Identifying a need for a local infective endocarditis clinic

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Infective endocarditis (IE) is associated with high levels of morbidity and mortality and prolonged hospital stays (1).

Close surveillance of patients in the first year after an episode of IE, beginning with baseline assessment and repeat echocardiography on completion of antimicrobial therapy, is recommended (2).

In our hospital, which has around 1100 acute adult beds, a weekly IE multidisciplinary team meeting (MDT) facilitates shared care of patients between the cardiology and infectious diseases teams.

Currently, there are no systems in place to ensure timely cardiology clinical and imaging follow-up of patients after an admission with IE.

OBJECTIVES

- To audit current practices in treatment and cardiology follow-up of patients admitted with IE
- To produce an end-of-treatment checklist to incorporate into the IE MDT
- To develop a dedicated IE clinic

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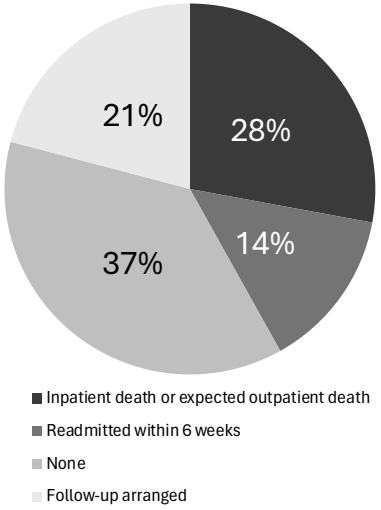
PRELIMINARY AUDIT

In Scotland, data hospital admissions are captured through the Scottish Morbidity Scheme (SMR). Consecutive patients with an ICD-10 discharge code for IE (I33, I38, B376) in the first or second diagnostic position from 1/1/18-31/12/18 and 1/1/22-31/12/22 were included. The IE diagnosis was validated. Recurrent hospitalisation and mortality data were linked. Additional clinical data were obtained from electronic records.

In total, 43 patients had a validated discharge diagnosis of IE in the two years reviewed. Mean age was 64 years (IQR 54-77), 58% were men, median length of stay was 40 days (IQR 23-72) and 23% had surgical intervention.

- One-year all-cause mortality was 37%.
- Overall, 14% of patients were readmitted within 6 weeks (without interim review) and 37% did not have consultant-led cardiology follow-up arranged.
- Median time to outpatient review was 108 days (IQR 53-141) for those who had follow-up arranged and were not readmitted.



PROGRESS AND IMPLEMENTATION

Audit findings demonstrate that mortality and readmission rates are high after an episode of IE, and patients do not have access to timely cardiology follow-up. It is anticipated that a dedicated IE clinic could lead to improvements in readmission rates and better outcomes for patients.

A proforma containing fields relevant to diagnosis and treatment, as well as specific fields to prompt scheduling of repeat echocardiography and clinic review, has been devised and will be incorporated into routine use at the MDT.

Plans to pilot a once-monthly, cardiologist-led, one-stop IE clinic, which will combine clinical review with echocardiographic assessment, are ongoing. The clinic will also be used to deliver echocardiography training. Is it anticipated that the IE MDT checklist will trigger referral of those patients who would benefit from early review.

Stakeholders

Patients
Consultants
Physiologists
Clinical service managers
Cardiology trainees

CONCLUSIONS

There is a need for improved access to timely follow-up for patients after an episode of IE.

To address this, a pilot project is underway to develop a dedicated IE clinic.

Challenges include engaging stakeholders, barriers to introducing a new clinical service while still a trainee, and ensuring access to echocardiographic equipment.

REFERENCES

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