



# THORACIC SURGERY NEWS

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Dr. Douglas J. Mathisen, Rep. Charles Boustany (R-La.), and Dr. Blair Marshall, at briefing on thoracic surgeon shortage.

## A Third of 2007 Thoracic Residency Slots Unfilled

BY ALICIA AULT  
*Elsevier Global Medical News*

WASHINGTON — For the third consecutive year, a large number of residency positions in cardiothoracic surgery have gone unfilled, threatening access to and quality of care at a time when the baby boomers will most need heart and lung procedures, according to surgeons who spoke at a Capitol Hill briefing sponsored by the Society of Thoracic Surgeons.

The society noted that 78 million baby boomers will turn 60 this year—including President Bush.

For the 2007 appointment year, 126 positions were available, but only 91 graduates applied. The decline in applicants began 3

years ago. In 1995, some 200 applicants applied for the 140 or so available positions. In the last few years, not only has the number of applicants dropped, but the number of positions available has shrunk also, as programs have closed because of lack of interest, said J. Michael Hogan, director of government relations for the Society of Thoracic Surgeons, in an interview.

Surgeons hope to convince members of Congress to help shore up the specialty. Rep. Charles Boustany (R-La.), a cardiothoracic surgeon, was among those who pledged his assistance. The congressman has offered several amendments to the College Access Opportunity Act of

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## Adjuvant Therapy For Early-Stage NSCLC Falls Short

No 5-yr survival benefit seen in trial.

BY JANE SALODOF  
MACNEIL  
*Elsevier Global Medical News*

ATLANTA — Updated results from a clinical trial that helped establish adjuvant chemotherapy with paclitaxel and carboplatin as the standard of care for stage IB non-small cell lung cancer no longer show a significant improvement in overall survival.

At a median follow-up of 57 months, 5-year overall survival was 59% for the adjuvant chemotherapy patients and 57% for those randomized to observation in the Cancer and Leukemia Group B (CALGB) trial known as CALGB 9633. The 2% difference was not statistically significant.

Patients who were given adjuvant chemotherapy did benefit from significantly improved 2- and 3-year survival in the new analysis. They also had a significantly longer failure-free survival duration, with a hazard ratio of 0.74.

Dr. Gary M. Strauss reported

the new data on behalf of CALGB at the annual meeting of the American Society of Clinical Oncology (ASCO). Despite some positive effects, CALGB 9633 “can be interpreted as a negative study and, perhaps I should say, should be interpreted as a negative study,” he said.

In a shift from his presentation 2 years ago at the same meeting, Dr. Strauss of Brown University, Providence, R.I., said that “the results of CALGB 9633 do not mandate adjuvant chemotherapy as the standard of care in all stage IB patients.”

He added that the investigators believe the results do, however, support continued consideration of adjuvant paclitaxel and carboplatin for stage IB patients, in particular, for those with tumors 4 cm or more in diameter.

CALGB 9633 had been the only trial among three influential adjuvant therapy studies to report a survival advantage in

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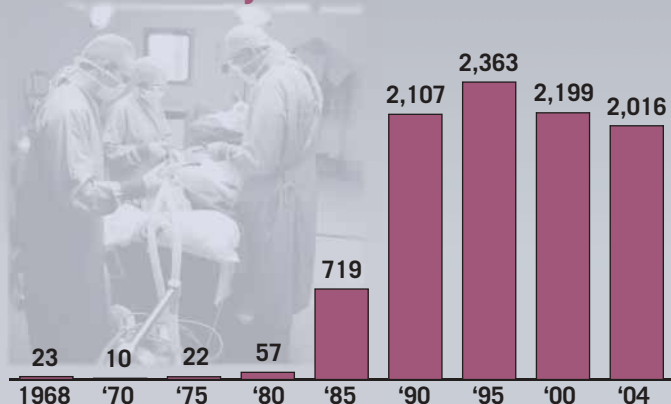
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#### Number of Heart Transplants Relatively Stable Since 1990



Note: Based on data from the United Network for Organ Sharing.  
Source: Circulation 2006;113:e85-e151

## New Valvular Disease Guidelines Issued

BY BRUCE K. DIXON  
*Elsevier Global Medical News*

CHICAGO — The Guidelines for the Management of Patients with Valvular Heart Disease recommend the widespread use of echocardiography and Doppler imaging to develop a more objective and quantitative approach to valve assessment and surgery.

