



AATS

AATS DAILY NEWS

Official newspaper of the AATS 104th Annual Meeting **Preview Edition** Saturday April 27, 2024

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The AATS 104th Annual Meeting opens its doors!



Lars G. Svensson

It is with tremendous honor that I welcome you to Toronto for the AATS 104th Annual Meeting. This city has been a gracious host for our meetings in the past, and on behalf of the Program Committee and the wider AATS team, I am excited to build upon the incredible energy and momentum from our 103rd Annual Meeting, which was led by our first woman president, Dr. Yolonda L. Colson.

This year we have received a record-breaking number of submissions, resulting in more than 950 presentations that bolster the cutting-edge program of this, the world's most prestigious thoracic surgery event. For all in attendance – and we're proud to say that is also a new record this year – you can expect the best cardiothoracic surgery educational offerings in our specialty, including a new submission category focused on the structural heart, further expanding the extraordinary variety of educational features available.

As president of the AATS, I am honored to serve in this leadership role, and I envision a meeting where we can all learn valuable lessons of leadership, regardless of our career stage. Throughout the planning process, we have made significant efforts to highlight programmatic elements focused on discussions and collaborations to advance our leadership skills, including a theorem for leadership that you can build upon.

We must recognize that our work as cardiothoracic surgeons is truly impossible without the additional members of our surgical team. The multidisciplinary approach to patient care is integral to achieving quality outcomes, and we need every voice in the room, whether it be from nurses, anesthesiologists, perfusionists, medical oncologists, or other valuable team members.

To further strengthen this multidisciplinary approach, we are holding our Annual Meeting in conjunction with the Society of Cardiovascular Anesthesiologists (SCA), as our cardiovascular anesthesiologists are critical to our daily cardiothoracic surgery efforts. Look out for joint AATS/SCA sessions throughout the program.

Another exciting addition to this year's Annual Meeting is the Complex Valve Scenarios Symposium, which was held yesterday, before the official start of the Annual Meeting. This half-day, case-based symposium provides an unparalleled opportunity to learn from the masters in heart valve disease, with leading surgeons and interventionalists from around the world sharing their approaches to the most complicated problems they've faced in the treatment of heart valve disease.

In addition to our engaging scientific program, I have invited several expert speakers from across the spectrum to share their insights on leadership, organizational behaviors, and strategic thinking during plenary sessions on Saturday and Sunday. On Saturday, these distinguished speakers include: Guy David (Chair, Health Care Management, Wharton School), who speaks on the future vision and leadership in American care; Beri Ridgeway (Chief of Staff, Cleveland Clinic), tackling the topic of physician performance and safety with 'objectives and key results' strategies across a global healthcare system; and Arnold Schwarzenegger, Former Governor of California, who we are delighted to host to hear about his journey leading in America.

The session also features an Institutional Leadership Panel comprising Tomislav Mihaljevic (CEO and President, Cleveland Clinic), Colleen Koch (Dean, University of Florida

Continued on page 2

Continued from page 1

College of Medicine), Geoffrey Martha (CEO, Medtronic), and Robert Ford (CEO, Abbott).

On Sunday, another roster of expert speakers will explore the ins and outs of leadership, strategy, values, culture, and team building. I am very much looking forward to the presentations on these exciting topics by Peter Rea (Vice President, Integrity and Ethics, Parker Hannafin Corporation), Gary Ahlquist (Principal, Healthcare Strategy, PwC), Tom Falkowski (Kates Kesler/Accenture),

Eduardo Salas (Psychology Department Chair, Rice University), and Susan Galbraith (Executive Vice President, Oncology Research & Development, AstraZeneca).

As Monday dawns, Stanley Hazen (Director, Center for Microbiome & Human Health, Cleveland Clinic), the leading expert on the influence of diet and the gut microbiome on disease – particularly cardiovascular disease – will give the Basic Science Lecture. Finally, the David J. Sugarbaker Memorial Lecture will be delivered by Patrick Soon-Shiong,

a pioneering transplant surgeon, Founder & CEO of NantWorks, and Chairman of the Chan Soon-Shiong Family Foundation.

I am confident that the AATS 104th Annual Meeting will provide you with new ideas, collaborations, and the opportunity to lead and improve patient care at your institution. Have a fantastic stay in this tremendous city, and a safe journey home.

