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James K. Kirklin, MD, ISHLT President (2009-2010)

CELEBRATING 30 YEARS OF ISHLT

The ISHLT 30th Anniversary meeting will convene in Chicago, April 21-24, 2010. The newly formed Presidents' Council has extended special invitations to past Presidents, recipients of Lifetime Service and Lifetime Achievement Awards, and past Pioneer Lecturers for this historic meeting. These pundits from the past will be recognized in the opening plenary session during my Presidential Address, "The Evolution of a Revolution," which will offer revelations about the historical roots and evolution of the fields of heart and lung transplantation and mechanical circulatory support and the cascade of key players who weaved the international fabric of our society.

The ISHLT Monograph Series will provide a meeting highlight with the release of the fourth monograph, dedicated to the History of the ISHLT. The monograph features unique insights on the developmental history of our society and the field of advanced heart and lung failure through the perspective of



societal pioneers, past presidents, and recognized experts in the field. The opening chapter is a special contribution by Donald McRae, author of the riveting book *Every Second Counts: The Race to the First Human Heart Transplant*.

The actual scientific sessions will be cloaked in ISHLT history, as a montage of historical images, video, and interviews with historical figures entertains and informs attendees between sessions. We hope these special accoutrements to the outstanding science on display will entice our entire membership to join us at this 30th Anniversary Celebration.



FROM THE JHLT EDITOR'S DESK

Mandeep R. Mehra, MD, MBBS, FACC, FACP



The momentum continues with our launch of **Thematic Journal Issues** – Undoubtedly, you have seen the *First Pediatric Focus issue* with a staggering array of high impact perspectives, editorials and original clinical science. The journey continues in January 2010 with the launch of the

new journal cover coupled with a *Focus issue on Mechanical Circulatory Support*. The new journal design is contemporary with a changing cover each issue that will allow us to profile a featured figure in each journal issue. The interior has been redesigned to reflect a more modern layout to emphasize a new font and greater highlights on tables and figures to enhance readability. In February 2010, we shall launch the first *Focus issue on Pulmonary Arterial Hypertension*. You will notice that these focus issues reflect the moving emphasis of the society and the journal's intent to be the premier voice in these particularly special fields of therapeutic and disease hubs.

Meanwhile, we continue to show strong growth in submissions (23%) and a well maintained benchmarking of accountability indices. Currently,

we are tracking a time to first decision from submission of 17 days; 3 days are spent in an editor's review and if we elect to refer the paper for reviewer or editorial board consultant critique, an additional 14 days are allowed in the review cycle. The editorial office is currently rejecting 30% of papers without further review and the absolute rejection rate has increased to 70%. We sincerely hope that these quality initiatives will bear fruit and the readers will continue to be proud of the high science that typifies our field. As we are fortunate to work with an outstanding cadre of consultants and reviewers, we are noticing a strong and uniform trend to be less tolerant of anything but the highest standard of scientific expression.

In summary, your Journal is continuing its journey to excellence with the highest rigor and integrity. It is our sincere hope to escalate the journal to become the preferred voice of our field, now no longer narrowly expressed in the areas of heart and lung transplantation but in fact expanded to cover a broad array of late stages of heart and lung failure. We hope you will be pleased with these changes and would like to hear from you at jhlteeditor@medicine.umaryland.edu.



JOIN ISHLT IN *Chicago* AS WE CELEBRATE THE 30TH ANNIVERSARY MEETING!

Dear Colleagues:

As Scientific Program Chair, I would like to invite you to the 30th Anniversary Meeting of the ISHLT to be held in the beautiful city of Chicago in April 2010.



Once again, with the enormous help of our Program Committee members and Abstract Reviewers, an outstanding scientific congress has been created. This year much input has been received and considered from the various Scientific Councils resulting in an excellent series of satellite meetings preceding and accompanying the scientific meeting.



Over 800 abstracts were submitted, many of which were accepted as oral, mini-oral, or poster presentations. In addition, highly distinguished invited speakers were chosen for the plenary sessions speaking next to highly ranked, specifically selected abstract presentations.

Since this is the 30th Anniversary Meeting, we created a special Plenary Session with very interesting presentations on the history and evolution of the ISHLT given by distinguished members and past presidents of our society.

