PECSIG

PECSIG Summer Meet 2026

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Approved for RCPCH CPD credits

Friday, 12 June 2026
09:00 – 17:00

Shendish Manor Hotel & Golf Course
Hemel Hempstead, HP3 0AA

Hosted by
Lister Hospital Stevenage Team

PECSIG

NHS
East and North Hertfordshire Teaching NHS Trust

PECSIG
SUMMER MEET 2026

Meet the Organising Team

PECSIG

LEAD ORGANISER

Dr Anshoo Dhelaria

CO-ORGANISER

Dr Meraj Siddiqui

ORGANISING COMMITTEE

- Kavya Haran
- Siddhi Maisuria
- Aditi Dhelaria
- Aayushi Dhelaria

Thank you for your dedication and contribution to the successful delivery of PECSIG Summer Meet 2026.

PECSIG SUMMER MEET 2026

Organisers: Dr Anshoo Dhelaria & Dr Meraj Siddiqui
(Lister Hospital, Stevenage SG1 4AB)

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FRIDAY

08:30-08:50 Registration & Refreshments

9:00 – 10:50 | Session 1: Neonatal Cardiology
Chairs: Dr Vikranth Venugopalan & Dr Emmanuel Quist Therson

DR ANSHOO DHELARIA

Consultant Paediatrtician with expertise in Paediatric Cardiology, Lister Hospital, Stevenage.

08:50-09:00 | Welcome & House Keeping

DR ANAY KULKARNI

Consultant Neonatologist, St. George's Hospital, London

09:00 – 09:20 | Pulmonary Hypertension management in Ex-preterm

DR NIM SUBHEDAR

Consultant Neonatologist, Liverpool Women's Hospital, Liverpool

9:20 – 09:40 | First UK Pulmonary Hypertension registry-RePHyNn

DR BIKASH BHOJNAGARWALA

Consultant Neonatologist, Medway NHS Foundation Trust

09:40-10:10 | Evolving landscape of haemodynamic assessment

DR LINDSEY HUNTER

Consultant Paediatric and Foetal Cardiologist, Royal Hospital for Children, Glasgow

10:10 -10:30 | Asymptomatic cardiac shunts: Do they matter?!

10:30-10:45 | Panel Discussion / Q&A

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FRIDAY

10:45 – 11:00 Refreshment Break

11:00 – 12:45 | Session 2: Clinical Cardiology
Chairs: Dr Anshoo Dhelaria & Dr Bikash Bhojnagarwala

MR NAGARAJAN MUTHIALU

Consultant Paediatric Cardiothoracic and Tracheal Surgeon, GOSH, London

11:00-11:20 | Chest Wall Deformity- Tips for PECs

DR VENUGOPALAN POOTHIRIKOVIL

Consultant Paediatrician with expertise in Cardiology, University Hospital Sussex NHS Foundation Trust

11:20-11:40 | Syncope & Pre-syncope in children

DR FLEUR S. VAN DIJK

Consultant in Clinical Genetics, London North West University Healthcare NHS Trust, London

11:40-12:00 | EDS: Genetics & Cardiac Screening

DR NITHA NAQVI

Consultant Paediatric Cardiologist, Royal Brompton Hospital, London

12:00-12:20 | Kawasaki disease- what every PEC needs to know

DR WILLIAM REGAN

Consultant in Paediatric Cardiology and Electrophysiology, London

12:20-12:35 | The Role of AI in Paediatric Cardiology

12:35 -12:45 | Panel Discussion / Q&A

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12:45 – 13:45 Hot Lunch & PECSIG AGM

13:45 – 15:25 | Session 3: Imaging & Cardiac Arrythmia
Chairs: Dr Sanjay Raina & Dr Venu Gopalan

DR LEONIE WONG

Consultant Paediatric Cardiologist, Royal Brompton Hospital, London

13:45-14:05 | Cardiac arrhythmias: Red flags & When to refer ?!

MS ALEX SAVIS

Paediatric cardiac physiologist, Evelina Children's Hospital, London

14:05-14:25 | Cardiac Tumors: ECHO Assessment

DR SARAN DURAIRAJ

Consultant Paediatric Cardiologist, East Midlands Congenital Heart Centre, Leicester

114:25-14:45 | Mitral annular Dysjunction – an evolving concept

PROF STEVE HUMPHRIES

Emeritus Professor of Cardiovascular Genetics, University College of London

14:45-15:05 | Managing children with Familial Hypercholesterolemia: what is new in 2026?

15:05-15:25 | Panel Discussion / Q&A

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15:25- 15:40 Refreshment Break

15:40- 17:10 | Session 4: Evidence Based Cardiology & Abstracts
Chairs: Dr Dhaval Dave & Dr Meraj Siddiqui

DR ANSHOO DHELARIA

Consultant Paediatrtician with expertise in Paediatric Cardiology, Lister Hospital, Stevenage.

15:40-15:50 | Fenfluramine associated cardiac complications

CECILIA BOGLE

5th Year Medical Student, University College London (UCL)
Supervising Consultant: Dr Sankara Narayanan

15:50 -16:00 | PFO Survey: Results & Clinical Implications

16:00-16:40 Oral Presentation Session

DR OMER BERK

Post CCT Fellow, East and North Hertfordshire NHS Trust, Lister hospital, Stevenage

16:40-17:00 | AI in Day-to-Day Practice

DR VIKRANTH VENUGOPALAN

Consultant Neonatologist with expertise in Paediatric Cardiology, Sandwell and West Birmingham NHS Trust

17:00-17:10 | Closing Remarks & Prize distribution

End with a photo followed by Dinner at 18:00 (Need separate registration for dinner)

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08:30-08:50 Registration & Refreshments		
08:50-09:00	Welcome & House Keeping	Dr Anshoo Dhelaria
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09:00- 09:20	Pulmonary Hypertension management in Ex-preterm	Dr Anay Kulkarni
09:20-09:40	First UK Pulmonary Hypertension registry-RePHyNn	Dr Nim Subedar
09:40-10:10	Evolving landscape of haemodynamic assessment	Dr Bikash Bhojnagarwala
10:10-10:30	Asymptomatic cardiac shunts: Do they matter?!	Dr Lindsey Hunter
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10:45 – 11:00 Refreshment Break		
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11:00-11:20	Chest Wall Deformity- Tips for PECs	Mr Nagarajan Muthialu
11:20-11:40	Syncope & Pre-syncope in children	Dr Venugopalan Poothirkovil
11:40-12:00	EDS: Genetics & Cardiac Screening	Dr Fleur S. Van Dijk
12:00-12:20	Kawasaki disease- what every PEC needs to know	Dr Nitha Naqvi
12:20-12:35	The Role of AI in Paediatric Cardiology	Dr William Regan
12:35-12:45	Panel Discussion / Q&A	
12:45 – 13:45 Hot Lunch & PECSIG AGM		
13:45 – 15:25 Session 3: Imaging & Cardiac Arrythmia. Chairs: Dr Sanjay Raina & Dr Venu Gopalan		
13:45-14:05	Cardiac arrhythmias: Red flags & When to refer ?!	Dr Leonie Wong
14:05-14:25	Cardiac Tumors: ECHO Assessment	Ms Alex Savis
14:25-14:45	Mitral annular Dysjunction – an evolving concept	Dr Saravanan Durairaj
14:45-15:05	Managing children with Familial Hypercholesterolemia : what is new in 2026?	Prof Steve Humphries
15:05-15:25	Panel Discussion / Q&A	
15:25– 15:40 Refreshment Break		
15:40– 17:10 Session 4: Evidence Based Cardiology & Abstracts. Chairs: Dr Dhaval Dave & Dr Meraj Siddiqui		
15:40-15:50	Fenfluramine associated cardiac complications	Dr Anshoo Dhelaria
15:50 -16:00	PFO Survey: Results & Clinical Implications	Dr Sankara Narayanan
16:00 -16:10	Safe to Wait: Impact of PDA non-Intervention in the NICU	Marika Lasokova et al.
16:10 -16:20	Is there a Future Role for AI in Improving Antenatal and Postnatal Diagnosis of Congenital Heart Disease in the NHS	Charlotte Peacock et al.
16:20 -16:30	Heart Rate Characteristics and Symptom Burden in Children with Postural Orthostatic Tachycardia Syndrome (POTS): A Matched Observational Study	Alanna Wyncoll et al.
16:30-16:40	Impact of COVID-19 lockdown on obesity and hypertension in paediatric cardiology patients: a retrospective audit from a UK tertiary centre	Jemima Ball et al.
16:40-17:00	AI in Day-to-Day Practice	Dr Omer Berk
17:00-17:10	Closing Remarks & Prize distribution	Dr Vikranth Venugopalan

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Meet the Faculty

Dr Anshoo Dhelaria is a Paediatric consultant with expertise in Paediatric Cardiology (PEC) working at Lister Hospital for nearly 16 years.
She has undertaken various leadership roles including being the lead for local cardiac service, regional training program director, trust LED tutor, RCPCH Area officer for East area.
Amongst her accolades, her passion to provide exemplary training and education was marked by securing from the worst to "The best training unit" in the region towards the end of her college tutor career.
She is dynamic, positive and socially active person participating in various charity events, enjoys dancing, singing, swimming and cycling. She has recently accomplished the 48mile "Palace to Palace" cycling challenge and is intending to secure another bigger event medal this year.
She is a proud mum of twins who are now in A level and they also play badminton at national level.

Dr Anay Kulkarni is a Consultant Neonatologist at St George's University Hospitals NHS Foundation Trust, London, and Honorary Consultant in Paediatric Cardiology at Royal Brompton and Harefield Hospitals, London, UK. He is an Executive Committee member of the NEOFOCUS Group of the British Association of Perinatal Medicine, leading the Guidelines and Framework Group.
He completed his undergraduate and postgraduate paediatric training at Mumbai University, India, followed by specialist training in Neonatology and Paediatric Cardiology in London. Dr Kulkarni holds European Certification in Congenital Heart Disease Echocardiography (EACVI) and has performed over 3000 neonatal echocardiography assessments.
His interests include neonatal cardiology, haemodynamic assessment, PDA, pulmonary hypertension, and functional echocardiography, and he is well published in peer-reviewed journals. He leads the Neonatal Cardiology Service at St George's and directs Echocardiography for Neonatologists courses.

Dr. Nim Subhedar is a Consultant Neonatologist working at Liverpool Women's Hospital and Honorary Clinical Senior Lecturer at the University of Liverpool. He graduated from the University of Bristol and received a MD from the University of Liverpool for his thesis on neonates with pulmonary hypertension. His research interests include neonatal pulmonary hypertension, inhaled nitric oxide therapy, neonatal haemodynamics and echocardiography. He previously led the first randomised controlled trial of inhaled nitric oxide in preterm neonates and was a co-applicant on the UK multicentre Baby OSCAR trial of early selective treatment of patent ductus arteriosus. He is the Chief Investigator of the international Registry of Pulmonary Hypertension in Neonates (RePHyNe) and a member of the NeoFOCUS-UK BAPM Executive Committee.

