IN THE SPOTLIGHT: ISHLT 2015 Recapitulation: Summary of the Plenary Sessions at ISHLT 2015

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The inimitable Andreas Zuckermann opened the 35th Annual ISHLT Meeting Plenary Sessions in the South of France by assuring that everyone will be famous for 15 minutes - Andy Warhol. Andreas pointed out that the meaning of Zuckermann in English, Sugarman, now who are you calling “sucker?” In his Program Chair Report, 2900 attendees represents the largest gathering of any ISHLT meeting outside North America. An all-time record of 1706 abstracts were submitted with 61% accepted. There is continued expansion of emerging nations from the Middle East, Asia, Eastern Europe and South America up another 3.5%. With that, two Emergent Regions Concurrent oral sessions and one Emergent Regions Poster session have been added to the slate. A shout out was made to having more abstracts submitted from Latin American countries and the Middle East and, overall, 59% of the abstracts were from the United States and 21% from western Europe. He went on to describe his year as Program Chair as being as difficult as traversing a huge mountain in Austria. With a good team, he managed to ascend the steepest cliffs and celebrate at the top, but he warned us of the treacherous descent resulting in surgery, a cast and confinement. The silver lining of this mishap was that it allowed him to dedicate more time to the ISHLT and the meeting. Amanda Rowe recognized that Andreas has set a precedence for future Program Chairs to dedicate more time to the ISHLT and the upcoming meeting. Among the highlights of his summary was how he chose the program committee. Picture three overlapping rings: 1) Dream big, 2) Get shit done and 3) Know how to have fun – Andreas pointed out that the people he preferred were those who possessed elements from all three rings. He concluded his summary with a demand – Go to the Sessions and not to the Beach!!!

After the Program Chair’s report, the Thoracic Registry and MCSD Reports were delivered by Drs Josef Stehlik and James Kirklin. Josef began the 32nd Annual Report with a Focus theme of Early Graft Failure – Mortality or Retransplantation within 30 days of transplant. Now over 40% of patients who underwent heart transplant were previously supported by LVAD. The hazard ratio of 30-day early graft failure in heart transplant correlates unfavorably with increasing donor age by multivariable analysis. Donor age just above 30 crosses unity then up to just under age 55 where the risk of 30-day early graft failure doubles. Also, freedom from chronic allograft vasculopathy has improved over the last decade when compared to the prior decade from 85% to 86% at 5 years which although statistically significant (0.03), may not be clinically significant. Nevertheless, there has been an obvious drop in early graft failure from 3% to 1% in the last 5 – 7 years. The proportion of children undergoing heart transplantation from mechanical support is close to 30%, most from VAD support. In lung transplantation, the incidence of early graft failure has shown improvement from 2005-2008 to 2009-2013 eras. There has been a 35% reduction in incidence to 2% at 30 days in the most recent era. Those undergoing lung retransplantation are twice as likely to experience 30-
day early graft failure at 4%. Josef concluded his report showing the strength of the US Dollar versus the Euro increasing nearly 25% over the last 12 months.

Dr. Kirklin outlined the MCSD report with a review of its history, acknowledgements, an important point on its governance, enrollment update and some data from implants. From January 2013 – December 2014 there have been nearly 6000 implants, 87% between 40 – 80 year olds with nearly two-thirds from Intermacs profiles 2 and 3, progressive decline (sliding) or stable but dependent on inotropes, respectively. About 55% are bridged to either transplant or candidacy and another 40% are implanted for destination therapy. An LVAD is used 93% of the time. The one-year survival is 80%. Most deaths are related to multisystem organ failure, neurologic causes, heart failure, infection and hemorrhage. Jim concluded that the first IMACS annual report will be submitted for publication very soon with a detailed analysis of adverse events and the first multivariable risk factor analysis.

Herman Reichenspurner followed with his Presidential Address focusing on “Our Obligations Toward the Next Generation through Youth and Enthusiasm.” Throughout his presentation, he showed the importance of the Platforms provided by ISHLT, plus an individual’s enthusiastic contribution, can result in an opportunity for a Career within ISHLT. The International Society, which began as a small gathering of about 15 cardiologists and cardiac surgeons in 1981, has grown to its internationally diverse membership of over 3000 members, representing nearly 50 countries, who manage patients with end-stage heart and lung diseases across the globe. ISHLT has broadened its scope from transplantation to mechanical support and replacement. There is enthusiasm with research, high quality scientific meetings, and an important scientific journal along with many research grant possibilities sponsored by our Society. For individual involvement, there are 11 different Councils with the Council for Junior Faculty Trainees highlighted for our youth. Each Council functions independently with similar structure and workforces along with unified term limits for consistency within our expanding Society. The Junior Faculty Council in particular emerged in 2008 as an independent council for the interest of our younger members. Activities and symposia are now part of the Annual meeting giving many opportunities for our youth to be involved. There is now an international transplant fellowship database, a “job board” and an online repository of teaching slide sets in thoracic transplantation. Hermann highlighted the Grants and Awards Program and displayed the past recipients of the Caves Award. He also pointed out the importance of the International and Inter-Society Coordination Committee (I2C2) and its role in facilitating liaisons with other organizations in order to develop joint standards and guidelines with other medical and scientific societies. With an International vision there have been provisions to work with governmental organizations such as the Ministries of Health and grant funding organizations which have opened doors to exchange scientific information and collaboration. Finally, he summarized the Board actions including the creation of a Governance Task Force and the initiation of a Strategic Planning Process. Hermann paralleled his personal experience and ascendency to this year’s President with the evolution and expansion of ISHLT. He summarized for emphasis that ISHLT provides the ideal platform for young clinicians and scientists, but it requires Youth and Enthusiasm, as demonstrated by the Federal Youth Ballet, choreographed by John Neumeier.

In tune with the expectations of high quality health care with focus on certain never events, Wolfgang Müller-Pietralla, who heads the department of Future research and Trend Transfer within the
Volkswagen Group from Wolfsburg, Germany, delivered his innovative presentation of Vision ZERO – Cutting Edge Technology for Ultimate Protection. He demonstrated a Volkswagen driving on auto-pilot with many high tech feature and sensors to reduce automobile accidents, thus exemplifying the focus on safety; a lesson we must take from the automobile industry and apply to health care in ISHLT for the safety of our patients.

The Pioneer Lecture, From Allogeneic to Xenogeneic Heart and Lung Transplantation – A 30-Year Journey, was given by Bruno Reichart. He captivated the audience with his opening slide and references to Hotel Le Negresco and Lewis Carroll’s little Alice asking the Cheshire cat, “Would you tell me, please, which way I ought to go from here?” The cat, forever grinning from ear to ear, responds, “That depends a good deal on where you want to get to.” Bruno recounted his experience with the ever quotable Norman Shumway, who teaches us “nothing is routine,” “the best way to predict the future is to invent it,” and “xenotransplantation will be the future – and always will be.” Bruno shared with us the importance of animals for what we do, from anti-lymphocyte globulin produced by Bavarian horses to research on piglets, rhesus monkeys and baboons. Along the way, he displayed the similarities of hearts from the white, black and yellow patients with reference to the United Colors of Benetton to reiterate the combat against the culture of hatred in all forms. He described his accomplishments and experience from Cape Town, across South Africa and then to “the toaster” – Grosshadern Hospital of Ludwig-Maximilians-University (LMU) in Munich. His notable contributions included, among others, the possibility of cardiac xenotransplantation, improvement of lung preservation with low-potassium, and the use of simvastatin on chronic allograft vasculopathy. He concluded with the importance of bringing together immunologists, bio-engineers, virologists, primatologists, ethicists and clinicians by coordinating the Collaborative Research Center at LMU which included the Technical Universities of Munich and Dresden, the Medical University of Hannover, researchers at the Helmholtz Center in Munich, the Friedrich Loffler Institute, the German Primate Center, the Paul Ehrlich Institute and the Robert Koch Institute.

The second day of the Plenary sessions was opened by Francis Delmonico MD, Professor Surgery, Harvard Medical School, Executive Director of Istanbul Custodian Group, Advisor of the World Health Organization, Medical Director of the New England Organ Bank, and Professor Willem Weimer of Erasmus Medical Center in Rotterdam.

Dr. Delmonico put together the Declaration of Istanbul on Organ Trafficking and Transplant Tourism and presented his talk on Fighting Transplant Commercialism: The Impact of the Declaration of Istanbul. He informed us that organ trafficking is a highly lucrative business, a global phenomenon, and is possibly underestimated at up to 10%. He advocated for all of us to prohibit transplant commercialism because it targets the impoverished and vulnerable leading to inequity or injustice. Transplant tourism is to be forbidden by law. He referred us to – Organ Trafficking and Transplant Tourism: The Role of Global Professional Ethical Standards – The 2008 Declaration of Istanbul. Transplantation 2013; 95:1306-12. The WHO Guiding Principle of Transparency advocates such practices while simultaneously ensuring personal anonymity and protecting the privacy of donor and recipients. He also referred us to the recent article on Organ Transplantation for nonresidents of the United States: a policy for transparency. Am J Transplant 2014; 14:1740-3. Now that we are
educated, we must advocate and participate by fighting against such transplant-related atrocities which are criminal. We must play a pivotal role.

Professor Weimer’s presentation was on Tackling Transplant Commercialism: A Criminological Approach. His main message was: **It is just not enough to say “STOP.”** Human Organ Transplant Commercialism is a billion dollar industry, rounding out the top ten just behind the gold industry. From a survey of nearly half transplant professionals in The Netherlands who had treated patients who traveled abroad for kidney transplantation, 70% were either suspicious or certain that the kidney was purchased. He suggested what works to guard against using a “top-down” and “bottom-up” approach. Bottom-up measures include: dissuade patients from purchasing organs from abroad, advocate for health insurance regulations, encourage patients to bring their donors from abroad and simplify national visa procedures for kidney transplantation. Also, we must strive for self-sufficiency by expanding living kidney donation, optimizing deceased donation, participating in home-based education programs, removing disincentives to donate, implementing incentives to donate such as lifelong health insurance exemption. Top-down measures, though controversial, might include withholding medical records or refusing care and disclosing patient information to the authorities, particularly when there are threats. From the referenced article, Policy Statement of Canadian Society of Transplantation and Canadian Society of Nephrology on Organ Trafficking and Transplant Tourism, Transplantation 2010;90:817-20, “Physicians should not prescribe medications or otherwise facilitate obtainment of medications that will be used during the transplantation of a purchased organ?”

