south african heart association

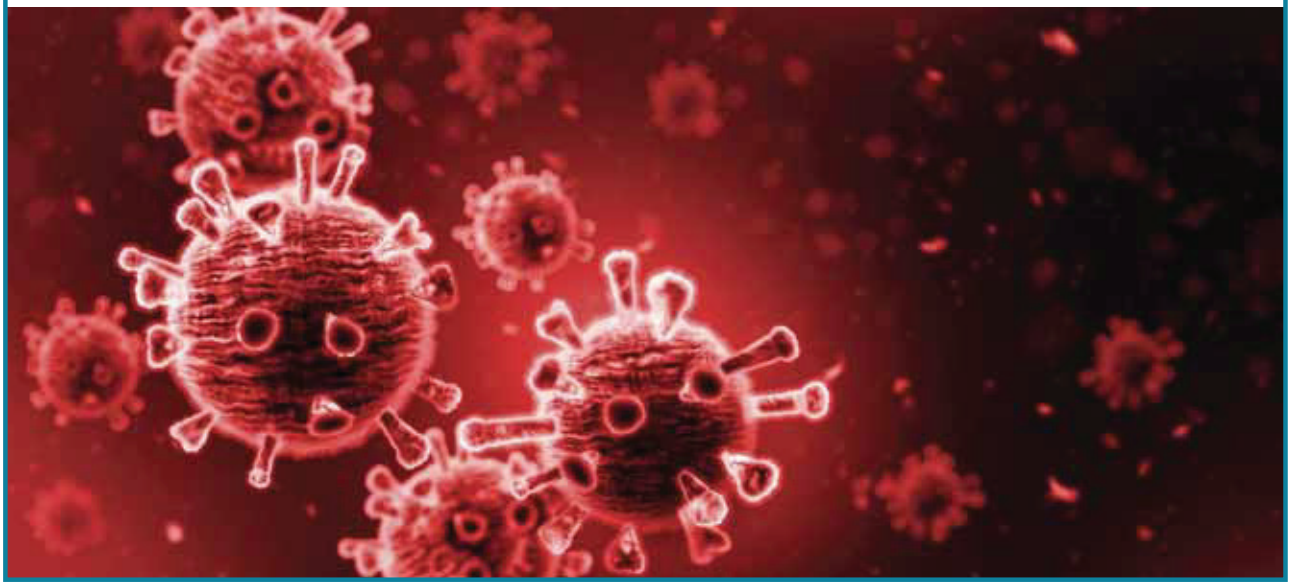
NEWSLETTER
2020
Volume 17 Number 3

MY COVID-19 PERSONAL JOURNEY

At the beginning of the year one would have never guessed that we would be navigating such interesting times as we are now. Like everyone else at the beginning of the year I went for my annual vacation with the family from 4 - 13 January. Actually, we ended up spending another day at the Holiday resort and only arrived back in South Africa on 14 January and I was back at work from 15 January. This annual retreat was full of fun and a lot of rest as I had worked throughout the Christmas and New Year's season, much to the displeasure of my family. I also had a lot of time to reflect and plan for the coming year and like most people we made New Year's resolutions, I had resolved to eat better, spend more time with the family and to exercise more.

So, once we got back home and settled, I decided to buy some vitamins for myself and the family. I reminded kids to eat at least 5 fruits or vegetables a day. As for myself I thought that eating 5 fruits or vegetables was not going to be feasible due to the nature of my work schedule, so I stocked up on good brand of vitamins and other supplements to last me at least 6 months. On the exercise front I have always tried to walk wherever possible and my target has always been to go jogging at least 3 times a week. On average I would run for at least 30 minutes. So, my rhythm was set, and I was going to conquer 2020.

From what I now know on 31 December 2019, the Wuhan Municipal Health Commission in China reported a cluster of cases of pneumonia in Wuhan, Hubei Province, and the COVID-19/Novel Coronavirus was eventually identified. The first recorded case outside China was on 13 January 2020 in Thailand. On 22 January 2020 the World Health Organisation ("WHO") issued a statement saying that there was evidence of human to human transmission in Wuhan but more investigation was needed to understand the full extent of transmission. By 30 January 2020 there were 7 818 total confirmed cases worldwide with the majority of these in China, and 82 cases reported in 18 countries outside China. On 11 March 2020 the world concerned by the climbing levels of spread in severity and by the levels of inaction, the WHO made the assessment that CoVID-19 can be characterised as a pandemic. Back home on 23 March 2020 the President announced that South Africa would embark on a national lockdown starting on 26 March 2020. I vividly remember having a conversation with my wife and advising her to go shopping in preparation for the lockdown. She also works full time and when she finally got time to go and do some shopping it was a nightmare because most of the shops in the Sandton area where empty. She came home on that day after going to multiple shops and purchasing only part of her grocery list. My birthday was on 25 March and Portia decided to spoil me on that day and took me for measurements for a



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MY COVID-19 PERSONAL JOURNEY continued

bespoke suit. I reluctantly went in for the measurements because I was not sure when I would get to wear the suit and little did I know at that time that a COVID storm was about to hit.

Being based in Sandton and coming into contact with people that travel frequently abroad for business and leisure I had a sense that this would become the Wuhan of South Africa. So, since beginning of March I was one of those people who had started wearing scrubs on a daily basis, not just for my procedures in the lab. I received lots of compliments from my colleagues as they thought that I was making a fashion statement but in truth I took this approach because I had a premonition that this virus was closer than we knew and I felt I had to dress for war.

I wouldn't let my family come near me when I arrived home from hospital before going through my "decontamination" procedures. As a precaution I also started taking Chloroquine prophylaxis for the prevention of COVID-19 around the same time and even discussed an "Evacuation plan" with my wife in the event that either one of us or the children fell ill and needed to rush to hospital.

We all talk of Black Tax and part of my COVID-19 Black tax included buying Hand Sanitiser in bulk for distribution to my extended family. I managed to secure 500 litres of hand sanitiser on 23 March 2020.

On 26 March 2020 I joined the Intensive Care Unit ("ICU") Gauteng Corona Group which had been formed on 21 March 2020 in Gauteng and has since spread nationally and regionally as a platform to share from local experience and guide clinical patient management. The first paper I obtained and read on that group was a 2007 article entitled "Severe acute respiratory syndrome coronavirus as an agent of emerging and re-emerging infection", by Vincent C. Cheng, published in Clinical Microbiology Reviews Oct;2007: 660-694. The authors commented that the presence of a large reservoir of SARS-CoV-like viruses in horseshoe bats, together with a culture of eating exotic animals in Southern China, is a ticking time bomb.

At the beginning of the lockdown I recall that the drive to work during the first days of lockdown was surreal because the Gauteng roads were empty, it felt like Johannesburg in during Christmas. I literally used to pinch myself to make sure it was not a dream. I also recall that chloroquine was the flavour of the Month. I remember going frantically from pharmacy to pharmacy looking for whatever little stock of Chloroquine I could get. On the work front once the initial shock of being locked down began to wane we started having multiple planning meetings for COVID-19 from the beginning of April. I remember us discussing who was more at risk during one of those meetings, and I remember thinking to myself I am surely low risk since I am generally healthy and physically active.

As part of our preparation for the coming flu season my family went for flu vaccination on 16 March 2020. I normally do not get the flu vaccine. But this year with all the uncertainties around COVID-19, I decided to get vaccinated.

My first scare was on 30 March 2020 when I woke up with a running nose and slight fever. I was so paranoid that day that I decided to go and get tested for COVID-19, but the results came back negative. I also did the swab for respiratory viruses which came back positive for Rhinovirus. These symptoms settled within 2 days. I then had to retest for COVID-19 on 15 April 2020 as part of screening of all staff at the Mediclinic Morningside. This test was negative as well.

However, on Monday 20 April I had a team meeting through which I felt restless. I struggled to focus, I could not properly articulate my items on the agenda and the meeting appeared to take longer than was necessary. I just thought it was fatigue as I had worked over the weekend. Even though the hospital had been closed for admissions, I had a few patients still admitted, some post-surgical. The following day at work was busy as well as I had a busy clinic. Later that night I felt a bit feverish and I woke up around midnight my wife checked my temperature and it was 38 degrees and my heart sank, I knew in that moment that this was it.

Since the beginning of the lockdown I had been monitoring my temperature daily and it had never gone beyond 37 degrees. I had a restless night and the following morning I got up early and immediately went to the drive through testing station. I got there before they had opened the testing station and nervously watched the staff set up. Impatiently I sat in my car while at the same time bracing myself for the uncomfortable test. I had a lot of thoughts racing through my mind wondering what I would do with my remaining patients in the wards at such short notice. Asking myself where I would quarantine since I was now

symptomatic and my wife and children were all confined to the home. After what seemed like a lifetime the lady walked to my car and administered the test. This time I could not help it, I felt the tears welling up in my eyes as reality set in while she turned the swab a few times down my nose into the pharynx. After this I drove home and when I got into the house the kids were preparing to start their online sessions and they got so excited that I was back so early which broke my heart because my presence didn't mean spending time together but rather time apart.

My wife prepared a warm drink for me and got me settled into bed. She started asking me a lot of questions with worry etched on her face and most importantly she wanted to know why I wasn't going to hospital and why I muttered that I did not want to be put on a ventilator etc? I explained to why I was not keen on being admitted into hospital, but assured her that I would be honest with her should I deteriorate significantly and urgently needed to go to the hospital and that she should be ready to execute our "Evacuation plan" as discussed.

What she did not know was that since the hospital had been closed voluntarily for deep cleaning the previous week, we were not admitting general patients, but they had made a provision for staff members to be admitted as required. I was aware some of the people I had worked with in the ICU and High Care areas needed to be admitted for supplementary Oxygen therapy into the wards and the thought that this could be me weighed heavily on my mind.

My wife quickly recognised that I wasn't myself and even without the confirmation of the test results we proceeded as though I was positive and agreed that I would isolate at home. My wife moved out of our bedroom and made our room and study out of bounds. Our bedroom was ideal because it has a door that opens out to the garden so I could step out without interaction with the rest of the family and I could work in the study without running into the online scholars. In my mind I thought I was going to be able to sit and catch up on outstanding reports during the isolation period. I therefore arranged for my Personal Assistant to deliver some patient files to the house. I still had about 10 patients in the hospital, so I made a few phone calls to hand them over and my colleagues were more than happy to assist. There was one patient who had presented with a Non ST Elevation Myocardial Infarction (Heart Attack) to Mediclinic Sandton with some respiratory symptoms who needed further treatment and I had been trying to refer her to another hospital group for care since we were not admitting patients to the catheterisation laboratory at Mediclinic Morningside. I received a positive COVID test result for that patient and the other Hospital Management upon hearing that decided it was risky for that patient to come across to them. As it turned out this specific patient was also a healthcare worker and worked in one of the hospitals in Johannesburg and I had already received a few anxious calls from the family and colleagues as well. So, I had to counsel them telephonically and also explain the changes in management strategy as a result of the positive test result. Fortunately, the patient had responded to medical therapy initiated on presentation and was pain free. As a Cardiologist one always wants to know the anatomy as soon as possible in patients with Acute Myocardial infarctions. During all these telephonic interactions I did not disclose that I was symptomatic and started my isolation, I had to wear the Doctor cap all the while dealing with my own internal turmoil.

