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Thursday, April 25, 2013
Opening Plenary Session
8:00 AM – 10:00 AM, Room 517CD

8:00 AM  Welcome/Program Chair Report
Allan R. Glanville, MBBS, MD, FRACP
St. Vincent’s Hospital, Sydney, NSW, Australia

8:05 AM  President’s Report
David O. Taylor, MD
Cleveland Clinic, Cleveland, Ohio, USA

8:15 AM  Thoracic Registry Report
Josef Stehlik, MD, MPH
University of Utah School of Medicine, Salt Lake City, Utah, USA

8:30 AM  IMACS Registry Report
James K. Kirklin, MD, University of Alabama at Birmingham, Birmingham, Alabama, USA

8:40 AM  FEATURED ABSTRACT: (2) Two-Year Outcomes in the Destination Therapy Post-FDA-Approval Study with a Continuous Flow Left Ventricular Assist Device: A Prospective Study Using the INTERMACS Registry;
U.P. Jorde,1 S.S. Khushwaha,2 A.J. Tatooles,3 Y. Naka,1 G. Bhat,3 J.W. Long,4 D. Horstmannhof,4 R.L. Kormos,5 J.J. Teuteberg,5 M.S. Slaughter,6 E.J. Birks,6 D.J. Farrar,7 S.J. Park,2 1Columbia University Medical Center, New York, NY; 2Mayo Clinic, Rochester, MN; 3Advocate Christ Medical Center, Oak Lawn, IL; 4Integris Baptist Medical Center, Oklahoma City, OK; 5University of Pittsburgh Medical Center, Pittsburgh, PA; 6University of Louisville, Louisville, KY; 7Thoratec Corporation, Pleasanton, CA.

8:55 AM  INVITED LECTURE: The Human Microbiome: What Is It, How Do We Measure It, What Does It Mean For Thoracic Transplantation?
Ronald G Collman, MD
University of Pennsylvania School of Medicine
In this lecture, clinicians and investigators will understand what is meant by the "human microbiome" and what it means for transplantation science. Dr Collman will focus on 4 objectives: (1) to describe what is meant by the "microbiome", and the emerging tools used to investigate it; (2) highlight current knowledge of the human respiratory tract microbiome in health and in selected lung disease including lung transplantation; (3) show how the microbiome in other sites, such as gut, can influence cardiac and pulmonary disease including transplantation; (4) identify potential future applications for these approaches including diagnostic or monitoring purposes.

9:20 AM    FEATURED ABSTRACT: (3) Longitudinal Holistic Profiling of the Lung Transplant Microbiome; D. Willner,1 N.A. Ab-Ghani,1 S. Yerkovich,2,3 M.E. Tan,2,3 P.M. Hopkins,2,3 D.C. Chambers,2,3 P. Hugenholtz.1 1Australian Centre for Ecogenomics, University of Queensland, St. Lucia, QLD, Australia; 2School of Medicine, University of Queensland, Herston, QLD, Australia; 3Queensland Lung Transplant Service, The Prince Charles Hospital, Brisbane, QLD, Australia

9:35 AM    PIONEER LECTURE: Cardiac Replacement, A Journey Outside The Box

Jack G Copeland, MD
University of California San Diego
San Diego, California, USA

The Pioneer in Transplantation award is bestowed every other year to an ISHLT member who is recognized for their landmark contributions as a pioneer in the field of heart and/or lung transplantation. This year’s recipient, Jack G Copeland, MD, will take us through the journey of cardiac replacement, looking at risk taking in medicine and defining a pioneer by the past selections ISHLT has made. Dr Copeland will discuss the many individuals who were influential in his professional career, and give us insight into the Total Artificial Heart, past and present.

Friday, April 26, 2013
Plenary Session: How To Succeed When The Right Ventricle Fails
10:00 AM – Noon, Room 517CD

Session Summary: The right ventricle is often held accountable for morbidity and mortality in patients with advanced heart and/or lung disease. Moreover the right ventricle is frequently blamed for poor outcomes seen in patients receiving left ventricular assist device or heart transplantation. This session will provide the participant with a better understanding of right ventricular structure, function and physiology; how to evaluate right ventricular function in health and disease; and importantly management of right ventricular failure both through medical and surgical/device options.

10:00 AM    INVITED LECTURE: Right Ventricular Structure And Function In Health And
Disease

Andrew N Redington, MD, FRCP(C), FRCP(UK)
The Hospital for Sick Children
Toronto, Ontario, Canada

Dr Redington’s talk will address normal myocardial structure and function, and the pathophysiology of failure in the normotensive and hypertensive right ventricle. Special emphasis will be placed on right-left heart interactions and possible approaches to modifying them for therapeutic benefit.

10:25 AM INVITED LECTURE: Clinical Assessment And Imaging

David Langleben, MD
Jewish General Hospital
Montréal, Québec, Canada

Dr Langleben will focus on the physiology of the failing right ventricle and how this can be assessed by means of imaging, and how this translates to the clinic.

10:45 AM INVITED LECTURE: The Failing Systemic Right Ventricle

Daniel Bernstein, MD
Stanford University
Stanford, California, USA

Dr Bernstein will describe several models of RV pressure and volume overload which have allowed us to evaluate RV remodeling as it progresses from the sub-acute to the chronic state, and to uncover the molecular mechanisms of the progression to RV failure. These data provide impetus for the development of new therapeutics aimed at the failing RV as well as potential biomarkers for early detection of adverse RV remodeling.

11:05 AM INVITED LECTURE: Medical Management

John Granton, MD
University of Toronto
Toronto, Ontario, Canada

Right ventricular function correlates is the major cause of morbidity and mortality in patients with pulmonary arterial hypertension. In the absence of prospective studies, treatment of right ventricular failure must rest upon physiological principles. This lecture will build upon the knowledge gained in the previous presentation and lead to the development of the key principles of managing the patient with RV failure. Reducing RV afterload, protecting coronary blood flow, minimizing myocardial oxygen demands and resolving adverse RV-LV influence will be the key points of discussion.
11:25 AM  INVITED LECTURE: Surgical Approaches, Devices and Transplant

Martin Strueber, MD
Heart Center Leipzig, University Leipzig
Leipzig, Germany


Saturday, April 27, 2013
Plenary Session: From Bench to Bedside
9:45 AM – Noon, Room 511

Session Summary: The final plenary session on Saturday represents one of the clear highlights of the meeting in Montreal and one you will miss at your peril. The session opens with great examples of translational science from the Society represented by two consensus reports on major areas in cardiac transplantation namely primary graft failure and a review of listing criteria based on a thorough review of the latest data. Marlene Rabinovich, one of our major invited speakers with a fantastic reputation throughout the scientific world, will then illustrate how basic research on BMPRII is offering new targets for much needed therapy in PAH in classic bench to bedside story. She will be followed by Mary Amanda Dew presenting novel data on recognizing the importance of mental health as well as physical health in all aspects of the Society’s Interests. The session ends in a flourish with a grand debate on an extended role of VAD implantation in acute heart failure by two of the Society’s most respected daughters. This plenary is a true synthesis of many facets of translational science at its best.

9:45 AM  Awards Presentations
Duane Davis, MD
ISHLT Grants & Awards Committee Chair

10:00 AM  ISHLT Consensus Report: Primary Graft Dysfunction (PGD) in Heart Transplantation

Jon Kobashigawa, MD
Cedars Sinai Medical Center
Los Angeles, California, USA

Dr Kobashigawa’s lecture will focus on defining PGD after heart transplantation, assessing donor risk factors for the development of PGD, and assessing the treatment of PGD.

10:08 AM  ISHLT Consensus Report: 2013 Heart Transplantation Listing Criteria
Dr. Mehra will focus his lecture on a review of listing criteria based on a thorough review of the latest data.

10:15 AM   INVITED LECTURE: BMPR2: From Mutation to Manipulation

Marlene Rabinovitch, MD
Stanford University School of Medicine
Stanford, California, USA

Dr Rabinovitch will be discussing a number of potential therapies, ready for the clinic, that are based upon uncovering the pathway that is mutated and/or dysfunctional in patients with idiopathic pulmonary hypertension.

10:40 AM   FEATURED ABSTRACT: (363) Survival in Pulmonary Arterial Hypertension Patients Awaiting Transplant;

M. Gomberg-Maitland,1,8 C. Glassner-Kolmin,1 S. Watson,2 R. Frantz,3,8 M. Park,4,8 A. Frost,5 R. Benza,5,8 F. Torres,7,8 1Department of Medicine, University of Chicago, Chicago, IL; 2Department of Health Studies, University of Chicago, Chicago, IL; 3Mayo Clinic College of Medicine, Rochester, MN; 4Department of Medicine, University of Maryland School of Medicine, Baltimore, MD; 5Department of Internal Medicine, Baylor College of Medicine, Houston, TX; 6Department of Medicine, Allegheny General Hospital, Pittsburgh, PA; 7Department of Internal Medicine, University of Texas Southwestern Medical Center, Dallas, TX; 8Scientific Council on Pulmonary Hypertension, International Society for Heart and Lung Transplantation, Addison, TX.

10:55 AM   INVITED LECTURE: The Mind Matters

Mary Amanda Dew, PhD
University of Pittsburgh School of Medicine and Medical Center
Pittsburgh, Pennsylvania, USA

Dr Dew will describe the impact of mental health or lack thereof on all that we do and try to achieve via a systematic review on psychological distress in transplant recipients.

