RACGP

Curriculum and syllabus for Australian general practice (7th edition)

Cardiovascular health

RACGP Curriculum and syllabus for Australian general practice (7th edition): Cardiovascular health.

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Cardiovascular health

Context

Cardiovascular disease (CVD), including heart disease, stroke and peripheral vascular disease, is a complex, multifactorial condition affecting 6.7% of adult Australians and 28% of those aged 75 and over.1 It remains a leading cause of death, responsible for 1 in 11 deaths and associated with 1 in 5 deaths, and accounts for annual health system expenditure of more than $16 billion.2,3

CVD disproportionately affects Aboriginal and Torres Strait Islander peoples and the age-standardised mortality rate is 1.5 times the rate of non-indigenous Australians.4 Early screening and risk factor management are therefore essential, with recommendations to commence CVD screening from age 18, and risk factor screening from age 12.5

GPs play a pivotal role in prevention by helping patients address modifiable risk factors such as smoking, obesity, physical inactivity, high c0holesterol, hypertension, excessive alcohol intake, and poor diet.[5] These remain the most effective targets for reducing CVD burden.

Children can also be affected by cardiovascular conditions, including congenital heart disease and infectious causes such as rheumatic fever. Rates of acute rheumatic fever are particularly high among Aboriginal and Torres Strait Islander children in rural and remote regions.6 Without timely diagnosis and treatment, it can progress to rheumatic heart disease.7 GPs are key to identifying at-risk children and providing appropriate, community-informed care. Opportunistic cardiovascular assessments can also detect early valvular disease, helping prevent long-term morbidity and mortality.

Atrial fibrillation is another common cardiac condition that increases the risk of stroke and heart failure. Its management often occurs entirely in general practice, with GPs focusing on symptom control, prevention of complications, and avoidance of hospitalisation.[7]

Socioeconomic and geographic inequalities further contribute to poor cardiovascular outcomes. Australians in rural and remote areas have a higher CVD mortality than those in metropolitan regions.[8] Barriers such as cost, transport, distance, and limited access to diagnostic and specialist services compound these risks.[9] GPs are therefore essential advocates for equitable access to cardiovascular and general health services and must be supported to deliver comprehensive care with the resources available locally.

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Learning outcomes

The GP is able to:

- understand the approach to chest pain and cardiovascular symptoms including consideration of red flags
- diagnose, investigate appropriately and manage emergency cardiovascular presentations in both children and adults
- diagnose, investigate appropriately and manage acute, chronic and progressive cardiac conditions
- diagnose, investigate appropriately and manage palpitations, chest discomfort, shortness of breath and dizziness
- understand the approach to patients with valvular heart disease
- diagnose, investigate appropriately and manage peripheral vascular disease conditions
- diagnose, investigate appropriately and manage hypertension and hypotension
- recognise cardiovascular risk factors (eg hypercholesterolaemia) and engage patients in preventive health activities
- demonstrate appropriate risk stratification and management of complications
- conduct and interpret an electrocardiogram (ECG)

Key areas of learning

Understand the approach and management to chest pain caused by:

- acute coronary syndrome
- pericarditis
- myocarditis
- endocarditis.

Diagnose, investigate appropriately, and manage palpitations, chest discomfort, shortness of breath, and dizziness symptoms due to (or incidental findings of):

- atrial fibrillation
- atrial flutter
- supraventricular tachycardia
- ventricular fibrillation
- atrial and ventricular ectopic beats
- heart blocks/conduction disease
- heart failure
- cardiomyopathies.

Diagnose, investigate appropriately and manage patients with valvular heart disease, or risk factors for developing this, such as:

- mitral stenosis
- mitral regurgitation
- aortic stenosis including bicuspid aortic valves
- rheumatic fever and rheumatic heart disease.

Understand the approach to preventive health measures and risk stratification tools for:

- SNAP
- absolute cardiovascular risk calculator
- CHADsVASC2
- HAS-BLED.

Diagnose, investigate appropriately, and manage hypertension (both primary and secondary)

Identify, investigate appropriately and manage hypotension, such as that caused by:

- postural tachycardia syndrome (POTS)
- iatrogenic causes or other medical conditions.

