

## “Alternative Access” TAVR Study Will Examine Benefits of Non-Femoral Access

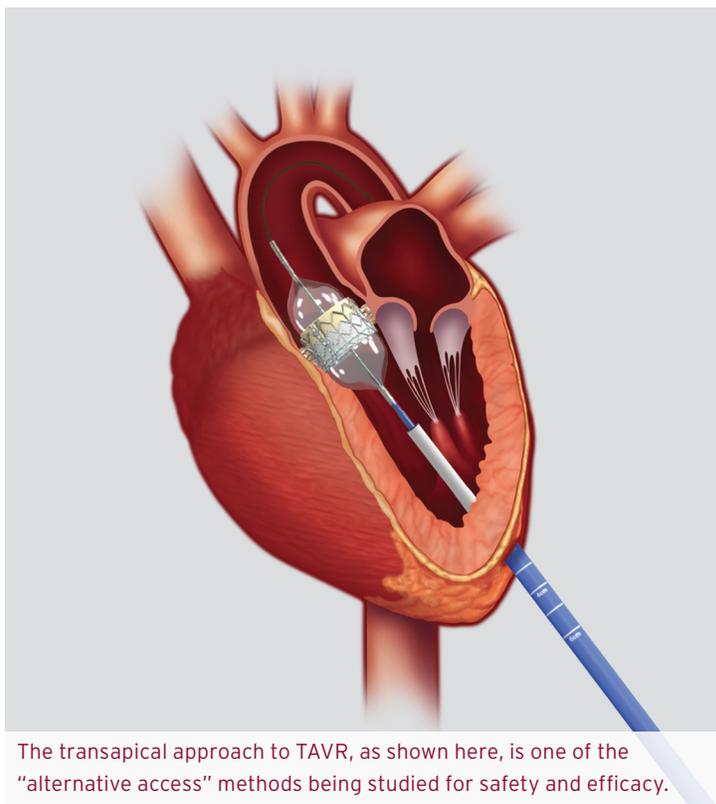
STS has launched an investigational study with the American College of Cardiology that may allow more patients to benefit from transcatheter aortic valve replacement (TAVR).

TAVR using the Edwards SAPIEN valve was recently approved in the United States for inoperable or high-risk patients with aortic stenosis. For most patients, the transfemoral approach is used, but some patients have too much disease in the femoral artery to permit using this approach.

The new study will evaluate the safety and efficacy of “alternative access” approaches for TAVR, including transapical, transaortic, transsubclavian/transaxillary, and transiliac.

“An estimated 1 in 4 patients has been ineligible for TAVR because advanced disease precludes use of the FDA-approved access site,” said STS Research Center Director Fred Edwards, MD, Emeritus Professor of Surgery at the University of Florida, Jacksonville, and one of the study’s principal investigators. “This trial will determine whether ‘alternative access’ procedures are as safe and effective as procedures using the presently approved approaches.”

Earlier this year, the US Food and Drug Administration granted STS and the ACC a unique



investigational device exemption (IDE) to study the alternative access approaches using the STS/ACC TVT Registry™, which is a device surveillance and benchmarking tool the two organizations developed to track clinical outcomes and improve patient safety. The IDE is believed to be the first sponsored by any medical specialty society.

The study will use TVT Registry data pertaining to inoperable patients aged 18 years and older who undergo TAVR for severe aortic stenosis using any non-femoral access approach with an Edwards SAPIEN valve between now and December 31, 2018.

continued on page 6 →

## New Guidelines on Aortic Valve Disease Now Online

STS has released clinical practice guidelines to address major advances in the evaluation and management of patients with aortic valve disease. An executive summary of the guidelines was published in the April issue of *The Annals of Thoracic Surgery*, while the full guidelines were published as a supplement to the June issue.

“For cardiac surgeons and cardiologists, there have been few options and no guidelines on how to manage high-risk, previously inoperable patients,” said Lars G. Svensson, MD, PhD, Chair of the Guideline Task Force. “In creating these new guidelines, we wanted to outline the pros and cons of treatment options for repairing the aortic valve, replacing the valve, and using transcatheter approaches. We also wanted to outline areas where more research is needed and incorporate quality metrics.”

The new aortic valve and ascending aorta clinical practice guidelines make recommendations in 26 areas, including mechanical aortic valves, biological valves, and transcatheter aortic valve replacement. You can access these and several other STS clinical practice guidelines at [www.sts.org/guidelines](http://www.sts.org/guidelines).



# Screening for Lung Cancer: An Important Opportunity to Advocate for Our Patients

Douglas E. Wood, MD, President

The STS mission is “to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.” We accomplish this mission in innumerable ways: leading research through our new Research Center, enhancing quality through our STS National Database, educating surgeons during our annual meeting and multiple freestanding courses, collaborating with like-minded specialty societies in education and guidelines, and advocating for health care policy that is important in the delivery of thoracic and cardiovascular care. Increasingly our mission leads us into initiatives and engagement that directly impact our most important constituency, our patients. Last year we successfully supported a National Coverage Determination for TAVR, assuring our patients equal access to consistent high-quality care related to this new technology. This year, opportunities may arise related to new therapies for mitral and pulmonic valves; however, perhaps no issue has more urgency or imperative than the emergence of lung cancer screening. Herein lies the prospect for STS members, individually and as a Society, to substantially lower lung cancer mortality by serving as patient advocates and facilitating access to lung cancer screening for patients at risk.

The National Lung Screening Trial (NLST) randomized more than 53,000 patients to screening with low-dose computed tomography (LDCT) versus chest x-ray, and, in October 2010, the NLST was halted due to a 20% mortality reduction identified in the study population (LDCT). A 20% mortality reduction is, by far, the most profound

finding that benefits our patients at risk for lung cancer, overshadowing improvements in surgical care, new chemotherapy drugs, and evolution in radiation combined. This immediately led to a reassessment of lung cancer screening by specialty physician groups and patient advocates. The first, and probably the most comprehensive, new guideline supporting lung cancer screening was published by the National Comprehensive Cancer Network (NCCN) in October 2011. The multidisciplinary NCCN guidelines group considered not only the complex issue of patients at risk for lung cancer who are screening candidates, but also the conduct of the screening program itself and management of abnormal findings. Several US societies have already published guidelines or statements recommending lung cancer screening, including STS, the American Cancer Society, the American Lung Association, the American College of Chest Physicians, the American Society of Clinical Oncology, and the American Association for Thoracic Surgery. (Read STS’s statement at [www.sts.org/LungCancerStatement](http://www.sts.org/LungCancerStatement).) The NCCN has completed its third annual update of lung cancer screening guidelines, refining and revising them each year as new data are published.

What is remarkable is that the primary body responsible for recommendations that direct national health policy, the United States Preventive Services Task Force (USPSTF), has yet to make any recommendations about lung cancer screening, even though the NLST results were announced nearly 3 years ago. This is in spite of assurances from AHRQ, which oversees the USPSTF, that screening recommendations would be forthcoming in 2012. This past May, I joined other physicians and government officials in a Senate briefing

to educate policymakers about the major opportunity to save lives from our most common cause of cancer death and shine a light on the long delay in action by the USPSTF.