11:15 AM   FEATURED ABSTRACT: (364) Frailty Index Predicts Mortality but Not Rehospitalization after Destination Left Ventricular Assist Device;

S.M. Dunlay,1 S.J. Park,2 L.D. Joyce,2 R.C. Daly,2 J.M. Stulak,2 S.M. McNallan,3 V.L. Roger,1 S. Kushwaha.1
1Internal Medicine, Cardiology, Mayo Clinic, Rochester, MN; 2Cardiothoracic Surgery, Mayo Clinic, Rochester, MN; 3Health Sciences Research, Mayo Clinic, Rochester, MN
The President’s Debate:

VAD support leads to recovery
Partial support works?
Heart failure patients should be implanted earlier?

This grand debate will focus on the extended role of VAD implantation in acute heart failure by two of the Societies’ most respected daughters.

**PRO:**
Emma Birks, FRCP, PhD
University of Louisville
Louisville, KY, USA

**CON:**
Mariell Jessup MD
University of Pennsylvania
Philadelphia, PA, USA
ISHLT ALERT!

*Mycobacterium abscessus:*
Yet One More Thing to Worry About in Cystic Fibrosis

Stanley I Martin, MD
ISHLT Links Associate Editor (Infectious Diseases)
stanley.martin@osumc.edu

At the end of March, researchers from the UK published in *The Lancet* their findings on genome sequencing among *M. abscessus* isolates from cystic fibrosis (CF) patients.[1] Battling drug-resistant infections in the respiratory tract of CF patients is nothing new, and non-tuberculous mycobacteria (NTM) have always been a challenge in this group of patients, particularly when thinking about their potential transplantability. The study, done by Cambridge, looked at 168 consecutive isolates of *M. abscessus*—one of the more drug-resistant and tenacious of the NTM—from 31 CF patients at one center. The researchers performed whole-genome sequencing and found a significant degree of similarity among isolates from different individuals (more so than you often find in any one patient). These data, along with time and environment tracings, strongly suggest a potential common source outbreak and even the possibility of actual person-to-person transmission.

The spread of drug-resistant pathogens in CF is not unique (*Burkholderia*, for example), but historically TB was the only *Mycobacterium* thought to be easily transmitted from person-to-person. All NTM are thought to be acquired from environmental sources such as water or soil. These data suggest that common source transmission is a factor and the infection may spread from person-to-person in an indirect fashion in the healthcare setting. This could have obvious implications for infection control measures when our lung transplant recipients and pre-transplant patient care are occurring in close proximity. These findings have prompted the authors to begin screening sputum of all their CF patients for NTM, segregating infected patients within a dedicated outpatient clinic and using negative pressure rooms for inpatient care. Whether these measures will reduce transmission rates, however, remains unclear.

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

Dr Martin is an Associate Editor (Infectious Diseases) for the ISHLT Links Newsletter, a member of the ISHLT 2013 Program Committee, and the ISHLT Infectious Diseases Council Standards and Guidelines Committee Workforce Leader. He is an Assistant Professor in the Division of Internal Medicine at The Ohio State University Medical Center.

References:

Tweeting at the Meeting: Use hashtag: #ISHLT2013

Stephen Chavez
Public Relations Director
ISHLT Annual Meeting
stephenc@proterraadvertising.com
@stephen_chavez

Stay connected at the ISHLT Annual Meeting this year by following us on Twitter - the real-time information network that connects you to the latest stories, ideas, conversations, opinions and news about what you find interesting.

If you already have a Twitter account, FOLLOW US! (@ISHLT or https://twitter.com/ishlt). To help you stay up-to-date on the latest news and events taking place onsite, we will be tweeting before, during, and after the Annual Meeting in Montréal, using the hashtag #ISHLT2013. (If you don't know what a hashtag is or how to use it, keep reading!)

NOTE: if you don't have a Twitter account, you can still read the conversations posted under the twitter hashtag. (Creating an account will allow you to get real time updates and post your own messages.)

What's a hashtag?

If you see the pound symbol (#) before a word or phrase, it is essentially a keyword tag for the tweet so that others can find it more easily. On Twitter, this is called a hashtag, and they can be serious, to help people search for your tweet (like #advice or #blogging) or funny (like #ImSoDarnTired). Not every tweet needs hashtags. Basically, it's a way to follow the stream of everyone talking about a specific subject. However, you don't want to overuse them — 2 or 3 is enough.

How to use our hashtag:

➢ At the end of every tweet, type #ISHLT2013. This will allow everyone to follow the conversations happening at the Meeting
  ◦ Example: Great afternoon symposium focused on pediatric VADs #ISHLT2013.
➢ On Twitter, search #ISHLT2013 to read what your ISHLT colleagues are tweeting.

We encourage you to join our online conversation. Please tweet your reactions, comments, and interesting things you learn throughout the daily sessions at the Annual Meeting.

Here are a few Twitter Do's and Don'ts:

Do:
1. Use a hashtag, #ISHLT2013 for all posts.
2. Engage in the conversation by retweeting (RT) content that interests you. When retweeting, add your own comments before the RT’ed message so it is apparent what you are saying versus what the other person has said. For example, you could tweet: “Me too! RT @allison_boyer I love research”. Most Tweeters add their own comments before the RT. In any case, if you do add your own comments, make sure it is apparent that they are yours.
3. Remember that you are on a public forum. Once you say it online, it’s hard to take back.
4. When speaking to someone, remember to use their Twitter handle (basically the person’s screen name) for example, @anyperson.

5. Be sure to give credit where credit is due. When quoting or paraphrasing info, be sure to mention them in the tweet. Always credit your source if you find content worth sharing, it’s a matter of respect.

6. Only Tweet accurate info.

7. Don’t be afraid to show your personality.

Don’t:

1. Don’t be crass, use bad language or talk poorly about someone. This is a very public forum. Keep it clean!

2. Post full URL’s. Use a URL shortener like www.bit.ly to shorten links. Remember you only have 140 characters and they go fast.

If you are new to Twitter and want to learn more about this online communication tool, below are some great info links:

https://twitter.com/about
http://mashable.com/guidebook/twitter/

If you need a Tweetorial (to set up a new Twitter account), please stop by the Press Room on-site at the Palais des congrès de Montréal anytime during the meeting. Our Press Room staff would be happy to help you start Tweeting!
Highlights for Junior Faculty and Trainees

Pali Shah, MD
Chair, ISHLT Junior Faculty and Trainee Council
pdedhiy2@jhmi.edu

This year’s annual meeting will feature several unique sessions sponsored by the Junior Faculty & Trainee Council (JFTC), some of which are highlighted below. The JFTC will also feature a booth near the registration area this year where meeting attendees can discuss activities of the council and learn about ways to become engaged with ISHLT.

- **Wednesday**: the annual Junior Faculty Mentor Luncheon will take place from 12:15–2:15 PM in Room 514C, creating an informal round table setting for junior faculty and trainees to meet and discuss broad career interests with members of the ISHLT leadership. Registration is through the meeting website at [http://www.ishlt.org/meetings/annualMeeting.asp](http://www.ishlt.org/meetings/annualMeeting.asp)

- **Thursday**: Members early in their careers who are interested in being more active within ISHLT are encouraged to attend the JFTC meeting (Noon-2:00 PM, Room 514C).

- **Friday**: will feature a new symposium entitled *JHLT at ISHLT: The Year in a Capsule* (8:00-9:30 AM, Room 513DEF), where presenters will summarize some of the most exciting publications in the JHLT over the past year.

- **Saturday**: This year our popular session, *Clinical Case Dilemmas in Thoracic Transplantation* (Concurrent Session 40, 8:00-9:30 AM, Room 513DEF) has been enhanced to feature an expert panel of discussants who will discuss their clinical thought process as the case unfolds, with the final diagnosis revealed only at the end.

We look forward to seeing you at the 33rd ISHLT Annual Meeting in beautiful Montréal, Canada!

**Disclosure Statement**: the author has no conflicts of interest to disclose.
Abstract Session Highlights

Basic Science and Translational Research

New Frontiers in Cardiothoracic Organ Regeneration - From Cosmetic to Prosthetic will showcase the rapid developments in bioengineering which are already impacting on heart and lung transplantation, and which will transform our field into the future. Chaired by Sonja Schrepfer and Shaf Keshavjee, the session will cover the breadth of organ rejuvenation from the relatively cosmetic improvements which can be made during ex-vivo lung perfusion to the 'knock-down and rebuild' approach to organ replacement achieved using decellularised matrix.

The session combining the highest scoring abstracts on exploration and modification of the immune system, Exploring and Modifying the Immune Response - Cells, Antibodies, and Tolerance, will feature presentations on the impact of natural killer cells and T-cell deficiency on graft survival and BOS in lung transplantation. Innovative therapeutic approaches discussed in this session include pre-clinical evaluation of JAK 1/3 inhibitors and MHC-encoding chitosan-DNA microparticles in animal models.

During The Fundamental Difference- Innate Immunity and Xenotransplantation, new research on the challenges of platelet activation and aggregation in the setting of xenotransplantation and lung reperfusion will be presented. Further presentations evaluate Caspase 1 as a serum marker of myocardial remodeling and pre-clinical data on therapeutic use of VEGF-C/D for improved cardiac allograft survival.

