SUBJECTIVE: , The patient states that she feels better. She is on IV amiodarone, the dosage pattern is appropriate for ventricular tachycardia. Researching the available records, I find only an EMS verbal statement that tachycardia of wide complex was seen. There is no strip for me to review all available EKG tracings show a narrow complex atrial fibrillation pattern that is now converted to sinus rhythm.,The patient states that for a week, she has been home postoperative from aortic valve replacement on 12/01/08 at ABC Medical Center. The aortic stenosis was secondary to a congenital bicuspid valve, by her description. She states that her shortness of breath with exertion has been stable, but has yet to improve from its preoperative condition. She has not had any decline in her postoperative period of her tolerance to exertion.,The patient had noted intermittent bursts of fast heart rate at home that had been increasing over the last several days. Last night, she had a prolonged episode for which she contacted EMS. Her medications at home had been uninterrupted and without change from those listed, being Toprol-XL 100 mg q.a.m., Dyazide 25/37.5 mg, Nexium 40 mg, all taken once a day. She has been maintaining her Crestor and Zetia at 20 and 10 mg respectively. She states that she has been taking her aspirin at 325 mg q.a.m. She remains on Zyrtec 10 mg q.a.m. Her only allergy is listed to latex.,OBJECTIVE:,VITAL SIGNS: Temperature 36.1, heart rate 60, respirations 14, room air saturation 98%, and blood pressure 108/60. The patient shows a normal sinus rhythm on the telemetry monitor with an occasional PAC.,GENERAL:

She is alert and in no apparent distress.,HEENT: Eyes: EOMI. PERRLA. Sclerae nonicteric. No lesions of lids, lashes, brows, or conjunctivae noted. Funduscopic examination unremarkable. Ears: Normal set, shape, TMs, canals and hearing. Nose and Sinuses: Negative. Mouth, Tongue, Teeth, and Throat: Negative except for dental work.,NECK: Supple and pain free without bruit, JVD, adenopathy or thyroid abnormality.,CHEST: Lungs are clear bilaterally to auscultation. The incision is well healed and without evidence of significant cellulitis.,HEART: Shows a regular rate and rhythm without murmur, gallop, heave, click, thrill or rub. There is an occasional extra beat noted, which corresponds to a premature atrial contraction on the monitor.,ABDOMEN: Soft and benign without hepatosplenomegaly, rebound, rigidity or guarding.,EXTREMITIES: Show no evidence of DVT, acute arthritis, cellulitis or pedal edema.,NEUROLOGIC: Nonfocal without lateralizing findings for cranial or peripheral nervous systems, strength, sensation, and cerebellar function. Gait and station were not tested.,MENTAL STATUS: Shows the patient to be alert, coherent with full capacity for decision making.,BACK: Negative to inspection or percussion.,LABORATORY DATA: , Shows from 12/15/08 2100, hemoglobin 11.6, white count 12.9, and platelets 126,000. INR 1.0. Electrolytes are normal with exception potassium 3.3. GFR is decreased at 50 with creatinine of 1.1. Glucose was 119. Magnesium was 2.3. Phosphorus 3.8. Calcium was slightly low at 7.8. The patient has had ionized calcium checked at Munson that was normal at 4.5 prior to her

discharge. Troponin is negative x2 from 2100 and repeat at 07:32. This morning, her BNP was 163 at admission. Her admission chest x-ray was unremarkable and did not show evidence of cardiomegaly to suggest pericardial effusion. Her current EKG tracing from 05:42 shows a sinus bradycardia with Wolff-Parkinson White Pattern, a rate of 58 beats per minute, and a corrected QT interval of 557 milliseconds. Her PR interval was 0.12.,We received a call from Munson Medical Center that a bed had been arranged for the patient. I contacted Dr. Varner and we reviewed the patient's managed to this point. All combined impression is that the patient was likely to not have had actual ventricular tachycardia. This is based on her EP study from October showing her to be non-inducible. In addition, she had a cardiac catheterization that showed no evidence of coronary artery disease. What is most likely that the patient has postoperative atrial fibrillation. Her WPW may have degenerated into a ventricular tachycardia, but this is unlikely. At this point, we will convert the patient from IV amiodarone to oral amiodarone and obtain an echocardiogram to verify that she does not have evidence of pericardial effusion in the postoperative period. I will recheck her potassium, magnesium, calcium, and phosphorus at this point and make adjustments if indicated. Dr. Varner will be making arrangements for an outpatient Holter monitor and further followup post-discharge.,IMPRESSION:,1. Atrial fibrillation with rapid ventricular response.,2. Wolff-Parkinson White Syndrome.,3. Recent aortic valve replacement with bioprosthetic Medtronic valve.,4. Hyperlipidemia.