

UT SOUTHWESTERN

Heart Beat



Mark Drazner, M.D. Associate Professor of Internal Medicine, Medical Director of Heart Failure and Cardiac Transplantation and holder of the James M. Wooten Chair in Cardiology. Dr. Drazner specializes in the care of patients with cardiomyopathy and advanced heart failure, including those who undergo implantation of a ventricular assist device or a cardiac transplant.

Medical School: Washington University Medical School, St. Louis (1989)

Residency: UT Southwestern, Internal Medicine (1989 - 1992) UT Southwestern, Chief Resident, Internal Medicine (1992 - 1993)

Fellowship: Duke University, Cardiology (1993 - 1996); Brigham and Women's Hospital, Heart Failure/Cardiac Transplantation (1996 - 1997).

LVADs: A New Era in Mechanical Support for the Failing Heart

Mark Drazner, M.D.

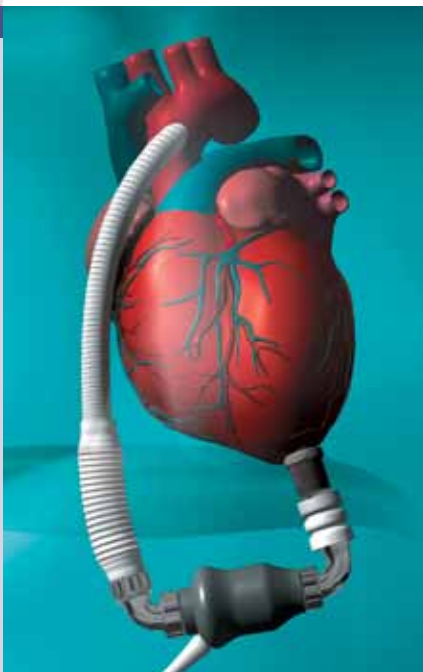
The Situation Today

Despite advances in pharmacological and pacemaker therapies, patients with chronic heart failure can progressively decline and develop such refractory symptoms as "advanced heart failure," or "end-stage heart failure." These patients may have a very poor quality of life, with minimal ability to exert themselves and are likely to have exacerbations of symptoms requiring emergency department visits or hospitalization.

Cardiac transplantation is the gold-standard therapy for such patients, but its use is constrained by donor organ availability. Chronic drug infusions are sometimes helpful symptomatically but do not prolong life; stem-cell therapy remains investigational.

Recent Advances

Fortunately, recent advances in the development of left ventricular assist devices (LVADs) can fill the void between cardiac transplantation and traditional medical therapy. LVADs are implantable, mechanical pumps that provide circulatory support to patients with advanced systolic heart failure (i.e., a reduced left ventricular ejection fraction). A common configuration of the LVAD (Figure left) has the LVAD accepting blood from the left ventricle through one tube and then pumping or propelling it back to the aorta through another. In many instances, the



heart becomes a passive chamber and no longer pumps blood, and the systemic circulation is supported entirely by the pumping function of the LVAD. Although the LVAD is not directly connected to the lung circulation, because the device lowers left ventricular filling pressures, which in turn reduces pulmonary artery pressures, it often effectively lowers lung pressures and reduces the work of the right ventricle. Therefore, many patients with both right and



Daniel K. Podolsky, M.D.

President

UT Southwestern Medical Center



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5323 Harry Hines Blvd.
Dallas, Texas 75390-8588

www.utsouthwestern.org

Dear Colleague:

Welcome to the first issue of *HeartBeat*, a newsletter that highlights clinical care and research activities of the UT Southwestern Heart, Lung and Vascular Center.

In order to best serve the needs of our patients, we have long believed that physicians involved in the treatment of heart and vascular diseases should work collaboratively in an environment that encourages and builds on innovation, discovery and advances in clinical care – while employing the latest technological advances.

To streamline care and keep it patient-centric, our outpatient clinics, operating rooms and interventional suites were redesigned so that cardiologists, vascular surgeons, interventional radiologists, and cardiac and thoracic surgeons work together in shared physical space to evaluate patients and perform complex procedures. While in many centers these specialists are competitors, we believe our team approach to the treatment of heart and vascular disease is the way to excellence in patient care in an environment ripe with innovation and research.

The value of this approach is especially clear in serving the needs of patients suffering from congestive heart disease. We dedicate ourselves to providing the very best care for the most severely ill patients in our region as evidenced in this issue by our mechanical device support program, which offers hope to many advanced heart failure patients who once had very few options. We have developed one of the first integrated disease management programs in the region, and our heart and lung transplant programs consistently rank in the top 10 percent nationally in patient outcomes.

In addition to meeting the needs of today's patients, we at UT Southwestern have long been dedicated to discovery of new knowledge that will help tomorrow's patients through research with a focus on early recognition and prevention. UT Southwestern Medical Center has made many groundbreaking contributions to cardiac care, including Nobel Prize-winning work in cholesterol metabolism, which led to the development of statin drugs and the most important contribution to cardiac risk reduction in the past 25 years.

Through this and future issues of *HeartBeat*, we look forward to continuing to share with you our efforts to improve cardiovascular care, not only for those we serve already, but for prospective patients throughout the region and across the nation.

Daniel K. Podolsky, M.D.

