Focus cardiac ultrasound core curriculum and core syllabus of the European Association of Cardiovascular Imaging†

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There is a growing trend of using ultrasound examination of the heart as a first-line diagnostic tool for initial patient evaluation in acute settings. Focus cardiac ultrasound (FoCUS) is a standardized but restricted cardiac ultrasound examination that may be undertaken by a range of medical professionals with diverse backgrounds. The intention of this core curriculum and syllabus is to define a unifying framework for educational and training processes/programmes that should result in competence in FoCUS for various medical professionals dealing with diagnostics and treatment of cardiovascular emergencies. The European Association of Cardiovascular Imaging prepared this document in close cooperation with representatives of the European Society of Anaesthesiology, the European Association of Cardiothoracic Anaesthesiology, the Acute Cardiovascular Care Association of the European Society of Cardiology and the World Interactive Network Focused On Critical Ultrasound. It aims to provide the key principles and represents a guide for teaching and training

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† The document is endorsed by the Acute Cardiovascular Care Association (ACCA) of the European Society of Cardiology, the European Association of Cardiothoracic Anaesthesiology (EACTA), the European Society of Anaesthesiology (ESA), and the World Interactive Network Focused On Critical Ultrasound (WINFOCUS).
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Background

Cardiac ultrasound can provide important, often life-saving information in critical/emergency settings. Data acquisition depends on specific imaging targets, conditions or scenarios, the ultrasound equipment used, techniques and protocols applied, and related to the level of training and skill of the operator and the individual operator’s profile. Ideally, these examinations should always be performed by an experienced acute/intensive care practitioner, appropriately trained both in echocardiography and acute/intensive cardiovascular care.1,2 Although historically cardiologists were almost exclusively responsible for performing/supervising and interpreting echocardiographic examinations in acute/emergency settings, fully trained cardiologists are not always available where medical emergencies occur.

The European Association of Cardiovascular Imaging (EACVI) has long recognized that a range of medical professionals are involved in the management of cardiovascular emergencies on a daily basis, and not only cardiologists.1,3 These include emergency physicians, intensive care specialists, anaesthesiologists, sonographers/cardiac physiologists and fellows in training.1,3 Despite their diverse medical backgrounds, all of them are able to recognize important findings and obtain key answers in emergency settings by using cardiac ultrasound, provided they have the appropriate training. Indeed, from the ethical point of view, emergency ultrasound examination of the heart should be performed by any properly trained medical professional and avoid delay in diagnosis.1,3

There is a growing trend for using cardiac ultrasound as a first-line diagnostic tool for initial patient evaluation in acute settings.1,3 To make critical decisions, the attending physician does not necessarily need the whole data set of cardiac morphology and function that is required for a comprehensive echocardiographic exam.4 Instead, in the majority of emergency situations, restricted information may be used to understand underlying pathophysiology, narrow the differential diagnosis, initiate therapy and/or to trigger further diagnostic work-up. Since the introduction of transthoracic echocardiography in the hands of non-cardiologists in the late 80’s, it has been convincingly demonstrated that relevant information regarding the heart and circulation in acutely ill patients can be collected by means of rapid echocardiographic scanning protocols.5 Current evidence supports the contention that operators do not need always to be fully trained in comprehensive echocardiography in order to obtain crucial diagnostic information.6–29

Figure 1 Basic FoCUS examination views. From the parasternal window (1), parasternal long-axis (PLAX) and short-axis (PSAX) views can be obtained; apical 4-chamber view (A4CH) is obtained from the apical window (2); subcostal inferior vena cava (SIVC) and subcostal 4-chamber (S4CH) views can be obtained from subcostal window (3).
Focus cardiac ultrasound (FoCUS) is defined as a point-of-care cardio-vascular ultrasound examination, performed according to a standardized, but restricted, scanning protocol (Figure 1), as an extension of the clinical examination. It is undertaken by an operator not necessarily trained in comprehensive echocardiography, but appropriately trained in FoCUS, who is usually responsible for immediate decision-making and/or treatment. When compared with comprehensive echocardiography, FoCUS is limited by a number of factors, including time constraints, restricted image acquisition protocol, the experience of the operator, and the technical capabilities of available equipment (e.g., pocket-sized imaging devices). Accordingly, there is a risk of missing potentially important abnormalities and/or misreading/misinterpretation of an incomplete data set.