Heart Failure and Transplantation

Heart Failure: What's New in Translational Science
CD34+ transplantation, post-transcriptional regulation, and miRNA modulation are center stage. For your pleasure, progenitor cells will circulate, free fatty acid will challenge glucose in the oxidation contest, and expression of cardiolipin biosynthesis will change your way of thinking about heart failure as a simple clinical phenomenon.

Heart Failure: Focus on the Right Heart
The delicate, innocent, yet vulnerable Right Ventricle brings together all corners of the ISHLT. Here are some of the most recent RV carols manufactured and interpreted for you by the Clinical Heart Failure Choir in six tasty chapters including prognosis, sildenafil, pulmonary wedge pressure and arrhythmogenic cardiomyopathy.

Heart Transplantation: Can We Improve Transplant Risk Assessment and Outcome Prediction?
Titanic dilemmas and naïve questions — in an effort to save as many lives as it is possible with our more and more limited donor heart resources — will be prepared and served to you in the form of six short stories about HIV-positive recipients, UNOS status modifying human fate, kidney-heart brotherhood in transplantation, and others.

Heart Transplantation: News from the Registries - What We Need To Learn To Achieve Long-Long Term
Very long term survival and guidance to support customized strategies: two holy grails that transplant clinicians cannot achieve with the limited everyday single center experience. In this concurrent session, evidence confirming or
contradicting common experience-based concepts will be served, thanks to robust data regarding age and causes of death, racial differences and PRA, oversized hearts and recipients’ pulmonary hypertension, and long term survival.

**Coronary Artery Vasculopathy in 2013 - Diagnosis, Prognosis and Treatment**
This concurrent session will provide a late breaking overview of a classical topic at the ISHLT meeting. Ranging from novel diagnostic views to detect prognostic relevant CAV, to the effects of mTOR inhibitors on coronary morphology and cardiovascular events, the audience will have a great opportunity to receive a full update on current and future perspectives on CAV diagnosis, prognosis and treatment.

**Living with a Transplanted Heart - A Narrow Pathway in the Jungle**
A successful heart transplant surgery is just the beginning of a hopefully long, but surely complex, journey in a minefield, which often distances recipients’ life from the mirage of healthy normality. The dream of a successful pregnancy, the amplified negative effects of excessive food intake, the torture of receiving periodical invasive procedures, the nightmare of facing chronic and hazardous diseases of organs other than heart: the management these side-effects of our life-saving strategy—substituting one deadly disease with a bunch of dangerous others—will be discussed in this exciting session that will provide audiences with compass directions to recover the many patients wandering in the jungle.

**Are All Antibodies Equal? Predicting, Managing and Treating the Risk for AMR**
After being “easily” accustomed to pathologists’ biopsy diagnoses—sometimes disconnected from patients clinical picture—transplant clinicians now must learn to deal with immunogenetists, a new species of lab-people providing reports containing obscure antibody names and typing, that may or may not be coherent with pathologists’ readings, and may or may not trigger a treatment. In this session, the audience will have a unique opportunity to attend cutting edge presentations unraveling the complexities of different kinds of HLA antibodies, their time course, and how to manage organ allocation and post-transplant treatments. Returning back to clinic attendance, participants will have new tools to build a coherent view and management of the clinical and laboratory picture of sensitized patients.

**Mechanisms and Markers of Acute Rejection: Within and Without Biopsy Sampling**
Endomyocardial biopsy is still considered a gold standard for the diagnosis of rejection in clinical practice. However, established grading for T-cell mediated rejection, but also for antibody-mediated rejection, does not always include all the available information that could be gained from the myocardial specimens. On the other hand, non-invasive markers for rejection diagnosis haven’t conquered clinical practice yet. In this visionary concurrent session, the audience will be excited by novel ways of looking at a biopsy to understand different mechanisms of rejection, insights on promising non-invasive methodologies for rejection diagnosis, and global clinical views on the interplay between histology, DSA and hemodynamics.

**Infectious Diseases**

**Concurrent Session 18: From Fungus to Virus - The Microbiome Elicited**
Come one, come all, from virus to fungal ball! As our knowledge grows of microbial colonization and growth in the lung allograft, share in these new findings and the implications they have for our lung transplant recipients.

**Concurrent Session 25: MCS 6: Infectious Issues and Pump Failure**
One of the biggest limitations in mechanical circulatory support today remains infectious complications and pump failure. Come pump up your own knowledge of these issues with a host of abstracts on these complications and their implications for patient management.

**Junior Faculty and Trainees**

The Junior Faculty Trainee Committee is again hosting the very popular session, *"Clinical Case Dilemmas in Thoracic Transplantation."* Test your own clinical skills as junior faculty present clinical conundrums to the fields’ experts. Ask questions, share management strategies, and enjoy intellectual banter.

**Mechanical Circulatory Support**

A record 337 MCS abstracts were submitted to the 2013 ISHLT Annual meeting. This made the job of the planning committee—to prepare a terrific MCS program—quite easy! The top graded abstracts were selected for presentation in 11 oral and 2 mini-oral sessions. Two oral sessions will explore specifics of different devices as well as patient selection considerations. Another session will focus on physiological changes seen after VAD implant. Several sessions will focus on key complications seen with MCS support and discuss approaches to prevent and treat these. A review of clinical outcomes will be provided and approaches to maximize patient quality of life and survival after VAD placement discussed. A separate session will analyze the cost of achieving longevity and good quality of life in advanced heart failure patients through MCS support. A number of additional topics will be addressed during MCS poster sessions.

And, finally, do not forget to attend the ‘Great Debates in MCS’ symposium session. Several of the pressing topics explored by investigators in oral and poster submissions will be addressed by thought leaders from different parts of the globe in this engaging session: Should Stable LVAD Patients Receive Organ Allocation Advantage?; Should Sensitization Warrant Higher Priority on the Waiting List?; Does Mechanical Support Work for Those With Poor Social Support?; Are VAD Destination Therapy and Hemodialysis Compatible?

In summary, MCS has become a dynamic force in our Society, and the 2013 MCS program promises to be a platform to advance MCS science through scientific presentations, discussions and networking.

**Nursing, Health Sciences & Allied Health**

**Implications and Innovations throughout the Lung Transplant Trajectory**

This session sponsored by the NHSAH Council is sure to interest clinicians from a variety of disciplines who are involved in lung transplantation. Several of the presenters will discuss predictors of post-lung transplant outcomes, such as hospital readmission, medication adherence, health related quality of life, and survival. Other presenters will discuss the impact of novel interventions, including a consent process where recipients choose their donors and a stress reduction intervention for family caregivers. The research findings will be directly relevant to clinical practice and quality improvement in the setting of lung transplantation.

**MCS and Heart Transplantation: Assessment, Outcomes and Interventions**
This session sponsored by the NHSAH Council combines topics of interest to clinicians who are involved in the care of patients with heart failure facing MCS or heart transplantation. Several of the presenters will discuss the challenges of managing MCS devices such risk for hospital readmission and driveline site selection. Other presenters will discuss the impact of interventions on heart transplant candidates and early and long-term outcomes among heart recipients, including cardiac rehabilitation on cardiac vasculopathy, psychosocial assessment on medical outcomes, and the relationships between adherence, mental health and hygiene behaviors. The research findings will be directly relevant to clinical practice and quality improvement in the setting of heart failure and heart transplantation.

**Pediatric Transplantation**

There are few cities in the world that own Montréal's mixture of buzz and vitality, a taste of Europe in North America. We believe the Pediatric content of the Abstract Sessions at the 2013 ISHLT Annual Meeting reflect this great mixture, combining the best of Pediatric Heart and Lung Transplantation, Pediatric Infectious Diseases and Mechanical Circulatory Support in Children.

There are three Oral Sessions planned including "Pediatric Heart and Lung Transplantation", "Pediatric Heart Failure and Heart Transplantation" and "Mechanical Circulatory Support in Children". The Session on "Pediatric Heart and Lung Transplantation" focuses on aspects such as de novo donor specific HLA antibodies and rejection and graft loss in Pediatric heart transplant recipients, CMV specific immunity, the lung microbiome and the development of BOS in Pediatric lung transplantation, and Pediatric thoracic multi-organ transplantation.

In addition, there is a Mini Oral Poster Session on Pediatrics and Infectious Diseases.

Finally, more than 40 abstracts were selected for Poster Sessions, the largest number ever of Pediatric abstracts accepted for presentation at an ISHLT Annual Meeting. So you better make your travel arrangements and register for the 2013 ISHLT Annual Meeting in Montréal in April to be part of the ever growing Pediatric cardio-thoracic transplant community.

**Pharmacy and Pharmacology**

The Pharmacy and Pharmacology Council, now in its second year, continues to evolve in developing unique educational programming focused on pharmacologic therapy for the ISHLT Annual Meeting. For the 33rd Annual Meeting, the Program Committee has designed sessions and symposiums showcasing innovative science and real world clinical applications. Our programming which focuses on drug therapy lends applicability across all disciplines represented by the ISHLT membership.

