

The use of pocket size imaging devices: a position statement by the European Association of Echocardiography¹

Pocket size imaging devices are a tool to complement physical examination and not a device for a complete diagnostic ECHO examination. Luigi P. Badano, EAE President discusses the developments for CardioPulse

In the last few years, a wide variety of echo machines have been developed: from small, but complete echo machines with all conventional tools providing two-dimensional (2D), colour Doppler and transoesophageal echocardiograph modalities, to hand-held echo devices with limited technical and/or functional capabilities. The aim of this European Association of Echocardiography (EAE) position paper is to provide recommendations on the use of pocket size imaging devices in the clinical arena, by profiling the educational needs of potential users other than cardiologists that are experts in echo.

Currently available echo machines may be classified into four main categories: (i) stationary high-end systems (i.e. fully equipped systems with 3D and other advanced modalities). Despite having wheels, they are quite heavy and are not supposed to be moved. (ii) Mobile systems, equipped with standard modalities, but not necessarily all the advanced modalities. They are smaller than category 1 machines, on wheels, and can easily be transported inside health care facilities; (iii) Portable machines that can be carried by a person and usually offer all essential modalities to perform a complete echo study but not all advanced modalities; (iv) Pocket size, hand-held imaging devices.

Pocket size imaging devices are not echo machines and have been equipped with just 2D and colour-Doppler modalities on purpose. Their technical characteristics may be summarized as: (i) gray scale images have a 2D sector angle of $<75^\circ$ and depth of <25 cm, (ii) colour flow imaging (available in one product only) has a fixed colour box size and a fixed pulse repetition frequency (PRF), (iii) measurements are restricted to distances and areas, (iv) options for patient identification are limited, and (v) connectivity requires dedicated software tools.

Therefore, technical characteristics and image quality are usually sufficient for the qualitative evaluation of: left and right ventricular function; pericardial and/or pleural effusion; B-lines in lungs as a sign of interstitial lung fluid; size and respiratory changes of inferior vena cava; and extent of calcification and motion of aortic cusps. If

available, valve regurgitation can be assessed based on colour Doppler.

Current pocket size imaging devices should only be considered as screening tools or used to complement the physical examination since they do not allow for the performance of complete echocardiography examinations. This has the potential to deliver marked change in cardiac care. Pocket size imaging devices should complement the physical examination in outreach clinics, coronary and intensive care units, may serve as a tool for fast initial cardiac assessment in emergency units, during cardiology consultation inside or outside healthcare facilities and hospitals, for first cardiac evaluation in ambulances and for screening programmes in schools, industries, and other community activities. Moreover, pocket size imaging devices may be used for the triage of patients in need of a complete echocardiography examination. Pocket size imaging devices may become a valuable teaching tool in medical schools.

All these applications would allow faster and more accurate clinical diagnoses, save healthcare resources, reduce waiting lists for in-patient echocardiography examinations, and improve teaching by allowing the immediate checking of physical signs and auscultatory findings. However, since such devices are so powerful and are supposed to be used not only by cardiology-echocardiographers but also by general medicine practitioners, anaesthesiologists, emergency medicine specialists, and internists, the cost/effectiveness of their clinical use is necessarily linked to proper training and education of the users.

Expert (accredited) echocardiographers do not need any training for the use of pocket size imaging devices. Conversely, specific training is recommended for cardiologists not fully conversant with echocardiography. For non-cardiologists and/or other medical professionals, a dedicated training and revision of basic cardiac physiology and pathology knowledge should be mandatory. This appears to be the only way to avoid abuse and potential harm to patients due to both over- and under-diagnosis of serious heart diseases.

Although policies may differ in certain EU member countries, the EAE position is that current generation pocket size imaging devices do not allow for a complete diagnostic examination, and should be regarded as a tool to complement a physical examination. Therefore, no reimbursement should be warranted.

Andros Tofield

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Liver toxicity of sitaxentan in pulmonary arterial hypertension

Following Pfizer's decision to voluntarily withdraw Thelin from the worldwide market, the Task Force of the ESC/ERS 2009 Pulmonary Hypertension Guidelines reports...

