CONGENITAL CARDIOLOGY TODAY
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An Interview with Dr. Macdonald Dick II

A discussion of the recent book Reimagining a Child's Heart: The Lone Pines of Congenital Cardiology, memories of Dr. Tom Kulik, and reflections on the individuals who forwarded our field

Caren S. Goldberg, MD, MS & Macdonald Dick II, MD

I am excited to share the conversation I had with Dr. Macdonald Dick, as we talked about the recent book, *Reimagining a Child's Heart, The Lone Pines of Congenital Cardiology*, written by Dr. Tom Kulik, edited along the way and ultimately completed by Mac, following the much too early loss of Tom in January 2021.

Reimagining a Child's Heart brings the lives of the Lone Pines into clear definition. Through the book, Tom and Mac review the important and foundational developments that made surgical treatment of single ventricle heart disease possible. There is much focus on the thought processes of the individuals and the inner workings of the teams behind these foundational developments.

CG: Mac, do you want to start by describing the term lone pine? What is a lone pine?

MDII: Lone Pines, that was a term of Tom's. In our discussions I asked him the same question. It turned out as everyone knows, Tom was interested in cars, loved cars, had a Ferrari, in fact. Did you know that?

CG: Yeah, I did know that.

MDII: Well, I didn't know that until he moved to Boston. He was very interested in cars and there was a story that he told me that in the car industry, the automobile industry, in their development, in their emergence in the beginning of the 20th century, late 19th, there were these "lone pines" that stood out in the engineering world that created "high performance" cars. He didn't name them, as I recall. And I tried to find that story somewhere in the literature. I googled the term and I couldn't find it within the automobile engineering history but I think it's a real term, and Tom was quite serious about it. So he borrowed that term, and it essentially meant, as he outlined in his introduction, and I did in my forward, individuals who seized the moment and acted in an innovative fashion.



FIGURE 1 *Mac Dick as we spoke for this interview*

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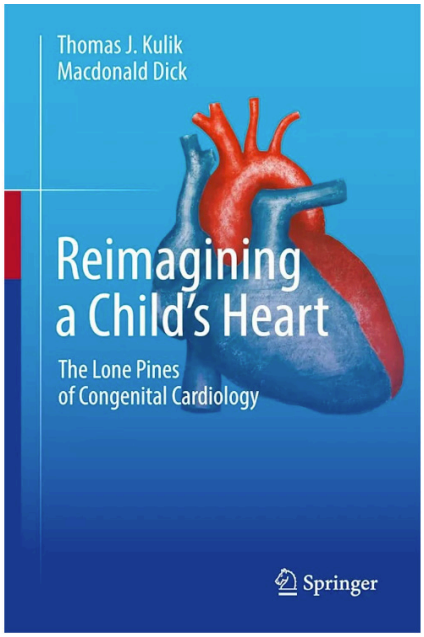


FIGURE 2 *Reimagining a Child's Heart is published through Springer Publishing and is available on Amazon*

They had original thoughts and were willing to take risks on their original thoughts. They thought they had a good idea and would push it. They were inventive, and they would stick to it. They didn't retreat. They pushed the envelope very, very strongly and at least a couple of times would get in trouble for it. Certainly Lillehei pushed the envelope as Tom outlines, to the point of getting in trouble with the chairmen of internal medicine and pediatrics at Minnesota, but the Chair of Surgery, Owen Wangensteen stood up for him; Lillehei allegedly was his favorite.

So, that is where lone pine came from, that's the thought, and Tom admired those characters, admired the person who would stand up. Remember how we'd be sitting in surgical conference and one of the faculty would say something that didn't make sense, and he would say, that's the (mild expletive) dumbest thing I ever heard. And by the way he would never say that to one of the fellows. You remember those times? So, yeah, that is sort of what he meant by that term.