There are two sessions sponsored by our council this year. The first is an Oral Scientific Session on Friday titled, *Innovative Pharmacotherapeutic Approaches to Thoracic Transplant and Mechanically Assisted Patients*. This session explores novel uses of drug therapy to improve outcomes in multiple therapeutic areas including treatment strategies for rejection and infection in heart and lung transplant patients as well as pharmacologic treatments for pulmonary hypertension in patients requiring mechanical circulatory support.
The second, on Saturday, is a symposium that continues our successful “Lifecycle Journey” series creating an enduring case to create a panel facilitated and audience supported best practice based discussion at predefined key “journey intervals.” This year the session is titled, *A Lifecycle Journey in Cystic Fibrosis and Lung Transplantation*. In this session, members of the Pharmacy and Pharmacology and the Pulmonary Transplantation Councils will focus on four “journey points” which include: (1) listing considerations and pre-transplant infections, (2) peri-operative and immediate post-operative management issues, (3) metabolic and interaction considerations to drug dosing and (4) immunomodulation strategies for the management of bronchiolitis obliterans syndrome.

In addition, several posters selected by our council demonstrating the diversity and scope of pharmacotherapy as applied to multiple areas, including; Heart Transplantation, Lung Transplantation and Mechanical support will be presented.

**Pulmonary Hypertension**

The 2013 meeting promises to be another banner conference for pulmonary hypertension. A total of 53 abstracts will be presented covering a broad variety of clinical and translational research topics in the field. The Thursday oral session entitled “*All About Outcomes*” will lead off with the much anticipated initial results from the PROSPECT registry of 331 PAH patients treated with the room-temperature stable epoprostenol with arginine (Veletri®). The group from the University of Minnesota will present survival data using a simplified version of the REVEAL prediction model that does not require right heart cath or pulmonary function variables. Vizza et al will present their intriguing finding of a relatively high proportion of extra-cardiac causes of death in PAH. As the use of extra-corporeal support continues to expand worldwide, the Papworth group will present their experience with this modality following thrombo-endarterectomy for chronic thrombo-embolic pulmonary hypertension. Granton and co-workers will show the results of a microarray expression study in explanted PAH lungs demonstrating prominent upregulation of osteopontin, a potent vascular smooth muscle mitogen. The session will be rounded out with a paper from Rigshospitalet, Denmark on pulmonary hypertension in end-stage IPF.

Reflecting the increasingly recognized importance of right ventricular (RV) function in PH, two oral sessions will be devoted to this topic on Friday. The morning session, “*Right Ventricular Matters*” will include 2 presentations on the use of RV strain and other echocardiographic derived indices of RV function as predictors of outcome in PAH. Large animal models of RV failure were used in three studies to characterize RV function, assess RV angiogenesis and explore the feasibility of mechanical RV support. Wrapping up the session will be the team from Sapienza University in Rome presenting data on the impact of RV dyssynchrony in PAH. Later in the day, 6 more outstanding abstracts on “*Right Ventricular Assessment and Function*” will be presented. Investigators from Lyon, France will report on the prognostic value of RV ejection fraction in PAH. Researchers from Alberta, Canada will describe the role of HIF-1α signaling in RV myocardium. Saggar and colleagues will report their experience with parenteral treprostinil therapy on RV function in PH associated with pulmonary fibrosis. Finally, the group from Allegheny General Hospital in Pittsburgh will report on echocardiographic assessment of the RV as a predictor of RV fibrosis, as determined by late gadolinium enhancement by MRI and the prognostic value of the latter.

**Pulmonary Transplantation**

The Pulmonary Council is looking forward with great excitement to the ISHLT annual scientific program in Montreal April 2013. Council members and the Program Committee have worked diligently to create a program that includes
several valuable sessions and symposiums that are vital to setting the tone for an outstanding educational forum for all ISHLT attendees.

The scientific program itself is filled with vital symposia and sessions presenting a forum for challenging debates and discussions on important issues regarding lung transplantation.

There are eight total symposia throughout the meeting, which cover a broad range of important topics. Some of these are collaborative efforts with other councils (including pathology, basic science, nursing, health science and allied health, and pharmacy).

Along with the scientific program, there are a large number of original scientific investigations focused on both basic and clinical science that were submitted for the meeting. These topics will be highlighted in six oral presentation sessions (thirty-six abstracts), eighteen mini-oral presentations and more than eighty posters for presentation.

Translational science will be highlighted in the “Bench to Bedside” session. Topics will range from BOS to infection.

There will be several sessions highlighting antibody mediated rejection (AMR) in lung transplantation. AMR has become increasingly more recognized over the last several years; however, there still is considerable controversy on its diagnosis, unique features and treatment. Two symposia in collaboration with the pathology and basic science councils will focus on discussions that will hopefully lead to better understanding of this issue. The interest in the current topic is also featured in the oral, mini-oral and poster sessions.

Bronchiolitis obliterans remains a major complication after lung transplant and is the major cause for late morbidity and mortality. We now understand that different processes can lead to allograft dysfunction. The term chronic lung allograft dysfunction (CLAD) has been incorporated to include these other processes. One symposium will provide state-of-the-art information on these issues and an abstract session will update us on its pathophysiology.

Another area of significant interest to our council members is how to best support patients with end-stage lung disease while bridging them to a successful lung transplant. A symposium will bring experts together to discuss techniques of bridging patients that are critically ill prior to transplant. A Sunrise symposium will discuss patient selection as part of this ongoing debate.

Immunosuppression is also featured prominently with an abstract session presenting interesting conundrums on the use of different therapeutic agents. This session will be nicely paired with a symposium on T cells and their roles post-transplant.

Other interesting sessions include outcomes after lung transplantation. Primary graft dysfunction is featured in an abstract session and a Sunrise symposium will discuss patient-reported outcomes. Two additional Sunrise symposia have been planned: one will assess anastomotic issues and the utility of bronchoscopy; the other will present different lung allocation systems around the world and discuss their merits and limitations.

Finally, common topics of interest that will also be discussed include a joint Saturday symposium with the Pharmacy council which assesses the journey of a cystic fibrosis patient through transplant. It discusses many unique pharmacologic, infectious challenges that this group of patients face, while undergoing lung transplantation.

We look forward to an exciting annual meeting that will stir discussion and add further momentum to the already energetic academic lung transplant community.
PRocrastination, PReparation, PRactice, PReäsentation
The PRs for all in Montréal

Vincent G Valentine, MD
Allan R Glanville, MBBS, MD, FRACP
John Dark, MB, FRCS

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 success in Montreal comes from 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. 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.

You might want to note a couple points:

According to the famous Irish Playwright and Critic, George Bernard Shaw; Mark Twain is the “American Voltaire” who taught Shaw this great piece of wisdom: “Telling the truth’s the funniest joke in the world.”

This American Voltaire was subjected to procrastination, all the time:

“I was born lazy. I am no lazier now than I was forty years ago, but that is because I reached the limit forty years ago. You can’t go beyond possibility.”

PREPARATION

Knowing the 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, you must 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.”

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, so keep your slides simple and direct. Each slide should convey one idea, have one diagram, or contain one or two pictures.
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.

**PRACTICE, PRACTICE, PRACTICE**

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.

While practicing your speech, 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. Do not speak in monotone. 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. Convey the idea to the audience that there’s 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.

**PRESENTATION**

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.

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. Use hand gestures economically, and be careful about swaying or using bizarre or repetitive gestures.

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!

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.

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. Most of all, **DO NOT EXCEED YOUR TIME LIMIT** by cramming too much material in your presentation.
Finally with repetitious repetition:

1/ Keep it simple
2/ Know your time limit and stick to it
3/ Include full disclosures at the beginning and references at the end
4/ Leave time for questions

Oh, and remember to PRACTICE, PRACTICE, PRACTICE!

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

This article has been modified from its original version which appeared in the March 2012 issue of the ISHLT Links Newsletter, Procrastination, Preparation, Presentation, Prague.
More Annual Meeting Resources & Information

ISHLT Meeting Website: www.ishlt.org/meetings/annualMeeting.asp

Abstracts Available Online

The 2013 accepted abstracts are now available to view online at: http://www.abstracts2view.com/ishlt

The Abstracts2View™ (A2V) program will enable you to search and view complete abstracts online. You will be able to search abstracts of interest by session, author, title, keyword, create an itinerary to download as a document or to Outlook. You will need to set up a username and password to enter the program and then proceed by searching on desired abstract information.

Accepted abstracts also have been published in the April 2013 issue of the Journal for Heart and Lung Transplantation.

Presenting an abstract in Montréal

Please visit the Speaker Information webpage for more information on presenting an abstract, including access to slide templates, poster presentation information and instructions, speaker ready room hours, and more.

Free Wifi

Free Wifi can be accessed throughout the convention center, in the sessions, in the exhibit hall, in the public spaces, even outside and door-to-door to many of the official ISHLT hotels! We will have people tweeting about the sessions during the sessions - look for the ISHLT meeting hash tag and plan to engage!

Hotel Questions

Have questions about your hotel reservation? Contact Tourisme Montréal, who handles all of the ISHLT hotel bookings.

Phone: 514-844-0848 or 888-722-2220 (toll free North America)
Email: reservation@tourisme-montreal.org

Links to Past Annual Meeting Spotlight Articles

- Committee & Council Meetings and Workshops (March 2013)
- What's New for ISHLT 2013 in Montréal (February 2013)
- Mouth-watering Montréal! Mr/s XYZ at ISHLT 2013: Sugar Shack and Other Culinary Excursions (December 2012 and January 2013)
- Make Time For Some Family Fun! (November 2012 and January 2013)
- The Magic of Montréal (October 2012)
- ISHLT 2013 Exposed! (September 2012)
Fun Facts You Might Not Know About Montréal!

