

Perfusionist



Quarterly publication of
The Society of Clinical Perfusion Scientists
of Great Britain and Ireland

Volume 49, Number 3
July-September 2025

Medtronic in ECLS

Innovative
like no other



Crescent™ Jugular Dual Lumen Catheter



Nautilus™ Smart ECMO Module



Bio-Medicus Life Support™

See the device manual for detailed information regarding the instructions for use, indications, contraindications, warnings, precautions, and potential adverse events. For further information, contact your local Medtronic representative and/or consult the Medtronic website at www.medtronic.eu. For applicable products, consult instructions for use on www.medtronic.com/manuals. Manuals can be viewed using a current version of any major internet browser. For best results, use Adobe Acrobat® Reader with the browser. This information is intended only for users in markets where Medtronic products and therapies are approved or available for use as indicated within the respective product manuals. Content on specific Medtronic products and therapies is not intended for users in markets that do not have authorization for use.

Perfusionist

Publication of The Society of Clinical Perfusion Scientists of Great Britain and Ireland

SCPS e-mail address: admin@scps.org.uk

SCPS web site: www.scps.org.uk

The contents of this publication are the property of the Society, and may not be reproduced without its permission. Published quarterly, this journal is issued free to all entitled to it. The views expressed in it are solely those of the contributors. Articles of scientific interest related to perfusion are welcome, as are letters to the Editor regarding Society and perfusion matters. They should be sent to the Editor at the address below, or e-mailed to editor@scps.com

Editor **Andrew Nichols**
Clinical Perfusion Manager
Leeds Teaching Hospital Trust
Telephone: 0113 392 5342
andrew.nichols1@nhs.net

SOCIETY OFFICERS

President **David Chambers**

Chairman **Noel Kelleher**
University Hospital Wales, Cardiff
Telephone: 02920 746841
e-mail: chairman@scps.org.uk

Secretary **Aswani Parmer**
St Barts Hospital, London
e-mail: secretary@scps.org.uk

Registrar **Laura Kerr**
Great Ormond Street Hospital, London
Telephone: 0208 725 1489
e-mail: registrar@scps.org.uk

Treasurer **Alan Rayner**
London Bridge Hospital
Email: Alan.Rayner@HCAHealthcare.co.uk

C O N T E N T S

EDITORIAL	3
THE SOCIETY THANKS OUR CONGRESS SPONSORS	4
QUANTUM DIRECTED PERFUSION – HOW HAS IT IMPACTED OUR SERVICE?	6-9
EXAMINER'S WORKSHOP 2025	9
WILLIAM NEVILLE MARTIN OBITUARY	11
COLLEGE COUNCIL VACANCIES	11
A TRAINEE'S PERSPECTIVE: ATTENDING THE LONDON CORE REVIEW CARDIOTHORACIC SURGICAL COURSE 2025	12-13
CONGRESS 2025 AWARDS AND PRIZES	15
CONGRESS 2025 PROGRAMME	16-17
LETTER FROM BRISTOL UNIVERSITY OF BRISTOL	18
CONTEXT FOR UNIVERSITY OF BRISTOL LETTER	19
GUEST EDITORS WANTED	23
RECRUITMENT	26
EXECUTIVE COMMITTEE	28

"PERFUSIONIST"
and
**THE SOCIETY OF CLINICAL
PERFUSION SCIENTISTS**
of Great Britain and Ireland

is extremely grateful to

LivaNova

for bearing the cost of postage of each edition
of this publication.

COMMERCIAL ADVERTISING

Price on application

SITUATIONS VACANT

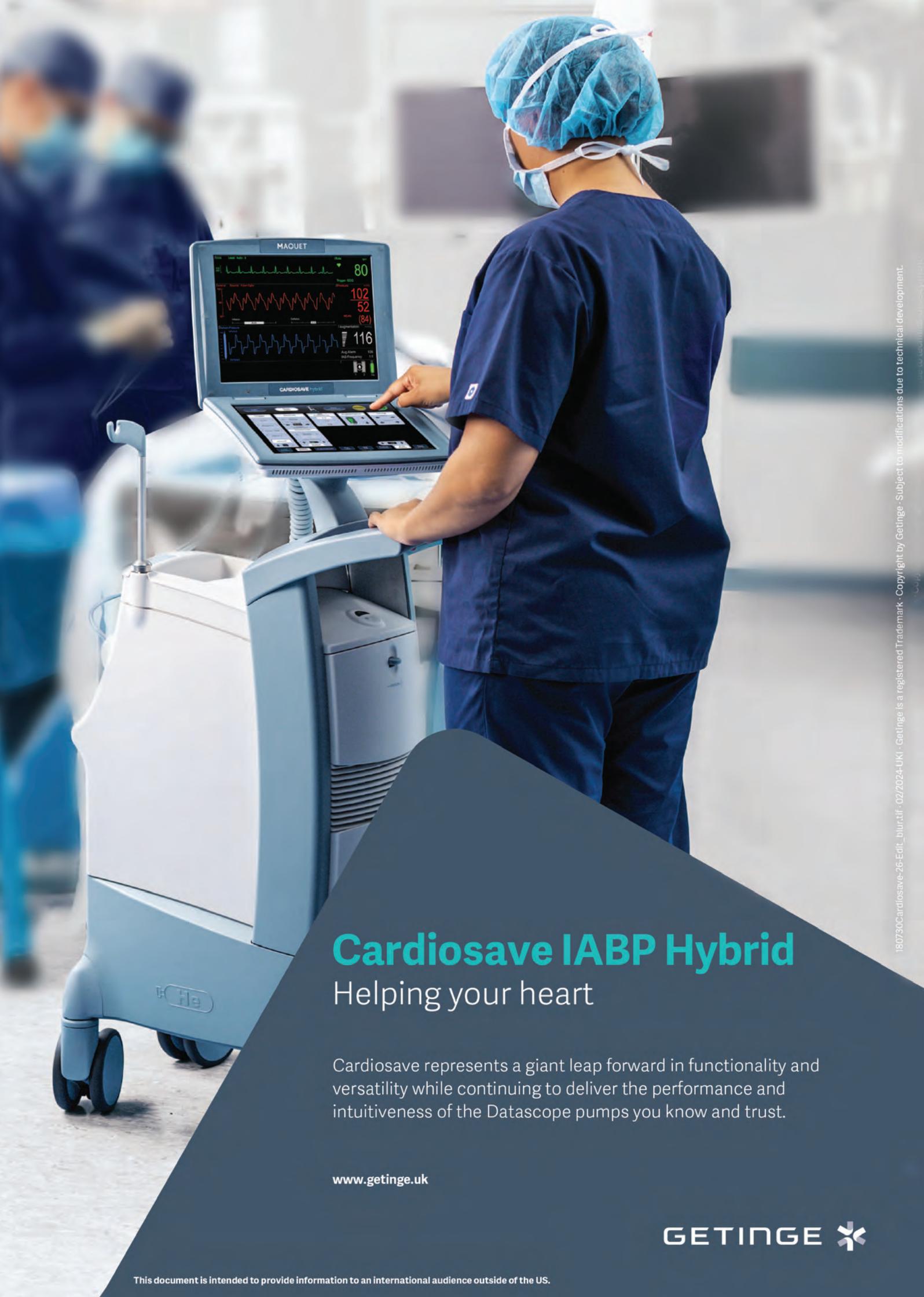
Price on application
(includes entry onto Society website).
No VAT is payable on invoices.
Quarter Page (133mm x 86mm)
Half Page (133mm x 178mm)
Full page (272mm x 178mm)

For all commercial advertising enquiries
including Society Website:

Les Allen
131 Botany Road
Broadstairs
Kent
CT10 3SB
m: 07944 295613
e: perfads@icloud.com

For all general enquiries from the
membership and public:

Valerie Campbell, Administrator
Zenia Simone, Assistant Administrator
SCPS
The Royal College of Surgeons of England
38-43 Lincoln's Inn Fields
London, WC2A 3PE
t: +44 (0)20 7869 6891
e: admin@scps.org.uk



180730Cardiosave-26-Edit_blur.tif - 02/2024-UKI - Getinge is a registered Trademark - Copyright by Getinge - Subject to modifications due to technical development.

Cardiosave IABP Hybrid

Helping your heart

Cardiosave represents a giant leap forward in functionality and versatility while continuing to deliver the performance and intuitiveness of the Datascope pumps you know and trust.

www.getinge.uk

GETINGE 

This document is intended to provide information to an international audience outside of the US.

Andrew Nichols, Editor



Dear Reader,

Welcome to the third *Perfusionist* of 2025. I hope all of you had a good summer and are now planning for the winter ahead. I'd like to start by apologising and giving the correct recognition for an article published in volume 49, number 2. The audit looking at the working day in the perfusion community had been written and submitted by Georgia Mee-Evans from Nottingham University Hospital. I missed that her name been included on the article. Sorry for that.

This edition includes information about our upcoming annual congress and AGM in November. We are of course returning to the West Midland Conference centre for the third time, which is testament to how good the facility is for accommodating our congress. There is news about changes to the examining process for the MSc. We have a write up, by Mia Fava from St Georges who attended this years London core review. Thanks also to Jack Satchwell from Sheffield Northern General for his article on Quantum directed perfusion.

I must of course mention the achievements of the England women's Rugby team, who went on to win the rugby world cup. I was lucky enough to watch the runners up in their first group stage against Fiji. On the same theme, we mustn't forget the England women's football team who have done it again and retained the European title. It just shows what can be achieved with the right backing and quality leadership. Long may this reign continue.

Sadly, we have lost another of the founders of our Society, Neville Martin had been the chief perfusionist at Killingbeck in Leeds for many years and was instrumental in the merger of the two cardiac centres to make the General Infirmary as it is today. One of his key achievements was in retaining all the Perfusion staff from both sites, despite opposition from senior management at the time. Printed in the Oct-Nov 2024 edition of *Perfusionist*, was material from the first ever meeting of the soon to be

formed society, held at Killingbeck hospital. No doubt Neville had a significant amount of involvement in organising the event.

