

June 4, 2012

Thoracic Surgery Residency Program Directors and Administrators

Dear Program Directors and Administrators:

The American Board of Thoracic Surgery (ABTS) and Thoracic Surgery Residency Review Committee (RRC) would like to provide instructions about the transition of cardiothoracic case logs from CTSNet to the ACGME case log system. The American Board of Surgery and Surgery RRC already have been using the ACGME system successfully for many years, so all residents graduating from general surgery programs are already experienced with this system. The ABTS and RRC have worked together to create a similar ACGME framework for cardiothoracic case log entry that is built to accommodate the index case requirements being implemented in July 2012. After considerable discussion between the Board and the RRC, we believe that the following plan will be the best for both your residents and for your programs.

In an effort to create a smooth phased in transition, we will require that all of the I-6 programs switch to the ACGME coding system beginning in July 2012. We know that many of your residents are using the system already to log their general surgical cases. They would, however, have to manually keep track of their experience with multidisciplinary patient management conferences, cardiothoracic critical care case management experience, and simulation. This will give us an opportunity to beta test the system across the whole spectrum of our case requirements before extending the ACGME case log entry to all programs in 2013. Integrated residents who have begun using the CTSNet case log system should switch to the ACGME system in July 2012, and the ABTS will accept both case logs until the transition is complete.

Traditional 2 and 3 year thoracic residency programs should continue to track their operative cases using the CTSNet application which will reside in the near future on the Board's website. These residents will also need to manually keep track of the multidisciplinary patient management conferences, cardiothoracic critical care case management experience, and simulation as well as the newer requirements that we have highlighted in the accompanying document reviewing the new index case requirements. However, individual residents or programs may elect to voluntarily convert to the ACGME case log system in July 2012, in anticipation of mandatory conversion in July 2013.

In July 2013, residents starting in all programs will be required to record their cases using ACGME's system. For residents who would be in year two of a two-year or year two or three of a three-year programs, we would give those residents the choice to convert into ACGME, which would require them to input their earlier experience into the ACGME operative logs or have them remain with CTSNet. The Board would accept both applications for these transitional years.

We certainly understand that these transitional years will be somewhat difficult, but we hope that by phasing this new ACGME operative log system will allow more accurate completion of the data, a chance to work out the bugs in a small number of programs and residents while providing a more constant and tried system of the CTSNet application.

We sincerely appreciate your patience during this transition, and I look forward to answering any questions you might have.

Best regards,



William A. Baumgartner, MD  
ABTS Executive Director



Douglas E. Wood, MD  
RRC-TS Chair

**For Residents who start their training on or after July 1, 2012**

<b>Cardiac Focused</b>		<b>Requirements</b>	<b>General Thoracic Focused</b>	
<b>Total</b>	<b>Subtotal</b>		<b>Subtotal</b>	<b>Total</b>
		<b>CONGENITAL HEART DISEASE</b>		
10		Primary surgeon		
10		First assistant		
		Primary surgeon or first assistant		10
<b>20</b>		<b>Subtotal Congenital Heart Disease Experience</b>		<b>10</b>
		<b>ADULT CARDIAC</b>		
50		<b>Acquired Valvular Heart Disease</b> Any combination of mitral valve, aortic valve, and/or tricuspid valve replacement or repair. **Tricuspid valve procedures performed with CABG can be double-counted with CABG		25
80		<b>Myocardial Revascularization</b>		40
	15	<b>Re-Do Sternotomy</b> **Can be double-counted with any cardiac procedure	5	
20		<b>Interventional Skills or Procedures</b> Any combination of intra-aortic balloon pump (IABP), intravascular ultrasound, angiography, transvenous pacemaker insertion, image-guided intervention over a wire, percutaneous tracheostomy, tracheal/esophageal stent placement, PleurX® catheter (or similar pleural drainage catheter) insertion, ultrasound-guided pigtail catheter placement for pleural drainage, radiofrequency ablation, and TEVAR.		20
10		<b>Conduit Dissection and Preparation</b> Open or endoscopic saphenous/radial vein harvest and preparation **Can be double-counted with CABG		5
10		<b>Aortic Procedures</b> Any combination of ascending aorta/aortic root replacement, descending aortic replacement, TEVAR, aortic dissection, aortic trauma **Can be double-counted with CABG/Valve Procedures ** TEVAR can be double-counted as an aortic procedure and interventional skills		5