LVADs: A New Era ...



continued from front cover

left ventricular heart failure have dramatic improvement with just an LVAD, obviating the need for a right ventricular assist device or a total artificial heart. Following implantation, patients are usually stabilized in the hospital and, once they have been educated in the maintenance and care of the LVAD, are discharged home. With restoration of an adequate circulation of blood in their bodies, patients can then gradually increase their activity level and regain their strength, including an ability to walk long distances.

Latest Developments

Second-generation devices are now in use. The initial LVADs were pulsatile devices that pumped blood, but the second-generation LVADs are non-pulsatile with rotary pumps. Many patients with second-generation devices will have no pulsatile flow in their systemic circulation. Specifically, they will have only a mean arterial pressure measurable rather than a systolic and diastolic blood pressure, and there will be no palpable pulses on examination. Despite this, patients have no detectable cognitive abnormalities, and renal function is preserved. At UT Southwestern Medical Center, we are currently investigating the impact of these devices on circulatory flow throughout the body.

Several strategies are used for LVAD implantation (Table 1). The initial strategy, bridge to transplant, consisted of using the LVAD to allow patients with deteriorating heart failure to survive long enough to undergo transplantation. Because this use was so successful, LVADs then were offered to patients who were not transplant candidates. This strategy, destination therapy, was tested in a multicenter, randomized trial called the REMATCH trial (Randomized Evaluation of Mechanical Assistance for the Treatment of Congestive Heart Failure), sponsored by the National Heart, Lung and Blood Institute. UT Southwestern was one of 20 sites in the United States to participate.

This landmark trial demonstrated that patients who were not transplant candidates could live longer if they underwent LVAD implantation than if they continued on optimal medical therapy. The success of the REMATCH trial led to Medicare approval for destination therapy.

A third strategy, bridge to decision, is for use when a patient's suitability for transplantation is uncertain. There have been recent reports of individuals in whom an LVAD was implanted and were treated with aggressive pharmacological therapy that led to recovery of left ventricular function. This strategy, bridge to recovery, is currently undergoing further testing in clinical trials.

The LVAD Candidate

Which patients would be suitable candidates for LVAD implantation (Table 2)? In general, patients should have a reduced left ventricular ejection fraction (<25%) and advanced, symptomatic heart failure such that they have been hospitalized in the last year and/or remain short of breath with minimal activity. A deterioration in kidney function and/or increasing abdominal symptoms such as early satiety or unintentional loss of body weight are warning signs that a patient's condition is worsening and warrants evaluation.

In our advanced Heart, Lung and Vascular Center at UT Southwestern, we are always happy to provide a consultative visit to see whether an LVAD, cardiac transplant, or other therapy may be indicated for the patient with heart failure.

To refer a patient, please call our dedicated Heart Failure/VAD/Transplant referral line at (214) 645-7544 or page Dr. Mark Drazner at (972) 601-9432.

Table 1

LVAD Strategy	Objective
Bridge to Transplant	To keep patients alive and ambulatory before suitable donor organ cardiac transplantation.
Destination Therapy	To prolong survival and improve quality-of-life for patients with end-stage heart failure who are not transplant candidates.
Bridge to Decision	To provide time to allow physicians to determine whether patient is a transplant candidate (assessing neurological function after a patient has suffered a cardiac arrest).
Bridge to Recovery	To provide mechanical support to allow native cardiac function to improve.

Table 2

Clues that your patient has advanced heart failure and could be considered for referral to an advanced heart failure/VAD/transplant center
More than 1 hospitalization or ED visit in the last year for CHF
Systolic blood pressure < 100 mm Hg
Labile renal function (rising creatinine and BUN)
Unable to tolerate beta-blocker (development of CHF decompensation)
Unable to tolerate ACE-inhibitor (development of hypotension and/or renal failure)
Persistent NYHA 4 symptoms (short of breath while dressing or showering)
Unintentional weight loss
"Nonresponder" to biventricular pacing

Latest Advances in Atrial Fibrillation Ablation

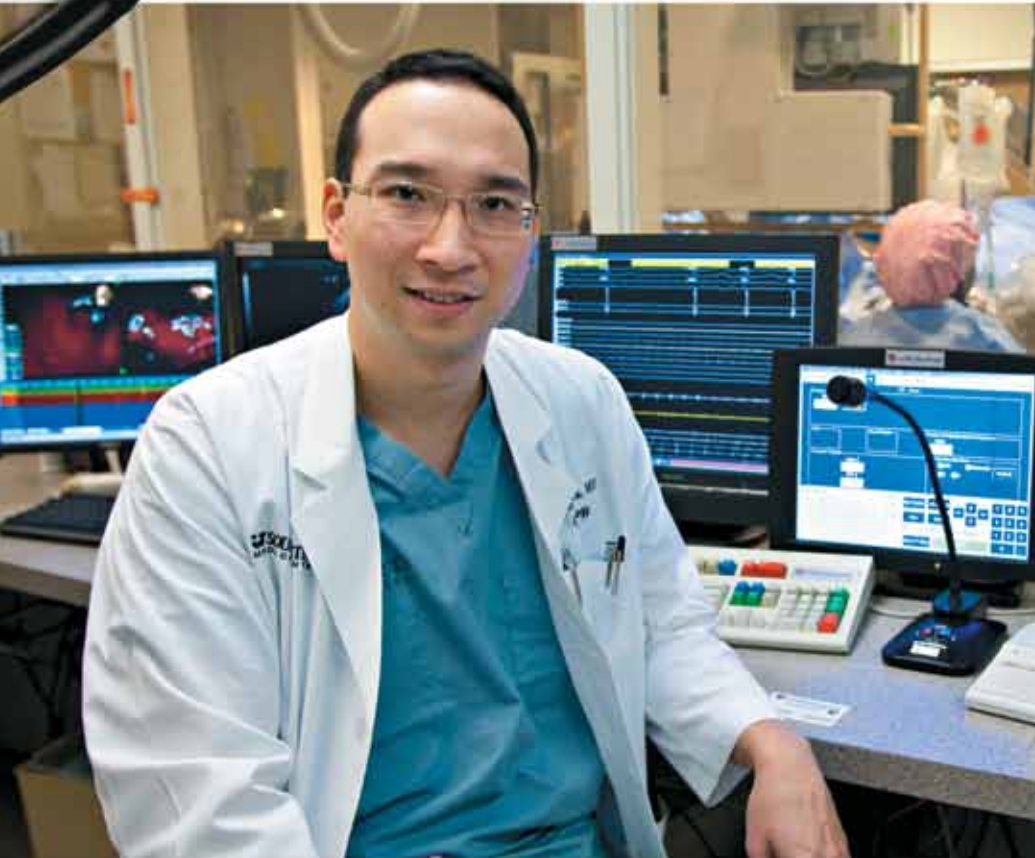
Richard Wu, M.D.

