Heart Failure and Transplant
University of Michigan Health System
Cardiovascular Center
1500 E. Medical Center Dr., SPC 5853
Ann Arbor, Michigan 48109-5853

Department of Internal Medicine
Division of Cardiovascular Medicine
(734) 936-9561 Clinical
(800) 694-0184 Clinical
(734) 763-8075 Fax

FACSIMILE

TO: **Johanna**

FAX #: **313-473-6828**

TEL #:

FROM: **U of M Heart Failure/Transplant-Sandy Miller**

DATE: TIME:

NO. OF PAGES (including coversheet): 6

COMMENTS:

As per your request.

Progress Notes

Progress Notes by Nicklas, John Michael, MD at 6/19/2017 12:34 PM

Author: Nicklas, John Michael, MD | Service: (none) | Author Type: Physician
Filed: 6/19/2017 6:17 PM | Encounter Date: 6/19/2017 | Status: Signed
Editor: Nicklas, John Michael, MD (Physician)

Dear Dr. Piko,

I had the pleasure of seeing in the Cardiology Clinic at the University of Michigan on June 19, 2017, for follow-up of his nonischemic dilated cardiomyopathy and history of ventricular tachycardia status post ICD implantation in 2008 and possible upgrade to a biventricular ICD in 2013, in the setting of a history of prostate cancer status post XRT, diabetes, history of polysubstance abuse, and medication non-adherence. Mr. was evaluated at the University of Michigan in 2011 and noted to have stage D systolic heart failure dependent on intravenous milrinone. He had been evaluated for polysubstance abuse and medication non adherence. Recent outside medical records from Henry Ford and Oakwood reveal that the patient was hospitalized in October 2016 at Henry Ford for "possible cardiogenic shock" where right heart catheterization revealed a cardiac index of 1.8, a right atrial pressure of 2 mmHg, a pulmonary artery pressure of 44/20 mmHg, and a pulmonary capillary wedge pressure of 9 mmHg. He was evaluated for possible LVAD, but the patient states that he declined LVAD because he lived alone and was uncertain that he could take care of the device. He states that he was not listed for heart transplant at Henry Ford but was referred to the University of Michigan for further evaluation. He was hospitalized from May 16, 2017, to May 19, 2017, at Beaumont after he could not walk or see. He was experiencing generalized abdominal pain, hypotension, shortness of breath, and acute renal failure. At the time of his discharge his lisinopril, bumetanide, Reglan, captopril, and Ceftin were discontinued.

Over the past three weeks, Mr. has been hospitalized three times. Prior to first of these hospitalizations, he was taking 80-120 mg of lasix in the morning and 80 mg in the evening. He was initially hospitalized at St. John's in Gross Point for four days for dizziness, abdominal swelling, discomfort, and hypotension. He was discharged following diuresis, and again hospitalized for four days at Beaumont in Gross Pointe for similar symptoms. His diuretics were held upon discharge due to his hypotension. He was seen in the Emergency Room a third time at Beaumont for abdominal swelling and discomfort, hypotension, and vision problems but was not admitted.

Since his most recent hospital discharge June 14, 2017, Mr. reports feeling weak and fatigued. He used a scooter in clinic today and uses a cane to walk at home. He notes that his symptoms over the past six months have significantly worsened. He experiences occasional nausea, abdominal and lower extremity swelling, lightheadedness, presyncopal episodes, orthostatic dizziness, and night sweats. He experiences constant abdominal fullness and pain that does not change when eating. He denies fevers, chills, dysuria, and does not have any sick contacts at home. He does not smoke, drink alcohol, or use illicit drugs.

Asprin
carvedilol 3.125 mg
Atorvastatin 20 mg
Isordil 30 mg three times daily

Review of 12 of 14 systems was negative except as noted above.

Current Medications:

