



102nd Annual Meeting



May 14-17, 2022
Hynes Convention Center
Boston, MA, USA

Late Breaking Clinical Trial Abstract Submission Guidelines

Abstract Submission Deadline: Monday, February 7, 2022 at 11:59PM Eastern Time

SUBMISSION OF ABSTRACTS

- Authors must use **electronic submission ONLY**.
- AATS is not responsible for work not submitted by the submission deadline.
- No new submissions may be added to the system after the posted deadline.
- Submissions must be submitted in their final form by the deadline to be considered for presentation. **Abstracts will be published exactly as submitted.** Proofread carefully to avoid errors.
- An author may not revise or resubmit a submission in order to make corrections after the submission deadline. Rather, the submission may be withdrawn or, if accepted, the error may be revised and indicated during presentation.
- All expenses (e.g., registration, airfare, lodging, etc.) associated with the submission and presentation are the responsibility of the presenter.
- Submission of an abstract constitutes a commitment by the author(s) to present if accepted. Failure to register for the activity and present the accepted work, if not justified, will jeopardize future acceptance of abstracts by AATS.

SUBMISSION CATEGORIES

Select from the following categories, which most accurately defines the field your abstract represents.

- **Adult Cardiac:** Clinical and translational studies pertaining to the selection, treatment, and outcomes of patients with acquired cardiovascular conditions.
- **Congenital:** Clinical and translational studies pertaining to the selection, treatment, and outcomes of patients with congenital disorders of the heart, lungs, and great vessels.
- **Thoracic:** Clinical and translational studies pertaining to the selection, treatment, and outcomes of patients with benign and malignant conditions of the lungs, airways, mediastinum, diaphragm, and chest wall.
- **Perioperative Care:** Presentations that address perioperative evaluation and management including, but not limited to, perioperative imaging and assessment, intraoperative hemodynamic and pharmacologic interventions, postoperative management protocols and evidence-based trials of critical care pathways, and short-term cardiopulmonary support.
- **Other:** Presentations on subjects, which the submitter is uncertain about the proper category such as surgical education and training, quality assurance, workforce issues or other broad programs that do not fit neatly into one of the other categories.

ABSTRACT SUBMISSION POLICIES

Author Name(s)

- There is no limit to the number of abstracts an author may submit.
- Authors do not need to be AATS members to participate.
- Additions or deletions of author names are not permitted after the submission deadline.
- If an author's name appears on more than one submission, it must be identical on each submission.
- The submitting author listed for each case video serves as the presenting author and as the primary contact for all correspondence regarding the submission, unless otherwise specified in the contact information provided during the submission process.
- The presenting author must be one of the co-authors listed on the submitted abstract.

- If an author has more than one submission accepted for presentation, he/she may only present **one** submission personally and must assign one of his/her co-authors to present any subsequent abstracts.
- The submitting author **must** notify **all** co-authors that this work has been submitted
- For ACCME purposes, the presenting author **cannot** be an employee of an ineligible company* if the content of the abstract relates to their employer's business line and/or products.

**Please note that ACCME defines an ineligible company as the following: An ineligible company is any entity producing, marketing, re-selling, or distributing health care goods or services consumed by, or used on, patients.*

Format

- All abstracts **must** be structured using the following four section headings or they will not be considered. The labels must be submitted in bold font. Please see the sample abstract at the end of this document.
 - **Objective:** The hypothesis tested or purpose of the study.
 - **Methods:** Details of the study design or protocol.
 - **Results:** Results of the study with appropriate statistical inferences.
 - **Conclusions:** Clinical importance and potential significance of findings.
- The text of your abstract **must** be less than 3,000 characters including spaces (title, authors, institutions, and one table or one image will not be counted).