1. **Montréal is an island.**
   The main city of Montréal occupies a 30-mile long island along the convergence of the St. Lawrence and Ottawa rivers. The island is linked to the mainland by a tunnel and 15 bridges. Although this makes it sound quite expansive, most of the city’s main attractions are within decent walking distance of one another, or a short bus or train ride away. Just don’t expect tropical breezes and luaus!

2. **Montréal is the second largest French speaking city in the world (after Paris).**
   Most Montréalers are bilingual, especially downtown. A non-Speaker of French can do well by greeting strangers with a confident *Bonjour!* Chances are that anyone who speaks French will recognize the lack of French capability and switch to English. In stores, many clerks will greet patrons with “*Bonjour/Hi*”, indicating bilingual capability; a response of *bonjour* will begin a transaction in French. At the end of a transaction, you will often be sent on your way with a friendly *Bonne journée* (Have a nice day).

3. **Montréal’s predominant religion is Hockey.**
   No, really. Organized ice hockey, as we know it today, has its true origins in Montréal. In 1875, a McGill University student by the name of J.G.A. Creighton established a set of formal rules. In 1879, the McGill University Hockey Club was formed, making it the first organized team. Montréal’s been playing hockey ever since.

4. **85% of the world’s maple syrup comes from Québec, Montréal’s Provence.**
   The maple sap collected used to make maple syrup is also used to make all kinds of maple goodies including maple butter, maple candy, marinades and baked goods. Though it’s fun to pile into a bus and take off for a real country sugar-shack experience during the Temps des Sucres (sugaring-off time), it’s not really necessary to hit the highways and byways of small-town Québec to taste the delicious sweet tang of maple sugar. These days, there are plenty of urban sugar-shack type experiences in the city of Montréal to satisfy your sweet tooth:
   - Terrasse Nelligan (atop Hotel Nelligan, covered and heated with themed décor and panoramic views of Old Montréal)
   - Bistro Cocagne
   - Les 400 Coups
   - Au Pied de Cochon

5. **Montréal boasts the second highest number of restaurants per capita in North America (after New York City).**
   Looking for places to eat? Not hard to do in this lovely city. For starters, [RestoMontreal](#) lists restaurants in close proximity to the Palais des congrès de Montréal. Also, try the [Yahoo Restaurant Guide](#). Want to try a really unusual dining experience? The [O. Noir](#) restaurant in Montréal is a unique place where one can dine in complete darkness. There are no lights, candles or matchsticks. So in a nutshell, bring your appetite!

6. **Mount Royal is a nice hike with a great view.**
   Montréal lies at the foot of Mt. Royal, from where the place received its name. Mount Royal Park is located on the mountain and was designed by Frederick Law Olmsted, the same person that designed New York City’s Central Park. Okay so it’s more of a *hill* than a mountain, since it’s less than 150m high, but it does offer the best views of the city.
7. **Montréal’s flag has five symbols.**
   1. The **cross** which represents the Christian principles on which the city was founded.
   2. The **fleur-de-lis** for the French
   3. The **Lancastrian rose** for the English
   4. The **shamrock** for the Irish
   5. The **thistle** for the Scottish

8. **Montréal hosted the 1976 Olympics.**
   These games were perhaps most famous for witnessing Romanian gymnast, Nadia Comaneci, score the perfect 10-heard-round-the-world and capture the gold in the All-Around. Today, the Olympic Park is quite a popular tourist attraction, and features a **biodome** that has re-created various climate zones and animal habitats.

9. **Get Down Tonight and shop in Montréal’s Underground City!**
   The Underground City is a climate-controlled labyrinth of 2000 shops, spread over an area of 18 miles. When navigating this subterranean complex, you’ll know you’re on the right track when you see these four little letters: RÉSO, a short form of the French word réseau, which means “network.” [View map](#) (PDF). Everything in pink indicates where you can trek without ever stepping foot outside – a heavenly boon in sub-zero weather.

10. **Montréal is home to more than 500km of bike routes and paths and many more km located in the surrounding region.**
    From mid-April to November 30 the city operates the Bixi bike share system modeled after the successful Vélib system in Paris, France. All it takes is the swipe of a credit card to borrow one of the more than 5,000 bikes at 400 self-serve stations around the city centre. An interactive map on the [Bixi website](#) indicates the current number of bikes and empty docks at each station.
A Journey to the Other Side, Part 2

Stewart Howard

My wife and I moved into a motel in Brisbane until such time as an apartment could be leased. For the sake of convenience, we had picked a location very near the transplant hospital. This led to some tense moments in the weeks that followed.

I received a call from the hospital soon after. “There is a possible donor.” This contact came as a complete surprise to Barb and me. We panicked! We hadn't prepared mentally for this eventuality. What should I take to hospital? Where to go? Not knowing what to expect, Barb and I arrived at the hospital in fear and trepidation but with an element of hope. I also felt a deep sense of finality; I had been a control freak in my professional life. I was now in the hands of an unknown group. Would this be the last day of my life? Would I die on the operating table?

False alarm: final tests revealed a mismatch. A wave of relief overwhelmed me. Tonight was not the time of my death! I coughed my way back to the motel, in the misguided and ridiculous glow of not having been murdered on an operating table. My lungs might be severely dysfunctional but they were mine—factory original—and they still worked, some of the time. My wife, on the other hand, was deeply disappointed; her husband was no closer to being treated.

I received a second call from the hospital a few weeks later. Another false alarm. On that occasion the donor organs were determined to be slightly impaired. Let me tell you, these non-events play havoc with your emotions and your mind! Hope, life, death and fear blend into an unpalatable cocktail. I left the hospital in a state of blind confusion.

These close calls, despite the emotional chaos they created, made me register that the specialist team had indeed targeted me as high priority. This was confirmed every time I looked in the mirror, when I would see a withering body straight out of a wartime concentration camp.

Our close proximity to the hospital enabled us to hear and sometimes see the medical helicopters as they flew in and out. I noted that I became tense subsequent to their arrival. Were they carrying patients or, possibly, donor organs? Would I receive another phone call soon after hearing the beat of the chopper blades? Would it be just another cruel false alarm? I grew to loathe the sound and sight of those aircraft.

Soon I was again called by the hospital. “Stewart, there is a possible donor. Would you make your way to the hospital immediately?” I received the news with the enthusiasm of being told that I needed a root-canal filling.

Two weeks later I walked, unaided, out of hospital having becoming the recipient of a new set of lungs. I was now “on the other side”. I had survived! And I had stopped coughing. Completely.

So, what was involved in the operation? Well, I had my chest cut open from top to bottom and my rib cage spread wide apart, thereby granting access to my defunct lungs. These were removed and replaced with quality items from a donor. The tricky part was connecting the various blood vessels and airways to the new lungs. The surgeons also temporarily fitted four drain pipes to my chest enabling the extraction of waste fluid that would inevitably build up around the new lungs over the course of the next few days. (These pipes exited the front of my chest and were subsequently connected to vacuum pumps.) Then there were the simple matters of closing the rib cage, wiring my
sternum back together and stitching up the large opening in my chest. For the life of me, I can't imagine why I worried prior to the operation; you'd wonder what all the fuss was about!

Fast forward: so, here I am, very much alive in January, 2013. Every day is a gift! With the passing of each week, I place a greater significance on a life I have so graciously been given. Once again, I see a sparkle in the eyes of those in my family. This is such a simple thing but one which is so rewarding. I find myself trying harder than ever—even before the onset of my disease—to support, and to demonstrate my love, to family and friends. Life has now become finite and with it, more meaningful. It always was, but I had never registered the notion of my demise until the disease hit. Now every day counts.

When you have experienced, first-hand, the risk of losing everything, in particular your life, your perspective changes if you are fortunate enough to survive the crisis. One notable development is now having the clarity of vision to differentiate between that which is important as opposed to that which is not. I feel that I can no longer spend time on the unimportant.

One of the principal surgeons involved in my transplant told me after the successful operation, “You have been given a terrific set of lungs, Stewart. Do not, like some, recede into your home, inside a protective bubble. Get out into the world and use them!” And so I do.

With increased vigour, I have fully engaged with the various passions of my life. I regularly “go bush” with our camper-trailer together with family and friends. My love of motorcycling sees me riding the highways with renewed joy. When I pick up my guitar, I experience a sense of increased satisfaction (despite my poor playing). I have returned to the golf course together with my wife, loving her company while we play. Swimming and cycling have again taken their place in my exercise programme.

In summary, my appreciation of life has been magnified significantly since the operation. I simply adore living! My friends tell me that it shows on my face. I am frequently found smiling or even chuckling to myself. I see beauty in the simplest of actions or events, for example, when people meet in shopping centres and express their affection towards one another through the simple act of shaking hands or giving a hug. Every time I watch a sunrise, I think of the privilege that I enjoy. Without medical advances over the past 25 years, I would be dead! But I’m not. Importantly, every day I think of the donor, that unknown person, who made this all possible. I wish I could tell them how much their gift of life means to me and my family. Perhaps they know?

Oh, as for retirement, it is not as good as I had hoped. It’s very much better!

Part 1 is available at A Journey to the Other Side, Part 1

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

Stewart Howard is a retired engineer who enjoys golfing with his dear wife, motorcycling where it doesn’t snow and wild music on his electric guitar.
ATS Course on Lung Transplantation Available This Year

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We would like to highlight an ATS postgraduate course on "Evolving Concepts in Lung Transplantation" offered on Saturday, May 18, Philadelphia.

