

HEART CARE PARTNERS GREENSLOPES PRIVATE HOSPITAL OPENING

By Chairman of the Clinical Management Committee Dr Stephen Cox

Heart Care Partners were proud to open their new, hi-tech rooms in the Ramsay Specialist Centre, Greenslopes Private Hospital on 27th Feb.

The rooms were officially opened by the Hon. Stephen Robertson. GPH doctors and staff as well as key Ramsay personnel were present. The opening of these rooms, a HCP first at a Ramsay facility in Queensland, is a signal of the shared common vision of both organisations - being leaders in health care.

With over 3,000 doctor referrals a year, Heart Care Partners invested in this state of the art facility to expand its ability to service Brisbane and South East Queensland residents in need of cardiac care. The facility will allow us to better serve our patients and referring doctors on the southside. Dr. Anders Taylor has been our lead cardiologist at GPH, and

he has been joined by Dr. Karen Phillips. Anders will continue to offer his expertise in cardiac catheterization and angioplasty.

Dr Karen Phillips, a 35 year old cardiologist, has recently returned from training at the Cleveland Clinic in the USA. Karen's area of subspecialty is the diagnosis, management and treatment of heart rhythm disorders. Her expertise in pacing and ablation procedures is a welcome addition to our Greenslopes practice.

The new space will allow us to offer increased patient access to consulting and non-invasive testing - particularly stress echo.

Please contact Anders or Karen through the rooms on 3394 3100 to discuss a new case or patient problem. Testing bookings at this site can be made by calling us also on 3394 3100.



Dr Geoff Holt (left) and Hon. Stephen Robertson (right)



From left: Dr Karen Phillips, Dr Anders Taylor, Dr Peter Cain and Dr Ben Fitzgerald

HEART CARE PARTNERS - CARDIOLOGY CONNECTIONS CONFERENCE

By Chairman of the Clinical Management Committee Dr Stephen Cox

Heart Care Partners in conjunction with our co-sponsors Servier and Medtronic, hosted 62 GPs at our second annual educational conference. This year it was at Twin Waters and provided a family friendly backdrop for the weekend.

A range of topics were discussed in the group sessions including heart failure, AF, palpitations, ischaemic heart disease, report interpretation and carotid stenting.

Dr Greg Scalia gave an insightful and entertaining plenary session on the role of non-invasive testing in cardiac disease. Greg reiterated that unstable patients need to be seen in the ER setting. He discussed the additional structural and functional data that SE give to referring GPs over and above regular treadmill or thallium testing.

Dr Karen Phillips reassured us that in patients with palpitations the presence of a structurally normal heart on Echo and a negative stress test were excellent prognostic signs. Karen said documenting the rhythm disturbance on ECG or Holter monitoring was important.

Dr Peter Cain discussed the content of Echo reports and how to read them. He reminded us that a call to the Echo lab (3870 4144) for clarification was welcome.

Dr Robert Fathi, a cardiac and carotid interventionalist, spoke about the place of stenting in carotid disease. He reminded us that carotid duplex screen of patients with multiple cardiac risk factors can pick up patients with asymptomatic severe disease that should be referred for assessment.

Dr Tony Rafter discussed the COURAGE trial results. He made the point that

patients with stable symptoms and non-life threatening disease can be safely managed medically. Tony pointed out that this seemed to be a small subset of patients as many preferred angioplasty to reduce their symptoms.

Dr Ben Fitzgerald discussed Atrial Fib. He made the strong point that the CHADS2 score was very useful to determine which patients should receive warfarin to lower their stroke risk. He gave us the Wikipedia web site address for reference - http://en.wikipedia.org/w/index.php?title=CHADS_Score&oldid=161132505

Dr David Cross discussed the management of heart failure. He made the point that up-titration of medication to the maximum tolerated seemed important prognostically. David told us that a resting blood pressure of 90mmHg was OK in heart failure if the patient wasn't light-headed all the time.