> "I had a premonition that this virus was closer than we knew and I felt I had to dress for war."

With all my patients handed over I finally was in a position to start sorting myself out, then it dawned on me what I was up against. By late afternoon I was feeling fatigued and feverish and so I decided to start myself on Zithromax and continue on the Chloroquine. I had already taken a few paracetamols as I had a light headache which I thought was

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MY COVID-19 PERSONAL JOURNEY continued

more stress related than anything. Fortunately, a colleague had sent me script, but I could not get the Chloroquine dispensed from my hospital pharmacy because they needed a confirmed positive COVID-19 result which was not yet out. Fortunately, I still had some strategic stock of my own which I started using. From that night onwards my condition deteriorated quickly as I became more febrile and short of breath. Initially I thought it was just the anxiety of waiting for my results but objectively this was beyond anxiety. I lay awake that night and would check for my results every 30 minutes. I literally did not know what to do with myself. Other symptoms that I also developed included hypersomnia, back pains, generalised joint pains and severe cough. Even when I changed position in bed, I would have severe coughing spasms which would take some time before settling. So I would focus my energy on trying to find a comfortable position and do my best to keep it.

The shortness of breath rapidly worsened, I recall getting up at some stage to use the bathroom and almost falling from dizziness. I literally stayed up all night as I focused on making sure that I kept breathing. I found that if I prone the back pain was better and breathing improved, but it was not a comfortable position as I am not used to sleeping on my chest and stomach. The following morning, I was exhausted and I had little appetite and I struggled to keep down the small amounts of food I ate. I recalled the need to keep well hydrated and I would force myself to drink water slowly. I asked my wife to prepare plain vegetable soups which became my main source of nutrition for the following 2 weeks. Because of the pain in the back and joints I took a lot of Paracetamol sometimes even 4 hourly. Eventually I would look back in shock when realised that I had taken almost 100 tablets in 10 days.

By day 4 I had also developed severe epigastric burning sensation which I attributed to Chloroquine and the Zithromax and so I decided to stop the Chloroquine. The following day I got a script of Prednisone and started taking 40mg twice a day. That brought some relief to my breathing or lessened the intensity of my coughing spasms. With it I also started an oral anticoagulant and I took very high dosages on the first 2 days and then continued with normal doses daily which I have continued to date. I had heard of various steaming techniques and the first time I tried steaming I had such a bad coughing spasms such that I thought I was going to die. However, when I changed steaming with common Vicks I had a lot of relief in my chest and sinuses. I drained so much mucus it was shocking. I always observed the colour of the mucus. What really helped was combining steaming self-chest physiotherapy and postural drainage. This meant that I would spend a lot of time kneeling on the bathroom floor.

During the first week I spent most of the time lying in bed. Most of my time was spent in meditation and prayer as I had experienced multiple moments when I would run out of breath precipitously even whilst lying in bed and I would think that my moment of death had approached. A few times my wife walked into the room and would hear me breathing heavily and she would insist on taking me to hospital and I would beg her to allow me to settle down, saying that this was a passing phase. During those moments I would also refuse to have my saturations measured as I knew that they were very low and that it would cause her to worry. At some stage I had measured them alone and noticed that I had come down to 80% and so I would focus on breathing whenever I was having these episodes. One thing exacerbated these breathing paroxysms was cold air and so we made sure that the room was very warm and I also used a humidifier 24 hours a day.

When my wife would come in and clean my room, etc. I would sit in the garden, but I could barely walk without feeling like my chest in fact my whole body was on fire. Another worrying symptom which stayed with me is severe palpitations on exertion and I subsequently started myself on a beta blocker with great relief. An echocardiogram done 2 weeks later revealed that my heart was structurally and functionally normal. A Chest X-ray done then also showed bilateral infiltrates confirming a COVID pneumonia.

On Thursday 30 April I managed to walk out of the house for the first time and I sat in the sun for 2 hours. On that day I recorded 1 119 steps. It was on the same day that I saw my 2 older children for the first time since the night of the 21 April. I remember my daughter coming to the window whilst inside the house and she blew me a kiss and that just broke me. I could not help the tears just welling up in my eyes as I waved back at her. Since 21 April I had the great fear of infecting my family and I would ask my wife to leave the bedroom soon after she brought me a beverage or a meal sometimes voicing my concern to her that the room was contaminated with the Coronavirus.

She developed a system which included setting aside crockery, cutlery and trays exclusively for my use and she would leave meals in a tray by my bedside and steaming concoctions and some beverages in the bathroom.

Since I battled to sleep during the night (if I'm being honest I was afraid to fall asleep as I thought I would die). I would sleep in the mornings and my days then venture out from some sunshine from about noon. From that initial venturing into the garden on 30 April I started going out every day and trying to do more walking. Those were precious moments for me where my 2 older kids would watch me and as I got stronger enough to walk down to the tennis court at the bottom of the garden they would follow, and we would have light conversations whilst keeping a safe distance. As I gained more strength they started joining me for walks and competing with me on who can go around the court the quickest. Those moments I spent with them reinforced the reasons I do what I do daily. Also, more and more I was spending time talking to family and friends on the phone. Initially I avoided video calling because the first comment was always how much weight I had lost, etc. I learnt to also avoid calls during times when I was out of breath especially when talking to elderly members of the family. I also spent a lot of time in prayer every night, would have communion and that was my sustenance. My faith kept me going, gave me the strength to look forward to another day. Also, the many people who called to just pray with me helped me deal with a lot of fears I had.

On 4 May I decided to go and have another COVID-19 test which came back positive. On that day I met some of the Emergency rooms staff in the parking lot where the testing was being done and they encouraged me to continue to fight this virus. When I received that positive result, I was disappointed, but I also knew that it could be due to the fact that I was shedding dead viruses and hence the positive result. My greatest supporter, my wife noticed my disappointment when I got the result the following day and tried her best to cheer me up.

I also could sense that she was tired because she was looking after the children, supervising their home schooling, fielding calls from concerned friends and family so whenever she would do checks on me I would tell her I was fine and that she shouldn't worry.

I continued to grow stronger and on Friday 8 May and went again to retest for COVID-19 and it came back negative. At the time I knew that in-order to go back to work safely I needed to produce a negative test result. So I was so excited the Saturday morning when I got the negative result and started making plans to start going back to work. My wife was not keen on the idea of me going back but later agreed when I mentioned that I was going back to catch up on my reports. It was also important to me that I not be controlled by fear. So, Monday 11 May I have returned to work. It was also on that day that I made a Video which I posted on my YouTube channel which traumatised some people as I was still quite short of breath at the time.

When I got to the hospital the walk from my car to my rooms was painfully long. I had to pace myself but it was good to be back in the belly of the beast even though for the first week I did not see patients. The masks made breathing a lot more difficult since then I have learnt to pace myself with all activities. It has slowly been getting better as the weeks have gone by. The tachycardia or palpitations are better on the beta blockade.

I have not yet resumed running because I had started doing some stretching and low impact exercises after 4 May and when I tested my muscle and cardiac enzymes they were significantly raised further motivating my taking of beta blockers and slowing my return to extreme exercise.

One of the most important lessons I have learnt in this whole experience is to always value the relationships we have as human beings. With the love and support of my wife I would not have been able to go through this successfully. Also the many friends and family who called or sent a message just to say you are in our thoughts and prayers. Also my Faith kept me going, I have never before had to dig this deep in prayer. I think Spirituality is an essential part of every person's life.

I used a lot of experimental medication at the time and medical interventions are important. However, there is a lot of value in loving relationships, good nutrition, good habits, i.e. prayer, exercise, no smoking, sobriety and work life balance when you can achieve it. This foundation and support system can only but help us when we face the storms of life, and the storms will come.

Dr Farai Dube

ADDRESSING THE HIGH MATERNAL MORTALITY DUE TO CARDIOVASCULAR DISEASE IN SOUTH AFRICA

THE 5TH ANNUAL CAPE TOWN CARDIAC DISEASE IN PREGNANCY SYMPOSIUM

Cardiac disease is an important contributor to maternal death in both lower-to-middle and higher-income countries. There has been a steady increase in the overall institutional maternal mortality due to cardiovascular disease in South Africa. The most important contributors are Peripartum Cardiomyopathy (PPCM), Rheumatic Heart Disease and unoperated congenital heart disease.

The annual Cape Town Cardiac Disease in Pregnancy Symposium is unique in that it draws participants from a broad spectrum of disciplines – obstetricians, gynaecologists, cardiologists, internal medicine specialists, anaesthetists and basic scientists. Our previous meetings have facilitated fruitful and engaging discussions which have led to new collaborations, research projects and publications.

Recent advances in female heart disorders during maternity were the focus of the first "Cape Town Cardiac Disease in Pregnancy" symposium: from bench-to-bedside to population studies held in 2015. The aim was to provide up-to-date information on physiological changes in pregnancy, cardiac diseases in maternity, their pathological mechanisms, current management and diagnosis and clinical research and therapies. The enthusiastic response received from both speakers and delegates led to this becoming an annual symposium and the 5th Cape Town Cardiovascular Disease in Pregnancy symposium will take place at the Hatter Institute, Chris Barnard Building, Faculty of Health Sciences, University of Cape Town, from Monday, 28 - Tuesday, 29 September 2020 (World Heart Day). This event provides an opportunity for leaders in the field of cardiovascular diseases in pregnancy to gather in Africa.

Professor Karen Sliwa, Director of the Hatter Institute for Cardiovascular Research in Africa, hosts these annual international events. The academic programme combines a broad spectrum of clinical and basic science topics, with an impressive line-up of cardiac and/or maternity specialists from around the globe, including South Africa, United Kingdom, Israel, Germany and France. Attendees include physicians, nurses, scientists and students.

Just to highlight a few of the presentations - Professor Justiaan Swanevelder (Head of Anaesthesia, Groote Schuur

Symposium participants 2019 show solidarity for a young woman who died due to PPCM.

Hospital, Cape Town) will give a talk on managing peri-operative hypotension in pregnant women and the role of ECMO.

Dr Ranio Zhang (Uganda Heart Institute) will present original and unpublished research data on cardiotoxicity of breast cancer medication in a female Uganda population.

A session chaired by Dr Blanche Cupido and Professor Mushi Matjila (Groote Schuur Hospital), will have five clinical scenarios of cardiac disease in pregnancy, presented by a range of speakers.

Professor Karen Sliwa will present the results of more than 700 patients enrolled in the European Cardiac Society EURObservational Registry on Peripartum Cardiomyopathy showing some surprising data (Sliwa, et al. Eur Heart Journal 2020, in press).

Professor Ntobeko Ntusi (Head, Department of Medicine, Groote Schuur Hospital and University of Cape Town) will review the variety of cardiovascular imaging modalities available for pregnant women to confirm the diagnosis, to assess disease severity and stratify risk, to prognosticate, and plan for appropriate management and to assess response to therapy. One feature is about safety counselling for women and the need to balance the goals of beneficence with avoidance of harm to mother and foetus.

The importance of climate change on cardiovascular pathology contributing to maternal death will be addressed by Professor Priya Soma-Pillay, who is a Member of the South African National Committee for Confidential Enquiry into Maternal Deaths (NCCEMD).

The two-day symposium will be an exciting learning and networking opportunity and 10 clinical and 2 ethic CPD points will be provided (MDB001/013/09/2019).

