



The **Academy NEWSLETTER**

THE AMERICAN ACADEMY
OF
CARDIOVASCULAR PERFUSION
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FALL 2010

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2011 Academy Meeting Remaining True to Our Safety Roots

Twenty-five years ago, at the 7th Annual Academy Meeting, Mark Kurusz presented "Perfusion Accident Survey". This comprehensive survey of perfusion accidents quickly became one of the most referenced articles on perfusion safety and has had a profound impact on the evolving safety culture in the perfusion community.

Throughout its history, the Academy has led the way in the understanding, and promotion of safety in perfusion. This theme has permeated our annual conferences through fireside chats, scientific presentations and special sessions. Our meetings have been privileged to feature fresh and unique looks at safety in perfusion. For example, in 1999 at the Academy meeting in San Antonio, Texas the now classic Brian Mejak survey "A retrospective study on perfusion accidents and safety devices" was unveiled and provided updated data on incidents and devices. Then, a special panel forum at the 2001 conference "Perfusion Accidents and Lessons from the Cockpit" became a defining moment in our safety history. Richard Ginther, Jr. stimulated introspection by uncovering the paradox between crisis management protocols and actually practicing those protocols. Last year, the Academy hosted an eye-opening special panel called "Developing a Safety Culture: It's More Than Rules, Policies and Procedures" and our scientific sessions featured presentations on Human Factors and Systems Engineering to Improve Outcomes (J. Sistino) and the affect of practice on oxygenator change-out times (B. Searles). Thankfully over the years, David Palanzo has regularly catalogued and compared the perfusion safety literature to help us keep it all straight!

The 2011 Academy meeting continues in this proud safety tradition with two special sessions on safety. Invited expert speakers include: Mark Kurusz, CCP (*Reflections by a Plaintiff Expert Witness*), Dr. Steven Howard (*The Effects of Sleepiness and Fatigue in Medical Personnel*) Dr. Bruce Speiss (*Flawless Operative Cardiovascular Unified Systems (FOCUS) Initiative*), Bruce Searles, CCP (*The Role of Simulation in Training Perfusionists to Manage High Risk, Low Frequency Events*), Daniel FitzGerald, CCP (*Perfusion Safety: Taking Personal Responsibility*), Dr. Paul Friday (*Master-Minding the Monster*).

Continued on Page 4

32nd Annual Seminar of The American Academy of Cardiovascular Perfusion

Grand Sierra Resort and Casino

Reno, Nevada

January 27-30, 2011

Thursday, January 27, 2011

9:00 AM – 1:00 PM

Council Meeting

10:00 AM – 3:00 PM

REGISTRATION

2:30 PM – 4:30 PM

Fireside Chats

Perfusion safety and culture, crisis preparation, accidents and errors

Managing a perfusion department

ECMO, what's new, what's hot and what's not

Perfusion oncology, peritoneal, thorax, limb and more

Perfusion simulation

5:00 PM – 7:00 PM

REGISTRATION

5:00 PM

Opening Business Meeting

Fellow, Member, Senior and Honorary Members

5:30 PM – 8:00 PM

Sponsor's Hands-On Workshop & Reception

Friday, January 28, 2011

7:00 AM

REGISTRATION

8:00 AM – 9:30 AM

Scientific Session

9:30 AM – 10:00 AM

Break

10:00 AM – 11:30 PM

Scientific Session

11:30 PM – 1:00 PM

Lunch

1:00 PM – 3:30 PM

Special Scientific Session (Panel)

Perfusion Safety (Part I)

3:30 PM – 5:30 PM

Fireside Chats

Cutting edge pediatrics, are we there?

Computer assisted bypass and automated electronic records

Hemostasis management and blood conservation strategies

Future of perfusion

Mechanical assist (VADs)

6:30 PM

Induction Dinner

Fellow, Senior, Honorary Members & Guests

Saturday, January 29, 2011

7:00 AM

REGISTRATION

8:00 AM – 9:30 AM

Scientific Session

9:30 AM – 10:00 AM

Break

10:00 AM – 11:30 PM
11:30 PM – 1:00 PM
1:00 PM – 3:30 PM

Memorial Session
Lunch
Special Scientific Session (Panel)
Perfusion Safety (Part II)

