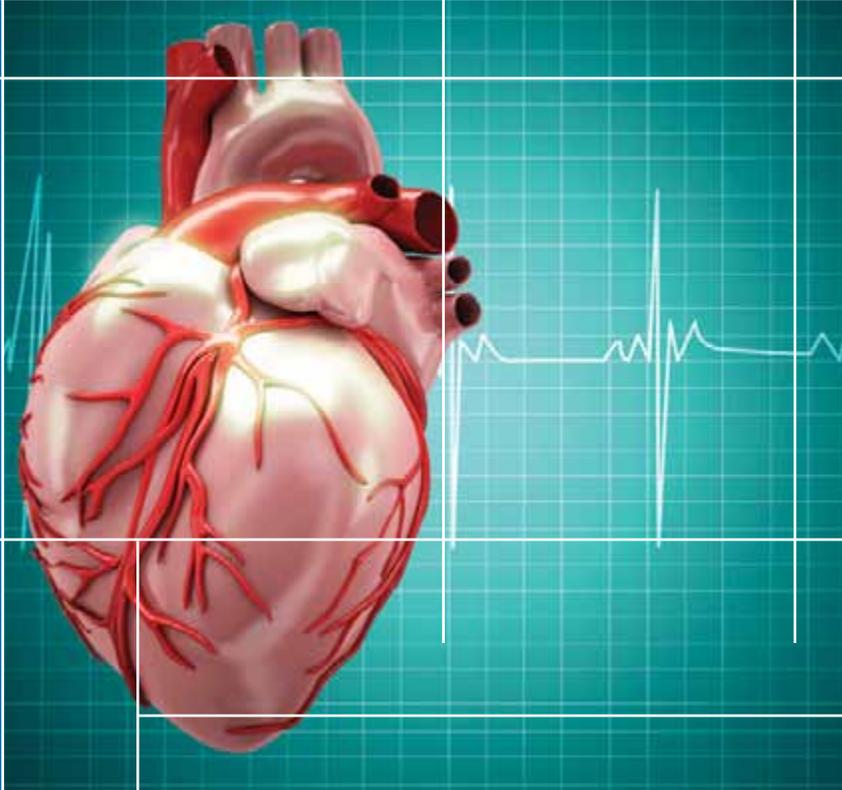




CardioVISION™

OFFICIAL JOURNAL OF THE APACVS

Spring 2014



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Edward Ranzenbach, PA-C, MPAS, FAPACVS

Editor Emeritus
Doug Condit, PA-C, FAPACVS

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MISSION & CONTENT

The mission of *CardioVISION™* is to provide a means of communicating pertinent information among practitioners of the specialty and among related professionals in the medical field and industry. *CardioVISION™* is a peer-reviewed quarterly journal that includes articles on practice issues, credentialing issues, educational opportunities and more. *CardioVISION™* also includes classified job ads and industry advertisements.

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FROM THE PRESIDENT'S DESK

David E. Lizotte, Jr., PA-C, MPAS, FAPACVS



David E. Lizotte, Jr., PA-C, MPAS, FAPACVS

In looking for inspiration to summarize the change the APACVS has been going through the last few years, in an effort to provide the highest level of service to its members and foster innovation within the association and the specialty, I stumbled across the following quote by Warren Buffet:

"In a chronically leaking boat, energy devoted to changing vessels is more productive than energy devoted to patching leaks."

After a careful review of our relationship with Technical Enterprises, Inc. at the end of last year, the APACVS Board unanimously voted to end that relationship and seek new management that was better aligned with our strategic goals and had the expertise we felt necessary to help us achieve these goals. Ever mindful of our obligations to the membership and the specialty, we sought a management company that possessed an advanced understanding of both. After a comprehensive search, we found a company that has managed cardiothoracic surgical physician associations for 6 decades including the American Association for Thoracic Surgery, (AATS), Western Thoracic and the International Society for Minimally Invasive Cardiothoracic Surgery (ISMICS): the company is PRRI, Inc. They became our new management company beginning February 1, 2014. Starting in the next few

months you will see a transformation of the APACVS website, live CME offerings and web based CME that are befitting a 30 year old specialty association. As always, your feedback is appreciated along the way and we will solicit your feedback on a number of topics in formal surveys beginning later this summer.

