Vincent’s Phobophobic Sense

What do you get when you cross Ben Franklin and luck? Diligence. Ben Franklin has given us many pithy quotes. We know from Louis Pasteur, “fortune and chance favor the prepared mind.” Our first American always gazing at us from the U.S. one-hundred dollar bill gives us the idiom, “diligence is the mother of good luck.” In this issue Herman Reichenspurner provides us with the dividend of 30 years of diligence. John Haney and Matthew Hartwig from Duke reincarnate Dr Franklin into a cardiothoracic surgeon diligently adding life to our lung recipients. We anxiously await the results of the RESULT trial to see if the Nissen fundoplication procedure can alter the natural history of BOS.

From the Pulmonary Hypertension Council we are provided timely updates and the tremendous progress that has been made for our sufferers of pulmonary hypertension, as the late Dr Eugene Robin would refer to over 30 years ago as, “denizens of the near dead.” Sorry about the macabre association with Halloween and the recent rage from the cinema about World War Z (if you’re familiar with this movie, there are “endless” examples of diligence). Nevertheless, pulmonary hypertension patients did not do so well in the past. However, today they are very much alive, quite functional and out of the “valley of Death”. Be sure not to miss their “Nice” update from the 5th World Symposium on Pulmonary Hypertension, Progress in PAH Prognostics and Therapy: Improving the State of the Disease, and The New Face of PAH.

On a lighter side, the Pulmonary Council teases us about California led by the surf of San Diego. This has nothing to do with penguins, I think. And Jim George’s article on Writing a Successful Abstract is sure to help you get a ticket to the surf all on your own.

Lastly, be careful of being blind-sided by Coke, Soda, Pop or Sodi-Pop and by those who claim to have your back. Recall from 2009, The Blind Side, Sandra Bullock and the words of Alfred Lord Tennyson…Theirs not to make reply, Theirs not to reason why, Theirs but do and die…. According to Michael Oher in The Blind Side, he believes Tennyson wrote for us to try for courage and hope for honor. And that our leaders, chiefs, chairpersons, administrators, managers, advisors, coaches or quarterbacks are not left “spineless” and actually have the same courage and honor when we have their backs and of course, vice versa. Is it just fear of fear itself or are we just one of 600.

Happy October

Vincent Valentine, MD
ISHLT Links Editor-in-Chief
IN THE SPOTLIGHT: Stay Classy, San Diego!

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“Stay classy, San Diego!”

I am reminded of these words spoken by Ron Burgundy from the movie Anchorman as I sit writing this description of the 2014 ISHLT program on a warm sunny early autumn day in Philadelphia, with crisp air and bluebird skies. I feel compelled to find some way to get outside and enjoy each moment of it, because days like these in the U.S. Northeast are like breaths or heartbeats – we only get so many. Not so in the beautiful microclimate in San Diego: the site of the 2014 ISHLT conference. Yet, as we know from previous ISHLT conferences in this beautiful city, San Diego offers so many more attractions beyond its stellar weather.

In this wonderful setting, the 2014 Program is shaping up to be very exciting. In a new format this year, the meeting has shifted to open on Thursday with pre-meeting symposia and close Sunday, in order to best include a Saturday night stay. Pre-meeting symposia focus on novel issues in device technology and management and cutting-edge content integrating bench science and clinical themes in advanced heart and lung disease care, including pulmonary hypertension, lung and heart transplantation. Woven throughout the meeting is an emphasis on the integrative multi-specialty teams that permeate our society, including children, nursing and allied health professions, infectious diseases and pharmacology.

Exciting plenary sessions cover personalizing approaches to patient care, including how “Digitizing Humans Changes the Future of Medicine.” Sir Terrence English will be granted the Lifetime Achievement Award and will inspire Society members to “Follow your Star” in his acceptance lecture. A Plenary session focused on timely issues in thoracic organ donation includes reports of novel trials of DCD transplants, capped with an invited lecture from Nobel Laureate Dr. Al Roth discussing the ethics and economics of organ allocation policy. The President’s Debate on Sunday will settle (or at least try to settle) whether it is time to “stop treating patients with secondary PH now.”

Despite these exciting symposia and plenary sessions, the strength of the meeting will remain the submitted scientific content from the membership. In anticipation of your contribution of high quality, novel scientific work, we have again set aside 6 series of concurrently running oral sessions to showcase the highest scoring abstracts. In addition, as was started last year, all poster sessions will be moderated by a team of experts, to facilitate scientific interactions while sipping and nibbling on wine and cheese. So be sure to send in your best science to be part of the program.

The setting this year is ideal. The Manchester Grand Hyatt San Diego offers a resort feel right on the San Diego Bay, along the waterside path to the city’s popular Seaport Village, and blocks from
the famous Gaslamp Quarter. Taking advantage of this beautiful locale, the President’s Cocktail Reception will be held poolside on Friday night, and the Program Committee has already placed friendly wagers on who will be the first one in the pool, yelling “Cannonball!”

Now is the time to start planning to come to the 34th ISHLT in San Diego. The Annual Congress is a shining star in our Society, but it is one that relies heavily on participation of the membership to be the most successful. So “Stay Classy ISHLT” and anchors aweigh to San Diego.

Disclosure statement: the author has no conflicts of interest to report.
As a participant in the 5th World Symposium on Pulmonary Hypertension (WSPH), held February 2013 in Nice, France, I was struck by several things—first was the beautiful scenery. The best of Nice: breathing fresh Mediterranean air while walking along the Promenade des Anglais, viewing the deep blue waters of the Cote d’Azur and an eagle eye view of the whole city from atop Castle Hill, eating exquisite Gelato and French cuisine, and best just sitting at a café at Plaza Massena and relaxing. Nice is one of my favorite places to visit, thus, is not surprising the ISHLT board of directors choose this amazing city for their meeting in 2015.

The WSPH convenes every 5 years to discuss updates in the field. The symposium is designed to create guidelines to improve clinical practice and to standardize both pathologic and clinical definitions. A consensus on standard of care therapy is difficult in an orphan disease but these guidelines will help physicians better treat their patients. More importantly, it provides perspectives of future investigations. The 5th WSPH had a record attendance, in excess of 1000 participants—a diverse group that included clinicians, researchers, pharmacists and industry personnel all sitting in one room, the main auditorium.

