[redacted]

[redacted] Progress Notes Signed Encounter Date: 11/22/2022

Specialty: Cardiothoracic Surgery

Cardiothoracic Surgery Consultation

Patient Name: [redacted] Date of Birth: [redacted] MRN: [redacted]
Date of Service: 11/22/2022

Reason for Consult: Aortic valve stenosis
Primary Care Provider: [redacted]
Referring Provider: [redacted]

ASSESSMENT AND PLAN:

Mr. [redacted] is a 69 y.o. referred to the Structural Heart Program for assessment of treatment options for aortic valve disease.

The patient has developed progressive DOE over the last year and currently reports symptoms that are consistent with NYHA functional class III.

I have reviewed both the images and reports from the following diagnostic tests which are notable for the following:

- **TTE** 10/12/2022: EF 60-65%, PG 57 mmHg, MG 41 mmHg, AVA 1.00 cm2, DVI 0.25, trace aortic insufficiency
- **Cardiac cath 9/2/2021:** mild non-obstructive CAD. Moderate AS on invasive assessment AVA 1.1 cm2, MG 31 mmHg. LVEDP 23 mmHg. Mild pulmonary HTN (PA 34/16 mean 24)
- **EKG** 8/31/2021: sinus, PR 164, QRSD 80

Based on symptoms, physical exam, and diagnostic studies I agree that the patient has severe symptomatic aortic stenosis. I feel that aortic valve replacement is indicated. He is a good candidate for either SAVR or TAVR. He is on a significant amount of immunosuppression so would healing and infection would be a concern with open surgery. On the other hand, he has a relatively small aortic root but I still think he will have significant functional improvement with a transcatheter aortic valve. The patient states a goal of improving his DOE and low energy levels.

[redacted]

[redacted]

I had a long detailed conversation with Mr. [redacted] today in clinic. He is a very bright gentleman, he understands the risks and benefits of both transcatheter aortic valve replacement as well as surgical aortic valve replacement and the relative merits of each. We discussed both procedures in detail, the timing, recovery, and after our PARQ discussion using a shared decision-making model he is elected to move forward with transcatheter aortic valve replacement. We will plan to schedule him for December. Today after a PARQ discussion with both myself and Dr. [redacted] he has signed his consent. Prior to surgery we will repeat his cardiac catheterization, this is due to the a long interval from his last catheterization as well as his symptoms of chest pain.

The patient will require inpatient admission and I anticipate 1-2 days of stay.

I spent 30 minutes on the unit with Mr. [redacted] Greater than 50% of this time was spent counseling him and coordinating his care.

Prior to the patient's visit, additional time 15 minutes was spent for review of the patient's extensive outside records and studies.

Chief Complaint: Chest pain and DOE

History of Present Illness: Mr. [redacted] is a 69 y.o. male who is referred for consideration of treatment options for aortic stenosis. They have traditionally been followed by [redacted] MD for cardiovascular co-morbidities. Last year, due to progressive chest pain, a TTE noted moderate AS with normal LV function. A coronary angiogram/RHC in 09/2021 noted moderate AS on invasive valve assessment, mild non-obstructive CAD, and mild pulmonary HTN. Due to persistent chest pain a year later, follow up TTE obtained in 10/2022 demonstrated progression of AS to severe with preserved systolic function. He was subsequently referred to the structural heart program for consideration of interventional options.

Currently:
[redacted] (lived there since April). He continues to work as a lawyer in litigation and business/trust law, but has considerably pulled back his hours over the last few years as he moves into retirement. He is an avid golfer, playing 18 holes at least twice a week. He has a brittany spaniel that he walks regularly as well. On days that he golfs, he achieves at least 10K steps, and on non-golf days, ~5K steps. When golfing, he does use a cart but there is still a lot of walking involved to and from the cart, often up short hills.

He felt like things initially went downhill when he was first diagnosed with psoriatic arthritis in 2010. He has had mild SOB and fatigue since 2012, but it has been progressive since then, particularly over the past year. Presently he feels tried every day; he gets 10 hrs of sleep, and still does not feel well rested. He has never had a formal sleep study.

