RCPE Symposium – Cardiology

Shruti S Joshi[1]

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Correspondence to:
Shruti S Joshi
Department of Cardiology
Royal Infirmary of Edinburgh
51 Little France Crescent
Edinburgh EH16 4SB
UK

Email:
shrutishree.joshi@gmail.com

The Cardiology symposium 2019 gave us a comprehensive and evidence-based approach to common cardiovascular presentations in our clinical practice. Although there have been significant advancements in clinical care, clinicians must remember the Hippocratic oath – 'primum non nocere' – when providing care to an increasingly comorbid population.

Session 1: Clinical cardiology: learning from experience

Dr Peter Currie (NHS Tayside) opened the symposium with a talk on chest pain, highlighting the importance of history taking and examination skills. He concluded with a message to tailor investigations and optimise medical therapy initially as there is no benefit in mortality with intervention over medical therapy in patients with chronic stable angina.[1]

Dr Mark Francis's (NHS Fife) talk focused on breathlessness and cardiac failure. He explored the physiology and challenges of managing patients with cardiac failure with preserved ejection fraction (HFPEF). These patients frequently have multiple comorbidities, management being particularly challenging as there are no evidence-based treatments available for HFPEF. He emphasised the need to be pragmatic and holistic in our approach to clinical care in those with advanced age and multiple morbidities.

The penultimate talk of the session was Dr Douglas Elder's (NHS Tayside) presentation on assessing a patient with syncope and the European Society of Cardiology's (ESC) classification of syncope.[2] He summarised the available investigations for cardiac syncope, with the implantable loop recorders being most useful and cost effective compared to standard investigative tools.[3]

Dr Chris Skene (Wythenshawe Hospital) discussed the clinical approach to palpitations and the key features in history that help differentiate between different causes of palpitations. He defined the 'red flags' that one should identify and also summarised new modalities of cardiac rhythm monitoring.

Session 2: Ask the experts

Dr John Mandrola (Baptist Health, Louisville, USA) delivered the prestigious Andrew Rae Gilchrist lecture titled 'Speaking to the patients: words that maim, words that heal'. He discussed the neuropsychological mechanisms involved in the interaction between the doctor and patient during a consultation. He stressed on the need to be careful in our choice of words whilst interacting with patients, being mindful of the 'nocebo' effect of a negative consultation. The future of medicine should focus on empowering patients to participate in shared decision-making with structured education.

Dr Paul Broadhurst (Aberdeen Royal Infirmary), accompanied by an expert panel including Professor Stephen Leslie (Raigmore Hospital, Inverness), Dr Ingibjorg Gudmundsdottir (The University Hospital, Reykjavic, Iceland) and Dr Margaret McEntegart (Golden Jubilee Hospital, Clydebank), took us through challenging cases that fall outwith published guidelines, where realistic medicine and clinical judgement must be applied.

Session 3: Treatments, investigations, evidence-based medicine and guidelines: trials and tribulations!

Professor Darrel Francis (Imperial College Hospital, London) summarised the study design and results of the landmark trial 'Orbita',[1] highlighting that coronary intervention does

[1]Cardiology Registrar, Department of Cardiology, Edinburgh Heart Centre, Royal Infirmary of Edinburgh, Edinburgh, UK

not prevent death or significantly improve exercise times in patients with chronic stable angina.

Professor John McMurray (University of Glasgow) addressed the role of implantable cardioverter defibrillator (ICD) in impaired cardiac function. Where the competing risk of noncardiovascular death is high, the potential to prolong life with an ICD is minimal, as seen in the elderly with multiple comorbidities. ICDs are most useful in younger patients with persistently low ejection fraction despite medical therapy, NYHA II class cardiac failure and in those with genetic susceptibility to sudden cardiac death.[4] Better risk stratification tools are currently needed to aid decision-making.

Dr Nicola Johnston (Royal Hospitals, Belfast) discussed the role of echocardiogram and cardiac MRI (CMR) in assessment of valve disease and concluded that echo remains the investigation of choice but CMR is increasingly utilised. CMR is established as a mainstream investigation, being used in daily clinical practice and has multiple class I indications in ESC guidelines.

Session 4: Learning from patients: cases that have taught me about medicine

Dr Andrew Docherty (Wishaw General Hospital), Dr Peter Clarkson (Raigmore Hospital, Inverness) and Dr Helen Oxenham (North Tees and Hartlepool NHS trust) shared challenging cases of patients that they have encountered in their practice. They encouraged us to pursue a diagnosis in uncertain situations and reminded us that in certain scenarios, advanced care interventions may be inferior to simple lifestyle changes.

Take home messages

Following an inspiring day at the symposium, the delegates left with the message to revive the lost art of history taking and examination in our clinical practice. It was an engaging symposium for every generalist and specialist in the audience. My personal take home messages as a trainee were that a personalised care approach should be sought in an ageing population and involving patients in shared decision-making should be implemented in our practice.

References

1 Al-Lamee R, Thompson D, Dehbi H-M et al. Percutaneous coronary intervention in stable angina (ORBITA): a double-blind, randomised controlled trial. *Lancet* 2018; 391: 31–40.

2 Oebel S, Hindricks G. Management of syncope in clinical practice: what has changed according to the new ESC guidelines 2018? *Herz* 2018; 43: 701–9.

3 Solbiati M, Casazza G, Dipaola F et al. Cochrane corner: implantable loop recorder versus conventional workup for unexplained recurrent syncope. *Heart* 2016; 102: 1862–3.

4 Fink T, Kuck KH, Metzner A; European Society of Cardiology. ESC guidelines 2015 for ventricular arrhythmias and prevention of sudden cardiac death. What is new? *Herz* 2015; 40: 1034–42.