Prof Karen Sliwa

THE VALUE OF BEING A MEMBER OF SA HEART®

Members often ask what value there is to belong to SA Heart®, the association representing their professional interest. "In hand material benefits" are often hard to spell out, they would include e.g. the annual congress, the SA Heart® Journal with CPD opportunity and access to scholarships. However, intrinsic value of belonging to a group of peers, networking, getting advice and feeling supported is invaluable too. Leadership and committees work in the background and spend many hours to ensure you can concentrate on your practice and patient care.

Our president, Dr Jankelow, also member of the private practice committee, spends many an hour mediating between members and medical funders. One of these members recently expressed his gratitude in a letter directed to Dr Jankelow:

I'm writing this note to personally express my heartfelt thanks for all your assistance with regards to my recent enquiries with one of the medical funders. As unpleasant as the enquiry was, I am most grateful for your personal time and effort that it took to get through this process. The continuous engagement with the medical fund concerned required an extraordinary amount of time and dedication, and not once did you complain nor become impatient with me. I'm not sure if you have anyone to assist you with these processes, considering how much time and effort they involve.

I certainly felt supported as an SA Heart® member, throughout this ordeal. I am almost sure that had it not been for the society's full support, I may have found myself bullied into submission. Please pass on my thanks to the rest of the Private Practice committee for their assistance and to SA Heart® Board at large. Feel free to use this letter to remind everyone of the importance of this particular role that you, in particular and the private practice committee, in general, continue to do for those of us in private practice. It has certainly been comforting and helpful to have the society's support. I trust that you will continue to provide the same support for any other colleague that may find themselves in this unfortunate situation.

PAEDIATRIC CARDIOLOGIST EXPERIENCE

Dr George Mukhari is an Academic Hospital situated in the North of Tshwane (Pretoria). It serves as a teaching hospital for the Sefako Makgatho Health Sciences University formerly known as the Medical University of Southern Africa. It mainly serves the people of Northern Tshwane and receives referral from some parts of North West and Limpopo Provinces. The paediatric outpatient clinic sees over 10 000 patients annually and 10% of those are cardiac patients. The department of Paediatrics and Child Health functioned for a long time with general paediatricians with special interest in different subspecialities, the only two subspecialised wards were oncology and neonatology. There has been significant growth and development in the department with the divisions of paediatric cardiology, nephrology and oncology having been recognised and accredited for training by the HPCSA and all headed by women.

I was born in Soweto from a staunch Catholic family, and the 9th child from a family of 11 children. My late parents loved the phrase " Ora et labora" which means pray and work in Latin, and that has really worked for me. My husband and I have also adopted the phrase for our 3 beautiful children. I completed my undergraduate degree at Medunsa in 1995, obtained Fellowship in Paediatrics with the College of Medicine of South Africa in 2002 and started working as a general paediatrician in 2003 at Dr George Mukhari Academic Hospital, then Ga-Rankuwa Hospital. I have always had an interest in paediatric cardiology and wanted to improve the outcomes of children born with congenital heart diseases. Since then I was responsible for the paediatric cardiology patients together with my colleague Dr Nkohane, who also has great interest in paediatric cardiology, and gained quite a lot of experience in doing echocardiograms and cardiac catheterisations from the previous paediatric cardiologist.

It was a challenge to offer proper care to cardiac patients because we were not trained in the field. Therefore, most of our patients had to be referred to Steve Biko Academic Hospital for further management, and that was really frustrating. It was also a great disadvantage to both undergraduate and post graduate students in paediatrics as they only had exposure to simple cardiac lesions that we could manage onsite. It was through the help of Prof Takawira, who is the head of Paediatric Cardiology division at Steve Biko Academic Hospital and Prof Mawela the current head of the Paediatric and Child Health Department at Dr George Mukhari Academic Hospital and Sefako Makgatho Health Sciences University that I joined the paediatric cardiology unit at Steve Biko Academic Hospital in 2014. The whole cardiology team at Steve Biko Academic Hospital was very supportive throughout my training and I successfully completed my Fellowship in Paediatric Cardiology in 2016.

I went back to Dr George Mukhari Academic Hospital in 2017 and had to deal with the challenge of trying to set up a paediatric cardiology unit in a department that was not prepared for subspecialists.

Some of the challenges faced were:

- motivating for a dedicated cardiac cubicle for better management of cardiac patients;
- motivating for appropriate equipment in the clinic, wards and the cardiac catheterisation theatre; and
- dealing with the expectation to look after all general patients and only focus on "your speciality" afterwards.

We often left the hospital after 6, sharing general paediatric calls equally with colleagues while being on call for paediatric cardiology daily. We managed to succeed with some of the challenges. The paediatric cardiology clinic sees about 25 patients per week and we have about 10 cardiac admissions per week. We also have one theatre day per week and perform cardiac catheterisations on 2 patients per week, mainly diagnostic catheterisations. We did our first percutaneous Patent Ductus Arteriosus (PDA) closure and balloon dilatation of the pulmonary valve on the 20 April 2017 and we are grateful to Prof Takawira for his support as we were taking baby steps. We initially started with simple procedures with the aim to progress to complex interventions when the whole team had gained experience and confidence. This has really made a significant difference to patients that had to be on the long surgical waiting list and has led to reduced hospital stays. We are gaining confidence and experience daily and plan to do all complex cardiac interventions onsite in the near future. Currently I attend to these patients with colleagues at Steve Biko.

The challenges we are facing are staff shortages, on both the medical and support staff. Being the only paediatric cardiologist in the hospital basically means being on call every day for the whole year. It also means that the majority of time is spent on patient care and teaching and very little time, if any on research, which is not good for an academic institution. There is also a lack of an experienced

nursing team in the cardiac catheterisation theatre. We only have one experienced nurse who works with monthly rotational nurses, which does not give them adequate exposure to gain experience and confidence. This poses a great challenge when faced with complex cardiac lesions and complex cardiac interventions. The whole team should always be ready to act promptly and effectively when doing procedures in the catheterisation theatre to prevent and to react to complications that may occur. We have a long waiting surgical list for the complex congenital heart lesions. Lack of cardiothoracic surgeons with interest in congenital heart lesions is our other challenge, our onsite cardiothoracic surgeons are mainly operating on the simple congenital heart lesions and we have to refer our complex cases to Steve Biko Academic Hospital. There is only one surgeon there and he will be retiring at the end of this year. This is also a challenge because our ICU and theatre nursing staff, cardiothoracic registrars and the paediatric cardiology fellow are not getting adequate exposure to intra operative and post-operative management of these patients.

The Paediatric Cardiology unit at Dr George Mukhari Academic Hospital and Sefako Makgatho Health Sciences University is growing with the support from the head of our department and the paediatric cardiology team at Steve Biko Academic Hospital. We received accreditation and recognition for training by the HPCSA in 2018 and we started with training of our first fellow in July 2019. We plan to train more fellows and expand our paediatric cardiology unit and services to make a significant contribution to the outcomes of children born with congenital heart problems.

Dr Mamokgethi Moshe, Paediatric Cardiologist.

Dr Mamokgethi Moshe, Paediatric Cardiologist
Department of Paediatric Cardiology
Dr George Mukhari Academic Hospital

WEBSITE LINKS

SA Heart®	www.saheart.org
CASSA	www.cassa.co.za
HeFSSA	www.hefssa.org
PASCAR	www.pascar.org
PCSSA	www.saheart.org/pcssa
SASCAR (Research)	www.sascar.org.za
SASCI	www.sasci.co.za
ACC	www.acc.org
ESC	www.escardio.org
World Heart	www.world-heart-federation.org

HEART FAILURE SOCIETY OF SOUTH AFRICA

It is amazing how we as health care professionals have adapted to the changes the COVID-19 pandemic has brought before us, and it is with great pride that I count myself among the thousands who are ready to assist at the frontlines.

I would like to express my thanks to my Executive Committee Members for their continued and unwavering dedication to furthering heart failure, even during this pandemic. The Exco are Martin Mpe (President), Jens Hitzeroth (Vice-President), Eric Klug (Ex-Officio President), Darryl Smith (Treasurer) and Nash Ranjith (Secretary), as well as Karen Sliwa, Tony Lachman, Makoali Makotoko, Nqoba Tsabedze, Ntobeko Ntusi and Mpiko Ntsekhe.

HEFSSA HEART FAILURE GUIDELINES

We are excited to announce that the HeFSSA Chronic Heart Failure Guidelines 2020 (based on the ESC HF 2016 guidelines, with substantial Africanisation) has been accepted by the SAMJ and will be published and available by mid-August 2020. Thank you to Dr Jens Hitzeroth who led the review, with substantial contributions from the HeFSSA Executive (as clinical and research experts). This publication includes an update of the Chronic Heart Failure Algorithm and will be made available on the HeFSSA website.

HEART FAILURE SPECIALIST WEBINAR

On Thursday, 2 July, HeFSSA hosted a Heart Failure Specialist Webinar specifically for cardiologists and specialist physicians. Dr Nqoba Tsabedze focused on an update overview of SARS-COV2 and the viral pathology and links to heart failure, and Prof Mpiko Ntsekhe spoke from personal experience on the Western Cape as the epicenter of the South African pandemic at the beginning of July. This webinar was sponsored by Pharma Dynamics and well attended by 250 delegates.

HEFSSA NON-CARDIOLOGIST WEBINAR SERIES

The HeFSSA Non-Cardiologist Webinar Series focuses on Contemporary Heart Failure Management, and specifically targets the General Practitioner, Specialist Physician and Allied non-prescriber HCP. Topics and faculty include:

Webinar "Tele-Cardiology and Lifestyle Modifications for the Heart Failure Patient" (11 July)

Dr Tony Lachman presented on the Role of Tele-Cardiology and the impact of the COVID-19 Pandemic on the Heart Failure Patient. Dr Sandra Pretorius spoke on nutrition and advising heart failure patients on immune-boosting and heart healthy food choices. This event was well attended by more than 400 delegates, not only from across South Africa, but also continental.

Webinar "A Review of the Heart Failure Guidelines 2020" (1 August)

Dr Jens Hitzeroth will give an in-depth review of the upcoming guidelines publication in the SAMJ, with Prof Ntobeko Ntusi, Dr Blanche Cupido and Dr Charles Kyriakakis as panelists. We have 1200 RSVPs at the time of writing and expect at least 700+ delegates to dial in.

The next 2 Non-Cardiology webinars are planned for:

- 22 August on COVID-19 and Heart Failure, with Prof Naresh Ranjith.
- 12 September dealing with Diabetes and Heart Failure, with Prof Eric Klug as the lead.

> "We are ready to assist at the frontlines."

A recording of the above webinars will be made available on the HeFSSA website for those delegates who are not able to attend on the day (please allow 10 days following the meeting for posting).

We are privileged to acknowledge our corporate supporters for the unconditional grants which allow us to offer these events free of charge, namely: AstraZeneca, Boehringer Ingelheim, Cipla, Pfizer, Pharma Dynamics, Novartis, Novo Nordisk, Servier and Vertice Medtech.

Several other projects are still in planning such as Cardio Update for Non-Cardiologists and HF Snapshot Survey (research).

