

HR-UK

Heart Rhythm UK



NEWS

Summer, 2006

President's letter

Welcome to the shortest "President's Letter" yet. This month I only have one message: if you have not yet registered for the UK Heart Rhythm Congress, please do so as soon as possible.

The congress takes place at the National Motorcycle Museum, adjacent to Birmingham Airport, on September 19-21, 2006. Members of council visited the venue this week, and I can assure you that it will be an excellent conference venue (even for non-bikers). The event is being co-hosted by Heart Rhythm UK and the Arrhythmia Alliance, and will include a didactic course on pacing and ICDs (formerly the "Cambridge course"), a one-day electrophysiology course (the "Bard Masterclass"), advanced interactive sessions on electrophysiology and devices, a young investigators competition, and live ablation cases. In addition, our Annual General Meeting takes place during the congress. More details can be found on the congress website: www.ukheartrhythm.org.uk, and elsewhere in this newsletter.

We are certain that the congress will have something for everyone, and there are specific sessions for nurses and physiologists, as well as general sessions. Our international faculty includes Pedro Brugada, who will be speaking on his eponymous syndrome as well as aspects of device management.

We are determined to make this congress a success, and to ensure that it becomes an annual event. We hope that it will become the major UK arrhythmia conference, and we are already beginning to plan next year's congress. We also look forward to receiving constructive feedback from all attendees, in order that we can plan our educational initiatives to best suit the needs of our members, so your comments will be greatly appreciated.

I look forward to seeing you next month at the Congress.

Derek Connelly
President

**UK Heart Rhythm Congress –
19 – 21 September 2006**

Cardiac Physiologists, Arrhythmia

The previous Cambridge course which leads to what is now the HRUK certificate of accreditation will be held during the UK Heart Rhythm conference in Birmingham. The course is very similar to the previous ones and covers the foundations of pacing and ICD's. It is aimed at Cardiac Physiologists, Arrhythmia Nurses and SPR's working in this field. If anybody wants more detailed information about this please contact the conference organiser www.ukheartrhythm.org.uk or one of the HRUK physiologist representatives.

An EP Masterclass, formerly “The Bard Course” is taking place on Tuesday 19 September 2006. This course includes sessions on setting up an EP lab, mapping systems, atrial fibrillation ablation and atrial flutter ablation. For more information on the full programme please go to www.ukheartrhythm.org.uk.

Case Presentations

On the Thursday afternoon of the UK Heart Rhythm Congress (www.ukheartrhythm.org.uk) there is a session for case presentations. It is hoped that this will give upcoming EP trainees a chance to present. Consultants may also present.

This is to be chaired by Derick Todd and Neil Grubb.

If you would like to present a case please submit it to derick.todd@ctc.nhs.uk. Neil and Derick will pick a range of cases.

The minimum requirements for current submission are:

1. Clinical details
2. Images / electrograms

We do not expect the whole polished presentation but at least a flavour of it.

Latest date for submission Saturday 3rd September.

Successful applicants will be informed by 10th September.

HRUK Certificate of Accreditation

THE NEW SYSTEM

The BPEG certificate of competence was introduced in 1999 as a qualification designed initially to assess the level of knowledge required to run pacemaker and ICD clinics and was aimed primarily at technicians. Times have changed and when I took over as chair of the Examination Committee last year it was felt that the certificate needed to be changed to reflect the current membership of the society and it was also decided that it was not appropriate to award a certificate of “competence.” Thus in 2005 we set an examination that was similar to previous years and with the same logbook. However, from this year the process will change. There will still be one examination but now it will consist of 80 multiple choice questions, of which 50 will be “core.” There will be 2 specialist sections: devices and electrophysiology, each will consist of 30 questions and candidates will be expected to complete only one of these sections at any one sitting. There will be 4 redesigned logbooks: devices, electrophysiology, clinical/EP and clinical/devices. Success in the examination and completion of a logbook will lead to the award of a Certificate of Accreditation in devices, electrophysiology, clinical/EP or clinical/devices. It was felt that this format would address the varying needs of physiologists, nurses and doctors. The examination will take place in a number of centres across the UK on Friday 8th December 2006. Candidates will have until the end of December 2007 to complete their logbooks.

