Pocket

Cardiology and Vascular Medicine

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ASSURED
QUALITY
BY EXPERTS

Compendium
medicine

An essential pocket-sized book on Cardiology and Vascular Medicine.

The Compendium Method©
Manual

In *Compendium Medicine* we use the same concise, visual and schematic description of the various medical specialties. Everything is geared towards overview and structure, facilitating study and practice. We call this the *Compendium Method©*.

Fixed layout

All our medical specialties are presented in the same, recognisable way and each has its own colour and icon. The pockets have a fixed chapter structure. The table of contents of each pocket tells you exactly which topics are covered. The symbols in the corner of the page show what kind of information is being discussed.

- ATLS
- Anatomy
- Physiology
- Patient history
- Physical examination
- Diagnostics
- Treatment
- Differential diagnosis
- Conditions
- Clinical reasoning
- Appendices
- References
- Abbreviations
- Index

Illustrations

The figures provide at-a-glance insight into topics like anatomy or the typical patient. They are also intended for study and practice, such as checking whether you can identify the letters in a picture without looking at the caption.

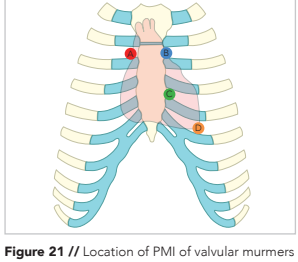

Figure 21 // Location of PMI of valvular murmers
A: Aortic valve **B:** Pulmonary valve **C:** Tricuspid valve **D:** Mitral valve

Conditions

Each condition in this pocket starts with a full-sentence definition followed by a telegram-style explanation. For each condition, the following icons (as applicable) are discussed. These visual cues that convey specific attributes or features of the condition are also useful when studying. You can cover the text and quiz yourself.

- D Definition
- E Epidemiology
- Ae Aetiology
- R Risk factors
- Hx Patient history
- PE Physical examination
- Dx Diagnostics
- Tx Treatment
  - General
  - Paramedical care
  - Pharmacological treatment
  - Invasive, non-pharmacological treatment
- P Prognosis
- ! Watch out/don´t forget

Tables

We use tables to arrange the information in a clear and structured manner, with columns representing different conditions and rows indicating features or characteristics. Centered formatting for matching features makes it easy to identify similarities and differences.

Diagrams

→ = positive/yes/+ → = negative/no/-

Diagrams help you reason clinically, starting from a particular symptom, using the green and red arrows as signposts. Always remember that the full differential diagnosis may consist of additional diagnoses.

Icons & frames

Fun fact: our founders are Dutch, and in the Netherlands, we refer to a mnemonic as a "donkey bridge". That's why the symbol for mnemonics in our books is a donkey.

Throughout this pocket you will find highlighted frames.

QR code	Note	Reference to another chapter
Alarm!	Description of the typical patient	Mnemonic
Formula		

Punctuation marks

The punctuation in our books also focuses on overview and ensures that the subject matters are covered concisely and effectively.

(--) Rare	(++) Most common	↓ Decrease/detoriation
(-) Uncommon	→ Consequence	♀ Female sex
(+) Very common	↑ Increase/improvement	♂ Male sex

Abbreviations

We make extensive use of abbreviations, medical terms and symbols for scientific units and quantities. Below are some examples of the abbreviations used in this pocket.

sec	second/seconds	d	day/days	min.	minimum
min	minute/minutes	wk	week/weeks	max.	maximum
h	hour/hours	mo	month/months	e.g.	for example
		y	year/years	L	litre/litres

Index

The pockets include a comprehensive and easy-to-use index. It contains all the topics covered in the books so you can quickly navigate and find the information you are looking for.

Appendices

In the pockets, you will find space for your notes, additional information, reminders, or insights. In addition, handy appendices have been added; these contain specific information that you would like to have at hand and are therefore located at the back of the pockets.

They/theirs

We realise that sex and gender identity are not binary and that there is more variation than just 'woman' or 'man'. For readability's sake (as well as for grammatical reasons) we have therefore chosen to use the pronouns 'they/theirs', regardless of sex or gender identity.

Warning

When studying this pocket, be mindful of the protocols within your own facility and adhere to the established guidelines. It is also essential to understand the circumstances under which you may or may not provide assistance in a given country, as this can potentially have legal consequences.

Want to know more about the Compendium Method©? Scan the QR code.

Table of contents
Cardiology and Vascular Medicine

Table of contents
Cardiology and Vascular Medicine

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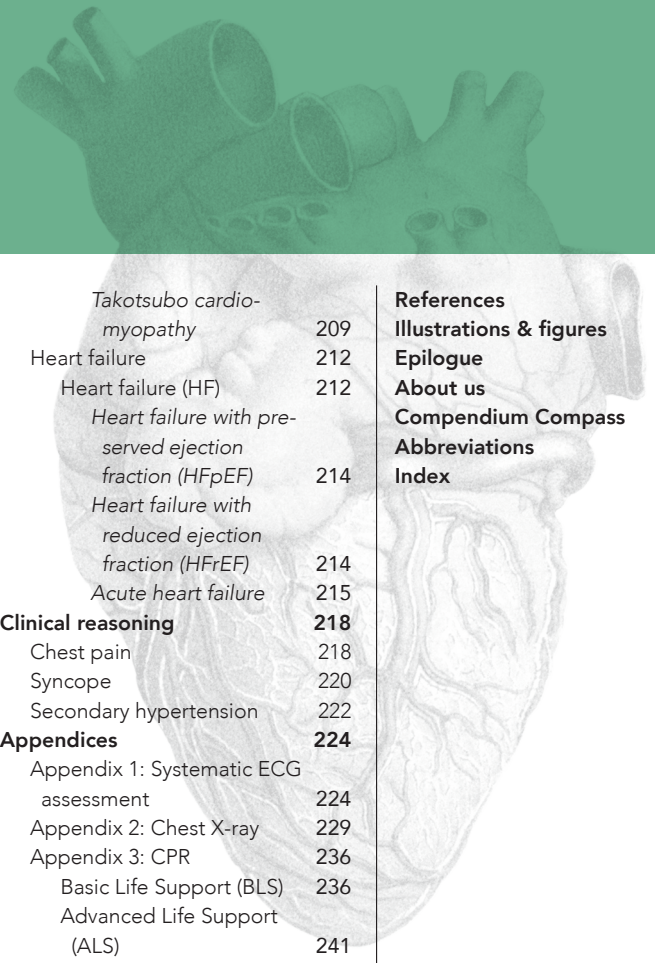


