Pediatric Heart Transplant Society

PEDIATRIC HEART TRANSPLANTATION TODAY

PHTS Newsletter

Dr. Juan "Chuck" Alejos, Senior Editor
Dr. Ashish Garg, Junior Editor

August 2026



Dear PHTS Colleagues,

Welcome to the August 2026 edition of the PHTS Newsletter.

Somehow, we're already past the halfway point of 2026. It feels like we were just catching up at ISHLT, and now many of us are already thinking ahead to Sydney for ISHLT 2027. Time certainly flies.

It is truly an honor to serve as the new Junior editor of the newsletter. I want to begin by thanking Drs. Chuck Alejos and Neha Bansal for their thoughtful leadership over the past several years. They created a newsletter that has been both informative and a wonderful way to stay connected as a community.

One of the things I appreciate most about PHTS is that, despite working at different centers around the world, it always feels like a remarkably close community. We celebrate each other's successes, learn from difficult cases, collaborate on research, and occasionally discover that someone else has already asked the same transplant question we've been debating for an hour.

My hope is that this newsletter continues to reflect that spirit. Beyond sharing new science and society updates, I hope it remains a place where our community stays connected. If you have an interesting case, research update, or idea for a future issue, I'd love to hear from you. Thank you for everything you do for children and families with advanced heart failure and transplantation. I hope you enjoy this issue.

Ashish



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PHTS GROWTH*

13,515 → Patients Enrolled
13,899 → Total Listings/relisting entered
10,281 → Transplants entered
416 → Listings for 2025
333 → Transplants for 2025
2 → Listings for 2026
2 → Transplants for 2026

*as of February 3, 2026

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The Evolving Role of Ventricular Assist Device Support in Adolescents with End-Stage Dilated Cardiomyopathy

Over the past two decades, there have been incredible advances in the application of ventricular assist device (VAD) support for children with end stage heart failure. Many of us have witnessed this evolution firsthand, and I will briefly share some illustrative experiences.

Fifteen years ago, recently graduated from fellowship and immersed in an on-the-job apprenticeship in pediatric heart transplantation under Drs. Jim Kirklin and Bennett Pearce, I admitted a 9-year old girl with a new diagnosis of severe dilated cardiomyopathy. Incredibly enough, having just wheeled into the unit, this little girl suffered a devastating left MCA occlusive stroke right before my eyes. Remarkably, she was in the best possible place to have a stroke — a full-service pediatric heart center embedded in a tertiary adult hospital. Within two hours, she had complete neuro-interventional recanalization and was left with mild, almost imperceptible, right arm deficits. Despite her neurologic recovery, she remained too unstable on inotropic therapy, and our team worried how she would wait for an organ match. At that time, the use of VADs in pediatric patients was still a burgeoning field. Most of the experience had been extrapolated from adult patients and older adolescents, with only scattered case reports and small series available from a handful of institutions. The Berlin Heart Excor pediatric trial had been completed, but we remained concerned about the risk of intracranial hemorrhage associated with that device in that era. After careful consideration, we elected to implant a HeartWare VAD as a bridge to transplant.[1]

A decade later, now an experienced heart transplant attending, I evaluated two additional candidates for transplantation. Both had new diagnoses of severe dilated cardiomyopathy. One was a 16 year old girl with multisystem organ failure, BMI > 40 kg/m^2 and a tumultuous home environment and social support structure. The other was a 15 year old boy with an intensely managed salt-wasting renal disorder. The care team weighed the pros and cons of transplant and VAD support. Both patients ultimately underwent placement of HeartMate 3 (HM3) left VAD.

These three cases illustrate a fundamental shift in how we think about mechanical circulatory support – from VADs as reluctant short-term bridges to their emerging role as a deliberate, longer-term therapeutic strategy. In just over a decade, the medical literature documenting the use of these devices has evolved from single case reports and small case series to more recent multi-institutional registry reports. These studies remain small compared with the adult experience, where larger trials have provided much of the evidence informing longer-term expectations.