CG: I think there are a lot of things that come out as we talk more just about the "lone pines" - Lillehei wasn't alone related to getting into some trouble. I am curious on your thoughts about some of those qualities that get people into trouble, are they the qualities that also allow them to move the needle forward?

MDII: They get in less trouble if they're successful. Aldo (Casteneda) when he came to Boston he began using circulatory arrest and hypothermia for infants and then later, in the 80s, with the (arterial) switch. It was risky but rational; deep hypothermia and circulatory arrest had been developed in Japan, used in New Zealand by Dr. Brian Barratt-Boyes and even used in the United States in Seattle, but Aldo was supremely rational and not hampered by a lack of confidence. The compact to go forward with these riskier procedures was between the parent and the surgeon. The parent of the patient of his first arterial switch operation was an engineer.

CG: A true confidence.

MDII: He was just extremely confident in every aspect of life. And particularly in the operating room. And Ed (Bove), I think, had that to a large extent as well and it extended into his teaching and his worldwide reputation.

CG: Absolutely. You've gotten to know a lot of the greats.

MDII: I have. I'd stare at them at meetings.

CG: C'mon, you are one of the giants in our field - you did more than stare at them. As I said when we started, you and Tom are two people who have been important mentors to me, and important examples throughout my career. I wondered if you wanted to describe some of the traits that you noted and admired about Tom, and maybe the traits that pushed him to work on this book for so long.

MDII: I learned about his interest in writing a book in 2006 I think. I had published a little book and Tom came into my office and admired it and shared then that he was working on a book about the treatment of Congenital Heart Disease. That is the first time I heard about it. Then I did not hear any more about it much until he started sharing the chapters with me, which was just before COVID; he started sharing the chapters then and continued until he died. And that is how I got involved in it.

With regard to his mentorship, he had a unique approach as you know. I wasn't a regular participant in those Thursday morning ICU rounds, but I remember and you can confirm this, or not, maybe apocryphal, but I don't think so. Oftentimes he would start the discussion by saying, "Caren, let me ask you this musical question. Do you remember that?

CG: Absolutely 100% true. He would say that "Ask you a musical question" not just at conference but at other times as well.

MDII: He asked the musical questions and of course, it had nothing to do with music; it had to do with the physiology of this patient over in this bed. And he would conduct those questions in elegant Socratic fashion, much more elegant than my approach. And I think it was painless to the fellow, for the most part.

CG: You know at Michigan that ICU conference is now named Kulik Rounds, so all the fellows, even in the current era, have a chance to learn about Tom.

MDII: And there is one other powerful story that I want to share. I was not there but was told, that he was at a national meeting, maybe a cardiac intensive care session and the presentation came to an end and Tom rose, and there was absolute silence, just like EF Hutton, when Tom speaks, people want to listen. I think that was in large part true, and that if anybody can confirm that or deny it, that'd be great.

CG: I do remember him traveling to interview people back when he was here at Michigan. Maybe for a short sabbatical. Maybe he went to Italy?

MDII: I was not aware of that. He did interview people. I sensed that it was mostly on the telephone and through correspondence. He has a lot of notes. He did say he talked to this person or that. He talked to a lot of people, Mike Freed about prostaglandins, Aldo Castenada, Jim Moeller.

CG: Speaking of all those notes of conversations, there are a huge number of references.

MDII: There are 31 pages, single line! Linda (Kulik) will tell you that he was forever getting a new book, printing a

new paper. So you can see where the 31 pages emerged.

CG: So the book was in development for such a long time as I understand it morphed over time?

MDII: As I said, in the forward, Tom started thinking about Congenital Heart Disease the minute he started medical school. Tom was also very interested in cars and thought a lot about engineering. As I said I was editing chapters for Tom but after he died and I wanted to finish this book on his behalf, but I had a hard time making it flow as he had interspersed the engineering sections among the medical chapters with musings about the differences. So, if there's writer's block, there's also editor's block. I actually paused for a year on the editing as I couldn't get beyond what I thought was an awkward arrangement. I wanted it to be Tom's book and Tom's voice. But finally I said to Linda, because Linda was involved every step of the way, "Linda, I just don't think it flows if we put these engineering chapters interspersed amongst the medical chapters, let's put them as Appendices at the end." And she actually said, "Fine, do whatever you want." She agreed and so after getting over that hurdle, it sort of spilled out after that much more smoothly and I think it reads better that way too.