Anatomy

Heart

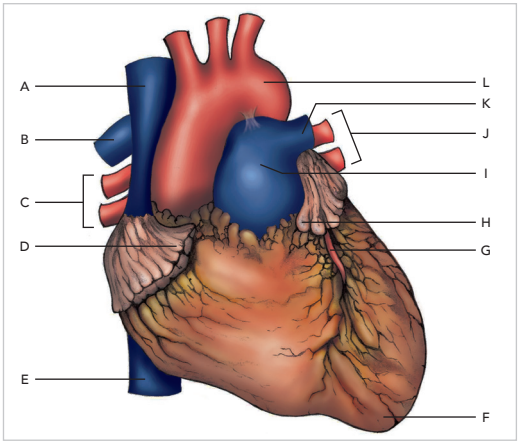


Figure 1 // Anterior view of the heart
A: Superior vena cava **B:** Right pulmonary artery **C:** Right pulmonary veins **D:** Right atrial appendage **E:** Inferior vena cava **F:** Apex **G:** Left coronary artery **H:** Left atrial appendage **I:** Pulmonary trunk **J:** Left pulmonary veins **K:** Left pulmonary artery **L:** Aortic arch

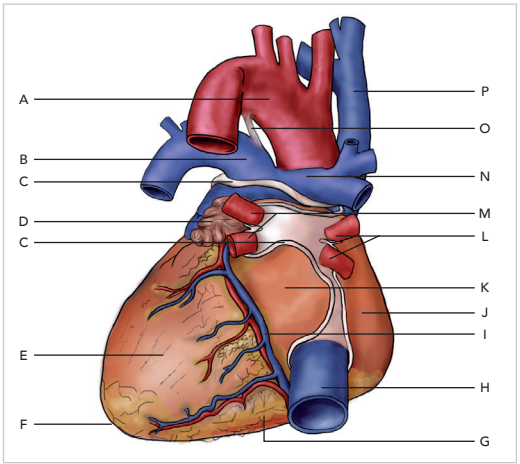


Figure 2 // Posterior view of the heart
A: Aortic arch **B:** Left pulmonary artery **C:** Pericardium **D:** Left atrial appendage **E:** Left ventricle **F:** Apex **G:** Right ventricle **H:** Inferior vena cava **I:** Coronary sinus **J:** Right atrium **K:** Left atrium **L:** Right pulmonary veins **M:** Left pulmonary veins **N:** Right pulmonary artery **O:** Arterial ligament **P:** Superior vena cava

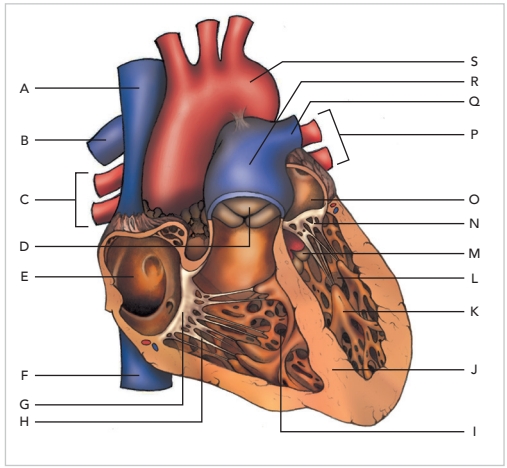


Figure 3 // Cross-section of the heart
A: Superior vena cava **B:** Right pulmonary artery **C:** Right pulmonary veins **D:** Pulmonary valve **E:** Right atrium **F:** Inferior vena cava **G:** Tricuspid valve **H:** Chordae tendinae **I:** Right ventricle **J:** Interventricular septum **K:** Papillary muscle **L:** Left ventricle **M:** Aortic valve **N:** Mitral valve **O:** Left atrium **P:** Left pulmonary veins **Q:** Left pulmonary artery **R:** Pulmonary trunk **S:** Aortic arch

Valves

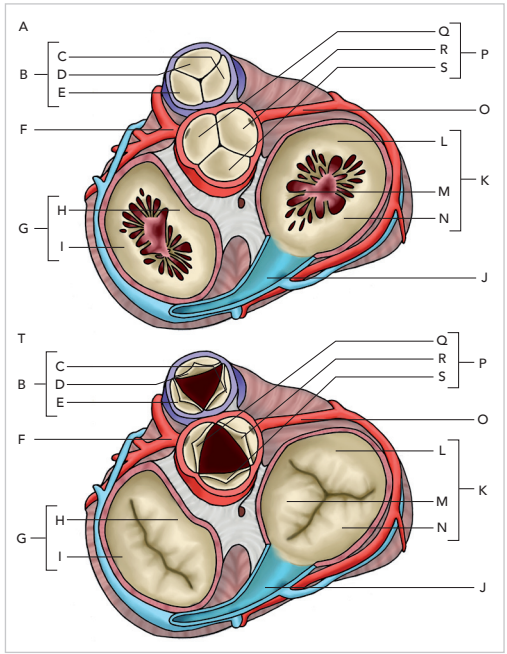


Figure 4 // Heart valves
A: Diastole **B:** Pulmonary valve **C:** Right semilunar cusp **D:** Anterior semilunar cusp **E:** Left semilunar cusp **F:** Left coronary artery **G:** Left atrioventricular valve (mitral valve) **H:** Anterior mitral valve leaflet **I:** Posterior mitral valve leaflet **J:** Coronary sinus **K:** Right atrioventricular valve (tricuspid valve) **L:** Anterior tricuspid valve leaflet **M:** Septal tricuspid valve leaflet **N:** Posterior tricuspid valve leaflet **O:** Right coronary artery **P:** Aortic valve **Q:** Left coronary cusp **R:** Right coronary cusp **S:** Non-coronary cusp **T:** Systole

