Firstly I would like to thank members for re-electing me as your President for another term. It is an honour and privilege to lead this organisation and hopefully we can all look forward to another exciting and important year for MATCVS in 2012. I would like to congratulate Prof Dr. Raja Amin and his organising committee for the excellent organisation of the fruitful 2011 annual scientific meeting (ASM) (14th MATCVS) in Subang last November. This year the MATCVS will be co-hosting the Association of Thoracic & Cardiovascular Surgeons of Asia (ATCSA) biennial meeting in Kota Kinabalu, Sabah in conjunction with our 15th ASM. I am confident the chairman Dr Mohd Ezani Md Taib and the rest of the organising team will put on a good show and do our society proud.

The MATCVS through our council and subcommittee; the Malaysian Board of Cardiothoracic Surgery (MBCTS) has also taken a lead role in establishing the framework for an accredited postgraduate training programme similar to that of the Royal Australasian College of Surgeons (RACS). We hope this will in the future attract more high calibre, motivated young doctors into our specialty and help maintain professional standards. Our Honorary Secretary Prof Dr. Zamrin Dimon has been very involved in developing this framework and will elaborate more on the proposed training programme and postgraduate certification later in this newsletter.

Another important milestone is the launch of this first issue of our society newsletter, Berita MATCVS which has emerged largely due to the enthusiasm of our Editor, Dr Anand Sachithanandan. The aim is to enhance networking amongst surgeons, help keep us up to date with the latest research and simultaneously promote the activities of the MATCVS not only to members but also aspiring future surgeons and other healthcare professionals. Ours is a small and relatively new specialty that must be preserved and promoted. We must diligently and deliberately attract the best doctors to join our craft otherwise the future generation of cardiothoracic surgeons in Malaysia may be substandard. We hope to raise the profile and awareness of our specialty and our MATCVS society firstly via the newsletter and subsequently with our interactive website.

There are many challenges ahead for the MATCVS this year. The professional fee schedule, appropriate credentialing of specialists in the economic era of AFTA and establishing clinical practice guidelines are just a few issues that come to mind. The MATCVS is your society and I hope all members, junior and senior, those in the public (MOH) or private sector, IJN or the universities will actively participate and contribute towards MATCVS. A strong and united cardiothoracic community is vital to chart and secure a successful future for our specialty. My council and I will strive to represent all members to the best of our ability. Thank you once again for the mandate to remain your President.

We must diligently and deliberately attract the best doctors to join our craft otherwise the future generation of cardiothoracic surgeons in Malaysia may be substandard.
February 2012 signals the start of the auspicious Lunar New Year of the Dragon and marks an important milestone for the MATCVS with the circulation of the inaugural issue of our society newsletter, the Berita MATCVS. The principle aim is to enhance communication and interaction within the small but exclusive cardiothoracic surgical fraternity in the country despite our different working environments and geographical distribution. Berita MATCVS will be published three times a year, in February, June and October. We hope it will be informative, educational, interesting and perhaps even humorous or inspirational at times. We hope Berita MATCVS will become a forum for discussion of pertinent contemporary professional matters and chronicle the origins of our specialty and the MATCVS society, in particular the contributions of the local pioneer surgeons. All members are strongly encouraged to share any interesting experiences, voice an opinion or comment on any relevant issues. Contributions can be sent via e-mail to the MATCVS Secretariat.

“It’s a great feeling of comfort or reward when some so-year-old patient will tell me that I operated on them when they were 2 weeks old, and they felt like their life was made possible from that surgery. Not many other professions can enjoy those kind of rewards”

Denton A. Cooley, Texas Heart Institute, Houston, USA.

Risk stratification and careful patient selection is fundamentally important for a good outcome following heart surgery. The new Euroscore II has several new changes one should be familiar with.

It is worth remembering the words of pioneer American heart surgeon Alfred Blalock who eloquently said, “Just because a patient is going to die doesn’t necessarily mean one should operate on the patient”.

<table>
<thead>
<tr>
<th>Patient related factors</th>
<th>Cardiac related factors</th>
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<td>Age 1 (years)</td>
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<td>Gender</td>
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<td>Renal impairment 2</td>
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<td>Chronic lung disease 0</td>
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<td>Active endocarditis 8</td>
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<td>Critical preoperative state 7</td>
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<td>Diabetes on Insulin</td>
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Notes about euroSCORE II

[1] Age - in completed years. Some of the weighting for age is now incorporated into the renal impairment risk factor, so it is important that all risk factors are entered to give reliable risk estimations - see note [2]. Of over 20,000 patients in the EuroSCORE database, only 21 patients were aged over 90 - therefore the risk model may not be accurate in these patients. Please exercise clinical discretion in interpreting the score. The oldest patient in the EuroSCORE database was 95 - EuroSCORE II is not validated in patients over this age.
Renal impairment - there are now 3 categories based on creatinine clearance calculated using Cockcroft-Gault formula. Unlike serum creatinine in the old EuroSCORE model, some of the weighting for age is directly incorporated into this factor, as age is a component of creatinine clearance. The 3 categories are:

- on dialysis (regardless of serum creatinine level)
- moderately impaired renal function (50-85 ml/min)
- severely impaired renal function (<50 ml/min) off dialysis

Creatinine clearance (ml/min) = (140-age (years)) x weight (kg) x (0.85 if female) / [72 x serum creatinine (mg/dl)]

### Cockcroft-Gault creatinine clearance calculator - for EuroSCORE II renal impairment

<table>
<thead>
<tr>
<th>Plasma creatinine (µmol/L) only</th>
<th>Weight (kg)</th>
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<td>Note: 1 mg/dL = 88.4 µmol/l</td>
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<th>Age (years)</th>
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<td>Note: 18 - 95 for EuroSCORE II</td>
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<td>m or f (lowercase only)</td>
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<th>Creatinine clearance (ml/min)</th>
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<td>Click in box for result</td>
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* Weight (and creatinine) have not been directly included in the main EuroSCORE II calculator because they are not direct risk factors in the EuroSCORE II model, other than they contribute to creatinine clearance.

### References

3. The manuscript which supports the new model is being submitted for publication. The new model has been validated by the EuroSCORE Project Group and awaits validation by users worldwide. It was presented at EACTS in Lisbon on 3rd October 2011.

### Terms of Use

Copyright - EuroSCORE Study Group 2011. This webpage and calculator (“EuroSCORE II calculator”) is provided “as is” - it is a free tool for unrestricted online use by clinicians, patients and researchers alike. It will be regularly updated and enhanced, so it is important to always use the online version.
First of all, I would like to congratulate Mr Anand Sachithanandan for his efforts in making this Berita MATCVS newsletter a reality. I am sure this will be an avenue to connect members of MATCVS and at the same time position MATCVS towards other professions and societies.

MATCVS has made a lot of progress under the leadership of Prof Dato Dr Zainuddin Wazir. I am sure this has been possible only with the full support and cooperation from all members of MATCVS. I would like to highlight some of our recent developments.

