TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
<th>Title, Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td><strong>In the Spotlight: 2013 Strategic Planning Meeting Report</strong>, by David Taylor</td>
</tr>
<tr>
<td>4</td>
<td><strong>NEW! Laughing Links</strong></td>
</tr>
<tr>
<td>5</td>
<td><strong>Outta This World Links</strong></td>
</tr>
<tr>
<td>8</td>
<td><strong>Battling Links: Controversial Debate Topics</strong></td>
</tr>
<tr>
<td>10</td>
<td><strong>Tattling Links</strong></td>
</tr>
<tr>
<td>11</td>
<td><strong>Infectious Diseases Council Report</strong>, by Fernanda Silveira</td>
</tr>
<tr>
<td>13</td>
<td><strong>Junior Faculty and Trainee Council: What Lies Ahead</strong>, by Christina Migliore</td>
</tr>
<tr>
<td>15</td>
<td><strong>World-wide MCS Outreach Through I2C2</strong>, by Sean Pinney</td>
</tr>
<tr>
<td>16</td>
<td><strong>Nursing, Health Sciences and Allied Health Council Report</strong>, by Masina Scavuzzo</td>
</tr>
<tr>
<td>18</td>
<td><strong>Pharmacy &amp; Pharmacology Council: Lessons Learned and a Bright Future</strong>, by Michael Shullo</td>
</tr>
<tr>
<td>20</td>
<td><strong>PH: Forward Acceleration on the “Right” Side</strong>, by Mardi Gomberg-Maitland</td>
</tr>
<tr>
<td>22</td>
<td><strong>ISHLT Pediatric Lung Transplant Monograph Now Available!</strong></td>
</tr>
<tr>
<td>23</td>
<td><strong>International Traveling Scholarship Awards</strong></td>
</tr>
<tr>
<td>24</td>
<td><strong>Editor’s Corner: The Heart or Root of Matter</strong>, by Vincent Valentine</td>
</tr>
</tbody>
</table>
In 2007, ISHLT embarked on an aggressive strategic plan formulated by the leadership after two 2-day planning meetings in February and July 2007. The focus of the final plan was quite broad, from education to membership, from research to clinical affairs and importantly included governance structure. The majority of the recommendations have been fully implemented. These efforts are primarily responsible for the growing success of ISHLT today. For example, the current highly effective functioning of the Society is a direct result of the reworking of the Council and Committee structure. This has not only improved the efficiency of getting ideas from formulation to action but, just as importantly, engaging many more members, especially younger members, in the process of governance. Another example is the restructuring of the planning process for the current Annual Scientific Sessions which has continued to evolve (and continues to evolve) and was responsible for the outstanding meeting we just experienced in Montreal. The pre-meeting Academies came directly from the strategic plan as well, as did the Links newsletter you are currently reading. The ongoing focus on core curricula, standards, and guidelines were also a large focus of the original strategic plan. The I2C2 (international, inter-society coordinating committee) is a direct outgrowth of several recommendations from SPv1.0. Policies and procedures for I2C2 are currently in the final phase of development but the committee has been extremely active, coordinating a number of educational events this year and next between ISHLT and several other international societies.

Fast-forward to this February, when a representative group of members met again to review the remaining potential gaps for the Society. Due to the success of the first strategic plan, the gaps were few and thus the focus much more narrow. We examined the current gaps in the delivery of education, particularly in the age of the internet and smartphones and the use of electronic communication for the Society in general and the members in particular. We discussed the current and future membership, the ISHLT ‘Brand,’ our Mission Statement, and even the name of the Society. While entire version 2.0 of the strategic plan is not yet ready for a beta-test, parts of it have already found their way into policy and process. The Education Committee has been reorganized under the
direction of Chris Wigfield expanding its role to bring all educational activities under one umbrella and one clear, yet strict, set of policies and procedures in order to best meet the educational needs of our members. The Montreal meeting was a highly successful test of the new mobile meeting app and the recently released on-line, on-demand, meeting content. The strategic planning group debated the merits of additional CME and non-CME content, independent of the annual scientific sessions. We debated how electronically ‘connected’ the Society and its members need to be for optimal benefit for both. We debated whether a name change for the Society should be considered and, if so, what should that name reflect. Obviously, with a Society so broad in its membership and its interests, no name could adequately encompass everything we currently do or hope to do in the future. Yet concern persists that our current name is not an adequate representation of what we do and could hinder our growth in those areas not clearly represented in the name.

What can members expect to come out of SPv2.0? Expect a major push toward additional educational opportunities beyond the annual meeting, including in-person meetings as well as on-line, on-demand opportunities. Expect I2C2 to gain more traction, moving beyond education to include public policy and international standards.