3:30 PM – 5:30 PM

Fireside Chats

Aortic surgery, approaches, techniques and pitfalls
Myocardial protection, techniques, devices, formulas and strategies
Perfusion in the hybrid OR and beyond, less or more invasive?
Perfusion safety and culture, crisis preparation, accidents and errors
Student perfusionist forum (Students Only)

Sunday, January 30, 2011

8:00 AM – 10:00 AM
10:00 AM – 12:00 PM

Scientific Session
Fireside Chats

Cutting edge pediatrics, are we there?
Future of perfusion, chat with the manufacturers
Hemostasis management and blood conservation strategies
The business of perfusion

12:30PM

Closing Business Meeting
Fellow, Senior and Honorary Members Only

Our 2011 Host Hotel



Grand Sierra Resort and Casino Reno, Nevada

Luxury Summit Accommodations
\$99.00 Single/Double Occupancy

*(\$10 daily resort fee allows you access to the health club,
free valet parking, airport shuttle to the Reno-Tahoe Inter-
national Airport, free local phone calls, wireless internet
and two bottles of Fiji water.)*

Reservations: 800-501-2651

*Remember when making reservations to mention that you
will be attending the AACP Meeting.*

www.grandsierraresort.com

The Student

Section

Comparison of the Risks and Benefits Associated with Multiple Autologous Cell Processing

It is estimated that between 10 and 20 percent of all blood transfusions in this country result from cardiovascular surgery, though studies show their use increases both morbidity and mortality postoperatively.¹ Risks associated with allogeneic transfusions, including the transmission of viral and bacterial infections and possible immunosuppression, can be decreased by processing remnant blood from the cardiopulmonary bypass circuit and reinfusing it into cardiac patients. Autologous transfusions also help lower demand on already strained blood banks. The cell processing can be done in one of several ways, including: cell washing, modified ultrafiltration, and the use of a Hemobag.

Modified ultrafiltration and the Hemobag are quite similar, with their main benefit being the preservation and concentration of plasma components such as platelets, proteins, and clotting factors. This helps to stabilize hemodynamics postoperatively because patients receive a concentrated form of their own whole blood. These techniques also reduce hemodilution by removing excess plasma water. Though hemodilution is a useful technique during cardiopulmonary bypass, theoretically improving regional blood flow and oxygen delivery to tissues as a result of decreased blood viscosity, it can be helpful to remove that excess volume before patients are sent to the ICU.²

One of the main differences between the two procedures is that the

Hemobag does not delay surgical time as modified ultrafiltration does. This is due to the fact that blood is concentrated in a separate "recovery loop" circuit.³ The extracorporeal circuit is available simultaneously, allowing surgeons to finish the procedure, decannulate, and give protamine while the patient's blood is being processed. Patients must remain heparinized for the duration of modified ultrafiltration, significantly delaying protamine reversal.⁴

Cell washing, makes use of centrifugation rather than filtration to separate red blood cells from other, less dense blood components. It produces a final product with hematocrits up to 70%, which is generally higher than that provided by either modified ultrafiltration or the Hemobag, but it also discards all plasma, plasma proteins, platelets, and clotting factors that the other two processes preserve.¹ Cell washing also removes a majority of heparin, so if washed cells are given perioperatively heparin concentrations and activated clotting times should be monitored closely. However, the technique does remove undesirable byproducts such as activated immune mediators and debris from the surgical field.⁴ There is much less hemolysis than when blood is simply returned to the venous reservoir via suction, as long as the operator uses a level of vacuum recommended by the manufacturer. Suction is also associated with the production of lipid microemboli, which have the potential to deposit in

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the brain and lead to strokes and less-severe neurological changes. Cell washing helps prevent such microembolization.⁵ The undesirable contaminants that are removed via cell washing are not completely removed by the Hemobag, but reduced levels still benefit patients.³

There are certain patient populations that may particularly benefit from these techniques. Jehovah's Witnesses believe they are prohibited by the Bible from ingesting blood, including receiving allogeneic transfusions or autologous blood donated preoperatively. However, blood salvaged intra-operatively and reinfused into patients is deemed acceptable. Any of the above three processing methods could provide a Jehovah's Witness with the blood products they require post-operatively.^{4,6} There is also abundant literature on the dramatic decreases in post-operative morbidity and mortality in children and neonates who receive blood that's been processed with modified ultrafiltration.^{7,8}

These methods of remnant blood processing are not without their risks and obstacles. Use of cell washing is contraindicated when patients have infections or malignancies in the surgical field that may be disseminated by the washed cells. There is also a risk during modified ultrafiltration of trapping air in the arterial cannula, in which case the procedure must be abandoned.⁴ Despite such risks, the processing of remnant blood prevents or decreases the use of allogeneic transfusions, which have their own inherent set of risks and obstacles.