Together with the new examination, the syllabus has been redesigned in a similar format. Copies of the syllabus will be available from HRUK offices at hruk@bcs.com after 8th August or downloaded from the HRUK website. The syllabus has been produced after much discussion by a Committee comprised of doctors, physiologists and nurses and has been reviewed and approved by Council. There are significant changes compared to the old syllabus but it was felt that this was more relevant to current practice.

THE OLD SYSTEM

I am aware that there has been a lot of delay in awarding certificates to candidates who have already submitted their logbooks which is clearly less than ideal. However, it must be pointed out that success in the examination, in isolation, has no standing and in order to receive the

certificate of accreditation, a logbook must be submitted and checked. Therefore, we recently held a “marking day” where all logbooks that had been submitted were checked and where appropriate candidates were awarded their certificate.

The following candidates have been awarded their certificate of accreditation this year:

Khaled Albouiani	Sarah Law
Mellissa Baker	Helen Sarah Lindsay
Gill Binns	Marie Lithgow
Claire Boden	Sinead Loane
Lorraine Bonner	Mark Lyons
Lydia Bradley	Lorraine MacKinnon
Ciara Brennan	Sally Mann
Victoria Cavanagh	Erica McEwan
Sudipta Chattopadhyay	Paul McClinchey
Helen Clements	Christine Monaco
Shirley Clynick	Michelle Morgan
Lisa Crawford	Ann-Marie Newsholme
Victoria Cresswell	Ernest Ng
Ian Culshaw	Ruth Oliver
Joanne Devlin	Ruth O'Rourke
Marna Dreyer	Faye Owen
Tracy Edge	Linda Pilling
Katherine Fyfe	Lianne Roberts
Melanie Garner	Noel Roberts
Alison Gilliland	Alex Sackfield
Donald Greenhalgh	Diane Saunders
Vivienne Hansell	Celeste Schlebusch
Grant Heatlie	Jason Simpkin
Catherine Hewson	Paul Skinner
Margaret Hill	Clare Snow
Rebecca Hill	Nolan Stain
Tim Hodson	Denise Thomas
Michelle Howard	George van de Merwe
Justine Jones	Leandra Victor
Carol Kemp	Kerry Wilkinson

We have decided that from now on we will not accept any further logbooks from candidates who sat the examination in 2004 or before unless an extension has already been applied for and agreed. Candidates who sat the examination in December 2005 have until the end of December 2006 to submit their logbook, which is still in the old format.

Nick Linker
HRUK Examination Committee Chairman

HRUK Arrhythmia Nurses update

The number of arrhythmia nurses continues to grow with another five being appointed across the country in recent months. It is great to see that they are all making early contact with those of us who are already in post and are finding it extremely beneficial to access our established clinical network.

A number of the arrhythmia nurses have been working closely with the British Heart Foundation (BHF), advising on training and development for the twenty-four Arrhythmia Care Coordinator (ACC) posts recently funded by them and for others involved in the specialty. Work is ongoing to develop an arrhythmia module at masters level and an advanced practice masters programme in arrhythmia management. Teesside University, Middlesbrough and South Bank University, London are working with BHF and a number of health care professionals specialising in arrhythmia management with the aim of having these programmes in place by 2007. I will keep you updated on the development of these programmes. On the topic of education and development I am delighted to say that there has been a fair amount of interest from the nurses regarding the HRUK exam.

The BHF have also indicated that funding for education and use of the data systems developed for evaluation of services may be available for those who are adopted by them. This currently only applies for those already in post who are acting as a mentor for one of the new ACC's. However the BHF have suggested that it may be possible to adopt all of the arrhythmia nurses currently in post. There is a lot of discussion to be had around this and it would obviously only apply to those who wanted to move in this direction. The benefits would include:

- Accessing the same education would ensure standardised level of competence
- All working to the same model would promote equitable services
- Using the same data sets would allow for national comparison of data
- Support from existing arrhythmia nurses would be available for the new ACC's
- It would allow for development of effective clinical networks
- It would reduce risk of creating dual roles when we should all be following the same model
- Current nurses may benefit from links with BHF heart failure specialist nurses where they have a large remit with device patients & vice versa

We plan to provide more information regarding all of these developments at the UK Heart Rhythm Congress in September.

Jayne Mudd, Representing arrhythmia nurses on HRUK Council

Heart Rhythm Training Update – June 2006

The Basic and Advanced Heart Rhythm Curriculum are contained in the attached supplement.