The Problem

Atrial fibrillation (AF) is a common arrhythmia affecting more than 2 million Americans. Instead of beating in an orderly fashion, the atria quiver at a rate of 300 to 600 beats per minute. The irregular impulses often cause a rapid and irregular heartbeat. Some patients are unaware of their condition, while others may suffer from pounding or irregular heartbeats (palpitations), chest discomfort, fatigue, dizziness and shortness of breath. Because the top chambers of the heart do not beat or contract in a normal pattern during AF, these patients have a higher risk of stroke, heart failure and death.

The Solution

Catheter ablation is a procedure that treats AF using a device inserted into the blood vessels from the legs. Catheters are advanced into the heart and used to locate and destroy abnormal electrical impulses.



Richard Wu, M.D. Associate Professor of Internal Medicine and Director of the UT Southwestern University Hospital Electrophysiology Lab and Heart Rhythm Clinic. Dr. Wu's clinical interests and expertise include treatment and management of atrial fibrillation or flutter (AF). Dr. Wu specializes in catheter ablation of complex arrhythmias particularly in patients with heart rhythm disorders associated with advanced heart disease and those who have previously failed attempts at ablation. **Medical School:** *Duke University School of Medicine, Durham (1994)* **Residency:** *Johns Hopkins Hospital, Internal Medicine (1994 - 1997)* **Fellowship:** *Johns Hopkins University School of Medicine, Cardiovascular Disease (1997 - 2001), Clinical Cardiac Electrophysiology (2001 - 2002).*

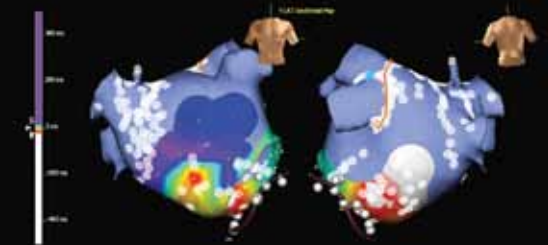


Figure 1 Cardiac CT image of the left atrium and pulmonary veins after 3D reconstruction, mapping, and ablation of atrial fibrillation. This patient underwent pulmonary vein isolation as well as ablation of both left atrial tachycardia and flutter.

The most common approach for catheter ablation of AF is creation of circumferential or circular lesions around the orifices of the pulmonary veins where they attach to the left atrium. This procedure is also called pulmonary vein isolation because the electrical activity in the pulmonary veins is eliminated after successful ablation.

Advanced Procedures

UT Southwestern Medical Center heart rhythm physicians (cardiac electrophysiologists) have expertise in the ablation of AF and complex atrial arrhythmias. The approach used by our specialists includes the use of detailed information from a CT or MRI scan of the heart. An image from each patient undergoing AF ablation is imported into a computer system, allowing for precise three-dimensional mapping (localization and guidance) of catheters within the heart during the procedure (Figure 1).

An intra-cardiac echo catheter (ultrasound probe) placed inside the heart is also used to visualize structures and other catheters within the heart during the study to improve the safety and efficacy of the procedure. One catheter is used to deliver energy (either radiofrequency energy to heat or liquid nitrogen to freeze) at the site of abnormal electrical activity to eliminate the triggers for arrhythmias and eliminate AF.