Dr Martin Mpe

INCORPORATING MULTIMODALITY IMAGING IN TRAINING IN THE SOUTH AFRICAN CONTEXT

INTRODUCTION

In daily clinical practice, cardiovascular (CV) imaging has experienced major strides and advances in relation to cardiac imaging procedures of echocardiography, nuclear cardiology and lately cardiac computed tomography (CT) and magnetic resonance imaging (MRI).[1,2] Therefore, it is perhaps time to revise the training standard for fellows interested in CV imaging.

OLD AND THE NEW

Many qualified Cardiologists are seeking training experiences through courses and conferences to acquire new skills in cardiac CT and MRI because such technologies did not exist during their training period.[1,2] Due to a deficiency of cardiologists it is no longer sufficient to have general cardiologists possessing expertise in only 1 or 2 of the 4 imaging modalities. It surely would be advantageous if newly qualified cardiology fellows entering the field could provide expert supervision and interpretation in various cardiac imaging techniques.

CURRENT STATUS REGARDING CARDIAC IMAGING IN SOUTH AFRICA

- Training at most institutions limited to Echocardiography during the 3-year Fellowship.
- Echocardiography is the domain of the Cardiologist. Radiologist not trained formally in this imaging modality.
- Cardiac CT, MRI mostly done at private institutions by Radiologists/Radiographers.
- Recently there has been an emergence of cardiac MRI service in 4 major academic public institutions.
- Nuclear Medicine available at major academic public and private institutions.
- No institution offers formal Fellowship training in multimodality cardiac imaging.

PROPOSED STRATEGY FOR DEVELOPING A MULTIMODALITY CARDIAC IMAGING CENTRE(S) IN THE SOUTH AFRICAN CONTEXT

- Multi-disciplinary approach is vital. Use of existing local resources and expertise.
- Non-invasive Cardiologist, Radiologist, Nuclear Physicist, Electrophysiologists and interventional Cardiologist need to collaborate.
- Compulsory rotation of Fellows training in Cardiology, Nuclear Medicine and Radiology fellows to each of the abovementioned disciplines with the aim of acquiring at least level 1 competency.[1,2]
- Currently in South Africa Imagers are functioning in Silos and this is detrimental to all and above all to patient care.
- Establishment of cardiac Imaging centres of excellence that is all inclusive to those training in the field of Cardiac Imaging and want to function independently as a cardiac imager.

> “It is perhaps time to revise the training standard for fellows.”

ROLE OF CARDIAC IMAGING SOCIETIES

- The role of the cardiovascular imaging societies should remain strong and relevant if this new advanced multimodality imaging discipline is to succeed.[1,2]
- The societies must continue to be campaigners for research and development of cardiovascular imaging modalities.
- They should continue with a strong attention on education in the form of continuous medical education offerings, publications, annual conferences, and provision of educational resources and mentors.

Continued on page 382

INCORPORATING MULTIMODALITY IMAGING continued

- Examinations in their specific fields to assess knowledge and interpretive skills and evaluate competency should be offered to ensure a high standard of reporting and safety.

CONCLUSION

The future of cardiac imaging in South Africa is a multidisciplinary integration of all imaging modalities. This will facilitate better training and enhance patient care. My vision is a dedicated multimodality cardiac imaging centre in South Africa equipped with imaging experts, researchers and equipment that offers advanced training and certification in a cost-effective manner to all interested in cardiac imaging.

Below are examples of 2 patients (Figure 1 and 2) that underwent multimodality imaging at Chris Hani Baragwanath Academic Hospital.

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Dr Ruchika Meel
Consultant and Post-doctoral Carnegie Fellow, Cardiology, Chris Hani Baragwanath Academic Hospital and University of the Witwatersrand

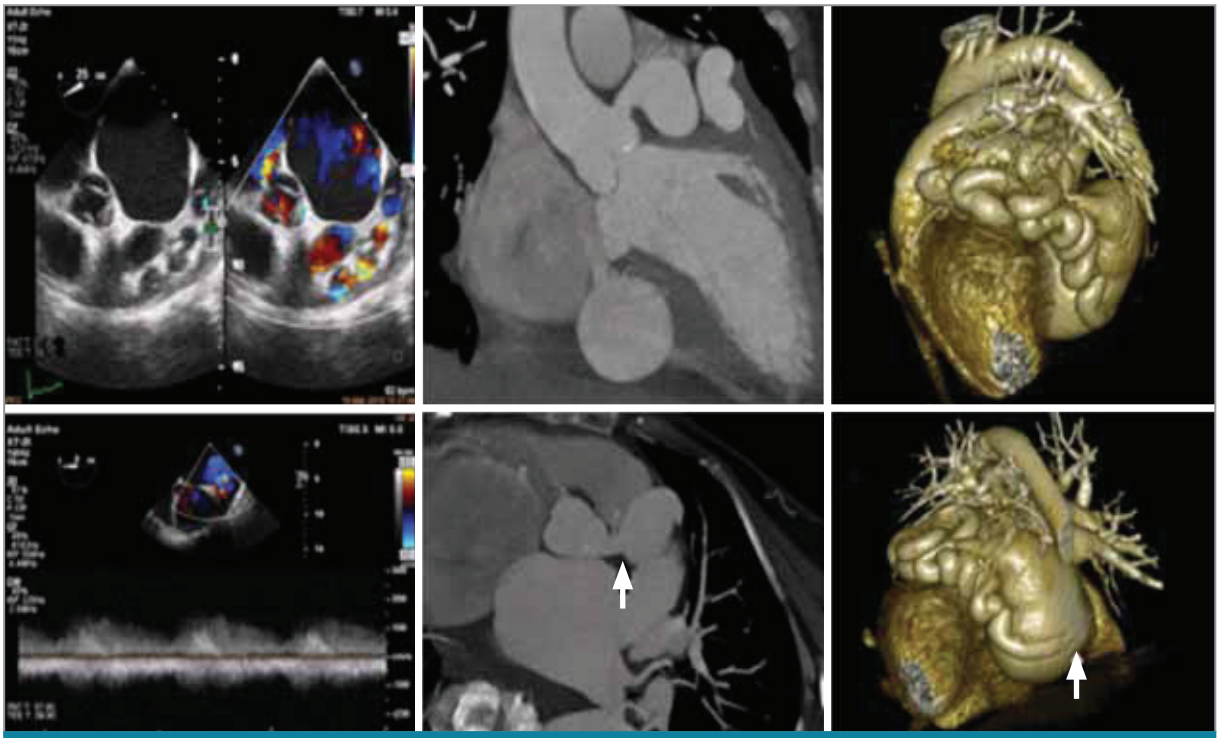


FIGURE 1: Multimodality imaging of a patient with giant circumflex artery aneurysm (arrows) with Trans-oesophageal echocardiography (far left, top and bottom) showing beaded appearance on cross-section with continuous flow and cardiac computed Tomography (middle top and bottom panels and far right top and bottom panels) delineating the origin and drainage of the aneurysm through a fistula into the coronary sinus.

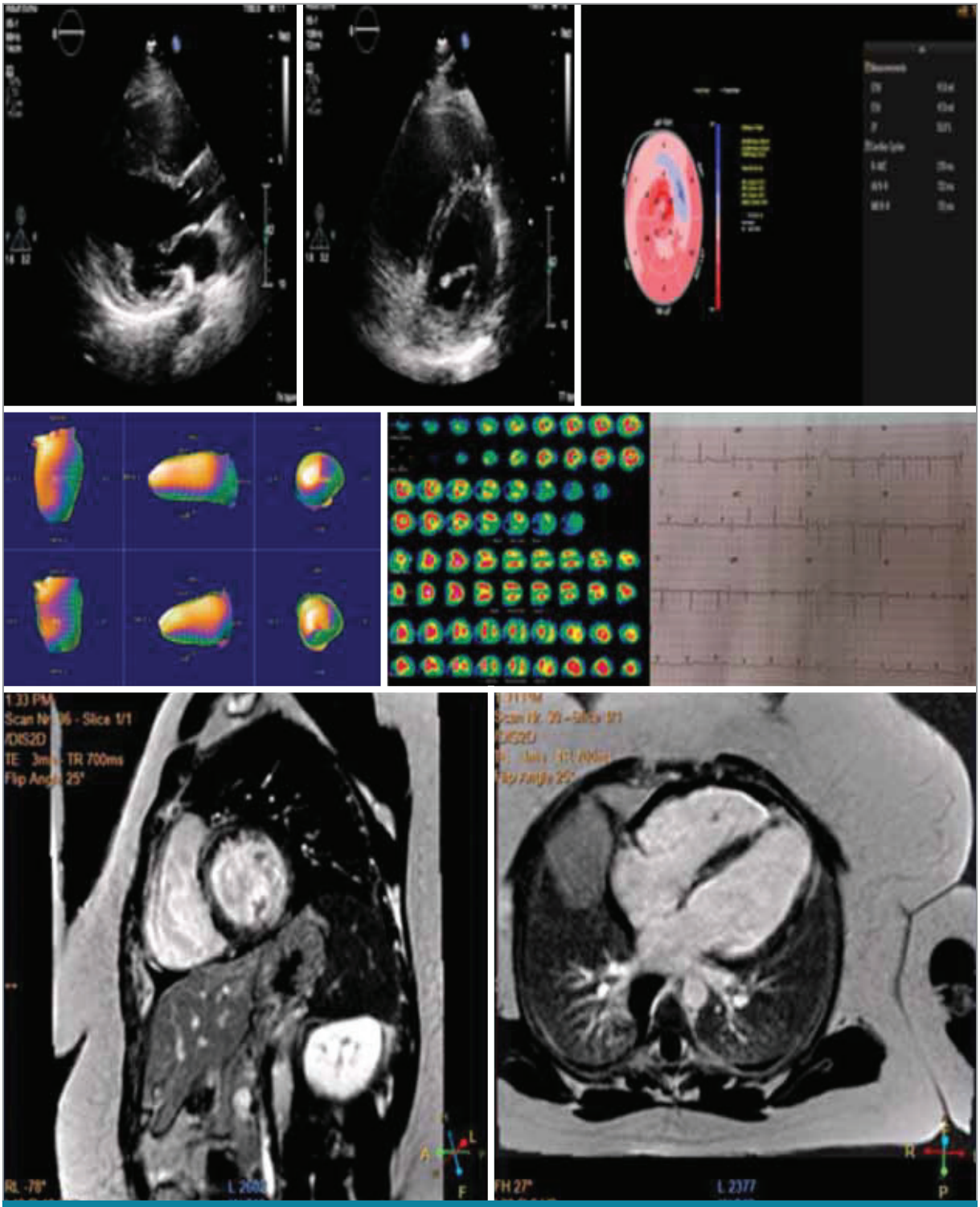


FIGURE 2: A case of systemic sclerosis complicated by an aneurysm and patchy fibrosis of the heart imaged with 2 dimensional echocardiography (top left and middle panel), strain imaging (top right panel), nuclear scan (top left and middle panel) and Magnetic Resonance Imaging (bottom panels).

BIOGRAPHY - THABO GREGORY NGAKA

Thabo Gregory Ngaka, a 26-year-old young man from Mount Fletcher, a small town in the Eastern Cape, South Africa. I am a Chief Cardiac Technologist based at the Nelson Mandela Academic Hospital (NMAH) in Umtata. My career journey started in 2012 when I left for Durban to study Clinical Technology at the Durban University of Technology. In all honesty, I didn't have much of a clue about the course except for the fact that there was an option to specialise in the heart. Given how attentive I used to be in high school during Life Sciences (Biology) when we were learning specifically about the cardiovascular system, I thought it was worth a try. I beat Murphy at his own game because – well, here I am!