CG: The book starts with a beautifully written explanation of embryologic cardiac development and oxygen delivery and metabolism and then extends to the realm of cardiac surgery with cooling, with bypass, the development of prostaglandins, and ultimately the ability to conceptualize and perform newborn operations on patients with single ventricle and who are ductal dependent. And so, while the book refers to the Lone Pines, in many ways there was really a forest of contributions.

MDII: That sounds like language Tom would appreciate.

CG: I could hear his voice on every page.

MDII: When I was reading the chapters, as we were emailing them back and forth when he was in Boston, my editorial was often a little smiley face whenever he had a clever use of a word or an interesting phrase, because he had a lot of them!

CG: Nearly every page made me smile at the word choice or language use. He had a unique voice and use of language.

CG: Given that there were many contributions and contributors, can you comment on the role of teamwork driving progress versus absolute independent thinking?

MDII: I think that Tom recognized the importance of collaboration and cooperation and cordial relations and that is critical. But I think he mostly saw and admired, as I mentioned earlier, the clear, independent thinking, the risk-taking and the innovation. And yes, nearly everybody who did that did it within an institution – a collaborative structure. Aldo spoke about the collaborative environment that he and Dr. Nadas fostered; it was not like that before Aldo's arrival in Boston. I think Tom's focus was on the creativity of an individual who then got people to buy in, which is probably how it works anyway, even in a in a highly collaborative environment.

MDII: One of the things I enjoyed was when Tom and I talked about the innovation and progress. As he talked you got a sense of each of these people as a person. You got a sense of Maude Abbott, this poor fragile lady who wore dresses backwards and fell off donkeys and got her hand banged in a door yet capably and generously shared her life with her cognitively impaired sister. And, as Tom emphasized, she created the first systematic review of Congenital Heart Disease. And you really get to know her as this very nice, kind Canadian lady who you wondered how she got out of bed in the morning- but she did, and she made this great contribution!

Paul Dudley White said something to the effect that, you know, without her, there would have been no Congenital Heart Disease: Gross said it too.

MDII: And didn't you love how he talked about Galen as this grumpy old grandfather?

And Helen Taussig who was a patrician of the first order - from a Harvard family; her father was a highly respected economics professor, and apparently a wonderful father. And she struck out on her own, leaving Radcliff for UC Berkeley. She was apparently dyslexic. She couldn't get into Harvard Medical School (no women), but Hopkins was taking women at the time. Actually, Hopkins and Michigan were among the first to accept women to medical school as I recall.



FIGURE 3 *A few colleagues attended our conversation. Pictured here from right to left are: Caren Goldberg, Mark Russell, Macdonald Dick, Tim Cotts, and Adam Dorfman*

And then there was this young southern gentleman of Blalock coming from a small town in Georgia, being a bit of a ladies man, and a party boy when he was in medical school. And also at Vanderbilt.

Do you all know the name Tinsley Harrison? He was a big deal when I was in medical school - he wrote or edited the big thick internal medicine textbook. He was at Hopkins when Blalock was there and they were friends. I don't know if you caught the bit when Tom referenced Tinsley, that Blalock was much more famous scientifically for his work on shock than for the Blalock-Taussig-Thomas Shunt. Blalock tried to get a house officer job at Hopkins but could only get it for one year, so off he went to Vanderbilt. At Vanderbilt, Blalock worked his butt off and did most of his own lab work before he hired Thomas and joined the Vanderbilt faculty. As Tom said, several people turned down the Hopkins chief of

surgery job, so it was offered to Blalock and the rest is history.