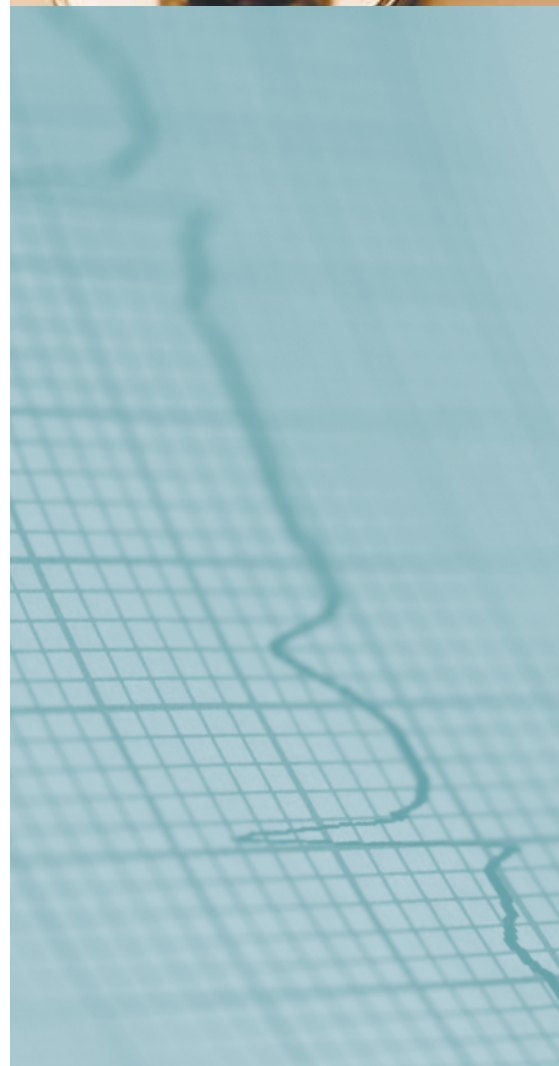
The success rate of AF ablation depends on a variety of patient factors. Generally, younger patients with normal-size hearts and intermittent or paroxysmal AF have the highest success rates. Lower success rates are expected in older patients, those with other forms of heart or lung disease and patients who are in continuous persistent AF. It is not uncommon for patients to require more than one

attempt at ablation. These repeat or "redo" procedures are sometimes more complicated or difficult. However, based on our experience, and that of other clinical investigators throughout the world, repeat procedures can significantly improve the overall success rates of AF ablation.

Specializing in Complexity

Our center at UT Southwestern specializes in the management of patients with advanced forms of cardiac arrhythmias, including those who may require AF, atrial flutter or atrial tachycardia ablation. Our heart rhythm cardiologists can give you more detailed information about the success and complication rates of catheter ablation and discuss current and future treatment options for the management of atrial arrhythmias and AF.

To refer your patient, please call (866) 645-5455. To reach Dr. Wu's paging system call (972) 601-8876.

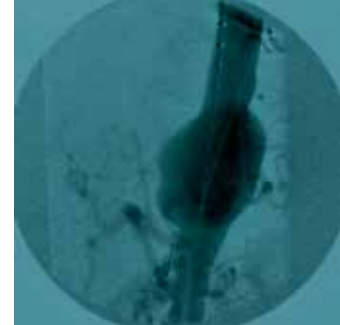


Atrial fibrillation is a common arrhythmia affecting more than 2 million Americans.



Fenestrated Endografting for the Treatment of Thoracic and Abdominal Aneurysms

Michael E. Jessen, M.D. • Frank R. Arko, M.D. • J. Michael DiMaio, M.D.



Introduction

The mortality of untreated thoracic aortic aneurysms can exceed 80 percent at five years. Operative repair traditionally has required large thoracoabdominal incisions, aortic cross-clamping and left-heart bypass and standard surgery, which can be associated with significant morbidity and mortality.

Thoracic endovascular aortic aneurysm repair (stent grafting), first described in 1994, is a minimally invasive procedure associated with less blood loss, lower morbidity and shorter ICU and hospital stays. This technique can be limited in certain patients by the anatomical constraints of large aortic vessels branching, which can interfere with adequate proximal and distal landing sites required for sealing and fixating the graft. Ironically, the patients who would most benefit from thoracic endovascular aortic aneurysm repair are often excluded because the most complex aortic anatomy and disease are seen in older patients with advanced comorbidities.

The advent of fenestrated and branched endografts has now allowed endovascular techniques to be considered in patients with complex disease. Fenestrated endografts have been applied to our patients in aortic branches in the chest and abdomen.



Pictured from left to right

Michael E. Jessen, M.D. Professor and Vice Chairman of Cardiovascular and Thoracic Surgery. Dr. Jessen directs the residency program in thoracic surgery and holds the Robert Tucker Hayes Foundation Distinguished Chair in Cardiothoracic Surgery. His active clinical practice focuses on cardiac surgery, surgical electrophysiology, aortic surgery and cardiac transplantation. **Medical School:** University of Manitoba, Winnipeg, Canada (1981) **Residency:** Duke University Medical Center, Thoracic Surgery (1988 - 1990); University of Manitoba, General Surgery (1982 - 1986) **Fellowship:** Duke, Surgery Research (1986 - 1988).

Frank R. Arko, M.D. Associate Professor of Vascular Surgery and Chief of Endovascular Surgery. Dr. Arko's clinical expertise is in stent graft (including fenestrated endografts) and open treatment of complex thoracic and abdominal aortic aneurysmal disease; stenting and endarterectomy in carotid arterial disease; renovascular hypertension; aortoiliac occlusive disease; and mesenteric vascular and minimally invasive therapy in venous disease. **Medical School:** Texas A&M Health Science Center College of Medicine (1994) **Residency:** Scott & White Hospital/Texas A&M University Health Science Center, Chief Resident, General Surgery (1998 - 1999); Clinical Instructor, General Surgery (1998 - 1999); General Surgery Residency (1994 - 1999) **Fellowship:** Stanford University Hospital, Endovascular (2000 - 2001), Postdoctoral Research (2000 - 2001), Clinical Vascular (1999 - 2000).