This will be my final editorial for *Perfusionist*, as I am standing down after four years. Please consider putting yourself forward to take on the role. Les Allen, our publisher, does a huge amount of the work and is very experienced with our publication. It is very rewarding, especially when you receive something in your inbox, that you can't wait to share with the membership. So, if being editor is not for you, then please think about what contributions you could make. In this digital age, there is still something personal and permanent about having a copy in your hand.

Thank you to all the contributors over the last four years. A special thank you to Les.

Best wishes

Andrew Nichols



Opportunity for Commercial Companies



The Editor would welcome submissions from the commercial sector on interesting subjects and commercial news of relevance to the membership of the Society.

The Society wishes to thank the following companies for their support of the 2025 Perfusion Congress:



Abbott



CBM Lifemotion



Chalice



Cytosorbents



Eurosets



Getinge



GTA (UK) Ltd



Haemonetics



Hart Biologicals



LINC Medical Systems Ltd



Liva Nova



Medtronic



Nordic Pharma



Nova Biomedical



Pharmapal



Spectrum Medical



Stago UK



Teleflex



Terumo



Werfen



CUSTODIOL®

HTK - Bretschneider®

YOUR **CARDIOPLEGIC SOLUTION** FOR **ALL SITUATIONS**

COMPLEX HEART SURGERY
VALVE SURGERY
MICS
CABG
PEDIATRIC SURGERY
HEART TRANSPLANTATION



www.custodiol-college.com

CUSTODIOL Solution for **cardioplegia / organ preservation**

Composition: 1,000 ml of the solution contain: 0,8766 g sodium chloride (15.0 mmol), 0,6710 g potassium chloride (9.0 mmol), 0,8132 g magnesium chloride x 6 H₂O (4.0 mmol), 27,9289 g histidine (180.0 mmol), 3,7733 g histidine hydrochloride monohydrate (18.0 mmol), 0,4085 g tryptophane (2.0 mmol), 5,4651 g mannitol (30.0 mmol), 0,0022 g calcium chloride x 2 H₂O (0.015 mmol), 0,1461 g α-ketoglutaric acid (1.0 mmol). Water for injections. Potassium hydroxide solution, (for pH adjustment). **Indications:** Cardioplegia in cardiac surgery operations, preservation of organ transplants; perfusion and cold storage (heart, kidney, liver, pancreas). **Posology and method of administration:** See prescribing information. **Contraindications:** Hypersensitivity to the active substances or any of the excipients. **Warnings and precautions for use:** Not for systemic administration. See prescribing information. **Shelf life:** 1 year. **Storage:** Store in a refrigerator (2-8°C)

Pack sizes: 6 bags x 1,000 ml, 4 bags x 2,000 ml. POM. PL41891/0001.

MAH: Dr. Franz Köhler Chemie GmbH, Werner-von-Siemens-Str. 14-28, 64625 Bensheim, Germany

UK Distributor: PHARMAPAL Ltd., 404 Centennial Park, Elstree, Herts WD6 3TN, Phone: 0208 91 25 333

E-mail: info@pharmapal.co.uk

Please see Full Prescribing Information.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
Adverse events should also be reported to medinfo@pharmapal.co.uk

References:

1. Custodiol Solution for cardioplegia / organ preservation. Summary of Product Characteristics, 2024;
2. Hummel B, et al. Innovations 2016;11: 420-424

Quantum Directed Perfusion – How has it impacted our service?

Jack Satchwell MSc AACP LCCP

Introduction

As some of you who attended the 2024 AGM in Glasgow might remember, I have been reviewing the impact of Quantum Directed Perfusion (QDP) on our service and patient outcomes at Sheffield Teaching Hospitals (STH) NHS FT.

We purchased Quantum Workstations and Diagnostic Modules in 2023 to replace our previous in-line monitoring equipment, as we had been almost completely unable to secure the consumables required for ~12 months. This meant we were routinely rationing consumables, causing variability in care quality & equivalence, and broad non-compliance with CCPS minimum standards during cardiopulmonary bypass (CPB). This frequent compromise to patient care was flagged to the Trust's risk management group via governance pathways. The imminent prospect of running CPB with very limited / zero in-line monitoring was deemed an unacceptable risk to patients. As a result, we secured urgent funding to replace our in-line monitoring kit with Spectrum equipment, which at the time was the only available, fully minimum-standards compliant, consumables free system on the market. These were installed onto our Stöckert S5 HLMS, see Figure 1.

The adoption of the Spectrum kit allowed us to immediately adopt QDP-led CPB, which was a major improvement in many aspects of our service at STH. The primary benefits included:

- Consumables-free fully compliant in-line blood gas monitoring, insulating STH from further supply chain disruption and ensuring consistent care quality.
- The adoption of goal directed perfusion (GDP) principles, utilising advanced perfusion metrics and physiological indices (primarily indexed oxygen delivery (DO_{2i}) & perfusion ratio (PR) (DO₂:VCO₂)) to better optimise CPB.
- PR is particularly insightful for septic / infected patients with elevated metabolic rates.
- A more anticipatory approach for better optimising CPB based on post-haemodilution DO_{2i} projections.
 - Running CPB at a higher CI to augment DO_{2i} to compensate, if possible.
 - More frequently implementing retrograde (+/-) antegrade autologous priming / blood priming, to reduce haemodilution and avoid exposure to suboptimal DO_{2i}.
- Adopting suboptimal DO_{2i} of <280ml/min/m² as a primary transfusion trigger (instead of a Hb of 7.5g/dL).
 - Whilst our previous in-line monitoring system could derive DO_{2i}, it relied on constant manual flow updates, which were often based on displayed rather than delivered flow, meaning this value was often inaccurate. The inability to source consumables meant this value often wasn't available at all.
- The routine use of flow probes.
 - For validation of arterial flow - particularly helpful when using arterial roller pumps.
 - The routine use of venous flow probes to validate venous drainage adequacy.
 - Being able to monitor 3 flow probes simultaneously has hugely enhanced our complex aortic service.
- The development of custom Spectrum formulas to measure and graphically plot oxygenator transmembrane pressures in real time and monitor oxygenator gas transfer performance during surgery (P/F ratio).
- Moving away from paper charting to a fully integrated Spectrum EPR system (and improving our CCPS compliance in this regard, too).
 - This also allowed us to begin auditing cases, conduct research

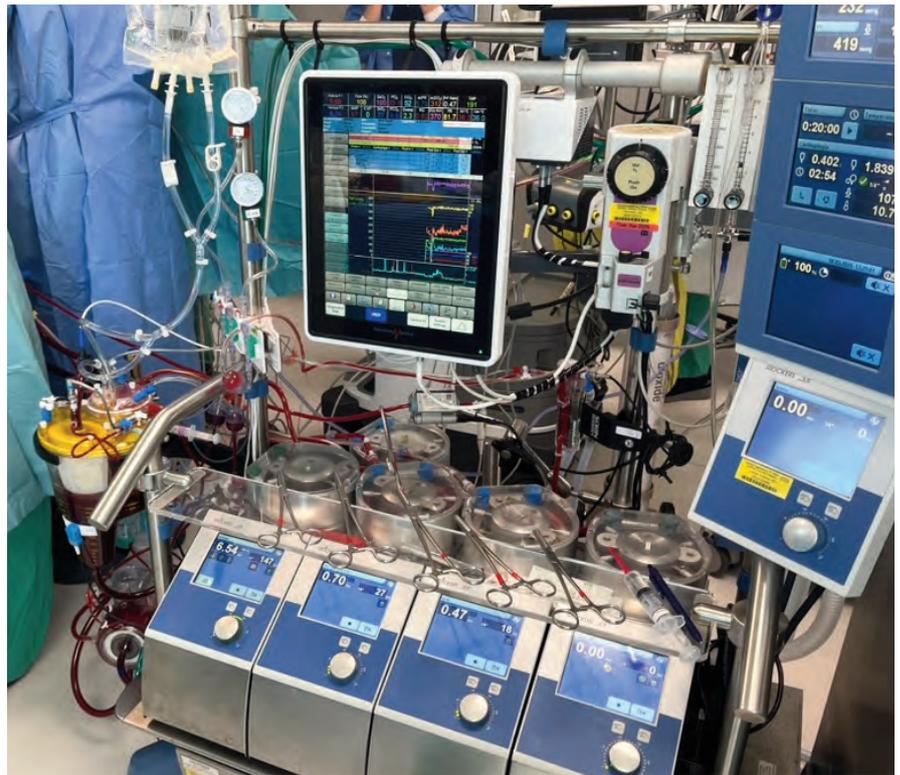


Figure 1: Our HLMS with the Workstations and QDMs fitted. The Workstations function as both our in-line monitoring system and in-theatre EPR

and develop & implement a departmental quality assurance framework.

All of these aspects have played a major role in improving our departmental minimum-standards compliance, allowed us to embrace emerging evidence and clinical recommendations, and most importantly the quality and consistency of care we provide at STH.

Audit

In early 2024, our anaesthetic colleagues anecdotally commented that they'd noticed that our postoperative outcomes had seemingly improved since we installed Spectrum in-line monitoring equipment and adopted QDP strategies. I decided to review the direct impact on our patient outcomes attributable to this service enhancement, to see if our patient outcomes had indeed meaningfully improved.

Based on the evidence in the literature, my hypothesis was that the adoption of QDP principles at STH would have led to:

1. Reduced overall ICU length of stay (LOS) after cardiac surgery.
2. Better renal outcomes (i.e. a lower incidence of post-operative RRT requirements).

Unfortunately, clinical data isn't incorporated into one overarching EPR system at STH (at present) and is instead spread across numerous databases... which made data extraction and amalgamation tricky. Clinical data was pooled from our Perfusion case log document and cross referenced against several databases including our Infoflex surgical (pre & post-operative) data, Spectrum case report PDFs, and post-operative CICU ICNARC data.

