Junior Faculty and Trainee Council (JFTC) Report

Daniel Dilling, MD
JFTC Chair

Since its inception in 2008 as an independent council of the ISHLT, the JFTC has worked to serve the needs and represent the interests of its younger members. As such, we aim to develop interesting activities and symposia at the annual meeting and to seek opportunities for advancement of younger members.

As you can see in some of the articles in this edition of ISHLT Links, the JFTC will once again sponsor the Mentoring Lunch, the Clinical Case Symposium, and conduct a Council Meeting to encourage participation and seek new ideas.

Current activities and plans include the following:

- Development of an international transplant fellowship database
- Development of a “job board” through the ISHLT website, where members may seek new opportunities and transplant programs may seek new hires
- Working with the editorial staff of the JHLT to match junior members with senior authors to write “Year in Review” articles for the content areas
- Development of an online repository of teaching slide sets in thoracic transplantation
- Creation of a “Google Group” for junior members to ask questions or solve clinical problems through conversation with peers
- Coordination of the Society’s Mentoring program (see the paired articles by Jonathan Singer and Lianne Singer in the edition of ISHLT Links for an example)

Please join us at our council meeting for more information or to get involved. See you in Prague!

Disclosure Statement:
The author has no conflicts of interest to disclose.
Prague is coming up fast! You probably already reserved your accommodations and bought your airplane ticket. But what about getting the most from the meeting? As an introduction to the Annual Meeting for new members and, specifically, for junior faculty and trainees, this article is meant to help you navigate through the various sessions and to highlight ways to get involved in the Society at the meeting.

First of all, ISHLT is a relatively small society and you should feel welcome to meet and mingle with other attendees after and in-between sessions. The Society wants junior members to participate in Council meetings, to stand up and comment on oral presentations and posters discussions, and to engage in informal conversations between the sessions. Interactions such as these go a long way toward bringing in fresh ideas or new perspectives on controversial topics.

Sessions are categorized into various types:

**Plenary Sessions:** These sessions take place in a large lecture hall, do not coincide with any other educational offerings, and are intended for all delegates. The topics are usually broad (across all clinical areas of the ISHLT or even involve general medical and scientific topics) and are given by invited speakers and featured abstract presenters.

**Satellite Symposia:** These sessions are comprised of invited speakers and focus on a specific topic. Several satellite symposia take place at the same time, but are usually scheduled so that there is minimal overlap among clinical areas.

**Concurrent Sessions:** Longer (15-minute) oral presentations of select abstracts that constitute one area and are presented and discussed with moderators.

**Mini Oral Sessions:** Short (5-minute) oral presentations of select abstracts that constitute one area and are presented and discussed with moderators.

**General Poster Sessions:** Posters are divided into clinical arenas and displayed all day, usually in the Exhibit Hall area. Authors will be at the posters on an assigned evening, which is the best time to view the posters.

There is a wealth of information about the Annual Meeting on the ISHLT website. If you are presenting at the meeting, be sure to read, “Procrastination, Preparation, Presentation, Prague” for tips from senior members on delivering a great speech or making a great presentation.

Next, make sure you attend the following sessions that are geared toward and designed by younger members:

- The Junior Faculty Mentor Lunch (Thursday, April 19, 1:15-3:15 PM, Club A)
- Clinical Case Dilemmas Concurrent Session (Thursday, April 19, 5:00-6:15 PM, Meeting Hall 4)
- The JFTC Meeting (Friday, April 20, 1:00-3:00 PM, Club D)

Incorporation of new and younger members is often achieved through the Society’s Council structure. Make sure you attend the open Council meetings that pertain to your clinical interests. Once there, meet others and volunteer yourself for Council work and to be a reviewer of abstracts for next year’s meeting.

**Wednesday, April 18, 1:00–3:00 PM**

- Pulmonary Hypertension (Club B)
- Pediatric Transplantation (Club C)
- Pathology (Club D)
Quotable Quotes

On St. Patrick's Day:

St. Patrick's Day Toast
Here's to a long life and a merry one.
A quick death and an easy one
A pretty girl and an honest one
A cold beer – and another one!

“If a man who cannot count finds a four-leaf clover, is he lucky?” – Stanislaw J. Lec

“If you’re enough lucky to be Irish, you’re lucky enough!” – Irish Saying

On Preparation:

“If people only knew how hard I work to gain my mastery, it wouldn’t seem so wonderful at all.” – Michelangelo

“Before anything else, preparation is the key to success.” – Alexander Graham Bell

“Education is not preparation for life; education is life itself.” – John Dewey

On Public Speaking:

“There are always three speeches for every one you actually gave. The one you practiced, the one you gave, and the one you wish you gave.” – Dale Carnegie

The best way to sound like you know what you’re talking about is to know what you’re talking about. – Author Unknown

“Start strong with a ‘grabber’. A personal story, a quote from an expert or a shocking statistic—something that takes a hold of your audience and gets them hooked and opens their mind to your message. Give the audience a chance to see your personal connection to the topic.” – Conor Neill

On Chocolate:

“A little too much chocolate is just about right.” – Daniel L. Worona

The ISHLT staff would like to thank Ashim Aggarwal for spoiling us with the recent gift of chocolates!!

Disclosure Statement: The author has no conflicts of interest to disclose.
And Now For Something Completely Different....
Clinical Case Dilemmas in Thoracic Transplantation

Lorriana Leard, MD
University of California-San Francisco

Four years ago a group of Junior Faculty and Trainee members of the ISHLT collaborated to add a new twist to the International Meeting. With so many master clinicians together, it was determined that one thing that could enhance the meeting would be a forum to highlight the diagnostic and management challenges that confront us in thoracic transplantation.

Thus in Chicago in 2010, the first Clinical Case session entitled *Dilemmas in Thoracic Transplantation* was held. The session was very well received, as the room was packed to overflowing, and the discussion it provoked was invigorating. Given the tremendous success of that first session, the Junior Faculty and Trainee Council continues to sponsor *Clinical Case Dilemmas in Thoracic Transplantation* each year. The contribution of clinical cases has grown to include a poster session in addition to the cases presented. To recognize the outstanding contributions by junior faculty and trainees, the society has awarded the best case presentation with complimentary registration for the next international meeting. Last year, this award went to Michelle Kittleson for her case illustrating the “Threat of Donor Transmitted Amoebic Encephalitis in a Heart Transplant Recipient.”

This year, the cases were submitted by junior faculty and trainees at the same time as the abstracts. Fascinating cases from around the world were submitted, and the review process was difficult.

Six remarkable cases have been selected for presentation at the meeting in Prague. These six cases will highlight some of the current challenges that confront clinicians in *Lung Transplantation, Heart Transplantation, Infectious Diseases, Pediatric Thoracic Transplantation, Mechanical Circulatory Support*, and *Pulmonary Hypertension*. Master clinicians have been invited to discuss the intricacies of these cases and share clinical pearls. We hope that you will join us to participate in what promises to be, once again, a controversial discussion of the issues raised by these challenging cases.

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

**Remembering Our Deceased Members**

Each year at the Annual Meeting, we set aside a time to remember those members of the Society who have passed away during the prior year. If you know of any ISHLT members who died during 2011 or the beginning of 2012, please send us the following information so that we can include them in this memorial process:

* Photo (jpeg or gif format)
* Dates of Birth and Death
* Most recent professional position and institution
* Any other significant information

Please email the above materials to susie.newton@ishlt.org no later than Friday, March 30, 2012.

Thank you for your assistance

Amanda W. Rowe
Executive Director
International Society for Heart and Lung Transplantation
ISHLT Links

Junior Faculty Mentor Luncheon
Sitaramesh Emami, MD
The Ohio State University, Columbus, Ohio

On behalf of the JFTC, I would like to extend an open invitation to attend the annual Junior Faculty Mentor Luncheon at this year’s Annual Meeting and Scientific Sessions in Prague. The luncheon is designed to facilitate conversation between those in the early phases of their careers and senior members of the ISHLT. Each year we invite several distinguished mentors who are renowned within their fields, have a history of successfully guiding mentees, and have served as leaders within the ISHLT. Our mentors will guide informal, small group discussions with attendees, addressing topics such as finding a job, creating research opportunities, getting published, and achieving work-life balance. The atmosphere is casual, open, and very enjoyable for everyone in attendance.

Our mentors for this year are already excited about the luncheon and are adding it to their calendars. Past participants have enjoyed the opportunity to meet senior members, ask questions, and network in a relaxed forum. In particular, we would also like to extend a special invite to those of you in the basic science fields or who may be members of the Nursing, Health Science, and Allied Health Council to register as well. If you are a trainee, in the early phases of your career, have questions about career development, or just want a chance to meet the bigwigs of the Society, come join us on Thursday, April 19th! We are looking forward to seeing you in Prague!

Disclosure Statement: The author has a small research grant from Medtronic, Inc, that does not pertain to the subject matter of the submitted article.

Register for the Luncheon!

During the Online Registration process, select add event on the 2nd page of registration. In the dropdown menu, select JFTC Mentor Luncheon.