Like all major upgrades and updates, SPv2.0 will have some glitches and hiccups but that shouldn’t deter us from continuing our efforts to make the Society successful beyond belief.

To quote that great American philosopher, Buzz Lightyear: “To infinity….and beyond.”

Disclosure statement: The author has no conflicts of interest to disclose.
We are introducing a new monthly feature of ISHLT Links. While some of the newsletter's features are intended to inform or to network our members (with a bit of entertainment value sometimes too), Laughing Links is meant ONLY to give you a chuckle. We hope that it becomes the part you click on first as a way to lift the haze from your brain after a long day in the operating room or the clinic. Feel free to write in with humorous ideas, links from the media or YouTube, or just a good joke you've heard recently (assuming it is printable). Enjoy!

And so now the humorous part ...

We knew we couldn't stray far from Mark Twain. Thereby we cannot ignore the Mark Twain Prize for American Humor.

You know Laughter is the Best Medicine. There have been 16 winners, it does not discriminate and Richard Pryor was the first recipient, Tina Fey has been the youngest, and Ellen DeGeneres was last year's recipient. And this year's winner is Carol Burnett.

When announced she was the 2013 winner, her one-line retort was:

"It’s almost impossible to be funnier than the people in Washington."

— Dan Dilling and Vincent Valentine
Outta This World Links

Interesting, Inspiring and Intriguing Links Around the Globe

American Lung Association Mourns the Passing of Senator Frank Lautenberg
American Lung Association, June 3, 2013

The American Lung Association joins the nation in mourning the passing of Senator Frank Lautenberg (D-NJ), life-long lung health champion, and offers condolences to Senator Lautenberg’s family and loved ones. Senator Lautenberg will be remembered as one of the greatest champions for public health in U.S. Senate, particularly for championing prohibiting smoking in airplanes and helping to write the 1990 Clean Air Act amendments. Senator Lautenberg’s tireless efforts for lung health have led to untold lives saved and the health of our nation forever improved. Read more...

Kathleen Sebelius to review lung transplants after Pennsylvania girl, 10, denied
Associated Press, June 2, 2013

Secretary of Health and Human Services Kathleen Sebelius is calling for a review of policies affecting patients needing lung transplants as a 10-year-old Pennsylvania girl whose parents say she's been denied the life-saving surgery because of her age remains hospitalized on a ventilator. Read more...

The $2.7 Trillion Medical Bill
The New York Times, June 1, 2013

Whether directly from their wallets or through insurance policies, Americans pay more for almost every interaction with the medical system. They are typically prescribed more expensive procedures and tests than people in
other countries, no matter if those nations operate a private or national health system. A list of drug, scan and procedure prices compiled by the International Federation of Health Plans, a global network of health insurers, found that the United States came out the most costly in all 21 categories—and often by a huge margin. Read more...

Singing opera with someone else's lungs
The Washington Post, May 27, 2013

For an opera singer, lungs are a musical instrument—like a Steinway to a pianist or a Stradivarius to a violinist. They expand and contract, carefully expelling air to create beautiful arias and emotional duets. Singers spend years training their lungs. To lose them is to face losing one’s dream, and, of course, one’s life. Read more...

Ochsner Medical Center Implants 1st Total Artificial Heart in Gulf South Region
SynCardia via YouTube, May 7, 2013

When Alfred Williams was admitted to Ochsner Medical Center in December, the 41-year-old father of five had exhausted all treatment options for his enlarged heart. His condition, known as dilated cardiomyopathy, had progressed to end-stage heart failure affecting both sides of his heart. Unable to walk, he had been confined to a bed for months. Hospice care seemed like the only option Mr. Williams had left... until doctors approached him about becoming Ochsner's first patient to receive the SynCardia temporary Total Artificial Heart. Read more...

Lung transplants provide new start
Kingston Whig-Standard, April 29, 2013

For Shillane Labbett, the double-lung transplant she received seven years ago was literally a breath of fresh air. The issue of organ donation is something near and dear for the Kingston resident and she was busy during National Organ and Tissue Awareness Week last week informing people how organ donation saves lives and how many recipients can live full normal lives. Read more...
Pacemaker pioneer now lives with device
April 26, 2013

Dr. Vincent L. Gott was part of an innovative group of doctors who trained with Dr. C. Walton Lillehei, considered to be the father of open-heart surgery. When Lillehei performed the first open-heart surgery in 1954, Gott was observing as an intern. He later drew an illustration of the operation showing the defects in the patient's heart, which caught Lillehei's eye. Gott went on to become one of the pioneers in the development of the pacemaker -- a device that he himself benefits from today.