Lars G. Svensson
AATS President

Thoracic Scientific Session: Lung Cancer: Improving Outcomes Room 801 Saturday 1:30 PM

NSCLC surgery ‘must be faster’

An important study with far-reaching implications on health systems will be presented today by Haley Tupper, a resident general surgery physician at the University of California, Los Angeles (UCLA) who performs research within the UCLA and Kaiser Permanente health systems (CA, USA). She will present data from a new multi-center retrospective cohort study that identifies the optimal time from non-small cell lung cancer (NSCLC) diagnosis to surgery to reduce mortality.

“The optimal time to get your lung cancer treatment for early-stage lung cancer is still up for debate,” said Jeffrey B. Velotta, a clinical professor in the Department of Clinical Science at the Bernard J. Tyson Kaiser Permanente School of Medicine (CA, USA) and a clinical assistant professor in the Department of Surgery at the University of California, San Francisco (UCSF) School of Medicine (CA, USA). Dr. Velotta, who talked to *AATS Daily News* ahead of the 104th Annual Meeting, is the principal investigator of the study Dr. Tupper will present.

Most patients tend to want surgery immediately, and it’s the first question they are concerned with. “They say, ‘Well, should we get it out tomorrow? Should it be next week?’” said Dr. Velotta. “They think, ‘Wait, Doc, if you can’t get me in in a month, is it going to grow? Is it going to spread?’”

Before this research, Dr. Velotta was unable to answer such questions. “We have a mixed bag of data with many varying diagnosis dates, so



there’s no standardized guidelines as to when we should actually perform surgery,” he said.

Dr. Velotta, Dr. Tupper, and the rest of the team followed patients with clinical stage I-II NSCLC who underwent surgical resection without neoadjuvant therapy between 2009 and 2019, to determine long-term mortality rates. Specifically, they looked at different time points between diagnosis and surgery: 2, 4, 6, 8, 10, and 12 weeks in 2,567 early-stage patients.

They found that for patients treated within eight weeks, long-term mortality decreased, and survival was improved. After eight weeks, there was nearly a 20% mortality increase at five years. And if the patient waited even longer, i.e. 10 to 12 weeks, mortality was as high as 31%. “Here your mortality risk actually starts to exponentially increase as well,” said



“We’re waiting longer, and these patients are dying earlier.”

Jeffrey B. Velotta & Haley Tupper

Dr. Velotta. “So, the longer you wait, the worse it gets.”

Curiously, the group found that there isn’t a great deal of difference in mortality rates before that eight-week period. “The eight-week window is the main cut-off point; anything within eight weeks did not have worsened mortality,” he explained, adding that there is also an increased chance of a recurring

nodule in another spot in the lung over five years if surgery is done later on.

Based on the multicenter (21 hospital) database of the Kaiser Permanente Northern California health system, the largest of its type in California, this study’s data came from a large, diverse population. “This is real-world population data from different ethnicities, sex, smoking status and neighborhood deprivation indices,” noted Dr. Velotta. The data also established a uniform diagnostic point of lung cancer. “We defined a suspicious computed tomography [CT] scan as that set point,” he explained, with other studies before using biopsy or positron emission tomography (PET) scan results.

On that very topic, a previous study conducted by his team last year had also looked at PET scans and CT-guided biopsies, and they were able to extrapolate the data back to the more definitive set point of the CT scan: “CT is almost always going to be the first scan – and usually it takes 2–4 weeks on average to obtain PET scans and/or biopsies after CT.”

The establishment of an optimal time also helps doctors to talk to their patients, said Dr. Velotta. “If there’s a standard that patients know to expect, that’s good for them,” he added. The main upshot of these findings however, said Dr. Velotta, is that health systems will need to determine how to get patients treated more quickly. “Whether it is the Veterans Administration, private insurance, Medicaid, Medicare, or another insurance, it doesn’t matter. I

think this is universal,” he said.

In other words, Dr. Velotta advocates establishing a standard. “Based on our data, we recommend a quality metric that can be measured universally. We think that this is going to be a game changer for all health systems.” A quality metric would incentivize faster treatments too, said Dr. Velotta, as hospitals that do not ensure patients are treated within eight weeks of their CT scan would be penalized.