If you already registered for the meeting and would like to add this event, download the ISHLT Official Registration Form, complete the first 3 lines at the top, and add the Junior Faculty Mentor Lunch. Include payment at the bottom of the form and FAX to ISHLT.

Thursday, April 19, 1:15–3:15 PM

VINCENT’S TWO SCENTS

This month, we focus on our Junior Faculty and Trainee Council which simply embodies what we do with our knowledge in the ISHLT. We experience it, observe it, organize it, analyze it, simplify it, describe it, ruin it, and cultivate it. In time, we recognize and reason with the dos and don’ts. We realize in the end there are more don’ts than dos, but rest assured mistakes provide the best opportunities. Regardless, there are dilemmas, travels, rest, reflection, hard work, awards, celebration, drinking, linking and what matters most.

Named in honor of the Roman God of War, March comes in like a lion and goes out like a lamb. In this third month, we have the Ides of March, St Patrick’s Day, sometimes Easter, and of course the vernal equinox, just to name a few milestones. For those of us in the northern hemisphere, spring begins anew with flowers, weeds and grass. With grass we take note of the varieties of grass and can water it, aerate it, thatch it, edge it, groom it, smell it, mulch it, compost it, chew it, eat it, paint it, stain it, spread it, change it, feed it, kill it, smoke it, sell it, and grow it. But for many of us we must mow it. Happy mowing and enjoy our grandsons, Devin and Dylan.
March Into Mentorship

Jonathan P Singer, MD MS
University of California, San Francisco

On the eve of the 32nd ISHLT Annual Meeting (while preparing my poster and making lists of things to do in Prague), I’ve reflected on how the mentorship I’ve received over the last two years from this Society has tangibly impacted my career development. In anticipation of my 3rd mentorship meeting next month, I was asked to describe my experience in the ISHLT Mentorship Program. As an added wrinkle, I was asked to tie it creatively to the month of March. The Ides of March was suggested as an example. It didn’t take me long to realize that my experience with my Society mentor and others has been very different from that of Julius Caesar and Marcus Junius Brutus! Instead of the Ides, March has come to signal two important events – the U.S. collegiate basketball playoffs (aptly nicknamed “March Madness”) and preparing each year for the ISHLT annual Meeting.

Two years ago, I attended my first ISHLT Meeting in Chicago. Several months earlier, an email arrived inviting new/junior attendees to submit a description of their career goals with the aim of identifying a like-minded Society mentor. In my response, I explained that I was a graduating pulmonary/critical care fellow, had completed an additional clinical fellowship in lung transplantation and a year-long, structured post-doctoral training program in clinical research. I noted that I was seeking a career that blended clinical transplant medicine with patient-centered outcomes research, including health-related quality of life (HRQL). I soon learned just how seriously the ISHLT took their goal of identifying well-matched mentors. As I sat in the coffee shop of the Chicago Hilton, my Society mentor approached and introduced herself, “Hi, I’m Lianne Singer. When I was a transplant fellow at Stanford, I did the same clinical research training program you did. I do clinical transplant medicine and I’m interested in patient-centered outcomes research, including HRQL.” Impressive, I thought to myself—even our names match (we actually are not related).

At that first meeting, we chatted about the many opportunities within the ISHLT available to junior members. I’ve made every effort to take full advantage of these great resources. After only two years, it’s hard to recount the many mentorship opportunities available without creating what feels like a laundry list. That year in Chicago and the following year in San Diego, I felt immediately welcomed at the Pulmonary Scientific Council Quality of Life Workforce meetings. It was exciting to sit with many of the people whose research has informed my thinking. As a direct result of those meetings, I’ve begun to work with Lianne and others on the developing multicenter pilot study aimed at collecting longitudinal quality of life data which will be linked to the ISHLT Registry (Quality of Life in Lung Transplantation [QUILT]). Beyond serving as my society mentor, Lianne is also an advisor on my K23 mentored career development award through the National Institutes of Health anticipated to begin this July. For this award, others I met through the Society reviewed and offered valuable advice on how I might respond to the critiques on the proposal’s initial submission.

The opportunities for mentorship in the Society didn’t end with Lianne. At the Junior Faculty and Fellows Luncheon, I learned strategies for successfully publishing research directly from Mandeep Mehra and James Kirklin. I applied these strategies, as well as ideas from chats with Lianne and others in the Society, to develop projects based on data from within my own institution as well as UNOS Registry data. Moreover, my first research project in lung transplantation was presented as a “mini-oral” presentation in Chicago and later published in the Journal of Heart and Lung Transplantation. Beyond being interesting research questions in and of themselves, I’ve used these projects to hone the analytic skills I will need to analyze the longitudinal impact of lung transplantation on patient-centered outcomes through a prospective cohort study here at UCSF and with my new Society colleagues through the QUILT project and other planned collaborations.

The mentorship and collaborations I have found through the ISHLT have played a truly important role in my early career development.
as an aspiring academic transplant pulmonologist. The Society is committed to the mentorship of junior members: it “walks the walk.” As the first day of spring arrives, March signals lots of great college basketball on television and the anticipation of the 32nd ISHLT Annual Meeting, where I plan to have more great talks with Lianne and others mentors about exciting opportunities and future collaborations.

Disclosure Statement: Dr. Singer has an investigator-initiated grant from Novartis to study health-related quality of life outcomes in lung transplant recipients.

References:


Photo: the author, pondering new research ideas in lung transplant medicine.

March Into Mentorship

Lianne G Singer, MD, FRCPC

Toronto General Hospital

March in Toronto—the snow melts (although we’ve barely seen any this winter), the Maple Leafs’ hockey team playoff hopes sink deeper into oblivion, and our team prepares for the ISHLT meeting in Prague. The ISHLT is a society that strives to make new members feel welcome. In my case, this meant assuming a leadership position within the Pulmonary Scientific Council only a few years into my first faculty position. What better way to pay it forward than to enlist as a society mentor?

Two years ago in Chicago, it was a pleasant surprise to meet another transplant pulmonologist who does patient-centered outcomes research. We had a great initial meeting sharing our backgrounds—some similarities (training at UCSF, skiing, having a father whose last name is Singer – not the same one) and some differences (he’s an ace surfer, me – not so much) - and strikingly compatible research interests.

Like many more experienced faculty, I have lots of data and not enough time. We discussed ways to collaborate in research, combining my data and experience with Jon’s great ideas and enthusiasm. Jon eagerly agreed to participate in the Quality of Life Workforce and our QUILT (Quality of Life in Lung Transplantation) study, and offered a computer program available to UCSF researchers to collect the data for this study. I am happy to serve as an advisor on Jon’s NIH Career Development Award proposal.
Jon and I have met or emailed several times over the past couple of years, and it’s really refreshing to take a break from all the presentations at the ISHLT meeting to chat about clinical problems, research ideas, and life outside of work. Not every mentor will be paired with a mentee who has the same name and does the same sort of research and clinical work as they do. However, every mentor will benefit from the exchange of ideas, the opportunity to share their experience and advice, and the knowledge that they are helping to build the future of our Society.

Disclosure Statement: The Author has no conflicts of interest to disclose.

Pictured above: the author, with her friend, contemplating new research ideas in lung transplant medicine.

EDITORS’ RECOMMENDATIONS

VIEWING

In the wake of the 84th Annual Academy Awards show, and in anticipation of the upcoming performances at our Annual Meeting in Prague, we can’t miss this opportunity to recommend some of the best performances in motion pictures today! In keeping with the international flavor of our Society, take note of the following global blockbusters:

**The Artist**, written, directed, and edited by Michel Hazanavicius (France) Winner of five 2012 Academy Awards including Best Picture, Best Director, Best Actor (Jean Dujardin), Best Costume Design, and Best Original Score, The Artist tells the story of a charismatic movie star unhappily confronting the new world of talking pictures. Mixing comedy, romance and melodrama, The Artist is itself an example of the form it celebrates: a black-and-white silent film that relies on images, actors and music to weave its singular spell.

**The Help**, based on the best-selling novel by Kathryn Stockett, directed by Tate Taylor (USA) Nominated for four Academy Awards, including Best Picture, Best Actor (Brad Pitt), Best Supporting Actor (Jonah Hill), Film Editing, Sound Mixing and Writing (Adapted Screenplay), Moneyball is a biographical sports drama about Oakland A’s general manager Billy Beane’s successful attempt to put together a baseball club on a budget by employing computer-generated analysis to draft his players.

**A Separation**, written, directed and produced by Asghar Farhadi (Iran) Winner of the 2012 Academy Award for Best Foreign Language Film, A Separation is the story of a married couple faced with a difficult decision—to improve the life of their child by moving to another country or to stay in Iran and look after a deteriorating parent who has Alzheimers.

**Saving Face**, directed by Daniel Junge (Pakistan) Winner of the 2012 Academy Award for Best Documentary Short, Saving Face follows the personal stories of two Pakistani women who survived violent acid burns, their battle for justice, and their journey of healing. Plastic surgeon Dr. Mohammad Jawad leaves the prominence of his London practice to make multiple surgical mission trips to his home country of Pakistan to help these and other victims.