It is easy to understand caution on the part of the USPSTF. Cancer screening is not the same as treatment of a disease. Legitimate potential harms of screening may outweigh the benefits, particularly if the population selected for screening is too broad, leading to fruitless workups, unnecessary testing, and perhaps even risky procedures being performed on individuals at low risk for cancer. And the USPSTF has recent experience in the consequences of overreach in breast and prostate screening programs, as well as the political backlash of trying to pull back from screening guidelines precedent. But there are also harms of delay or too narrow interpretation of the patient population at risk. The evidence supporting lung cancer screening is compelling. The benefits far outweigh the risks of screening in the NLST population, meaning that delay in recommendations and coverage decisions denies the chance of cancer cure for some of the 160,000 people who die of lung cancer each year. Further, it is naïve and narrow-minded to argue that only patients with the NLST inclusion criteria should be eligible for screening given decades of research that have outlined additional risk factors other than smoking. I believe our patients who are at risk of developing and dying of lung cancer deserve thoughtful and timely access to lung cancer screening. This is a time when we can support and advocate for our patients. Write to your Congressional representatives and/or HHS Secretary Kathleen Sebelius, urge action by the USPSTF, and do not let politics or finances interfere with clear evidence of benefit from lung cancer screening for our patients. ■

See page 14 for more information.

The Society's mission is to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, research, and advocacy.

#### IN THIS ISSUE

- 5 In Memoriam
- 6 News Briefs
- 9 New *Annals* Website
- 10 STS Members Abroad
- 12 Stroke Prevention Efforts
- 13 Anesthesiologists Encouraged to Join STS
- 14 Washington Scene
- 15 STS 50th Anniversary

*STS News* is a quarterly publication for members of The Society of Thoracic Surgeons. If you have a comment regarding the content of this publication or story ideas for future issues, please contact us. STS is not responsible for the opinions expressed by its writers and/or editors. © Copyright 2013. It is acceptable to duplicate and distribute *STS News* for personal use.

**Managing Editor**  
Heather Watkins

**Editorial Advisors**  
Robert A. Wynbrandt  
Natalie Boden

*STS News*  
633 N. Saint Clair St.  
Floor 23  
Chicago, IL 60611  
**Phone** (312) 202-5800  
**E-mail** [stsnnews@sts.org](mailto:stsnnews@sts.org)

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## Coding Help Desk Addresses Common Questions, Scenarios

Every cardiothoracic surgeon wants to maximize his/her reimbursement within the prescribed payer rules. And while the intricacies of coding may seem complicated, the best outcomes are often achieved when the surgeon is informed and works in tandem with the office billers.

The following represent a recent sampling of questions and answers from the STS Coding Help Desk. For an extended version of this article, visit [www.sts.org/codingarticles](http://www.sts.org/codingarticles).

### GENERAL THORACIC SURGERY

**Question:** A patient had an adenocarcinoma of the left lower lobe of the lung and an undiagnosed nodule of the left upper lobe. A thoracotomy with a left upper lobe wedge resection and a left lower lobectomy were performed. What are the correct codes that should be used to report this procedure?

**Answer:** For this scenario, report code 32480 – “removal of lung, other than pneumonectomy; single lobe (lobectomy)” as the primary code and code 32505-59-51 – “thoracotomy; with therapeutic wedge resection (e.g., mass, nodule), initial” as the secondary code.

These codes are bundled in the Medicare National Correct Coding Initiative (NCCI) edits; however, in this scenario, the procedures are performed in different lobes, so both may be reported and modifier -59 should be appended to the wedge resection (32505) to pull it out of the bundle. Modifier -51 communicates that the same physician performed multiple procedures in the same session, and the secondary procedure (32505) is subject to the multiple procedure discount.

### ADULT CARDIAC SURGERY

**Question:** According to NCCI edits, codes 33860 – “ascending aortic graft with cardiopulmonary bypass includes valve suspension when performed” and 33870 – “transverse arch graft with cardiopulmonary bypass” are bundled procedures. If an ascending aortic graft procedure (codes 33860 – 33864) extends anatomically into the transverse aortic arch but the anastomosis remains proximal to the origin of the innominate artery (e.g., a hemi-arch), can code 33870 be reported separately?

**Answer:** Code 33870 is bundled into all of the ascending aorta graft procedures (33860 – 33864). For procedures that involve reimplantation of the head vessels—either as an island pedicle or individually—the -59 modifier should be appended to code 33870 to pull it out of the bundle. The edit is to ensure that 33870 is not reported for situations where a hemi-arch repair is done and the head vessels are not involved in the procedure.

### CONGENITAL CARDIAC SURGERY

**Question:** Is a Sano shunt (code 33608 – “repair of complex cardiac anomaly other than pulmonary atresia with ventricular septal defect by construction or replacement of conduit from right or left ventricle to pulmonary artery”) separately billable with a Norwood, code 33619 – “repair of single ventricle with aortic outflow obstruction and aortic arch hypoplasia (hypoplastic left heart syndrome) (e.g., Norwood procedure)”?

**Answer:** No. The shunt (33608) is considered part of the Norwood procedure (33619), regardless of how it is accomplished. The use of the Sano shunt is just a modification of how the shunt in a Norwood is accomplished and is already valued into the work of the Norwood.

For more help with coding questions, contact the STS Coding Hotline at (303) 209-7358.

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Get answers to complicated coding questions by attending the STS Coding Workshop, November 7-9 in Orlando. The workshop will include information on the upcoming ICD-10 transition, Medicare coding, cardiothoracic evaluation & management coding, and detailed coding issues for adult cardiac, general thoracic, congenital heart, and vascular surgery. Learn more at [www.sts.org/codingworkshop](http://www.sts.org/codingworkshop) and encourage your billing staff to attend as well.



# On Continuous Improvement in the STS National Database

Robert A. Wynbrandt, Executive Director & General Counsel | DeLaine Schmitz, Director of Quality

*Continuing the STS management team's series of guest columns for STS News, DeLaine Schmitz provides a timely update on the latest initiatives related to our crown jewel, the STS National Database. In her capacity as Director of Quality, DeLaine oversees STS activities in the areas of patient safety and evidence-based surgery, as well as the operations of the STS National Database and its quality-related byproducts; she also works closely with Fred Edwards, Cynthia Shewan, and the STS Research Center team on research initiatives based on the STS National Database. DeLaine joined us in April 2012 after a 14-year tenure at the American Society of Plastic Surgeons, most recently serving as its Senior Director of Quality Initiatives.*

As the STS 50th Anniversary approaches and members contemplate the many achievements that have taken place over the past five decades, the creation of the STS National Database in 1989 stands out as one of the organization's finest accomplishments. Over the years, the Database has become a powerful tool that is highly regarded in the medical, governmental, policy, and payer communities. Due to the capabilities of the National Database and the Society's associated initiatives, STS has earned a leadership role in the national and international quality arenas. Analogous to the 1970s E. F. Hutton commercials, when the STS National Database is quoted, people listen.

