Dr Christopher Brereton

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04/06/2025

Dr Emilija Sokolovska
Dear Emilja

Re: Mr John McMullen DOB: 05/04/1938
61 Pioneer Road, Bellambi NSW 2518 Ph: 0448 114 333 (Makenzie, Grandaughter)

Assessment:
1. Exertional dyspnoea, likely related to aortic stenosis, upcoming TAVI procedure later this year
2. Recurrent vomiting of unclear cause, gastroenterology referral made

Thank you for referring John, 87-year-old retired heavy machinery operator, for evaluation of exertional dyspnoea.

John describes progressive exertional dyspnoea over the past 6 months. He now needs to stop on his usual walk down to the local club 3 times due to breathlessness. Despite this he does not describe any orthopnoea or paroxysmal nocturnal dyspnoea. He has had lower limb pedal oedema recently but this has been managed well with frusemide and is now under control. He suffers a mild dry cough in association but no haemoptysis. He has had recurrent episodes of vomiting with weight loss of unclear cause. There is no haematemesis or coffee grounds. He has never had a gastroscopy before.

John's past medical history is notable for being a former smoker between the age of 14-60, approximately 5 cigarettes/day. He is on a Trelegy inhaler and derives some mild benefit from this. He has never been diagnosed with any formal lung disease. He has aortic stenosis which is significant enough that he is being considered for an upcoming transaortic valve implantation later this year (Dr Amit Michael). He also has ischaemic heart disease and has had previous coronary artery bypass grafting in 2003. His medications at present include isosorbide mononitrate, atorvastatin, mirtazapine, esomeprazole, and Trelegy inhaler. He previously worked as an excavator driver for the water board. There were minimal occupational exposures from this and no further environmental exposures were identified.

On examination today, John's oxygen saturation was 97% on room air and he had reduced breath sounds at both bases with occasional bibasal crackles but no wheeze. A loud systolic murmur was heard in the aortic area radiating to his carotids. He did not appear hypervolaemic to me. Spirometry testing today was suggestive of restriction with an FEV1 of 1.69 L (67%) and FVC of 2.34 L (68%). There was a significant bronchodilater response with a 330 mL increase in his FVC (14%).

I reviewed his recent chest x-ray and previous CT chest from 7 years ago at PRP radiology which showed some bronchial wall thickening but no significant parenchymal lung disease.

In summary, I suspect John's exertional dyspnoea is more related to his cardiac issues but I have organised an up-to-date CT chest to exclude parenchymal lung disease given the bibasal crackles I could appreciate today. The vomiting and weight loss is concerning and I have made a referral to Dr Humphris for an opinion and to consider endoscopy. I suggested we reassess John after his TAVI procedure and if his exertional dyspnoea improves with this then we will have our answer. I would be happy to see John sooner if the CT chest identifies any concerning findings.

Kind Regards,

Dr Chris Brereton
Respiratory & Sleep Physician

cc:
Dr Amit Michael
Dr Jeremy Humphris

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HealthLink: ISMCENTR