Vincent’s Eucharistic Sense

No, this is not coming from the church but it is related to the theme of this issue. There’s a great deal to be thankful for but there is not enough time in the day or in the month of November 2013. What a memorable month it will be.

Our Spotlight is on the 2014 Annual Meeting. We hope you plan to join us in the sunny city of San Diego this April 2014. Not only will Basic Science and Heart Failure & Transplant Medicine be hot topics throughout the Scientific Sessions, two ISHLT Academies have been planned to focus on these disciplines.

Let us give thanks to our very own Howie Eisen for making it clear of the amount of damage that occurs to our DNA every day. He provides us with an insightful treatise on Epigenetics and Transplantation.

We have reports on the Donor Management Research Consensus Conference by David Nelson, Updates from the Annual Heart Failure Society of America meeting by Robert Cole and Alanna Morris, submissions from the ISHLT Grants and Awards and the International Traveling Scholarships--don’t miss out on these valuable opportunities!

And to link it all together, your Editor-in-Geek out of Fear and Negotiation reminds you of our Dedication and Devotion from our past to carry us to our patients in the present and the future without mentioning that it could simply be all Greek to me. Be sure to check out the Word of the Month. Oh and just one more thing (as Lieutenant Columbo would say), here’s to our 2015 Program Chair, Andreas Zuckermann, a hardcore New Orleans Saints fan, check out our new little Saint in the Rattling Links.

Happy Thanksgiving!

Vincent Valentine, MD
Editor-in-Chief, ISHLT Links Newsletter
IN THE SPOTLIGHT:
ISHLT 2014 in Sunsational San Diego!

Featuring overviews of the 34th Annual Meeting and ISHLT Academies, and including highlights from:

- Basic Science and Translational Research
- Heart Failure and Transplant Medicine

The ISHLT is very excited to return to the beautiful, sunny city of San Diego in April 2014 for the ISHLT 34th Annual Meeting & Scientific Sessions to be held at the Manchester Grand Hyatt hotel. A wealth of information about the meeting can be found on the Annual Meeting website, including Abstract Submission, Registration & Housing information, the Daily Timetable, the Preliminary Scientific Program, the Schedule At-A-Glance, and much more. Please note that the Annual Meeting begins on Thursday, April 10, one day later than usual, and concludes at mid-day on Sunday, April 13.

Prior to the Annual Meeting, the ISHLT will be conducting five Academies. The first two will be held simultaneously on Monday and Tuesday, April 7-8, at the Loews San Diego Bay Resort in Coronado, California:

1. ISHLT Academy: Core Competencies in Mechanical Circulatory Support
2. ISHLT Academy: Masters Course in Mechanical Circulatory Support

Then, on Wednesday, April 9, the ISHLT will host three additional Academies simultaneously at the Manchester Grand Hyatt Hotel in San Diego:

3. ISHLT Academy: Core Competencies in Basic and Translational Science
4. ISHLT Academy: Core Competencies in Heart Failure and Cardiac Transplant Medicine
5. ISHLT Academy: Core Competencies in Nursing, Health Science, and Allied Health

Detailed information about each academy is available on the ISHLT Academy website, including course descriptions, registration and hotel information, and scientific programs.

Since this month’s newsletter focuses on Basic Science and Translational Research as well as Heart Failure and Transplant Medicine, below are highlights of the upcoming meetings related to these disciplines.

BASIC SCIENCE AND TRANSLATIONAL RESEARCH HIGHLIGHTS:

Basic Science and Translational Research will be showcased like never before at ISHLT 2014. The ISHLT Academy: Core Competencies in Basic Science will be held on Wednesday, providing an opportunity for delegates to gain or refresh knowledge in the fundamentals of basic science. The
course will fill gaps in practice by assisting clinicians in improving their understanding of the scientific background behind clinical practice, updating basic and translational researchers on recent discoveries, encouraging interaction between basic/translational researchers and clinicians and stimulating discussion of common basic topics in the fields of heart versus lung failure and transplantation. This first ISHLT BSTR Academy will focus on basic concepts in immunology and molecular biology related to heart and lung transplantation.

At the Annual Meeting beginning on Thursday, Pre-Meeting Symposium 5: Lung Transplantation: Decoding Early Engraftment Events That Control Survival will present new insights into ischemia reperfusion injury, T cell activation, and humoral immunity that impact the maintenance of allograft tolerance as well as long-term survival, using a clinical case to guide the presentations. The goal of these presentations is to educate the wider transplant community of potential new therapeutic targets and translational opportunities for the development of novel immunosuppression approaches for lung transplant recipients.

BSTR will really take to the sky in Pre-Meeting Symposium 11: Crossing Clinical Barriers on the Wings of Science: Evolution of ABO Incompatible Heart Transplantation. This multiple-purpose symposium is intended to show how scientific concepts are developed for clinical application. It will show the history of ABO incompatible heart transplantation, but from the point of view of the designer of therapy. The session will delineate some of the technical details in the path of a very significant advance in transplantation from idea to clinical reality. In so doing, we hope that this session will be both informative, and inspirational, stimulating the thought processes necessary to take other burgeoning ideas from bench to bedside by giving a better understanding of the processes involved in translating science to our patients.

Pre-Meeting Symposium 24: Lung Transplant Immunology 201-Plus: Recent Advances will provide an update on recent basic immunology discoveries in the field of lung transplantation. It is a more advanced level than what is covered in the Transplant Immunology session offered in the BSTR Academy, and is directed to a basic science audience.

For our early risers, Sunday morning's Sunrise Symposium 13: Lab Methods 101: What Everyone Needs to Know to Read Transplant Papers, is a primer for budding researchers and will shed light where currently there is only darkness.

Finally, in Sunday's Closing Plenary Session, Dr. West will discuss how one might trade the ABO and HLA sensitization hands one is often dealt to improve long-term outcomes.

HEART FAILURE AND TRANSPLANT MEDICINE HIGHLIGHTS:

The ISHLT Academy: Core Competencies in Heart Failure and Cardiac Transplant Medicine is designed to be of benefit for clinicians and allied professionals who are in the early stages of their careers or who are in training, are part of a new program or desire an update on the current state of the field. The information presented is intended to provide a strong foundation of the
overarching principles of heart failure and transplant medicine, rather than as a detailed update for those who are already proficient in the field.

The ISHLT 2014 Annual Meeting will offer new insights into some of the most intriguing and provocative areas of Heart Failure and Transplant Medicine and Heart Transplantation. There are three Pre-Meeting Symposia, two Sunrise Symposia and a Concurrent Symposium, all of which are guaranteed to keep your interest so that you don't wander to the beach or to Petco Park to watch the Padres play baseball. We believe that you will be enthralled by these programs.

Three Pre-Meeting Symposia on Thursday will highlight areas of emerging technologic advances and of controversies. Pre-Meeting Symposium 3: Ex-Vivo Donor Heart Support: Expanding Availability and Optimising Function will explore the use of ex-vivo support of donor hearts to expand organ availability and to recondition and optimize donor heart function. Topics to be discussed include the following: Establishing a new ex-vivo organ support service; Strategies for evaluating organ function; Potential for pre-transplant and ex-vivo treatment of donor hearts; Reconditioning of extended-criteria organs; Role in facilitating the use of hearts from NHBD for clinical transplantation; Economic evidence supporting ex-vivo donor organ management. This symposium will provide a much needed educational update, to multi-disciplinary participants, on a topic in organ transplantation that is evolving very rapidly and will provide the necessary baseline appreciation and acceptance of this technology.

Heart transplantation and Mechanical Circulatory Support are therapies that result in improvement in survival and quality of life in patients with end-stage heart disease. Heart transplantation has a long track-record with current estimated survival of about 60% at 10 years. Mechanical circulatory support, on the other hand, is a relatively young field, but current survival with second generation devices is approaching 80% at two years, similar to transplantation in some instances. As the technology improves, the expected survival with mechanical support should continue to increase and maybe even equate that of transplantation. Pre-Meeting Symposium 12: To VAD or to Transplant? will compare transplantation to mechanical support in regards to survival, quality of life and morbidity.

Finally, the goal of Pre-Meeting Symposium 21: The "Sexiest" Controversies in End Stage Heart Failure and Heart Transplantation is to discuss important and controversial issues in Heart Failure and Transplantation in a way that will keep people awake, alert, attentive and perhaps amused.

