



## **Inaugural ACE (Australasian Collaboration in Endocarditis) Newsletter.** **25<sup>th</sup> October 2022.**

A HUGE thank you to all those of you who participated in or encouraged the IE National Forum which was convened on October 11<sup>th</sup> to discuss synchronising data-fields.

Discussions included the purposes of these proposed data-fields, with emphasis on a two-tiered model with “compulsory fields” to encompass minimum data necessary to answer clinical questions or to allow benchmarking for quality assurance (QA), which could be performed by smaller centres that do not possess cardio-thoracic surgery (CTS). “Voluntary fields” would enable the collating of additional data (eg additional echo-sonography parameters, time on cardio-pulmonary bypass) which could still be used for statistical analysis but as the name suggests would likely have only a few contributors due to the logistics required.

The QA portion (part of compulsory or essential data) would likely include access to MDTs, TOEs, CTS, dentistry, proportion requiring surgery, and reasons for surgical delays or non-surgery.

By having the two tiers, we hope to identify barriers to optimal outcomes in various centres, especially regional non-CTS centres, which does require the participation of these smaller centres in the registry.

As this innovation aims to chart real-time changes in epidemiology etc, the inclusion of TAVIs is a certainty.

REDCAP Is the planned platform for this. A data dictionary will be performed.

The role of medical imaging (including PET-FDG) in Australia for IE could be a further focus.

When the ACE committee starts the planning process, there will likely be consideration of some data-fields being “time-limited”, that is, when the clinical question they are addressing is answered they can be removed from “essential list” to allow other fields for a new question to be substituted without making the data-entry process “bigger than Ben Hur”.

On a separate note, there was unanimous support for this multi-state initiative to be re-badged as ACE, to enable us to approach national professional bodies for recognition or endorsement and funding.

ACE would not only spearhead multi-centre studies to improve knowledge of IE related phenomena (which may improve management algorithms), but also to enable benchmarking between centres to improve outcomes, with emphasis on promoting MDTs.

Several ACE committees will be formed, to reflect the multi-disciplinary nature of this disease, with cardiology, CTS, Stroke and radiology including nuclear medicine soon. In the interim, the provisional inaugural ID-micro committee consists of Eugene Athan, Indy Sandaradura, Sharon Chen, Renjy Nelson, Siong Hui, and Robert

Horvath. Extra spots may be created if others feel they can contribute (especially from NZ as note the A in ACE is for Australasia!).

Until a suitable website can be found, the provisional ACE webpages will be part of the ieQ website. [infective endocarditis Queensland \(ieQ\) - Medical School - University of Queensland \(uq.edu.au\)](http://infectiveendocarditisqueensland.ieq.med.uq.edu.au).

Or Google “endocarditis Queensland” to access it.

Further newsletters will be emailed to ACE members. Please forward to colleagues who may wish to be members, and please indicate if you’d like to be mentioned on the “members page” which will be similar to the ieQ members page in that only name/specialty and site mentioned, no contact details. This will enable networking without the worry about unsolicited 3<sup>rd</sup> parties using your email addresses. Dedicated email lists will be drawn up (but may use BCC option) for newsletters and news, as we expect as this evolves, considerable numbers of members will not be ASID members.