These concerns have been expressed and addressed in detail by the EACVI in the document on FoCUS, which emphasized the need for specific education and training in FoCUS in order to fully exploit its advantages and mitigate potential risks. The EACVI viewpoint on FoCUS is summarized in Table 1.

Since cardiovascular diseases are often associated with pulmonary abnormalities/manifestations (such as pulmonary oedema and pleural effusions), lung ultrasound examination (LUS) is considered in the FoCUS core curriculum. We believe that LUS limited to the recognition of pleural effusions and interstitial syndrome should be performed in each case as an integral part of FoCUS examination, in analogy with the physical examination of the patient that always entails auscultation both of the heart and the lungs. In addition, since FoCUS may reveal key information in cardiac arrest that may directly change the management, it is currently integrated in the advanced cardiovascular life support ( ACLS) algorithm.

By definition, therefore, the content and duration of education and training programmes and competency requirements are substantially different comparing FoCUS with comprehensive echocardiography. Currently, recommendations, statements, and protocols for education and training in FoCUS are defined by a range of diverse societies/organizations who are fully responsible for organizing teaching courses and ensuring final competence/skillset of practitioners. The EACVI recognized that both cardiologists and non-cardiologists can perform either echocardiography or FoCUS depending on their background/training, the clinical circumstances, existing equipment and expertise. Indeed, the question is not whether FoCUS should be used by non-cardiologists in situations when critical information is needed to direct patient management, but rather how to define standards for training and education in order to secure safe and efficient use of FoCUS in emergency cardiac care. If FoCUS is performed by an operator not formally authorized for clinical decision-making (e.g., sonographers, fellows in training), it is essential to ensure that the findings are promptly communicated to the physician responsible for patient care.

### Rationale/scopes/aims of this curriculum and syllabus

Whereas respecting the complexity of the topic and diversity of medical professionals who undergo training in FoCUS, there is a growing need to set standards in education/training in FoCUS by the EACVI in their role as a reference echocardiography community. The EACVI Task Force members believe that the development of defined recommendations for education/training and knowledge/skills requirements is essential to achieve full integration of FoCUS into the management of the critically ill/emergency patient. The EACVI Task Force members also believe that this activity should be coordinated between professional societies/organizations already involved in education/training in FoCUS. Thus, the current document is prepared in close cooperation with representatives of the European Society of Anaesthesiology (ESA), the European Association of Cardiothoracic Anaesthesiology (EACTA), the Acute Cardiovascular Care Association (ACCA) of the European Society of Cardiology, and the World Interactive Network Focused On Critical Ultrasound (WINFOCUS). This document should therefore provide a good foundation for a future collaboration between the EACVI and the respective societies/associations/organizations involved in FoCUS educational and training activities, by means of preparing

### Table 1 Summary of the EACVI viewpoint on FoCUS

- FoCUS should only be used as a point-of-care cardiac ultrasound examination, aimed to detect a limited number of critical cardiac conditions
- FoCUS may provide key clinical information regarding the presence of pericardial effusion/cardiac tamponade, left and right ventricular size and function, intravascular volume status, and may aid decision-making during cardiopulmonary resuscitation
- FoCUS should never be considered or reported as echocardiographic examination
- Educational curriculum and training programme for FoCUS should be designed and conducted by the specialty professional organizations/societies involved in treating medical emergencies, including cardiac, with continual collaboration with reference echocardiographic communities
- FoCUS should only be used by the operators who have completed appropriate education and training programme, and who fully understand and respect its scope and limitations
- Whenever the information about cardiovascular abnormalities provided by the FoCUS exam is insufficient for the immediate or definitive care of patients, these should be referred to a comprehensive echocardiographic examination as soon as possible, and as compatible with clinical priorities
- FoCUS examinations should be recorded and permanently stored and reports issued in a timely manner
- Continual supervision and quality control of the FoCUS examinations are essential, provided preferably by accredited echocardiographic laboratories and emergency echocardiography services
- Reference echocardiographic community representatives should actively follow developments in the field and, whenever appropriate, work on improving educational and training curricula in concert with respective specialties professional societies/organizations, to deliver the best possible care for the patients

Modified from reference 3.
Training and competence for performance and interpretation of FoCUS

All education and training programmes on FoCUS should result in full understanding and respect of the scope and limitations of FoCUS. Only in this way FoCUS can improve emergency cardiovascular care.