The Basic Curriculum is given during the first three years of Specialty Training, and at the moment, cardiology trainees all need to complete a further two years of subspecialty training, (which may be modular, e.g. device therapy combined with heart failure), in order to obtain a CST. During the Basic Curriculum years, there is also some Acute and Internal Medicine requirement, but currently only to Level 1 standard of competency with

the Acute and Internal Medicine Curriculum. This is available for review on the JCHMT website, (<http://www.jchmt.org.uk/>). Our Basic and Subspecialty Curriculum can also be reviewed there. There is still a risk that the PMETB may insist that a CST for cardiology is awarded after the first 3 Basic Curriculum years, and that any further subspecialty training comes in the form of CME/CPD, rather than structured training that contributes to gaining the final CST.

At or around the end of the third year, there will be a Knowledge-Based Assessment, or exam.

During the first 3 years, there will be regular DOPS in:-

- Angiography
- Echocardiography
- Cardioversion
- Temporary pacing
- Permanent pacing, (routine cases, under supervision, about 25 cases normally required to achieve the anticipated exposure)

There will also be Mini-CEX, (Mini-Clinical Exams), where theoretical subjects are addressed, but these are under development.

There will also be 360° Assessments, where colleagues and allied staff are invited to offer assessment of a trainees abilities and attitudes.

There are moves afoot to change the structure of the SAC, with more elected members and officers, closer ties with the BCS, and closer representation of the sub-specialty groups, e.g. HR-UK, BCIS etc.

Regional Advisors and STSC Chairman will also likely become elected for a set term.

Dr Adam Fitzpatrick
HRUK Council – Interventional EP Subgroup

Revised National Cardiac Rhythm Management Reports

The national summary reports for calendar years 2003 – 2004 have been revised based on updated information received via the Postcode Mapping Study. These numbers have increased substantially and will be of interest to many of you. These revised reports are ready to download from www.ccad.org.uk.

Dr A D Cunningham
Heart Disease Project Manager
Central Cardiac Audit Database

DANPACE UK

How should patients with symptomatic sinus node disease be paced? NICE guidance recommends dual-chamber pacing *except* in patients in whom, after full evaluation, there is no evidence of impaired atrioventricular conduction; in this situation, single-chamber atrial pacing is appropriate. It is too early to say whether this guidance, published in February 2005, is being followed but talking to colleagues, it is clear that clinical opinion is divided, with some implanters showing enthusiasm for single-chamber atrial pacing and others pursuing a uniform strategy of dual-chamber pacing for all.

The relative merits of the two approaches are currently being evaluated in DANPACE, the ongoing Danish trial, in which patients aged 18 years or over, with symptomatic sinus node disease and no evidence of impaired atrioventricular conduction, are randomly assigned to receive either a single-chamber atrial pacing system (AAIR) or a dual-chamber pacing system (DDDR). The primary end-point is all-cause mortality and secondary outcomes include cardiovascular death, atrial fibrillation, congestive heart failure, thromboembolism, need for re-intervention, quality of life and an economic evaluation.

The trial is currently being conducted in all of the pacing centres in Denmark (a truly impressive example of national collaboration) and a little over 1,200 patients have been recruited, with a target of 1,900. Recruitment has been well-maintained since it started in 1999 but the Danish group are keen to accelerate its completion and they have invited me to assemble and coordinate a group of enthusiastic UK centres to collaborate in the trial. Over 20 centres have already expressed an interest in participating and we would very much welcome any others who would like to be involved in this interesting and important study. If you feel that it may be of interest or would simply like to find out more about the trial, please contact me on 0116 250 2500 or by e-mail: w.toff@le.ac.uk

Dr William D. Toff, Senior Lecturer in Cardiology,
University of Leicester & UHL NHS Trust
Glenfield Hospital, Leicester

How to establish rapid access chest pain clinics for the NSF for arrhythmias

INTRODUCTION.