Another interesting piece is that the ethical structure in the '50s and '60s when Lillehei was pushing this envelope was, shall we say, totally unregulated. I mean, it was all a patient-parent-surgeon—physician interaction. There was no oversight, there was no IRB review. The only review that you possibly could have would be like the chairs of pediatrics and internal medicine at Minnesota, who were trying to stop things that they thought were not, "ethical," putting children and other people at risk. But as noted, Wangensteen backed up Lillehei so that the work could proceed.

By the way, do you know that Lillehei means little mountain in Norwegian? Lillehei came to give a talk when I was a house officer at Virgina. And his opening remarks were - my name is Lillehei, it means Little Mountain, and Monticello means Little Mountain also. I don't recall all the details about his talk, but I do remember that.

CG: There were a range of personalities - I was struck by John Gibbons, who really got the ball rolling on cardiopulmonary bypass and then stopped short of bringing that to the clinical realm.

MDII: Yes, Gibbons, as a resident, was driven because he lost a patient with pulmonary embolus, and he thought: "How can you take out the embolus and fix the issue?" He had an engineering mind and started working on a pump for sustaining the circulation. However, he was stumped by the inability to oxygenate the blood. After working at the Massachusetts General Hospital, he went to the University of Pennsylvania and then to Jefferson Medical College. Eventually, he was able to connect with IBM who invested in the project. Together the pump and oxygenator were ready for prime time. He lost his first patient, but the second was successful, and was the first successful open heart surgery using the cardiopulmonary bypass pump. I think he lost several patients a little later and sort of gave up in terms of cardiac surgery. He became a chair and widely sought speaker. And his success in getting IBM involved in developing the heart lung machine is as fine an example that you have for collaboration, a single man wouldn't have been able to create this – a true piece of the collaborative process.

And then there was John Lewis who was a brilliant guy with multiple interests and Tom has a long piece on him in the book. He actually, I think, did the first ASD closure using deep hypothermia alone, but later a patient died and then he stopped. Tom describes that you have to be all in if you're pushing this kind of innovation.

This was big innovation. And in fact, at the time, probably, I would say from the '50s up until the '70s, cardiovascular surgery was probably the brightest innovation on the medical horizon. The wonderful cancer therapy hadn't emerged. Understanding of the immune system was still primitive. I remember a definition in pathology said, what is an antibody? A protein that responds to an antigen. What is an antigen? It's a substance that stimulates an antibody. I'm not sure this gets me very far. We need to learn a little bit more.

CG: You know, Mac, you're recognized as one of the patriarchs of pediatric electrophysiology.

MDII: A patriarch?

CG: Don't you think so?

MDII: Old person, yes, patriarch I don't know?

CG: Okay, one of the people who really started the field of pediatric electrophysiology, a pioneer, a lone pine. But also a major part of your legacy is in mentorship. You've trained so many electrophysiologists across the country and mentored some of us who aren't even electrophysiologists.

MDII: Some of them snuck in.

CG: But when you think about what you impart in your teaching, do you emphasize that independent thinking, or the collaborative effort, or some combination? You've had an influence on many people.

MDII: Well, they influenced me. It's bidirectional. I did tell people when I interviewed them, "I don't care what your grades were in Medical school—couldn't care less - what I'm interested in is that you have been trained at a place where you've taken care of sick children. And know how to take care of sick children and arer not afraid of sick children. I want you to get in there and rub your elbows in it. And also we want to create, to train, academic cardiologists. It's not guaranteed. It's mostly up to you. That's what our goal is. It's OK if you don't. We still love you but that's our goal. And we want you to have the impulse of curiosity, hard work and adding to the body of knowledge. But the impulse comes from you. We provide the environment and the resources. But the impulse to do research-doesn't have to be laboratory research, doesn't have to be entirely original, doesn't have to be prize winning. I couldn't care less what it is. But we expect you to do some research and then to present it at local and national meetings and to have it published." Now, most of the time it worked, I'd say over 60%.

