

DR TONY KULL B. Med FRACP
Interventional Cardiologist

24th June 2025

19 Kingsley Avenue, **WOY WOY**
Kanwal Medical Complex (Suite A5), **Kanwal**
Tel: 0491 117 221
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Dr Peter Hansen
North Shore Private Hospital
Po Box 139
ST LEONARDS NSW 2056

RE: Mr Graham Shepherd DOB: 15/09/1942
6 Mimosa Road BUDGEWOI NSW 2263
Home: 4390 8664 Mobile: 0403740003

Dear Peter,

RE: TAVI workup at RNSH

Problem List

Aortic stenosis, severe 2025. LVEF 62%
Paroxysmal atrial fibrillation
2nd degree heart block with Bisoprolol
CKD, eGFR 11ml/min,
Polyarticular gout
- Allopurinol, Cartia, Spiractin 50mg/d, Atorvastatin 80 mg/day, Duodart, Colchicine 1/d, Irbesartan 300mg/d, Lercandipine 20mg/d, Thiamine, Somac

Thank you for arranging to meet this 82 year old gentleman who has severe aortic stenosis with significant coronary disease on a background of severe renal impairment. His last eGFR was 11mL/min. Today, he came in for his coronary angiogram with pre and post hydration and I used only 24ml of contrast. Unfortunately, he has significant triple vessel disease and you may want to consider revascularisation. I think a TAVI CT should be done as an inpatient because of his renal impairment. The angiogram images will be uploaded to the RNSH server.

Kind regards,
Signed electronically
Dr Tony Kull

Encl. Consult letter, renal physician letter x 2, echocardiogram, angiogram; renal function



Health
Central Coast
Local Health District

Gosford Hospital

Cardiovascular Unit
76 Holden Street
Gosford NSW 2260

CARDIAC CATHETERISATION REPORT

Name:	SHEPHERD, Graham	Sex:	MALE	Proc. Date:	24/06/2025
MRN	70-53-38	DOB:	15/09/1942	Age:	82
Ht:	166 cm	Wt:	86.2 kg	Study ID:	2-806/25

GP: G.Morgan

Referring Dr: Dr Tony Kull

cc report to: S. Roger, Dr Peter Hanson, RNSH

PROCEDURES

(Clinically Stable) Angiogram

OPERATORS

Physician: Kull, Tony Dr.

Nursing Staff: Yates, Madelene RN , Banks, Tamie RN van Breugel, Cassandra Laverack, Talltha RN

Radiographer: Robson-Boyd, Lucy Rad

INDICATIONS

Clinically Stable Group. Valvular disease: Aortic stenosis

Patient Verification: After the risks of the procedure were explained, informed consent was obtained.**Access:**Terumo 6 Fr Glidesheath Slender, right radial artery number of punctures: 1**RESULTS****DOMINANCE:** Right dominant**LEFT MAIN:**

Minor disease

LEFT ANTERIOR DESCENDING ARTERY:

Heavily calcified, 60% ostial disease, 90% mid vessel disease. Severe diagonal disease.

LEFT CIRCUMFLEX ARTERY:

Mild diffuse disease, 80% distal stenosis.

RIGHT CORONARY ARTERY:

80% calcific ostial stenosis. Moderate PDA disease.

COMPLICATIONS

Nil complications

CONCLUSIONS

Severe calcific 3 vessel disease.

RECOMMENDATIONS

Proceed with TAVI work-up. Heart team discussion concerning revascularisation

Kull, Tony Dr

Interventional Information:HEMODYNAMICS:

Heart Rate: 71

AO: 158/68 Mean Arterial Pressure: 100

Equipment:

Catheters: Unknown Ultrasound Probe cover, Medline Radial Anglo Pack, Bayer/Bayer Hand Controller Sheath, Bayer/Bayer Display Unit Sheath, Terumo 1.5mm angled Glidewire 180cm, Terumo 5F Radial TIG, COOK Roadrunner UniGlide Hydrophilic Wire Guide, Cordis Standard, Exchange J-Tip 260cm, Cordis 5F JL 3.5 catheter, Cordis 5F JR 4 catheter,

Contrast: Omnipaque 350 24 ml

Medications:

Midazolam 1 mg IV

Fentanyl 25 mcg IV

Lignocaine (Lidocaine) 20 mg SC

Glycerol Trinitrate (GTN) 200 mcg IA

Heparin 2000 units IA

SR:NL

Tuesday, 11 February 2025

Dr Geoffrey Morgans
Castle Hill Medical Centre
Shop 207-217 Castle Mall
4-16 Terminus St
CASTLE HILL NSW 2154

Dear Geoffrey

RE: **Graham Shepherd – DOB: 15/09/1942**

I caught up with Julie and Graham for follow up of his:

1. **Gout**
 - High dose colchicine: diarrhoea.
 - Gouty tophi with current uric acid approximately 0.55mmol/L (not on allopurinol).
2. **Anaemia**
 - Haemoglobin up to 107g/L on Mircera but dose unknown. Now has iron deficiency (11/24), ferritin 96 μ g/L, IV iron (01/25).
3. **Renal status**
 - Creatinine 215 μ mol/L with proteinuria almost 20x normal (11/24).
 - Renal ultrasound (10/24): 108mm kidneys, 14ml post micturition residual (on Duodart).
4. **Cardiac status**
 - Moderate/severe aortic stenosis. LVEF 62%.
 - Paroxysmal AF.
 - Betablocker induced second degree AV block.