Despite this, the eight-week cut-off might be tough for many health systems, where there are often lengthy waits between scans and surgery. “The process of getting authorization for a CT scan or PET scan, biopsy or pulmonary function tests, can sometimes take anywhere from three to six months,” stressed Dr. Velotta. Referrals to certain high-volume surgeons can take many months too.

What a quality metric may do is help them consider changing care pathways. “The hospital could figure out different ways to help expedite the surgical process,” reasoned Dr. Velotta. Indeed, the data collected by his team did establish specific

bottlenecks in the system. Delayed PET scans, biopsies, and mediastinal lymph node staging were observed in the prolonged surgery group. “It’s not the patient’s fault. It’s often the other workup testing that you need to get before the patient goes into the operating room,” he said.

As a result, said Dr. Velotta, it means negotiating with our radiology and pulmonology colleagues. “At Kaiser we’re going to them, showing the data and saying, ‘How do we prioritize this patient that needs a biopsy, or this patient that needs a PET scan?’” he said.

Whatever methods are used, the eight-week cut-off period must be taken seriously, concluded Dr. Velotta. “This is a call to action. We now need to really think about how we get our healthcare systems – whether it’s our surgeons or other team members – to get our patients in for imaging and/or procedures earlier. We’re waiting longer, and these patients are dying earlier.”

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ERAS for Cardiac Surgery: Next Steps in Perioperative Management Room 714 Saturday 7:30 AM

Does enhanced recovery trump minimally invasive cardiac surgery?

A debate that pits enhanced recovery after surgery (ERAS) against minimally invasive cardiac surgery (MICS) will be held this morning. In his talk, Rawn Salenger, an executive board member of the National ERAS Cardiac Society, and Chief of Cardiac surgery at the University of Maryland St. Joseph Medical Center (MD, USA) will make the case for ERAS, relating his experience in creating one of the first cardiac ERAS programs in the US at St. Joseph Medical Center. Perspectives on MICS will be presented by Marc Gerdisch (Franciscan Health, Indianapolis, IN, USA), and a panel discussion with well-known MICS experts will follow.



Rawn Salenger

In 2018, members of a high-quality program run by doctors, nurses and administrators at St. Joseph’s met to see how they could improve the cardiac surgery program. “We wanted to take it to the next level, to potentially be the best cardiac surgery program in the world,” Dr. Salenger recalled. “I stumbled upon the idea of ERAS, and saw a group of people trying to implement that within cardiac surgery, which was a new concept for the specialty at the time.”

ERAS is essentially a collection of recommended

care bundles that span the three phases of preoperative, intraoperative, and postoperative care, noted Dr. Salenger. They might consist of enhanced patient education, shortened preoperative fasting periods and oral carbohydrate load, postoperative nausea prophylaxis, multimodal opioid-sparing analgesia, early extubation, and early mobilization.

“The overarching view of enhanced recovery is utilizing patient-centered best clinical practice in every phase of care in order to optimize recovery,” he explained. “It’s also getting rid of anything along the way that doesn’t add value for the patient, and doesn’t help the patient recover more safely and quickly.”

The first set of cardiac ERAS guidelines were published in 2019,¹ but they are updated regularly. Today, the guidelines contain recommendations to implement 22 different care bundles. A consensus statement has also been developed jointly with the Society of Thoracic Surgeons which contains



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additional innovative recommendations.²

On paper, today's debate asks whether ERAS or MICS is more important for patients, but Dr. Salenger wants to re-frame the question: "Fundamentally, we really want people to think about the relationship between these entities, and how they can complement each other," he said.

Dr. Salenger views ERAS as a way to develop cardiac surgery into a high-reliability program. "We believe in standardized work and team-based learning, and we're obsessed with our failures," he said. "You continuously audit your performance, look at where you failed and change your process to get better outcomes."

Research on which parameters allow for this kind of enhanced recovery is growing. Groups are publishing data showing that using fewer opioids, fewer transfusions, and providing earlier extubation and mobilization benefit patients.^{3,4} "Giving patients the preoperative care, nutrition, physical training and education that they need, alongside optimizing their comorbidities can all lead to earlier recovery," he said.