A noteworthy accomplishment for the Database in 2013 was the July launch of a web-based anesthesia module within the Adult Cardiac Surgery Database. This long-anticipated collaborative project between STS and the Society of Cardiovascular Anesthesiologists (SCA) provides an opportunity for anesthesiologists to join their cardiac surgeon colleagues in the collection of adult cardiac anesthesia data. A dedicated anesthesia report section will be incorporated in the main quarterly harvest reports for review by both surgeon and anesthesiologist participants. The anesthesia data collection form and data specifications created by SCA representatives, in consultation with Duke Clinical Research Institute and STS staff, are located on the STS website. To obtain information regarding anesthesiology module participation, contact

STS National Database Operations Manager Gerry Tarafa at [gtarafa@sts.org](mailto:gtarafa@sts.org).

The STS Public Reporting initiative is another prime example of an important and continuously growing STS National Database activity, and in January 2013, aortic valve replacement (AVR) composite star ratings became available for public reporting. For the 2013 "harvest one" public reporting period that will be posted online in August, 464 Adult Cardiac Surgery Database participant sites will be publicly reporting their coronary artery bypass grafting (CABG) and/or AVR composite star ratings on the STS website voluntarily. New composite measures are currently in various stages of development and will provide further public reporting opportunities in the future. With a 3-year contract between the Society and Consumers Union recently completed, the option to also publicly report via Consumer Reports will remain available through 2015.

International participation, another recent initiative, is now open for all three components of the Database, with the General Thoracic Surgery Database becoming available for international participation earlier this year. International representation has expanded to include four countries. Surgeons in Brazil, Israel, Turkey, and Jordan participate in the Adult Cardiac Surgery Database, and surgeons in Turkey also participate in the Congenital Heart Surgery Database.

It is estimated that more than 200 STS member surgeons, research scientists, data managers, and other health care professionals are actively engaged in leadership activities

that relate directly to the care and feeding of the STS National Database (and this is distinct from the population of STS members involved in closely related research, education, and advocacy initiatives); this represents a level of commitment that is remarkable, even by STS standards, and is the envy of other medical specialty societies. These individuals follow in the footsteps of previous STS visionary leaders who continually strived to move the Database forward and meet the challenges of the time. This positive trend is evident in 2013 as participation in all three component databases continues to grow, specification upgrades are devised and executed, risk-adjustment models are updated, and new initiatives are launched. This continual process improvement will be supported this year by a 1.5 day Database Think Tank meeting in September, bringing together a group of stakeholders to look toward the future and plan the steps necessary to help ensure that the Database continues to be a robust, powerful resource for many years to come. Any suggestions or comments for Think Tank participants should be directed to STS Director of Quality DeLaine Schmitz at [dschmitz@sts.org](mailto:dschmitz@sts.org).

And especially for our data manager Associate Members—but also for surgeon and anesthesiologist participants alike—it's not too early to start planning for your attendance at our 10th production of Advances in Quality & Outcomes (AQO): A Data Managers Meeting, scheduled for September 26-28 in Boston. The annual AQO conference represents a unique opportunity to witness STS National Database continuous improvement in action; registration is available at [www.sts.org/aqo](http://www.sts.org/aqo). ■

**For related information,  
see page 13.**

## Herbert E. Sloan Jr., MD

STS PAST PRESIDENT (1974-1975)  
EDITOR, *THE ANNALS OF THORACIC SURGERY* (1969-1984)



The Society mourns the loss of STS Past President Herbert E. Sloan Jr., MD, who passed away on May 17 at the age of 98.

Dr. Sloan earned his medical degree and completed his general surgery residency at The Johns Hopkins University School of Medicine in Baltimore. He completed his thoracic

surgery training in 1949 at the University of Michigan in Ann Arbor, where he was then hired as an instructor and rose rapidly through the ranks.

He was named Professor of Surgery in 1962 and led the Section of Thoracic Surgery from 1970 to 1985. Dr. Sloan held several other important positions at the University of Michigan, including Chief of Clinical Affairs, Medical Director of the Operating Rooms, and Medical Director of M-Care HMO.

In addition to serving as STS President from 1974 to 1975 and President of the American Association for Thoracic Surgery from 1979 to 1980, Dr. Sloan was Editor of *The Annals of Thoracic Surgery* from 1969 to 1984. He was also closely involved with the American Board of Thoracic Surgery, serving as Vice Chair from 1971 to 1973 and Secretary-Treasurer from 1973 to 1986. He also received the STS Distinguished Service Award in 1981.

“Dr. Sloan was a force in thoracic surgery and was dedicated to improving our specialty,” said STS Past President Mark B. Orringer, MD. “The hours—often Sundays—he committed to his positions as Editor of *The Annals* and Secretary of the ABTS were a source of awe to his junior faculty at Michigan. His integrity and clinical judgment were unparalleled. He was demanding and precise in the OR—a superb and innovative pediatric cardiac surgeon. His often stern demeanor mirrored his unwavering insistence upon clinical excellence; he had little tolerance for errors in patient management. Beneath that countenance was a compassionate physician, mentor to countless residents, and loyal friend to his colleagues. Herbert Sloan earned his place among the giants of thoracic surgery.” ■

## Thomas B. Ferguson, MD

STS PAST PRESIDENT (1976-1977)  
EDITOR, *THE ANNALS OF THORACIC SURGERY* (1984-2000)



The Society mourns the loss of STS Past President Thomas B. Ferguson, MD, who passed away on May 26 at the age of 90.

Dr. Ferguson attended Duke University and Duke University School of Medicine, graduating in 1947. He then went to Washington University School of Medicine in St.

Louis to train in thoracic surgery. Except for a brief stint in Florida from 1960 to 1964, Dr. Ferguson was a Clinical Associate Professor and then Professor of Surgery in the Cardiothoracic Surgery Division at Washington University School of Medicine until 1985, when he became a full Professor and then Emeritus Professor.

In addition to serving as STS President from 1976 to 1977 and President of the American Association for Thoracic Surgery from 1981 to 1982, Dr. Ferguson was Editor of *The Annals of Thoracic Surgery* from 1984 to 2000. He was also Chair of the American Board of Thoracic Surgery from 1977 to 1979 and Founding Editor of CTSNet, Inc. He received the STS Distinguished Service Award in 1991. In 2000, with support from Medtronic, Inc., the Society established the Thomas B. Ferguson Lecture at the STS Annual Meeting in his honor.

“Tom Ferguson was a team player and a team leader. He had a goal-focused vision and the unique ability to make everyone who worked with him feel like they were part of that leadership and part of the mission,” said STS Past President W. Gerald Rainer, MD. “His contributions to our specialty, STS, AATS, and CTSNet are incredible. We will miss him greatly.”

In his 1977 Presidential Address, Dr. Ferguson reminded STS members to preserve a surgeon’s most precious commodity—the one-on-one relationship between a patient and a physician.

