

Dr James Rogers
M.B., B.S., F.R.A.C.P., F.C.S.A.N.Z.
Cardiologist

All Correspondence to:

Suite 5
14-18 Jarrett Street
North Gosford NSW 2250
Phone: (02) 4323 2907
Fax: (02) 8212 5881
Provider No: 0333782F
Email: cardiologist@healthemail.com.au

Also At:
Kanwal Medical Centre
Suite C1
654 Pacific Highway
Kanwal NSW 2259

10 Jun 2025

Prof Ravinay BHINDI
North Shore Private Hospital
North Shore Cardiac Centre
Suite 11, Level 3, ST LEONARDS NSW 2065

Dear Ravinay,

**Re: Mr Grahame MOONEY - DOB: 31/12/1942 37 Village Road, Saratoga NSW 2251 Mobile: 0438 247 099 m/c
2163337872 2, HCF 03158934**

- Seen in 2005 with hypertension, some subsequent episodes of hypotension. Left middle cerebral artery stenosis 5/10. Diverticular disease, colonic polyps.
- **Atypical right parasternal back pain on exertion, coronary angiography 2010 showed 50-60% LAD, 50% Cx and 40-50% mid dominant RCA treated medically. Ongoing symptoms, July 2011 repeat angiography and stenting to the mid LAD, proximal LAD, proximal Cx and mid RCA. Symptoms did not fully settle, repeat angiography in 2014 showed patent stents.**
- Arthroscopy June 2016, bradycardia under anaesthetic, PPM inserted.
- Radical prostatectomy 2016. Right shoulder rotator cuff surgery 2017. Grafting following resection of a right ear BCC. Right TKR 1/18.
- Osteoarthritis, neuropathic pain. Finger fracture 11/20.
- **Coronary angiogram 1/21 showed lesions not requiring intervention (30-40% left main, 40% LAD, under 30% RCA), and mild aortic stenosis, LVEDP (end diastolic pressure) was mildly raised at 18mmHg (normal 4-12).**
- **Coronary angiography 11/23 because of possible exertional angina showed a good result: mild ostial left main, to patent proximal and mid LAD stents, mildly diseased diagonals, patent Cx proximal stent, mildly diseased OM, dominant RCA widely patent mid stent. LVEF > 60%, normal LVEDP, pullback aortic valve gradient 25 mmHg.**
- Migraine (visual).
- Variable hypertension, with variable mild postural hypotension.
- **PPM check 2/25 noise on RV lead, considered no longer MRI compatible.**
- **Echo 5/25 moderate to severe AS (peak velocity 3.3 m/s, peak gradient 44 mmHg, mean gradient 24 mmHg, AVA 1 cm²), mild MR.**
- **Left hand numbness, slightly impaired balance, cervical spondylotic myelopathy, assessed as needing surgical intervention (laminectomy infusion) as soon as reasonably possible.**

Current medications: aspirin 100 mg daily, amlodipine 2.5 mg nocte, ezetimibe/rosuvastatin 10/20 mg daily.

Grahame is scheduled to have a TAVI CT. I think he should have a TAVI performed (NS Private?) and then go ahead with cervical surgery as soon as possible afterwards. Obviously he would not be able to be on DAPT for cervical surgery and ideally would be off aspirin for the procedure. Jonathan Parkinson is worried about the risk of cervical myelopathy if Grahame doesn't have surgery reasonably soon. He may need prior angiography but his last angiogram was only November 2023 so would defer to your preference. Andrew Hill performed his last angiogram.

Yours sincerely,



Dr James Rogers

CC: Dr James McKinney (GP), SARATOGA 2251; Dr Andrew Hill, NORTH GOSFORD 2250; Dr Jonathon Parkinson (Neurosurgeon), ST LEONARDS 2065
JR:skj

Demographic Details			
Practice:	Mr	MOONEY	Grahame
Lab:	895454501-C-E606	MOONEY	GRAHAME JOHN
Provider:	Douglass Hanly Moir Pathology		
Reference Details		Collection Details	
Medicare:	2163337872	2	Collected: 10/06/2025 11:59:00 AM
Veterans:			Copy to: DR JAMES MCKINNEY; DR JAMES MCKINNEY EM
Pension:			Referred by: DR JAMES ROGERS

Investigation Result: MOONEY, Grahame

Page 1 of 2

NT-proBNP (Roche)

NT-proBNP 131 ng/L <1800

NT-proBNP (Roche)

For patients with dyspnoea in an emergency department setting, NT-proBNP is highly sensitive for the detection of acute congestive heart failure. In addition, an NT-proBNP <300 ng/L effectively rules out congestive heart failure with 99% negative predictive value. Knowledge of each individual's NT-proBNP level may be more useful than using single cut points for every patient.

For patients undergoing diagnostic assessment in a non-hospital setting, an NT-proBNP <125 ng/L has a negative predictive value in ruling out heart failure of at least 94%, whereas follow-up, e.g. echocardiography or specialist referral, should be considered for an NT-proBNP level that exceeds this threshold.

Marked elevations for NT-proBNP may be observed in states other than left ventricular heart failure including acute coronary syndromes, right heart strain/failure (including pulmonary embolism and cor pulmonale), critical illness, renal failure and advanced age.

Conversion factor: ng/L (pg/mL) x 0.118 = pmol/L

Age-related reference limits:

<50 years:	<450	ng/L
50 - 75 years:	<900	ng/L
>75 years:	<1800	ng/L

NT-proBNP (Roche)

NATA Accreditation No 2178

NT-proBNP (Roche)

Tests Completed: CK(s), TropI HS(s), NT-proBNP (Roche)

NT-proBNP (Roche)

Tests Pending :

NT-proBNP (Roche)

Sample Pending :

Clinical Notes : AORTIC STENOSIS

NT-proBNP

NT-proBNP 131 ng/L (<1800)
Comment on Lab ID 895454501

For patients with dyspnoea in an emergency department setting, NT-proBNP is highly sensitive for the detection of acute congestive heart failure. In addition, an NT-proBNP <300 ng/L effectively rules out congestive heart

failure with 99% negative predictive value. Knowledge of each individual's NT-proBNP level may be more useful than using single cut points for every patient.

For patients undergoing diagnostic assessment in a non-hospital setting, an NT-proBNP <125 ng/L has a negative predictive value in ruling out heart failure of at least 94%, whereas follow-up, e.g. echocardiography or specialist referral, should be considered for an NT-proBNP level that exceeds this threshold.