Basic theoretical knowledge on cardiovascular disease

Since various medical professionals who intend to use FoCUS may have relatively limited knowledge of cardiovascular diseases compared with cardiologists, additional theoretical learning might be needed to enable trainees with different medical backgrounds to understand, interpret and fully integrate cardiac ultrasound findings into the clinical context. The cardiovascular diseases/conditions proposed by the EACVI for additional learning programmes for non-cardiologists undergoing training on emergency echocardiography, are addressed in the theoretical/teaching part of FoCUS training programmes (Part 1, in Table 2).

Learning technique for performing FoCUS

FoCUS does not equate to comprehensive echocardiographic examination. Furthermore, FoCUS should be distinguished from ‘goal-oriented’ (targeted) echocardiographic examination, performed by the fully trained echocardiographer attempting to obtain an answer to a specific, often critical and frequently complex clinical dilemma (e.g. failure to wean from mechanical ventilation, exclusion of inter-ventricular dysynchrony, echocardiography in mechanical circulatory support). In comparison to comprehensive echocardiography, the learning curve for FoCUS is relatively rapid, as the content and duration of training can be simplified and narrowed. It is important to appreciate, however, that the inherently limited approach linked to FoCUS scanning protocols does not imply substandard imaging, technical simplicity, and easily achievable competence in FoCUS. We believe that full competence in performing FoCUS cannot be achieved in few days, no matter how well a particular course is organized and/or how skilled the teachers are. Thus, although the relevant courses can be delivered in one or a few days, they are the starting point of additional supervised practice until competence in FoCUS is achieved. It is especially important to understand that higher technical skills are often needed for optimal image acquisitions by FoCUS in unfavourable emergency settings typically using a portable or pocket size imaging device, compared to elective scanning of stable patients in the echocardiography laboratory with a high-end imaging system, low-level lighting and in the left lateral position. Of note, due to the logistics related to emergency cardiovascular care and due to its limited scope, the FoCUS examination provides mostly qualitative assessment of cardiac morphology and function. Therefore, widely available, low-cost, portable, hand-held, and pocket-size imaging devices are likely to be used more frequently by FoCUS operators instead of fully equipped echocardiographic machines. While in this way FoCUS can be performed in virtually
all situations where it is needed, the inherent limitations of such devices must be considered. Trainees should master not only the examination technique but also the interpretation of findings and professional communication in a time-sensitive manner. This should be clearly explained during the training process and fully appreciated by both teachers and trainees.

Suggested teaching and training targets for FoCUS are listed in Table 3. Studies demonstrate that identification of these basic, but critical cardiovascular conditions and pathologies by FoCUS may beneficially modify patients management and predict outcome. Any attempt to expand this list of teaching and training targets for FoCUS should be discouraged due to increased risk of inappropriate use and errors. Thus, only a simple detection of abnormally enlarged cardiac chambers, signs of severe left and right ventricular dysfunction, large pericardial effusion, and/or extremely altered intravascular volume status, should be the part of FoCUS exam. Although trained FoCUS operators may occasionally identify gross valvular abnormalities, large intracardiac masses, or striking regional wall motion abnormalities, such patients should be referred to an expert for a comprehensive echocardiographic evaluation. In all cases where a cardiac cause is suspected but FoCUS findings are negative (‘normal’), patients should be immediately referred for