Later on the second day, April 17, 2015, we had the Annual Business Meeting. Our Editor-in-Chief of the Journal, Dr. Mandeep Mehra described the rise of the source normalized impact per paper (SNIP) measure, which weighs citations based on the number of citations in a subject field. He pointed out that “all citations are not created equal.” The SCImago Journal Rank (SJR) showed a near doubling in three years. This measure ranks journals by “average prestige per article.” He further showed that the relative impact of mechanical support and citations increased by 250%. The primary features of the Journal we can expect include: State of Art Series, Junior Faculty Engagement, Online Video Content and Supplementary Material, Thematic Issues, the New Cover and the Virtual Microscope.

Stuart Sweet delivered the Treasurer’s Report, showing a near doubling of the net worth of ISHLT in six years. Key plans for 2015 include: support of disciplined financial decision making, oversee an ISHLT audit and evaluate changing the Society’s investment policies to apportion some of our excess fund balance for income generation.

On the final day of Plenary Sessions, I did not attend. The Awards Presentations were scheduled, followed by Consensus Reports on Antibody Mediated Rejection in Lung Transplantation, given Dr. Debbie Levine, and Listing Criteria in Heart Transplantation by Dr. Mandeep Mehra. The Plenary Sessions ended with what I am very sure was a lively debate by our talented and illustrious speakers, Heather Ross and Marshall Hertz on The Q’s: Quagmire of the Quantity/Quality Quandary; Live Long, Don’t Prosper version by Heather and Live Fast, Die Young by Marshall. I am sorry I missed this, but it did conjure up, at least in my mind, James Dean and his immortalized quote, “Dream as if you’ll live forever. Live as if you’ll die today.”
Disclosure statement: The author has no conflicts of interest to disclose.
The 34th ISHLT Meeting and Scientific Sessions, held from April 15th to 18th, gathered the largest audience ever for an ISHLT European venue. Besides the charming Promenade des Anglais, the freshness of the seafood at Café de Turin, and the Italian taste of the old downtown, what is going to remain in the heart of the many cardiologists crowding the Acropolis conference Center?

This year, congress dealt with many of the current needs and doubts of a physician working in the field of heart failure and heart transplantation, identifying four major topics of novelty: 1) utilization of hearts from DCD donors; 2) optimization of LVAD use, indications and outcomes; 3) intriguing insights into the use of mTOR inhibitors; 4) novel approaches to monitor for rejection and digging into the AMR conundrum.

A still heart, resuscitated, warm perfused, reconditioned, and successfully transplanted. The breathtaking reports from Sidney and Cambridge discussed in a pre-meeting symposium and in a concurrent session, presented two different techniques, both based on the cardiac organ care system (OCS), allowing successful heart transplants from DCD donors. The phases of minimization of organ damage during withdrawal, organ preservation and assessment of heart function before implantation were presented and discussed, as well as related ethical issues and ex vivo assessment of their function. This is probably the foremost important novelty showed at the meeting in the heart transplantation field. Despite the rise of the machines to mechanically assist circulation is epidemiologically overcoming transplantation, Peter MacDonald and Steven Tsui groups brought us back to a crucial task of our mission of taking care of patients with severely failing heart: improve organ utilization and quality of donors. Their techniques not only allows safe utilization of organs from a rising category of donors, those with circulatory death, but also shed light on the need to improve in everyday practice the under-use of many organs from brain dead donors. If a still heart may resuscitate and work in a severely ill heart failure patient, couldn’t we recover and use some of the many beating hearts currently feared too risky to be taken?

Besides the annual INTERMACS registry report, showing constant improvement of outcomes in patients bridged to transplant, but also treated with a LVAD as destination therapy, several studies have reported novel insights regarding the use, indications, management and results of LVAD therapy. A study from Grimm et al, it appeared that bridge to transplant with a VAD > 1 year doesn’t confer an increased risk of mortality. One of the most relevant news is ENDURANCE trial, a non-inferiority prospective randomized study comparing safety and efficacy of HVAD pump vs Heartmate-II pump (2:1 randomization) among 447 patients within NYHA IIIb and IV ineligible for
transplantation. The primary endpoint was disabling stroke-free survival (Modified Rankin Score \( \geq 4 \)) at two years, defined as alive on the originally-implanted device, transplanted or explanted due to patient recovery. HVAD system achieved the non-inferiority endpoint, showing a higher rate of strokes but a lower rate of device malfunctions requiring exchange or transplant compared to Heartmate-II. HVAD system appeared to improve quality of life and 6-minutes walking test; sintering of the inflow cannula in HVAD resulted in a marked reduction in pump thrombosis, comparable to the one of Heartmate-II; multivariate analysis confirmed the previously-observed link between neurological events and mean arterial pressure, as elevated blood pressure was the strongest predictor of neurologic events. Thus, the results of a second destination therapy cohort, designed to confirm observations from ENDURANCE, that sites adhering to more regular monitoring and management of patient blood pressure witnessed a notably lower incidence of neurological events, are waited. Results from a subgroup analysis of REVOLVE registry confirmed the excellent outcomes on the HVAD device at 2 years. A study from Maltais et al showed a comparable neurological risk between the HMII and the HVAD devices in a contemporary cohort of patients bridged to transplantation, remaining advanced age the primary determinant of neurological events.

The issue of the comparison between medical therapy and LVAD implantation in ambulatory patients with advanced heart failure not inotropic dependent was investigated for the first time in the multicenter non randomized ROADMAP study, assessing the effect of Heartmate-II pump compared to optimal medical management; the results indicated that the HeartMate II enhanced long-term outcomes (1-year survival 80% vs 64%) Regarding myocardial recovery, RESTAGE-HF study, a prospective multicenter trial on myocardial recovery in LVAD patients suggested that a standardized regime of optimal pharmacological therapy combined with LVAD unloading and regular testing of underlying myocardial function may result in a higher rate of explantation and remission from Stage D heart failure.

A specific focus on the importance of renal issues has been made throughout LVAD or transplant candidates and transplanted patients. In particular, some contributions showed the importance of a careful assessment of renal function prior to LVAD implantation, including albuminuria detection, as a possible risk factor for subsequent right ventricular failure. The difficult interplay between heart and kidney function has been the topic of a Wednesday’s concurrent symposium, focused on the role played by venous congestion in determining renal failure and in contributing to the worsening of heart insufficiency, and in concurrent sessions, reporting renal sparing strategies by minimization or avoidance of calcineurin inhibitors in heart transplanted patients by the SCHEDULE and MANDELA trials.

The three years outcomes of the SCHEDULE study have been reported in several abstracts dealing with primary and secondary endpoints. This study compared an immunosuppressive strategy based everolimus and MMF with cyclosporine withdrawal at month 1-2 after heart transplant with a standard MMF-CyA arm. The three years results confirmed maintenance of the good kidney function data achieved at year 1 in the CyA free arm, despite some cross-overs mainly related to the increased number of biopsy detected cellular rejections. In addition, patients in the everolimus-MMF arm showed less CAV progression at three years as compared to the control arm. Similar outcomes were reported in the German MANDELA trial, in which two everolimus arms were compared: one with
complete CNI withdrawal at month 3 after transplant, the other with CNI (either TAC or CyA) minimization. The primary endpoint was renal function at one year. The novelty of this study was the association in de novo heart recipients of everolimus with TAC. Similarly to SCHEDULE the CNI-free regimen was associated with better renal function but more cellular rejection.

Antibody mediated rejection and non-invasive diagnosis of rejection were the two other main transplant topics at the meeting. Unfortunately, except for further confirmatory data about the prognostic and diagnostic role of donor-specific antibodies, and of the pAMR grading, no big news on evidences on treatments efficacy and safety were available. As stated in the pre-meeting symposium on B-cells, AMR still seems a big elephant examined by many blind researchers, all telling the truth, but none of them really aware of the big picture behind.

On the other hand, promising results on the side of non-invasive diagnosis for rejection have been brought by the CARGO II study investigators presenting several retrospective analyses on donor-derived cell-free DNA. This biomarker appears to identify biopsy-proven rejection with good accuracy, when used alone, and with excellent predictive ability when combined with the allomap scores. Despite limitations due to retrospective design and lack of prognostic correlation, this approach suggest a roadmap to identify an optimal approach for non-invasive diagnosis of rejection: the combination of immune-monitoring with a sensitive and specific marker for graft damage may lead to significant improvement of post-transplant management and reduction of unnecessary invasive procedures.

It has overall been a very exciting meeting, cutting edge, and also a meeting in which the changing of the era in the spirit and composition of our society was clearly touchable. New challenges are upcoming, as well as new excitement. The machine for the next meeting is already moving. See you in Washington and remember to submit your proposals for symposia!!

Disclosure statement: The author has no conflicts of interest to disclose.
The ISHLT in Nice: Viewed Through the Eyes of One Heart Failure/Transplant Cardiologist

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The ISHLT meetings in Nice provided a true potpourri of items of significant interest and importance to heart failure/transplant cardiologists. Although it is impossible to summarize the myriad presentations in a few paragraphs, some themes predominated and are worthy of highlighting (seasoned with a generous dose of personal opinion).

First, the burgeoning field of mechanical circulatory support versus the stable field of heart transplantation was clear. The functional benefits of LVAD implantation in patients with advanced heart failure continue to be shown, while the side effects (neurologic and bleeding in particular) continue to give us pause to expanding the use of LVADs to less ill patients. Fortunately, numerous presentations were aimed at trying to provide a basic understanding of the mechanisms of the complications that occur in VAD patients, which hopefully over time will allow a decrease in complications and more comfort in implanting VADs in less ill patients. In addition, one of the major benefits of our society, its international membership, provided the opportunity to compare and contrast VAD patient management strategies in centers around the world.

Two major VAD trials were presented at the meeting. The ROADMAP Study (Risk Assessment and Comparative Effectiveness of Left Ventricular Assist Device and Medical Management in Heart Failure Patients) was an observational study of the Thoratec HeartMate II LVAD compared to optimal medical management in patients with advanced heart failure. Thirty day mortality was the same in both groups (1%) while one year survival was 80% in the LVAD group compared to 64% in the medical group (on an as treated basis). Functional status and quality of life improved significantly more in the LVAD group (analyzed by 6 minute walk, health related quality of life, and NYHA class). Unfortunately, adverse events in the LVAD group remained similar to what was previously reported in the DT trial, with bleeding being the most frequent adverse event.

