HISTORY OF PRESENT ILLNESS:, I was kindly asked to see Ms. ABC who is a 74-year-old woman for cardiology consultation regarding atrial fibrillation and anticoagulation after a fall.,The patient is somnolent at this time, but does arouse, but is unable to provide much history. By review of the chart, it appears that she fell, which is what she states when she got up out of a rocking chair and could not get herself off the floor. She states that 1-1/2 hours later she was able to get herself off the floor.,The patient denies any chest pain nor clear shortness of breath.,PAST MEDICAL HISTORY: , Includes, end-stage renal disease from hypertension. She follows up with Dr. X in her office and has been known to have a small-to-moderate sized pericardial effusion since 11/07 that has apparently been followed and it appears that the patient was not interested in having diagnostic pericardiocentesis done. She had an echocardiogram today (please see also that report), which shows stable and small-to-moderate sized pericardial effusion without tamponade, normal left ventricular ejection fraction at 55% with mild concentric left ventricular hypertrophy, mildly dilated right ventricular size, normal right ventricular ejection fraction, moderate mitral regurgitation and severe tricuspid regurgitation with severe pulmonary hypertension, estimated PA systolic pressure of 71 mmHg when compared to the prior echocardiogram done 08/29/07, previously the mitral regurgitation was mild and previously the PA systolic pressure was estimated at 90 mmHg. Other findings were not significantly changed including pericardial effusion description. She has a history of longstanding

hypertension. She has been on hemodialysis since 1997 for renal failure, history of mini-strokes documented several years ago, history of seizure disorder, she has a history of right upper extremity edema and right breast enlargement from right subclavian vein occlusion. She has a history of hypertension, depression, hyperlipidemia, on Sensipar for tertiary hyperparathyroidism.,PAST SURGICAL HISTORY: , Includes, cholecystectomy, post fistula in the left arm, which has failed, and right arm, which is being used including number of operative procedures to the fistula. She follows up with Dr. Y regarding neurovascular surgery.,MEDICATIONS: , On admission:,1. Norvasc 10 mg once a day.,2. Aspirin 81 mg once a day.,3. Colace 200 mg two at bedtime.,4. Labetalol 100 mg p.o. b.i.d.,5. Nephro-Vite one tablet p.o. q.a.m.,6. Dilantin 100 mg p.o. t.i.d.,7. Renagel 1600 mg p.o. t.i.d.,8. Sensipar 120 mg p.o. every day.,9. Sertraline 100 mg p.o. nightly.,10. Zocor 20 mg p.o. nightly.,ALLERGIES: , TO MEDICATIONS PER CHART ARE NONE.,FAMILY HISTORY: ,Unable to obtain as the patient becomes quite sleepy when I am talking.,SOCIAL HISTORY: ,Unable to obtain as the patient becomes quite sleepy when I am talking.,REVIEW OF SYSTEMS: , Unable to obtain as the patient becomes quite sleepy when I am talking.,PHYSICAL EXAM: ,Temperature 99.2, blood pressure ranges from 88/41 to 108/60, pulse 70, respiratory rate, 20, O2 saturation 98%. Height is 5 feet 1 inch, weight 147 pounds. On general exam, she is a pleasant elderly woman who does arouse to voice, but then becomes quite sleepy and apparently that is an

improvement from when she was admitted. HEENT shows the cranium is normocephalic and atraumatic. She has moist mucosal membranes. Neck veins are difficult to assess, but do not appear clinically distended. No carotid bruits. Lungs are clear to auscultation anteriorly. No wheezes. Cardiac exam: S1, S2 regular rate, 3/6 holosystolic murmur heard with radiation from the left apex towards the left axilla. No rub, no gallop. PMI is nondisplaced. Abdomen: Soft, nondistended. CVA is benign. Extremities with no significant edema. Pulses appear grossly intact. She has evidence of right upper extremity edema, which is apparently chronic.,DIAGNOSTIC DATA/LAB DATA: , EKGs are reviewed including from 07/07/09 at 08:31 a.m., which shows atrial fibrillation with left anterior fascicular block, poor R-wave progression when compared to one done on 07/06/09 at 18:25, there is really no significant change. The atrial fibrillation appears present since at least on EKG done on 11/02/07 and this EKG is not significantly changed from the most recent one. Echocardiogram results as above. Chest x-ray shows mild pulmonary vascular congestion. BNP shows 3788. Sodium 136, potassium 4.5, chloride 94, bicarbonate 23, BUN 49, creatinine 5.90. Troponin was 0.40 followed by 0.34. INR 1.03 on 05/18/07. White blood cell count 9.4, hematocrit 42, platelet count 139.,IMPRESSION: , Ms. ABC is a 74-year-old woman admitted to the hospital with a fall and she has a history of vascular dementia, so her history is somewhat unreliable it seems and she is somnolent at that time. She does have chronic atrial fibrillation again documented at least

present since 2007 and I found an EKG report by Dr. X, which shows atrial fibrillation on 08/29/07 per her report. One of the questions we were asked was whether the patient would be a candidate for Coumadin. Clearly given her history of small mini-strokes, I think Coumadin would be appropriate given this chronic atrial fibrillation, but the main issue is the fall risk. If not felt to be significant fall risk then I would strongly recommend Coumadin as the patient herself states that she has only fallen twice in the past year. I would defer that decision to Dr. Z and Dr. XY who know the patient well and it may be that physical therapy consult is appropriate to help adjudicate.,RECOMMENDATIONS:,1. Fall assessment as per Dr. Z and Dr. XY with possible PT consult if felt appropriate and if the patient is not felt to be at significant fall risk, would put her on Coumadin. Given her history of small strokes as documented in the chart and her chronic atrial fibrillation, she does have reasonable heart rate control on current labetalol.,2. The patient has elevated BNP and I suspect that is due to her severe pulmonary hypertension and renal failure and in the light of normal LV function, I would not make any further evaluation of that other than aggressive diuresis.,3. Regarding this minimal troponin elevation, I do not feel this is a diagnosis especially in the setting of pulmonary hypertension and her small-to-moderate sized stable pericardial effusion again that has been longstanding since 2007 from what I can tell and there is no evidence of tamponade. I would defer to her usual cardiologist Dr. X whether an outpatient stress evaluation is appropriate for risk

stratification. I did find that the patient had a prior cardiac stress test in 08/07 where they felt that there was some subtle reversibility of the anterior wall, but it was felt that it may be artifact rather than true ischemia with normal LV function seen on that study as well.,4. Continue Norvasc for history of hypertension as well as labetalol.,5. The patient is felt to be a significant fall risk and will at least continue her aspirin 81 mg once a day for secondary CVA, thromboprophylaxis (albeit understanding that it is inferior to Coumadin).,6. Continue Dilantin for history of seizures.