Marked elevations for NT-proBNP may be observed in states other than left ventricular heart failure including acute coronary syndromes, right heart strain/failure (including pulmonary embolism and cor pulmonale), critical illness, renal failure and advanced age.

Conversion factor: ng/L (pg/mL) x 0.118 = pmol/L

Age-related reference limits:

<50 years:	<450	ng/L
50 - 75 years:	<900	ng/L
>75 years:	<1800	ng/L

NATA Accreditation No 2178

Tests Completed: CK(s), TropI HS(s), NT-proBNP (Roche)

Tests Pending :

Sample Pending :

End of Report :

Demographic Details			
Practice:	Mr	MOONEY	Grahame
Lab:	895454501-C-C141	MOONEY	GRAHAME JOHN
Provider:	Douglass Hanly Moir Pathology		31/12/1942 Male
Reference Details		Collection Details	
Medicare:	2163337872	2	Collected: 10/06/2025 11:59:00 AM
Veterans:			Copy to: DR JAMES MCKINNEY; DR JAMES MCKINNEY EM
Pension:			Referred by: DR JAMES ROGERS

Investigation Result: MOONEY, Grahame

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Biochemistry

CK 101 U/L 40-200

Routine Biochemistry

NATA Accreditation No 2178

Routine Biochemistry

Tests Completed: CK(s), TropI HS(s)

Routine Biochemistry

Tests Pending : NT-proBNP (Roche)

Routine Biochemistry

Sample Pending :

Clinical Notes : AORTIC STENOSIS

BIOCHEMISTRY

Date	11/06/16	11/06/16	10/06/25			
Time	0705	1202	1159			
Lab ID	247444783	247444710	895454501	Units	Reference	
CK	107	99	101	U/L	(40-200)	

NATA Accreditation No 2178

Tests Completed: CK(s), TropI HS(s)

Tests Pending : NT-proBNP (Roche)

Sample Pending :

End of Report :

Demographic Details				
Practice:	Mr	MOONEY	Grahame	31/12/1942 Male
Lab:	895454501-C-E849	MOONEY	GRAHAME JOHN	31/12/1942 Male
Provider:	Douglass Hanly Moir Pathology			
Reference Details		Collection Details		
Medicare:	2163337872	2	Collected:	10/06/2025 11:59:00 AM
Veterans:			Copy to:	DR JAMES MCKINNEY; DR JAMES MCKINNEY EM
Pension:			Referred by:	DR JAMES ROGERS

Investigation Result: MOONEY, Grahame

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Troponin I

hs Troponin I 6 ng/L <26

TROPONIN I

Comment: TROPONIN I

A negative cardiac Troponin result does not exclude acute coronary syndrome (ACS). A rise in the level of Troponin is dependent upon the interval between a possible ischaemic event and specimen collection. If ACS is suspected, then serial Troponin testing is recommended.

Please note that for the purpose of assessing serial changes in cardiac marker status, Troponin values obtained by different methods may not be directly comparable.

TROPONIN I

NATA Accreditation No 2178

TROPONIN I

Tests Completed: CK(s), TropI HS(s)

TROPONIN I

Tests Pending : NT-proBNP (Roche)

TROPONIN I

Sample Pending :

Clinical Notes : AORTIC STENOSIS

hs Troponin I (Abbott Method)

hs Troponin I 6 ng/L (<26)

Comment on Lab ID 895454501

A negative cardiac Troponin result does not exclude acute coronary syndrome (ACS). A rise in the level of Troponin is dependent upon the interval between a possible ischaemic event and specimen collection. If ACS is suspected, then serial Troponin testing is recommended.

Please note that for the purpose of assessing serial changes in cardiac marker status, Troponin values obtained by different methods may not be directly comparable.

NATA Accreditation No 2178

Tests Completed: CK(s), TropI HS(s)
Tests Pending : NT-proBNP (Roche)

Sample Pending :

End of Report :

Demographic Details			
Practice:	Mr	MOONEY	Grahame
Lab:	17293933	MOONEY	GRAHAME
Provider:	PRP Diagnostic Imaging		
Reference Details		Collection Details	
Medicare:	2163337872	2	Collected: 23/05/2025 10:49:00 AM
Veterans:			Copy to: DR JONATHON PARKINSON; PROF ROBERT HEA
Pension:			Referred by: DR JAMES F ROGERS

Investigation Result: MOONEY, Grahame

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ECHOCARDIOGRAM

ECHOCARDIOGRAM

To view images: <https://mypatient.prpimaging.com.au/viewer/visits?code=61e5fca02a0c5ad649a280c4c4f06c0428700d2e634943ccf92e0f50b2d9b0203477307cf082b4e06289a1f44a2ae7973c72df89f1a5bde09f3973b96a54b3>

This report is for: Dr J. F. ROGERS

Referred By:-:

Dr J. F. ROGERS

Copies:

Dr J. PARKINSON

Prof R. HEARD

Dr P. MCGIMPSEY

ECHOCARDIOGRAM 23/05/2025 Reference: 17293933

TRANSTHORACIC ECHOCARDIOGRAM

HISTORY: 82 year old male. Aortic stenosis. Progressed.

COMPARISON: Echocardiogram 02/03/2023 (PRP)

Height:1.75 m Weight:80 kg BSA:1.96m² Rhythm: Sinus rhythm

IMPRESSION

1. Normal LV cavity size with normal contractility. Mild to moderate LV hypertrophy, some speckling (amyloid possible, will get strain added next week). LVEF: 65% (visually).
2. Normal RV size and systolic function. Endocardial lead noted in the right chamber. Normal estimated pulmonary artery systolic pressure of 26mmHg.
3. Moderate to severe (looks severe on 2D, possibly bicuspid) calcific aortic valve stenosis. (PkVel: 3.3m/s, PkGd: 44 mmHg, MnGd: 24mmHg, AVA:1.02cm²). Mild mitral regurgitation.
4. Mildly dilated left atrium.
- 5.

CHAMBERS

LEFT VENTRICLE: Normal LV cavity size with normal contractility. Mild LV hypertrophy. Grade 1 diastolic dysfunction.

LEFT ATRIUM: Mildly dilated left atrium.

RIGHT VENTRICLE: Normal RV size and systolic function. Endocardial lead noted in the right chamber.

RIGHT ATRIUM: Normal right atrial size.