**Moneyball**, based on the 2003 book by Michael Lewis, directed by Bennett Miller (USA) Nominated for six Academy Awards including Best Picture, Best Actor (Brad Pitt), Best Supporting Actor (Jonah Hill), Film Editing, Sound Mixing and Writing (Adapted Screenplay), Moneyball is a biographical sports drama about Oakland A’s general manager Billy Beane’s successful attempt to put together a baseball club on a budget by employing computer-generated analysis to draft his players.

LISTENING

We know that some of the greatest music written and recorded is also recognized each year at the Grammy Awards. We hope you take a few minutes to listen to the following Grammy Award winners:

**Rolling in the Deep** by Adele (UK) – Record of the Year, Song of the Year, Best Short Form Music Video (2012)
**Someone Like You** by Adele (UK) – Best Pop Solo Performance (2012)
**Behind These Hazel Eyes** by Kelly Clarkson (USA) – from Best Pop Vocal Album, Breakaway (2006)
**Paradise** by Coldplay (UK) – nominated for Best Pop Duo/Group Performance (2012)
**Every Breath You Take** by Sting (UK) – Song of the Year (1984)
**Thriller** by Michael Jackson (USA) – Best Long Form Music Video (1985)
**A Hard Day’s Night** by The Beatles (UK) – Best Performance By a Vocal Group (1964)
**Here Comes the Sun** by George Harrison (UK) – from the Grammy Hall-of-Fame album, Abbey Road, by the Beatles.

Obviously, the Links Staff enjoys Brit singers!
To deliver a good speech or make a great presentation, let’s refer to the January 2012 ISHLT Links, Issue 8, Volume 3, On Teaching and Learning. From this article, pay attention to the following points: 1) the one who learns the most while sharing knowledge is the teacher or presenter, and 2) when teaching, presenting your poster, delivering your lecture, or writing your paper, you should ask yourself, “What do I want the intended audience to know five years from now?” Perhaps better advice can be found in the rules for posters and presentations. Finally, the best advice for the success of ISHLT 2012 in Prague is in the June 2011 ISHLT Links, Issue 1, Volume 3 article, On to Prague, from our Program Chair, Stuart Sweet: “brevity and clarity will be key, particularly in oral presentations.”

**PROCRASTINATION**

Whatever means you have used to overcome procrastination, now is the time to prepare. From June 2011 Vol. 3, Issue 1, Quotable Quotes remain mindful of Benjamin Franklin’s quote, “By failing to prepare, you are preparing to fail.” You will also find his wise words on procrastination in January 2012 Vol. 3, Issue 8, Quotable Quotes.

**PREPARATION**

Knowing these basic rules for being prepared will make you aware of your allotted time (see Vol. 3, Issue 1, Rules of Engagement). Within this allotted time, your presentation should comprise no more than 75% of the total time for you to speak. Why? You want your presentation to be memorable. To be memorable, find a way to captivate and/or involve the audience. Involving the audience is easier than captivating them. Save time for questions and answers and invoke the Chinese proverb “Tell me and I’ll forget; show me and I may remember; involve me and I’ll understand.”

During preparation, be self-critical and practice. Videotape yourself delivering a speech. Your goals are to liven up your presentation, so practice being dynamic, informative, interesting and persuasive. Consider your presentation as a performance (although tempered with the notion that you are not competing for an academy award!). Study the mannerisms of great lecturers or your favorite speakers. To be an effective lecturer, you must plan, begin, and think about your audience.

What about “ticks and fleas”? Are they distractions to your performance? Identify and suppress your verbal and nonverbal tics. Some common verbal tics are: “hmmm,” “ahh” and, “you know.” Recently a speaker said, “hmmm – K” after every sentence. And let’s not forget “sort of,” “like,”

Woodrow Wilson’s attempt at everlasting peace and creating international harmony with his fourteen points and the Treaty of Versailles after WWI.

At left is Carey Orr’s response to America’s response to the League of Nations.
“whatever,” “really,” and “seriously.” You’ve got to be kidding! These verbal tics impair your ability to project purpose and confidence. They also waste time, and time is of the essence in a scientific presentation.

You will notice that some speakers just can’t stand still. Remember to stand upright. Don’t lean on the lectern (unless very drunk from the night before) or stand still for a long time. Walk around, and consider standing in front of the lectern instead of behind it. (Do not dance, however.) Use hand gestures economically. Be careful about swaying, using bizarre or repetitive gestures. Videotape and study these tapes of your presentations—be self-critical before others have the chance to criticize. Dramatic silences are powerful, especially when accompanied by the right facial expression. Will the results confirm or refute the hypothesis? Will the patient live? and remember, appearance is important. The old adage applies here, especially for us silver-tongued, graying bunch: “we may not be any good, but at least we try to look good.” In other words, dress to impress! During your presentation, smile, make eye contact and choose your mood. You know your topic, so show passion for your topic. Bring enthusiastic energy and delight to your subject!

Study the recent success of Harvey Weinstein (a movie mogul and winner at the podium). He turned two movies into Best Picture Academy Award winners for two consecutive years. The King’s Speech (2011), is a movie about an English king who, to cope with a stammer, seeks help from an Australian speech therapist. (In keeping with our best performers of the ISHLT—who is the Australian and who is the Englishman here?) The other, The Artist (2012), is a silent movie; these two films are proof that overcoming “a tic” and well-time pauses of silence are very successful and quite theatrical.

PRESENTATION

With these points in mind, you are now on the road to a great formal presentation. Through repetition and review you will know your topic better than most—if not the entire—audience, therefore you must keep your presentation simple, especially simple from your point of view. But this audience still knows the background. The ISHLT does not need to be told that “lung transplantation is an accepted treatment for end-stage pulmonary disease” or something equivalent, an often predictable opening line. Don’t insult the listener by stating something they know!

• Begin your presentation by introducing your topic. – Introduction

    • Approach and means to support or refute your topic. – Methods
    • Talk about your topic by giving details and various means of supporting your topic. – Results and Discussion
    • Finally, summarize your topic. – Conclusions

Let’s restate the above with a few more details.

Tell the audience what you will say, then say it and repeat what you have just told them. Keep your messages clear and simple. Lively and animated speakers with an upbeat cadence and movement are more entertaining and memorable, engage the audience, add humor where appropriate—at some point, the audience must smile!—but don’t overdo it. Include full disclosures at the beginning and references at the end. Leave time for questions.

A Few Words on Slides

Today, PowerPoint presentations (slides) have become necessary for delivering information during our ISHLT meetings. As with anything in life, there are benefits and hazards of using slides. They are just one of many different teaching technologies. We must use them wisely and effectively. Living by slides could lead to dying by slides. Above all, prepare any presentation as if there are no slides—there may be some unforeseen technical difficulty. There is no substitute for an actual person speaking persuasively with a commanding and gripping performance that holds the attention of the audience.

Slides are used most effectively for an outline, complicated diagrams, and pictures. While preparing, you might ask, what will my audience gain by using slides? What will my presentation lose? Be aware how the audience divides their time between you and the screen. Slides can interfere with the audience-lecturer relationship. What happens when the lights are dimmed? It provokes sleep! With this thought, remember—NEVER read from your slides!!! They are there to enhance and clarify, not duplicate, not become a substitute or, certainly, not distract. The slides must supplement your talk, not act as a prompt. What you say must
differ from what the audience reads—repetition is a further waste of time ... a squandering of opportunity. Keep your slides as simple as possible—simple and direct. Each slide should convey one idea, have one diagram, or contain one or two pictures. You will never have to apologize for a cumbersome table if you never show one! And again, do not insult the audience by prefacing a slide with, “as you can see here.”

When you proceed on to a descriptive topic while being persuasive, don’t leave the slide on the screen. Avoid gimmicks, avoid noises, avoid added colors, avoid fancy colors, and avoid stripes. These are all distractions. There are enough studies indicating the most effective slide design for audience friendliness is either black words on a white background or off-white (eggshell) or yellow words on a dark blue background. Avoid red and green words and backgrounds. Use pictures. For content, use case-based presentations or well-placed jokes to enhance and possibly clarify your presentation into a more memorable one. **Keep slides simple.**

Finally, plan not to use a pointer. The audience is distracted when you turn away, and the microphone may lose your voice. If there is multi-screen projection, the pointer is seen on only one. Using the mouse is an alternative, but you have to look at the screen, thereby losing eye contact. Instead, build pointers into your slides—arrows on a photo, underlining a key part of a table, encircling the data you are referring to, etc.

**Before the session starts, always** check the podium and, ideally, talk to the projectionist, if there is one. Will they display your opening disclosure slide? What mechanism advances the slides (mouse, button, keyboard)? Who controls the lights? Is there a timer controlled by the Chair? Doing all this ahead of time makes you look professional and avoids embarrassing pauses and gaps.