The social highlight will be the President's Gala Reception with a very festive opening and great entertainment provided by the well known band "Marginal Donors".

The whole Organizing Committee is looking forward to seeing all of you in Chicago in April 2010!

Yours sincerely,

Hermann Reichenspurner, MD, PhD
2010 Scientific Program Chair





ANNOUNCING THE ISHLT ACADEMY

In response to goals developed at the 2006-2007 Strategic Planning Meeting, the ISHLT Education Committee is pleased to announce the establishment of the **ISHLT Academy**. The **ISHLT Academy** draws on the wealth of experience and expertise within the society to deliver high quality educational experiences with the goal of enabling our members to improve and maintain the highest possible standards in the care of patients with advanced heart and lung disease and those undergoing heart or lung transplantation.

The **ISHLT Academy** will operate under the auspices of the ISHLT Education Committee, which consists of representatives from each of the Society's nine Scientific Councils. The **ISHLT Academy** represents the 'brand name' that will be associated with the educational opportunities offered by the ISHLT to its members and interested non-members. The purpose of the **ISHLT Academy** is to develop an enduring resource of education in core competencies in the field of cardiopulmonary transplantation, mechanical and biological support of the failing heart, advanced lung disease (including pulmonary vascular disease) and cell replacement therapy. These educational endeavors will complement the ISHLT's existing activities in the promulgation of new science, registry analyses, guideline statements and monograph series as a consolidated activity designed to train and educate young clinicians, trainees and those looking for a refresher course in clinical practice mandates in the field.

The opportunities provided by the **ISHLT Academy** will be multi-modality and multi-disciplinary and will be

guided by the identified educational needs or 'practice gaps' of ISHLT members. When available, core curriculum and competency documents for different disciplines within the society will guide content of **ISHLT Academy** activities. The activities of the **ISHLT Academy** will run throughout the societies interface with its members with material provided in written format via articles in the Journal of Heart and Lung Transplantation, via the ISHLT Monograph series and via educational meetings. Select educational activities included within the Annual Meeting will also carry the **ISHLT Academy** brand and will run in concert with the scientific content of the annual meeting.

The **ISHLT Academy** theme at the 2010 annual meeting is Heart Failure and Heart Transplantation, and you will find a number of sessions in the Annual Meeting program carrying the **ISHLT Academy** logo to highlight educational content that fits with this year's **ISHLT Academy** theme. In addition, at the conclusion of the Annual Meeting, we will conduct the first **ISHLT Academy** Masters Course on Advanced Heart Failure, Cardiac Transplantation, and Mechanical Support. Program information is below. Registration for this course will be available online at the ISHLT web site. You may also register for this course via the Annual Meeting registration form. Attendance at the Annual Meeting is NOT required in order to register for the Masters Academy Course. Registration for this Masters Academy Course is limited to the first 150 individuals.



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academy

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ISHLT MASTERS ACADEMY: ADVANCED HEART FAILURE AND CARDIAC TRANSPLANTATION CORE COMPETENCIES

Saturday, April 24, 1:45 PM – Sunday, April 25, Noon
Hilton Chicago, Chicago, IL
Chairs: James K. Kirklin, MD and Mandeep R. Mehra, MD

This educational activity will offer 10 hours of intensive teaching activity focusing on core competencies of Advanced Heart Failure, Mechanical Circulatory Support, Pulmonary Hypertension and Cardiac Transplantation.

SATURDAY, APRIL 24, 2010

1:50 PM Opening Remarks

2:00 PM SESSION 1: ADVANCED HEART FAILURE AND HIGH RISK SURGERY

This session will cover the following topics via lectures and panel discussion:

Advanced Heart Failure: Overview

- 1) Diagnosis
- 2) Etiology
- 3) Approach to management
- 4) Recent clinical trials and trials in progress

Heart Failure: Prognosis

- 1) Individual prognostic markers and algorithms (SHFS, HFSS, EFFECT)
- 2) Overview of CPET

Advanced Heart Failure: Treatment

- 1) Current standard of care for treatment of advanced HF
- 2) Timing of referral for advanced therapies (MCSD, Transplant, CRT).

