielding any fly balls, line drives, fouls, etc. that are missed, dropped, or simply overlooked by your current Chair.

One of the biggest bats to be wielded is by our new Education Committee Workforce Leader, Debra Dodd (Vanderbilt University, Nashville, Tennessee). Dr. Dodd has re-positioned herself in the roster as the new captain of this squad. Daphne Hsu (Montefiore, Bronx, New York) will remain involved on the squad as pinch
hitter for the Master Academy and Core Competencies in Pediatric Thoracic Transplantation. The remaining Education Workforce lineup includes Christian Benden (Sydney, Australia), Gerard Boyle (Cleveland, Ohio), Erik Edens (Iowa City, Iowa), Kimberly Gandy (Kansas City, Missouri), Paul Kantor (Toronto, ON, Canada), Beth Kaufman (Philadelphia, Pennsylvania), Michael Kuhn (Loma Linda, California), David Morales (Houston, Texas), Elfride Pahl (Chicago, Illinois), Bart Rottier (Groningen, the Netherlands), Janet Scheel (Baltimore, Maryland), Jeffrey Towbin (Cincinnati, Ohio), T.P. Singh (Boston, Massachusetts), and Simon Urschel (Edmonton, Canada).

Richard Chinnock (Loma Linda, California) announced at this year’s Council Meeting that he is a free agent, so the Pediatric Council is looking for a relief pitcher for the Registries and Databases Committee Workforce. If you are interested in being drafted as the new Leader of the Registries and Databases Workforce, contact Dr. Chinnock (rchinnock@llu.edu) or Melanie Everitt (melanie.everitt@imail.org). Please note that a signing bonus is not part of the deal. However, you will be welcomed to the Registries and Databases Workforce by a number of resourceful team veterans: David Rosenthal (Stanford, California), Elfride Pahl (Chicago, IL), and T.P. Singh (Boston, Massachusetts). The launching of PEDIMACS in August will count toward this year’s “runs batted in” for Pediatric Heart Failure and Transplant. Dr. Rosenthal (davidnr@stanford.edu), Betsy Blume (elizabeth.blume@cardio.chboston.org), or David Morales (David.morales@cchmc.org) can field additional questions/interests related to PEDIMACS.

The ISHLT Board has given the home plate wave to the Heart Failure Workforce. Dr. Yuk Law (Seattle Children’s Hospital, Washington) has stepped up to the plate as Leader of this new Workforce. The goals of the Pediatric Heart Failure Workforce include education, communication, advocacy, and community awareness/resource development for children with heart failure and those caring for them. Contact Dr. Law if interested (yuk.law@seattlechildrens.org).

The Pediatric Council welcomes Anne Dipchand (Toronto, ON, Canada) in her new role of switch-hitter. She will represent the Pediatric Council on the International and Inter-Society Coordinating Committee (I2C2) of ISHLT. The role of the I2C2 is to develop formal relationships with other Societies where mutual benefit may be attained, membership shared, and common goals exist.

Shifting now to the football pitch (or as we say in America, the soccer field), Robert Boucek (Seattle, Washington) earns a return as striker of the Standards and Guidelines Committee Workforce. He is joined by midfielders Samuel Goldfarb (Philadelphia, Pennsylvania), Michael Carboni (Durham, North Carolina), and Debra Dodd (Nashville, Tennessee). Contact Dr. Boucek if you are interested in this Workforce (Robert.boucek@seattlechildrens.org).

Kimberly Gandy (Kansas City, Missouri) will vie for more Communications Workforce success. Juan Alejos (Los Angeles, California), Jonathan Johnson (Rochester, Minnesota), Beth Kaufman (Philadelphia, Pennsylvania), Nagarajan Muthialu (London, United Kingdom), and Marc Richmond (Columbia University, New York) round out this squad. They hope for a sell-out crowd with the Pediatric Transplant Google Group initiative that is underway. For your ticket to this tournament, contact Dr. Gandy (kgandy@mac.com).