### Table 2 Minimal education/training requirements for achieving competence for performing FoCUS

<table>
<thead>
<tr>
<th>Part 1. Basic theoretical knowledge on cardiovascular disease&lt;sup&gt;a&lt;/sup&gt;</th>
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<tbody>
<tr>
<td>Acute coronary syndrome/acute myocardial infarction</td>
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<tr>
<td>Mechanical complications of acute myocardial infarction</td>
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<tr>
<td>Acute aortic syndrome/aortic dissection</td>
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<tr>
<td>Acute pulmonary embolism</td>
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<tr>
<td>Acute heart failure/cardiogenic shock</td>
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<tr>
<td>Acute pericarditis</td>
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<tr>
<td>Cardiac tamponade</td>
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<tr>
<td>Acute myocarditis</td>
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<tr>
<td>Cardiomyopathies</td>
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<td>Aortic stenosis</td>
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<tr>
<td>Acute valvular regurgitation</td>
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<tr>
<td>Ventricular hypertrophy</td>
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<tr>
<td>Pneumothorax</td>
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<tr>
<td>Endocarditis</td>
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<tr>
<td>Cardiac sources of embolism (tumours and masses)</td>
</tr>
<tr>
<td>Traumatic injuries of the heart</td>
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<tr>
<th>Part 2. Pre-recorded cases review (25 cases)&lt;sup&gt;b&lt;/sup&gt;</th>
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<tbody>
<tr>
<td>LV dilatation/dysfunction</td>
</tr>
<tr>
<td>RV dilatation/dysfunction</td>
</tr>
<tr>
<td>Pericardial effusion</td>
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<tr>
<td>Tamponade</td>
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<tr>
<td>Hypovolemia</td>
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<tr>
<td>Cardiac arrest</td>
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<tr>
<td>Pleural effusion</td>
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<tr>
<td>LUS B-lines</td>
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<tr>
<th>Part 3. Mastering technique for performing FoCUS—log-book (50 cases) to include minimum number of the following conditions&lt;sup&gt;c&lt;/sup&gt;:</th>
</tr>
</thead>
<tbody>
<tr>
<td>LV dilatation/dysfunction</td>
</tr>
<tr>
<td>RV dilatation/dysfunction</td>
</tr>
<tr>
<td>Pericardial effusion or tamponade</td>
</tr>
<tr>
<td>Hypovolemia</td>
</tr>
<tr>
<td>Cardiac arrest or peri-arrest</td>
</tr>
<tr>
<td>Pleural effusion</td>
</tr>
<tr>
<td>LUS B-lines</td>
</tr>
</tbody>
</table>

Competency evaluation should be incorporated in the ongoing training process and required numbers increased if needed to achieve competence of each trainee.

<sup>a</sup>Essential information of practical clinical importance only (lectures, web-based e-learning) (modified from the reference 1).

<sup>b</sup>Pattern recognition by online teaching with self-evaluation or reading with experts.

<sup>c</sup>At least one case in each category must be performed by the trainee under direct expert supervision; the rest of the cases trainee can perform unsupervised, but the images and reports must be reviewed together with the supervisor.

<sup>d</sup>Modified from references 3 and 32.

<sup>e</sup>Based on detection of 2D signs of compression of right-sided chambers (systolic collapse of the right atrium, diastolic collapse of the right ventricle) rather than Doppler-based study of intracardiac flows.

<sup>f</sup>Major LV dilatation or severe hypertrophy, right ventricular hypertrophy, major atrial dilatation.

<sup>g</sup>Recognizable by FoCUS without the use of Doppler-based techniques (e.g. massive disruption or marked thickening of leaflets, flail, anatomic gaps).

<sup>h</sup>Large valve vegetations or visible intracardiac or inferior vena cava masses/thrombi.

<sup>i</sup>Subtle regional wall motion abnormalities as well echocardiographic signs of acute aortic syndrome are not evidence-based targets for FoCUS; therefore, despite actual FoCUS findings, all patients with chest pain and suspected acute coronary syndrome or acute aortic syndrome, should be referred as soon as possible to comprehensive echocardiography.

DCM, dilated cardiomyopathy; HCM, hypertrophic cardiomyopathy; LV, left ventricular; MI, myocardial infarction; RV, right ventricular.
emergency echocardiography examination to be undertaken by an echocardiographer trained to the level of independent operator (Figure 2).\(^1\)

Numerous high-quality FoCUS courses and programmes are widely available. They may have different characteristics (e.g. not all have ACLS-compliance as a part of syllabus), but several commonalities. All of them aim to enable individuals to undertake a focused scan and identify basic cardiac conditions and pathologies after a short, intensive and narrowly-targeted training.\(^5,17,35\) These courses should be considered as an introductory/starting point for education/training process, offering theoretical/didactic learning (Table 2, Part 1), reviews of pre-recorded cases together with experts (pattern recognition) (Table 2, Part 2), and initial hands-on training on live models or patients. However, we believe that in order to achieve full competence in FoCUS, it is essential that practical training is extended to post-course proctored ultrasound examinations in real-life scenarios according to these requirements (Table 2, Part 3). Although it seems unlikely that strictly predefined minimal number of hours of hands-on image acquisition training, or the number of performed/interpreted cases would ever fit all,\(^3,6,7,17-27\) the EACVI proposes minimal requirements that, if fulfilled, should result in competence in performing FoCUS by the vast majority of trainees (Table 2). Competency evaluation should be incorporated into the ongoing training process and, if needed, the proposed numbers in Table 2 may be increased to achieve full competence in FoCUS in all trainees.\(^3\)