Findings: The definition of PAH did not change, defined as a mean pulmonary artery pressure (mPAP) ≥ 25 mmHg and wedge pressure ≤ 15 mmHg. The cutoff of mPAP 25 mmHg was chosen as was the valued used in all clinical trials and previous PAH registries. Pulmonary vascular resistance (PVR) will not be included, as was in Dana Point [1]. A very interesting discussion took place about the true upper limits of normal for mPAP: ~ 20 mmHg based on published data. Nonetheless, patients with mPAP in the 20-24 range have not been included in clinical trials and more data regarding the natural history is needed. Based in current epidemiological data, it is not even clear if these patients will develop PAH in the future, but it is particularly concerning for the very high risk populations, such as patients with scleroderma.

Exercise-induced PH remains controversial. Abnormal exercise-induced pulmonary pressures could allow for an earlier diagnosis of PAH, but thus far, there is not conclusive evidence of a universal abnormal threshold in mPAP. Studies showed that in younger persons, < 50 yrs, mPAP ~ 35 mmHg can be considered normal during exercise [2]. More importantly, in contrast to pressures at rest, mPAP during exercise is largely age-dependent, presumably as a result of increasing stiffness of the left ventricle and the pulmonary vessels and mPAP ~ 30 mmHg during mild exercise have been seen in 50% of apparently healthy subjects aged > 50 yrs. The definition of a “normal” value for
the wedge with exercise is also still debated. Without the appropriate data and consensus, no recommendation could be made on exercise hemodynamics.

The right ventricle (RV) continued to be an important topic at the symposium. Since our therapeutics have not cured the disease, it is clear that we need therapies that alter both the pulmonary vasculature and the RV. Our therapies help improve patients’ exercise capacity and recently completed trials reaffirm that they improve morbidity (clinical worsening events) [3-5]. The message at the 5th WSPH was clear: we should aim for normal RV function by imaging (RV ejection fraction and size), biomarkers (natriuretic peptides), hemodynamics (right atrial pressure < 8 mmHg and cardiac index ≥ 2.5 L/mg/m2 and functional class (I or II)! The importance of objective evaluation of RV function in clinical trials will require study in early trial development so we can learn what is a clinically relevant improvement. Adaptive and creative trial designs are needed as well as (or as it is?) a better way to utilize our limited patient cohort in trial development.

Finally, with the globalization of our pivotal trials the ethics and needs that now arise in performing these trials will need to be considered. The final guidelines manuscript should be published in the upcoming year. ISHLT San Diego will discuss many of these topics in more detail.

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

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Pulmonary arterial hypertension is a progressive, fatal disease characterized by progressive vascular proliferation and remodeling of the pulmonary arteries (PA), ultimately leading to increased pulmonary vascular resistance (PVR) and right sided heart failure (RHF). The field of PAH has seen remarkable improvements in patient outcomes, owing to heightened awareness with emphasis on earlier diagnosis and referral, creation of predictive models for disease progression and prognostication, as well as advancements in drug therapy.

The National Institutes of Health (NIH) registry in 1981 was the first registry evaluating survival in PAH patients in an era when modern, standard therapies were not yet available, and therefore does not accurately reflect the current state of the disease [1]. Four modern day registries, the French Registry, the Pulmonary Hypertension Connection registry (PHC), Mayo Clinic PAH registry, and the largest of all, the Registry to Evaluate Early and Long-Term PAH Disease Management (REVEAL), have consistently demonstrated improvement in PAH survival across PAH subgroups, compared with the historical NIH control group [2-3] (Figure 1). The prognostic equations generated from these registries, which incorporate multiple, incremental clinical and hemodynamic data, are useful in clinical practice for predicting survival in patients with similar cohort population characteristics. If further studies confirm the utility of these equations for serial risk prediction over time, individual disease trajectories could be ascertained and targeted with timely medical interventions to avoid future morbid and mortal events. In this manner, an incremental benefit in survival may be realized by facilitating a personalized management profile for individual patients. It is important to recognize however, that more contemporary predictors of survival, using modern imaging techniques and biomarkers, may emerge as important and more accurate predictors of survival. In particular, evaluations of right ventricular (RV) function, RV-PA coupling, and RV energetics by cardiac magnetic resonance imaging and PET, respectively, will likely provide additive prognostic power if incorporated into future risk models. Given the power of RV function in mortality prediction, identification of novel imaging or biomarker signals of early RV failure, and studies assessing the direct effects of newer therapeutic agents on the RV, should remain a top research priority.

**Figure 1.** Survival from time of diagnostic RHC in the REVEAL
cohort compared to the estimated survival in the historical NIH cohort (matched for age, sex, and mean PAP). Median contemporary survival improved to greater than 7 years in the REVEAL registry, compared with a dismal median survival of 2.8 years in “untreated” patients by the NIH registry [2].

On the treatment front, two new therapeutic agents have demonstrated promise for treatment in PAH. Riociguat, an oral soluble guanylate cyclase stimulator, designed to increase cyclic guanosine monophosphage (cGMP) for enhanced pulmonary vasodilation, was shown to improve PVR and exercise capacity by six minute walk distance in two recent, placebo-controlled randomized studies of PAH (PATENT-1) [4] and inoperable chronic thromboembolic pulmonary hypertension (CTEPH) or persistent PH following pulmonary endarterectomy (PEA) (CHEST-1) [5-6]. The latter is particularly important, as until now, there have been no specific medical therapies for CTEPH. Pulmonary endarterectomy remains the treatment of choice in patients who are suitable surgical candidates with operable disease, despite the complexity of the procedure and significant complication rates [7-8], and the limited number of experienced centers. The potential benefit of medical therapy in these patients represents a significant advancement with targeted PAH therapies, although it is important to recognize that patients should firstly be considered for PEA which remains the superior and curative treatment option. Riociguat was unanimously approved by the US Food and Drug Administration in August 2013 for use in CTEPH patients and in WHO Group I PAH patients to prevent clinical worsening.

Macitentan is a new ERA with dual receptor antagonism (ETA and ETB) shown in the large, placebo-controlled trial, SERAPHIN [9] to significantly decrease morbidity and mortality over long-term follow-up in PAH patients, with the primary combined endpoint driven by reduction in reductions in PAH worsening. Historically, drug approval for PAH therapies have been on the basis of short-term studies showing improvements in 6MWD. The PH community will continue to demand more event-driven trials such as this one, with emphasis on assessing disease stabilization and long-term benefit with current and future therapies. The beneficial effects of macitentan were observed in both treatment-naïve patients and in those already on background PAH therapies, and minimal liver toxicity was observed. FDA review is presently underway for macitentan.