Endothelial function is increasingly recognized as a general barometer of health. There is extensive data that endothelial function is impaired in patients with heart failure, and it may be a marker of development of allograft vasculopathy in transplanted patients. A better understanding of the pathophysiology of endothelial dysfunction in heart failure, VAD and transplanted patients, the methods of endothelial dysfunction assessment, and its relation to outcome following VAD and transplant is crucial for specialists caring for patients undergoing advanced heart failure management. It is also critical for scientists working in the field of vascular physiology and outcomes research to understand the interaction between the different modalities and endothelial
function in order to further enhance research in this arena. In Friday morning’s Sunrise Symposium 3: Endothelial Dysfunction in Advanced Heart Failure, Mechanical Circulatory Support, and Transplant: It’s a Pipe and Pump Issue, the first discussions will provide a general overview of the pathophysiology of endothelial dysfunction. The subsequent talks will provide in depth analyses of the development, treatment, and morbidity of endothelial dysfunction development, treatment, and morbidity in patients with heart failure, transplant, and MCS.

Saturday’s Sunrise Symposium 8: Exercise Training in Heart Transplantation will examine the role of structured exercise training in the post heart transplant population, including physiology and potential benefits, with a view toward providing transplant physicians with new information on the impact of exercise training on outcomes.

Finally, Saturday’s Concurrent Symposium 29: Approach to the Highly Sensitized Patient Awaiting Heart Transplantation is designed to provide attendees with practical information and strategies to manage sensitized patients awaiting heart transplantation. Recent research publications and program experience will inform this session.

With this line-up of Symposia, we know that we will see you in San Diego at the ISHLT Annual Meeting (and not at Pacific Beach or the Nordstrom's near the hotel!!).
Epigenetics and Transplantation

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Recently, while actively engaged in my hobby—writing patient notes in our electronic medical record—I was confronted with a sudden, unexpected outage of the system. Not knowing when the system would restart, I began to ponder complexity, in this case complexity in entering patient data and in how we conduct medical care. As it was clear that the outage was not going to end anytime soon and since the last patient in whose record I was entering information had recently been diagnosed with breast cancer, I thought about the complexity of the genetics of this disease and how the understanding of genesis of malignancies has become far more intricate.

Certainly, the understanding of genetics has become far more complex in recent years. If you are like me, your first introduction to genetics in school was the mid-19th century experiments of Gregor Mendel on pea plants in Bohemia. Mendel identified seven traits that were independently inherited including seed shape, pod shape, flower color and so on. From this work, involving over 29,000 pea plants (apparently without the help of graduate or medical students or fellows or residents), the concepts of alleles and inherited recessive and dominant traits were first proposed and understood. In the mid-20th century, Avery’s identification of DNA as the heritable material (a discovery that did not apparently merit the Nobel Prize) and Watson and Crick’s deciphering of the structure of DNA provided a molecular understanding of genetic inheritance (1,2). The idea that all inheritance came from the nucleotide sequence of DNA would remain the cornerstone of genetic inheritance for the next few decades. However, even in the 1970s, it appeared that the prevalent conception of genetics as it applied to human diseases such as cancer was lacking in details. While the term “epigenetics” was first coined in 1942 to mean the differentiation of cells from the initial embryonic ones, the present definition is “the study of mitotically or meiotically heritable changes that cannot be explained by changes in DNA nucleotide sequences” and must therefore imply stable changes in chromosome structure but not DNA sequences (3,4). Numerous mechanisms can account for this including DNA methylation, an important regulator of gene expression, and modification of the chromatin proteins such as histones associated with DNA; the latter play a role in gene expression and may be activated or silenced (5,6). Processes that can cause epigenetic changes include gene silencing, imprinting, X chromosome inactivation, reprogramming and the effects of carcinogens and teratogens (7,8). The latter work through damage of DNA with subsequent repair (DNA damage occurs a surprising 10,000 times per day per human cell which kept me up for most of the night after I realized this). It is these repair sites that are subject to epigenetic changes such as methylation or gene silencing.

Where epigenetic changes such as DNA methylation, seem to have the most obvious impact in clinical medicine is in oncology. Familial mutations account for a very small number of malignancies
whereas epigenetic changes resulting in diminished expression of DNA repair genes are quite frequent. These epigenetic changes have become potential targets of new cancer therapies with an inhibitor of histone deacetylase (HDAC), vorinostat, being introduced to blunt HDAC’s facilitation of squamous cell cancer progression.

Is any of this relevant to organ transplantation? Transplantation is more complex in some ways than oncology because we are dealing with two genomes (the donor organ and the recipient) and the epigenetic changes that occur to each of these. There are several ways that these seem to be manifested in transplantation. Modern immunosuppression has been very successful in controlling acute cellular rejection but more chronic insults such as cardiac allograft vasculopathy (CAV) have been more resistant. Additionally, immunosuppression can be weaned or doses reduced over time. Why is that possible if the donor-recipient combination remains the same?

Ischemia/reperfusion is known to produce epigenetic changes in MHC antigen expression levels in donor organs through activation of Hypoxia-inducible factor which modifies histones and in turn increases MHC expression (9). This would make the transplanted organ more of a target to the recipient immune system. Epigenetic biomarkers might therefore allow a way to quantify the immunogenicity of transplanted organs and thus determine the rate of immunosuppression weaning and other adjustments in post-transplant management. Epigenetic markers may also provide a way of assessing over time the immunogenicity of the transplant organ and guide post-transplant therapy.

Epigenetics also play a role in the allo-immune response to the transplanted heart. HDACs mentioned above are involved in regulatory T cell (Treg) activity. HDAC inhibitors have been shown to inhibit T cell reactivity and may promote tolerance, highly desirable in transplantation (10). An important gene in the regulation of Tregs, Foxp3, is also susceptible to changes in its expression modulated by epigenetic regulation. Foxp3 levels can be altered by methylation (11). HDAC also plays a role in Foxp3 expression and Treg generation and stability (11). As with the cardiac allograft, epigenetic biomarkers may be useful in assessing immune reactivity to the allograft, this time on the recipient side, and may help guide adjustment of immunosuppression as well as identifying patients at risk for acute cellular rejection, antibody-mediated rejection or CAV. Even more intriguing is the thought that drugs that modulate epigenetically regulated genes might be useful as immunosuppressive therapy and may accomplish this through the generation of Tregs. For example, HDAC inhibitors increase the number and activity of Tregs in mice (11,12) and primates (11,13). This offers the possibility of new therapies with fewer side effects than standard immunosuppression and with far more specific effects including the prevention of chronic adverse sequelae like CAV. These epigenetic therapeutic agents might be used in conjunction with much lower dose of traditional immunosuppressive agents, reducing their adverse side effects like infection and malignancy. With the development of epigenetic regulators as therapeutic agents for malignancies, some of these agents may also prove useful in solid organ transplantation. But the use of oncologic agents in organ transplantation is actually an old story: remember azathioprine? What we may well see in the future is an updating and a logical extension of an old tradition of cross-fertilization between the clinical arenas of oncology and organ transplantation.
Disclosure statement: The author has no conflicts of interest to disclose. He is now able to rest more easily despite knowing about the large numbers of DNA errors that occur in each of his cells every day.

References:

Shedding Light on the Black Box of Science: Basic Science and Translational Research Academy Day

Wednesday, April 9, 2014
Manchester Grand Hyatt Hotel
San Diego, CA, USA

Tereza Martinu, MD
Esme Dijke, PhD
Christopher Wigfield, MD, FRCS(C/Th)
ISHLT BSTR Academy Co-Chairs

Would you like to better understand how T cells cause rejection or how antibodies are generated? Or wonder why it matters in the first place? Have you already been involved in transplant-related research and would like to review the basic concepts and hear an update on recent research breakthroughs? Or are you a basic scientist who would like to learn about the clinical relevance of basic pathways and mechanisms? At the ISHLT Academy: Core Competencies in Basic Science and Translational Research, there will be helpful information for everyone. This academy day is aimed at shedding light on the dark spots of your knowledge, tying together basic science, translational research, and their clinical relevance in both heart and lung transplantation.