Interpret investigation results and provide management options (including education, pharmacological therapy and referral if needed) for:

- heart failure
- ischemic heart disease
- hypertension
- hypercholesteremia
- acute rheumatic fever.

Diagnose, investigate appropriately, and manage peripheral vascular disease conditions caused by:

- arterial insufficiency
- varicose veins
- chronic skin ulcers (including venous, arterial, malignant, and pressure)
- phlebitis
- deep vein thrombosis
- thrombophlebitis
- vasculitis.

Diagnose, investigate appropriately, and manage aneurysms, such as:

- thoracic
- abdominal
- intracranial
- peripheral.

Diagnose and manage lymphoedema

Diagnose, investigate appropriately and manage paediatric cardiac conditions, including referral if needed:

- minor congenital cardiac conditions; atrial septal defects, ventricular septal defects and patent ductus arteriosus
- major congenital cardiac conditions; tetralogy of Fallot, transposition of the great arteries and coarctations
- rheumatic fever/rheumatic heart disease
- Kawasaki disease.

Conduct and interpret an ECG.

Opportunities for learning

Words of wisdom

- Maintain a low threshold for suspecting silent ischaemia in patients with cardiovascular risk factors or those presenting with dyspnoea alone. This under-recognised condition is associated with poorer outcomes due to delayed diagnosis.

- Recognise the value of the therapeutic relationship. Consistent, brief motivational interviewing can lead to meaningful lifestyle changes over time. Perform opportunistic cardiovascular examinations. Simple assessments such as vital signs, and heart and lung auscultation can yield valuable diagnostic information — in both adults and children.

- Screen for heart failure in all patients presenting with unexplained shortness of breath.

- Consider acute coronary syndrome and aortic dissection in patients presenting with new-onset chest or abdominal pain.

- Ask about claudication when assessing patients with limb pain, as this may indicate peripheral arterial disease.

Learning strategies

On your own

Review the RACGP Red Book (Guidelines for preventive activities in general practice) and the RACGP National Guide to preventive healthcare for Aboriginal and Torres Strait Islander people to ensure your preventive care aligns with current recommendations.

- *Are you familiar with and regularly using the absolute cardiovascular risk calculator?*
- *Is it being documented and used to guide your discussions and shared decision-making with patients?*

Conduct a random case review of five recent patients.

- *Is their cardiovascular screening consistent with current guideline recommendations?*
- *What preventive activities or lifestyle factors were addressed, and which were overlooked?*
- *Have you considered assessing for related conditions in those with cardiovascular risk factors – such as peripheral vascular disease or diabetes?*

With a supervisor

Review a recent case of cardiac failure with your supervisor.

- *Has an echocardiogram been performed to classify the type of heart failure?*
- *Have evidence-based medications with mortality benefit been commenced and titrated to the maximum tolerated dose?*
- *Was the management consistent with current evidence-based practice?*
- *Was the documentation clear, comprehensive, and clinically appropriate?*
- *How did your supervisor's approach differ from your own? What might you do differently next time?*

With your supervisor, discuss how you would assess and manage a patient presenting with palpitations.

- *Create and compare your differential diagnosis lists, then discuss management strategies for each potential diagnosis*
- *Which conditions must not be missed, and how would you rule them out?*
- *What are some common pitfalls to avoid in the assessment and management of palpitations?*

In a small group

Role play a consultation using motivational interviewing techniques to encourage lifestyle changes that improve cardiovascular health – for example, smoking cessation or increasing physical activity.

- *Provide constructive feedback to each other: did the 'patient' feel supported, judged, or motivated?*
- *Reflect on the feedback and repeat the exercise in a few weeks to assess improvement*
- *Consider: How can you best empower your patients to make sustainable lifestyle changes?*

Run a teaching session for your peers (eg management of atrial fibrillation).

- At the end of the session, ask participants to work through short case scenarios to assess understanding and application of the content
- Include variations such as 'How would management differ if this were an elderly patient with a high falls risk?'
- Afterwards, reflect on the session:
    - *How well did the learners grasp and apply the material?*
    - *What key teaching points did you emphasise, and why?*
    - *What could you adjust or improve next time?*

With a friend or family member

Conduct a role play where you explain to a patient why you are prescribing a medication – particularly for an asymptomatic condition such as hypertension or hyperlipidaemia. Use a cardiovascular risk calculator to guide your explanation.