This is an exciting time in PAH, as drug development and approval is entering a new phase. It has been some time since we have seen new promising therapies for this debilitating, progressive disease. Current developments in PAH therapeutics and better trial design with robust clinical outcome measures will undoubtedly continue to improve the state of the disease.

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

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Pulmonary arterial hypertension (PAH) is characterized by proliferation and remodeling of the small pulmonary arteries, leading to increased pulmonary vascular resistance and ultimately right ventricular failure and death. The classic textbook description of idiopathic pulmonary arterial hypertension is it more commonly affects middle-aged female. This comes from the historic National Institutes of Health (NIH) registry from the 1980’s [1]. The mean age of the patients enrolled in the NIH registry was 36 and the female to male ratio was 1.7: 1. Their 1-, 3-, and 5-year survival were 67%, 45%, and 37% respectively prior to the approval of currently available PAH-specific therapies [1].

Data from several contemporary PAH registries from different parts of the world suggest that the epidemiology of PAH has changed significantly in the last 3 decades [2-6]. The mean age of the patients enrolled in the contemporary registries ranged from 48-53 years, which is significantly higher when compared to the NIH registry, and there was an increase in the female to male ratio [2-6]. In addition, patients in the modern registries had a better survival when compared to the patients in the landmark NIH registry. A possible explanation for the difference is the predominance of prevalent cases in the contemporary registries. Over representation of prevalent cases (~85%), who have survived for reasons including intrinsic variation in disease lethality and/or the effects of therapy, could potentially introduce survivor bias. However, recent analysis from the pulmonary hypertension registry of the United Kingdom and Ireland revealed that even in treatment-naïve incident PAH patient population, the mean age at the time of diagnosis in the current era is significantly higher [5]. This registry prospectively followed 482-treatment naïve patients diagnosed with idiopathic, familial, or anorexigen-associated PAH between 2001-2009. The median age at the time of enrollment in the registry was 50 years, and 13.5% were actually older than 70 years of age at the time of diagnosis. These patients also had significantly higher comorbidities including hypertension, diabetes, atrial fibrillation, and coronary artery disease5. These data clearly indicate that the current face of PAH is different when compared to the 1980’s.

There is no clear explanation for the change in the demographic of PAH in the current era. One intriguing question is whether pulmonary hypertension in the elderly (>50 years) is truly a different phenotype of PAH or is it a classification drift. Are we misclassifying patients with pulmonary hypertension associated with heart failure with preserved ejection fraction as PAH due to overreliance on a single measurement of a resting pulmonary capillary wedge pressure? This question raises since the phenotype of the elderly patients diagnosed with PAH based on the current diagnostic criteria (mean pulmonary artery pressure > 25 mm Hg and resting pulmonary capillary wedge pressure <=15 mm Hg) shares several similar characteristics with pulmonary hypertension associated with heart failure preserved ejection fraction – both groups have increased
incidence of comorbidities including hypertension, diabetes, atrial fibrillation, and ischemic heart disease \[5,7\]; the severity of pulmonary hypertension is only moderate as opposed to severe as in younger patients with PAH \[5,7\]; and finally survival in both groups is worse as compared to younger patients with PAH, despite the presence of only moderately severe pulmonary hypertension. The differentiation between PAH and pulmonary hypertension associated with heart failure with preserved ejection fraction is important since the treatment and prognosis significantly differs between the two diagnoses. Further studies are needed in the future to better differentiate aging PAH from pulmonary hypertension associated with heart failure with preserved ejection fraction, and also to assess the response to PAH-specific therapies in elderly patients with PAH.

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Lung Transplantation In California

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Like so much else, organ transplantation in California benefits from an abundance of riches. With great beaches and weather, vibrant cities, the movie industry, and a bountiful agricultural climate (especially for grapes), California is certainly a land of plenty. And did I mention the food? Any type of food is available from the chic restaurants in Los Angeles to the culinary creativity of San Francisco (which many consider the second best dining city in the country - do you even need to ask? New Orleans). So with all this going in its favor, and with a population of nearly 40 million people to support a robust organ donor and patient referral base, there are not surprisingly several active lung transplant programs.

From our 4 active Organ Procurement Organizations (OPOs), in 2012 there were a total of 386 lungs procured in California. Just for perspective, in the same year, there were around 3200 lungs procured in the entire United States. Let’s see: California has a little more than 10% of the total US population and a bit more than 10% of all procured lungs. And the California economy represents 13% of the US Gross Domestic Product ... well, you get the point.

But the biggest beneficiary of the California lung transplant environment is the patients. From NorCal to SoCal, there are a several excellent transplant programs from which to choose, meaning that a patient that lives in Southern California can have his or her pick of several different programs such as UCLA, UCSD, USC, and Cedars-Sinai. All of these Programs have significant transplant experience and have leaders in the field working within the Centers. UCLA, the busiest lung transplant program in California, has consistently achieved patient outcomes that surpass national and local benchmarks.

In the Northland (remember: ideally situated near the wineries), UCSF and Stanford both have active transplant programs, transplanting nearly 100 lungs per year between the two programs. UCSF has been a leader in transplanting sick patients with Interstitial Lung Diseases of all sorts and has consistently delivered excellent outcomes. Stanford has also been in the lung transplant business for a long time, with Dr. Bruce Reitz performing the first heart-lung transplant in 1981. As I remind Dr. Reitz frequently, I was a junior in high school at the time. He has since retired, doubtlessly in no small part due to such conversations. But we still benefit from his wisdom.

As a result of having several good, active programs, a large population base, and excellent donor networks, there were 192 lung transplants performed in California in 2012. Yeah, you guessed it ...
a little over 10% of all lung transplants occurring in the US that year. My personal opinion is that even a greater number of lung transplants could be performed in the state, given the quality and number of the organ donors available within California. For example, just consider the California Transplant Donor Network (CTDN) operating in Northern California: 150 to 160 lungs are procured by CTDN each year, 20% of which are exported out of the region to Centers as far away as Duke and Toronto. With all due respect to my exceptional colleagues at these two Programs, I would like to see them coming to California less for our donor lungs and more for social reasons!

The California lung transplant community welcomes the ISHLT back to San Diego in 2014, where the intellectual vigor and community vibrancy is as bright as a day at the beach in Coronado. We hope everyone enjoys the meeting and takes the time to enjoy all that California has to offer. See you there.