The ENDURANCE trial randomized patients eligible for DT 2:1 to the HeartWare centrifugal flow LVAD versus the HeartMate II axial flow LVAD. The trial did reach its primary noninferiority endpoint of stroke free survival at 2 years (55.0% in the HeartWare patients versus 57.4% in the HeartMate II patients). Of note, a change in the design of the HeartWare device during the trial (sintering of the inflow cannula) appeared to decrease the incidence of pump thrombosis. Overall, the stroke rate was higher in the HeartWare arm whereas device malfunctions requiring exchange or urgent transplantation were more common in the HeartMate II arm. Data analysis suggested that better blood pressure control in the HeartWare arm may decrease the stroke rate and a second cohort of patients is being enrolled with more attention being paid to blood pressures management.
A notable presentation regarded the possibility that the vWF degradation fragments in patients on continuous flow LVAD support may increase angiogenesis and angiodysplasia, a possible mechanism of the increased risk of GI bleeding. It was also of interest that many European centers do not routinely treat LVAD patients with aspirin, but only with vitamin K antagonists, and whether this would be adequate in the U.S. patient population where aspirin has more routinely been used is unclear.

Despite the rapid advances being made in mechanical circulatory support, heart transplantation remains the treatment of choice for patients with severe heart failure. However, the shortage of donor hearts and the number of sensitized patients on our waiting lists means that heart transplantation will never be the answer for all patients with end stage heart failure, even those deemed to be transplant candidates. Several presentations concerned approaches to the sensitized patient, including removal of antibody, prevention of antibody formation, blockade of the complement system, and immune modulation using IVIg, among others, but no consensus exists and timing the desensitization to take effect at a time a donor organ might be available is like trying to read tea leaves. The challenge is made even greater by the increased sensitivity of current assays to define the presence and strength of HLA antibodies, for which in many cases clinical relevance has not been clearly defined. Indeed, what does it truly mean if patients have negative cytotoxic crossmatches (which have allowed successful transplants for years) but virtual positive crossmatches based on solid phase assays? It raises the concern that by excluding donors based on more sensitive assays we may be doing our patients a disservice by excluding donor hearts that might work just fine.

An additional theme was heart allocation systems. Significant controversy remains regarding the appropriate priority for patients on implanted LVADs and with sensitization. Although LVADs can stabilize patients and allow hospital discharge, LVADs are not complication free and waiting until a patient has had a VAD complication to give them priority on the waiting list often results in a worse candidate for transplantation (i.e., one with a poorer outcome) or even precludes transplantation. For a sensitized patient, the donor pool is limited to donors who have antigens that are not felt to preclude successful transplantation, but under what circumstances (if any) should this give the sensitized patient the highest priority for a compatible donor, particularly with incomplete standardization of antibody detection techniques in different centers?

Presentations at the 2015 ISHLT Annual Scientific Sessions provided some answers to dilemmas we face daily in trying the optimize the outcomes of candidates for cardiac transplantation and those fortunate enough to become transplant recipients. However, they also brought to light even more areas where ongoing research is needed, and this is an equally important part of the meeting. To meet with colleagues from around the world and share our collective knowledge and challenges is a true strength of our society and its annual scientific sessions. I am already looking forward to next year’s edition.

Disclosure statement: The author has no conflicts of interest to disclose.
B Cells: Tolerance, Accommodation, Regulation, Immunodeficiency and Therapy

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During the 35th Annual Meeting and Scientific Sessions of the International Society for Heart and Lung Transplantation from April 15th through April 18th, the contribution of B cells to accommodation, rejection or tolerance of the allograft was a topic of interest. Current understanding of the role of B cells in heart and lung transplantation is limited. What follows are some highlights from distinct sessions.

In a specific pre-meeting symposium (number 18) with focus in B cells in transplantation, Dr Esme Dijke opened the session with a great review of the role of B cells in the alloimmune response. Potential biomarkers related with donor specific IgG antibody secreting B cells (number, persistence and mutations of V region) should be taken into account. Dr Platt who originally described and named a phenomenon called “accommodation” reviewed the role of B cells in this phenomenon and in transplantation tolerance. Accommodation is important for the survival and function of organ transplants. It is interesting how the humoral immune response under certain conditions can modulate the damage to the allograft. There was an interesting discussion going on at the end of the session about what is better tolerance or accommodation. We donʼt know clearly yet which is the frontier between accommodation and tolerance. B cells have the capacity to control or regulate the immune response to the allograft. Dr. Paul Blair reviewed definitions of regulatory B cells in humans [CD20+CD24(hi)CD38(hi)IgM(hi)IgD(hi)CD1d(hi)]. These are IL10 producing B cells. These cells can inhibit disease activity or control the activation of other immune cells. He discussed about the challenges for regulatory B cell therapy in the future.

Targeting plasma cells in transplantation was the title of an interesting presentation made by Dr. Meena Clatworthy. Why do we care about acute antibody mediated rejection, chronic antibody mediated rejection and long lived plasma cells? These are a barrier for desensitization and for the therapy of antibody mediated rejection. Long lived plasma cells reside in multicomponent plasma cell niches. The role of chemokines, eosinophils, BAFF and APRIL in the niches and drugs that target plasma cells and distinct components in the niches were discussed.

Finally, Dr. Jignesh Patel presented data on desensitization protocols for sensitized patients awaiting heart transplantation including combined therapy with plasmapheresis and Bortezomib (abstract 61), terminal complement inhibition with eculizumab (abstract 62), or high dose IVIG combined with eculizumab. The potential role of prophylactic extracorporeal photopheresis and of Belatacept in the prevention of development of donor specific antibodies in heart transplantation were also discussed.

The regulation of the immune system is tightly connected to immune tolerance. B cells can also secrete cytokines and subsequently regulate immune responses mediated by T and innate cells. In
the symposium The Future of Tolerance (number 12) Carla Baan reviewed the role of cytokines. IL-35 is a recently described cytokine that inhibits the proliferation of Th1 and Th17 cells. This cytokine is expressed by T regulatory cells, tolerogenic dendritic cells and also by regulatory B-cells and plasma cells.

B cell contribution to allograft dysfunction was explored in lung transplantation. In a study performed by Dr E. Vandermeulen and collaborators, CD20+ B cells were increased in patients with restrictive allograft syndrome and BOS (abstract 57).

Cardiac allograft vasculopathy (CAV) is a barrier for long term survival after heart transplantation. An interesting study performed by Dr C. Moore (abstract 248) characterized the clonal composition of B cell infiltrates in human cardiac allograft with CAV demonstrating the prevalence of polyreactive B cells in situ. Longitudinal B cell clone tracking was suggested from fixed paraffin sections.

The potential role of B-cells has also been investigated in ventricular assist device (VADs) users. VADs are associated with increased HLA antibody production in the bridge to transplant. Dr. M.H. Kwon and collaborators (abstract 605) observed that patients who had strong HLA antibody production had an increase in median levels of B cell activating factor (BAFF) as compared with nonsensitized patients.

Immunosuppressive therapies can lead to a secondary B-cell immunodeficiency state. One of the biomarkers of this state is hypogammaglobulinemia. Dr. R.S. Traister (abstract 367) presented data of a prospective study in lung recipients to evaluate the relationship between hypogammaglobulinemia and clinical outcomes. Among 133 lung recipients, those with hypogammaglobulinemia at 3 months after transplantation were at risk for developing recurrent pneumonia and increased mortality at 1 year. Hypogammaglobulinemia was a component of an immunological score to identify heart recipients at risk of infection in a prospective study presented by Dr. E. Sarmiento and collaborators (abstract 317). The same group presented data of a pilot clinical trial in which the replacement of hypogammaglobulinemia with IVIG was associated with a decreased risk of infection in heart transplantation (abstract 316).

Thus, the information presented during the meeting emphasizes that B cells contribute in multiple ways to allograft dysfunction, rejection, but also to regulation and tolerance, and suggest a complex balance that exists between the positive and negative regulatory functions of B cells after transplantation.

Disclosure statement: The author has no conflicts of interest to disclose.
Crossing the Bridge of Eastern and Western Cultures: Lung Transplantation in Turkey

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After the growing pains, lung transplantation is slowly becoming more common and successful in Turkey.

The first several attempts at lung transplantation in Turkey occurred in 1999 with no long-term survivors. The fifth recipient of lungs ten years later in 2009 was the first to achieve prolonged survival before succumbing to chronic allograft rejection. Between 2009 and 2014, 105 lung transplants have been performed in six centers (four of these are in Istanbul and two in Ankara). Only three of them have done more than 10 transplants while two have performed more than 30 transplants each. Interestingly, the vast majority of these transplants have occurred in non-university hospitals.

This initial six-year experience has been plagued by early postoperative and high one-year mortality rates which have translated into suboptimal long-term outcomes. However, there are interesting observations. First, silicosis and non-CF bronchiectasis seem to be the two most common indications for transplant referrals rather than interstitial pulmonary fibrosis and COPD for unclear reasons. Experienced thoracic surgeons can attest to the surgical challenges of explanting lungs from patients with silicosis and post-infectious bronchiectasis; the latter also poses other difficulties such as management of multidrug resistant infections following surgery. Second, transplant recipients during this early experience have been done on very sick who were definitely not “cherry-picked” during the pre-transplant evaluation. I had the opportunity to spend an entire day at a conference in Istanbul in 2014 to review the experience of transplant physicians in Turkey. Throughout the day, many transplant cases were presented to highlight various surgical or post-transplant medical issues, but one thing was obvious from the first slide of each presentation that outlined recipient characteristics; the candidates were very sick going into transplant. Perhaps this is one area to focus on to refine the outcomes of patients post-transplant especially during the learning and growth period of this field. There have also been tremendous successes during this early period, such as: successful use of ECMO to bridge to transplant, the use of EVLP, and cadaveric lobar lung transplant in spite of the many obstacles to success related to the lack of infrastructure and insufficient personnel in these emerging programs.

Another major challenge is donor lung availability and management in Turkey. In 2014, despite a population of 75 million, there were only 850 brain death declarations and 379 multi-organ donors; from these, only 33 lungs were used for transplantation. In order to advance the field of lung transplantation in Turkey, large efforts will have to be undertaken to improve the availability of donor lungs in parallel to the strides in patient selection and post-transplant management. An important consideration for the country is the designation of centers of excellence for lung transplantation
where transplants and research are performed and training of future transplant specialists is provided during the growth phase, which is hoped to result in controlled proliferation of other successful centers.

We look forward to receiving the positive news and results of lung transplants performed in Turkey. The platform of mentorship, teaching and learning and camaraderie provided by the ISHLT can assist in the healthy development and successful growth of lung transplantation in Turkey.

