New Year, New Design!

As a new year begins, the Workforce on Publications is pleased and proud to present a new design for STS News. We hope you like this updated look to the Society’s quarterly newsletter, which still contains important features, columns, announcements, and member news.

Through feedback from the 2004 and 2005 STS News reader surveys, the Society learned that members rely on certain articles, such as the front-page features, Washington Scene, and columns from the Society’s President and Executive Director & General Counsel. At the same time, STS News readers want to learn more about clinical topics, practice management issues, and the future of the specialty. The redesigned STS News includes a visual Table of Contents at the bottom of the front page of each issue, so members can choose which subject they want to read about first: the Message from the President, the Washington Scene, Meeting Updates, abstracts from The Annals of Thoracic Surgery, or Member News.

On behalf of the Workforce on Publications, I hope you enjoy this newly designed format to the quarterly publication devoted to news about our Society and specialty. If you have questions or comments about the new design, please send a message to (sts@sts.org). Your ideas and suggestions will always be welcome.

As the saying goes, “Off with the old, and on with new!”

David R. Jones, MD, Chair
Workforce on Publications

STS 42nd Annual Meeting in Chicago!

McCormick Place • January 30-February 1, 2006
Tech-Con: January 28-29, 2006 • STS University: February 1, 2006

The STS 42nd Annual Meeting will convene in Chicago, January 30 – February 1, 2006. The Society relocated the 2006 meeting from New Orleans to Chicago after excessive damage to New Orleans by Hurricane Katrina. Chicago is proving to be an outstanding host city, offering fine dining at its best, amazing architecture, dozens of museums and art

(continued on page 3)
In my first “Message from the President” last spring (STS News, Vol. No. 11, Issue 2), I asked for your continued support and active participation to make 2005 a year to remember. Now, as the year draws to a close, I look back at 2005 with appreciation and pride for all the Society has accomplished in 12 months. I would like to highlight three important STS initiatives that underscore the Society’s commitment to both development and leadership: thoracic endovascular training, pay for performance, and the Legislative Advocacy Workshop (LAW).

Earlier issues of STS News have explained the progression of the Society’s Endovascular Training Program, from the formation of an Endovascular Surgery Task Force in 2004, to a course at STS University in January 2005, to the first Thoracic Endografting Symposium in August 2005. After the success of that first program, STS sponsored a second filled-to-capacity Thoracic Endografting Symposium Dec. 10-11 in Chicago.

This cutting-edge program helped attendees learn about the fundamentals of endovascular therapies for the treatment of the thoracic aorta, the necessary evaluation and pre-operative planning specific to endovascular therapies, the role of endovascular approaches and their potential complications in relation to diverse thoracic aortic pathologies, and the essential components involved in the initiation of an endovascular surgical practice. The development of this program is a fine example of the Society’s commitment to “help cardiothoracic surgeons serve patients better” by diversifying the skill sets of its members.

In the quality arena, STS Director-at-Large Jeffrey B. Rich testified as a key witness on Capitol Hill in March about Pay for Performance. Dr. Rich noted in his testimony: “We believe that only through a focus on quality can sustainable reductions in health care costs be achieved.” It comes as no surprise to me that STS is leading the way in pay-for-performance quality initiatives, considering the Society’s innovation in establishing the STS National Database in 1989.

Following Dr. Rich’s congressional testimony, the Society sent an e-mail message to all STS National (Cardiac) Database (NCD) Data Managers in August about health-care entities using NCD data in their quality-improvement programs. The message highlighted the Society’s position that any evaluation of STS members should be with relevant, accurate, and appropriate clinical data that correctly reflect the nature of cardiothoracic surgical care nationwide.

As you know, STS worked to develop the NCD as the platform for Continuous Quality Improvement in cardiac surgery, which influenced the National Quality Forum’s Quality Performance Measure Set for Cardiac Surgery in December 2004. To read more about these measures, please...
In the wake of the devastating effects of Hurricane Katrina, The Society of Thoracic Surgeons Board of Directors voted at its October 16th, 2006 meeting to provide 2006 dues and Annual Meeting registration fee waivers to STS members directly affected by the September catastrophe. This benefit extends to those members in the “core disaster area” in Alabama, Louisiana, and Mississippi, as defined by the federal government. This action will reduce the Society’s dues income for 2006 by about $62,000.

If you have been affected by Hurricane Katrina, or if you would like to learn more about these fee waivers, please contact Membership Coordinator Sonia Armendariz at (312) 202-5843, or send a message to (sarmendariz@sts.org).

STS 42nd Annual Meeting continued from cover...

galleries, a renowned theatre district, and shopping second to none. The STS Member Social Event for 2006 will highlight the Chicago experience. Held at Chicago’s famed Art Institute, the evening will include a reception with dinner hors d’oeuvres and drinks and, because Chicago is famous for its jazz, too, a jazz band will perform for members during the reception. Members will be able to stroll through the Impressionist Gallery filled with famous works by Monet, Degas and van Gogh. The evening will end with a special performance by Second City especially for STS members. The Second City show will be held in an auditorium at the Art Institute and, at its conclusion, buses will take members back to their hotels.

The Annual Meeting Program Book has mailed and will be arriving soon. When it does, you’ll find that the Chicago meeting also offers exceptional educational events. Look for exciting new programs such as Cardiothoracic Surgeons in the Military and Cultural Competence. STS/AATS Tech-Con 2006 will launch the meeting on Saturday, January 28 and Sunday, January 29. Start there and stay through STS University, such a hit last year and back, now bigger and even better. STS President Sidney Levitsky invites all members to attend, saying “The Annual Meeting provides more than just first-rate educational programs; it also provides countless opportunities to catch up with old friends, meet new acquaintances, learn from experienced colleagues, and explore a vibrant city.”

Society Offers Financial Break to Members Affected by Katrina

In the wake of the devastating effects of Hurricane Katrina, The Society of Thoracic Surgeons Board of Directors voted at its October 16th, 2006 meeting to provide 2006 dues and Annual Meeting registration fee waivers to STS members directly affected by the September catastrophe.

This benefit extends to those members in the “core disaster area” in Alabama, Louisiana, and Mississippi, as defined by the federal government. This action will reduce the Society’s dues income for 2006 by about $62,000.