Current Outpatient Prescriptions

Medication	Sig	Dispense	Refill
ALBUTEROL SULFATE (VENTOLIN INHL)	108 mcg.		
amiodarone (PACERONE) 400 mg tablet	Take 1 Tablet by mouth Daily start 1 tablet twice a day for 1 week; refills for 30 tablets/month	45 tablet	6
aspirin (ECOTRIN LOW STRENGTH) 81 mg delayed release tablet	Take 1 Tablet, Delayed Release (E.C.) by mouth Daily		
atorvastatin (LIPITOR) 20 mg tablet	Take 20 mg by mouth once daily.		
benzonatate (TESSALON PERLES) 100 mg capsule	Take 100 mg by mouth.		
captopril (CAPOTEN) 25 mg tablet	Take 25 mg by mouth.		
carvedilol (COREG) 6.25 mg tablet	Take 1/2 Tablet by mouth Two times a day	tablet	
digoxin (LANOXIN) 125 mcg tablet	Take 1 Tablet by mouth Daily	tablet	
FREE-TEXT MEDICATION	625 mcg. Ellipta Spray		
FREE-TEXT MEDICATION	1 mL. Microfine injection		
furosemide (LASIX) 20 mg tablet	Take 20 mg by mouth.		
guaiFENesin (ROBITUSSIN) 100 mg/5 mL liquid	Take 1 tsp Liquid by mouth Every 4 to 6 hours prn	tablet	
hydrALAZINE 100 mg tablet	Take 1 Tablet by mouth Three times a day	90 tablet	5
HYDROcodone-acetaminophen (VICODIN) 5-500 mg tablet	Take 1-2 Tablet by mouth Every 6 to 8 hours PRN	tablet	
insulin glargine (LANTUS SOLOSTAR) 100 unit/mL injection pen	Inject 100 units into the skin.		
INSULIN GLARGINE,HUM.REC.ANLOG (INSULIN GLARGINE SUBQ)	Take 70 units by mouth Daily		
isosorbide mononitrate (IMDUR) 60 mg 24 hr tablet	Take 1 Tablet Sustained Release 24 hr by mouth Daily start with 1/2 tablet daily, increase as directed	30	5
lactulose (KRISTALOSE) 10 gram packet	Mix contents of in water and then drink once daily. Indications: 30 mL once a day, also called cephulac		
lisinopril (ZESTRIL) 2.5 mg tablet	Take 2.5 mg by mouth.		
losartan (COZAAR) 25 mg tablet	Take 25 mg by mouth.		
metFORMIN (GLUCOPHAGE) 500 mg tablet	Take 500 mg by mouth two times daily.		
MILRINONE LACTATE (MILRINONE IV)	Inject 0.375 mcg/kg/min in the vein		

nitroglycerin (NITROSTAT) 0.4 mg SL tablet	Place 0.4 mg under the tongue as needed. May repeat every 5 minutes if needed. Max of 3 doses in a 15-minute period.		
• olopatadine (PATANOL) 0.1 % ophthalmic solution	Place 1 drop in the affected eye(s).		
• omeprazole (PriLOSEC) 20 mg delayed release capsule	Take 20 mg by mouth once daily, 30 min prior to meal.		
• POLYETHYLENE GLYCOL 3350 (MIRALAX ORAL)	as needed.		
• POTASSIUM CHLORIDE ORAL	20 mEq.		
• simvastatin (ZOCOR) 40 mg tablet	Take 1 Tablet by mouth At bedtime	tablet	
• spironolactone (ALDACTONE) 25 mg tablet	Take 1 Tablet by mouth Daily	tablet	
• TIOTROPIUM BROMIDE (SPIRIVA RESPIMAT INHL)	18 mcg.		
• valsartan (DIOVAN) 40 mg tablet	Take 40 mg by mouth.		
• bumetanide 2 mg tablet	Take 1 1/2 Tablet by mouth Two times a day	90 tablet	5

On physical examination today, Mr. , was a very pleasant man in no acute distress at rest, accompanied by his wife. Vital Signs: BP 88/46 (BP Location: Left arm, BP: Patient position: Sitting, BP Cuff Information: Adult 23-33 cm) Comment: manual | Pulse 58 | Temp 36.5 °C (97.7 °F) (Oral) | Ht 1.727 m (5' 8") | Wt 87.5 kg (193 lb) | SpO2 97% Comment: room air | BMI 29.35 kg/m2

Wt Readings from Last 3 Encounters:

06/19/17	87.5 kg (193 lb)
05/22/17	93.7 kg (206 lb 9.6 oz)
01/10/17	90.3 kg (199 lb)

There was no visible jugular venous distention. There were trace crackles at the right base. Breath sounds were normal. I was unable to palpate the cardiac apical impulse. No parasternal activity was present. S1 was normal with both T1 and M1 components present. S2 was single with a normal P2 component. No murmurs or gallops were audible. The abdomen was distended and tender to palpation in the right upper quadrant. Bowel sounds were normal. There were no audible bruits. The extremities showed trace dependent edema. Peripheral pulses were 1+ bilaterally.

An electrocardiogram today demonstrated AV paced rhythm at a rate of 58 beats per minute, unchanged from previous electrocardiograms.

A right heart catheterization performed on Oct 25, 2010, demonstrated a right atrial pressure of 12 mmHg, a pulmonary artery pressure of 64/39 mmHg, and pulmonary capillary wedge pressure of 28 mmHg. The thermodilution cardiac output was 6.9 L/min with calculated cardiac index of 3.0 min/mm2 and fick cardiac index of 4.5 L/min with calculated cardiac index of 2.2 L/min/mm2. The calculated pulmonary vascular resistance was 4.2, which decreased to 1.5 with a nipride challenge.