“Each of us can recall instances when for one reason or another we have become emotionally involved in a patient’s illness and given of ourselves to that patient. And win or lose, the family remembers us with kindness longer, and we remember the patient and his family longer than our brilliant technical triumphs that come and go every day,” he said. “This commodity is a mighty influence, which, if believed in and nurtured, defies federal purchase, manipulation, and spindling or mutilating.” ■

## “Alternative Access” TAVR Study Will Examine Benefits of Non-Femoral Access

→ continued from cover

The primary analysis will be performed when data on the first 1,000 evaluable patients are available.

“Implementing this study through the STS/ACC TVT Registry provides a unique opportunity to enroll a very diverse group of patients from a number of different institutions, providing us with a large sample population in which to study alternative access,” said Dr. Edwards. “This level of collaboration and use of registries will enable us to gather accurate information that may ultimately lead to label expansion.”

Four principal investigators—including Dr. Edwards; John Carroll, MD, from the American College of Cardiology; and J. Matthew Brennan, MD, MPH, and Sean O’Brien, PhD, from Duke University—will oversee the study.

As of early July, 239 US institutions were enrolled in the TVT Registry. The institutions are located in 46 states and the District of Columbia. ■

## STS and ACCF Co-Sponsor THV Symposium

On April 25–26, the Society partnered with the American College of Cardiology Foundation for the Transcatheter Heart Valve Symposium in Dallas. The goal of the course was to prepare cardiothoracic surgeons, cardiologists, and the rest of the health care team for the still-evolving role and impact of THV therapy.

Attendees learned about expanded indications for transcatheter aortic valve replacement, new data from the STS/ACC TVT Registry™ and clinical trials, and new financial implications of TAVR. Sessions included hands-on device demonstrations, case presentations, and a review of the latest US and global experiences. ■



In this photo from the event, course instructor Joshua D. Rovin, MD demonstrates the transapical approach for TAVR.

## Register Now for the STS Symposium: Mechanical Circulatory Support for Advanced Cardiopulmonary Disease

Advanced mechanical device technologies for cardiac and pulmonary support are providing new opportunities for both temporary and long-term patient treatment options. Register now for the STS Symposium: Mechanical Circulatory Support for Advanced Cardiopulmonary Disease, September 20–21 in Chicago. This 1.5-day symposium will cover the complexities of patient management, new device technologies, and important governmental regulations associated with initiating and maintaining an advanced technologies program. View the agenda and registration details at [www.sts.org/mcs](http://www.sts.org/mcs).

## Support Your STS Regional Group

Participants in the STS Adult Cardiac Surgery Database (ACSD) have an opportunity to join a regional collaborative group. STS Regional Groups bring together surgeons and data managers to strategize about ways that ACSD data can help improve surgical outcomes. Surgeon involvement and leadership are especially needed in the following Regional Groups—Minnesota (MN, ND, SD), Wisconsin, Rocky Mountain (AZ, CO, NM, UT, WY), Ohio, Missouri/Kansas, Florida, Gulf States (AL, LA, MS), and Arkansas/Kentucky/Tennessee.

Contact your local regional group leader to join. More information is available at [www.sts.org/regionaldatabasegroups](http://www.sts.org/regionaldatabasegroups).

## Member News



### HIGGINS NAMED CHAIR

This past April, Robert S. D. Higgins, MD, MSHA was named Chair of the Department of Surgery at The Ohio State University College of Medicine. He will continue in his roles as Director of OSU's Comprehensive Transplant Center and Director of the Division of Cardiac Surgery. An STS member since 1997, he currently serves as the Society's Treasurer, in addition to serving on the Board of Directors, the Executive Committee, and the Workforce on Media Relations & Communications.

Submit news about yourself or a colleague to [stsnews@sts.org](mailto:stsnews@sts.org). Submissions will be printed based on content, membership status, and space available.



### THOURANI RECEIVES TEACHING AWARDS

Vinod H. Thourani, MD recently received two awards honoring commitment and excellence in teaching: the American College of Cardiology's W. Proctor Harvey, MD Young Teacher Award and the Thoracic Surgery Residents Association's Dwight C. McGoon Award. Dr. Thourani is currently an Associate Professor of Cardiothoracic Surgery and Co-Director of the Structural Heart and Valve Center at Emory University in Atlanta. He has been an STS member since 2008.



### JONAS HONORED WITH GIBBON AWARD

Richard A. Jonas, MD has received the prestigious Gibbon Award from the American Society of Extra-Corporeal Technology. The Gibbon Award recognizes an individual who has made significant contributions to the cardiopulmonary discipline interrelating with the field of extracorporeal circulation. Dr. Jonas is currently Chief of Cardiac Surgery and Co-Director of the Children's National Heart Institute at Children's National Medical Center in Washington, DC. He has been an STS member since 1989.



### LIPTAY LEADS CT SURGERY AT RUSH

Michael J. Liptay, MD has been named Chairman of the Department of Cardiovascular-Thoracic Surgery at Rush University Medical Center in Chicago. Dr. Liptay was formerly Chief of the Division of Thoracic Surgery at Rush. He also serves as Program Director of the thoracic surgery residency program and holds the Mary Denny Weaver Chair of Cancer Research. An STS member since 1998, Dr. Liptay serves on the Society's General Thoracic Surgery Database Task Force. ■

## Staff Updates

**Jogesh Sehdev** joined STS on April 22 as its Accounting Assistant. He is responsible for accounts payable and receivable, as well as assisting with other accounting tasks. Previously, Jogesh worked as an accountant at Gabrus Consulting and DHR International. Currently pursuing a Masters of Business Administration degree and Certified Public Accountant licensure, Jogesh holds a bachelor's degree in accountancy from DeVry University. To contact him, e-mail [jsehdev@sts.org](mailto:jsehdev@sts.org).

**Erin Luytjes** joined STS on June 10 as its Meetings Coordinator. As part of the Meetings & Conventions team, she is responsible for coordinating activities related to meeting planning for the Society's Annual Meeting and all ancillary meetings, including meeting logistics, advance registration preparation, collaboration with vendors, and related administrative tasks. Previously, Erin worked as a Meetings Coordinator at the American Association of Diabetes Educators. Erin holds a bachelor's degree in business marketing from Michigan State University. To contact her, e-mail [eluytjes@sts.org](mailto:eluytjes@sts.org).

**Lindsey DeBene** joined STS on June 17 as its Marketing & Communications Coordinator. She is responsible for assisting with all aspects of marketing and communications for the Society. Previously, Lindsey worked as an Account Executive at AKHIA Public Relations & Marketing and as a Project Coordinator Assistant at The Innovation Center at the University of Pittsburgh Medical Center. Lindsey has a bachelor's degree in communications from John Carroll University. To contact her, e-mail [ldelbene@sts.org](mailto:ldelbene@sts.org).

**Josh Krantz** joined STS on June 17 as its Government Relations Coordinator. He will work on grassroots advocacy, as well as legislative and regulatory issues, as part of the Society's staff in Washington, DC. Previously, Josh worked as a Finance Assistant for the political consulting firm Molly Allen Associates. He also has experience working on state and national campaigns. Josh holds bachelor's degrees in management and political science from Binghamton University in New York. To contact him, e-mail [jkrantz@sts.org](mailto:jkrantz@sts.org).

