adelaide cardiology

Our Cardiologists

Adelaide Cardiology provides an extensive range of cardiac services and subspecialties ensuring that patients have access to the complete range of cardiac care within our Practice.

John Sangster
Echocardiography

Robert Waltham
Echocardiography

Peter Steele
Interventional

Joseph Montarello
Interventional

Michael Brown
Interventional, Non-invasive Cardiac Imaging (CT, MRI)

Glenn Young
Electrophysiology

Daniel Cehic
Electrophysiology

Enzo DeAngelis
Interventional, Cardiac Transplant

Peter Sage
Interventional

Stephen Worthley
Interventional, Non-invasive Cardiac Imaging (CT, MRI)

Patrick Disney
Echocardiography, Grown up Congenital Heart Disease

Karen Teo
Non-invasive Cardiac Imaging (CT, MRI)

Dimitrios Lypourlis
Electrophysiology

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Contact us

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08 8232 3692
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Locations

City & Suburbs

270 Wakefield Street
Adelaide SA 5000

St Andrew's Clinic
349 South Terrace
Adelaide SA 5000

Modbury Clinic
71 Smart Road
Modbury SA 5092

Calvary Clinic
1st Floor, Calvary Hospital
89 Strangways Terrace
North Adelaide SA 5006

Regional

Angaston Hospital
29 North Street
Angaston 5353

Bridge Clinic
8 Standen Street
Murray Bridge 5253

Broken Hill Base Hospital
Thomas Street
Broken Hill 2880

Clare Medical Centre
Old North Road
Clare 5453

Victoria Road Medical Centre
16 Victoria Road
Clare 5453

Gawler Health Services
21 Hutchinson Road
Gawler 5118

Mannum Medical Centre
Parker Street
Mannum 5238

Wallaroo Hospital
Ernest Terrace
Wallaroo 5556

adelaide cardiology

the beat

autumn 09

Educational meetings

Adelaide Cardiology are continuing to run educational meetings for medical practitioners.

These are sessions where our cardiologists attend your Practice to talk about a particular topic that is of interest to you. Alternatively, it can be a more general discussion about updates in cardiology. Ideally, these sessions are run as lunch time meetings, however, we are happy to be flexible with times that best suit you and your Practice.

If you would like further information about these educational meetings or have a topic that you would like to learn more about, please send us an email to info@adelaidecardiology.com.au and we will be in touch to organise a suitable time.

A list of our cardiologists and their subspecialties is provided for your reference.

Prevention of Endocarditis - New Guidelines

The Australian guidelines for the use of antibiotics to prevent infective endocarditis have recently been revised and follow the lead of the United States and much of Europe, reducing the categories of patients for whom prophylaxis is recommended.

The changes are based upon the following set of data :-

- Efficacy of antibiotic prophylaxis for infective endocarditis has never been shown in a randomized trial.
- Few cases of infective endocarditis are now secondary to oral Streptococcus, and Staphylococcus (often acquired from nosocomial infection or IV drug use) is now the most common pathogen.
- Daily oral activities (tooth brushing, chewing) cause transient streptococcal bacteremia, resulting in annual cumulative exposure thousands to millions of times greater than that caused by tooth extraction.
- A direct link between routine dental procedures and infective endocarditis has never been proven, and the associated bacteraemia is up to four orders of magnitude below that needed to cause infective endocarditis.
- Amoxicillin is not 100% effective in preventing bacteremia in dental extraction.
- For many (47% in one French series), infective endocarditis arises in the absence of previously documented cardiac disease.

Antibiotic prophylaxis is now recommended only for patients who have :-

- Prosthetic (mechanical or bioprosthetic) cardiac valves in situ.
- A history of previous infective endocarditis.
- Unrepaired cyanotic congenital heart disease (CHD).
- Repaired CHD with residual shunts.
- Repaired CHD within the previous six months.
- Valvular regurgitation following cardiac transplantation.

In such high risk patients, it is appropriate for all dental procedures involving manipulation of gingival tissue or the periapical region of teeth, or perforation of oral mucosa.

Genito-urinary and gastrointestinal procedures (transoesophageal echo, esophagogastro-duodenoscopy, colonoscopy etc) do not warrant prophylaxis even in high risk patients unless active infection is present.

Respiratory tract procedures needing incision or biopsy of the mucosa probably do warrant antibiotic prophylaxis in high risk patients.

When administered, antibiotic prophylaxis should be in the form of Amoxil 2gm orally, one hour before dental procedures, or 1gm IV just before the procedure, or Clindamycin 600mg orally in penicillin sensitive patients.

Antibiotic prophylaxis is no longer indicated in adolescents and young adults with congenital or acquired native heart valve disease, nor in patients who develop valve diseases such as aortic stenosis, mitral stenosis or mitral valve prolapse.

These guidelines represent a huge departure from prior recommendations and emphasize the need for an evidence based approach to infective endocarditis prophylaxis.

It is to be expected that doctors changing their practice will encounter established expectations in patients with most forms of valvular heart disease.

Detailed antibiotic prophylaxis guidelines separately targeting dentists and doctors are available upon request from Adelaide Cardiology.