And when I was talking to medical students, I'd tell them to pay attention to two things: the science and the patient.

CG: There is so much interesting detail and science included in the book, how do you recommend someone take in everything in this book? I know that you read each chapter multiple times through the editing process, but for the average reader what do you think the best approach might be to learn the most?

MDII: You don't have to learn it all, we hope you enjoy it!

CG: And from your perspective, who's the best audience?

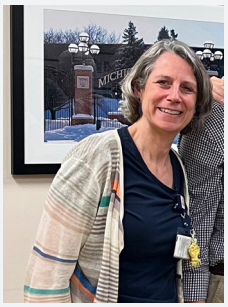
MDII: Of course students or fellows in cardiology and cardiac surgery, students who are interested in cardiology. Tom was from day one, you know, interested in Congenital Heart Disease. I'm not sure if all parents and patients would be interested in it, maybe a little too esoteric. And, as I said, engineers, and particularly engineers who are parents, I think.

CG: Thanks so much for taking the time to talk today.

I'm fortunate that Tom and Mac have both been important mentors and sponsors for me throughout my career and as I've read

Reimagining a Child's Heart, I delight particularly in the ability to hear their voices throughout the book. I think that as Mac said, this is a great book for anyone interested in understanding more about the progress in treatment of Congenital Heart Disease and the role of a forest of lone pines who made it all possible.

The book is published by Springer Publishing and is available on Amazon. I hope you enjoy and share with others!



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The Top 50 Children's Hospitals for Cardiology, Heart Surgery

Mariah Taylor

Texas Children's Hospital ranked as the top children's hospital for cardiology and heart surgery in the nation, U.S. News & World Report found.

U.S. News and RTI International, a North Carolina-based research firm, analyzed clinical data from 114 children's hospitals nationwide, assessing facilities across structural, process and outcomes measures. The two also surveyed thousands of pediatric specialists and weighed their responses in compiling the rankings. Learn more about the methodology here. This year, 91 hospitals were ranked among the top 50 in at least one specialty.

BECKER'S CARDIOLOGY

Below are the top 50 children's hospitals for cardiology and heart surgery.

1. Texas Children's Hospital (Houston)
2. Children's Hospital Colorado (Aurora)
3. Duke Children's Hospital and Health Center (Durham, N.C.)
4. Children's Hospital of Philadelphia
5. Children's Health Dallas
6. MUSC Children's Heart Network of South Carolina (Charleston)
7. Children's Healthcare of Atlanta
8. Boston Children's Hospital
9. Dell Children's Medical Center (Austin, Texas)
10. Rady Children's Hospital (San Diego)
11. Intermountain Primary Children's Hospital-University of Utah (Salt Lake City)
12. Children's Memorial Hermann Hospital (Houston)
13. UPMC Children's Hospital of Pittsburgh
14. Cincinnati Children's and Kentucky Children's Hospital Joint Heart Program
15. NewYork-Presbyterian Children's Hospital-Columbia and Cornell (New York City)
16. Ann & Robert H. Lurie Children's Hospital of Chicago
17. UF Health Shands Children's Hospital (Gainesville, Fla.)
18. Cleveland Clinic Children's Hospital
19. University of Michigan Health C.S. Mott Children's Hospital (Ann Arbor)
20. Children's Hospital Los Angeles
21. American Family Children's Hospital (Madison, Wis.)
22. Levine Children's Hospital (Charlotte, N.C.)
23. Nationwide Children's Hospital (Columbus, Ohio)
24. Oklahoma Children's OU Health (Oklahoma City)
25. Hassenfeld Children's Hospital at NYU Langone (New York City)
26. Children's Mercy Kansas City (Mo.) Hospital
27. Mayo Clinic-Children's Minnesota Cardiovascular Collaborative (Rochester)
28. Children's National Hospital (Washington, D.C.)
29. Ochsner Children's Hospital (New Orleans)
30. Loma Linda (Calif.) University Children's Hospital
31. Riley Hospital for Children at IU Health (Indianapolis)
32. Arkansas Children's Hospital (Little Rock)
33. Nemours Children's Hospital-Delaware (Wilmington)
34. UCSF Benioff Children's Hospitals, San Francisco and Oakland
35. UCLA Mattel Children's Hospital and CHOC Joint Heart Program (Los Angeles)
36. Seattle Children's Hospital
37. SSM Health Cardinal Glennon Children's Hospital (St. Louis)
38. Lucile Packard Children's Hospital Stanford (Palo Alto, Calif.)
39. Le Bonheur Children's Hospital (Memphis, Tenn.)
40. Johns Hopkins Children's Center (Baltimore)
41. Children's Hospital of Alabama at UAB (Birmingham)
42. Rainbow Babies and Children's Hospital (Cleveland, Ohio)
43. St. Louis Children's Hospital-Washington University
44. Phoenix Children's Hospital
45. Johns Hopkins All Children's Hospital (St. Petersburg, Fla.)
46. University of Iowa Stead Family Children's Hospital (Iowa City)
47. Cook Children's Medical Center (Fort Worth, Texas)
48. Nicklaus Children's Hospital (Miami, Fla.)
49. Corewell Health Helen DeVos Children's Hospital (Grand Rapids, Mich.)
50. Monroe Carell Jr. Children's Hospital at Vanderbilt (Nashville, Tenn.)