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Meet the Faculty

Dr Bikash Bhojnagarwala, FRCPCH, is a Consultant Neonatologist at Medway NHSFoundation Trust with specialist expertise in neonatal haemodynamics, paediatric cardiology, and point-of-care ultrasound (POCUS). He leads neonatal services and paediatric cardiology at the Oliver Fisher Neonatal Unit and has pioneered the clinical integration of lung ultrasound and ultrasound-guided line placement. He serves as Honorary General Secretary of PECSIG and Honorary Treasurer of NeoFOCUS-UK, contributing to national initiatives including the UK Neonatal Haemodynamic Framework, POCUS-for-lines guidance, and lung ultrasound implementation programmes. Dr Bhojnagarwala is an active educator and researcher with multiple national and international conference presentations.

Dr Lindsey Hunter trained in Glasgow and in London at the Evelina London Children's Hospital. Dr Hunter has been a consultant in paediatric and fetal cardiology at the Royal Hospital for Children (RHC), in Glasgow since 2014. She has led the national fetal cardiology service in Scotland over the last 12 years and continues to be passionate about paediatric & cardiac echo teaching. Dr Hunter is currently vice chair of the British Fetal Cardiac Association (BFCA) and is the paediatric cardiology representative in the development of neonatal echocardiography guidelines with BAPM. Dr Hunter continues to publish in the field of fetal and paediatric cardiology and has contributed to fetal book chapters in collaboration with the Teams from the Mayo Clinic (USA), Birmingham Children's hospital, and the Evelina London Children's Hospital.

Dr Nitha Naqvi is a Senior Paediatric Cardiology Consultant at the Royal Brompton Hospital, now part of Evelina London Children's Hospital (GSTT), and has supported the PECSIG community since its inception. She trained at Guy's and St Thomas' Medical School, graduating with first-class honours. She ranked first in the London Paediatric SHO, Paediatric NTN and Paediatric Cardiology NTN interviews, and during dual training received both the Royal Society of Medicine Paediatric Prize and the BCCA Prize. Passionate about education, she established the EACVI PECSIG course and co-led it for 8 years with Dr Venugopalan. She also led the Annual Royal Brompton Hands-on Echocardiography with Morphology course with Professor Yen Ho for 12 years.

Her leadership roles have included Paediatric Echocardiography Lead, Aortopathy Lead and CHD Network Director, where she served as a Level 1 CHD peer reviewer, organised Network Days, established a Network Board and developed funded consultant roles. She is also a trustee of the Marfan Trust and leads National Patient Engagement Days.

Alongside her clinical work, Dr Naqvi founded Fast Track Medics Ltd and personally trained over 3,000 doctors for the GMC PLAB examination, achieving a >95% success rate and contributing significantly to the NHS workforce.

Her achievements include receiving the Asian Woman of the Year award, recognition at 10 Downing Street, inclusion in the Migration Museum's Heart of the Nation NHS exhibition, and being featured on the Piccadilly Circus billboard.

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Dr Venugopalan Poothirikovil (Dr Venu) is a Consultant Paediatrician with expertise in Paediatric Cardiology at the Royal Alexandra Children's Hospital (ALEX), Brighton. He holds Honorary Consultant post at the Evelina London Children's Hospital. He is fully accreditation in echocardiography with the European Association of Cardio-vascular imaging (EACVI).
Dr Venu has had more than 20 years of experience in both general paediatrics and paediatric cardiology in the UK. His areas of interest in cardiology include heart murmurs, chest pain, palpitation, syncope, and screening for family history of heart disease. He has published around 100 Medline indexed publications and contributed to several text books in cardiology and general paediatrics.
Dr Venu is an Honorary Senior Clinical Lecturer at the medical School in Brighton. At the RCPCH he is the immediate past Chair of the DCH Clinical Examinations. He is also an examiner and senior examiner for MRCPCH and DCH clinical examinations in the UK and overseas. Dr Venu is well known for the various courses in Cardiology (ECG and Hands on Echo courses).

Fleur van Dijk is an consultant clinical geneticist based in LNWUH and has been working since 2016 in the Northwest Thames Regional Genetics Service (NWTRGS) which covers Northwest London (NWL) as well as Luton & Bedford area.
She also runs a separate nationally commissioned highly specialised service since 2016 for rare monogenic EDS types. She has a passion for clinical and translational research, especially in the field of inherited connective tissue disorders.

Dr. Nagarajan Muthialu is a consultant pediatric cardiothoracic surgeon at Great Ormond Street Hospital in London. He leads programs in pediatric thoracic and airway surgery, lung transplantation, and surgical ECMO, and is internationally recognized for his work in many areas, including complex airway reconstruction. He has trained at leading centers in the UK and internationally and has made significant contributions to advancing pediatric airway and transplant surgery.

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Dr William Regan, is a consultant in paediatric cardiology and electrophysiology based at Evelina London Children's Hospital, part of Guy's and St Thomas' Trust. Will studied medicine as a post-graduate at Warwick Medical School, before completing core paediatric training in London. He trained across three London centres in paediatric cardiology: Evelina (Guy's and St Thomas'), Great Ormond Street and Royal Brompton hospital, including a year of electrophysiology based across the St Thomas' (adult) and Evelina (paediatric) sites. He was appointed as a paediatric cardiology consultant at Evelina in July 2021, sub-specialising in electrophysiology and inherited arrhythmias. His recent publications focus on this sub-speciality, and he has contributed to several international multi-centre studies.

Dr Leonie Wong is a consultant paediatric cardiologist and electrophysiologist at Royal Brompton Hospital. He jointly runs the paediatric electrophysiology and inherited arrhythmia service and has clinical and research interests in childhood arrhythmias, inherited arrhythmia syndromes and sudden death syndromes.
He undertook general paediatric registrar training in the Oxford Deanery, before pursuing specialist paediatric cardiology training in Bristol and London where he developed an interest in paediatric electrophysiology and inherited cardiac conditions. He carried out BHF-funded research into the genetics of sudden unexplained infant death at St George's University of London prior to his consultant appointment in 2017.

Alexandra (Alex) Savis, BSc MSc is a highly experienced congenital cardiac physiologist, specializing in Echocardiography in fetal and paediatric patients with congenital and acquired heart disease.
Alex is the lead paediatric cardiac physiologist lead for research, training and education at the Evelina London Children's Hospital and the cardiac physiologist representative on the LifeLong CHD Network Board.

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Dr Saran Durairaj is a Consultant Paediatric Cardiologist at the East Midlands Congenital Heart Centre, Leicester, UK, where he has been in post since 2016 and serves as Clinical Lead for Paediatric Cardiology from 2023. He has specialist expertise in congenital cardiac MRI and CT, with advanced sub-specialty training at Evelina Children's Hospital and Guy's & St Thomas' NHS Foundation Trust, London.
Dr Durairaj completed his General Paediatric and Paediatric Cardiology training in the UK and holds a CCT, with extensive experience in paediatric intensive care, including cardiac and ECMO care. He leads the cardiac MR service in Leicester and supports the cardiac CT programme, with a strong interest in multimodality imaging, artificial intelligence-based segmentation, and 3D printing for clinical and surgical planning. He has a sustained academic interest in congenital heart disease, with numerous peer-reviewed publications and international presentations. Dr Durairaj is committed to lifelong clinical excellence in paediatrics and paediatric cardiology. He is also part of UK based charity which deliver CHD surgeries across the world for the disadvantaged children.

Steve Humphries - is a world-renowned expert in cardiovascular genetics with a focus on Familial Hypercholesterolaemia (FH). He worked at UCL from 1991, where he was the British Heart Foundation Professor of Cardiovascular Genetics, retiring in September 2015 and is the BHF UCL Emeritus Professor of Cardiovascular Genetics. He directed a major research programme to develop and implement molecular strategies to study the genetic causes and clinical and psychological consequences of FH. He was the Lead Advisor to the UK NICE guidelines on FH published in 2008, and updated in 2017, and has published on the health economics of cascade testing and Universal Screening for FH. He is is a member of the Cholesterol and FH expert Advisory Group and is the Director of the UK FH Paediatric Register and the Simon Broome FH Register. He is actively involved with teaching, ethics, and public awareness aspects of the implementation of genetic testing for FH.

Cecilia Bogle
I am a fifth-year medical student at University College London (UCL) with an intercalated BSc in Medical Physics and Biomedical Engineering. I have a particular interest in paediatric cardiology.
I have been working through the data, and it is looking really promising. There are some significant results emerging, particularly around the difference in intended discharge rates between Consultant Paediatric Cardiologists and Paediatricians with Expertise in Cardiology (PEC) - with Consultants reporting substantially higher rates of discharge across all three vignettes. The analysis also shows a clear and significant effect of patient age, with discharge rates increasing from infancy through to adolescence.

15:05-15:25 Refreshment Break

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Meet the Faculty

Dr Sankara Narayanan is a Consultant Neonatologist and Paediatrician with Expertise in Cardiology at West Hertfordshire Teaching Hospitals NHS Trust, with accreditation in congenital heart disease echocardiography. He has a specialist interest in neonatal and paediatric cardiology, and has a focus on reducing unwarranted variation in care and improving consistency across services. His work spans clinical practice,education, and system-level quality improvement, including regional and national initiatives to standardise care.

As MedicalEducation Lead for the East of EnglandNeonatal Network, he leads programmes that link clinical capability with service standards. His interests include neonatal haemodynamics, point-of-care ultrasound, and workforce development.

Dr Omer Berk MD MRCPCH is a post CCT fellow with over 20 years of clinical experience, including seven years as a Consultant in Turkey and extensive NHS experience.

His interest in AI and digital health is grounded in direct clinical application. He has completed formal training in AI in clinical medicine at Cambridge Centre for Innovation and Development, the University of Manchester with NHS England, and Stanford Online, with additional training in systematic review methodology at Johns Hopkins University.

In practice, he has designed a digital patient flow system using Microsoft Planner as a dynamic real-time ward tracking tool, replace a paper-based process, delivered educational sessions on AI particularly focussing on the practical, day-to-day integration of AI tools into clinical workflows.

End with a photo followed by Dinner at 18:00 (Need separate registration for dinner)

SAFE TO WAIT: IMPACT OF PDA NON-INTERVENTION IN THE NICU

Marika Lasokova[1], Sandeep Shetty[1], Donovan Duffy[1], Justin Richards[1], Anay Kulkarni[1]

[1]St George's University Hospitals NHS Foundation Trust, London, United Kingdom

Objectives: Management of Patent ductus arteriosus (PDA) remains controversial topic in the neonatal medicine. Aim of this project was to evaluate outcomes following the introduction of expectant management for PDA in tertiary neonatal Unit.

Method: This was a retrospective study including inborn infants <29 weeks'. Infants were divided intotwo 34-month epochs. Epoch1 included 150 infants born between 01/11/2019-31/08/2022 and Epoch 2 included 150 infants born between 01/09/2022-30/06/2025. 2 EPOCHs were comparable in baseline characteristics.