## STS Participates in AATS Annual Meeting

This past May, STS hosted a booth at the American Association for Thoracic Surgery Annual Meeting in Minneapolis to share information about the Society's many activities. Visitors received the latest updates on participation in the STS National Database (including international participation), public reporting initiatives, developments from the STS Research Center, the STS Key Contact Program, and other STS membership benefits. ■



## 2014 Looking to the Future Scholarship Applications Available Soon

Help support the future of cardiothoracic surgery by encouraging general surgery residents and medical students interested in the specialty to apply for an STS 2014 Looking to the Future Scholarship.

Scholarships include registration fees for the STS 50th Annual Meeting and STS/AATS Tech-Con 2014 in Orlando; a 3-night stay at an STS-designated hotel; participation in special events exclusively for scholarship recipients; an assigned mentor to help plan a schedule of educational programming and facilitate introductions; and reimbursement of up to \$500 in related travel expenses.

If you know of an aspiring cardiothoracic surgeon, encourage him or her to apply. You can also offer to write a letter of recommendation on the applicant's behalf. ■

Applications will be available at [www.sts.org/lttf](http://www.sts.org/lttf) in September. For more information, contact Rachel Pebworth, Senior Coordinator, Affiliate Organizations, at [rpebworth@sts.org](mailto:rpebworth@sts.org).

## Roundtable Videos Available Online

Visit the Society's YouTube channel at [www.youtube.com/thoracicsurgeons](http://www.youtube.com/thoracicsurgeons) to view several roundtable discussions filmed at the STS 49th Annual Meeting. In the videos, leading experts discuss a wide range of topics, including:

- Controversies in Mitral Valve Repair
- Developing Clinical Guidelines for Perfusion
- Current Therapies and Controversies in Aortic Dissection
- International Expansion of the STS National Database
- Health Policy Advocacy Opportunities
- Lung Cancer Screening
- Adults with Congenital Heart Disease
- Transcatheter Aortic Valve Replacement

Also, watch videos of STS leaders past and present as they discuss the Society's history and look to its 50th anniversary this coming January. ■

## STS Leadership Self-Nomination Process Opens in September

All members are invited to participate in the Society's self-nomination process for committee and workforce appointments. Submissions will be accepted September 1–30. You will receive an e-mail with further information on how to self-nominate.

A full list of the Society's standing committees and workforces can be found at [www.sts.org/leadershipstructure](http://www.sts.org/leadershipstructure). Leadership appointments are approved by the STS Executive Committee each year, usually at its December meeting. Leadership appointments for 2014–2015 will commence after the STS 50th Annual Meeting in Orlando, January 25–29, 2014. The majority of open positions are for 3-year terms, renewable on a one-time basis. ■

If you have questions about the STS leadership structure and the self-nomination process, contact Grahame Rush, Director of Information Services, at [grush@sts.org](mailto:grush@sts.org) or (312) 202-5848.

# How to Register Your *Annals* Online Account

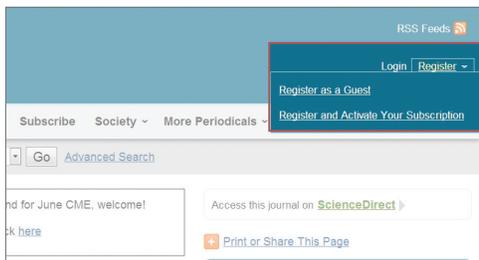
The *Annals of Thoracic Surgery* has a new online home: [annalsthoracicsurgery.org](http://annalsthoracicsurgery.org).

The site offers an improved search function, Continuing Medical Education, publish-ahead-of-print articles, online-only supplemental material such as videos, and article subject collections—all with enhanced capabilities. Additionally, the new online journal site will soon offer mobile-friendly access, improved navigation, surveys, and press clippings.

## HOW TO REGISTER AND CLAIM YOUR ONLINE ACCESS

To access full-text articles, you must register an account on the site. Registration also allows you to take advantage of the high degree of site personalization, including abstract e-mailing, e-mail alerts for newly released tables of contents, saved searches, a citation manager where you can save references, and alerts for articles of your choosing.

1. Go to [annalsthoracicsurgery.org](http://annalsthoracicsurgery.org) and click “Register” in the banner at the top right, and then choose “Register and Activate Your Subscription.” (If you already subscribe to an Elsevier journal, you can log in with the username and password you’ve already registered with them.)



2. Enter your e-mail address (which will be your username going forward) in the top field. Click the button to the left of “Register an Account,” and then click “Continue.”



3. At the Register a New Account page, create a password and fill out the requested profile information. Here, you can opt in to receive e-alerts for new issues. Select that you have read the terms of use and click “Register.”

4. On the confirmation page, claim your access to full-text articles. Click “I receive my subscription through a society membership.” Enter your 6-digit STS membership ID number and last name, then click “Claim.” (If you need assistance with your STS membership ID number, contact Sarah Foreman, Member Services Coordinator, at [membership@sts.org](mailto:membership@sts.org).)

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The *Annals* is still available via CTSNet, but to access the journal, you have to use your new username and password. ■

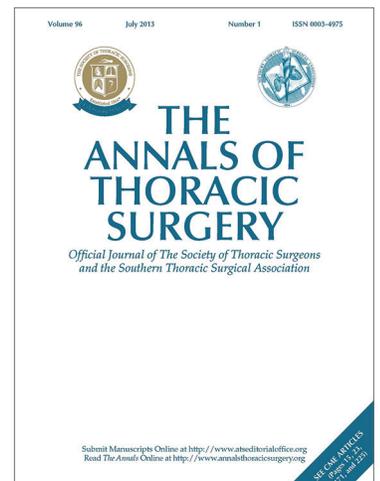
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## STS Members Help Save Lives, Create Sustainable Surgery Programs Abroad

There's an old saying: "Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime."

Several STS members are taking that maxim to heart by participating in charitable mission trips to developing countries. Not only are they performing dozens of life-saving surgeries, but they are also educating the local medical staff.

For the last 8 years, Jeffrey P. Jacobs, MD, from Johns Hopkins Children's Heart Surgery at All Children's Hospital in St. Petersburg, Fla., has made annual trips to the Bustamante Children's Hospital in Kingston, Jamaica.



The surgical team, including STS members Jeffrey P. Jacobs, Harald L. Lindberg, Frank G. Scholl, and Vinay Badhwar, scrubs before operating in Jamaica.

The trips are organized through the Cardiac Kids Foundation of Florida, of which Dr. Jacobs is President. The Larry King Cardiac Foundation, Edwards Lifesciences, St. Jude Medical, Medtronic, and Mending Kids International are all major supporters of these missions. The project has grown over the years and now includes 40-50 travelers on each trip. STS Education Manager Michele Chao joined the group during its most recent trip in April. Over the years, the team has operated on 84 children between the ages of 2 days and 16 years.