Postgraduate Training in Cardiothoracic Surgery

Realizing the importance of a structured cardiothoracic surgery program, a series of academic visits were held with other specialties in Malaysia such as MS of Reconstructive Science, MS of Neuroscience Surgery and MS of Urology. After studying various cardiothoracic surgery training programs in the world, the Council is keen to set up a similar cardiothoracic surgery training program as that conducted by the Royal Australasian College of Surgeons (RACS). The RACS was positive about the future establishment of a similar cardiothoracic surgery training program in Malaysia. The educational cooperation and many future possibilities that have been proposed by MATCVS have been accepted positively by the RACS.

The program is now awaiting the DG’s approval and support for implementation. The curriculum is in its’ final draft. The program is expected to have the first intake batch in June 2012. The owner of this program will be MATCVS through the Malaysian Board of Cardiothoracic Surgery (MBCTS). Various committees have been formed and all respective committee members will be appointed by the council. The MBCTS subcommittees are the Curriculum committee, Selection committee, Supervisors committee, Examination committee and Accreditation committee.

Summary of the training program:

It will be a six year program: 2 years of Basic Cardiothoracic Training (BCT) followed by 4 years of Specialty Training in Cardiothoracic Surgery (STCS) which is equivalent to a Doctor of Cardiothoracic Surgery. BCT training will be conducted at selected cardiothoracic centers all over the country. The entry requirement level is at least 1 year experience as Medical officer. At the end of BCT, the candidate will need to pass a Generic Surgical Examination, Basic Cardiothoracic Surgery Examination and a Clinical Examination. Following this the eligible candidates will proceed to 4 years of solid STCS training, in collaboration with selected university centers. At the end of STCS training, candidates will sit for an exit exam / fellowship examination.

To accomplish this program, MATCVS will sign a Memorandum of Agreement (MOA) with Institute Jantung Negara (IJN), Ministry of Health (MOH), Universiti Kebangsaan Malaysia (UKM) and Universiti Malaya (UM). This document is currently under review by our appointed lawyer.

At the same time, we are reviewing the MATCVS constitution and any amendments will be done accordingly to ensure smooth running of this program. Participation and cooperation from all members is very critical to ensure the success of this program. Suggestion, ideas and comments are most welcome.

14th MATCVS Annual Scientific Meeting - November 2011

The 14th MATCVS Annual Scientific Meeting that was headed by Prof Dr Raja Amin Raja Mokhtar was held at The Saujana Hotel, Kuala Lumpur from 16th to 19th November 2011. The conference had 449 registered delegates and 24 corporate vendors and distributors.

Some highlights during the 14th MATCVS:

1. Opening ceremony was officiated by HRH Raja Muda of Perak, DYTM Raja Dr Nazrin Shah Ibm Sultan Azlan Muhibbuddin Shah.
2. The 2nd Post Graduate Cardiothoracic Review course was conducted in collaboration with the Birmingham UK surgeons (Mr Tim Graham & Mr Pala Rajesh).
3. The special arrangement was the Charity Gala Dinner and 10th Razali Hashim Memorial Lecture which was delivered by YBhg Prof Dato’ Dr Saw Huat Seong entitled Medical Industry Today – “Separating Wheat From Chaff”.
4. This year, the Young Investigator Award (YIA) was awarded to Dr Mohamed Rizuan Abdul Razak, University Malaya (UM) for his research work entitled “Comparison of the Accuracy Between Acef, Perscore and STS Risk Score in Predicting Mortality of Elective Open Cardiac Surgery and the Effect of Including an Intra-operative Parameter Into the Acef Model”. Congratulations to the winner.
5. The gala dinner this year for the first time was a charity dinner to raise funds for needy patients. RM 60K has been collected from this dinner and the fund will be co-managed by MATCVS and the Cardiothoracic Unit of UM.

Congratulations to the organizing committee (OC) for their tremendous effort to ensure the success of this event. The society really appreciates the efforts of the OC that ensured the smooth running of the conference this year, the invited speakers from overseas and local, people from supporting industries and all the delegates in making this year’s (2011) annual meeting a success. We look forward for more opportunity to enhance a stronger collaboration and cooperation amongst ourselves for the benefit of progress in the cardiothoracic surgery field.

21st ATCSA in conjunction with the 15th MATCVS and 20th Anniversary of the National Heart Institute - Nov 2012

Malaysia was selected to host the Association of Thoracic and Cardiovascular Surgeons of Asia (ATCSA) biennial meeting in 2012. Dr Mohamed Ezani Md Taib has been given the responsibility to head the organizing committee. This conference will be held from the 15th to 18th November 2012 at the Magellan Sutera Harbour Resort, Kota Kinabalu, Sabah with the theme of ‘Unity in Cardiovascular and Thoracic Care’.

MMA Fee Schedule Committee

This committee is chaired by YB Dato Dr Rozali Wathoo. The committee has made several recommendations to the Ministry of Health, protecting the interests of members. Various meetings have been conducted however the attendance has been very minimal. I would like to urge all members, especially those in private practice to fully cooperate and attend the next meeting/briefing from the Fee Committee. (To be announced).
What is the optimal timing for surgery in infective endocarditis with cerebrovascular complications?

Michele Rossi*, Alina Gallo, Ravi Joseph De Silva and Rana Sayeed


Neurologic dysfunction complicates the course of 10–40% of left-side infective endocarditis (IE). In right-sided IE, instead, when systemic emboli occur, paradoxical embolism should be considered. The spectrum of neurologic events includes embolic cerebrovascular complication (CVC), intracranial haemorrhage, ruptured mycotic aneurysm, transient ischaemic attack (TIA), meninges, encephalopathy and brain abscess. Cardiopulmonary bypass might exacerbate neurological deficits due to: heparinization and secondary cerebral haemorrhage; hypotension and cerebral oedema in areas of the disrupted blood brain barrier. A best evidence topic was written according to a structured protocol. The question addressed was: whether there is an optimal timing for surgery in IE with CVCs. One hundred papers were found using the reported search criteria, and out of these 20 papers, provided the best evidence to answer the clinical question. We found that evidence is conflicting because of lack of controlled studies. The optimal timing for the valve replacement depends on the type of neurological complication and the urgency of the operation.

The new 2009 Guidelines on the prevention, diagnosis, and treatment of infective endocarditis (IE) recommend a multidisciplinary approach and to wait for 1–2 weeks of antibiotics treatment before performing cardiac surgery. However, early surgery is indicated in: heart failure (class 1a), uncontrolled infection (class 1 b) and prevention of embolic events (class 1b/C). After a stroke, surgery should not be delayed as long as coma is absent and cerebral haemorrhage has been excluded by cranial CT (class IIa level B). After a TIA or a silent cerebral embolism, surgery is recommended without delay (class I level B). In intracranial haemorrhage (ICH), surgery must be postponed for at least 1 month (class I level B).

In-hospital mortality was 5.5% (n = S). Mortality for isolated coronary artery bypass graft surgery and isolated aortic valve replacement was 2.2% (observed to expected ratio = 1.05, 95% confidence interval: 0 to 3.02) and 5.6% (observed to expected = 1.46, 95% confidence interval: 0 to 3.76), respectively. Other complications included reoperation (all = 8.8%, cardiac = 2.2%), sepsis (2.2%), sternal wound infection (1.1%), transient ischaemic attack (1.1%), renal failure requiring dialysis (1.1%), and prolonged ventilation (18.7%). Major complication rates were not significantly different between the elective group and the urgent group.