PERICARDIUM: Normal. No pericardial effusion.

AORTA: Normal calibre aortic root, ascending aorta and arch.

VALVES

AORTIC: Possibly bicuspid, with moderate on doppler, severe on 2D, calcific aortic valve stenosis. Trivial regurgitation(LVOT Vel: 1.0m/s, LVOT VTI:20.8cm, AoV PkVel: 3.3m/s, AoV VTI: 66cm, PkGd: 44mmHg, AoV MnGd: 24mmHg, AVA: 1.02cm², LVOTd: 21mm, DVI: 0.3).

MITRAL: Mildly thickened leaflets with mild regurgitation. (E/A:0.6, E: 0.5m/s, A: 0.8m/s, e'med:3.5cm/s, e'lat: 5cm/s, E/e' Avg:12.5, MVA PHT: 1.42cm²).

PULMONARY: Normal leaflet motion. Trivial regurgitation. (PV PkVel: 1.0m/s).

TRICUSPID:Normal leaflet motion with trivial regurgitation.

PASP: Normal estimated pulmonary artery systolic pressure. (TR PkVel:

2.4m/s, TRPkGd: 23mmHg, RAP: 3mmHg, PASP: 26mmHg, IVC: 19mm).
OTHER: Mobile interatrial septum, no definite PFO detected by colour
Doppler. Normal IVC size with > 50% collapse on inspiration.
MEASUREMENTS:

AoRoot	3	(31-37mm	AscAo:	3	(<37mm)	LVEF(Visual)	60-6	(>51%)
:	7)	:	7	:	:	5	
LVEDD:	4	(42-58mm	AoArch:	3	(<37mm)	LVEF(BP):		(>51%)
0)		6					
LVESD:	2	(<40mm)	LA(A-P)		(<40mm)	FR Short:	43	(>34%)
3			:					
IVS:	1	(6-10mm)	LAVI:	3	(<34ml/m ²	RV Basal:	28	(<42mm
3			9)))
PW:	1	(6-10mm)	RAVI:	1	(<32ml/m ²	TAPSE:	21	(>17mm
3			4)))

Dr Jim Rogers

Electronically verified by: Dr Jim Rogers - 23/05/2025 17:36

CT Calcium scoring available at PRP Gosford

To view images: <https://mypatient.prprimaging.com.au/viewer/visits?code=61e5fca02a0c5ad649a280c4c4f06c0428700d2e634943ccf92e0f50b2d9b0203477307cf082b4e06289a1f44a2ae7973c72df89f1a5bde09f3973b96a54b3>

Demographic Details				
Practice:	Mr	MOONEY	Grahame	31/12/1942 Male
Lab:	25-13161037-VBF-0	MOONEY	GRAHAME	31/12/1942 Male
Provider:	Laverty Pathology			
Reference Details		Collection Details		
Medicare:	2163337872	2	Collected:	15/04/2025 10:00:00 AM
Veterans:			Copy to:	PATIENT; DR JAMES ROGERS
Pension:			Referred by:	JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

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B12, FOLATE, R.C.FOLATE (VBF-0)

Vitamin B12	318 pmol/L	156-740
Active Vitamin B12	>146 pmol/L	> 40

Comment

For patients with total B12 levels in the low or borderline range, testing for active B12 (holotranscobalamin II) will automatically be performed to resolve B12 status. Active B12 is the biologically active fraction of total serum B12, and a superior indicator of B12 status. Up to 15% of individuals may have a deficiency of the carrier protein haptocorrin, which does not result in clinical B12 deficiency, despite low total B12 levels.

Comment

This active B12 result indicates that the patient is likely to be vitamin B12 sufficient. Patients with renal impairment may still be B12 depleted despite an active B12 level within this range. For these patients, correlation with total B12, homocysteine and/or methylmalonate is required.

VITAMIN B12 AND FOLATE STUDIES

Request Number	26655492	27672839	13161037
Date Collected	20 May 24	17 Dec 24	15 Apr 25
Time Collected	09:05	09:42	10:00

B12	(156-740) pmol/L	405	418	318
Active B12	(> 40) pmol/L			> 146

Serum Vitamin B12 Assay:

DEFICIENCY	BORDERLINE	SUFFICIENCY
<150 pmol/L	150 - 300 pmol/L	>300 - 740 pmol/L

For patients with total B12 levels in the low or borderline range, testing for active B12 (holotranscobalamin II) will automatically be performed to resolve B12 status. Active B12 is the biologically active fraction of total serum B12, and a superior indicator of B12 status. Up to 15% of individuals may have a deficiency of the carrier protein haptocorrin, which does not result in clinical B12 deficiency, despite low total B12 levels.

Serum Active B12 Assay:

This active B12 result indicates that the patient is likely to be vitamin B12 sufficient. Patients with renal impairment may still be B12 depleted despite an active B12 level within this range. For these patients, correlation with total B12, homocysteine and/or methylmalonate is required.

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details

Practice:	Mr	MOONEY	Grahame	31/12/1942	Male
Lab:	25-13161037-GLU-0	MOONEY	GRAHAME	31/12/1942	Male
Provider:	Laverty Pathology				

Reference Details

Medicare: 2163337872 2
Veterans:
Pension:

Collection Details

Collected: 15/04/2025 10:00:00 AM
Copy to: PATIENT; DR JAMES ROGERS
Referred by: JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

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GLUCOSE (GLU-0)

Glucose	6.0 mmol/L	3.4 -5.4	H
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GLU Comment

Equivocally elevated fasting glucose result. If not recently performed, recommend follow-up assessment with an oral glucose tolerance test or HbA1c.

SERUM/PLASMA GLUCOSE

Request Number	19404640	26655492	27672839	13161037
Date Collected	9 Aug 22	20 May 24	17 Dec 24	15 Apr 25
Time Collected	08:21	09:05	09:42	10:00
Fasting status	Fasting	Fasting	Fasting	Fasting
Serum (3.4-5.4)	mmol/L	5.9	6.0	6.0

Equivocally elevated fasting glucose result. If not recently performed, recommend follow-up assessment with an oral glucose tolerance test or HbA1c.