To recap, please consider signing on for any of the above Workforces. Please contact us if you are interested in leading the Registries and Databases Workforce. Stay tuned for more Pediatric coverage in the ISHLT Links Newsletter, especially in the Pediatric edition of the newsletter coming in November.

Disclosure Statement: Melanie Everitt is not a baseball player nor does she live in a city that hosts a Major League team. Her soccer knowledge is limited to that learned from the touch line of her 6-year-old’s recreation league. The preceding article was not intended to endorse a particular sport, team, league, or player, but rather intended to keep morale going through the seventh inning stretch and stoppage time. No other disclosures.
“I always think of this shape [a cone tapered outward away from oneself], you know, meaning that you begin and the possibilities are going out this way, which means that you’ll have a good story to tell… as opposed to this shape [a cone tapered inward at oneself], which means that somewhere in the second verse or something, you’ve finished. So, you’ll want to begin in some way that leaves open a lot of possibility…” -- Paul Simon (on recording the Graceland album)

Over the coming year, our council’s possibilities are vast, and our adventure will continue. The core competency statement will be completed and published. Our contributions to the ISHLT Links are planned. Collaborations with other councils and their leadership on guideline and scientific statements, JHLT contributions, and meeting symposium for the 2013 meeting are underway. Outreach efforts to other related societies, pharmacy and pharmacology groups, and international colleagues are ongoing to disseminate the benefits of ISHLT membership and the mission and vision of the Pharmacy and Pharmacology Council. This year promises to be filled with great work, hard effort, and epic fun. Let the adventure begin!

Disclosure Statement: The author has no conflicts of interest to disclose.
In medical school we were taught: “When you hear hoof beats, think horses, not zebras.” So we focus on the most likely possibilities when making a diagnosis, not the unusual ones. But sometimes, physicians need to look for a zebra. In the cardiothoracic community, the zebra can be pulmonary arterial hypertension.

The Pulmonary Hypertension (PH) Council was created 5 years ago by a group of physicians interested in this rare disease. Today, our council has grown-up. Our clinical and research interests have expanded and include all different etiologies for PH. The right ventricle (RV) has taken center stage in our symposium planning committee. No longer considered a mere bystander in the cardiovascular system, RV function is recognized as an important contributor and prognostic indicator in cardiopulmonary diseases as well as post transplantation.

RV research is burgeoning, representing—along with PH—a major theme of the 2012 ISHLT Scientific Sessions in Prague, continuing an evolving trend over recent years. We had 58 abstracts accepted for 2012 (our record high), compared to 42 in 2011 and 50 at our previous vastly successful meeting in Paris in 2009. We offered 3 Pre-meeting symposia: 1) Potpourri of Special Topics in PH; 2) The RV and Pulmonary Vascular Load in Health and Disease; and 3) Congenital Heart Disease: PH Dilemmas in Pediatrics and Adult Patients. There were also 3 Scientific Sessions Concurrent Sessions: 1) Lung Transplantation for PAH – World-wide Panel Discussion; 2) Following the RV through Thick and Thin; and 3) PH in Chronic Parenchymal Lung Disease – Does it Matter? In addition, a lunch session was offered: Optimised PAH Management: Doing the Right Thing for the Right Heart (sponsored by United Therapeutics).

For the 2013 ISHLT Scientific Sessions in Montreal, we will focus our educational efforts in cross-council collaborative sessions. We will also promote broader attendance and participation of the PH community, including non-transplant and international PH specialists, as well as trainees. The ISHLT, unlikely other societies, offers a distinctive opportunity for all of us as cardiologists, pulmonologists and surgeons, to come together and challenge each other with new ideas and projects. This is undoubtedly important in the field of PH, a common disease pathway for patients with end-staged heart and lung disease. We will continue to spread PH-related topics throughout the meeting and submit a proposal for a Plenary Session. Right ventricular (dys)function, its imaging, its assessment, and its management, will remain in the spotlight.