In the spirit of this re-inventive course we have charted, we have reviewed the Winter Meeting and have planned significant changes to its timing, geography and content. As many of you may know, the APACVS Winter meeting has preceded the STS meeting for the last 18 years. For years this was felt beneficial for four primary reasons: 1. Many attendees at our meeting stayed over and went to the STS, saving them on travel and other expenses; 2. It is easier for us to get speakers for our meeting, as surgeons planning to attend the STS could simply come earlier and speak at our meeting before going to the STS; 3. It is more convenient for our corporate sponsors because they too could simply come earlier and attend both meetings, saving them on manpower and expenses by combining the two meetings; 4. It was the basis of our relationship with the STS to have joint meetings between our Board and the STS Board during our concurrent CME meetings.

Upon further review, very few attendees come to both meetings. Be it shrinking CME reimbursement or difficulty getting away from our practices for 8 days, by show of hands fewer than 10 people were staying over from our last Winter Meeting in Orlando and attending the STS. Similar results were obtained at the last two Winter Meetings. We began to get feedback from surgeons we were pursuing as speakers that it was difficult to be away from their practices for a protracted time and speak at our meeting and then attend the STS. We met with our key corporate sponsors and queried them

about staying in the same location/time as the STS meeting and they too overwhelmingly supported separation as it is challenging to staff concurrent exhibit halls and have staff on site for more than a week. Lastly, I had an opportunity to meet with senior STS staff and review our annual joint Board meeting and we mutually agreed this has become an ineffective way to communicate between us as we are both busy with our CME meetings and it is difficult to find time to meet. We have discussed and planned alternate ways to communicate with the STS including video conferencing that will be, in my opinion, more productive. The relationship with the STS remains strong and is independent of this joint Board meeting as the STS Board was themselves largely unable to attend our meeting the last several years due to other commitments. Furthermore, the STS releases the location of their meetings only after they have secured all of the desirable properties in that city, leaving us to pick and scrape from left-over properties that sometimes limits the size and even duration of our CME meetings. It does not take a consultant to see that the alignment of our Winter CME meeting with the STS meeting does not best meet the goals of the APACVS and our partners and a change therefore is in order. Having the freedom to select the timing of the meeting and its geographical location permits us to better serve our members by allowing us to select properties that are scalable so that we can expand our CME offerings, that are located in more family friendly locations or generally more desirable locations than can accommodate a meeting the size of the STS, allowing us to plan out several years so we can make the best possible contracts with hotels and plan new offerings for attendees, so that we can provide this enhanced experience to our members.

With all of this in mind, after careful consideration by your CME

committee and Board of Directors, the Winter Meeting will no longer be aligned with the STS meeting effective in 2015. The 2015 Winter Meeting will take place from March 1-4, 2015 at the Bellagio Resort and Casino in Las Vegas, Nevada. We will have an expanded program including hands-on and simulation training. Details of future meeting dates and locations will be published prior to this meeting so that you can plan ahead. We will monitor

the feedback of attendees and make adjustments as necessary. Again, as always, your feedback is appreciated.

We are very focused as a Board and determined to continue to improve the value to our members through advocacy, CME offerings, procedure logging, salary and benefit surveys and key strategic relationships. The president of the AAPA was an invited speaker at our recent Orlando meeting and we had the opportunity during his stay to discuss ways

the APACVS and AAPA can work together, including developing joint membership at a reduced cost. The APACVS Board will work tirelessly on all of these projects and keep you abreast of these as they evolve.

Thank you for your membership and support of the specialty.

Best Regards,

David Lizotte PA-C, MPAS,
FAPACVS

DOUG CONDIT – EDITOR EMERITUS

Edward Ranzenbach, PA-C, MPAS, FAPACVS

With the fall issue of *CardioVISION™* there was a changing of the guard. Since 1973, Doug Condit has served in some capacity from contributor to Editor to almost every publication associated with PAs. Doug now holds the title *Editor Emeritus* of *CardioVISION™*, and I have big shoes to fill. I thought it important that we look back on Doug's immeasurable contributions to this organization and to surgical PAs in whole.