While speaking, vary your sentence length. Use short action verbs and short crisp sentences. Long complex words are even more difficult to pronounce correctly in front of 2000 people. Use rhetorical questions (frequently more informative) rather than making declarative statements. Be aware of your tone of voice, variations in volume, and appropriate gestures. Vary your vocal inflections from loud to soft and from a high pitch to a low pitch. Paradoxically, the audience pays closer attention when you become quieter. **Do not speak in monotone.** Convey the idea to the audience that there is no place you’d rather be than talking about the topic you are enthusiastically delivering free from any distraction. Passion—and commitment to the subject—matter most when giving a presentation.

**DO NOT READ YOUR LECTURE OR PRESENTATION.** Written and spoken presentations differ. Presentations and speeches are spoken, so be a conversationalist. Pay attention to gestures and use of eye contact. You want to connect with and monitor the reaction of the audience as they listen to you. Otherwise, how do you know if you’re getting your message across? Study body language and try not to look at your notes. Do not memorize your entire lecture, but memorize the sequence of important things.

Most of all, **DO NOT EXCEED YOUR TIME LIMIT** by cramming too much material in your presentation. Know your time limit—this applies just as much during hours as after.

**PRAHGE**

The most important goals of your presentation are to make the audience feel they have learned something and have enjoyed themselves. Nevertheless, when all is said and done, it may not make a difference. Sometimes, “you can’t teach that!” So instead, follow the Irish custom **Pota Phadraig** (or Patrick’s Pot): “drown the shamrock” and have a beer!

**Disclosure Statement:** The authors have no conflicts of interest to disclose.
Thoracic Surgery became an independent specialty after separating from Cardio-thoracic surgery in 1985 in Turkey, resulting in gross improvements in thoracic surgery overall during the last two decades. However, such a separation probably delayed the first successful lung transplantation in our country. That is to say, until recently, only the cardiovascular surgeons –by law– were eligible to conduct heart and lung transplantation programs and, as a result, they prematurely abandoned performing lung transplantations after a few unsuccessful attempts. In 2007, we established a lung transplant program and presented it to our National Organization for Organ Transplantation. It was approved and now, thoracic surgeons are entitled to perform lung transplants as well.

At the beginning of 2009, the first successful lung transplant was performed in our hospital -a tertiary chest diseases and thoracic surgery center - where more than 2,000 thoracic surgical procedures are performed annually, but without any experience in organ transplantation. Despite maximum efforts, the team faced a number of unforeseen problems (most of which were organizational) in the management of postoperative complications for subsequent patients. With the increasing workload of the team, we soon realized that a revision was required for the routine work of both surgical and anesthesiology departments as well as the need to attain contribution of other specialties to the transplantation program. During this reorganization process, we did not get enough support from the hospital management, making our improvements more difficult resulting, at times, in some undesired, and even chaotic, outcomes.

Although lung recipient selection criteria are well defined and widely accepted, it is common for a new transplant team to have a tendency to use their priorities for desperate cases. Likewise it was true in our country, especially for those presenting with silicosis for whom the team feels additional social pressure. Their whole course is unexpected in many occasions and timing for the operation is not well documented. Almost half of our initial cases were suffering from silicosis, and we had great difficulties at every stage of the process due to their unexpected course as a whole.

Members of our team trained at different transplant centers in the United States and Europe that employ differing protocols, such as performance of surveillance transbronchial lung biopsies postoperatively. Conflicts and dilemmas regarding many aspects of lung transplant are vast, especially for those situations that require urgent decision making. In this regard, it was troublesome for our team to develop a common approach to certain clinical problems.

Many issues originating from regional restrictions are inevitable and of course need some time to resolve; however, one issue that should not be resolved over time is the unanimous training of every member of the team by the same reference center willing to collaborate with the demanding team. It is this type of support that, from the very beginning, can positively influence a vulnerable transplant program.

Disclosure statement:

Merih Kalamanoglu Balci was granted by the Turkish Thoracic Society to have a 3 month Scholarship for training in the Department of Lung Transplantation at Loyola University, Chicago, IL, USA.

Cemal Asım Kutlu has no conflicts of interest to disclose.

Güven Olgaç has no conflict of interest to disclose.
The International Society for Heart and Lung Transplantation is searching for a Medical Director for its International Heart and Lung Transplantation Registry. The Registry was established in 1983 to provide on-going up-to-date information on the worldwide thoracic organ transplant experience. This Registry is the only one of its kind. Every institution currently performing heart and lung transplantation is invited to contribute its data for inclusion in the Registry. Collected statistical information includes outcome data, survival data, and risk factor data segregated into subgroups according to various demographic criteria as well as the type of transplant.

Selected applicants will be invited for a personal interview with the ISHLT Board of Directors on Tuesday, April 17, 2012, in Prague, Czech Republic. The Medical Director will be selected following the interviews, and the successful candidate will assume the position of Medical Director on July 1, 2012. The Medical Director’s term is for 5 years, renewable for up to 5 additional years. Compensation is $20,000 annually, payable to the Director’s institution. Resumes will be accepted at the Society’s Headquarters office until March 15, 2012 (see below for information).

POSITION: Medical Director, ISHLT International Heart and Lung Transplantation Registry

Candidates for the position should be willing and able to make a significant (10%) time commitment for 5 years; may have a background in any area related to cardiothoracic transplantation; must enjoy the administrative as well as the academic aspects of the position; must desire to be responsive to the ISHLT members; must be thorough and have excellent follow-through of all pending matters; must be committed to the growth and improvement of the Registry; must be committed to maintaining full communications and a positive working relationship with the Society’s Board of Directors and staff, the staff of the Registry database contractor (UNOS), and the Registry Steering Committee (comprised of 7 Associate Medical Directors for Adult Heart, Adult Lung, Pediatric Heart, Pediatric Lung, Outcomes, Biostatistics, and Organ Exchange Organization (OEO) Relations, as well as ISHLT staff and UNOS staff).

JOB RESPONSIBILITIES:
The Director is responsible for leading the Registry Steering Committee and the Registry Advisory Committee; developing and implementing improvements to the Registry; increasing the number of participating centers and OEOs; improving data completeness and integrity; developing and maintaining positive working relationships with each participating center and OEO; insuring that the database is dynamic and productive; reporting on a bi-annual basis to the Board of Directors; working with the Registry Steering Committee to co-author the annual Registry Reports; overseeing UNOS’s activities as they relate to the Registry and the terms of the contract with UNOS; working with the Registry Steering Committee, ISHLT staff, and UNOS staff to review and promptly respond to data analysis requests; working with the Registry Steering Committee and ISHLT Board to initiate data analysis projects; raising corporate funds and securing grants to support the ongoing costs of the Registry; working with the Registry Steering Committee to review in a timely manner all manuscripts and abstracts citing Registry data; improving the public perception of the Registry; working with the ISHLT Board and staff in managing the business affairs of the Registry.

OTHER RESPONSIBILITIES:
Candidates must indicate their institution’s willingness to provide adequate workspace and the necessary equipment for use by the Medical Director. Additionally, upon selection, the Medical Director will be required to provide an annual letter from his/her institution confirming that the Director will be able to commit the 10% minimum time required of the position.

Please email (preferred), mail, or fax your resume/cv (3 page maximum) and description of what you would bring to the position by March 15th to:

Susie Newton
The International Society for Heart and Lung Transplantation
14673 Midway Road, Suite 200, Addison, TX 75001
Phone: 972-490-9495
Fax: 972-490-9499
susie.newton@ishlt.org
In 2006, I received the Philip K. Caves Award from the ISHLT in Madrid, Spain, for my presentation on T cell regulation in tolerant lung transplantation recipients in a miniature swine model. I was working on this research from the lab at Hannover Medical School (HMS) for the better part of 8 years. Tolerance induction in lung transplantation and, recently, T cell regulation in transplantation, are my major research interests. In the latter field, I received thorough training from Kathryn J. Wood during my 2 years research fellowship in Oxford, UK, from 2004 to 2006.

At the time I received the Caves award, I was 32 years old, was just back from Oxford, and still was a resident in cardiac surgery in only my 3rd year of clinical training. My major clinical interests since medical school have been lung (and heart) transplantation. I actively took part in the program at HMS from then on, by first being responsible for our intermediate care and transplant ward.

Things have really changed a lot since the Caves award, which came at the right time. In 2009, I was board certified as a cardiac surgeon and in 2010 I was promoted to the director of the thoracic transplant program at HMS after Andre R. Simon left Hannover to take over the transplant program at Harefield Trust in London, UK. I am very grateful to my boss, Axel Haverich, for his confidence in me.

In March 2010, I instituted a new innovative transplant program structure at HMS with two junior cardiac surgeons and long-standing colleagues of mine, Igor Tudorache and Christian Kuehn, to lead and share the program with me. We have increased numbers and upgraded the quality of our transplant program in Hannover. In 2010, we performed 114 lung transplants, and 131 in 2011 (including 6 and 5 combined heart-lung transplants, respectively). We discarded the use of standard cardiopulmonary bypass in lung transplantation and substituted with veno-arterial ECMO that is instituted in those 35% of the patients requiring extracorporeal circulation. We also try to avoid mechanical ventilation for bridging to lung transplantation and, instead, substitute with ‘awake ECMO’. These and quite a few other improvements have reduced 90-day mortality from more than 14% in 2009 and years prior, to 9.6% in 2010 and, so far, 7.0% in 2011.