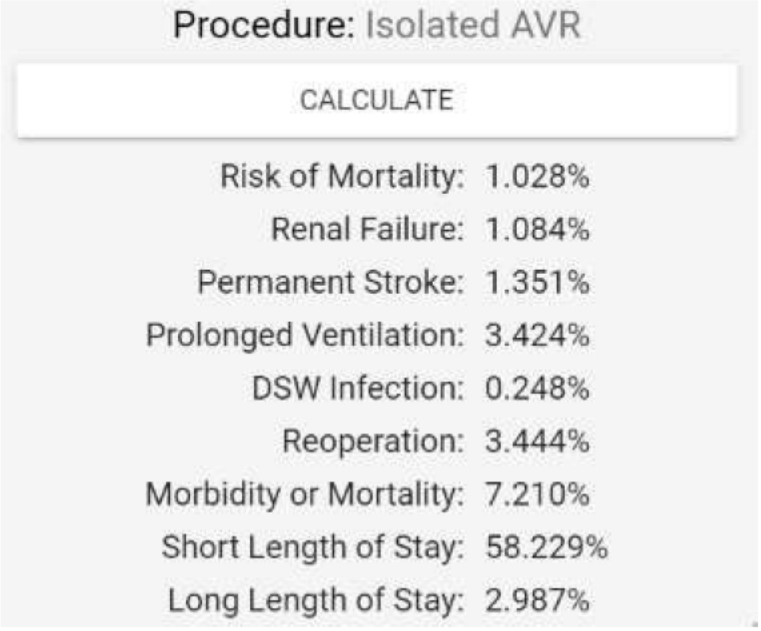
While DOE and fatigue have been noticeable for 10 years as above, symptoms have become drastically more apparent as of late and are starting to interfere with his regular activities. He no longer takes his dog for long walks due to DOE, chest pressure/pain, dizziness, and fatigue. When golfing, he will get SOB and develop chest pain when walking up hills, and will get lightheaded when bending over to pick up a golf ball. During activities with heavier exertion (e.g. hanging a ladder), he will get SOB, have progressive chest discomfort, and become lightheaded; it takes nearly an hour for symptoms to dissipate if he has pushed himself too hard. He experienced a syncopal episode this past summer when walking up a hill at elevation;

[redacted]

"came to" after about 5 seconds. He has not experienced recurrent syncope, but does report presyncope with heavy exertion.

Regading psoriatic arthritis, took a long time for formal diagnosis, and was in severe pain until the right "cocktail" was figured out for him. 3 mg of prednisone daily is about as low as he can go. If he misses his weekly Humira dose, it will take him about 2 weeks for symptoms to re-stabilize after resuming normal course if he misses 2 weeks of Humira, it can take a few months for symptoms to stabilize.

STS Adult Cardiac Surgery Database Version 4.20
RISK SCORES



Allergies

Allergen	Reactions
• Penicillins	Rash and Hives

Past Medical History:

Diagnosis	Date
• Allergic rhinitis	
• Anemia	
• Angina pectoris (CMS/HCC)	09/2021
• BPH (benign prostatic hyperplasia)	
• Coronary artery disease	
• Depression	
• ED (erectile dysfunction)	
• Heart murmur	
• History of lipoma	
• Hyperlipidemia	
• Hypertension	
• Nonrheumatic aortic (valve) stenosis	
• Peripheral neuropathy *BLE*	
• Pulmonary hypertension (CMS/HCC)	
• Spinal stenosis, lumbar region, with	02/2022

[redacted]

neurogenic claudication

Past Surgical History:

Procedure	Laterality	Date
• APPENDECTOMY		
• CATARACT EXTRACTION	Bilateral	
• CORONARY ANGIOGRAPHY W LEFT AND RIGHT HEART CATHS *Performed by [redacted] at SBH CARDIAC CATH LAB*	N/A	9/2/2021
• FORAMINOTOMY MINIMALLY INVASIVE OF CERVICAL SPINE W/ C-ARM		
• NECK SURGERY *growth removed*		11/2020
• SOFT TISSUE TUMOR RESECTION *benign tumor*		
• TONSILLECTOMY		