Results: Descriptive statistics were used for comparisons. Medical PDA treatment was administered to 17 infants in Epoch 1 and none in Epoch 2; Mortality was higher in Epoch 1 (17% vs 12%, p=ns). More infants were extubated by day 7 in Epoch 2 (56% vs 37%, p=0.0023). There were no significant differences in postnatal steroid use (19% vs 23%, p=ns), bronchopulmonary dysplasia at 36 weeks (70% vs 69%, p=ns), or necrotising enterocolitis (8% vs 8%, p=ns). However, fewer infants were discharged on oxygen in Epoch 2 (48% vs 31%, p=0.0064). Pulmonary haemorrhage (12% vs 5.3%, p=0.04) and severe intraventricular haemorrhage (grade III or higher) (20.6% vs 12%, p=0.04) were more frequent in Epoch 1. Retinopathy of prematurity occurred more often in Epoch 2 (12% vs 18%, p=ns). We did not observe significant difference between two epochs in subgroup analysis <25 weeks, except pulmonary haemorrhage which remained more frequent in Epoch 1 (23% vs 16%, p=ns).

Conclusion: Expectant management of PDA in extremely preterm infants was not associated with increased mortality nor major adverse outcomes compared with routine treatment. These findings support the safety of a non-intervention approach in contemporary neonatal care.

Is there a Future Role for AI in Improving Antenatal and Postnatal Diagnosis of Congenital Heart Disease in the NHS

Charlotte Peacock[1], Rupal Patel[2], Abdul Karim[2]

[1]Hull York Medical School, Hull, United Kingdom
[2]Hull University Teaching Hospitals NHS Trust, Hull, United Kingdom

Objectives: Congenital heart disease (CHD) is the most common congenital anomaly in the UK (NICOR, 2025). Early diagnosis is critical to optimising neonatal and long-term outcomes. Advances in artificial intelligence (AI), particularly machine learning and deep learning, have demonstrated potential to enhance diagnostic accuracy across modalities including foetal ultrasound, echocardiography and electrocardiography (ECG). As AI technologies increasingly integrate into NHS diagnostic pathways, understanding their application and limitations is essential for clinical practice.

Method: A scoping review was conducted to evaluate current evidence on AI applications in CHD in antenatal and postnatal diagnosis, particularly within the NHS. After screening 13 studies were analysed for diagnostic performance, validation methods and reported limitations.

Results: AI models, particularly convolutional neural networks, demonstrate high sensitivity and specificity in detecting structural cardiac anomalies on echocardiography and foetal ultrasound, with some studies reporting performance comparable to expert clinicians; see figure below for more detailed results. Automated image segmentation and pattern recognition reduce operator dependency and may improve screening efficiency. However, limitations include small datasets, lack of external validation, potential algorithmic bias and limited prospective UK-based evaluation.

Conclusion: AI has significant potential to augment CHD diagnostic pathways, particularly in screening contexts. However, safe implementation requires robust validation, regulatory oversight and clinician understanding of algorithmic limitations. Future doctors must develop digital literacy, critical appraisal skills and an understanding of AI governance to practise safely within an evolving NHS landscape. Integrating AI awareness into the undergraduate curriculum will support preparedness for technology-enhanced clinical practice.

Heart Rate Characteristics and Symptom Burden in Children with Postural Orthostatic Tachycardia Syndrome (POTS): A Matched Observational Study

Alanna Wyncoll[1], Pramod Nair[1]

[1]Bedford Hospital, Bedfordshire Hospitals NHS Foundation Trust, Bedford, United Kingdom

Objectives: To compare heart rate characteristics and patient-reported events between children with POTS and matched controls

Method: Children aged between 12-17 with a diagnosis of POTS were matched to controls by sex and age. Data was extracted from 24-hour ambulatory electrocardiograms (ECG): minimum heart rate (HR), maximum HR, average HR, tachycardia burden) and patient-reported events. Statistical analysis was performed using GraphPad Prism. Normally distributed paired differences were compared using paired t-tests. Non-normally distributed or non-continuous variables (including patient-reported events and tachycardia burden) were analysed using Wilcoxon matched-pairs signed-rank test.

Results: 33 matched pairs of children with POTS and controls were included. Average heart rate and minimum heart rate were significantly higher in children with POTS compared with controls (mean difference 7.4 bpm, 95% CI 3.6-11.2, $p = 0.0004$, mean difference 5.9, 95% CI 2 to 9.8, $p = 0.004$, respectively). There was no significant difference in maximum heart rate (mean difference 1.18, 95% CI -7.4 to 9.7, $p = 0.78$). Tachycardia episode count was significantly higher in children with POTS (median difference 9.6, $p = 0.0007$). There was no significant difference in patient-reported events (median difference 0, $p = 0.57$).

Conclusion: Children with POTS demonstrated significantly higher average and minimum HR and greater tachycardia burden, but no difference in maximum HR. Despite these objective differences in HR parameters, there was no significant difference in patient-reported events.
Prior studies using 24-hour ambulatory ECG have found increased HR spikes and higher mean maximum HR in adults with POTS (1, 2), but literature is limited, particularly in paediatric populations. Further study on a larger scale would aid understanding of the implications for assessment and monitoring of POTS in children.

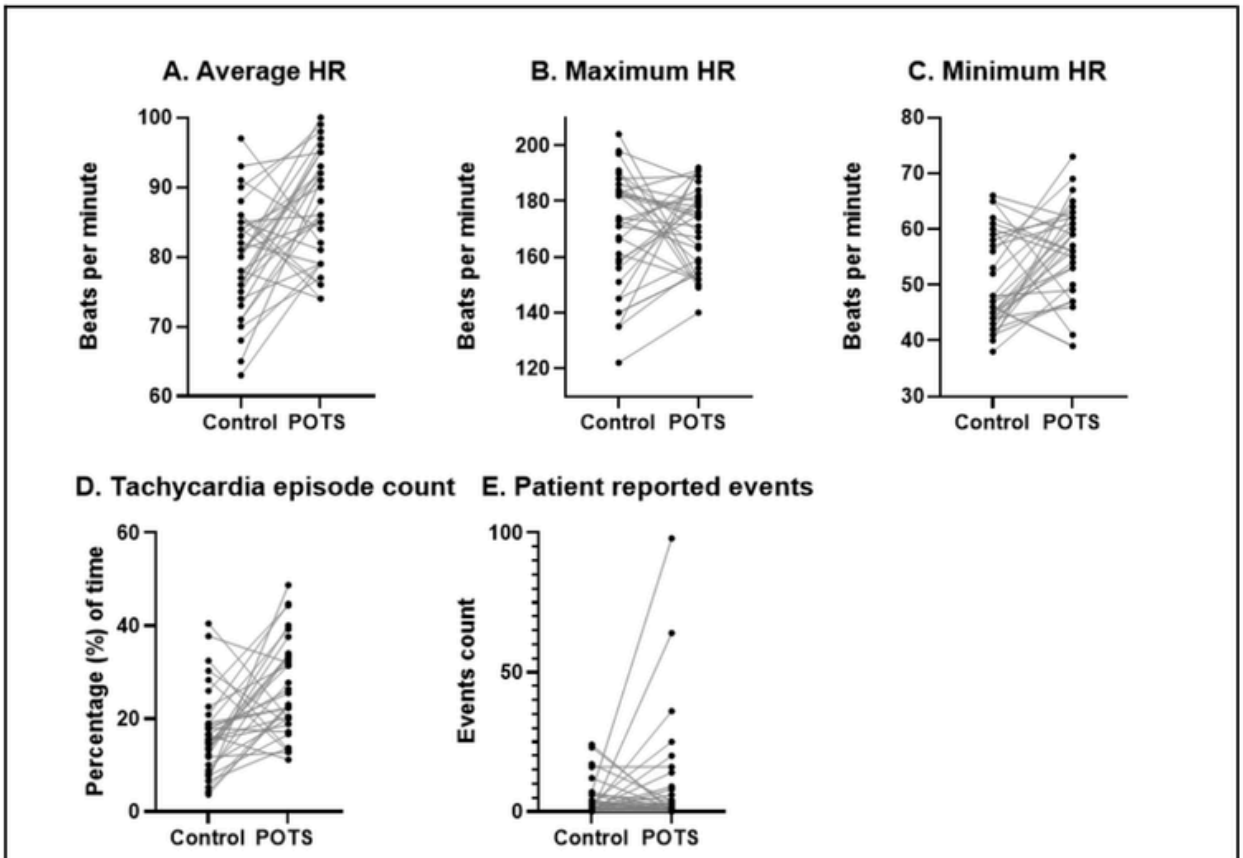


Figure 1: Comparison of heart rate parameters and symptom burden between children with POTS and matched controls.

Paired data are shown with lines connecting matched individuals. Panels show (A) average HR, (B) maximum HR, (C) minimum HR, (D) tachycardia episode count, and (E) patient-reported events.

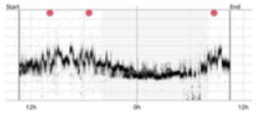
Can 24-hour ambulatory ECG monitoring identify differences in heart rate parameters in children with POTS compared to matched controls?

Children with POTS (n=33)

- Aged 12-17
- Not on rate limiting medications
- No known rhythm disorders
- No other significant medical conditions that could impact rate or function

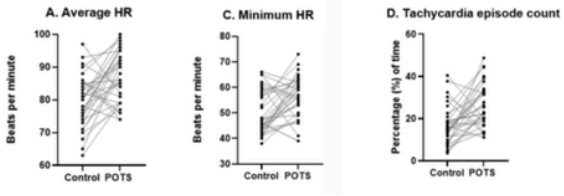
Matched controls (n=33)

- Matched by sex and age to within one year



Key findings:

↑ average heart rate
↑ minimum heart rate
↑ proportion of tachycardia episodes
No difference in maximum heart rate
No difference in patient-reported events



There are significant differences in heart rate parameters present in children with POTS, but no significant increase in reported symptoms. This suggests 24-hour ambulatory ECG monitoring may provide useful objective markers in the assessment of children with POTS.

Figure 2: Graphical abstract

Impact of COVID-19 lockdown on obesity and hypertension in paediatric cardiology patients: a retrospective audit from a UK tertiary centre

Jemima Ball[1], Jasmine Hulme Kenny[1], Charalampos Kotidis[1], Taha Rasul[1]

[1]East Midlands Congenital Heart Centre, University Hospitals of Leicester, United Kingdom

Objectives: To evaluate the impact of COVID-19 lockdown measures on the prevalence of obesity and hypertension in paediatric cardiology patients, and to assess how consistently these comorbidities were recognised and managed in routine outpatient practice.

Method: This was a retrospective clinical audit conducted at the East Midlands Congenital Heart Centre. Height, weight, and blood pressure data were extracted from outpatient clinic letters before and after COVID-19 lockdown. BMI and BP percentiles were calculated to classify weight status and hypertension stage. Pre- and post-lockdown cohorts were compared, including subgroup analysis by ethnicity and CHD severity.