I completed my in-service training at Groote Schuur Hospital (GSH) in Cape Town, Western Cape, where I saw myself grow remarkably both academically and personally. As I progressed, I discovered that I had the love for sharing knowledge. With GSH being an academic hospital, I had the opportunity to teach and train student Cardiac Technologists, which turned out to be very productive.

As I grew in the field, I developed an interest in Pacing and Electrophysiology (EP) because I had always found it interesting to observe – even though I hadn't had the slightest idea of what was happening - the 3D mapping of the heart on the CARTO Mapping System. The 2 EP-specialised Technologists, Human Nieuwenhuis and Marclyn Govender, together with Prof Ashley Chin (Electrophysiologist at GSH), played a huge role in my growth in EP and Pacing. I later identified a gap in knowledge in this field amongst other Technologists, which prompted me to start a WhatsApp Group through which I share Zoom-recorded videos of myself presenting educational content on this subject. I found that through teaching, I get to advance in knowledge and retain information better, while someone else also benefits from the knowledge – it's a win-win.

When a new Cath Lab was established at NMAH, I identified an opportunity to become a part of a team that will render cardiac services that have never been rendered there before. I had already been equipped with the necessary skills, and I felt that I was ready to apply them on home ground. That was when I decided to leave Cape Town for Mthatha to begin my new journey.

Thabo Gregory Ngaka, Cardiac Technologist

CATH LAB (MTHATHA)

Since the opening of the Lab in June 2019, we managed to do a total of 132 cases, most of which were referrals from East London (EL) and Port Elizabeth (PE). This includes both adult and paediatric patients. Before I came to Mthatha, I had never had the opportunity to be a part of a paediatric case, be it an intervention or diagnostic study. The first 2 weeks were a little troubling for me because everything I knew regarding paediatrics was theoretical. However, after the first 2 weeks, I was more confident with the cases as I better understood the study protocols and the pathologies. I always say that one truly knows something when both theory and practical are married. The team managed to do 43 paediatric cases, with just over a quarter of them being PDA closures. These interventions were mind-blowing for me, especially with a diligent Paediatric Cardiologist like Dr Zongezile Makrexeni. I have learnt a lot from him. The rest of the patients were adults. The acute coronary syndromes (ACS) were mostly referrals from EL and PE, while cardiomyopathies and valvular heart disease patients came from local regions. We managed to do close to 30 coronary interventions with Dr Khulile Moeketsi, whose calm demeanour and openness to opinion during cases ticks some boxes in the team. The rest of the cases were diagnostics, Pericardiocentesis (for the IMPI Trial) and prosthetic valve screening.

Back row (left to right): Sr T.T. Mazingela, Dr T.O. Fathuse, Sr. S. Mntonintshi and Mr T.G. Ngaka.
Front row: (left to right): Sr N. Mananga, Dr K.M. Moeketsi, Sr N. Masiza and Mr C. Siyongwana

Left to right: Sr N. Masiza, Dr Z.M. Makrexeni, Sr T.T. Mazingela and Dr L. Ralarala.

First permanent pacemaker implant at NMAH.

ECHOCARDIOGRAPHY

I had already anticipated that I would be doing many Echocardiograms because of the very prevalent rheumatic heart disease (RHD) in the Eastern Cape. About 240 transthoracic echocardiograms were performed from June 2019, majority of which were from the Cardiac Clinic and those that were being worked up for referral to Inkosi Albert Luthuli Hospital (IALH) in Durban, KwaZulu-Natal (KZN), for Cardiac surgery. The clinic is primarily referred to as the Super-Specialist Clinic as it is shared amongst Cardiology, Rheumatology, Endocrine and Gastro-Intestinal clinics.

PACING

One of the concerns I had was whether I'd get a chance to do some pacing work since this is my favourite area of Cardiology. Fortunately, there were some cases that required permanent pacing. So far, we have implanted 11 VVI pacemakers, 1 primary ICD, and 1 ICD generator replacement. Because of budget constraints, we prioritise primary device implants. However, we had to do the ICD generator replacement as it had already reached its recommended replacement time.

TEACHING AND THE FUTURE

Cardiology is a new department at NMAH, which means that there are a lot of new concepts and protocols that need to be taught to nursing staff and doctors. I have personally done some training lessons with nurses in the wards and the ICU. Our Cardiologists, Nurses and Radiographers are also playing their part in training and education. There have been requests to assist registrars and medical officers with ECGs and Echocardiography, which I assist with where I can. I do this through a WhatsApp group as well. However, with Echocardiography, I usually encourage identifying patients in the wards and then having a bed-side scan and discussion. I find that this is the most effective way because the more you do something, the better you become.

I am looking forward to many more lessons because I also get to learn a lot from the doctors clinically. For as long as we maintain that relationship, this will be a very productive journey.

My long-term goal, however, is to be more specialised in Pacing and Electrophysiology. I want to become a Certified Electrophysiology Specialist (CEPS) and a Certified Cardiac Device Specialist (CCDS). I want to be able to continue sharing my EP and Pacing expertise with fellow Technologists. Until then, I shall continue doing what I do as best as I can, with the hope that the Universe will smile upon me.

SA HEART® EMERGING LEADERS PROGRAMME – BUILDING A PIPELINE

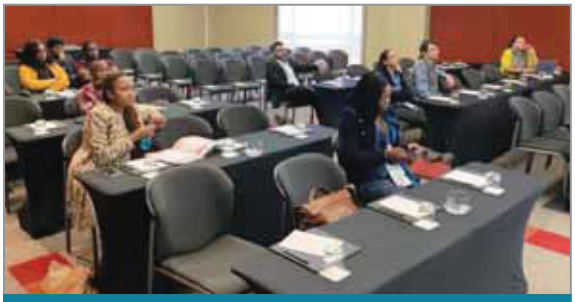
In 2018, SA Heart® together with Discovery launched the SA Heart® Emerging Leaders Award. This award was aimed at clinicians - in the field of cardiology (adult or paediatric) or cardiovascular practice - under the age of 40 or within 3 years of qualifying. The aim was to identify leaders in their field, based on previous achievements, current projects and their vision for cardiovascular care in South Africa.

The 8 finalists elected were:

- Dr Khulile Moeketsi
- Dr Blanche Cupido
- Dr Alfonso Pecoraro
- Dr Ruchika Meel
- Dr Tim Pennel
- Dr Mamaila Lebea
- Dr Annari Van Rensburg
- Dr Don Zachariah

The award was presented to Dr Khulile Moeketsi at the SA Heart® Congress in Sun City in 2018. This entailed not only a monetary stipend but also opportunities in leadership training as well as mentorship by leadership of SA Heart®.

At the SA Heart® Congress in 2019, there was an opportunity for these emerging leaders to showcase the work they were involved in as well as their future visions. Regrettably this session (The CVD Imbizo) followed on immediately after our amazing World Cup win over England and attendance at the session was therefore dismal.



Poor attendance at the session.

Dr Tim Pennel and Dr Alfonso Pecoraro.

This however did not detract from the amazing work presented at that forum. Though admittedly on a high from the rugby win, I left the session even more elated at the prospect of our organisation and our profession being home to such amazing talent and drive.

The session was chaired by Dr Khulile Moeketsi and Dr Mamaila Lebea. Dr Moeketsi presented by the vision for his newly established cardiology unit in Umtata and a fruitful discussion delineating the problems and some suggestions for solutions ensued.

Dr Tim Pennel and I spoke of the scourge of heart failure in South Africa, the poor outcomes and the fact that simple measures to streamline referral practices and clear pathways can open up earlier life-saving therapies for South Africans. A long discussion on how to expand transplantation and allow access for other provinces took up quite a lot of time, and though immediate solutions to such a complex problem is not imminent, hearing the diverse opinions was enlightening to help form future solutions.

Alfonso Pecoraro showcase the basic cardiac ultrasound training programme for community nurses that has proven successful in their secondary level facilities, and we all learnt many tips on how such a programme can be duplicated in our own settings.

Dr Ruchika Meel spoke of the need of an integrated well-rounded imaging training programme for Cardiologists as a potential non-interventional cardiology track. Her power and passion on this topic was striking and very uplifting and

very much needed in an area of Cardiology that has thus far been relatively neglected in the mainstream.

The session ended with Don Zachariah providing an overview of how public and private partnerships have uplifted and promoted community cardiology care and provided a model that one certainly hopes can be duplicated across our country.

As the incoming president elect of SA Heart®, I was particularly encouraged. This is who we are – innovative, driven and eager to overcome adversity. It really makes my heart glad to see the passion of our clinicians for our people and I look forward to building with all of you in future….

Blanche Cupido

Proudly South African.

TRIBUTE

PASSING OF PROF LUNGILE PEPETA ON 7 AUGUST 2020

With great sadness we mourn the loss of our colleague and friend, Professor Lungile Pepeta – Paediatric Cardiologist, former Vice-President of SA Heart® and Dean of Nelson Mandela Faculty of Health Sciences.

A gentle giant, a dedicated and paediatrician, and a wonderful family man. He loved his profession and his country. He will be sorely missed in our community.

We promise to take up the baton you have left behind for us to pick up, in your passionate quest to uplift and improve the health of our commmunities, with the resolve to never fail you.

Lala ngoxolo tata Pepeta. Sithi ngxe kusapho nakwiisizwe siphela.

PASSING OF PROF SOLLY LEVIN ON 9 AUGUST 2020

It is with great sadness that we learn that Prof Solly Levin has passed away on Sunday afternoon. We wish his immediate and extended family comfort and peace during this time of mourning. A giant of a man who loved teaching and whose knowledge knew no bounds. All paediatric cardiologists in South Africa and beyond our borders are indebted to him for his contribution to the subspeciality.

Prof Solly Levin, Paediatric cardiologist and honorary SA Heart® member died after a short illness and following the death of his wife just days ago. He will be deeply mourned.

On behalf of PCSSA, all his colleagues and SA Heart®.

AN UPDATE ON LIPIDOLOGY FROM THE LASSA COMMITTEE

The Lipid and Atherosclerosis Society of Southern Africa (LASSA) is interested in all matters related to lipid and lipoprotein metabolism, including the common problems of dyslipidaemia relating to atherosclerosis and now known to be eminently preventable by lifestyle and in many instances, medication. Hypertriglyceridemia linked to atherosclerosis and pancreatitis is also common. The lipidologist, though able to deal with the whole spectrum of problems, focuses on the most severe of the common problems and deals with several other metabolic disorders. LASSA aims to provide the expertise in service, teaching and research in Lipidology despite its small membership and limited resources.

The past few decades in South Africa saw an emphasis on infectious disease: tuberculosis (TB) and human immunodeficiency virus (HIV) infections. Control of the HIV infection by medication improved the prognosis but now leaves people at high risk for cardiovascular disease. The recent acute infectious epidemic of COVID-19 affected older people and those with diabetes and underlying heart disease very severely as well.