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details			
Practice:	Mr	MOONEY	Grahame
Lab:	25-13161037-A1C-0	MOONEY	GRAHAME
Provider:	Laverty Pathology		
Reference Details		Collection Details	
Medicare:	2163337872	2	Collected: 15/04/2025 10:00:00 AM
Veterans:			Copy to: PATIENT; DR JAMES ROGERS
Pension:			Referred by: JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

Page 1 of 2

GLYCATED HAEMOGLOBIN (A1C-0)

Hb A1C	5.2 %	4.0-6.0
SI Hb A1C	33 mmol/mol	20-42

Comment

The WHO recommends that an HbA1c cut-off of $\geq 6.5\%$ (48 mmol/mol) is used to diagnose type 2 diabetes.

While it is recognised that HbA1c levels approaching this cut-off place patients at increasingly higher risk of developing diabetes ($<6.5\%$), there is no consensus as to exactly which cut-off at the lower end of the continuum to use for categorising patients as high risk. Various groups quote lower limits for at-risk patients that vary between 5.5% and 6.0% (37 and 42 mmol/mol).

Please note that HbA1c should not be used for diagnosing diabetes mellitus in the following circumstances:

- Children and young people
- Pregnancy - current or within the past 2 months
- Suspected Type 1 diabetes mellitus
- Symptoms of diabetes for <2 months
- Patients who are acutely ill
- Patients taking drugs that can cause rapid onset hyperglycaemia such as corticosteroids, antipsychotic drugs
- Acute pancreatic damage or pancreatic surgery
- Kidney failure
- Patients being treated for HIV infection

Please be cautious when requesting or interpreting HbA1c when patients:

- May have an abnormal haemoglobin
- May be anaemic
- May have an altered red cell lifespan (e.g. post-splenectomy)
- May have had a recent blood transfusion

GLYCATED HAEMOGLOBIN (HbA1c)

Request Number	19543757	22908441	27672839	13161037
Date Collected	22 Mar 23	31 Oct 23	17 Dec 24	15 Apr 25
Time Collected	08:10	10:36	09:42	10:00
Specimen Type:	EDTA			
HbA1c- NGSP (4.0-6.0)%	5.4	5.4	5.6	5.2
HbA1c- IFCC (20-42) mmol/mol	36	36	38	33

The WHO recommends that an HbA1c cut-off of $\geq 6.5\%$ (48 mmol/mol) is used to diagnose type 2 diabetes.

While it is recognised that HbA1c levels approaching this cut-off place patients at increasingly higher risk of developing diabetes ($<6.5\%$), there is no consensus as to exactly which cut-off at the lower end of the continuum to use for categorising patients as high risk. Various groups quote lower limits for at-risk patients that vary between 5.5% and 6.0% (37 and 42 mmol/mol).

Please note that HbA1c should not be used for diagnosing diabetes mellitus in the following circumstances:

- Children and young people
- Pregnancy - current or within the past 2 months
- Suspected Type 1 diabetes mellitus
- Symptoms of diabetes for <2 months
- Patients who are acutely ill
- Patients taking drugs that can cause rapid onset hyperglycaemia such as corticosteroids, antipsychotic drugs
- Acute pancreatic damage or pancreatic surgery
- Kidney failure
- Patients being treated for HIV infection

Please be cautious when requesting or interpreting HbA1c when patients:

- May have an abnormal haemoglobin
- May be anaemic
- May have an altered red cell lifespan (e.g. post-splenectomy)
- May have had a recent blood transfusion

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details			
Practice:	Mr	MOONEY	Grahame
Lab:	25-13161037-FBE-0	MOONEY	GRAHAME
Provider:	Laverty Pathology		
Reference Details		Collection Details	
Medicare:	2163337872	2	Collected: 15/04/2025 10:00:00 AM
Veterans:			Copy to: PATIENT; DR JAMES ROGERS
Pension:			Referred by: JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

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HAEMATOLOGY (FBE-0)

Hb	170 g/L	130-180
RCC	5.4 x10*12/L	4.5-6.5
Hct	0.49	0.40-0.54
MCH	32 pg	27-34
MCHC	346 g/L	320-360
MCV	92 fL	79-99
RDW	12.2 %	10.0-17.0
WCC	7.1 x10*9/L	4.0-11.0
Plat	237 x10*9/L	150-400
Neut	4.8 x10*9/L	2.0-7.5
Lymph	1.4 x10*9/L	1.0-4.0
Mono	0.6 x10*9/L	0.2-1.0
Baso	0.1 x10*9/L	< 0.2
Eos	0.2 x10*9/L	< 0.7

Film Comment

HAEMATOLOGY: FBC parameters are within reference range.

HAEMATOLOGY						
Request Number	22908441	26655492	27672839	13161037		
Date Collected	31 Oct 23	20 May 24	17 Dec 24	15 Apr 25		
Time Collected	10:36	09:05	09:42	10:00		
Specimen Type: EDTA						
Hb (130-180) g/L	157	166	161	170		
Hct (0.40-0.54)	0.48	0.48	0.47	0.49		
RCC (4.5-6.5) x10^12 /L	5.1	5.3	5.1	5.4		
MCV (79-99) fL	93	91	92	92		
MCH (27-34) pg	31	31	31	32		
MCHC (320-360) g/L	328	343	343	346		
RDW (10.0-17.0) %	12.6	12.0	12.6	12.2		
WBC (4.0-11.0) x10^9 /L	9.0	6.2	8.3	7.1		
Neut (2.0-7.5) x10^9 /L	6.7	4.0	6.5	4.8		
Lymph(1.0-4.0) x10^9 /L	1.4	1.4	0.9	1.4		
Mono (0.2-1.0) x10^9 /L	0.7	0.5	0.7	0.6		
Eos (< 0.7) x10^9 /L	0.2	0.3	0.2	0.2		
Baso (< 0.2) x10^9 /L	0.0	0.1	0.0	0.1		
Plat (150-400) x10^9 /L	222	221	182	237		

HAEMATOLOGY: FBC parameters are within reference range.

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details

Practice:	Mr	MOONEY	Grahame	31/12/1942	Male
Lab:	25-13161037-FE-0	MOONEY	GRAHAME	31/12/1942	Male
Provider:	Laverty Pathology				

Reference Details

Medicare:	2163337872	2
Veterans:		
Pension:		

Collection Details

Collected:	15/04/2025 10:00:00 AM
Copy to:	PATIENT; DR JAMES ROGERS
Referred by:	JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

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IRON STUDIES (FE-0)

Ferritin	228 ug/L	30-400
FE Comment	No evidence of iron deficiency.	