Doug's career in journalism started when he was in the Boy Scouts. Doug was, of course, an Eagle Scout. While attending an international Boy Scout Jamboree, he was invited to write an article for event's weekly newspaper. At the age of 14 he published his first article, and got paid for it! During high school, Doug was a member of the journalism club. The newspaper in Glenwood Springs Colorado published weekly articles written by students at the high school. Doug was a frequent contributor and eventually parlayed this into a weekly column called "Out Of the Cave with Tidnoc".

After serving honorably as a *Hospitalman* during the Vietnam War, Doug attended physician assistant school at the University of Alabama, graduating in 1972. This was followed by a surgical postgraduate residency at Montefiore Medical Center at the Albert Einstein College of Medicine, where Doug has

been working ever since as the senior physician assistant for cardiothoracic surgery.

In 1973, he published his first article for *The P.A. Journal*, which was the official journal of the American Academy of Physician Assistants. This publication later went on to become JAAPA.

Beginning in 1975 Doug became Contributing Editor to *Physician Assistant*. This was followed by a position as Contributing Editor from 1977 and 1981 for *Health Practitioner*. He became a Consulting Editor to *Physician Assistant/Health Practitioner* in 1981 and served as Clinical Articles Editor from 1982 to 1991 for both *Infections in Surgery* and *Infections in Medicine*. In 1984 Doug became Chairman of the Editorial Board of a publication called *PA 84*, a publication he helped to found. He also sat on the editorial board of *Physician Assistant* from 1991 to 2001 and the editorial advisory board of *Physicians* from 1991 to 1999. Through his association as a Contributing Editor to *Physician Assistant*, Doug met a publisher named Susan Lusty. Susan had done research into the idea of publishing a journal specifically targeted to surgical physician assistants. When the publisher of *Physician Assistant* declined to participate in this venture, Susan struck out on her own, literally creating and publishing *Surgical Physician Assistant* from her

basement. She approached Doug and asked if he would be interested in helping to start this new publication, and become its Editor-In-Chief. Doug was the first and only Editor-In-Chief of *Surgical Physician Assistant* from its creation in 1995 until its demise in 2004 when Susan passed away unexpectedly from glioblastoma.

On September 26, 1988, Doug Condit became the first PA in history to address the Society of Thoracic Surgeons at their annual meeting. Montefiore was at the forefront of the AIDS epidemic and Doug's presentation entitled "Human Immunodeficiency Virus and the Cardiac Surgeon: A Survey of Attitudes" was a groundbreaker for us as PAs. His original research article was published in the *Annals of Thoracic Surgery*, a very rare accomplishment for PA written research.

Rick Milam, one the APACVS's founding members and first Presidents, and its first Executive Director, began publishing a quarterly newsletter early in the history of the organization. In 1990, he asked Doug to take over as Editor-In-Chief of what was to become *CardioVISION™*. As Editor-In-Chief, Doug was responsible for editing content for each and every issue. He also wrote monthly columns and contributed many articles of his own. He encouraged and nurtured numerous new authors

for all of his publications, including myself.

Over the years, Doug has published over 230 articles and has given more than 120 presentations, both domestically and internationally. In 1990 Doug was named the fifth recipient of the prestigious Kirkland Award for PAs in surgery, a recognition for his contributions to the development of PAs as a surgical specialty.

While interviewing Doug for this article, I asked if he had any words of encouragement for perspective PA authors. His response...

"All the knowledge 'we' have learned in our medical careers has originated from an article written by a PA, RN, MD who came before us. Information from these articles has been incorporated into books and our teachers have used this information to educate us. Ergo,

I believe we have the obligation to educate our peers and those who will follow us. As Henry David Thoreau said: "The purpose of life is to make a difference." I think that authoring just one article can make a difference to someone."

Can you make a difference? Can you author an article? *CardioVISION*TM stands ready as a venue to pursue your literary talent.

ROBOT SURGERY: A TEAM APPROACH TO MITIGATE RISK AND IMPROVE OUTCOMES

Scott Yoder, MHS, PA-C



Surgical intervention is an essential component to modern medicine. It may alter the patient's life forever. Each intervention performed on a patient comes with inherent risks and benefits associated with the procedure. Each patient brings a unique level of health with different co-morbidities which can alter the level of risk. Certainly the goal of any surgical intervention is improve the quality and/or length of life by capitalizing on the benefits, and avoiding the complications.