Diagnostics

Cardiovascular diagnostics

Electrocardiogram (ECG)

An ECG is a safe, non-invasive test in which electrodes are used to measure the electrical activity of the heart. It is important to interpret ECGs systematically. Indications for an ECG include palpitations, dyspnoea, chest pain (CP), epigastric pain, intoxication, cyanosis, syncope, reduced exercise tolerance, monitoring of critically ill patients, electrolyte disturbances, follow-up of hypertension, diabetes mellitus (DM) and heart disease. Allergy for ECG electrodes is a relative contraindication for an ECG. In these cases hypoallergenic electrodes can be used.

A standard ECG consists of 12 leads, including six limb leads that visualise the frontal plane (I, II, III, aVR, aVL, aVF) and six precordial leads that visualise the axial plane (V1-V6), see Figure 24. See Table 27 for the location of precordial ECG electrodes. The leads pick up electrical activity moving towards a particular part of the heart and project it as a deflection on the ECG. See Table 28 for an overview of the leads and the corresponding areas of the heart. Electrical cardiac activity moving towards the positive electrode is shown as a positive deflection on the ECG, while electrical activity moving away from the positive electrode is projected as a negative deflection.

$$QTc = \frac{QT}{\sqrt{RR - interval\ (sec)}}$$

Formula 1 // QTc calculation with Bazett's formula

The QT interval is probably normal if QT <50% of the RR interval.

ECG EVENT	DURATION
PR interval	120-200 ms
QRS complex	80-120 ms
QTc segment	♂ <350 ms ♀ <460 ms

Table 29 // Duration of different ECG events in adults

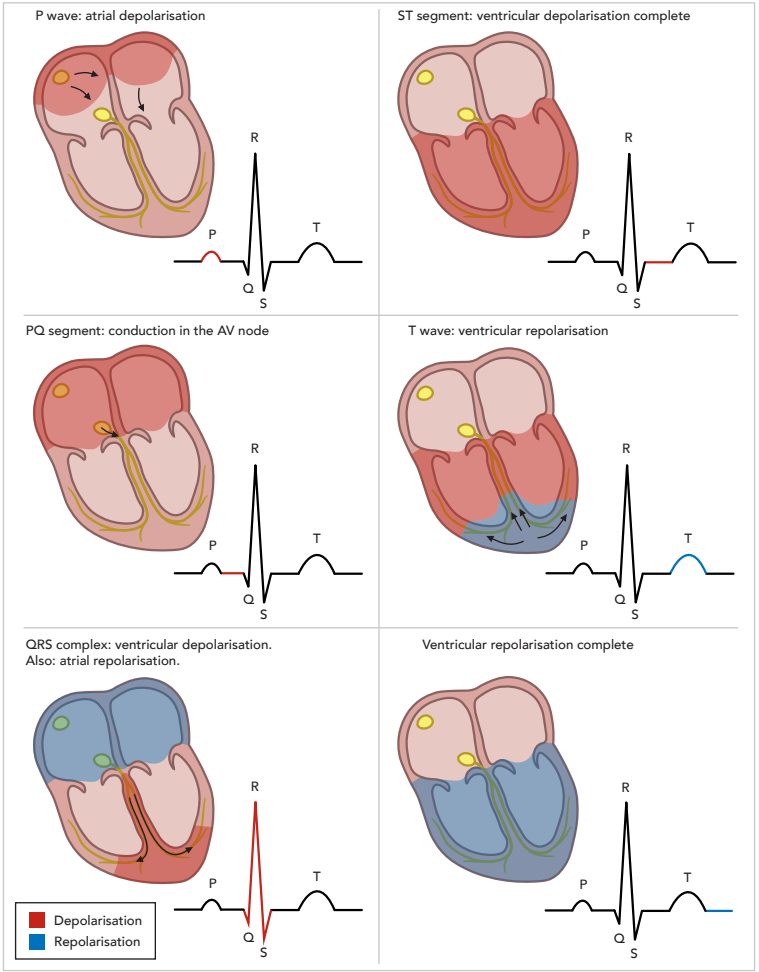


Figure 27 // Physiology of ECG components

Imaging

Chest X-ray

For more information on interpreting chest X-rays (including more illustrations), see Appendix 2 and Figure 29.

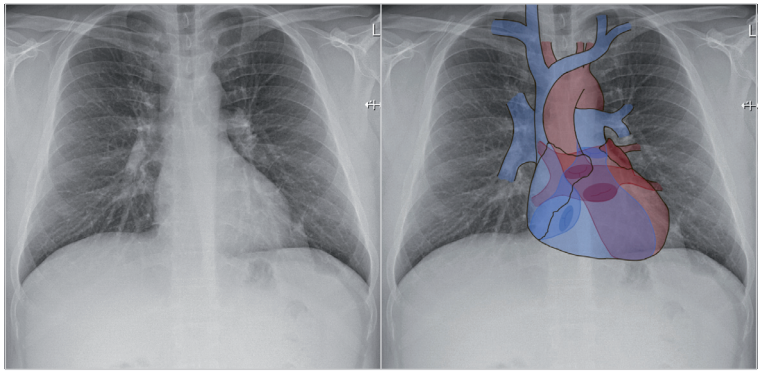


Figure 29 // Chest X-ray

Echocardiography

Echocardiography is an imaging modality of the heart using ultrasound. During echocardiography, a transducer is placed on various positions on the thorax or in the oesophagus to visualise the heart from different angles. It examines various aspects, such as cardiac morphology and dimensions, systolic and diastolic function, valvular function, myocardial thickness and pericardial effusion. Doppler imaging can be used to visualise blood flow, and to measure velocities or calculate pressure differences across heart valves, or intracardiac shunts. 3D echocardiography can be used as a modality to visualise the heart valves in more detail, or to measure atrial and ventricular volumes. A more recently developed technique in echocardiography is strain imaging (see Figure 30). Strain imaging evaluates cardiac deformation or shortening of various segments of the heart during systole compared to diastole. Greater negative values indicate adequate systolic shortening and thus function.