Keywords

Sitaxentan • Hypertension • Pulmonary • Liver toxicity

Ambrisentan, bosentan, and sitaxentan are endothelin receptor antagonist (ERA) drugs approved for the treatment of patients with pulmonary arterial hypertension (PAH) and are included in the treatment algorithm of the 2009 Pulmonary Hypertension (PH) Guidelines of the European Society of Cardiology (ESC) and the European Respiratory Society (ERS).¹

Hepatotoxicity is a frequent side-effect of ERA therapy which is contra-indicated in patients with mild to severe hepatic impairment (Child-Pugh Class A–C for sitaxentan and Child-Pugh Class B–C for ambrisentan and bosentan) and elevated serum aminotransferases prior to initiation of treatment. In addition, liver function testing is recommended on a monthly basis in PAH patients treated with these compounds to detect an increase in the serum aminotransferases.¹ In most cases, liver injury is dose related and reversible with dose reduction or drug discontinuation, suggesting that hepatotoxicity is caused by a dose-dependent toxic effect. The exact mechanisms by which ERAs cause liver injury are not clear. It has been suggested that ERAs or their metabolites competitively inhibit a bile salt transporter pump leading to intracellular accumulation of bile salts, but other mechanisms cannot be excluded.

Seven cases of severe hepatitis-like drug reactions have been described in association with sitaxentan, two at a higher dose than currently approved (one patient died from liver failure),² five were treated with the currently approved dose of 100 mg once daily (one patient died from liver failure, one underwent heart, lung, and liver transplantation and one recovered after prednisone treatment, two recovered after standard treatment).^{3–5}

Two additional cases of fatal liver injury related to the use of sitaxentan in PAH patients have been recently reported.⁶ In all

these cases, liver function deteriorated despite discontinuation of the drug. To our knowledge, there are no reports in the medical literature about similar complications with bosentan or ambrisentan. In fact, no deaths related to liver toxicity have been reported for bosentan out of ~80 000 patients treated worldwide and for ambrisentan out of ~10 000 patients treated. In contrast, four deaths and one case of liver transplantation related to the use of sitaxentan have been observed among the ~2000 patients treated worldwide. However, a warning label has been added to the US prescriber information of bosentan, mentioning rare cases of liver failure in patients treated with bosentan.

It has been suggested³ that there are at least two types of liver injury associated with the use of ERA; one toxic, i.e. dose-dependent and reversible after dose reduction or discontinuation of the drug, and the other, possibly idiosyncratic or immunologically mediated. The former type of liver injury is by far more common and almost invariably has a benign clinical course. The second type appears to be rare but at the same time very dangerous, as it can result in severe liver failure.

The recent report of the two additional cases of fatal liver injury related to the use of sitaxentan in PAH patients enrolled in a randomized controlled study has prompted Pfizer to voluntarily discontinue all ongoing clinical trials with this compound and to withdraw the commercial drug (Thelin, 100 mg sitaxentan tablets) from the market worldwide.⁶ Thelin has been authorized in the European Union (EU) since 2006 for the treatment of PAH and has been marketed in 16 EU Member States, in Australia, and in Canada.

It has been suggested by the European Medicines Agency⁶ that patients taking Thelin or participating in Thelin studies are advised not to stop treatment and to consult their treating

physician to review their treatment at their next scheduled appointment.

The task force of the ESC/ERS 2009 PH Guidelines would like to make the following recommendations to the treating physicians:

- (1) For the time being, no PAH patient should start *de novo* therapy with Thelin.
- (2) For patients already on treatment with Thelin transition to another ERA such as bosentan (Tracleer) or ambrisentan (Volibris) should be considered.
- (3) In case a PAH patient was treated with Thelin due to previous adverse reactions with Tracleer and Volibris, the transition to another class of PAH approved drugs should be considered (prostanoids or PDE-5 inhibitors).

Nazzareno Galiè¹, Marius M. Hoeper², J. Simon R. Gibbs³ and Gerald Simonneau⁴, for The Task Force for the Diagnosis and Treatment of Pulmonary Hypertension of the European Society of Cardiology (ESC) and the European Respiratory Society (ERS).

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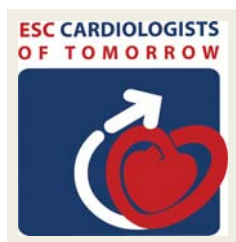
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Cardiologists of tomorrow plot their future

The ESC's Cardiologists of Tomorrow initiative will facilitate the exchange of scientific, clinical and educational information, between young cardiologists from different countries



The European Society of Cardiology (ESC) has launched a Cardiologists of Tomorrow group for young cardiologists and cardiologists in training.