Family History

Problem	Relation	Age of Onset
• Rectal cancer	Mother	
• Other *valve surgery, ?BAV*	Father's Brother	

Social History

Social History Narrative
• Not on file

[redacted]

Review of Systems

Constitutional: Positive for malaise/fatigue.
HENT: Negative.
Eyes: Negative.
Cardiovascular: Positive for chest pain, dyspnea on exertion and near-syncope.
Respiratory: Positive for shortness of breath.
Endocrine: Negative.
Hematologic/Lymphatic: Negative.
Skin: Negative.
Musculoskeletal: Negative.
Gastrointestinal: Negative.
Genitourinary: Negative.
Neurological: Negative.
Psychiatric/Behavioral: Negative.
Allergic/Immunologic: Negative.

BP 121/79 (BP Location: Left arm, Patient Position: Sitting) | Pulse 73 | Wt 110 kg (242 lb) | SpO2 97% | BMI 34.72 kg/m²

[redacted]

[redacted]

Physical Exam

Vitals reviewed.

Constitutional:

General: He is not in acute distress.

Appearance: Normal appearance. He is not ill-appearing.

HENT:

Head: Normocephalic and atraumatic.

Right Ear: External ear normal.

Left Ear: External ear normal.

Nose: Nose normal.

Eyes:

Extraocular Movements: Extraocular movements intact.

Pupils: Pupils are equal, round, and reactive to light.

Cardiovascular:

Rate and Rhythm: Normal rate and regular rhythm.

Heart sounds: Murmur heard.

Medium-pitched blowing holosystolic murmur is present with a grade of 3/6 at the upper right sternal border and upper left sternal border.

Pulmonary:

Effort: Pulmonary effort is normal. No respiratory distress.

Breath sounds: Normal breath sounds. No wheezing or rales.

Abdominal:

General: Bowel sounds are normal. There is no distension.

Palpations: Abdomen is soft.

Tenderness: There is no abdominal tenderness. There is no guarding.

Neurological:

Mental Status: He is alert.

IMAGING STUDIES:

I personally reviewed the patient's cardiac catheterization, echocardiogram and CT scan.

LABS:

Lab Results

Component	Value	Date
WBC	7.8	08/31/2021
HGB	13.4	08/31/2021
HCT	40.2	08/31/2021
MCV	104.4 (H)	08/31/2021
PLT	214	08/31/2021

Lab Results

Component	Value	Date
GLUCOSE	98	08/31/2021
CALCIUM	9.0	08/31/2021
NA	137	08/31/2021
K	4.3	02/16/2022
CO2	27	08/31/2021

[redacted]

[redacted]

CL	100	08/31/2021
BUN	33 (H)	08/31/2021
CREATININE	0.9	08/31/2021

Lab Results

Component	Value	Date
CREATININE	0.9	08/31/2021

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Portions of this medical record were completed using Dragon speech recognition software. There may be unintended errors in spelling, grammar, context or punctuation that are inherent in voice recognition programs. While I have done my best to correct those errors, if there are any questions about the content of the note please contact me for clarification.

Office Visit on 11/22/2022 *Note viewed by patient*

Additional Documentation

Vitals: BP 121/79 (BP Location: Left arm, Patient Position: Sitting) Pulse 73 Wt 110 kg (242 lb) SpO2 97%
BMI 34.72 kg/m² BSA 2.27 m²

Orders Placed

COVID-19 (SARS-CoV2), Hologic NAAT/RNA Molecular (SCHS) (Resulted 12/13/2022, Abnormal)

Medication Changes

As of 11/22/2022 3:11 PM

None

Visit Diagnoses

Primary: **Nonrheumatic aortic valve stenosis** I35.0
Essential hypertension I10
Nonobstructive atherosclerosis of coronary artery I25.10
Mild pulmonary hypertension (CMS/HCC) I27.20

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