IRON STUDIES

Request Number	22908441	26655492	27672839	13161037
Date Collected	31 Oct 23	20 May 24	17 Dec 24	15 Apr 25
Time Collected	10:36	09:05	09:42	10:00
Specimen Type: Serum				
Ferritin(30-400) ug/L	229	178	256	228

No evidence of iron deficiency.

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details				
Practice:	Mr	MOONEY	Grahame	31/12/1942 Male
Lab:	25-13161037-LIP-0	MOONEY	GRAHAME	31/12/1942 Male
Provider:	Laverty Pathology			
Reference Details		Collection Details		
Medicare:	2163337872	2	Collected:	15/04/2025 10:00:00 AM
Veterans:			Copy to:	PATIENT; DR JAMES ROGERS
Pension:			Referred by:	JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

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LIPID STUDIES (LIP-0)

Cholesterol	3.2 mmol/L	3.9-5.2	L
HDL Cholesterol	1.3 mmol/L	1.0-2.0	
LDL Cholesterol	1.4 mmol/L	1.5-3.4	L
Triglyceride	1.0 mmol/L	0.5-1.7	
Chol/HDL Ratio	2.5	< 5.0	
Hours	Fasting		
P.C/Fasting/Random			

Comment

Reference intervals are included for reference only, and interpretation / treatment goals should be guided by patient-specific cardiovascular risk assessment (see Australian Cardiovascular Risk Charts. Alternatively, the web-site www.cvdcheck.org.au can be accessed in order to complete a risk assessment for individual patients.)

Comment

NVDPA TARGET LIPID RANGES (MMOL/L) FOR PATIENTS AT HIGH / MODERATE RISK OF CARDIOVASCULAR DISEASE:

TOTAL CHOLESTEROL	<4.0	
TRIGS (FASTING)	<2.0	
HDL-C	>= 1.0	
LDL-C	<2.0	
NON HDL-C	<2.5	

Non-HDL Cholesterol	1.9 mmol/L	< 3.4
Trig/Chol Ratio	0.3	
Haemolysis	Nil	0 -0
Icterus	Nil	0 -0
Lipaemia	Nil	0 -0

LIPID STUDIES

Request Number	22908441	26655492	27672839	13161037
Date Collected	31 Oct 23	20 May 24	17 Dec 24	15 Apr 25
Time Collected	10:36	09:05	09:42	10:00
Specimen Type:	Serum			

Reference intervals are included for reference only, and interpretation / treatment goals should be guided by patient-specific cardiovascular risk assessment (see Australian Cardiovascular Risk Charts. Alternatively, the web-site www.cvdcheck.org.au can be accessed in order to complete a risk assessment for individual patients.)

Haemolysis	Nil	Nil	Nil	Nil
Icterus	Nil	Nil	Nil	Nil
Lipaemia	Nil	Nil	Nil	Nil

Fasting status	Random	Fasting	Fasting	Fasting
Chol (3.9-5.2)	mmol/L	3.2	3.5	3.8
Trig (0.5-1.7)	mmol/L	1.3	1.7	1.1
HDL (1.0-2.0)	mmol/L	1.1	1.2	1.6
LDL (1.5-3.4)	mmol/L	1.5	1.5	1.7
Non-HDL (< 3.4)	mmol/L	2.1	2.3	2.2
Chol/HDL(< 5.0)		2.9	2.9	2.4

NVDPA TARGET LIPID RANGES (MMOL/L) FOR PATIENTS AT HIGH / MODERATE RISK OF CARDIOVASCULAR DISEASE:

TOTAL CHOLESTEROL	<4.0
TRIGS (FASTING)	<2.0
HDL-C	>= 1.0
LDL-C	<2.0
NON HDL-C	<2.5

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details				
Practice:	Mr	MOONEY	Grahame	31/12/1942 Male
Lab:	25-13161037-PSA-0	MOONEY	GRAHAME	31/12/1942 Male
Provider:	Laverty Pathology			
Reference Details		Collection Details		
Medicare:	2163337872	2	Collected:	15/04/2025 10:00:00 AM
Veterans:			Copy to:	PATIENT; DR JAMES ROGERS
Pension:			Referred by:	JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

Page 1 of 1

PROSTATE SPECIFIC ANTIGEN (PSA-0)

PSA (Alinity)	<0.01 ug/L	0.25-9.00	L
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PROSTATE SPECIFIC ANTIGEN			
Request Number	19543757	26655492	13161037
Date Collected	22 Mar 23	20 May 24	15 Apr 25
Time Collected	08:10	09:05	10:00
Total PSA (Alin)	ug/L	< 0.01	< 0.01

Reference Interval Total PSA ug/L: (0.25 - 9.00)

Progress assessment.

Please note change in PSA reference intervals on 20/11/2023.

It is important that the same method is used for serial testing because PSA values may differ between methods for different patients.

If interpretive assistance is required please contact a pathologist on (02) 9005 7373.

Guidelines regarding PSA testing available at: <https://bit.ly/3SbDaY7>

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details

Practice:	Mr	MOONEY	Grahame	31/12/1942	Male
Lab:	25-13161037-MBA-0	MOONEY	GRAHAME	31/12/1942	Male
Provider:	Laverty Pathology				

Reference Details

Medicare: 2163337872 2
Veterans:
Pension:

Collection Details

Collected: 15/04/2025 10:00:00 AM
Copy to: PATIENT; DR JAMES ROGERS
Referred by: JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

Page 1 of 2

SERUM CHEMISTRY (MBA-0)

Sodium	144 mmol/L	135-145	
Potassium	4.7 mmol/L	3.6-5.4	
Chloride	104 mmol/L	95-110	
Bicarbonate	26 mmol/L	22-32	
Urea	6.5 mmol/L	3.0-10.0	
Creatinine Concentration	75 umol/L	60 -110	
Anion Gap	19 mmol/L	10-20	
Bilirubin	8 umol/L	< 20	
ALP	89 U/L	35-115	
ALT	29 U/L	< 35	
AST	26 U/L	< 35	
GGT	73 U/L	< 40	H
Albumin	48 g/L	36-48	
Globulin	24 g/L	20-38	
Total Protein	72 g/L	60-82	
Calcium	2.69 mmol/L	2.10-2.60	H
Corr Calcium	2.59 mmol/L	2.10-2.60	
Phosphate	0.85 mmol/L	0.75-1.50	
Urate	0.28 mmol/L	0.20-0.42	
EGFR	81 mL/min/1.73m ²	> 60	

EGFR Comment

eGFR values between 60 and 89 mL/min/1.73m² should be interpreted with caution. These results are only consistent with CKD in the presence of other evidence such as microalbuminuria, proteinuria or haematuria.