Examination technique should be learned first on virtual echocardiography simulators, live models or stable elective patients, and then mastered in real-life clinical scenarios where FoCUS is typically performed. For training, not only fully equipped echocardiographic machines, but also portable and pocket-size imaging devices should be used.\(^17\) Initially, scanning should be performed under direct proctored supervision. Later, this can be partially replaced with supervised review of recorded material and reports. Every attempt should be made to expose trainees to a

Figure 2 The FoCUS examination by on-call physician did not reveal a potential cause of a cardiac murmur in a young febrile patient (A). Comprehensive echocardiography showed a small ventricular septal defect (B, arrow) along with suspicious tricuspid valve vegetation (C, arrow), which was confirmed by transoesophageal echocardiography (D, arrow). Apical 4-chamber view is shown in panels A, B and C.
Focus cardiac ultrasound core curriculum and core syllabus

Core syllabus

The FoCUS Core Syllabus of the EACVI describes the fundamental knowledge required for the accurate practice of FoCUS and provides a framework for FoCUS education and training. Additionally, it represents part of the recently updated Echocardiography Core Syllabus of the EACVI, modified according to the restricted scope of FoCUS and in line with existing documents proposed by respective specialty societies/associations/organizations already engaged in FoCUS education and training.

It is strongly recommended that all FoCUS practitioners undertake specific training in the use of FoCUS as a part of ACLS algorithm (i.e. Focus Assessed Transthoracic Echocardiography—FATE, Focused Echocardiography in Emergency Life Support—FEEL, or similar), in order to achieve necessary proficiency.

It should be recognized that all individuals who have undergone full training in echocardiography and/or have successfully passed the EACVI certification process may be considered able to perform FoCUS in a competent way, with three provisions. First, that they are familiar with FoCUS scope, approach and Core Curriculum. Second, that they have completed additional training in basic LUS. Third, that they have undertaken specific training in the use of FoCUS as a part of ACLS algorithm, with a focus on the expected pathologies, communication of findings to the resuscitation team, and ACLS compliance.

Focus Cardiac Ultrasound (FoCUS) Core Syllabus of the European Association of Cardiovascular Imaging 2018

Based/Modified/According to:

II. Basic ultrasound instrumentation and knowledge

(1) Digital ultrasound machines
- High-end ultrasound systems
- Portable ultrasound machines
- Pocket-size ultrasound devices

(2) Image display, analysis, and storage
- Pixels—effect on image resolution
- Display devices—digital monitors, flat screen
- Display controls—brightness, contrast
- Off-line image analysis/reporting
- Storage—temporary/permanent

(3) Probes suitable for FoCUS and their differences
- Transthoracic cardiac phased-array transducer is the preferred probe for FoCUS
- Microconvex and abdominal transducers are not ideal for FoCUS, although their use may be considered when no other probes are available
- Vascular linear probes are not suitable for FoCUS

(4) Setting up the ultrasound machine
- Default settings
  - Cardiac/non-cardiac (abdominal, obstetrics/gynaecology, vascular) presets
- Frequency
  - The relation between the frequency, image quality and penetration
- Depth
- Sector width
- Gain
  - Overall gain and image brightness
  - Choosing gain in different imaging environments
- Time-gain compensation
  - Changing the brightness in different regions of the image
- Focus
  - Positioning the focus point
- Dual- and multi-focal imaging
- Frame rate
  - Temporal versus lateral resolution
- Zoom
- Acoustic power
  - Definition
  - The trade-off between improved image quality and the risk of biological effects
- Harmonic vs. fundamental imaging
  - Definition
  - Image quality vs. image resolution
- Machine settings affecting spatial (axial and lateral) resolution
- Machine settings affecting temporal resolution