I collated two datasets, one pre-QDP (02/2022-02/2023) and one post-QDP adoption (02/2023-02/2024) and included all cases that were transferred to ICU post-operatively and survived to ICU discharge, see Figure 2. I excluded:

- Off-pump cases (for obvious reasons)
- Deaths in theatre and ICU
- Cases transferred to recovery post-operatively
- Patients that were reopened
 - Re-exploration for bleeding is a recognised marker for increased morbidity and mortality and prolongs ICU LOS.
 - Additionally, re-exploration after cardiac surgery is a strong, independent predictor of cardiac surgery associated AKI, which could augment the LOS and prevalence of

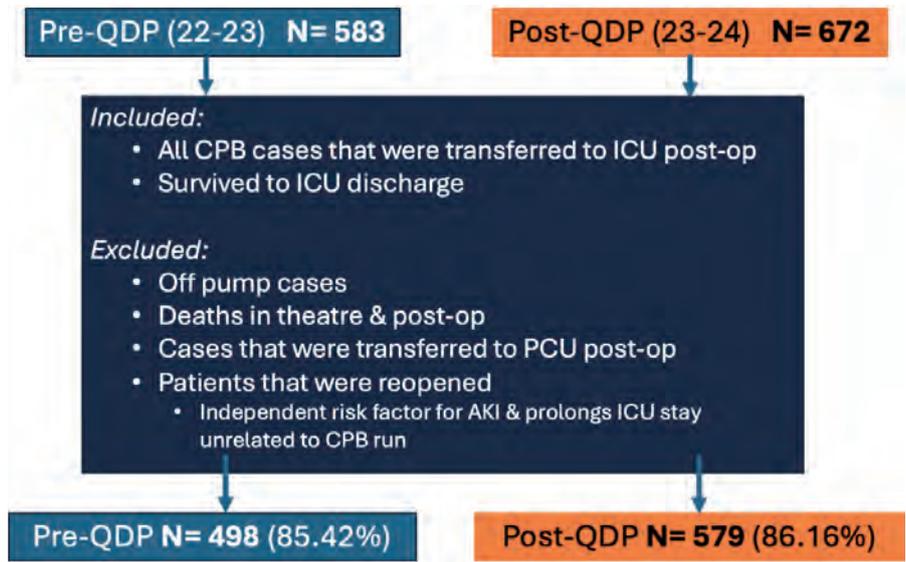


Figure 2: A schematic of inclusion and exclusion criteria used for this research

AKI in the postoperative patient population, in the absence of complications attributable to the CPB run.

It should be noted that there were no other changes to clinical practice, staffing, equipment, surgical strategies or anaesthetic / ICU patient management during the period in which QDP was implemented. We were running two cardiac lists (down from three) per day over the entire 24-month study period

due to theatre refurbishment work. The change in our in-line monitoring and intraoperative patient management / clinical practice is therefore the only variable that could have impacted our patient population.

Analysis

Both cohorts were compared to determine if there were any statistically significant differences between them. Figures 3 and 4 show the comparisons.

Parameters		Pre-QDP	Post-QDP	p
Number of patients (n)		498	579	
Gender (%)	Female	136 (27.3)	156 (26.9)	0.947
	Male	362 (72.7)	423 (73.1)	
FEV1 (L) (mean (SD))		2.56 (0.81)	2.55 (0.80)	0.855
FVC (L) (mean (SD))		3.45 (1.47)	3.55 (1.68)	0.412
Hypertension (%)	No	199 (40.0)	221 (38.2)	0.591
	Yes	299 (60.0)	358 (61.8)	
LV function (%)	Good	332 (66.7)	390 (67.4)	0.953
	Moderate	119 (23.9)	140 (24.2)	
	Poor	38 (7.6)	39 (6.7)	
	Very poor	9 (1.8)	10 (1.7)	
Preoperatively dialysis dependent (%)	No	492 (98.8)	575 (99.3)	0.577
	Yes	6 (1.2)	4 (0.7)	
EGFR (mL/min/1.73m ²) (mean (SD))		73.1 (18.44)	72.43 (17.78)	0.122
Haemoglobin (g/dL) (mean (SD))		13.53 (1.79)	13.63 (1.75)	0.52
Operative urgency (%)	Elective	259 (52.0)	336 (58.0)	0.135
	Urgent	219 (44.0)	228 (39.4)	
	Emergency	19 (3.8)	15 (2.6)	
	Salvage	1 (0.2)	0 (0.0)	
Euroscore (logistic) (mean (SD))		8.72 (10.07)	8.02 (8.17)	0.210
CABG surgery (%)	No	296 (59.4)	341 (58.9)	0.906
	Yes	202 (40.6)	238 (41.1)	
Valve surgery (%)	No	158 (31.7)	178 (30.7)	0.778
	Yes	340 (68.3)	401 (69.3)	
Major aortic surgery (%)	No	445 (89.4)	495 (85.5)	0.071
	Yes	53 (10.6)	84 (14.5)	
Other cardiac procedure (%)	No	408 (81.9)	478 (82.6)	0.85
	Yes	90 (18.1)	101 (17.4)	
Surgical access (%)	Median sternotomy	439 (88.2)	534 (92.2)	0.168
	Mini sternotomy	39 (7.8)	27 (4.7)	
	Right anterior thoracotomy	12 (2.4)	8 (1.4)	
	Other	1 (0.2)	1 (0.2)	
	N/A	7 (1.4)	9 (1.6)	
Arterial pump	Centrifugal (%)	264 (45.6)	237 (47.6)	0.553
	Roller (%)	315 (54.4)	261 (52.4)	
CPB duration (minutes) (mean (SD))		108.22 (48.30)	114.37 (58.56)	0.06
Patient height (cm) (mean (SD))		170.22 (9.85)	170.90 (9.72)	0.262
Patient weight (kg) (mean (SD))		84.44 (17.95)	84.72 (19.08)	0.809

Figure 3: All compared parameters and p values

As the data shows, the pre- and post-QDP cohorts were well matched with no statistically significant differences in any category. They are therefore well matched for comparison.

Histograms were put together to assess the distribution of data within each parameter. I haven't included them as I don't want to take up the whole magazine with graphs, but they were all comparable, with no major outliers skewing the data in any category, with the exception of one patient in the pre-QDP group who had an extremely long ICU LOS of 68 days.

Results

	Pre-QDP	Post-QDP
N	498	579
ICU LOS median (days)	2	2
ICU LOS range (days)	68	33
ICU LOS mean (days)	4.25	3.3
≤48h LOS %	57%	67%
Total ICU days	2116	1909

Despite operating on 81 (16%) more patients in the post-QDP cohort, total ICU days fell by 207 (9.7%) for all patients included in the analysis, with a greater proportion of patients having an ICU LOS of ≤48h (57% pre-QDP vs 67% post-QDP).

Importantly, the mean ICU LOS fell from 4.25 days to 3.3 days (23% reduction, $p=0.011$) which is statistically significant and supports the first hypothesis. There was no change in median LOS, however that is largely expected in a rightward skewed data set.

Postoperative RRT requirements fell from 2.6% to 1.3% (50% reduction), and total RRT days per patient fell from 0.25 days/year to 0.09 days/year (67% reduction) however this was not statistically significant ($p=0.102$), which unfortunately doesn't support the second hypothesis.

Limitations & Considerations

There are several assumptions and concessions that have been made in this analysis, due to both the complexity and limitations of the available data.

- ICU LOS is arguably a crude way to measure patient outcomes, and it can be impacted and extended by a lack of ward beds for patients to be stepped down to, particularly in the winter months, which has certainly been the case at STH. This may well have impacted this audit.
 - However, the seasonal ward bed pressures we have faced

led to similar numbers of theatre cancellations in both 2023 and 2024 (that are proportional to each cohort), so I expect this aspect will have had a similar impact on both patient groups.

- Conversely, the discharge of patients from ICU (via LOS) is quite insightful as a standalone holistic metric, as it conveys that all organ systems are adequately recovered from surgery, the patient is satisfactorily weaned off all inotropic support and is haemodynamically stable enough to be stepped down to a ward.
- Due to the lack of an overarching / comprehensive EPR system at STH (at the time of the audit), my ability to analyse more granular postoperative metrics such as time to extubation, reintubation rates, inotrope infusion rates / weaning etc. was hindered.
- The operative urgency demographics were slightly different between the patient cohorts, although this was not statistically significant ($p=0.135$).
 - We performed more elective operations in the post-QDP cohort (336 vs 259); however, the proportions of these patients were similar between both groups (58% vs 52%). A slight reduction in ICU LOS might therefore be expected due to this.
- The pre-QDP cohort might have been waiting for surgery for longer in the post-COVID service recovery era, so may have been more deconditioned pre-operatively. However, the logistic Euroscores were not statistically significantly different ($p=0.210$), implying that this may not have been a major factor in the reduction in ICU LOS.
- I had wanted to analyse EUROSCORE-II values, but the data was very patchy, so I had to use the logistic Euroscores. Whilst superseded in the clinical world, logistic Euroscores are acceptable for research (according to the website).
- One major consideration is the fact that the pre-QDP cohort underwent CPB with inconsistent in-line monitoring due to a shortage of consumables. This will have led to occasions where

blood gas control & regulation was suboptimal, with potentially longer durations of hypo/hypercapnia & hypo/hyperoxaemia between sweep gas and FiO₂ interventions, and where DO_{2i} wasn't available at all. This could have exposed patients to short periods of respiratory acidosis / alkalosis during CPB, which was completely avoided in the post-QDP group. However, this will only have impacted a fraction of the pre-QDP cohort so the impact will have been fairly minimal, but it's worth bearing in mind.

- A final consideration was the fact that some dialysis dependent patients may not have needed RRT in ICU (due to exceptional in-theatre management by the perfusion team, obviously), but might have subsequently needed RRT once discharged to a ward several days post-op. This aspect won't have been captured in this study, as I was only able to access (limited) ICU data and thus have missed some post-op RRT requirements that fell outside of this net.

Discussion

QDP adoption has coincided with a statistically significant 23% reduction in our mean ICU LOS at STH, which is very substantial for patient throughput and unit efficiency. It is also hugely considerable in terms of expenditure – the average cost of a cardiac ICU bed in the NHS is approximately £1800/day, so a reduction of nearly one ICU bed day per patient on average is very financially significant.