If you have been affected by Hurricane Katrina, or if you would like to learn more about these fee waivers, please contact Membership Coordinator Sonia Armendariz at (312) 202-5843, or send a message to (sarmendariz@sts.org).
STS member Vincent A. Gaudiani, MD has recently published a thoughtful—and thought-provoking—“In My Opinion” piece on CTSNet titled, “Rethinking Innovation” (http://www.ctsnet.org/sections/newsandviews/inmyopinion/articles/article-56.html). As a prelude to his discussion of how external changes (e.g., the evolution of catheter-based interventions) have altered the way cardiac surgeons must think about innovation, Dr. Gaudiani notes that over the course of the past 50 years, “innovation has been the tonic chord of cardiac surgery.”

Just as all cardiothoracic surgeons—indeed, all professionals—need to continually “rethink innovation” in light of the constant changes in their environments, so do professional societies like The Society of Thoracic Surgeons. In recent years, a myriad of changes in the environment have caused the Society to assume direct responsibility for its management, to restructure its entire mode of governance and to redirect its resources in order to address critical concerns in the areas of education, quality/research and advocacy.

As this edition of STS News goes to press, the Society is at the approximate mid-point in a strategic planning process that is scheduled for completion during the second quarter of 2006. This process already has helped to sharpen the focus of the Society’s leadership as it rethinks innovation from an organizational perspective, and charts a course for the prioritization of our operational responses to developments in areas of key interest to the membership.

Meantime, as the new STS strategic plan continues to take shape, organizational innovation is not dormant; the Society recently has embraced a wide array of innovations that (to borrow from Dr. Gaudiani) we will be “executing” in 2006 in order to produce desired “outcomes”. Examples abound:

**Education** – The year ahead will see the rollout of e-learning modules developed in collaboration with CTSNet and the Joint Council on Thoracic Surgery Education, the Society’s first experience with journal-based CME (see pp. 12-13), a collaboration with the American College of Chest Physicians that likely will yield two distinct educational offerings for ACCP and STS members and, of course, STS University and all of the other educational innovations that will be available to you at the Society’s 42nd Annual Meeting in Chicago (not to mention an attendee party like none other in the annals of STS history, combining food, art, jazz and Chicago’s incomparable Second City comedy troupe).

**Quality/Research** – As reflected in the fall 2005 edition of STS News and other recent member communications, the Society continues to work closely with a variety of government and third-party payor entities in an effort to influence their respective approaches to the pay-for-performance phenomenon. In concert with these efforts, the Society will be embarking on an external data auditing initiative in the coming year that will serve to enhance the integrity of its National Database, initially in the Adult Cardiac Surgery arena.

**Advocacy** – As noted in Sid Levitsky’s column (see pp. 2-3), the Society conducted its inaugural Legislative Advocacy Workshop in September, and is currently planning an even bigger and better LAW event for this fall. In addition, our members can now utilize new and convenient online advocacy tools (see www.sts.org/takeaction), as well as customized action kits and other means provided through our Washington office to promote “grassroots” STS advocacy initiatives—an absolutely essential ingredient in any professional society’s efforts to influence healthcare policy and law.

Even this issue of STS News reflects innovation in action, with our new design and a focus on content that is responsive to feedback secured through reader surveys.

Innovation ranks among the five core values that have been adopted by the STS staff in its mission statement (along with respect, teamwork, ownership and quality service). To borrow once more from Dr. Gaudiani, we intend to work closely with STS officers, directors and other leaders in the continuous examination of “the intention, the execution and the outcome” of all STS innovations, including those referenced above, in our joint efforts to advance the interests of the Society and the profession as a whole.

In closing, on behalf of the entire STS staff, we wish you and yours a happy, healthy, prosperous and innovative New Year. See you at the Annual Meeting in Chicago!
CME Linked to Evaluations for Tech-Con and 42nd Annual Meeting

The CME/evaluation process implemented last year for physicians attending both Tech-Con and the STS 41st Annual Meeting will be used again at the 42nd Annual Meeting in Chicago.

Following last year’s pattern, the CME and the session evaluation forms will be part of the same form. Physicians who wish to receive credit for sessions they attend will be required to complete the evaluation form for the session. This will be the only way physicians will be able to earn CME credit for their attendance.

The evaluation form will provide physicians the opportunity to offer feedback to the Workforce on Annual Meeting regarding content offered, including: information regarding applicability of the content to current practice, quality of the material presented, and recommendations for future programming. This information is invaluable in the planning of future STS educational programs, including the 43rd Annual Meeting in San Diego.

In addition to being useful for program planning, evaluation is an important component of the requirements that the STS must meet to maintain accreditation through the Accreditation Council for Continuing Medical Education (ACCME). STS is able to award CME credit for educational programming by meeting the requirements established by the ACCME.

How the Process Works

CME/evaluation forms will be available on site at every session. Each evaluation will include a series of questions regarding the program content. In addition, physicians will need to fill in their membership ID and the actual amount of time spent in individual sessions. CME credit cannot be awarded without this information.

To make this process easier, member identification numbers will be printed on the conference badge receipt. Non-members will have a number that is generated for this purpose. Physicians will simply fill in their member ID number or specially generated number, note the actual time spent in the session, complete the evaluation, and submit it in an evaluation bin. Evaluation forms will be processed soon after the Annual Meeting and entered into an electronic file that STS staff members will use to generate CME certificates after the meeting. These certificates will be mailed to physicians. In future years, plans are underway to make the process entirely electronic. For now, however, it is important that physician attendees complete the paper evaluations.

This process allows the STS to maintain an electronic record of CME earned by physicians. Files will be maintained for a minimum of six (6) years. Any questions regarding this procedure should be directed to Damon K. Marquis, Director of Education and Member Services, at (312) 202-5813, via e-mail at (dmarquis@sts.org). As always, the Society thanks you for your cooperation!

Medicare Action Alert

On January 1, 2006, the Medicare payment rate for each procedure provided to Medicare beneficiaries decreased by 4.4%. Although a Senate bill passed on Dec. 22 included a payment freeze, this bill must be approved by the House before it can become law.

Members of STS with e-mail addresses on file were recently contacted with an urgent request to participate in a campaign to educate legislators about the need to reverse Medicare reimbursement cuts. A flyer with a copy of the e-mail message has been inserted with this issue of STS News.

All members are urged to contact legislators via e-mail and to set up meetings with their representatives and senators in the coming weeks while Congress is in recess and many representatives are in their home districts. To prepare for such meetings, STS members can contact the Washington Office to request the Medicare Action Kit, which provides talking points and data on the harmful impact of past and potential future reductions on cardiothoracic surgery and patient safety.