Read more...

New transplant technology keeps organs 'alive' outside body
CNN, April 25, 2013

In every medical drama the scene is the same: The surgeon carefully places the delicate organ in a cooler filled with ice and snaps the lid shut. The transplant team then sprints toward the door, hoping to reach its patient in time. That speed isn't just for dramatic effect. Transplant teams rush because they have less than eight hours to transport the organ to the operating room, prepare it for surgery and implant it into the recipient's body.

Read more...

First infant heart transplant is 'storybook case' for Children's
Omaha World-Herald, April 22, 2013

Lainey Wilkinson doesn't know it yet, but one day she'll learn that the entire staff at Children's Hospital and Medical Center was just waiting for someone like her to be born. Lainey became the first infant to receive a heart transplant at Children's on April 8, two weeks after her birth there. The little girl from Council Bluffs is now doing so well that she is expected to be released in the next week or two.

Read more...

Research aims to boost lung transplant success
Pittsburgh Post Gazette, April 22, 2013

For a lung transplant to be successful, donor lungs must be maintained from the moment they are harvested until the transplant. And before the transplant occurs, the recipient must maintain a level of fitness to optimize the outcome. Because both can affect the success of a lung transplant, UPMC and University of Pittsburgh researchers and transplant surgeons are working to advance both ends of that equation.

Read more...
"A transplant fellowship is NOT necessary for a career in lung transplant pulmonology."

The PRO side of above topic was debated in April 2013 by Erin Lowery, MD (see 2013 April Battling Links). Below is another submission on the PRO side of this topic.

An extra lung transplant fellowship is not necessary to produce highly functioning lung transplant physicians. Pulmonary/critical care fellowship provides the foundation for an adequate knowledge base to care for the severely advanced lung disease patient prior to lung transplantation. Current training goals of pulmonary/critical care fellowship include competency in the diagnosis and management of obstructive and interstitial lung diseases. These are the two most common indications for transplantation. Initial fellowship training with subsequent patient experiences provides the tools necessary to determine risk for morbidity/mortality without transplantation. This is a key factor necessary to determine appropriate timing for listing for transplant and allow for the maximum survival and quality of life benefit following transplantation.

In addition, pulmonary fellowship training provides the backbone for management of the complex immunocompromised transplant recipient. Pulmonary fellows learn key infectious disease concepts in this population through consultative management of individuals who are solid organ recipients, bone marrow transplant patients, and those with acquired immunodeficiencies such as as the immunocompromised oncologic patient. These experiences allow the well trained fellow to generate appropriate broad differential diagnoses that include atypical and unusual infectious pathogens as well as non-infectious etiologies of lung diseases.

Furthermore, pulmonary and critical care fellowship provides key insight into the management of the critically ill patient including complex ventilator management, cardio-pulmonary physiology, and management of multi-system organ failure. Procedurally, the graduating fellow is accomplished in airway management, line placement, pulmonary artery catheter interpretation, bronchoscopy, and bedside ultrasonography. As ECMO continues to become more widely available, this too is a skill that the critical care fellow will have familiarity. These skills allow for adequate bridging of the awaiting transplant candidate. They are also necessary for the early post operative management of the recipient as well as those who develop early and late complications following lung transplantation.

Although it is true that further experience with this specialized subset of pulmonary patients through an additional year or two of training may provide valuable experiences to the future transplant pulmonologist, there are some real limitations to this approach as well. As we all know, lung transplantation occurs on its own timetable. This often means the donor assessment, management, procurement, implantation, and post-operative management occurs over many consecutive hours. These often span the night and extend well into the following day or days. These shared
Responsibilities of the transplant physicians and surgeons occur in addition to ongoing clinic, inpatient ward, and ICU call schedules. Current work hour restrictions for trainees limit the extent of exposure that one can master in a short year of additional training. Rather, one can argue that the gamut of transplant experiences that a new young faculty member, unencumbered by such work hour restrictions and with good mentorship, provides the best and most efficient pathway to a long and fulfilling career in lung transplantation.