The day will be broken up into 5 broad sessions covering ischemia reperfusion injury, acute rejection, chronic rejection, antibody-mediated rejection, and relevant pharmacology. Teaching of key concepts in basic science will alternate with discussions of mechanisms and pathways relating to specific clinical scenarios. These basic science discussions will be linked by brief case presentations to emphasize the clinical relevance of the topics and of our mission. Above all, through this academy, we would like to foster interaction between basic scientists, translational researchers, and clinicians and help them understand each other's language. Panels of clinically- and basic-science-oriented academicians will stir your thoughts and provoke discussion. Mingling, questioning, doubting and arguing will be greatly encouraged. We hope to see you there, on April 9th, 2014, in San Diego!

Download the BSTR Academy Scientific Program (PDF)

For more information and to Register, visit:
http://www.ishlt.org/meetings/registrationHousingForms.asp

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Donor Management Research Consensus Conference

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The Health Resources and Services Administration (HRSA) and the Organ Donation and Transplantation Alliance (ODTA) convened a national consensus conference on donor management research in Arlington, Virginia, September 16-17. I had the privilege of being one of the conference co-chairs, along with Peter Abt, an abdominal surgeon from the University of Pennsylvania, and Richard Hasz, Vice President, Clinical Services, Gift of Life donor program. Peter was lead author of a recent American Journal of Transplantation (AJT) article identifying the need for a national infrastructure to facilitate and oversee donor-related research. The article grew out of a white paper from the American Society of Transplant Surgeons (ASTS) exploring the themes that dominated the consensus conference. The White Paper received significant input from stakeholders who later were represented on the consensus conference planning committee. Planning committee membership included the Advisory Committee on Organ Transplantation (ACOT), the American Society of Transplantation (AST), ASTS, the Association of Organ Procurement Organizations (AOPO), the Organ Donor Research Consortium (ODRC), ODTA, and the Office for Human Research Protections (OHRP).

Three workgroups were formed dedicated to donor-focused issues, oversight, and transplant center issues. The donor-focused group addressed consent/authorization, donor IRB issues, and other OPO-related matters. Productivity of this group was greatly enhanced by its chair, Alexandra Glazier, J.D., M.P.H., who is vice president and general counsel of the New England Organ Bank. The oversight group was so named because it explored the concept of a national Institutional Review Board (IRB) and was chaired by Sandy Feng, abdominal surgeon from UCSF, who was one of Peter Abt's co-authors on the AJT article. The transplant center group focused on recipient consent and the financial impact on transplant centers. It was chaired by Jeff Punch, an abdominal surgeon who is the chief of transplantation at the University of Michigan.

Three key issues that were shared by the oversight and transplant center groups were:
1. Effect of donor research on allocation;
2. Communication of study details to transplant teams;
3. Monitoring the outcome of recipients of target and non-target organs from an investigational donor.

The oversight group evolved the concept of a national IRB into consideration of 3 oversight bodies:
1. A Scientific Review Board to assess the scientific merit of projects, ensure adequate protection of non-study recipients, and consider national research priorities;
2. A national IRB that would function in a traditional IRB role and would consider effect on stakeholders, equity, and impact on non-studied organs;
3. A Data and Safety Monitoring Board (DSMB) that would function in the usual role of patient protection from avoidable risk and also ensuring scientific and ethical merit of the research. It is anticipated the DSMB would be guided by the OHRP, FDA, and funding agencies.

The transplant center group determined that the national review process should grade risk, determine consent requirement based on risk, and have the power to reject protocols. Availability of research protocol information to transplant centers was considered paramount, and one communication paradigm discussed included the following:

1. Communication of Board-approved studies to transplanters via UNOS' mailing list;
2. Web-based “clearing house” of study information;
3. Abstracted protocol version on DonorNet organ offers;
4. 24/7 PI contact availability;
5. Serious adverse event data transparency;
6. Communication of study notices.

Two examples of unresolved topics at the conference were:

1. How does a program with a recipient enrolled in the study reconcile that study with an organ offered from a donor who is also enrolled in a study?
2. Can an OPO insist on initiating the research protocol if it has not already done so when the center has accepted an organ offer but declines research? It may sound straightforward that UNOS’s allocation policy should trump a Board-approved investigation, but there was real concern at the conference that this would have a serious adverse effect on donor management research.

None of the concepts reported above represent final conclusions or recommendations of the conference. Proceedings of each workgroup were recorded by a transcriptionist, and ODTA staff and Planning Committee members are waiting to review the transcriptionists’ records before discussing a report. The Planning Committee will also be meeting post conference to discuss the next step in developing the ideas generated at the Consensus Conference.

Opening speakers of the meeting included ASTS past president Kim Olthoff and AST past president Roz Mannon.

The guiding principles for the Consensus Conference and the national infrastructure that it seeks to promote were:

- Respect for the donor, recipient, and all families will be paramount;
- Processes in the donor management research continuum will not threaten public trust in the system;
- Donor management studies must not have a high risk of causing a transplantable organ to become unsuitable for transplantation;
- The donor management research process should not alter the allocation required by policy.

Disclosure statement: The author has no conflicts of interest to report.
ISHLT Academy: Core Competencies in Heart Failure and Cardiac Transplant Medicine

Wednesday, April 9, 2014
Manchester Grand Hyatt Hotel
San Diego, CA, USA

David Baran, MD
Jose Tallaj, MD
Christopher Wigfield, MD, FRCS(C/Th)
ISHLT HFTXM Academy Co-Chairs

The ISHLT Academy: Core Competencies in Heart Failure and Cardiac Transplant Medicine will provide a concise review of clinical knowledge and essential professional skills to facilitate best practice of surgical and medical aspects involved in the care of patients with advanced heart failure, assessment as candidates and as recipients of mechanical circulatory device and heart transplantation. The course consists of focused presentations with an emphasis on clinical practice. All lectures will be delivered by internationally recognized experts in the field. Related topics will be discussed in Question and Answer sessions following each section. The course will be interactive and assist participants with more detailed individual review. This course is designed to be of benefit for both seasoned clinicians and allied professionals practicing in the field, but is primarily arranged for current trainee physicians, current fellows, and providers in the early stages of their careers.

The course is based on the ISHLT Heart Failure and Transplant Medicine Core Competency Curriculum (ISHLT HFTM CCC), which will be available on the ISHLT web site in May 2014. Extensive referencing in that document should assist selective individual study and review of published evidence for each topic. The ISHLT HFTM CCC document also includes active hyperlinks and related multi-media resources. The core curriculum also serves hospital programs with a tool to review their standards of care, develop protocols and implement current guidelines established in advanced heart failure.

Download the HFTXM Academy Scientific Program (PDF)

For more information and to Register, visit:
http://www.ishlt.org/meetings/registrationHousingForms.asp
Updates from the Annual Heart Failure Society of America (HFSA) Meeting

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The 17th annual scientific meeting of the Heart Failure Society of America (HFSA) was recently held in Orlando, FL, from September 22-25, 2013. The turnout for the meeting was fantastic and, as always, there were many posters and presentations of particular interest to the ISHLT community. While there simply isn’t enough time to discuss all of the abstracts pertinent to ISHLT members, please enjoy a few of the highlights below!

Wait List Mortality is Higher for Female Heart Transplant Candidates – Abstract 207
(Morris AA, Veledar E, Cole R, et al.)

Morris and colleagues from Emory University analyzed outcomes in over 38,000 patients listed for heart transplant in the OPTN database from 1985 to 2012 to assess for differences in wait list mortality based on gender. After adjusting for a number of wait-list variables (age, weight, ABO group, inotropic support, balloon pump support, ICD wedge pressure > 15 mmHg, and creatinine), female gender was an independent risk factor for wait-list mortality or removal from the transplant list for being “too sick to transplant” (HR 1.14, 95% CI [1.04, 1.24], p=0.005). Upon further analysis, women on the transplant list during this time interval were statistically less likely to have an ICD and less likely to have an LVAD as bridge-to-transplant. This may account for their higher wait-list mortality, but more work needs to be done to assess this.

Race and Worsening Renal Function after Solid Organ Transplantation – Abstract 051
(Lanfear D, Shafiq A, Peterson E, et al.)