This year, we welcome Dr. Robert Frantz as our new Chair and Dr. Mardi Gomberg-Maitland as Vice-Chair. They will carry on the tradition set by Dr. Myung Park (past-Chair) and Dr. Raymond Benza (board of directors liaison) in developing and strengthening our group. The council continues to expand both in our membership numbers as well as in the multitude of ongoing and new projects in which we are dedicated. In addition, we are pleased to welcome Dr. James West as our basic science and transitional research liaison. Dr. West’s research...
focuses on early molecular events in the etiology of heritable pulmonary arterial hypertension, and whether these events are applicable to the broader field of idiopathic pulmonary arterial hypertension.

This year we have new committee leaders, full of enthusiasm and eager to share their fresh ideas:

1. The Registries and Database Committee workforce led by Drs. Stephen Mathai and Ivan Robbins, with assistance of previous representatives Mardi Gomberg-Maitland and Fernando Torres, will evaluate outcome queries based on database analyses regarding PH, RV function and transplantation.
2. The Education Committee workforce led by Dr. Dana McGlothlin, who was re-elected for her second term, will have the important task to develop the Masters Academy for 2014 in San Diego: Core competencies in Pulmonary Hypertension.
3. The Standards and Guideline Committee workforce led by Dr. Teresa De Marco is developing several projects: guidelines regarding management of RV failure in patients with PH; perioperative management of PAH patients during non-cardiac surgery; and a consensus on hemodynamic criteria and nomenclature for PH in left-sided heart disease.
4. The Development Committee workforce led by Dr. Evelyn Host will maintain current industry support (Gold Partner: United Therapeutics; Silver Partners: Actelion, Gilead; Corporate Partner: Bayer) as well as cultivate new sources of support.
5. The I2C2 Committee workforce will be led by Dr. John Granton.

Our ultimate goal is to cure PH. With your help and ideas, one day we will do that. For now, we want to raise awareness so every physician will have appropriate knowledge of new developments in the field of PH and RV failure. Stay tuned!

Disclosure statement: The author has received research support from Actelion and United Therapeutics and consultant and speaker bureau for Gilead.

WHO’S WHO AND WHAT’S NEW?
PULMONARY TRANSPLANT COUNCIL REPORT

Tereza Martinu, MD
PULM TX Council Communications Liaison


Who’s who in the Pulmonary Transplant Council leadership:

The chair: The baton has been passed from the outgoing chair Lianne Singer (Toronto General Hospital) to the current chair David Weill (Stanford U). In one year, the baton will go to the vice chair, Michael Mulligan (U Washington).

The committee representatives: The representatives to the 2013 Annual Meeting Program Committee are Denis Hadjiliadis (U Pennsylvania), Deborah Levine (UT-San Antonio), and Geert Verleden (Leuven, Belgium). The representative to the Development Committee is Patrick Evrard (Yvoir, Belgium), to the Education Committee Kevin Chan (U Michigan), to the I2C2 Committee Lianne Singer (U Toronto), to the Registries and Databases Committee Shaf Keshavjee (U Toronto), and to the Standards and Guidelines Committee David Weill (Stanford U).

The liaisons: Duane Davis (Duke U) will liaise the council to the Board of Directors, Daniel Chambers (Brisbane, Australia) will connect
Everolimus or Mycophenolate Mofetil and CNI Lowering for Renal Protection

In the Long-term follow-up of the SHIRAKISS randomized, prospective study, 34 recipients 1 to 4 years after heart transplantation and with 25 to 60 ml/min of creatinine clearance (CrCl) were randomized to everolimus with a very low dose (C0: 50 to 90 ng/ml, n = 17) or MMF with low dose of cyclosporine (C0: 100 to 150 ng/ml, n = 17). Follow-up was prolonged up to 3 years, and calculated CrCl was the main efficacy measure. Cyclosporine nephrotoxicity improved after a prolonged dose reduction in patients receiving MMF. At 3 years, the everolimus-based strategy provided a similar benefit only in patients without baseline proteinuria.