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

NEXT MONTH: We are looking for someone to refute the statements by Drs. Lowery and Whelan with a piece supporting the need for a lung transplant fellowship to prepare a pulmonologist for a career caring for lung transplant recipients. If interested, please contact Susie Newton or Daniel Dilling for details on how to submit your point of view.
Stuart C Sweet, MD, PhD: Dying Girl Sparks Debate Over Organ Transplants (Here & Now, May 30, 2013)

Roger Evans, PhD: Immunosuppressive Drug Costs Decline, But Still Expensive (May 19, 2013)

Jack Copeland, MD: Dr. Jack Copeland Honored with Pioneer in Transplantation Award at ISHLT (PR Web, May 16, 2013)

Marian Zembala, MD: CARMAT: Agreement with the Silesian Center for Heart Diseases in Zabrze, Poland, to perform implants of CARMAT's bioprosthetic artificial heart (May 15, 2013)

Aditya Bansal, MD and Hector Ventura, MD: Ochsner Medical Center performs Gulf South Region's first implant of SynCardia Total Artificial Heart (PR Newswire, May 9, 2013)

Abbas Ardehali, MD: New transplant technology keeps organs 'alive' outside body (CNN, April 25, 2013)

Robert Spicer, MD and James Hammel, MD: First infant heart transplant is 'storybook case' for Children's (Omaha World-Herald, April 22, 2013)

Christian Bermudez, MD: Research aims to boost lung transplant success (Pittsburgh Post Gazette, April 22, 2013)
Infectious Diseases Council Report

Fernanda Silveira, MD
ID Council Chair
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We had a great meeting in Montreal, filled with high quality scientific content, networking opportunities and the chance to chat with colleagues from around the world. The fungal infections working group had a whole day meeting and the discussion was lively and thought provoking. We had the opportunity to hear the results of the survey on preventive strategies in MCS which was responded to by more than 100 member centers, with at least 70% of them expressing their willingness to participate in future intervention studies. We were kept very awake in early morning learning about the nightmare syndromes in thoracic transplantation. The speakers did an excellent job discussing thrombotic microangiopathy, central nervous systems infections, donor-derived infections, parasites and hemophagocytic syndrome. The CMV session was state-of-the-art and included the latest in prevention, immune monitoring and therapy of resistant viruses. The meeting was closed with a session that addressed infectious risk in donors and recipients as well as related to travel, leisure and outdoor activities post-transplant.

We held online elections for vice-chair after the meeting and I am happy to announce the election of Paolo Grossi, who will serve as vice-chair for the next 2 years, and the final roster of our executive committee:

Chair: Fernanda Silveira
Vice-chair: Paolo Grossi
Past-chair and Board of Directors Liaison: Lara Danziger-Isakov
Program Committee representatives: Stanley Martin and Amparo Sole
Education: Me-Linh Luong
I2C2: Martha Mooney
IMACS Registry: Margaret Hannan
Registries & Databases: Dennis Hadjiliadis
Standards & Guidelines: Stanley Martin and Amparo Sole
Communications/LINKS: Michele Estabrook and Mace Schuurmans
JFTC: Saima Aslam

The immediate weeks following the meeting have been dedicated to assimilate everything new that was presented; to develop a strategic plan for the year ahead; and to create symposium ideas for next year’s meeting.
The year will be busy, with the wrap up of ongoing initiatives and initiation of new projects. The fungal infections working group is expected to generate the first draft of the consensus document in the fall. Shimon Kusne will lead the writing of the manuscript reporting the MCS survey results. Several members of our council, led by Martha Mooney and Michele Estabrook, have been developing our core competencies document, which is close to being finalized. Margaret Hannan will continue to work with the IMACS committee on the final approval of the ID variables for submission to the board. Amparo Sole and Fernanda Silveira have submitted a proposal for a diagnostic guideline in thoracic transplantation to the Standards & Guidelines committee and intend to obtain approval of the format and author’s list in order to start the development of content. This proposal incorporates intense participation of members of the JFT council with most chapters being authored in collaboration by a senior and a junior member.

The new initiatives for the year include the creation of a mini-registry of thoracic transplantation and MCS in HIV infected individuals. This initiative will be led by Professor Paolo Grossi and the next steps include the development of a case report form, detection of interested centers and securing center commitment for participation. We are happy to have the enthusiasm of our colleagues in the Pharmacy and MCS councils, who want to join us in this endeavor. In response to the feedback we obtained at the meeting we will also develop a proposal for the establishment of a multidisciplinary MCS prevention strategies working group, with representation from the MCS, Pharmacy and Nursing councils.

As one can see, we are on track to have a very productive year, strengthen old and establish new collaborations. I encourage members interested in participating in these initiatives to contact me or the leaders of each initiative and I hope to see you all in San Diego next April.

Disclosure statement: The author has no conflicts of interest to disclose.
Junior Faculty and Trainee Council: What Lies Ahead

Christina Migliore, MD  
JFTC Communications Liaison  
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The JFTC was created 6 years ago and included only a handful of members. Our size has increased to over 300 members with a quarter of its members from outside the US. The goal of the Council has always been to tap into the enthusiasm of junior faculty and trainees and make them an integral part of the society.