J. Michael DiMaio, M.D. Associate Professor of Cardiovascular and Thoracic Surgery and holder of the Laurence and Susan Hirsch/Centex Distinguished Chair in Heart Disease and the James William Taylor, Jr. family research fund. His clinical interests include transplantation, cardiac surgery (including coronary and valve procedures), ventricular aneurysm repair, minimally invasive surgery and the usage of Holmium-YAG laser therapy for tracheal and thoracic obstructive processes, and aortic stenting. **Medical School:** University of Miami School of Medicine, Miami (1987) **Residency:** Duke University Medical Center, Surgery (1994 - 1996), Thoracic Surgery (1996 - 1998) **Fellowship:** Duke, Surgery Research (1992 - 1994).



Figure 1 Aortogram in lateral projection demonstrating only a 10mm distal fixation zone for thoracic endografting to the level of the celiac artery. However, there is 20mm to the takeoff of the superior mesenteric artery.



Figure 2 The Talent Thoracic stent graft is fully deployed outside of its sheath and using the 3D measurements and the thoracic aortogram a fenestration is created using eyeing cautery to prevent fraying of the edges.

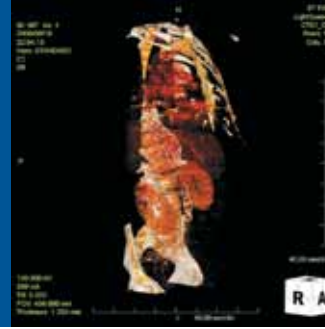


Figure 3 Follow-up CTA with 3D reconstructions at 6 weeks shows the stent graft to be excluded with filling of the celiac artery through the iCast stent without evidence of an endoleak.



The advent of fenestrated and branched endografts has now allowed endovascular techniques to be considered in patients with complex disease.



Case Example

An 82-year-old woman with a medical history significant for oxygen-requiring chronic obstructive pulmonary disease, coronary artery disease, hypertension and morbid obesity was referred for treatment of a 6cm descending thoracic aneurysm. CT angiography confirmed a long proximal neck distal to the left subclavian artery that measured 24mm in diameter. Distally the neck length was 10mm above the celiac artery. (Figure 1)

A custom fenestrated endograft (single 36mm Talent Thoracic stent graft, Medtronic, Santa Rosa, CA) was created and fully deployed outside the body. Using the measurements of the angiogram and CT angiography, a 7mm fenestration was created using an ophthalmic cautery, and the stent graft was reloaded into the sheath (Figure 2). Using figure-of-eight markers on the stent graft to align the fenestration with the celiac artery on a lateral arteriogram, the graft was deployed just proximal to the superior mesenteric artery. A reversed-curved catheter then was used to cannulate the fenestration and the celiac artery. A 7-French Pinnacle sheath (Terumo, Somerset, NJ) was passed into the celiac artery and a 7mm x 22mm iCast covered stent (Atrium, Hudson, NH) was passed into the fenestration and deployed.

The patient did well and was discharged home on the third post-operative day. CT angiogram at six weeks confirmed patency of fenestration and exclusion of the aneurysm (Figure 3). To date we have performed custom fenestrated endografts on multiple patients and have fenestrated the grafts to the renal, subclavian and celiac arteries.

Discussion

Fenestrated endografts allow the preservation of aortic branch vessels by incorporating them into the endovascular repair. This is accomplished by stenting open the aortic branches through adjacent fenestrations in the endograft. Fenestrations may be created by the surgeon at the time of operation, as was done in our patient, or may be pre-made by graft manufacturers in certain clinical trials. However, pre-made fenestrations are still not approved for use by the Food and Drug Administration in the United States and when they will be commercially available is unknown. Either way, the side holes in the graft are created by measurements obtained from three-dimensional CT data using orthonormal views of the aorta to determine the relationship of the side branches to each other and the new endograft.

Overall, many patients with thoracoabdominal aneurysms who were once considered ineligible for endovascular repair may, in fact, be candidates with the further development of fenestrated endografting. Until further experience is obtained, fenestrated or branched endografting is probably ideally suited for patients who desire repair but whose comorbidities place them at significant operative risk for the standard open or hybrid techniques. UT Southwestern Medical Center is currently the only institution in Texas performing successful fenestrated endografts as a result of our large referral base and the large number of patients being treated.

To refer your patient, please call (866) 645-5455. To page Dr. Frank R. Arko call (214) 992-0247.

CREST: UT Southwestern Contributes to Historic Study

Carlos H. Timaran, M.D.



Carlos H. Timaran, M.D. Assistant Professor of Vascular Surgery, UT Southwestern and Chief of Endovascular Surgery at Dallas Veterans Affairs Medical Center. He is the institutional principal investigator and only internationalist in Dallas for the NIH-funded Carotid Revascularization Endarterectomy versus Stenting Trial. He also specializes in the endovascular repair of complex thoracic and abdominal aortic aneurysms. **Medical School:** University Del Cauca, Popayan, Colombia (1991) **Residency:** National University of Colombia - San Juan de Dios Hospital, General Surgery (1994 - 1997); University of Tennessee Medical Center, General Surgery (1997 - 2002) **Fellowship:** Montefiore Medical Center/Albert Einstein College of Medicine, Vascular Surgery Clinical (2002 - 2004).