In light of the well-recognized nephrotoxicity associated with calcineurin inhibitors post-transplant, Lanfear and colleagues at Henry Ford Hospital looked to determine if African-American transplant recipients had a higher burden of renal dysfunction compared to other races. They analyzed data from over 2,800 patients undergoing solid organ transplant between the dates of January 2000 and June 2012 to see if there was an association between TAC/CYA exposure and serial changes in creatinine by race. After adjusting for age, gender, HTN, and DM, they found that TAC exposure was associated with a greater rise in creatinine in African-Americans than other races. Over the study period, a 1 ng/ml rise in TAC level was associated with a 0.09 mg/dl rise in serum creatinine in African Americans, whereas this was associated with an improvement in renal function in non-African Americans (reduction in serum creatinine by 0.06, interaction p = 0.001). There was no difference in renal function changes for patients who received cyclosporine during that same time period.
The Impact of Lower Post-operative HMII Pump Speeds and Delayed Warfarin Initiation on Subsequent GI Bleeds - Abstract 047
(Carey S, Ng H, Sass D, et al.)

An all-too-familiar complication of continuous flow LVADs, the dreaded GI Bleed, occurs in as many as 22% of patients supported with HMII devices. There have been a number of strategies attempted to help reduce the burden of GI bleeding, including adjustments of pump speed and changing anticoagulation targets. Carey and colleagues out of Baylor University Medical Center (Dallas, TX) presented their success with a new strategy: immediate post-op speed reductions (starting speed 8400-8800) and delayed anticoagulation (warfarin initiation delayed until transfer out of CCU to telemetry, mean POD 3). Prior to this new strategy (6/2008 to 2/2012), patients at their center were started at a speed of 9200-9600 and had Coumadin started on POD 2. Their rates of GI bleeding during that period were 47% in women and 28% of men (at least one GI bleed) in 128 patients. Since the initiation of the low speed/delayed warfarin strategy, they have not had any GI bleeds in patients implanted from 2/2012 to 2/2013. Certainly a dramatic improvement, but longer follow-up will be necessary to see if these rates continue with this strategy.

Implantable Cardioverter-Defibrillators Are Not Associated with Survival in Patients with a Left Ventricular Assist Device – Abstract 167
(Sayer G, Bhat G, Gallagher C, et al.)

Sayer and colleagues from Advocate Christ Medical Center analyzed data on 215 patients with continuous-flow LVADs from 2005-2013 to determine if the presence of an ICD improved survival. Their study compared survival in 28 LVAD patients without an ICD to those with an ICD (n=187). 84% of the patients were implanted as destination therapy. After a median follow-up of 506 days, there was no statistically significant difference in survival between the ICD and non-ICD groups (HR 0.91; 95% CI [0.46 – 1.80] P=0.78). Of note, 13% of the patients with an ICD did receive appropriate shocks for VT, while 4% received inappropriate therapy for sinus tachycardia/SVTs.

Outcomes of Donor Hearts Offered for Transplantation, Declined by a Single Center and Transplanted at a Secondary Institution – Abstract 011
(Aulakh S, Cadeiras M, Biniwale R et al)

Aulakh and colleagues from UCLA Medical Center looked at outcomes for donor hearts that were declined at their center on the basis of quality. Compared to the 319 donor hearts (Group A, 61.8%) accepted at UCLA, 198 (Group B, 38.2%) eventually underwent transplantation at a different center. Declined hearts had significantly greater left ventricular hypertrophy (p=0.04), downtime events (p=0.06), CDC high risk status (p<0.01), and older donor age (p<0.01). Group B donors were more frequently accepted later in the donor offer sequence (p<0.01). Kaplan-Meier analysis revealed lower allograft survival in Group B at 30 days, but not at longer term follow up
(median survival for both groups was 661 days). On multivariate analysis, higher sequence acceptance number was a predictor of poor outcomes (p=0.013). The authors concluded that since the early 30-day mortality seen with higher risk hearts was no longer significant at longer-term follow-up, criteria for acceptable donor hearts should be continuously evaluated in order to expand the donor pool.

**Experience with Antithrombotic Therapy for Primary Treatment of LVAD Thrombosis – Abstract 170**

(Morine K, Kiernan M, Kapur et al)

Morine and colleagues at Tufts Medical Center (Boston MA) retrospectively reviewed medical records of patients who received continuous flow LVADs at their institution from 1/2010 to 12/2012. LVAD thrombosis (LVAD-T) was suspected in 18 of 116 patients (incidence rate 0.15/patient-year) based on the presence of LDH >4 times upper limit of normal. Mean time to first occurrence of LVAD-T was 188 days (range 4-993). On presentation, 8 patients had abnormal power spikes, 7 had LVAD malfunction on ramped speed study, and 3 had symptomatic heart failure. Primary therapy for 11 patients was unfractionated heparin (UFH) while 7 were treated with bivalirudin. Due to lack of response among the 11 patients treated with UFH alone, 9 were later given eptifibatide/UFH (2), eptifibatide (1), bivalirudin (4), or tPA (2). Five patients first treated with bivalirudin were later treated with eptifibatide (1), tPA (1), or VAD exchange (3). Adverse events included 2 episodes of intracranial hemorrhage (1-UFH and 1-bivalirudin), one resulting in death, and 2 episodes of GI bleeding (1-eptifibatide/UFH and 1-eptifibatide). Twelve of the 18 patients (67%) were treated with anticoagulants alone, without the need for tPA or VAD exchange. Of the 12 patients successfully discharged following LVAD-T, there was recurrence in 7 (58%) patients leading to 11 readmissions. The authors concluded that despite the high morbidity associated with LVAD-T, carefully selected patients may be managed medically, although recurrence is common.

**Role of C4d Staining in Endomyocardial Biopsies after Cardiac Transplantation – Abstract 176**

(Bhat G, Siddiqua T, Aggarwal A et al)

Bhat and colleagues reviewed C4d staining in 583 endomyocardial biopsy (EMB) specimens from 36 consecutive heart transplant recipients over one year. Group 1 (n=8) had C4d positive biopsies at a median of 65 days (20-250) post-transplant, while Group 2 (n=28) had C4d negative biopsies. Acute cellular rejection (1R) was more common in Group 1 patients (p=0.003), as was clinical suspicion of antibody mediated rejection (p=0.02) and donor-specific antibody (p=0.09). There was no difference in mortality between the two groups (p=0.8). The authors concluded that C4d in the presence of acute cellular rejection may be a biomarker for early or subclinical antibody mediated rejection, however more data is needed from a larger group of transplant patients.

Disclosure statement: the authors have no conflicts of interest to disclose.
Putting the “I” into International

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Back in the spring of 2011, at the San Diego Annual meeting, our Society introduced the concept of the Travelling Scholarship. We are an International society, with a wonderful meeting every year, but we wanted to create more opportunities for our members to meet and learn. In particular, we wanted to give the opportunity for any member of our transplant teams to go and see how things were done elsewhere, to learn and maybe also to teach. This opportunity would be of equal value to surgeons, nurses, pharmacists and basic scientists, to list but a few.

Not only did the ISHLT establish the scheme, but the Board of Directors voted $60,000 per year to provide up to $6000 for each applicant. Priority would be for those going to different continents, across oceans. They had to be supported by, and travel to, ISHLT members, but there were precious few other rules.

For the past 2 years, the application closing dates have been on August 1st and December 1st. To date, 22 Scholarships have been awarded, and the Society has spent a little over $108,000. What have we had for our money?

The geographical spread has been gratifyingly wide. We did not forbid cross border visits in North America, but only 3 trips were of this nature; all the rest crossed oceans.

We can summarise the journeys made in a simple form:

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<th>From</th>
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<tr>
<td>USA: 6</td>
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<td>Canada: 4</td>
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<td>Europe: 8</td>
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<td>Australia: 2</td>
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<td>South America: 2</td>
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We might have expected many of the applications to come to the USA, and whilst that is the commonest, it’s gratifying to see the variety. Australia, for some incomprehensible reason, is disproportionately popular!

Who travelled? Again, we might have expected a preponderance of MD’s, and they were the biggest group, 13 out of the 22. But we were delighted to see 4 nurses, a pharmacist and no fewer than 4 basic scientists. They spent periods varying from 2 weeks to 4 months living in a different city, seeing different programmes, learning techniques, making new friends.