This course will cover mechanisms of lung allograft rejection and new approaches to avoid allograft dysfunction following lung transplant. We will examine and discuss basic principles of lung transplantation and focus on our current understanding of transplant immunology, primary graft dysfunction, acute and chronic rejection, and autoimmunity. The translation of basic research findings to newer approaches to lung transplant that promote improved allograft function and patient survival will be emphasized. Evolving techniques to improve the donor lung supply and quality (such as ex vivo lung perfusion), promote allograft tolerance and prevent rejection, diagnose and manage chronic lung allograft dysfunction (CLAD) will be discussed.

The intent is to improve attendees’ knowledge of recent advances in lung transplantation enhance competency in managing lung transplant recipients.

Individuals who attend this course will better understand concepts of allograft injury, tolerance, and rejection as well as evolving approaches to the diagnosis and management of lung transplant complications.

Link to the ATS postgraduate course website:
http://conference.thoracic.org/2013/program/postgraduate-courses/

Disclosure Statement: The authors have no conflicts of interest to disclose
International and Inter-Society Coordinating Committee
I2C2

Represent your Country!

♦ Connect ISHLT to the issues important to you and your geographic area
♦ Work with the I2C2 Committee to develop global policy and representation
♦ Help create links with your national Societies with related interests

Emerging International Issues

I2C2 takes a leadership role in reacting to important international developments of interest to the membership of ISHLT. The group works closely with the Board of Directors and Councils to develop timely and appropriate responses and policies for the benefit of the Society and the patients we serve.

Inter-Societal & International Outreach

I2C2 develops formal relationships with other Societies where mutual benefits may be attained, membership shared, and common goals exist. There are many areas of benefit to ISHLT members where collaborative working can take place on a formal basis and meaningful liaisons developed. This includes establishing external representation for ISHLT on the international stage and ensuring that we exert influence in the interests of ISHLT’s wider aims. I2C2 also promotes the development of emerging programs and units through a system of advisory visits and educational programs.

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Update: ISHLT 2013 in Montreal: IMACS Registry Booth and Users’ Meeting

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The International Society for Heart and Lung Transplantation Registry for Mechanically Assisted Circulatory Support (IMACS) is proud to present the web based data entry system in the Exhibit Hall at the Palais des congrès de Montréal, Québec, Canada. The IMACS staff has diligently carried out plans to provide an innovative exhibit booth that will provide a live demonstration of the IMACS Registry.

IMACS Registry Booth
The following will be available at the IMACS Registry Booth, April 23-26, 2013:

- IMACS Registry Live Demonstration – Training staff for IMACS will be demonstrating the web based data entry system
- Protocol and User’s Guide – Hard copies will be available for review and distribution

In addition to the demonstration and literature distribution, knowledgeable IMACS staff will be available to answer any questions that participants may have in regards to IMACS.

IMACS Registry Users’ Meeting
On Tuesday, April 23, 2013 at the Montreal Convention Centre, IMACS will have a Users’ meeting for all participants interested in the IMACS Registry. This meeting will take place from 5:00-8:00pm and we strongly encourage your participation as we provide a current update on IMACS and live web based data entry tutorial. If you are interested in attending, please email the IMACS staff at IMACS@uab.edu. There are only 24 more seats left!

Enrollment in IMACS
IMACS will provide continuous monthly updates regarding enrollment until the 2013 ISHLT Annual Meeting in April.

IMACS currently has forty-one hospitals and three collectives that have expressed interest in participating and submitting data to the registry. Eighteen of these hospitals have moved forward with the enrollment process by initiating regulatory requirements and one hospital is enrolled. IMACS has also received additional email inquiries from new sites that are on the verge of enrolling as well and strongly encourage the ISHLT community to continue to spread the word.

Requirements for enrollment can be found on the IMACS website under the Site Enrollment section - http://www.ishlt.org registries/siteEnrollment.asp. First, if a hospital or collective is interested in registration and enrollment in IMACS, they should complete an IMACS Registry Institutional Enrollment Form and submit it via email to IMACS@uab.edu. Next, an IMACS staff member will contact the interested site to continue the enrollment process. In order to be enrolled in IMACS, the following items or forms will be requested:

1. IMACS Registry Institutional Enrollment Form
2. International Society for Heart and Lung Transplantation Registry for Mechanically Assisted Circulatory Support (IMACS) Memorandum of Agreement
3. Human Subjects Research certification (Ethics Board, Institutional Review Board, etc.)
4. Completed Training – At least one IMACS staff member at the institution must complete the IMACS training process. A live web-based data entry training session will be scheduled with the designated staff member at each institution. This training will be conducted in English.

Each item or form will need to be completed satisfactorily before a hospital or collective is officially enrolled in IMACS. Once a hospital is enrolled, they will be sent a user name and password is sent to begin entering data into the IMACS Registry.

Friendly IMACS staff members are available to answer all questions or inquiries regarding the registry. Please send an email to IMACS@uab.edu. We are looking forward to hearing from you and meeting you at the ISHLT Annual Meeting in Montréal, Québec, Canada!

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

Dr. Kirklin is Professor and Director of the Division of Cardiothoracic Surgery at the University of Alabama, Birmingham, Alabama, USA.
Outta This World Links
Interesting, Inspiring and Intriguing Links Around the Globe

I Donated My Body To Medicine (i09.com)

Lung Removal Won't Hinder New Pope, Doctors Say (newsmaxhealth.com)

Lung Transplant Hazard May Rise With Obese Recipients, Smoking Donors (health.usnews.com)
"A transplant fellowship is NOT necessary for a career in lung transplant pulmonology."

The system of apprenticeship was first developed in the Middle Ages, where a master craftsman employed young people as an inexpensive form of labor in exchange for food, lodging, and formal training in the craft. After completion of their contract, usually a term of seven years, they were free to acquire their own workshops. Our formal medical training system of modern times is not too dissimilar to this antiquated definition of apprenticeship. In addition to the 6 years following medical school that pulmonologists train in their craft, some have suggested that a transplant fellowship is necessary for a career in lung transplantation. I plan to convince you otherwise.

A transplant fellowship is not necessary to become a transplant pulmonologist, but what is necessary is a carefully planned and focused pulmonary fellowship at a busy transplant center with strong mentors in lung transplantation. Early in my pulmonary/critical care fellowship, a career in transplant pulmonology piqued my interest. Accordingly, during fellowship I deliberately allowed for plenty of exposure to lung transplantation, taking advantage of research opportunities and attending conferences focused on lung transplantation, which provided the foundation for a career in transplant pulmonology. This base training was much more valuable in my preparation as a transplant pulmonologist than an additional year of training in a transplant fellowship earning PGY7 salary, and moonlighting incessantly in order to make up the salary difference.

During my pulmonary/critical care fellowship I purposefully rotated on our lung transplant service often, in order to gain exposure to the medical management of these complex patients. Throughout my fellowship, performing bronchoscopies on lung transplant recipients was plentiful, and I encountered such issues as anastomotic dehiscence diagnosed via bronchoscopy, bronchostenosis, and PTLD in the trachea, to name a few examples. Taking extra effort to attend our weekly multidisciplinary lung transplant board meetings, I was educated on the issues grappling our transplant recipients and learned how my mentors would handle such issues. From these meetings I learned which candidates are appropriate for transplantation and when to consider retransplantation. Performing lung transplant research with a strong mentor, as I was fortunate during my fellowship, furthered my knowledge in lung transplantation. It also led to additional opportunities as a junior faculty member, undertaking an early career registry award, allowing me to work with statisticians at ISHLT on lung transplant registry data.

In addition to mentors and opportunities during my pulmonary fellowship, I took advantage of opportunities through the ISHLT. By attending the ISHLT Academy Core Competencies in Lung Transplantation in San Diego 2011, I was able to learn the basics and the most up to date knowledge from the experts in lung transplantation. Attending the ISHLT conference during my fellowship enhanced my knowledge of the latest research in lung transplantation, and introduced me to the lung transplant community.

As you can see, a separate transplant fellowship in lung transplantation is not necessary, particularly if steps are taken during pulmonary fellowship to enhance lung transplant knowledge. An additional year of training would only have been just that, an additional year of training. No one has mastered their trade by the completion of their ‘apprenticeship’. It is the valuable early years in practice when the learning curve is highest. Don’t we all continue to learn after the completion of our ACGME fellowship? It seems that fellowships have become continually more and more specialized,
adding years and years to an already prolonged training process. At some point, the training wheels need to come off and the fellow needs to advance to the attending level. Adding additional years of servitude does not necessarily make the transition easier. Instead, focusing on continuing to learn and continuing to find opportunities and networks in the transplant community, will strength and smooth the transition from fellow to attending.

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NEXT MONTH: The CON side of this debate topic will be addressed by Timothy Whelan, MD, Associate Professor of Medicine at the Medical University of South Carolina in Charleston, SC.

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** Tattling Links **

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Eduardo Marbán, MD, PhD: Cedars-Sinai Heart Institute Ranked First in Adult Heart Transplants for Third Year in a Row (newswise.com)
The Incomparable and Unending Mark Twain

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For this issue it is just plain simply impossible to sum up this year’s focus on Mark Twain. This is no surprise with nearly two centuries of material to work with therefore I will pour in much of “his” words for our entertainment. Mark Twain who lived in a thousand places all around the world exclaimed,

“I was made merely in the image of God, but not otherwise resembling him enough to be mistaken for Him by anybody but a very near-sighted person.”