RESULTS: Bloodless cardiac surgery in Jehovah’s Witness patients can be performed with excellent outcomes in both elective and urgent situations. Mortality rates for isolated coronary artery bypass graft surgery and isolated aortic valve replacement are within the expected 95% confidence intervals of STS predicted mortality.

Emergency procedures on the descending thoracic aorta in the endovascular era

Mitchell ME, Rushton FW Jr, Boland AB, Byrd TC, Baldwin ZK.

BACKGROUND: Thoracic endovascular aortic repair (TEVAR), initially developed for the treatment of degenerative aneurysms of the descending thoracic aorta, has been applied to the entire spectrum of descending thoracic aortic pathology in both the elective and emergent settings. This single center study evaluates the effectiveness of TEVAR for the treatment of acute aortic emergencies involving the descending thoracic aorta, including traumatic aortic disruption [1A], ruptured descending thoracic aneurysm (RDA), and acute complicated type B dissection (cB1).

METHODS: A retrospective review of the medical records of all patients undergoing emergent TEVAR at the University of Mississippi Medical Center between August 2007 and November 2010 was undertaken. Patients were studied for 30-day survival, complications, type of device used for the repair, and technical aspects of the procedure.

RESULTS: A total of 44 patients (59% male) with an average age of 49 years (range, 10-87 years) underwent emergent TEVAR during the study period. The technical success rate was 100%, with no patient requiring emergent open surgery for conditions involving the descending thoracic aorta at our institution during the study period. The majority (73%) of the repairs were accomplished using commercially available thoracic stent grafts. Abdominal endograft proximal extension cuffs were used in 12 (38%) of the 32 patients undergoing repair of IAD. Twenty-one patients (48%) required coverage of the left subclavian artery, two (10%) of whom subsequently required subclavian artery revascularization.

Procedure-related complications included two strokes, one (0.4%) or cord ischemia, one unintentional coverage of the left subclavian artery, one episode of acute renal failure, and three access site injuries. One patient undergoing repair of IAD had collapse of the stent graft in the early postoperative period. He was successfully treated by placement of an additional stent graft. Seven patients (16%) died within 30 days of surgery. Three of the deaths occurred in patients who had successfully undergone repair of a TAD and died of associated injuries.

CONCLUSIONS: Emergent TEVAR has become the treatment of choice for acute surgical emergencies involving the descending thoracic aorta. Short-term morbidity and mortality compare favorably with historic results for emergent open surgical procedures on the descending thoracic aorta. Survival is highest in patients undergoing repair of IAD. Using current endograft technology, nearly all emergent conditions of the descending thoracic aorta can be successfully treated with TEVAR.

Effect of normothermic cardiopulmonary bypass on renal injury in pediatric cardiac surgery: A randomized controlled trial

Massimo Caputo, MD,a,b,* Nish Patel, FHCSb, Gianni U. Angelini, FHCS, Paolo de Siena, MD,a, Sergio Stoica, FRCSa, Andrew J. Parry, FRCSa, Chris A. Rogers, PhDb
J Thorac Cardiovasc Surg. 2011;142: 1090-1097

OBJECTIVE: Hypothermic cardiopulmonary bypass (CPB), although associated with a reduction in oxygen transport, has a number of disadvantages including detrimental effects on enzymatic function, energy generation, and cellular integrity. Normothermic perfusion is potentially a more physiologic method to maintain the functional integrity of major organ systems. One of the aims of this trial was to compare the effect of normothermic and hypothermic CPB on renal injury in pediatric patients undergoing cardiac surgery.

METHODS: Fifty-nine children (median age, 78 months; interquartile range, 39–130) undergoing corrective cardiac surgery were randomized to either hypothermic (28°C) or normothermic (35°C-37°C) CPB. Urinary albumin, retinal binding protein (RBP) and N-acetyl-β-glucosaminidase (NAG) were measured preoperatively, end of CPB, 4, and 24 hours postoperatively and
were expressed as a ratio of urinary creatinine. Serum creatinine was measured preoperatively, end of CPB, and 24 and 48 hours postoperatively. Results are expressed as a difference in means (normothermic – hypothermic) or as a ratio of geometric means (normothermic/hypothermic).

**RESULTS:** Baseline characteristics were similar in both groups. For these biochemical markers no significant interactions between treatment and postintervention time were found. Serum creatinine (r2.10; 95% confidence interval [CI] 4.61-2.31, R2: 0.96; 95% CI, 0.65-1.41), and Na (ratio, 0.86; 95% CI, 0.56-1.36) were similar in the 2 groups (P = .34), but the urinary albumin was significantly lower in the normothermic group (ratio, 0.63; 95% CI, 0.42-0.95, P = .03).

**CONCLUSIONS:** Normothermic CPB is associated with similar renal impairment to hypothermic CPB in children undergoing heart surgery.

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**Long-Term Survival of Patients With Ischemic Cardiomyopathy Treated By Coronary Artery Bypass Grafting Versus Medical Therapy**

Eric J. Velazquez, MD,a,b, Judson B. Williams, MD,c, Eric Yow, MD, Linda K. Shaw, MD, Kerry L. Lee, PhD, Harry K. Phillipis, MD,a,b, Christopher M. O’Connor, MD,a,b, Peter K. Smith, MD,a,b, and Robert J. Hotz.


**BACKGROUND:** We prospectively applied the Surgical Treatment of Ischemic Cardiomyopathy trial entry criteria to an observational database to determine whether coronary artery bypass grafting (CABG) decreases mortality compared with medical therapy (MED) for patients with coronary artery disease and depressed left ventricular ejection fraction.

**METHODS:** This was a retrospective, observational, cohort study of prospectively collected data from the Duke Databank for Cardiovascular Disease. Long-term mortality was the main outcome measure. Between January 1, 1995, and July 31, 2009, 80,874 patients underwent cardiac catheterization for suspected ischemic heart disease and were evaluated for inclusion in the analysis.

**RESULTS:** A total of 2,624 patients were found to have left ventricular ejection fraction less than 0.35, coronary artery disease amenable to CABG, and no left main stenosis of greater than 50%. After exclusions including ongoing Canadian Cardiovascular Society class III angina and acute myocardial infarction, 763 patients were included for propensity score analysis, including 624 who received MED and 139 who underwent CABG. Adjusted mortality curves were constructed for those patients in the three quintiles most likely to receive CABG. The curves diverged early, with risk-adjusted mortality rates at 5 years of 46% for MED versus 29% for CABG, and the survival benefit of CABG over MED continued through 10 years of follow-up (hazard ratio, 0.63; 95% confidence interval, 0.45 to 0.88).

**CONCLUSIONS:** Among a propensity-matched, risk-adjusted, observational cohort of patients with coronary artery disease, left ventricular ejection fraction less than 0.35, and no left main disease of greater than 50%, CABG is associated with a survival advantage over MED through 10 years of follow-up.

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**Endoscopic Venous Harvesting by Inexperienced Operators Compromises Venous Graft Remodeling**

Sorosh Kiani, MDa,b, Pranjali H. Desai, MDa, Namnam Thummaruk, MDa, Dinesh John Kurian, BSb, Mary Margaret Flynn, MDCfa, XiaoQing Zhao, PhD, Robert S. Poston MD.