Scientists learned new lab skills, surgeons saw different approaches to organ donation. They went from places as diverse as Sao Paulo, Hamburg and Newcastle to visit Edmonton, Columbia and Melbourne.
Presentations were made at Grand Rounds, papers written, new collaborations hatched. Some sections in a particular report, from Manon Huibers, who travelled from Utrecht in the Netherlands to spend 4 months in George Tellides lab at Yale University, describe very well what all this is about:

“What we did achieve in this period is a great basis for collaboration in the future. **Enthusiasm and experience cannot be transferred by phone or email, we really needed personal contact.** In the last few months we gained very promising results which will need future experiments. We will definitely continue this collaboration and finish this project.”

In her report entitled, **Learning from the Best** ([read full report](#)), she went on to say:

“Besides, every lab has its strengths; one might be better at one technique, while another might be better at another technique. We cannot all be ‘the best’ at everything without each others help. Combining our strength and collaborating will bring us further in research and closer to understanding CAV and maybe finding a cure.”

This opportunity is there for everyone in the ISHLT. Our next closing date for applications is a month away, December 1st. So make some contacts, drum up support from your institute and the other across the world, go to the website to apply ([http://www.ishlt.org/awards/awardIntlTravelScholar.asp](http://www.ishlt.org/awards/awardIntlTravelScholar.asp)) and you might be packing your bags!

Disclosure statement: the author has no conflicts of interest to disclose.
It’s All Greek To Me

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As we continue to improve our communication skills when running into something not understandably written, spoken or even perhaps a complicated or convoluted diagram, we turn to the old reliable dead metaphorical expression, “it’s all Greek to me.” Is Greek so foreign and incomprehensible? Was it because of Shakespeare’s play *Julius Caesar*? Fortunately for us in health care the largest Greek contribution to English vocabulary is found in the scientific, medical and technical neologisms. One problem is that many of the Greek terms were introduced to English through Latin, therefore distinguishing Greek and Latin origins of words written in English is not easy. Take the words pedestrian, peon, and pediatrics. “Ped-” refers to “feet” in Latin therefore pedestrian becomes obvious or does it. Pedestrian refers to “on foot” as opposed to equestrian – “on horseback.” Pedestrian also means plain, dull or prosaic. Peon cryptically comes from the Latin base “ped-” but is borrowed from French originally meaning a “foot soldier.” However in Greek “ped-” means “child” which shows up in English with pediatrician. Let’s cast the Latin borrowings aside and deal with the Greek origins.

With this game afoot we have “pod-” which is the Greek base for “foot.” There you have the familiar words of tripod and podiatry. Our focus is on Greek vocabulary but the word “vocabulary” is of Latin origin. It would be more correct here to use the Greek derived word “lexicon.” So this article will focus on the influence of Greek on the English lexicon. To begin with, Greek mythology and history have become embedded into the English lexicon and we are fortunate to recognize the Greek-like words that never existed in Greek in the lexicon of medical and scientific terminology. Unmistakably Greek words are erudite.

A word that refers to the creation and study of dictionaries is lexicography. We have “-graphy,” which means to “write” or “delineate.” In the sciences we have geography (delineating the earth) and bibliography (the writing of books). The root “ge-” means “earth” and “bible-” means “book.” To describe writing we have words such as stenography, calligraphy, and orthography. Stenography means “tight or narrow writing” or shorthand. Calligraphy means “beautiful writing.” Then there is orthography which means “correct writing” or “proper spelling.”

Now for some real “linking” fun let’s move to “ortho-,” a Greek prefix meaning right correct, straight or true and “doxa” meaning opinion or belief which is related to “dokein” – to think. From here you have the word orthodox, the correct opinion or belief. Orthodontia or orthodontic gives you “straight” teeth while orthopedics coming through French refers to surgically correcting physical deformities which actually began in children then was later generalized to all musculoskeletal conditions.
Since we are on our medical topic, let's examine the path of the Greek root “chron-” which means "time." Easy enough we have chronicle, chronology, chronobiology and chronic. Chronic also comes in through French, going back through Latin and then to the Greek, and it originally means "of time," chronic; and refers to medical conditions that last a long time. After a review of the *Corpus of Contemporary American English* there is a tendency for words to occur before and after chronic; and among the most common are: *disease, pain, fatigue,* and *illness* with reference to our medical world. But along with chronic health problems there are chronic funding problems, chronic problems with discipline and of course our favorite, chronic boredom. It seems that chronic connotes a lot of negativity.

To steer away from all this negativity let’s go back in time with chronology and use some logic with the root "log-" referring to "speech," "word," or "reasoning." Recall Aristotle’s three rhetorical appeals, *ethos* (character), *pathos* (emotion), and *logos* (the appeal to reason). These are all Greek but the "log-" is found in a lot of places in English, the speech that comes before is the *prologue*, the speech in addition, after or at the end is the *epilogue*. If we think about the prefix "epi-" and note it means in addition to or after, this might help you understand the meaning of *epigenetics*, "after the initial genetic action" and epiphenomenon, "in addition to the primary phenomenon." Of course I make no apology for all of this Greek which actually came into English through Latin. In Greek, an apology is when you’re speaking something away, meaning to “fend off a charge,” then later has evolved into “an explanation accompanied by an expression of regret.” I will leave the root “log-” with the other English words, *analogy*, *logarithm*, *logistics*, and *logic*, and not to mention the “new words,” *neologisms*. To remember all of this there is the Greek root “mne-” “remember” for our famous *mnemonics* and then our “tendency to forget” *amnesia*. Of course some of the most delightful words in the English language come from Greek mythology and Greek names.

*Epicurus* the source of the word *Epicurean* gives us a pleasant influence on the English language. *Epicurus* tells us that “pleasure is the only possible end of rational action, and the ultimate pleasure is freedom from disturbance.” But although *Epicurus* was thought of as *votary*, of unrestrained indulgence, in a strict sense *Epicureanism* is distinguished from *hedonism* which in common parlance means living for the moment. However, *Epicurus* advocated the renunciation of momentary pleasures in favor of more permanent ones. His greatest good was the pursuit of pleasure through the practice of virtue which today leaves us with the word *epicure* meaning “a person with fastidious tastes, especially in food or wine,” uh-hmm, Allan Glanville.

The polar opposites of *Epicurus* are *Procrustes* and *Draco*. *Procrustes* was a robber of Attica who tortured his victims by placing them on a certain bed and stretched them or lopped off their legs to conform their body to the bed’s length. *Procrustean* means producing conformity by cruel or violent actions. The ruthless *Draco*, a statesman of Athens prescribed the penalty of death for nearly all crimes, “for smaller crimes because they merited it, and for greater because he knew of no penalty more severe,” according to the *Century Dictionary* (1914). Today, we have the word *draconian* meaning ruthlessly severe. While we are on punishments there was the mythical punishment of *Tantalus* which gives us the verb *tantalize*. *Tantalus* stood in the water in Hades unable to drink it.
because it would recede and unable to reach the fruit over his head. *Proteus* continuously changes, as can *protean* things.

Recall *Achilles’* mother held him by his heel when she dipped him into the River Styx to make him invulnerable except for his *Achilles*. Today we call any kind of weakness—an *Achilles’ heel*. *Titanic* refers to things that are enormous, like the Titans. *Herculean* tasks require the strength of *Hercules*; and any long journey is an *odyssey*. While *Odysseus* was on his odyssey, his son was educated by an advisor named Mentor, the source of the English word *mentor* today.

For a few more Greek-derived words with little time for explanation I leave you with *ostracism* “banishment by general consent,” *solecism* for speaking “incorrectly,” or “any violation of etiquette,” and *meander* from the winding Meander River. For the final meandering back into healthcare is the condition *acyanopsia* meaning the “inability to see the color blue.”