Later in 2010, my application for ‘Habilitation’ (the approximate equivalent of a junior professorship within the German academic system) passed, adding the title ‘Privatdozent’ to my name.

For the last 3 years, I also have set up a dedicated transplant immunology laboratory within our department which routinely monitors regulatory T cells in clinical lung transplant recipients. Further, I have a pilot study (very close to recruiting the first patient) which will transfer parts of our long-standing tolerance induction protocol in miniature swine lung transplantation into our clinical program.

In 2011, HMS became part of the German Centre for Lung Research. In this major research body, I am one of 20 principal investigators from Hannover, and am responsible for 3 grants of relevance for the lung transplant program.

In early 2011, I started using the transportable ‘organ care system’ for warm perfusion of donor lungs in a clinical pilot trial at HMS. Since December 2011, we initiated the respective worldwide prospective, randomized 'INSPIre' trial and already recruited the first 12 patients in Hannover.

The years since receiving the Caves Award have been very exciting with my involvement thoracic transplantation. I will always be grateful to the Society for recognizing that I made a scientific contribution which would one day improve clinical care, something I believe epitomizes the Caves Award. Today, I eagerly look ahead to new horizons, especially the ISHLT meeting in Prague!

Disclosure Statement:
The author has no conflicts of interest to disclose.
This month brings the first day of spring: a time for new starts and new beginnings. During medical school, this meant where you would match for residency, where you would spend the next several years of your life. During residency, it meant where you would do your fellowship. Nothing compared to the decision that awaited you in the spring of your final year of medical training ... where you would begin your career as an attending physician. All of these decisions were of great importance. They would determine who your mentors would be, where you would live, how you would mold your medical career.

Most attending physicians I know have made these life-changing decisions. But what if you didn’t make a change? I mean, what if you started, continued your medical training, and eventually got your first job as an attending at the same institution? Just imagine--the same place where you started as an intern, became a resident, graduated, became a fellow, graduated –is now where you work as an attending physician. For those of us who traveled such a course in our medical careers, being “home grown” can have its rewards and challenges. What I learned after being an attending for 3 years is that I wouldn’t have done it any other way. I would want anyone considering this road to have an overview of the positives and negatives of such a decision.

I will start with the negatives because I think every article should end on a positive note. There will still be some hospital employees, nurses and physicians who will ask you, “Didn’t you graduate yet?” When you do your first bronchoscopy you will be asked, “Which attending will you be doing this case with?” My favorite is after doing my first consult on the pulmonary service, the attending asked me, “Who is the attending on service with you?” I was initially disheartened by this and began to question my choice. Would I ever be seen as an attending physician? Could I ever go into the attending lounge and not feel awkward? How could I learn and grow in this environment after all this time?

It was during this period that an attending for whom I had an enormous amount of respect said to me, “I don’t envy your decision, attendings will see you as still a fellow and residents will see you as still one of them.” He had experienced this himself since he became an attending at the same institution where he did all of his training. The advice he gave me next I only recently have begun to realize. He said, “Give it 3 years!” In that time, residents and fellows will have graduated, and attendings will have vaguely remembered your training days. He advised me to focus on my own referral base with other attendings who were recent graduates. I began to realize just this past year how true this really was. I cannot say precisely when this occurred, only that it has come to pass and that it was indeed worth the wait.

With that being said, of course there are the positive aspects. Besides knowing the obvious—where is radiology, how do I log on the computer to get labs, what not to eat in the cafeteria—you have learned how to get things done quickly and efficiently. But, can you grow and learn in a place where you feel so comfortable? Do you have to “move on” to grow? Comfort is a strange thing. It can be a disadvantage if you become static or it can be your biggest advantage. You have the basics part of the institution behind you and you can hit the ground running! Take pride in being “home grown”.

Remember Robert Frost’s famous poem:

I shall be telling this with a sigh
Somewhere ages and ages hence:
Two roads diverged in a wood, and I–
I took the one less traveled by,
And that has made all the difference.

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

Photo credit: www.martin-liebermann.de
Over the last decade, there has been a clear trend within ISHLT towards the reduction of emphasis and expertise in the basic and translational sciences. As a result, ISHLT President Lori West has called for redirecting the energy and goals within the BSTR Council.

The reasons for the drop in emphasis are many. First of all, the field—including clinical practice—has undoubtedly reached a level of maturity where many procedures have become standard rather than experimental. Next, changes in educational and training patterns within our fields have occurred. In the past, basic and/or translational research experience was highly encouraged in the path of becoming a transplant physician and caregiver; however, today’s budding transplant providers are less likely to have such training.

The attempt to remain competitive for the best and brightest from the new generation, a group clearly recognizing the lifestyle benefits of hastening the completion of training, has resulted in shorter training periods. Additionally, obtaining funding for research efforts requires more time than ever before. Grant writing has become an art in itself. There are many good ideas that will never be funded for lack of an ability to present that research in a manner consistent with a fundable grant. In truth, however, this pattern is consistent with the realization that it takes more than ideas in the current era to move research forward.

Change is a constant, and part of our charge as a Society is to recognize and predict the patterns of change, and then adapt to them in a manner that will benefit the field. As we attempt to determine the prospective positions of basic and translational science within our society, I would like to request that we recognize a few fundamental principles rarely discussed.

The appreciation and value of research define a mentality. The mentality that fuels a scientist to search for answers not there before is the same type of mentality that fuels a clinician to figure out a way to approach a patient beyond the obvious. This probing mentality prevents complacency from creeping into our approach to treat our patients. If we accept complacency as a quality, the entire character of our workforce will change.

We need individuals who want to achieve excellence in doing what has been done for decades. We need those who want to define new treatment paradigms, and are willing to carefully validate them. These forces may at times oppose each other, but in the end will strengthen each other, and it is the respectful co-existence of these forces that will preserve and strengthen our future.

Currently, there are approximately 100 members of the BSTR Council, chaired by myself and co-chaired by Sonja Schrepfer, MD, PhD. The board liaisons, James George, PhD and Lori West, MD, PhD, provide continuous guidance. Other officers are in the process of being appointed.

We are devising strategies to determine the best methods of reinvigorating the basic sciences within the ISHLT. At present, these strategies consist of: 1) reducing membership and meeting fees for undergraduate, medical, and graduate students who historically have not been attending our meetings, 2) conducting problem-focused training symposia at meetings to encourage interaction between basic, translational, and clinical scientists, 3) forming alliances with strong basic science training centers with incentives to encourage students to pursue research in related fields that may be considered strategic initiatives for the ISHLT, 4) organizing a host of senior scientific advisors to include some of the best minds in transplantation, pulmonary medicine/pulmonary hypertension and cardiovascular medicine, and encouraging their input into our methods of scientific support for our society.

Our current website is http://www.ishlt.org/councils/basicScience.asp. If you would like to contribute thoughts and/or ideas, please join our Google Discussion Group, a forum we hope to begin using within the next month to encourage the exchange of ideas within the society. If you would like to join this group, send your e-mail address to klgandy2@gmail.com. I will then send you an invitation to the group and bring you into the discussion forum.
This year, our Council meeting at the ISHLT Annual Meeting & Scientific Sessions will have two parts. During the first part, basic ideas and proposals will be presented. Students from all levels, scientists, and clinician scientists are encouraged to attend. After this period, a group of council members will adjourn to review the ideas that have been presented.

Research originates from a questioning mentality and a mentality that will not accept that what one sees before them is absolute. There are reasons that medical research has been partnered with clinical medicine since its inception. For one, close inspection of a clinical problem leads the inquiring mind to see many more issues which can and should be addressed. But research also provides solace.

Disclosure Statement: The author has no financial relationships to disclose.

VAD REIMBURSEMENT SESSION

ISHLT will be conducting an educational session at the Annual Meeting in April in Prague regarding how to accommodate the recently implemented changes to MCS billing by CMS. This session will take place during the MCS Council Meeting. Look for details on date/time/location of the MCS Council Meeting in the 2012 April Links issue.

The US Center for Medicare and Medicaid Services (CMS) has proposed significant changes in reimbursement for transplant and mechanical circulatory support procedures. The ISHLT supports advocacy of its membership as well as for patient care and is developing a forum to educate US surgeons and HF cardiologists of these regulatory changes and of the requirements necessary to capture reimbursement of postoperative care at this year’s 2012 ISHLT Scientific Meeting in Prague. In the spirit of the ISHLT, we will also devote a portion of the session to any new major MCS reimbursement issues outside of the US.

The following changes have been proposed by CMS:

- A reduction in reimbursement for VAD implant procedures but allowances for reimbursement of VAD-related “critical care”.
- Effective Jan. 1, 2012, the physician payment policy for Ventricular Assist Device removal procedures will change. Payment values will be reduced and no longer include reimbursement for in-hospital and out-patient evaluation and management services. Payments could be reduced dramatically - up to 30 percent - unless you prepare for this change.