Results: A total of 800 patients were included. Mean BMI increased from 17 to 20 kg/m², with a 3% rise in obesity prevalence following lockdown. South Asian children were the only ethnic group to demonstrate a significant increase in BMI percentile. Patients with severe CHD had lower BMI compared to those with mild or repaired lesions.
BP percentiles decreased significantly post-lockdown ($P < 0.001$); however, 29% of patients met criteria for stage 1 or stage 2 hypertension. This is likely an overestimate due to reliance on single automated readings and potential white-coat effect. A stronger post-lockdown correlation between BMI and systolic BP (pre-lockdown $r = 0.164$; post-lockdown $r = 0.297$).
Despite this, only 2% of patients with hypertension and 2% of those with obesity were appropriately referred for further management.

Conclusion: Obesity and hypertension are common but under-recognised and undertreated in paediatric cardiology patients. The observed association between BMI and BP highlights the need for systematic use of centile-based assessments, repeated manual BP and ambulatory monitoring. Improving recognition and management pathways is essential to optimise long-term cardiovascular outcomes in this high-risk population.

A case to get the heart racing: A Novel cause of arrythmia in a preterm newborn

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Objectives: To describe a rare cause of neonatal atrial flutter secondary to thyrotoxicosis from previously undiagnosed maternal Gravesdisease highlighting the importance of identifying reversible causes of neonatal arrythmia.

Method: We conducted a retrospective reviewof a 34-week preterm neonateadmitted to NICU with respiratory distress. From day 4 of life, the infant developed intermittent tachycardia, with heart rate peaks of 240 bpm. A 24-hour ECG demonstrated a variable-rate atrial tachyarrhythmia. Echocardiography excluded structural heart disease, confirming atrial flutter with variable block. A comprehensive evaluation for reversible causes was undertaken, including sepsis screening, maternal substance exposure, and endocrine assessment. Maternal features of tremor, proptosis, and hyperactivity prompted thyroid function testing.

Results: The 24-hourECG confirmed recurrenttachycardia >200 bpm due to variably blockedatrial flutter, with atrial rates up to 300 bpm, consistent with a re-entrant atrial circuit. Neonatal thyroid function tests demonstrated thyrotoxicosis (TSH <0.01 mU/L, free T4 54.5 pmol/L), while maternal testing confirmed hyperthyroidism.
The infant was commencedon carbimazole and propranolol, resultingin rapid rate control and clinical stabilisation. Neonatal urine toxicology was inconclusive, and substance exposure could not be excluded, although an endocrine aetiology was more likely. During follow-up, the child remainedwell. Treatment was successfully weanedwithout recurrence of arrhythmia or thyroid dysfunction. At 2-year follow-up, maternal substance misuse was disclosed, suggesting a possible but unproven contributing factor.

Conclusion: Neonatal thyrotoxicosis is a rare but reversible cause of atrial flutter. Early ECG recognition and targeted investigation, including maternal assessment, are essential. Prompt treatmentwith carbimazole and beta-blockers is effective, and a multidisciplinary approach is crucial for optimal cardiac outcomes.

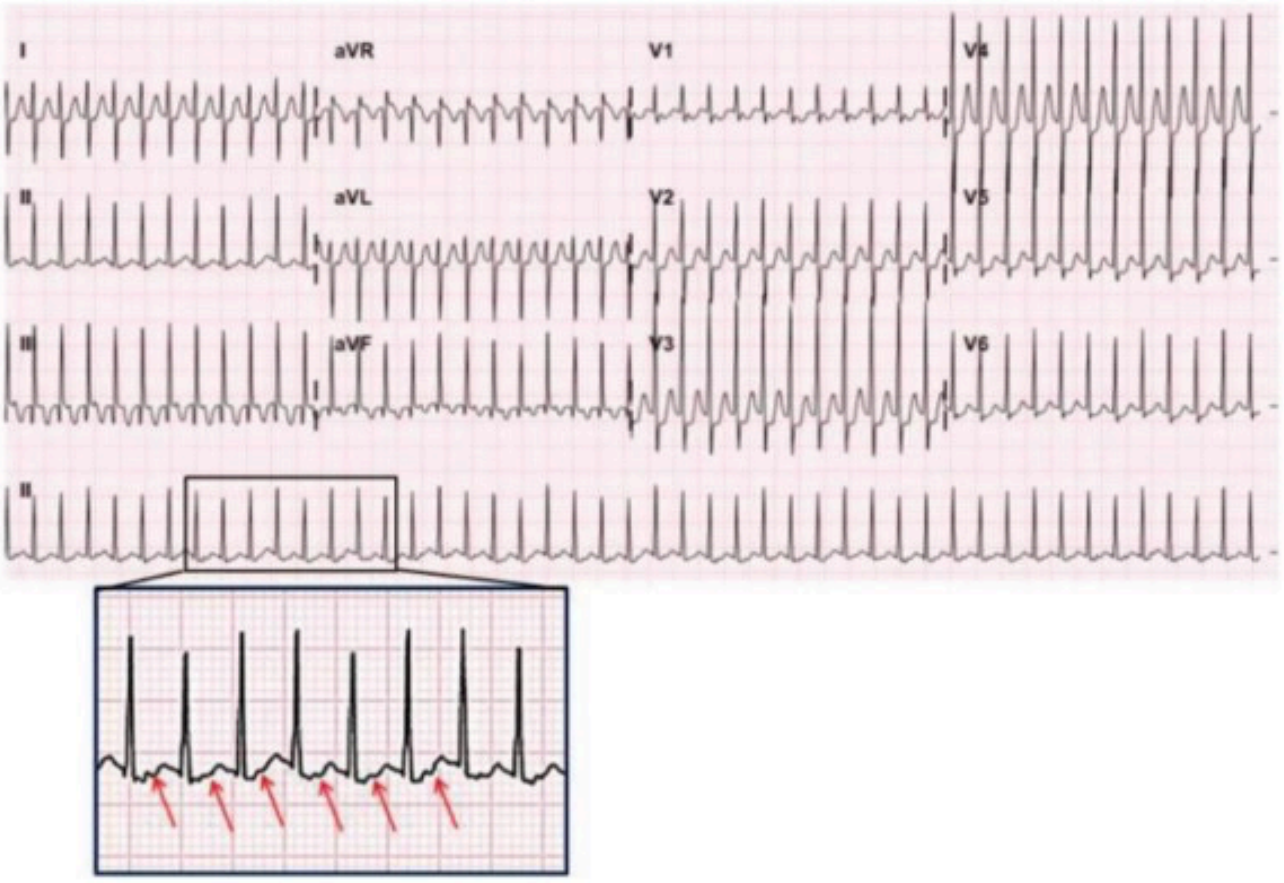

Figure 1. Atrioventricular reentrant tachycardia. HR of 245 bpm with short PR interval typical of AVRT. Retrograde P waves demonstrated by arrows in the ST segment of lead II (5).

The first case of a Caucasian child with calmodulinopathy related to CALM2 N98S mutation

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Objectives: To present a rare case of CALM2 N98S calmodulinopathy in a young child presenting with sudden cardiac arrest, highlighting diagnostic uncertainty and atypical arrhythmic features that expand the recognised phenotypic spectrum.

Method: We report a case of a previously well 2-year-old Caucasian girl presenting with out-of-hospital cardiac arrest following emotional stress. The initial rhythm demonstrated broad-complex tachycardia progressing to ventricular fibrillation. Investigations included electrocardiography, 24-hour Holter monitoring, biochemical analysis, imaging, and genetic testing. The patient was managed with beta-blocker therapy and implantable loop recorder monitoring.

Results: A 2-year-old Caucasian girl presented with sudden cardiac arrest following emotional stress. Initial rhythm demonstrated broad-complex tachycardia degenerating into ventricular fibrillation. Baseline ECG showed sinus rhythm with a normal QT interval (420 ms) and no repolarisation abnormalities. Holter monitoring demonstrated no arrhythmia. Structural and metabolic investigations were unremarkable. Genetic testing identified a de novo CALM2 p.Asn98Ser mutation. The patient was commenced on propranolol and monitored with an
implantable loop recorder. Early outcome has been favourable, with no recurrence of arrhythmia to date.

Conclusion: This case represents the youngest reported patient and the first British Caucasian individual with the CALM2 p.Asn98Ser variant. While the exact arrhythmic phenotype remains unconfirmed, the documentation of regular broad-complex tachycardia progressing to ventricular fibrillation represents an atypical pattern not consistent with classical calmodulinopathy phenotypes. This suggests that calmodulinopathies may exhibit a broader spectrum of arrhythmogenic mechanisms than previously recognised.

Poster 3 – Audit/QI

Service evaluation project to assess adherence to best practice guidelines for cardiac management of children with Duchenne muscular dystrophy (DMD)

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Objectives: To evaluate the extent to which current clinical practices align with published best- practice guidelines for the cardiac care of patients with DMD, with focus on identifying gaps in implementation, consistency of monitoring, and opportunities to improve patient outcomes through optimized management strategies.

Method: A retrospective review was undertaken of children with DMD attending a regional multidisciplinary clinic. Data collection focused on key indicators of cardiac care, including the timing of the first echocardiogram, adherence to annual cardiac follow-up, age of initiation of ACE inhibitor therapy, and documentation of parental awareness regarding cardiac involvement. Additionally, the existing clinic structure and follow-up processes were evaluated to identify variability and potential gaps in care delivery. Based on these findings, alongside established best-practice guidelines, a standardized cardiac care pathway was developed to facilitate early ACE inhibitor initiation, and improve clinical outcomes for patients with DMD.

Results: A total of 16 children with DMD were identified within the health board cohort. The majority (87%) received regular cardiology follow-up, with full compliance (100%) for annual echocardiographic surveillance. However, early cardiac assessment was less consistent, with only 19% of patients undergoing their first echocardiogram before the age of 6 years. Similarly, initiation of ACE inhibitor therapy was suboptimal, with only 17% of eligible children commenced on treatment by the age of 10, suggesting a gap in adherence to preventative management guidelines. Parental awareness of the risk of cardiac involvement in DMD was 100%.

Conclusion: Cardiology follow-up and annual echocardiographic surveillance were well maintained within this cohort. However, delays in initial assessment and low rates of timely ACE inhibitor initiation show incomplete adherence to best-practice guidelines. A standardized care pathway could improve consistency, promote earlier intervention, and optimize long-term cardiac outcomes.

Enhancing the Assessment of Paediatric Syncope: A Retrospective Clinical Audit of Guideline Adherence and Documentation Quality

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Objectives: To evaluate the quality of clinical assessment and documentation for paediatric patients presenting with syncope against national and regional guidelines, and to identify areas for service improvement.