III. Anatomy and physiology of the heart and great vessels

(1) Left ventricle
- Dimensions
- Wall thickness
IV. The FoCUS exam

Focus cardiac ultrasound core curriculum and core syllabus

(1) Image acquisition principles

- Technical considerations
  - Appropriate use of equipment controls
  - Recognition of technical artefacts
  - Recognition of setup errors

(2) Standard FoCUS scanning

- ECG monitoring (whenever possible)
- Respiratory cycle monitoring (constriction, tamponade)
- Standard FoCUS windows/2D views
  - Parasternal
    - Long-axis (LAX) view of the LV
    - SAX view of the LV (at the level of the papillary muscles)
  - Apical
    - 4-chamber view (4CH)
  - Subcostal
    - IVC view
    - Subcostal 4CH view

(3) Principles of echo measurements

- Timing (end-diastole/end-systole)
- 2D echo (current recommendations)
  - 2D still end-diastolic/end-systolic frame
- M-mode—only if it is feasible to align cursor perpendicular to the measured structure

(4) Assessment of volume status

- Pitfalls and limitations
  - Image quality, drop-outs, poor cavity outline
  - Worse border delineation on frozen frames vs. moving 2D image
  - Poor RV borders delineation, including IVS right side border

V. Targets of the FoCUS exam

(1) Screening for signs of chronic pre-existing cardiac disease

Qualitative (eye-balling) assessment of heart chamber size and size variation (relevant LA and LV dilatation, marked LV hypertrophy, RA dilatation, RV dilatation with hypertrophy, relevant valve calcifications)

(2) Global LV systolic function

1. FoCUS measures of global LV systolic function
   - Visual ejection fraction
   - Visual fractional area change (mid-papillary SAX view)

2. Conditions requiring caution in global LV systolic function interpretation (afterload and preload dependence)
   - Bradycardia and tachycardia
   - Severe hypotension and hypertension
   - Mitral/aortic regurgitation
   - Aortic stenosis/severe hypertrophy
   - Mitral stenosis
   - Ventricular septal defect
   - Severe anaemia, hyperthyroidism, other hyperdynamic states (sepsis)
   - LV underfilling
   - Inotropes

3. Regional LV systolic function

- Myocardial segmentation and coronary territories of distribution
- Wall motion analysis—gross wall motion abnormalities
- Qualitative
  - Endocardial motion with concomitant myocardial thickening
  - Hyperkinesis, Normokinesis, Hypokinesis, Akiness, Dyskinesis
  - Scar recognition (wall thinning, hyperechogenicity)
- Awareness of limitations related to limited scanning views and expertise
- Awareness of need for referral to comprehensive echocardiography in patients with detected/suspected abnormalities

(3) Basic assessment of global RV systolic function

1. Visual estimation of global RV ejection fraction
   - Hallmarks of RV failure
     - dilatation
     - free wall hypokinesia
     - septal dyskinesia/flattening

2. Acute vs. chronic cor pulmonale
   - morphological clues towards chronic pulmonary hypertension (marked RV hypertrophy, RV dilatation)