Although 2012 was one of our most productive years, 2013 promises to be even better! The council is focusing on outreach for 2013-2014. New this year, the JFTC set up a booth to advertise the council, promote the council’s role in the ISHLT and attract new members to the society and council.

We have exciting projects for the upcoming year:

1. New to the meeting this year was a collaborative symposium between the JFTC and senior members of the society entitled “JHLT and JFTC: Year in Review” This session proved to be very popular and had great feedback. We plan to publish this session in the journal this year!

2. 'International Fellowship Training Database' survey. The aim of the survey is to create an online directory of training opportunities (medical and surgical) for adult and pediatric heart failure, thoracic organ transplantation/mechanical assist devices, and pulmonary hypertension. Once compiled, the information will be available on the ISHLT website and includes informational and contact details. We are trying to improve visibility of these highly specialized training programs to individuals seeking advanced training opportunities. Please join us in making this endeavor a success and boost young trainee and faculty involvement in ISHLT! Programs interested in submitting their training program information should go to http://www.surveymonkey.com/s/FellowshipDatabase.

3. JFTC members will be writing brief biographical summaries of our field’s pioneers and marvels—stay tuned for this addition to an upcoming Links.

4. The July and December issues of the Links will feature the council. If you have anything you would like to submit, please feel free to contact me at cmigliore@barnabashealth.org.
The council has started 2013 under our new leadership:

Chair: Jennifer Cowger
Vice Chair: Manreet Kanwar
Secretary: Eugene C. DePasquale
Past Chair: Pali Shah
Program Committee (2014); Esme Dijke
Development: Arezu Aliabadi
Education: Matt Morrell
I2C2: Reema Hasan
Registries and Databases: Keyur Shah
Standards and Guidelines: Steven Kindel
Board of Directors Liaison: David O. Taylor
BSTR Council Liaisons: Zsuzsanna Hollander and Esme Dijke
Communications Liaison: Christina Migliore
ID Council Liaison: Me-Linh Luong

The council would love to thank our outgoing leader Pail Shah for her tireless efforts this year. As the council continues to grow, the mark you have left will not be forgotten.

Finally, we are now calling for symposium submissions for 2014! If you have ideas for 2014 symposia that you would like to develop with the JFTC or co-develop with another council, please contact our new fearless leader Jennifer Cowger at jennifercowger@gmail.com.

Disclosure statement: The author has no conflicts of interest to disclose.
World-wide MCS Outreach Through I2C2

Sean Pinney, MD
I2C2 Committee MCS Council Workforce Leader
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I am very pleased to represent the MCS council on the International and Inter-Society Coordination Committee (I2C2). As the name implies, this committee’s charge is to expand the reach of the ISHLT by taking a leadership role in reacting to important international developments of interest to the ISHLT membership; by fostering the participation and growth of international MCS and thoracic transplant centers within the ISHLT; and by developing formal relationships with other professional societies where mutual benefits may be attained, membership shared, and common goals exist. It is hoped that through the efforts of the I2C2, the ISHLT will become an even stronger advocate for thoracic transplant and MCS professionals and their patients.

In many regards this committee is still in its exploratory phase. As the year unfolds, it will be important to identify international partners who share in our goal of expanding care and improving patient outcomes. To work more efficiently and to reflect cultural and local diversity, the I2C2 has grouped countries into 5 regions. I2C2 members will be distributed to a single region and cooperate closely with regional Ambassadors and the I2C2 executive committee. A similar need exists to identify strategic partners in various societies such as the ESOT, AST and others who share our vision of expanding access and improving patient outcomes. Collectively, these efforts should help to establish external representation for the ISHLT on the international stage and, with the permission of the Board, make the I2C2 a policy-making group where relevant.

Disclosure statement: The author has no conflicts of interest relevant to this report.
Nursing, Health Sciences and Allied Health Council Report

Masina Scavuzzo, RN
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It is hard to believe that almost a month has gone by since the annual meeting in Montreal. I am very privileged to work with a talented group of nurses and social workers as our council executive. All have worked hard to continue to move our council goals forward.

Our annual general council meeting was extremely well attended with 79 members in attendance, standing room only. I believe that this is the best attendance ever. We encourage all of our members to get involved with one of the many workforces. This is a wonderful way to network and to help us grow our council. I encourage that we build membership from the health science and allied health group as well. I am delighted that Samantha Anthony, Social Worker is our Vice Chair. She will bring an added perspective to our council.