Discussions with national cardiology societies at the 2009 ESC Congress in Barcelona revealed that many already had a group for future or young cardiologists. It was felt that creating a network of these groups called ESC Cardiologists of Tomorrow

would benefit national cardiology societies, the ESC, and the young cardiologists themselves.

Some of today's top European cardiology figures began their organizational involvement at national society level, then added ESC commitments on top. It is hoped that the initiative will enthruse young people in becoming engaged with their national society and with the ESC.

The ESC is keen to interest more young people in becoming members of its Working Groups, Councils, and Associations. Dr Steen Dalby Kristensen, MD, DMSc, FESC, interventional cardiologist in the department of cardiology at Aarhus University Hospital in Skejby, Denmark, is worried that recruiting clinicians and scientists to volunteer their time to ESC activities could become difficult in the future. The best antidote is to stimulate young people's interest in participating who will in turn benefit from the experience.



Cardiologists of Tomorrow Nucleus, ESC congress 2010

'All the contacts that you get, all the colleagues you meet, is really very rewarding both for your career and also for your personal development', says Kristensen.

The intention is not to steal all the good people from the national societies but rather to work with the national societies to foster participation at both levels.

Experienced cardiologists in the ESC will also gain from the experience. 'It's always nice to have young people to work with', says Kristensen. And the cardiologists of tomorrow can provide insight into how to reach their contemporaries, who access information through different avenues to the older generation.

A European network of national groups will facilitate the exchange of scientific information and for young people working on specific research projects it should help them make contacts with other young people or senior researchers in their field of interest internationally.

Exchange is also expected on clinical aspects of cardiology and education. Young cardiologists will be able to find out how education is organized in other countries and push for improvements at home. Knowledge can be circulated about grants that are available within the ESC and at the European Union (EU) level, and for cardiologists in training who want to get further scientific or clinical training elsewhere in Europe; young colleagues from other countries can advise them of the top locations.

Kristensen has been developing the Cardiologists of Tomorrow initiative during his term as an ESC vice president, together with the ESC staff for national societies and two colleagues from the ESC board, Professor Keith Fox, MD, FESC, from Edinburgh and Professor Adam Torbicki, MD, FESC, from Warsaw. Their discussions were supported by the ESC president at the time, Italy's Professor Roberto Ferrari, MD, FESC, and the ESC Congress Programme Committee Chair Professor Fausto Pinto, MD, FESC. The new ESC president, France's Professor Michel Komajda, MD, FESC, has signalled his support for the initiative.

As a way of promoting the new group, a session was held at the 2010 ESC Congress in Stockholm called 'Forum for future leaders in cardiology'. The session was devoted to clinical cases because

these would be of interest to all young physicians working in cardiovascular medicine.

A call for abstracts produced more than 70 submissions and 3 applicants were selected to give a presentation. A panel of five leaders from national young cardiologist organizations helped run the session. They asked questions of the presenters and decided by vote who should be the winner and the runners up.



Ana M. Lebreiro forum session winner

The first prize of a diploma and €1500 was awarded to Dr Ana Margarida Lebreiro from Portugal for her presentation 'Diffuse ST segment elevation and ventricular fibrillation without structural heart disease—a new electrocardiographic presentation of a channelopathy?'

The two runners up, Dr Raphael Pedro Martins from France and Dr Oya Yuksel, FESC, from Turkey, each won a prize of €500 for presentations on myocardial infarction and endocarditis.

Around 100 delegates attended the session, which was an 'enormous success', says Kristensen. 'I was very impressed by their enthusiasm'.

The ESC will continue to support the group but it is time for the cardiologists of tomorrow to channel their energy for the initiative into concrete activities. A small temporary nucleus has been established with six contact people from different countries. In future, the group may adopt a more formal structure with elections.

The ESC has provided a framework and some tools to pave the way for the group to operate. A website has been set up for young people to access further information, <http://www.escardio.org/communities/cardio-tomorrow/Pages/welcome.aspx>.