This is the first revision of the practice guidelines of the ACC and the American Heart Association, originally released in 1998. It contains a new section on bicuspid valve with aortic root dilatation and updates indications for mitral valve repair and aortic valve replacement in patients with stenosis or regurgitation. New data helped the committee expand on the management of patients with low-gradient, low-output aortic

stenosis, and the use of vasodilators in aortic disease. The role of intraoperative echocardiography has been added, as has a new focus on surgical considerations in the selection of valve prostheses, according to the chairman of the guideline writing committee, Dr. Robert O. Bonow, chief, the division of cardiology, Northwestern University in Chicago.

The revised guidelines were

released at a meeting sponsored by the American College of Cardiology. Revisions include:

► **Aortic stenosis.** While the basic guidelines for aortic stenosis (AS) remain largely unchanged, the revision clarifies the definition of “severe” asymptomatic aortic stenosis and states that adults with this diagnosis may be considered for valve replacement.

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# Residents Group Leads the Way to Advanced Training

BY BRUCE K. DIXON  
Elsevier Global Medical News

In order to thrive as a specialty, cardiothoracic surgery must embrace new technologies, including minimally invasive approaches to existing operations, robotic surgery, and image-guided and nonincision-based therapy, according to Dr. John R. Mehall, the president of the Thoracic Surgery Residents Association. This imperative is underscored by a continuing dearth of quality positions in cardiothoracic surgery for residents without these skills, Dr. Mehall added.

"It's important to the survival of our specialty to continue to advance and evolve our therapy through new technology and less-invasive approaches, and residents who come equipped with extensive experience in new techniques are poised to take this evolution to the next step," Dr. Mehall said in an interview.

In an effort to introduce residents to the latest therapies, the Thoracic Surgery Residents Association (TSRA), in collaboration with the Thoracic Surgery Directors Association (TSDA), organized the first annual Cardiothoracic Technology Symposium. The inaugural event was recently held at the University of Cincinnati's new Center for Surgical Innovation.

"The goal is to expose residents to what's available and what's possible with the hope of motivating them to develop these leading-edge skills, to broaden our field, and to continue to offer the best surgical therapy to patients with cardiothoracic diseases," said Dr. Mehall, who also is chief resident in cardiothoracic (CT) surgery.

The 3-day symposium drew 60 residents from the United States, Mexico, and Canada who benefited from the expertise of 23 speakers from 22 institutions and who

had access to 25 industry sponsors. Residents spent about half their time in hands-on animal and cadaver labs and attended a minimally invasive mitral valve repair wet lab conducted by Dr. J. Michael Smith of Good Samaritan Hospital, a University of Cincinnati affiliate.

"It's very important for CT residents, many of whom are concerned about their ability—once they get through their training—to be proficient in new technologies," said Dr. Carolyn Reed, chair of the American Board of Thoracic Surgery, who held an educational session at the symposium. She added that such conferences are needed to provide a concentration of experts that's not typically enjoyed by residents in need of advanced training.



**The goal is to expose residents to what's available to motivate them to develop leading-edge skills.**

DR. MEHALL

Residents need exposure to a very compact, standardized, and high-quality venue such as this symposium, said Dr. Jeffrey Gold, president of the TSDA. "As an employer of physicians, I'm most interested in being sure that the residents we hire as attending physicians and community-based practitioners are as knowledgeable about innovative techniques as possible," said Dr. Gold, who is dean of the Medical College of Ohio, Toledo. Endografting is an example of a cutting-edge technology that requires an entirely new set of skills and experience, Dr. Gold said in an interview. "This kind of course creates an awareness of how rapidly the endografting field is moving, creates a network of contacts for the residents in programs that are doing a large amount of these new procedures, and in a sense whets their appetites for enhanced study."

The renewed emphasis on learning comes as the Society of Thoracic Surgeons (STS) confronts a shortage of heart and lung surgeons. At a special Congressional briefing on Capitol Hill on June 20, STS specialists warned of a "deadly national trend that has resulted in nearly one-



The symposium featured six cadaver stations, four animal stations, and a da Vinci Robot so residents could try new techniques and products with faculty instruction.

third of residency programs for cardiothoracic surgeons going unfilled this year," (see story on page 1).