For more information visit the Government Relations section of www.sts.org. You can also call the Washington Office at (202) 481-1026 or e-mail Advocacy@sts.org.

If you did not receive this important blast e-mail, please contact sts@sts.org with your correct e-mail address to ensure that you don’t miss future announcements about developing Washington issues.
FRIDAY, JANUARY 27, 2006
1:00 p.m. - 6:00 p.m. • North Lobby
Registration: STS/AATS Tech-Con 2006, Annual Meeting, Spouse & Guest

SATURDAY, JANUARY 28, 2006
8:00 a.m. - 6:00 p.m. • North Lobby-Level 2
Registration: STS/AATS Tech-Con 2006, Annual Meeting, Spouse & Guest
12:00 p.m. - 6:30 p.m. • S406 Foyer
STS/AATS Tech-Con 2006 Exhibits
1:00 p.m. - 5:05 p.m. • S406
STS/AATS Tech-Con 2006
5:30 p.m. - 6:30 p.m. • S406 Foyer
STS/AATS Tech-Con 2006 Reception
6:00 p.m. - 9:00 p.m. • Chicago Hilton: Waldorf Room
Women in Thoracic Surgery 20th Anniversary Meeting

SUNDAY, JANUARY 29, 2006
7:00 a.m. - 6:30 p.m. • North Lobby
Registration: STS/AATS Tech-Con 2006, Annual Meeting, Spouse & Guest
7:30 a.m. - 11:00 a.m. • S406 Foyer
STS/AATS Tech-Con 2006 Exhibits
7:55 a.m. - 4:30 p.m. • S406
STS/AATS Tech-Con 2006
8:30 a.m. - 1:30 p.m. • N136 B
Spouse Post-Graduate Program
9:00 a.m. - 11:30 a.m. • N426
Medical Legal Symposium
9:00 a.m. - 11:40 a.m. • S401
Technology in Thoracic Surgery
11:45 a.m. - 12:55 p.m. • S100 B/C
Rapid Fire Luncheon: Joint STS/AATS Tech-Con and Parallel Surgical Forums Luncheon
12:30 p.m. - 4:30 p.m. • Exhibit Hall C
42nd Annual Meeting Exhibits and Scientific Posters Open
1:00 p.m. - 4:45 p.m. • S404
Parallel Surgical Forum: Congenital
1:00 p.m. - 4:45 p.m. • S401
Parallel Surgical Forum: General Thoracic
5:00 p.m. - 6:30 p.m. • Chicago Hilton: Continental Ballroom C
Patient Safety Town Hall Meeting
5:00 p.m. - 7:00 p.m. • Chicago Hilton: Continental Ballroom B
International Symposium
6:45 p.m. - 8:30 p.m. • Chicago Hilton: Continental Ballroom A
Cultural Competence Symposium
MONDAY, JANUARY 30, 2006
6:30 a.m. - 5:30 p.m. • North Lobby-Level 2
Registration: Annual Meeting, Spouse & Guest
7:45 a.m. - 9:30 a.m. • S100
General Session I: Welcome & Opening Remarks
J. Maxwell Chamberlain Memorial Award Presentations
Recognition of New Orleans & STS Members Affected by Hurricane Katrina
Oral Presentations
9:30 a.m. - 10:15 a.m. • Exhibit Hall C
Break
10:15 a.m. - 12:00 p.m. • S100
General Session I: continues
Award Presentations
Presidential Address
Sydney Levitsky, MD
9:00 a.m. - 4:30 p.m. • Exhibit Hall C
Exhibits and Scientific Posters Open
12:00 p.m. - 1:15 p.m. • Exhibit Hall C
Visit Exhibits & Scientific Posters and Redeem Your Lunch Voucher
Scientific Poster Questions & Answers
12:00 p.m. - 1:15 p.m. • N126, N128, N129, N130
Meet the Experts: Adult, Aortic, Congenital, and General Thoracic Cases
12:00 p.m. - 1:30 p.m. • N426
Thoracic Surgery Residents' Association Meeting
12:15 p.m. - 1:15 p.m. • S501D
English International Language (EIL) Workshop: Part I
1:30 p.m. - 3:45 p.m.
Parallel Surgical Forum I: Adult Cardiac • S100
Parallel Surgical Forum II: General Thoracic • S401
Parallel Surgical Forum III: Congenital Cardiac • S404
Parallel Forum IV: The Workforce on Aging Symposium • S405
3:45 p.m. - 4:30 p.m. • Exhibit Hall C
Break
4:30 p.m. - 6:00 p.m. • S100
Business Meeting (Members Only)
6:15 p.m. - 7:45 p.m. • Chicago Hilton: Waldorf Room
Cardiothoracic Surgeons in the Military Symposium
7:00 p.m. - 8:30 p.m. • Chicago Hilton: Boulevard Room
Challenges & Opportunities in Global Cardiothoracic Surgery 2006
8:00 p.m. - 10:00 p.m. • Chicago Hilton: Continental Ballroom A/B/C
Surgical Motion Pictures

TUESDAY, JANUARY 31, 2006
6:30 a.m. - 5:00 p.m. • North Lobby
Registration Annual Meeting, Spouse & Guest
7:00 a.m. - 8:00 a.m. • S401
Health Policy Forum
7:00 a.m. - 8:00 a.m. • N230B
English International Language (EIL) Workshop: Part II
7:00 a.m. - 8:00 a.m. • See Ticket for Location
Ticketed Breakfast Sessions
8:15 a.m. - 10:15 a.m. • S100
General Session II:
Oral Presentations
Health Policy Lecture
Debate: Our Health Care System at the Crossroads:
Single Payer or Market Reform?
9:00 a.m. - 4:30 p.m. • Exhibit Hall C
42nd Annual Meeting Exhibits and Scientific Posters
10:15 a.m. - 11:00 a.m. • Exhibit Hall C
Break
11:00 a.m. - 12:00 p.m. • S100
General Session II: continues
Thomas B. Ferguson Lecture:
Prof. David P. Taggart, MD (Hons), PhD, FRCS
9:00 a.m. - 4:30 p.m. • Exhibit Hall C
Exhibits and Scientific Posters Open
12:00 p.m. - 1:30 p.m. • S502
Residents' Luncheon
12:00 p.m. - 1:15 p.m. • S501D
English International Language (EIL) Workshop: Part III
1:30 p.m. - 5:45 p.m.
Parallel Scientific Session I: General Thoracic • S401
Parallel Scientific Session II: Congenital Cardiac • S404
Parallel Scientific Session III: Adult Cardiac • S100
Parallel Session IV: Practice Education Symposium • S405
7:00 p.m. - 10:00 p.m. • Art Institute
Social Event for Meeting Participants and Guests at the Art Institute