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Surf’s Up: The World’s Top 10 Cardiothoracic Transplant Programs

Compiled by Daniel Chambers and Tereza Martinu
(with a committee of some equally unbiased fellow-adjudicators ...
yes they are all from Queensland ...)
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Many key performance indicators can be used to rate the success of individual programs: survival, transplant numbers, donor utilisation, research output, etc. But one potentially important criterion has been completely neglected in the literature (and notably by Marshall and Josef in the ISHLT Registry): the quality of the local surf-break. We decided to rectify this oversight.

10. Toronto

Toronto: Here’s our little secret.
World reaction: Wow ... is there anything you guys can’t do?
Reference: http://torontoobserver.ca

9. Melbourne

Melbourne: Low budget is better than no budget!
World: Why did this get up to number 9?
Reference: http://api.ning.com/files/...

8. Stanford (Huh???)

Stanford: Ice is overrated.
World: Where’s the water?
Stanford: 15 miles west, bring your wetsuit!
Reference: http://math.stanford.edu/

7. Chicago

Chicago: The surf is up! And when the ice moves in, we surf with hockey sticks and win Stanley Cups. Chicago has it all ....
World: We’d rather go skating.

6. Sydney

Sydney: We were deliberating about keeping this a secret but decided to show a picture of the Sydney local break ... so it is just a matter of rolling out of bed, as you can see. The picture shows Tom Carroll (five time world champion) surfing Avalon. BTW: shark attacks are a rare event!
World: Sydney’s not that bad after all...
Reference: http://imgflip.com/i/3qxwv

5. Newcastle upon Tyne

Newcastle: It has all been too predictable so far - California, Gold Coast and Hawaii. If you want hardcore then you need to come to the North East of England to Longstands Beach in
Tynemouth! Just 4 miles from The Institute of Transplantation, Freeman Hospital, Newcastle. But remember to bring a thick wetsuit!!

World: Hoax! It's a hoax. Been there, never seen a surf like that there. It's a hoax!

Newcastle: No hoax! Look at the evidence.

World: Is that a wave or did someone make a ripple in the water?

Reference: [http://www.theljournal.co.uk/news/](http://www.theljournal.co.uk/news/)

4. North Carolina

Duke and UNC: It may not be the best known surf in the world, but where else do you have big wave surfing and windsurfing within 500 feet of each other (e.g. Hatteras Island)? Where else can you surf with wild ponies? And where else can you surf inside a hurricane? We are truly unique!

World: Horses and hurricanes? Is this Alice in Wonderland or North Carolina?


3. Brisbane

Brisbane: Check out a Go-Pro video of ISHLT member Peter Hopkins during a standard set.

World: We see a "breakout session" at ISHLT 2014 in Peter's future.

2. San Francisco – Mavericks - Epic!

San Francisco: Told you we should have planned to have the ISHLT meeting in San Fran!

World: Let's do that in 2016?

Reference: [http://vimeo.com/58345611](http://vimeo.com/58345611)

1. San Diego – the biggest wave of them all!

San Diego: No comment. The picture says it all.

World: Can't wait!

Reference: [http://www.flytweed.com](http://www.flytweed.com)

See you in California!
Nissen Fundoplication and Lung Transplantation

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“An ounce of prevention is worth a pound of cure” – Benjamin Franklin

If the esteemed Mr. Franklin were a lung transplant surgeon, certainly one at the writers’ institution, he might have rephrased his sentiment “an early Nissen is better than a late retransplant”.

Gastroesophageal reflux disease (GERD) is a common finding in patients with advanced lung disease. A recognized factor in diseases such as asthma and bronchitis, it has been found with high incidence in end-stage lung diseases such as cystic fibrosis and pulmonary fibrosis [1]. More impressively, the incidence of GERD as defined by abnormal esophageal acid contact time increases after lung transplantation, detectable in up to 65-75% of patients [1,2]. Proposed mechanisms for this increase include vagal nerve irritation or injury, altered diaphragm mechanics and the effects of post-transplant immunosuppression, especially by corticosteroids, on lower esophageal sphincter (LES) function [1]. None of these mechanisms have been clearly elucidated and the increased incidence is not explained entirely by altered esophageal or gastric motility. Importantly, the majority of transplant patients remained asymptomatic.

Early studies on transplant patients found a relationship between GERD and the development of bronchiolitis obliterans syndrome (BOS) and diminished graft function as determined by forced expiratory volume in one minute (FEV1) [3]. Corresponding animal work has shown the development of airway inflammation and remodeling in response to the induced aspiration of gastric contents, leading to the development of obliterative bronchiolitis lesions by neutrophil-derived inflammatory mediators [4]. Critically, these results are not entirely explained by acid exposure [5]. While neutralization of acid ameliorates some of the inflammatory activity, perhaps by preventing the activation of acid-dependent proteases such as pepsin within the aspirate, alkalinization alone does not ameliorate all of the deleterious effects. As a result, our group and others have taken an aggressive stance towards the surgical management of reflux, advocating uniform screening and fundoplication as a physical barrier to reflux. It has been a decade since initial results of early fundoplication found an association with improved FEV1 and delayed onset of BOS [6]. Our most recent examination of the largest cohort to date of nearly 300 patients found an association between early fundoplication and preserved graft function, as patients undergoing fundoplication within the first year of transplantation had 1-year percent predicted FEV1 nearly 10 percentage points higher than those with abnormal acid contact times who did not undergo fundoplication [2]. The laparoscopic fundoplication has evolved into the clear technique choice for
fundoplication, and studies have found this to be safely performed in transplant and non-transplant patients alike [7]. Compared to non-transplant recipients, transplant patients have a longer postoperative stay after fundoplication and higher rates of readmission as one would surmise. It has been our bias to perform 360°, or Nissen fundoplication, on these patients provided esophageal motility and gastric anatomy allow for that. This is occasionally combined with a laparoscopic pyloroplasty or gastrojejunostomy for those with severe gastric emptying problems.

Similar studies by Pittsburgh [8] and Loyola [9] also found protective effects of anti-reflux surgery in lung transplant recipients. Hoppo and colleagues found improvement in FEV1 in 90% of patients following anti-reflux surgery and a statistically significant reduction in episodes of acute rejection, while Fisichella and colleagues also found a reduction in reflux and episodes of acute rejection and progression to BOS. Enrollment has recently concluded in the RESULT trial, Reflux Surgery in Lung Transplantation, a multicenter prospective trial of over 600 patients designed to identify clinically useful markers of GERD-induced lung injury that correlate with adverse outcomes. The trial has an additional goal of a future randomized multicenter trial to definitively establish these relationships and identify the best means of preventing them. RESULT has recently closed enrollment and data are being processed.