Pulmonary Hypertension In Chronic Obstructive Pulmonary Disease

The presence of pulmonary hypertension (PHT) in COPD subjects is associated with increased mortality, morbidity and use of health-care resources. In this review paper the evidence supporting the postulated mechanisms contributing to PHT in COPD are discussed. Hypoxia plays a pivotal role in the development of COPD-associated PHT. However, other mechanisms are also likely involved in the pathogenesis of increased pulmonary vascular resistance in this cohort, including acidemia, dynamic pulmonary hyperinflation, parenchymal destruction, pulmonary vascular remodeling, endothelial dysfunction and inflammation. These mechanisms are interdependent, modulated by genetic factors, and may be confounded by comorbidities such as sleep-disordered breathing, left heart failure and pulmonary thromboembolism.

Bronchial Carcinoma After Lung Transplantation

The development of primary bronchial carcinoma (BC) and its outcomes impact was examined in 9 of 92 single Lung Transplant (LTX) patients (transplanted for emphysema or lung fibrosis) who...
developed a bronchial carcinoma in their native lung, whereas only 4 of 224 bilateral LTx patients (also for emphysema or fibrosis) developed a bronchial carcinoma (p = 0.0026). At diagnosis, 4 patients had local disease (cT1N0M0 and cT2N0M0), whereas all others had regionally advanced or metastatic disease. Five patients were surgically treated; however, 1 had unforeseen N2 disease with additional pleural metastasis at surgery. All other patients (except 2 who died very soon after diagnosis) were treated with chemotherapy with or without radiotherapy. The median survival after diagnosis was only 10 ± 7 months.

**MELD Scores And Outcomes After MCS Or Transplantation**
Advanced HF is associated with congestive hepatopathy and progressive functional and ultrastructural changes of the liver. In the first of 2 separate papers, investigators examined the relationship of the Standard Model for End-stage Liver Disease (MELD) scores were calculated and a modified MELD score with albumin replacing INR (modMELD) to eliminate the confounding effects of anti-coagulation, with outcomes after Heart Transplantation. Individuals with a higher pre-transplantation MELD or modMELD score had worse outcome 30 days post-transplant and reduced long-term survival over a 10-year follow-up. In the 2nd paper examining this relationship on Ventricular Assist Devices (VAD), Patients with MELD or MELD-excluding INR (MELD-XI) < 17 had improved on-VAD and overall survival (p < 0.05) with a higher predictive power for MELD-XI. During VAD support, cholestasis initially worsened but eventually improved. Patients with pre-VAD liver dysfunction who survived to transplant had lower post-transplant survival (p = 0.0193). However, if MELD-XI normalized during VAD support, post-transplant survival improved and was similar to that of patients with low MELD-XI scores.

**B-Type Natriuretic Peptide Infusion and Total Artificial Heart Implantation**
In this pilot study, infusion of low-dose exogenous BNP increased urine output after ventriculectomy and implantation of a Total Artificial Heart in 5 patients who were compared to a cohort of 5 historical controls. These encouraging findings require further detailed study to define the influence of longer term outcomes.

**ISHLT TRAVELING SCHOLARSHIP AWARD**
Next application deadline: August 1st, 2012

The ISHLT Travelling Scholarship Award was established to facilitate the exchange of knowledge and techniques regarding heart and lung transplantation and the treatment of end stage heart and lung failure and to build relationships between individuals, institutions, and countries. The Scholarships may be used to learn new techniques in the clinic, operating room, or laboratory or just to experience first-hand how others deal with challenging problems. These awards are open to any member of the Society, in any country. They represent a unique opportunity for garnering fresh ideas and collaborative work across the globe.

The ISHLT will fund a minimum of ten scholarships per year. Each award will be in an amount of up to $6,000. ALL members of the Society are eligible to apply for a Scholarship. Applications for the next round close on August 1st.

For more information and application instructions/eligibility requirements, visit the International Traveling Scholarship webpage at http://www.ishlt.org/awards/awardIntlTravelScholar.asp.