Future activities could include involvement in the ESC Congress, taking a point of action to ESC Working Groups, Councils or Associations, holding meetings, and using the website to share information about scientific, clinical, and educational activities. 'There are many opportunities and we hope that the young cardiologists are ready to take on the challenge and take advantage of this opportunity', says Kristensen.

J. Taylor, MPhil

Cardiology in Egypt is improving through increased links with Europe and the USA

The president of the Egyptian Society of Cardiology discusses his vision for bringing the speciality onto the 'world stage' with Jen Taylor



M. Sobhy

The Egyptian Society of Cardiology was founded by 10 doctors in 1954. Today, membership stands at 1954 and it has a 15-strong board.

The society is a member of the European Society of Cardiology (ESC) and has four votes for the ESC president.

Professor Mohamed Sobhy, MD, FACC, FESC, Professor of Cardiology in the Faculty of Medicine at Alexandria University and Chairman of the International Cardiac Center, is the society's President from 2010 to 2012.

He has a number of goals, which include upgrading the society's website, CardioEgypt <http://www.cardioegypt.com/>, and linking it to other societies. He also wants to have Egyptian sessions at the ESC Congress and the American College of Cardiology (ACC) meetings. The society already has sessions at EuroPCR, the official congress of the European Association of Percutaneous Cardiovascular Interventions (EAPCI).

Another goal is to establish credentials for cardiologists who perform angioplasty and other procedures.

And he wants to improve the society's journal, the *Egyptian Heart Journal*, by establishing greater links with European and American journals. To that end he met with the ACC board at the conference CardioAlex and has had discussions with *EHJ* editor Professor Thomas Lüscher, MD. Options include sharing peer reviewers.

Sobhy is chairman of the international PanArab Interventional Cardiology Conference CardioAlex, which is hosted by the Egyptian Society of Cardiology and the Cardiology Department at Alexandria University every year in June, <http://www.cardioalex.com/>.

It is one of the two big cardiology meetings held annually in Egypt. The second, CardioEgypt, is in February and this year the 5-day event had 48 guest speakers from the USA, Canada, Europe, and Arab countries and more than 360 Egyptian speakers and chairpersons.

The Egyptian Society of Cardiology hosts 13 working groups that have been active for a number of years: Interventional Cardiology; Electrophysiology & Pacing; Echocardiography; Preventive Cardiology; Heart Failure; Nuclear Cardiology; Continuous Medical Education; Thrombosis and Haemostasis; The Egyptian Working Group of Pediatric Cardiologists; Cardiovascular Drug Therapy; Lipidology, Vascular Biology and Research; Cardiovascular Diseases in Women; and Peripheral Vascular Disease.

The working groups collaborate with international societies, and their main objective is to hold specialist conferences.

Creating a core syllabus for young cardiologists is another major project. Sobhy, who is Egypt's national coordinator for ESC guidelines, has received approval from Professor Alec Vahanian, MD, chairman of the ESC's Committee for Practice Guidelines from 2006 to 2010 and Professor Roberto Ferrari, MD, president of the ESC from 2008 to 2010, to adapt ESC guidelines to Egyptian cardiologists.

'We don't have Egyptian guidelines', says Sobhy. 'It's very difficult because we don't have trials.' The society and its Cardiovascular Drug Therapy working group agreed that they needed to adapt the guidelines that would most closely fit the Egyptian situation and that these would be the ESC guidelines.

This year there will be new Egyptian Practice Applied Guidelines for PCI, hypertension and acute coronary syndrome. Before publication they will be tested in 3 zones in Egypt: zone 1 Cairo, zone 2 Alexandria, and zone 3 the Upper Egypt area. Around 500 doctors in each zone will try using the guidelines.

The ESC is set to send representatives to audit the process of preparing and adapting these guidelines.

This year the Egyptian Society of Cardiology will participate in Stent for Life, a programme run by the EAPCI and EuroPCR. The programme is designed to help national societies, together with their ministries of health, to increase access to primary PCI and put in place the logistics for meeting the treatment guidelines.

Sobhy's vision is to set up an epidemiology and surveillance study of heart failure in Egypt, but the project will require help from the ESC. He says: 'Heart failure in Egypt is different to other causes of heart failure in Europe because we have a lot of valvular disease, we have a lot of cardiomyopathies, and 26% of our patients have hypertension'.

