



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

Peter Steele

Interventional

Joseph Montarello

Interventional

Michael Brown

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

Glenn Young

Electrophysiology

Daniel Cehic

Electrophysiology

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)

Julie Bradley

Echocardiography

Georgy Chacko

Interventional

Maria Santos

Electrophysiology



Contact us

270 Wakefield Street
Adelaide 5000
South Australia

Telephone

08 8202 6600

Facsimile

08 8232 3692

adelaidecardiology.com.au

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

Unley Road Clinic
313 Unley Road
Malvern SA 5061
Telephone 8202 6677

Regional

Angaston Hospital
29 North Street
Angaston SA 5353

Bridge Clinic
8 Standen Street
Murray Bridge SA 5253

Broken Hill Base Hospital
Thomas Street
Broken Hill NSW 2880

Clare Medical Centre
Old North Road
Clare SA 5453

Gawler Health Services
21 Hutchinson Road
Gawler SA 5118

Gumeracha Hospital
2 Albert Street
Gumeracha SA 5233

Littlehampton
89 North Terrace
Littlehampton SA 5250

Maitland Health Centre
69 Robert Street
Maitland SA 5573

Mannum Medical Centre
Parker Street
Mannum SA 5238

Minlaton Medical Centre
7 South Terrace
Minlaton SA 5575

Walleroo Hospital
Ernest Terrace
Walleroo SA 5556



the beat



Welcome...

to our Summer 2013 issue of "the beat", Adelaide Cardiology's quarterly publication which provides information about our Practice and cardiology topics of interest.

Dr Maria Santos

We are very pleased to announce that Dr Maria Santos has recently joined Adelaide Cardiology.

Maria completed her physician training in NSW and advanced cardiology training in Melbourne (Austin Hospital). Maria was admitted to the Royal Australian College of Physicians in 2009 and following her advanced training completed Fellowships in Electrophysiology at The Prince Charles Hospital in Brisbane (2010) and the University of British Columbia, Vancouver Canada (2011).

Maria has an interest in all aspects of clinical cardiology with a particular interest in implantable electronic devices, heart failure device therapy and syncope. Maria joined Adelaide Cardiology in November and consults at our metropolitan, Gawler, Angaston and Clare rooms.

Urgent Appointments

Adelaide Cardiology recently made some changes to its appointment scheduling that will improve access for the rapid assessment of patients with suspected angina. Across our 4 metropolitan locations we now routinely reserve 15-20 appointments per week for patients requiring this rapid cardiac assessment. These appointments are held and only made available for use 48 hours ahead time and can be accessed on or main practice number 8202 6600. If you suspect your patient is suffering from unstable angina or a myocardial infarction then, of course, immediate referral to an appropriate Accident and Emergency Department is the best course of action.

Christmas Opening Hours

Friday 21 December	Normal Hours
Monday 24 December	On call service from 4pm (For on call Dr details Ph 8202 6600)
Tuesday 25 December	On call service only
Wednesday 26 December	On call service only
Thursday 27 December	Normal hours except Unley rooms are closed
Friday 28 December	Normal hours except Unley rooms are closed
Monday 31 December	Normal hours except Unley rooms are closed
Tuesday 1 January	On call service only
Wednesday 2 January	Normal Hours resume

**Adelaide Cardiology wishes you and your loved ones
a Merry Christmas and a Happy New Year.**

Novel Oral Anticoagulants in AF

Atrial fibrillation is ubiquitous in medical practice. Its importance lies in the symptoms it can cause and the consequences of systemic thromboembolism.



Dr Daniel Cehic

The most frequent manifestation of thromboembolism is stroke. It is one of the most devastating consequences of the condition.

The assessment of atrial fibrillation should always include an assessment of stroke risk. In recent times there has been widespread use of the CHADS2 scoring system to estimate that risk. However, the CHA2DS2-VASc scoring system is now preferred by many, including the European Society of Cardiology in its latest guidelines. Aids to calculate the CHA2DS2-VASc score can be found in many electronic medical records programs as well as iPhone apps! Remember that these apply to nonvalvular atrial fibrillation. Patients with mitral stenosis, for example, are at much higher risk.

When trying to come to a decision regarding the use of oral anticoagulants it is important not just to calculate the thromboembolic risk of the condition. It is also important to calculate the bleeding risk associated with the treatment. A commonly used algorithm is the HAS-BLED scoring system.

Once the decision is made to use oral anticoagulants rather than aspirin, which should be used? Until recently there was no real choice apart from Warfarin, which has been proven in multiple trials conducted decades ago to be effective. However, there are now novel oral anticoagulants such

as Dabigatran (a direct thrombin inhibitor) and Rivaroxaban and Apixaban (factor Xa inhibitors) to choose from. The major advantages of these novel agents are the lack of INR monitoring, less food and drug interactions and trials suggesting improved clinical outcomes.

Which should you choose? Apart from clinical grounds there are also financial grounds involved in the decision as none of the newer oral anticoagulants are currently available on the PBS, although it is impossible to think that they will not be listed at some point in the future in this country.

Dabigatran was compared to Warfarin in the RE-LY trial. The 150mg BD dose was found to be significantly better than Warfarin in reducing stroke with no greater risk of bleeding and the 110mg BD dose was found to be noninferior to Warfarin in preventing stroke with a significantly reduced risk of major bleeding.

Rivaroxaban and Apixaban were compared to Warfarin in the ROCKET AF and ARISTOTLE trials respectively. Rivaroxaban (given as a once daily dose) was found to be noninferior to Warfarin in preventing stroke and systemic embolisation with no significant difference in major and nonmajor clinically relevant bleeding (although there were less intracranial haemorrhages and fatal bleeds in the Rivaroxaban arm). Apixaban (given as a BD dose) was found to be superior to Warfarin in preventing stroke and systemic embolisation while also having less risk of major bleeding and showing a significant reduction in the rate of all cause mortality.

So these agents are certainly promising. However I would suggest that we don't throw the baby out with the bathwater but rather see these novel agents as adding to our armamentarium for the treatment of atrial fibrillation as there are some concerns. Recent publications have raised concerns over the use of Dabigatran in the elderly (>80 years of age) or those with impaired renal function or low body weight with concerns that the bleeding risk in these patients may not be fully understood or appreciated yet. In addition, Dabigatran and Apixaban are given as a BD dose and so compliance is always a issue. None of these agents have proven effective antidotes yet. In addition, our clinical experience with these agents is limited compared to our experience with Warfarin.

When they are funded and the real world experience is found to be consistent with the trials I suspect that they will be increasingly adopted as first line agents. However, I am not sure when that time will be.