Indications for echocardiography:

- Flow and pressure gradient over valves (valvular heart disease)?
- Dimensions of cardiac compartments (enlargement, hypertrophy, cardiomyopathy)?
- Function of ventricles?
- Regional wall motion abnormalities in an infarction?
- Fluid buildup around the heart (pericarditis, cardiac tamponade)?
- Anatomical (congenital) abnormalities?
- Miscellaneous (traumatic abnormalities, abscesses in endocarditis, masses, etc.)?

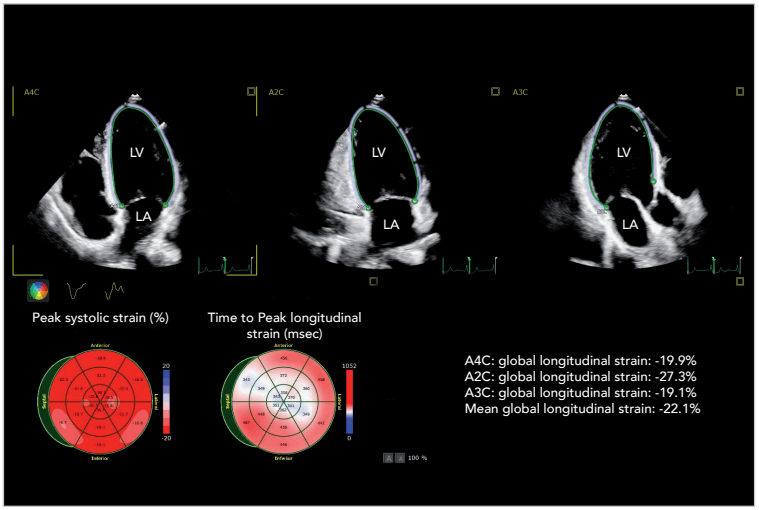


Figure 30 // Strain echocardiography of a structural normal left ventricle.
A2C, apical 2 chamber view; A3C, apical 3 chamber view; A4C, apical 4 chamber view; LA, left atrium; LV, left ventricle

Transthoracic echocardiography (TTE)

TTE is a safe, non-invasive type of echocardiographic imaging in which a probe is placed on the chest. TTE is used to evaluate myocardial morphology, myocardial function, pericardial effusion, and valvular function. During a TTE, the echo probe is placed on various places of the chest to obtain different views of the heart. There are several standard plains that evaluate the myocardium. The parasternal long axis view (see Figure 31) mainly visualises the left atrium, left ventricle and aorta. It can be used to assess left atrial and ventricular dimensions, left ventricular wall thickness and valvular function of the aortic and mitral valve. The parasternal short axis view (see Figure 32) provides a plane through the left and right ventricle. It can be used to assess ventricular contractility and regional wall motion as well as right ventricular pressure overload. The apical four chamber view (see Figure 33) visualises the four chambers of the heart and can be used to assess dimensions, volumes, systolic and diastolic function and regional wall motion. The subcostal view (Figure 34) is obtained in supine position and visualises all four cavities of the heart. It is also possible to visualise pericardial effusion.

The calcium score, also known as the Agatston score, is used to assess the extent of coronary artery calcification. This score, assigned based on the calcium density in Hounsfield units (HU) reflects the risk of a major adverse cardiac event.

Coronary CT angiography has high accuracy to exclude and detect coronary plaque and stenosis in patients with chest pain and lower pretest probability.

Severe calcification results in 'blooming' which leads to overestimation of stenosis degree. Depending on the scanner technology, high or irregular heart rates could result in motion or step artefacts.

Cardiac MRI

A cardiac MRI is a scan of the heart made using electromagnetic waves. It can be used to obtain static and dynamic images of the heart, visualising ventricular function, valvular function, myocardial pathology and quantify blood flow. A cardiac MRI, without and with gadolinium contrast, is an excellent technique to characterise cardiac tissue, including oedema, post-infarct scarring, fibrosis, and fat (see Figure 37 and 38). Furthermore, stress MRI can be performed by administering regadenoson or adenosine. Indications for a cardiac MRI scan include cardiomyopathy, congenital heart disease, evaluation of the myocardium (e.g. ischaemia, post-infarction). Cardiac MRI enables tissue characterisation by identifying the proportion of fat, water and fibrosis in the tissue, with a gadolinium based contrast agent. Contraindications to a cardiac MRI scan may include temporary pacemaker leads, insulin pumps and metallic foreign bodies in vivo. Relative contraindications to an MRI scan depending on the type of intracardiac device are pacemakers and ICDs, and claustrophobia.

For the detection of myocardial ischaemia the contrast enhancement sequences during stress are essential. Imaging in rest is not required for the diagnosis.

- Ischaemia: subendocardial perfusion defect, no delayed contrast enhancement;
- Infarction: subendocardial perfusion defect and delayed contrast enhancement (indicating scarring/fibrosis) of the same region.

Cardiac MRI is a central test to diagnose the type of cardiomyopathy, and a very sensitive technique to detect myocardial ischaemia, old infarction, and assess viability.