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

References: This article was written based on information provided by Dr. Cemal Asim Kutlu, Surgical Director of Lung Transplant Program, Dept of Thoracic Surgery and Lung Transplantation, Kartal-Koşuyolu Research and Training Hospital, Istanbul, Turkey
Welcome to beautiful Nice from Andreas Zuckerman, Program Committee Chair

Thank you all in the Program Committee for out-performing! And thank you to the members of our Society for their active participation on submitting wonderful proposals for the pre-meeting symposia - an all-time high of 130! This year’s meeting will be truly international. An international venue, an international President cooperating with an international program chair giving us an international flavor.

Amazing science will be presented. Its quantity and quality of science for this year’s meeting fills me with awe. Abstract submissions were an all-time high indicative of a premier Society where novel data on the care for those with advanced heart and lung diseases.

Let’s get ready to rumble!!

On Thursday, the opening plenary session will stage reports on the Program, registries, and a unique President’s address. Continuing on ‘off the beaten Track’ a lecture on Safety, protection and a new vision from another area of technology. Mr. Müller-Pietralla will share new paradigms of safety in the automobile industry. His lecture and the performance of the Federal Youth Ballet are sponsored by Volkswagen. The first featured abstract of the meeting will feature the results of the ENDURANCE trial, a huge MCS destination therapy trial. The Pioneer lecture will be delivered by Prof. Dr. Bruno Reichart, a true pioneer of thoracic transplantation. He will share with us his never ending exploration of xenotransplantation.

Friday’s Plenary session will start with important ethical and legal aspects of transplantation. Two globally respected speakers, Dr. Frank Delmonica and Dr. Willem Weimar, will highlight their views on Transplant Commercialism and how to guard against it. Another MCS featured abstract will share data from the ROADMAP trial. The following lecture will tackle new developments in protecting vessels from obstruction in every aspect of transplantation. Thereafter, the session will move to different areas of medicine: New developments in clinical research and patient management with the help of the Internet will be discussed by Dr. Marcus and an important issue for our daily work will be the lecture of Dr. Quittner focusing on what influences us in our judgment and decision making processes.

Saturday’s closing plenary session will start with the awards presentations. Consensus Reports on AMR in Lung transplantation and the new updates of listing criteria in heart transplantation will be presented.
The highest ranked abstract of the meeting will present the data of the GRIPHON study, on a new therapy in pulmonary hypertension. Next, the session will focus on two new developments in organ preservation: ‘supercooling’ will feature the ‘cool’ side of organ protection, whereas ‘going the distance’ will discuss the newest developments on DCD heart transplantation. Lastly, the traditional president’s debate will be battle of philosophies on quality of live vs. quantity of life. Heather Ross vs. Marshall Hertz will verbally fight it out. Everyone who knows our discussants, can be sure on a tough but entertaining contest.

As at last year’s meeting, poster sessions will be moderated by experienced leaders of the Society, so please grab a glass of wine and trampse through the session. This year promises to be an incomparable meeting. Along with President Reichenspurner, I welcome you to the 35th ISHLT Annual Meeting and Scientific Sessions at the Opening Plenary in Nice!

**Answer the Palliative Survey for ISHLT Members: The Twenty Questions Survey**

On behalf of the Councils for Heart Failure and Transplant and MCS we are asking ISHLT members complete “The Twenty Questions Survey” which examines attitudes and practices with respect to the role of palliative care in thoracic organ transplantation and MCS therapies.

As a Society of health professionals and caregivers that have chosen to spend our careers dealing with patients that have end stage organ failure we often assume the role of the cardiac or pulmonary “oncologists”. The care of end of life patients often falls to our care teams.

We would like to explore the ways in which we are integrating these services/attitudes and practices into our work. It is an important discussion and we would like get responses from our broad international membership.

We thank you in advance for completing the survey. If you choose to do this on line rather than in the paper format available at the ISHLT Nice meeting, please go to: [https://www.surveymonkey.com/s/NNKQM7W](https://www.surveymonkey.com/s/NNKQM7W)

Please complete only one survey.

**Pre Meeting Symposium 2: Heart Allocation Policies: The times they are A-Changin’**

**Heart Allocation Policies – Directions for the future?**

In the current climate of restricted organ availability, and the era of a growing population of patients supported by VADs, this pre meeting symposium chaired by Dr. Kobashigawa and Dr. Leprince looks to be an informative summary of experiences with the current heart allocation policies in the United States, Canada and Europe. This will illustrate the principle differences within the three regions and highlight some of the similarities for discussion. These presentations will lead on to the anticipated and controversial debates on whether patients with a ventricular assist device should be listed as a priority for heart transplantation, and whether heart allocation should be based on scoring systems rather than waiting times? We look forward to the arguments proposed by Dr. Schulz, Dr Strueber, Dr Smits and Dr Taylor during this topical session.
Pre Meeting Symposium 6: Psychological Assessment: Tools, Tips and Opportunities

To SIPAT or not to SIPAT, that is the question.
Psychosocial assessment is the frontline in determining if a patient is an acceptable candidate for MCS or transplant. There are many available tools that can be difficult to assess which one is “right”. The famous SIPAT tool creator, Dr. Jose Maldonado from Stanford University in the USA, will join this hot symposium. This session will be held today at 8:30 am in Euterpe.

Pre-Meeting Symposium 7: Moving MCS Therapy Forward

Next Steps in MCS Therapy
There have been tremendous achievements in the field of MCS over the last few years. However there is still room for improvement and so the experts in the symposium will discuss how to move MCS therapy forward. First, Dr. Mark Slaughter will address where we are now with fully implantable LVADs. Next to be discussed by Dr. Pagani are the traditional indications of bridge to recovery, bridge to transplant and destination therapy and whether or not it is now appropriate, to start moving away from these indications. Then Dr. Claudius Mahr will give a talk on how to reduce length of stay and readmissions of MCS patients, to improve resource utilization and to make the therapy more cost effective. At the end of the session there are two debates. One on whether all LVAD patients should receive heart failure medications, discussed by Dr. Birks (PRO) and Dr. Teuteberg (CON) and the second on whether LVAD patients should have a pulse, where the PRO part is covered by Dr. Schueler, while Dr. Potapov will provide the CON part.

Pre-Meeting Symposium 10: Therapeutic Strategies in Pulmonary Hypertension: Current Evidence and New Directions

Pulmonary hypertension is a significant cause of overall mortality and leads to decreased survival outcomes in patients with advanced heart and lung disease who undergo transplant. The expert panel including Drs. Mardi Gomberg-Maitland and Nazzareno Galie will discuss the benefits of combination and sequential therapy. Next, Dr. Marc Humbert will present emerging therapies followed by a discussion of pulmonary hypertension in clinical trials by Dr. J. Simon Gibbs. To conclude, Dr. David Jenkins will present evolving management for pulmonary hypertension.

Pre-Meeting Symposium 24: Clinically Relevant Thoracic Transplant Pathology

What are the cells behind rejection?
Don’t miss this primer symposium regarding rejection in heart and lung transplantation. Come to witness the specifics behind acute cellular rejection and antibody mediated rejection. How are they different? Hear insights from Denmark, the UK and USA. The session will be held today at 5:00 pm in Euterpe.
Get More Out of the Meeting with Tweeting! Use hashtag: #ISHLT2015

The modern way to stay connected at the 2015 ISHLT Annual Meeting is to follow us on Twitter - the online social network that connects you to news, stories, pictures and conversations that you’ll find interesting.

Why Twitter?
Twitter allows you to use 140 characters to put down your thoughts in a message. It also lets you follow other Twitter users, and retweet interesting content. You can begin conversations with other users by typing their Twitter handle (person's user name) for example, @person. We highly encourage you to join our online conversations as we keep you up-to-date with the latest news, meeting information and events taking place at this year's meeting.

We will be Tweeting before, during and after the Annual Meeting in Nice, France using the hashtag #ISHLT2015.

If you have a Twitter account go and Follow us now! (@ISHLT or https://twitter.com/ishlt). If you want a twitter account, you can easily go to www.twitter.com and create one for free! If you don’t have an account you can still search for #ISHLT2015 on Twitter and read what is posted.

The Power of the #hashtag
In the Twitter world, a pound sign (#) is called a hashtag. It is a keyword tag for the tweet so that other followers can find it. Just by simply hashtagging #ISHLT2015 you are following the trend and enlightening other followers on content associated with the 2015 Annual meeting.

Looking to learn more about Twitter, Twitter lingo and how to use it? Below are some great links for you to look at:

http://usat.ly/1bBzXEO
http://read.bi/1d15Qpn
http://twiends.com/how-to-twitter

WARNING: Once you get the hang of it, Twitter is entertaining, informative and addicting. Have fun and tweet away! 😊

7 Super Tips That Will Make You a Tweeting Pro
1. If you reach the max 140 characters in your tweet, try abbreviating words to make more space for your message.
2. Found a tweet that you found interesting? Go ahead and retweet it (RT)! Doing so will allow you to re-share the tweet giving credit to that source or follower.
3. Keep it professional and respectful. Stay away from foul language and thoughts. Remember, Twitter is a public forum. Once you say it online it’s hard to take it back.
4. When creating a message don’t overuse hashtags. 2 or 3 are enough for your message.
5. Be sure to give credit where credit is due. Always make sure to give credit to the person you are paraphrasing from or source you are quoting.

6. There will be a ton of eyes on your content. Be sure to Tweet accurate information for them to follow.

7. Let the world know who you are by showing your personality through each tweet!

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France, Science, ISHLT and Nice

What better venue to bring the International potpourri of the ISHLT than to Nice. Before credit is given to France for the many important scientific achievements from the 18th and 19th Century, think about the parallel influence from Germany of then and now. Also, other influences from Europe cannot be ignored especially from England, Italy, Switzerland, Austria, The Netherlands, Russia and other parts of the world. But because we are in France, because France had an edge in the days of the Enlightenment, and because most of the major figures seem to have come from France and the Academy of Sciences in France, let’s recall some of these names that still shape us today.

It was the great German Philosopher, Immanuel Kant (1724-1804) who characterized the enlightenment as a waking up to the realization that we created realms separate from ourselves on which we have become dependent. He further stated that enlightenment requires the courage to discern this, and that we must get rid of this self-imposed dependency or bias. Also, Germany gave us four faculties of education, Philosophy (included the Arts and Sciences) and the higher faculties: 1/ Law, 2/ Medicine and 3/ Theology - which takes care of life by teaching students how to settle people's differences, keep people healthy and take care of their souls.

Time will not permit much detail other than an alphabetized list of those from France and a word or two of their accomplishments.