The argument for fundoplication in lung transplantation may be summarized as follows: Gastroesophageal reflux disease is quite common post-transplantation, detectable in up to three-quarters of transplant recipients [2]. Animal models of lung transplantation have shown a role for aspirated gastric contents in causing bronchiolitis obliterans-like pathology [4], and retrospective observational human studies have shown an association between reflux and progressive graft dysfunction and bronchiolitis obliterans syndrome [3]. Further evidence suggests that the ubiquitous medical management of reflux by pH neutralization is likely ineffective at eliminating all of the deleterious effects [5]. Surgical fundoplication reduces reflux and may be performed safely in the lung transplant population [7]. Finally, multiple retrospective studies have found an association between early fundoplication and preserved graft function and delayed development of BOS [2,8,9]. With a median survival hovering at five years, a lung transplant recipient’s long-term outcome is still driven primarily by graft function. A laparoscopic fundoplication performed safely offers the potential to extend graft function in a low-risk, high-reward fashion. After all, can we really argue with our Founding Father?

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“How Lucky ... to be President-Elect of the ISHLT!”

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While rotating on my student elective at Stanford University Hospital in 1982, the transplant group within the department was very excited that there was a new scientific society focusing only on heart transplantation. Two years later in New York City in 1984, I attended my first Society meeting and presented my thesis on "Cyto-immunological monitoring after heart transplantation." At that time the Society was called the International Society for Heart Transplantation. Despite being very nervous in the presentation and discussion, I received the Philip K Caves award - my first scientific award and a very proud moment! (Read more on the Philip K. Caves Award at http://www.ishlt.org/awards/.)

Early on, I started working in different scientific councils, was invited to participate on several program committees, and eventually was elected to the Board of Directors. When Jim Kirklin became president of the ISHLT, he asked me to serve as Program Chair for the meeting in Chicago in 2010. This was the highlight of my career in our society and turned out to be a major challenge since the whole meeting was jeopardized by the eruption of a volcano in Iceland! Nevertheless, the meeting was a great success and we had lots of fun.

The ISHLT is such a great society because it is a very mixed group of highly motivated and intelligent scientists (not only boring surgeons – just kidding!), composed of different clinicians, researchers and nurses focusing on diagnosis and treatment of terminal heart and lung failure.

In my experience, members of the ISHLT are extremely reliable and our committee meetings are always on time with a high presence of all participants—something rarely seen in any other scientific society.

In recent years we have encouraged involvement among our young members by founding the highly motivated Junior Faculty and Trainee Council and organizing exciting mentor meetings and lunches.

My plans would be for ISHLT to remain the home of all scientists, clinicians and nurses focusing on heart and lung failure and to expand its horizons beyond transplantation. Many topics have rapidly rising importance such as mechanical circulatory support and pulmonary hypertension. Very importantly, basic research plays a major role and will hopefully thrive even more in the future.

I can state openly that ISHLT always has been and always will my most favorite scientific society!

Disclosure statement: The author has no conflicts of interest to disclose.
Attending annual meetings are an important part of professional life. It is an opportunity to meet other professionals face-to-face and to present research or ideas to a critical audience. While meeting people is easy enough, getting on the program of a clinical/scientific meeting involves convincing a committee of abstract reviewers that your work is of high enough quality and sufficiently interesting to warrant giving it one of a finite number of slots available for presentation. It is here where a number of investigators, especially junior ones, run into a roadblock without understanding what went wrong or why their abstract was rejected. Investigators don't usually hear why they failed to get on the program, which can lead to erroneous conclusions such as "they did not consider our work interesting" or "they just didn't get it". Based on my experience on abstract review committees, the latter conclusion, while usually incorrect, may be closer to the truth. The reviewers may not have understood the abstract or may have been unable to evaluate the work.

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

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

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

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

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

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

2014 ISHLT San Diego
You are invited to submit your best science for presentation at the 34th Annual Meeting & Scientific Sessions, April 10-13, 2014 at the Manchester Grand Hyatt San Diego. The Abstract Submission Site is live at www.ishlt.org. Abstract Submission deadline is November 15, 2013 at 11:59 PM EST. Registration and housing for the Annual Meeting and the Academies will be available online in October 2013. Check the ISHLT web site for details.

ISHLT Grants and Awards Program
The 2014 ISHLT Grants and Awards applications will be available online November 1, 2013. For general information, funding stipulations/award policies and the grant applications/instructions, go to the ISHLT Website at www.ishlt.org. Click on "Awards" to access the information. 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. For 2014 info, visit: 2014 Grants and Awards Program. Also, view a Special Invitation for JFTC members.

LAUGHING LINKS
35 Terrible Puns to Brighten Your Day
by Dan Dilling
Everybody loves a good pun. Here are 35 to brighten your day. Some of these were quite sophisticated and even multi-media! Read more →

WORD OF THE MONTH
Diligence (n) - persevering application: devoted and painstaking application to accomplish an undertaking.

(From Merriam-Webster’s Third New International Dictionary of the English Language Unabridged, 2002.)

Also, specifically in France it is a large closed public horse-drawn carriage formerly used for long journeys. Car may be short for carriage and because of the oppressive heat and humidity of the Southeastern United States there were "open cars" pulled by our equine friends before the automobile as there were "open cars" pulled by steam engine locomotives on the rail lines. After an evening and humid journey by horse and buggy when you disembarked you had to "get down from the car." More on this in the Editor's Corner.
OUTTA THIS WORLD LINKS
Interesting, Inspiring and Intriguing Links from Around the Globe

FROM AUSTRALIA:

Such bravery in adversity
TheStar.com, 18 Sept 2013
When I first met Tianna Formosa, she could have been mistaken for any normal 16-year-old, trying to get on with life. Except there was one major obstacle in her way, a hurdle that is virtually impossible for any of us to imagine. She was on hold for a life-saving transplant operation. I had arrived that day in 2011 to take pictures at a photo shoot organised by Transplant Australia, the aim being to document the journey and emotions that go hand in hand with waiting for that all-important call. I remember being taken aback by the overwhelming restrictions under which Tianna had to live her life. Her fate was out of her hands. Read full article →

FROM CANADA:

Toronto General Hospital gets new head of transplant program
TheStar.com, 18 Sept 2013
When the SARS outbreak hit Toronto in 2002, organ transplant doctors at Toronto General Hospital had to decide whether to cancel or carry on with the life-saving procedures. They decided to continue, largely due to the presence of Dr. Atul Humar, an infectious disease specialist, then with the program. "Atul played a pivotal role in making sure it was safe," says Dr. Gary Levy, the liver specialist who developed TGH's multi-organ transplant program and, until this month, led it. "He became recognized as a world's expert. That propelled him into leading infectious disease groups and establishing rules on how to deal with highly infected patients." Read full article →

FROM COSTA RICA:

Costa Rica on alert for organ trafficking
Latina Lista, 5 Sept 2013
What started with an email turned into the dismantling of an international organ-trafficking ring. American surgeon Francis L. Delmonico, the chairman of the World Transplant Society, emailed Jorge Cortés, the director of Hospital Clínica Bíblica—one of the three private centers authorized to perform transplants in San José—in November 2012 that an Israeli had undergone an illegal kidney transplant in Costa Rica. Delmonico became suspicious when the Israeli who received the transplant became sick. Seven months later on June 18, Francisco Mora, the head of the Nephrology Unit at Hospital Calderón Guardia at the time and who performed the transplant, as well as an unidentified 32-year-old woman who allegedly was in charge of finding donors, were arrested. Read full article →
FROM THE UNITED KINGDOM:

My double lung transplant and the stranger who gave me my life back
The Independent, 24 Sept 2013
After a lifetime of coping with cystic fibrosis, in August last year it looked as though my life was over. I was in Harefield Hospital, awaiting a donated pair of lungs to replace my diseased ones. I had become used to constant infections and constant treatments and a life interrupted by long stays in hospital. But now I was barely conscious as my condition declined and a machine took over the job of oxygenating my blood. Then the machine was no longer sufficient and my family had to face it: I had only hours to live. That I am here to tell this story is down to a stranger I never knew and will never meet. Read full article →

FROM THE UNITED STATES:

Video: Widow of slain N.J. cop meets husband's heart transplant recipient for first time
nj.com, 9 Sept 2013
When Jersey City police officer Marc DiNardo was gunned down in the line of duty in July 2009, his wife decided to donate his organs. Last week, the mother of three finally got the chance to meet the man whose life was saved by her husband's heart. In a report on the CBS Evening News, Mary DiNardo was introduced to 70-year-old Don Zolkiwsky, who received the transplant after a virus destroyed his own heart. The two met for the first time at NJ Sharing Network's headquarters in New Providence. Read full article →

Life and death decisions about who gets organs
Post-Gazette.com, 17 Sept 2013
A story out of Newtown Square, Pa., is known to many millions of people: Sarah Murnaghan, now 11 years old, received two lung transplants in June after highly emotional attention in news and social media and a public debate over the merits of transplant allocation policy. Sarah has end-stage cystic fibrosis, and a judge ordered her added as an equal to the adult and adolescent lung transplant lists when she was originally at the bottom of those lists because she was too young. Read full article →

Pulmonary fibrosis: Lung disease kills as many as breast cancer | Federal Way woman starts support group
Federal Way Mirror, 17 Sept 2013
In the mid-1990s, Carole Reaney suffered from bronchitis and a constant cough in the wintertime. Medications and breathing treatments couldn't cure the ailment. The dry hacking cough was so commonplace that it became a family joke. If the kids needed to find Reaney in the store, for example, they would "listen for mom's cough." "It just wasn't getting any better," said Reaney, 69, a Federal Way resident. She eventually underwent a lung biopsy. In August 2011, Reaney was diagnosed with pulmonary fibrosis. She was given three years to live. Read full article →
TATTLING LINKS
ISHLT Members in the News

FROM AUSTRALIA:

Robert G. Weintraub, FRACP, FACC
Royal Children's Hospital
Melbourne, Australia

Heart muscle disease research reveals children at greatest risk
theInformationDaily.com, 3 Sept 2013

Key risk factors such as young age and lower weight will be able to predict which children with heart muscle disease—the most common cause of sudden death in young people—are at greatest risk of death or need for heart transplant, US scientists have revealed in the Lancet.

Read full article →

FROM CANADA:

Terrence M. Yau, MD, MSc
Toronto General Hospital
Toronto, ON, Canada

Surgeon operates on hearts of mom, son in the same week
theStar.com, 25 Sept 2013

Jason Truong lay in a bed at Toronto General Hospital clinging to life, fighting for the strength necessary for a heart transplant. The 38-year-old Scarborough man, had just undergone cardiac surgery, was fighting a bacterial infection and his lungs had failed. He was at death's door, so sick that he was removed from the transplant list.

Read full article →

FROM INDIA:

Paul Ramesh Thangaraj, MD
Apollo Hospital Chennai
Chennai, India

Rare genetic lung condition treated
Deccan Chronicle, 9 Sept 2013

A blind schoolteacher from Andhra Pradesh, who was suffering from a rare genetic condition called the Hermansky-Pudlak Syndrome (HPS), underwent a successful double-lung transplantation at the Apollo Hospitals here. The double-lung transplantation for this genetic condition is the first case in India and second in the world. The first successful transplant was done in the US in 2005, said Dr Paul Ramesh Thangaraj, senior consultant cardiothoracic and transplant surgeon at Apollo Hospitals.

Read full article →
FROM ISRAEL:

Mordechai R Kramer, MD  
Rabin Medical Center Belinson  
Putsch Tikva, Israel  

Man who had lung transplant to blow shofar for first time in 40 years  
The Jerusalem Post, 11 Sept 2013

57-year-old man who used to blow the shofar in his synagogue until he was 17 years old, when he suffered serious lung damage in a prank played on him, succeeded this week to blow the ram's horn again for the first time. It was made possible after rehabilitation at the Rabin Medical Center-Beilinson campus in Petah Tikva, where a new lung disease center was dedicated recently.  
Read full article →

FROM THE UNITED KINGDOM:

Steven SL Tsui, MD, FRCS  
Papworth Hospital NHS Trust  
Cambridge, United Kingdom  

UK's 1st SynCardia Total Artificial Heart Patient Bridged to Transplant at Papworth Hospital  
virtual-strategy.com, 10 Sept 2013

SynCardia Systems, Inc. announced today that Matthew Green, the UK's 1st patient to be discharged with the SynCardia temporary Total Artificial Heart, has been successfully bridged to transplant after almost two years of support. Green, his wife and their 7-year-old son celebrated his new beginning with a holiday.  
Read full article →