We have just completed a theatre refurbishment at STH and hope to increase our cardiac theatre throughput capacity to 900+ cases/year. Assuming we hit that target the 23% reduction in mean ICU LOS via QDP-led CPB will lead to operational efficiency savings of ~£1.5m/yr. Add in the cost savings from no longer having to buy in-line monitoring consumables (~£80k/yr+), the reduction in RRT equipment utilisation, and reduced theatre cancellations due to lack of ICU beds (due to improved patient throughput), and the cost savings mount even more.

2025

SCPS ANNUAL CONGRESS
07-09 NOVEMBER 2025

We're excited to announce that **Werfen will be exhibiting at the 2025 SCPS Annual Congress**, showcasing our latest innovations in cardiac surgery.

Visit us at Stand 5 to explore our cutting-edge technologies designed to support perfusionists and enhance patient care:

GEM Premier 7000 - Blood Gas With Haemolysis Detection

Experience our groundbreaking advancement in blood gas analysis with real-time haemolysis detection, now available on the new GEM Premier 7000 instrument.



VerifyNow – Antiplatelet Testing

Discover how our VerifyNow system delivers rapid, reliable platelet function testing to support critical decision-making in cardiac procedures.



ROTEM Sigma – Patient Blood Management

Learn how ROTEM Sigma provides comprehensive viscoelastic testing to optimise transfusion strategies and improve outcomes.



GEM Hemochron 100 - Rapid ACT Testing When Seconds Count.

Discover the GEM Hemochron 100 – Werfen's next-generation point-of-care analyser for fast, reliable ACT results in cardiovascular care.



For more information contact: sales.uk@werfen.com

werfen
Powering Patient Care

William Neville Martin Obituary

Keith Kincaid

It is with sadness I report the death of William Neville Martin aged 86 on the 15th May 2025. Neville was my Perfusion Manager for 20 years until his retirement in 1997.

Neville suffered from tuberculosis towards the end of his National Service and was treated at Killingbeck Hospital in Leeds. It was there he saw that healthcare would be a good future opportunity and joined Leeds General Infirmary Cardiology Department as a Physiological Measurement Technician. In the late 60's Neville moved to Killingbeck Hospital as the adult and paediatric cardiology and surgery service started. Following a split with Cardiology he headed up the cardiac theatre and ICU service, growing to include perfusion, patient monitoring, ventilator servicing other sundry technical services, eventually employing a dozen technicians, and regularly recruiting a new student each year with most becoming qualified in perfusion.

Neville always had an eye to the future and was instrumental in the formation of the Society of Perfusionists of Great Britain and Ireland, holding the position

of Registrar. The first national meeting of the Society, the forerunner to the Spring meeting, was held in a marquee in the grounds of Killingbeck Hospital in 1974 with the first AGM and Scientific meeting later that year in Dublin.

Neville was an enthusiast for education, training and qualification and for cooperation between technical specialities and was the Society's representative to the Federated Association of Medical Technology with its links to government and its role in the ultimately ill-fated development of National Vocational Qualifications in Perfusion. These were however, successfully superseded by our College of Perfusion based qualifications we have now. For his services in this field, Neville was awarded the Fellowship of the Society.

A major preoccupation of Neville's was the long-speculated merger of Killingbeck's adult and children's cardiac services with those of Leeds General Infirmary at a site somewhere in Leeds. The merger eventually taking place in 1997 in the new Jubilee Wing in Leeds

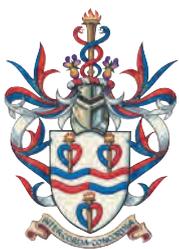


General Infirmary. Neville and his department were closely involved in the planning of the perfusion facilities and other parts of the new development. Due to his efforts every perfusionist working in Leeds at the time, made it to the new department. Neville however, retired with the closure of Killingbeck Hospital.

In retirement Neville remained active in NHS retired members groups, was elected to parish and district councils and was active in the election and support of the first Labour MP for Selby.

At his funeral it was heart-warming to see former colleagues and friends of his, from all his life activities. He leaves behind his widow Diane and two children.

With Regards, **Keith Kincaid**



The College of Clinical Perfusion Scientists of Great Britain and Ireland



Council Positions

The Executive Committee of the Society is asking for expressions of interest from the membership for positions on the College Council following the 2025 AGM.

Any perfusionist holding Full membership of the Society and with eight years' post-registration experience who wishes to put themselves forward for College Council seats should contact Valerie Campbell, the College's Administrator, for an outline of the roles and responsibilities of a Council member.

Expressions of interest briefly outlining experience and reasons for wishing to take up a Council seat should be submitted to Valerie Campbell by Monday 27th October 2025. The Society's Executive will consider all expressions of interest and appoint new members to start after the AGM.

Noel Kelleher,
Society Chairman

A Trainee's Perspective: Attending the London Core Review Cardiothoracic Surgical Course 2025

Mia Fava



The London Core Review Course is a credible and well-established cardiothoracic surgical course delivered over three intensive days. Organised by course directors Mr. Aziz Momin, Mr. Alex Shipolini and John Doty, MD, the course is held at the Wellcome Collection in London Euston and is advertised for a variety of delegates. While primarily aimed at young medical professionals sitting key surgical exams—including the FRCS – CTh, Cardiothoracic surgery board exams in the USA and Cardiovascular Surgeons Exams (EBTCS) – the course is also available for other healthcare professionals; Nurses, Clinical Perfusion Scientists, Echocardiographers, Cardiac Physiologists, and practising or retired cardiothoracic surgeons.

Each day featured focussed sessions on adult cardiac, congenital or thoracic surgery, divided into four sections, with the final forty minutes of each dedicated to a panel of senior surgical consultants who critically discussed real-life cases with members of the audience – mirroring multi-disciplinary team meetings.

Highlights from Day One: A Cardiac Interaction

Day one encompassed a diverse range of cardiac lectures from the named course directors, Lee McCann MD, Brian

Whisenant MD, Professor David Taggart, Mr. Simon Phillips, Mr. Simon Wilson, Professor Laurent De Kerchove and Dr. Iqbal Malik. The morning lectures provided some particularly engaging moments from Mr. Alex Shipolini, who presented a highly interactive MCQ case experienced 10 years ago about a middle-aged female who entered A&E with a kitchen knife lodged between her scapula and fourth vertebrae from a dispute with her significant partner. Similarly, Professor David Taggart provided a lecture on current updates of coronary artery bypass grafting (CABG) guidelines and passionately discussed the ACC/AHA's significant downgrade of



COR for CABGs suggesting it as a danger to patients. This led to a heated discussion with Mr. Simon Wilson during the forty-minute case discussion about whether a healthy, forty-year old, 10K runner with critical coronary disease should undertake a PCI or CABG.

Finally, a talk was then presented by Mr. Simon Phillips on the 'Tips and Tricks' of Cardiopulmonary Bypass (CPB), specifically what the surgical team can do to improve patient outcomes via CPB, as well as how Clinical Perfusion Scientist's conduct bypass, patient specific Goal Directed Perfusion (GDP) and the most significant challenges and problems faced for the perfusion team during cardiac surgery.

The afternoon featured opportunities for the audience to speak to the course

sponsors; Getinge, Meril, AtriCure, Abbott and Medtronic, before an inspiring, future-forward cardiac surgical lecture about device innovation, leadership dynamics and surgical training from Chief Medical Officer for Medtronic, Professor Peter Kappetein and Professor Laurent De Kerchove who spoke about his insight into the tips and tricks within mitral valve repair and replacement surgeries employed in Brussels, specifically the three teams who conduct robotic mitral valve repairs.

Highlights from Day Two: Continuing Cardiac

Day two introduced talks from new speakers, Dr. Alison Duncan, Dr. Riyaz Kaba, William Caine, MD and Professor Borut Gersak, with continued focus on cardiac surgery. Dr. Alison Duncan is an associate specialist in cardiology and transcatheter valve therapies who provided an in-depth talk about cardiac imaging and echocardiography, Dr. Duncan explained how to rapidly identify abnormal valvular pathologies using different echocardiograms, supplying images from her own work, as well as up-to-date quantification of these abnormal pathologies.



Another memorable moment was the presentation by Dr. Riyaz Kaba and Mr. Aziz Momin on their decade-long collaboration in developing the Convergent Hybrid Atrial Fibrillation (AF) Ablation Program. This innovative program is targeted for patients with

persistent, treatment-resistant AF. Patients undergo an epicardial ablation approach through the posterior left atrial wall and pulmonary veins with a subsequent endocardial catheter ablation. Results have

allowed patients to be discharged home on the same day and retain long-term maintenance of sinus rhythm, making a meaningful difference in patient care.

A Clinical Perfusion Perspective

As part of my ongoing professional development, I attended the London Core Review Cardiothoracic Surgery Course. It was an outstanding opportunity for a Trainee Clinical Perfusion Scientist as it significantly enriched my development and, although the course is designed for surgical apprentices, it still offered immense value from a perfusion standpoint by deepening my understanding of surgical principles, decisions undertaken within cardiothoracic surgery and clinical challenges faced by the team. Upon

gaining this insight it has allowed me to better appreciate the rationale behind various approaches and how these influence perfusion strategies and patient management for procedures I support daily.

The course not only offered material on evidence-based practice and current guidelines, but it also gave the opportunity to meet a wide range of healthcare professionals from across the globe, including Switzerland, the USA and Malaysia. These interactions helped me to build professional relationships and better understand the importance of teamwork, fostering a valuable interdisciplinary dialogue.

Overall, the London Core Review encourages open discussions, critical thinking and the exchange of global practices, all of which significantly enriched my understanding in the evolving field of cardiac surgery. I would strongly recommend this course to fellow Trainee Clinical Perfusion Scientists looking to expand their

knowledge and contribute more effectively to cardiac care.

By scanning the QR code you can directly access the London Core Review Course's website. There is an exclusive 2 for 1 offer for perfusionists to attend the 2026 Course with limited amount of spaces. All attendees will receive free meals at the venue, books, pens, bags and 12 months access to the Core Review App!

<https://www.londoncorereview.com/perfusionists-2026-registration>



Benchmark Monitoring of up to 22 vital patient parameters

The CDI OneView System is Terumo's new perfusion innovation

Featuring an elegant new design and up to 22 Goal Directed Perfusion parameters, the CDI OneView System offers real-time insight for real-time decision making. It gives perfusionists the precision, control, and confidence they demand for optimal patient management.