WEDNESDAY, FEBRUARY 1, 2006
6:30 a.m. - 12:00 p.m. • North Lobby-Level 2
Registration: Annual Meeting
7:00 a.m. - 10:00 a.m. • See Ticket for Location
STS University Courses
9:00 a.m. - 4:30 p.m. • Exhibit Hall C
42nd Annual Meeting Exhibits and Scientific Posters
10:00 a.m. - 10:30 a.m. • S100 Foyer
Break
10:30 a.m. - 12:30 p.m. • S100
STS University Live Surgical Procedures and Congenital Video Demonstrations

(Please see The STS Meeting Bulletin, the Society’s Convention Newspaper, for Convention Center and Exhibit Hall floor plans).
STS 42nd Annual Meeting

EXHIBITORS

Exhibit space is sold out at the STS 42nd Annual Meeting in Chicago. Come find out why. Exhibitors provide important information on new products and technologies as well as help support the cost of the meeting. Be sure to stop by to learn the latest and to thank STS's exhibitor partners.

The STS Exhibit Hall will be open:
Sunday, January 29, 12:30 p.m. – 4:30 p.m.; Monday, January 30, 9:00 a.m. – 4:30 p.m.; and Tuesday, January 31, 9:00 a.m. – 4:30 p.m.

Exhibit Guide Name
3F Therapeutics, Inc.
3M Health Care
A&E Medical Corporation
ABIOMED, Inc.
American Association for Thoracic Surgery
American Heart Association
Association of Physician Assistants in CardioVascular Surgery
Applied Fiberoptics
Army Medical Recruiting
Arrow International
Atricure, Inc.
Atrium Medical Corporation
ATS Medical, Inc.
Baxter
Baxter
Bayer Pharmaceutical Corporation
Berlin Heart AG
BFW, Inc.
Bryan Corporation
California Medical Laboratories, Inc.
CAOS
CardiacAssist, Inc.
CardioAccess
CardioGenesis Corporation
CardioMEMS, Inc.
Cardiosonix Ltd.
Care Wise Medical Products
Carilion Health System
Ceremed, inc
Chase Medical
CHF Solutions, Inc
CONMED Electrosurgery
Cook Incorporated
CryoCath Technologies, Inc.
CryoLife, Inc.
CTSNet, Inc.
Cubist Pharmaceuticals
Datascpe Cardio Assist
Delacroix Chevalier - Peters Surgical
Denver Biomedical, Inc.
Designs for Vision, Inc.
EACTS - European Association for Cardio-Thoracic Surgery
Edwards Lifesciences
Elsevier
Elsevier - Saunders - Mosby
Enpath Medical, Inc.
ESTECH Least Invasive Cardiac Surgery
ETHICON, INC./CardioVations
Fehling Surgical Instruments, Inc.
Fresenius Medical Care Extracorporeal Alliance
Genesee BioMedical, Inc.
Guidant - Cardiac Surgery
Haemonetics Corporation
Haemoscope Corporation
Heart Hugger/General Cardiac Technology, Inc.
Hodder Arnold Publishers
Hospira Worldwide, Inc.
HRA Research
I-FLOW CORPORATION
Inquire Market Research, Inc.
International Society for Minimally Invasive Cardiothoracic Surgery
Intuitive Surgical, Inc.
Kapp Surgical Instruments, Inc.
Karl Storz Endoscopy- America, Inc.
KCI
Kimberly-Clark Corporation
King Pharmaceuticals, Inc.
KLS - Martin L.P.
Koros USA, Inc.
Lippincott, Williams & Wilkins Medical Publishers
Luxtec Corporation, Division of LXU Healthcare
Maquet Cardiopulmonary
Medela, Inc.
ON-X Valves MCRI
Medi-Stim
Medtronic, Inc.
Micro Touch
Nadia International, Inc.
Olympus Surgical America, Inc.
ONCOTECH
Pioneer Surgical Technology
Porter Medical Products, Inc.
Power Medical Interventions
QAS
Quest Medical, Inc.
Rultract/Pemco, Inc.
Scanlan International, Inc.
Scios, Inc., a Johnson & Johnson Company
Shelhigh, Inc.
Smith & Nephew, Endoscopy
Somansetics Corporation
Sonotec Instruments, Inc.
Sorin Group
SSI Ultra Instruments
St. Jude Medical, Inc.
Starron Instruments
Sunoptic Technologies
Surge Medical Solutions, LLC
Surgical Physician Assistant Consultants
Surgitel/General Scientific Corporation
Synthes CMF
Teleflex Medical
Terumo Cardiovascular Systems Corporation
The Annals of Thoracic Surgery
The Medicines Company
Thompson Surgical Instruments, Inc.
Thorameet Surgical Products, Inc.
Thoratec Corporation
TomTech Corporation
Transonic Systems, Inc.
The Thoracic Surgery Foundation for Research and Education (TSFRE)
Tyco Healthcare
VeinSolutions
Velos, Inc
Vitaclor, Inc.
VNUS Medical Technologies
Voice Factor/PCS
W. Lorenz Surgical
Gore & Associates
Wexler Surgical Supplies
World Heart Corporation
Xillix Technologies Corp.
Meet the Experts
Monday, January 30, 2006; 12:00 p.m. – 1:15 p.m.

The “Meet the Experts” session has been revised this year. The new program provides meeting participants one-on-one opportunities to discuss their own cases with experts in the field. This exciting program will take place on Monday, January 30, 2006, from 12 p.m. until 1:15 p.m.

Attendees interested in taking part in this activity must bring their own cases. A laptop, LCD projector and x-ray view box will be available for this program. Content experts taking part in this program are:

Adult Cardiac Cases:
William E. Cohn, Houston, Texas and
Joseph S. Coselli, Houston, Texas

Aortic Cases:
Aubrey C. Galloway, New York, New York and
Randall B. Griepp, New York, New York

Congenital Cases:
Duke E. Cameron, Baltimore, Maryland and
Joseph A. Dearani, Rochester, Minnesota

General Thoracic Cases:
Daniel L. Miller, Atlanta, Georgia

David Taggart to Give 2006 Ferguson Lecture

David Taggart, Professor of Cardiovascular Surgery at the University of Oxford in England, will deliver the 2006 Thomas B. Ferguson Lecture at the STS 42nd Annual Meeting, January 31, 2006. Dr. Taggart’s research interests are in vascular biology, cerebral injury and large scale clinical trials. Most recently he has studied the increasing tendency among cardiologists to treat patients with multi-vessel and left main stem coronary artery disease by percutaneous intervention without consideration of a surgical option.