Surgical outcomes have been tracked since the advent of surgery. Comparisons have been made between surgical techniques and their associated outcomes. More recently analytic tools and methods have been developed to aide in risk stratification, and risk-adjusted outcomes. These tools allow surgeons and hospitals to compare their outcomes with their competitors. Insurance

companies track the outcomes and are interjecting on behalf of their patients, based upon cost and outcomes. Patients are increasingly reviewing data prior to enrolling in surgery.

In a cost-conscious, transparent world, high quality surgical outcomes are tantamount. New technologies are constantly being introduced, attempting to improve outcomes. The process is dynamic as new techniques and products evolve. Over 50 years ago, Donabedian detailed a relationship between structure, process, and outcomes. Varying structure and process directly and indirectly affects outcome (Donabedian, 1966). In 2001, The Joint Commission examined these relationships, and has created an increase awareness of the effects of structure and process on outcomes (<http://www.dzcowan.com/Tech%20Attachments/Quality/6-SPO/QualityTriad.pdf>).

Robot-assisted surgery has altered the structure and processes within the operative suite. Due to this relatively new but highly complex technological advancement, new surgical methods have been developed. Advanced technology brings new benefits and risks. The new technology, if not understood and used appropriately could push the risk/benefit continuum into the wrong direction. Now more than ever, the outcomes are reliant upon

expert utilization of robot-assisted technology. One expert alone cannot mitigate all risks associated with this technology. A team of experts is required to function at the level necessary to yield the most positive result. Dr. Francis P. Sutter, Chief of Cardiac Surgery at Lankenau Medical Center states, "A consistent robotic team is required. These team members should be dedicated and engaged while performing robotic procedures that offer an alternative, do the least amount of trauma, using beating heart and robotic techniques to the patient."

Robot assisted surgery requires new skill sets for every team member. Surgeons are sometimes controlling three or four instruments simultaneously. The first assistant and scrub nurse or tech must learn new skills, and coordinate their activities with those of the surgeon. The first assistant and scrub nurse or tech have significant contributions to procedure. Outcomes can be attributed not only to the skill and ability of the surgeon, but the skills and abilities of the assistant and scrub person, and the team's ability to coordinate activities together.

According to Dr. Sloane Guy, Chief cardiovascular surgeon at Temple University Hospital, "A dedicated team of professionals is a key component to the success of a robotic surgery program." When developing his team, he sought

highly motivated individuals with the interest and ability to invest time in learning, developing and practicing new skills. This required travel, observation, and discussion with some of the leaders and pioneers in this field. Similar to a sports team, skill development at the personal level is necessary. Skill development takes effort, time, and repetition. The newly acquired skills will need to be coordinated with other team members. "The highest level of ability and coordination cannot be achieved if the team is in flux or new team-members are constantly being introduced," says Dr. Guy. Consistent personnel is a key component for success.

Dr. Bradley Taylor, Associate Professor of cardiac surgery at University of Maryland states, "The first assistant is a key component to a successful operation to act as a partner to perform a key role in the procedure." Dr. Taylor adds that coaching, training, and providing an atmosphere of patience can have a positive impact on the development of the first assistant's skill level and confidence.

Intuitive Surgical emphasizes the need for proficient teams which can only happen with proper education

and training. The company provides product training, clinical training, and continuing clinical education to surgeons, residents, first assistants, and coordinators. Training should not be limited to individual competencies. Team competency, which measures the team's ability to jointly perform a task, is paramount to developing a successful robot surgery team.

There have been recent publications over safety concerns regarding robot-assisted surgeries. In a study involving 150 patients receiving thoracic robot-assisted surgery, Cerfolio, Bryant, and Minnich (2011) have found pulmonary resections, and mediastinal mass resections to be safe and oncologically sound. They do emphasize the need for training for the entire surgical team. Nakamura (2014) performed a literature review examining the safety and efficacy of robot-assisted lobectomies. He found the procedure comparable to thoracoscopic surgery but cited concerns over cost and length of surgery.

In an era, where outcomes are measured, quantified, and compared; robotic surgery has to provide patients with results better than traditional surgical approaches. This can only

be accomplished through dedication, extensive training, and teamwork. The power of a hardworking, dedicated team should not be underestimated. Currently there are validated training programs for surgeons but no such training programs exist for entire teams. Standardized team-based training programs should be developed, studied, and validated.