Thoughtfully created with a focus on improved patient outcomes the CDI OneView System is superior insight on display.^{1,2}

To learn more about the CDI OneView Monitoring System visit:
www.CDI-OneView-Monitoring-System/index



TERUMO
CARDIOVASCULAR

1. Ranucci, M, et al. Goal-directed perfusion to reduce acute kidney injury: A randomized trial. The Journal of Thoracic and Cardiovascular Surgery. 2018 Nov;156(5):1918-1927.
2. Condello, I, et al. Association between oxygen delivery and cardiac index with hyperlactatemia during cardiopulmonary bypass. JTCVS Techniques. 2020;Vol 2:92-99.
©2025 Terumo Europe N.V. CV482GB 09.25 SK-I(09.25)E. Company names and brand names used herein/hereon are trademarks or registered trademarks of TERUMO CORPORATION, its affiliates, or unrelated third parties. Refer to this device's Instructions For Use (IFU) for full prescribing information, including indications, contraindications, warnings, precautions and adverse events.

Rapid, accurate platelet reactivity testing for many points of care

Single-use platelet function testing

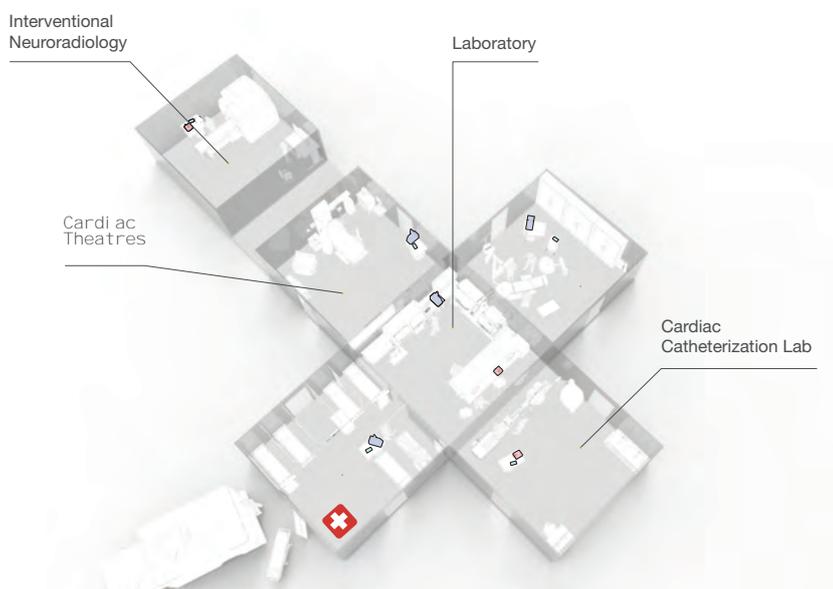
for the assessment of individual antiplatelet therapy response to antiplatelet agents, including aspirin, clopidogrel, prasugrel, and ticagrelor.

Identify patients at risk for bleeding, quickly and accurately

- Individualised test response for better patient management
- Assesses drug response and compliance for interventional and surgical procedures
- Supports Patient Blood Management (PBM) initiatives
- Results in <15 minutes



Ideal for multiple clinical settings*



*Based on ordering department location.

PRUtest™

Measures platelet P2Y12-receptor blockade **to help identify patient response to antiplatelet therapy.**

Aspirin Test

Measures ADP-receptor blockage.

Easy to use

- Fully contained, single-use test device
- No pipetting, sample preparation, or special handling requirements
- Handheld barcode scanner enables easy operator ID and patient ID entry



Congress Awards and Prizes



Congratulations to the trainees and limited registrants who have qualified and who will be presented with their certificates at the congress.

Thank you to the presenters who will be giving talks during the scientific sessions. The Society will present the Cliff Dawson Silver Salver prize to the speaker who is judged to have given the best presentation. The Andy Pastellopoulos prize will go to the best Trainee presenter.

In addition, there will be a Best Poster prize, as well as a prize to the perfusionist with the most engagement with the exhibitors.

New Fellows of the College will also receive their certificates during the awards ceremony.

We look forward to seeing as many of you as possible to celebrate these achievements during the awards dinner at the EMCC Nottingham on Saturday 8th November 2025.

**SCPS Executive
CCPS Council**

WELL DONE



 **ECMOLIFE**
HEATER COOLER

Complete ECLS Heater Cooler capable of warming/cooling the patient in the range of 15-39°.

**EUROSETS
HEATING AND
COOLING
SOLUTIONS
FOR ECLS**

 **free life**
FT2800PRO

Unique warming system for ECLS with disposable tubes that do not require any disinfection procedure.




EUROSETS
EVERY LIFE MATTERS

Friday 7th November

- 09.00 Registration and coffee** – Valerie Campbell, Zenia Simone
- 10.00 Welcome to AGM 2025** – *Chairperson: SCPS Chairman Noel Kelleher*
- SCIENTIFIC SESSION 1** – *Chairperson tbc*
- 10.15 Panel Discussion: Equality, Diversity and Inclusion**
– Panel Lead: Aswani Parmar, Barts Health NHS Trust + EDI Committee
- 11.20 The Journey of a Berlin Heart Patient**
– Victoria Molyneux, Great Ormond Street Hospital
- 11.40 Diagnosis and Management of Heparin Induced Thrombocytopenia in Paediatric Congenital Heart Disease Populations - A State of the Art Review**
– Guy Hetherington, Bristol Royal Infirmary
- 12.00 SPONSORED PRESENTATION – Stago**
- 12.20 Lunch/Exhibition**
- SCIENTIFIC SESSION 2** – *Chairperson tbc*
- 13.20 Secret Life of Suckers**
– John O'Neill, Barts Health NHS Trust
- 13.40 Tbc** – tbc
- 14.00 The impact of "N+1" staffing standards on patient safety and risk mitigation in clinical perfusion science**
– Jorge Costa, Barts Health NHS Trust
- 14.20 SPONSORED PRESENTATION – Werfen**
- 14.40 Tony Fisher Lecture: Workforce modelling and SEIPS planning**
– Danielle Blackie, Barts Health NHS Trust
- 15.00 Coffee/Exhibition**
- SCIENTIFIC SESSION 3** – *Chairperson tbc*
- 15.30 Percutaneous aspiration of an infective endocarditic lesion of the tricuspid valve using the extracorporeal AngioVac system. A case study and introduction to the technology from a Clinical Perfusionist's perspective**
– Ashley Felton, Mid and South Essex NHS Foundation Trust
- 15.50 SPONSORED PRESENTATION – Getinge**
- 16.10 SPONSORED PRESENTATION – CBM Lifemotion**
- 16.30 College AGM** – *Chairperson: CCPS President Paul Fricker*
- 17.30 Exhibition & Manufacturers Drinks**

Saturday 8th November

- 08.00 Registration**
- SCIENTIFIC SESSION 4** – *Chairperson: TBD*
- 8.30 Haemovigilance**, Dr Shruthi Narayan, Medical Director of SHOT

- 08.50 Caring for a Patient Who Is a Jehovah's Witness — A Collaborative Approach,**
– Mark Tarrant, Hospital Liaison Committee of Jehovah's Witnesses
- 9.10 Tbc – tbc**
- 09.30 Intraoperative Perfusion Management in Acute Type A Aortic Dissections: A 20-year retrospective analysis**
– David McGauran, Royal Brompton Hospital
- 09.50 SPONSORED PRESENTATION – LivaNova**
- 10.10 Coffee/Exhibition**
- SCIENTIFIC SESSION 5 – Chairperson: TBD**
PLENARY PAUSED: Delegate and Manufacturer Round Robin
- 12.00 Lunch/Exhibition**
- 13.00 SCIENTIFIC SESSION 6 – Chairperson: tbd**
The Experiences of Surgeons and Perfusionists using del Nido Cardioplegia in Children's Cardiac Surgery: A qualitative sub-study of the DESTINY trial
– Kirsty Wilson, Birmingham Children's Hospital
- 13.20 Asanguinous priming in patients under 10kg: a single centre retrospective study**
– Becky Gendall, Royal Brompton Hospital
- 14.00 SPONSORED PRESENTATION – Spectrum**
- 14.20 SPONSORED PRESENTATION – Cytosorbents**
- 14.50 GUEST SPEAKER**
Taking ECMO closer to point of wounding
– Dr Jeynathan and Dr Scott
- 14.40 Coffee/Exhibition**
- 15.10 SCIENTIFIC SESSION 7 – Chairperson: SCPS Chairman: Noel Kelle**
GUEST SPEAKER – Dr Sean Bennett
- 15.30 SCPS Annual General Meeting – Chairperson: SCPS Chairman: Noel Kelleher**
- 16.30 End of Session**

Sunday 9th November

- 09.00 Safety Committee discussion session**
– *Chairperson:* Jacqui Simmons, University Hospital Coventry & Warwickshire
– Jacqui Simmons: University Hospital Coventry & Warwickshire
- 11.00 Safety Incident Discussion**
– Andrew Nichols, Leeds Teaching Hospitals
- 12.00 Closing remarks**
– SCPS President Noel Keheller

Dr Fiona Holmes
 School Education Director
 Director MSc/PGCert Clinical Perfusion Science
 Bristol Medical School
 University of Bristol
 Research Floor Level 7
 Bristol Royal Infirmary
 Upper Maudlin St
 Bristol, BS2 8HW
 Tel: +44 (0)117 455 6864
 Email: f.e.holmes@bristol.ac.uk

28 September 2025

Dear SCPS and CCPS,

I am writing as School Education Director of Bristol Medical School to outline our mark assurance processes and timeline following the structure of the academic year and education governance changes. Instead of the previous monthly Exam Boards, these are scheduled in a standardised way across the University, 4 times per year.

June Exam Board: This ratifies all completed unit marks and makes reassessment decisions for failed units. If PGCert students have passed their practical exam by this time, they can be awarded the PGCert. Reassessments take place in August.

August Exam Board: This ratifies reassessments. It can also include awarding PGCerts to those who have by now passed their practical exam.