References

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4. My Blood First. *The Hemobag – Methodology*. Global Blood Resources. [Internet, WWW]. Available: My Blood First website; ADDRESS: <http://www.mybloodfirst.com/method-phy.html>. [Accessed: 28 January 2010].
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6. Moskowitz DM, Klein JJ, Shander A, Perelman SI, McMurtry KA, Cousineau KM, Ergin MA. Use of the Hemobag® for modified ultrafiltration in a Jehovah's Witness patient undergoing cardiac surgery. *J Extra-Corpor Technol* 2006; 38: 265-270.
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The 2011 Academy Meeting will, as always, be rich in content. The thing that makes the meeting really work is the people who attend. Our membership has passion and heart for this profession that inspires me! It is an honor to serve you all!

I encourage you to join me in Reno, for the 2011 AACP Meeting. All of the meeting information can be obtained at our website, www.TheAACP.com, or by contacting the National Office at 717-867-1485.

My best to you and your families!

Edward M. Darling, CCP
President, AACP

43 Years of Service



August 3, 2010 marked the 40th anniversary of employment for Dennis R. Williams at the Penn State Milton S. Hershey Medical Center. It also marked his last day as a practicing perfusionist after 43 years in the field.

Dennis started his medical career in the U.S. Navy Medical Corps. After graduating from the Corps in 1965, he went on to attend their cardiovascular perfusion technology school. He completed his training at Lennox Hill Hospital in New York City and New York University graduating in 1967.

He remained at Lennox Hill Hospital until accepting the position as Chief Perfusionist of the newly opened Milton S. Hershey Medical Center in Hershey, Pennsylvania in August 1970.

Dennis was also the Director of the Perfusion Technology Training Program at the medical center for 30 years. During that time he was instrumental in training over 80 perfusionists.

He was involved in the perfusion community as a member of the American Society of Extra-Corporeal Technology (AmSECT), the Perfusion Programs Directors' Council (PPDC), Charter Member and Past President of

The American Academy of Cardiovascular Perfusion (AACVP), Director of the American Board of Cardiovascular Perfusion (ABCP) and AmSECT's *Perfusionist of the Year* for 1990.

Dennis semi-retired to a part-time/per diem position in 2005 but he still enjoyed coming into the hospital to "pump a case".

With his interests in hunting, fishing and model trains requiring more and more of his time, he perfused his last clinical case 40 years to the day from when he started at the medical center.

Dennis has made an impact on many people over these 43 years including: patients, physicians, residents, perfusion students and staff alike.

We thank him for his many years of dedication and service to the field of cardiovascular perfusion and we wish him well in all future endeavors.



Dennis pumping his last case at the Penn State Hershey Medical Center.

If you know of anyone retiring from the field of perfusion, please send us a short biography and a picture and we will publish the information in a future newsletter.

**Abstract Deadline
for the 2011 Meeting
October 15, 2010**

**IF YOU WOULD LIKE THE ACADEMY
NEWSLETTER EMAILED TO YOU DIRECTLY,
PLEASE SEND YOUR NAME, CITY, STATE
AND EMAIL ADDRESS TO
OFFICEAACVP@AOL.COM.**

All About our Corporate Partners

Today's Population is Becoming Conditioned to Expect an Electronic Lifestyle

New Advances in Technology Make Our Lives Easier

Electronics have successfully entered almost every phase of our lives -- from talking to our friends on Facebook, to driving with a GPS, and watching television using a DVR. New technology is continually being introduced into our lives, freeing up our time and focus for other activities.

The same is true in the operating room. New technology continues to make daily tasks and responsibilities more efficient.

For example, to remain current and keep up with ever changing business processes hospitals are transitioning from old paper files to sophisticated computer databases for patient records. This creates a system for the electronic use and exchange of health information.