Thinking about the two more recent teenage patients on HM3 support, I was often asked in the ensuing months when they would be waitlisted. Having seen adolescents and young adults struggle with medication compliance and suffer rejection and death, I wondered if we were justified in maintaining long-term VAD support. In these two particular patients with their unique circumstances, would extending VAD support provide a survival benefit over proceeding with transplantation? All other things being equal, wouldn't transplanting someone at 23 instead of 16 lead to a longer life – especially if they could better care for their transplant medical condition as an adult? I could not find helpful pediatric data at the time, though adult data was promising. On the transplant side, I questioned whether pediatric registry studies accurately capture long term outcomes as some single center studies focused on transition reveal worrying mortality rates.[2,3]

With these uncertainties in mind, I embarked on a combined PHTS and PediMACs analysis with Dr. David Morales. We were ultimately joined by an excellent group of co-authors from the two registries. The results of this analysis Comparing Outcomes of HeartMate 3 and Heart Transplantation in Older Children with Dilated Cardiomyopathy – Can Transplantation Be Delayed or Avoided? are published in the latest issue of Pediatric Transplantation.[4] Briefly, we found excellent 3 year survival in both groups and a very low incidence of bleeding, stroke, and device malfunction in the HM3 group. Unfortunately, our analysis was quite limited by the high rate of HM3 patients undergoing transplantation by one year after device placement, and this rate of transplantation did not decrease over the study era (2018 to 2022). Future registry or multicenter analyses with more complete follow-up and more recent data would be very informative and represent an excellent opportunity for investigators in this space.

I believe that the decision to place a VAD or offer transplantation to an adolescent patient with dilated cardiomyopathy should be individualized based on expected patient survival with either of these strategies. Late adolescence into early adulthood is a well-established period of increased risk for heart transplant recipients, driven by biological susceptibility to rejection, medication nonadherence, and vulnerability during the pediatric-to-adult care transition. While many patients will have a more favorable expected outlook with transplantation, there will certainly be some patients whose medical and social support factors raise the question of how successful they will be managing their new transplanted organ. In these patients, clinicians should certainly consider the role of VAD support, weighing the potential cumulative risks long term. Current iteration of devices offer good long term outcomes but still have important complications and patient desirability factors including an externalized drive line. However, just as devices have evolved greatly over the past generation, so too do they have the potential to continue evolving and improving. In my view, the ultimate goal of mechanical support would be a VAD that has real-world long term survival outcomes greater than transplantation without jeopardizing transplant candidacy (i.e. sensitization) and with patient desirability at least as good as or better than transplantation. The patient desirability would come from improvements in internalization of the power source and continued low risk of bleeding and stroke with a simpler anticoagulation regimen. (For further reading on the future prospects of LVAD evolution, the reader is pointed to a review article by Kanwar et al in the latest issue of the *Journal of Heart and Lung Transplantation*.[5] Once we arrive at that point in our field, then clinicians and patients may willingly prefer device support over transplantation, leaving the latter to some future time where device support can no longer be continued. As my co-author Dr. Morales has proposed, sequential use of device therapy and then transplantation has the potential to improve overall net survival for patients compared to transplantation alone as an initial step. This sequential strategy would also come with the side benefit of increasing the supply of donor hearts for patients who are not optimal LVAD candidates.

Further research to evaluate the role of longer-term VAD support in adolescents with cardiomyopathy should be a priority for our field. Survival represents only one component of treatment success; however, pediatric HM3 research to date has not addressed other important factors. Patient-reported outcomes, psychosocial development, functional status, and quality of life are well studied in adults, where significant challenges have been documented; the absence of comparable data in adolescents is a notable gap. The impact of long-term VAD support on subsequent transplant outcomes requires further study. Likewise, healthcare resource utilization and cost-effectiveness will become increasingly relevant as our community adopts longer-term VAD support. Importantly, all of these questions are discussed in the context of biventricular hearts and can not necessarily be extrapolated to our single ventricle patients who will have their own unique medical factors. Our analysis was not designed to address these additional considerations.