This decline in applications is a direct result of a drop-off in job opportunities that began several years ago, according to Dr. Mehall. "The decline relates to decreases in case volume and reimbursement, and also [to] the fact that many practitioners have postponed retirement," he said, citing a survey by the Association of American Medical Colleges showing that about one-fourth of CT surgeons are age 65 or older.

Data from the STS suggest that half of the current CT surgeons will retire within the next decade, drastically worsening the practitioner shortage and painting a bleak scenario for the approaching rush of baby-boom patients. Dr. Mehall said that the drop in case volume was caused primarily by four factors:

- ▶ Increases in nonincision-based therapy for the traditional diseases that CT surgeons treat—primarily coronary stenting—but also endovascular, endoscopic, and bronchoscopic treatments.
- ▶ Practitioners who first see patients are able to provide therapy for some of those patients using incisionless modalities, creating a "self-referral bias."
- ▶ Large amounts of industry money driving the development and marketing of new therapies.
- ▶ Traditional open operations—which have been the bread and butter of CT surgery—are becoming increasingly unpalatable to patients.

A major hurdle to training in advanced technologies, said Dr. Reed, is the lack of leadership needed to train new doctors in, for example, aortic stent grafting. While the Society of Thoracic Surgeons has a task force to deal with the training issue, getting around this training bottleneck will require creativity and flexibility, one idea being to send residents to other centers for a month or two of special training. "There's a rule in place that you have to do your final year of training in one place and that needs to be made less rigid," she said, adding that these TRSA symposia should inspire residents to go back to their institutions and either learn more or look for

additional training at centers of excellence.

"Certainly CT surgery is evolving, and the way we train people to practice medicine needs to evolve with it," said Dr. Walter Merrill, chief of the section of cardiothoracic surgery at the University of Cincinnati.

"That's a complicated process because we could argue for days about what's going to happen next with regard to training, but I think there's a lot of discussion going on that says patients want more minimally invasive procedures—they're interested in prompt recovery and quality of life. If we can make the procedures better and safer, everybody wins," Dr. Merrill said in an interview.

With CT technology advancing on greased rails, Dr. Mehall counts himself among those concerned that treatment advances may overtake proof of efficacy. "New technologies must be developed and implemented in a stepwise fashion based on accurate results and reporting of data, and this can be compromised when industry dollars drive market demand; the desire for those technologies has to be tempered with patient safety and appropriate research and development."

Yet those who fail to adapt to the minimally invasive paradigm may find themselves on the outside looking in, said Dr. Mehall.

"Unless CT practitioners equip themselves to compete in a different world, they're still going to face the challenges that people looking for jobs today are, in that they're not going to have the right skills to treat patients in the future."

"We have to continue to push those advances through the education of residents and by capturing their imaginations—and motivate them to take the ball and run with it," he said, concluding that "cardiovascular surgeons must diversify beyond the scalpel in order to survive and flourish."

The next Cardiothoracic Technology Symposium will be April 20-22, 2007 at the University of Cincinnati Center for Surgical Innovation. Lecture content and more photos from the 2006 CT Symposium, as well as additional information, is available at [www.ctsymposium.org](http://www.ctsymposium.org).

## CMS Urges Physicians to Apply Now for New ID Number

Physicians need to apply now for a national provider identifier number in order to start using it in May 2007, according to the Centers for Medicare and Medicaid Services.

The national provider identifier (NPI) is a 10-digit number that does not expire or change; it is used to speed claims processing. The Health Insurance Portability and Accountability Act mandates that the NPI be used for all standard health care transactions involving both public and private payers starting on May 23, 2007. Small health plans, defined as having annual receipts of \$5 million or less, are given an additional year to comply.

A physician needs only one NPI, regardless of the number of specialties, licenses, or practice locations he or she

may have. Once assigned to the physician, that number will stay with him or her through job changes and relocations.

Physicians will need to have several numbers on hand before applying, such as their health care license number or certificate number and any "legacy identifiers," such as a unique physician identification number (UPIN). If physicians have numbers issued by Medicaid and other health plans, they also need to be included in the application.

—Nancy Nickell

Physicians can apply online for an NPI at <https://NPPES.cms.hhs.gov>; or call 1-800-465-3203 for a paper application.

More information can be found at: [http://www.cms.hhs.gov/apps/npi/01\\_overview.asp](http://www.cms.hhs.gov/apps/npi/01_overview.asp).