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Dr. Teng-Kiong Kek
P.O. Box 3020
MOUNT DRUITT VILLAGE NSW 2770

Dear Teng-Kiong,

RE: Mr. Arnold Nas (#13592)
DOB: 30/07/1947

I was delighted to review this gentleman in rooms today. He's more short of breath than usual. You organized a chest x-ray, which showed an enlarged heart, and he went on to have a CT scan, which showed a small pericardial effusion. If you remember, in my previous letter, which I sent to you last year in December, his echocardiogram suggested at that point in time that he had a small pericardial effusion. He had normal biventricular function back then. He had severe biatrial dilatation back then. He had mild to moderate mitral and tricuspid regurgitation back then as well.

Today, he was noted to be more short of breath, particularly when he was doing things, and that's why you investigated him.

Upon examination today, his heart rate was 60 bpm and in atrial fibrillation. His blood pressure was 120/70 mmHg. He had a mitral regurgitant murmur. His chest was clear to auscultation. Resting ECG showed controlled atrial fibrillation, with a bundle branch block pattern.

You'll be aware, last year he had a MIBI scan which showed no evidence of reversible myocardial ischemia; that was done in December last year. He had good left ventricular ejection fraction calculated at 68%.

Today, his echocardiogram showed that he had normal biventricular function, with the same small persistent pericardial effusion, which is unchanged from last year. His right ventricular size is slightly more dilated than normal. Again, he had severe biatrial dilatation, which we knew. He had mild aortic regurgitation, which is stable. He had mild to moderate mitral regurgitation, which is stable. And he has moderate to severe tricuspid regurgitation, which has gotten worse, and so has his pulmonary pressures; he has pulmonary hypertension now.

I'm not quite sure what's driving this. He's on Pradaxa at a therapeutic dose for his atrial fibrillation; this should also prevent him from getting pulmonary emboli.

I'm arranging for Arnold to have a CTCA to make sure there's no evidence of coronary artery disease, because all his MIBI scans have always been the same and always been normal. I'm also arranging for him to have a Holter monitor to make sure he's not having any bradyarrythmias, which may be precipitating this, which may require him to have a pacemaker put in. Once this is done, then we'll need to explore his pulmonary hypertension in more detail, and he might need a respiratory physician. But let's clear the cardiac issues first.

Yours Sincerely,

Clyne Fernandes
Interventional Cardiologist