For a surgeon who is performing a sternotomy, therefore, the message is not that they must use MICS. "If you look at the US cardiac guidelines, nowhere do they endorse or advocate for MICS," he said. Rather, the message is that all

patients can benefit from ERAS, whether they have had a minimally invasive procedure or a traditional sternotomy.

Dr. Salenger went on: "That doesn't mean that MICS is not valuable in certain patients, because it is. But if you're still giving lots of opioids, transfusing your patients, not getting them extubated earlier, and not getting them up and about to mobilize them, then that's not a minimally invasive experience overall, even though your incision may be small," explained Dr. Salenger.

Of course, Dr. Salenger recognizes the tension in the field of cardiac surgery regarding ERAS programs. "There are skeptics," he added. "Our evidence base is immature, but then we've only really started publishing since 2018." The reality is that most ERAS research is in non-cardiac surgery, he added. "You can't necessarily translate that research to cardiac surgery," he said. "It's a valid criticism."

On the other hand, the tension is helpful because it may fuel more research. "What we need is people to take our care bundles and test them," he said. "If they are valuable, then hopefully people will adopt them. If they show they're not valuable, we'll be the first ones to stop."

In other words, ERAS is not any one specific care bundle, stressed Dr. Salenger. Rather, it

is a way of approaching the patient. A take-away message is that ERAS gives specific recommendations, many of which are outside what is traditionally considered to be cardiac surgery. "It's the ERAS method to study those care bundles and, if they're not adding value, we will replace them with something that does add value for the patient," he said.

"For me, ERAS has been an unbelievable educational experience. I've learned from some of the most talented people in our field, and it has definitely benefited our patients."

Read more about Dr. Salenger et al.'s work in their 'Update on minimally invasive cardiac surgery and enhanced recovery after surgery', published recently.⁵

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Adult Cardiac Scientific Session: Advanced Surgical Approaches to the Aortic Valve Room 718A Saturday 1:30 PM

TAVR in younger patients begs for randomized data to buffer new trends

New data from an important trial on transcatheter aortic valve replacement (TAVR) will be presented by Michael E. Bowdish, Professor, Vice Chair, and Clinical Chief of the Department of Cardiac Surgery of the Smidt Heart Institute at Cedars-Sinai Medical Center, Los Angeles (CA, USA). With his colleagues, Dr. Bowdish has been looking at the use of transcatheter and surgical aortic valves in younger patients – those less than 65 years of age. “There have been several trials of less-invasive aortic valve replacement that have moved into clinical practice,” Dr. Bowdish told *AATS Daily News*. “But these trials included very few young patients.”

More importantly, current guidelines set out by the American

“I think that most people caring for these patients want to come together to do the right thing, which is looking at this scientifically.”

Michael E. Bowdish



College of Cardiology and American Heart Association recommend surgical aortic valve replacement for patients less than 65 years old. Despite these guidelines, national data demonstrates increasing numbers of younger people are receiving TAVR or non-surgical valves. “With this in mind, the objective of our study was to use administrative claims data from California, New York, and New Jersey to look at long-term outcomes of surgical valve replacement [SAVR] and TAVR in young patients,” said Dr. Bowdish. “If you combine the populations of those three states, it represents about 20% of America. We pulled out procedures and comorbidities from those claims, and matched patients to try to get equal groups.”



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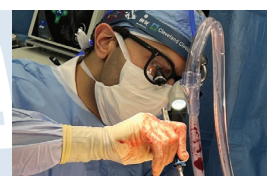
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- AATS Foundation/WTS Mid-Career Investigator Award



The AATS Everts A. Graham Memorial Traveling Fellowship has given me a once in a lifetime experience to further my education and development in cardiac surgery. I expect that the opportunity to develop skills in robotic mitral valve surgery with my mentor, Dr. Marc Gillinov and his team at the Cleveland Clinic, will transform my career trajectory and my ability to provide the most innovative and high quality care to patients. Furthermore, the immersion in a different culture and healthcare system and the associated friendships and connections made with some of the most respected leaders in our profession will undoubtedly be one of the most valuable parts of the fellowship for me.”