Ann Thorac 2012; 83(1): 11-17.

**BACKGROUND:** Endoscopic vein harvesting (EVH) is the standard of care for coronary artery bypass grafting (CABG) in the United States, but recent comparisons with open harvesting suggest that conduit quality and outcomes may be compromised in EVH. To test the hypothesis that problems with EVH may relate to its learning curve and conduit quality, we analyzed the technique and early quality of conduits procured by technicians with varying experience in EVH.

**METHODS:** Experienced (more than 900 cases, n = 55) and novice (less than 100 cases, n = 30) technicians performed EVH during CABG. Subsequently, optical coherence tomography (OCT) was used to examine the conduits for vascular injury, with segments identified as injured being further examined for gene expression with an array of genes related to tissue injury. Conduit diameter was measured intra- and postoperatively (day 5 and 6 months, respectively) with OCT and computed tomographic angiography.

**RESULTS:** Endoscopic vein harvesting by novice harvesters resulted in a greater number of discrete graft injuries and greater expression of tissue-injury genes than EVH done by experienced harvesters. Regression analysis revealed an association between shear stress and early dilation of engrafted vessels (positive remodeling) (R2 = 0.48, P < 0.01). Injured veins showed blunted positive remodeling at 5 days after harvesting and a greater degree of late lumen loss at 6 months.

**CONCLUSIONS:** Under normal conditions, intraluminal shear stress leads to positive remodeling of vein grafts. Continued shear stress during the first postoperative week was associated with injury to conduits, a frequent sequela of the learning curve for EVH, was a predictor of early graft failure and of blunted positive remodeling and greater negative remodeling of endoscopically harvested vein grafts. Given the current annual volume of cases in which EVH is used, rigorous monitoring of the learning curve for this procedure represents an important and unrecognized issue in public health.

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**Long-Term Mortality of Coronary Artery Bypass Grafting and Bare-Metal Stenting**

Chuntao Wu, MD, PhD,a,b, Songyang Zhao, MD, Andrew S. Wechsler, MDc, Stephen Lahey, MDG, Gary Walford, MDa,b,*, Judson B. Williams, MD,a,b, Robert J. Hotz, MD,a,b, Jeffrey F. Gold et al.

Ann Thorac Surg 2011; 92(6): 2132-8

**BACKGROUND:** There is little information on relative survival with follow-up longer than 5 years in patients undergoing coronary artery bypass grafting (CABG) and patients undergoing percutaneous coronary intervention (PCI) with stenting. This study tested the hypothesis that CABG is associated with a lower risk of long-term (8-year) mortality than is stenting with bare-metal stents for multivessel coronary disease.

**METHODS:** We identified 18,359 patients with multivessel disease who underwent isolated CABG and 13,377 patients who received bare-metal stenting from 1999 to 2000 in New York State’s vital status registry through 2007 using the National Death Index (NDI). We matched CABG and stent patients on the number of diseased coronary vessels, proximal left anterior descending (LAD) artery disease, and propensity of undergoing CABG based on numerous patient characteristics and compared survival after the 2 procedures.

**RESULTS:** In the 7,235 pairs of matched patients, the overall 8-year survival rates were 78.0% for CABG and 71.2% for stenting (hazard ratio [HR], 0.68; 95% confidence interval [CI] 0.64 to 0.74; P < 0.001). For anatomic groups classified by the number of diseased vessels and proximal LAD involvement, the HRs ranged from 0.53 (P < 0.001) for patients with 3-vascular disease involving proximal LAD artery disease to 0.78 (P = 0.05) for patients with 2-vascular disease but no disease in the LAD artery. A lower risk of death after CABG was observed in all subgroups stratified by a number of baseline risk factors.

**CONCLUSIONS:** Coronary artery bypass grafting is associated with a lower risk of death than is stenting with bare metal stents for multivessel coronary disease.

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**Surgical Approach To End-Stage Heart Failure (Review Article – Recommended Reading)**

Stefan Klotz and Hans H. Scheld.

Curr Opin Anesthesiol 2012; 24(6): 96-91

End-stage heart failure is a challenging disease with a high mortality rate. With decreasing heart transplant rates worldwide organ preserving therapies become, again, of interest. The purpose of the present review is to examine the potential challenges of surgical therapies in patients with end-stage heart failure. The gold-standard for end-stage heart failure is and will be cardiac transplantation. However, due to organ shortage this therapy is limited to a few patients. Therefore implantation of ventricular assist devices (VADs) or long-term minimal-invasive partial support devices will increase. Improvements in device design with smaller devices, easier implantation techniques, and modified anticoagulation outcome and long-term success will likely improve. In addition, good quality of life as destination therapy is almost available. Organ conservation surgery (coronary artery bypass grafting and surgical ventricular restoration or surgical repair of mitral valve regurgitation) in endstage heart failure patients could not prove the expected results. Transcatheter or minimal-invasive approaches of these therapies might become routine in the near future.

**SUMMARY:** Due to the overwhelming outcome rates, cardiac transplantation is the most established surgical therapy for end-stage heart failure. VAD therapy is increasing and minimized VADs might further open the market for destination therapy/permanent support.

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**Surgical Management And Outcomes Of Elderly Patients With Early Stage Non-Small Cell Lung Cancer: A Nested Case-Control Study**

Rivera C, Falcoz PL, Bernard A, Thomas PA, Dahan M.


**BACKGROUND:** The number of oncogeriatric patients with non-small cell lung cancer (NSCLC) is expected to increase in the next decades.

**METHODS:** We used the French Society of Thoracic and Cardiovascular Surgery database Ephor that includes information on > 140,000 procedures from 98 institutions. We prospectively collected data from January 2004 to December 2008 on 1,969 patients aged ≥ 70 years with NSCLC stage I or II and matched them with 1,969 control subjects aged < 70 years for sex, American Society of Anesthesiology score, performance status, and FEV1. Surgical treatment and postoperative outcomes were compared between the two age groups.

**RESULTS:** The absence of radical pneumonectomy was more frequent in the older patients (14%, n = 269) than in the younger patients (9%, n = 170) (P < .0001). There was no significant difference in type of resection between older and younger patients, respectively pneumonectomy, 8% [n = 164] vs 11% [n = 216]; lobectomy, 79% [n = 1,559] vs 77% [n = 1,521]; bilobectomy, 4% [n = 88] vs 5% [n = 97]; sublobar resection, 7% [n = 143] vs 8% [n = 118] (P = .08). Differences in number (P = .07) and severity (P = .69) of complications were not significant. Postoperative mortality was higher in elderly patients at every end point (30-day mortality, 3.6% [n = 70] vs 2.2% [n = 43] [P = .01]; 60-day mortality, 4.1% [n = 80] vs 2.4% [n = 47] [P = .003]; 90-day mortality, 4.7% [n = 93] vs 2.5% [n = 50] [P = .0002]).
CONCLUSIONS: Elderly patients with NSCLC should not be denied pulmonary resection on the basis of chronic age alone. Among patients aged ≥ 70 years, 90-day mortality compared acceptably with mortality among younger matched patients. Additionally, the data show that for older patients, a 90-day mortality better represents their real mortality risk than 30- or 60-day figures. Our contemporary, multi-institutional data importantly reveal that elderly patients, compared with their younger counterparts, do not have increased morbidity, incidence, or severity after pulmonary resection.

