Current and future projects of the adult congenital heart disease WG:
• Establish a robust European ACHD accreditation system through the ESC.
• Improve infrastructure of Central/East and South-East European Countries in ACHD to the benefit of adult patients with CHD across Europe.
• Increase membership through networking and collaboration with other groups and societies, with the mid- to longer-term aim of becoming an ESC Association of ACHD.
• Revisit the opportunity of an EHJ sister journal with an ACHD focus.
• Enhance educational opportunities, such as the EuroACHD Meeting, towards further integration and consolidation with other educational/training curricula in London and the rest of the world.
• Patient education, advocacy, and closer involvement.

Adult congenital heart disease is not a Cinderella specialty any longer, the number of patients, the complexity of work and the opportunities and challenges ahead call for increasing visibility and stronger voice, more collaborative work and us being more inclusive yet without compromising patient care. Adult congenital heart disease encompasses all aspects of cardiology and overlaps with many other disciplines, including high-risk obstetrics for example. We are truly marching with the patients and learning from each other. There are so many rewards on this journey. We need to share our knowledge and optimism for the future with the patients, junior, and senior colleagues, like you. DO JOIN OUR ACHD WG of the ESC TODAY!

https://www.escardio.org/Working-groups/Working-Group-on-Adult-Congenital-Heart-Disease/Membership.

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COVID-19 and congenital heart disease in perspective

A short report on health, patients and well-being, by Michael A. Gatzoulis in London

Cycling to work in London now feels surreal: very few people about, a metropolis stripped of its many attractions (museums, restaurants, shops, etc.), but buildings and other material objects remain intact. It is only people who are affected. Uncertainty looms large on relaxing the draconian measures taken to slow down the spread of the disease, so we can return to some ‘normality’. Last, but not least, legitimate concerns are about the economic and psychosocial implications of the pandemic, and the consequent disruption of the societal fabric, as we know it.

And yet, there is no doubt that we will weather this, as man did weather virus pandemics and other global challenges in our long history. There is always opportunity with crises. One hopes that at the other end of this storm we will be better people, more humane, considerate, together, and appreciative of healthcare and of science, and of all other support services essential to a smooth running of a society.

This short communication is of course about health, patients, and well-being. While the frenzied efforts to combat the COVID-19 pandemic are understandable, we must not forget our primary obligation to look after our patients; their needs should not be neglected. This includes patients with life-long diseases, such as congenital heart disease (CHD), emergencies such as acute coronary syndromes, patients with suspected or newly diagnosed cancer, and many more.

We, for example, at the Royal Brompton Hospital became a COVID Centre ‘overnight’. While excited at being part of a national/global effort to defeat this aggressive virus and energized to engage in a new area (intensive care), I have some concerns regarding the care and well-being of the 12 000 adult patients with CHD that my colleagues and I collectively look after, and not only about them. We, as everybody else, converted quickly to tele-health clinics and deferred all inpatient interventions—other than necessary—to protect patients from COVID exposure. We also worked hard to inform and reassure—as much as possible—patients about COVID-19 utilizing webinars, patient association initiatives, social media, etc., and this was very well received.

However, COVID will not be with us forever. We must start preparing now for resuming our non-urgent/elective work and for catching up with all things deferred during the pandemic. Furthermore, there is now an opportunity like never before to create a new and better model of care, utilizing technology, empowering patients, and giving them a better life experience and journey. This is particularly suited to adult CHD as we have argued for some time. Now is the time to plan for it and do it. We must not lose sight, even during the pandemic, that our primary responsibility is the care and well-being of our patients; in the case of the writer; that is adult CHD patients. Our profession and healthcare planners will be judged on this, when the COVID pandemic is over.
What adult CHD (and other) patients must do/expect during the COVID-19 pandemic and beyond

- Social distancing (all, until further notice)
- Shielding of high-risk patients [i.e. single ventricle physiology, pulmonary arterial hypertension, immunosuppressed/compromised patients, other specific patients (consult your local provider)]
- Tele-health clinics and deferment of elective/prognostic procedures to minimize COVID exposure; these temporary measures need/should not compromise outlook.

- Made aware of contingency plans for urgent care: Where, How, When? Follow guidance from NHS and other sites, particularly so from local providers
- Regular updates/information sharing about COVID-19
- Mental and psychosocial well-being, exercise, lifestyle modification(s), improve oneself
- A new improved model of care after COVID, utilizing technology, artificial intelligence, and, crucially, education and patient empowerment.

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Heart Team meetings during COVID-19

Different formats of multidisciplinary Heart Team meetings under the gathering restriction rules due to the coronavirus disease-2019 pandemic are discussed

Introduction

At the end of 2019, a novel strain of the coronavirus emerged in Wuhan, China and caused a respiratory infection named coronavirus disease 2019 (COVID-19).1 Due to the rapid worldwide spread of the virus, the World Health Organization (WHO) officially declared COVID-19 a pandemic on 11 March 2020.2 In order to minimize the spread of the disease, many countries enacted precautionary measures, such as restrictions on gatherings and social distancing, following WHO guidelines.3

In daily clinical practice, the coming together of physicians for multidisciplinary team (MDT) meetings is essential for good patient care. Examples in the cardiovascular field are Heart Team evaluations for coronary revascularization, valvular pathologies, and endocarditis, which have been recommended by the European Society of Cardiology (ESC).4–6 Although these meetings are necessary and by definition not restricted, they could potentially increase the risk of spreading the virus, which should be prevented at all costs, particularly between healthcare professionals. In order to continue to provide good patient care while minimizing the risk of spreading the virus, other alternatives for conducting MDT meetings should be considered. In this article, we present four alternative methods (Figure 1), along with their benefits and drawbacks (Table 1).

Table 1  Benefits and drawbacks of the four alternative methods proposed for the Heart Team meetings

| Methods               | Benefits                                                                 | Drawbacks                                           |
|-----------------------|--------------------------------------------------------------------------|-----------------------------------------------------|
| Adjusted physical meeting | Physical meeting with same setting                                       | Remaining risk of infection or transmission of microorganisms |
| Video conference      | No risk of infection or transmission of microorganisms                   | Connection problems                                  |
| Electronic communication | No risk of infection                                                     | Time consuming                                       |
| Extended reality      | No risk of infection                                                     | Still in development                                 |