"The most striking thing is that we encounter a lot of problems that we very rarely see in the United States," Dr. Jacobs said. "In the

United States, babies with tetralogy of Fallot usually have heart surgery by the age of 6 months. In Jamaica, it's not unusual to repair children with tetralogy who are 5 or 6 years old, and occasionally even 11, 12, or 13 years old. Usually, prior to surgery, these older children with tetralogy are quite ill, but after surgery, they become very healthy!"

Vinay Badhwar, MD, from the University of Pittsburgh School of Medicine, has joined Dr. Jacobs on these trips for the last 3 years. He's worked to help address a common problem in that region—rheumatic mitral valve disease. Dr. Badhwar's expertise has made

it possible to repair children's valves rather than replace them.

"Our rheumatic mitral repair methods involve releasing the restrictions on the mitral valve leaflets and using the patient's own pericardium to augment the anterior leaflet of the mitral valve," Dr. Badhwar said. "Our

hope is that this prevents a reoperation until these children get well into adulthood."

He noted that flexibility and creative thinking can be important when operating in a foreign environment. "At home, you normally rely on special monitors, special imaging, and access to special drugs, but when you're abroad, sometimes those things are not available," he said. "So we have to be malleable and use whatever equipment is on hand."

Another member of the team is anesthesiologist David F. Vener, MD, from Baylor College of Medicine in Houston. This year's trip was Dr. Vener's fifth.

"I've really enjoyed working on the tetralogies, ventricular septal defects, and atrial septal defects," he said. "I find those the most satisfying because the kids are usually running around by the time we leave the country."

Although the role of an anesthesiologist in Jamaica is not dramatically different from that in the United States, Dr. Vener said he did have to make a few adjustments.

"You have to scramble and use a MacGyver technique sometimes, trying to find one type of monitor from one place and a different type of monitor from another place and putting it all together to get a working set of consistent monitors," he said.

Over the years, the local team has made great strides with its onsite surgical program. When Dr. Jacobs first started visiting Jamaica, the country had only three adult cardiac surgeons who would occasionally operate on children. Now, Sherard Little, MD, a full-time pediatric heart surgeon, is on staff, which means more surgeries are performed by the local Jamaican team throughout the year.

"That's kind of the whole goal of what we're doing—to partner with the team in Jamaica, create something sustainable, and save thousands of lives instead of just hundreds," Dr. Jacobs said. "We are proud of every life we save, but what I'm most proud of is the fact that we've been able to work with this local team and empower them to do more and more independently."

### STS MEMBERS FIND SIMILAR SATISFACTION IN RWANDA

Sustainability is also the primary goal of the Human Resources for Health program currently operating in Rwanda. The US government is funding a 7-year program that started in August 2012 to build the health care education infrastructure and workforce necessary to create a high-quality, sustainable health care system in Rwanda. Health care workers from across the US are traveling to

Rwanda for anywhere between 2 months and a year to instruct the local medical staff.

One participant is Ivan K. Crosby, MD, from the University of Virginia Health Sciences Center in Charlottesville. He arrived in Rwanda's capital city, Kigali, last August and stayed for 4 months.

As the first cardiothoracic surgeon to participate in the program, Dr. Crosby was tasked with a multi-faceted goal.

“Part of the goal was to introduce a US-style educational program with a lot more emphasis on didactic teaching. But we also wanted to teach the residents to operate by doing procedures with them,” he explained. “Another important aspect was setting up an acute surgery training program to better deal with handling trauma cases, which makes up a very large component of their patients in the hospitals.”



STS member Ivan K. Crosby with a Rwandan patient he treated for thoracic teratoma.

His first 2 weeks consisted primarily of meeting people and getting the lay of the land. Over the next few months, he performed approximately 25 surgeries. “In the pediatric age group, there's a lot of pulmonary infection

and destroyed lungs because they have poor treatment for pulmonary infections. Tuberculosis is really common. They have a lot of children with empyemas requiring decortication,” he said.

Dr. Crosby quickly learned the importance of adapting to the circumstances, getting back to basics in many regards. “Typically in lung surgery, you use staplers to staple along the edges so it doesn't leak,” he said. “They don't have that there, so you have to manually sew things.” Since the hospital's portable x-ray machine was broken for most of his stay, they had to disconnect patients from ventilators and hand-bag them for trips to the X-ray Department. Despite the lack of technological advances, Dr. Crosby said the enthusiasm of the Rwandan surgical team was outstanding.

“I have nothing but great praise for the Rwandan surgeons. They're very gracious and very friendly. I think they are very anxious for this program to be successful,” he said.

Thomas M. Daniel, MD, also from UVA, spent 2 months in Rwanda earlier this year performing surgeries at the two hospitals in Kigali and teaching cardiothoracic simulation in an abandoned library at the public hospital. He brought a chest “manikin” lung model, donated by Richard H. Feins, MD, from The University of North Carolina (UNC) at Chapel Hill.

Dr. Daniel's initial plan was to teach a left upper lobectomy, but the thoracic surgery needs in Rwanda were more focused on rapid control of the main pulmonary artery in settings of massive trauma, myotomy for achalasia,



STS member Thomas M. Daniel (center) taught thoracic surgery in Rwanda's CHUK Surgical Simulation Center.

techniques for durable repair of diaphragmatic rupture, and exposure of the ligamentum arteriosum for PDA ligation practice.

The change in surgeries was one improvisation Dr. Daniel had to make. Another was finding the right tissue to use with the model.

“The pig tissue typically used with the UNC model was difficult and expensive to obtain in Rwanda, requiring a full day's trip out to a weekly village market and participation in the slaughter and acquisition of the mediastinal tissue,” Dr. Daniel said. “After doing some research, I realized we could substitute goat tissue, which was more readily and cheaply available.”

The model also needed to be as economic as possible. Multiple simulation surgeries were performed on one tissue block. Expensive fake blood, IV tubing, and bags were not available, so Dr. Daniel had to improvise again—with ketchup.

Despite the challenges, the effort to set up the chest surgery simulation model was well worth it, he said.

continued on page 12 →

## STS Works to Reduce Stroke Incidence after Cardiac Surgery

Society leadership is embarking on a new initiative to address the occurrence of stroke following coronary artery bypass grafting (CABG) surgery and aortic valve replacement (AVR).

“Although the risk of stroke is very low after cardiac surgery, it remains a devastating complication that has a major impact on quality of life for those rare patients. STS and cardiothoracic surgeons have identified stroke as a real opportunity to improve outcomes and quality of life for our patients,” said STS President Douglas E. Wood, MD.

According to a meta-analysis published in the *Journal of the American College of Cardiology* in August 2012, the 30-day stroke rate was 1.2% following CABG compared with 0.34% after percutaneous coronary intervention.

To tackle this problem, STS surgeon leaders formed the Task Force on Neurologic Events Following CABG and AVR to analyze the available data and come up with suggestions on what steps cardiothoracic surgeons can take to reduce the incidence of stroke in their practices.

**“STS and cardiothoracic surgeons have identified stroke as a real opportunity to improve outcomes and quality of life for our patients.”**

*—Douglas E. Wood, MD*

“The ultimate objective of the task force is to come up with a series of recommendations for how programs can change their treatment algorithms to limit stroke,” said John S.