**Congratulations to our 2011 International Traveling Scholarship recipients:**

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<thead>
<tr>
<th>August 2011</th>
<th>Disease</th>
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<tr>
<td>Stephanie T. Yerkovich, PhD</td>
<td>Chermside, AUSTRALIA</td>
</tr>
<tr>
<td>The Prince Charles Hospital</td>
<td>December 2011</td>
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<tr>
<td>Brisbane, Queensland,</td>
<td>Kimberly M. Derkatz, BNSc</td>
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<tr>
<td>AUSTRALIA</td>
<td>University of Alberta, Pediatrics</td>
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<td>Host Institution:</td>
<td>Edmonton, Alberta, CANADA</td>
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<td>Toronto General Hospital</td>
<td>Host Institution:</td>
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<tr>
<td>Ontario, CANADA</td>
<td>Stanford University</td>
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<tr>
<td>Sarrah E. Gilpin, PhD</td>
<td>Microbiology &amp; Immunology</td>
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<tr>
<td>University of Toronto</td>
<td>Stanford, California, USA</td>
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<tr>
<td>Ontario, CANADA</td>
<td>Jennifer Conway, MD, FRCPC</td>
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<td>Host Institution:</td>
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<td>The Prince Charles Hospital</td>
<td>Toronto, Ontario, CANADA</td>
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<td>Queensland Centre for</td>
<td>Host Institution:</td>
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<tr>
<td>Pulmonary Transplantation and Pulmonary</td>
<td>University of Louisville</td>
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TATTLING LINKS
** ISHLT MEMBERS IN THE NEWS **

EXTRA! EXTRA! READ ALL ABOUT IT!!

Did you miss the Plenary Session on Thursday, April 19, 2012 in Prague? Then you missed the truly incredible presentation given by Sharon Hunt, MD, the 2012 ISHLT Lifetime Achievement Award recipient. Never fear! We have the next best thing: view her presentation, along with the introduction by Heather Ross, MD, on YouTube at http://www.youtube.com/watch?v=a439G1mwDtY.

You can also read about Dr. Hunt in the 2012 Spring Stanford School of Medicine Quarterly Newsletter (http://medicine.stanford.edu/newsletter/2012-spring/lifetimeachievement.html) as well as in the Stanford News (http://med.stanford.edu/ism/2012/may/hunt-0521.html).

MORE MEMBERS IN THE NEWS:

** Shaf Keshavjee, MSc, FRCSC, MD **
appeared in the May 28, 2012 Metro article, Better to transplant smokers’ lungs than staying on wait list: study. Link to article: http://metronews.ca/health/241384/better-to-transplant-smokers-lungs-than-staying-on-wait-list-u-k-study-finds/

** Shelley A. Hall, MD **
was quoted in the May 16, 2012 WFAA.com article, Heart recipient makes debut at HP Byron Nelson Championship. Link to article: http://www.wfaa.com/sports/Heart-recipient-makes-debut-at-HP-Byron-Nelson-Championship-151632905.html

** Sean P. Pinney, MD **
was quoted in the May 4, 2012 Medscape article, Heart Transplant Waiting List Priorities May Need Adjustment. Link to article: http://www.medscape.com/viewarticle/763357

** Robert Bonser, FRCS, FRCP **
was quoted in the March 28, 2012 Philly.com Health article, Use of Smokers’ Lungs for Transplant Has Pros, Cons. Link to article: http://www.philly.com/philly/health/HealthDay665150_20120529_Use_of_Smokers__Lungs_for_Transplant_Has_Pros__Cons.html?cmpid=138896494

** Joseph B. Zwischenberger, MD **
was quoted in the March 28, 2012 Shots (NPR's Health Blog), A Struggle To Define ‘Death’ For Organ Donors. Link to article: http://www.npr.org/blogs/health/2012/03/27/149463045/a-struggle-to-define-death-for-organ-donors

** James K. Kirklin, MD **
was quoted in the March 26, 2012 Medscape article, Cheney Waited Longer Than Average for Heart Transplant. Link to article: http://www.medscape.com/viewarticle/760917

** Christian Benden, MD **
was quoted in the March 13, 2012 Medscape article, Slight Gains in Lung Transplant Outcomes Noted for Kids and Young Adults. Link to article: http://www.medscape.com/viewarticle/760169