Ten-Year Results Of Thoracoscopic Unilateral Extended Thymectomy Performed In Nonthymomatous Myasthenia Gravis


OBJECTIVE: The aim of this study was to analyze the 10-year results of thoracoscopic unilateral extended thymectomy (TUE) performed in nontumoral myasthenia gravis according to the Myasthenia Gravis Foundation of America recommendations.

BACKGROUND DATA: Thoracoscopic unilateral extended thymectomy has the benefits of a minimally invasive approach. Previous data have shown promising midterm results but long-term results were lacking.

METHODS: Two hundred forty patients with nontumoral myasthenia gravis who underwent surgery between 1999 and 2009 were eligible for the study. The mean follow-up was of 67 months (range: 12-215), 134 patients completed follow-up assessments more than 60 months after TUE.

RESULTS: There were 39 males (16.3%) and 201 females (83.7%), with an age range from 18 to 60 years. The mean preoperative disease duration was 21.5 months. All patients underwent preoperative steroid therapy. Anticholinesterase drugs were required for 123 patients (51.3%), and immunosuppressive drugs were required for 87 (36.3%) patients. The pathologic findings were as follows: normal thymus in 13 patients (5.5%), involuted thymus in 65 patients (27%), and hyperplastic thymus in 162 patients (67.5%). The average weight of the thymus was 110 ± 45 g. Ectopic thymic tissue was found in 147 patients (61.3%). There was no mortality, and morbidity consisted of 12 patients (5%). Complete stable remission was achieved in 61% of the patients, and the cumulative probability of achieving complete stable remission was 0.88 at 10 years.

CONCLUSIONS: With zero mortality, low morbidity, and comparable long-term results to open surgery, TUE can be regarded as the best treatment option for patients undergoing surgery for myasthenia gravis. Do multidisciplinary team meetings make a difference in the management of lung cancer?

Boxer MM, Vinod SK, Shafiq J, Duggan KJ.
Cancer 2011; 117(22): 5112-20.

BACKGROUND: There is limited evidence regarding the effectiveness of multidisciplinary team (MDT) meetings in lung cancer. The objective of this study was to compare the patterns of care for patients with newly diagnosed lung cancer who were presented at a lung cancer MDT meeting with the patterns of care for patients who were not presented.

METHODS: All patients who had lung cancer newly diagnosed in South West Sydney (SWS) between December 1, 2005, and December 31, 2006, were identified from the local Clinical Cancer Registry. Patient and tumor characteristics and treatment receipt were compared between patients who were and were not presented at MDT meetings. A logistic regression model was constructed to determine predictors for receiving treatment and survival.

RESULTS: In total, there were 988 patients, including 504 patients who were presented at MDT meetings and 484 who were not presented at MDT meetings. The median patient age was 69 years and 73 years in the MDT group and the non-MDT group, respectively (P < .01). There was no pathologic diagnosis for 13% of non-MDT patients compared with 4% of MDT patients (P < .01). Treatment receipt for MDT patients versus non-MDT patients was 12% versus 13%, respectively, for surgery (P value nonsignificant); 66% versus 33%, respectively, for radiotherapy (P < .001); 46% versus 29%, respectively, for chemotherapy (P < .001); and 66% versus 53%, respectively, for palliative care (P < .001). In patients with good performance status, the MDT group had significantly better receipt of radiotherapy among patients with stage I through IV N-stage (P < .01). MDT discussion was associated with better treatment receipt, which potentially may improve quality of life for patients with lung cancer. However, it did not improve survival.

A Prospective Controlled Trial Of Endobronchial Ultrasound-Guided Transbronchial Needle Aspiration Compared With Mediastinoscopy For Mediastinal Lymph Node Staging Of Lung Cancer

Kazuhiro Yatsufuku, MD, PhD,a Andrew Pierre, MD, MS,c,a Gail Darling, MD et al.
J thorac cardiovasc surg 2011; 142:1393-400

OBJECTIVE: The study objective was to compare endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) with mediastinoscopy for mediastinal lymph node staging of potentially resectable non–small cell lung cancer.

METHODS: Patients with confirmed or suspected non–small cell lung cancer who required mediastinoscopy to determine suitability for lung cancer resection were entered into the trial. All patients underwent EBUS-TBNA followed by mediastinoscopy under general anesthesia. If both were negative for N2 or N3 disease, the patient underwent pulmonary resection and mediastinal lymphadenectomy.

RESULTS: Between July 2006 and August 2010, 190 patients were registered in the study, 159 enrolled, and 153 were eligible for analysis. EBUS-TBNA and mediastinoscopy sampled an average of 3 and 4 lymph node stations per patient, respectively. The mean short axis of the lymph node biopsied by EBUS-TBNA was 6.9 ± 2.9 mm. The prevalence of N2 or N3 disease was 35% (53/153). There was excellent agreement between EBUS-TBNA and mediastinoscopy for mediastinal staging in 136 patients (91%; Kappa, 0.8; 95% confidence interval, 0.7–0.9). Specificity and positive predictive value for both techniques were 100%. The sensitivity, negative predictive value, and diagnostic accuracy for mediastinal lymph node staging for EBUS-TBNA and mediastinoscopy were 81%, 91%, 93%, and 79%, 90%, 93%, respectively. No significant differences were found between EBUS-TBNA and mediastinoscopy in determining the true pathologic N-stage (McNemar’s test, P=0.78). There were no complications from EBUS-TBNA. Minor complications from mediastinoscopy were observed in 4 patients (2.6%).

CONCLUSIONS: EBUS-TBNA and mediastinoscopy achieve similar results for the mediastinal staging of lung cancer. As performed in this study, EBUS-TBNA can replace mediastinoscopy in patients with potentially resectable non–small cell lung cancer.
Professor Ludwig Karl von Segessor (VS) is one of the contemporary giants of cardiovascular surgery. A graduate of Basel University medical school, he trained in his native Switzerland (Geneva and Zurich) and Houston, Texas. Von Segessor has been Professor and Chief of Cardiovascular Surgery at University Hospital Vaudois, CHUV, Laussane Switzerland since 1995. A highly innovative pioneering surgeon with vast longstanding research interests including work on cardiopulmonary bypass, mechanical circulatory support and modification of blood exposed synthetic surfaces, he has published extensively (with over 700 publications on Medline’s PubMed and in total has contributed to over 1700 publications) and has numerous design patents for various cardiovascular devices used in our everyday clinical practice.

A member of over 30 international surgical societies, ten editorial boards, Prof von Segessor was Editor-in-Chief of both the European Journal of Cardiothoracic Surgery (EJCTS) for 10 years and the open access online Interactive Cardiovascular & Thoracic Surgery (ICVTS) which he launched in 2002. He has been the President of the Swiss Heart Foundation since 2004, a past president of the Swiss Society for Thoracic & Cardiovascular Surgery and he is the current President of the European Association of Cardiothoracic Surgery (EACTS). I had the privilege to speak with this exceptionally gifted and creative but remarkably humble surgeon at our recent 14th 2011 MATCVS meeting last November in KL.