If you do VAD procedures, you are providing a substantial amount of critical care as well as in-patient and out-patient care, which are currently reimbursed automatically. However with these changes, those services must be processed in an itemized fashion for each patient. Accurate documentation of services provided requires surgical insight and is the surgeon’s responsibility, and accurate documentation is critical for correct coding and ultimately correct reimbursement.
Thanks to an ISHLT Travelling Scholarship, I had the opportunity to visit the Toronto Lung Transplant Program and, in particular, the laboratory of Prof Tom Waddell, to foster and enhance our collaborative interests. Therefore, at the end of 2011 I left the sunny shores of Brisbane, Australia bound for the cold of Toronto, Canada.

The travel itself was an adventure and it is only when you undertake international travel that you realise how isolated Australia really is. I left a warm 30°C (86°F) Brisbane day to arrive nearly 24 hours and 2 long-haul plane flights later in Toronto at a mere 5°C (41°F). Apparently this was warm for the time of year, which was lucky for me! However, I was keen for the temperature to plummet so I could see snow, and excitedly I saw the first winter snow flurries a few days after my arrival. Work was promptly halted, the camera retrieved and like a tourist many photos were taken. The travel award allowed me to visit places like the spectacular Niagara Falls (at right).

The collaboration between our research groups, headed by Dr Daniel Chambers and Prof Tom Waddell, began at the 2010 ISHLT Annual Meeting in Chicago through Dr Sarah Gilpin. Sarah had presented some of her work demonstrating the appearance of bone-marrow derived epithelial progenitor cells, which are hypothesised to aid in epithelial repair, in the circulation of patients with advanced lung disease and post-lung transplant. We also had been looking at a similar cellular population and, following that meeting, began a collaboration using her cell markers and our unique access to the airway epithelium at post-transplant bronchoscopies to identify if these cells traffic to and reside in the lung following transplant.

While the collaboration has been maintained since our first meeting, with yearly catch-ups at the annual ISHLT meeting and via email, the opportunity to meet face-to-face and spend a period of time in Prof Waddell’s lab was too good an opportunity to pass up. My visit lasted 2 weeks and was both a productive and positive experience. The primary aim of the visit was to discuss our results, spend time with Sarah looking at her data, and getting her opinion on our data.

Being able to discuss the data in person and perform the flow cytometry analyses together, while having the opportunity to perform the cell staining in the laboratory, was extremely valuable. As the epithelial progenitor cells are a rare population, it was crucial to be able to compare how we both independently perform the staining and to ensure consistency. The project has benefitted enormously from our time together and some of the results will be presented at the upcoming ISHLT meeting in Prague.

My visit also allowed me to share our techniques, especially the small airway brushing protocol which offers a unique source of primary epithelial cells that can be used for a variety of projects. Visiting such a large, vibrant and diverse transplant-focused research program was a fantastic and unique opportunity, which is especially important with the limited and isolated laboratory-based transplant research occurring across Australia.

Although our laboratories are on oppsites sides of the world, it is amazing how similar they are. I felt very at home in the Toronto labs where the equipment is the same, the layout is similar and all the same boxes of consumables can be found. That also goes for scientists and researchers in general who will happily talk to the new person about experimental plans and new ideas. Naturally, this often happens over a coffee and the need for a morning coffee is universal.

Finally, having the opportunity to be immersed in both the research and clinical components of a large transplant program has given me a broader understanding of lung transplantation in general.
Overall the visit was a valuable experience and I would like to thank ISHLT for providing the Travelling Scholarship, Prof Tom Waddell and Dr Sarah Gilpin for hosting my visit, and all the clinical and research members of the Toronto Lung Transplant Program for being so accommodating and willing to share their program with me.

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

Myself (left) and Dr Sarah Gilpin at the Toronto Lung Transplant Program’s Christmas Party.

Ninth Prague Adventure of Mr/s XYZ at ISHLT 2012: The Best of Prague

Tereza Martinu, MD
Duke University Medical Center

“Could you please stow away your tray-table and fasten your seat belt?”

You wake up from your daydreaming and look up at the flight attendant. Hastily cleaning up your papers from your tray-table you reluctantly obey the airplane rules.

As soon as the flight attendant straps in for takeoff, you dig up your diary again to return to your project. You know the minute you touch ground at home, the duties and obligations of real life will return to weigh heavily on your shoulders. You remember the grant due in 5 days, the talk you need to prepare for your next conference, the data that needs to be analyzed which you have been neglecting for over a week now ... but you promptly suppress these thoughts and return to your Prague daydreaming.

Your significant other mandated you with the task of exploring Prague so that you can plan your next trip there together. So you open to the new entry in your diary titled, “The Best of Prague”. You start racking your brains ...

One absolutely cannot leave without visiting:

- Your favorite walk around key landmarks following the King’s Way from the Old Town square to Charles’ Bridge, towards Malostranské Náměstí (square), Nerudova Street, and up the stairs to the castle.
- Prague Castle: St. Vitus Cathedral (right) with a view of the city from the spire and the Golden Lane.
- Jewish Quarter
- Vyšehrad church and fortress
- Petřín tower and surrounding orchard
- Loreta Monastery with its hourly carillon bell music
- Strahov Monastery with its impressive antique library
- Vrtbovská Garden with sculpted flower beds
- Queen Anne’s Summer Palace (Belveder) in the Prague Castle gardens with its Italian renaissance style
- Kampa Island with its quaint houses and ancient water mill
- Trója Chateau near the zoo with an art gallery of Czech paintings from the 19th century
- Křižíkova Fontána featuring a light-music show

Quick tour of architectural styles through history:
- Roman style: Bazilika Svatého Jiří (St. George Basilica) within the Prague castle grounds
- Gothic style: St. Vitus Cathedral of the Prague Castle and Týnský Chrám (Church of Our Lady before Týn) on Old Town square
- Baroque style: St. Mikuláš Church on Malá Strana square
- Neo-renaissance style: National Museum, National Theater
- Modern style: Dancing House

Best one-day excursions from Prague:
- Karlštejn Castle
- Český Krumlov town and its castle
- Kutná Hora with the cathedral of Our Lady, St. Barbara’s church, and Sedlec ossuary (church decorated with human bones)
- Karlovy Vary spa town and Moser Glass Factory and Museum
- Breweries: either Pilsner Brewery or Velké Popovice Brewery
- Memorials to Nazi atrocities: Terezín Memorial (largest concentration camp in the Czech republic), Lidice Memorial (exterminated village with memorial to the children)
- Křivoklát Castle
- Hluboká Chateau
- Teč town with baroque houses and renaissance chateau
- Mělník town with winery and renaissance castle

Best castles:
For a good sampling of castles, Karlštejn Fortress, Hluboká Chateau, and Český Šternberk Castle make a nice compilation. For the castle aficionado, other gems include:

- Křivoklát
- Kost
- Konopiště
- Pernštejn
- Jindřichův Hradec
- Nelahozeves Castle (and the birthplace of the composer Antonín Dvořák)
- Nižbor Castle (with the Nižbor Glass Factory)
- Orlík
- Zvíkov
- Veltrusy Chateau
- the quaint Průhonice Chateau on the outskirts of Prague

Best museums:
- National Museum—the National Museum institution oversees many collections throughout the Czech Republic. The main building on Václavské (Wenceslas) square is an impressive neo-renaissance palace designed to house an impressive collection of items. It is currently closed until 2015 for major reconstruction due to accumulated damage from the world wars and recent wear and tear.
- Antonín Dvořák Museum
- Villa Bertramka—museum of W.A. Mozart, in memory of Mozart’s stay in this building in 1787 when he was finishing the Don Giovanni opera and preparing to conduct it in Prague.
- The Lapidárium—museum of Czech sculptures (it houses some of the original sculptures from the Charles Bridge or Vyšehrad)
- Franz Kafka Museum
- Exposition of historical
**ISHLT Links**

- **pharmacies** in the Golden Lion House, close to the Prague Castle
  - Moser Crystal Museum on the Old Town square
  - Prague City Museum (Museum Hlavního města Prahy)—focused on the history of Prague
  - Museum of Decorative Arts (Uměleckoprůmyslové museum), featuring arts and crafts from the Bohemian lands through history.
- Best art galleries: **Mucha Museum** (Alphonse Mucha is the most famous Czech Art Nouveau artist, best known for his decorative paintings (below) of women in flowing robes), The Fair Trade Palace (Veletřízní palace) with a large collection of modern and contemporary art, St. Agnes of Bohemia Convent (Czech medieval art), St. George Convent (Czech baroque paintings from the era of Emperor Rudolph II), The House of the Black Madonna (Czech cubism), Kinský Palace (Czech landscape paintings).