Our advice to all GPs is that if you're worried - call, if you're not sure - call.

Our job is to help you and your patients. Heart Care Partners is here to help - 38588666 for doctor Hot Line.



Can you guess which "Cardiologist" had his face painted?



HEART CARE PARTNERS... YOUR PARTNERS IN CLINICAL EDUCATION RENAL ARTERY STENOSIS AND STENTING: WHO, WHEN AND WHY?

By Robert Fathi M.B.B.S., PhD, F.R.A.C.P.

Renal artery stenosis is the most common cause of secondary hypertension. The Majority of cases (90%) are caused by atherosclerotic stenosis (RAS) and a minority (10%) by Fibromuscular dysplasia (FMD), a disorder of fibrous overgrowth involving the intima, media or adventitia. Atherosclerotic RAS typically involves the elderly male population and often co-exists with end-stage renal disease (ESRD). In contrast FMD typically involves young females and is unlikely to be associated with significant renal impairment.

Diagnosis of RAS is largely based on radiological investigation as examination findings are generally non-diagnostic (a renal artery bruit is occasionally audible). If RAS is suspected the investigation of choice is renal ultrasonography with Duplex examination of renal artery blood



▲ Renal artery stenosis caused by Fibromuscular dysplasia in a young hypertensive female. Note the typical beading appearance of the renal artery.

flow. The advantages of this technique are that it is non-invasive, involves no ionizing radiation, and can provide anatomic and functional data. It can also provide physiologic information to predict recovery of renal function with revascularization. Kidneys that are significantly atrophic (<8cm) generally do not benefit from revascularization. The major disadvantage of this technique is limited accuracy in obese patients and in patients with multiple (accessory) renal arteries. In such cases CT angiography can be used as a second line investigation.

Renal artery stenting is a minimally invasive technique for renal artery revascularization and is associated with a very high procedural success rate.

The data for revascularization of renal arteries with balloon dilatation and



Dr Robert B Fathi
M.B.B.S., PhD,
F.R.A.C.P.

Having completed his general training at the Royal Brisbane Hospital, Robert undertook advanced cardiology training at the Princess Alexandra Hospital.

His interest in vascular medicine culminated in a PhD from the University of Queensland. To advance his expertise in the field of interventional cardiology and stroke prevention, Robert completed an interventional fellowship in coronary, peripheral and carotid angioplasty at the Cleveland Clinic, USA, from 2004-2005.

He returned to Heart Care Partners with a high level of expertise and experience in vascular intervention. Robert is consulting at Mount Ommaney and the Wesley several times a week and visits **Hervey Bay** on a monthly basis.

or stenting as compared to medical therapy is limited. In patients whose blood pressure could be controlled with medical therapy alone, no trial was able to demonstrate a statistically significant difference in blood pressure between balloon angioplasty and medical therapy. In patients with refractory hypertension to medical therapy, the results of the DRASTIC trial demonstrated that balloon angioplasty was better than medical therapy in respect of more efficient blood pressure control with a reduction in the number of medications that are required to control hypertension. Renal stenting has been shown to improve or stabilize renal function in patients with atherosclerotic renovascular renal impairment. The majority of patients showing benefit had bilateral or solitary (single kidney) RAS.

	ATHEROSCLEROTIC	FMD
Age at onset	> 50 y	35-45 y
Sex	Male > female	Female > male
Prevalence	High	Low
Location	Ostium (single)	Periphery (multiple)
Progression to ESRD	Common	Unusual
Effective intervention	Angioplasty + stent	Angioplasty - stent
Cure of hypertension	Unlikely	Up to 75% at 1 yr

▲ Summary of Differences of atherosclerotic RAS versus Fibromuscular dysplasia

KEY POINTS

1. Suspect renal artery stenosis in patients with difficult to control hypertension or renal impairment
2. Renal ultrasonography is the investigation of choice
3. Renal artery stenting is an effective revascularization strategy in appropriately selected patients.