There are three types of heart failure in Egypt and he wants to find out whether incidence is similar to Europe and whether or not it is being appropriately treated. The country seldom offers cardiac resynchronization therapy (CRT) and it does not do heart transplantation.

Interventional cardiology is making great strides in Egypt. The country has 300–350 interventional cardiologists, most of whom have been trained in Europe or the USA. 'At the beginning we didn't have anything, so we had to go abroad to train and bring the knowledge and also bring the machines', says Sobhy. 'So we started to create [our own services] in the last 30 years'.

Today, some of the younger cardiologists are being trained in Egypt. At the age of 57, Sobhy has 30 years of experience to pass on. And the last 10 years have seen an increase in live transmissions of interventions, visits from experts to perform procedures, and interventional cardiologists from Egypt going to meetings abroad. The relationship with cardiologists internationally is strong and each month there are joint meetings in Egypt or elsewhere.

There are 72 cath labs in Cairo, 12 in Alexandria, 10 in Delta, and 6 in other parts of Egypt. Of these, 38 are owned by the government and 62 by the private sector. In the last year, there were 60 000 diagnostic catheter procedures performed,

of which 50% were PCI. Last year saw 8000 drug eluting stents used and 2700 bare metal stents.

Simple and complex coronary angioplasty is performed in Alexandria hospitals. Some universities specialize in paediatric cardiology and are performing interventional procedures in children.

Mitral valvuloplasty has been performed since 1987, at about 1000 cases per year.

In the last 5 years, just 1–2% of patients have been sent outside Egypt for interventional procedures. Sobhy adds: 'Some experts will come to Egypt to do some complex cases with us'.

The society's working group on Interventional Cardiology holds an annual meeting and a different university takes responsibility each year. For example, the 2009 conference was organized by the Ain Shams University in Cairo.

Regarding the future for interventional cardiology in Egypt, Sobhy would like to see more training courses from companies and more cooperation with societies in Europe and the USA that lead to grants, training, and exchanges for young Fellows. He would also like to have the Egyptian Society of Cardiology's interventional activities presented at more meetings.

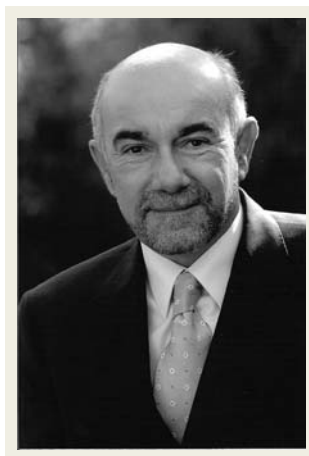
He adds: 'I think the most important is to include Egypt as a part of clinical trials in most of the European trials in the future'.

Jennifer Taylor, MPhil

Personal experiences: Pedro Brugada

Chasing the challenge

As a young doctor, Prof. Pedro Brugada relocated from his home country Spain to northern Europe to pursue a career in the new discipline of electrophysiology. **Helen Jaques** speaks to him about his intrepid approach to cardiology and how he coped with the move first to the Netherlands and then Belgium.



Prof. Pedro Brugada

Prof. Pedro Brugada, MD, PhD, FESC—Head of the Heart Rhythm Management Centre, Professor of Cardiology, and Scientific

Director of the Cardiovascular Division at Vrije Universiteit Brussel in Brussels, Belgium—is a man who likes challenges. His career has been defined by identifying areas of need in the field of electrophysiology and fearlessly heading out to address them, regardless of language barriers, lack of funding, or other practical drawbacks.

Starting out in cardiology

In fact, Brugada first came to study electrophysiology precisely because it was difficult. While he was training in cardiology in Barcelona, Spain, in the 1970s, he bought an electrophysiology textbook and was horrified to realize that he did not understand a word of it. 'I became very exasperated and thought "that's not possible, if you're a cardiologist you should be able to understand the book"', he recalls. 'And that is the reason I got so interested in electrophysiology, which was quite an esoteric topic at the time'.

It was this formative experience that led him to seek out specialist training in electrophysiology. The discipline was not receiving much attention in Spain though. Undeterred, the resourceful young doctor wrote to cardiology centres around the world and saved hard until he had enough money to last him abroad for 6 months.