He was a printer’s apprentice, a steamboat pilot, a prospector who never struck gold and a confederate soldier who never fought a battle. He was considered the funniest man on earth, a brilliant performer on the lecture circuit, a failed businessman, but above all he was a writer, a natural born story teller, a self-taught genius with words. He idealized the American language. He wrote constantly: newspaper stories, travel pieces, books, political diatribes, irreverent musings about religion, and flawless letters. Above all, Mark Twain told the truth. He was not afraid to deal with things that other people were afraid to deal with, particularly on the topics of racism, religion and politics. He became the voice of the American people. From an early age, he was deeply scarred – a sister and a brother who each died of childhood disease. He suffered from terrifying nightmares.

Being a printer’s apprentice, he was given a tactile possession of words. He was able to lay his hands on the letters, set them in type, and literally feel his way to make words. On ambition he wrote,

“When I was a boy, there was but one permanent ambition … That was, to be a steamboat man. We had transient ambitions of other sorts, but they were only transient. When a circus came and went, it left us all burning to become clowns; the first negro minstrel show that came to our section left us all suffering to try that kind of life; now and then we had a hope that if we lived and were good, God would permit us to be pirates. These ambitions faded out, each in its turn; but the ambition to be a steamboat man always remained.”

Sam persuaded his younger brother Henry to work on the steamboats. One day, Henry was fatally burned when boilers exploded on another ship. Sam wrote,

“…the horrors of three days have swept over me they have blasted my youth and left me an old man before my time. For 48 hours, I labored at the bedside of my poor burned and bruised but uncomplaining brother. My poor Henry will have finished his blameless career, and the light of my life will have gone out in utter darkness.”

He obviously blamed himself for luring Henry onto the river and by the time Sam Clemens was 22-years-old he had endured the deaths of his three siblings and his father. In many ways these deaths and the responsibility he had put on himself for these deaths annealed the great sense of remorse he carried to his own grave. On healing, he later wrote, “…the source of all humor is not laughter, but sorrow,” and he said “there is no laughter in heaven.”

This brings home the point about the most cost-efficient and effective remedies in medicine, laughter.
His time on the river was his schooling in which, “I got personally acquainted with about all the different types of human nature that are to be found in fiction, biography, or history.” The Mississippi River became for Mark Twain his Harvard and his Yale, the way that Melville says the whaling boat was his Harvard and his Yale.

“Every character I had ever written about and created in my literature, I met on the Mississippi River.”

His piloting days abruptly stopped on April 12, 1861 because of the Civil War. Instead of joining the confederate army, Sam Clemens jumped into a stagecoach and went west, leaving the states behind. “There was a freshness and breeziness and an exhilarating sense of emancipation.” Sam brought along his pipes, 5 pounds of tobacco, and a pistol that had only one fault- “you could not hit anything with it.” During his stagecoach ride he noticed it was the first time that he had ever seen a man’s front yard on top of his house and that,

“...it was a comfort to sit up and contemplate the majestic panorama of mountains and valleys spread out below us and eat ham and hard-boiled eggs while our spiritual natures reveled alternately in rainbows, thunderstorms and peerless sunsets. Nothing helps scenery like ham and eggs – ham and eggs and after these, a pipe, an old, rank, delicious pipe.”

For a moment here, I picture Jack Nicholson in the movie, “As Good As It Gets.” I see Jack in the character of Melvin Udall making a similar sarcastic comment about blissful happiness as in the scene with Carol the waitress and Simon. During their drive to Baltimore in a convertible and after Simon bares his soul to Carol, Melvin responds with the usual charm that only Jack Nicholson or perhaps Mark Twain can get away with as follows:

“Some of us have great stories … pretty stories that take place at lakes with boats and friends and noodle salad … and that’s what makes it hard. Not that you had it bad but being pissed that so many had it good.”

As I link these thoughts together this is no different than Sam Clemens’ “ham and eggs, a downgrade, a flying stagecoach, a fragrant pipe, and a contented heart, it’s what all the ages have struggled for.”

After he arrives to Carson City, the capital of the Nevada Territory, he writes his mother.

“My Dear Mother, the country is fabulously rich in gold, silver, copper, lead, coal, iron, quicksilver, thieves, murderers, desperadoes, lawyers, Christians, Indians, Chinamen, Spaniards, gamblers, Sharpers, coyotes, poets, preachers, and jackass rabbits.”

Going west accidentally brought him into the company of a great proto-psychedelic, counterculture newspaper society out west in Nevada—a bunch of talented wild men improvising a whole new newspaper art form with tall tales and lies and hoaxes and great writing. He was later carousing with the leading writers and intellectuals after he landed a writer’s job in San Francisco. His editor quietly let him go after a libel lawsuit and an arrest for public drunkenness. He was literally down to his last silver 10-cent piece—“and I held to it and would not spend it on any account, lest the consciousness coming strong upon me that I was entirely penniless might suggest suicide.” One day, he put a revolver to his head and almost pulled the trigger. ”...many times, I have been sorry I did not succeed,” he wrote years later, “but I was never ashamed of having tried.”
It was from this low point where he got a break and went back to the Sierras and penned his first story about the jumping frog of Calaveras County. Soon after that in early 1866 he landed a plum assignment writing about the Sandwich Islands (Hawaii) for the Sacramento Union and he writes,

“...at noon, I observed a bevy of nude native young ladies bathing in the sea and went and sat down on their clothes to keep them from being stolen. I begged them to come out, for the sea was rising and I was satisfied that they were running some risk. But they were not afraid and presently went on with their sport.”

He then gently lampooned American missionaries' efforts to convert these islanders. “How sad it is to think of the multitudes who have gone to their graves on this beautiful island and never knew there was a hell.”

By the suggestion from a friend Twain reluctantly turned these articles into lectures earning $400 from his first lecture—more than he earned as a steamboat pilot in a month. He became an unintentional genius of the stage. Because he was petrified with anxiety over the prospect of failing in front of a live audience, at the beginning of his first performance he held a stammering pause then later that evening he recognized his success. As his performances or lectures went on, he began to see that these pauses were great formulations. These pauses were the great preludes to the cascade of humor, so the silence onstage led to something else. He developed it into a great art form. He understood the pause. It was later from his pilgrimage to the Holy Land when he questioned the $8.00 charge by a boatman for a short sail on the Sea of Galilee, “do you wonder now that Christ walked?”

Sam became thunderstruck and uncontrollably drawn to the love of his life, Olivia (Livy). He courted her for 17 months with 184 letters, carefully numbered by Livy. Clemens found an opportunity formally to ask Jervis Langdon (Livy’s father) for his daughter’s hand. Jervis gave Sam conditional approval, provided he could supply him with some names of friends out west who could attest to his character. Sam writes,

“...they said with one accord that I got drunk oftener than was necessary and that I was wild and godless, idle, lecherous, and a discontented and an unsettled rover, and they could not recommend any girl of high character and social position to marry me. But as I had already said all that about myself beforehand, there was nothing shocking or surprising about it to the family.”

They were married. After the success of his first book, The Innocents Abroad, and the two bundles of joy, Langdon and later Olivia Susan (Susy), tragedy struck. Langdon contracted diphtheria and died in his mother’s arms. Just as he had blamed himself for the death of his brother Henry, Clemens held himself responsible for his son's death. It is from this depth of despair where he creates humor to balance his life.

On building a home for his family,

“I have been bullyragged all day by the builder, by his foreman, by the architect, by the tapestry devil who is to upholster the furniture, by the idiot who is putting down the carpets, by the scoundrel who is setting up the billiard table and has left the balls in New York, by a book agent whose body is in the backyard and the coroner notified. Just think of this going on the whole day long, and I am a man who loathes details with all my heart! But I haven’t lost my temper.”

His family grew with the addition of Clara and Jean. Now the Clemens family included three adoring daughters living in their home, the Hartford House. But they would travel to Elmira, NY to be with Livy’s sister, Susan Crane, at her country place called Quarry Farm for 20 summers. In one of these early summers, his sister-in-law surprised him with a writing place all his own. Twain later wrote:
"It is the loveliest study you ever saw, octagonal with a peaked roof, each face filled with a spacious window, perched in complete isolation on the top of an elevation that commands leagues of valley and city and retreating ranges of distant blue hills. It is a cozy nest and just room in it for a sofa, table, and 3 or 4 chairs. And when the storms sweep down the remote valley and the lightning flashes behind the hills beyond and the rain beats upon the roof over my head, imagine the luxury of it."

From here is the birth of all American modern literature. In a manner of 20 years he went from a penniless, friendless, self-loathing loser who contemplated suicide in California to the best known writer in America, now rich enough for his family to live like millionaires.

The years 1885-1895 defined Clemens' times of commercial struggle and collapse. He lost money through many ventures including his publishing company, but the devastating blow to his riches was the failure of the Paige typesetting machine. He was forced to declare bankruptcy in 1894. He did recover financially but never emotionally and imaginatively. He went on the world lecture tour to repay his debt and maintain his character which he did. Later, the final two deaths in his family, his favorite daughter, Susy in 1896 and his wife, Livy in 1904 brought out his darkest, sharpest and most pessimistic writings.