Dr. Taggart’s lecture in Chicago will address this trend and challenge the assumption that angioplasty is as effective as conventional bypass surgery in relieving symptoms and improving life expectancy in patients with significant coronary artery disease. More and more, he notes, some cardiologists are solely deciding patients’ treatment plans and not conferring with surgeon colleagues. Failure to involve a multidisciplinary team, Dr. Taggart will show, denies patients the opportunity to make a fully informed choice and falls short of best practice.

Dr. Taggart will speak Tuesday, January 31, 2006, 11:00 a.m. – 12:00 p.m. at McCormick Place in Chicago.

New Annual Meeting Sessions Highlight Cultural Competence, CT Surgeons in Military

Cultural Competence: Effective Communication Skills for Cardiothoracic Surgeons
Sunday, January 29, 2006; 6:45 – 8:30 p.m.

Effective communication with the patient is key to follow-up compliance and a completely successful outcome. Cardiothoracic surgeons work with patients from a wide variety of social and cultural backgrounds, all of whom possess varied perspectives, values, beliefs, and behaviors regarding their health. In order to provide appropriate care, cardiothoracic surgeons must recognize that these patients will vary in their recognition of symptoms, their thresholds for seeking care, their ability to communicate symptoms, their ability to understand the rationale for operative versus non-operative management, and their preference for or against complex surgical procedures. The goal of cross-cultural education is to improve health care providers’ ability to understand, communicate with, and care for patients from diverse backgrounds.

To learn more about this important topic of the 21st Century, please attend Cultural Competence: Effective Communication Skills for Cardiothoracic Surgeons on Sunday evening, January 29, at 6:45 p.m.

Cardiothoracic Surgeons in the Military
Monday, January 30, 2006; 6:15 p.m. – 7:45 p.m.

This exciting and informative session on cardiothoracic surgeons in the military will be presented by Col. Philip Charles Corcoran, MD of the U.S. Army, Cmdr. Donald Bennett, MD of the U.S. Navy, and Lt. Col. Michael Moulton, MD of the U.S. Air Force. The session will provide information on topics such as hospital experiences in Afghanistan and Iraq, challenges of critical care air transport, and navy hospital ship support of Operation Enduring Freedom and Operation Iraqi Freedom. Learn from the source what your colleagues are experiencing and find out more than the TV news stories can ever tell.
As the days got shorter and colder in Washington and the calendar marched toward year’s end, the Congress struggled to enact a 2006 budget bill that would reduce net spending by $39.7 billion, a bill that also held the fate of physician payments under Medicare in doubt. At 6:00 a.m. on Dec. 19, as Monday morning dawned over the Capitol, the House of Representatives passed the Deficit Reduction Act (DRA) by a 212-206 vote. However, two days later on the following Wednesday, a series of points of order were raised against the bill on the Senate floor, which struck out three provisions in the legislation. A vote to waive these points of order failed with three Republicans voting with all Democrats. The Vice President cut short a trip to the Middle East to return and cast the deciding vote in a 50-50 tie, passing the bill. But the bill has been altered, necessitating that the House reconsider the altered version. Unfortunately, the House had already left for the holidays and will not return until the scheduled convening of the second session of the 109th Congress, on January 31st.

For physicians, the bill contains a one-year delay of the cuts, freezing rates at their 2005 level for one year while removing onerous pay-for-reporting requirements for 2007 and beyond. “A payment freeze as included in the failed budget bill is nothing to celebrate given medical practice cost inflation, and the historic devaluation of the most common CT procedures, but it will be necessary to do triage before we can begin to repair our payment system,” said Michael Hogan, Director of the Society’s Washington DC Office.

“Maintaining the political will to keep a provision that costs $7.3 billion in a bill that reduces spending by $39.7 billion will be no easy feat. Ultimately, we’ve got to do more than play defense. We’ve got to change the system, to stabilize physician payments with positive updates that keep up with inflation. But we must stop the bleeding before we can move forward to increase compensation,” said STS Council on Health Policy and Relationships Chairman Keith S. Naunheim.

Also affecting surgeons directly or indirectly are provisions in the Act that reduce payments for imaging on contiguous body parts and the technical component of imaging services to the hospital outpatient price. Such provisions also allow limited demonstrations of gainsharing arrangements between hospitals and physicians, make payment for some screenings for abdominal aortic aneurysms, and continue restrictions on physician ownership in specialty hospitals. All of these changes may or may not survive depending on what the House of Representatives does upon its return.

Among the groups opposing the bill is the American Association of Retired Persons (AARP), which argues that Medicare part B (physician spending) is tied to Medicare beneficiary premiums. If Congress and the administration increase payments to doctors, they will simultaneously increase the monthly payments required of beneficiaries. The administration and Congress are very sensitive that the beneficiary premium increase announced for next September (two months before crucial 2006 mid-term elections) does not approach $100 per month.

The involvement of all STS members will be necessary to reverse these payment cuts! Cardiothoracic surgeons start each year in a deeper “hole,” while hospitals, home health facilities, nursing homes, and other providers start each budget year with an assumed payment increase based on a medical inflation index, or “market basket” update. The link to beneficiary premiums should be severed so that surgeons are no longer at odds with patients in a political budget battle.

One of the easy yet important steps you can take to make this happen is to e-mail your Congressman and to urge passage of the budget bill and reverse the 4.4% physician payment cut.

STS will have phones at its Health Policy booth at the STS 42nd Annual Meeting in Chicago so that members can call their Member of
Congress. Computers will also be available to facilitate advocacy e-mail. Washington staff will continue to fight to stop the cuts early, and will then embark on an aggressive campaign to win back reimbursement in several key areas.

There are several other issues in Congress where STS plays a major role in policy determination, but which were not resolved during the 2005 session. These include:

**Medical Liability Reform – Aggressive Pursuit of Resolution**
Medical liability reform has been a hot button issue on Capitol Hill for the past three years, yet the crisis remains unresolved. STS and other pro-reform organizations have been successful in pushing the issue and getting the necessary votes in the U.S. House of Representatives. However, the U.S. Senate remains the major stumbling block, filibustering any legislation containing a cap on non-economic damages.