This newsletter comes as the COVID-19 epidemic in South Africa is hopefully receding. What are the 2 most important issues for LASSA to consider when we return to normality after the epidemic? Firstly, to provide expertise in the relatively new discipline of Lipidology not only to serve those with people and patients at risk but also to teach and perform research. Secondly, to educate the medical profession and public about familial hypercholesterolemia (FH) not only because this is a particular problem in South Africa, but also because there is an international move to ensure that this common disorder is recognised and dealt with.

THE PROMOTION OF LIPIDOLOGY

Cardiovascular disease resulting from atherosclerosis manifests in heart attacks, angina, heart failure, strokes, impaired circulation to the legs and gangrene. Such diseases are common causes of suffering and premature death in developed countries and were predicted to exceed infectious disease in developing countries by 2020.[1]

Over the past 2 - 3 decades moderate dyslipidaemias, encompassing blood cholesterol concentrations between 5 and 7mmol/L, triglycerides between 1.7 and 5mmol/L, higher-than-ideal LDL cholesterol and lower-than-ideal HDL cholesterol, have been researched intensely. These are the typical setting in which most people with atherosclerosis are found. Especially the statins have proved safe and effective treatment. The South African Guidelines for dyslipidaemia,[2] brought out jointly by LASSA and the South African Heart Association (SAHA), guide the medical practitioner to assess the risk of patients by a calculation according to which lifestyle and medication are prescribed similar to overseas guidelines. This caters for the majority of cases of dyslipidaemia but the calculation is invalid in severe dyslipidaemias. There is, unfortunately, limited expertise for more severe dyslipidaemias and management is often not optimised for these patients.

Such severe or uncommon problems should be evaluated by lipidologist or at least by specialists with more training or experience. Owing to the withdrawal of support for special clinics and dedicated laboratories at teaching hospitals, there is concern about the training in Lipidology received by specialists in internal medicine, paediatrics, cardiology and endocrinology. Lipidology courses were planned to alleviate this problem. Prof Dirk Blom (Western Cape) and Prof Derick Raal (Gauteng) made important contributions to international studies in the treatment of FH. They participated in the LASSA Lipidology courses. In 2018 a 3-day teaching course was arranged in Cape Town, chiefly for members of the Netherlands Lipid Association. In 2019 another course was held in Cape Town for senior registrars and other medical practitioners. The steps taken to combat the COVID-19 epidemic in South Africa resulted in the cancellation of 2 intended courses on Lipidology for 2020. LASSA will endeavour to resume these as soon as the epidemic recedes.

The need to develop Lipidology was emphasised in the document submitted by LASSA to the Department of Health at the end of last year when input was requested concerning non-communicable diseases. Only the teaching hospital clinics in Cape Town and Johannesburg offer expert consultations to the public and private sector. The research laboratory in Cape Town is currently the only means of doing more specialised testing in Lipidology. All of these

services can be approached for assistance. The most expedient way of providing consultation and diagnosis for severe disorders such as FH might be to create dedicated facilities within a National Health Insurance scheme so that the public and private sector patients can receive best care. Relevant teaching and training can flow from this until the training of specialists improves.

2020 IS FOR RENEWED INTEREST IN FH WORLD-WIDE

FH is not rare. Somehow, despite recent advances in its diagnosis and big advances in its treatment, FH has not received due attention world-wide. South Africa is renowned for founder effects of FH. Prof David Marais and Prof Derick Raal are involved in the networks created within the European Atherosclerosis Society FH Study Collaboration. The FH Foundation is a lay organisation dedicated to the cause of FH in the USA. Their "call to action" was published in January 2020.[3] Prof David Marais participated in the awareness programme about FH by the FH Foundation.

So, firstly, what is FH and when and in whom should this diagnosis be suspected? (2) Is there effective treatment? (3) What do we know about FH in South Africa? (4) How can we improve care for FH in South Africa?

FH is an inherited condition in which the removal by the liver of LDL, the particle that carries most of the blood cholesterol, is impaired as a result of a fault in the LDL receptor (LDLR) activity from errors in the gene. Consequently, the LDL concentration is elevated in every affected person from birth. The same problem can arise when apoB100, the protein on LDL that should bind to the LDLR, does not work. Rarely, there is a problem of excessive degradation of the LDLR by an overactive protein called PCSK9. Each of these problems may affect one of the two genes a person has for these proteins, in which case the condition is said to be heterozygous FH (heFH). The characteristics of heFH are that the LDL cholesterol is >5mmol/L (corresponding to a total of >7.0mmol/L), the Achilles tendons often become thick in young adults, and heart attacks occur in most affected people before the age of 55 years. Occasionally 2 parents with heFH pass only their defective genes to their children. Such a child has the doubly severe problem of homozygous FH (hoFH). In hoFH the cholesterol levels are at least double those of heFH and cholesterol can deposit in the Achilles tendons as well as in the skin of children. Heart disease often happens during the teenage years. The diagnosis of heFH and hoFH can be made fairly simply and might be confirmed by genetic testing. Such testing is available at the research laboratory in Cape Town but should be requested through the medical practitioner who look after patients with severe dyslipidaemia so that the most appropriate tests can be done. A few underlying other disorders affecting the kidney and thyroid should be considered. Very rare other disorders may need to be considered in some unusual cases.

> "LASSA aims to provide the expertise in service, teaching and research in Lipidology."

The first effective treatment for FH arrived in the 1980s: the statins. A recent publication demonstrated the difference in health in heFH children who commenced treatment around 1990 and have now reached adulthood. They reached the age without the severe heart disease that their parents had so prematurely.[4] Although the statins are safe and only rarely cause severe adverse effects, they are often not powerful enough to achieve the levels of LDL with the least risk in FH. The addition of a drug that arrived in the year

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AN UPDATE ON LIPIDOLOGY continued

2000, namely ezetimibe, provides very good additional lowering. But a few persons with heFH may still need additional treatment. This is expected to arrive soon in South Africa: monoclonal antibodies to PCSK9. These neutralise PCSK9 and thus sustain the LDLR. HoFH responds less well and still poses a challenge to treatment. Nevertheless, modern medication has also made a big impact on health in this serious condition.

FH occurs in all populations around the world. South Africa is renowned for the high prevalence of FH in several immigrant communities. The high prevalence, possibly 1 in 75 families, was noted in Afrikaners in the 1970s. Subsequently a prevalence of 1 in 100 was noted in Jewish and Indian communities. FH was found in several other population groups in South Africa but the precise prevalence is unknown. Errors in all 3 causal genes have been documented and were published last year[5] along with an editorial indicating the problems of treating FH.[6] There is already experience with the newest agents in South Africa[7] but the approval of these PCSK9 neutralisers has been slow.

Recognition of FH is vital because early and proper control of the LDL concentration and other risk factors can ensure good health that was rare in previous generations with FH. There are about 250 000 persons with FH in South Africa. The Heart and Stroke Foundation of South Africa is thus an appropriate organisation to promote public awareness of this condition as well as its successful treatment. The FH Foundation in the USA has not only educated the public but also attracted the support for early diagnosis and treatment in medical insurance companies.

The year 2020 saw drastic measures being taken to limit the expected premature deaths from COVID-19. Hopefully, later this year and certainly in 2021, LASSA will ensure that FH is identified and treated so that about 200 000 premature deaths can be delayed. South Africa, with its founder effects and large backlog in identifying FH ought to join the "global call to action" for FH. LASSA looks forward to joining forces with SAHA, the Department of Health, Medical Schemes, the Heart and Stroke Foundation, and the public in the interest of FH.

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Prof David Marais, University of Cape Town)

Prof Derick Raal, University of Witwatersrand, Gauteng Provincial Government

Prof Dirk Blom, University of Cape Town, Provincial Government of Western Cape

Dr Dee Blackhurst, University of Cape Town

THE SOUTH AFRICAN HEART ASSOCIATION RESEARCH SCHOLARSHIP

This scholarship is available to full and associate members of the SA Heart® Association living in South Africa. It is primarily intended to assist colleagues involved in much-needed research to enhance their research programmes.

REQUIREMENTS

- Applicants need to be fully paid up members/associate members in good standing for at least one year.
- Applications must include:
  - The applicant's abbreviated CV
  - A breakdown of the anticipated expenses
  - Ethics approval
  - Full details of the research
  - The completed application form - please request a fillable MS Word document from erika@saheart.org
  - Contact details of Head of Department or supervisor/mentor

RECOMMENDATIONS

- Preference will be given to early and mid-career applicants (<5 years post-qualification as specialist and/or <5 years post-PhD qualification).

CONDITIONS

- Applicants may only submit 1 application every second year. Preference is given to those who have not had previous scholarships awarded.
- Awards are granted for one specific research project. Should that specific project be cancelled or the full amount allocated not be utilised for any reason, then the funds must revert to SA Heart®.

APPLICATIONS MUST BE EMAILED TO:

erika@saheart.org

THE SELECTION PANEL WILL REVIEW APPLICATIONS ANNUALLY AND THE CLOSING DATE IS 30 SEPTEMBER 2020.

One scholarship to a maximum amount of R65 000 will be awarded annually.

SA Heart® commits to inclusive excellence by advancing equity and diversity.

We particularly encourage applications from members of historically under represented racial/ethnic groups, women and individuals with disabilities.

SASCI, SASCI PPC, ISCAP AND STEMI SA NEWS

After a good and optimistic start to the year for most of us the world, as we know it, came to a grinding halt with the COVID-19 pandemic. Academic meetings were cancelled, people were prevented from going to work and patients were prevented from coming to hospital. I expected to have very little feedback to give but, in true South African fashion, people found new and innovative ways to continue providing services, and it is with more than a little pride in my colleagues that I present this report.

Educational initiatives continue to be a cornerstone activity for the Society.

Calendars are filled with webinars that have become the new normal for education events and meetings, and the unintended consequence of "webinar fatigue" is difficult to avoid. SASCI is, however, focused on providing continuous education to the cardiology community though interesting and worthwhile topics. This format allows for extended reach of audiences and expert faculty internationally.

The highlights of our educational initiatives since the last SA Heart® Newsletter is:

SASCI INTERNATIONAL WEBINAR: COVID-19 AND THE HEART

SASCI hosted, together with the Stellenbosch University (Tygerberg Hospital), an International Webinar on COVID-19 and the Heart, on 30 April 2020 via Zoom. Close to 300 attendees from 23 African countries (including RSA, Ghana, Morocco, Namibia, Mauritius, Zimbabwe, Kenya, Algeria, Tanzania, Zambia, Congo, Cameroon, Ethiopia, Gabon, Uganda, Cameroon, Egypt, Benin, Angola, Niger, Cabo Verde, Sudan, Botswana), as well as Singapore, Russia, Ireland, Romania, Belgium and the USA participated in this event. This truly reflects the tremendous reach virtual events allow us in delegate attendance and faculty.

A local perspective on the Epidemiology and Projected Course of Disease were provided by Prof René English and Prof Heike Geduld (Stellenbosch University). International faculty included Dr Eric Eeckhout (Switzerland), Prof Gregory Barsness (USA), Dr Paul Ong (Singapore) and Prof Chris White (USA), who provided their insight into how COVID-19 affected interventional cardiology practice around the world. Dr Karim Hassan presented on "COVID-19 and Myocarditis" with Dr Hellmuth Weich elaborated on "Heart drugs for the COVID Patients and COVID drugs for Heart Patients".