There are a few things:

1. **Spironolactone** – normally I wouldn't have started it at 50mg/day but rather escalate it from 12.5mg up. However his potassium is alright, there has been a jump in the creatinine but I am happy to tolerate that.
2. **Belly pain/diarrhoea** – I'll get the chemist to stop the colchicine.
3. **Dapagliflozin** – the proteinuria has gone up to now 30 x normal. As mentioned, I'd normally be keen to undertake a kidney biopsy but I've left the needle in the top drawer. The ultrasound showed cortical thinning but the kidneys are a good size.
4. **Anaemia** – His haemoglobin is 101g/L which is on target for someone who would be on EPO (100-115g/L). I'll get them back in a couple of months' time and make that decision.
5. **Blood pressure** – I stopped the amlodipine because it may have contributed to the ankle swelling so I've put him on lercanidipine at a bigger dose of 20mg/day. They can do home blood pressure monitoring and bring in the average when I see him in the couple of months.

Best wishes,

SIMON ROGER
Renal Physician
Director, Renal Research, Gosford

cc Dr* Tony Kull 19 Kingsley Ave WOY WOY NSW 2256

For your information, I am happy to receive correspondence via the Argus system.

VW:GR

Wednesday, 23 April 2025

Dr Geoffrey Morgans
Castle Hill Medical Centre
Shop 207-217 Castle Mall
4-16 Terminus St
CASTLE HILL NSW 2154

Dear Geoff

RE: Graham Shepherd – DOB: 15/09/1942

I followed up with Graham in the context of his:

1. **Gout**
 - High dose colchicine: diarrhoea.
 - Gouty tophi with current uric acid approximately 0.55mmol/L (not on allopurinol).
2. **Anaemia**
 - Haemoglobin up to 107g/L on Mircera but dose unknown. Now has iron deficiency (11/24), ferritin 96 μ g/L, IV iron (01/25).
3. **Renal status**
 - Creatinine 215 μ mol/L with proteinuria almost 20x normal (11/24).
 - Renal ultrasound (10/24): 108mm kidneys, 14ml post micturition residual (on Duodart).
4. **Cardiac status**
 - Moderate/severe aortic stenosis. LVEF 62%. (04/25):' severe AS, 75/44mmHg, 1.1cm².
 - Paroxysmal AF.
 - Betablocker induced second degree AV block.

Graham underwent his CKD education and understands that he may need dialysis. He is accepting of haemodialysis as a treatment modality.

We have touched base on the possibility of dialysis post angiogram or TAVI surgery.

I have asked Graham to repeat his bloods to confirm what his trend is like. He has an appointment with us coming up in May and was due to see Tony soon. As he is accepting of dialysis, I have advocated for Tony to proceed with the angiogram and TAVI workup for Graham.

Best wishes,



VIDU WIJERATNE
Renal Physician

cc Dr* Tony Kull 19 Kingsley Ave WOY WOY NSW 2256
CKD Education (email)

For your information, I am happy to receive correspondence via the Argus system.

SR:NW

Tuesday, 27 May 2025

Dr* Tarig Mahmoud
Halekulani Medical Centre
4/5, 105 Scenic Drive
BUDGEWOI NSW 2262
reception@halekulanimedical.com.au

Dear Tarig

RE: Graham Shepherd – DOB: 15/09/1942

Graham came back with his wife for follow up of his:

1. Gout

- High dose colchicine: diarrhoea.
- Gouty tophi with current uric acid approximately 0.55mmol/L (not on allopurinol).

2. Anaemia

- Haemoglobin up to 107g/L on Mircera but dose unknown. Now has iron deficiency (11/24), ferritin 96 μ g/L, IV iron (01/25).

3. Renal status

- Creatinine 215 μ mol/L with proteinuria almost 20x normal (11/24), current creatinine 410 μ mol/L, eGFR 11ml/min/1.73m² (05/25).
- Renal ultrasound (10/24): 108mm kidneys, 14ml post micturition residual (on Duodart).
- Wanting haemodialysis.

4. Cardiac status

- Moderate/severe aortic stenosis. LVEF 62%. (04/25): severe AS, 75/44mmHg, 1.1cm².
- Paroxysmal AF.
- Betablocker induced second degree AV block.

His renal function continues to fall off the perch.

I would not be at all surprised if he requires renal replacement therapy after the diagnostic coronary angiogram prior the workup for a TAVI.

We can dialyse him through a tunnelled line if required. I haven't gone down the path of fistula formation etc. as yet as it would need to be post-procedure in case there is hypotension that resulted in a clotted fistula.