The NSF for Arrhythmias represents many challenges because of the complexity and diversity of heart rhythm care. Amongst the challenges are ways of establishing more equal and more rapid access to heart rhythm care. Rapid access clinics have been a success for the NSF for CHD where they have dealt with chest pain. However, not all aspects of cardiac care can be provided using an adapted Rapid Access Chest Pain Clinic, (RACPC) model. Many RACPCs function well with a specialist nurse or SAS doctor running them, with distant supervision from a named consultant, or a consultant on-call. The decision-making process usually centres on demonstrating exercise or stress-induced myocardial ischaemia and relating this to a patient's presenting symptoms. In many cases this function can be performed with conventional treadmill exercise-testing, after a simple history has assessed a patient for the presence of angina-at-rest, and examination has excluded other causes, e.g. aortic stenosis. In contrast, assessing patients for heart rhythm disorders is dependent

on a wider variety of symptoms and presentations. Heart rhythm patients may present with; palpitations, dizziness, blackouts, chest pain, breathlessness, minimal or no symptoms. The latter may be the case with chronic atrial fibrillation, (AF). Whereas millions of people have coronary artery disease and no symptoms, and do not come to medical attention, new guidelines stemming from the NICE AF Guideline will require action in asymptomatic AF. This is because 1:3 patients admitted to hospital in the UK with a stroke is found to be in AF, but only 20% of eligible patients with AF are being anticoagulated appropriately in the NHS. There is most surely a link, and strokes could be avoided with better care for AF. Thirty Points will be awarded to GPs for detecting AF through the Quality Outcomes Framework under their new contract, and this is worth £30m. GPs will detect a lot of AF, and require rapid effective systems for sorting it out.

ALL ARRHYTHMIAS ARE NOT THE SAME.

The type of heart rhythm problem should determine the type of access, the speed of access, and the characteristics of the evaluating clinical staff. Patients with unexplained blackouts cannot be evaluated by clinicians who are not trained and experienced in the evaluation of patients with unexplained blackouts, and gathering this experience takes years, because these clinicians need to master the management algorithms of syncope, epilepsy, psychogenic blackouts and falls. The latter cost the NHS over £1bn per annum, and data from Falls Clinics show that 30% or more of fallers actually have syncope prior to a fall. Since this age group is elderly, intermittent conduction tissue disease is likely to be the cause of their syncope. They need pacing before the next fall/hip fracture. As we achieve less than half the pacing rate of Western Europe, (430/million versus >900/million), it's tempting to point to this relative lack of pacing access as an important cause of the NHS's vast falls expenditure. It cannot make sense to continue to spend vast amounts on falls, rather than spending more money on pacing services. The process needs re-engineering to pace appropriate patients before their next fall/hip fracture.

In contrast to Blackouts Clinics, AF clinics could quite easily lend themselves to management by specialist nurses working to protocol. In the case of Palpitations Clinics, many GPs would find these very useful, and a relatively simple triage would show; where symptoms were due to simple atrial or ventricular ectopy, there was no evidence of a primary electrical disease, (e.g. LongQT Syndrome), and no evidence of structural heart disease, e.g. previous Q-wave MI.

Therefore, taking all these considerations into account, it seems reasonable to advocate 3 Rapid Access Clinic settings:-

- Rapid Access Palpitations Clinics
- Rapid Access AF Clinics
- Rapid Access Blackouts Clinics

The NSF for Arrhythmias identifies another important area for improved access, and this is the Familial & Genetic Arrhythmia Clinic. This is likely to be run in a Regional Centre, and examples already exist in London, Liverpool and Manchester. For these patients access should be speedy, but it is probably more important that such clinics exist, that they have the necessary multidisciplinary expertise and resources, and that they have strong links with the Rapid Access Clinics. Where a patient is symptomatic and attends one of the Rapid Access Clinics, recognition of a familial or genetic arrhythmia is part of the triage process, and onward referral needs to be swift. Where patients are asymptomatic, they will usually be contacted directly by the Familial & Genetic Arrhythmia Clinic staff because of symptoms or tragic death in a relative. However, to keep these clinics effective, they are likely to be better focussing on symptomatic referrals or family screening rather than general widespread screening in asymptomatic people with no family history of sudden cardiac arrest or familial or genetic arrhythmia condition. Such screening would require

massive resources, although programmes do exist, e.g. in Italy where all schoolchildren need to be screened before taking part in school sport.

RAPID ACCESS PALPITATIONS CLINICS

Many patients in primary care have troublesome palpitations but are unlikely to have an important arrhythmia or arrhythmia substrate. Nevertheless, they occupy the time of GPs, and GPs are “fundholders”, (strictly generic sense, of course!). It follows that they will be anxious to achieve an early answer to important questions, and these are twofold:-

- Is there any reason to believe that this patient’s symptoms might indicate a dangerous arrhythmia?
- Can you reassure the patient and close the episode, (without further uncertainty, and therefore, cost)?