Method: A retrospective study of 77 paediatric patients presenting with syncope was conducted between January 2024 and August 2025. Clinical documentation was appraised against the “Yorkshire & Humber Congenital Heart Disease Network: Management of Syncope”, adapted from PECSIG standards and relevant NICE guidelines, evaluating 14 criteria across historical features (symptoms, posture, triggers, prodromes, red flags), cardiac past medical and family histories, physical examination (vital signs, cardiovascular findings), and investigations (ECG).

Results: Vasovagal syncope was the most prevalent diagnosis (75%). Adherence was high for CVS examination (97%) and ECG performance (88%). However, critical deficits were identified in documenting triggers (40%), associated presyncope chest pain (39%), cardiac past medical history (27%), and cardiac family history (31%). Postural vital signs were documented in only 56% (BP) and 61% (HR) of cases. Despite these gaps, cardiology referrals (30%) successfully identified high-risk pathology, including one case of restrictive cardiomyopathy necessitating orthotopic heart transplant, one case requiring loop recorder implantation and another case of recurrent unexplained syncope due to genetic microdeletion.

Conclusion: Although most presentations involve benign vasovagal syncope, substantial gaps in the key assessment and documentation of essential cardiac screening questions persist in acute practice. To enhance diagnostic precision and tackle the current deficits, we have introduced a dedicated, user-friendly “Paediatric Syncope Proforma”, and conducted departmental education. Such systematic interventions are critical for the early detection of rare, life-threatening cardiac conditions and the standardisation of specialist referral pathways.

Williams Syndrome Presenting with Interrupted Aortic Arch Type A and Shone Complex: A Rare and Severe Congenital Cardiac Phenotype

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Objectives: To describe a rare and severe congenital cardiac phenotype in Williams syndrome.

Method: We report a term male infant, small for gestational age, with duct-dependent systemic circulation. Clinical, imaging, genetic, surgical, and outcome data were reviewed.

Results: A term male infant (2240 g at 37+1 weeks), small for gestational age, had early neonatal hypoglycaemia; mild hypothermia; jaundice requiring phototherapy; and a soft systolic murmur, but remained clinically stable.
Early discrepancies in oxygen saturation were noted, with upper-limb saturations of 100% and lower-limb values of 89–92%, resolving with warming and attributed to peripheral perfusion.
At 17 days, he presented with duct-dependent systemic circulation, including differential oxygen saturations (94% vs 85%), weak femoral pulses, and hepatomegaly. Prostaglandin E2 was commenced, and he was transferred to a tertiary cardiac centre.
Imaging confirmed an interrupted aortic arch type A, a large ventricular septal defect, supravalvar aortic stenosis, and a borderline left ventricle, consistent with a Shone complex phenotype. Genetic testing confirmed a pathogenic 7q11.23 microdeletion.
He underwent staged surgical repair, including aortic arch reconstruction with pulmonary artery banding and supravalvar aortic stenosis repair with ascending aortic reconstruction, with the ventricular septal defect left open for staged repair. He required 159 days of tertiary care. His course was complicated by bronchomalacia, left pneumothorax requiring chest drainage, non-occlusive thrombus in the right internal jugular and innominate veins treated with heparin and subsequent aspirin, chylothorax, vocal cord palsy, and necrotising enterocolitis. He required readmissions but is currently stable with further repair planned.

Conclusion: This case highlights a rare and severe cardiovascular phenotype in Williams syndrome. Recognition of such complex anatomical combinations may support appropriate investigation and management.

Poster 6 – Case Report

The diagnostic challenge of Incomplete Kawasaki Disease

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Objectives: Incomplete Kawasaki disease (KD) is associated with an increased risk for coronary artery aneurysms (CAA), particularly in infants[1]. This case series presents five challenging cases of incomplete KD, highlighting diagnostic challenges and key clinical learning points.

Method: Retrospective review of five suspected Incomplete KD cases presenting to a District General Hospital (DGH) (June 2024 to October 2025). The cases were reviewed within the context of the American Heart Association's international guidelines and local guidance[2,3].

Results: The five cases included three infants and two children <five years of age. The first learning point was that evolving symptoms of KD were variably present[4] and developed during the admission. All presented with fever, but classical features evolved sequentially. Oromucosal changes were universal, while extremity changes (n=3), cervical lymphadenopathy (n=3), conjunctivitis (n=2), and rash (n=1) were variably present, often emerging during admission. Secondly, we observed there were potential confounding symptoms and diagnoses. Gastrointestinal symptoms were frequent, alongside features such as abdominal pain and non-weight bearing. Alternative or concurrent diagnoses included adenovirus, Group A streptococcus, pyelonephritis, and lymphadenitis, contributing to diagnostic uncertainty and delayed recognition. Finally, we know that incomplete KD is challenging to diagnosis, may have a delayed diagnoses and an increased risk of CAA[1]. Two patients developed coronary involvement (one mild dilatation, one giant CAA). Treatment was initiated between day 6–12 of fever; all received IVIG and aspirin, with escalation to corticosteroids or infliximab in selected cases.

Conclusion: Incomplete KD remains a diagnostic challenge due to its evolving phenotype and frequent confounding diagnoses. Early consideration and parallel investigation of KD alongside differentials are essential. Local guidance and early discussion with tertiary centres may mitigate diagnostic delay and reduce the risk of coronary complications.

Giant vegetation endocarditis, unusual cause of MCA infarct in a toddler- a case report

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Objectives: Infective endocarditis is commonly associated with congenital heart disease, especially with cyanotic heart disease and repaired heart disease with residual lesions and external conduits. The presence of vegetations is the main criteria for the diagnosis of infective endocarditis. Larger vegetations are strongly associated with complications reassociated with infective endocarditis. Our patient had giant vegetation on aortic valve and developed cerebral infarct.

Method: A 1-year-old, previously well boy presented with right sided weakness and balance disturbance. At home, mum noted that he was unable to hold a biscuit in his right hand. He had fever over the weekend up to 39.5 C. However, the fever subsided and he went to nursery. He had few presentations with fever which was put down to likely viral illness. He was born at term and had normal development. He was treated for possible protracted bacterial bronchitis 2 months ago. There was no significant past medical or family history.

Examination revealed right sided hemiparesis, and a heart murmur. His CT head showed a large infarct in the left middle cerebral artery territory. Upon further investigations, his echocardiogram showed a giant vegetation (1.3X0.8cm) on the aortic valve with significant aortic valve stenosis and regurgitation. It was not clear if the aortic valve was bicuspid or dysplastic. He was commenced on the treatment for infective endocarditis and was transferred to tertiary cardiac centre. He later had Ross procedure with good results. He is currently getting neurorehabilitation.

Conclusion: This case highlights the importance of appropriate and timely workup to check for the cause of cerebral infarcts in children. Although there were no peripheral stigmata of infective endocarditis, but the new onset murmur, persistent fever and neurological symptoms were significant enough to consider infective endocarditis and septic embolism as one of the differential diagnoses.

Improving Network Communication within the South West Congenital Heart Disease Network

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Objectives: The project aimed to improve the quality and consistency of communication with regional hospitals within the South Wales and South West Congenital Heart Disease Network, with a focus on children with cardiac conditions discharged from the tertiary centre to their local district general hospitals.

Method: The initial phase involved updating and verifying contact details for all Paediatricians with Expertise in Cardiology (PECs) across the network and improving the system for distributing discharge summaries. Structured feedback was then gathered from PECs to identify key areas where discharge communication was frequently incomplete or unclear, enabling the agreement of priority domains for improvement.

An initial audit of discharge summaries was conducted against these domains to assess the extent of missing or suboptimal documentation. Targeted interventions were subsequently introduced, centred on education for junior medical staff. These included the development of infographic reference materials for daily clinical use and the incorporation of discharge communication guidance into junior doctor induction programmes.

Results: A re-audit was completed 12 months later to evaluate the impact of these measures.
Improvements were seen in documentation of oxygen saturation targets, feeding plans, medication plans and treatment duration, alongside a significant increase in dissemination of discharge summaries to key healthcare professionals.
Ongoing areas for improvement include more consistent documentation of surgical interventions, clearer echocardiography findings, and inclusion of standardised advice on aspirin therapy, post-cardiopulmonary bypass risks and immunisation guidance.

Conclusion: The project has strengthened the quality and reliability of discharge communication across the network, with clear improvements following targeted educational interventions. Continued focus on remaining priority areas will be essential to achieving fully consistent, high-quality communication for children transitioning back to their local hospitals.

A three-year-old male with treatment refractory kawasaki disease and progressive development of multiple giant coronary artery aneurysms, a case report

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Objectives: Kawasaki's disease is an acute multisystem vasculitis with predilection to involve coronary arteries causing aneurysms. Majority of coronary aneurysms are small to medium and range between 2-7 mm. In rare cases, giant aneurysm (> 7 MM) develop and significantly increase the risk of mortality and morbidity. Our patient developed multiple giant aneurysms along the left and right main arteries.

Method: A toddler presented with 7 days of fever, rash, red eyes, sore lips and reduced oral intake. He was admitted with diagnosis of Kawasaki disease. He received IVIG on day 8 of illness along with high dose aspirin. His initial Echocardiogram on day 10 of illness showed small fusiform dilatation of coronary artery, but coronary artery sizes were within the normal range. His fever persisted despite a second dose of IVIG and methylprednisolone for 3 days. Serial echocardiograms showed enlarging aneurysms in the left anterior descending artery measuring11 mm, and right coronary artery measuring up to 7mm. He received 2 doses of Infliximab. He was later transferred to tertiary cardiac centre where his CT angiogram showed giant coronary aneurysms in RCA (10mm) and LAD (13mm) along with multiple distal aneurysms both in right coronary artery and LAD. His fever subsided after 2 doses of infliximab. However, due to enlarging aneurysms, he was commenced on Warfarin. He showed good recovery afterward with reduction in the size of aneurysms. His latest echo showed normal size of coronary arteries.

Results: NA

Conclusion: By presenting this case, we wish to highlight the importance of early detection of IVIG resistant cases of Kawasaki disease and possibly doing the scoring for IVIG resistance. Second line treatment should be initiated promptly if resistance to IVIG is observed. Although giant coronary artery aneurysms are uncommon in Caucasians, but they can still develop in Kawasaki's disease and should be appropriately managed with the tertiary cardiology team support.

Rare genetic cause of Long QT

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Objectives: We want to report a case of Timothy syndrome, incidentally detected post induction for orchidopexy.

Method: Electronic records used to collect data. Timothy syndrome is a rare genetic disorder characterized by an abnormally prolonged cardiac "repolarization" time (long QT interval). This predisposes individuals to arrhythmias, cardiac arrest and sudden death. Other features associated with this syndrome are dysmorphic facial features, webbing of fingers and/or toes

Case report: 8yr old boy was admitted to hospital for elective left orchidopexy, during induction he was developed 2 degree AV block with T Talterans, maintaining reasonable cardiac output throughout, QTc 504 msec.
Past medical history - an episode of syncope after climbing a flight of stairs reportedly looked grey and had stopped breathing, was associated with jerking of limbs resuscitated by father and subsequently taken to hospital where he was diagnosed to have a seizure and discharged home. Currently being evaluated for autism.
His physical exam was normal. Holter, showed QT c prolongation with T alternans. His genetic testing showed positive gene mutation CACNA1C. The family counselled for the need for implantable defibrillator and ICD implanted.