The angiogram is booked in for the middle of June so I will see him the week after.

Best wishes,

SIMON ROGER
Renal Physician
Director, Renal Research, Gosford

cc Dr* Tony Kull 19 Kingsley Ave WOY WOY NSW 2256
dialysis education cclhd-ckdeducation@health.nsw.gov.au

For your information, I am happy to receive correspondence via the Argus system.

DR TONY KULL B. Med FRACP
Interventional Cardiologist

19 Kingsley Avenue, **WOY WOY**
Kanwal Medical Complex (Suite A5), **Kanwal**
Tel: 0491 117 221
Email: dockull@gmail.com

Patient Information Sheet

Name: Mr Graham Shepherd

Age: 82

Address: 6 Mimosa Road BUDGEWOI NSW 2263

Date of Birth: 15/09/1942

Medicare Number: 2002195218

DVA Number:

Phone Numbers: 4390 8664 0403740003

Email:

Private Insurance: HCF Health Fund 49504118

Pension Number: 220504965T

GDH/WDH MRN: 070-53-38

15th May 2025

Dr Tarig Mahmoud
Halekulani Medical Centre
4/5, 105 Scenic Drive
BUDGEWOI NSW 2263

Re: Mr Graham Shepherd DOB: 15/09/1942

Dear Tarig,

Background History

Aortic stenosis, severe 2025. LVEF 62%

Paroxysmal atrial fibrillation

2nd degree heart block with Bisoprolol

CKD, eGFR 11ml/min,

Polyarticular gout

- Allopurinol, Cartia, Spiractin 50mg/d, Atorvastatin 80 mg/day, Duodart, Colchicine 1/d, Irbesartan 300mg/d,
Lercandipine 20mg/d, Thiamine, Somac

I reviewed this 82 year old gentleman in the rooms today. He has been symptomatically stable. He was seen by Vidu who is happy for us to proceed with TAVI workup. Graham knows there is a possibility he may need dialysis after TAVI workup or a TAVI.

His last eGFR was 11 mL/min with a creatinine of 410 µmol/L.

Conclusion

Proceed with TAVI workup.

Comments and Management Plan

I will book him for an angiogram with admission the day before for prehydration and for suspension of Spironolactone, Irbesartan. I do not think he is a candidate for a DOAC and he remains in sinus rhythm so I stopped Apixaban and started low-dose Aspirin. I will refer him to RNSH for further TAVI workup and they should likely do his TAVI CT.

Kind regards,

Tony Kull

cc Prof Simon Roger
Dr Geoffrey Morgans

9th April 2025

Dr Tarig Mahmoud
Halekulani Medical Centre
4/5, 105 Scenic Drive
BUDGEWOI NSW 2263

ECHOCARDIOGRAM REPORT

Re: Mr Graham Shepherd DOB: 15/09/1942

History: Aortic stenosis. CKD. HT.

Height: 173cm **Weight:** 79kg

1. Aortic root (sinuses)	46	Male 31-37mm, Female 27-33mm
2. Left atrium	49	<40mm
3. Septal thickness	13	07 – 10mm
4. LV end diastolic dimension	44	Male 42-59mm, Female 39-53mm
5. LV end systolic dimension	30	25 – 41mm
6. Post LV wall thickness	13	07 – 10mm
7. Right ventricle	34	27 – 33mm

CARDIAC CHAMBERS: Left ventricular chamber size and systolic function appears normal. LVEF 69%. (Simpson's). Grade I Diastolic Dysfunction. Right ventricular chamber size and systolic function appears normal. Moderately dilated left atrium (LA volume index = 45ml/m²). Mildly dilated right atrium (RAA 19.3cm²). No pericardial fluid. Moderate concentric LVH and sigmoid septum. No intracardiac thrombus detected. Mildly dilated aortic root (46mm), proximal ascending aorta (45mm) and arch (38mm).

CARDIAC VALVES: Mild aortic regurgitation. Severe aortic stenosis (MG 44mmHg, PG 75mmHg, AVA (VTI) 1.1cm², AVA index = 0.54cm²/m², AVDI 0.25). Mild mitral regurgitation. Mitral valve sclerosis. Mild mitral annular calcification. Thickened mobile leaflets. Mild tricuspid regurgitation. Trivial pulmonary regurgitation. Mildly elevated pulmonary artery systolic pressure estimated at 38mmHg.

CONCLUSION:

1. Normal biventricular systolic function (Hyperdynamic LV).
2. Severe aortic stenosis with mild aortic regurgitation. AVDI 0.25.
3. Mitral valve sclerosis. Mild mitral regurgitation.
4. Moderately dilated aortic root, ascending aorta and arch.
5. Moderate left atrial dilatation. Mild right atrial dilatation.
6. Moderate LVH. Sigmoid Septum and lipomatous interatrial septum.
7. Increased mid LV cavity velocity OF 1.82m/s (sigmoid septum).

Kind regards,

Tony Kull
Technician: KE

cc Prof Simon Roger; Dr Geoffrey Morgans