Edwards Earns FDA Approval for First-of-its-Kind Size-Adjustable Pediatric Heart Valve

Skyler Rivera

Edwards Lifesciences earned FDA approval for its Autus size-adjustable heart valve, a surgical pulmonary heart valve for pediatric patients with Congenital Heart Disease, the company announced today.

The first-of-its-kind valve is designed to expand as the child grows, reducing the need for repeat open-heart surgeries. It's also the first artificial heart valve approved in the United States with polymeric material leaflets rather than animal-derived tissue leaflets.

"For decades, Edwards has worked to address the needs of structural heart patients with complex conditions, Edwards Lifesciences CEO Bernard Zovighian said in the announcement. "The Autus valve represents a meaningful advancement for children who have historically had limited treatment options. Our commitment extends beyond innovation to generating clinical evidence and collaborating with physicians, medical societies and patient groups to help address the evolving needs of patients with Congenital Heart Disease."

The Autus valve can be initially implanted as small as 13 mm in diameter, the appropriate-sized valve for a toddler or preschool-age patient, FDA said. Over time, valve expansion is performed through a minimally invasive transcatheter procedure that widens the valve using a balloon catheter. The Autus valve can reach a maximum size of 22 mm, comparable to an adult-sized pulmonary valve.

"For children born with congenital heart disease, valve replacement timing has always been a difficult decision — wait too long and you risk harm to the child, but intervene too early and they may need multiple open-heart surgeries as they grow," FDA Center for Devices and Radiological Health Director Dr. Michelle Tarver said.

Treatment of pediatric congenital heart disease may improve blood flow and repair congenital defects but, patients could also develop significant pulmonary regurgitation. Over time, this regurgitation weakens or enlarges the right ventricle and the need for a replacement valve increases as the child grows.

"The Autus size-adjustable valve gives doctors the option of far fewer trips to the operating room, which may result in better quality of life for these children and their families," Tarver said.

Traditional animal-derived tissue leaflets harden and break down faster in children, according to the FDA, often causing earlier repeat surgeries. One-year follow-up data showed Autus' polymeric material leaflets "hold up well over time," the FDA said. The approval marks the first time a valve with polymeric leaflets was approved for any indication.

