Result Type: Progress Note Medical
Result Date: 31 July 2025 12:03 AEST
Result Status: Auth (Verified)
Result Title: Orthogeris Consult
Performed By: Sanossian, Avedis (JMO) on 31 July 2025 12:04 AEST
Verified By: Sanossian, Avedis (JMO) on 31 July 2025 12:31 AEST
Encounter info: Royal North Shore, Inpatient, 28/07/2025 - 01/08/2025

Orthogeris Consult

Patient: **WADEY, Mr Anthony Keith** **MRN: 050-18-59**

Age: **89 years** Sex: **Male** DOB: **02/02/1936**

Associated Diagnoses: **None**

Author: **Sanossian, Avedis (JMO)**

Progress Note

Orthogeris consult - Sanossian (AT)

89 M presenting with 2 week history of worsening SOB

PMHx: CAD (awaiting revascularisation ?stent vs CABG, known to Dr Peter Vale), HTN, vascular dementia KT Dr Ann Basci

SHx: Lives with wife, Ex-smoker (15-20 Pack yr), 1 glass wine/day

Issues

SOBOE with CAP +/- superimposed pulmonary oedema on b/g known obstructive CAD awaiting revascularisation

- 2g Ceftriaxone IV (Commenced 28/07), 3 day course of Azithromycin 500mg (28/07)

Urinary retention

- IDC inserted on admission

#known Aortic Stenosis

- Moderate AS in 2020

On review

Noted progress and suggestion for respiratory review for CT findings

Sitting up in bed

Alert

Orientated to year, month, place, DOB

Able to state MYOB backwards

Able to describe his cardiac issue

- States that his valve is tight and preventing blood flow to the rest of his body

Able to describe the symptoms

- Worsening dyspnoea on exertion

- Intermittent chest pain

- Nil syncope

Able to describe how the procedure generally works

- Line being inserted that will flow through to his heart to open up his valve

Able to state the risks including bleeding, bruising, MI, stroke

Accepts the risks associated with TAVI procedure

Is looking forward having the TAVI

Re Dementia

- KT Dr Ann Basci

- Reports he's on donepezil 10 mg for 3 years now to good effect; keen to continue

- Aware that he has short term recall deficiency - as demonstrated through cognitive assessment with OT today

Explained re increased risk of delirium

- Has had bilateral knee and single hip previously, last about 5 years ago and experienced nil delirium at the time

- Note he is on solifenacin for urinary incontinence, explained can be a factor for delirium

- Accepting risk of delirium

Was working full time as master of vessel at Captain Cook Cruises until 8 years ago.

Lives at home with wife

I - ADLS

OT review noted

SOCIAL SITUATION

- Pt lives with supportive wife.

- Pt has one sister in ACF in Northern NSW, brother passed away

- Nil children or other family members

- Private cleaner

HOME ENVIRONMENT

General: Double storey house

Access: Via front

Front: 3x steps

Rear: N/A

Internal: 1x flight of steps

Downstairs- Kitchen, laundry, sunroom, pt's bathroom and toilet

Upstairs- Pt's bedrooms, bathroom, toilet

Bathroom: Shower recess, nil hob, shower track, 2x rail, shower chair

Toilet: Combined; 1x rail, nil equipment

Other equipment: Nil

PREADMISSION FUNCTION

Self Care / ADL: Independent showering and toileting; nil incontinence

Functional Mobility: Independent mobility furniture crawling indoors and use of 2x hiking poles for outdoors, (I) transfers

Domestic tasks / IADL: Wife (A) cooking, laundry, shopping tasks

- Private cleaner 1x fortnight

Community Living Skills: Pt relies on wife

Falls History: Nil reported

Cognition: Gradual decline in memory. Pt acknowledges he cant remember names and reporting he is suffering from dementia

Perception (Vision/Hearing): Nil issues

Communication: Nil issues

Upper limb: (R) UL dominant

Rx:

CURRENT FUNCTION

Functional Mobility- Pt mobilising to and from bathroom using 1x hiking pole

Transfers- Pt is (I) with bed and STS transfers

Self care- Pt requires min (A) self care tasks; seated on shower chair

Toileting- Pt requires min (A) with emptying IDC bag, nil incontinence.

- use of 1x grab rail for toilet transfers.

Pressure care- Pt has been provided with verbal education re: regular repositioning self in bed and chair. Nil existing pressure injuries

Cognition- Pt is alert and orientated to his surroundings.

- MOCA version 8.1 ax completed this am. Pt scored

OT explained purpose and consent obtained from pt.

Pt SOOB. Hearing aids insitu. NIL glasses available

Total Score= 24/30

- As per the MoCA guidelines- A final score of 26 and above is considered normal.

The following ranges may be used to grade severity: 18-25 = mild cognitive impairment, 10-17= moderate cognitive impairment and less than 10= severe cognitive impairment.

Subscores:
Visuospatial/Executive= 5/5

Naming= 3/3

Attention= 6/6

Language= 3/3

Abstraction= 2/2

Delayed Recall= 0/5 (pt able to recall all words when multiple choice cue given)

Orientation= 5/6 (Incorrect date- 21st (31st)
IMPRESSION:
- Based on results, pt has mild cognitive impairment in areas of delayed recall and may require assistance with recalling new and important information relating to his health.

OT SUMMARY:

Pt requires min (A) with self care and (I) toileting tasks on the ward
- (A) with emptying IDC bag

- Pt mobilising using 1x hiking pole, (I) transfers

- Pt is able to reposition self in bed and chair. Nil existing pressure injuries.

- MOCA ax completed, pt scored 24/30 with impairments in delayed recall 0/5- required multiple choice cue, orientation 5/6.

From OT's perspective, pt is close to baseline with mobility, transfers and ADLs.

- Pt has a shower chair at home and rails in the shower and toilet.

- Pt may benefit from self care (A) on d/c.

Examination

- Observations are within the normal range, afebrile

- Low Flow NP in situ

- Alert

- HSD ESM, appreciable throughout precordium

- ASNT

- CSNT
- Nil peripheral oedema

IDC in situ - dilute urine

Anticoagulation: Nil DVTp charted

BO: Type 5 medium

Ix

CT chest

Subsegmental consolidation/collapse in the posterior segment of the right upper lobe with bilateral interlobular septal thickening and ill-defined patchy ground glass opacities. Moderate right and small left pleural effusion.

Appearances are non-specific, primary considerations include pneumonia +/- superimposed pulmonary oedema in the correct clinical context, however malignancy cannot be excluded. Respiratory review and pleural cytology as well as progress imaging are suggested.

Multiple mildly enlarged right hilar and mediastinal lymph nodes.

Impression

Mr Anthony Wade is an 89 year old gentleman who has presented with worsening dyspnoea and hypoxia, currently being treated for CAP on a background of symptomatic aortic stenosis.

He has an established diagnosis of vascular dementia on Donepezil, however is able to explain his condition, the TAVI procedure, and risks associated with the procedure.

He does have an increased risk of developing post-op delirium; however he is understanding of this risk and is keen to proceed.

His OT review is reassuring in view of his functional and cognitive status.

There is not an absolute an absolute contraindication from Aged Care perspective with proceeding with the TAVI once medically stable, however ideally would benefit from respiratory input regarding non-specific CT findings and whether it would contribute to his prognosis.

Team to consider TOV in the morning if opening bowels well

Avedis Sanossian

Orthogeris AT

via switch