5		<b>Arrhythmia Surgery</b> Left atrial or biatrial maze, pulmonary vein isolation, right-sided maze, isthmus ablation **Can be double-counted with CABG/valve procedures		0
4		<b>Cardiopulmonary Bypass set-up and pump run with perfusionist</b>		4
10		<b>Circulatory Assist/Cardiac Transplant</b> Any combination of IABP, ECMO, VAD, Cardiac Transplant **Can be double-counted with another operation		5
<b>189</b>		<b>Subtotal Adult Cardiac Experience</b>		<b>104</b>
		<b>GENERAL THORACIC</b>		
60	30	<b>Lung</b> Major anatomic resections (segmentectomy, lobectomy, pneumonectomy, lung transplantation**) **Only 1 pneumonectomy can be double-counted for bilateral lung transplant.	50	100
	5	Major VATS/robotic anatomic resections	10	
	25	Open or VATS lung biopsy/wedge resection, lung procurement for transplantation	40	
10		<b>Pleura**</b> Major (decortication, pleurectomy decortication, extrapleural pneumonectomy (EPP), or other tumor resection) Minor (biopsy, pleurectomy, VATS sympathectomy, VATS Bleb resection, VATS pleurodesis) **EPP can be double-counted as Pleura and Lung procedures	5 15	20
3		<b>Chest Wall and Diaphragm**</b> Chest wall resection, pectus repair, diaphragm resection or plication, repair of Morgagni, Bochdalek, or traumatic hernia **Can be double-counted with pulmonary resection		6
5		<b>Mediastinum</b> Tumor/cyst/mass resection via open, VATS, or robotic technique		10
0		<b>Tracheobronchial – Airway Surgery**</b> Tracheal-bronchial resection/reconstruction,		5

		laryngotracheal resection/reconstruction, airway anastomosis **Sleeve lobectomy and carinal pneumonectomy can be double-counted with major anatomic lung resection **Lung transplantation can be counted as either Tracheobronchial or Lung		
15	10 5	<b>Esophagus</b> Esophagectomy (Open or minimally invasive) Benign Esophagus-Major Repair of perforation, drain perforation, diverticulectomy, myotomy, hiatal hernia repair  <b>For the GT focused pathway, at least 5 of the 30 esophageal procedures must be performed minimally invasively.</b>	20 10	30
93		<b>Subtotal General Thoracic Experience</b>		171
302		<b>TOTAL MAJOR OPERATIVE EXPERIENCE</b>		285
		<b>MINOR PROCEDURES**</b> **All may be double-counted		
30		<b>Bronchoscopy</b> Simple (BAL, diagnostic, TBBx, Bx) Complex (laser, dilation, stent, navigational bronchoscopy, photodynamic therapy)	30 10	40
10		<b>UGI Endoscopy</b> Simple (diagnostic, Bx) Complex (dilation, stent, EUS, EMR)	20 5	25
20	10 5	<b>Mediastinal Assessment</b> Mediastinoscopy EBUS/FNA Chamberlain or mediastinal node dissection	15 10 5	30
60		<b>Subtotal Minor Procedures</b>		95
362		<b>TOTAL OPERATIVE EXPERIENCE</b>		380

ADDITIONAL REQUIREMENTS				
100	50 50	<b>Consultation Experience</b> New Patients Follow-up Patients	50 50	100
20		<b>Multidisciplinary patient management conferences</b> Any combination of tumor board, cardiac catheterization conference, multidisciplinary clinics, transplant selection committee meetings, etc.		20
75	20 20	<b>Cardiothoracic critical care case management experience (provide log sheet for each case with at least one case from each of the seven categories. See below)</b> General thoracic Cardiac and congenital	20 20	75
20 hrs		<b>Simulation (hours required from any technique-based simulation curriculum or simulation of cardiopulmonary bypass management)</b>		20 hrs
X		<b>Previous or current FLS, ATLS, ACLS certification required</b>		X

### CT Critical Care Management Documentation

Select the patients who best represent all the essential aspects of intensive care unit management. Each resident is to develop a CT Critical Care Index Case (CCIC) log of at least twenty patients who best represent the full breadth of critical care management. At least two out of the seven categories listed below should be applicable to each chosen patient. The completed CCIC log should include experience, with at least one patient, in all seven of the following essential categories:

1. Ventilatory Management
  - a. Etiology/indications
  - b. Ventilatory modes/techniques
  - c. Ventilator days
  - d. Weaning method
2. Bleeding (non-trauma) greater than 3 units necessitating transfusion/monitoring in ICU setting
  - a. Etiology
  - b. Coagulopathy: yes no
  - c. Hypothermia: yes no
  - d. Autotransfusion: yes no

3. Hemodynamic Instability
  - a. Etiology
  - b. Volume resuscitation
  - c. Inotropic/pressure support: yes no
  - d. Mechanical assistance of cardiac failure: (IABP, LVAD, BiVAD)
4. Organ Dysfunction/Failure (etiology/mode of management)
  - a. Pulmonary
  - b. Renal
  - c. Hepatic
  - d. Central nervous system
  - e. Endocrine (Hypothyroidism, Adrenal insufficiency, Panhypopituitarism, Diabetes insipidus, SIADH)
5. Dysrhythmias
  - a. Etiology
  - b. Drug management
  - c. Therapeutic interventions
  - d. Monitoring
6. Invasive Line Management/Monitoring
  - a. Arterial cannulation
  - b. Pulmonary artery catheter
  - c. Intracardiac catheter
  - d. Complications
7. Nutrition
  - a. Route (parenteral/enteral)
  - b. Indications/contraindications