Discussion: Classic timothy syndrome (TS) is a rare genetic disorder with dysfunction in multiple organ systems, clinically characterized by long QT syndrome and syndactyly.
Classic TS is inherited AD, although it usually is the result of a de novo mutation. Patients with TS are prone to life threatening ventricular arrhythmias due to prolonged QT interval.

Conclusion: Timothy syndrome is a rare congenital arrhythmia disorder, high risk for sudden death due to life threatening ventricular tachyarrhythmia. Implantation of an ICD at a very young age may be the best means to prevent sudden death in this group.

Not all adolescent hypertension is white coat. The benefits of local cardiac evaluation in the identification of near interruption of the aorta in an asymptomatic teenager.

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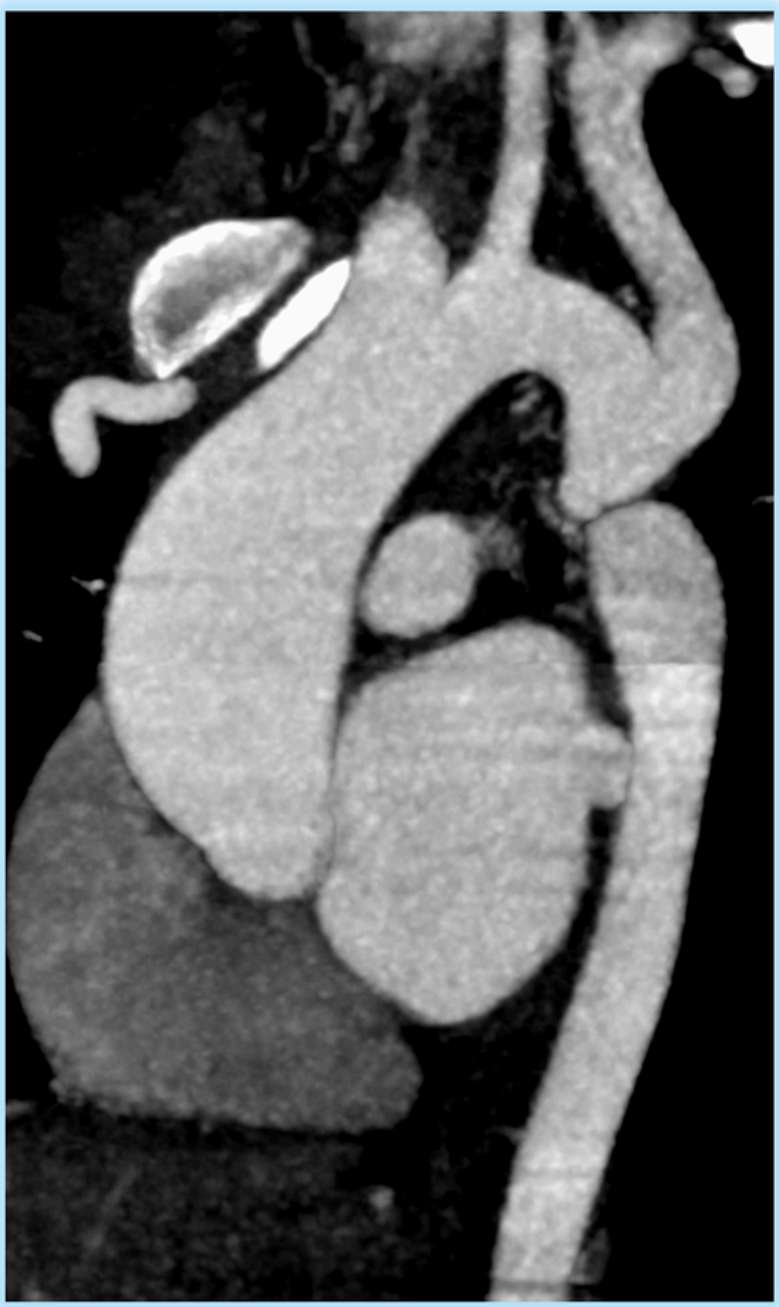
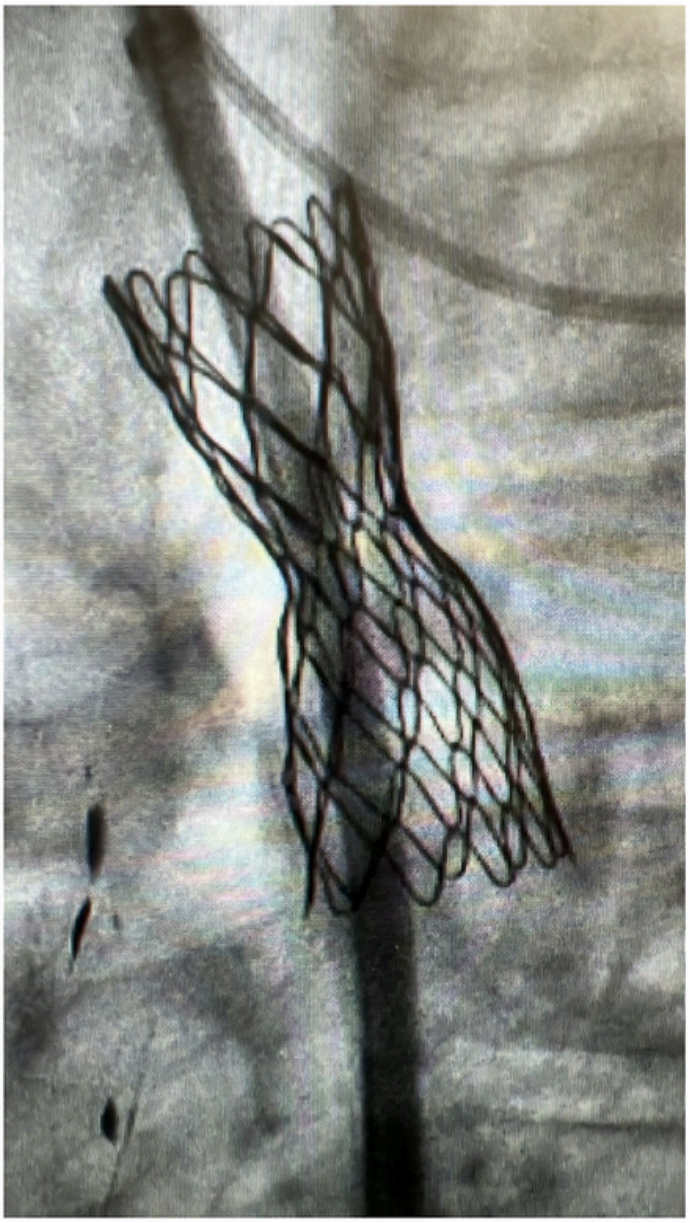
Objectives: To highlight the importance of recognising and appropriately investigating hypertension in adolescents, and to demonstrate how significant cardiovascular pathology may present incidentally in otherwise asymptomatic patients.

Method: A case of incidental hypertension in an adolescent male undergoing endocrine evaluation was retrospectively reviewed. Diagnostic work-up included clinical examination, ABPM, echocardiography, and CT angiography, with findings discussed at a multidisciplinary team meeting to guide management.

Results: A previously well 14-year-old male was noted to have incidentally elevated blood pressure during endocrine assessment, initially attributed to anxiety. Persistently elevated readings prompted ABPM, which confirmed sustained hypertension (mean 161/98 mmHg).
Subsequent echocardiography demonstrated left ventricular hypertrophy and raised suspicion of aortic coarctation. CT angiography confirmed severe coarctation with near-interruption of the aortic arch distal to the left subclavian artery, with extensive collateral circulation and associated aortic dilatation. Despite significant anatomical and physiological abnormalities, the patient remained asymptomatic, with no exercise limitation or claudication. He underwent catheter-based intervention in March 2026 and is currently awaiting follow-up.

Conclusion: This case demonstrates that severe coarctation of the aorta may remain clinically silent into adult life, with hypertension as the only presenting feature. It emphasizes that elevated blood pressure in children should not be attributed to anxiety without objective confirmation and ambulator monitoring with subsequent cardiovascular review can facilitate timely diagnosis of significant underlying cardiovascular disease.





Analysis of Paediatric Cardiology Outpatient Referrals: Waiting times, Outcomes and Referral Patterns in a DGH

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Objectives: Cardiovascular conditions in children require timely specialist assessment to optimise outcomes. Referrals originate from primary care, emergency departments, general paediatrics and various specialities within Paediatrics. Inappropriate or delayed referrals may increase waiting times and service burden. This audit evaluates referral patterns in a district general hospital (DGH). To evaluate patterns, efficiency, and appropriateness of referrals to PEC clinics (Paediatrician with cardiology interest) in a DGH.

Method: A retrospective analysis of new patients seen in PEC clinics over a period of 6 months. Data collected included referral source, urgency, clinical indication, patient age, waiting time, echocardiogram findings, and clinical outcomes. Data were analysed descriptively.

Results: 174 new patients seen. 85% of referrals were routine. 65% of patients were aged 5–16 years. The most common indications for referral were heart murmurs (27%), palpitations/syncope (20%), chest pain (13%), family history of CHD (13%), and other associated medical conditions (7%).
71% of patients waited 3–6 months for assessment. Only 1% were seen within one month. Echocardiograms were performed in 165 patients, of which 81% were normal. Overall outcome- 49% discharged after first visit, 41% requiring follow-up, 5.8% were referred to tertiary centre.

Conclusion:
• A substantial proportion of referrals represent low-risk cases, as evidenced by high normal echocardiogram rates and discharge after first assessment.
• PEC led clinics are a very useful resource to screen low risk cases
• These findings highlight the need for further education to clinicians including primary health care on referral criteria for common paediatric cardiac conditions.

When Vessels Take the Wrong Route — Vascular Rings and Slings in Paediatric Practice

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Objectives:

• To illustrate the clinical spectrum of vascular rings and pulmonary artery slings through a case-based approach, highlighting key diagnostic challenges, red-flag presentations, and the importance of multimodal imaging when echocardiography is inconclusive.
• To reinforce that not all anatomical vascular rings cause symptomatic compression, and to outline indications for surgical intervention.

Method: We reviewed cases of aortic arch anomalies managed at our institution, 2 years in retrospect, representing a spectrum of presentations. Each case was evaluated with echocardiography along with CT angiography. ENT assessment, bronchoscopy, and contrast swallow studies were used as adjuncts based on symptom profile.

Results:

• Echocardiography confirmed arch sidedness and branching pattern but was insufficient to exclude a compressive ring in one of the cases.
• CT angiography was definitive in delineating the vascular anatomy and degree of airway/oesophageal compression.
• Biphasic stridor and feeding difficulties unresponsive to standard management were among the reliable clinical indicators.
• All surgically treated patients achieved complete or near-complete symptom resolution.