Dynamic cardiac MRI is used for calculation of the ejection fraction, wall motion (incl. abnormalities), and wall thickness, in particular if echocardiography is inconclusive.

Not all pacemakers and ICDs are MRI compatible. See MRIsafety.com whether a technician is required to turn off the implant prior to the MRI.

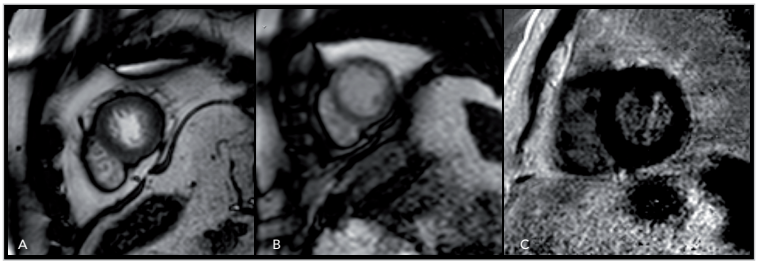


Figure 37 // Short axis cardiac MRI image of a normal heart
A: T1 weighted image **B:** normal perfusion during stress **C:** no delayed enhancement

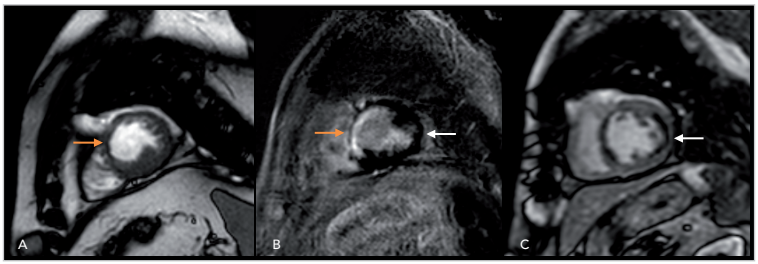


Figure 38 // Short axis cardiac MRI image of a patient with septal infarction and ischaemia of the lateral wall. Ischaemia is indicated by the perfusion defect of the lateral wall without delayed enhancement (white arrows B and C). The area of infarction (orange arrow) of the LV septum is diagnosed based on hypokinesia and wall thinning (asymmetrical myocardial contraction in A), subendocardial delayed enhancement (hyperintense signal, B) and perfusion defect (hypointense signal, C).

Conditions

NB! The following pages are random pages from this pocket. This means that many conditions are incompletely represented in this preview.

Ischaemic heart disease

Ischaemic heart disease

D Ischaemic heart disease is caused by reduced oxygenation of the heart. A distinction can be made between ischaemic heart disease (see Table 61) and acute coronary syndrome (see Table 63 and Figure 53).

	CHRONIC CORONARY SYNDROME	ISCHAEMIA WITH NON OCCLUSIVE CORONARY ARTERIES	
		Microvascular angina	Coronary artery spasm
D	Crushing CP due to transient myocardial ischaemia. Typically induced by exercise and disappears within minutes at rest.	A type of angina pectoris with signs of cardiac ischaemia in which the epicardial coronary arteries appear normal. Formerly known as cardiac syndrome X.	A type of angina caused by coronary spasms. Also known as Prinzmetal angina.
E	Prevalence age 45-64: 4-7%, increasing with age	Exact epidemiology unknown	Rare
Ae	Significant coronary stenosis → insufficient O_2 supply with increased cardiac demand for O_2	Exact aetiology unknown, suspected vasomotor dysfunction of the cardiac microvasculature	Vasospasm of the coronary arteries → temporary high-grade coronary obstruction
R	General cardiovascular risk factors		General cardiovascular risk factors, especially smoking, drug use and coronary interventions
Hx	• Crushing CP, may radiate to left shoulder/arm and/or throat/jaw (see Table 62 for classification) • Dyspnoea on exertion, nausea ⊖, sweating ⊖ • Provoking factors: exercise, emotion, stress, cold, food	CP at rest and during exercise	• Chest pain, dyspnoea, vegetative symptoms • Typically occurs at rest, exercise tolerance is often preserved • Very good response to nitrates
PE	Auscultation: normal ⚇, sometimes S3 or S4		Normal

Table 61A // Stable ischaemic heart disease

For a detailed look at chest pain, see the section on Clinical reasoning.

	CHRONIC CORONARY SYNDROME	ISCHAEMIA WITH NON OCCLUSIVE CORONARY ARTERIES	
		Microvascular angina	Coronary artery spasm
Dx	• Labs: troponins/CK-MB =, evaluate lipid profile • ECG at rest and during exercise: normal, ST depression, T-wave inversion • Echocardiography/stress echocardiography: normal or regional hypokinesia and wall motion abnormalities • Coronary CT: evaluation of coronary stenoses • Perfusion scan: normal or zones of hypoperfusion in stress scans		• Labs: troponins/CK-MB = • ECG/Holter monitoring: ST elevation and/or high T waves and/or T-wave inversion during symptoms, normal between episodes • Echocardiography: normal
	Coronary angiography: if disease or therapy resistance/intolerance progresses	Coronary angiography: no significant coronary stenoses	Coronary angiography: to rule out coronary stenoses, vasospasms may be visualised
Tx	Cardiovascular risk management		Smoking cessation
	Sublingual nitroglycerin (symptomatic)		
	Short-acting nitrate to relieve episodes, maintenance medication if >2 episodes/wk: beta blocker or calcium antagonist, possibly long-acting nitrate, acetylsalicylic acid Cardiac catheterisation if symptoms persist despite optimal pharmacological treatment (OPT): PCI for significant stenosis (>70% or FFR <0.80) or coronary artery bypass graft (CABG) in triple vessel disease, main coronary artery stenosis and combined valvular heart disease	Beta blocker, calcium antagonist, nicorandil	Calcium antagonist
P	Depends on underlying cause, comorbidities and cardiovascular risk profile		• 5-year survival rate: 94% • 25% of cases are complicated by myocardial infarction (MI) or ventricular arrhythmias if not treated
!	Silent angina: myocardial ischaemia in the absence of symptoms. At-risk population: DM, hypertension.	N/A	Association with migraine and Raynaud's phenomenon

Table 61B // Stable ischaemic heart disease

The typical male patient with ischaemic heart disease is >65 years of age, makes a restless impression and presents with crushing CP radiating to left jaw/shoulder. This pain disappears at rest in stable ischaemic disease but persists in unstable ischaemic disease (acute coronary syndrome). The presentation can differ in women. Crushing CP may not be the primary symptom. Atypical symptoms (e.g. nausea, heartburn, neck and jaw pain) are more frequent in women.

