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| **Tricuspid Patient Summary** |  | | |
| **Dr Bhindi** | | | |
| Name: Mrs Janice A Van De Velde  1 Edgecliff Esplanade, Seaforth, NSW, 2092  0418 440 644  Daughter- Jacqui 0413 301 088  Patient mobile is 0417 274 856. | | | Referrer: Dr Choong |
| DOB: 1/06/1936 | | | Allergies: |
| ME number: ME00225818 | | | Antiplatelets/anticoagulation: Eliquis 2.5mg bd |
| Age: 88  Weight: 59kg  Height: 157cm | | | Current Symptoms:  Exercise tolerance 25 to 50metres.  She denies breathlessness, palpitations, chest pain and leg swelling. |
| **Past Medical History** | | |  |
| * AF – Pradaxa 110mg BD * TAVI 10/2020 (Bhindi) * OA * Breast Ca (Prof Elgene Lim & Dr Jeremy Mo) * CKD * Hypertension * Pulmonary fibrosis | | | **Social:** mobilises with 4WW |
| **Current Medical Heart Failure Therapy** | | | |
| |  |  |  | | --- | --- | --- | | **Drug Type** | **Drug Name** | **Dosage** | | Beta Blocker | Metoprolol (Minax) | 25mg BD | | ACE/ARB/ARNI | Entresto | 49/51mg BD | | MRA |  |  | | SGLT2 |  |  | | Diuretics | Furosemide | 20mg OD | |  | Digoxin (Lanoxin) | 62.5mcg OD | |  |  |  | | | | |
| **Baseline blood**s | | | |
| Date: 28/02/25 Hb: 127 Plat: 181 INR: Creat: 128 eGFR: 32 | | | |
| **ECG** | | | |
| Rhythm: Afib LBBB | | | |
| **Right Heart Catheter 02/2025 Dr Choong** | | | |
| |  |  | | --- | --- | | PASP - 55/19(32) | PCWP 12/11(11) | | mPAP mildly elevated | CO 4.3 | | PVR 4.9 | TPG 21 | | | | |
| **CT** | | | |
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| **TOE/TTE 21/02/2025** | | | |
| **TR Grade:**  **Mechanism of TR:**  Primary  Atrial functional  Ventricular functional  Device related   |  |  | | --- | --- | | LV EF: 60% | RV function: Low normal radial systolic function. Reduced longitudinal function. | | TAPSE: 1.5cm | ePASP: 49mmhg | | Afterload mismatch (TAPSE/PASP): 0.30 |  | | Imaging comments:  TAVI prosthesis, well seated. Normal leaflet appearance and excursion. Trivial posterior paravalvular regurgitation. Marked posterior mitral annular calcification extending onto the base of the posterior leaflet. Mildly thickened distal posterior leaflet and anterior leaflet. Mild mitral regurgitation arising centrally in the valves between A2 and P2.  Structurally normal tricuspid valves (trileaflet). Severe secondary tricuspid regurgitation arising centrally (septal posterior) with a smaller component anteriorly (septal-anterior). Coaptation gap between the septal and posterior leaflets measured at 5mm from multiplanar imaging.  The patient was studied after optimization of heart failure therapy and was judged to be clinically, euvolaemic. In the transthoracic study of 27th November 2024, the pulmonary artery pressure was estimated at 77mmHg and if this is still present, would be prohibitive for percutaneous tricuspid valve intervention. With optimatisation of heart failure therapy, repeat right heart catheterisation would be useful. The transthoracic study will be repeated on the following day, particularly to obtain repeat estimation of a pulmonary pressure and TAPSE. | | | | | |
| **Procedure Plan** | | | |
| Tri-score:  GLIDE score is 1  TV Repair  Difficulty of Procedure: **ORANGE**  Pre-operative optimisation plan:  Approved at feasibility  Admit 1 week prior for offloading pre tri-clip. | | | |
| **Resp Review, Don** | | **Aged Care Dr Warrier 17/06/25** | |
| Note consideration for TriClip. No operative respiratory contradictions. | | MOCA 26/30  In summary, given that Janice has an excellent level of function and is cognitively intact, I would be happy to support her in undergoing a Tricuspid Clip (TriClip) procedure. I have warned her of the risk of a postoperative delirium with a general anaesthetic. | |

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| 19/05/2025 | Called daughter. Daughter reports that patient is more sick than she is letting on. She is concerned that she is not concordant with her heart failure medications. To arrange appt with dr warrier who they know but who has not yet seen Jan. |
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