FROM THE UNITED STATES:

Kalpaj R Parekh, MD  
University of Iowa Hospitals & Clinics  
Iowa City, IA, USA  

Lung transplantees walk on air with their U of I docs  
Des Moines Register, 29 Sept 2013

As participants arrived Saturday morning at Principal Park in Des Moines for the American Lung Association's annual Fight for Air one-mile and five-kilometer walk, many introduced themselves not by name, but by number. "I'm number six," said Pete Wilgenbusch of St. Charles. "You look good. I'm 83," said Don Reed of Bettendorf as the men shook hands. Their numbers were the order in which they underwent lung transplants at University of Iowa Hospitals and Clinics' lung transplant program.  
Read full article →
Richard Ha, MD
Stanford University
Stanford, CA, USA

**Stanford Hospital now offers total artificial heart**
abcLocal.go.com, 24 Sept 2013

A new program at Stanford Hospital is helping to keep the most at-risk heart patients alive while they wait for a transplant. It not only offers them a bridge to life, but a surprising amount of freedom as well. Chess coach Van French attacks the game with both intelligence and heart. "It's equivalent to what an athlete would feel. When you know you have your opponent on the ropes in boxing, that is chess as well," he says. [Read full article →](#)

Marie M Budev, DO, MPH
The Cleveland Clinic
Cleveland, OH, USA

**Nurses surprise lung transplant patient and his fiancee with a hospital wedding after the couple was forced to call off nuptials when donor became available**
theDailyMail.co.uk, 25 Sept 2013

Nurses at a Cleveland hospital have surprised a lung transplant patient and his fiancee by organizing them a wedding—a month after the couple was forced to cancel their nuptials when a donor became available. Doug Smith, a police officer with life-threatening pulmonary fibrosis, was just a week from marrying girlfriend Susan when they got the call that the hospital had a lung for him. [Read full article →](#)

Alanna A Morris, MD
Emory University School of Medicine
Atlanta, GA, USA

**Women on Heart Transplant List Need Better Care**
Medpage Today, 26 Sept 2013

Women heart failure patients who are candidates for a transplant have a higher risk of death and morbidity at 1 year than men, researchers found. After adjusting for age, race/ethnicity, ABO blood group, BMI, diabetes, glomerular filtration rate, pulmonary wedge pressure, inotropes, and support with extracorporeal membrane oxygenation or intra-aortic balloon pumps, women had a 10% greater likelihood of being removed from the wait list at 1 year because of death or comorbidities (95% CI 1.01-1.20, P=0.026), according to Alanna A. Morris, MD, of Emory University School of Medicine in Atlanta, and colleagues. [Read full article →](#)
Sanjeev Aggarwal, MD  
Mid America Heart Institute  
Kansas City, MO, USA

**Sunshine Heart Implants First Patient in COUNTER HF US Pivotal Trial**  
benzinga.com, 12 Sept 2013

Sunshine Heart, Inc. announced today the first patient implant in the Company's U.S. pivotal trial, COUNTER HF. The COUNTER HF study is a prospective, randomized, multi-center, controlled trial that will evaluate the safety and efficacy of the C-Pulse system for the treatment of NYHA Class III and ambulatory Class IV heart failure. Integral to the COUNTER HF study is the assessment of C-Pulse's unique balloon counterpulsation treatment designed to improve heart function and reduce re-hospitalizations due to worsening heart failure. [Read full article →](#)

Asghar Khaghani, MD, FRCS  
Spectrum Health  
Grand Rapids, MI, USA  
**Theodore J Boeve, MD** and **Tomasz A. Timek, MD**  
West Michigan CT Surgeons Grand Rapids, MI, USA

**Spectrum performs state’s 15th combined heart, lung transplant**  
Midland Daily News, 18 Sept 2013

Spectrum Health said last week that its surgeons performed the first combined heart and lung transplant in West Michigan and the first in the state in 14 years on Aug. 23 at the Spectrum Health Fred and Lena Meijer Heart Center. Jeffery Sargent, 56, of Rockford, emerged from surgery that morning and is in good condition. [Read full article →](#)

O Howard Frazier, MD, FACS, FACC  
Texas Heart Institute  
Houston, TX, USA

**St. Luke’s heart patient releases acoustic guitar album**  
YourHoustonNews.com, 6 Sept 2013

Widely known as one of the top acoustic guitarists in the world, Pete Huttlinger has finally released his highly anticipated, 15-track album that he began working on in 2006. He credits St. Luke's Medical Center (SLMC) in Houston and the Texas Heart® Institute for giving him the opportunity to finish what he started. [Read full article →](#)
Gift of life given to Wheatfield man
Niagara Frontier Publications, 6 Sept 2013

Tim Synor considers himself a lucky man. He is recovering from a heart transplant received at the University of Rochester Medical Center and recently returned to his wife, toddler son and infant daughter in Wheatfield. "I am so grateful to the donor and their family and the doctors and nurses who cared for me. I am also incredibly thankful for all of the support that my family and I received during my illness. I have a new lease on life now. I feel better than I've felt in a long time and am excited to resume my life with my family," said Synor, 46. Read full article →

Long Beach Baby With Deadly Heart Condition Receives Transplant
CBS Los Angeles, 6 Sept 2013

A Long Beach baby who was born with a deadly heart condition has received the gift of life. Last week, KCAL9's Kristine Lazar told the story of Brooklyn Ledesma, who was entering her eighth month on the heart transplant list after she was diagnosed with dilated cardiomyopathy. A machine, called the Berlin Heart, was keeping her alive. On Monday, the day Brooklyn turned 10 months old, her mother, Miriam, got a call that a heart was available. Read full article →

New System Gives Hospitals More Time For Lung Transplants
IndianaPublicMedia.org, 9 Sept 2013

Indiana University Health Methodist Hospital is one of seven centers in the country that is now using the XVIVO Lung Perfusion System. The system allows surgical teams to take somewhat marginal lungs, place them on the machine to study them and then perform interventions to improve the lung so it's usable for transplant. The first surgery was performed six weeks ago on a patient who had end-stage lung disease. It was the first one in the state using XVIVO technology. Surgical Program Director Dr. Thomas Wozniak says this means an increased availability of lungs for patients on transplant waiting lists. Read full article →
Abbas Ardehali, MD
UCLA School of Medicine
Los Angeles, CA, USA

TransMedics keeps donor hearts beating en route to transplant patients
america.aljazeera.com/, 8 Sept 2013