Why CREST?

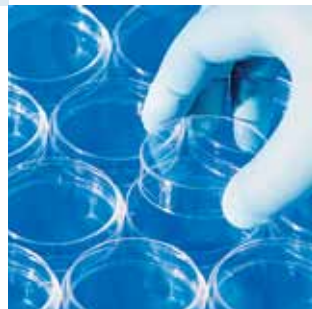
Stroke is the leading cause of long-term disability and the third most common cause of death in North America. Approximately 600,000 new strokes are reported annually, of which 150,000 are fatal. Seventy-five percent of strokes occur in the distribution of the carotid arteries. Among strokes of a thromboembolic etiology, carotid disease is the most common cause. In the United States, the annual cost for care of stroke victims is estimated to be more than \$30 billion.

Although carotid endarterectomy (CEA) is still considered the gold standard for treatment of patients with significant carotid stenosis with durable results, carotid artery stenting (CAS) has recently emerged as an alternative to CEA. Whether CAS provides equivalent or better results compared with CEA in patients who are not at high surgical risk has not been established.

The Future

In the near future, the results of the Carotid Revascularization Endarterectomy versus Stenting Trial (CREST) will provide the necessary evidence to answer this clinical question. This is the largest randomized clinical trial for the prevention of stroke ever conducted in North America. It is funded by a branch of the National Institutes of Health and is currently being conducted in 117 locations in the United States and Canada. The primary aim of CREST is to contrast the relative effectiveness of CAS versus CEA in preventing stroke, myocardial infarction and death in patients with carotid stenosis who have had a transient ischemic attack or a mild stroke and in those who have not had any symptoms. A total of 2,520 eligible patients have been randomized to trial.

The study completed recruitment in July 2008 and is currently in the follow-up phase, which will continue for up to 10 years. The early one-year results will be presented and published in late 2009.



The primary aim of CREST is to contrast the relative effectiveness of CAS versus CEA in preventing stroke, myocardial infarction and death in patients with carotid stenosis who have had a transient ischemic attack or a mild stroke and in those who have not had any symptoms.

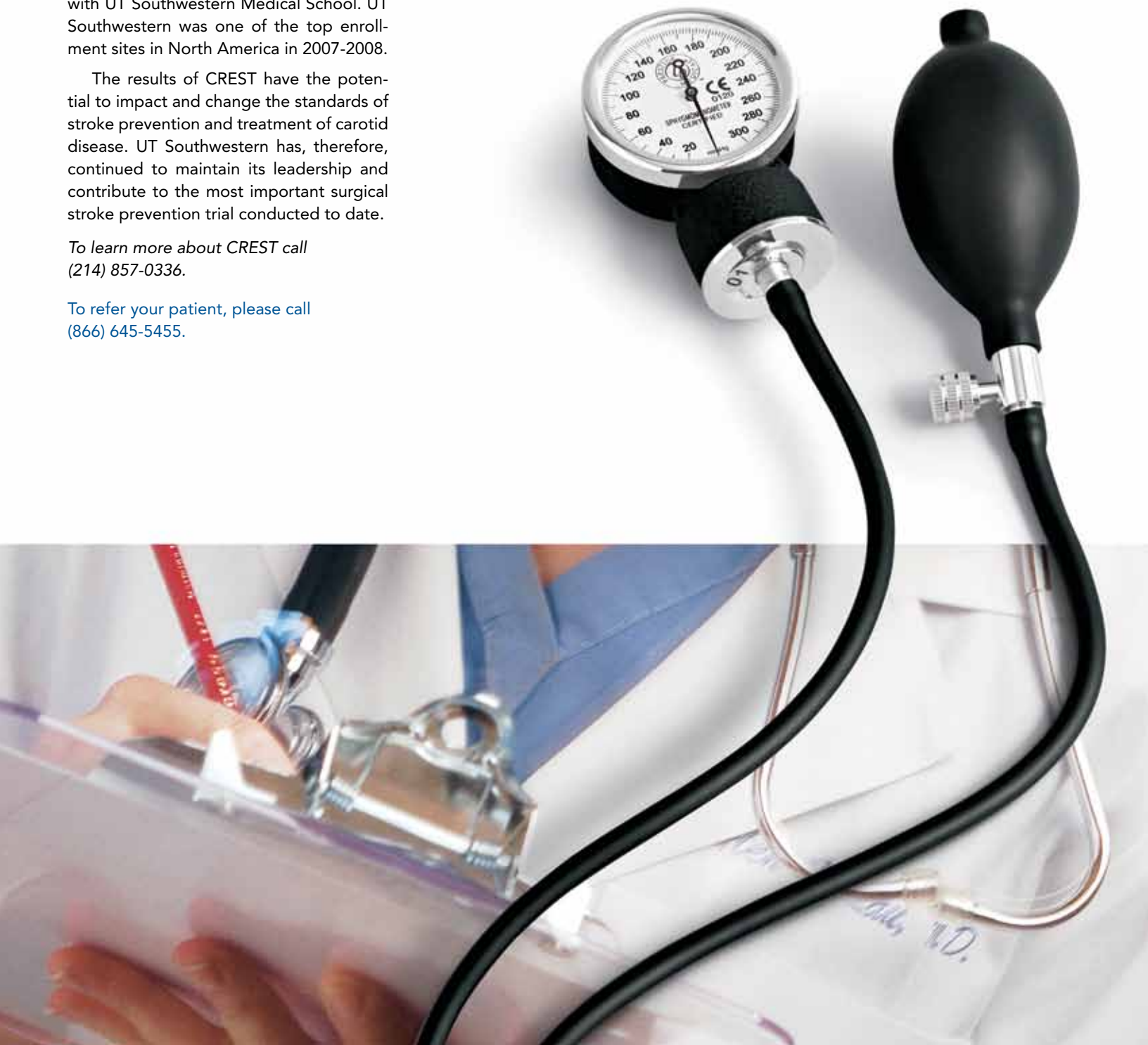
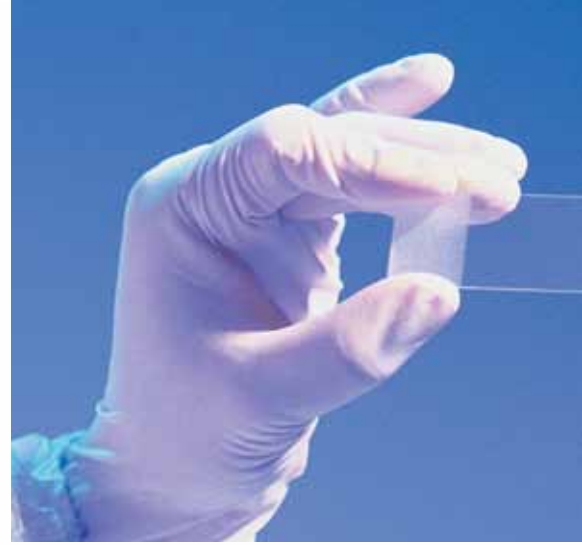
Participants