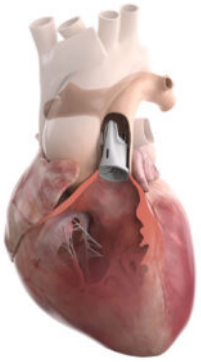
The FDA previously granted the valve Breakthrough Device designation. Autus was also the first pediatric approval from the FDA's Total Product Life Cycle Advisory Program (TAP).

The approval was based on data from a clinical study with 62 pediatric patients. Through the first 30 days, 100% of patients were free from device-related complications and demonstrated favorable valve performance with no Autus valve reintervention through six months, Edwards said.

At the six-month follow-up, 60 patients demonstrated acceptable hemodynamic performance and no more than mild regurgitation, FDA said. All patients who completed the one-year follow-up showed consistent outcomes with less than moderate pulmonary regurgitation and no valve reinterventions, the device developer said.

Patients will continue to be followed for 10 years to collect additional data to show that expansion can maintain a functional valve, leading to fewer surgical procedures.

"For far too long, children with congenital heart defects who need pulmonary valve replacement have had very limited surgical options, and those options have historically required multiple open-heart surgeries as children grow," Acting FDA Commissioner Kyle Diamantas said. "Today's landmark approval is a historic turning point and reflects the Trump Administration and the FDA's commitment to help bring innovative, life-changing devices to the patients who need them most."



Edwards Lifesciences' Autus size-adjustable heart valve (Illustration courtesy of Edwards Lifesciences)



The Autus valve can be initially implanted as small as 13 mm in diameter (pictured closed here). (Illustration courtesy of Edwards Lifesciences)



The Autus valve can reach a maximum size of 22 mm, comparable to an adult-sized pulmonary valve (Illustration courtesy of Edwards Lifesciences)

More and More Young Children Now Taking GLP-1 Drugs for Weight Loss

Michael Walter, Managing Editor, Cardiovascular Business

More and more young children are starting to be prescribed GLP-1 drugs to manage their weight, according to new research published in Pediatrics.[1]

The study's authors focused exclusively on obese children without diabetes between the ages of 8 and 11. In 2019, just 0.03% of those children were on GLP-1 medications. However, that number skyrocketed to 9.3% in 2026. The group estimated that approximately 20,000 children between the ages of 8 and 11 have been prescribed GLP-1 drugs during that time.

"Our study offers the first national overview in young children of the use of GLP-1 drugs to fight the obesity epidemic in the United States and shows that while the absolute numbers of children under the age of 12 receiving GLP-1 treatment is still low, GLP-1 use is accelerating rapidly," first author Babak J. Orandi, MD, PhD, MSc, a transplant surgeon and obesity specialist with NYU Langone Health's NYU Grossman School of Medicine, said in a statement. "The careful use of GLP-1s remains a valuable tool in confronting the obesity epidemic among young Americans."

Orandi emphasized that some parents may be unsure about the idea of giving their children these medications. However, he said, the alternative may be a lifetime of high blood pressure and other potentially harmful health conditions.

The study's authors focused on three GLP-1 drugs for this analysis: liraglutide, semaglutide and tirzepatide. Liraglutide is sold by Novo Nordisk under the brand name Saxenda. Semaglutide is sold by Novo Nordisk under the brand names Wegovy and Ozempic. Tirzepatide, meanwhile, is sold by Eli Lilly and Company as Zepbound and Mounjaro.

Another key takeaway from the group's research was the fact that children with obesity in higher-income communities were 55% more likely to be prescribed one of these medications than children with obesity living elsewhere. This difference in care for patients in low- and high-income communities mirrors trends regularly seen in medications for adults; the study's authors emphasized that access to these drugs should be consistent throughout the United States.

"Physicians and health policymakers alike have a responsibility to ensure, as use of GLP-1 medications continues to rise, that all young children with obesity who need these drugs have access to them and that these valuable and sometimes costly treatments become available to more than those who have access to health insurance and can afford to visit pediatric clinics," co-author Allan B. Massie, PhD, a professor with NYU Grossman School of Medicine, said in the same statement.