The Nursing, Health Sciences and Allied Health Council has a very exciting year ahead. The ISHLT Board of Directors has approved the NHSAH for an Academy at the Annual 34th ISHLT meeting in San Diego, April 2014. We have some work ahead of us to complete and receive approval on our core competencies curriculum for heart and lung transplant nurses. Once completed and approved we will need to put together our 2014 Academy. A preliminary outline has been submitted to the council executive to review. The final step will be to identify the speakers for the Academy and to send in the submission for final approval from the Board of Directors at their next board meeting in July. Given the annual meeting will be in San Diego, we are hopeful that this will attract attendees for the Academy.

We also have created a standardized heart transplant patient teaching slide template for those who provide patient education in groups. The Pharmacy Council has reviewed the template and shortly the revisions will be made and hopefully will be available through the ISHLT website. This slide set can be modified to local practices and protocols but contains the basic important patient information. We will also be developing a lung transplant patient teaching slide template to come out by the next annual meeting.

Our other goals for the upcoming year include continuing to provide CEPTCs via the American Board of Transplant Certification to attendees of the meeting as well as for any web–based interaction recognizing that not all members of our council are in the position to attend the annual meeting. ISHLT has shown their commitment by digitally capturing all the symposia, oral abstract sessions, plenary sessions and the two ISHLT Academies
(MCS and Pediatric Heart and Lung Transplant) for a nominal fee and will be available through March 31, 2014. Details are on the ISHLT website at [www.ishlt.org](http://www.ishlt.org).

We would also like to develop liaisons between the NHSAH Council and the other councils. Given that our members tend also to be members of the other councils and are involved in many educational endeavors, we are asking to have our general council meeting at the beginning of the meeting along with the Pharmacy and Junior Faculty to be followed by a joint reception to facilitate networking. Along these same lines we aim to foster formal partnerships with professional groups that share similar goals and interests. This will be developed through the International and Intersociety Coordination Committee (I2C2). Michael Petty is our representative on that workforce.

Lastly, we would like to grow our “Google Group” further and increase the interaction/comments on the wide variety of topics that have been featured. What a wonderful way to stay in touch with our council members. If not a Google group member, we encourage you to join. The link is posted on our [NHSAH council page](http://www.nhsah.org) along with a tutorial of how to navigate the Google Group. ISHLT is working on ‘private community software’ to replace the use of Google groups and it will be used by all of ISHLT. It will allow us to have a ‘connected community’ and allow for a more flexible discussion forums and a number of other perks that will facilitate networking and collaboration.

Disclosure statement: The author has no conflicts of interest to report.
Pharmacy & Pharmacology Council: Lessons Learned and a Bright Future

Michael A Shullo, PharmD
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Two years ago small group of pharmacy practitioners interested in thoracic pharmacotherapy gathered to discuss what we perceived as an unmet need in the ISHLT; a voice and home for those with specific expertise or those interested in all areas of drug therapy. This was the birth of our council. We believed this council could touch each and every discipline represented by ISHLT and, through partnerships, collaborations, research, and sheer will, improve the health of those patients cared for by ourselves and fellow members. To that end under the expert leadership of my predecessors, Drs. Patricia Uber and Christopher Ensor, we organized, gained structure, planned, and collaborated, with great results as evidenced by the our councils successes at this past year’s ISHLT meeting.

Now as we evolve, our membership is driven for more. We have learned that being new and a virtually unknown commodity within the society means we are not the first council mentioned when an idea is conceived or a project is initiated. This was appropriate as we were untested and unproven; however, we will improve with time, exposure, and high quality work. Motivated by this knowledge, this year we will continue to move forward, innovate, and be vocal within the society. We will be pushing to increase our scientific presence at the annual meeting, actively seeking out participation in new and ongoing projects, clinical guidelines, and consensus statements. This will be achieved through our exceptional committee representatives/liaisons and a motivated membership.

The next year brings additional new focus items via these representatives/liaisons:

- Ed Horn, our communications liaison, will be creating a forum updating our members on specific PPC issues. Additionally, Ed plans to enhance the communication between senior and junior council members to improve collaboration and idea sharing.
- Adam Cochrane, our Standards and Guidelines committee representative, will be working with his committee leadership refining their processes to expedite document review.
Tam Khuu, our Registries and Databases Committee representative, will be working on three projects: the establishment of pharmacy/pharmacotherapy award applicant criteria, initiation of active award applications for Early Career Award, and personally spearheading a TAH Bridge-to-Retransplantation mini-registry with Drs Ali Nsair and Mario Deng.