UT Southwestern Medical Center is the only medical center in Dallas included in the trial. Since 2006, CREST has been conducted successfully by a team of vascular surgeons supported by selected neurologists at the University Hospitals affiliated with UT Southwestern Medical School. UT Southwestern was one of the top enrollment sites in North America in 2007-2008.

The results of CREST have the potential to impact and change the standards of stroke prevention and treatment of carotid disease. UT Southwestern has, therefore, continued to maintain its leadership and contribute to the most important surgical stroke prevention trial conducted to date.

*To learn more about CREST call
(214) 857-0336.*

*To refer your patient, please call
(866) 645-5455.*



Women should change bad habits sooner, not later

Doctors at UT Southwestern Medical Center recently found that women are less likely to change poor lifestyle habits such as smoking and not exercising, even when they have a family history of heart disease. The findings were published in the *American Heart Journal*.

Dr. Amit Khera, Director of UT Southwestern's Program in Preventive Cardiology, led the study, which found that women with a family history of heart disease don't change unhealthy habits as frequently as men with similar family histories.

"Although the prevalence of cardiovascular disease is generally low for young women, the consequences can be more severe," said Dr. Khera, Assistant Professor of Internal Medicine. "For instance, women are twice as likely as men to have fatal heart attacks."

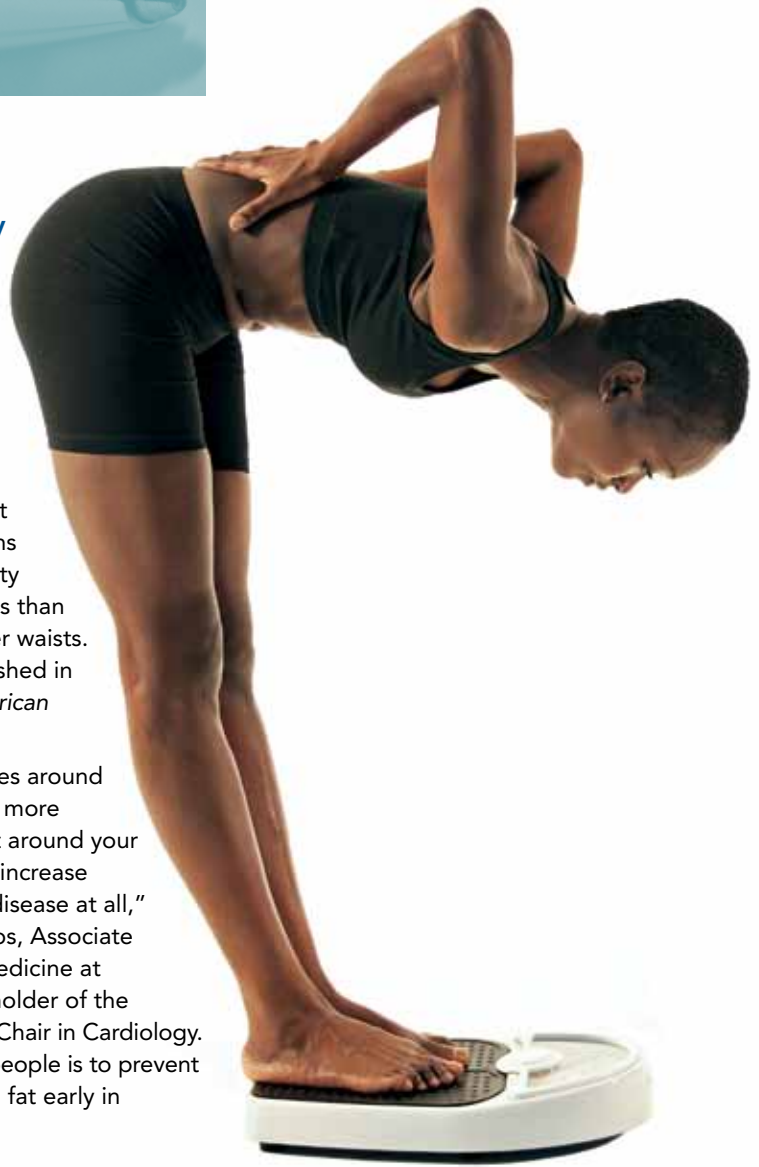
He said physicians can help patients by asking basic questions about family history of heart disease, and that women should change unhealthy habits earlier, not later.