Conclusion: Vascular rings and slings should be considered in any infant or child with unexplained biphasic stridor, recurrent wheeze unresponsive to bronchodilators, or progressive feeding difficulties. A normal or reassuring echocardiogram does not exclude a symptomatic vascular ring cross-sectional imaging (CT or MRI angiography) is indicated when clinical suspicion remains. Not every anatomical vascular ring is compressive; management decisions should be guided by symptom burden and imaging evidence of airway or oesophageal compromise. Surgical correction is associated with excellent outcomes, though postoperative tracheomalacia and dysphagia may require ongoing rehabilitation. Multidisciplinary collaboration Paediatrics, Cardiology, ENT, Radiology, Speech and language therapy, and Paediatric surgery—is essential for timely diagnosis and optimal management.

Improving ECG interpretation & documentation in a DGH

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Objectives: To improve structured and complete interpretation of ECGs, including senior reviews and appropriate escalation, from baseline to >90% within 4 weeks.

Method: Retrospective case-note audit of paediatric ECGs from emergency department, paediatric assessment unit and ward before and after intervention. Intervention included written communication, departmental teaching and creation of an electronic ECG interpretation template.
Presence of structured ECG interpretation and documentation of senior review (ST6 resident or above) was assessed. A cardiology registrar independently re-evaluated each ECG to ensure appropriate interpretation and escalation.

Results:
Pre-intervention: No ECGs (total 30) had complete structured review. 20/30 (67%) had partial interpretation, 5/30 had overall impression only and 5/30 had no written review. 100% of ECGs from ED had some interpretation, compared to 50% of ECGs from paediatric areas. When indicated, 9/19 (47%) ECGs had a senior review. Element documentation varied, with rhythm documented in 60% and QTc in 47% but axis in only 23% and ST segment in 7%. Tertiary cardiology discussion was needed in 8/30, half of which were not detected until independent review (pathologies: abnormal P axis, PR prolongation and QTc prolongation).
Post-intervention: There was a significant increase in complete structured review (10/27, $P<0.01$). All 6 elements with poor documentation pre-intervention showed a significant improvement. Senior reviews increased by 34% ($p<0.05$). There was no significant difference in the number needing tertiary discussion, but there was a reduction in abnormal pathologies not detected until independent review (50% vs 18%).

Conclusion: Structured ECG interpretation is attainable within acute paediatric services. Although 90% target was not met, rapid improvement was achieved across all elements. Departmental teaching aided confidence in detecting abnormalities and a simple online template (linking to interpretation guidelines) provided an accessible standardised approach for documentation, ensuring accurate diagnosis and timely management.

Improving the patient experience at the Princess Royal University Hospital's paediatric cardiology clinic, using a child-focused video

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Objectives: Children are often unsure what to expect in a paediatric cardiac clinic appointment. Their anxiety or fear can impact diagnostic accuracy. Most pre-appointment information provided is aimed at parents not young children. The aim of our Quality Improvement Project (QIP) was to improve patient and family experiences through the use of an animated video.

Method: This project recruited all new patients aged 0-16 years attending the paediatric outpatient cardiac clinic over 5 months, across 2 PDSA cycles. A child-friendly questionnaire assessed level of preparedness (LoP) and child fear score (CFS) and was completed before and after appointments. In Cycle 2, the video was shown to participants prior to their appointments.

Results: There were 18 patients in Cycle 1 (mean age 7.09 years) and 21 patients in Cycle 2 (mean age 6.57 years) [p=0.733].
Pre-appointment LoP (using a 10-point scale) was similar between the cycles (8 vs 8, p=0.72, Mann–Whitney U test; n=18 vs 21). LOP pre and post appointment was unchanged in Cycle 1 (10 vs 10, p=0.50; n=13) but increased in Cycle 2 (8 vs 10, p=0.005; n=21; Wilcoxon signed-rank).
CFS median pre-appointment scores were similar between groups (1 vs 1, p=0.87; n=17 vs 17). CFS decreased in both Cycles (Cycle 1: median 1.5 vs 1, p=0.034; n=16; Cycle 2 1.5 vs 1, p=0.064; n=16; Wilcoxon signed-rank).
Suggestions following Cycle 1 included information leaflets (n=8), explanatory video (n=4) and posters (n=2). Improvements recommended following Cycle 2 were earlier access to the video and resources tailored for older children.

Conclusion: Our QIP demonstrated well-defined educational resources have the potential to increase patient preparedness, reduce anxiety and improve the overall experience for the families.

World's first: Robot saves life of 11-year-old boy with recurrent life-threatening haemoptysis with casts post TCPC.

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Objectives: Life-threatening haemoptysis is a recognised complication post TCPC. Coil embolisation of aortopulmonary collaterals is the usual first-line approach.
Plastic bronchitis, a rare catastrophic complication of TCPC (4% of cases), results in coughing up of rubbery, tree-shaped casts potentially causing fatal haemoptysis and/or airway obstruction. 5-year mortality-rate is 50%. We present a case managed with shared care (PECS & tertiary centre).

Method: Age
1-month-old presents with cyanosis- diagnosed with cTGA, straddling right-sided mitral valve, DORV with subpulmonary stenosis, secundum ASD & large malaligned VSD.
6 months: bidirectional Glenn, atrial septectomy with pulmonary valvectomy.
5 years: Collaterals occluded via catheterisation.
6 years: Immediately following extracardiac-fenestrated-TCPC, haemoptysis began. Despite catheter collateral occlusion, this persisted for 2-weeks, requiring transfusion and procoagulants.
11 years: A&E presentation with large haemoptysis(Fig 1). Cast noted(Fig 2).
Catheter revealed normal haemodynamics & hypoplastic LPA.
Plastic bronchitis diagnosed.
CT - vascular left lower lobe with multiple tiny collaterals.
Low-fat diet & spironolactone controlled symptoms for 8-months.
Recurrent small haemoptysis during following winter respiratory infections managed using tranexamic acid & antibiotics.
Eventually represented to DGH with 400ml haemoptysis.
Listed treatments above no longer effective; recurrent haemoptysis occurring multiple times daily.
MRI lymphangiogram showed isolated left lower lobe abnormality possible sequestration.
Using the Davinci machine (Fig 3a), a robotic-assisted left lower lobectomy was performed through four 8mm ports and one 15mm assistant port. The left lower lobe was carefully separated from the oesophagus, mobilised, fissure carefully dissected out (Figs 3b&3c).
Histology confirmed intralobar sequestration.
5 months post procedure - No further haemoptysis or cast production despite normal fat diet, activities and aspirin.

Results:
Fig 1 - haemoptysis
Fig 2 - cast mimicing shape of bronchial tree where formed
Fig 3a - DaVinci Surgical System
Fig 3b - resection of abnormal left lower lobe
Fig 3c - resected segment, measuring 55 x 15 x 44 mm

Conclusion: We report the first successful robotic treatment of haemoptysis and cast production post-TCPC in a child.

Fig. 1- haemoptysis

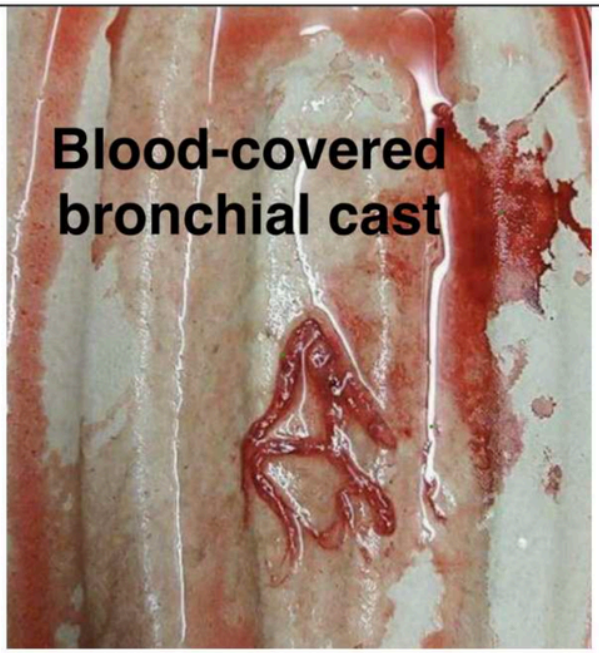

Fig. 2- cast mimicing shape of bronchial tree where formed

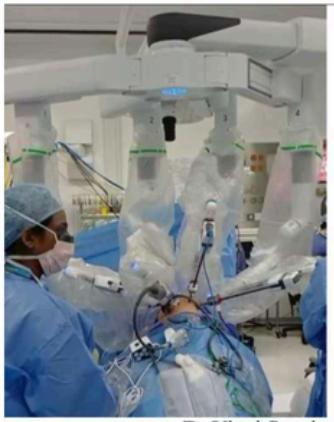

Fig.3a- DaVinci Surgical System

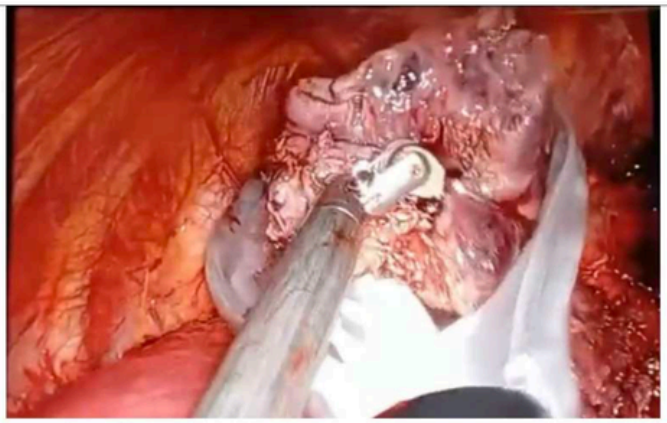

Fig.3b- resection of abnormal left lower lobe

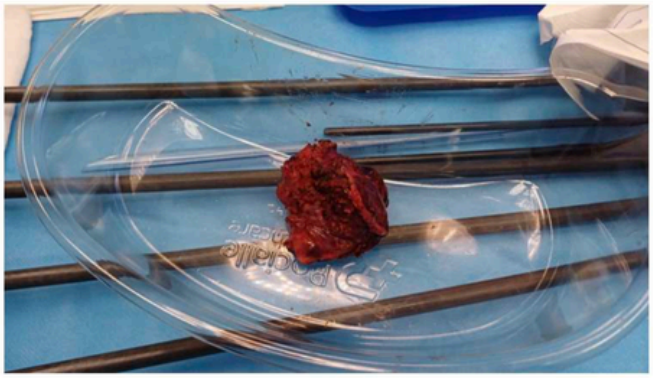

Fig.3c- resected segment, measuring 55 x 15 x 44 mm

Antenatal detection rate of congenital heart defects

Sonya Gandhi[1], Fehmida Sultana[2], Sivakumar[2], Venugopalan[2]

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[2]MMUH (Midlands Metropolitan University Hospital), United Kingdom

Objectives:

- Percentage of CHD detected antenatally
- Gestation of the anomaly scan
- Outcome of the antenatal scan
- Gestation of the fetal medicine scan
- Age of postnatal ECHO
- Association with genetic conditions
- Management of the CHD postnatally

Method: Retrospective data sampling and analysis of congenital heart defects (CHD) was retrieved from Badgernet. The exclusion criteria were patent ductus arteriosus, patent foramen ovale, atrial septal defect and small or moderate sized VSD. The sample size collected was 23, from August 2022 to August 2025.