Indications for CRT

- 1) Evidence-based approach to patient selection and outcomes with CRT
- 2) Overview of off label indications including the difficult cases (RBBB, AFib)

End of Life Care

- 1) Framework for assessing issues in patients with advanced HF nearing end of life
- 2) Advanced care directives

4:15 PM BREAK

4:30 PM SESSION 2: MECHANICAL CIRCULATORY SUPPORT

This session will cover the following topics via lectures and panel discussion:

Indications for MCS

- 1) Short-term versus long-term support
- 2) Bridge to transplant, bridge to recovery, and destination therapy
- 3) Left ventricular, right ventricular, and bi-ventricular support
- 4) Bridge to transplant and destination therapy CMS criteria

The Influence of Patient Selection on Outcomes

- 1) Identification of co-morbidities
- 2) INTERMACS Classifications
- 3) Review of Lietz-Miller Risk Analysis of destination therapy patients



- 4) SHFM
- 5) Importance of prognostic models
- 6) Correlation of risk factors and outcomes

Classification of Pumps

- 1) Centrifugal, pulsatile, and axial
- 2) Percutaneous, implantable, and paracorporeal
- 3) Review of current FDA approved VADs

Surgical Nuances: Intraoperative and Early Post-operative Management

- 1) Operative Techniques
- 2) Use of TEE intraoperatively
- 3) RV Function
- 4) Suction Events
- 5) Ventricular Arrhythmias
- 6) Pulmonary Hypertension

The Nuts and Bolts of Outpatient Management

- 1) Blood pressure assessment and management

- 2) Anticoagulation regimens
- 3) Diagnosis and Management of GI bleeding
- 4) Thromboembolic Events
- 5) Driveline Infections
- 6) Non-device related Infections

6:30 PM BREAK

7:00 PM SESSION 3: DINNER SESSION – PICTURES ARE WORTH A THOUSAND WORDS: IMAGING, BIOPSIES AND HEMODYNAMICS

This session will cover the following topics via case discussions and use of an audience response system:

- Advanced Heart Failure
- Cardiac Allograft Vasculopathy
- Antibody-Mediated Rejection
- Mechanical Circulatory Support
- Pulmonary Hypertension

SUNDAY, APRIL 25, 2010

7:00 AM Continental Breakfast

7:30 AM SESSION 4: CARDIAC TRANSPLANTATION

This session will cover the following topics via lectures and panel discussion

- 1) Heart Transplant Candidacy
- 2) Immediate Post-Transplant Care
- 3) Immunosuppression
- 4) Cellular and Antibody-Mediated Rejection
- 5) Cardiac Allograft Vasculopathy
- 6) Infection/Nephropathy
- 7) Other Complications (hypertension, hyperlipidemia, malignancy, diabetes, etc)

9:30 AM BREAK

9:45 AM SESSION 4: PULMONARY HYPERTENSION

This session will cover the following topics via lectures and panel discussion

- 1) Classification and overview of pathogenesis
- 2) Diagnosis and end points for clinical management
- 3) Physiology and pathophysiology of the Right Ventricle
- 4) Managing the potential heart transplant recipient with a raised PVR
- 5) Treatment of PAH - State of the Art Overview

11:45 AM CONCLUSION AND ADJOURN



FACULTY AND STEERING COMMITTEE MEMBERS

Co-Chair: James K. Kirklin, MD, University of Alabama at Birmingham, Birmingham, AL
Co-Chair: Mandeep R. Mehra, MD, University of Maryland School of Medicine, Baltimore, MD
Heather J. Ross, MD, FRCPC, Toronto General Hospital, Toronto, CANADA
James B. Young, MD, Cleveland Clinic Foundation, Cleveland, OH
John B. O'Connell, MD, St. Joseph's Hospital, Atlanta, GA
Francis D. Pagani, MD, PhD, University of Michigan Hospital, Ann Arbor, MI
Andreas Oliver Zuckermann, MD, University of Vienna, Vienna, AUSTRIA
Roberta C. Bogaev, MD, FACC, Texas Heart Institute, Houston, TX
Jayan Parameshwar, FRCP, Papworth Hospital, Cambridge, UNITED KINGDOM
Jon Kobashigawa, MD, Cedars Sinai Heart Institute, Los Angeles, CA
Patricia A. Uber, Pharm.D, University of Maryland, Baltimore, MD
Paul A. Corris, MB FRCP, Freeman Hospital, Newcastle Upon Tyne, UNITED KINGDOM
Myung H. Park, MD, University of Maryland School of Medicine, Baltimore, MD
Allen S. Anderson, MD, University of Chicago Medical Center, Chicago, IL
Anne I. Dipchand, MD, Hospital for Sick Children, Toronto, CANADA
James F. George, PhD, University of Alabama at Birmingham, Birmingham, AL