Many physicians are already moving toward electronic health records for convenience, efficiency and market pressure. In fact, a survey by The Centers for Disease Control and Prevention found that in 2009, thirty-eight percent of physicians reported using full or partial e-records system, not counting billing. This is up from 25 percent in 2005.

This aspect of healthcare received national prominence from President Barack Obama who vowed to improve quality and reduce inefficiencies in the health care system by dedicating significant federal funds to health information technology. "To improve the quality of our health care while lowering its costs, we will make the immediate investments necessary to ensure that within five years, all of America's medical records are computerized. This will cut waste, eliminate red tape and reduce the need to repeat expensive medical tests. But it just won't

save billions of dollars and thousands of jobs, it will save lives by reducing the deadly but preventable medical errors that pervade our health care system," President Obama said.

How does this impact your hospital?

By enacting an electronic data management program, perfusionists can help hospitals meet the changing technological standards. A data management system can save time on documentation and offer better management of a clinical practice. This type of system has many advantages, including efficiently performing data analysis for clinical studies or surgeon requests.

The primary considerations in selecting a data management system are: design, customization, ease of use and support. Clinicians prefer a seamless system to help them better focus on the patient, as well as one that is comprehensive yet easy-to-use, can conform to the various hospital needs, and offers data analysis.

What are the perfusionist advantages to go paperless?

- Improves efficiency
- Makes accurate data available for quality-assurance analysis
- Ensures better documentation and uniform charting
- Provides a vehicle to access patient records easily from several locations within the hospital's central database
- Reduces health care costs resulting from inefficiency and incomplete information

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Choose the TLink™ Data Management System



The TLink™ Data Management System touch screen

Terumo Cardiovascular Systems released the TLink™ Data Management System (DMS) in 2007. To continue to meet the changing needs of perfusionists, Terumo has updated its TLink DMS software annually.

The TLink System allows the perfusionist to have full control of their data. They can control the type of data, the organization and the frequency that the data is collected during the case, and then can complete post-case analysis using the Query Manager.

Here are details on the three most talked about features:

Query Case Data

The TLink System's query management is integrated into its software. The TLink DMS stores data efficiently and provides easy access to the data whenever necessary. The enhanced open-ended query capabilities can optimize analysis post-case.

Perfusionists can select any combination of parameters that they collect in the TLink System. The user can set the criteria and the TLink database will search the patient case records and present the cases that fit the criteria. The search could be as

simple as blood usage per staff member, or more comprehensive by analyzing several parameters. The findings can be used for staff education to identify opportunities for future practice changes or to assist with data analysis relevant to studies.

