Paediatric Cardiology

Guidance for actions during referral review and acceptable time frames to clinic

Staff relevant to:	Consultant Paediatric Cardiologists & GP, Community and UHL referrers to Paediatric Cardiology (EMCHC)
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Version:	2
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Written by:	Prof Frances Bu'Lock
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1. Referral Information: see below for 'guidance on a page'

This guidance is based on information gleaned from individual triage of >1000 referrals to EMCHC in 2023. It should be read in the spirit it is intended; as a guide to referral triage by cardiologists it should also guide referrers as to what is reasonable to refer to paediatric cardiology services, as well as what is not,. It should be read in conjunction with guidance such as the Syncope Evaluation UHL Childrens Medical Guideline and Cardiology Handbook UHL Cardiac Guideline, UHL Chest Pain Guideline etc .

It is not exhaustive and is subject to revision over time .

It does not apply to urgent referrals for inpatients nor for those diagnosed prenatally with major congenital heart disease

It does not replace requests for telephone advice from Cardiology consultants and Registrars (see Medirota), nor GP use of the Advice and Guidance facility.

Guidance for actions during referral review and acceptable time frames to clinic

Post NIPE check for Family History of Congenital Heart Defect (CHD);

- if Atrial Septal Defect (ASD)/Patent Ductus Arteriosus (PDA) see 3-6 months of age.

OTHERWISE YOU MUST check if the mother had a fetal echo:-

- If history is of left/right heart obstruction then see by 6 weeks of age **even if fetal echo normal.**
- If history other structural heart disease e.g. Ventricular Septal Defect (VSD) or Tetrology of Fallot etc; **do not need to be seen** unless prenatal concerns or concerns on NIPE check. Polite letter to cons Neonatologist to reject

Prenatal diagnosis of 'minor' Congenital Heart Defect e.g. small VSD, Pulmonary Stenosis, Right arch left duct etc; within 6 weeks unless otherwise specified by fetal cardiologist

NIPE/6 week check murmurs with no concerning features; 3 months from referral

Palpitations with cardiac symptoms/preceding syncope see ASAP

Convincing suggestions of arrhythmia, without syncope/presyncope; within 3 months (Consider 48 hour tape in advance of clinic), otherwise reject with explanation increased awareness of normal changes in heart rate / ectopics + ADC syncope article and 'palpitations' guideline/leaflet (in press).

Family History (1st degree relative) sudden death < 40 years; timescale depends on history; can request detail

Chest pain ON EXERTION, with realistic possibility cardiac; +/- murmur; target within 6 weeks

NON-CARDIAC sounding chest pain does not need to be seen, send polite decline letter; no benefit from cardiac logical review, with Chest Pain Guideline and ADC article (s)

Murmur and chest pain/syncope/v concerning Family History; see SOON (<6 weeks)

New asymptomatic murmur in older child; within 6 months if otherwise well

Syndromic child for screening; within 6 months unless murmur etc.

Pre-op screening request in syndromic child or child with murmur; target within 3 months

Family History of Bicuspid Aortic Valve; within 6 months

Attention Deficit Hyperactivity Disorder (ADHD) and clinical reason to be seen e.g. murmur; write back to start meds and see within 6 weeks (other ADHD; - Cardiac input not required unless fits other cardiology referral screening criteria e.g. 1st degree relative sudden cardiac death)

Hypermobility type Ehlers-Danlos Syndrome; decline till mid-teens (Suggest around 14,) and remind them that we do not manage dysautonomia.

Dizziness/near syncope on standing/postural: decline; normal 'phase'; write back with syncope leaflet+ADC article and suggest advice to increase salt and water intake, ensure adequate diet, and learn to manage changes in posture slowly.

Postural Tachycardia Syndrome (POTS)/Family History of POTS/? POTS; as for syncope; unless any genuine arrhythmic concerns, decline and divert to POTSUK.org; we do not provide a dysautonomia service.

Previously diagnosed CHD elsewhere; maybe depends on where but certainly within 3 months unless very certain it is minor (may be underplayed to the GP)

New Duchenne Muscular Dystrophy; within 3 months as parents will be justifiably very anxious

'**Cyanosis**'; if otherwise well, decline, ask GP to check oxygen saturations and refer if abnormal

Murmur with pyrexia; if otherwise well, decline and ask GP/paeds to re-examine when afebrile and refer if persists. For older children suggest check Hb also.

3. Education and Training

It takes a minimum of 5 years post MRCP/MRCPCH (i.e. ST4+) training to be come a Paediatric Cardiologist.

Paediatric (Congenital and Paediatric) Cardiology is a full 'physicianly' speciality. Paediatric Cardiology at UHL is part of the East Midlands Congenital Heart Centre (EMCHC) now split with the paediatric centre in the Kensington building at LRI and the Adult Congenital Heart Disease (ACHD) centre above the South Entrance at Glenfield.

'Paediatric Cardiologists' can train in a wide range of subspecialty areas from fetal cardiology, across childhood and into the care of adults born with CHD, and includes for example, complex structural interventions, electrophysiology, and the use of state of the art imaging modalities.

Adult cardiologists can also subspecialise in ACHD. EMCHC is the recognised training centre for the East Midlands and currently trains 4 NTNs in Paediatric Cardiology, I – 2 NTNs in ACHD, as well as 1-2 Paediatricians with expertise in Cardiology (SPIN module from Paediatrics at ST6-8) and a number of fellows. The specialists work hand in hand with congenital heart surgery, intensive care and specialist anaesthesia, as well as relying on many other specialists for their many patients with complex medical needs.

4. Monitoring Compliance

None

5. Supporting References

None

6. Key Words

Congenital heart defect, Paediatric cardiology, Chest pain, Syncope, NIPE, EMCHC

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) Prof Frances Bu'Lock - Cardiologist			**Executive Lead** Chief Medical Officer
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
Feb 2025	**1**		**minor updates**