- André-Marie Ampère, 1775-1836 – electrodynamics
- Georges-Louis Leclerc, Comte de Buffon, 1707-1788 – evolution
- Sadi Carnot, 1796-1832 – heat, thermodynamics
- Georges Cuvier, 1769-1832 – Father of Comparative Anatomy
- René Descartes, 1596-1650 – Father of Modern Philosophy
- Jean-Baptiste Lamarck, 1744-1829 – Evolution of species
- Pierre Laplace, 1749-1827 – Astronomy, Physics, Statistics, Laplace’ Law (T=pr) the influence on heart, lung and circulatory physiology
- Antoine Lavoisier, 1743-1794 – Father of Modern Chemistry, oxygen, combustion
- Louis Pasteur, 1822-1895 – Principles of vaccination, microbial fermentation and pasteurization

What we know here is very little, but what we are ignorant of is immense
- Pierre Laplace
All of the above has made us a high reliability organization. We must act as one committed to truth in a culture of safety no different than the automobile industry with a vision to ZERO problems or never events. Thanks to Hermann and Andreas.

Not to be missed is the Federal Youth Ballet performance during this morning’s Opening Plenary. The first of the dances is set to the music of the String Quartet by Ludwig van Beethoven and has been choreographed by the Director of the Company, John Neumeier. The second is a dance-impression of saying "Thank You" by young choreographer Sasha Riva. The ballet performance is sponsored by Volkswagen.

**You can’t always get what you want, but you get what you need**

*A Review of Pre-meeting Symposium 06*

Dr. Jose Maldonado’s popular assessment tool was presented by psychologist, Quincy Young. The SIPAT tool consists of measured domains: readiness level, psychosocial stability, social support system, and substance dependence/abuse.

Review of studies using the SIPAT tool found it easy to use with confidence and reliability with reasonable results. Some negatives of the tool included difficulty with treatment adherence and relapse of psychiatric problems. Average scoring of the SIPAT tool ranges from 0-20. Perfect score is 0 and the higher the score, the greater the psychosocial risk. A score of >20 is concerning. Scoring summary: 0-6 excellent, 7-20 majority, 21-39 minimally acceptable psychosocial transplant candidacy. The tool additionally can predict rejection, hospitalizations and infection occurrences. Another limitation was the lack of accessing organ failure and mortality. This recent study was based on 1 year outcome and in the future would be beneficial to look at longer duration to assess the effectiveness of this tool. For more information and free tool access, email to request a form to Quinc Young: Qyoung@providencehealth.bc.ca

**Heart and Kidney: Not just an interface but an interlace**

*A Review of Pre-Meeting Symposium 08*

This appropriately titled session chaired by Drs. Gonzalez-Costello and Baran contained six informative presentations. Dr. Colombo started off by describing how venous congestion can begin several days before symptoms of heart failure become apparent. He described how endothelial activation occurs as a separate entity leading to an inflammatory cascade. This was suitably followed by Dr. Costanzo describing the cardio-renal syndrome and in particular the sequence of events and consequences of splanchnic, hepatic and splenic congestion. She also presented some data from the CHAMPION trial and discussed how early detection of congestion prior to symptoms and its management reduced hospitalizations.

Dr. Testani went on to describe the metrics of congestion and the poor correlation between weight loss and fluid loss. He also eluded to the poor correlation between central venous pressure and blood volume and discussed hemoconcentration as a surrogate for volume but cautioned that this was not a marker to be used solely to guide decision making, merely an additional tool. Next, Dr. Burch presented the sequelae of a failing Fontan circulation including protein losing enteropathy and plastic bronchitis. He explained
that appropriate timing of transplantation remains difficult, and with respect to medical therapy, Bosentan remains the only agent, shown to have clinical improvement (reduction in NHYA class and improvement in VO2) in this group.

The final two presentations saw Dr. Czer tell of the Cedars Sinai experience with combined heart and kidney transplantation and how this is similar to the UNOS results with similar survival outcomes to heart transplant alone. Dr. Barten explained the strategies for renal sparing post cardiac transplant including delaying the introduction of CNI, CNI reduction and withdrawal with the use of everolimus as a possible alternative (NOCTET, SCHEDULE and on-going MANDELA study).

**Extreme Donors: Pushing the Boundaries**

*A Review of Pre-Meeting Symposium 14*

As organ donor shortage is a big issue in heart transplantation, this Pre-Meeting Symposium addressed the possibilities to enlarge the organ donor pool. First Dr. Freed gave an overview on the implications of Heart donation from DCD donors and also pointed out which critical role the media play in this field, with questions like “Do we hasten death for transplantation?” or “Dead enough?”. Dr. MacDonald then presented three essential rules for successful transplantation from DCD donors. First, to minimize organ damage during withdrawal of life support, second to optimize organ preservation and third to assess organ function prior to transplantation. In his second talk, Dr. Freed presented a method of ex-vivo assessment of hearts from DCD donors, which might be an important future tool to evaluate those hearts before transplantation. Dr. Kirk and Dr. Messer shared their experience on Heart Transplantation from DCD Donors from a Pediatric and an Adult Perspective, and demonstrated that we have in both fields a necessity to widen the donor pool, as still many patients are dying on the waiting list.

Dr. Baran finally closed this interesting session with his talk on risk factors for transplantation of hearts from DCD donors, and concluded that there is a large need for organ rehabilitation strategies as the hearts that we nowadays need to accept are of poorer quality. We therefore need to go new ways and do everything possible to maintain in the future the good results of heart transplantation that were achieved in the past.

**From Novice to Expert: The biting start!**

*A Review of Pre-Meeting Symposium 24*

Dr. Carmela Tan from Cleveland Clinic in Ohio gives an excellent overview for the novice clinician in transplantation. Endomyocardial biopsy is the gold standard for ACR and antibody mediated rejection (AMR). Biopsies are taken from the right side of the interventricular septum. Several types of biotoms can be utilized for this process. Biopsy pieces generally range in size from 2-3 mm. Biopsies can be processed within 1 hour. There is a minimum of 3 specimens retrieved and stained, which reduces chance of biopsy sampling error. Biopsy site may cause an Endomyocardial thickening at the site of testing. The biopsy may appear as thrombus if recurrent biopsy from the same area. Additionally a large amount of fat seen on biopsy may indicate the biopsy was taken from the free wall instead of septum. The working diagnosis, which was newly updated in 2005 now combines the old Grade 1A, 1B and 2 called Grade 1R. Grade 2R shows modular infiltrates which is more diffuse. Higher rejection can be identified on a lower magnification. Additionally the biopsy may show diffuse multiple lesions indicating myocytes
injury. Other identifiers that can mimic rejection include guilty effect, infection and lymphoproliferative disorder. Diagnosis may only be in one cell, which can be misleading. Also biopsy artifact can make interpretation difficult. This was a very descriptive instruction on the specific steps and interpretation of ACR.

**TODAY’S FEATURES**

**Concurrent Session 1: Outcomes with mechanical circulatory support**

**VADs: How they doin’!**

If you are interested to learn more about the evolving outcomes for patients on mechanical circulatory support be sure to attend the Thursday late morning session chaired by Dr. Birks and Dr. Santise in Apollon. The session opens with Dr. Schmitto presenting real world registry data (The REVOLVE registry) and experience with the HeartWare VAD across Europe and Australia. Dr. Potapov will then discuss the German experience with the HeartMate II device in an almost 500 patient cohort with an acceptable low complication rate. The session will also include results from a multi-center European study of 1000 patients with the HeartWare device presented by Dr. Krabatsch from Berlin.

**Concurrent Session 3: Choosing the Best Recipients for Lung Transplant in the Era of Urgency**

**How they compare!**

The Cohort of Lung Transplantation (COLT) Study is an ongoing, prospectively gathered patient cohort from multiple institutions with the goal of identifying mechanisms involved in chronic organ rejection. The study presented in this abstract examines a subset of patients within the COLT cohort defined as high-emergency by a sudden decline in clinical status. Dr. Lacoste will present the results of the first 1000 patients who met these criteria and discuss short and long-term survival outcomes under the new regulations of organ allocation within the French system.

**Concurrent Session 4: Donor Management-Organ Preservation-Heart: Extending the Margins**

**How to overcome organ donor shortage?**

Due to organ shortage, it is time for new ways in terms of organ preservation. In this Session, held today at 11am in Erato, Uranie it will be discussed how to increase the donor pool from donors outside standard acceptability criteria. Dr. Garcia Sáez will present data on normothermic organ preservation, while Dr. Connellan will provide information on the techniques of heart procurement in the Donation after Circulatory Death scenario. Furthermore Dr. Messer will present interesting data on functional assessment of the DCD Heart within the donor and ex vivo from a porcine model.
Concurrent session 7: Supporting the MCS Patient & Caregiver

Caregivers are our patients too!

Further review and assessment regarding quality of life and different factors associated with caregivers will be discussed in this dynamic session presented by The University of Tokyo, Japan.

Answer the Palliative Survey for ISHLT Members: The Twenty Questions Survey

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As a Society of health professionals and caregivers that have chosen to spend our careers dealing with patients that have end stage organ failure we often assume the role of the cardiac or pulmonary “oncologists”. The care of end of life patients often falls to our care teams.

We would like to explore the ways in which we are integrating these services/attitudes and practices into our work. It is an important discussion and we would like get responses from our broad international membership.

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https://www.surveymonkey.com/s/NNKQM7W

Please complete only one survey.
You are invited to participate in a discussion forum on

Thoracic Transplant Nursing

Hosted by
Cedars-Sinai Heart Institute

in collaboration with the
Nursing, Health Science and
Allied Health Council of the ISHLT

Friday, April 17th, 2015
12:30pm - 2:30pm
(lunch will be served)

NH Hotel (Hotel Novotel)
2-4 Parvis de l’Europe
Nice, France
(adjacent to the Acropolis Convention Center)

Complete a pre-meeting survey by visiting:
https://www.surveymonkey.com/r/TransplantNursing

**See a meeting announcement card in your ISHLT delegate bag
for more information and a meeting map**

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A Cabaret of Senses: A Touch of Class

The origin of Nice can be traced to ancient Greece, at least in name. The Greeks believed music had the power to change nature, heal the sick and transform the human heart. The ISHLT and its roots have been changing hearts for the sake of humanity for nearly half a century. But yesterday, it was Hermann and Andreas who orchestrated a change to the programmed arrangement of the ISHLT Plenary by immersing us into a blend of visual and auditory delight. This was accomplished by bringing their inimitable music cultures for us to witness the aesthetic beauty of the arabesque, assemblé, penché, piqué, pirouette and plié, among the many ballet terms (France formalized ballet which can provide one an introduction to the French language) performed by the Federal Youth Ballet choreographed by John Neumeier and set to none other than Beethoven’s String Quartet. We were left with a bit of impressionism of merci by the Ballet’s final piece.