PATHOLOGY AND BASIC SCIENCE COUNCIL



Dear Colleagues,

I am happy to report on the Heart Session of the Tenth Banff Conference on Allograft Pathology. This session was organized with mutual agreement of the Board of Directors of the International Society for Heart and Lung Transplantation and the Banff Conference on Allograft and took place in August (<http://cybernephrology.ualberta.ca/banff/2009/programme.htm#day3>).

There were more than 60 participants in the heart session, including immunologists, pathologists and at least 10 clinical cardiologists. The sole focus of the session was on antibody-mediated rejection (AMR) in heart transplantation. Dr. Lori West was present as the representative of the Board of Directors of the ISHLT. The incoming Chair of the Pathology and Basic Science (Dr. Annalisa Angelini) and the Current Chair of the Heart Failure and Transplant Medicine Council (Dr. Marisa Crespo-Leiro) also participated in the conference.

The passing of Dr. Margaret Billingham was communicated to the participants and a brief eulogy was presented by Dr. Margaret Burke from Harefield Hospital in the U.K. Introductory presentations encompassed: gene expression in heart biopsies with focus on the microvasculature, a brief review of the complement system and its regulators and aspects of donor-specific antibody (DSA) testing in pre-sensitized patients and post-transplant testing recommendations.



These talks were followed by presentations surveys on the practice and diagnostic approach to AMR in Europe (29 centers) and in North America (94 centers). Both surveys substantiated the lack of a uniform, standardized approach to the diagnosis of AMR. This was followed by presentation of specific clinical protocols used for evaluation of AMR in the UK, Boston and Cleveland. The afternoon session was dedicated to the presentation and discussion of the results of an exercise in the reproducibility of immunostaining human myocardium to detect products of complement activation C4d and C3d. These included two non-transplant control cases and 10 post-transplant autopsy cases which had AMR diagnosed.

Thirteen centers participated by staining the exact same tissues with their local methods for detection of C4d deposition by immunoperoxidase. Seven centers also immunostained these tissues to detect C3d deposition. This exercise showed high reproducibility of the immunoperoxidase stains with expected variations on the “extreme” cases (i.e. very weak or very strong immuno-reactivity). A rapid consensus was achieved in several points:

1. There is very good reproducibility between centers in North America and Europe in immunoperoxidase staining for C4d and C3d in the myocardium. Minor technical adjustment to the immunohistochemical techniques used in individual laboratories should provide close to 100% reproducibility.
2. There was consensus that the vascular territory to be evaluated should only include capillary vessels. Immunostaining of arterioles, veins, arteries, endocardium, vessels in Quilty lesions, myocyte sarcoplasm and the interstitial connective tissue should not be considered in the immunohistochemical evaluation of AMR.
3. The use of immunostains with low sensitivity and low specificity reported in recent literature (such as immunoglobulins) should be obviated.
4. There seems to be good equivalence between immunofluorescence detection of C4d and C3d and immunoperoxidase detection of these two markers.

E. Rene Rodriguez, MD
Past-Chair, Pathology and Basic Science Council, ISHLT;
Chair, Heart Session, Banff Conference on Allograft
Pathology 2009

SPOTLIGHT ON *Brazil*

Brazil established its heart transplant program in 1985 and there have since been about 1400 transplants performed at 11 active centers around the country. The Heart Institute of the University of São Paulo is the most active center under the direction of Prof Noedir Stolf, a transplant pioneer in Brazil.



The Heart Institute of the University of São Paulo Staff with some patients.

The Brazilian program has made advancements in heart transplantation for Chagas' disease, focused on control of disease reactivation. Approximately 20

percent of heart transplants in Brazil are due to Chagas' disease.