Results: The data showed 4 babies between 34 and 40+5 weeks were born with CHD. The gestational age of first anomaly scans was between 19 weeks to 37 weeks. 4 CHD postnatal diagnoses did not have anomaly scan. The final antenatal scans were performed by fetal medicine from 20 weeks to 39 weeks. The outcome was 47% of CHDs were detected antenatally. The 17 postnatal echoes were completed on day 0 to 3. The final CHD diagnoses included Coarctation of aorta, Tetralogy of Fallot, hypertrophic heart syndrome, atrioventricular septal defect, partial anomalous pulmonary venous drainage, Ebstein's anomaly, and TGA or dextrocardia. 7 were diagnosed with T21; 2 with Digeorge syndrome; 1 Edward's syndrome; 2 other genetic abnormalities and 11 with no genetic abnormalities. All patients were discussed and transferred to BCH and management such as prostaglandins, diuretics, respiratory support, inotropes or surgery.

Conclusion: CHD are life-threatening conditions, often associated with genetic conditions. Antenatal anomaly scans can prepare for a child to be born with CHD and management options. The antenatal detection rate in MMUH in 2015 was 52%, compared to 47% in 2025. The national average detection rate in the UK by ICS from NCHDA is 53% in 2024/25.
Continuing to audit and implement changes can help improve outcomes for CHD.

Improving Parental Awareness of Infective Endocarditis and Oral Health in Children with Congenital Heart Disease: A Quality Improvement Study

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[1]Morriston Hospital, Swansea Bay University Health Board, South Wales and Southwest Congenital Heart Disease Network, United Kingdom

Objectives: To assess parental awareness of infective endocarditis (IE) and its association with oral health in children with congenital heart disease (CHD), and to identify gaps in knowledge and preventative practices to inform targeted educational interventions.

Method: A structured questionnaire was administered to parents of children with CHD attending the paediatric cardiology clinic at Morriston Hospital, within the South Wales and Southwest Congenital Heart Disease Network. The survey assessed awareness of IE, understanding of its association with oral health, dental attendance, oral hygiene practices, and knowledge of antibiotic prophylaxis. Following baseline assessment, a standardised parent information leaflet will be introduced to address identified knowledge deficits and enhance awareness of IE prevention.

Results: 21 parents participated. Over 50% had no prior awareness of IE, and most were unaware of its association with oral health. Suboptimal oral hygiene practices were common, with 45% of children not meeting recommended toothbrushing standards and 25% not registered with a dentist. Nearly half of parents did not recall receiving dental advice at diagnosis; when provided, this was predominantly verbal and rarely supported by written information. Knowledge of IE symptoms and appropriate response was limited, and uncertainty regarding antibiotic prophylaxis prior to dental procedures was frequent.

Conclusion: There are significant gaps in parental awareness and preventative practices in this high-risk population. A simple, standardised written educational intervention represents a scalable and cost-effective strategy to improve knowledge, promote preventative behaviours, and support early recognition of IE. Embedding consistent education within paediatric cardiology services may improve patient safety and reduce preventable morbidity.

Enteroviral Myocarditis and Meningitis in a Neonate: A Case Report

Anshoo Dhelaria[1], Lyn Ventilacion[1], Rosalind Teh[1], Manish Shah[1], Jamin Koo[1]

[1]East and North Hertfordshire Teaching NHS Trust, United Kingdom

Objectives: Enteroviral infections in neonates can present with severe manifestations, including myocarditis and meningitis. We present a case of Coxsackie B5 virus infection causing significant cardiac and neurological involvement in a 5-day-old infant.

Case Presentation: A term female neonate presented on day 5 of life with fever, grunting, and mottling. Initial management for presumed sepsis revealed enteroviral meningitis, with subsequent development of myocarditis. The patient required escalation of care to a tertiary cardiac centre, where she received multidisciplinary management including intravenous immunoglobulin (IVIG), respiratory support, and cardiac medications.

Conclusion: This case highlights the diagnostic challenges of neonatal enteroviral infection, the importance of comprehensive viral screening in unexplained sepsis-like presentations with cardiac involvement, and the benefits of early recognition and multidisciplinary management.

Keywords: Enterovirus, Coxsackie B5, neonatal myocarditis, meningitis, case report

Cardiac follow up for DRAVET patient on Fenfluramine treatment-A survey for PEC Consultants

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[2]Medical School, University College London, London, UK

Background
There is a common practice of performing echocardiogram before starting Fenfluramine treatment in DRAVET paediatric patients at the beginning of treatment, then every 6 months for the first 2 years, and annually thereafter for possible cardiac complications.

Aim
We aimed from this survey to explore the current practice of following up paediatric DRAVET patients who have started on Fenfluramine in cardiology clinic and to find out how frequent cardiac complications happened in this cohort of patients.

Method
An online survey has been created and distributed on PEC groups. We aimed to collect responses from consultants only. The survey included multichoice questions and free text spaces if more detail was required.

Results
A total of 33 responses were received from PEC consultant across 28 NHS Trusts in the UK. 33% of respondents are in the East of England, while 24% are in Midland. 48% from all respondents had managed DRAVET patients on Fenfluramine, 81% of which followed their patients at the beginning of treatment, then every 6 months for the first two years. Only 2 consultant (12.5%) reported two patients who developed Aortic regurgitation and mild Mitral regurgitation at 2-year of follow up (Dose of 0.2 mg/kg BD confirmed by email). Dose information was poorly documented. Only 3 respondents recorded a specific dose 0.2 mg/kg twice daily.

Conclusion
We concluded from the survey that the incidence of cardiac complications because of Fenfluramine treatment in DRAVET paediatric patients is low. Whether follow up frequency could be adjusted accordingly requires more research.

Observational Survey of Patent ForamEN Ovale (OPEN) Follow Up Practices in the UK

Cecilia Bogle[1], Ryan Abumehdi[2], Sankara Narayanan[3]

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[2]Consultant Paediatric Cardiologist, NHS Greater Glasgow and Clyde, United Kingdom
[3]Consultant PEC, West Hertfordshire Teaching Hospitals NHS Trust, United Kingdom

Objectives: Patent Foramen Ovale (PFO) is a benign foetal structure that persists in 25% of the general population and up to 80% of premature infants. Most PFOs close spontaneously within the first year of life, a proportion persist beyond childhood. In adults, PFO is associated with cryptogenic stroke, migraine, and decompression illness, though paediatric evidence remains limited. No UK national guidance exists on follow up monitoring of asymptomatic, isolated PFO in children, and prior survey data suggest significant variability in follow-up practice. To describe current UK practice in the follow-up of incidentally detected, haemodynamically insignificant PFO in children across different age groups, clinical roles, and centre types.

Method: OPEN survey was an R&D-approved, validated national survey distributed to UK Paediatric Cardiology practitioners (Paediatric Cardiologists and PECs) Respondents were presented with three clinical vignettes of a 6-month-old, a 5-year-old, and a 13-year-old, each with identical echocardiographic findings of a small PFO with normal biventricular function and no prior neurological events and asked to answer questions on follow up need and frequency. Responses were in Microsoft Excel.

Results: 135 practitioners responded from across all four UK nations, comprising 46 Paediatric Cardiologists, 84 PECs, and 5 other clinicians. Discharge rates increased significantly with patient age (Cochran's $Q=19.40$, $p<0.0001$), with 50% changing their management plan based on age alone despite identical echo findings. Cardiologists discharged more readily than PECs at every age (OR 2.79 to 3.78). Eight percent of respondents applied unsolicited numerical size thresholds, and 14% cited parental anxiety as a reason for ongoing follow-up.

Conclusion: Significant variation in PFO follow up practices exist, driven by patient age, clinician role, and centre type rather than clinical evidence. These findings highlight an urgent need for a national consensus statement and targeted educational interventions to standardise practice.

Dr Anshoo Dhelaria for

EAST & NORTH HERTFORDSHIRE NHS TRUST CHARITABLE FUND

Riding for Children's Big Build

LONDON — 56 MILES — BRIGHTON

On **21 June 2026**, I and my cycling team are taking on the historic 56-mile London to Brighton route to raise funds for the **Lister Hospital Children's Big Build.**

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PECSIG

NHS
East and North Hertfordshire Teaching NHS Trust

PECSIG Summer Meet 2026

Organized by: Dr Dhelaria and Lister Hospital Team
Stevenage, SG1 4AB

Endorsed by: Paediatricians with Expertise in Cardiology Specialist Interest Group (PECSIG)

Venue: Shendish Manor Hotel & Golf Course, Hemel Hempstead, HP3 0AA
~20–25 min from Luton Airport; London Euston–Midlands train line, ~1–1.5 miles from station.
Date & Time: Friday, 12 June 2026, 09:00 – 17:00

Category	Non-Member	Non-Member (Early Bird)	Member	Member* (Early Bird)
Type 1 – Consultant	£150	£130	£130	£110
Type 2 – Residents	£120	£100	£100	£80
Type 3 – Medical Students / Nurses / Physiotherapists	£90	£70	£70	£50

Registration: Please scan the QR code for registration or use the link.
Early Bird deadline extended to 30 May 2026
RCPCH CPD approval applied

Abstract Submission: Please use the abstract template link and email the abstract to thepecsig.uk@gmail.com. Max 300 words (PDF)
Deadline: Midnight, 30 April 2026 & presenting authors must be registered

- Conference Drinks & Dinner: 12 June 2026 | 18:00 – Midnight
  Shendish Manor Banquet Suite

Accommodation: Bed & breakfast accommodation for 11 June is available on site at limited discounted rates, offered on a first-come, first-served basis.
Phone: 01442 232220 (please **ask for the event rate**).

Contact: thepecsig.uk@gmail.com

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Connecting the Children's Heart Community

In collaboration with ECHO charity the team at Princes Royal University Hospital under the able guidance of Dr Ola Elmasry, have generated an excellent video to prepare patients regarding expectations when attending cardiac clinic. Please see the link and use for your own clinic.

Link: https://youtu.be/HTo30aeT4es?si=LxCBTMmogzZtK2mZ

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Thank You

The Paediatricians with Expertise in Cardiology Specialist Interest Group (PECSIG) would like to thank all our speakers, delegates, sponsors, abstract presenters, and organising committee members for their invaluable contribution to the success of the PECSIG Summer Meet 2026.

We are grateful for your continued support, enthusiasm, and commitment to advancing paediatric cardiology and improving the care of children with heart disease.

We look forward to welcoming you again at future PECSIG events.