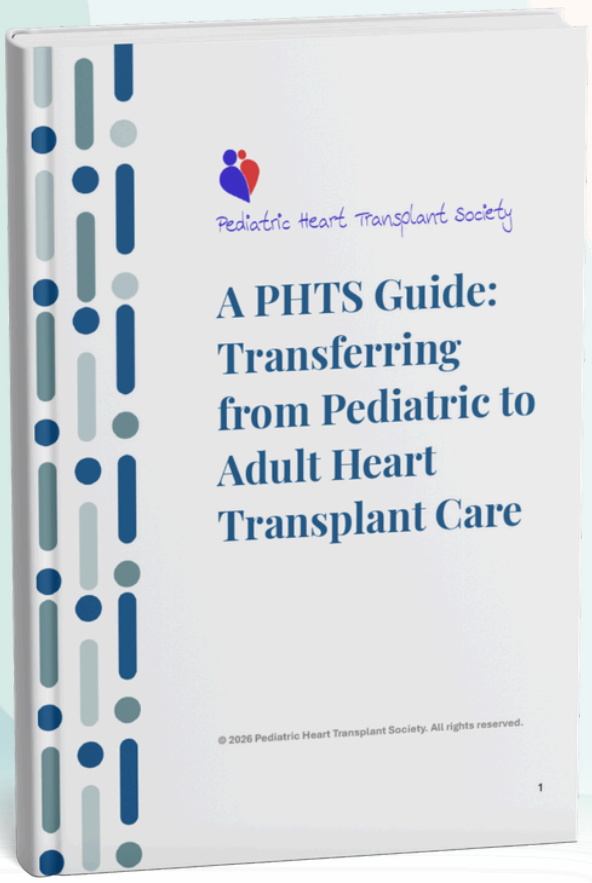
Finally, future changes in pediatric heart allocation policy could inadvertently accelerate this evolution. Excellent outcomes with improving VADs raise the question of whether these patients merit status 1A listing priority. Lower waitlist priority for stable VAD patients would lead to longer support times, providing the very evidence needed to establish durable VAD therapy as a viable longer-term strategy.

We are fortunate to have been involved in remarkable progress in pediatric VAD support and great improvement in outcomes of patients with end-stage heart failure. Revisiting the three patients I mentioned above is worthwhile. Fifteen years after overcoming two potentially fatal new diagnoses on the same day, that 9-year old girl, originally bridged to transplant with a HeartWare VAD, got married – with Dr. Kirklin in attendance. She is wonderful example of how a VAD can safely bridge a child to transplantation, allowing time for recovery, rehabilitation, and optimization before transplant. The teenagers who required HM3 support are doing well. The young lady is now 4 years on her device, achieving weight loss success and working towards transplant candidacy. The young man is now 3 years on his device and doing quite well with no stated interest in transplantation. Both patients have transitioned to the adult VAD program. These children illustrate the evolving role of VAD support in the individualized decision-making surrounding end-stage heart failure. I look forward to the next fifteen years of innovation in VAD technology and the new opportunities these advances will create to individualize therapy, improving and prolonging the lives of children with end-stage heart failure.

References

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NEW MEMBER RESOURCE



A PHTS Guide: Transferring from Pediatric to Adult Heart Transplant Care

A guide to supporting adolescent and young adult heart transplant recipients through transition of care

Available at www.PHTSociety.org

Endorsed by Pediatric Heart Transplant Alliance

Member Spotlight

Enduring Hearts
Healthy Kids ♥ Stronger Hearts ♥ Longer Lives



PHTS – Enduring Hearts Investigator Award Recipient

Benjamin Borg, MD

Primary Graft Dysfuncation and Rejection Phenetype as Drivers of Chronic Allograft Dysfuncation



Manuscript Published to Pediatric Transplantation

Deipanjan Nandi, MD

Impact of Anti-HLA Antibody Desensitization Strategies in Pediatric Heart Transplant Recipients: A PHTS-PHIS Linkage Analysis



Manuscript Published to Pediatric Transplantation

Wally F. Carlo, M.D.

Comparing Outcomes of Heartmate 3 and Heart Transplantation in Older Children with Dilated Cardiomyopathy – Can Transplantation Be Delayed or Avoided?

