Aus pioneers share how to build a cardio-oncology service

RESEARCH

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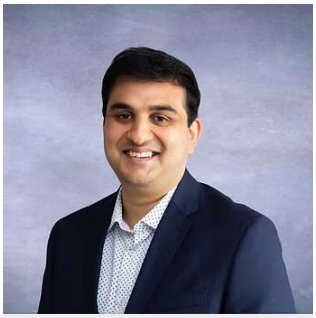
Building personal relationships with oncologists matters more than any clinical protocol when setting up a cardio-oncology service, specialists told Australia's first dedicated cardio-oncology meeting this month.

The message came through clearly at the inaugural Australian Cardio-Oncology Research and Education Symposium (ACORES), held at Chris O'Brien Lifehouse in Sydney on 14-15 March. A closing panel brought together clinicians from three established services to compare notes on what works, what doesn't, and where the field needs to go.

"I think everyone here will know that cardio-oncology in Australia is an emerging field," said Dr Satish Ramkumar, a cardio-oncologist at the Victorian Heart Hospital who set up Monash Health's service after returning from a fellowship in the UK.

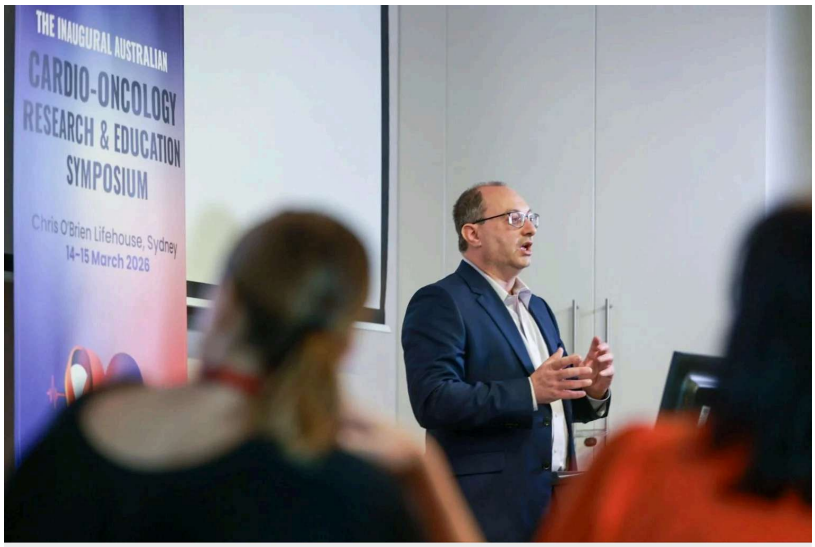


Dr Satish Ramkumar

"Trying to get all the pieces of the puzzle from clinic space, funding for a practice nurse, engagement from oncology and haematology, that took a bit of time."

Professor Aaron Sverdlov, who launched what became one of Australia's largest cardio-oncology programs at Newcastle in 2017, described a "build it and they will come" approach that has since grown into a service seeing roughly 30 patients a week across multiple clinics.

The program now employs 16 people including clinicians, researchers and allied health staff, and is supported by a consumer advisory group of seven. Since 2017, the Newcastle service has logged close to 5,000 patient visits in the public setting and around 2,000 in private.



Professor Aaron Sverdlov

Getting there required navigating governance across two campuses run by different health entities, persuading haematologists to move away from nuclear medicine for cardiac monitoring, and spending three years putting together a business case to expand echocardiography access before COVID intervened.

“Eventually we succeeded in getting more echo access, more sonographers, another machine that was more dedicated to cancer patients,” Professor Sverdlov said.

The Peter MacCallum Cancer Centre’s cardio-oncology service predates both, having developed over more than a decade. It now runs about three clinics a week across four cardiologists, seeing around 25 patients weekly, and is booked out months in advance. The service has partnerships with the Royal Melbourne Hospital and runs three randomised clinical trials in collaboration with the Baker Heart and Diabetes Institute.

For Dr Lorcan Ruane, who recently spent time at the Royal Brompton Hospital in London under Professor Alex Lyon, the author of the ESC cardio-oncology guidelines, the lesson from one of the world’s most advanced services was straightforward. “The key ingredient to the success there was just those real personal relationships between Alex and the haematologists and oncologists,” he said. “I’m trying to replicate that: just actually spending time in front of these people, getting to know them, so that they know and trust you.”

That theme of trust ran through the audience discussion too. One clinician described early resistance from oncologists and haematologists who saw cardiologists as obstructive rather than helpful. “Initially there was no trust, and the oncology and haematology teams considered us as people being obstructive and telling them that what you do destroys the heart,” he said. “We should work on trust more if we want our cardio-oncology services to work better.”

An oncologist from Newcastle, reflecting on the service’s origins, said co-location and timeliness had been critical to winning over colleagues. “Being able to just chat in a corridor or in a clinic that ran at the same time, being able to have timely consultations with patients, I think that smoothed the entry of the cardio-oncology service.”

One speaker who has set up two separate services argued strongly for physically embedding cardio-oncology within oncology or haematology departments rather than asking patients to travel to a separate cardiology unit. They also pointed to a practical operational fix that made a significant difference: securing a reserved urgent echocardiography slot. “If I see someone who needs chemotherapy tomorrow, I can get an echo today,” they said. “You need to talk to the people running that service so that you have an urgent spot for those patients.”

Regional access drew pointed commentary. Professor Sverdlov noted that only half of Hunter New England Local Health District’s one million-person catchment lives within 45 minutes of the Newcastle hospital. The service has responded by establishing telehealth clinics reaching Maitland and Tamworth, and is expanding outreach to further regional centres, with Cancer Institute NSW funding supporting nurse-led clinics in some locations. “If we can do a combination of telehealth and outreach services and make them cost-effective so that public health will actually support it, that would be the way to go,” he said. “It’s a long haul.”