Two centres offered him a place to train in electrophysiology: one was the University of Chicago, USA, and the other was the University of Maastricht in the Netherlands. Brugada chose to go to the Netherlands, not only because it was nearer to his family, but also because the University of Maastricht was a new and vibrant institution where he could really forge his own path. By the time he was 30, he had become the Director of the Electrophysiology Laboratory, and at 36, he became Professor of Cardiology.

The language was the first challenge Brugada had to deal with when he moved to Holland. However, he started off on a good grounding, having been learning languages his whole life. In the small village of Banyoles, Spain, where he grew up, there was a cosmopolitan multilingualist keen to keep practicing his language skills. Brugada, his two brothers, and his sister went round to this teacher's house most days after school, almost as a sort of crèche.

'We started at 5 o'clock in the afternoon with German for instance, then moved to Italian and then to English and then at 8 o'clock you could stop or you could continue and take some other language', recalls Brugada. 'And the teacher gave classes not because of the money, he was a very rich man and he had no children. He did it because he wanted to keep speaking the languages. And you cannot speak Chinese every day in a little town like Banyoles'.

When it came to learning Dutch in Maastricht, Brugada put faith in his aptitude for languages and jumped in at the deep end. 'I was put in a total immersion course in a school that was led by nuns, the youngest one was about 85 years of age', he says. 'Over three weeks they taught me the whole basics of the language'.

It was not just the language that was different in the Netherlands; the cardiology patients were quite unlike those he had been treating in Spain. 'I had never seen coronary angiograms that were so ugly with such a lot of atherosclerosis', says Brugada. 'I remember saying, "that looks like a cancer of the coronary arteries instead of coronary artery disease". It was horrible'.

The demographics of disease were also distinct from southern Europe. Whereas in Spain Brugada had largely been treating men who were heavy smokers and usually had a single coronary stenosis, in Holland all of a sudden he was seeing a lot of female patients too, a difference he puts down to the rich diet in northern Europe.

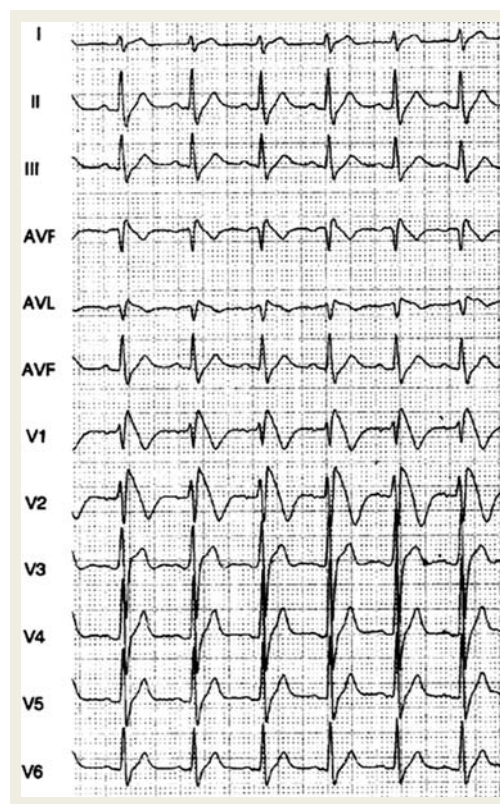
Brugada syndrome

It was at the University of Maastricht that Brugada made the discovery that would define his career. A 3-year-old boy was brought to his department from Poland by his father. The boy had a history of fainting and cardiac arrest and had been resuscitated several times by his father. His sister had experienced similar symptoms and had died suddenly.

The boy had a peculiar electrocardiogram showing ST segment elevation in the precordial leads V1–V3 and a pattern in the QRS complex resembling right bundle branch block. When Brugada got his hands on the sister's electrocardiogram, he realised it showed a very similar pattern.

Over the next 4 years, Brugada and his brother Josep came across two more cases who had similar symptoms and electrocardiograms and presented all four cases at the North American

Society of Pacing and Electrophysiology (NASPE) conference in 1991. They then collected four additional patients and published the first paper on the syndrome in 1992.