(4) Assessment of volume status

1. Severe hypovolemia and volume responsiveness
   - Rationale for the use of FoCUS to assess volume status
   - Echocardiographic features of severe hypovolemia
     - small, hyperkinetic LV (visual assessment)
     - small, hyperkinetic RV (visual assessment)
     - small IVC (<12 mm)
   - Effect of positive pressure mechanical ventilation on IVC size
2. Volume overload
   - FoCUS features of systemic venous congestion
   - Interpretation of a systemic venous congestion IVC pattern
   - Interatrial septum position
2. Signs of cardiac tamponade
   - Irrelevance of effusion amount for the diagnosis of tamponade
   - Echocardiographic signs supporting the diagnosis of tamponade
     - Pericardial effusion vs. hematoma/clot
     - Semi-quantitation of pericardial fluid
2. 2D signs of cardiac tamponade
   - Irrelevance of the diagnosis of tamponade
     - Echocardiographic signs supporting the diagnosis of tamponade
       - Pericardial effusion vs. epicardial fat
       - Pericardial effusion vs. hematoma/clot
   - Cardiac tamponade despite no detectable echocardiographic features
     - Clinical status of tamponade diagnosis
   - Localized collections—peri cardiac hematoma (after cardiac surgery, interventional cardiology procedures)—cannot be ruled out by FoCUS!
   - LV diastolic collapse
   - LA collapse (rare)
   - IVC plethora
   - Swinging heart
   - Cardiac tamponade despite no detectable echocardiographic features (clinical basis of tamponade diagnosis)
   - Localized collections—peri cardiac hematoma (after cardiac surgery, interventional cardiology procedures)—cannot be ruled out by FoCUS!
   - RA systolic collapse
   - LA collapse (rare)
   - IVC plethora
   - Swinging heart
2. Gross assessment of heart valves
   - Goals and limitations of cardiac ultrasound valves assessment by FoCUS
     - FoCUS aim: trigger formal comprehensive echocardiography
     - False-negative early diagnosis of cardiac tamponade
   - Normal mitral valve morphology and function
     - Thin leaflets, complete opening, complete closure at annulus level
   - Normal mitral valve findings associated with severe dysfunction:
     - Morphological (marked leaflet thickening, calcifications, masses, ‘holes’)
     - Functional (hypermobility, hypomobility)
   - Clues towards chronic mitral valve disease
     - Marked calcifications, LA enlargement, LV enlargement, RV dilatation and hypertrophy
3. Aortic valve
   - Normal aortic valve morphology and function
     - Thin leaflets, complete opening, complete closure at annulus level
   - Aortic valve findings associated with severe dysfunction:
     - Morphological (marked cusps thickening, calcifications, masses, ‘holes’)
     - Functional (hypermobility, hypomobility, prolapse into left ventricular outflow tract (LVOT))
   - Clues towards chronic aortic valve disease
     - Marked calcifications, LV Hypertrophy, LV dilation, LA enlargement
6. Large intracardiac masses
   - Large valve vegetations or visible intracardiac or inferior vena cava masses/thrombi
   - FoCUS aim: with the exception of right heart thrombus suspected in the context of cardiac arrest, detection of masses should trigger formal comprehensive echocardiography
V. FoCUS in cardiac arrest and peri-arrest
   - Rationale and indications of the use of FoCUS in cardiac arrest and peri-arrest scenarios (non-shockable rhythms)
   - Specific goals of the use of FoCUS in cardiac arrest (differentiation of electro-mechanical dissociation (‘True PEA’) from organized mechanical contraction with no pulse (‘Pseudo-PEA’), early detection of return of spontaneous circulation, identification of potentially treatable causes)
   - PEA conditions detectable with FoCUS in cardiac arrest (mechanical causes of PEA: severe hypovolemia, massive pulmonary embolism, cardiac tamponade, dramatic LV dysfunction, pneumothorax)
   - Asystole confirmation (cardiac standstill)
   - The FEEL protocol
     - Advanced cardiovascular life support (ACLS) compliance of FoCUS in cardiac arrest
     - The FEEL protocol [cardiopulmonary resuscitation (CPR) and preparation, execution, CPR resumption, interpretation, and management]
VI. FoCUS in shock and/or dyspnoea
   - FoCUS patterns in shock
     - Acute LV failure
     - Acute RV failure
     - Acute biventricular failure
     - Hypovolemia/vasodilatation
     - Cardiac tamponade
     - Suspected acute valve disease
   - Interpretation of FoCUS findings in clinical context
   - Immediate referral for comprehensive echocardiography in situations going beyond FoCUS diagnostic capability
     - Doubtful/inconclusive findings
     - Acute chest pain—suspected acute coronary syndrome
     - Suspected acute aortic syndrome
     - Chronic heart disease
     - Suspected valve disease
     - Findings not matching with the clinical context
   - Simplified FoCUS reporting
     - Wet lungs pattern—multiple, diffuse bilateral B-lines (lung ‘comets’) by LUS
VIII. Lung ultrasound (LUS)
   - Pleural effusion
     - Ultrasound appearances of pleural fluid
 IX. Acknowledged competence in FoCUS after completion of training process