Ikonomidis, MD, PhD, Task Force Chair and Chair of the Workforce on Adult Cardiac and Vascular Surgery. “The idea is that we would like to try and get our stroke rates down to or below the levels seen in patients that undergo percutaneous intervention.”

The Task Force will now carefully analyze the years of data stored in the STS National Database to come up with a comprehensive risk prediction model

for stroke following CABG and AVR. Once the model has been created, the Task Force will use it to identify opportunities across the board for improvements.

The Task Force will also scrutinize those programs in the Database that have high and low stroke rates in order to understand the differences between them. Task Force members will also take a close look at the newest technologies and techniques to identify those that have been most efficacious in reducing stroke.

“We don’t have a good handle on all the risk factors, and we don’t really understand the mechanisms of what causes stroke after coronary bypass, so our efforts will include these areas as well,” Dr. Ikonomidis said.

While there isn’t a target date for completion of this project, Dr. Ikonomidis said the STS leadership considers it to be a high-priority issue, so things should move forward quickly. Read more about the importance of this new STS initiative in the July issue of *The Annals of Thoracic Surgery*, which features an editorial on the topic from Drs. Wood and Ikonomidis. ■

## STS Members Help Save Lives, Create Sustainable Surgery Programs Abroad

→ continued from page 11

“Teaching the Rwandan general surgery faculty in the simulation lab was a very satisfying experience,” Dr. Daniel said. “It was particularly exciting to subsequently observe these faculty members teaching simulation techniques to their residents.”

Dr. Daniel is planning a return trip this August to further develop the thoracic surgery program in Rwanda.

Drs. Jacobs, Badhwar, Vener, Crosby, and Daniel all encourage their colleagues to get involved in charitable mission trips.

“This is one of the most rewarding things a thoracic surgeon can do. While not easy, it is very rewarding to know that we have the privilege of affording these children and their parents a very different outlook on life,” Dr. Badhwar said. “And if we can

contribute to the education of the local team, as has been the focus of this project, then it is probably the best thing we can do as STS members. After all, a major objective for STS is to impart knowledge on our colleagues and to enhance the ability of cardiothoracic surgeons to provide the highest quality patient care through education, and that is really what we are doing through this effort.” ■

## Anesthesiologists Encouraged to Join the Society and Participate in STS National Database

With the recent introduction of an anesthesia data module in the Adult Cardiac Surgery component of the STS National Database, the involvement of cardiovascular anesthesiologists in both STS membership and Database activities is more important than ever.

David F. Vener, MD, an Associate Professor of Pediatric Anesthesiology and Cardiology at Baylor College of Medicine in Houston, was the first anesthesiologist to become an STS Associate Member when non-cardiothoracic surgeon physicians were invited to join the Society in 2011. He said joining STS has benefited his career in several ways.

“Being an STS member has given me a level of credibility at my home institution that has been quite helpful,” Dr. Vener said. He also enjoys the free subscription to *The Annals of Thoracic Surgery* that comes with STS membership. “I find it very interesting and helpful for my career because it gives me a much better understanding of what the surgeons I’m working with are reading and doing.”

**“Being a member of STS has given me a level of credibility at my home institution that has been quite helpful.”**

*—David F. Vener, MD*

Dr. Vener also participates in the STS Congenital Heart Surgery Database, which has incorporated anesthesia data since 2009. As an STS member, he has served in Society leadership roles related to his Database participation, such as the Congenital Heart Surgery Subcommittee of the Access and Publications Task Force. He urged cardiovascular anesthesiologists to participate in the STS National Database.

“By participating in a national dataset, you’re able to aggregate information from around the country in a much more timely manner in terms of things like practice variability, adverse outcomes—issues that previously have not really been accurately ascertained,” he said. “Normally, the major complication researchers have looked at for anesthesia is cardiac arrest and whether or not that was specifically related to the anesthetic management. Things like complications with IVs, complications with central lines, airway complications—those sorts of issues have never really been looked at in a comprehensive manner prior to this.”

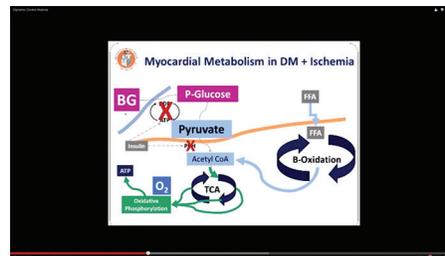
The new Adult Cardiac Surgery Database anesthesia module was made possible by a collaboration between STS and the Society of Cardiovascular Anesthesiologists. “It goes without saying that the Society of Cardiovascular Anesthesiologists is pleased to now be a part of this premier dataset,” said SCA President Solomon Aronson, MD. “Everyone who is eligible to participate should do so with conviction and confidence that it will help leapfrog our specialty of cardiac anesthesia forward to shape and manage patient care with evidence-based arguments.” ■

If you know of an anesthesiologist who may be interested in STS Associate Membership and/or participating in the Congenital Heart Surgery or Adult Cardiac Surgery components of the STS National Database, encourage him or her to visit [www.sts.org/membership](http://www.sts.org/membership) and [www.sts.org/national-database](http://www.sts.org/national-database).

**For related information, see page 4.**

## View the Glycemic Control Webinar Recording

More than 200 people tuned in on April 16 for an STS webinar on glycemic control. If you missed it or want a refresher, a recording of the webinar is now available at [www.sts.org/webinars](http://www.sts.org/webinars). Moderated by Kevin W. Lobdell, MD, the webinar included presentations by Anthony P. Furnary, MD and Harold L. Lazar, MD, two recognized experts in the field.



## STS Works to Advance Lung Cancer Policy, Patient Advocacy on Capitol Hill

The STS Strategic Plan, “Strategy for Leadership and Change,” directs the Society to strengthen its influence with Congress, regulatory agencies, and policymakers. It also encourages broader advocacy targets to include more patient-focused issues.

In response to this directive, STS has aligned with patient- and disease-focused organizations on several important advocacy issues. One example is the Society’s work with the Lung Cancer Alliance, a national non-profit organization dedicated solely to providing support and advocacy for people living with or at risk for lung cancer.

Lung cancer is the leading cause of US cancer deaths and cancer costs under Medicare. The American Cancer Society projects that 159,000 Americans will die from lung cancer this year—more than breast, prostate, colon, and pancreatic cancers combined. The 5-year lung cancer survival rate remains dismal at 16%.

STS has supported several lung cancer policy initiatives, including the Lung Cancer Mortality Reduction Act. This bipartisan legislation, introduced in the 112th Congress, called for a multifaceted plan to address all aspects of lung cancer. Through a series of legislative compromises, language from the legislation was combined with the Pancreatic Cancer Research & Education Act to form the Recalcitrant Cancer Act of 2012, which was passed by Congress and signed into law in January 2013. The Act directs the National Cancer Institute (NCI) to convene a working group and establish a scientific framework for recalcitrant cancers. Recalcitrant cancers, such as lung cancer, are defined as types of cancers that have a 5-year relative survival rate of less than 20% and are estimated to cause at least

### STS has supported several lung cancer policy initiatives, including the Lung Cancer Mortality Reduction Act.



STS President Douglas E. Wood, MD speaks at the “Lung Cancer Screening: What’s at Stake Now?” briefing on Capitol Hill on May 21.