Two active organizations are the ABTO (Brazilian association for organ transplantation) and the Brazilian Society of Cardiology, which are responsible for the elaboration of the Brazilian Guideline in Heart Transplantation published in the Arquivos Brasileiros de Cardiologia (www.arquivosonline.com.br). The next Guideline will be published in January 2010.

Each state is responsible for organ allocation. The great majority of centers are in São Paulo state, representing 60 percent of transplants. It is estimated that about 45 percent of patients die while on a waiting list.

Brazil does not have an active VAD program, with about 5 implants in total per year. Because it is still very expensive to maintain a VAD program, transplant centers are in discussion with the Brazilian authorities to change this situation. Reimbursement is very low and lack of donors remains a problem.

For more information visit www.incor.usp.br, fbacal@uol.com.br



SOUTH AFRICA'S ROLE IN TRANSPLANTATION

Dr. Graham Cassel

Member of Milpark Hospital, Heart Transplant Team

The first human orthotopic heart transplant was performed by Dr. Christiaan Barnard at the Groote Schuur Hospital in Cape Town, South Africa in December 1967. Chris will always be remembered as a pioneer in an area of work which has now become routine in countless numbers of units in almost every country in the Western world. The legacy that he left has continued to the present time



and currently four active heart and lung transplant units operate throughout South Africa. One is still housed at the prestigious Groote Schuur Hospital, Cape Town, the second at a private hospital in Cape Town aptly named Christiaan Barnard Hospital, a third unit is at Ethekwini Hospital and Heart Centre in Durban, and the fourth one at Milpark Hospital in Johannesburg. A very active Southern African Transplant Society operates throughout the country and is involved in training, congresses and day-to-day activities of the transplantation world. Apart from heart and lung transplants other solid organ transplantations performed prolifically in South Africa include kidney transplantation, liver transplantation and more recently pancreas transplantation. Cornea transplants have been performed for years.

The four heart and lung transplant units operate independently, each having their own transplantation team working closely with a clinical

coordinator employed by the state and private hospitals in the respective areas. Each Unit keeps independent records, but when necessary the results are coordinated and presented jointly as representative of heart and lung transplantation in South Africa.

The transplant law in South Africa varies compared to other countries in Europe. No citizen is assumed to be an organ donor unless they carry a donor

card stipulating their own preference. In most cases consent is required from the family member once the patient has been declared brain dead. Under all circumstances authority is also required from the District Surgeon, a representative of the Department of Health of South Africa. The allocation of hearts and lungs in the two unit performing both operations is sometimes difficult as we often do not have the personnel both medical and nursing to perform two separate transplantation operations simultaneously. An amicable decision is made between the cardiologist and pulmonologist as to which operation should take place and then the other organ is "offered" to other transplant centres in the country. Each unit has one person in charge of the recipient list and makes the decision as to who should receive which organ when a heart or lung becomes available. In our unit in Johannesburg, Dr. Cassel, the cardiologist, is in control of that allocation.



A national recipient registry is kept by the coordinators to ensure that urgent recipients on waiting lists receive priority regardless of the origin of the donor. A 24-hour team is available to fly to different parts of the country to harvest organs to ensure that all suitable organs are transplanted into worthy recipients.

HOSPITAL	SURGEON	YEAR OF INCEPTION	TOTAL	2008	2009
GROOTE SCHUUR	Dr. Johan Brink	1967	520	5	5
CHRISTIAAN BARNARD	Dr. Willie Koen	1996	153	15	6
ETHEKWINI HOSPITAL	Dr. Robert Kleinloog	1997	57	14	5
MILPARK HOSPITAL	Dr. Martin Sussman	1993	82	10	9

A large number of recipients have end stage ischemic heart disease often having undergone previous bypass surgery. We do, however, have a number of young patients who have contracted a Cocksackie viral myocarditis who progressed to end stage heart failure and require transplantation. The age range of these patients is from 10 years to 30 years. Currently only Dr. Robert Kleinloog's unit in Durban is performing heart and lung transplantation and to date have performed three, whereas lung transplantation is performed both in their unit and the one in Johannesburg. To date 20 lung transplants have been performed in Durban and 46 in Johannesburg over eight years with six being done in 2008 and four to date this year.

