SMITH, DEANE R. 5/28/03

Follow-up office visit 5/28/2003 for the following medical problems: 1) atherosclerotic cardiovascular disease with coronary artery disease, 50 percent LAD, 40 percent circumflex stenosis, 2) LV ejection fraction 45 percent, 3) chronic atrial fibrillation, 4) chronic Coumadin anticoagulation, 5) right bundle branch block with left posterior fascicular block.

Since previous evaluation, the patient has had medical evaluation for progressive fatigue, exertional intolerance, palpitations, and weakness. Holter monitor revealed significant tachybrady syndrome with peak heart rates as high as 180-190 beats per minute, and multiple 2.0-2.7 second pauses. I have discussed tachycardia-bradycardia syndrome with the patient and his wife and I have recommended consideration for permanent pacemaker.

REVIEW OF SYSTEMS: Reveals no fevers, chills, sweats, recent acute blood loss or weight loss. He denies orthopnea, pedal edema, or syncope. He has tolerated Coumadin without evidence of GI, GU, or ENT bleeding. He has had surgical evaluation for breast mass and surgical excision has been recommended. I recommended pacemaker insertion be times to correlate after his surgical wound has time to heal.

PHYSICAL EXAMINATION:

GENERAL:	Reveals a comfortable and well-appearing male.
VITAL SIGNS:	Blood pressure is 128/86. Pulse is 70 and regular. Respiratory rate is 16.
HEENT:	Normocephalic, atraumatic cranium. Jugular venous pressure is normal with irregular contour. Carotid upstroke is +2 bilaterally.
LUNGS:	Lungs are clear.
CARDIAC:	Reveals an irregularly irregular rhythm. S1 and S2 are normal. A 2/6 apical murmur is present.
ABDOMEN:	Reveals a soft and nontender abdomen.
EXTREMITIES:	No edema.

IMPRESSION: The patient has chronic atrial fibrillation with well-controlled risk prevention management with Coumadin therapy. He has moderate mitral regurgitation and noncritical coronary artery disease. He is at significant risk, however, both from tachycardia and bradycardia and I have recommended placement of permanent pacemaker to minimize bradycardia and then addition of digoxin or selected antiarrhythmic therapy to optimize protection against tachycardia. The risks, benefits, expected outcomes, and alternatives from pacemaker therapy have been recommended and the patient is agreeable to these recommendations, to be performed following breast nodule excision. Laboratory panel reveals a normal hematocrit, glucose, electrolytes, cholesterol, TSH, and SGOT. Follow up in four to six weeks, sooner if necessary for symptomatic deterioration.

PRK/cmt

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