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WINTER EDUCATIONAL MEETING ROUND UP

This year's winter educational meeting offered numerous topics on cardiac surgery, thoracic surgery, and critical care. The meeting was approved for maximum of 27 hours of category one CME by the American Academy of Physician Assistants (AAPA). Among the most popular sessions was an Endoscopic Vein Harvesting (EVH) panel moderated by Anthony Furnary, MD with Robert Poston, MD Peter K Smith, MD, Soroosh Kiani, MD and Donald Likosky, MD. As most of our membership knows, Dr. Furnary has been a champion of PAs and EVH. A spirited discussion was had regarding open versus endoscopic technique and vein preparation and handling.

Also very popular in this year's lectures was a three-hour symposium on the Affordable Care Act (ACA). The dais included Kenneth Serio, MD, co-director of the Intensive Care Unit at Scripps Green Hospital in La Jolla California and noted lecturer on the ACA, Norman Brooks, MBA, founder and principal of Lee – Brooks, a national consulting firm specializing in regulatory compliance and reimbursement strategies for CT surgery practices, Larry Herman, MPA, PA-C, DFAAPA, President of the American Academy of Physician Assistants. The discussion was moderated by Steven Gottesfeld, PA-C, Vice President of the APACVS.

EDITORS CORNER

Edward Ranzenbach, PA-C, FAPACVS



Welcome to the new CardioVISION. I know the transition to a new management company has left us a little behind but we have PRRI in place now and things should move ahead on schedule.

I wanted to take this issue's column and talk a little bit about the grand plan for providing a publication venue for our specialty.

It's no secret that I believe in the notion of "publish or perish." I think one of the things that separates us from our NP colleagues and makes them much more visible is the fact that they publish. While not everything that they publish can be considered research, or even contributions to evidence-based medicine, every article that they produce promotes their profession and increases their visibility with physicians and the public as a whole. Nursing is considered a "noble"

profession, probably so much more than that of the physician assistant or associate (PA). We all know that what we do matters; that patients benefit from our work, but we're not near as visible or endeared to the public as our nursing colleagues. Nursing's been around since at least the beginnings of the Christian church. St. Paul was said to have sent a Deaconess Phoebe to Rome as the first visiting nurse. In the beginning nursing care was provided mostly by nuns. Modern nursing, the work of Florence Nightingale, is 150 years old. Nurse Practitioners (NPs) benefit directly from this rich history. PAs have only been around for about 50 years. It was estimated in 2008 there were 3.1 million registered nurses. According to the AAPA, there are a little less than 100,000 of us. To say that our work, to promote our profession, is cut out for us is an understatement.

My goal as your editor-in-chief is not only to encourage you to publish, but to provide you a venue for your publication. Publishing in a peer-reviewed physician journal of the stature of the *Annals of Thoracic Surgery* is a daunting task. Forgetting that many of us are actually members of the Society of Thoracic Surgeons, articles dealing with PA issues are not viewed as interesting to the readers of the *annals*. Even publishing a surgical article in the *Journal of the AAPA (JAPPA)* is a minefield. As many of you know, I speak from

experience.

Our publishing heyday of course was in the years of *Surgical Physician Assistant*, the journal conceived of and published by Susan Lusty. Unfortunately her untimely death led to a dissolution of that publication venue.

It is the goal of the APACVS to offer you a peer-reviewed journal as a venue for publication of articles relevant to your specialty. We're in the early discussion phase of designing that journal and it is difficult at this point to say exactly what that might look like. In the interim however, you do have a home for your publications. *CardioVISION* stands ready to accept your abstracts, your case reports, your literature reviews, and your original research.

I encourage you, start small. Tell us of interesting cases that you have had. Tell us of experiences with equipment or nuances in technique that you'd like to share with your colleagues. Not only will your article be published quickly, in a journal that reaches your specialty peers, we will assist you in refining your ability to write and produce articles worthy of publication in peer-reviewed journals. Moreover, you could find that your article is submissible for the *Susan Lusty Excellence in Publication Award*.

Forget "publish or perish", publish and be recognized!

POLAR VORTEX NOT COLD ENOUGH TO FREEZE OUT THORACOSCOPIC FIRST ASSIST COURSE!