In the palpitations clinic, therefore, protocols will focus on assessment of risk by history, examination, resting 12-Lead ECG, and, in many cases, an echocardiogram. This could be effectively undertaken by specialist nurses and cardiac technicians working with a supervising junior doctor or SAS doctor. The latter would be better, as an SpR would need direct consultant supervision of their decisions. A named consultant should be in overall charge of the clinic, the algorithms being used, quality-control, and clinical governance, as a clinic director. However, they might not need to be present in the clinic, provided time is set aside in job-planning for discussing cases. Alternatively, such clinics could be scheduled alongside existing clinics, which maximises efficiency. Examples exist of effective systems, such as the clinic in West London. Examples exist of device clinics running alongside conventional consultant-lead outpatient clinics and run by technicians and nurses. Rapid Access Clinics could run in a similar way.

RAPID ACCESS AF CLINICS (RAAFC)

RAAFCs will be needed by GPs to support the process of better identification and management of AF in the community. AF affects 500,000 people in the UK, and the incidence is rising by about 5% per annum with an aging population. The objectives of a Rapid Access AF Clinic will be to:-

- Identify any AF patient with a treatable underlying cause, e.g. thyroid dysfunction
- Separate symptomatic from genuinely asymptomatic AF patients
- Separate paroxysmal AF from persistent and chronic AF patients
- Identify AF patients who should be anticoagulated according to the established evidence-based criteria
- Decide upon a strategy of rate versus rhythm control for persistent/chronic AF
- Organise nurse-lead cardioversion using best-practice techniques
- Review patients to assess medical compliance, side-effects and secondary effects/complications of AF or treatment, e.g. the presence of heart failure
- Assess AF patients for onward referral to an electrophysiologist for physical therapies if drug therapies are not working. These include device therapy, catheter ablation or a combination of both

AF clinics will probably be relatively simple to set up and run according to protocols using specialist nurses, probably in primary care settings once larger primary care centres begin to open. However, they must retain strong links with local secondary and tertiary centres to ensure that patients with continuing problems get assessed early for physical therapies and do not get lost in the system. Patients lost in the system typically represent the continuing burden of unplanned admissions to hospital with AF in the UK. Even without counting stroke patients who are admitted because of untreated AF, extrapolation from US data suggests that the UK has approximately 575,000 AF related admissions per annum, and

94,000 AF-caused admission per annum. AF also consumes 1% of the NHS annual budget. AF clinics can reduce morbidity, mortality and costs.

RAPID ACCESS BLACKOUTS CLINICS.

These are not the same as Syncope Clinics.

An effective approach to patients with blackouts requires a multidisciplinary team. Blackouts are caused by epilepsy, syncope and psychogenic causes. Additionally, many patients are admitted with an apparent fall, but in fact this apparent fall was precipitated by syncope, and often this goes unreported and unrecognised. To establish a Syncope Clinic ensures that a large proportion of patients in the diagnostic “grey area”, who do not have simple fainting or obvious generalised epilepsy will not be evaluated by a multidisciplinary team lead by consultants from the key disciplines. Rather, patients assumed to have syncope will be referred. Syncope is caused by transient global impairment of cerebral perfusion, and it is not synonymous with transient loss of consciousness of unknown cause. Patients referred to syncope clinics are either assumed to have had transient loss of consciousness due to global impairment of cerebral perfusion, (i.e. a cardiovascular cause of blackout), or they are referred there because it is not understood that syncope is not the same as a blackout. This is nothing if not confusing. Blackout is synonymous with transient loss of consciousness. The European Federation of Neurological Societies Working Group on Terminology calls this “T-LOC”.

These disciplines that need to be involved in RABCs are:

- Neurology, (and epileptology where needed)
- Cardiology, (and electrophysiology where needed)
- Psychology, (and neuropsychology where needed)
- Care of the elderly

In addition, in planning and managing such clinics, advice and consultation are needed with colleagues in Emergency Medicine, Acute Medicine and Primary Care, because these disciplines “own” the problem of blackouts, and want to know what best to do with blackout patients.