All completing students have already had their taught units ratified in June except the practical exam if not done by this time, and the research dissertation unit.

November Finalist Exam Board: This Board ratifies all Medical School post-graduate taught degree classifications, and reassessment decisions if any students have failed the research dissertation unit, considering the impact of student exceptional circumstances. The timing of this is consistent across the University and is later than before due to the later standardised dissertation deadline, and to allow sufficient time for marking and External Examiner moderation. As Clinical Perfusion Science is a relatively small cohort of students, we will be able to complete the marking and assurance process earlier than this and release assessment marks to students before the exam board (in the same way that we do for coursework). We will know if any student has failed the dissertation at this time (and therefore has not yet completed the MSc). Student marks will not change as a consequence of the Exam Board.

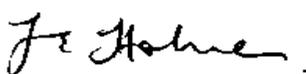
January Exam Board: This is for degree classification decisions for any students who did not submit their dissertations in time for the November Board.

To confirm, once the students have received their assessment marks, there is no reason why these should change at the time of the Exam Board.

I hope this provides reassurance that once the programme confirms that students have passed their dissertations, and the SCPS have confirmed they have passed their practical exam, then I can see no reason why their Clinical Perfusion registration would need to be rescinded.

I hope this helps.

Yours sincerely,



Fiona Holmes

Context for University of Bristol Letter

Nicholas Trafford, *Chair for Education & Training – SCPS*

Dear Membership,

This year, Bristol University have pushed their exam board sign off until 18th November 2025. As such, this puts the issuing of accreditation to this year's graduates in jeopardy, as this date is after that of the AGM date of 7-9th November 2025. Issuing accreditation would be done so on the proviso that the pass/fail status of each student is not subject to change by the exam board. Naturally, if there are any students that are borderline and teeter on the pass/fail threshold, then they may fall foul of retrospective changes to their pass/fail status, to which accreditation would not be issued. Thus, the college and society are walking a tight rope by issuing accreditation status on the back of a pass mark that hasn't been fully ratified by the exam board.

However, I am pleased to have received clarification from Bristol University in the form of a letter I received on 1st October 2025. Bristol University has provided assurances that no trainee or limited registrant will have their marks retrospectively changed from the preliminary marks they have received, thus giving CCPS and SCPS the green light to award the trainees with their certificate of accreditation at this year's AGM and issue qualified registration through CCPS. This is obviously subject to each trainee completing all relevant academia and practical exam/viva.

Kind regards

Nicholas Trafford

Perfusionist



The *Perfusionist* publication needs to generate regular content from the Perfusion community. If you have undertaken or have any:

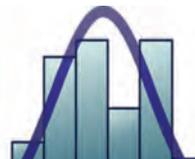
- *Case reports* • *Research projects* • *Book reviews*
- *Product evaluations* • *Posters* • *Meeting reports*
- *Visits to other units* • *Protocols* • *SOPs* • *Departmental news or updates*
- *Product launches* • *Company updates & relocations*
- *New procedures and techniques* • *Journal reviews* • *Surveys* • *Overseas expedition work reports*

These items can be submitted for publication.

For more information

please contact the Editor:

editor@scps.org



Health economics study signals safe way to reduce costly blood transfusions*

Impact on long-term life expectancy

A cost analysis report⁽¹⁾ in the *Journal of Medical Economics* highlights a safe way to reduce allogeneic blood transfusions and save more than £38,000 annually. **Potential cumulative savings over five years were calculated to be approximately £465,000.** Further, it would reduce nurse and medical time by 15%.

Overall £ savings per 600 patients 	
ONE YEAR	£38,000
FIVE YEARS	£465,000

The benefit for long-term patient outcomes is significant. The report estimates that in only one year, **adverse effects from donor platelet transfusions would be reduced by 24%, plus 17% in the loss of labile blood products.**

A meta-analysis study⁽²⁾ had already indicated that life expectancy is reduced by as much as 15 years for those who have had perioperative transfusion of allogeneic blood during cardiac surgery, even if in the short term it saved lives. Comprehensive cell salvage presents a way to reduce the need for allogeneic blood transfusion.

Limitations of centrifugation

Data in the 'Organizational and budget impact model (OBIM) of **same™**, a new autotransfusion medical device' is based on a reference analysis of 600 cardiothoracic patients. They presented with haemorrhages ranging from mild (57%), moderate (23%) and massive (20%).

First introduced to perfusionists last year, **same™** is distributed in the UK by global haemostasis experts Diagnostica Stago. It is based on filtration technology, which overcomes the limitations of existing centrifugation cell salvage procedures. This latter technology may be familiar to use - but it significantly inhibits the recovery of platelets and other elements essential to the coagulation process.

In contrast, as well as its excellent retrieval of red blood cells (RBC), **same™** offers significant retrieval of functional platelets - enhancing coagulation at a time of high haemorrhagic risk. A 2023 study shows that **same™** can retrieve and preserve more than 52% of a patient's own platelets, of which over 84% are fully functional.⁽³⁾ This is especially valuable with national blood stocks, particularly O Rh-negative, being under pressure.

Unique platelet retrieval & salvage

Same™ retrieves:

-  **≥ 52% of patient platelets**
-  **≥ 84% are fully functional**
-  **≥ 86% of patient RBCs**

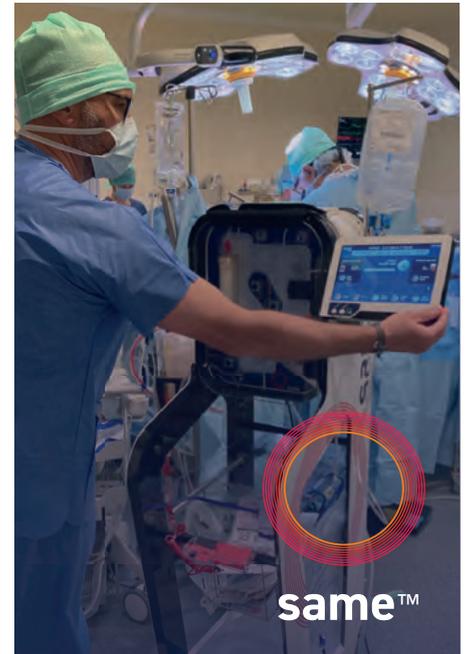
Donor transfusions down by 60-90%

Findings just published in *Anesthesia & Analgesia*⁽⁴⁾ show that patients treated with **same™** required significantly fewer donor blood products than those treated with a well-established centrifugation-based system. One of the authors, Prof. Fadi Farhat, will discuss these findings in Stago's SCPS AGM presentation on 7 November. This single centre French study initially involved 104 patients. It has now been extended across four cardiac hospitals and 972 patients. Results are due to be published within months.

Impact on clinical efficiency

-  **Donor platelet transfusions - 60-90%**
-  **Medical/nursing time reduced - 15%**

In addition, the OBIM study explains that using **same™** would achieve a 45% reduction in the use of donor red cells and a 60% and 90% reduction in donor platelets in moderate or massive haemorrhage, respectively. This was based on an average allogeneic transfusion of 4.19 packed red



blood cells and 0.62 platelet concentrate per patient.

Improving patient care pathway

With donor blood transfusions, patients risk both immediate adverse effects as well as a threat to their long-term survival. The opportunity to preserve and return a patient's functional platelets would enhance survival when the bleeding risk was high.

By improving patient care pathways, the **same™** cell salvage and retrieval system offers clinical teams a safe and cost effective way to reduce post- and perioperative haemorrhage. Further, as well as the impact on patients, the OBIM report confirms the financial benefits **same™** would offer UK health services.

JOIN STAGO UK
at our presentation on
BLEEDING MANAGEMENT
and **same™**

Main Lecture Theatre, SCPS AGM, East Midlands Conference Centre, Nottingham

Cell salvage: is platelet saving a new game changer?
same™ by i-SEP

Speaker: Prof Fadi Farhat, Infirmierie Protestante de Lyon, France

Friday, November 7, 2025 at 12 noon

*Referring to allogeneic blood transfusions
REFERENCES ON REQUEST

Cost savings in sterling are approximate, as original OBIM data given in Euros



Stago UK Bleeding Management Solutions distributes i-SEP **same™**
0845 0540614 • bleedingmanagement@uk.stago.com

Scan QR code
for more
information





Medtronic
Cardiac Surgery

Now CE
marked

A one-system ECMO solution

Designed for simplicity and performance, the VitalFlow™ ECMO system can be configured to accommodate your clinical preferences and hospital protocols to offer you:

- Ultimate performance
- Radical simplicity
- Exceptional configurability
- Future-proof design

Empowering your ICU team to deliver high performance ECMO with ease.

Looking forward to seeing you all at SCPS in Nottingham, 6th - 8th November

[medtronic.com](https://www.medtronic.com)

©2025 Medtronic. Medtronic, Medtronic logo, and Engineering the extraordinary are trademarks of Medtronic. All other brands are trademarks of a Medtronic company.

VitalFlow™
ECMO system



Become
unstoppable

With every beat,
expect more.



Rapid assessment at a glance

Enables rapid clinical decisions

- First results in <10 minutes. Actionable results, including amplitude information, in <15 minutes
- Enables clinical decisions to be made in significantly less time than with traditional methods, facilitated by no sample incubation time and use of rapid activators
- Heparin neutralisation allows testing during cardiopulmonary bypass
- Live viewing options for real-time diagnosis, enabling timely clinical decisions

Easy to use

- Fully automated cartridge system eliminates sample pipetting with closed tube direct sampling
- Cartridges can be stored at room temperature for rapid use at the point of care (POC)
- Intuitive touchscreen interface
- Automated assay initiation upon sample introduction

Rapid, actionable results guide **patient management**.

Fully automated cartridge system eliminates sample pipetting.

Remote, live viewing options enable **timely clinical decisions**.

Accurate, reproducible results

- Integrated quality control (QC) at the POC, with continuous internal system monitoring
- Reduced user interaction delivers more consistent result

Enhanced interpretation

- Large, easy-to-view TEMograms
- Four independent channels for differential diagnosis of coagulopathy
- In-process results can be compared with reference curves with profile and patient overlays

Guest Editors Wanted



*Guest Editors for Specialist Editions of the **Perfusionist** are needed.*

No experience required, all support will be provided.

