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CTMC
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11/2/1990 12:00:00 AM
Discharge Summary
Unsigned
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Admission Date :
11/02/1990
Report Status :
Unsigned
Discharge Date :
11/06/1990
DISCHARGE DIAGNOSES :
1) MITRAL STENOSIS .
2) HYPERTENSION .
3) ATRIAL FIBRILLATION .
4) HYPERCHOLESTEROLEMIA .
HISTORY OF PRESENT ILLNESS :
Ms. Kotekoorsner is a 57 year old white woman with mitral stenosis , atrial fibr illation , and cardiac risk factors including a positive family history , hypert ension , and hypercholesterolemia who presented for catheterization because of p rogressive worsening of fatigue and dyspnea on exertion .
The patient was told that she had a heart murmur approximately twenty years ago .
However , she had been asymptomatic at that time .
She now gives a history of progressively worsening dyspnea on exertion and fatig ue which has become more incapacitating over the past several months .
She states that previously , she had been fairly active but now does not feel th at she can do much of anything .
She denies chest pain but complains of episodes of light headedness accompanied by diaphoresis which occur at rest approximately once per week and last for seve ral minutes .
She also complains of a tight feeling in her abdomen .
She also has had a cough for the past several years which is worse in the winter time and is non-productive .
She denies hemoptysis , orthopnea , or paroxysmal nocturnal dyspnea .
She complains of ankle swelling for the past several months .
Her course has been complicated by atrial fibrillation first diagnosed in New Ye ars Eve of l989 and she has been on Digoxin and Coumadin .
Because of her worsening symptoms , the patient had an echocardiogram at an outs ide hospital in Chogejuan St.ver , New Hampshire in September of l989 which show ed mitral stenosis .
She is now referred to the Retelk County Medical Center for evaluation of her mi tral valvular disease .
The patient 's cardiac risk factors include a positive family history in th at both parents died in their fifties of heart disease and two brothers had coro nary artery bypass graft procedures in their thirties , hypercholesterolemia for several years , and hypertension .
PAST MEDICAL HISTORY :
There is no history of rheumatic heart disease recalled by the patient , removal of benign lump in the left breast .
CURRENT MEDICATIONS :
Coumadin 5 mg q.d. (this was discontinued one week prior to admission) , Digox in 0.25 mg q.d. , Mevacor 20 mg q.d. , Propranolol 20 mg q.d. , and Penicillin f or dental procedures .
ALLERGIES :
She had no known drug allergies .
SOCIAL HISTORY :

The patient lives with her husband in Glendmin .
She has four children , ages 22 through 27 , and works as a cook at a grammer sc
hool .
PHYSICAL EXAMINATION :
Ms. Kotekoorsner is a very pleasant woman who appears her stated age and is in n
o acute distress .
Vital signs showed that she had a blood pressure on the right which was l80/ll0
and a blood pressure on the left arm which was l84/ll0 , her pulse was 90 and wa
s irregularly irregular , and her respirations were l6 per minute and were unlab
ored .
HEENT :
Unremarkable .
LUNGS :
Clear to auscultation and percussion .
CARDIAC :
Carotid arteries showed normal upstroke and volume without bruits bilaterally .
There was jugular venous distention to l7 cm at 45 degrees .
The point of maximal impulse was at the fifth intercostal space in the mid clavi
cular line .
There was a left parasternal lift .
There was a loud Sl and a physiologically split S2 with a prominent P2 component
 .
There was an opening snap immediately following the P2 .
There was a diastolic rumble at the apex which radiates to the axilla which is g
raded as a I / VI .
There was also a I / VI apical systolic murmur .
The patient 's peripheral pulses were full .
There was no evidence of edema in the extremities .
ABDOMEN :
Soft , slightly distended , and there was a slight right upper quadrant fullness
 .
NEUROLOGICAL :
Non-focal .
However , there was evidence of subtle mental status change on the evening after
 the patient 's valvuloplasty .
She was having difficulty remembering certain events which had occurred that day
 .
It was felt that because her neurological examination was non-focal at this time
 and that these changes represented no real change in her mental status from the
 time of admission , that no further work-up was required .
DISPOSITION :
DISCHARGE MEDICATIONS :
Nadalol 20 mg p.o. q.d. , Coumadin 5 mg p.o. q.h.s. , Mevacor 20 mg q.d. , and D
igoxin 0.25 mg q.d.
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11/06/90
Batch :
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Report :
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T :
11/08/90
Dicatated By :
RA LERKNEIGHKIH , ZBE5
cc :
A L. RALLSCHIRD , M.D.
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