In 1967, doctors in a South African hospital performed the very first successful human heart transplant. Now approximately 5,000 heart transplants are performed worldwide each year. At 2,000 transplants a year, U.S. surgeons handle the bulk of those procedures. Heart surgery has become more efficient and fairly routine over time, but one aspect of the organ transplant process hasn't changed since that first operation: Transport. Read full article →

Navin Rajagopalan, MD and Charles W. Hoopes, MD
University of Kentucky
Lexington, KY, USA

Heart-lung transplant can't keep longtime middle school teacher out of the classroom
kyforward.com, 9 Sept 2013

After 34 years in the classroom, many schoolteachers might be looking to move on to new things. Not David Morrow. The 57-year-old science and language arts teacher at East Washington Middle School in Pekin, Ind., is now in his 35th year of teaching and still going strong. That alone is impressive enough. Even more impressive? The fact that Morrow is back in his classroom today after undergoing a combined heart and kidney transplant at UK Chandler Hospital last November. Read full article →

David D'Alessandro, MD and Jacqueline Lamour, MD
Albert Einstein College of Medicine at Montefiore Medical Center
New York, NY, USA

Montefiore Medical Center Department of Cardiovascular and Thoracic Surgery: A Heart Transplant Team for All Ages
MDNews, 3 Sept 2013

Each year, multiple cases bring the pediatric and adult branches of the cardiac medicine program together in practiced harmony. The story began with a string of referrals. Daniel Blanco, a 17-year-old boy from the Dominican Republic, was suffering from dilated cardiomyopathy due, his family believed, to a viral infection he contracted when he was a toddler. Upon hearing of the case from physicians in the boy's home country, Mario Garcia, MD, Chief of Cardiology at Montefiore, recommended the patient come to New York for advanced treatment. Read full article →
Editor’s Corner: Coke, Soda, Pop or Sodi-Pop

Vincent Valentine, MD
Links Editor-in-Chief
vqvalent@utmb.edu

In the last month’s issue of the Links on English, Communication and Confusion, we barely scratched the surface about the distinct Englishes across the globe in an effort to increase our awareness of the differences that could simultaneously improve communication and add to confusion. To further lead you into “muddy waters” on this issue and in this issue of the Links, we will look at some of the dialects (regional variations of terms) used across the United States. Yet this is another example of the importance of appreciating the variations of the English language to improve communication. Moreover, do not mistake dialect for accent, dialect for slang or dialect for jargon. For the finer distinctions of our mutually intelligible English see Dialects: Reveling in Linguistic Freedom. In this link by Lesley Lanir, take note of the US map of dialects and isoglosses and also understand the balance of linguistic freedom and how it shapes our communication.

Well back to the task. Torrential rains can put a real damper on outdoor weddings, outdoor concerts, or any outdoor festivity or activity: parades, Mardi Gras, Oktoberfests, and for the end of October in America, Halloween, just to name a few. The yard sale or the tag sale of the east coast or garage sale of the Midwest would have to be cancelled because of a deluge. The richness of the English language also gives us for a hard rain: a flash-flood, gully washer, downpour, pour-down, frog strangler, goose drowner, trash mover, stump mover, fence lifter, chunk floater, turd floater, and a fence lifter. Personally, I can remember when it used to rain cats and dogs.

Also, according to the Dictionary of American Regional English (DARE) there are over 170 terms for “dust balls” found under the bed. These potentially antigenic nuisances pile up over time. And if you have carpet, they may go unnoticed for years. However, many Americans have noticed these masses of fine dry particles of matter, especially hair and skin particles and have given various names for them depending on the region of America you’re from. Pardon me while I scratch my itch. Anyway, terms for these dust bunnies as we called them in the south include: dust kittens, gollywogs, fooskies, curds, reebolees or ghost manure, just to mention a few. For more on this I refer you to DARE, the six-volume compendium which began, according to the New York Times as “one of America’s most ambitious lexicographical projects” and was conceived by Frederic Cassidy over 50 years ago as a homegrown answer to the Oxford English Dictionary. The DARE researchers traveled in their vans (word wagons) with various recording devices using 1847-item questionnaires for decades to harvest the different words Americans use to describe the same things.

So how do you address a group of people? Originally, in the history of English, thou was a singular second person nominative pronoun and ye and you were plural. After thou and ye died off, you took over for both functions. Today, the Southern dialect gives us the word y’all for the plural you.
Depending on where you’re from, you might hear you guys, you all, you mob, you lot, your lot, the whole lot of you, yours, you ens and yinz. “Yinz” labels you from Pittsburgh and in some parts of Texas y’all is singular so you may hear, all y’all for the plural form.

With tremendous variation across America, the descriptor for something that’s diagonally across from something else is considered Catty corner especially in the south where I’m from. This is an example where English is trying to reduce the number of words to describe things or whatever with a goal towards brevity. Catty corner is actually Kitty-corner if you are from the North, North Midland or the West. While I’m in my corner, I’ll enjoy a Shrimp Po ’boy which, thanks to Subway, is just a sub in the rest of the United States unless you’re from New England. There it might be a grinder. (For all y’all Bostonians, yours guys might prefer a grindah.) It could be a hoagie or a hero if you are from New Jersey or the New York City area or just a hoagie if you’re from Pennsylvania. Then, when you’re done with your sandwich on a casual day, you might take a walk or stroll in your sneakers, tennis shoes, gym shoes, trainers, Converse, Keds or Nikes. In the south, we used to sneak around in tennis shoes as do others in the Midwest and along the west coast. Others from the mid-Atlantic States would play tennis in their sneakers while gym shoes and trainers are used interchangeably.

To quench your thirst you might want to go to the water fountain or a drinking fountain, but in Wisconsin they will send you to the bubbler which is also found around Rhode Island and Massachusetts. For more calories you might down a cabinet in Rhode Island. In the south, we prefer a malt and elsewhere it’s a milkshake. We usually leave our dishes and cups in the cabinet. Lately, America has changed its waistline primarily because of fountain drinks. In the East, Northeast and along the West Coast you might be offered a soda. In the Midwest and Northwest you might be offered a pop. Along the Mid-Atlantic seaboard people would offer you a “soft drink.” If a group of you attend an LSU football game in Baton Rouge, my family with true southern hospitality after ”getting down from their car”, instead of ”getting out of their car” will ask you, ”Would you like a coke?” Your reply might be, yes please, I’ll have a Dr Pepper and my wife will take a Barq’s.

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