- Ask your friend, family member, or peer for feedback:
    - *Did they feel included in the consultation and decision-making process?*
    - *Did they understand your explanation of cardiovascular risk and the rationale for treatment?*

- Reflect on whether there are resources or visual aids (eg risk charts, patient handouts, RACGP or Heart Foundation tools) that could support clearer communication.

Ask your friend or family member what they know about modifiable risk factors for heart disease.

- *Where did their knowledge come from?*
- *Have they experienced any barriers to making positive lifestyle changes?*
- *Have they felt supported to improve their health? What strategies or resources have been most helpful?*
- *Reflect on their responses – what insights could you incorporate into your own clinical communication and patient engagement?*

Case example

Lila, a 55-year-old woman with a history of type 2 diabetes and hypertension, presents with several days of fluctuating epigastric pain that partially improves with antacids. On examination, she appears pale but is haemodynamically stable. Her BMI is 35 kg/m^2. Cardiovascular and respiratory examinations are unremarkable, and abdominal examination reveals a soft abdomen with mild epigastric tenderness.

In a case-based discussion, questions relating to each role could be:

Communicator

- What communication strategies could you use to obtain a clear and accurate history?
- How might your communication approach differ if Lila lived in a remote Aboriginal or Torres Strait Islander community? Who else might contribute useful collateral information?
- How would you adapt your communication if Lila were from a non-English-speaking background?
- How would you explore Lila's ideas, concerns and expectations?
- What would you do if she became anxious or distressed when told her condition may be serious?
- What culturally and linguistically appropriate health resources are available for non-English-speaking patients?

Clinician

- What additional past medical or family history would be important to explore?
- What investigations are indicated, and within what timeframe should they be performed?
- What safety-netting strategies would you use in this situation?
- How might your approach differ if Lila were a healthy 25-year-old with associated shortness of breath?
- How would your management change if she were an elderly patient living in a high-dependency aged care facility?
- How would you adapt your approach if the initial consultation occurred via telehealth?
- Given Lila's cardiac risk factors, would you perform an ECG? If normal, what would be your next steps? If the ECG showed ST elevation in leads V1–V2 with reciprocal depression elsewhere, how would you manage her?
- Do you feel confident in identifying and managing a deteriorating patient or cardiac arrest in the clinic setting? If not, what further training or simulation could enhance your skills?
- Could you independently perform an ECG if no nurse were available?
- Are your intravenous cannulation skills current?
- How would your management differ if you were practising in a rural setting three hours from the nearest hospital?

Health advocate and leader

- How could this encounter serve as an opportunity to educate Lila, her family and her community about the varied presentations of acute coronary syndrome?
- How would you approach this discussion in a remote Aboriginal or Torres Strait Islander community, and who would you involve?
- Which other health professionals could support Lila's long-term cardiovascular care?
- How would you ensure Lila remains engaged in follow-up and ongoing management?

Professional

- How would you manage the situation if the ECG showed changes consistent with acute coronary syndrome, but the patient refused hospital transfer? What supports or escalation pathways could you access?
- How would you document the consultation if Lila were a new, acutely unwell patient without identification or medical records?

Scientist, educator and researcher

- What resources or pathways could you access if you diagnosed a STEMI while practising in a metropolitan setting?

Learning resources

The curriculum website includes learning resources within each unit.

Assessment

Content in this unit will be assessed in a variety of ways.

Workplace based assessments

Mini-CEX	RCA	MSF	CBD	Reflective exercise	Audit	Mid and end term assessment

Fellowship examinations

AKT	KFP	CCE

KEY

- Expected to be assessed here always
- Often assessed here but not in every example / case / assessment
- May at times be here or contribute to the assessment

ABBREVIATIONS

Mini-CEX – Mini-clinical evaluation exercise
RCA – Random case analysis
MSF – Multi source feedback
CBD – Case-based discussion
AKT – Applied knowledge test
KFP – Key feature problem
CCE – Clinical competency exam