Ref:Lamb EJ et al in Ann Clin Biochem 2005; 42:321-345.

Haemolysis	Nil	0 -0
Icterus	Nil	0 -0
Lipaemia	Nil	0 -0

SERUM CHEMISTRY

Request Number	22908441	26655492	27672839	13161037
Date Collected	31 Oct 23	20 May 24	17 Dec 24	15 Apr 25
Time Collected	10:36	09:05	09:42	10:00
Specimen Type:	Serum			

Haemolysis	Nil	Nil	Nil	Nil
Icterus	Nil	Nil	Nil	Nil
Lipaemia	Nil	Nil	Nil	Nil

Na	(135-145) mmol/L	141	145	143	144
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K	(3.6-5.4)	mmol/L	4.6	4.3	4.4	4.7
Cl	(95-110)	mmol/L	104	106	106	104
HCO3	(22-32)	mmol/L	23	27	25	26
An Gap	(10-20)	mmol/L	19	16	16	19
Urea	(3.0-10.0)	mmol/L	12.5	6.5	9.0	6.5
Creat	(60-110)	umol/L	95	80	75	75
eGFR	mL/min/1.73sqM		66	80	81	81
Urate	(0.20-0.42)	mmol/L		0.30	0.33	0.28
Bili	(< 20)	umol/L	11	13	15	8
AST	(< 35)	U/L	23	33	38	26
ALT	(< 35)	U/L	30	45	51	29
GGT	(< 40)	U/L	54	61	73	73
Alk Phos	(35-115)	U/L	81	89	88	89
Protein	(60-82)	g/L	69	70	67	72
Albumin	(36-48)	g/L	45	45	44	48
Glob	(20-38)	g/L	24	25	23	24
Ca	(2.10-2.60)	mmol/L		2.58	2.49	2.69
Corr Ca	(2.10-2.60)	mmol/L		2.54	2.47	2.59
PO4	(0.75-1.50)	mmol/L		0.79	0.77	0.85

eGFR values between 60 and 89 mL/min/1.73m² should be interpreted with caution. These results are only consistent with CKD in the presence of other evidence such as microalbuminuria, proteinuria or haematuria.

Ref:Lamb EJ et al in Ann Clin Biochem 2005; 42:321-345.

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details

Practice:	Mr	MOONEY	Grahame	31/12/1942	Male
Lab:	25-13161037-TFT-0	MOONEY	GRAHAME	31/12/1942	Male
Provider: Laverty Pathology					

Reference Details

Medicare: 2163337872 2
Veterans:
Pension:

Collection Details

Collected: 15/04/2025 10:00:00 AM
Copy to: PATIENT; DR JAMES ROGERS
Referred by: JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

Page 1 of 1

THYROID FUNCTION TEST (TFT-0)

TSH	1.3	mIU/L	0.5-4.0
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TSH Comment Result(s) consistent with euthyroidism.

THYROID PROFILE

Request Number	22908441	26655492	27672839	13161037
Date Collected	31 Oct 23	20 May 24	17 Dec 24	15 Apr 25
Time Collected	10:36	09:05	09:42	10:00
Specimen Type:	Serum			
TSH	(0.5-4.0)	mIU/L	1.1	2.2
			1.2	1.3

Result(s) consistent with euthyroidism.

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details					
Practice:	Mr	MOONEY	Grahame	31/12/1942	Male
Lab:	25-13161037-UMM-0	MOONEY	GRAHAME	31/12/1942	Male
Provider:	Laverty Pathology				
Reference Details			Collection Details		
Medicare:	2163337872	2	Collected:	15/04/2025 10:00:00 AM	
Veterans:			Copy to:	PATIENT; DR JAMES ROGERS	
Pension:			Referred by:	JAMES MCKINNEY	

Investigation Result: MOONEY, Grahame

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URINE MICRO/CULTURE (UMM-0)

Urine Leucocytes	<3 ($\times 10^6/L$)	< 11
Urine Erythrocytes	<4 ($\times 10^6/L$)	< 11
SPEC TYPE	Midstream	
Urine Glucose	nil	
Urine Protein	nil	
Urine pH	6.0	
Urine Blood	nil	
Urine Squamous Cells	<5 ($\times 10^6/L$)	
Culture	No growth	

Comment

A urine with these results is not usually infected. Although culture has been performed, a further report will only be issued if the culture is positive.

Specimen	URINE EXAMINATION				
	Midstream				
CHEMISTRY	MICROSCOPY				
pH	6.0	Leucocytes	< 3	$\times 10^6$	/L (< 10)
Protein	nil	Erythrocytes	< 4	$\times 10^6$	/L (< 10)
Glucose	nil	Epithelial cells	< 5	$\times 10^6$	/L (< 10)
Blood	nil				

A urine with these results is not usually infected. Although culture has been performed, a further report will only be issued if the culture is positive.

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details

Practice:	Mr	MOONEY	Grahame	31/12/1942	Male
Lab:	25-13161037-UMA-0	MOONEY	GRAHAME	31/12/1942	Male
Provider:	Laverty Pathology				

Reference Details

Medicare:	2163337872	2
Veterans:		
Pension:		

Collection Details

Collected:	15/04/2025 10:00:00 AM
Copy to:	PATIENT; DR JAMES ROGERS
Referred by:	JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

Page 1 of 1

URINE MICROALBUMIN (UMA-0)

Creatinine Concentration	5.7 mmol/L		
Albumin/Creatinine Ratio	7.1 mg/mmol	< 2.5	H
Albumin Concentration	40.4 mg/L		

URINE MICROALBUMIN

Request Number	26655492	27672839	13161037	
Date Collected	20 May 24	17 Dec 24	15 Apr 25	
Time Collected	09:05	09:42	10:00	
Urine albumin	mg/L	130.5	71.8	40.4
Urine creatinine	mmol/L	11.6	16.2	5.7
Alb/Crt (< 2.5)	mg/mmol	11.2	4.4	7.1

Urine albumin: creatinine ratio between 2.5-25 mg/mmol is consistent with microalbuminuria. If not already done, suggest repeat on a first morning void urine sample to confirm.

