REASON FOR VISIT: , I have been asked to see this 63-year-old man with a dilated cardiomyopathy by Dr. X at ABCD Hospital. He presents with a chief complaint of heart failure.,HISTORY OF PRESENT ILLNESS: , In retrospect, he has had symptoms for the past year of heart failure. He feels in general ""OK,"" but is stressed and fatigued. He works hard running 3 companies. He has noted shortness of breath with exertion and occasional shortness of breath at rest. There has been some PND, but he sleeps on 1 pillow. He has no edema now, but has had some mild leg swelling in the past. There has never been any angina and he denies any palpitations, syncope or near syncope. When he takes his pulse, he notes some irregularity. He follows no special diet. He gets no regular exercise, although he has recently started walking for half an hour a day. Over the course of the past year, these symptoms have been slowly getting worse. He gained about 20 pounds over the past year.,There is no prior history of either heart failure or other heart problems.,His past medical history is remarkable for a right inguinal hernia repair done in 1982. He had trauma to his right thumb. There is no history of high blood pressure, diabetes mellitus or heart murmur.,On social history, he lives in San Salvador with his wife. He has a lot of stress in his life. He does not smoke, but does drink. He has high school education.,On family history, mother is alive at age 89. Father died at 72 of heart attack. He has 2 brothers and 1 sister all of whom are healthy, although the oldest suffered a myocardial infarction. He has 3 healthy girls and 9 healthy grandchildren.,A complete review of systems was

performed and is negative aside from what is mentioned in the history of present illness.,MEDICATIONS: , Aspirin 81 mg daily and chlordiazepoxide and clidinium - combination pill at 5 mg/2.5 mg 1 tablet daily for stress.,ALLERGIES: , Denied.,MAJOR FINDINGS:, On my comprehensive cardiovascular examination, he is 5 feet 8 inches and weighs 231 pounds. His blood pressure is 120/70 in each arm seated. His pulse is 80 beats per minute and regular. He is breathing 1two times per minute and that is unlabored. Eyelids are normal. Pupils are round and reactive to light. Conjunctivae are clear and sclerae are anicteric. There is no oral thrush or central cyanosis. Neck is supple and symmetrical without adenopathy or thyromegaly. Jugular venous pressure is normal. Carotids are brisk without bruits. Lungs are clear to auscultation and percussion. The precordium is quiet. The rhythm is regular. The first and second heart sounds are normal. He does have a fourth heart sound and a soft systolic murmur. The precordial impulse is enlarged. Abdomen is soft without hepatosplenomegaly or masses. He has no clubbing, cyanosis or peripheral edema. Distal pulses are normal throughout both arms and both legs. On neurologic examination, his mentation is normal. His mood and affect are normal. He is oriented to person, place, and time.,DATA: , His EKG shows sinus rhythm with left ventricular hypertrophy.,A metabolic stress test shows that he was able to exercise for 5 minutes and 20 seconds to 90% of his maximum predicted heart rate. His peak oxygen consumption was 19.7 mL/kg/min, which is consistent with mild cardiopulmonary

disease.,Laboratory data shows his TSH to be 1.33. His glucose is 97 and creatinine 0.9. Potassium is 4.3. He is not anemic. Urinalysis was normal.,I reviewed his echocardiogram personally. This shows a dilated cardiomyopathy with EF of 15%. The left ventricular diastolic dimension is 6.8 cm. There are no significant valvular abnormalities.,He had a stress thallium. His heart rate response to stress was appropriate. The thallium images showed no scintigraphic evidence of stress-induced myocardial ischemia at 91% of his maximum age predicted heart rate. There is a fixed small sized mild-to-moderate intensity perfusion defect in the distal inferior wall and apex, which may be an old infarct, but certainly does not account for the degree of cardiomyopathy. We got his post-stress EF to be 33% and the left ventricular cavity appeared to be enlarged. The total calcium score will put him in the 56 percentile for subjects of the same age, gender, and race/ethnicity.,ASSESSMENTS: , This appears to be a newly diagnosed dilated cardiomyopathy, the etiology of which is uncertain.,PROBLEMS DIAGNOSES: ,1. Dilated cardiomyopathy.,2. Dyslipidemia.,PROCEDURES AND IMMUNIZATIONS: , None today.,PLANS: , I started him on an ACE inhibitor, lisinopril 2.5 mg daily, and a beta-blocker, carvedilol 3.125 mg twice daily. The dose of these drugs should be up-titrated every 2 weeks to a target dose of lisinopril of 20 mg daily and carvedilol 25 mg twice daily. In addition, he could benefit from a loop diuretic such as furosemide. I did not start this as he is planning to go back

home to San Salvador tomorrow. I will leave that up to his local physicians to up-titrate the medications and get him started on some furosemide.,In terms of the dilated cardiomyopathy, there is not much further that needs to be done, except for family screening. All of his siblings and his children should have an EKG and an echocardiogram to make sure they have not developed the same thing. There is a strong genetic component of this.,I will see him again in 3 to 6 months, whenever he can make it back here. He does not need a defibrillator right now and my plan would be to get him on the right doses of the right medications and then recheck an echocardiogram 3 months later. If his LV function has not improved, he does have New York Heart Association Class II symptoms and so he would benefit from a prophylactic ICD.,Thank you for asking me to participate in his care.,MEDICATION CHANGES:, See the above.