If you know of an ISHLT member in the news, please let us know! Email information and/or news links to Susie Newton at susie.newton@ishlt.org.
The Life of Samuel Clemens spanned 75 years while his career as Mark Twain covered 45 years. Many aspects of his life influenced his writing beginning in his childhood. He was born in Florida, Missouri on November 30, 1835. Although he had an older brother, Orion, an older sister, and a younger brother, and three other siblings who died as young children, as his pen name implies, Twain was not a twin. His father, John Marshall Clemens, a native Virginian, moved his family to Hannibal, Missouri, just before Samuel was four in quest of better economic opportunities. He was 11 when John Marshall died of pneumonia. Samuel Clemens described his father as a very serious man who left his family with two legacies; one, an inordinate hope for the future; the other, several business failures. These failures left his family to struggle for subsistence. And as Twain would later describe from chapter 42 in his novel, *Roughing It*, "He left us a sumptuous level of pride in his fine Virginian stock and its national distinction, that Twain found he could not live on that alone without occasional bread to wash it down with." Twain would refer to families of lawyers and judges from Virginia several times in his writings, probably because his father was a lawyer and a judge. He would also refer to old Virginian grandees, descendents from the First Families of Virginia (FFV) in *Pudd’nhead Wilson*. In effect, one can learn a great deal about the life of Samuel Clemens through Mark Twain’s fiction.

Because of his father’s death, Clemens had to go to work which began in printing offices where he learned to be a typesetter. Perhaps being an apprentice in a printing establishment, or a printer’s devil, helps one set the stage of being a prominent American; consider among others, the likes of Benjamin Franklin, Thomas Jefferson, Walt Whitman, and now, Samuel Clemens. He spent a year in several eastern cities including New York, Philadelphia, Cincinnati, and Washington, D.C. He never moved back to Hannibal, but he did return there imaginatively. Hannibal was the inspiration for the idyllic river town of St Petersburg in *The Adventures of Tom Sawyer* and the *Adventures of Huckleberry Finn*, as well as the inspiration for Dawson’s Landing in *Pudd’nhead Wilson*.

Samuel Clemens had considerable exposure to slavery. Growing up in the slave state of Missouri, slavery became a major theme in his fiction. He saw no reason to question authority—he never heard anyone argue that there was anything wrong with it. From one of his autobiographical dictations as a child, “in church we were told God approved it. Slavery was a Holy thing.” He also recalled bearing witness to slave sufferings, describing a group of slaves chained together, waiting to be sold or waiting to be taken “down the river, to be sold.” Some of you may be thinking and linking your thoughts with the alternative rock group from North Wales, “The Alarm,” and their song, “*Sold Me Down the River*.” I wonder if they heard of or read any of Mark Twain’s books?

Anyway, Clemens also recalled one slave being stoned to death by an overseer simply for committing an “awkward” act. He spent a great deal of time with slaves at his uncle’s farm back in Florida, Missouri. He heard stories about slaves from one particular slave named Dan'l. From Dan'l, Twain developed material for his lecture circuit about the man with the “Golden Arm.” Later, Twain wrote about Dan’l Webster, the name of the titled jumping frog from his short story, *The Celebrated Jumping Frog of Calaveras County*. (I will not mention that Daniel Webster was a leading American Statesman and Senator during the period leading up to the Civil War. I also will not mention that Andrew Jackson, the seventh American President, is the name Twain gave to the feisty dog in the same frog story.)

As Clemens approached adulthood, he became impatient to leave Hannibal. In 1853, he ran away to New York City because there was a World’s Fair there and New York seemed to be the center of the universe. He spent a year in several eastern cities including New York, Philadelphia, Cincinnati, and Washington, D.C. He never moved back to Hannibal, but he did return there imaginatively. Hannibal was the inspiration for the idyllic river town of St Petersburg in *The Adventures of Tom Sawyer* and the *Adventures of Huckleberry Finn*, as well as the inspiration for Dawson’s Landing in *Pudd’nhead Wilson*.

