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05/01/1992 12:00:00 AM
1. SICK SINUS SYNDROME .
2. PULMONARY CONGESTION .
3. STATUS
Unsigned
DIS
Report Status :
Unsigned
ADMISSION DATE :
05/01/92
DISCHARGE DATE :
5/12/92
DIAGNOSIS :
1. Sick sinus syndrome .
2. Pulmonary congestion .
3. Status post mitral valve replacement , with a porcine valve , and coronary ar
tery bypass grafting surgery .
4. Chronic obstructive lung disease .
SPECIAL PROCEDURES AND OPERATIONS :
A temporary pacemaker on 5/4/92 , coronary angiogram and left and right heart ca
theterization on 5/5/92 , and permanent VVI-pacemaker on 5/6/92 , using an Inter
medex pacemaker at 292-03 number , and set in the VVI mode with an escape rate o
f 65 .
MEDICATIONS ON DISCHARGE :
Zestril , 10 , b.i.d. , coumadin , to be regulated , digoxin , 0.125 mg. , alter
nating with 0.25 , every other day , verapamil , 80 , 4 times a day , Asthmacort
, four puffs , b.i.d. , Atrovent , 2 puffs , 4 times a day , and quinine sulfat
e , 325 , q.h.s.
HISTORY OF PRESENT ILLNESS :
This patient is a 77 year old female who has had a Hancock mitral valve replacem
ent on 10/28/76 by Dr. Melvean Ace .
She had a bypass graft with marginal artery at that time , with a flow of 85 cc.
's .
She subsequently had done well , although she had had chronic obstructive lung d
isease .
She had been converted to normal sinus rhythm in 1977 , but in 1988 , the mitral
valve on an echocardiogram was O.K.
Her ejection fraction was 81% , with no mitral regurgitation seen , with a peak
gradient of 9 and a mean gradient of about 3 .
In 1988 , she developed chronic obstructive pulmonary disease and asthma , and h
as been followed by Dr. Times , as well as the pulmonologist down where she live
s .
She had been in and out of atrial flutter and fibrillation most of the time for
the last few years .
She , on one occasion , had sinus rhythm very briefly .
Dr. Avejoh Wierst at the Pedines Community Hospital found her to be in congestiv
e heart failure on two occasions over the last six weeks or so .
A TEE showed minimal mitral regurgitation and good left ventricular function .
Nevertheless , because of recurrent failure , it was felt that she should be tra
nsferred up to the Bri Health for further evaluation .
HOSPITAL COURSE :
On examination here , I could hear no mitral regurgitation murmur .
The observation in the hospital showed that she had recurrent runs of rapid atri
al fibrillation as well as rapid supraventricular tachycardia going around 130 .

This was on diltiazem and digoxin .

At the same time , she had two 0.4 second pauses intermittently .
Because of this , the diltiazem was stopped , and she was further observed .
We could not catheterize her right away because her prothrombin time was a littl e too high .
Over the weekend of observation , she continued to be in supraventricular tachyc ardia , but also developed a 4.4 second pause on digoxin alone , which was in lo w therapeutic range .
She also had supraventricular tachycardia which was going up to 160 .
Therefore , a temporary pacemaker that put in on 5/4 , and diltiazem was restart ed .
A cardiac catheterization was carried out on 5/5 , once her prothrombin time had fully normalized .
It showed that she had a large big right dominant coronary artery , which was fr ee of any significant disease .
The graft to the marginal artery was open , with good runoff into a large vessel .
The left anterior descending had perhaps a mid-40% lesion only , with good left ventricular contraction and no mitral regurgitation seen on left ventricular ang iogram .
There was a very modest to moderate mitral valve gradient .
The mitral valve area was calculated at 1.2 square centimeters , and then with m odest exercise , the mitral valve area calculated to 1.7 square centimeters .
Thus , she had , at the most , modest mitral stenosis of no clinical significanc e .
With this data in hand , it appeared that her previous congestive episodes was p robably related to sustained periods of rapid heart action with minimal mitral s tenosis .
A permanent pacemaker was put in on 5/6/92 .
This was an Intermedex 292-03 pacemaker , set in the VVI mode with an escape rat e of 65 .
She tolerated the procedure well .
On diltiazem , 60 , q.i.d. , she continued to have supraventricular tachycardia , running at around 130 , so we switched her over to verapamil , four times a da y , along with digoxin , 0.125 , alternating with 0.25 , qD , which gave her a b lood level of 1.0 .
On this program , she is now beginning to ambulate with a heart rate of around 7 9-80 , and is starting to feel a lot better .
We will ambulate her over the next couple of days .
We have stopped her Lasix , and we will be watching her daily weight , and that has been quite stable .
If she remains stable over the next couple of days , she will be discharged on t his program , to be followed jointly by Dr. Avejoh Wierst and Dr. Em Neighburce .
EM Z. TIMES , M.D.
TR :
enp / bmot
DD :
5/9/92
TD :
05/12/92
CC :
For the patient , at Dalee , Alaska , for Dr. Avejoh Wierst , c / o Pedines Comm unity Hospital , in Stumphi Road , Biinss , South Dakota 59762 .
[report_end]