Upcoming Meetings & Events

SAVE *the* DATE

Boston Children's Hospital

presents

2027 PHTS Symposium

March 17, 2027

Charleston, South Carolina

Keynote speakers, scientific and committee sessions, interactive large and small-group discussions, poster presentations, networking and social events

Open to all PHTS members interested in exploring insights from the PHTS Registry, shaping the future of PHTS initiatives, and connecting with fellow members and investigators in a dynamic, first-of-its-kind format—while enjoying the beauty of South Carolina.

More information coming soon!

In Collaboration with the IPTA 2027 Congress
https://ipta2027.org/

Sponsorship information can be found here
https://pediatricheartransplantsociety.org/2027-phts-symposium/

PHTS Live!

September 16, 2026

"Welcome to Transition"

Speakers: Leigh Reardon MD, Karen Caulfield, Melissa Dazo MSN, CPNP-AC

PHTS Live continues to grow as a valuable space for shared insight and collaboration. As we plan for our 2026 sessions, we welcome your ideas for topics you would like to see highlighted. Your suggestions help keep PHTS Live relevant and impactful for our community.

Host



Juan Alejos, MD



Manu Varma, D.O.



Lynsey Barkoff, CPNP

Job Postings

Pediatric Heart Failure & Transplant Physician Opening Charlotte NC

Join Advocate Health as a Pediatric Cardiologist Physician in Charlotte, NC—part of Advocate Health, one of the largest nonprofit integrated health systems in the country.

To learn more or to submit a CV for confidential consideration, please contact: Lexy Doane, Physician Recruiter, Atrium Health at Lexy.Doane@atriumhealth.org

New Heart Transplant Cardiologist and multiple NP/PA/RN job openings at Texas Children's Hospital

All of the below new job postings are additions to our currently existing team which includes 8 cardiologists, 2 APPs, 3 VAD coordinators, 7 heart transplant RN coordinators, and 3 heart failure/cardiomyopathy RN coordinators.

Pediatric Heart Failure/Transplant Cardiologist
Pediatric Heart Failure/Transplant Advanced Practice Provider x 2
Ventricular Assist Device Coordinator
ACHD Cardiologist with heart transplant experience

Reach out to Joey Spinner (spinner@bcm.edu or 713-387-9540) if you have any questions or would like more information.

NP Position at Columbia/Children's Hospital of New York

The Division of Pediatric Cardiology at Columbia University Medical Center (CUMC)/ Morgan Stanley Children's Hospital of New York is seeking a Nurse Practitioner to join our team in a full-time position to work within the Pediatric Advanced Cardiac Care and Transplantation Program.

Questions regarding this position can be addressed to Dr. Marc Richmond (Director, Pediatric Advanced Cardiac Care mr2306@cumc.columbia.edu, Dr. Matthew Crystal (Chief Medical Officer, Pediatric Cardiology) mac2376@cumc.columbia.edu or Ms. Michelle Silverio (Division Administrator, Pediatric Cardiology) ms7254@cumc.columbia.edu

Faculty Position at Nationwide Children's Hospital

The Heart Center at Nationwide Children's Hospital (NCH) seeks a heart failure/ transplantation & pulmonary hypertension specialist, at any professorial level, to join its growing and dynamic program.

Candidates may submit their curriculum vitae by mail or email to:
Antonio G. Cabrera, MD FAHA
Division Chief, Pediatric Cardiology
The Heart Center at Nationwide Children's Hospital
Antonio.Cabrera@NationwideChildrens.Org

Job Postings

Call for Applications: Cincinnati Children's 4th Year Fellowship in Cardiomyopathy, Heart Failure, Transplant and Mechanical Circulatory Support

We are thrilled to announce that Cincinnati Children's Hospital Medical Center is now accepting applications for our 4th year advanced fellowship in Pediatric Cardiomyopathy, Heart Failure, and Transplant for the 2027-2028 academic year. Eligible candidates will have completed a categorical pediatric cardiology fellowship in time for a start date of July 2027.

