MANU MATHUR FRACS
CARDIOTHORACIC SURGEON

Provider No. 0817707Y

Suite 7, Level 4
North Shore Private Hospital
Westbourne Street
ST LEONARDS NSW 2065

Tel: (02) 9901 3312
Fax: (02) 9436 3613
Email: info@drmanumathur.com.au

June 24, 2025

Dr Ravinay Bhindi
Suite 11, Level 3
NSPH
ST LEONARDS NSW 2065

Dear Ravinay

RE: Angelo PAVLIDIS - DOB: 23/01/51
17 Parkwood Grove, WEST PYMBLE NSW 2073 0415 100 153

Thank you for asking me to see this 74 year old gentleman who has symptomatic severe aortic stenosis.

I note his history of a CABG in 2006. He now complains of exertional angina and breathlessness and echocardiogram has revealed severe aortic stenosis with a valve area of 0.7cm² with preserved left ventricular function. Coronary angiography revealed an atretic mammary to his LAD, significant lesion in the right vein graft, patent RIMA to ramus, an occluded vein graft to a small circumflex branch.

Past medical history includes hypertension, hypercholesterolemia, diabetes, obesity, sleep apnoea, peripheral vascular disease with right leg stents, chronic renal failure on peritoneal dialysis.

Current medications include Irbersartan, Frusemide, Metoprolol, Isosorbide Mononitrate, Aspirin, Ozempic, insulin, Crestor, Ezetimibe, Duodart, Pantoprazole, Magnesium, Cholecalciferol.

Clinically he was in a regular sinus rhythm with a systolic ejection murmur consistent with significant aortic stenosis. Right lower leg saphenous veins have been harvested, however both thigh saphenous veins were satisfactory.

I have reviewed his coronary angiogram and note the significant short lesion in the right vein graft, occluded vein graft with distal circumflex vessels ungraftable and the atretic mammary probably failing due to competitive flow as the LAD did not seem that significant.

The symptomatic and prognostic benefits of aortic valve replacement in the setting of symptomatic severe aortic stenosis has been explained. I think he would be better off with a TAVI for his aortic stenosis as this would be lower risk than redo surgery with patent grafts. Vein graft to the right could be easily stented and the LAD could be dealt with if FFR revealed significant disease. I think reoperative surgery would be associated with a higher perioperative death and stroke and a definitely higher risk of worsening renal failure culminating in requiring haemodialysis rather than peritoneal dialysis. If TAVI however is not possible, I would be happy to offer him reoperative surgery and the risks of this have been discussed at length.

Mr Pavlidis and his wife would prefer a TAVI procedure and I have explained that his investigations and case will be discussed at the next heart team meeting.

Thanks for the referral.

Kind regards

MANU MATHUR

cc: Dr Thomas Yeoh, Burwood Specialist Centre, Burwood Specialist Centre, BURWOOD NSW 2134
cc: Dr Ali Zahedi, Kendall Street Medical, 73 Kendall Street, WEST PYMBLE NSW 2073