Content

- PowerPoint files are **not** accepted as part of the abstract submission.
- Submissions containing identical or nearly identical data submitted from the same institution and/or authors will be disqualified, and all authors and co-authors may face a two-year sanction.
- Authors should not split data to create several abstracts from one study, clinical trial, and/or experiment. If splitting is judged to have occurred, priority scores of all related abstracts will suffer, and abstracts may be disqualified.
- The use of tables or graphics are encouraged if they are relevant to the research submitted. You may include one table **or** one figure within your submission. Please be mindful that tables and graphics, if the quality submitted is poor, will appear badly in print and electronic publications.
 - The submission site supports both .gif, .png, and .jpg graphic formats.
- Abstracts should clearly reflect the content of the completed paper.
- The abstract should **not** use abbreviations, which are not commonly accepted within the cardiothoracic surgical literature. Commonly accepted abbreviations within the cardiothoracic surgical literature will be accepted (i.e. - CABG, FEV1, GERD, CPR). However, other medical acronyms (i.e. - bronchiolitis obliterans syndrome (BOS)) should be first spelled out.
- When percentages are used, the absolute numbers from which the fractions are derived must also be stated.
- The abstract language is English.

****Abstract submissions may be disqualified, sanctioned, and/or removed from the program if the policies listed above are not followed.***

EMBARGO POLICY

- Abstracts submitted to the AATS Annual Meeting may not be presented or published by **any** other entity outside of the AATS Annual Meeting prior to selection notification by the Planning Committee.
- Once an abstract is accepted, it is **prohibited** from being submitted, presented, and/or published anywhere other than *The Journal of Thoracic and Cardiovascular Surgery* (JTCVS), including online journals, prior to its presentation at the AATS Annual Meeting.
- Manuscript submission to the JTCVS is **mandatory** for all accepted abstracts with the exception of C. Walton Lillehei Resident Forum submissions, posters, or case video abstracts.
- Failure to follow this policy will jeopardize the eligibility of **all** authors to submit abstracts to future AATS activities and/or submit manuscripts for publication in the JTCVS for up to two years.

WAIVER POLICY

- Requests for waiver of mandatory manuscript submission for publication in JTCVS **must** be made during the abstract submission process.
- Authors should list only **one** journal to which the manuscript will be submitted.
- If the waiver is approved, an update of the manuscript submission and publication progress must be provided to the AATS (journals@aats.org) within six months after the presentation and additional progress reports should be provided every six months until the paper is accepted for publication or submitted to JTCVS.
- Authors must note that the paper was originally presented at the AATS Annual Meeting on the title page or in the acknowledgements. If the manuscript is rejected from the journal for which the waiver was granted, then the authors may submit to another high-impact journal, but must first receive approval from the AATS. If the manuscript is rejected, the authors must then submit the manuscript to the JTCVS.
- Acceptance of an abstract remains a commitment to present at the AATS Annual Meeting regardless of any waiver request for publication.
- AATS may decide not to grant a waiver. If a waiver is not granted, the authors **must** submit a manuscript to JTCVS or withdraw the abstract from the Annual Meeting.
- Failure to follow this policy will jeopardize the eligibility of **all** authors to submit abstracts to future AATS meetings and/or submit manuscripts for publication in the JTCVS for up to two years.

CRITERIA FOR APPROVING WAIVER REQUESTS

Waivers will be granted based on the following criteria:

- Prospective (or randomized) clinical trial particularly for novel treatments or surgical techniques.
- Translational research utilizing human tissues or novel models of disease, particularly if they provide a new therapeutic target with preliminary human trial data.
- Large, prospective, cohort studies, particularly if they demonstrate that one treatment or technique is better than another.
- Novel mechanistic studies at a cellular, molecular, genomic, etc. level performed with novel methods or in unique and clinically relevant models of disease.

