Mr. Thompson says that having Dr. Abdulrehman at the TBRHSC for the past 12 years has already made a big difference in terms of patient care in the Thunder Bay area. In addition to the cases where he’s travelled to Toronto with patients to do EVAR, he’s performed 265 procedures in Thunder Bay, she says, and 200 of those cases were actual surgeries, while the other 65 were diagnostic or minimally-invasive procedures.

“So already, in our first year with only one surgeon, we’ve been able to serve almost 400 patients at home,” she says. “And next year, that’ll be closer to 500.”

Mr. Thompson says the TBRHSC’s cardiothoracic program is only limited by surgeon resources (“we’re actively recruiting,” she says) and capital for specialized equipment, so they can do EVAR and other more complex operations in Thunder Bay. “For our patients, the most important thing is that patients and their families are able to stay within their own region and keep their family and cultural support systems intact.”

Plans are in place to make that happen, says Dr. Rubin. “The end game is that the majority of heart and vascular surgery will happen in Thunder Bay, and only patients with complex problems or who require redo surgery will be sent to the PMCC,” he says. Dr. Abdulrehman says he’s looking forward to that day: “We want to be able to tell the patients that we can offer the appropriate treatment for them here in Thunder Bay, and we’re almost at that point.”

Mr. Thompson notes that the relationship between the TBRHSC and the PMCC is more than “pen on paper” – it’s a true partnership.

“Each week, we have multiple team meetings with the key members from the PMCC. They are helping train our staff. They’re working with us on research projects around cardiac and vascular disease. So much more than just actual services. We’re truly becoming a partner, through many levels within the organization,” she says. In keeping with the partnership model of the program, Dr. Abdulrehman gets the benefits of regular interaction with the vascular team at the PMCC.

“The heart transplant clinic is ground zero for complicated operations,” says Dr. Thomas Lindsay, Chief of Vascular Surgery at the PMCC, who provides support through “telemonitoring” and phone calls as an essential part of the “core program, two sites” model.

“I talk to him on the phone regularly. He texts me questions. We have electronic rounds on Wednesdays, and he joins our case conference every other week. We reserve some spots for him to present cases for discussion,” says Dr. Lindsay. “We’ve never lost the patient, but we can look at their X-rays and CT scans and say, ‘Well, it’s looking like this is the right thing to do, or we may have some additional suggestions on management and operative strategies.’ Because of this digital interaction, it’s like they are down the hall. It’s just a thousand miles down the hall,” adds Dr. Lindsay.

Plans are also underway to bring in additional vascular surgeons to join the vascular team on the ground in Thunder Bay. Dr. Rubin says the vision is to have one vascular surgeon and two cardiac surgeons available and working at the TBRHSC. He says the Government of Ontario has embraced the idea, and they are also working with the Cardiac Care Network of Ontario to operationalize the plan.

“Cardiac surgery is going to be a longer lead time because to do cardiac surgery, you need to have a specific type of operating room,” he says. “You need to have a team. You need to have operating nurses specifically trained to operate, and that’s going to take some time, so we expect to go live with that in 2019 or 2020.”

The challenges, says Dr. Rubin, are both organizational and financial: a project of this magnitude involves many components and significant funding requirements. But the potential to create a genuine, changing new model that will provide services to the province’s most vulnerable cardiovascular patients is enormous, he adds.
me straight.” Dr. Ross also remembers that day clearly, but it’s not the most pleasant scene she’s seen. She recalls the first impression of Mr. Cook. He had an incredible attitude, she says, especially in light of what he was facing. “When you’re a young man and are told that you have heart failure, most people get down, but you managed to keep it all together,” she says. “He had such a sense of humor that showed that he was totally engaged in the partnership that’s required between the patient and the health-care team. He helped make our job easier.”

**INSERTIONS**

While the biobank is still being used to answer clinical heart failure questions, the biobank is considered to be a valuable resource. For example, Ms. Kozuszko, a Clinical Research Coordinator at the University Health Network’s PMCC and Surgical Director of theFailure and Transplant Clinic, who also points to Mr. Cook’s positive attitude as a reason why he has done as well as he has. When they first met, Mr. Cook came to the Hospital’s Coronary Intensive Care Unit, hooked up to an IV, which was administering heart-stimulating drugs. Every time I was tempted to worry about him off the medication, his heart would fail. “He was in a very dire situation,” recalls Dr. Badawi. In 2012 Mr. Cook had to undergo a heart transplant. He had none of the usual complications and was discharged home from the hospital just 5 days after. He is alive today and doing well. He is now part of the PMCC biobank.

Unfortunately, not all patients are so lucky. Dr. Badawi, cardiologist at the PMCC and Surgical Director of the University Health Network’s Heart Transplant Clinic, who also points to Mr. Cook’s positive attitude as a reason why he has done as well as he has. When they first met, Mr. Cook came to the Hospital’s Coronary Intensive Care Unit, hooked up to an IV, which was administering heart-stimulating drugs. Every time I was tempted to worry about him off the medication, his heart would fail. “He was in a very dire situation,” recalls Dr. Badawi. In 2012 Mr. Cook had to undergo a heart transplant. He had none of the usual complications and was discharged home from the hospital just 5 days after. He is alive today and doing well. He is now part of the PMCC biobank.

While Charles Cook’s heart cardiomyopathy was relatively mild, his story really began when he was 15 years old. At that time, he was sent to the Peter Munk Cardiac Centre for treatment for a heart condition called hypertrophic cardiomyopathy. Dr. Rakowski, the cardiologist who treated Cook, notes that the disease is caused by a mutation in a gene on chromosome 14, which results in thickened heart muscle. The disease can be asymptomatic, or it can lead to symptoms such as chest pain, shortness of breath, or dizziness.

Charles Cook was diagnosed with hypertrophic cardiomyopathy (HCM) at the age of 15. The disease is characterized by the thickening of heart muscle, which can lead to complications such as heart failure, sudden cardiac arrest, and death. HCM is a genetic disorder that can be inherited from one or both parents. It can affect people of any age, and it can cause a wide range of symptoms, including chest pain, shortness of breath, and fatigue.

While the disease is often asymptomatic, some people may experience symptoms such as chest pain, shortness of breath, and dizziness. In severe cases, HCM can lead to heart failure, which can be fatal. HCM is a serious condition that requires lifelong management and close monitoring by a healthcare team.