In terms of classical music, here in Nice, we witnessed a cabaret of cultures. This cabaret stems from the Viennese Classical style of Wolfgang Mozart’s and Germany’s Ludwig van Beethoven to France’s own Claude Debussy who gave voice to musical Impressionism. Impressionism is a visual manifestation of the French language, an art movement celebrating blended lights, nuanced colors and blurred edges. It’s the idea of an image rather than the image itself. Does Monet come to mind? Debussy’s music evokes similarly water-dominated, brilliantly-colored, subtly-shaded and blurred-edge imagery as does Impressionist painting. From music, to paintings and language, the French are more concerned with not what you say, but how you say it or rather how you express it. In contrast, the German language as manifested by its music from Beethoven and Brahms is clear, crisp, well-articulated and most of all, to the point.
On your own, carefully listen to Claude Debussy's *Prelude to the Afternoon of a Faun*, which reflects the French language of impressionism with lack of crispness and clarity with utter beauty characterized by finesse and nuance. This impressionism can be carried over into the aromatic perfumes and fragrances as well as the culinary industry. It was Hermann who told me that the World's smallest book is the German Cookbook. Think about it. In Germany they feed you. In France they dine you. There are centuries of practiced refinement and nuance in a bottle, this takes us to wine. Now reflect on the music, the ballet, the food, the drink and the cultures of Germany and France in Nice.

Again, time will not permit the detail of some of the accomplished French composers:

- **Claude Debussy**, 1862-1918: *Trois Nocturnes; La Mer*
- **Maurice Ravel**, 1875-1937: *Bolero*
- **Hector Berlioz**, 1803-1863: *Symphonie fantastique*
- **Gabriel Fauré**, 1845-1924: *Claire de lune; Après un rêve*
- **Camille Saint-Saëns**, 1835-1921: *Danse Macabre, Opus 40; The Carnival of the Animals*

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**Evolution of Depressive Symptomatology and Caregiver Burden in Partners of LVAD Patients**

*A Review from Concurrent Session 7: Supporting the MCS Patient & Caregiver*

Many patients receive an LVAD as a bridge to therapy in order to assist with scarce organ availability for transplantation. Discharge from the hospital post LVAD may contribute to emotional stress for both patients and caregivers, but evidence on caregiver burden is limited. This prospective study looked at patients and caregivers, at 1 and 3 months after discharge, with variables including depression, anxiety, and stress, using the stress scale (DASS-21). Additionally this study utilized the Dutch Objective Burden Inventory (DOBI). This measurement tool consisted of 4 domains: personal care, emotional, motivational, and practical support.

The study showed:

- 70% of patients and caregivers experienced symptoms at time of discharge
- 58% of patients and caregivers experienced symptoms at 1 month post discharge
- 33% experienced symptoms at 3 months post discharge.

This study was limited by a small sample size in a single center with lack of understanding of whether care provided by partners is congruent with patient’s need. This study was able to establish that many caregivers experience severe depressive symptoms. Study results encourage adequate psychological screening and treatment for this specific patient population with continued ongoing assessment, and suggests not to leave known emotional strain on caregivers unattended.

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Some people wish above all to conform to the rules, I wish only to render what I can hear. There is no theory. You have only to listen. Pleasure is the law.

- Claude Debussy
Impact of the 18th Birthday on Wait-list Outcome for US Patients Listed for Heart Transplant

A Review from Concurrent Session 14: Philip Caves Award Candidate Presentations

This retrospective cohort study utilized UNOS data to assess patients that ranged in age from 16-19 years. The endpoint was wait time from listing to waitlist removal due to transplant, death or clinical deterioration. The study used a large sample size of 721 patients. The adult patients wait list time was significantly longer, with median of 144 days, than pediatric patients with a median waiting time of 67, a highly significant difference. There was a trend toward significance in mortality due to longer wait time with the adult cohort. Per David Peng, MD, Stanford University, "Providers should be aware of this arbitration at the patient's 18 birthday."

LVADs and Myocardial Recovery

A Review from Concurrent Session 15: Myocardial Recovery - Moving Forward

This extremely interesting session chaired by Dr. Drakos and Dr. Rame held in the Thursday afternoon session, was dealing with myocardial recovery in LVAD patients. Dr. Birks opened the session presenting early results from the Remission From Stage D Heart Failure (RESTAGE-HF) study, a prospective Multi-center trial on myocardial recovery in LVAD patients. The early data from this study suggest that a standardized regime of optimal pharmacological therapy combined with LVAD unloading and regular testing of underlying myocardial function may result in a higher rate of explantation and remission from Stage D heart failure. However, she also critically admitted that the duration of recovery needs extended follow-up. Furthermore Dr. Pan was presenting results from the UNOS registry on myocardial recovery from short- and long-term cardiac support. He showed that incidence of myocardial recovery is still low in the current era of MCS. Looking for factors influencing myocardial recovery he found younger age and non-ischemic myopathy as statistically significant predictors.

Insight into Development of Chronic Lung Allograft Dysfunction following Lung Transplant

A Review from Concurrent Session 17

Dr. Miyoshi from Okayama University Hospital presented an excellent summary of this institution's experience with chronic lung allograft dysfunction (CLAD) after bilateral living donor lobar lung transplantation. Severe national organ shortage led to Okayama University Hospital's rich and unique experience with living donor lung transplant, where thoracic surgeons perform clinical management. In this study of 77 patients who underwent living donor lobar lung transplant, 59 who underwent bilateral living donor lung transplant were included. Twenty of these patients developed CLAD with an 80.5% 5-year freedom from CLAD development. Survival outcomes were favorable for these patients after development of CLAD: 89.2% were alive at 1 year and 64.7% were alive at 10 years post-transplantation. Those patients with a pure bronchiolitis obliterans picture had better outcomes than the 9 patients with a mixed or restrictive pattern. In summary, CLAD after bilateral living donor lobar lung transplantation occurred at a low rate and had better survival than that reported for the general lung transplant population. The authors conclude that while alloimmune independent factors may be an inciting event, alloimmune dependent factors are key in the development of CLAD.
How's it done there? VADs and Transplant Around the World
A Review from Concurrent Session 19

Thursday's emerging countries session saw Dr. Pya present outcomes from the destination therapy VAD program in Kazakhstan, which began in 2011. Devices implanted were a combination of the HM II and Heartware VAD. Dr. Pya explained that as time has moved on, the cardiac transplant program has developed alongside the VAD program with greater survival due to improved patient selection. Further keys to success in establishing the program have been a dedicated, highly trained multi-disciplinary team, government support and reliable devices. The second presentation saw Dr. Chan deliver the outcomes from the LVAD program in Singapore where cardiac transplantation is infrequent despite an "opt out" system. A total of 50 patients have been treated, both as BTT and DT since the program began in 2009, similarly with the HM II or Heartware device. Chan concluded that VADs have been well tolerated in this South East Asian population and program continues to mature. Dr. Sargin from Siyami Ersek hospital in Istanbul described the current status of heart transplantation and MCS in Turkey where transplants and implants are performed in 16 licensed centers. Dry Sargin highlighted that 78 heart transplants were performed last year, and since financial reimbursement was secured, 470 LVADs and 25 TAHs have been implanted over the 3 years between 2012-2015. A National Registry for MCS is now required in Turkey to collate further data for presentation. Heart transplantation in Saudi Arabia was presented by Dr. Selimovic who told of the 209 transplants performed between 1989-2014, with a mean age at transplant of 33 years. He outlined the improved survival rates over the past 8 years with greater numbers of procedures and tailoring of immunosupression. This session was an intriguing insight into developing VAD and transplant programs around the world.

TODAY’S FEATURES

Concurrent Session 27 Basic Science 2: Organ Preservation Including Ex-Vivo Management, Ischemia/Reperfusion

How to prevent Ischemia/Reperfusion injury?

Ischemia/Reperfusión is traditionally a field of high interest among heart failure researchers. In this Concurrent Session, which is held today at 11am in Calliope, the basic science research community will present news concerning Ischemia/Reperfusion. The session chaired by Dr. Schulze and Dr. Gelman contains six presentations including one on inhibition of NF-kB Activation to attenuate Ischemia-Reperfusion injury in Heart transplantation, presented by Dr. Kawajiri and one on Ex-vivo therapeutic use of Carbon Monoxide (CO) to improve donor lungs for transplantation, which is held by Dr. Kalaf-Mussi.

Concurrent Session 35: Complex Patients Require Complex Solutions: Predicting Adherence

More use of the SIPAT

The Predictive Value of the SIPAT for Clinical Outcomes in End-Stage Heart Failure Candidates will be presented by S. D. Gordan. A valuable session to further assess the psychosocial tool.
Concurrent Session 37: The fate of the right heart after LVAD
The Black Box or the right heart?

Perhaps it could be argued that predicting and managing right heart failure after LVAD implantation remains more of an art than a science, but could there be light at the end of the tunnel? This interesting session on the fate of the right heart after VAD chaired by Drs. Teuteberg and Krabatsch will enlighten us on some of the challenges faced in current practice. The first abstract reports an attempt to determine the predictive value of commonly used indices and scoring systems to predict the need for RVAD support, this will be presented by Dr. Tchantchaleishvili. Dr. Bhama will later describe the use of temporary right ventricular MCS for the treatment of RV failure in the setting of cardiac transplantation and LVAD. The session will conclude with Dr. Takeda's presenting his group's experience with late right heart failure after LVAD and the impact this has on survival.

Concurrent Session 40: Lung, AMR: HLA and Beyond
Impact of Non-HLA Antibodies on Acute Rejection in Lung Transplant

Do they matter?

Non-HLA antibodies have shown to be independent predictors of acute rejection in kidney and heart transplantation. Dr. Reinsmoen, representing the work of three institutions, will discuss the outcomes of 162 lung transplant patients with sera analyzed for antibodies to angiotensin type 1 receptor and endothelin type A receptor both pre- and post-transplantation. Be sure to attend this interesting talk at 4:45 in Hermes!

Concurrent Session 41: Heart Matters: Truth and Justice
The Question of Cost

Cost is frequently in the back of our minds in healthcare. M.R. Danger will be presenting a Comprehensive Analysis of Hospital Charges Between Direct Heart Transplantation and Patients Bridged With a Left Ventricular Assist Device.

Available Now! ISHLT Monograph Volume 9: Pulmonary Hypertension and Right Heart Failure

View a sample copy at the On-site Registration Desk.