MANUSCRIPT SUBMISSION TO THE JTCVS

Submission of an abstract for consideration constitutes a commitment by the author(s) to present the paper if accepted, and an exclusive, binding obligation to submit a full-length manuscript to *The Journal of Thoracic and Cardiovascular Surgery* (JTCVS), with the exceptions noted below*. Please refer to the Journal's Information for Authors at www.editorialmanager.com/jtcvs for submission guidelines and requirements. Manuscripts **must** be submitted to the [JTCVS electronically](#) prior to presentation and **NO LATER than the start of the Annual Meeting**. Please select "AATS Annual Meeting Manuscript" as the article type upon submission. To expedite review and publication, you can submit prior to the meeting.

**The requirement for manuscript submission to the JTCVS does not apply to abstracts selected for the C. Walton Lillehei Resident Forum, posters, or case videos abstracts.*

AUTHORS' CONSENT AND WAIVER OF CLAIMS FOR ABSTRACT SUBMISSIONS

- Each author agrees they have read and consent to all rules and regulations as outlined, pertaining to the submission of abstracts. It is the responsibility of the author to be in accordance with these rules and regulations during all parts of, but not limited to, the abstract submission and review process.
- Upon submission, authors waive any and all claims against the AATS and any reviewer and/or Planning Committee Member pertaining to, but not limited to, the abstract submission and review process.
- If the presenting author has been trained or utilized by a commercial entity or its agents as a speaker (e.g. participation in the speaker's bureau) for any ineligible company, the promotional aspects of that work must not be included in the presentation in any way in order to comply with the [Standards for Integrity and Independence in Accredited Continuing Education](#).
- Presenting authors must act in full accordance with [HIPAA Research Policies](#). Any and all abstracts and presentation materials must follow these guidelines.

ABSTRACT WITHDRAWAL

- Abstract withdrawal requests should be emailed to meetings@aats.org. Please include the activity name, your abstract control number, title, the presenting author's name, and the reason for withdrawal in your email.
- Requests for withdrawal of an abstract must be received in writing **no later than February 11, 2022**. Withdrawal requests made after the withdrawal deadline may result in a two-year sanction of the submitting author and all co-authors.

ABSTRACT REVIEW

- After the submission deadline, all abstracts are considered **Complete** and will be forwarded to review.
- Submissions with an **Incomplete** status after the submission deadline will not be considered for presentation.
- Submitted abstracts are peer-reviewed by a panel of graders. Grading is blinded and selections for presentation are based solely on scientific merit.
- After the program is constructed, abstracts are then unblinded to assure a program balanced in authorship and institutional representation.

ABSTRACT NOTIFICATION

- Abstract notifications will be distributed to the submitting author via email. It is the responsibility of the submitting author to notify **all** co-authors of the decision.

COPYRIGHT

- Full text of accepted abstracts will be published as submitted in advance of the AATS activity.
- AATS, as holder of the copyright of the accepted abstract, reserves all rights of reproduction, distribution, performance, display, and the right to create derivative works in both print and digital formats.
- The audio-visual recording of the scientific presentations will be the property of the AATS.

ABSTRACT PRESENTATION

- All abstracts presented at AATS activities must conform to the eligibility criteria listed above.
- All presentations and questions-and-answer periods will be in English (unless otherwise instructed). If presenters need assistance in understanding or responding to questions in English, they are encouraged to have a member of their research group assist them.
- Each presenting author is required to comply with the AATS Disclosure Policy.
- Disclosure information collected during the submission process will be published in AATS's final program materials. To be in compliance with this policy, presenting authors must disclose at the beginning of their presentation.
- Any additional or revised guidelines for abstract presentation will be provided to presenting authors of accepted abstracts in their notification email.

ACCME GUIDELINES

Based upon ACCME criteria, authors should consider the following three questions when submitting an abstract:

- What quality gap (limitation or problem) in the practice of cardiothoracic surgery does this research address?
- How does this project change surgeon competence or improve patient outcomes?
- Does this abstract address one of the following ACCME Competencies: medical knowledge, patient care, interpersonal and communication skills, professionalism, practice-based learning and improvement and systems-based practice?