Our council goals for the next year are ambitious, including the completion of ongoing projects and several new initiatives. First, we will complete our Core Competency Statement for Pharmacy and Pharmacology Practitioners in Thoracic Diseases. Second, we will continue forward with existing cross-council collaboration with the Nursing, Health Sciences, and Allied Health Council working on patient education materials for heart and lung transplant recipients. Third, we will develop new cross-council collaborations including working with the Infectious Disease council on the MCS infection management workgroup and the Pulmonary council on the AMR workgroup. Fourth, we will finalize ACPE continuing education for the ISHLT 2014 meeting in San Diego, perhaps removing one possible travel barrier for our membership. Fifth, increase council membership through outreach efforts. And lastly, expand our presence at the ISHLT 2014 meeting by continuing our successful lifecycle series and increasing scientific and educational submissions.

I believe the upcoming year is ripe with opportunities, indeed our future is a bright one....

Disclosure statement: The author has no conflicts of interest to disclose.
Pulmonary Hypertension: Forward Acceleration on the “Right” Side

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As a growing council within ISHLT we continue to grow in maturity. The Council, under the outstanding leadership of Chair, Robert Frantz, MD (Mayo Clinic, MN), has achieved many of its annual goals. The meeting in Montréal successfully incorporated basic science and clinical pulmonary vascular disease medicine. Our goal for Montréal was to promote cross-council collaboration and to feature the right ventricle and pulmonary arterial hypertension at a Plenary Session. Thanks to our program committee representatives of 2012-2013, we attained this goal.

ISHLT 2013:

First and foremost, the Council commends all presenters of individual research as the quality of the poster and oral presentations continues to rise.

Dr. Marlene Rabinovitch (Stanford University) gave a Plenary session presentation dedicated to Dr. Robyn Barst, a pioneer in the field of PH, in remembrance of her commitment to both the science and the patient. The talk, entitled “BMPR2: From Mutation to Modulation,” simplified the complex pathways of pulmonary vascular disease and the role of this pathway not only in familial PAH but in other forms of PAH.

The myriad symposia included sessions on medical and surgical approaches to chronic thromboembolic pulmonary hypertension, lung transplantation in PH, the role of right heart catheterization in MCS patients, and proteomics and inflammatory pathways in PAH.

Finally, our focus on “the right side” continues to expand across specialties and culminated in a plenary session on the right ventricle.

Going back to Cali … ISHLT San Diego 2014

Leadership: the election for Vice Chair of the PH Council will occur in San Diego, 2014, and the following Council leadership positions will become vacant (to be appointed by the Council chairs): Registries and
Databases, Education, Standards and Guidelines, Development, and I2C2. In addition, Dr. Myung Park (University of Maryland) our past chair is now the board liaison and Dr. Raymond Benza (Allegheny General) has rotated off the board.

**ISHLT-World PH Consensus Initiative: PH and left heart disease international collaboration:** Using the JHLT manuscript on PH and left heart disease as a start with the World Congress consensus from the Conference this year (Nice, France), an esteemed group of internationally recognized clinicians and surgeons with focus on this disease. Over the next year, the three taskforces will identify key gaps in knowledge and research initiatives in the context of heart failure/transplantation and mechanical circulatory support. The updates of this work will be presented at the San Diego meeting as a symposium. The group’s publishing goal is to complete this document by the 2015 Master’s Academy.

**Future:**

**International Research Collaboration Initiative:** The PH Council is proposing support for a database to perform focused research on PH topics. An example is imaging of the right ventricle in acute right heart failure and predictors of right ventricular failure post lung/heart transplantation.

**Master’s Academy:** A comprehensive curriculum is complete for a 2015 Nice, France ISHLT. Under the direction of the Education Leadership with Dana McGlothlin, MD (San Francisco) the will continue to be updated in preparation for the meeting. The curriculum focuses on the broad needs of the ISHLT encompassing therapeutics, biomarkers, and diagnostics for all PH: PAH, PH with left heart or lung disease, mechanical support options, and lung transplantation.

**Membership and I2C2:** The goal of the council is to increase junior faculty membership and responsibility within the council. Collaboration between ISHLT and the Pulmonary Vascular Research Institute (PVRI) is in progress and will initiate at the PVRI meeting in 2014 (Giessen, Germany). In addition, collaborative research efforts with the European Respiratory and Cardiology Societies are in discussion.

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**Disclosure statement:** The author reports the following conflict of interest information: Consultant / Steering Committee / DSMB: Actelion, Gilead, Medronic, Merck, and Pfizer. The University of Chicago has received money from Actelion, Gilead, Medtronic, and Novartis to support the conduct of clinical trials.
ISHLT Pediatric Lung Transplant Monograph Now Available!

The ISHLT Pediatric Lung Transplant Monograph is now available! The monograph includes an international cadre of authors and covers the full gamut of issues related to pediatric lung transplant including indications, waiting list management, donor management strategies, surgical techniques, post-transplant management and outcomes. Special aspects relevant to pediatrics, including growth, cognitive development, adherence and adolescence, and transition to adult care are also included.