Highlights include:

- Latest on the epidemiology, mechanisms of disease, and approaches to evaluation and treatment of pulmonary arterial hypertension (WHO Group 1) including focus on combination approach and assessing response to therapy
• Pulmonary hypertension associated with heart and lung disease (WHO Group 2 and 3 PH) with focus on assessing patients and treatment approaches

• How to manage patients with chronic thromboembolic pulmonary hypertension (CTEPH WHO Group 4), how to evaluate them, where surgical interventions and medical therapies fit in the treatment plans

• A huge focus on the right ventricle, from its unique anatomy, function, and management of patients with right heart failure due to different etiologies of heart and lung diseases

• The frequently faced dilemma of perioperative management of a pulmonary hypertension patient, from perioperative risk assessment to impact of anesthesia and mechanical ventilation

• The most up-to-date on surgical support for patients with pulmonary hypertension and right heart failure, including mechanical circulatory support and lung transplantation. This comprehensive compendium of topics on pulmonary hypertension and right heart failure will provide an excellent resource for anyone who manages patients with pulmonary hypertension and right heart failure.


Update: Yesterday’s mention of the SIPAT tool provided an expired email address. For more information and free access to SIPAT tool, contact Quincy Young: Qyoung@providencehealth.bc.ca

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Feast Your Eyes

In 1889, Debussy wrote, “To a Frenchman, finesse and nuance are the daughters of intelligence.” This can be more applicable to static artistry, which can move us as much as art in motion and in music. However, words cannot begin to express the impression the Musée Marc Chagall and Musée Matisse will leave on us from their static artistry. When one thinks of France and Paris, it’s the visual stills created that have moved humanity and will continue to do so in perpetuity. It is from France, as alluded to yesterday, and the “impression” we’ll have as we approach our departures with the “blurs” and “wisps of clouds” now a part of us because of the 35th Annual ISHLT in Nice. Perhaps we’ll carry back with us more clarity than what we had just prior to our arrivals.

Regarding Marc Chagall, visit his museum, but one fascinating fact; his wife Bella, the inspiration for so many of the newlyweds and lovers in his paintings, died suddenly in 1944. Penicillin could have saved her, but was unavailable as it was reserved for military use. With grief, he turned all his canvases to face the wall and did not paint for nine months.

Regarding Henri Matisse, visit his museum, but one fascinating fact; he became confined to a wheel chair following operations for duodenal cancer. He refused to be defeated. As a gesture of thanks to a young nurse, Monique Bourgeois, Matisse designed the beautiful Chappelle du Rosaire de Vence (Chapel of the Rosary), in France (1949-1951). Matisse stated: “In spite of all its imperfections, I consider it as my masterpiece.” Because his stubbornness against defeat and confinement, he perfected another art form with scissors and bright-colored paper which resulted in stunning and joyful collages of les gouaches découpées - paper-cut outs. On viewing these works, his doctor boldly advised the “master of colors” to wear dark glasses!
The famous art movement – Impressionism – may have come about by accident from an independent exhibition of painters in Paris in 1874: “Exhibition of Impressionists.” The works of Monet, Degas, Renoir, Cezanne, Morisot, Sisley and Pissarro were on this impressive roster, but at the time these artists were derided for their revolutionary new techniques. It was Louis Leroy who came up with impressionism and was actually scorning their works by bluntly stating that their paintings were less finished than the most basic of wallpapers. This term stuck and gradually lost its negative connotations, and voilà “Impressionism” was born.

Sunrise, Monet

It should be obvious that Impressionism and Claude Monet can be linked to the ISHLT and Nice, but other than Impressionism what would Pierre-Auguste Renoir have in common with Nice. Well, in 1880, Renoir met Aline Charigot, young girl sitting at the table playing with the dog in Luncheon of the Boating Party. He was 20 years her senior. They had three sons, Pierre, Jean and Claude. Jean Renoir became one of the greatest film directors of all time. How about that for a “Link” to pictures in motion!

Luncheon of the Boating Party, Renoir

Again, time will not permit the detail of some of the accomplished French artistes:

- Camille Pissarro, 1830-1903
- Edgar Degas, 1834-1917
- Alfred Sisley, 1839-1899
- Paul Cézanne, 1839-1906
- Claude Monet, 1840-1926
- Berthe Morisot, 1841-1895
- Pierre-Auguste Renoir, 1841-1919
- Henri Matisse, 1869-1954
- Marc Chagall, 1887-1985

In our life there is a single color, as on an artist’s palette, which provides the meaning of life and art. It is the color of love.

- Marc Chagall

Age, Kidneys and Time from Symptom Onset: Variables in the VAD Equation

A Review from Concurrent Session 22: LVADs: Factors influencing outcomes

This session, addressing the factors influencing LVAD outcomes opened with Dr. Loyaga-Rendon presenting data illustrating that patients with acute heart failure seem to have better long term outcomes despite more severe acuity of illness at the time of support. Next, Dr. Gosev presented results from an American multi-center study, the largest series to date with extended survival on cFLVAD support. The series included 129 patients who had ≥ 4 years support with a mean survival of 7.6 years. He showed that in this cohort, 50% of patients who had survived 4 years after LVAD implantation would survive another
Dr. Ciarka delivered an interesting abstract focusing on the associations between age, BTT cfLVAD use and outcomes after cardiac transplant. She reiterated the dramatic increase of MCS as BTT particularly in older patients, despite the on-going donor organ shortage. Older age was associated with worse crude post transplant survival both overall and in patients with a cfLVAD. However cfLVAD was not associated with worse crude or adjusted post transplant outcomes in any age group. Pre-implant GFR as a predictor of adverse outcomes post LVAD placement was presented by Dr. Mohamedali. This was a retrospective study of 232 patients with cfLVAD (predominantly DT), risk stratified based on a baseline GFR cut off of 60. Post device implantation, in patients with GFR<60 there was a higher incidence of early right heart failure, stroke and need for RVAD support, and pre implant GFR<60 was associated with poorer survival outcomes.

Finally Dr. Brisco discussed albuminuria in patients undergoing LVAD (HM II devices) as a predictor of subsequent renal recovery. She told of how albuminuria is often incorrectly assumed to indicate irreversible structural kidney disease and is common and underappreciated amongst the HF patients undergoing LVAD. Albuminuria can serve as a marker of cardiorenal syndrome and an unrecognized burden of renal dysfunction, with the potential for improvement in intrinsic renal function post LVAD.

**Mechanical Cardiac Support in Children: Outcomes and Registry Data**

*A Review from CONCURRENT SESSION 32*

This Friday afternoon session chaired by Dr. Almond and Dr. Sheel discussed outcomes of mechanical cardiac support in children with a focus on registry data. In adults, the continuous flow LVADs have largely replaced the pulsatile devices. In pediatric patients, however, only little data is available on outcomes of patients with continuous flow assist devices. Important questions like the influence of timing of LVAD implantation on post transplant survival were addressed. In his presentation, Dr. Keeshan showed that patients with VAD implantation after listing have worse outcome compared to those supported at time of listing. However, he admitted that the optimal time-point of VAD implantation has to be defined in further studies.

The Pediatric Interagency Registry for Mechanical Circulatory Support (PediMACS) is an NIH-supported national registry for FDA-approved VADs in patients < 19 years of age. Dr. Rossano presented the utilization and outcomes of continuous-flow ventricular assist devices pediatric patients from this registry. In this study, 72 patients undergoing placement of durable CF VADs were included and their outcomes were compared to adults from INTERMACS. The 6 months post-implant results, Dr. Rossano presented in this session, showed that 57% of patients were transplanted, 40% were alive with the device in place, and 3% died before transplantation. The overall adverse event rate was very low with a number of 4.4/100 patient months. These outcomes compared favorably to the outcomes in adults supported with CF VADs as a bridge to transplant. At the end of his presentation, Dr. Rossano, however, remarked that there is a need for further studies to determine impact of patient and device characteristics on outcomes in pediatric patients.
‘Don’t Push Me ‘Cause I’m Close to the Edge’
A Prospective Randomized Trial of EVLP in Standard Donor Lungs: Can it Improve Results?

A Review from Concurrent Session 30

Dr. Aigner presented the interim results of a randomized trial comparing EVLP and cold static preservation for standard lung donors at a single institution. The objectives of this trial were to compare post-transplant outcomes, identify functional impairments unrecognized in the donor, and to safely prolong total preservation time. This study utilized 1:1 randomization between groups. The EVLP arm used 4 hours of EVLP using the Toronto protocol. To date, there have been 32 recipients each in the EVLP and control groups. Four lungs were rejected from the EVLP group, two due to functional decline. The recipients and donors were comparable for all characteristics aside from a longer preservation in the EVLP group. The authors found no difference in functional parameters or short-term outcomes. Five patients in the EVLP died within one year while 1 patient in the control group died within one year. The authors conclude that short term outcomes are comparable between groups and that EVLP has the potential to detect previously unrecognized impairments, safely allows prolongation of preservation time, and may reduce the need for post op ECMO. Following this presentation, there was a heated discussion concerning the two pair of lungs that did not make it to the study. We look forward to the final results of this interesting trial!

A Fine-Tooth Comb Look at Psychosocial Scoring Tool Predictions

A Review from Concurrent Session 35: Complex Patients Require Complex Solutions

Dr. Ashrith presented this psychosocial risk assessment tool comparison. These tools are not only to identify risk factors for criteria and acceptance, but additionally to heighten surveillance of weakness areas post LVAD. The SIPAT tool is validated to predict outcomes for medical and psychosocial outcomes. This talk reviewed 3 psychosocial evaluation tools. PACT, SIPAT and mPACT. PACT scores have been associated with poor outcomes post LVAD in BTT population. The mPACT tool has better accuracy than PACT. A higher mPACT score is associated with a decreased 30-day readmission rate. Score of >40 is associated with a 75% chance of being denied an LVAD. In patients that were readmitted to hospital post LVAD secondary to infection SIPAT was a significant predictor with a score of >25. Psychosocial scores were not associated with mortality after LVAD implantation in this particular study. In the future it would be beneficial to focus on the caregiver and burden as well. Currently the author is in the process if developing a decision tool to predict how well a patient may do after LVAD. It is unfair to withhold life saving therapy based on SIPAT score alone. The presenter stated that the "tool is utilized to identify higher risk patients that may require additional therapies and assistance to optimize success".