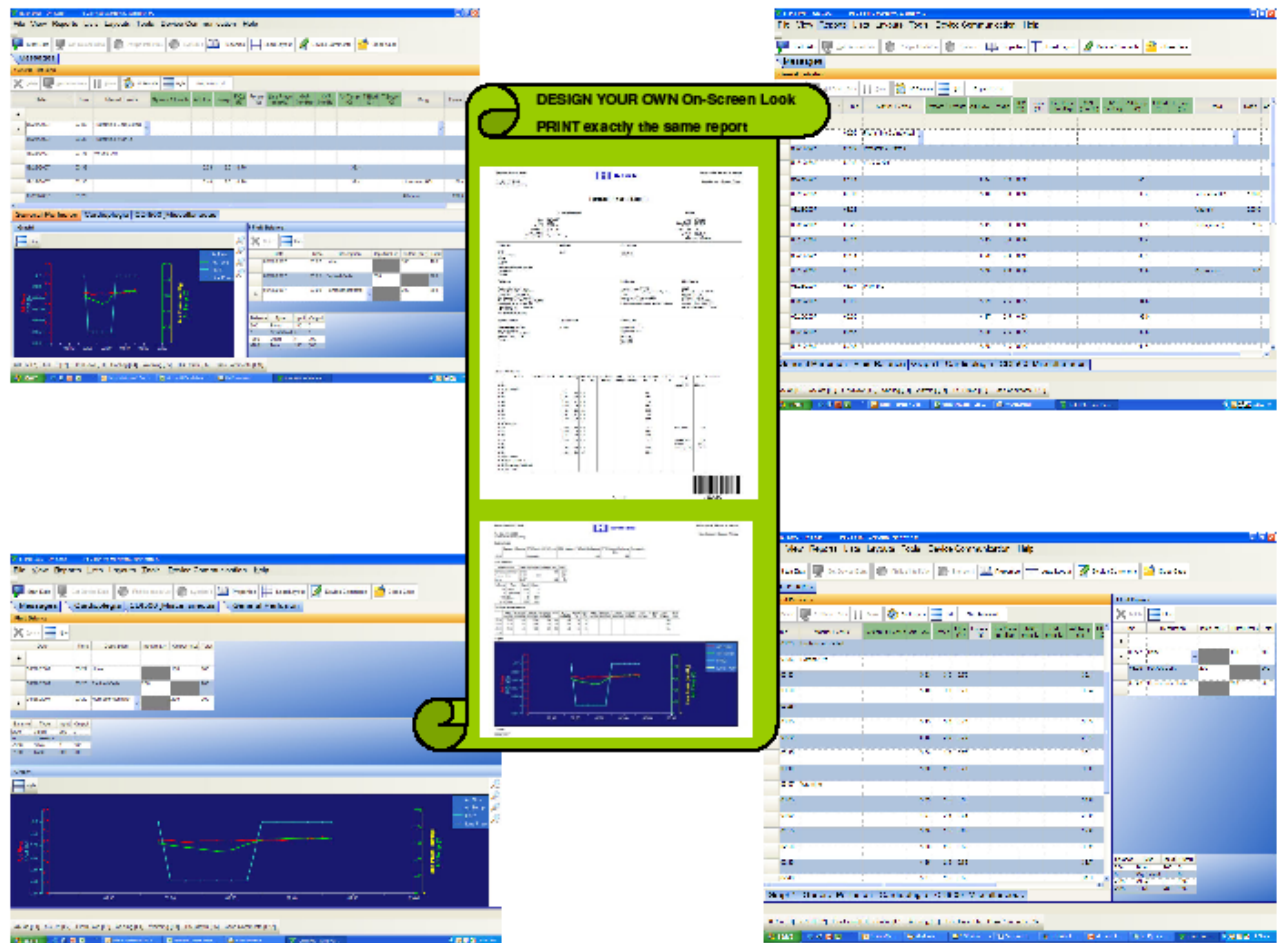
Customizable

The TLink System provides customized management of perfusion case information. Each perfusionist can decide which features to use. It can be simple or comprehensive depending on the comfort level of the user. The System is configurable making it possible to evolve as the practice changes.

The pump records are customized in the TLink System. Multiple templates can be configured -- examples include bypass, pediatric, adult or autotransfusion. The data is organized and grouped to mimic the hospital's current paper record design. By mimicking the hospital's existing pump record, the transition to TLink Data Management System is easy and familiar.



The TLink™ Data Management System is shown with the Terumo® Advanced Perfusion System 1.



The pump records are customized in the TLink System and multiple templates can be configured.

Perfusionist in Control

Terumo's goal with the data management system is to provide flexibility so the perfusionist can remain focused on the patient. The system allows the perfusionist to determine what data to collect, how often to collect it, and how to view it on a case.

Data can be collected automatically from other operating room devices at timed intervals specified by the perfusionist. The system can also be set up to collect data 'on-demand' if desired, allowing the perfusionist to touch a button when they want data documented. Customized drop-down menus are set up for easy entry of items such as events, drugs, fluids and demographic information. The system will also document data using function keys and barcode

scanning.

The TLink System provides the capability to enter data post-case if needed and offers paperless capability at any time.

Whether it is keeping up the societal forces, physician request, or your own desire to seek an electronic record, the TLink Data Management System is a robust system keeping pace with perfusionists' needs now and into the future.

For more information on the TLink Data Management System, contact your Terumo CVS sales representative or call (800) 521-2818.

THINK YOU'RE HAVING A BAD DAY?