AS: What are the ingredients for success?

VS: I think you have to be curious, interested in new things, have an open mind and never give up.

AS: Why did you become a doctor?

VS: My late father was a urologist/general surgeon – but that was not the main reason. I had a lot of interest in technology, architecture, many other things but finally when I had to make a choice I wanted to do something where I could see that it’s useful to other people and I end up with medicine.

AS: And more specifically how did you end up becoming a heart surgeon?

VS: Originally my plan was to go for general surgery/urology because my father was doing this but then when I was in Geneva, a (training) slot opened in cardiac and vascular surgery, I went in there and I stayed there…but as you can see I’m still in piping! You cannot plan. It’s impossible to plan- it depends on available opportunities.

AS: Who has had the biggest influence on your career. I believe you worked for some of the giants in the specialty like Marko Turina whom you later succeeded as the EJCTS editor-in-chief and earlier in your career in the mid-1980s you worked with Denton Cooley at the Texas Heart Institute.

Is there any one surgeon or surgeons who have inspired you?

VS: I learnt a lot from my father. He was a general surgeon initially and became one of the pioneer urologists. In my city he was the first and for a long time the only urologist and many techniques they use, we use in vascular surgery, so I learnt a lot from him.

AS: What would you say is your proudest or greatest professional achievement?

VS: I know you have an immense number of scientific publications and design patents, you created and established the ICVTS – the journal impact factor has steadily increased over the decade to an impressive 2.29 and last month (Oct 2011) had over 40,000 downloads – surely this must be top of the list?

AS: As an industry leader and a highly innovative surgeon, may I ask your opinion as to what are the likely future trends in cardiovascular and thoracic surgery in this next decade?

VS: I think the development of catheter based technology will go on and I encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encouraged surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved. Many things have started in surgery and disappeared from our activity and encourage surgeons to stay involved.

AS: What advice would you give to a young surgeon starting his or her career as an independent surgeon?

VS: They need wire skills. Our cardiologists’ ask me what is the difference between a cardiologist and a cardiac surgeon… I say you work with a wire size 0.14 and we surgeons work with a wire size 0.35… just slightly bigger.

AS: In your opinion what have been the most important or relevant contributions and advances in the field of cardiothoracic surgery in the past 5 decades?

VS: I think the first step was cardiopulmonary bypass- without that you could not open the heart. Then next came valves that last for more than a few hours; this made a big big difference. Now we have assist devices coming around the corner which may have a solution for long term problems we cannot solve otherwise. Of course transplantation was a big step but we can never get the volume we need because finally for all of us the heart stops and thus there is unlimited need or demand and you cannot match this with transplantation even if you “breed or culture” hearts, I think.

**USUALLY THE MOST IMPORTANT ACHIEVEMENT IS ALWAYS THE NEXT ONE**

AS: How would you say we should go about to attract and train the next generation of cardiothoracic surgeons – to attract high calibre and motivated individuals into our specialty? I ask this question Professor because as you know in recent years in the USA, the once highly competitive CT residency programmes are now undersubscribed.

VS: Yes, I think one of the problems is that how the surgeon is regarded has changed. In the past let’s say you were the only heart surgeon in town and you saved a few lives, everybody was in favour of what you do and supported you. Today, there is competition, inflation, less
prestige, and the financial rewards are not as they were... so for people who don’t really know what it is we do, that’s not very attractive. But in my experience the best candidates I found are students who if you catch them very early on before somebody else shows them another specialty, you can bring them to our side. Students are promising; the younger you get people involved the more promising they are.

AS: So would you say even targeting medical students after all our specialty is such an exciting dynamic field and raising the awareness of the specialty even at a very early age?

VS: Yes I think you tell the student during your lectures that cardiovascular disease is the number I disease worldwide and it’s the most frequent reason for prescription, for consulting, for visiting a hospital and also for dying. This is an important issue and if you can tell young people there are solutions for many of these problems and that they can contribute to that if they get involved early on. I think you can attract them to the discipline and then of course when they come to your unit as students you need to identify and grab the best of those. I think that’s the strategy to improve the recruitment we have because we are spoilt. In the past, everybody wanted to do this so we had to say no. And now we have to make a broader view and apply what you know from one discipline to another. To me for instance a Bentall procedure, mini root valve replacement, Ross procedure or arterial switch it’s all the same just a different size. And when you look at history, it evolved just like that: we did Bentall then we used homografts then mini roots but it didn’t work so well in the subcoronary position then we started with the Ross procedure (although it was developed before the valves because there were no artificial valves originally), and the switches came along and it’s just that you have to use your (surgical) magnifying loupes.

Basically it’s the same procedure so I think you can enlarge the volume of what we do if you take from different sizes – not just doing the same size always the same. And all these disciplines benefit from what is done in the other disciplines because in some cases one discipline is ahead of the other, then you can take something from the small ones and vice versa.

WHAT I DO IS PROBLEM-DRIVEN CARDIOVASCULAR RESEARCH AND SOMETIMES WE FIND A SOLUTION. THIS IS MY RELAXATION

AS: What do you do to relax – any interests or hobbies?

VS: I try to solve problems. But not in the newspaper (eg. crossword puzzles) but rather what we do in surgery. For example, I was involved in surface modification for oxygenators, or design of all sorts of stent grafts. What I do is problem-driven cardiovascular research and sometimes we find a solution. This is my relaxation and of course I also have a family.

AS: What or who inspires or motivates you? For someone who has achieved so much, you say what’s important is not what you have already achieved but what you are going to do next. So what drives you or makes you go for that next thing?

VS: I think it’s from within. There are people who like to solve crosswords and I like to solve problems in surgery but you solve one question and there are 10 new questions to answer...so it keeps you busy all the time.

AS: In the modern era is it still feasible to have a mixed cardiothoracic or cardio-vascular practice, or do you think it is inevitable we will all have to choose to practice as a pure adult cardiac or congenital cardiac or thoracic or vascular surgeon?

VS: I think there two issues here. First to get big volumes in a very narrow specialty and the other of course is to have a broader view and apply what you know from one discipline to another. To me for instance a Bentall procedure, mini root valve replacement, Ross procedure or arterial switch is all the same just a different size. And when you look at history, it evolved just like that: we did Bentall then we used homografts then mini roots but it didn’t work so well in the subcoronary position then we started with the Ross procedure (although it was developed before the valves because there were no artificial valves originally), and the switches came along and it’s just that you have to use your (surgical) magnifying loupes.

Basically it’s the same procedure so I think you can enlarge the volume of what we do if you take from different sizes – not just doing the same size always the same. And all these disciplines benefit from what is done in the other disciplines because in some cases one discipline is ahead of the other, then you can take something from the small ones and vice versa.

YES, IF YOU DON’T KNOW WHAT YOU DO, HOW CAN YOU IMPROVE?

AS: So we can learn from the different subspecialties within thoracic and cardiovascular surgery?