The American Association for Thoracic Surgery is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. AATS additionally designates educational activities for **AMA PRA Category 1 Credits™**. As such, the AATS must not only comply with the ACCME Criteria, Standards, and Policies, but also with those established by the AMA.

AATS has the obligation to ensure the delivery of CME content that is balanced, independent from ineligible companies, free of commercial bias, objective, and scientifically rigorous. As part of the call for abstracts process, AATS seeks to “maintain anonymity” during the review process, therefore, AATS requires that authors adhere to the guidelines provided below when submitting an abstract:

- Names of individuals, institutions, professional societies and organizations, and products cannot be included in the title nor in the body of the abstract (i.e. “1,000 Cases at University General Hospital” is **NOT** an acceptable title).
- Names of research databases may be included in the body of the abstract.
- **Product and/or trade names may not be included in the title or body of the abstract.** Please use generic, not commercial, names for all therapeutic agents.
- Brand promotion of devices or products is **not** allowed.
- Anyone who is in a position to control the content of the educational activity must disclose all financial relationships with any ineligible companies (those whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients) and **identify how the relationship(s) pertains to the content of the presentation. Failure to complete required disclosure(s) may result in disqualification of consideration for presentation at the AATS activity.**
- Employees/owners of ineligible companies (as defined by the ACCME) may not be in control of CME content related to the business lines of their employer.

QUESTIONS

For further information on submitting an abstract for consideration, please visit aats.org or contact us:

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Randomized Trial of Mediastinal Lymph Node Sampling Versus Complete Lymphadenectomy During Pulmonary Resection in Patients with N0 or N1 (Less than Hilar) Non-Small Cell Carcinoma: Results of the ACOSOG Z0030 Trial

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Objective: To evaluate whether mediastinal lymph node dissection (MLND) improves overall survival compared to mediastinal lymph node sampling (MLNS) in patients undergoing pulmonary resection for N0 or non-hilar N1, T1 or T2 NSCLC.

Methods: Patients with proven NSCLC underwent sampling of lymph node stations 2R, 4R, 7 and 10R for right sided tumors; and 5, 6, 7 and 10L for left sided tumors. If these lymph node stations were negative for malignancy, patients were randomized to no further lymph node resection (MLNS) or complete MLND. All surgeons were required to adhere to the technique described in written instructions and demonstrated in an approved instructional video. Following surgery, patients were followed for a minimum of 5 years.

Results: A total of 1,111 patients were randomized (555 MLNS and 556 MLND). After final eligibility review, 1,023 (498 MLNS and 525 MLND) patients were classified as eligible/evaluable. There were no significant differences between the two groups in terms of gender, race, age or ECOG performance status. The right upper lobe was the most common tumor location (MLNS: 213 vs MLND: 205) and adenocarcinoma was the most common histologic type in both arms (MLNS: 210 vs MLND: 235). There was no significant difference between the two arms in terms of type or extent of resection, stage, length of stay, morbidity or mortality. In the MLND group 20 patients (3.8%) were found to have occult N2 disease in the lymphadenectomy specimen. At a median follow-up of 6.3 years, 431 (42.1%) patients have died: 214 (42.9%) in the MLNS arm and 217 (41.3%) in the MLND arm. The median survival was 8.1 years (MLNS) versus 8.5 (MLND) (p=0.531). There were 493 recurrences including deaths: 54 local; 73 regional; and 224 distant. The median time to recurrence was 5.7 years in the MLNS group (243 recurrences; 24 local; 42 regional; and 110 distant) versus 6.1 years in the MLND group (250 recurrences; 30 local; 31 regional; and 114 distant) (p=0.655). There also was no difference for local (p=0.527) or regional recurrence (p=0.126) between the two groups.

Conclusions: MLND does not improve survival in patients with early stage NSCLC when a thorough preresection sampling of the mediastinal lymph nodes is negative. MLND also does not decrease the incidence of local or distant recurrences. These results are not generalizable to higher stage tumors.