Following interest at the 2019 AGM in Manchester from various individuals in putting together Specialist Editions of the *Perfusionist* it was intended to hold a Guest Editor's Workshop. Obviously that has been delayed. If you were or are thinking you may be interested in editing a Specialist Edition of the *Perfusionist* I thought it would be a good idea to run through a crash course in what is required to be the Editor of an edition on your chosen theme, so what's needed for an edition:

- ▶ One or two substantial articles (don't worry about word count or amount of pictures, can be trimmed if too long)
- ▶ Historical aspects of the editions main subject
- ▶ Short pieces new teaching techniques/horizon
- ▶ Maybe an opinion or experience piece on subject
- ▶ Letters
- ▶ Unit profiles
- ▶ Some commercial pieces, production information, new techniques, future regulation – maybe approach some specialists from our industry partners.
- ▶ Editorial – one page introducing articles and any opinion about 600 to 1000 words can insert a picture or two
- ▶ Included will be the standard pieces, News from SCPS, College EBCP.
- ▶ Deadlines – There will be no set dates if you prefer, leaving plenty of time for flexibility.
- ▶ Let our publisher can help with any publishing/advice/formatting issues and I will always be available.
 - Aortic Surgery
 - Myocardial protection
 - Pharmacology
 - Cerebral protection
 - Research
 - Emergency bypass
 - Paediatric bypass
 - Biocompatible coatings
 - Anticoagulation
 - Prime fluids in cardiac surgery
 - Cardiac Imaging
 - Cardiac support
 - Isolated limb perfusion & cancer therapies

In the pipeline Editions

- ▶ Education & Training
- ▶ Paediatrics

I hope that any perfusionists out there will seriously think about the Guest Editor edition positions or the opportunity to submit an article on a specialist subject.

What to do next

1. Choose an edition from the list or suggest an edition you would be interested in editing.
2. Email editor@scps.org.
3. Contact colleagues, friends, acquaintances, company representatives and specialists for articles.
4. Start collecting material . . . negotiate publication date and deadlines
5. Any questions let me know.
6. Good luck . . .

If you wish to submit an article for a Specialist Edition rather than edit then please email editor@scps.org.uk and I will forward to the Specialist Edition Editor.

Perfusion Insights: Where Science Sparks Innovation

29.11.2025



A ROOM
WITH A
ZOO Antwerp

07h30	Registration desk open
08h15 - 08h30	Opening Remarks: Korneel Vandewiele, President BelSECT
8h30 - 10h30	Session 1: Moderators: Didier Lintermans - Filip De Somer Christophe Vandembrielle (Belgium - UK) - Anti-Xa and aPTT Discrepancy Linked to Mortality in PVAD supported Cardiogenic shock patients Jacob Eifer Moller (Denmark) - Microaxial Flow pump or Standard Care in Infarct-Related Cardiogenic Shock Can Ince (The Netherlands) - Microcirculatory alteration during CPB Jan Turra (Germany) - Kinetics of tissue oxygenation during fast and slow CPB initiation
10h30 - 11h00	Coffee break
11h00 - 12h30	Session 2: Moderators: Korneel Vandewiele - Adam Blakey Dinis Dos Reis Miranda (The Netherlands) - Pre-hospital ECPR Filip De Somer (Belgium) - Anticoagulation during Cardiopulmonary Bypass: In control or Out Control Robert Hawkins (United States) - Del Nido vs Blood cardioplegia in cardiac surgery
12h30 - 14h00	Lunch break
14h00 - 15h30	Session 3: Moderators: Margot Vandersteegen - André Lemmers Tine Philipsen (Belgium) - Legal, clinical and ethical aspects of LVAD in destination therapy Stefaan Bouchez (Belgium) - The evolving Role of the modern perfusionist: insights from processed EEG Marije Rijpkema (The Netherlands) - Does heparin rebound lead to postoperative blood loss in patients undergoing cardiac surgery with CPB?
15h30 - 16h00	Coffee break
16h00 - 18h00	Session 4: Moderators: Kenny van Zwam - Jan Turra Raf Van den Eynde (Belgium) - Prognostic models for prediction of perioperative allogenic red bloodcell transfusion in adult cardiac surgery Filip Rega (Belgium) - Hypothermic oxygenated perfusion of the donor heart in heart transplantation Adam Blakey (United States of America) - Development of a Professional Advancement Model for Perfusionists Korneel Vandewiele (Belgium) - Lions of Perfusion or Monkey Guessing? Optimizing Cannula Selection in MICS
18h00 - 18h15	Closing Remarks - Mathieu Vandecandelaere, Chairman Symposium
18h30 - 19h30	Reception at Marble Hall
19h30 - 21h00	Walking diner at Marble Hall

NEW

PREMIER
GEM 7000
WITH iQM3™



A critical need

Haemolysis is the
#1 source of
preanalytical errors.¹



A breakthrough in blood gas testing: **haemolysis detection**

Identify preanalytical sources of error in point-of-care blood gas testing.

Introducing GEM Premier 7000 blood gas system, featuring next-generation Intelligent Quality Management (iQM3) technology with haemolysis detection. Offering automated quality assurance in real time, GEM Premier 7000 with iQM3 can detect more sources of error at the point of care—improving the quality of critical results, for greater confidence and enhanced patient care.

Learn more about our GEM Premier 7000 at <https://www.werfen.com/uk/en/acute-care-diagnostics/gem-premier-7000-iqm3>

¹ Lippi G, von Meyer A, Cadamuro J, Simundic A-M. Blood sample quality. *Diagnosis*. 2018;6(1):25-31. doi:10.1515/dx-2018-0018

For more information contact your local Werfen representative or email: sales.uk@werfen.com

GEM, Premier, GEM Premier ChemSTAT, ChemSTAT, GEMweb, iQM, Hemochron, VerifyNow, Avoximeter, and ROTEM are trademarks of Instrumentation Laboratory Company (d.b.a. Werfen) and/or one of its subsidiaries or parent companies and may be registered in the United States Patent and Trademark Office and in other jurisdictions. The Werfen logo is a trademark of Werfen and may be registered in the Patent and Trademark Offices of jurisdictions throughout the world. All other product names, company names, marks, logos, and symbols are trademarks of their respective owners. ©2024 Instrumentation Laboratory. All rights reserved.

werfen

ARROW



Introducing the Arrow AC3 Optimus Intra-Aortic Balloon Pump from Teleflex

The AC3 Optimus IABP offers the best of both worlds – remarkably accurate and precise therapy delivered with ease and simplicity. With its third generation AutoPilot Mode and proprietary WAVE Algorithm, the AC3 Optimus IABP offers automated, intra-beat timing – even in arrhythmic patients with heart rates as high as 200 bpm.¹ That means you can spend more time focused on the patient and less time managing the IABP.

Email iabp.uk@teleflex.com for more information 

References: 1. Donelli A, Jansen JRC, Hoeksel B, et al. Performance of a real-time dicrotic notch detection and prediction algorithm in arrhythmic human aortic pressure signals. J Clin Monit. 2002;17(3-4):181-185. Study sponsored by Teleflex.

Teleflex, the Teleflex logo, Arrow, AC3 Optimus, AutoPilot, and WAVE are trademarks or registered trademarks of Teleflex Incorporated or its affiliates, in the U.S. and/or other countries. All data current at time of printing (12/2018). © 2018 Teleflex Incorporated. All rights reserved. MCI-2018-0642

Teleflex

The Society of Clinical Perfusion Scientists OF GREAT BRITAIN AND IRELAND

Membership Subscriptions

The renewal date for subscriptions is 1st July every year.

Subscription charges are as follows:

Full member	GBP £85.00
Associate member	GBP £60.00
Overseas member	GBP £60.00
Trainee member	GBP £35.00
Retired member	GBP £10.00

Please pay by one of the following methods:

- Direct Debit:** Please contact Valerie Campbell or Zenia Simone for a DD mandate form if you have a UK bank account (admin@scps.org.uk)
- Credit/Debit:** Please scan the appropriate QR code to pay via Stripe:



Retired Membership



Trainee Membership



Associate/Overseas Membership



Full Membership

- Bank transfer:** Please send a payment to the Society's **new** bank account as follows:

Bank: Metro Bank

Account Name: The Society of Clinical Perfusion Scientists of GB and Irel

Sort code: 23-05-80

Account number: 56251979

IBAN: GB54MYMB23058056251979

BIC: MYMBGB2LXXX

ADVERTISE YOUR
JOB VACANCIES
ON THIS PAGE
WHICH INCLUDES
THE SOCIETY
WEBSITE

The Society of Clinical Perfusion Scientists

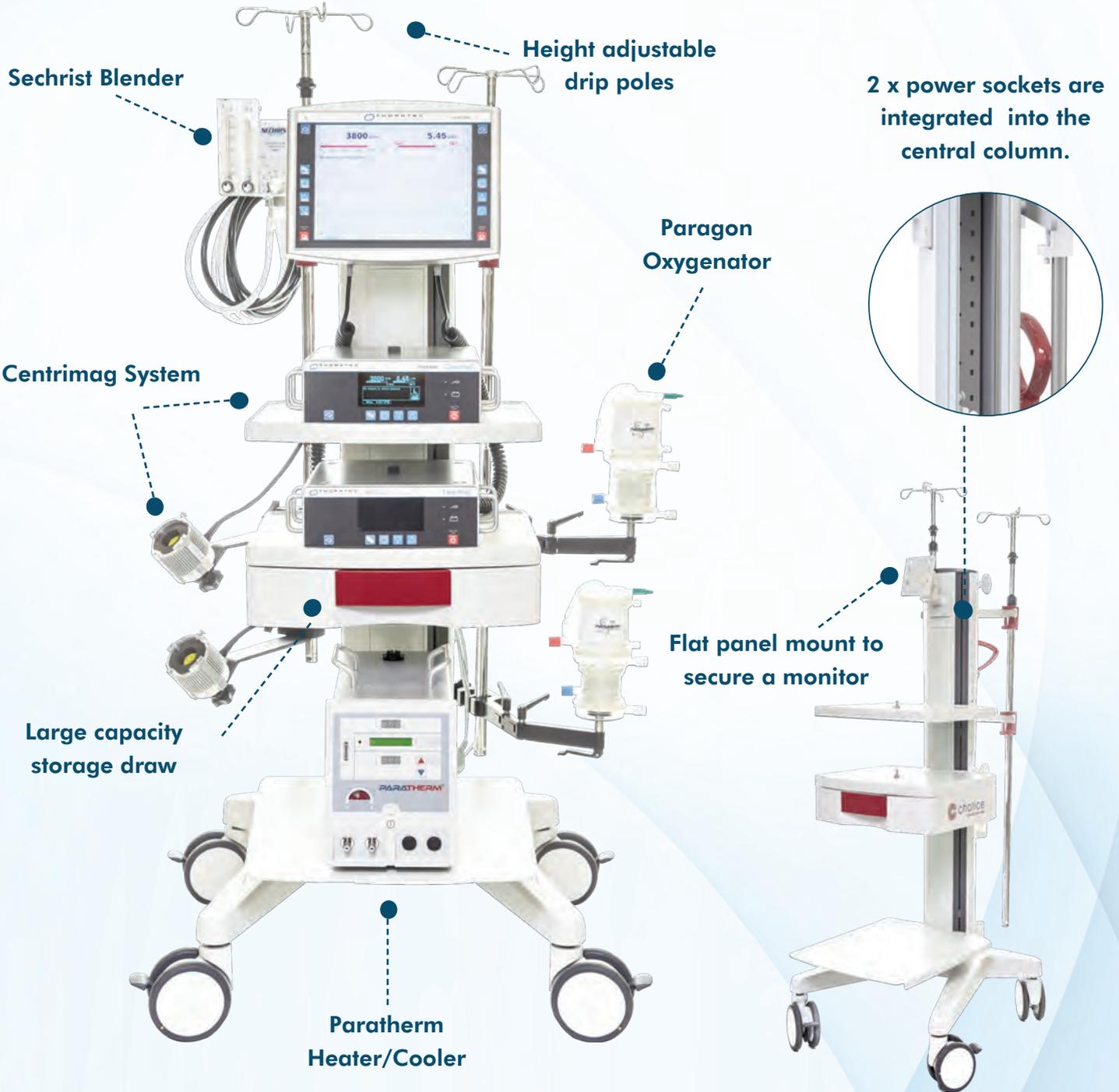
OF GREAT BRITAIN AND IRELAND

Sub-committees 2024/2025

- ◆ **Education and Training sub-committee:** Nick Trafford (Chair), Jacqui Simmons, Ben Middleton
- ◆ **Meetings and Seminars sub-committee:** Laura Kerr (Chair), Alan Rayner, Graeme Nias, Ben Middleton
- ◆ **IT/Website:** Ben Middleton, Graeme Nias
- ◆ **Equality, Diversity and Inclusion sub-committee:** Aswani Parmar (Chair), James Tyrrell
- ◆ **Safety Committee:** Jacqui Simmons (Chair), Alan Rayner, Andy Murray, Anne-Marie Murton, Bryce Pate
- ◆ **ECMO sub-committee:** Graeme Nias (Chair), Laura Kerr, Nick Trafford, Noel Kelleher



ECLS TROLLEY
SYSTEM V2



The Society of Clinical Perfusion
Scientists of Great Britain and Ireland

Executive Committee 2024/25

Officers and Committee members can be contacted via our Administrator, Valerie Campbell on 020 7869 6891, email: admin@scps.org.uk or at the addresses below:

Noel Kelleher (Chairman)

University Hospital Wales, Cardiff
Email: noel.kelleher@wales.nhs.uk

Aswani Parmar (Secretary)

St Barts Hospital
Email: aswani.parmar@nhs.net

Alan Rayner (Treasurer)

London Bridge Hospital
Email: Alan.Rayner@HCAHealthcare.co.uk

Laura Kerr (Registrar)

St Barts Hospital, London
Email: Laura.Kerr22@nhs.net

Jacqui Simmons

Walsgrave Hospital
Email: Jacqui.Simmons@uhcw.nhs.uk

Ben Middleton

Basildon Hospital CTC centre
Email: ben.middleton2@nhs.net

Graeme Nias

Royal Papworth Hospital
Email: Graeme.nias@cambridgeperfusion.com

Priya Joshi

Glenfield Hospital
Email: priyajoshi6@hotmail.com

Andrew Murray

Liverpool Heart & Chest Hospital
Andrew.Murray@lhch.nhs.uk

Nicholas Trafford

Cork Mater Private Hospital
nick.trafford@materprivate.ie

Society Administrator: Valerie Campbell
Assistant Administrator: Zenia Simone
The Society of Clinical Perfusion Scientists of Great Britain
and Ireland

The Royal College of Surgeons of England
38–43 Lincoln's Inn Fields, London WC2A 3PE

Tel: (+44) 020 7869 6891
E-mail: admin@scps.org.uk



Members are reminded that **Valerie Campbell**, the Society's Administrator, can supply information and advice on all administrative matters relating to the Society and the College.

She can be contacted at:

**The Society of Clinical Perfusion Scientists
of Great Britain and Ireland**
The Royal College of Surgeons of England
35–43 Lincoln's Inn Fields
London WC2A 3PE

Tel: (+44) 020 7869 6891

E-mail: admin@scps.org.uk

for advertising enquiries:

Perfusionist

Contact: Les Allen

telephone: 07944 295613

email: perfads@icloud.com

website

Contact: Valerie Campbell/

Zenia Simone

telephone: 020 7869 6890/1

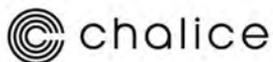
email: admin@scps.org.uk

for editorial enquiries:

Contact: Andrew Nichols

Telephone: 020 7869 6891

e-mail: andrew.nichols1@nhs.net



TEL: 01909 470777

www.chalicemedical.com

enquiries@chalicemedical.com

Future Quarterly Editions 2024

Autumn – July-September

Winter – October-December



Please submit your artwork/copy to the editor: admin@scps.org.uk by the 7th of the final month of the quarter.

LivaNova

Health innovation that matters

The Market leader in
Cardiopulmonary Equipment
and Disposables

LivaNova UK Ltd
A wholly owned subsidiary
of LivaNova Plc
1370 Montpellier Court
Gloucester Business Park
Gloucester
GL3 4AH

Tel +44 (0) 1452 638500
Fax +44 (0) 1452 638530
Email: salesuk@livanova.com
Website: www.livanova.com

GEM[®] HemoChron[™] 100

Whole Blood Hemostasis System
ACT, Point Of Care Testing

Werfen UK

712 The Quadrant, Cavendish Avenue, Birchwood, Warrington,
Cheshire WA3 6DE

Tel: 01925 810141

Email: sales.uk@werfen.com

www.werfen.com



werfen

Diagnostic Solutions for Life



- **Cascade Abrazo**
– Microsample coagulation monitoring
- **Actalyke**
– ACT system
- **Plateletworks**
– Platelet function testing

GTA (UK) Ltd
34 Nottingham South Ind. Est.
Ruddington Lane
Wilford
Nottingham
NG11 7EP

Tel: 0115 981 5703
mail@gtamedical.co.uk
www.gta-uk.co.uk

Pierson Surgical Ltd.

e: annie@piersonsurgical.com
t: 07785 295594
f: 07092 315510
w: www.piersonsurgical.com

High Quality Stainless Steel
Tubing Clamps



15 cm or 20 cm
Plain, Black or Gold Handles

Medtronic

Further, Together

CARDIAC SURGERY AND STRUCTURAL HEART

- Cardiopulmonary Products
- Paediatric Perfusion Products
- Extracorporeal Life Support (ECLS)
- Heart Lung Machine and accessories
- Blood Management and Diagnostics

Medtronic Limited
Building 9, Croxley Park, Hatters Lane
Watford, Hertfordshire, WD18 8WW
Tel: +44 (0) 1923 212213
Fax: +44 (0) 1923 241004

medtronic.co.uk

For further information please contact: rs.perfusion@medtronic.com
UC202107468 EN

Essenz™

Perfusion System



Elevating perfusion into a New Era

In the OR, advanced cardiopulmonary technology and the highly skilled hand of the perfusionist perform as one.

Essenz™ is LivaNova's next generation perfusion system that bridges five decades of proven performance, an enduring commitment to the safety of the patient, and the data accuracy you demand to bring more clinical wisdom to the OR.

The Wisdom of Breath and Beat.



Essenz Perfusion System is not available in all geographies. Please consult your labeling.

Essenz heart-Lung Machine

Devices are intended to perform, control, monitor and support extracorporeal blood circulation replacing the mechanical pumping function of the heart, monitoring and regulating physiologic parameters during procedures requiring extracorporeal circulation.

US: Essenz HLM is intended to be used during cardiopulmonary bypass for procedures lasting six (6) hours or less.

Essenz Patient Monitor

The Essenz Patient Monitor software is a modularly structured software program package that is exclusively used with LivaNova heart-lung machines. The system allows detailed recording of perfusion data during cardiopulmonary bypass procedures as well as the processing and evaluation of this data. The data may be recorded automatically or entered manually. The LivaNova Perfusion System Monitor is a panel PC intended to be exclusively used with LivaNova heart lung machines as a base and user interface for the Essenz Patient Monitor software.

Federal law (U.S.A.) restricts these devices to sale by or on the order of a physician.

The devices should be used by qualified and skilled personnel, able to follow the indications and instructions for use contained in the information provided by the manufacturer. Not approved in all geographies, consult your labeling. Please visit the LivaNova website to receive instructions for use containing full prescribing information including indications, contraindications, warnings, precautions and adverse events.

Legal Manufacturer:

LivaNova Deutschland, Lindberghstrasse 25 D-80939 Munich, Germany

Distributed in the USA by:

LivaNova USA, 14401 W 65th Way, Arvada, CO 80004, USA

Distributed in Canada by:

LivaNova Canada Inc., 280 Hillmount Road, Unit 8, Markham, ON L6C 3A1, Canada

CP-2300015



www.essenzperfusion.com
#NewEraOfPerfusion #EssenzEra