—S. Moby Rehman, MD
Everts A. Graham Memorial Traveling Fellowship recipient

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The claims data yielded 10,000 patients < 65 years of age who received a surgical or transcatheter aortic valve. After matching they ended up with approximately 2,000 patients in each group. The primary outcome was eight-year survival. “That is unique, and the major strength of this study, as other studies haven’t been able to include survival data,” said Dr. Bowdish.

The results were telling. In 2021, 54% of patients with aortic stenosis under the age of 65 underwent TAVR in California, New York, and New Jersey. TAVR was associated with a 2.3-fold increase in eight-year mortality in propensity-matched patients (27.5% vs. 15.3%).

“Similar to other studies, these data showed that the proportion of young patients getting a transcatheter aortic valve has grown tremendously in recent years,” said Dr. Bowdish. He noted a particularly large increase in the last three years, after the Food and Drug Administration’s approval of transcatheter aortic valves in low-risk patients.

“These data showed that the proportion of young patients getting a transcatheter aortic valve has grown tremendously in recent years.”

Michael E. Bowdish

“This study confirms other studies’ observations that a large proportion of young patients are receiving transcatheter aortic valves,” said Dr. Bowdish. “This really highlights the deviation that exists between clinical practice and guidelines.” In addition, the mortality data is striking, he noted.

Yet, there are limitations to the study which support the need for a randomized control trial, continued Dr. Bowdish. The hope would be that such a trial would allow us to help patients less than 65 make informed treatment choices.

The strikingly rapid increase in TAVR over the last three years may be due to multiple factors, but Dr. Bowdish posits that patients who

need aortic valves are approaching physicians knowing that they can, more conveniently, have the procedure through the groin and go home the next day. “If they come into the hospital to have their chest opened up, they are in the hospital for a week, and it takes two months to recover,” he said. “Those are two very different experiences. But if your survival eight years down the road is vastly different than that upfront risk of surgery, it is potentially justified.”

Dr. Bowdish emphasized that practice is changing, and despite the data, it will be hard to slow it down. “I think it is incumbent on us as a community to study this population of patients and get real answers about treatment options,” he said.

Certainly, there should be discussions around what constitutes low risk, and how it is not necessarily equivalent to a younger age, he added.

Dr. Bowdish is circumspect about how the broader community will react to the paper when it is published. Some will not be surprised, and some may only see limitations in the data and dismiss the broader findings, he imagines: “I think that most people caring for these patients want to come together to do the right thing, which is looking at this scientifically.”

Therefore, Dr. Bowdish asserts that it would be disingenuous to claim that mortality is generally worse for TAVR than SAVR in young patients just yet. “In this study, we can say that mortality was worse for this population, but most important, these results support the need for a randomized clinical trial,” he concluded.

References

1. Sharma T, Krishnan AM, Lahoud R, et al. National Trends in TAVR and SAVR for Patients With Severe Isolated Aortic Stenosis. *J Am Coll Cardiol.* 2022;80(21):2054-2056.

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104th Annual Meeting Papers published simultaneously with abstract presentations

The AATS proudly announces the simultaneous publication of 26 Annual Meeting Papers with their respective abstract presentation during the AATS 104th Annual Meeting. Most papers will publish in *The Journal of Thoracic and Cardiovascular Surgery (JTCVS)*, while others will publish in *JTCVS Open* and *JTCVS Techniques*. To coordinate publication with the meeting presentation, authors were asked to submit their Annual Meeting paper before February 5, 2024, to the *JTCVS*. We received a large number of early submissions, and we are grateful for the support from authors who expedited their initial submissions and revised their papers per the requests of our editors and reviewers.

The Association would like to take this opportunity to thank the editors, Editorial Board members, and reviewers for providing an expedited review process for these early submissions. We deeply appreciate their valuable time to peer-review manuscripts. Their efforts are responsible for the success of the AATS Journals.

The 26 presentations listed below will be accompanied by the simultaneous publication of their 104th Annual Meeting paper, which will be available on the morning of the presentation.