Interested applicants can learn more and should submit their CV, three letters of recommendation, and a personal statement on our website, https://www.cincinnatichildrens.org/education/clinical/fellowship/cardiology-fellowship/application-process, by August 14th. Questions or concerns can be emailed to our fellowship program manager, Maggie DeBruler, hi.fellowship@cchmc.org, or 4th year fellowship director, Dr. Ben Mantell, at Benjamin.Mantell@cchmc.org.

Advanced Fellowship in Advanced Cardiac Therapies at Children's Healthcare of Atlanta - Emory University

Children's Healthcare of Atlanta (CHOA) / Emory University is now accepting applications for advanced fellowship training in pediatric heart failure, mechanical circulatory support, and transplantation for the 2027-2028 academic year. Applicants must have completed a general pediatric cardiology fellowship at an accredited ACGME program prior to July 5th, 2027, start date.

Interested applicants should fill out the online application linked below and send a CV, three letters of recommendations and a brief personal statement to Chad Mao (maocha@kidsheart.com) by August 3th, 2026.

4th year fellowship at Primary Children's Hospital/University of Utah

Primary Children's Hospital/University of Utah is accepting applications for advanced training in pediatric heart failure, VAD, and transplantation for the 2027-2028 academic year. Applicants who have completed their general pediatric cardiology fellowship at an ACGME accredited program prior to the start date of July 2027 will be considered.

Interested applicants should submit an application, CV, personal statement and letters of recommendation (including one letter from the fellowship director) via this link (Interested applicants should fill out the online application linked below and send a CV, three letters of recommendations and a brief personal statement to Chad Mao (maocha@kidsheart.com) by August 3th, 2026.) by August 15, 2026.

Job Postings

Senior Fellowship Training in Advanced Cardiac Therapies at Boston Children's Hospital (2027-28)

Boston Children’s Hospital is now accepting applications for Senior Fellowship training in Advanced Cardiac Therapies for the 2027-2028 academic year. Applicants who will have completed their general pediatric cardiology fellowship training prior to the start date of July 1, 2027, will be considered. The Advanced Cardiac Therapies Division at Boston Children's is led by Dr. Elizabeth Blume and encompasses the Cardiomyopathy Program, Heart Failure Program, Heart Transplant Program, VAD Program, the Cardiac Antithrombosis Management Program, Cardio-Oncology Program, and Neuromuscular Cardiology Program.

Interested applicants should send their application, CV, three letters of recommendation and a brief personal statement to Kelly Hill (kelly.hill@cardio.chboston.org) by September 1, 2026. Please e-mail Ms. Hill to obtain a copy of the application form. If you have questions about the program or would like to learn more before applying, please contact Dr. Betsy Blume (Elizabeth.blume@cardio.chboston.org) with any questions.

NewYork Presbyterian seeks Director of Transplant Clinical Operations

The Director, Clinical Operations for Transplant provides strategic and operational leadership for all aspects of the transplant programs, including renal, cardiac, liver, lung, pancreas, as well as our unique multi-organ transplant program. This leader is responsible for overseeing operations, ensuring seamless transitions of care, and maintaining full compliance with UNOS, CMS, Joint Commission, and other state and federal regulatory agencies.

More information and apply at the link below, can email Marc Richmond mr2306@cumc.columbia.edu for additional information and qusetions

Faculty position at Primary Children's Hospital

This is an outstanding opportunity to join a vibrant and collegial academic environment and work in a children’s hospital ranked as one of the best in the U.S. The Department of Pediatrics, Division of Pediatric Cardiology at the Spencer Fox Eccles School of Medicine at the University of Utah is seeking a Pediatric Cardiologist with expertise in heart failure, cardiac transplantation, and ventricular assist device support.

Interested individuals can apply for the position at https://utah.peopleadmin.com/postings/191021. Cover letter and curriculum vitae are required. For additional information about the position, please contact Adam Ware, MD, Division Chief of Pediatric Cardiology, at adam.ware@hsc.utah.edu.

If you have a job posting that you would like to share with the PHTS Membership, visit the PHTS Basecamp board called Resources for Job Opportunities to add your job posting.