An echocardiogram performed on May 18, 2016 demonstrated an estimated left ventricular dilation with severe global hypokinesis and estimated ejection fraction of 20% with mild to

moderate mitral regurgitation and mild tricuspid regurgitation with an estimated right ventricular systolic pressure of 43 mmHg.

The patient's laboratory studies obtained today:

Results for orders placed or performed in visit on 06/19/17 (from the past 24 hour(s))

BNP (Brain Natriuretic Peptide)
Collection Time: 06/19/17 12:20 PM

Result	Value	Ref Range
B-Type Natriuretic Peptide	38	0 - 100 pg/mL

Comprehensive Metabolic Panel
Collection Time: 06/19/17 12:20 PM

Result	Value	Ref Range
Sodium	135 (L)	136 - 146 mmol/L
Potassium	4.5	3.5 - 5.0 mmol/L
Chloride	102	98 - 108 mmol/L
CO2	24	22 - 34 mmol/L
Urea Nitrogen	45 (H)	8 - 20 mg/dL
Creatinine	2.59 (H)	0.70 - 1.30 mg/dL
Glucose	133 (H)	73 - 100 mg/dL
Calcium	10.4 (H)	8.6 - 10.3 mg/dL
Protein	7.8	6.0 - 8.3 g/dL
Albumin	4.0	3.5 - 4.9 g/dL
AST	60 (H)	8 - 30 IU/L
ALT	54 (H)	<=35 IU/L
Alkaline Phosphatase	116	30 - 116 IU/L
Bilirubin, Total	0.3	0.2 - 1.2 mg/dL

Magnesium
Collection Time: 06/19/17 12:20 PM

Result	Value	Ref Range
Magnesium	2.1	1.5 - 2.4 mg/dL

CBC with Platelet Count
Collection Time: 06/19/17 12:20 PM

Result	Value	Ref Range
WBC	6.0	4.0 - 10.0 K/uL
HGB	10.9 (L)	13.5 - 17.0 g/dL
HCT	34.1 (L)	40.0 - 50.0 %
PLT	232	150 - 400 K/uL
RBC	3.99 (L)	4.40 - 5.70 M/uL
MCV	85.5	79.0 - 99.0 fl
MCH	27.3	27.0 - 32.0 pg
MCHC	32.0	32.0 - 35.0 g/dL
RDW	20.7 (H)	11.5 - 15.0 %
MPV	10.7	9.0 - 12.2 fl

Estimated Glomerular Filtration Rate
Collection Time: 06/19/17 12:20 PM

Result	Value	Ref Range
EGFR, Black	30 (L)	>59 mL/min
EGFR, Non-Black	25 (L)	>59 mL/min

Our impression is that Mr. , cardiomyopathy is marginally compensated at this time despite IV milrinone as well as carvedilol and nitrate therapy. The patient and his wife have been previously told and understand that he is not a candidate for LVAD or heart transplant. They are concerned about conflicting recommendations especially regarding diuretics, and

Encounter Date: 06/19/2017

we are unsure about the patient's medications. We catalogued the medications that the patient and his wife brought to clinic. There were three duplications of both carvedilol and nitrates. To eliminate duplications, we directed Mr. ife to use only "blue top" medication bottles. Although Mr. / frequently hospitalized, he does not have a clear indication for hospitalization at this time. He states that he believes that he has, or will arrange, an appointment with one of his cardiologists this week to reassess his need for diuretic therapy. In this context, I have not recommended any change in his current medications except to take only medications from the blue top bottles and have not recommended hospitalization at this time. We will arrange follow up appointments at Mr. ..s request or in referral in the future but have not scheduled a return visit here at this time.

If we can provide further information, please contact me. Thank you for allowing me to participate in the care of your patient.

Sincerely,

By signing my name below, I, Cayla Marie Pichan, *attest that this documentation has been prepared under the direction and in the presence of* John Michael Nicklas, MD.

Electronically Signed: Cayla Marie Pichan. 06/19/2017. 2:14 PM.

I, John Michael Nicklas, MD, *personally performed the services described in this documentation. All medical record entries made by the scribe were at my direction and in my presence. I have reviewed the chart and discharge instructions (if applicable) and agree that the record reflects my personal performance and is accurate and complete.*

Electronically Signed: John Michael Nicklas, MD. 06/19/2017. 2:24 PM.

Electronically signed by Nicklas, John Michael, MD at 6/19/2017 6:17 PM

Revision History [redacted]

Encounter Date

6/19/17

Progress Notes Info

Author	Note Status	Last Update User	Last Update Date/Time
Nicklas, John Michael, MD	Signed	Nicklas, John Michael, MD	6/19/2017 6:17 PM