Olivia Susan Clemens died of spinal meningitis. She was only 24 years old. Just as he held himself guilty for his younger brother's death, just as he had blamed himself for the loss of his 19-month old son Langdon in 1872, Clemens now blamed himself for Susy's death. The strain of his bankruptcy and the world lecture tour that tore his family apart were his own doings, and he was sure that together they had killed his beloved daughter. Meanwhile Livy was on a boat halfway across the Atlantic still unaware of Susy's death. It was August 19, 1896 when he poured his heart out into a stream of letters to his wife.

Dearest Livy,

Oh my heartbroken darling. No not heartbroken yet for you still do not know. But what tidings are in store for you. What a bitter world, what a shameful world it is. I love you my darling. I wish you could have been spared this unutterable sorrow.

Samuel

Dearest Livy,

I have spent the day alone thinking bitter thoughts, sometimes only sad ones, reproaching myself for laying the foundation of all our troubles. Reproaching myself for a million things whereby I have brought misfortune and sorrow to this family. It rains all day. No, it drizzles. It is somber and dark. I would not have it otherwise. I could not welcome the sun today. Be comforted my darling. We shall have our release in time. Be comforted remembering how much hardship, grief, pain she is spared and that her heart can never be broken now for the loss of a child. I seem to see her in her coffin. I do not know in which room, in the library I hope for there she, Jean, Clara and I mostly played when they were children together and happy.

She died in our own house not in another's. She died where every little thing was familiar and beloved. She died where she had spent all her life 'til my crimes have made her a pauper and an exile. How good it is that she got home again.

Give my love to Clara and Jean. We have that much of our fortune left.
Samuel

Susy’s death brought on the grief that trumped all other griefs in his life. Work then became his solace. He wrote more and more but now not to just entertain us, he was just trying to keep from killing himself. The one-time Nevadan Mark Twain said of writers:

“Ours is a useful trade, a worthy calling. With all its lightness and frivolity, it has one serious purpose, one aim, one specialty—and it is constant to it: the deriding of shams, the exposure of pretentious falsities, the laughing of stupid superstitions out of existence. And that whoso is by instinct engaged in this sort of warfare is the natural enemy of royalties, nobilities, privileges and all kindred swindles, and the natural friend of human rights and human liberties.”

Despite his losses, he did repay all his deaths. Now the press, writers and reporters came seeking his opinions on every imaginable topic. He loved the attention.

On laziness,

“I have seen slower people than I am and more deliberate... and even quieter, and more listless, and lazier people than I am. But they were dead.”

On moderation,

“as an example to others and not that I care for moderation myself, It has always been my rule never to smoke when asleep and never to refrain when awake and I have made it a rule, never to smoke more than one cigar at a time.”

On crime,

“It could probably be shone by facts and figures that there is no distinctly native American criminal class, except Congress.”

On fools,

“The trouble is not that the world is full of fools, it is just that lightning is not distributed right.”

On the two of the greatest characters of the 19th Century, Napoleon and Helen Keller, Twain stated,

“Napoleon tried to conquer the world by physical force and failed. Helen tried to conquer the world by power of mind — and succeeded!”

In Villa di Quarto Florence Italy on June 5, 1904 on his wife’s death:

“An, hour ago the best heart that ever beat for me and mine went silent out of this house, and I am as one who wanders and has lost his way.”

On death,

“Life was not a valuable gift, but death was. Life was a fever-dream made up of joys embittered by sorrows, pleasure poisoned by pain; a dream that was a nightmare-confusion of spasmodic and fleeting delights, ecstasies, exultations, happinesses, interspersed with long-drawn miseries, griefs, perils, horrors, disappointments, defeats, humiliations, and despairs – the heaviest curse devisable by divine ingenuity; but death was sweet, death was gentle, death was kind; death healed the bruised spirit and the broken heart, and gave them rest and forgetfulness; death was man’s best friend; when man could endure life no longer, death came and set him free.”
With his deep despair his opinion on the Bible is understandable:

“Our Bible reveals to us the character of our God with minute and remorseless exactness. The portrait is substantially that of a man. If one can imagine a man charged and overcharged with evil impulses far beyond the human limit. His acts expose his vindictive, unjust, ungenerous, pitiless and vengeful nature constantly. He is always punishing, punishing innocent children for the misdeeds of their parents, punishing unoffending populations for the misdeeds of their rulers. It is perhaps the most damnatory biography that exists in print anywhere. It makes Nero an angel of light by contrast.”

Nevertheless, his despair was balanced by his humor and his love for attention. He became the most conspicuous person on the planet. He loved the celebrity status. On reaching age 70:

“…before 70 we are merely respected at best and we have to behave all the time. But after 70, we are respected, esteemed, admitted, revered and don’t have to behave unless we want to.”

When offered an honorary doctorate of letters at Oxford, he eagerly set sail for London and chatted with the King and Queen. He made headlines in London simply by strolling across the street in his bathrobe. On being a great author:

“I was sorry to have my name mentioned as one of the great authors because they have a sad habit of dying off. Chaucer is dead, so is Milton, so is Shakespeare and I’m not feeling very well myself.”

In 1909, he began suffering with chest pain. He called it his tobacco heart so he cut back from 40 cigars per day to four. He was beginning a holiday “whose other end was the cemetery.” “Dear Madam, I try every remedy sent to me. I am now on No. 87. Yours is No. 2653. I am looking forward to its beneficial results.” As his conditioned worsened he received morphine in increasing amounts. “I had a picturesque night. Every pain I had was on exhibition and I am losing enough sleep to supply a worn out army.”

On April 21, 1910, Samuel Clemens died peacefully. His daughter Clara wrote, “While the sun dimmed out on the horizon, his great soul melted into that speechless state of majesty and calm he had so fervently yearned for.”

Twain’s final words of advice:

“I think we never become really and genuinely our entire and honest selves until we are dead. And not then until we have been dead years and years. People ought to start dead and then they would be honest so much earlier.”

“Upon arrival in heaven, do not speak to Saint Peter until spoken to. It is not your place to begin. You can ask him for his autograph. There is no harm in that. But, be careful. And don’t remark that it is one of the penalties of greatness. He has heard that before. Don’t try to Kodak him. Hell is full of people who have made that mistake. And leave your dog outside. Heaven goes by favor. If it went by merit, you would stay out, and the dog would go in.”

His longtime friend William Dean Howells writes as he gazed upon Samuel Clemens in his coffin, “I looked a moment at the face I knew so well; and it was patient with the patience I had so often seen in it, something of a puzzle; a great silent dignity, an ascent to what must be from the depths of nature whose tragical seriousness broke in laughter which the unwise took for the whole of him. Emerson, Longfellow, Lowell, Holmes – I knew them all and all the rest of our sages, poets, seers, critics, humorists; they were like one another and like other literary men, but Clemens was sole, incomparable, the Lincoln of our Literature.”
His works will go on altering human consciences forever.

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**Bibliography**

- “Mark Twain Quotations, Newspaper Collections, & Related Resources,” by Barbara Schmidt, [http://www.twainquotes.com](http://www.twainquotes.com).
- “The Mark Twain Papers and Project,” maintained by the Mark Twain Project at the Bancroft Library, University of California, Berkeley, [http://library.berkeley.edu/BANC/MTP](http://library.berkeley.edu/BANC/MTP).
“I am deeply moved by the warmth and courage of the Canadian people which I felt so strongly during my recent visit to your country. Your support of the struggle against apartheid restored me in my journey home and reassured me that many just people around the world are with us.” - Archbishop Desmond Tutu

“There are no limits to the majestic future which lies before the mighty expanse of Canada with its virile, aspiring, cultured, and generous-hearted people.” - Sir Winston Churchill

“In a world darkened by ethnic conflicts that tear nations apart, Canada stands as a model of how people of different cultures can live and work together in peace, prosperity, and mutual respect.” - Bill Clinton

“Canada is probably the most free country in the world where a man still has room to breathe, to spread out, to move forward, to move out, an open country with an open frontier. Canada has created harmony and cooperation among ethnic groups, and it must take this experience to the world because there is yet to be such an example of harmony and cooperation among ethnic groups.” - Valentyn Moroz

“Let us be French, let us be English, but most importantly let us be Canadian!” - John A. Macdonald
Near Misses, Near Hits
CLOSE CALL LEARNING EXPERIENCES

Have you encountered a situation or experience—a "near miss" or "near hit"—that yielded lessons on how to better manage patient care in the clinical setting, or conduct research in the lab, or lecture/teach in a classroom, or just how to do your job better? Do you have an experience to share with the ISHLT Links Newsletter readers about an occasion that taught you something significant about ways to improve health care in patients with end stage heart and lung failure? If so, we want to hear about it.

We encourage you to submit a brief (+/- 500 words) summary of your Near Misses, Near Hits to us for possible publication. Each month, the Links Newsletter will publish a collection of similar experiences sent to us by our readers. Sharing with others the benefit of your experience and the lessons you learned can be an invaluable aid to other health care providers.

You can send your summary directly to Susie Newton at susie.newton@ishlt.org. Put "Near Misses, Near Hits Submission" in the subject line; add your name and phone number at the bottom of the email.

Your report will be considered for publication in the new Near Misses, Near Hits page, and may be edited for style and length. Anonymity is guaranteed if you wish. No one but our Editor and Managing Editor will be permitted to access the report. Your name and telephone number are requested only so that the managing editor can contact you if necessary.

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