This comprehensive perspective on pediatric lung transplant will provide an excellent resource for anyone with an interest in pediatric lung transplantation.

For ordering information and to view the Preface and Table of Contents, please visit:

International Traveling Scholarship Awards

Next application deadline: **August 1st, 2013**

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

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

INTERNATIONAL TRAVELING SCHOLARSHIP APPLICATION & INFORMATION:
http://www.ishlt.org/awards/awardIntlTravelScholar.asp

PAST INTERNATIONAL TRAVELING SCHOLARSHIP RECIPIENTS:
http://www.ishlt.org/awards/awardIntlTravelScholarPast.asp
The Heart or Root of Matter

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It’s human nature. No, this is not the song by Madonna with the refrain beating on…”express yourself, don’t repress yourself,” and later the words, “you wouldn’t let me say the words I long to say….” But I refer you to it.

🎵 Human Nature. Anyway it’s been human nature for us to classify, well, just about everything. Now, that we know we are made up billions of cells, there are billions of microorganisms living as communities making up different microbiomes depending on the ecologic niche of their habitats such as: our skin, upper respiratory tract, lower respiratory tract, upper gastrointestinal tract and lower gastrointestinal tract, just to name a few. With his systematic process of classifying all living things, Carl von Linné of Sweden, better known by the Latin version of his name, Carolus Linnaeus, began this remarkable feat in his book *Systema Naturae* published in 1735. His system of groups, groups of groups, groups of groups of groups and so on gave his description of living things the appearance of a tree with larger branches divided into smaller and smaller branches down to the twigs referred to as species. This notion of biological evolution seemed very natural to Linnaeus even though he was strongly antievolution and clinging to the tale of Genesis.

Many of you may have seen this evolutionary tree in Dr Ronald Collman’s fascinating presentation in Montreal on The Human Microbiome. At the same time some of you may have linked the means to classify the origin or roots of the various bacteria and personified the origin or roots of the English language, well at least I did. Compare the metaphorical trees, the unrooted phylogenetic tree of microbes (Figure 1, left) with the origin of the English language beginning with a Proto-Indo-European (PIE) ancestor (Figure 2, below). Why? It’s human nature to improve our ability to communicate as we are racing along because of technology. Never before have we been in a situation with a language as global as English is today. It is the effect of globalization and
communication technology. English is a second language in many parts of the world, in fact second and foreign language speakers actually outnumber native English speakers.

To trace English back to its roots linguists have reconstructed ancient languages similar to methods used by molecular biologists in their quest to understand the evolution of life. As biologists identify the fundamental genetic make-up that defines living things, linguists seek corresponding syntax, grammar, vocabulary and
vocalization among known languages to reconstruct the “proto-language” or original tongue. To better understand English we must focus on the family of Indo-European languages. You may recall that English belongs to the Germanic family and as health care providers you undoubtedly know the tremendous influence the Italic family has had on the English language. By examining the PIE origin we can start with the ancestral root word “kard” which means heart. Through the evolution of language and vocalization, this root word branches into many daughter languages. In Latin the “k” consonant retains the hard sound as in “cor” or “cordis” as it does in Greek with “kardia.” In English we have the word heart. It was Jakob Grimm, of Grimm’s Fairy Tales, who identified how Germanic languages were related to their Latin counterparts in terms of consonant differences through the sound law known as Grimm’s Law. The PIE consonant /k/, according to Grimm’s Law became a Germanic /h/; it remained a /k/ in Latin and Greek. This explains the first consonant in heart and cardiac. Also, examine the words hearty and cordial. This pairing also explains the native English “horn” and the Latin borrowing “cornucopia” meaning “horn of plenty.” You should recognize Grimm’s /k/, /h/ relationship with the Latin “canis,” the German “hund,” and the English “hound.” Grimm’s Law also identifies the PIE consonant /d/ becoming Germanic /t/; therefore we have the second part of the cardiac/heart pairing. You might have wondered about the relationship of foot with pedestrian. Well, Grimm’s Law has the answer. Now that you recognize the /d/, /t/ relationship, there is a /p/,/f/ relationship. The Neogrammarians, including Grimm believed these set of sound changes operated without exception and helped explain how the different consonants in modern languages could be traced back to the same PIE root. Of course over time through further investigations exceptions did spring up and these exceptions seemed to follow a consistent pattern, thus another law sprang up, Verner’s Law.

I leave you with these thoughts. Are there intrinsic cultural or educated differences in wanting to see a heart doctor or a cardiologist, a foot doctor or a podiatrist or a dentist rather than a tooth doctor?

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