Saturday, April 27

8:30 AM, Room 716

AATS 2024 Expert Consensus Document: Ebstein Anomaly in Infants and Neonates

Speaker:

Igor Konstantinov

Royal Children's Hospital

8:30 AM, Room 718B

Mitral Valve Surgery in Patients with Marfan Syndrome

Commentator:

Gébrine El Khoury

Cliniques Universitaires St-Luc

Abstract Presenter:

Tirone David

Toronto General Hospital

8:45 AM, Room 718A

Personalizing Patient Risk of a Life Altering Event: An Application of Machine Learning to Hemiarch Surgery

Commentator:

Munir Boodhwani *The University of Ottawa Heart Institute*

Abstract Presenter:

Adam Carroll *University of Colorado Anschutz*

12:10 PM, Room 718A

TRPV4 Channel Inhibition Attenuates Lung Ischemia-Reperfusion Injury and Endothelial Barrier Disruption in a Porcine Lung

Transplant Model

Commentator:

Ankit Bharat *Northwestern University Feinberg School of Medicine*

Abstract Presenter:

Raymond Strobel

University of Virginia

2:00 PM, Room 718B

Safe and Controlled Technique of Aortic Cannulation for Thoraco-Abdominal Normothermic Regional Perfusion

Commentator:

Bryan Whitson

Ohio State University

Case Video Presenter:

Mohamed Abdullah *University of Pittsburgh Medical Center*

7:02 PM, Exhibit Hall, Theater 1

Prosthetic Root Endocarditis treated with Radical Debridement and Pulmonary Autograft Reconstruction

Case Report Competitor:

Chaoyi Qin *Western University/ London Health Science Center*

Sunday, April 28

8:00 AM, Room 717

Etiology Specific Risk Factors in Patients with Surgically Implanted

5.5 Liter Temporary Microaxial Transvalvular Left Ventricular Assist Devices

Commentator:

Amit Pawale *Washington University School of Medicine*

Abstract Presenter:

Jean-Luc Maigrot *Cleveland Clinic*

8:00 AM, Room 801

Single-Port Robot-Assisted Thoracic Surgery Using the Single-port Robotic System: Over 100 Cases

Commentator:

Justin Blasberg

Yale University School of Medicine

Abstract Presenter:

Hyun Koo Kim *Korea University College of Medicine*

9:00 AM, Exhibit Hall, Theater 1

Bicuspid Aortic Valve Replacement using Living Autologous Aortic Wall Leaflets

Rapid Fire Oral Presenter:

Timothy James

St. Joseph Hospital

9:18 AM, Exhibit Hall, Theater 2

Revisiting Outcomes of Transcatheter Versus Surgical Aortic Valve Replacement Across the Risk Spectrum: A Trial Sequential Analysis of 8 Randomized Trials Encompassing 8,935 Patients

Rapid Fire Oral Presenter:

Xander Jacquemyn *KU Leuven*

10:12 AM, Room 801

Costal Margin Reconstruction for Slipping Rib Syndrome: Outcomes and Advancements Beyond Earlier Sutured Repair Technique

Rapid Fire Oral Presenter:

Adam Hansen

West Virginia University

10:19 AM, Room 718A

Can We Safely Expand the DCD Donor Heart Pool by Extending the Donor Age Limit?

Rapid Fire Oral Presenter:

Yeahwa Hong *University of Pittsburgh Medical Center*

10:26 AM, Room 801

Bigger Pies, Bigger Slices: Resource Utilization by Lung Transplantation Recipients in the non-DSA Allocation Era

Rapid Fire Oral Presenter:

Andrew Kalra *Sidney Kimmel Medical College at Thomas Jefferson University*

10:47 AM, Room 801

The supraclavicular approach in the management of cervicothoracic-junction benign neurogenic tumors: a real-world analysis

Rapid Fire Oral Presenter:

Fujun Yang

Shanghai Pulmonary Hospital

10:54 AM, Room 801

Perioperative Outcomes and Survival of Modified Subxiphoid Thoracoscopic Surgery versus Median Sternotomy Thymectomy for T2-3 Thymic Malignancies: A Retrospective Comparative Cohort Study

Rapid Fire Oral Presenter:

Jian-Yong Ding

Zhongshan Hospital

11:01 AM, Room 714

Registry Results of Low-Dose Warfarin with a Novel Mechanical Aortic Valve Prosthesis: Five-Year Results

Rapid Fire Oral Presenter:

Marc Gerdisch *Franciscan Health*

11:08 AM, Room 801

Predictors of Prolonged Hospital Stay After Segmentectomy: A Large Single Institution Database Analysis

Rapid Fire Oral Presenter:

Fatemehsadat Pezeshkian

Brigham and Women's Hospital

11:36 AM, Room 801

Subcostal Uniportal Robotic Lung Resection: A Pilot Trial

Rapid Fire Oral Presenter:

Yin-Kai Chao *Chang Gung*

Memorial Hospital

11:43 AM, Room 716
Alarming rate of liver cirrhosis after the small conduit Extracardiac Fontan. A comparative analysis with the Lateral Tunnel.
Rapid Fire Oral Presenter:
Eiri Kisamori
Children's National Hospital

2:00 PM, Room 718A
Long-term Outcomes after Recurrent Aortic Dissection: Insights from the International Registry of Aortic Dissection
Commentator:
Hiroo Takayama
Columbia University
Abstract Presenter:
Takuya Ogami
NYU Langone Health

3:51 PM, Exhibit Hall, Theater 3
Surgical versus Transcatheter Aortic Valve Replacement in Low-Risk Patients under Age 75
Rapid Fire Oral Presenter:
J. Hunter Mehaffey
West Virginia University

Monday, April 29

8:00 AM, Exhibit Hall, Poster Area
Reassuring Survival and Considerable Reoperation in Patients with Bicuspid Aortic Valve Who Undergo Aortic Root Replacement
Poster Presenter:
Kavya Rajesh *NYPH-Columbia University Medical Center*

8:00 AM, Exhibit Hall, Poster Area
Impact of Non-Diameter Aortic Indices on Surgical Eligibility: Results from the Multi-Center TITAN: SvS Randomized, Controlled Trial
Poster Presenter:
Olina Dagher *Libin Cardiovascular Institute*

8:00 AM, Exhibit Hall, Poster Area
Transplantation for Adult Congenital Heart Disease: Impact of Univentricular vs.

Biventricular Physiology
Poster Presenter:
Alice Vinogradsky
Columbia University

2:00 PM, Room 718B
Efficacy of a Transaortic Approach to Midventricular and Apical Septal Myectomy to Treat Left Ventricular Outflow Tract Obstruction
Commentator:
Hartzell Schaff *Mayo Clinic*
Abstract Presenter:
Nicholas Smedira
Cleveland Clinic

3:00 PM, Room 718B
Sex Disparities in the Rate of Concomitant Atrial Fibrillation Procedures: A Multi-center Analysis
Commentator:
Marc Gerdisch *Franciscan Health*
Abstract Presenter:
Catherine Wagner
Michigan Medicine

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SESSION HIGHLIGHT


AATS/WTS Diversity, Equity, and Inclusion

Monday, 4:15 PM, Room 718A


MODERATORS

Daniela Molena *Memorial Sloan Kettering Cancer Center*
Mara Antonoff *Anderson Cancer Center*

PRESENTATIONS

318. Fifteen-Year Analysis of Gender Trends in Cardiothoracic Surgery Journal Editorial Boards 


- Commentator: Leah Backhus, Stanford Univ School of Medicine
- Abstract Presenter: Adrian Acuna Higaki, Yale School of Medicine

319. Impact of Lung Allocation Policy Change on Hispanic Lung Transplant Outcomes: Addressing Disparities and Improving Access 

- Commentator: Jasleen Kukreja, University of California San Francisco
- Abstract Presenter: Eric Klipsch

How to Reevaluate DEI in a Changing Landscape

- Speaker: Ashley Oliver, University of California Los Angeles

320. Diversity Presentations at Cardiothoracic Surgery Meetings: 



Daniela Molena


Opportunity to Align with Our Values

- Commentator: Monisha Sudarshan, Cleveland Clinic
- Abstract Presenter: Marianna Papageorge, Yale-New Haven Hospital

321. Can Industry Payments Fight Against Implicit Bias in Cardiothoracic Surgery?



Mara Antonoff

Differences in Industry Payments to Cardiothoracic Surgeons by Gender 

- Commentator: Lana Schumacher, Tufts Medical Center
- Abstract Presenter: Shubham Gulati, Icahn School of Medicine at Mount Sinai - NYC

 = Women in Thoracic Surgery