Clemens, planning to travel to South America in 1857, traveled down the Mississippi River toward New Orleans in April of that year. He met Horace Bixby, a steamboat pilot, who taught him to pilot the muddy waters. By 1859, Clemens became a licensed riverboat pilot instead of a South American adventurer. He loved that profession far better than any he followed since. This profession paid him well and brought him much attention. These piloting experiences allowed him to observe many different people who traveled by steamboat. He later reported that it was during this brief, sharp schooling, where he became personally and familiarly acquainted with various types of people.
of human nature found in fiction, biography or history.

The Civil War brought commercial river traffic to a halt as it cut the country in two. Then, Clemens enlisted as a volunteer in a confederate unit in Hannibal among people he grew up with. He later resigned “because of fatigue from persistent retreatting.” During the Civil War, Clemens traveled west to the Nevada territory to strike it rich. He vowed he would not return home until he made his fortune. It was his complete failure as a prospector in the silver mines which drove him to make a living with his words. He was hired as a reporter for the Virginia City Enterprise and, by 1863, began signing his articles as Mark Twain. In this identity, he finally found a way to succeed on the good fun his penname triggered, first in the local Nevada and California scenes, then by a “jump” into national prominence from the story of The Celebrated Jumping Frog of Calaveras County. This story made millions laugh in the funereal setting of America’s recovery in the wake of its Civil War.

BATTING LINKS

This is the place for interactivity and debate among members! Many controversial topics are worth debating – so please feel free to submit your ideas. One so-called “all-spark” that may pique your interest:

As opposed to transplantation, mechanical assist devices are virtually an unlimited therapeutic resource — sparing the cost — and with a peek at the near future, one might see the evolution of a life saving option for many more patients than transplant has ever provided. However, in an era of limited resources, for countries’ fiscal balances, and for public and private healthcare systems, unrestricted MCS implantation may have serious ethical and economic consequences, for example, an increase in the number of patients implanted would presumably improve survival of severe heart failure patients conceivably driving more centers willing to pursue implantation for fiscal reasons (profit), therefore compounding a health care spending problem. The balance between patient’s rights to receive modern and effective healthcare, physicians’ therapeutic freedom, and budgetary constraints from healthcare authorities, is like an exercise with a teeter-totter on a tight rope while holding a glass of battery acid on your forehead. On one hand it is seemingly unethical not to offer an effective therapeutic strategy to all the patients who may benefit from it. On the other hand, unbridled use of expensive resources may inappropriately divert funds from much less expensive therapies involving large numbers of subjects.

Should healthcare authorities strictly regulate MCS implant by limiting the number of centers allowed to implant? Is the policy of favoring the use of bridge to transplant indication over destination therapy still current? Are transplant centers entitled to represent the hub of a referral network to which non-transplant cardiac surgical centers connect and refer to share common policies for patients’ selection and indications? How do we avoid over-implantation (i.e. implant in patients not enough sick), and implantation in patients without a clear expected implant benefit over time? Will we reach a peak to balance discriminatory undertreatment with potentially non-beneficial overtreatment?

Anyone willing to participate in this debate bordering on becoming a bit pugilistic about it or any other controversial topic, please SEND IN your ideas, comments, rebuttals, opinions, etc. to us!

Some of these topics could generate an “all-spark” transformation of ideas (reminds me of the movie, Transformers), in areas as hot as the Red Hot Chili Peppers; if so, then This is the Place. Or we can simply debate over the usage of pique, peek and peak.
Are you lost?  
Are you confused?  
Out of focus and bemused?  
Do you never know exactly where you are?  
How do you solve a problem like understanding the structure of the ISHLT?  
You’ve come to the right place! The Links Newsletter is here to help, and it’s EASY!!

**ISHLT Structure**  
Board of Directors  
-> Committees  
-> Councils  
-> ISHLT Members

**Where do we go from here?**  
Only a clear program proposal will clarify the path.

The best way to GET INVOLVED IN THE SOCIETY is to JOIN A COUNCIL. Simply LOG-IN to the Members Only Website and view your MEMBER PROFILE. Scroll down to the Scientific Council list and check any/all of the Councils for which you are interested in joining—it’s that simple!

Be sure to check out the new BATTLING, RATTLING and TATTLING pages!