It is expected that in 2006, similar legislative attempts will not succeed in the U.S. Senate, especially because it is an election year. Nevertheless, STS remains committed to working with both sides of the aisle to address the crisis. Through its participation in Doctors for Medical Liability Reform (DMLR), STS leads the public education efforts on this issue and will seek to help elect pro-reform candidates to Congress next fall. In 2004, DMLR public education efforts likely helped elect pro-reform candidates to the U.S. Senate in Georgia, North Carolina, and South Carolina.

In the meantime, the STS Washington Office will continue its advocacy efforts on Capitol Hill. The message is clear — it is time to cast aside partisan politics and address the medical liability crisis with creative and comprehensive measures. Both sides of the aisle acknowledge the crisis, but all parties must come to the table willing to negotiate a real and effective resolution. STS is determined to bring both sides together on a reasonable, rational solution.

**Higher Education – Providing Debt Relief to Our Residents**
The past few years have brought a significant challenge to cardiothoracic surgery. The 2005 residency matching numbers, for the first time ever, showed fewer applications to thoracic surgery residency programs than actual residency positions available around the country. This trend continued with a further, sharper decline in 2006. Nearly one-third of all residency slots went unfilled. Thoracic surgery residency programs received just over 100 total applications from medical school graduates, only 73 of whom graduated from U.S. medical schools. This is a crisis for a specialty with an increasing average age. Indeed, by the time today’s first-year residents finish their training, more than 50% of the current surgeons will be at retirement age or have retired from practice.

There is no “one size fits all” solution to the problem, as a number of factors have played a role in this sharp decline. However, there are several steps that STS can take to help alleviate pressure at certain points. One such relief point is the burden of repaying medical student loans. Today’s medical school graduates face staggering loan repayments. The loan repayment schedule for cardiothoracic surgery residents is unfair and overly burdensome, given the eight years or more of training required for cardiothoracic surgeons.

STS is working with Congress on proposed legislation that will allow thoracic surgery residents to defer repayment of loans until they complete their training and fellowships. STS is working closely with Rep. Charles Boustany, Jr., MD (R-LA), an STS member, to ensure that thoracic surgery residents can focus on their training without the financial pressures of student loan repayments.
NEW!

The Annals of Thoracic Surgery Offers Members Journal-Based CME Credit


Three outstanding members of the Annals Editorial Board – Drs. Verdi DiSesa, Mark Ferguson and Gus Mavroudis – have agreed to undertake this educational project. These newly appointed CME Associate Editors will choose the monthly articles from those “in press” and prepare learning objectives, questions, and multiple-choice answers. CME activities are hosted on CTSNet; subscribers should visit the Annals Web site, access the electronic copy, and follow instructions. Readers who complete the activity will receive up to one-hour credit toward state licensure requirements and the Physician Recognition Award. Best of all, physicians can earn these credits when and where they choose.

Please take a moment to read the adjacent abstracts for the December 2005 journal-based CME articles. You will note that Dr. Ferguson chose an article that advocates “extended staging” for patients thought to have resectable malignant pleural mesothelioma by imaging studies. The idea is to avoid major surgery in patients who cannot be helped by an operation. Dr. DiSesa presents an article that mines the STS National Database to tout the merits of transmyocardial laser revascularization plus CABG for patients with unstable angina. Finally, Dr. Mavroudis examines the Ross operation at 10 years in a pediatric and young adult population. Each month the subject matter will change. Over time, the CME editors and I will plan a menu that blankets cutting-edge topics of each subspecialty.

Your Society and the Editorial Board of the *Annals* invite you to take a look, give the free activities a try, and share your thoughts in the evaluation form that accompanies each activity.

L. Henry Edmunds, Jr., MD
Editor, *The Annals of Thoracic Surgery*

---

**Cardiovascular Impact of Unstable Angina on Outcomes of Transmyocardial Laser Revascularization Combined With Coronary Artery Bypass Grafting**

Keith A. Horvath, MD a*, T. Bruce Ferguson, Jr, MD b, Robert A. Guyton, MD c and Fred H. Edwards, MD d

a National Heart, Lung, Blood Institute, National Institutes of Health, Bethesda, Maryland
b Louisiana State University Health Sciences Center, New Orleans, Louisiana
c Emory University School of Medicine, Division of Cardiothoracic Surgery, Atlanta, Georgia
d University of Florida, Shands Jacksonville, Division of Cardiothoracic Surgery, Jacksonville, Florida

Accepted for publication June 7, 2005

**Correspondence:** *Address correspondence to Dr Horvath, NHLBI, Bldg 10CRC, Room 6-5140, MSC 1454, National Institutes of Health, 10 Center Dr, Bethesda, MD 20892 (Email: khorvath@nih.gov).*

**BACKGROUND:** For sole therapy transmyocardial laser revascularization (TMR), unstable angina has been demonstrated to be a significant independent predictor of operative mortality. The objective of this study was to investigate the preoperative risk profile of patients undergoing TMR plus coronary artery bypass graft surgery (CABG) and to determine the impact of unstable angina on outcomes.

**METHODS:** Using The Society of Thoracic Surgeons National Cardiac Database from 1998 to 2003, 5,618 patients underwent TMR plus CABG. These patients were compared with 932,715 patients who underwent CABG only operations.

**RESULTS:** The TMR plus CABG patients had a significantly higher incidence of diabetes (50% versus 34%), renal failure (7% versus 5%), peripheral vascular disease (20% versus 16%), reoperative surgery (26% versus 9%), three-vessel coronary artery disease (80% versus 71%), hyperlipidemia (73% versus 62%; $p < 0.001$ for all comparisons). The incidence of preoperative unstable angina was similar (46% versus 47%). The unadjusted perioperative mortality was 3.8% for TMR plus CABG patients. When unstable angina patients were removed, the observed mortality for TMR plus CABG was decreased to 2.7%.

**CONCLUSIONS:** It is likely that patients who undergo TMR plus CABG have a higher prevalence of diffuse coronary disease based on their preoperative demographics. Despite the increased risk associated with such anatomy, the mortality rate was not significantly increased when TMR was added to CABG in an effort to provide a more complete revascularization. As was noted from the outcomes of sole therapy TMR, in unstable angina patients, TMR plus CABG carries a higher risk, but this risk is not significantly different from that of such patients treated with CABG alone.
Ross Operation in the Young: A Ten-Year Experience

Giovanni Battista Luciani, MD*, Alessandro Favaro, MD, Gianluca Casali, MD, Francesco Santini, MD, Alessandro Mazzaucco, MD

Division of Cardiac Surgery, University of Verona, Verona, Italy
Accepted for publication March 3, 2005.