VS: And even from other specialties and other sciences. Personally I am not in favour of ultra specialization – doing the same thing all the time every day ten times, but there are different views on that. But I have benefited a lot in not having subspecialised. So for instance here do you have to train in the Anglo Saxon system, do general surgery first then proceed to CT surgery?

AS: Yes, in Malaysia one usually completes a structured general surgical residency before entering CT surgery.

VS: When I was training, it was like that and I think this was good for me. Now of course we have cardiac subspecialty training (in Switzerland) but it’s too narrow because for example thoraco abdominal aneurysm surgery, you make a hole in the intestine, you have to call somebody else and you cannot finish the surgery.

AS: How do you balance your clinical service commitments with academia in terms of being editor or publishing papers or conducting research? Presumably you have both a good clinical team and a good academic team?

VS: Yes, you need a good team but you need to know what you do. We have a database with a professional database manager so we have 40,000 patients in our database so I can tell you in five minutes how many Ross procedures were done and their mortality etc. I can write a (research) abstract tonight. This helps. So you have to put in place the structure to be able to work. Once you know what you do, you can compare with what the others do, see where the problems are, it gives you new ideas, and then you have new problems to solve so you remain busy.

AS: So one of the key things is having the data and analyse what we do?

VS: Yes, if you don’t know what you do, how can you improve?

AS: Absolutely. And the ideas for your various research studies or projects – does this come from what you observe or curiosity (as you said at the start)?

VS: No. I think we constantly read about problems and we want to find a solution and then of course I have a very privileged relationship with the industry. They like to visit us, they show us what they have and in the old days there was no FDA so we said bring us the glossy brochure, bring us the device and we go in the lab, we’d test on three or four animals and we’ll tell you if we like it! Each time that’s a paper! Now we still do it but of course we have regulatory bodies and it’s more complicated but this was a driving engine for such research activity. Just try it instead of (just) reading it.

AS: In the future on retirement, how would you like to be remembered? What would you like your legacy to be?

VS: Well in good terms – that’s it. I don’t have anything to claim.
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First Announcement
The Division of Respiratory Medicine, Serdang Hospital
Malaysian Interventional Pulmonology Course
Collaboration with Arizona Pulmonary Specialist Group, USA
September 25 – 28 2012
Venue: Auditorium, Serdang Hospital
Serdang, Selangor, Malaysia

website: http://tserdang.moh.gov.my/respiratory

Royal Australasian College of Surgeons
81st Annual Scientific Congress
Kuala Lumpur Convention Centre, Malaysia
6 – 10 May 2012
Web: asc.surgeons.org
Convocation and Workshops: Sunday 6 May
Scientific Sessions: Monday 7 – Thursday 10 May

Provisional Program
It had been a long year of planning for this meeting held on 17-19 November 2011. Many personal sacrifices were made by members of the organizing committee especially the time spent in planning and brainstorming.

We had a subcommittee to handle the Scientific Meeting which consisted of our wonderful group of upcoming young cardiothoracic surgeons and trainees from UM, UiTM, UKM, KKM and IJN who efficiently divided the work to ensure high quality scientific sessions. I would like at this point to acknowledge and thank them for their invaluable contributions.

We had a subcommittee to handle the Scientific Meeting which consisted of our wonderful group of upcoming Young Cardiothoracic Surgeons & trainees from UM, UiTM, UKM, KKM and IJN

Mr. Sivakumar Sivalingam (IJN)
Assoc. Prof Dr Shahrul Amry (UM)
Mr. Anand Sachithanandan (KKM)
Mr. Paneer Selvam Krishna Moorthy (IJN)
Mr. Sivakumar Krishnasamy (UM)
Dr. Adli Azim (UiTM)
Dr. Mohd. Abid (UiTM)

Another subcommittee consisting of the nurses from University Malaya worked hand in hand with Ms. YM Kong and her staff from the Academy of Medicine and our delightful MATCVS Assistant Secretary Cik Nur Shidah Che Lah to organize the Annual Gala Dinner and Charity Event. These ladies formed the backbone of staff who expertly managed the overall meeting.

We had some major concerns and hurdles especially in deciding the date of the event as I was awaiting a reply from the Office of HRH the Sultan of Perak who is also the Pro Chancellor of University Malaya. This resulted in a slight initial delay in the overall organization of the meeting. I thought that our Society needed a boost to its image with the presence of HRH Sultan Azlan Shah at the Gala Dinner and Charity Event. We made sure the show during the gala dinner was of a high quality and thoroughly entertaining.

However we were blessed with the presence of HRH The Regent of Perak who is also the Pro Chancellor of University Malaya. The Crown Prince HRH Raja Dr Nazrin Shah graciously attended and officially opened the event at The Saujana with a most articulate and enlightening speech.

To show our appreciation to the participants and the industry, we made sure the show during the gala dinner was of a high quality and thoroughly entertaining. Guests were entertained by one of Malaysia’s best known comedians Harith Iskandar who got the crowd laughing immediately. Live music was courtesy of the University Malaya 60-piece Symphony Orchestra playing “Big Band” music from the likes of Frank Sinatra, Nat King Cole, Louis Armstrong and Michael Buble. Other live musical acts included singers Man Bai and Roy Azman. The food and décor was of a Moroccan theme with gold lined purple drapes, iron cast candles and light stands and golden draped tables transforming the Dewan Tunku Chancellor Hall into a 5 star Ballroom. This was an occasion for medical representatives from the industry to informally mingle with the doctors and discuss business in a relaxed atmosphere.

This gala event was jointly emceed by Dr Anand Sachithanandan and Miss Lizatul Akmar Abd Lah. Dr Anand later introduced our guest speaker pioneer surgeon, Datuk Prof Dr Saw Huat Seong who delivered the 10th Razali Hashim Memorial Lecture with an enlightening and witty talk entitled “Medical Industry Today: Separating Wheat from Chaff”.

We arranged for UM’s double decker buses complete with police outriders to efficiently transport participants to and from the venue. We are thankful to the Pro Chancellors and Vice Chancellor of University Malaya for attending our Gala Dinner and for their excellent support.

Overall, it was a successful event with the participants benefiting from the three high quality pre congress courses and main congress scientific sessions followed by a relaxing and entertaining gala night after long gruelling days listening to lectures.

As for the UM cardiothoracic unit, we are proud to have been given the opportunity to organize this event and showcase our university. The icing on the cake was the announcement that one of our surgical trainees was the winner of the MATCVS Young Investigator Award.
The PG Review course is unashamedly based on the successful format of the excellent internationally renowned Birmingham Review Course in Cardiothoracic Surgery (BRC)

The 2nd Malaysian Postgraduate Review Course in Cardiothoracic Surgery was successfully conducted on 17 November 2011 as a pre-congress workshop in conjunction with the 14th MATCVS annual scientific meeting. In contrast to the inaugural course (Melaka 2010), the 2011 course featured interactive seminars in addition to the morning session didactic lectures. The four seminars included a Thoracic Surgery station where participants revised their understanding of lung function tests, arterial blood gases and discussed management of common and interesting CXRs and CT scans. The ‘Echocardiography for Surgeons’ station provided ample exposure to gain a confident working knowledge of ECHOs and the “Assessment of Ischaemic Heart Disease” station was a comprehensive session on interpretation of coronary angiograms. The fourth and final seminar was a “Cardiopulmonary bypass” station which hopefully improved the trainees understanding on the intra-operative conduct of CPB and a better appreciation of the work of the cardiac perfusionist. Trainees and delegates rotated through all four stations at 30 min intervals. Informal feedback has been extremely positive so hopefully the interactive seminars will become a regular feature of future PG review courses.