LV assist devices are used at Christiaan Barnard Hospital and Milpark Hospital Units. In the Cape Town unit they have used five BiVad Berlin hearts of which four were successfully transplanted and discharged home. Other assist devices have been used as a bridge to recovery. The Tandem Heart percutaneous LVAD was pioneered at Milpark Hospital in Johannesburg more than a decade ago and is now a routine device in many centres in the world. They are currently using the device for four and eight patients per annum, both as a bridge to recovery and bridge to transplantation. The latter

has been successfully performed in three patients.

Donor shortage is a major problem throughout the world and currently figures from two of the units will show 23 patients on the Christiaan Barnard Hospital waiting list and 15 on the Milpark Hospital transplant waiting list. Five to ten patients per year die on the waiting list.

Scientific contribution in South Africa has mainly come from Groote Schuur Hospital being an academic department where they have been involved in the development of heterotrophic transplantation for many years. Seminal work on the deleterious hormonal effects of brain death in donor organs and methods to combat this has been part of their research. There has also been a lot of research work done on donor organ preservation.

Representatives of the different Transplant Units are members of Advisory Boards to different transplantation related drug companies to ensure that the best and most modern transplantation regimes are available to all our patients. Similarly, members of all the units travel extensively internationally and as is known, frequently attend the ISHLT International Congress.



The Council of the Groote Schuur Hospital in Cape Town have established a Heart Transplant Museum housed in the new Groote Schuur Hospital.

The exhibits date back to the first transplantation performed in December 1967 and many

memorabilia is on display. The Museum has become one of the tourist highlights of Cape Town and is visited annual by thousands of visitors.

GUIDELINES COMMITTEE

No, it wasn't a tea party and certainly not a walk in the park. It was more like scrambling up and down steep mountain slopes while trying to corral wild horses galloping in different directions. Oh, but the horses were magnificent and finally came together with the gentle, but persistent encouragement of three Musketeers, Sharon, David and Maria Rosa. No, this is not an excerpt from *Les Mémoires de Monsieur d'Artagnan*, cited by Alexandre Dumas as his source for the *Les Trois Mousquetaires*, but rather the story of the development of the ISHLT Guidelines for the Care of Patients after Heart Transplantation.

Over a period of 24 months nearly 50 writers generously donated their time and shared their knowledge in the preparation of the Guidelines documents. The work was divided among three Task Forces, the first dealing with the perioperative care of heart transplant recipients and chaired by me, the second addressing the issues of immunosuppression under the masterful guidance of David Taylor, and the third tackling the complex challenges of long term care under the direction of the Queen of Guidelinesland, Sharon Hunt. The three of us believe that the writing group faithfully reflected ISHLT's constituency, both in terms of geography and expertise. We quickly realized that the majority of recommendations are supported by expert consensus rather than being based on the results of controlled clinical trials. We also noted the many gaps in evidence affecting many

areas of our clinical practice, and we hope that this realization will spur further research. While acutely aware of these limitations in our clinical knowledge, we are proud that all three Task Forces' Documents are completed and currently being painstakingly reviewed by the Members of ISHLT's Guidelines Committee.

Sharon, David and I will revise the documents according to the Guidelines Committee's suggestions and will then forward the documents to the ISHLT's Board of Directors for review, and we sincerely hope, final approval. The Guideline's content will be presented at the 2010 ISHLT Scientific Meeting in Chicago and it will be published in the *Journal of Heart and Lung Transplantation* shortly thereafter.

We feel just like "Gus" McCrae, the former Texas Ranger of Larry McMurtry's *Lonesome Dove* who remembers his harrowing journey as a fine party!

And we hope the party will go on, enlivened by the comments, critiques and suggestions of our colleagues and fellow ISHLT Members.

Respectfully submitted,

[Maria Rosa Costanzo, MD, FACC, FAHA](#)
Chair, ISHLT Standards and Guidelines Committee



PULMONARY HYPERTENSION (PH) COUNCIL

The Pulmonary Hypertension (PH) Council is pleased to share the exciting progress we are making under the guidance of Ray Benza (Council Chair) and Myung Park (Vice-Chair).



The council is actively engaged in the following projects focused on highlighting PH as pertaining to ISHLT.