**Best souvenirs to bring home:**
- Bohemian crystal (sold everywhere in tourist areas): Egerman is an interesting brand; Moser is a high-end luxury brand
  - **Easter eggs** (right), called “kraslice” are ornate egg shells popular around Easter time
  - Wooden toys and wooden artwork
  - Puppets or marionettes: Puppet theater has a long history in entertainment in Prague. You can go see a show and puppets are for sale in all souvenir shops.
- Czech porcelain: two traditional brands are Cibulák and Henrietta. A small factory shop is located in Perlová ulice, a short distance from Národní třída. A big store is located on Jugoslávská street, west of náměstí Míru.
- Jewelry made with Czech garnets, Czech crystal, vltavín stone (Moldavite), and jantar (Amber): a factory shop with Czech garnet is located on Dlouhá třída (walking eastward from Old Town Square). One should check the store’s certificate of authenticity prior to purchasing gems.
  - Alcohol: Classic Czech hard alcohols include becherovka (a herbal bitter made in Karlovy Vary), slivovice (plum brandy), meruňkovice (apricot brandy), borovička (Juniper brandy), and absinth (anise-flavored spirit)
- Beer souvenirs such as T-shirts, hats, mugs or steins
  - Czech spa wafers (Lázeňské oplatky): best brand is Opavia; these are sold warm on Staroměstské náměstí (square)
  - Copy of artwork: most renowned painters include Alfons Mucha, Mikoláš Aleš, Josef Mánes, and Josef Lada (with cartoon-like pictures featured in children books)
  - Paintings of Prague landscape are sold all over old town.

In general, prices are better further out of Prague center but the selection may be better in the more touristic spots.

**Family Activities:**
In case you decide to bring your kids with you next time, you write down things that would likely entertain them.
- Žofín Island (also called Slovanský Island) with its playground and small boat rentals
- Boat rides on the Vltava River
- Petřín Hill with its funicular, mirror maze, observatory, pony rides, and planetarium
- Prague Zoo and nearby botanical garden
- Toy Museum near the Prague castle
- Railway Museum at the Masaryk Train Station
- National Technical Museum with its transportation, astronomy, photography, architecture, and other exhibits
  - You could do a tour of Prague on the nostalgic **Tram Number 91** (right) or hop on Tram Number 22, which also takes a scenic route around Prague.
- Puppet shows
  - Parks: Františkánská Zahrada and Vrtbovská Zahrada in center town. A little further out from the center are Havlíčkovy Sady and Letná Hill with their nice view of Prague and Riegrovy Sady and Stromovka with wide green spaces

**Dos and Don’ts:**
- Don’t wear jeans or shorts to the theater or concert hall. That may offend the locals who wear suits and dresses.
- Don’t use your credit card in sketchy places or small businesses. It's better to get cash (Czech koruna) from the bank or ATM for use in smaller shops, stands, and restaurants.
- Do consider wearing a money belt or pouch. Prague is a generally safe city, except for a pretty high risk of pickpocketing. Keep your hand on your purse/bag zipper in crowded places.

- Do beware of taxis: the general recommendation is to avoid these. Prague taxi drivers are notoriously and sadly on a mission to rip off unsuspecting tourists. If you need a taxi, call a reputable company (maybe have the hotel call one for you). Negotiating the price with the driver ahead of time is a good idea.

- Public transport: now, this was an interesting learning experience for you. It makes a lot of sense to take public transport in Prague since it’s cheap and gets you everywhere. However, there are some details to remember. One needs to buy a ticket ahead of time: either a short non-transfer ticket (called nepřestupný lístek) or a transfer ticket good for 90 minutes (called přestupný lístek). The other option is to get a one-day or a one-week pass. You need to stamp your ticket or pass at the entrance to the subway, bus or tramway and then you need to keep it until you are done riding. You may be asked to show your stamped ticket by a Czech-only-speaking undercover agent (wearing plain clothes).

You start laughing as you recall the day you almost assaulted the poor ticket agent, thinking he was a thief trying to rob you. Good thing some good-soul English-speaking local intervened and explained the situation to you. Your laughter attracted the attention of other plane passengers who are now staring at you from across the aisle. You refocus on your diary: the best food, the best pastries, the best beer … you have your work cut out for the rest of your flight!

Disclosure Statement: The author has no conflicts of interest to disclose.
It is no secret that we live in a world consumed by technology. In the past couple of years, advances in technology have touched every industry—mostly for the better. People now can shop, listen to music, watch movies, buy coffee, and even work—all from their phone. Books, magazines, and newspapers now are read on one of the many electronic tablets in the market. In other words, Welcome to the Machine.

There have been advances in medicine and surgery making recovery easier and treatments for various illnesses readily available. The medical world also has seen a push towards an online culture. Medical records are no longer kept with paper in big binders, but in software systems developed for hospitals. Medical histories—including test results, surgeries, allergies, and past illnesses—are easily accessible to doctors within one system. As for possible interactions between various medications a patient might be on ... don't worry, there's an app for that!

I have to wonder though, how has all of this electronic updating changed the interaction between doctor and patient? Is the patient getting more or less attention from their medical teams? Are we losing an important connection while the glow of the computer screen illuminates the examination room? With the multi-tasking of talking, typing, and updating, is the patient really getting the appointment they deserve?

I have noticed a change in the visits with my doctors over the last year. It was a slow and gradual change but one that made me sit back and reflect on my time in the system. Due to Cystic Fibrosis and a bi-lateral sequential lung transplant, I am no stranger to doctor visits. When I was younger, I would do my pulmonary function tests, which were then printed out for the doctor. Afterwards, I would sit across from the doctor in his office while he reviewed all of the tests, and we would have a conversation. We would talk about my health, necessary courses of action, new treatment plans, and how I was doing in general. There was sporadic note taking but nothing that ever distracted his attention away from me, the patient. I always assumed that when my appointment was finished and I left the office, the doctor would complete his sheet for the day and update my medical record.

Fast forward to 2012, when technology has taken over the world. I go into the office and the physician is able to pull up all my test results right on the computer. This obviously is more efficient and all information is readily available for the doctor and the patient. However, when it comes to the conversation with the patient, this is where I am noticing disconnect between patient and doctor. I am talking, but my doctor is focused on updating the electronic medical record—ferociously typing away on the keyboard. It is evident my doctor can hear me, but is he really listening to what I am saying? I wonder if he even knows the color of my eyes.

By not looking away from the computer, the physician could be missing important cues from his patient delivered through body language and gestures. If the doctor is concentrating on getting information into the system instead of making eye contact with his patient, it is a lot easier for the patient to tell him that they have been fully compliant, when in reality they have been cutting corners. Patients who are chronically ill also may say that they feel perfectly fine when they are not well. Doctors who are looking at their patient, fully attending to the conversation and concentrating on their patient, will be able to see these cues more readily.

There is no denying the fact that technology has been a positive
addition to medical care. My pulmonologist can check to see how my appointment with my oncologist went. My endocrinologist can get results from tests that my otolaryngologist ordered. This reduces duplicate testing, keeps all doctors up to date on all of my ailments, and hopefully reduces human error in the process. My transplant would never have been possible without advancements in medical technology. However, for all physicians out there, I implore you to look away from your computer. Pay full attention to your patient and update those electronic files later. Do patients have to compete with a machine for the attention of their doctor? After all, you never know when a patient might ask you the color of their eyes or if you noticed Angelina Jolie’s leg!

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**Just a Drop of the Hard Stuff**

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March 17th is the feast day of the patron saint of Ireland, Patrick, who is known for (amongst other things) converting the Celtic pagans to Christianity. While St. Patrick’s Day in Ireland is more of a religious celebration, Americans and other countries have assimilated the day for the purposes of merriment, inebriation, and enjoying all things “green” … including their beverages. In fact, St. Patrick’s Day was actually first “celebrated” in Boston, Massachusetts in 1737. According to folklore, St. Patrick was served an inadequate measure of whiskey at an inn. To teach the innkeeper about generosity, he told the innkeeper that a devil resided in the inn’s basement, and was growing fat from the innkeeper’s dishonesty. When St. Patrick revisited the inn months later, the innkeeper gave his patron an overflowing glass of liquor. St. Patrick then happily banished the emaciated demon from the inn and proclaimed that everyone should have a drop of the “hard stuff” on his feast day.

Perhaps folklore was on to something. Studies have shown that consumption of alcohol in moderate amounts (1-2 drinks/day) reduces all-cause mortality and cardiovascular disease (e.g. ischemic strokes, coronary heart disease). Scientific support for such outcomes includes a reduction in platelet aggregation and increased fibrinolysis and serum HDL. In red wines, flavonoids, resveratrol, and other polyphenols are believed to act as antioxidants and reduce adverse myocardial remodeling. However, Dr. Dipak Das, a scientist the University of Connecticut, was recently accused of falsifying data on resveratrol’s benefits and some argue that red wine studies are confounded by healthier lifestyles undertaken by moderate wine drinkers.

If alcohol does possess beneficial effects, the impact on mortality is likely “J” shaped at best. According to the World Health Organization, alcohol is the third largest risk factor for disease burden in the world. In addition to its impact on the liver, alcohol and its metabolites can be toxic to cardiomyocytes. Alcoholic cardiomyopathy (ACM) is reported to affect 21-32% of long-term heavy alcohol consumers. The clinical phenotype of ACM is similar to other nonischemic cardiomyopathies with four chamber dilation and a reduced ejection fraction. Changes in myocardial structure are usually seen with >90 g/day (equivalent to ≥ 6 drinks/day) of alcohol for over 5 years, but ACM can develop in “binge drinkers” and consumers of smaller amounts of alcohol with genetic defects (including in the angiotensin converting enzyme DD genotype and defects in aldehyde dehydrogenase). More men develop ACM than women, largely because alcohol abuse is more prevalent in men.
and men tend to consume larger quantities of alcohol. However, women often develop ACM earlier and at a lower “lifetime alcohol dose” because they have fewer alcohol-metabolizing enzymes and a greater proportion of body fat, both leading to slower blood stream alcohol removal.

