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Dr. James Lane
517 Ascot St.
Coquitlam BC
V3J 6H5

May 10, 2014

Re: Andrea Tester
01 October 1947

Dear Jim:

Thank you very much for asking me to be involved in the care of your patient, Andrea Tester2 and the management of her persistent atrial fibrillation.

As you are aware, this is a 66-year-old woman with the following past medical history:

1. Atrial fibrillation.
    a. CHADS2 score is 0, CHADS-VASc score equals 2 – is currently on apixaban.
    b. Rate controled with metoprolol, atenolol, verapamil, diltiazem and most recently bisoprolol but ineffective.
    c. No history of hypertension, heart failure, diabetes, strokes, TIAs, myocardial infarctions or peripheral vascular disease.
    d. Thyroxine from August 2013 was normal.
    e. Exercise treadmill test in February 2012 was normal.
    f. Negative obstructive sleep apnea test.
2. GERD.
3. Benign breast mass, resected many years ago.
4. Diverticulosis.
5. Acne

The patient reports that she was diagnosed with atrial fibrillation in Sept 2009. She reports that when she is in it, she feels very poorly with fatigue, being held back, developing heaviness and discomfort in her chest. She has not had any syncope. She says that with cardioversion, she feels significantly better. She was cardioverted three times in November as well as went to the emergency department in January where more aggressive rate control was taken. She believes that she has been in atrial fibrillation for at least a number of months.

SOCIAL HISTORY: She is a nonsmoker, has not used alcohol for months, and uses no illegal drugs or caffeine. She works as a professional taxi driver.

FAMILY HISTORY: Her eldest sister died of myocardial infarction suddenly at age 67. Her brother had a myocardial infarction at age 72.

PHYSICAL EXAMINATION: Physical exam today reveals a blood pressure of 120/85. She has an irregular heart rate at 90 beats a minute. Her JVP is 2 cm. She has clear lungs. She has no swelling of the ankles. She has an irregular S1, S2, but I cannot appreciate any extra heart sounds or murmurs.

ECG: ECG done today shows atrial fibrillation at 90 beats a minute. She has a narrow QRS complex with no specific ST- or T-wave changes.

ECHOCARDIOGRAM: Echocardiogram done in December 2012 – sinus rhythm with left atrial size of 4.2 cm. She has a sclerotic aortic valve without aortic stenosis, normal mitral and tricuspid valve. Mild TR, mild PR. Normal biventricular size and systolic function.

IMPRESSION AND PLAN: With respect to this patient, there are the following issues:

1. Anticoagulation – We explained that as she is over the age of 65, she should be anticoagulated. We discussed the use of warfarin vs NOAC. After discussing this in detail, she would like to start Apixaban. I have sent her for renal function and she will contact the Afib clinic after to see if her Cr is normal. If so, she will start Apixaban 5mg PO BID.
2. Symptoms – the patient is quite symptomatic despite aggressive attempts at rate control. Consequently, I think a rhythm control strategy would be ideal. I outlined for her the approach to this and explained that we would always try an antiarrhythmic drug prior to an ablation. I did discuss briefly the antiarrhythmic drugs including the 1Cs, sotalol, amiodarone, and dronedarone. Of these, my first choice would be a 1C agent given that she has had an exercise treadmill test which did not show any significant ischemic changes and she is already on a small dose of bisoprolol. I did explain to her that there is a risk of this developing atrial flutter at faster rate. Consequently, it is important that she stay on the bisoprolol with this.

   I also outlined for her ablation explaining the success for single procedure is in the order of 50% to 60%. With multiple procedures, this could be increased to around 80%. I explained that the risks are in the order of 5% to 7% including bleeding or infection at the site of insertion, myocardial infarction, stroke, tamponade, pneumothorax, need for urgent open heart surgery, risk of AV node injury such that she would require permanent pacemaker, esophageal injury, phrenic nerve injury, and pulmonary vein stenosis.

   After discussing all this, we have elected to start her on flecainide 50 mg p.o. b.i.d. I will ask the AFib Clinic to contact her to tell her to start this and to ensure that she has a followup ECG done a couple of days after this has been initiated. I have also ordered her creatinine and electrolytes.

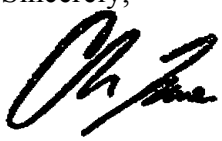
   The plan will be to start her on flecainide and arrange for her to have a cardioversion done a couple of weeks after the flecainide has been started. If she maintains sinus rhythm with flecainide, then we will plan to see her back in six months with a Holter monitor prior to this.

   If she is tolerating the flecainide but is not maintaining sinus rhythm, my recommendation would be to titrate this to 75 or may be even 100 mg b.i.d. To re-cardiovert her and if she is still having recurrences of atrial fibrillation that we would then book her directly for an AFib ablation. She is agreeable with this plan.

3. Etiologies – the patient has had her thyroid checked, and there is no significant structural heart disease and obstructive sleep apnea has been ruled out and consequently I do not think further investigations for etiology need to be undertaken.

Thank you very much for involving me in her care.

Sincerely,



Dr. Chris Lane
Dictated but not read

CL: pri/chr
T: 08/04/14

cc: Atrial Fibrillation Clinic, Royal Jubilee Hospital
Dr. Sarah Bussey