(1) Understanding of basic instrumentation of ultrasound machines
(2) Ability to obtain 2D FoCUS scan views
(3) Correct linear measure of RV free wall thickness (for detection of signs of chronic RV disease—chronic cor pulmonale)
(4) Digital storage of images and clips and digital archive management
(5) Ability to differentiate normal from abnormal global LV systolic function
(6) Ability to recognize basic ultrasound anatomy of heart chambers, valves, great vessels and pericardium
(7) Application of M-Mode on LV parasternal long-axis view (PLAX) or parasternal short axis view (PSAX) and IVC (subcostal inferior vena cava (SIVC) view]
(8) Recognition of interstitial syndrome
(9) Recognition of B-lines (multiple, diffuse, bilateral B-lines)
(10) Recognition of the ‘classical’ hypovolemic profile in the spontaneously breathing patient (hyperdynamic LV and RV, small IVC)
(11) Recognition of tamponade effects on IVC
(12) Recognition of pericardial effusion from pericardial fat pad and pleural effusion
(13) Differentiation of pericardial effusion from pericardial fat pad and pleural effusion
(14) Differentiation of pericardial effusion from pericardial fat pad and pleural effusion
(15) Recognition of FoCUS findings of PEA (cardiac standstill)
(16) Differentiation of pericardial effusion from pericardial fat pad and pleural effusion
(17) Differentiation of pericardial effusion from pericardial fat pad and pleural effusion
(18) Recognition of RA systolic collapse (A4CH and S4CH views), RV diastolic collapse [PLAX, A4CH and subcostal four chamber (S4CH) views] and LA systolic collapse (PLAX and A4CH views)
(19) Differentiation of pericardial effusion from pericardial fat pad and pleural effusion
(20) Differentiation of pericardial effusion from pericardial fat pad and pleural effusion
(21) Differentiation of pericardial effusion from pericardial fat pad and pleural effusion
(22) Differentiation of pericardial effusion from pericardial fat pad and pleural effusion
(23) Differentiation of pericardial effusion from pericardial fat pad and pleural effusion
(24) Differentiation of pericardial effusion from pericardial fat pad and pleural effusion
(25) Recognition for the need of volume responsiveness assessment tools other than FoCUS
(26) Recognition for the need of volume responsiveness assessment tools other than FoCUS
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(54) Recognition for the need of volume responsiveness assessment tools other than FoCUS
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Approaching shock (and dyspnoea) systematically: recognition of tamponade, LV failure, RV failure, biventricular failure, hypovolemia, severe (acute) valve disease, wet lungs

Integration of FoCUS findings with available clinical, biochemical and other findings in order to detect the cause of shock/ dyspnoea (tamponade, hypovolemia, cardiomyopathy, acute myocardial infarction, acute pulmonary embolism, sepsis, adult respiratory distress syndrome, severe (acute) valve disease, myocarditis, toxins, post-cardiac arrest, acute aortic syndrome, trauma)

Acknowledgement of the need for a comprehensive echocardiography/second opinion in shock patient

Acknowledgement of the need for a comprehensive echocardiography in patient with acute chest pain and suspected acute aortic syndrome or acute coronary syndrome

Appropriate action plan generation upon FoCUS findings in shock/dyspnoea and simplified FoCUS reporting

LUS diagnosis of pleural effusion

LUS diagnosis of pulmonary oedema (wet lung pattern)

Understanding of potential role of FoCUS in cardiac arrest, shock and dyspnoea

Full understanding of limitations of FoCUS and the need for referral to comprehensive echocardiographic examination.

Understanding and full acceptance of the role of supervision and team work

References


Core Syllabus Abbreviations list

4CH, four chamber (view)

2D, two-dimensional

A4CH, apical four chamber (view)

ACLS, Advanced Cardiovascular Life Support

ARDS, adult respiratory distress syndrome

CPR, cardiopulmonary resuscitation

FAC, fractional area change

FEEL, Focused Echocardiography in Emergency Life Support

FoCUS, focused cardiac ultrasound

IVC, inferior vena cava

LA, left atrium

LAX, long-axis (view)

LV, left ventricle

LUS, lung ultrasound

EF, ejection fraction

LVOT, left ventricular outflow tract

PEA, pulseless electrical activity

PLAX, parasternal long axis (view)

PSAX, parasternal short axis (view)

RA, right atrium

ROSC, return of spontaneous circulation

RV, right ventricle

S4CH, subcostal four chamber (view)

SAX, short axis (view)

SSAX, subcostal short axis (view)

SIVC, subcostal inferior vena cava (view)

Conflict of interest: E.S. is co-founder of USABCD Ltd, providing e-learning in ultrasound. No conflicts of interest reported by other authors.