Fight the Pot Belly

A tape measure may just be the simplest and most inexpensive way to gauge your risk for heart disease.

UT Southwestern researchers found that people who develop fat around their midsections have higher rates of fatty deposits in their arteries than those who have slimmer waists. The research was published in the *Journal of the American College of Cardiology*.

"Fat that accumulates around your waist seems to be more dangerous, whereas fat around your hips doesn't appear to increase risk for cardiovascular disease at all," said Dr. James de Lemos, Associate Professor of Internal Medicine at UT Southwestern and holder of the J. Fred Schoellkopf, Jr. Chair in Cardiology. "The key message for people is to prevent accumulation of central fat early in their lives."



G. Patrick Clagett, M.D., UT Southwestern, elected President of Society for Vascular Surgery



Dr. G. Patrick Clagett was elected 2008-2009 President of the Society for Vascular Surgery (SVS) during the Vascular Annual Meeting on June 6, 2008. Nationally recognized for his experience and leadership, he leads the country's largest vascular surgeon society with 2,600 members.

"Dr. Clagett's accomplishments in the vascular field make him the ideal leader to continue the society's role as the unified voice for vascular surgery in the U.S. and throughout the world," said Dr. K. Wayne Johnston, outgoing president of the SVS.

Dr. Clagett is Chairman of Vascular Surgery at UT Southwestern and holder of the Jan and Bob Pickens Distinguished Professorship in Medical Science. His research interests include surgical management of cerebrovascular disease, blood biomaterial interactions, the clinical utility of new anti-thrombotic agents and vascular prosthetic infections.

He earned his undergraduate and medical education at the University of Virginia; finished his general surgery residency at the University of Michigan; served as a research fellow at Harvard Medical School; and completed a vascular fellowship at Walter Reed Army Medical Center.

20

Milestone Lung Transplant ~ #200

Heart and Lung Transplant Program at UT Southwestern turns 20

The UT Southwestern Heart and Lung Transplant Program is now well established, with a 20-year history of exceptional results. The surgery team has performed transplants on more than 370 heart patients and 200 lung patients.

The Program has among the very best one-, three- and five-year post-surgery outcomes in the nation and is among the best in the state.

The seamless integration of physicians, nurses and health personnel improves care for each transplant recipient and consistently delivers renewed quality of life to hundreds of patients and their families.

Transplant physicians also remain committed to new discoveries in this area as they research new methods of immunosuppression and markers for rejection risk, and seek more efficient and comprehensive treatment strategies.

When Mr. Francis Moran, 57, was first diagnosed with familial pulmonary fibrosis, it didn't come as a surprise. The disease had already taken the lives of his mother and brother. A native of Honey Grove, Texas, Mr. Moran and his wife, Sarah, sought treatment in Dallas, where they learned about the pulmonary and transplant expertise of doctors at UT Southwestern.

"We met with the doctors here and immediately felt more confident that we would be able to fight the disease," Mr. Moran said.

He was placed on medicines that stabilized his condition and slowed the disease's progression. Within five years, he needed a lung transplant, and in January of 2009, he was placed on a list for a double lung transplant. Less than three weeks later, the phone call he and his family had been waiting for came.

"I felt confident. There was no hesitation for me," Mr. Moran said. "I knew the survival rate here was one of the best in the state."

Mr. Moran also donated his lung tissue to UT Southwestern researchers who are studying genetic lung diseases such as his. This partnership in a wide range of collaborative projects enables UT Southwestern to apply the latest research findings to provide patients with the most recent breakthroughs in lung therapies and surgical treatments.

Since completing the 200th procedure, lung transplantation at UT Southwestern continues to be one of the leading programs in Texas.

"I was very fortunate," Mr. Moran said. "I couldn't have asked for a more professional group."



The Power of Partnership: Physician Outreach



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Search our online physician directory at
www.utsouthwestern.org



Our dedicated Physician Outreach Team can help you navigate the many programs and resources that are available at UT Southwestern, by facilitating your access to experts in more than 62 medical subspecialties. Our staff can help with:

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- Assistance with patient admissions
- Accessing patient status reports and medical records
- Continuing Medical Education (CME) events
- UT Southwestern clinical programs and services
- Clinical trials information
- Hotel information for out-of-town patients and family
- Questions about accepted health care plans
- Information about affiliated hospitals and clinics

If you would like to know more about UT Southwestern Medical Center and how we can meet your patient care needs, please schedule a visit with one of our knowledgeable Physician Liaisons. If you have any problems with your patient referral, please do not hesitate to contact us. You can reach a Physician Liaison by calling 214-645-2942.

The University Hospitals of UT Southwestern include:

**University Hospital, St. Paul and
University Hospital - Zale Lipshy**