Introduction

Bill Bigelow's legacy was already secure. In 1946, he conceptualized the idea of using hypothermia as an adjunct to open-heart surgery. In fact, he quickly became the foremost contributor to the development of inflow occlusion as a means of operating inside the heart. In 1949, during a routine dog experiment, he noticed that electrical contractions could be produced by touching the animal's heart with a surgical instrument. This unexpected observation led researchers at Toronto General Hospital to produce the first reliable external pacemaker. Indeed, Bigelow was recognized as a pioneer in cardiac surgery. (See Figure 1) So why then, in 1951, did he embark on the outlandish quest of unlocking the secrets of hibernation? Obviously, humans are warm-blooded homeotherms. True hibernators are poikilotherms – animals whose body temperature parallels their environment during winter months. Had Bigelow lost his mind? What good could possibly come from knowing how and why some animals hibernate? Bigelow's reasoning was sound. His colleague William Mustard worked across the street from him at the famed Hospital for Sick Children. On several occasions between 1951 and 1953, Bigelow had witnessed Mustard's technique of using monkey lungs for oxygenation during complex congenital repairs. In Bigelow's mind, extracorporeal circulation was just too dangerous and just too unpredictable. Instead, he imagined the prospect of combining hypothermia with hibernation – in effect, turning the patient into

a poikilotherm. How spectacular would it be to safely extend the inflow occlusion time to over an hour, allowing the surgeon ample time to fix any defect! Bigelow's quest became a 10-year obsession. Initially, he surmised that animals such as the groundhog must possess some sort of chemical or hormone that induces the hibernating state. In time, Bigelow and his team would learn that Mother Nature guards her secrets very closely.

Groundhog Experiments

At his peak, Bigelow housed nearly 400 groundhogs at a custom-built farm north of Toronto. The first four years of his research focused on the groundhog's anatomy, with specific attention being directed at the hibernation gland. This gland, located near the groundhog's mediastinum adjacent to the

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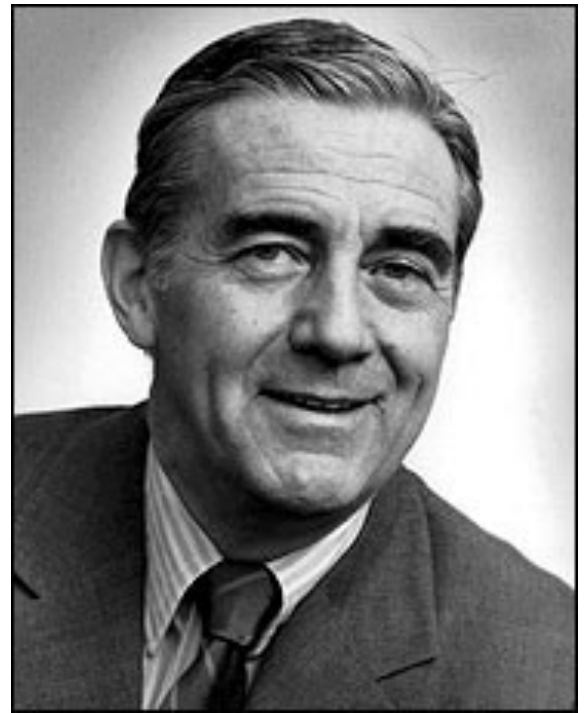


Figure 1. Dr. Wilfred G. Bigelow at the University of Toronto in 1965.

chest wall, appeared to reach maximum size just before the onset of hibernation. Furthermore, it contained streaks of brown fat. Bigelow was convinced that the secret hormone that triggered hibernation resided somewhere in this unusual brown fat. During the next four years, thousands of blood samples were obtained from hundreds of groundhogs in order to isolate the hibernating hormone. Over the years, Bigelow remained true to his goal – to discover the elusive hormone that would endow humans with the ability to withstand deep and prolonged hypothermia. Finally, after eight years of painstaking work, an extract was isolated. Unable to contain his excitement, Bigelow immediately named the chemical “Hibernin”. The final two-year phase of Bigelow’s research involved injecting Hibernin into small test animals such as rats or guinea pigs. Not only did they tolerate the injections, the animals withstood being cooled to body temperatures of 5°C. What excitement! The control animals could only be cooled to 14°C, below which they all died. Bigelow was so elated that he suspended his surgical practice, along with other members of his team. In addition, he sought a patent for his newly-discovered wonder drug. Remarkably, two human patients received Hibernin injections from Bigelow during this two-year period (1960-61). Both survived inflow occlusion and deep hypothermic repair of congenital defects. The recovery room nurses, however, reported that both patients acted drunk post-operatively.