It is important to recognise the limitations of RABCs clinics. Whereas RAAFCs can identify AF with great confidence, and RAPCs can diagnose palpitations due to ventricular ectopy in the absence of structural heart disease with some certainty, RABCs provide a triage stage. Some patients with simple fainting may be discharged back to their own GP to let time pass with a presumed diagnosis. Others may be found to have a clear electrophysiological diagnosis, such as WPW or the LongQT Syndrome and will need urgent onward referral, and some will be thought to have generalised epilepsy and need neurological review at an early stage. However, a lot of patients coming through the RABC will not be diagnosed, they will be given a working diagnosis and channelled more rapidly to the appropriate specialist for further assessment and care. The reason for establishing this triage layer is simple. About 1% of the population have a diagnosis of epilepsy, but evidence suggests that 30% of adults and 40% of children in the UK are misdiagnosed. This represents a major public health disaster, since up to 120,000 patients in the UK are wrongly diagnosed. Many of these will receive a “trial of therapy” with anticonvulsants. This serves only to cement a misdiagnosis, since many blackouts are isolated, and even true epileptic seizures may only occur rarely in patients who have a relatively low seizure-threshold. Epileptologists recommend that epilepsy should be diagnosed in patients with recurrent seizures, not a single episode. However, in practice many doctors are tempted to treat epilepsy after a first or second seizure. This is because of the important implications of epilepsy for education, relationships, employment, driving, insurance and childbearing. Such precipitous resort to

medication is unnecessary, since it has no effect on prognosis, but may substantially affect lives.

Many doctors assume that syncope can be diagnosed with a 24hr tape and a tilt-test, and that epilepsy can be diagnosed with an EEG and a CT Scan. In fact this is far from the truth. Holter monitoring has a yield of <1% in syncope, and tilt-testing in “all-comers” has a yield of about 20%. This is enhanced little with drug-provocation, and there is a false-positive rate of 10% in controls. The EEG is not diagnostic of epilepsy, especially in the over 35s. An EEG is used by epileptologists to define an epilepsy syndrome, once the *clinical* diagnosis of epilepsy has been made. Therefore a diagnosis of epilepsy, and a diagnosis of syncope, depend on the quality of clinical assessment, supported by simple bedside tests, such as the 12-Lead ECG. For this reason, clinicians staffing a RABC must be trained and experienced in such clinical assessments. Supervision and leadership should be by a multi-disciplinary team.

RABCs provide patients and doctors with a triage resource which should be made readily available, and avoids the difficulties associated with inexpert clinical assessment, poor diagnostic tests and a high rate of misdiagnosis. They will have a significant impact on triaging patients with blackouts of uncertain cause if correctly configured and well-directed.

Dr A P Fitzpatrick MD FRCP FACC
Consultant Cardiologist & Electrophysiologist
Member HR-UK Council
Manchester Heart Centre

Dates for your Diary

Tuesday 19th – Thursday 21st September 2006

The UK Heart Rhythm Congress 2006

National Motorcycle Museum, Birmingham. This is the first joint meeting between all the groups, and will incorporate the 'Cambridge' Course, the Annual Scientific meeting, Intervention meeting, HR UK Nurses meeting, 'Bard' Masterclass and patient group meetings. <http://www.ukheartrhythm.org.uk/>

Tuesday 19th September 2006 – HRUK AGM

Monday 4th – Thursday 7th June, 2007

British Cardiovascular Society Annual Scientific Conference & Exhibition
Scottish Exhibition & Conference Centre (SECC), Glasgow
Further details from www.bcs.com

For more information email hruk@bcs.com or go to www.hruk.org.uk

Welcome to New Members

We are delighted to welcome the following new and returning members, who have joined HRUK/BPEG in recent months:

Victoria Bailey
Nicola Baines
Abigail Boynes-Butler
Nina Moran
Karen Morris
Eleftherios Nicolaides
Denise Shearer
Amanda Varnava
Samuel Vella
Hazel White
Suzanne Robson
Kim Rajappan
Paul Reye
Sarah Beers
Catherine Renwick
Suzanne Kelly
Nick Jenkins
Dave Richley

PHYSIOLOGISTS – email addresses required!

Great progress has been made in completing the HRUK email database and we are nearly at the point where HRUK will be able to make contact with 75% of its members via email. We do still need your help! The majority of email address missing are for physiologists. So if you are a physiologist and haven't provided HRUK with your email address then contact Susannah today at hruk@bcs.com. If we don't hear from you then you may be missing out on important communications.

HRUK Contact details:

If you wish to contact HRUK/BPEG on any matter please telephone, write or email, to:
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