The pathophysiology for ACM development is likely multifactorial. Myocardial ultrastructure changes are similar to those seen in other cardiomyopathies and include an initial compensatory myocyte hypertrophy, followed by myocardial apoptosis, fragmentation of contractile proteins, expansion of intercalated discs, and diffuse fibrosis. Unfortunately, elucidating the mechanism underlying heart failure development in alcoholic abusers is compromised by an absence of good ACM animal models. While alcohol-induced cardiac dysfunction is seen in animals fed alcohol, some lack the myocardial fibrosis prominent in humans and all animal models show complete resolution of heart failure upon cessation of alcohol consumption, a finding not universal to humans who conquer alcohol addiction.

Several mechanisms for myocardial injury have been postulated, including increased oxidative stress, activation of the sympathetic nervous system, and damage to mitochondria energetics. During the metabolism of alcohol, alcohol dehydrogenase (present in the heart and liver) converts alcohol to acetaldehyde, a reactive organic compound. While acetaldehyde is normally converted to acetic acid by aldehyde dehydrogenase, free radicals are generated during acetaldehyde metabolism. Acetaldehyde and other free radicals can then interact with nucleophiles in myocardial proteins, nucleic acids, and lipids, forming adducts which stimulate apoptotic and fibrotic signaling pathways. In vivo studies have also shown acetaldehyde negatively impacts myocardial inotropy, lusotropy, and chronotropy through impairments in sarcoplasmic reticulum calcium handling. Finally, alcohol consumption stimulates the sympathetic nervous system, which leads to coronary vasospasm and augmentation of well-known cardiomyopathic signaling cascades (e.g. renin angiotensin system).

The most important determinants of survival with ACM appear to be alcohol abstinence and a shorter duration of symptoms prior to heart failure therapy initiation. In those who continue to abuse alcohol, survival is ~50% at 4 years. Up to 66% of patients who maintain alcohol abstinence and take evidence based heart failure medications can enjoy improvements (even normalization) in myocardial function, but this is likely contingent on the degree of myocardial damage the subject has sustained prior to achieving abstinence.

Thus, during this St. Patrick’s Day, remember to screen your patients regularly for alcohol abuse and consume your own green beverages safely.

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

(Endnotes)
2. Source: WHO fact sheet 2011
3. George A, Figueredo VM. J Cardiac Fail 2011;17:844-49
Two Hearts Are Better Than One

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“Two hearts are better than one,” on St Valentine’s Day. But now that we’ve reached St Patrick’s Day, can we still subscribe to that romantic idea? A patient well known to us received a heterotopic heart just over a year ago here in San Diego. The media was fascinated and he became famous for a few days. No one remembers him now, but he is still around and doing very well thanks to his piggy back heart. Donated from an athlete, it was implanted as a “biologic LVaD”, left atrium to left atrium, aorta to aorta, superior vena cava to superior vena cava and donor pulmonary artery to recipient right atrium. The patient’s pre-operative pulmonary artery pressure was 80-90 mm Hg systolic, the trans-pulmonary gradient and pulmonary vascular resistance were high. For financial reasons, an LVAD was not an option.

The patient was 43 years old at the time of transplant with a good right ventricle and no signs of high right sided filling pressures. His left ventricle had a pressure of 90 mm Hg with severe systolic failure on maximal medical therapy and IV milrinone. Rather than an LVAD bridge to transplant with the morbidity and mortality as well as cost of 2 operations, he had just one operation.

Perhaps we should reconsider the heterotopic heart transplant as an option. Two hearts have served him well since Valentine’s Day a year ago. He is fully active—living proof that he should not be forgotten. He has something great to celebrate this St. Patrick’s Day. We should all raise a green beer to him!

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Writing a Successful Abstract

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Attending annual meetings are an important part of professional life. It is an opportunity to meet other professionals face-to-face and to present research or ideas to a critical audience. While meeting people is easy enough, getting on the program of a clinical/scientific meeting involves convincing a committee of abstract reviewers that your work is of high enough quality and sufficiently interesting to warrant giving it one of a finite number of slots available for presentation.

It is here where a number of investigators, especially junior ones, run into a roadblock without understanding what went wrong or why their abstract was rejected. Investigators don’t usually hear why they failed to get on the program, which can lead to erroneous conclusions such as “they did not consider our work interesting” or “they just didn’t get it”. Based on my experience on abstract review committees, the latter conclusion, while usually incorrect, may be closer to the truth. The reviewers may not have understood the abstract or may have been unable to evaluate the work.

It is important to remember that the quality of any meeting is ultimately dependent on the quality of presentations in the program, and the only way that the program committee can evaluate the potential excellence is from the submitted abstract. So it is
imperative that you communicate the essence of your study with clarity and credibility. This is not a trivial task. The available space for an abstract is severely limited and ruthlessly enforced by the cold-hearted scripts on the abstract submission website. So the text must be clear and succinct with the goal of conveying the essential elements of a research study.

On the ISHLT abstract submission website, these essential elements are divided into four sections: Background or introduction (hypothesis), methods, results, and conclusions. The background is typically 2-3 sentences and should contain a clear statement of the hypothesis. The methods section should not contain details other than those that are essential to understanding the design. The primary objective of the methods section is to impart the essential elements of the experimental design, including controls or comparison groups. How many experiments were performed? How many patients were included in the study? What was the mean or median follow-up? The reviewers must be given a clear indication of how the question given in the background was approached. In a clinical study, this would include a clear description of the patient groups, the number of patients, mean or median follow-up as well as other information most relevant to the experimental design.

From the viewpoint of the reviewer, the results section is the most critical, and of all sections, is the primary determinant of whether or not a given abstract will be included in a scientific program, unless the background or methods sections have been written in such a way as to obscure its meaning. For the results, the most common mistake an abstract reviewer sees is the failure to include quantitative information and statistical evaluation of comparative statements. To say “levels of protein X were increased” is not enough. The reviewer will expect a statement like “levels of protein X increased from 8.3 ± 2.1 units (n=5) in the controls to 15.1 ± 3.4 (p=0.021, paired t-test, n=8).” Let me say this again. If you make comparative quantitative statements, they must be backed up with data and statistics. This is true for basic science as well as clinical studies. For studies in which the data are largely qualitative, the abstract must still provide evidence that any comparative statements are credible. The conclusions are a summation of what the data mean, so as such, they must logically follow the presented data. There is no need to say “in summary” or “in conclusion”. It is ok to simply list the conclusions and, if you like, to include a single sentence regarding their significance.

Writing a good abstract involves putting the information needed to clearly communicate a finding into a very small space. Judicious use of abbreviations (e.g. pts for patients), careful sentence construction, and inclusion of only what you need to make a point are helpful in fitting an abstract into the available space.

It is painful for an abstract reviewer to reject an abstract when he or she believes that there may be good work behind the words, but is unable to sufficiently determine the quality of the study and its conclusions. Keeping these considerations in mind will improve your chances of having your presentation included in the program.

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And the winners are…

This year, ISHLT Past President John Wallwork joins a distinguished list of recipients of the CBE Award (Commander of the Most Excellent Order of the British Empire), including Grammy Award-winning musicians Eric Clapton and Elton John, Academy Award-winning actor Colin Firth (pictured right), and two-time Academy Award nominee Helena Bonham Carter.

Lifetime Achievement Award winner Sharon Hunt will be recognized in the ISHLT Traditions Plenary Session in Prague on April 19, 2012, for her countless past and ongoing scientific contributions in heart failure and transplantation, and for her untiring service to the ISHLT. She joins a list of distinguished past winners: Margaret Billingham (2010), Sir Magdi Yacoub (2004), Keith Reemtsma (1999) and Norman Shumway (1996).

DID YOU KNOW …

The ISHLT International Travelling Scholarship is open to any member of the Society, in any country. It represents a unique opportunity for garnering fresh ideas and collaborative work across the globe. There are two submission dates annually: August 1 and December 1.

In this month’s issue, read about ISHLT member and International Travelling Scholarship award winner Stephanie Yerkovich’s visit from her home in Brisbane, Australia to Toronto, Canada, and what she learned from her global travels.

DID YOU KNOW …

Philip K. Caves and Branislav Radovancič, who were both prominent members of the ISHLT, will be featured in the April issue of the Links Newsletter.

In this month’s issue, ISHLT member and 2006 Caves Award winner, Gregor Warnecke, shares his career highlights since winning the award.

The ISHLT Abramson-Imhoff Links Travel Awards offer financial assistance for outstanding young writers to attend the ISHLT Annual Meeting. If you are interested in contributing for an upcoming Links issue, we would like to hear from you! Email us.

Read about our previous Award Winners.