We must acknowledge the diligent efforts of our faculty of local experts which included our cardiology, pulmonology and radiology colleagues:

Prof Dr Wan Azman Wan Ahmad (UM)
Dr Rahal Yusoff (HKL)
Assoc Prof Dr Pang YK (UM)
Asoc Prof Dr Yang Faridah Abdul Aziz (UM)
Assoc Prof Dr Shahrul Amry (UM)
Assoc Prof Dr Chee Kok Han (UM)
Dr Sivakumar Sivalingam (UM)
Prof Dr Raja Amin Raja Mokhtar (UM)
Dato’ Dr Venugopal Balchand (Pantai HKL)
Dr Pau Kiew Kong (IJN)
Dr Paneer Selvam Krishna Moorthy (IJN)
Dr Rais Sanusi (IJN)
Dr Jeswant Dillon (IJN)
Dr Mohd Ezani Md Taib (IJN)
Dr Balaji Badmanahan (Serdang, KKM)
Dr Anand Sachithanandan (Serdang, KKM)

In between the morning lectures and the afternoon seminars, a valve wetlab was conducted giving participants hand-on experience with implantation of the stentless Freedom Solo (Sorin) aortic bioprosthesis using an animal model.

The PG Review course is unashamedly based on the successful format of the excellent internationally renowned Birmingham Review Course in Cardiothoracic Surgery (BRC) hence it was most appropriate that our esteemed international faculty was once again led by the two surgical pioneers of the BRC, British surgeons Dr Tim R Graham (Queen Elizabeth Hospital, Birmingham) and Dr Pala B Rajesh (Heartlands Hospital, Birmingham) who were active teachers on the “Assessment of Ischaemic Heart Disease” and “Thoracic” stations respectively.

The parallel session Cardiothoracic Surgery Critical Care Course was exceptionally well attended, mostly by nurses and some physiotherapists, and this was in no small part due to the quality of the four speakers: Hayley Sachithanandan (Pantai HKL), Anmol Kaur Manjit Singh, Elviswari Pathan and Suguna Ramasamu (all UMMC) and their interesting topics.

Finally, the Advances in Cardiopulmonary Bypass Course ensured our perfusionist colleagues were not left out and gained further insight on ECMO and some practical experience with a hand-on session on the novel Emergency Bypass System (EBS).

The sterling “behind the scenes” work of Dr Sivakumar Krishnasamy (UM) and our Executive Secretary Nur Shidah Abd Lah must be acknowledged as this was vital for the organisational success of the PG Review course. The day concluded with a “Question the Experts” session (moderated by Drs. Paneer Selvam Krishnamoorthy & Anand Sachithanandan) during which trainees and junior surgeons quizzed the experts (Drs Tim Graham, Pala Rajesh, Jeswant Dillon, Sivakumar Sivalingam, and Dato’ Venugopal) on a wide spectrum of clinical issues.
Prof Zamrin Dimon and Prof Dato’ Dr Ramzisham Abdul Rahman have both recently been made full professors of cardiothoracic surgery at UKM.

Congratulations to Prof Dato’ Dr Ramzisham Abdul Rahman who was conferred the Darjah Sultan Ahmad Shah Pahang (DSAP) award by HRH Sultan of Pahang in conjunction with His Majesty’s 81st birthday celebrations in October 2011.

Mr Hamdan Leman has recently joined the Ministry Of Health at Hospital Serdang and Mr John Chan Kok Meng FRCS (CTh) will soon be joining the consultant staff at Sarawak General Hospital.

The Health Ministry’s cardiothoracic unit in Kota Kinabalu (headed by Mr David Tang) was officially opened on 1st February 2012 by our Deputy Health Minister YB Datuk Rosnah.

Congratulations to YAB Tan Sri Dato’ Dr Yahya Awang who was appointed the new Pro-Chancellor of Universiti Teknologi Malaysia (UTM) in September 2011 in conjunction with UTM’s 47th convocation.

Mr Jeswant Dillon has been appointed clinical director of Adult Cardiac Surgery at IJN, Mr Sivakumar Sivalingam is IJN’s new clinical director of Congenital & Paediatric cardiac services and Mr Mohd Ezani Md Taib is the Director of Cardiopulmonary Transplantation and the Mechanical Circulatory Support programme.

Congratulations to Dato’ Dr Azahari Yakub, Dato’ Dr Venugopal Balchand and Dr Mohd Ezani Md Taib who have all been recently conferred Professorships at Alliance University College of Medical Sciences (AUCMS), Penang.

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**NEWS**

**Heart Surgeon vs. Mechanic**

In a car garage, where a famous heart surgeon was waiting for the service manager to take a look at his Mercedes, there was a loud mouthed mechanic who was removing the cylinder heads from the motor of a car. He saw the surgeon waiting and lured him into an argument.

He asked the doc after straightening up and wiping his hands on a rag, "Look at this car I’m working on. I also open hearts, take valves out, grind them, put in new parts, and when I finish this baby will purr like a kitten. So how come you get the big bucks, when you and I are doing basically the same work?"

The surgeon very calmly leaned over and whispered to the loudmouth mechanic, "Try doing it with the engine running."
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EVENTS CALENDAR

8th International Congress of Update In Cardiology And Cardiovascular Surgery
1 – 4 MARCH 2012
VENUE
Antalya Turkey, Maxx Royal Convention Centre
ADDITIONAL INFORMATION
http://www.uccs2012.org

20th Annual Meeting Of The Asian Society for Cardiovascular and Thoracic Surgery (ASCVTS)
8 – 11 MARCH 2012
VENUE
Bali International Convention Center, Bali Indonesia
EMAIL
info@ascvtsbali2012.org
ADDITIONAL INFORMATION
http://ascvtsbali2012.org/

2012 Australasian Thoracic Aortic Symposium
9 – 21 APRIL 2012
VENUE
ofitel Melbourne, Victoria Australia
EMAIL
2012atas@tayloredimages.com.au
ADDITIONAL INFORMATION

NHAM Annual Scientific Meeting 2012
12 – 15 APRIL 2012
ORGANISE
National Heart Association of Malaysia
VENUE
Hilton Kuala Lumpur & Le Meridien Kuala Lumpur

The 61st International Congress of The European Society for Cardiovascular and Endovascular Surgery
25 – 28 APRIL 2012
VENUE
Dubrovnik Croatia (Hrvatska)
Valamar Lacroma Dubrovnik
EMAIL
info@escvs2012.org

Association of Cardiothoracic Anaesthetists & Society for Cardiothoracic Surgery in Great Britain and Ireland - 2012 Annual Meeting and Cardiothoracic Forum
18 – 20 APRIL 2012
VENUE
Manchester United Kingdom
ORGANISER
Society for Cardiothoracic Surgery in Great Britain & Ireland (SCTS)
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http://www.scts.org/