The Grand Failure

Bigelow was ready to announce to the world his discovery. Several articles were written, with plans to submit them to various medical journals. One of the articles, targeted for a surgical journal, reported the first cases where Hibernin was used during human heart surgery. Bigelow would surely be on the list for a Nobel Prize! Unfortunately, just as he was about to go public Bigelow received a letter from the U.S. Patent Office. Bigelow’s hibernating hormone, Hibernin, that was destined to revolutionize heart surgery was already patented! To his dismay, Bigelow’s

extract was actually a plasticizer. Yup, a simple phthalate ring with two side chains invented twenty years earlier to maintain the pliability of plastic tubing. Bigelow called an emergency meeting. Were the blood specimens somehow contaminated? The evidence was irrefutable in specimen after specimen. The blood had obviously picked up some of the leached plasticizer as it coursed through the sampling tubing. Unbelievable! Ten years of work down the drain. Bigelow could only laugh at the absurdity of it all. Why then did the studies show repeatedly that the animals (and humans) receiving Hibernin tolerated hypothermia better? Amusingly, the key ingredient in the plasticizer was butyl alcohol. Once purified, this extract had the same effect as beverage (ethyl) alcohol. This explained the observation by the recovery room nurses. Furthermore, it was known from reports of accidental hypothermia that drunks falling asleep in the snow had survived remarkably low body temperatures. Bigelow chuckled at the irony, there was little else he could do.

Conclusion

Bigelow’s legacy is intact – he is the undisputed Father of Hypothermia. After a brilliant career he passed away in 2005 at the age of 92. Throughout his long life, he taught us a valuable lesson, his ability to laugh in the face of obvious disappointment. His story should remind us of an enduring adage, “*when you get knocked down, get up*”. Establishing a new scientific truth, even when using sound research, can be extremely difficult. Bigelow’s story reminds us of just how much we do not know and that a little laughter can be a good thing these days.

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PRE-REGISTRATION FORM
The 2011 Annual Meeting of
The American Academy of Cardiovascular Perfusion



MEMBER Registration Fee 2011 Annual Dues Adult Guest to Workshop	FEE \$330.00 \$145.00 \$25.00	Amount _____ _____ _____	FIRESIDE CHAT REGISTRATION (make your first three choices each day) Thursday Sessions 1) _____ 2) _____ 3) _____ Friday Sessions 1) _____ 2) _____ 3) _____ Saturday Sessions 1) _____ 2) _____ 3) _____ Sunday Sessions 1) _____ 2) _____ 3) _____ Choices will be assigned in the order they are received. Each Fireside Chat is limited to 30 attendees per session each day.
NON-MEMBER Registration Fee Adult Guest to Workshop	FEE \$380.00 \$25.00	Amount _____ _____	
STUDENT PERFUSIONIST Registration Fee Adult Guest to Workshop <i>*MUST include a letter from the school director with registration.</i> <i>To take advantage of the Student rate of \$30.00, you must be a current Student Member of The Academy.</i>	FEE \$30.00* \$25.00	Amount _____ _____	
FELLOW or SENIOR MEMBER Registration Fee 2011 Annual Dues Guest to Induction Dinner Adult Guest to Workshop	FEE \$400.00 \$170.00 \$100.00 \$25.00	Amount _____ _____ _____ _____	

PRINT OR TYPE

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ FAX _____

E-MAIL ADDRESS _____ (Required for confirmation)

ANTICIPATED ARRIVAL DATE IN RENO _____

Please read all instructions and information before completing this form.

If you have questions completing this form, please call the national office. Hotel Reservations must be made separately through the hotel directly.

Total Amount of Payment \$ _____ METHOD OF PAYMENT: Check** ___ Money Order ___ Credit Card ___

VISA/MasterCard # _____ Exp. Date _____ 3-digit security code ___ _

Credit card billing address if different from above.

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Signature _____

** There will be a \$25.00 service charge for any check returned for insufficient funds.

INSTRUCTIONS and INFORMATION

o Complete each appropriate section of this form by printing or typing.

This form may be copied, but must include both pages.

o Members must pay their 2011 Annual Dues along with their registration fees by completing that portion of the form.

o You will receive acknowledgment of your pre-registration by January 15, 2011--bring it with you to the meeting.

o No pre-registration will be processed after January 3, 2011.