30,000 deaths annually. NCI must submit the framework to Congress by July 2014.

More recently, STS President Douglas E. Wood, MD participated in a May 21 Congressional briefing, “Lung Cancer Screening: What’s at Stake Now?,” hosted by the Lung Cancer Alliance. The briefing

focused on the US Preventive Services Task Force (USPSTF) delay in issuing a recommendation on lung cancer screening. The panelists, including

Dr. Wood, discussed research from the National Lung Cancer Screening Trial showing that low-dose computed tomography (CT) screening to detect early stage lung cancer can dramatically improve a patient’s chance for survival. Without screening, the majority of lung cancers will continue to be diagnosed at a late stage, when treatment options are extremely expensive and ultimately futile in almost all cases.

Dr. Wood also spoke about his experience on the Lung Cancer Screening Panel of the National Comprehensive Cancer Network

(NCCN). He noted that while the NCCN has had lung cancer screening guidelines for 3 years, the USPSTF has yet to make a recommendation about lung cancer screening. The USPSTF’s authority was expanded under the Affordable Care Act to not only determine which preventive services will be covered by Medicare and Medicaid, but also which services will be considered an “essential health benefit,” thus mandating coverage by the health plans offered through state and federal health care exchanges.

Given the proven lifesaving benefits and cost effectiveness of CT screening, panelists asked Congress for help in persuading US Health & Human Services Secretary Kathleen Sebelius to exercise her authority and insist on immediate action by the USPSTF. ■

Support this effort by:

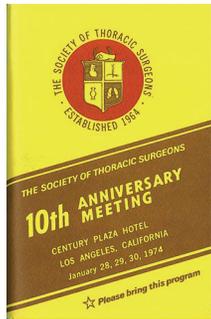
- Writing to your representatives in Congress using [capwiz.com/sts](http://capwiz.com/sts).
- Writing to Secretary Sebelius using sample text found at [www.sts.org/LungScreeningLetter](http://www.sts.org/LungScreeningLetter).

For further information, contact the STS Government Relations staff at (202) 787-1230 or [advocacy@sts.org](mailto:advocacy@sts.org).

As we count down to the Society's 50th Anniversary celebration at the STS Annual Meeting in Orlando, January 25-29, 2014, each issue of STS News will feature a different flashback. Also, regularly check the STS website for special videos commemorating the Society's rich history.

## STS 50th Anniversary Flashback

In 1974, the Rubik's Cube was invented, the Universal Products Code was used for the first time (to scan a pack of chewing gum), Hank Aaron tied Babe Ruth for the all-time home run record, and the Watergate scandal led to the resignation of President Nixon.



The year also marked the Society's 10th Anniversary. The 1974 STS Annual Meeting was held at the Century Plaza Hotel in Los Angeles. Earle B. Kay, MD, from Cleveland, delivered the Presidential

Address, "Thromboembolism on Mitral Valve Prostheses."

The meeting offered 38 scientific presentations, ranging from "Triple Bypass

Graft for the Treatment of Severe Triple Coronary Vessel Disease" to "An Exclusive Right Thoracic Approach for Cancer of the Middle Third of the Esophagus."

The registration fee for the 10th Annual Meeting was \$30; nurses and paramedical personnel attended for \$15; and residents and fellows were admitted for free. At least 69 exhibiting companies showcased products and services, ranging from surgical sutures to heart-lung machines and heart valves.

By 1974, Society membership had tripled to nearly 1,300 in 29 countries. The Society was also well on its way to solidifying its place as a leading provider of cardiothoracic surgery education. In 1973, STS was first listed among National Medical Scientific Societies in the registry of the American Medical Association. In 1975, STS was accredited by the AMA's Council on Medical Education. ■



At one of the social activities during the STS 10th Anniversary Meeting in Los Angeles, President Earle B. Kay, MD (left) posed with his wife and STS Secretary Ralph D. Alley, MD.

The Society of Thoracic Surgeons

50<sup>th</sup> Annual Meeting & Exhibition  
Orlando, Florida

www.sts.org/annualmeeting

January 25-29, 2014

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THE SOCIETY OF THORACIC SURGEONS

633 N. Saint Clair St., Floor 23

Chicago, IL 60611-3658

**Phone** (312) 202-5800 | **Fax** (312) 202-5801

**E-mail** sts@sts.org | **Web** www.sts.org

**PRESIDENT**

**Douglas E. Wood**

dewood@u.washington.edu

**FIRST VICE PRESIDENT**

**David A. Fullerton**

david.fullerton@ucdenver.edu

**SECOND VICE PRESIDENT**

**Mark S. Allen**

allen.mark@mayo.edu

**SECRETARY**

**Keith S. Naunheim**

naunheim@slu.edu

**TREASURER**

**Robert S. D. Higgins**

robert.higgins@osumc.edu

**IMMEDIATE PAST PRESIDENT**

**Jeffrey B. Rich**

rich@macts.com

**INTERNATIONAL DIRECTORS**

**Friedrich W. Mohr**

mohrfw@mac.com

**Shinichi Takamoto**

takamoto-cvs@umin.ac.jp

**CANADIAN DIRECTOR**

**Christopher A. Caldarone**

christopher.caldarone@sickkids.ca

**RESIDENT DIRECTOR**

**Cameron T. Stock Jr.**

cstock@partners.org

**DIRECTORS-AT-LARGE**

**Emile Bacha**

eb2709@columbia.edu

**Joseph E. Bavaria**

joseph.bavaria@uphs.upenn.edu

**John H. Calhoon**

calhoon@uthscsa.edu

**David R. Jones**

djones@virginia.edu

**Joseph F. Sabik III**

sabikj@ccf.org

**Cameron D. Wright**

cdwright@partners.org

**EDITOR**

**L. Henry Edmunds Jr.**

hank.edmunds@uphs.upenn.edu

**HISTORIAN**

**Nicholas T. Kouchoukos**

ntkouch@aol.com

**EXECUTIVE DIRECTOR &**

**GENERAL COUNSEL**

**Robert A. Wynbrandt**

rwynbrandt@sts.org

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## MARK YOUR CALENDAR

### Upcoming STS Educational Events

**September 20-21, 2013**

*Chicago, Illinois*

Mechanical Circulatory  
Support for Advanced  
Cardiopulmonary Disease

**September 26-28, 2013**

*Boston, Massachusetts*

Advances in Quality &  
Outcomes: A Data  
Managers Meeting

**November 7-9, 2013**

*Orlando, Florida*

Coding Workshop

**January 25-29, 2014**

*Orlando, Florida*

STS 50th Annual Meeting

Find out more at  
[www.sts.org/education-meetings](http://www.sts.org/education-meetings).