One of Modern Medicine's Biggest Trends

GLP-1 drugs such as semaglutide and tirzepatide were originally developed to treat diabetes. In recent years, however, they are now being used more and more for weight loss, even in patients without diabetes. These drugs have been linked to significant reductions in certain cardiovascular outcomes, including heart attack and stroke, and they are becoming so popular that the brand names are practically household names.

Reference

1. Orandi, et al. Trends in GLP-1 Receptor Agonist Prescriptions for Children Ages 8 to 11 With Obesity: 2019–2026. Pediatrics. Sept. 4, 2026.

Click the position title to view the full job description

Assist / Assoc Professor of Clinical Pediatrics & Child Health

Phoenix Children's
Phoenix, Arizona

Pediatric Cardiologist
Loma Linda University Children's Hospital
Loma Linda, California

Pediatric Cardiology Physician
The Pediatric Specialty Group at Kaiser Permanente Santa Clara Medical Group
Santa Clara, California

Pediatric Cardiologist

Stanford Medicine Children's Health
San Francisco, California

Pediatric Cardiac Interventionalist
Stanford University / Stanford Medicine Children's Health
Stanford, California

Pediatric Cardiologist

University of Iowa Stead Family Dept Pediatrics
Des Moines, Iowa

Pediatric Cardiology Opportunities

Ochsner Children's Hospital
New Orleans, Louisiana

Pediatric Cardiologist Advanced Imaging with Cross-Sectional Focus
MaineHealth Maine Medical Center
Portland, Maine

Regional Pediatric Cardiologists
Ochsner Children's Hospital
Baton Rouge, Lafayette, Monroe, Louisiana
Gulfport, Mississippi

Pediatric Cardiologist

The University of Utah Primary Children's Hospital
Las Vegas, Nevada

Pediatric Cardiologist Director of Cardiac Imaging
Akron Children's Hospital
Akron, Ohio

Pediatric & Congenital Interventional Cardiologist Faculty
Cincinnati Children's Hospital Medical Center
Cincinnati, Ohio

ACHD Faculty Director Noninvasive Imaging Faculty Acute Care Faculty
UPMC Children's Hospital of Pittsburgh
Pittsburgh, Pennsylvania

Assist/Assoc/Full Professor Pediatric Non-Invasive Imaging
Seattle Children's University of Washington
Seattle, Washington

Pediatric Electrophysiologist

Providence Medical Group
Spokane, Washington

NOVEMBER

05TH - 08TH

Phoenix Children's 15th Fetal Cardiology Symposium
Chandler, Arizona, USA
https://www.fetalcardio.com/

13TH - 14TH

Transcatheter Pulmonary Valve Summit
Istanbul, Turkey
https://tpvs2026.org/en/registration-accommodation.html

14TH - 15TH

ASE 5th Annual Echo in Pediatric and Congenital Heart Disease Virtual Experience
Virtual
https://www.asecho.org/education-events/echo-in-pchd/

17TH - 18TH

British Congenital Cardiac Association (BCCA) Annual Scientific Meeting
Leeds, United Kingdom
https://bccaconference.co.uk/

DECEMBER

01ST - 02ND

International Aortic Symposium 2026
Orlando, Florida, USA
https://floridaaorta.cme.ufl.edu/

Program Directory
2026-2027

Directory of Congenital & Pediatric Cardiac Care Providers in North America

Electronically available on CCT's website
CongenitalCardiologyToday.com/Program-Directory

Each program's contact information for Chief of Pediatric Cardiology & Fellowship Director

Lists each program's Pediatric Cardiologists & Cardiothoracic Surgeons

Lists Pediatric Cardiology Fellowships

Need to update your listing?
Contact Kate Baldwin
kate.f.baldwin@gmail.com

NEONATOLOGY TODAY
Peer Reviewed Research, News and Information in Neonatal and Perinatal Medicine

CONGENITAL CARDIOLOGY TODAY

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