Letter to the Editor

24 hour availability of echocardiography in Acute Medicine: time to get out of our 'silos'!

Dear Sir,

I read with interest the article by Ravikirti et al in the recent edition of Acute Medicine.[1] The authors rightly highlight the potential for atypical presentations of tamponade following cardiac surgery, which has been reported previously.[2] The investigation of any acutely unwell patient presenting after cardiac surgery should include some form of cardiac imaging. In the cases described the diagnosis was delayed, in part, due to the lack of an echocardiography service out-of-hours.

Recent years have seen the introduction of a variety of 'focused' emergency assessment echocardiography training modules: FAST (**F**ocused **A**ssessment with **S**onography for **T**rauma), ELS (**E**chocardiography in **L**ife **S**upport), FEEL (**F**ocused **E**chocardiography in **E**mergency **L**ife support), FATE (**F**ocus **A**ssessed **T**ransthoracic **E**chocardiography). An increasing number of specialist registrars and consultants are now trained in these techniques. Even in smaller District General Hospitals, it should be possible to ensure that there is, at any one time within a 24 hour period, a clinician available who can perform a focused examination to diagnose or exclude a pericardial effusion. Aiming for this goal may be more realistic than achieving a full 24/7 echocardiography service. This could be facilitated by creating a list of all the doctors who are skilled in above mentioned focused echocardiogram/ultrasound techniques.

Development of such a rota may require clinicians to work across speciality boundaries, and a breakdown of the traditional 'silo' mentality which often exists within hospitals. The trained individual may be working in any of a variety of specialities, including Emergency Medicine, Acute Medicine, Cardiology, Intensive Care, Anaesthetics or Radiology.

Establishing whether a pericardial effusion has haemodynamic significance may require a more detailed assessment which usually goes beyond the competence of a clinician trained in 'focused' echocardiography. However, if a pericardial effusion is detected at a time when a formal echocardiography service is not available, this could provide a valid argument for an urgent transfer to a tertiary cardio-thoracic centre for further assessment.

Contrast material-enhanced computed tomography of the heart can also be considered as an imaging modality for evaluating haemodynamically stable patients with suspected cardiac tamponade and cardiac injury.[3-5] In some instances, especially after cardiac surgery and if it is a localised pericardial effusion, computed tomography can even be superior to trans-thoracic echocardiography.[6,7]

Yours sincerely,
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