Treadmill stress testing has a sensitivity and specificity of approximately 50%. The absence of ischaemic changes on the ECG does not rule out ischaemic heart disease. In the presence of clinical symptoms, additional diagnostics should be pursued.

Atypical presentation of ischaemic heart disease and ACS is more common in the elderly and diabetics. Non-specific symptoms such as a general feeling of discomfort, abdominal pain and autonomic symptoms may be more pronounced than CP. Symptoms may also be very limited or nonexistent.

1-14% of infarctions occur without coronary occlusion and are classified as **MINOCA** (myocardial infarction with nonocclusive coronary arteries). In many cases the aetiology is unknown, but MINOCA may be secondary to coronary spasms, Takotsubo cardiomyopathy, microvascular dysfunction or viral myocarditis. Initial treatment is linked to the specific aetiology. If no aetiology is found, it should be treated as a non-ST elevation myocardial infarction (NSTEMI).

CLASS	SEVERITY OF ANGINA PECTORIS
0	No/asymptomatic angina pectoris
1	Angina pectoris with strenuous exertion
2	Angina pectoris with moderate exertion
3	Angina pectoris with mild exertion
4	Angina pectoris at rest

Table 62 // Canadian Cardiovascular Society grading of angina pectoris

Always consider adding a PPI to DAPT in order to prevent GI bleeding.

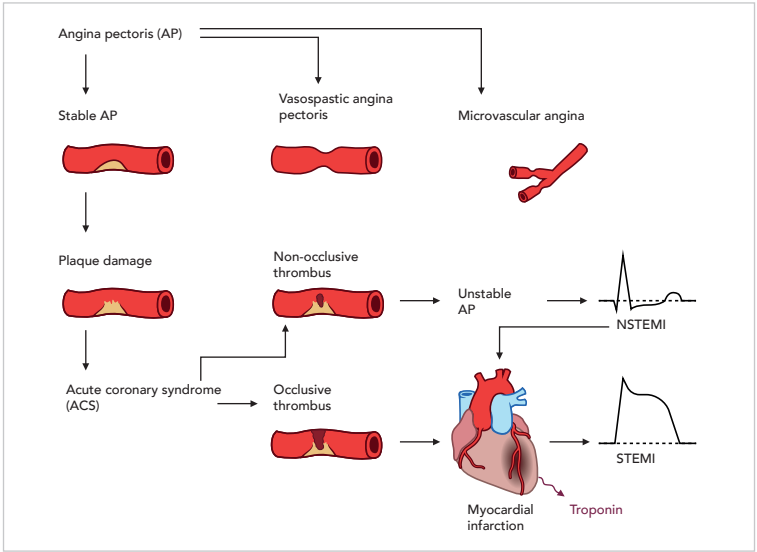


Figure 53 // Ischaemic heart disease

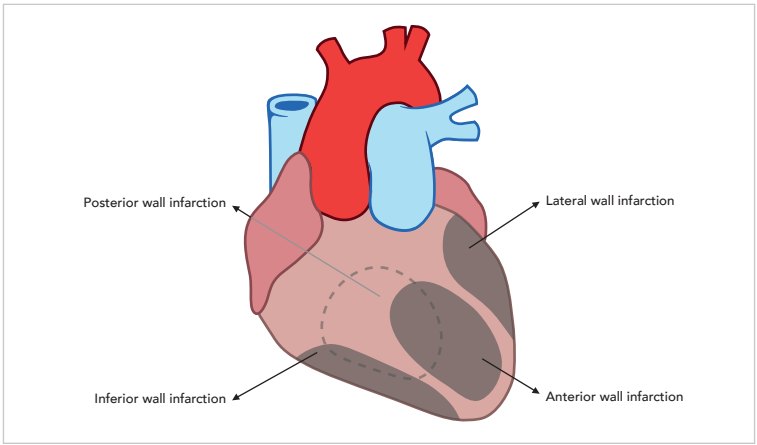


Figure 54 // Patterns of infarction in a STEMI

Heart failure

Heart failure (HF)

D HF, also called congestive heart failure, is a clinical syndrome caused by functional or structural cardiac pathology that results in decreased CO and/or increased intracardiac pressure. A distinction is made between chronic heart failure with preserved ejection fraction (HFpEF), with mildly reduced ejection fraction (HFmrEF) and with reduced ejection fraction (HFrEF), and acute heart failure (see Table 80).