Persistent albuminuria (present for >= 3 months) is consistent with chronic kidney disease. (Kidney Health Australia, CKD Management in General Practice 2015)

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Demographic Details			
Practice:	Mr	MOONEY	Grahame
Lab:	25-13161037-DVI-0	MOONEY	GRAHAME
Provider:	Laverty Pathology		
Reference Details		Collection Details	
Medicare:	2163337872	2	Collected: 15/04/2025 10:00:00 AM
Veterans:			Copy to: PATIENT; DR JAMES ROGERS
Pension:			Referred by: JAMES MCKINNEY

Investigation Result: MOONEY, Grahame

Page 1 of 1

VITAMIN D (DVI-0)

25-Hydroxy Vitamin D	107 nmol/L	51-200
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Comment

Suggested decision limits for Vitamin D status:

Sufficiency	51 -200	nmol/L
Mild deficiency	25 - 50	nmol/L
Marked deficiency	< 25	nmol/L
Toxicity	>250	nmol/L

References: Vitamin D and health in adults in Australia and New Zealand:
Position Statement. MJA 2012 June 18; 196(11), 686-687.

Haemolysis	Nil	0 -0
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VITAMIN D

Haemolysis	Nil	
Serum 25(OH) Vitamin D	107	nmol/L

Suggested decision limits for Vitamin D status:

Sufficiency	51 -200	nmol/L
Mild deficiency	25 - 50	nmol/L
Marked deficiency	< 25	nmol/L
Toxicity	>250	nmol/L

References: Vitamin D and health in adults in Australia and New Zealand:
Position Statement. MJA 2012 June 18; 196(11), 686-687.

Requested Tests : VBF, UMM, TFT, UMA, GLU, PSA, MBA, LIP, FE, FBE, DVI, A1C

End of Report:

Dr Andrew T Hill
MB BS FRACP DDU
Interventional Cardiologist

All Correspondence to:

Suite 8
14-18 Jarrett Street
North Gosford NSW 2250
Phone: (02) 4323 9909
Fax: (02) 4311 2346
Email: admin@drandrewhill.com.au
Provider No: 0580997L

Dr Jim Rogers
Suite 5
14-18 Jarrett Street
NORTH GOSFORD NSW 2250

Tuesday, 7 November 2023

Dear Jim,

Re: Grahame MOONEY - DOB: 31/12/1942

Thank you for requesting angiography in Grahame, with ongoing difficult to define exertional back pain. I note recent echo report of low flow aortic stenosis. I stented all coronary arteries 2011 and these devices were patent on angiograms 2014 and 2021. I reviewed his last angiogram as a prelude to check angiography via a 6 French left radial artery approach performed on Aspirin:

1. LVEF is >60%, with normal wall motion. Normal end-diastolic pressure of 5mmHg. BP 135/65mmHg and in sinus at 50bpm. No mitral regurgitation. Pull back gradient of around 25mmHg and relative ease in crossing the aortic valve with minimal restriction on fluoroscopy, would give me a bias in defining his degree of aortic stenosis as mild in category in the Cath Lab.
2. The left main has a dent of mild ostial disease and is still of a large calibre. It is otherwise unobstructed.
3. The LAD is of a good calibre with two widely patent proximal and mid-placed stents. Mildly diseased unobstructed diagonals. The LAD extends to the apex.
4. The circumflex is of a medium calibre with a widely patent proximal stent. It supplies one mildly diseased obtuse marginal and then terminated into two small unobstructed posterolaterals.
5. The right coronary artery is dominant with a widely patent mid-placed stent and no significant obstructive disease.

Jim, coronary anatomy is much the same today as back in 2021, which is of reassurance.

Kind regards



DR ANDREW HILL

cc Dr Peter McGimpsey - reception@saratogamedicalcentre.com.au
cc Medical Records/Gosford Private Hospital UR: 45898

Cardiac Catheterisation Procedure Report Summary

27/01/2021

Mr Graham Mooney
DOB: 31/12/1942

37 Village Road, SARATOGA NSW 2251

Jim, thank you for asking me to perform coronary angiography for Graham. Unfortunately his right proximal radial artery is occluded from previous angiography. I hence used the ultrasound to gain access to his left distal radial artery as it runs in anatomical snuffbox which may theoretically reduce the risk of proximal radial artery obstruction. I performed physiological interrogation of his left system due to the calcific shelf involving the ostial of the left main coronary artery. This showed that the stenosis was not significantly flow-limiting and can be safely deferred with ongoing aggressive medical therapies.

Primary Indication

Chest pain & dyspnoea. Previous PCI (four stents).

Procedures

1. USS guided vascular access (left distal radial - the right proximal radial is occluded from previous angiography)
2. Left heart catheterisation + ventriculography + coronary angiography
3. Guide catheter insertion and interventional diagnostic procedure (FFR of left coronary circulation)

Vascular Access

Location: USS guided left distal radial

Diagnostic Findings

Aorta: 170/63, mean 105 mmHg LV: 183/11, EDP 18 mmHg, aortic valve mean gradient 14 mmHg, peak to peak 13)

- * Left main: 30 to 40% calcific shelf at the ostial of the left main (FFR not significant)
- * Left anterior descending: patent stent in proximal and mid LAD, 40% outflow stenosis (not flow-limiting FFR 0.82) patent diagonals with minor regularities
- * Circumflex: non-dominant vessel, medium calibre with patent stent in the proximal vessel and tortuosity (FFR 0.90)
- * Right: large dominant very tortuous vessel patent bare metal stent in the mid-segment with mild InStent rate stenosis (under 30%)

Interventions - physiology no stenting

EBU 3.75 6 French guide from left distal radial approach. Intracoronary adenosine with FFR interrogation of left Main into both downstream branches. FFR LAD 0.82, FFR circumflex 0.90. The left main is not haemodynamically significant.