Correspondence: *Address correspondence to Dr Luciani, Division of Cardiac Surgery, University of Verona, O. C. M. Piazzale Stefani 1, Verona, 37126 Italy (Email: gbluciani@yahoo.com).

BACKGROUND: The Ross operation is an alternative to mechanical aortic valve replacement in the young. However, early and late complications after operation have been reported. In order to assess the role of the Ross operation in children and young adults, a 10-year clinical experience was reviewed.

METHODS: Ninety male and 22 female patients, aged 29 ± 10 years (range, 6-49) underwent cross-sectional clinic and echocardiographic examination. Indication for Ross operation was aortic regurgitation in 79 patients, stenosis in 11, and mixed lesion in 22; 82 (73%) had a bicuspid valve. Endpoints of the study were survival and freedom from autograft dilatation, from autograft and homograft dysfunction, and from reoperation.

RESULTS: There was 1 (1%) hospital and 1 late (1%) death, during an average follow-up of 5.1 ± 1.9 years (range, 0.1-10.6). At 10 years, survival was 98 ± 2%. Late autograft dilatation was identified in 32 (29%) patients and regurgitation in 15 (14%), 7 of whom had autograft dilatation. Ten-year freedom from autograft dilatation was 43 ± 8% and from regurgitation was 75 ± 8%. Multivariate analysis showed younger age (p = 0.05), preoperative aortic root dilatation (p = 0.02), root replacement technique (p = 0.03), and absence of pericardial strip buttressing (p = 0.04) to be predictive of autograft dilatation. Eleven (10%) patients required reoperation on the autograft (8 prosthetic valve replacement, 3 autograft root repair). Ten-year freedom from reoperation was 72 ± 10% and from replacement of the autograft was 88 ± 5%. Pulmonary homograft obstruction was identified in 6 (5%) patients, requiring homograft replacement in 1. All but 2 (2%) patients were in New York Heart Association class I, with a return to regular school grade or active employment.

CONCLUSIONS: Late outcome for the Ross procedure is excellent in terms of survival and quality of life. Late root dilatation, autograft regurgitation, and homograft stenosis, however, show increasing prevalence with time. Technical modifications of the procedure, yearly aortic root imaging, and early reintervention on the dilated neo-aortic root may further enhance the durability of the autologous pulmonary valve.

Extended Surgical Staging for Potentially Resectable Malignant Pleural Mesothelioma

David C. Rice, MB, BCh*, Jeremy J. Erasmus, MD, Craig W. Stevens, MD, PhD, Ara A. Vaporciyan, MD, Judy S. Wu, BS, Anne S. Tsao, MD, Garrett L. Walsh, MD, Stephen G. Swisher, MD, Wayne L. Hofsetter, MD, Nelson G. Ordonez, MD, W. Roy Smythe, MD

Department of Thoracic and Cardiovascular Surgery, The University of Texas M.D. Anderson Cancer Center, Houston, Texas
Accepted for publication June 7, 2005.

Correspondence: *Address correspondence to Dr Rice, Department of Thoracic and Cardiovascular Surgery, The University of Texas M.D. Anderson Cancer Center, Box 445, 1515 Holcombe Blvd, Houston, TX77030 (Email: drice@mdanderson.org).


BACKGROUND: Extrapleural pneumonectomy for malignant pleural mesothelioma (MPM) is a high-risk procedure, and patients require careful preoperative staging to exclude advanced disease. Computed tomography, magnetic resonance imaging, and positron emission tomography are useful staging modalities, but do not reliably identify contralateral mediastinal involvement or transdiaphragmatic invasion. We evaluated the role of extended surgical staging procedures, which generally includes a combination of laparoscopy, peritoneal lavage, and mediastinoscopy, to more precisely stage patients with MPM.

METHODS: One hundred eighteen patients with MPM, deemed clinically and radiologically resectable, underwent extended surgical staging. Mediastinoscopy was performed in 111 patients, laparoscopy in 109 patients, and peritoneal lavage in 78 patients.

RESULTS: Ten (9.2%) patients had gross evidence of transdiaphragmatic or peritoneal involvement. Peritoneal lavage was positive for metastatic MPM in 2 (2.6%) patients, neither of whom had obvious transdiaphragmatic invasion. Ipsilateral mediastinal nodes contained metastatic tumor in 10 of 62 (16.1%) patients. Contralateral nodes were positive in 4 of 111 (3.6%) patients. Of the patients who underwent biopsy of both ipsilateral and contralateral mediastinal nodes, and who had complete pathologic staging after extrapleural pneumonectomy (n = 46), 14 (30.4%) had N2-positive nodes. Only 5 of these patients were correctly identified by mediastinoscopy (sensitivity 36%, accuracy 80%). Extended surgical staging identified 16 (13.6%) patients who had contralateral nodal involvement, transdiaphragmatic invasion, or positive peritoneal cytology.

CONCLUSIONS: Extended surgical staging defines an important subset of patients with unresectable MPM not identified by imaging. Because of the potential morbidity associated with extrapleural pneumonectomy, we advocate that extended surgical staging be performed in all patients with MPM before resection.
STS Member Volunteers in Bangladesh

In November, STS Headquarters sent a blast e-mail to members announcing a need for cardiothoracic surgeons to volunteer in Bangladesh as part of the “Physicians for Peace” program. STS member David Evans, now of The Ocala Heart Institute in central Florida, traveled to Bangladesh from Nov. 29-Dec. 10 to share his knowledge and expertise. What follows are Dr. Evans’s answers to questions from STS News, as well as a personal commentary that he submitted.

For more information about the Physicians for Peace program, please visit www.physiciansforpeace.org.

STS News: What made you decide to participate in Physicians for Peace?

David Evans: “An expressed need, an organized trip with previous contacts and exposure, and a very solid charitable group with the highest efficiency ratings all contributed to my volunteering in Bangladesh.”

STS News: What areas did you concentrate on when you were in Bangladesh?

David Evans: “The main concentration was off-pump bypass surgery techniques, including OPCAB and thoracotomy approaches. The oxygenator is the prohibitive piece of equipment cost-wise. To eliminate the oxygenator, they can offer CABG surgery to anyone.”

