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Dr. D Metzak
1234 Blueberry Road
New Westminster, BC
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May 26, 2014

Re: Mr. Brad Tester
21 September 1948

Dear Dave:

Thank you for asking us to see Mr Brad Tester and the management of his tachycardia.
As you know he is a 66 years old gentleman with the following history:

PAST MEDICAL HISTORY:

1. The patient was diagnosed with tachyarrhythmia (SVT) in 2006, following up with Dr. Ryan in 2010. Started on verapamil. The patient declined AV study initially. He has a normal treadmill and normal echo.
2. Recent diagnosis of COPD
3. Bladder cancer, underwent surgery in 2010.
4. Rheumatoid Arthritis
5. Was discharged from hospital two to three weeks ago due to pneumonia.

SOCIAL HISTORY: The patient is an ex-smoker, stopped smoking 25 years ago. He currently drinks 4-5 alcohol beverages a day. He is retired, married, lives with his wife.

MEDICATIONS:

1. Diltiazem 120 mg b.i.d.
2. Atrovent 20 mcg.
3. Fluticasone 250 mcg.
4. Prednisone 40 mg daily for five days.

ALLERGIES: Ancef

HISTORY OF PRESENTING COMPLAINT: He was diagnosed with palpitations in 2006 after he had his surgery for bladder cancer. The patient said that he was started on antibiotics and that triggered the tachyarrhythmia. According to old reports, this arrhythmia was diagnosed as SVT. Then, the patient saw Dr. Ryan in 2010 and he started him on diltiazem which seems to control the arrhythmias.

The patient said that from time-to-time, he continues to get very short palpitation that only last for one minute then terminate spontaneously despite diltiazem. Sometimes he gets longer

symptomatic episodes with fatigue, shortness of breath, and lightheadedness, and that can last up to five hours. He noticed that these attacks occur while he is sick especially when he takes antibiotics. The last time he had this kind of attack was back in February where he was admitted to hospital for pneumonia.

The patient denys any history of shortness of breath on exertion, chest pain, syncope or presyncope or swelling of his ankles.

PHYSICAL EXAMINATION: The patient was lying down, comfortable, and not in respiratory distress. His blood pressure on the right arm was 120/75. Heart rate of 65 BPM. His chest auscultation was normal, good air entry with no added sounds. Heart sounds were S1 and S2. No added sounds. JVP was at about 1 cm. Abdomen was distended, evidence of an umbilical hernia, but soft and nontender. There is no evidence of peripheral edema.

LABORATORY INVESTIGATIONS:
ECG: ECG showing sinus rhythm with heart rate of 71.

ECHOCARDIOGRAM: Echocardiogram that was done in March 2014, ejection fraction 60% to 70%, LV diameter of 4.6 cm, and there is mild mitral insufficiency and elevation of the pulmonary pressure, but not significantly changed from December 2010.

IMPRESSION AND PLAN: A 66 years old gentleman with no history of cardiomyopathy or coronary artery disease who appears to have tachyarrhythmias most consistent with SVT. He is currently on diltiazem, doing well, but the patient wants to consider ablation due to unpredicted onset of these tachyarrhythmias.

1. We will give him a standing ECG to document the arrhythmia for us.
2. We discussed with the patient the risks and benefits of the ablation procedure and also the possibilities of the tachyarrhythmias that he has been experiencing. We advised the patient that there is a 90-95% success rate, but there is also a 2-3% risk of complications. These risks include bleeding or infection at the site of catheter insertion, stroke, heart attacks, risk of injury of the normal circuits which the patient has to end up with a pacemaker, and about a 1 in a thousand risk of needing emergency open heart surgery.

After discussing this in detail the patient would like to undergo an electrophysiology procedure and the possibility of ablation. We plan to stop the diltiazem for five days before the procedure.

Thank you for involving us in the care of this patient.

Sincerely,

Dr. Chris Lane
Dictated but not read

cc: Dr. Sam XYZ