And if you are hungry for more and feel it’s all Greek to you, then check out this link: [http://en.wikipedia.org/wiki/List_of_Greek_words_with_English_derivatives](http://en.wikipedia.org/wiki/List_of_Greek_words_with_English_derivatives)
Outta This World Links
Interesting, Inspiring and Intriguing Links from Around the Globe

FROM AUSTRALIA:

Transplant sisters relish gift of life
Herald Sun, 16 Oct, 2013

Sisters Nicole and Jayne Richards are two in a million. The Launceston girls live life to the fullest with donor hearts given to them six months apart. The Richards girls suffer from a genetic form of cardiomyopathy, a disease that weakens the heart muscle. Jayne, 17, was the first to get sick when she was nine years old. The doctor told her mum Christine that Jayne had gastro but she was flown to the Royal Children's Hospital in Melbourne when her health deteriorated. Read full article →

Lung transplant survivor takes to sky
IllawarraMercury.com, 1 Aug, 2013

After his double lung transplant 20 years ago, Jeff Leggett was told he might last a year. Yesterday, he celebrated 20 years since the operation with a tandem hang-glide off Bald Hill. The 47-year-old from Belfield in Sydney is the longest surviving double lung transplant recipient in Australia. He received the transplant because he had cystic fibrosis. "It's really the only way you can survive it—it's a lethal disease. By the time you reach your 20s your lifespan is pretty much over." The surgery was experimental 20 years ago, leading doctors to think it might give him another year. Read full article →

FROM CANADA:

Saanich man's lung transplant surgery is also an affair of heart
TimesColonist.com, 14 Oct, 2013

James Reimer is fond of saying he went to Toronto for lungs and found love. His story could be considered one about health, or resilience, or family. But the Reimers think of it—mostly—as a love story. James was born with the genetic disorder cystic fibrosis, which attacks mainly the lungs. Raised on SaltSpring Island, he had what he calls an ideal childhood with all the fresh air, pets, bikes and Nintendo games he wanted. His parents, Kathy and Al, knew their son might not see his 18th birthday. His sister Laura Jane died of the same disorder in 1982 at the age of five. Read full article →

Heart transplant procedures undergo amazing changes, extending patients' lives
montreal.ctvnews.ca, 28 Sep, 2013
About 40 heart transplant procedures are performed in Quebec every year, leaving many more patients languishing on the waiting list. Some die waiting for their new heart, but some amazing changes to medical technology in the field of heart transplant procedures over the past decade have given patients more hope for the future. Sunday marks World Heart Day, a good time to take a peek at advancements in heart transplants—some made right here in Montreal. Shelo Florestal was one of those patients who benefitted from those advancements. A personal trainer now opening his own fitness centre in Ile-Bizard, today he's the picture of good health. But five years ago, he was facing a life-threatening condition. Read full article →

FROM FRANCE:

Catherine Deneuve joins other celebs in organ donation campaign
Donate Life, 15 Oct, 2013

Actresses Catherine Deneuve and Victoria Abril, together with some 100 celebs from the worlds of culture, politics and journalism, headed a public call in France on Tuesday for organ donations. Launched to coincide with this Wednesday's celebration of the 9th World Day for Organ Donation and Transplantation, the declaration has signers agree to receive transplants and donate organs as a matter of "solidarity." Actors Vincent Cassel and Omar Sy, actress-singer Jane Birkin, writer Marc Levy, and writer Amelie Nothomb all support the raising of public awareness promoted by the Transplantation Foundation. Read full article →

FROM SPAIN:

Spanish Transplant Chief Recommends Punishing Transplant Tourists
TheEpochTimes.com, 29 Oct, 2013

A top transplant official in Spain has said that countries around the world should strengthen measures to deter their citizens from traveling abroad to receive illicit organ transplants, especially from countries like China, which harvest the organs from executed prisoners and, according to researchers, prisoners of conscience. Dr. Rafael Matesanz, the director of the National Transplant Organization in Spain, explained in an interview with New Tang Dynasty Television, partner media to Epoch Times, that Spanish law is unique in punishing people who go outside the country to buy an organ under questionable circumstances. Read full article →

FROM THE UNITED KINGDOM:

'I can do loads of things now!' Lung transplant teen walks five miles for charity
itv.com, 14 Oct, 2013

15 year-old Katie Gammon from Barnstaple had a lung transplant two months ago, after a 14-month wait. Her recovery has been remarkable—at the weekend she led a 5-mile charity walk for
the Cystic Fibrosis Trust. Katie was supported on the Tarka Walk by Kirstie Tancock, who is recovering from her second lung transplant. It's the third year Katie's family have organised the event, but this was the first time Katie was able to participate. Read full article →

FROM THE UNITED STATES:

Edmond man to walk in memory of heart donor
EdmondSun.com, 18 Oct, 2013

When Jim Hays, 69, limbers up for Sunday's Edmond CROP Hunger Walk, he'll be thinking about Neil Filley, someone who is close to his heart. On Aug. 20, 2012, Neil Filley, 20, died from massive head injuries sustained after a fall while exploring the cliffs of Fourmile Canyon. Neil's heart is beating in Jim's body. Jim said he wants to keep Neil's memory alive, part of a promise he made. "My goal was to walk in the Edmond CROP Walk," he said. "My intent is still to achieve that goal. I want to honor Neil. He gave a gift to me, the gift of life." Although he left this life at a young age, Neil Filley already had accomplished much. Read full article →

Erik Compton, on his third heart, to receive PGA Tour Courage Award
pga.com, Oct 2013

Two-time heart transplant recipient Erik Compton won the inaugural PGA Tour Courage Award on Wednesday. The PGA Tour Courage Award is for players who have overcome extraordinary adversity to make meaningful contributions to golf. It's hard to find a better candidate than Compton. He was diagnosed at age 9 with viral cardiomyopathy and had his first heart transplant three years later in 1992. He had a heart attack in 2008 and required a second transplant. Compton still managed to make it to the PGA Tour, and this year made it through two FedExCup playoff events. Read full article →

Transplant Warriors

Graduate students at the University at Buffalo have taken on a big task. Aisha O'Mally, along with Jessica Covert, is spearheading "The Transplant Warriors" in "Campaign 4 Life." "It's an initiative throughout New York State to increase the number of registered organ donors," said O'Mally. She started this group for a very special reason. "I received a heart transplant back in 2004," said O'Mally. When she was 23 years old, she discovered she had hyperthyroidism, a condition where the thyroid gland makes too many hormones. Read full article →

Anabel Stenzel, organ transplant advocate, dies
sfgate.com, 1 Oct, 2013

Anabel Stenzel, a Bay Area woman with cystic fibrosis who received two double lung transplants and authored a memoir with her twin sister, also a double lung transplant recipient, that inspired a
documentary film, died Sept. 22 at her Redwood City home of cancer. She was 41. When Ms. Stenzel and her sister, Isabel Stenzel Byrnes, were born with cystic fibrosis in 1972, doctors said they probably would not reach their 10th birthdays. Over the next four decades, Ms. Stenzel graduated from Stanford, earned a master’s degree from Cal and married. Read full article →

Love in the Kingdom of the Sick
TheMorningNews.org, 30 Sep, 2013

When an artist receives a heart transplant, his drawings of the procedure obtain all the gravity of a fever dream—intensely realistic, with hallucinations of the dead. Michael Bise was born in Flagstaff, Arizona, and moved to Dallas, Texas, in 1990. He received his Bachelor of Fine Arts in drawing and painting at the University of North Texas in 2001 and his Masters of Fine Art in drawing and painting at the University of Houston in 2005. In 2012 he was awarded The Hunting Art Prize, an Artadia Finalist, and a Nominee for the TX Contemporary Award. Read full article →

Dad With Terminal Cancer Gives Family Special Gift
myfoxphilly.com, 15 Oct, 2013

After finding out that he had only months to live, Fred Evans decided to give his daughters a special present. He walked his two unmarried daughters down the aisle and gave them his blessing for their future marriages. Fred was recovering from a lung transplant when doctors discovered that his skin cancer had spread. Because of the medication taken for the transplant, Fred would not be able to endure chemotherapy. Doctors gave Fred months to live. Though devastated by the news, Fred and wife Karla vowed to keep living each moment of life to the fullest. On a special day in a chapel, they planned a surprise ceremony for their two daughters, Gracie and Kate. Read full article →
Tattling Links

ISHLT Members in the News

FROM BELGIUM:

Dirk Van Raemdonck, MD, PhD
Univ Hospital Gasthuisberg
Leuven BELGIUM
http://www.medpagetoday.com/Pulmonology/GeneralPulmonary/42376

FROM CANADA:

Robert D. Levy, MD, FRCPC
Univ of British Columbia and St. Paul’s Hospital
Vancouver, BC, CANADA

FROM IRELAND:

Karen Redmond, FRCS CTh
Mater Misericordiae University Hospital
Dublin, IRELAND

FROM THE UNITED STATES:

Christian A. Bermudez, MD
UPMC Presbyterian
Pittsburgh, PA USA
Edward R. Garrity, Jr., MD and Wickii T Vigneswaran, MD
University of Chicago Medical Center
Chicago, IL USA
Daniel Kreisel, MD, PhD
Washington University School of Medicine
St. Louis, MO USA
http://www.medpagetoday.com/Pulmonology/GeneralPulmonary/42376

Steven Kindel, MD and James M Hammel, MD
Children’s Hospital Medical Center
Omaha, NE, USA  
http://www.omaha.com/article/20131011/LIVEWELL01/131019758/1685

**Cindy M. Martin, MD**  
University of Minnesota  
Minneapolis, MN, USA  

**Edwin C. McGee, Jr., MD**  
Northwestern Memorial Hospital  
Chicago, IL, USA  

Alanna A Morris  
Emory University  
Atlanta, GA, USA  

Elfriede Pahl Schuette, MD  
Lurie Children’s Hospital  
Chicago, IL, USA  
http://www.growingyourbaby.com/2013/10/08/two-heart-attacks-heart-transplant-speedy-recovery-baby-girl-preparing-go-home/

Masina Scavuzzo, RN  
Barnes Jewish Hospital  
St. Louis, MO, USA  
http://bjhconnect.wordpress.com/2013/10/14/scavuzzo-is-honored-for-her-hard-work/

Daniel G. Tang, MD  
Virginia Commonwealth University Medical Center  
Richmond, VA USA  

Rajat Walia, MD  
St. Joseph’s Hospital  
Phoenix, AZ USA  
http://pr-bg.com/content/view/60594/80/
ISHLT 2014 QUICK LINKS:

- Annual Meeting website
- Academy website
- Online Registration
- 2014 Preliminary Program (PDF)

REMINDER: The Annual Meeting begins on Thursday (one day later than usual) and concludes mid-day on Sunday.

NEWS AND ANNOUNCEMENTS:

ISHLT Grants and Awards Applications Now Online - APPLY TODAY!
The 2014 ISHLT Grants and Awards applications are now available online at www.ishlt.org/awards. Deadline for receipt of applications is Wednesday, January 15, 2014. Grants will be awarded at the ISHLT 34th Annual Meeting and Scientific Sessions, April 10-13, 2014 in San Diego, California. Also, view a Special Invitation for JFTC members.

Masina Scavuzzo (ISHLT NHSAH Council Chair) is honored for her hard work from Barnes-Jewish Hospital News
Preparing for a lung transplant—or any transplant—can be a big challenge. That's why transplant nurse coordinators work extensively with patients to ensure they're physically and emotionally prepared for the journey ahead. More than 13 years ago, Masina Scavuzzo, BSN, CCTC, left the University of Toronto, where she worked as a nurse and lung transplant coordinator, to work with one of the largest lung transplant programs in the country—the Washington University and Barnes-Jewish Transplant Center. Once she arrived in St. Louis and immersed herself in the program, her goal was to promote excellence in lung transplantation and transplant nursing. Recently, Scavuzzo's hard work and dedication earned her the International Transplant Nurses Society (ITNS) 2013 Nursing Excellence Award. Read more →

O2 Breathe Gala event planned to honor the legacy of (ISHLT Member) Dr. Robyn Barst, sponsored by the Pulmonary Hypertension Association (PHA)
An elegant evening is planned on November 7, 2013 in New York City, honoring the legacy of Dr. Robyn Barst. The event will raise funds and awareness to fight PH and features Dr. Barst's patients, colleagues and family speaking of her contributions to the PH community as well as a look forward to the next steps in PHA's fight against PH. What better way to honor a woman who dedicated her career to ending pulmonary hypertension than to raise funds for research to bring us closer to her dream of curing PH. Read more →
LAUGHING LINKS:
Q & A with Carol Burnett
2013 Mark Twain Prize Recipient Carol Burnett, award-winning actress and best-selling author, is widely recognized by the public and her peers for her work on stage and screen, most notably The Carol Burnett Show. A unique feature of the show consisted of an unrehearsed question-and-answer segment with the audience, lasting about 3-4 minutes at the start of most shows. Burnett would ask for the lights to be turned up ("lets bump up the lights") and then randomly pick audience members who raised their hands. Watch video →

RATTLING LINKS:
Newest Additions in the Links!
Cathy and Vincent Valentine are now the proud grandparents of their third grandson, Brennan Dane Oalmann, a 22 in, 8 lb 5 oz bundle of joy, born October 27, 2013. He joins his brothers, Devin and Dylan along with their proud parents, Kristen and Jeff Oalmann. Let's give the Oalmanns a warm ISHLT congratulations to their new little Saint.

WORD OF THE MONTH:
"Deipnosophist"
Deipnosophist is derived from the Greek words deipnon, a meal and sophistes, a wise man. Let's give thanks to Athenaeus of Naucratis, an Egyptian born Greek and author of Deipnosophistai, a collection of books in the form of an aristocratic symposium where the learned meet at a banquet. Today, a deipnosophist is one who is an adept conversationalist especially around the dinner table. Compare deipnosophism with symposium. Symposium comes from the dramatic dialogue of Plato and literally means drinking together or a drinking party. Be sure to get your abstract submitted and register for our annual meeting—you will find all the real learning in the nightly deipnosophistic symposiums but only after attending the daily symposiums or symposia.
Ask not what the ISHLT can do for you; ask what you can do for the ISHLT

November 2013 brings us Thanksgiving, dedication and devotion. We have Lincoln’s dedicatory Gettysburg address delivered 150 years ago on November 19, 1863. It was presented to you and what it means to the ISHLT in the 2011 Volume 3, Issue 6 of the Links. We have the Devotion, Dedication, Emancipation, and Election: the Clash of the Sound Heart and a Deformed Conscience of Mark Twain through the eyes of Huck Finn, Tom Sawyer and Slave Jim presented to you in the 2012 Volume 4, Issue 7 of the Links. Now, 50 years ago on November 22, 1963 is the assassination of a pragmatic, patriotic, charming, brilliant, witty and glamorous war hero who together with his wife revitalized the White House, encouraged intellectual and artistic activity, and stated in Berlin that “freedom is indivisible, and when one man is enslaved, all are not free,” who took pride in the words, “Ich bin ein Berliner.”

The manner in which Jacqueline Kennedy coped with her husband’s funeral pageantry during those tragic times was as follows. She told the presidential historian Theodore White that all she could keep thinking of was this line from a musical comedy: “Don’t let it be forgot, that once there was a spot, for one brief shining moment that was known as Camelot.” The Kennedy era turned into a fairy-tale shimmering with knights and kings and romance and heraldry in the mist of which it has been cloaked ever since.

Like President Franklin Roosevelt and Prime Minister Winston Churchill whom he admired enormously, John Fitzgerald Kennedy was born to wealth and privilege very much unlike the poor and uneducated roots of Abraham Lincoln from “undistinguished families.” Old Joseph Kennedy, JFK’s father, wanted young Joe to run for President and vindicate the Irish in the highest office of America. However, young Joe, JFK’s older brother, was killed during WWII. Then Old Joe convinced JFK (Jack) to take his brother’s place in the plan. “It was like being drafted,” Jack later recalled. “My father demanded it.” Jack was almost killed in the memorable PT-109 rammed by a Japanese warship during WWII. He was decorated as a war hero with medals. He was later asked, “how did you win those medals?” His wit emerged with this response, “I got my boat sunk.”

He became his father’s objective for political power. But originally, Jack wanted to be a writer—he was a good writer—and he wanted to be a teacher. He studied at the London School of Economics to finish his Harvard honors thesis on “Why England Slept,” closely related to Churchill’s “While
England Slept” highlighting why the English followed a policy of appeasement and negotiation while the Nazis were building their war machine.

In life and in politics, he was elected to the Senate and married very well. When he ran for president he grabbed America’s attention. He took on Lyndon Johnson as his vice-president. During the campaign there was a balance of Massachusetts political geography with Texas physical geography. There was a balance of Jack Kennedy’s aristocracy with Lyndon Johnson’s homespun humor. And they won. JFK was inaugurated and gave the most inspiring speech since FDR’s first inaugural address. It was a speech that would highlight the values of America at mid-century.