We are incredibly pleased with the attendance and positive impact of this webinar and look forward to continuing Educational Initiatives via Webinars during the lockdown period.

SASCI AND ISCAP ETHICS WEBINAR

On 11 June 2020, SASCI hosted an Ethics webinar on the controversial and thought-provoking topic of resuscitation of COVID-19 patients, and the risk to the healthcare practitioner, where Prof Henry Lerm, Chairperson-Legal of the South African Medico Legal Association, addressed the SASCI and ISCAP audience. Prof Lerm highlighted the fact that, even though we do not have all the answers now, South African Healthcare Practitioner's need to develop an advanced care/risk plan for dealing with pandemics in future.

Thank you to Dr Sajidah Khan for moderating this webinar and to Vertice Medtech for their unconditional educational grant and support. This webinar had a tremendous turnout of 350 delegates.

SASCI, CASSA AND PAEDIATRIC SOCIETY WEBINAR

The SASCI collaborative Webinar with the Cardiac Arrhythmia Society of Southern Africa and the Paediatric Society of South Africa was held on 22 July. We had the privilege to host Dr Kim Rajappan, a consultant cardiologist and electrophysiologist at the John Radcliff Hospital in Exford, England, who spoke on approaching the COVID-19 peak and what to expect in your arrhythmia patients. Prof Lindy Mitchell, a paediatric cardiologist at Steve Biko Academic Hospital and secretary of the Paediatric Society of South Africa, spoke on the tragic impact and effects of COVID-19 due to the delayed treatment of children with congenital heart disease.

Thank you to Prof Ashley Chin, President of CASSA, for moderating on the call and for Vertice Medtech for their continued support. This meeting was well attended by over 230 delegates.

SASCI - SOLUTION FOR CALCIUM – WEBINAR

SASCI Vertice Webinar on Solutions for Calcium was held on 28 July. During this webinar we were privileged to hear from international and local cardiologists on their experiences, and varied approaches to dealing with calcified arteries. Prof Anthony Gershlick, a cardiologist at Leicester's Hospitals UK, who was a visiting expert to South Africa in 2019, presented alongside Dr Pieter Van Wyk and Dr Farouk Mamdoo, with Dr Dave Kettles as moderator.

We had a great turnout of 240 delegates. Thank you to Vertice Medtech for sponsoring these webinars.

If you have missed any of these webinars, please visit the SASCI Website to listen to the recordings available (allow about a 10-day delay).

SASCI COLLABORATIVE WEBINARS

Renal Denervation Webinar

A SASCI collaborative Webinar, with Medtronic and PASCAR, on Renal Denervation. The international faculty included Dr Justin Davies (Cardiologist at the Imperial College London, UK) and Dr Jose Antonio Donaire (Nephrologist at the European University of Madrid, Spain). Dr Mohamed Kurdi (Interventional Cardiologist & President of the Saudi Cardiac Interventional Society in KSA), was the moderator for the webinar with Dr Iftikhar Ebrahim (Cardiologist at Netcare Unitas Hospital, Pretoria, South Africa) representing South Africa as part of the panel.

This two-part webinar took place on 28 and 29 May 2020, with great attendance from across Africa, Europe, UK, Middle East, and Asia.

Pan-African Association of Structural and Coronary Intervention Webinar

Pan-African Association of Structural and Coronary Intervention (PASCI), an affiliated group of PASCAR, hosted a Webinar on "How I moved my practice to complex intervention", with Prof Farrel Hellig (South Africa) as key faculty, and Dr Mohamed Jeilan (Kenya) and Dave Kettles (South Africa) as moderators. The panel included Drs Emmy Okello (Uganda), Awad Mohamed (Sudan), Habib Gamra (Tunisia) and Ahmed El Guindy (Egypt). Following an insightful lecture from Prof Hellig, questions from the delegates led to excellent discussions.

This Pan-African Webinar hosted more than 110 delegates from 20 African countries, as well as from as far afield as Europe, UK, and the USA. This webinar was made possible by unconditional support from Boston Scientific and Medtronic.

> "People found new and innovative ways to continue providing services."

SASCI Annual Fellows Workshop 2020

With the current COVID-19 pandemic and government regulations, the Fellows Workshop Organising Committee had to move this longstanding educational initiative to later in 2020 (14 and 15 November), and we plan for a hybrid meeting offering both face-to-face attendance, as well as joining remotely from different centres in South Africa (and even other African countries) through a webinar offering. A benefit is that virtual presentations will also expand our faculty reach to include international and other African countries. The academic content will be developed by the SASCI Executive under Convenorship of Drs Jean Vorster, Graham Cassel and Hellmuth Weich, in collaboration with the Society for Cardiovascular Angiography and Interventions (SCAI is the SASCI equivalent in the USA).

SASCI is also planning a monthly Fellows Webinar Series, culminating in the Annual Fellows Workshop, to ensure continuous education and engagement with our Fellows during this pandemic. More details will be shared in due course.

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SASCI, SASCI PPC, ISCAP AND STEMI SA NEWS continued

ISCAP (INTERVENTIONAL SOCIETY OF CATH LAB ALLIED PROFESSIONALS) UPDATE

ISCAP Unit Leaders Virtual Meeting

On 30 May, ISCAP hosted a Cath Lab Unit Managers and Leadership Meeting, with cath labs from across South Africa represented by more than 30 Unit Managers and ISCAP Exco Members. This meeting was focused on the challenges each lab faces during the COVID-19 Pandemic, of which PPE, redeployment of staff, slates, ethics protocol and emotional well-being and support staff were mentioned and discussed. ISCAP hopes to build on these relations in future, to ensure the support of Unit Managers and the Cath Lab teams.

ISCAP Catheterisation Electronic Manual

Thank you to all the Cath Labs that have embraced the online ISCAP Manual and continue to complete the online CPD Questionnaires. Each of these delegates receives a CPD Certificate for passing the questionnaire (70% Pass rate). Allieds who completed all 4 CPD Questionnaires receive 12 CPD points (3 CEU's per module and questionnaire completed).

Please do keep an eye out for communication on our UPCOMING ISCAP Webinars with Riverdene (August / September) and Medtronic later in 2020.

SASCI PPC, LEGAL AND REGULATORY UPDATE

A number of health-related issues, that SASCI felt was relevant to our members, were due to be presented to parliament or Government Departments. Therefore, with input from legal experts, we drew up and submitted formal comments for consideration:

NHI Bill

The objective of the NHI Bill is to provide universal access to quality health care for all South Africans, as enshrined in the Constitution. The Bill is currently before Parliament. However, the COVID-19 pandemic has had an impact on the expected timelines set out for the parliamentary processes on the Bill. Parliament took a decision (sometime in April) to suspend the programme of the National Assembly and the National Council of Provinces in the interests of social distancing. Though the national legislature seems to have found a continuity plan, there are expected delays in the enactment of this Bill. However, it cannot go without saying that South Africa's health system has been in the spotlight, but the focus has intensified and will continue to do so as the country fights the COVID-19 pandemic.

SASCI submitted comments on the NHI Bill and continues to monitor the legislative environment for further developments.

Draft Public Procurement Bill

It seems that, the Draft Public Procurement Bill of 19 February 2020 (Bill) is National Treasury's response to the obligations set in section 217 of the Constitution by regulating public procurement.

By the nature of the activities of SASCI members, in particular, many procedures are technical in nature and require the utilisation of a large variety of technical equipment and devices, including various components of equipment for vascular interventions, structural heart interventions, various pacemaker components, etc. These usually have highly technical specifications and SASCI was anxious that procurement of these items is made under the guidance of experts in the field, hence the commentary submitted by SASCI to the National Treasury on 30 June 2020.

This Bill is meant to consolidate all public procurement legislation and to streamline the legal framework in which the government can procure goods, services, and infrastructure. Furthermore, the Bill purports to address seemingly contradictory legislation and to address the justiciability of various instruments published by the National Treasury. As it appears, the Bill sets out to provide practical guidelines for the implementation of procurement rules.

National Multi-sectoral Strategic Plan for the prevention and control Non-communicable Diseases, 2021 - 2026

Non-Communicable Diseases (NCDs), pose one of the biggest threats to health and development globally, particularly in low- and middle-income countries. The National Strategic Plan seeks to direct the actions that will be undertaken between 2020 and 2025 across sectors to redress and to reverse the growing threat posed by NCDs. The overarching objective of this Plan is to prepare the country for reaching the Sustainable Development

Goals related to NCDs (to reduce, by one-third, premature mortality from non- communicable diseases (NCDs) through prevention and treatment, and promote mental health and well-being by 2030 (Goal 3.4).

SASCI is of the view that there are flaws in the National Multi-Sectoral Strategic Plan for the Prevention and Control of Non-Communicable Diseases 2021-2026, which need to be addressed. Consequently, SASCI has submitted comments to the National Department of Health on 31 July 2020.

We thank Ebbie Iheanyi (lawyer at EKA) for her diligent and professional legal services, as well as Dr Tom Mabin who continues to contribute substantially from the practitioner perspective.

SASCI INTERACTION WITH FUNDERS

Discovery Health CAD Programme for 2020

Discovery Health Coronary Artery Disease (CAD) Care Governance Initiative negotiations are underway with SASCI. There is a review of a draft proposal underway that is aimed at regulating the possible relationship between the individual practices which opt to participate in the programme and Discovery Health. There have been lessons learnt from the previous CAD agreements with Discovery Health, which necessitated a review of the contract. There have, furthermore, been learnings from the Discovery Health forensic audits on individual practices which had to be factored into the contract. SASCI will continue to work towards ensuring that our members interest is professionally represented to the ultimate benefit of your patients.

Medihelp TAVI case

SASCI's complaint to the Council for Medical Schemes (CMS), in terms of section 47 of the Medical Schemes Act, was ruled in SASCI's favour against Medihelp. Medihelp appealed the decision of the Registrar of the CMS and SASCI is seeking a set-down date at the Appeals Committee to have the matter heard. SASCI is cognisant of the delays which have plagued the CMS of late, and which have been exacerbated by the COVID-19 pandemic. Notwithstanding, SASCI will continue to engage with the CMS to bring finality to the matter.

Medihelp vascular codes

SASCI was extremely concerned about the non-funding of vascular codes by Medihelp, which are part of the scope of the profession of cardiology, and which activities cardiologists can, under Rule 21 of the HPCSA ethical rules, perform. The blanket ban imposed on payment for these valid and legislated procedures was unique to Medihelp and SASCI viewed this stance as unjustified and unacceptable. SASCI continued to engage Medihelp to resolve such matters and it appears that, after 2-year impasse, this seems to have been resolved. Members are requested to revert to the SASCI office if theses codes are rejected.

Whether a specialist physician can perform interventions in the field of cardiology

Medscheme was disputing payment of certain claims relating to interventional cardiology procedures on the basis that the healthcare professional was not registered as a Cardiology sub-specialist, but rather as a general Physician (018). Cardiology seems to only have been recognised as a sub-specialty by the HPCSA in the mid-1980s and, up to that time, all that was required to practise cardiology was 2 years cardiology training in a recognised training facility after registering as a physician. Such a generation of practitioners were recognised as cardiologists but were not registered as such by the HPCSA. SASCI's view was that, should the General Physician be trained and experienced in rendering the specific services, it would be irrational and unreasonable to prevent the healthcare professional from undertaking such services, in particular where patients require access to such life-saving interventions. Medscheme was informed therefore that they cannot prohibit a professional service from being performed however may question the professional codes being used and the fees which the professional charges.