E Prevalence in adult population = 1-2%, prevalence at age ≥70 = 10%, prevalence at age ≥85 = 20%

Ae Systolic function ↓, diastolic function ↓

R General cardiovascular risk factors (see Table 80)

Hx See Table 80 and Figure 75

PE See Table 80 and Figure 75

Dx
- Labs: NT-proBNP or other natriuretic peptides ↑
- ECG: possibly information about aetiology. Heart failure is unlikely with a normal ECG.
- Chest X-ray to rule out pulmonary pathology: signs of acute heart failure
- Echocardiography (gold standard): information about aetiology and cardiac function
- Cardiac MRI/PET-CT/CTCA/cardiac catheterisation (if ultrasound is inconclusive): information about aetiology, atrial and ventricular pressure and cardiac function
- Stress ultrasound or ECG (in follow-up phase): evaluation of exercise capacity

Tx
- Treat underlying cause
- Treatment is aimed at reducing symptoms, maintaining quality of life and improving prognosis
- Smoking cessation (especially with underlying coronary artery disease), exercise ↑, weight reduction, dietary changes (saturated fats/carbohydrates/salt/caffeine ↓, unsaturated fats ↑, fruit/vegetables ↑, fluid restriction), avoid alcohol consumption, avoid stress

See Table 80

P
- Depending on underlying cause, comorbidities and overall condition of patient
- 1-year mortality after hospitalisation (largely independent of aetiology): ±17%, in stable patients: ±7%

! Risk of cardiogenic shock, progression of heart failure and sudden cardiac arrest

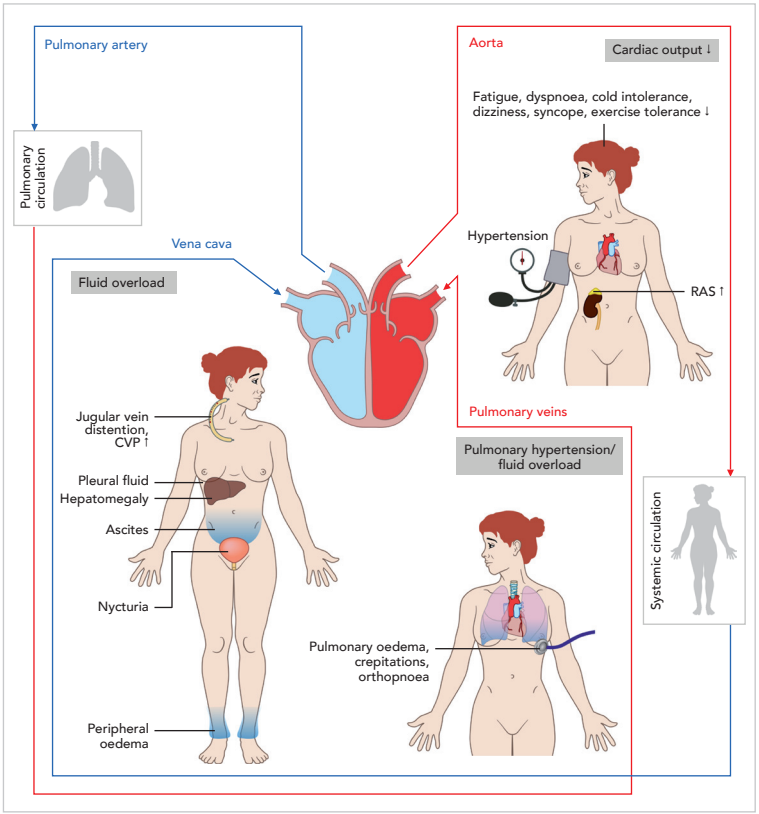


Figure 75 // Clinical symptoms of heart failure

The severity of heart failure is determined using the **New York Heart Association (NYHA) classification** for heart failure:
- NYHA I: asymptomatic
- NYHA II: dyspnoea during strenuous exercise
- NYHA III: dyspnoea during moderate exercise
- NYHA IV: dyspnoea at rest or during mild exercise

Appendices

Appendix 1: Systematic ECG assessment

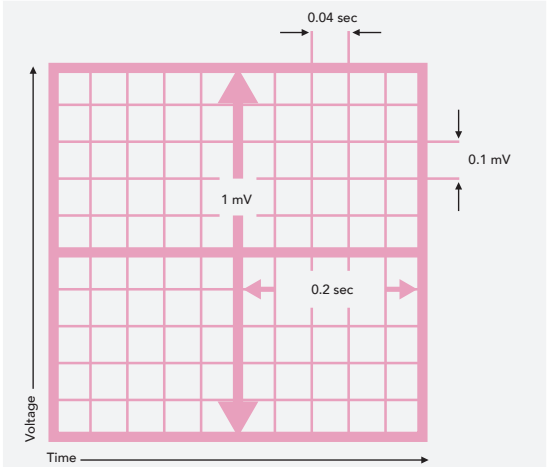
PERSONAL DATA & TECHNICAL QUALITY	
Check personal data	
Check calibration and paper speed	
Check placement and orientation of ECG leads	
Left arm/right arm reversal	Negative complex in I with negative P wave. Most common cause of right heart axis.
Neutral lead placed on arm instead of leg	Lead I, II or III (depending on the reversal) measures the potential difference between the two legs. Because this difference is negligible, the lead will show a flatline, with the possible exception of some far-field potential (i.e. electrical activity of the heart occurring far away from the lead, visualised as minuscule deflections on ECG). If the neutral lead is misplaced, almost all other leads will look abnormal too.
Chest lead reversals	Unexpected R-wave progression (e.g. increase - decrease - increase)

Table 81 // Personal data and technical quality

Incorrect placement of ECG leads can lead to inversion of limb leads of microvoltages in the chest leads.

RHYTHM	
In a sinus rhythm, each P wave must be followed by a QRS complex and each QRS complex must be preceded by a P wave. The P wave must also be sinusoidal, which means it must be biphasic in V1 and positive in II and aVF. The positive deflections in II and aVF are caused by the direction of atrial activation (down from the sinus node, i.e. towards II and aVF). In an atrial rhythm, the atrium is activated from a focus other than the sinus node, which results in a different shape depending on the origin of the impulse.	
Sinus rhythm	P wave is positive in I, II; biphasic in V1
Atrial flutter	Sawtooth wave on baseline, often regular, 300/min with 2:1 AV block
Atrial fibrillation	Irregular, no uniform P waves
Atrial rhythm	Abnormal P wave before each QRS complex
Junctional/ventricular escape rhythm	No P wave before each QRS complex

Table 82 // Rhythm

RATE	
Normal	60-100/min
Bradycardia	<60/min
Tachycardia	>100/min
Narrow complex tachycardia	→ always supraventricular
Wide complex tachycardia	→ ventricular or supraventricular tachycardia with bundle branch block (or aberrancy)
Regular rate: count number of large squares between R waves: 300-150-100-75-60-50 Irregular rate: count number of QRS complexes in 30 large squares (6 sec) x 10	

Table 83 // Rates

CONDUCTION TIMES	
PQ interval	**120-200 ms**
First-degree AV block	PQ >200 ms
Second-degree type I/ Wenckebach AV block	Gradually increasing PQ interval until impulses from the atria are no longer conducted to the ventricles.