S Scott Balderson, PA-C, FAPACVS

For the second year the APACVS offered a unique training opportunity for Physician Assistants to develop or improve their thoracoscopic assisting skills. The Thoracoscopic First Assist Course (TFA) was developed in an effort to address the need for qualified assistance in the operating room to accommodate the increasing volumes of thoracoscopic resections. A fundamental component of the TFA course is a porcine heart and lung tissue block that is suffused in order to simulate thoracoscopic lobectomy. The simulator was published by TFA course faculty Scott Balderson PA-C, FAPACVS, Thomas D'Amico, MD and Shari Meyerson MD in the Annals of Thoracic Surgery in 2010 (Ann Thorac Surg 2010;89:594 -7) The porcine tissue is procured in cooperation with the food industry, which, in turn, uses the remainder of the tissue for the food supply. The unprecedented weather earlier in the week that paralyzed a large part of the nation interrupted the planned tissue harvest. A slight alteration of the course schedule and expertise of the course faculty in tissue preparation facilitated the successful administration of the course for the second year and the benefit of all those in attendance.



Dr. Jerry Martin, Dr. Mark Berry, Dr. Shari Meyerson, Scott Balderson PA-C, FAPACVS and Kim Howard PA-C prepare the tissue blocks for the VATS lobectomy simulator at the Nicholson Center in Orlando, Florida.



The course was focused on giving participants the opportunity to interact with experienced faculty through operative skills stations designed to highlight the most significant contributions for the thoracoscopic first assistant. The course was held at the Nicholson Center, a state of the art simulation facility in Orlando, Florida. Participants were bussed over from the APACVS meeting about 10 minutes away.

The course began with a brief series of lectures describing the key elements of thoracoscopic team dynamics, thoracoscopic specific instrumentation, equipment and devices, as well as communication strategies and the steps for a lobectomy. The participants then divided into groups of three and rotated through four- 45 minute thoracoscopic skills stations.

The thoracoscopic skills stations included camera piloting with a 10mm 30 degree thoracoscope to navigate through maneuvers that highlighted the need to troubleshoot equipment, demonstrate proper focal length, 30 degree scope angles, and camera head rotation in order to optimize view. Another station simulated pulmonary nodules and participants were tasked with tumor localization, proper retraction, planning and performing wedge resection while preserving as much lung

parenchyma as possible while obtaining appropriate margins.

The highlight of the stations was the opportunity to assist an expert thoracic surgeon with a VATS lobectomy. Each participant rotated through two VATS lobectomy stations which were differentiated by instrument and device vendor. For example, one station contained Scanlan thoracoscopic instruments and Covidien staplers and another had Wexler thoracoscopic instruments and Ethicon staplers. This provided participants to perform consistent procedures with different equipment and instrumentation from what they may use currently. Additionally, the participants were instructed in troubleshooting equipment and instrumentation while honing their intra-operative skills.

The industry partners who helped to make this course possible included, Scanlan International, Wexler, Covidien, Ethicon Endosurgery, W.L. Gore, and Karl Storz. Thanks to all faculty and participants for their participation.



2015 APACVS Annual CME Conference Thoracic co-chair Evie Rodriguez PA-C and new APACVS Board of Directors member Shannon Ranella PA-C, FAPACVS work with Dr. Shari Meyerson at a VATS lobectomy station.



Kim Howard PA-C guides participants through a wedge resection



Dr. D'Amico works with participants at a VATS lobectomy station



Course participants celebrate the completion of the TFA course with course director Scott Balderson PA-C, FAPACVS