Summary/Impression

- * Patent stents with residual diffuse but non-obstructive CAD (involving ostial left Main)
- * Elevated LV end-diastolic pressure (LVEDP 18mHg, LVEF 60%).
- * Mild Aortic stenosis (mean gradient 14 mmHg)

Recommendations

* aggressive risk factor modification. Follow-up with Dr Rogers in 6 to 8 weeks
Dr Tom Ford

Interventional Cardiologist

MBChB(Hons), PhD, PGCME, FRCPE (UK), FRACP, FCSANZ

Jim, thank you again for the referral. Angiogram below shows ostial calcific left main shelf. (FFR not significant - 0.90 into Cx, 0.82 into apical LAD)

Dr Andrew T Hill

MB BS FRACP DDU
Cardiologist

All Correspondence to:

Suite 8
14-18 Jarrett Street
North Gosford NSW 2250
Phone: (02) 4323 9909
Fax: (02) 4324 8359
Provider No: 580997L

Dr James Rogers
Suite 5
14-18 Jarrett Street
NORTH GOSFORD NSW 2250

Tuesday, 15 April 2014

Dear Jim

Re: Grahame MOONEY - DOB: 31/12/1942

Thank you for requesting check angiography noting difficult symptoms and my reluctant impression that coronary artery disease was explanatory. After a bunch of stents into all three arteries symptoms have recurred. Via a 6F right radial artery approach using a TIG catheter the following information was obtained:

1. The left main is short, wide and unremarkable.
2. The LAD is of a good calibre with widely patent 2.75 x 12mm and 3 x 28mm Xience stents from July 2011. The LAD becomes rather small in the distal segment with mild diffuse disease. No culprits.
3. The circumflex is of a medium calibre and supplies a small diseased obtuse marginal. After this a 3 x 12mm Xience stent is widely patent from July 2011 with no other issues. This has secured two small posterolateral branches.
4. The right coronary artery is dominant and of a large calibre with stable top corner 40% disease. The mid placed 5 x 15mm Pro-Kinetic stent from July 2011 is widely patent without restenosis. No downstream issues.

Conclusions:

Jim, I don't think symptoms are cardiac. This has been of reassurance. Pleasing response to intervention albeit without an obvious clinical difference.

Kind regards

Dictated but not signed by Dr A Hill

ANDREW HILL

cc Dr Andrew White 29 Village Road SARATOGA NSW 2251
cc Medical Records/Gosford Private Hospital UR 45898

Dr Andrew T Hill

**MB BS FRACP DDU
Cardiologist**

All Correspondence to:

Suite 8
14-18 Jarrett Street
North Gosford NSW 2250
Phone: (02) 4323 9909
Fax: (02) 4324 8359
Provider No: 580997L

Dr James Rogers
Suite 5
14-18 Jarrett Street
NORTH GOSFORD NSW 2250

Thursday, 28 July 2011

Dear Jim

Re: Grahame MOONEY - DOB: 31/12/1942

Jim, this gentleman presented for his final intervention on a rather unconvincing mid RCA lesion in view of intrusive symptomatology involving his back. Via a 6F radial artery approach I achieved the following:

1. IR1 guide was used to engage the right coronary artery. I was able to pass a Rinato wire beyond a lot of bends into the distal vessel with the help of a 3.5 x 20mm Powerline balloon used to predilate the 50-60% mid RCA lesion.
2. I was unhappy with the distal position of the Rinato wire, so tried to manoeuvre into a more acceptable spot but unfortunately lost wire and guide support. I changed over to an interventional R4 guide and found a Hi-Torque Floppy wire with the backup support of a 2 x 20mm Powerline balloon to achieve excellent wire support and then straightforward positioning of a 5 x 15mm Pro-Kinetic stent that was deployed at 10 atmospheres. 40% top corner lesions were left alone as I doubt they are incriminated. Zero residual.

Jim, there is nothing else left to stent. I have given this gentleman the information that he should have no issues with his stents over the next six months and after that there is a small chance of restenosis. One year of Plavix and lifelong Aspirin. Please see enclosed cut shot.

Kind regards



ANDREW HILL

cc Medical Records BWPH CD 641/11 MRN 41473
Encl.



Thursday, 20 February 2025

Dr Jaimie Rees
Saratoga Medical
Shop 1, 10 Village Road
SARATOGA NSW 2251

Nicklas Howden

M.B.B.S, B.B. Med, FRACP
Advanced Imaging Cardiologist
VMO Gosford and Wyong Hospitals

SUITE 307, PLATINUM BUILDING
ILYA AVENUE, ERINA 2250

tel: (02) 4365 6533
fax: (02) 4365 5544
reception@platinumcardiology.com.au

Re: Grahame MOONEY DOB: 31/12/1942
37 Village Road SARATOGA NSW 2251 0438 247 099

PACEMAKER REVIEW	
Implant date	31/08/16
Indication	SA disease/brady
Model	St Jude Assurity MRI 2272 #4670539
Last review	11/07/24
Cardiologist	Dr James Rogers
Mode	DDDR
Underlying rhythm	SINUS
Pacemaker dependent	N
% paced	A 98% V 3.3%
Base rate	50
Upper rate	110
	A 0.7V 5.0mV
	V 3.8 @ 1.0 6.9mV
Mode switch	Y 0 episodes
Rate response	Y
Autocapture	Y
AF suppression	N
Battery test	Normal (2.3 years)
Next review	6 months
Comments	<ul style="list-style-type: none"> • Normal function. • Noise on ventricle lead.

NO LONGER MRI COMPATIBLE DUE TO VENTRICLE LEAD

*cc Dr Marc Coughlan, Dr James McKinney, Dr James Rogers, Dr Jonothan Parkinson,
Patient*

Nicholas Wilkes FRACP
Cardiologist

Platinum Building, Erina
Gosford Private Hospital
Toukley Specialist Medical Centre

11 July 2024

Dr Jaimie Rees
Saratoga Medical
Shop 1, 10 Village Road
SARATOGA NSW 2251

Mail Address:
SUITE 307, PLATINUM BUILDING
ILYA AVENUE, ERINA 2250

tel: (02) 4365 6533
fax: (02) 4365 5544

Re: Grahame MOONEY DOB: 31/12/1942
37 Village Road SARATOGA NSW 2251

PACEMAKER REVIEW			
Implant date	31/08/16		
Indication	SA disease;brady		
Model	St Jude Assurity MRI 2272 #4670539		
Last review	11/01/24		
Cardiologist	Dr James Rogers		
Mode	DDDR		
Underlying rhythm	Sinus		
Pacemaker dependent	N		
% paced	A 98% V < 1%		
Base rate	50		
Upper rate	110		
A 0.7V	5.0mV		
V 3.5V	9.0mV		
Mode switch	Y 0 episodes		
Rate response	Y		
Autocapture	Y		
AF suppression	N		
Battery test	Normal (3 years)		
Next review	6 months		
Comments	<ul style="list-style-type: none"> • Normal function. 		

NOTE: MRI compatible.

cc Dr Robert Heard