-- **After this date you must register at the meeting.**

o Your receipt and meeting credentials will be available for you at the Pre-Registration desk at the meeting.

o There will be **NO ADMISSION to any Fireside Chat without proper admission credentials.**

o If you are joining The Academy with your registration you must:

1) complete appropriate areas of the form;

2) you **MUST INCLUDE** the membership application form;

3) include the \$25 filing fee;

4) include \$145 for the 2011 Annual Dues;

(Your membership begins with the closing business meeting)

o ONLY VISA/MasterCard credit cards are accepted - with VISA/MasterCard you may FAX your registration to (717) 867-1485

o The AACP Federal Tax ID Number: 63-0776991 (for hospital use only)

o Refund policy: Anyone that is pre-registered for this meeting and is unable to attend will receive a full refund minus \$50.00 for handling, mailing, and processing upon written request before January 12, 2011.

o **Make checks payable to AACP (US dollars). Mail completed pre-registration form and check to:**

AACP

515A East Main Street

Annaville, PA 17003

IF YOU HAVE QUESTIONS FILLING OUT THIS FORM, PLEASE CONTACT THE NATIONAL OFFICE (717) 867-1485.

o If paying by VISA/MasterCard you may FAX this form to (717) 867-1485 or mail to above address.

Call for Video Presentations for the Annual 2011 Meeting

This year the American Academy is preparing a Video Session for all Perfusionists to share their techniques with others at our National Symposium which will be held in Reno, Nevada on January 27-30, 2011. The video presentations will be available to view for the entire meeting. You will be able to spend time reviewing each video at your leisure and we will provide USB output to download the video presentations, as well as policy or procedure materials provided by authors for you to take back and share with your perfusion teams at no extra charge.

These videos should be submitted by October 15, 2010. (Guidelines for production are listed on the AACP website. An example video is available on the website as well.) We are very pleased to add this teaching tool to our annual meeting.

It is very important for all Perfusionists to share their shortcuts, new techniques, special procedures, oxygenator change-outs, and other various skilled maneuvers that may enable others to gain experience from a video series.

Thank you in advance and we look forward to this exchange of Perfusion Techniques from your hospital in video form.

www.theAACP.com

Important Academy Dates

The ACADEMY ANNUAL MEETING DEADLINES

ABSTRACT DEADLINE	October 15, 2010
MEMBERSHIP DEADLINE	November 27, 2010
PRE-REGISTRATION	December 27, 2010
HOTEL REGISTRATION	December 27, 2010
2011 ANNUAL MEETING	January 27 - 30, 2011

Others Meetings

Canadian Society Clinical Perfusion

Palais des Congrès de Montréal
Montréal, Quebec, CANADA
October 23-27, 2010
Phone: 1-888-496-2727
Website: cscp@cscp.ca
Contact Name: Eric Laliberte
Contact Phone: 514-402-2399
Contact Email: agm@cscp.ca

Cardiology 2011

Hyatt Regency Scottsdale Resort and Spa at Gainey Ranch
Scottsdale, Arizona
February 2-6, 2011
Preliminary program available at
www.chop.edu/cardiology2011
Contact Name: Tami Rosenthal
Contact Phone: 267-425-6588

14th European Congress on Extracorporeal Circulation Technology

Valamar Lacroma Hotel
Dubrovnik, Croatia
June 15-18, 2011
Sponsored by the Foundation European Congress on Extracorporeal Circulation Technology (FECECT)
Website: www.fecect.org
Email: office@fecect.org

Contact Information for Our Sponsoring Partners

ABIOMED, INC.

Phone: 978-777-5410
Fax: 978-777-8411
Website: www.abiomed.com

MAQUET CARDIOPULMONARY

Phone: 888-627-8383
Website: www.maquet.com

MEDTRONIC PERFUSION SYSTEMS

Phone: 763-391-9000
Websites: www.medtronic.com
www.perfusionsystems.com

QUEST MEDICAL, INC.

Phone: 800-627-0226 or 972-390-9800
Fax: 972-390-2881
Website: www.questmedical.com

SOMANETICS CORPORATION

Phone: 248-689-3050
Fax: 248-689-4272
Website: somanetics.com

SORIN GROUP USA, INC.

Phone: 800-221-7943 or 303-467-6517
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SPECTRUM MEDICAL, INC.

Phone: 800-265-2331
Fax: 803-802-1455
Website: www.spectrummedical.com

TERUMO CARDIOVASCULAR SYSTEMS

Phone: 734-663-4145 or 800-521-2818
Fax: 734-663-7981
Website: terumo-cvs.com