All SASCI submissions can be accessed at http://www.sasci.co.za/content/page/sasci-guidelines

SASCI CODING PROJECTS OVERVIEW

There are two major coding projects being conducted in cardiology under the auspices of SASCI PPC, with Karen van der Westhuizen (coding expert) and Dr Tom Mabin (practitioner expert) as project leads:

- The Cardiology Coding Handbook (update 2020)
- The Cardiology MDCM (Medical Doctor's Coding Manual) Coding update with CCSA2018 crosswalk

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SASCI, SASCI PPC, ISCAP AND STEMI SA NEWS continued

THE CARDIOLOGY CODING HANDBOOK

The SASCI Coding Handbook was created in 2014 by Dr JP Theron, et al. The purpose of the handbook is to create uniformity in coding standard procedures. This also creates a platform for communication where available codes are not sufficient.

The SASCI Coding Handbook was extensively reviewed in the that past 6 months with assistance from various private sector practitioners and coding experts. New coding scenarios were added to the handbook and the master draft document has been sent for final review. We expect to issue the updated version to be available before the end of 2020.

The review of the document entails, but is not be limited to, the following:

- The handbook layout to be more user-friendly
- The coded scenarios should reflect current coding practice
- Possible clinical procedure shortfalls should be identified and address by consensus opinion

It is important to remember that the Coding Handbook is a living document. Scenarios and guidelines will be added as the need arises. Feedback from practitioners on the document is required to ensure clinical completeness and validity.

Once the Executive Committee has signed-off, and the legal opinion updated, the SASCI Coding Handbook 2020 will be ready for distribution.

THE CARDIOLOGY MDCM CODING UPDATE

A completed MDCM (Medical Doctor's Coding Manual) review was sanctioned by SASCI in February 2019. CCSA 2018 is used as the benchmark for the Cardiology MDCM update. CCSA is the industry accepted benchmark to use when a MDCM code update is requested. The MDCM updates are approved and published by SAMA (South African Medical Association) after submission and extensive consultation. This will be the first MDCM update in cardiology since 2006 and is crucial to substantially move cardiology coding forward.

The Cardiovascular System has now been cross walked to CCSA2018, except for the Open-Heart Surgery and Peripheral vascular system. SASCI is awaiting confirmation from the Paediatric cardiologists to update their section. New MDCM codes are proposed, based on CCSA2018 for procedures, as well as on new technology, while some MDCM descriptions will change based on CCSA2018, some will be deleted, and some will remain the same.

> "The SASCI Coding Handbook was extensively reviewed in the that past 6 months."

Meetings were held with Discovery and Medscheme to allocate resources for modelling and cost-analysis of the codes. Both meetings were very productive, and the funders expressed their gratitude for including them in the update process. Active engagement with the funders will continue through out 2020.

SAMA staff resources are unfortunately limited as the SAMA principal has been on sick leave since the beginning of the lockdown. SAMA indicated that normalisation is expected by August, which will lead to scheduling of the next SAMA review meeting.

The crosswalk is currently being analysed using the CCI-edits in combination with MDCM (CCI is the Correct Coding Initiative published in America to prevent unbundling or over coding). This CCI analysis will be utilised by the

funders to calculate the costing of the new crosswalk. This will indicate if the crosswalk is cost-neural to both funders and practitioners, or if the cost implication could be detrimental to either.

Please do engage with Karen van der Westhuizen (via the SASCI office if needed).

All of the above represents a significant investment of time and effort from many people (including admin staff, academic input, sponsors and legal experts) and I would like to end by thanking every individual involved. Without you the Society cannot exist.

Best wishes.

Hellmuth Weich
President SASCI

STEMI SA UPDATE JULY 2020

The aim of STEMI SA is to educate, improve networks and facilitate early reperfusion therapy of patients with ST elevation myocardial infarction in South Africa. This initiative is a national programme, under SASCI, with clear goals and timelines.

We have a well-balanced group from both the public and private sectors, who are young and more experienced, as well as incorporating those individuals who have been instrumental in setting up STEMI SA. We would like to thank Dr Adriaan Snyders for his leadership and we are grateful that we will have his continued support, as he has taken on the role of Sent Save A Life (SSL) liaison for our community.

It is now time for us to put words into action and establish a well-coordinated National Database, which is well-validated and that can be used for further research and collaboration, with the ultimate aim of improving the care of patients with STEMI. The plan is to implement a National STEMI Registry towards the end of 2020.

We intend to improve the Systems-of-Care through 2 main arms - namely research and education. The research should ultimately lead to publication, inform our educational initiatives, and improve systems of care.

RESEARCH

- The STEMI Datasheet has been finalised.
- It was decided that the STEMI India Database platform will be best suited to South Africa, it is a pre-existing online platform, minimal costs need to be incurred and we align with the vastly experience of Dr Thomas Alexander.
- A Publications Policy Task Team was formed to establish protocols, ethics, consent form and a publication policy.

PUBLICATIONS IN PRESS

- Interventional cardiology in the COVID-19 pandemic.
- Decline in acute coronary syndrome hospitalisation rates during COVID-19 lockdown in private hospitals in South Africa.
- Stent Save a Life! International survey on the practice of primary angioplasty during the COVID-19 pandemic.

EDUCATION

- We plan to update the online SASCI website with user-friendly slides on the investigation and management of STEMI.
- Regional education workshops will be planned post-COVD, with virtual education being made available as and when appropriate during the pandemic.

We would welcome involvement from healthcare providers and industry.
If anyone would like to participate, kindly liaise with George Nel at the SASCI office (george@medsoc.co.za).

We look forward to building the STEMI SA Network with you.

Ahmed Vachiat
STEMI SA Chair

LOUIS VOGELPOEL TRAVELLING SCHOLARSHIP

Applications are invited for the annual Louis Vogelpoel Travelling Scholarship for 2020. An amount of up to R20 000 towards the travel and accommodation costs of a local or international congress will be offered annually by the Western Cape branch of the South African Heart Association in memory of one of South Africa's outstanding cardiologists, Dr Louis Vogelpoel.

Louis Vogelpoel was a pioneer of cardiology in South Africa who died in April 2005. He was one of the founding members of the Cardiac Clinic at Groote Schuur Hospital and the University of Cape Town. He had an exceptional career of more than 5 decades as a distinguished general physician, cardiologist and horticultural scientist. Dr Vogelpoel's commitment to patient-care, teaching and personal education is remembered by his many students, colleagues and patients. Medical students, house officers, registrars and consultants benefited from exposure to his unique blend of clinical expertise, extensive knowledge, enthusiasm and gracious style.

A gifted and enthusiastic teacher, he was instrumental in the training of generations of undergraduates by regular bedside tutorials. He served as an outstanding role model for postgraduates and many who have achieved prominence nationally and internationally acknowledged his contribution to the development of their careers.

All applications for the scholarship will be reviewed by the executive committee of the Western Cape branch of the South African Heart Association. Preference will be given to practitioners or researchers in the field of cardiovascular medicine who are members of the South African Heart Association and are resident in the Western Cape.

Applications should include: (1) A brief synopsis of the work the applicant wishes to present at the congress; and (2) A brief letter of what the applicant hopes to gain by attending the relevant congress. The applicant should submit an abstract for presentation at the relevant national or international meeting. Should such an abstract not be accepted by the relevant congress organising committee, the applicant will forfeit his or her sponsorship towards the congress. (Application can however be made well in advance of the relevant congress but will only be awarded on acceptance of the abstract.) A written report on the relevant congress attended will need to be submitted by the successful applicant within 6 weeks of attending the congress. The congress report will be published in the South African Heart Association Newsletter.

> "A gifted and enthusiastic teacher, he was instrumental in the training of generations of undergraduates."

Applications should be sent to Dr Alfonso Pecoraro, President of the Western Cape branch of the South African Heart Association, Division of Cardiology, Tygerberg Hospital, Francie van Zijl Drive, Tygerberg 7505; or alternatively email: pecoraro@sun.ac.za.

Previous recipients of this prestigious award include Sandrine Lecour, Roisin Kelle, Liesl Zühlke and Prof Hans Strijdom.

Applications close on 31 January 2021.

TRAVEL SCHOLARSHIPS OF THE SOUTH AFRICAN HEART ASSOCIATION

Applications for the SA Heart® Travel Scholarship for the third term in 2020 are invited to reach the SA Heart® Office by 30 September 2020.

The scholarship is for the value of up to R25 000.00 for international meetings and R10 000.00 for local meetings.

This scholarship is available to all members residing in South Africa. It is primarily intended to assist junior colleagues to ensure continued participation in local or international scientific meetings or workshops.

REQUIREMENTS

- Applicants must be fully paid-up members for at least 1 year.

RECOMMENDATIONS

- Early and mid-career applicants (<5 years post-qualification as specialist and/or <5 years post-PhD qualification).
- Acceptance of an abstract/poster presentation at the scientific meeting to be attended.

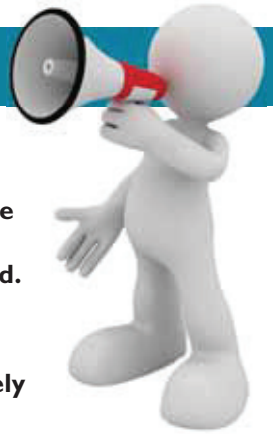
CONDITIONS

- Awards will not be made for conferences or workshops retrospective to the application submission deadline. If the conference is taking place within six (6) weeks following the submission deadline, please indicate this in the appropriate place on the application form.
- It is not a requirement for the abstract to be accepted by the conference travel application closing date. Should the acceptance of the paper, including proof of registration not be available at the time of submission of the application, then a provisional award may be made pending receipt of the acceptance of the paper.
- Please ensure that applications are made as well in advance as possible **(preferably at least 6 months prior to the conference date)**.
- Applicants may only submit 1 application every second year. The scholarship is for the value of up to R25 000.00 for international meetings and R10 000.00 for local meetings.
- Awards are only made in the event that a paper or a poster is being presented or in the event of a workshop attendance, if the reviewers deem the workshop attendance to be of high impact and consequently of benefit to the SA Heart® community.
- The applicant must ensure that the application is fully completed including the requirements as detailed in the checklist section. Applicants are asked to be concise and to only include applicable and relevant information.
- Awards are granted for 1 specific conference. Should that specific conference be cancelled or the full amount allocated not utilised for any reason, then the funds must revert to SA Heart®; and
- A written report on the relevant congress attended will need to be submitted by the successful applicant within 6 weeks of attending the congress. The congress report will be published in the South African Heart Association Newsletter.

SUBMISSION REQUIREMENTS

- For more information and application forms, please visit https://www.saheart.org/cms-home/category/39.

SA HEART® ANNUAL GENERAL MEETING



The SA Heart® AGM 2020 will take place online.

Due to the Pandemic many programmes and calendars have had to change. The date for the AGM, will be sent out electronically to all members of SA Heart® once it is finalised.

All members are invited to attend.

Ordinary members of SA Heart® are called to partake actively in the nomination and election process for office bearers.

NOTES