STS News: What surprised you most about the experience?

David Evans: “Bureaucracy exists in all nations, as expected. But in less-developed nations, that system may be harder to navigate.”

STS News: What was a typical day like while you were there?

David Evans: “Typically a day started with tea before I was picked up at the hotel. From there, I was taken to a hospital through crowded streets to Dhaka, a city of 17 million people. In Dhaka, I gave lectures to students, residents, and faculty each morning at 8:00. After more tea, we went to the operating theater, where each day I would demonstrate and/or tutor a different beating heart operation, including 3-vessel MID-CAB by thoracotomy, single vessel MIDCABS, OPCAB and also on-pump bypass to demonstrate my technique. I also attempted to add some efficiencies with that procedure as well, and would consult on new patients between duties, as well as review many cardiac cath films and discuss various options and strategies for revascularization. I would usually finish by 4:00 p.m. and return to the hotel to relax and go out for dinner. The Bangladesh Medical Association held several banquets to welcome us and create a forum to comment on topics concerning their development strategies.”

Staff Update

Kirsi Cronk, Government Relations Coordinator

The Society of Thoracic Surgeons welcomed Kirsi Cronk as the new STS Government Relations Coordinator on Tues., Nov. 15. A graduate of the University of Richmond, Kirsi earned a bachelor’s degree in International Studies with a concentration in Modern Europe in 2000. Her previous experience includes working as an Administrative Assistant and Soccer Coach at Episcopal High School in Alexandria, Va. for two years. Most recently, Kirsi worked as the Manager of Political Affairs at the USTelecom Association in Washington, where she managed the association’s Political Action Committee (PAC) with more than $200,000 in annual receipts. She also assisted the PAC Treasurer in preparing the cycle budget and PAC plan for the year, drafted the PAC literature, prepared all mailings, built relationships, and managed the peer-to-peer solicitation. In her new role with the Society, Kirsi will handle the STS PAC, the grassroots program, Government Relations events, Washington office administration, as well as additional legislative and regulatory responsibilities. To contact Kirsi, please call (202) 481-1026, or send a message to (kcronk@sts.org).
By David K. Evans, MD

Statistics are difficult to verify and at times the truth within them is elusive. Is Bangladesh really one of the poorest and most densely populated nations in the world? How do we grasp a population of 147 million with 18 million in Dhaka city alone? Is it true the average yearly income is equivalent to less than $450 US?

What is true is that the people we met have kind, generous hearts, an intense pride in their country, and a bright vision for the future of their people. The medical leadership has made great gains in care over the past decade, and they demonstrate an inexhaustible energy to continue forward.

As a cardiac surgeon, I could not help but see that the needs are overwhelming – not only the staggering number of people with minimal resources, but also the early age at which coronary artery disease is represented in the population. Essentially everything is reused. Patients who are diagnosed with critical coronary artery disease and who need intervention must raise approximately $500 for a stent or approximately $500 for an oxygenator for bypass surgery. The choice of bypass is often made when more than one stent is needed. There are patients who may go completely without treatment if unable to raise the needed funds. These are the unavoidable realities of demand massively outweighing supply.

I had the opportunity to speak to students, residents, fellows and faculty about various beating-heart and thoracotomy approaches to coronary revascularization. During the short stay, several patients were revascularized, as I was able to demonstrate techniques, as well as assist and observe the Bengali surgeons perform them independently with great success.

My hope is that through further exposure to various beating-heart bypass approaches and continued efforts improving availability of supplies, incremental improvements in technique and outcomes will allow the skilled surgeons of Bangladesh to treat their population more effectively. By providing procedures as advanced as those offered by other countries, the hope is that Bangladesh will be able to keep its limited wealth within the local economy allowing the private sector to help support the public health needs.

Beating-heart bypass can be done in their system nearly without cost. By adding thoracotomy approaches to limited revascularization and advanced pain care techniques, they will not only be able to expand the number of patients treated, but also offer a health care product that matches or surpasses other regional providers. Through a “teaching the teachers” effort, the impact of these new procedures on one of the most visible areas of health care need and one of the most prevalent can be as immense as the need.

Challenges and Opportunities for Global Cardiac Surgery Symposium • Monday, January 30

Under the auspices of the Workforce on International Relationships, the Challenges and Opportunities for Global Cardiac Surgery Symposium will be held Monday, January 30 at 7:00 pm – 8:30 pm at the Chicago Hilton in the Boulevard Room. Speakers will address the current status of the delivery of cardiothoracic practice and surgical health care around the world, examining in depth both problems and successes, as well as global trends and emerging issues.

Invited speakers include Kitipan Arom (Thailand), Juan Jose Arango (Colombia), Xin Min Ruan (China), Friedrich Mohr (Germany), Devendra Saksena (India), and Maher Deeb (Israel). Workforce members facilitating a panel discussion with the audience are Jack Matloff, W.Gerald Rainer, Robert Replogle, and Aurelio Chaux.

Of Related Interest:
International Symposium: Endovascular Treatment of Thoracic Aortic Diseases
Moderator: Tomas A. Salerno
Sunday, January 29, 5:00 pm – 7:00 pm
Chicago Hilton-Continental Ballroom B

(Check The STS Meeting Bulletin to confirm all times and locations.)
Society to Manage TSDA as of January 1, 2006

In mid-November, The Society of Thoracic Surgeons and the Thoracic Surgery Directors Association (TSDA) entered into an agreement that will engage the Society to provide management services for TSDA as of Jan. 1, 2006.

With a history dating back to 1928 (when the first organized training program for thoracic surgeons was formalized by John Alexander at the University of Michigan), TSDA was organized formally by its president, Dr. Hassan Najafi, and incorporated in 1978. The organization’s stated objectives were “to emphasize its mandate to improve thoracic surgery resident education and to facilitate the solution of administrative problems arising in the conduct of thoracic surgery training programs.”

As part of the arrangement, STS will coordinate all day-to-day administrative tasks and serve as primary point of contact for TSDA members. STS will also work closely with TSDA ancillary organizations, the Thoracic Surgery Residents Association (TSRA) and the Thoracic Surgery Residency Administrators/Coordinators Section (TS-RACS). The Society’s headquarters office in Chicago will serve as headquarters for TSDA, and STS Marketing and Communications Director Nancy Gray Puckett will act as Executive Director.

If you have questions about TSDA, or about the recent agreement, please contact Ms. Puckett at (312) 202-5819, or by e-mail at (npuckett@sts.org).