He started off his inaugural address with... The world is very different now. There Jack stood with his beautiful wife, Jackie: charming, beautifully dressed, a breath of fresh air. She spoke perfect French and had an elegant air about everything she did. In contrast, Mrs Eisenhower before her was your grandmother. Jack continued with his speech and told the world that we have ... the power to abolish all forms of human poverty and all forms of human life... ...the torch has been passed to a new generation of Americans. This generation had been hardened by the Cold War. It was a generation taking up the torch of freedom throughout his address. Kennedy inspired this new generation to dedicate themselves to America and ...ask not what your country can do for you; ask what you can do for your country. He demanded that this new generation reach out to the world and ...let us never negotiate out of fear. But let us never fear to negotiate.

Kennedy was not afraid of controversy. To kick off his presidency he appointed his brother Bobby Kennedy to serve as Attorney General of the U.S. Many responded by saying you can’t make your brother Attorney General, he is inexperienced and unqualified. “Why!” quipped President Kennedy, “he needs experience to be a lawyer.” Kennedy was a patriot and an idealist. He charged the young Americans with different tasks to put America on the move. The Peace Corps was started to promote world peace. Many Americans would learn a foreign language, bring proper hygiene to other nations that needed it and teach English in many foreign countries. But within his first hundred days in office the Bay of Pigs loomed ahead of him.

To better understand the Bay of Pigs fiasco, a review on communism and the Cold War is necessary. Communism today does not evoke the visceral response that it once did in Americans of the 1950’s and 1960’s – at that time Communism was synonymous with evil. The movie, The Invasion of the Body Snatchers, represented Hollywood’s view on Communism. “Commies” would invade our bodies, then we would all look alike and do evil things. In 1959 Fidel Castro had overthrown the corrupt dictator Batista. The American State Department had looked uninformed just as it did in the early 1950s with China. America had originally looked at Castro as an agrarian reformer, but he was a communist. The most ruthless communist dictatorship in the world emerged terrifyingly close to American soil. A regimen about as ruthless as Mao Tse-Tung’s China. The fear of all fears to 1950’s America suddenly was realized with a communist foothold in the Western Hemisphere. Leading up to this fear was the Cold War that led to the communist takeover of China and Russia boasting that it would bury America and Capitalism. The Cold War led to a Soviet atomic bomb and then the Russians were first to send a satellite into space. The education
system in America began questioning itself. Communism seemed to have a better education system. The Cold War left America shackled with terror that any day might actually be America’s last. Children were taught in preparation of a nuclear holocaust to dive under their desks, “duck and cover” in case of an atomic explosion. (I’d like to know how diving under a school desk might protect us from the potential evaporative effects of a nuclear explosion.) Also, throughout 1950’s and 1960’s America, some kids were issued dog tags for easy identification in the “end.”

Yet here was this flash of brilliance—John F Kennedy peering through the horizon giving America and its new generation the potential of a brighter future. But in his first hundred days as President, the Bay of Pigs dampened Kennedy’s spirit and the young Americans’ inspiration.

The plan of the Bay of Pigs, inherited by Kennedy’s administration, used Cuban exiles routed by an extremely well-trained Cuban army supplied with Chinese and Soviet weapons. Early on this made Kennedy and his administration appear totally incompetent in foreign affairs. And Kennedy accepted full responsibility. But Kennedy was determined and not afraid to negotiate. He did not negotiate out of fear. The handsome debonair Kennedy, born of wealth and privilege, met with the bald headed, snaggletooth Khrushchev, a hooligan of peasant stock, in Vienna. The young President’s first test did not go well. Khrushchev decided that Kennedy was weak, young and inexperienced. Therefore Khrushchev decided that America was weak. It had only been 7 years since the Korean War had ended and the Americans would not fight to the end. And America’s and Kennedy’s greatest sign of weakness was now the fiasco at the Bay of Pigs.

Khrushchev reasoned he could deploy missiles in Cuba, because Kennedy initially appeared incompetent in foreign affairs and there were US missile sites surrounding Russia, especially in Turkey. These missiles provided Castro some security. This brings us to the Cuban Missile Crisis of 1962. Americans once again crowded around their televisions and radio as they did during Kennedy’s first inaugural address. Kennedy laid out exactly what was going to happen: 1/ There were missiles in Cuba, 2/ They were in violation of our Monroe policy, 3/ If we allowed them to stay there, no friend or foe would take our word seriously. Kennedy was a pragmatic politician—proactive, not reactive. He and his advisors led by his most trusted advisor, his brother Bobby, had found a way out that allowed the Soviets to save face. America removed some of our obsolete missiles from Turkey. The Russians removed their missiles from Cuba. No armed engagement took place and the world breathed easier. This was the beginning of the end of the Cold War. Kennedy did not negotiate out of fear and he did not fear to negotiate. The dreaded nuclear holocaust was averted.

Later, Kennedy took his beautiful wife to Europe and introduced himself as Jacqueline Kennedy’s husband. With the crowds in his hands, he was going to Berlin to make a statement. At that time, Berlin was divided by a great wall. On the East side was a constant reminder of the failure of communism. On the West side was a little Island of Freedom amidst communism, bustling with well fed and successful people who could say and write what they wanted. Kennedy went to Berlin to proclaim our utter devotion to the freedom of Berlin, Germany. No nation mourned more deeply when Kennedy was killed than the Germans.
President Kennedy had a strong and vigorous foreign policy. But he was not loved by every American. Parts of the news media were frequently critical of him. There were elements of the African American community unsure of the depth of his commitment to Civil Rights. He was unpopular and considered weak on communism by very influential and well-funded groups throughout America. Some looked upon him as a communist the same way some looked upon Eisenhower as a communist. In the south Kennedy was considered far too strong on his civil rights policy. Many in the Democratic Party, the "dixiecrats," hated him.

In the fall of 1963 the subject of re-election came up. He was confident he would win because most Americans believed in a moderate approach to contain communism and were comforted by not having blown ourselves up. Also, many believed in a moderate approach to civil rights. Kennedy believed African Americans had a right to go to any school they wanted and have all the freedoms Americans were supposed to have.

He believed an educated public devoted to its country would be willing to consider many different forms of ideas. Fundamental tenets of Marxism were debated openly. Others believed communism must be absolutely resisted. It was better to be dead than red. This group believed America must return to a social and economic system back in the day of Herbert Hoover. Kennedy had accepted Roosevelt’s New Deal. He wanted to expand health care and have a liberal approach to the economy and he believed that Government had an important role in the economy.

After much debate, Kennedy decided to give his incumbent VP Lyndon Johnson another chance, but Johnson did not seem to control the deeply split Democratic Party in Texas. The liberal side admired Kennedy. The very conservative faction opposed civil rights totally, preferring a doctrine approach to communism and wanting government totally out of business. Kennedy went on a goodwill trip to Texas to fuse the feuding parts of the Democratic Party together and directly expose them to some of his ideas. He was warned against going to Dallas, but he was a man never to be afraid. He and Jackie flew into Fort Worth to speak to the Chamber of Commerce on Friday morning, November 22, 1963. She was late and he said, "Mrs Kennedy is late, when she gets here, she will look a whole lot better than the rest of us.” They later flew into Dallas. They landed and began that procession toward the Texas Book Depository and there, as we were told, was this lone assassin—Lee Harvey Oswald—a failure in everything he had done. He had been a marksman in the Marines. He had spent a good deal of time in Russia. His background was never fully understood, and his reason for what he did was never clear. But if what we were told is true, he fired that rifle with extraordinary marksmanship. JFK was dead. He was shot at 12:30 PM Central Standard Time on November 22, 1963 and pronounced dead just after 1:00 PM.

If Kennedy had lived, how would the world be different?

We were already involved in Vietnam. Military advisors were already there. Kennedy was reevaluating the Vietnam situation. He probably had the political wisdom, the political stature, and the political courage to understand by 1965 not to escalate our efforts in Vietnam but to withdraw. Vietnam was the one issue that tore the very fabric that held America together. Vietnam divided us into two factions that still today we have yet to overcome. Vietnam led to a distrust of what we
were told by our Presidents and Congresses and continues to cast a shadow today. In the immediate aftermath of Vietnam another country fell to communism. JFK’s assassination changed history.

And what really happened on the grassy knoll?

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