Cardiol Young 2001; 11: 476–477
© Greenwich Medical Media Ltd.
ISSN 1047-9511



Newsletter from the Association for European Paediatric Cardiology

Where are we going?

O. Daniëls (President-elect, Association for European Paediatric Cardiology)

SINCE WE LIVE IN AN ACTIVE WORLD, NO ONE WILL be surprised that things are changing! In the field of paediatric cardiology, specifically European Paediatric Cardiology, we see three main areas of significant change.

First of all, as both an Association and a profession, we are becoming bigger. More and more colleagues are involved in the field of paediatric cardiology. In this respect, in Europe, it is fortunate that children with acquired heart disease, such as rheumatic fever, endocarditis, and so on, are seen with less frequency. This means that more of us are now involved with children with congenital cardiac disease. This has also to do with our improved results over recent years. The mortality rates are continuously improving, and more and more, ever complex, cardiac malformations can now be treated. Also, the improved structure for provision of services in the different European countries makes it possible to treat virtually all our patients. The field now starts at fetal life, and continues throughout adulthood. Because of this, we must remember that, in the near future, there will be more adults than children with congenital cardiac malformations.

Secondly, because treatment is now possible for complex malformations, numerous patients will now survive with congenital cardiac disease. In the future, therefore, we will have to deal, over the long term, with patients having either chronic pressure or volume overload. This, of course, is because not all defects are really cured, but rather treated in palliative fashion, no matter how effective the palliation. So, our field is changing to incorporate not only anatomic diagnosis, but also the evaluation of cardiac function in the setting of chronic pressure and volume overload, and more importantly, its treatment.

Thirdly, because more and more colleagues from various disciplines are involved in the process, and because there is harmonisation of the profession in the European area, professional affairs become increasingly important.

How to deal with these items?

The growing numbers of delegates at our Annual General Meetings makes it necessary to organise these events in a more professional way. Although it is always good to have these meetings in different European countries, permitting us to gain from local qualities and cultures, it is not wise that the organiser of each and every congress must re-invent the wheel. For this reason, we have decided that the Association should have its own congress organisation.

This Congress Organisation will be tasked with arranging all our future Annual General Meetings, including teaching courses, satellite meetings, and so on. Fortunately, we have found some "Funding Fathers" who are prepared to support us financially so as to make this venture possible.

In terms of harmonisation of the profession, due to the fact that the Association grows every year in membership, and its professional affairs grow concomitantly, it has become inevitable that the Association itself should be reconstructed. In the past, the Association has its Advisory Professional Committee, and also hosted the Meeting of National Delegates. We anticipate increased activity in these areas. The Council welcomes all those colleagues who want to give active support to this process. The training programme, although well-defined, must be promoted and given more practical effect. The Council, therefore, has decided to introduce regular educational sessions, commencing with the Annual General Meeting in Porto, to be held in 2002.

Correspondence to: Dr Otto Daniëls, President-elect, Association for European Paediatric Cardiology, Childrens Heart Centre, University Medical Center St. Radboud, 6500 HB Nijmegen, The Netherlands. Tel: +31 24 3619060; Fax: +31 24 3619052; E-mail: od@aepc.org

https://doi.org/10.1017/S1047951101000658 Published online by Cambridge University Press

Starting this year, a half-day educational course will be an integral part of the annual programme arranged by the Working Groups at each meeting.

The sessions will be dedicated to trainees in paediatric cardiology and surgery, along with all other interested participants who require an up-to-date review on the topic chosen. The Council of the Association will ask respective Working Groups to organise the session on a rotational basis. The Working Group to whom responsibility is delegated will provide the detailed programme and invite the speakers. Official credits for Continuing Medical Education will be given to the participants. To cover at least a part of the expenses, a fee will be charged to all those participating, with the exception of junior members of the Association. At the Porto meeting, the course will be devoted to paediatric arrhythmias and electrophysiology, and will be organised by the Working Group of the Association active in this area.

Harmonisation of infrastructure

The field of paediatric cardiology requires a highly sophisticated infrastructure so as to take care of the catheterisation laboratory, echo-Doppler equipment, exercise testing equipment, facilities for long and short term registration of electrocardiograms, and so on. These demands are different for children when compared to adults. Until now, however, these demands have not been stated well enough. For the industry, it would make sense that we, in a broader field, formulate our needs. Having established our needs, the industry can then construct its products in the fashion we desire. The Council of the Association has already asked its councillors, together with the appropriate Working Groups, to formulate the guidelines for an optimal catheterisation laboratory for patients with congenital cardiac disease. The same task has also been given to the Working Group for Cardiac Imaging, asking them to produce guidelines for the optimal requirements for echo-Doppler cardiography. Not only must we harmonise our equipment, but, perhaps more importantly, we need to harmonise our medical protocols. As already stated, we will need to deal with more and more patients with chronic pressure and volume overload on the heart. Most of our understanding of the pharmacological effects of cardiac drugs comes from studies in adults. It is questionable if these effects are the same in infants and children. For example, what are the effects of chronic use of anti-arrhythmic drugs, β-blockers, or afterload reducers in children? Almost all cardiac centres in Europe are too small to investigate these effects on an individual basis so as to produce worthwhile information in the shortest time. It is here where the Association can play a major role. The appropriate Working Groups could organise joint studies, and co-operation with the pharmaceutical industry would be facilitated. Until now, this industry has not shown a great interest in the field of paediatric cardiology. But, as stated, with the growing field of patients, and the insight that children may not have the same metabolism, they might well be interested in the future.

It is equally important that we harmonise our nomenclature. The demand for the European Paediatric Cardiac Code is growing. It is clear that this infrastructure is of great importance to improve our "professional language" and to facilitate comparative results. The Coding Committee is already working on a new update. To avoid excessive printings, our intention currently is to put the Coding system on our website (www.aepc.org), with its own search engine. In this way, it will be available to all, so that everyone can use it, and have access to the latest up-to-date information.

In conclusion, therefore, many good things are in sight. But if we are to adopt this professional set-up, which is essential, our supporters, and particularly the industry, will ask more time from us all. Fortunately, several enlightened groups within the industry have already recognised this fact, and have supported us generously. It is now up to us to answer them, and shoulder our burden. In the long term, it will be our patients who will benefit most from these endeavours.

https://doi.org/10.1017/S1047951101000658 Published online by Cambridge University Press