Several members of our council

have been involved in special work forces that are dedicated to creating position papers in key areas of pulmonary hypertension that hold critical interest. Robert Frantz is coordinating a group in undertaking the creation of a state of the art paper on PH and the Right Ventricle. James Fang is supervising a group in the development of a paper on PH related to left heart disease. Evelyn Horn is leading efforts in developing a focused paper related to PAH topic. Adaani Frost is evaluating post-transplant survival based on multiple pre-and post-transplantation variables. The specific aim of these writing groups will be to develop a document that is designed to be both informative to the clinician as well as serve as groundwork for possible future studies.

Furthermore, we are most excited about the upcoming annual meeting in Chicago. The council has been working diligently with the Program Committee and we are very pleased with the scientific program agenda on PH.

It is being recognized that ISHLT provides the unique opportunity to interact with cardiologists,

pulmonologists and cardiothoracic surgeons interested and focused on PH and transplantation.

At the 2010 Annual Meeting, we are pleased to announce the formation of five sessions. These symposia include up-to-date information on challenging topics specifically including: management of right ventricular failure, innovative medical and surgical therapies of PH, universal issues in pulmonary vascular disease, and biomarkers in PAH. These topics, being addressed by the expert international faculty, will make for an outstanding educational forum and a basis for important debate and discussion.

Pulmonary Vascular Disease will be a key component of ISHLT's Masters Academy. These are sessions given at the end of the annual meeting focused on fundamental overview of several key topics in heart failure, transplant and PH.

Most importantly, the council is proud to share that the number of abstracts submitted and accepted in PH category is steadily increasing. These original scientific investigations will be highlighted in oral, mini-oral and poster sessions.

The PH Council is embarking on an ambitious trajectory, and we look forward to seeing everyone at our meeting in Chicago. We will be discussing the status of ongoing projects and brainstorming about plans for the upcoming year. It is always an informative meeting and a great way to get to know your colleagues!

We look forward to seeing you in Chicago!

[Deborah Levine, MD](#)
[Communications Workforce Leader;](#)
[ISHLT Pulmonary Arterial Hypertension Council](#)



INFECTIOUS DISEASES SCIENTIFIC COUNCIL

The ISHLT Infectious Diseases Scientific Council has had a busy year. In April, the 2009 H1N1 Influenza A pandemic put the ID council in the limelight with release of the “ISHLT Advisory Statement on the Implications of Pandemic Influenza for Thoracic Organ Transplantation” on the ISHLT web site. Then to address specific transplant concerns, “The Novel 2009 H1N1 Influenza Virus Pandemic: Unique considerations for Programs in Cardiothoracic Transplantation,” was published in the JHLT 10/21/09. Dr. Mandeep Mehra was instrumental in keeping the project on track for a timely release.

The ISHLT ID council has received approval to create the first Monograph on “Infections in Cardiothoracic Transplantation and Mechanical Circulatory Support”. The release date is 2011. We appreciate Dr. Jim Kirkland’s expert guidance in helping us get this project off the ground.

ISHLT ID council is sponsoring a workshop entitled, “Definition of Infections in Cardiothoracic Transplant and Mechanical Assist Devices Patients,” to be held the day before the Annual ISHLT 2010 meeting in Chicago. This workshop will be attended by the task force selected by the ISHLT ID council to include

key members of the ISHLT, including Cardiothoracic Surgeons, Cardiologists, Pulmonologists, and members of the Infectious Diseases scientific council. Additional international experts have been co-opted into the Task Force to ensure a high standard of international consensus as the final outcome. These standardized definitions will be incorporated into Cardiac transplant, Lung transplant, and MSC research database (CTRD), and provide a standardized data collection tool for infections so we can have meaningful reporting of infection from data submitted by different transplant centers. The definitions will be presented at a symposium during the upcoming 2010 Annual ISHLT meeting in Chicago. This marks the beginning of standardized reporting of infectious diseases in the cardiothoracic transplant and VAD patient.

The ID council appreciates the opportunity afforded by the ISHLT for developing Standards and Guidelines in these areas in Transplant infectious diseases which will support databases, registries and future quality research in clinical transplantation.

Margaret Hannan, MD
Chair, ISHLT Council on Infectious Diseases