Table 84A // Conduction times

About us

As medical students, we felt overwhelmed by the amount of medical knowledge available. An overview was lacking. Fueled by this need for change, we embarked on a journey that has now brought together over 500 students and doctors to create the entire *Compendium Medicine* book series. Our mission is to help and connect healthcare professionals globally by providing accessible knowledge.

The bigger picture

In 2015, at VU University in Amsterdam, the Netherlands, our paths crossed as we were both pursuing our medical educations. The vast sea of medical knowledge overwhelmed us, highlighting the need for a comprehensive overview. We were surprised by the isolated efforts of every hospital and university, each working on its own 'island', publishing individual books and reference works instead of fostering collaboration.

Motivated to make a difference, we envisioned a solution: a comprehensive guide encompassing all 35 subspecialties, enriched with figures, icons, charts, and mnemonics. Our vision was clear – our books had to be visual, concise, and to the point. With a dedicated team of students and doctors, we started writing an encyclopedia using our unique method. *Compendium Medicine* was born!

Book series

Following almost two years of dedicated effort, the first edition achieved sold-out status even before its official launch: a remarkable start to the ongoing rollercoaster journey. The most rewarding aspect of this experience has been – and still is – the overwhelmingly positive feedback from medical students and specialists. Our narrative caught the attention of prominent Dutch and Belgian newspapers and journals, leading to invitations to feature on popular talk shows on national television.

Compendium Medicine book series

Our white-coat pockets

One year later, both of us had started our clinical rotations. We recognized a common challenge faced by many peers: the need for quick and easy access to practical information. In response, we started creating our first series of pockets – concise yet comprehensive pocket-sized booklets designed to provide essential and practical information during a shift.

A period of many milestones followed. Our team expanded every month: from authors to medical specialists, from ambassadors to illustrators. With a growing number of followers on social media, a real community was born. With this team, we worked incredibly hard on new pockets as well as new additions like flashcards and pocket cards. As of now, we have launched a total of 18 different pockets!

Compendium Medicine pockets

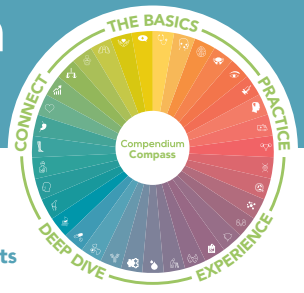
Expanding our mission globally

With the experience gained over the past years, we are committed to making a positive impact on medical students and healthcare professionals worldwide. This new phase kicked off with the distribution of our *Radiology* pocket to all continents. We were amazed to have reached readers from over 75 countries! Their positive feedback was instrumental in propelling us forward, and we are excited to present our second pocket in English: *Cardiology and Vascular Medicine*.. And this is just the beginning: we are actively working on bringing more pockets to you!

Romée Snijders & Veerle Smit

Doctors and founders of *Compendium Medicine*

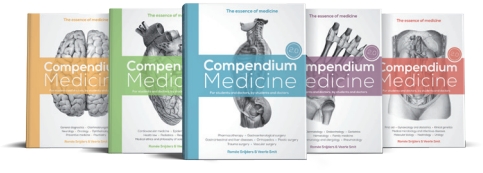
Compendium Compass



We believe that on your journey from medical student to retirement you continuously navigate these five steps. The Compendium Compass assists you along the way.

1 THE BASICS

Start at the foundation. Explore all 35 medical specialisms through our comprehensive series, featuring clear diagrams, tables, and illustrations. Visit our website for additional details.



2 PRACTICE

Reinforce your foundational knowledge with our 'Compendium Medicine' app and through our social media platforms! The app, which can be downloaded from the Apple and Android app stores, enables you to practice questions on a daily basis and participate in the monthly challenge.

Scan this QR code for more information.

3 EXPERIENCE

Learn on-the-go by carrying our pockets and pocket cards with you on the ward, during your shifts and rounds, anytime. Our first pockets are already available worldwide, with many more to come. See below for details!

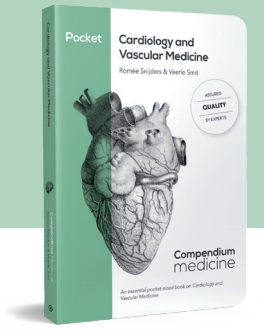
4 DEEP DIVE

Explore medical knowledge through extensive reading, immersing yourself in a variety of literature, guidelines, and the latest scientific articles.

5 CONNECT

Interested in connecting with individuals in your field? Become a member of our community through our social media platform – a network of students, physicians, specialists, and other healthcare professionals.

Do you want to receive the pocket *Cardiology and Vascular Medicine* as soon as possible?



Order the pocket here!

The pocket *Cardiology and Vascular Medicine* is a compact and practical handbook for everyone in healthcare. It covers the fundamentals before delving into cardiology-specific diagnostics and conditions.

We used our *Compendium Method*© to write this pocket. The method consists of comprehensible illustrations for every medical condition, straightforward tables, icons, and useful mnemonics. This method is designed to be visual, to the point and concise, all while maintaining the highest quality standards through rigorous supervision by medical specialists.

Do you want to know more about our journey?
Explore our website and connect with us on social media to learn more.

Curious about the other pockets of Compendium Medicine?
Click here.