The Detriment of These Life Saving Measures is the Hospital Charges

A Review from Concurrent Session 41: Heart Matters: Truth and Justice

Dr. Nick Heglund discussed financial charges related to an LVAD. Health care expenditures (2.9 trillion dollars) account for 22% of the federal budget in the United States and 18% of the gross domestic
product in 2013. These economic realities need greater attention. The study goal was to provide a costing platform to determine where the cost was going. Continuous flow devices was the patient population that was specifically assessed. The research team identified 12 categories that were assessed to focus efforts for cost reduction. This analysis according to the presenter "suggests that reducing length of stay and improving patient selection may be most impactful in cost reduction as many of the ancillary charges relate to inpatient status and related complications".

TODAY’S FEATURES

Concurrent Session 43: Mechanical Circulatory Support - New Surgical Approaches

How to Implant the New Generation VADs?

Continuous-flow LVADs have become a routine treatment tool for end-stage heart failure patients as bridge to transplant, bridge to recovery or bridge to destination therapy. However there is still a lot of progress in this field. This session chaired by Dr. Simon and Dr. Zimpfer, which is held today at 8.15 am in Athena, deals with new techniques of LVAD as well as BIVAD implantation with a special focus on minimally invasive implantation techniques.

Concurrent Session 45: Candidate Selection – the Who, When and Why?

The 3-W’s of Candidate Selection

Candidate selection for cardiac transplantation and timing of listing remains a hot topic. Saturday morning sees Drs. Crespo-Leiro and Bacal chair the concurrent session addressing these issues. Dr. Yang will present the abstract entitled “Evolution of status 1A heart transplant candidates” which will lead us through the impact of increasing numbers of VAD patients amongst those in status 1A. Dr. Herre will then discuss the improvements in waiting list survival amongst patients with end stage heart failure listed for transplantation. He will compare and contrast the improvement in survival amongst status 1 and status 2 candidates between the eras of 1990-2013. We look forward to these, and the other thought provoking abstracts within this early morning session.

Concurrent Session 46: A New Protocol for Heart Allocation in Iran

Dr. Mirhosseini and colleagues will present the results from 591 heart transplants in Iran from 1993-2014. A retrospective review revealed significant disparities in the policies for heart allocation, which led to the development of the Iranian Network for Organ Procurement and Transplantation. Since July 2014, 40 patients have undergone heart transplantation under a new allocation protocol using medical urgency, wait time, blood group compatibility, size, and ischemic time. Don’t miss this intriguing presentation in Hermes at 8:30 AM!
Concurrent Session 51: Risky Business – Transplant in High-Risk Populations

It’s Like a Jungle Sometimes, It Makes Me Wonder…

As we near the end of this splendid rendezvous in Nice, it would be disappointing to miss the interesting session covering transplantation in high risk populations chaired by Dr. Isaac from Calgary and Dr Pham from Stanford. The opening abstract presented by Dr. Zafar and will provide outcome data from the United States on multi-organ transplantation (MOTx) in adults with congenital heart disease. In brief, simultaneous MOTx is more commonly performed in adults with congenital heart disease (CHD) than in adults without CHD. The overall frequency of MOTx in adults with CHD has declined over the years primarily due to decreased number of heart-lung transplantations in this population. Survival in adults with CHD following MOTx is similar to adults without CHD. The second abstract will be delivered by Dr. Jasseron and will report on the French experiences with heart transplantation for patients on V-A ECMO and the survival benefits.

Pass It On

On Friday morning, Hermann officially passed the gavel to incoming ISHLT President Duane Davis, MD, MBA.

By the way, did you know that this year’s Program Chair Andreas is an avid New Orleans Saints fan? Notice the iconic French symbol used throughout this year’s Daily Links?

ASIA PACIFIC-ISHLT JOINT MCS SYMPOSIUM 2015
6-7 NOV 2015, SINGAPORE
Lectures, Discussions, Breakout sessions, Surgical & Echocardiography workshop
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2016 Call for Symposium Proposals

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Dear ISHLT Members and Colleagues:

Thanks to the enthusiastic participation of many of our ISHLT members, the 35th Annual Meeting in Nice, France, was a huge success! We are now asking you all to continue this momentum by proposing scientific content for the **ISHLT 36th Annual Meeting & Scientific Sessions** to be held in Washington, DC, USA, April 27-30, 2016.

As program chair for the 2016 meeting, I encourage you to submit your best ideas for the pre-meeting and sunrise symposia and/or invited Plenary talks. Although well worked-up complete symposia proposals are preferred, we also welcome suggestions for potential plenary speakers from outside the transplant community who will deliver an entertaining or thought-provoking presentation with widespread appeal to members.

Your input into this process will be invaluable to the Symposium Planning Committee since the majority of the invited scientific content for the Annual Meeting will arise from proposals submitted by ISHLT Members and Scientific Councils.

Below are links to the **symposium proposal submission site** and the **plenary lecture proposal form**:

- [2016 Symposium Proposal Submission Site](#)
- [2016 Plenary Lecture Proposal Form](#)

You are strongly encouraged to consult with the Education Workforce Chair(s) and Council Chair(s) appropriate to your topic before submitting a symposium proposal. They will provide guidance regarding educational areas identified as priorities for the Annual Meeting. Many Councils are using the Discussion Forums in **ISHLTConnect** to share ideas and collaborate, so I encourage you to log in and read what has been posted in your Council’s forum, or post your own ideas and gather feedback from your colleagues. Make sure you read the article in the [May 2015 issue](#) of the ISHLT Links Newsletter on how to use ISHLTConnect and join in the discussions!

I am keen on showcasing our cross-disciplinary collaboration for the 2016 meeting which distinguishes the ISHLT second to no other society. You are therefore encouraged to develop proposals that will demonstrate collaboration among the different ISHLT specialties. The list of current committees and councils can be found at [www.ishlt.org](http://www.ishlt.org) under the "Boards and Committees" and "Councils" tabs.

The deadline for receipt of proposals is Tuesday, June 2, 2015.
All proposals will be reviewed by program committee representatives from the relevant discipline area. The final development of invited scientific content will take place during the Symposium Planning Committee meeting in July.

If you have any questions about the submission process, please contact Susie Newton (susie.newton@ishlt.org) at the ISHLT office.

Please accept my thanks in advance for your valuable input. I look forward to seeing you in Washington, DC!

Yours sincerely,

Andrew J. Fisher, FRCP, PhD
2016 Scientific Program Chair

Disclosure statement: The author has no conflicts of interest to disclose.
Keep Calm and Connect Online!

Do you have a difficult case weighing heavily on your mind and would appreciate some advice & feedback from other ISHLT members who might have experience with a similar case? Perhaps you have an idea for a symposium for the 2016 Annual Meeting but would like to collaborate with others to fine tune it before actually submitting a proposal? Do you have a job opportunity at your institution and need a quick way to spread the word to fellow transplant professionals? Are you interested in mentoring a fellow member, or wish to be mentored by one? Are you interested in contacting members from a specific geographic location, or a specific professional specialty, or a specific center/institution, but have no idea how to find or contact them?

Look no further than your own desktop! You have the power to do all of the above and more right from your fingertips, simply by logging into ISHLTConnect, our Online Community. As many of our members already know, this online community provides you with a powerful tool for networking, sharing ideas, getting advice and feedback, comparing strategies, sharing documents and resources, posting job opportunities, mentoring, and interacting on many levels with your fellow ISHLT members.

**ISHLTConnect** offers a number of communities within the site which correspond to each of the ISHLT Scientific Councils, Scientific Workforces, and Committees. As an ISHLT member, you are automatically subscribed to the Councils, Workforces, and Committees on which you are already a member so you automatically have access to the discussion forums and document/resource libraries of those communities. Membership in the 11 ISHLT Scientific Councils is voluntary and open to all interested members. Membership in the Scientific Workforces and Committees is invitational only, based on whether you have been appointed to serve on one of them.

Accessing **ISHLTConnect** is easy! Go to [http://community.ishlt.org/home](http://community.ishlt.org/home) and login using your ISHLT username and password. (Can’t remember your username or password? Follow the “Forgot password?” link on the login screen and your username/password information will be emailed to you.) You can even set your **language preference** by using the “Select Language” feature in the upper left corner of the screen.

Once you’ve logged in, feel free to browse the site to see what it offers, update your personal profile and add a photo (you can bring this over from LinkedIn if you have a LinkedIn account), check to see that you are subscribed to the appropriate communities, customize your privacy settings and your subscriptions settings, create a contact list of other members, or post a message to your colleagues.
You can post a message to one of the Scientific Council Communities you belong to or in the **Open Forum**, to which all members are subscribed (see link on blue navigation bar). If you wish to be a member of a Scientific Council that you are not currently subscribed to, simply click on the link provided on the Council’s community page to access the ISHLT Members Only website, where you can update your profile and join any of the 11 Scientific Councils.

Unsure how to navigate, post a message or job opportunity, or update your profile? For answers to these questions and more, we’ve created a “How To” Guide which gives you easy to follow, step-by-step instructions on how to do everything in **ISHLTConnect**. See [http://www.ishlt.org/ContentDocuments/ISHLTConnect_HowToGuide.html](http://www.ishlt.org/ContentDocuments/ISHLTConnect_HowToGuide.html) to access the Guide.

We are confident that you will find **ISHLTConnect** user friendly, interesting, and enjoyable. If you have any questions or need any assistance with gaining access, please contact Susie Newton ([Susie.Newton@ishlt.org](mailto:Susie.Newton@ishlt.org)) or Megan Barrett ([Megan.Barrett@ishlt.org](mailto:Megan.Barrett@ishlt.org)) for assistance.
Editor’s Corner: An American Lunger in Nice for the ISHLT

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After great anticipation, the ISHLT meeting in Nice has come and gone. As usual, the meeting included strong content, important networking and mentoring, and a rich cultural experience. Nice did not disappoint. I soaked in the Côte d’Azur sun during my walk each day, ducking under clementine orange trees and stealing away for a brief visit to the nearby Matisse museum. And the food! But was that a tomato-infused ziti in my margherita hors-d’oeuvre or some sort of homage to red rubber suction tubing?

So of course I’m pulmonary inclined and so I can’t speak to the (naturally) excellent cardiac clinical content. But from my end, I was particularly impressed with presentations by Ramsey Hachem (who described poorer outcomes in patients who develop donor-specific antibodies after lung transplantation) and by Clemens Aigner (who presented data from a prospective randomized trial of ex-vivo lung perfusion in standard donor lungs < the question everyone is wondering about). These and many others are the reason we come each year. The junior faculty and trainee poster presentations stimulated our curiosities.

How can we top it? Washington DC has big shoes to fill! I doubt I can take a half day at the end of the conference in any place as beautiful as Eze. But I have high confidence that Andy Fisher and the program committee will not fail to impress.

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