Brugada ECG

It was not long until they were joined by Brugada's youngest brother, Ramon, who was at the time training in genetics in Houston, TX. Ramon analysed genome anomalies in patients with the syndrome and identified the first of many types of mutations in the cardiac sodium channel gene *SCN5A* that determine the genetic basis of the Brugada syndrome. In 1996, the phrase 'Brugada syndrome' entered the medical lexicon.



The Three Brugada brothers: Josep (left), Ramon (middle), and Pedro (right)

From the Netherlands to Belgium

By this time, Brugada had made another move, this time to Aalst in Belgium, and for similar reasons to his move to Maastricht. 'I moved from Spain to the Netherlands because of scientific misery, and I moved from the Netherlands to Belgium because the scientific misery was in Belgium by that time', he says. 'There was a great opportunity because the whole area of Belgium had basically no electrophysiologists'.

Brugada went on to make a huge contribution to how electrical disorders of the heart are treated in Belgium. When he first arrived at Onze-Lieve-Vrouweziekenhuis (OLV) in Aalst in 1990, there was no money allocated to electrophysiology or anything related to arrhythmias. With the help of an administrator of social security, he created the financing system for electrophysiology, which was signed off by King Baudouin in 1991 and has been in use across the country up until 2 years ago.

After 17 years in Aalst, Brugada began looking for new opportunities and made another move, to Brussels, where he is still working now. 'There was again this great opportunity because the only area in Belgium that was not moving as fast as the rest

in terms of rhythmology was the area of Brussels', he says. In Brussels, he set up a brand new department of rhythmology at the University Hospital of Brussels, the Vrije Universiteit Brussel.

Practicing in Belgium was different from practicing in Holland, Brugada observed. 'There are major differences in the way people are treated; for instance, people might not get a certain procedure because of age in Holland, something that is impossible in Belgium', he says. 'And I think the freedom of the patient in Belgium to choose the physician, the hospital, and everything, which is totally free, is a major plus point as compared with the Netherlands'.

Brugada admits that he is not likely to make another move any time soon, not least because of his new role at the Vrije Universiteit Brussel. He is now Chairman of the Cardiovascular Centre, a high-level role that will involve public relations and fundraising rather than clinical practice and research.

'I think this will keep me busy for I hope the next three years', he says. And after that? 'And then I will see', he replies. 'One thing I will not do for sure is retire. That I will certainly not do'.

Helen Jaques is a British freelance medical writer and editor.

People's corner

The European and Swiss Association for Paediatric cardiology announce the demise of their appreciated member Prof. Urs Bauersfeld MD who died last 3rd October 2010 aged 54 yrs after a long disease

Urs Bauersfeld was an internationally renowned paediatric cardiologist, particularly in the field of electrophysiology, pacemaker and implantable cardioverter-defibrillator (ICD) devices.

After a clinical Fellowship in paediatric electrophysiology at the Hospital for Sick Children in Toronto, he returned in 1993 to the University Children's Hospital in Zurich, where he developed the first dedicated paediatric catheter ablation program in Switzerland.

In 2001 he was appointed head of the division of paediatric cardiology at the same institution; in this position, with painstaking and dedicated work, he further developed research and clinical electrophysiology in all other subspecialties of paediatric cardiology. Patients were referred to him from all over Switzerland, and colleague's requests for his opinion reflected his reputation as a recognized expert in congenital electrophysiology.

Thanks to an integrative and multidisciplinary approach he succeeded in establishing a robust cooperation with cardiac surgery, cardiac anaesthesia, and intensive care medicine, and in developing the largest paediatric cardiac centre in Switzerland.

At the same time Urs Bauersfeld expanded his activities to national and international Working Groups (WG), such as the electrophysiology WG of the Swiss Society of Cardiology (SGK) and the European Association for Paediatric Cardiology (AEPC). In this position he substantially contributed to the organizing scientific meetings and teaching courses, and started the European Paediatric ICD and CRT registry, a multicentre project of the AEPC. Moreover, by using his personal contacts and his membership in the European Heart Rhythm Association and the ESC GUCH working group he achieved a better collaboration between the AEPC and the ESC.

Urs colleagues in Zurich, in Switzerland and in Europe will remember him as a friendly, calm and humble person. He was committed to the utmost of integrity, and his competent and precision work and thought processes were to provide the best possible care for patients and the best possible quality of clinical research. For these personal characteristics Urs will remain in the memory of his colleagues, friends and the children he helped.

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