Sample Type / Medical Specialty: Cardiovascular / Pulmonary

Sample Name: Cardiac Consult & Cardioversion

Description: Patient with a history of atrial fibrillation in the past, more recently who has had atrial flutter. The patient has noted some lightheadedness as well as chest discomfort and shortness of breath when atrial flutter recurred.
(Medical Transcription Sample Report)

HISTORY OF PRESENT ILLNESS: Mr. A is a 50-year-old gentleman with a history of atrial fibrillation in the past, more recently who has had atrial flutter, who estimates he has had six cardioversions since 10/09, and estimates that he has had 12 to 24 in his life beginning in 2006 when the atrial fibrillation first emerged. He, since 10:17 p.m. on 01/17/10, noted recurrence of his atrial fibrillation, called our office this morning, that is despite being on flecainide, atenolol, and he is maintained on Coumadin.

The patient has noted some lightheadedness as well as chest discomfort and shortness of breath when atrial flutter recurred and we see that on his 12-lead EKG here. Otherwise, no chest pain.

PAST MEDICAL HISTORY: Significant for atrial fibrillation/atrial flutter and again he had atrial fibrillation more persistently in 2006, but more recently it has been atrial flutter and that is despite use of antiarrhythmics including flecainide. He completed a stress test in my office within the past several weeks that was normal without evidence of ischemia. Other medical history is significant for hyperlipidemia.

MEDICATIONS:
As outpatient,
1. Atenolol 25 mg once a day.
2. Altace 2.5 mg once a day.
3. Zocor 20 mg once a day.
4. Flecainide 200 in the morning and 100 in the evening.
5. Coumadin as directed by our office.

ALLERGIES: TO MEDICATIONS ARE NONE. HE DENIES SHRIMP, SEA FOOD OR DYE ALLERGY.

FAMILY HISTORY: He has a nephew who was his sister's son who passed away at age 22 reportedly from an MI, but was reported to have hypertrophic cardiomyopathy as well. The patient has previously met with the electrophysiologist, Dr. X, at General Hospital and it sounds like he had a negative EP study.

SOCIAL HISTORY: The patient does not smoke cigarettes, abuse alcohol nor drink any caffeine. No use of illicit drugs. He has been married for 22 years and he is actually accompanied throughout today's cardiology consultation by his wife. He is not participating

in regular exercises now because he states since starting flecainide, he has gotten sluggish. He is employed as an attorney and while he states that overall his mental stress is better, he has noted more recent mental stress this past weekend when he was taking his daughter back to college.

REVIEW OF SYSTEMS: He denies any history of stroke, cancer, vomiting of blood, coughing up blood, bright red blood per rectum, bleeding stomach ulcers, renal calculi. There are some questions especially as his wife has told me that he may have obstructive sleep apnea and not had a formal sleep study.
Bodyweight : 300 pounds
BMI -> 28

PHYSICAL EXAM: Blood pressure 156/93, pulse is 100, respiratory rate 18. On general exam, he is a pleasant overweight gentleman, in no acute distress. HEENT: Shows cranium is normocephalic and atraumatic. He has moist mucosal membranes. Neck veins are not distended. There are no carotid bruits. Visible skin warm and perfused. Affect appropriate. He is quite oriented and pleasant. No significant kyphoscoliosis on recumbent back exam. Lungs are clear to auscultation anteriorly. No wheezes. No egophony. Cardiac Exam: S1, S2. Regular rate, controlled. No significant murmurs, rubs or gallops. PMI is nondisplaced. Abdomen is soft, nondistended, appears benign. Extremities without significant edema. Pulses grossly intact.

DIAGNOSTIC STUDIES/LAB DATA: Initial ECG shows atrial flutter.

IMPRESSION: Mr. A is a 50-year-old gentleman with a history of paroxysmal atrial fibrillation in the past, more recently is having breakthrough atrial flutter despite flecainide and we had performed a transesophageal echocardiogram-guided cardioversion for him in late 12/20/09, who now has another recurrence within the past 41 hours or so. I have reviewed again with him in detail regarding risks, benefits, and alternatives of proceeding with cardioversion, which the patient is in favor of. After in depth explanation of the procedure with him that there would be more definitive resumption of normal sinus rhythm by using electrocardioversion with less long-term side effects, past the acute procedure, alternatives being continued atrial flutter with potential for electrophysiologic consultation for ablation and/or heart rate control with anticoagulation, which the patient was not interested nor was I primarily recommending as the next step, and risks including, but not limited to and the patient was aware and this was all done in the presence of his wife that this is not an all-inclusive list, but the risks include but not limited to oversedation from conscious sedation, risk of aspiration pneumonia from regurgitation of stomach contents, which would be less likely as I did confirm with the patient that he had been n.p.o. for greater than 15 hours, risk of induction of other arrhythmias including tachyarrhythmias requiring further management including cardioversion or risk of bradyarrhythmias, in the past when we had a cardioverter with 150 joules, he did have a 5.5-second pause especially while he is on antiarrhythmic therapy, statistically less significant risk of CVA, although we cannot really make that null. The patient expressed understanding of this risk, benefit, and alternative analysis. I invited questions from him and his wife and once their questions were answered to their self-stated satisfaction, we planned to go forward with the procedure.

PROCEDURE NOTE: The patient received a total of 7 mg of Versed and 50 micrograms of fentanyl utilizing titrate-down sedation with good effect and this was after the appropriate time-out procedure had been done as per the Medical Center universal protocol with appropriate identification of the patient, position, procedure documentation, procedure indication, and there were no questions. The patient did actively participate in this time-out procedure. After the universal protocol was done, he then received the cardioversion attempt with 50 joules using "lollipop posterior patch" with hands-driven paddle on the side, which was 50 joules of synchronized biphasic energy. There was successful resumption of normal sinus rhythm, in fact this time there was not a significant pause as compared to when he had this done previously in late 12/09 and this sinus rhythm was confirmed by a 12-lead EKG.

IMPRESSION: Cardioversion shows successful resumption of normal sinus rhythm from atrial flutter and that is while the patient has been maintained on Coumadin and his INR is 3.22. We are going to watch him and discharge him from the Medical Center area on his current flecainide of 200 mg in the morning and 100 mg in the evening, atenolol 25 mg once a day, Coumadin _____ as currently being diagnosed. I had previously discussed with the patient and he was agreeable with meeting with his electrophysiologist again, Dr. X, at Electrophysiology Unit at General Hospital and I will be planning to place a call for Dr. X myself. Again, he has no ischemia on this most recent stress test and I suppose in the future it may be reasonable to get obstructive sleep apnea evaluation and that may be one issue promulgating his symptoms.

I had previously discussed the case with Dr. Y who is the patient's general cardiologist as well as updated his wife at the patient's bedside regarding our findings.

Keywords: cardiovascular / pulmonary, shortness of breath, chest discomfort, obstructive sleep apnea, normal sinus rhythm, sinus rhythm, atrial fibrillation, atrial flutter, flutter, cardiac, atrial, chest, coumadin, cardioversion, fibrillation, flecainide,