SAVE the DATE

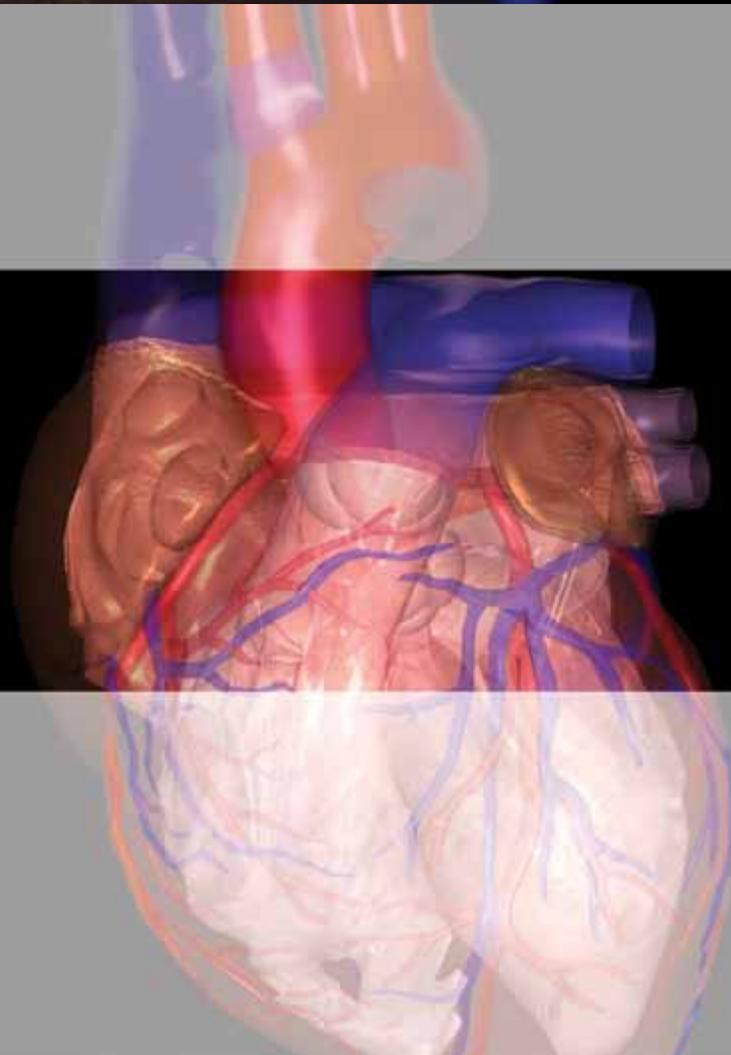
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34th Annual
APACVS
WINTER MEETING



Association of Physician
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CSU – ALS COURSE WOWS PARTICIPANTS

Edward Ranzenbach, PA-C, FAPACVS

The Cardiac Surgical Unit – Advanced Life Support Course (CSU – ALS) is a full-day course in resuscitation of postoperative cardiac surgery patients. The course was designed by Joel Dunning, MD and Adrian Levine, MD as an alternative to ACLS. It deemphasizes the use of massive inotropic intervention and external cardiac compression during cardiac arrest, instead concentrating on early direct access to the heart via emergency re-sternotomy. The course is taught in lecture/lab format utilizing specially designed manikins with a wired chest plate and Sim Man software. Participants are taken through various scenarios in which they must manage the hemodynamics of the patient and when the patient does crash, they sterilely gown and glove and work as a team to get the chest open quickly, perform internal cardiac massage, and internal defibrillation. The lecture portion of the format covers topics such as hemodynamic management and has an in-depth review of temporary pacemaker operation.

The course offered at this winter educational meeting was put on by doctors Dunning and Levine, Jill Ley, RN, CNS, Tara Bartley, RN, and Ed Ranzenbach, PA-C, FAPACVS. Ms. Ley is a clinical nurse specialist for cardiac surgery at Cal Pacific Medical Center in San Francisco and was primarily responsible for introducing

this course to the United States. Doctors Dunning and Levine have worked tirelessly to make this the de facto European standard for resuscitation of cardiac surgery patients within the first 10 postoperative days. This course has been endorsed by the European Association for Cardio-Thoracic Surgery (EACTS) and approved as an alternative to ACLS by the European Resuscitation Council (ERC). Doctors Dunning and Levine are currently working with the Society of Thoracic Surgeons (STS) for an endorsement here in the United States. The APACVS has aligned itself with this program and has thus far had approximately 100 attendees take part. Doctors Dunning and Levine, and Ms. Ley consider the APACVS and its members to be the gateway to bringing this paradigm to the United States. The APACVS plans to make this a regular offering at our meetings and to offer on-site training for sites wishing to avail themselves of this program.



Dr. Joel Dunning prepares students for scenario-based training.



Dr. Andrew Levine and Ed Ranzenbach PA-C, FAPACVS prepared to take students through Sim Man training



Student participation in Sim Man exercises.



Jill Ley, RN, CNS lecturing students on temporary pacemaker use



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- In-line instrumentation and 0° scopes, which allow ergonomic surgical control to improve harvesting technique

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