ST. MICHAEL'S HOSPITAL
A teaching hospital affiliated with the University of Toronto

Cardiac Arrhythmia Ambulatory Consult

Lenskyj, Adam Adolf Mr
MRN: 203·1473
D.O.B. Dec-02-1940

12 February 2010

Dr. Aisha Lofters
SMH 61 Queen St.. E
Toronto, ON M5C 2T2

Dear Dr. Lofters:

Mr. Lenskyj, a 69~year-old retired engineer, was seen in follow-up with respect to coronary artery disease and atrial flutter while in ICU in the context of urosepsis.

This gentleman has a history of coronary disease, prior inferolateral myocardial infarct, and a PCI to the right coronary and the left circumflex coronary arteries in 2005 with bare metal stents.

He has a history of controlled hypertension, hypercholesterolemia, and diabetes.

He was clinically stable up until this fa ll when he developed a renal stone and had a ureteric procedure which ultimately was associated with urosepsis and eventually was treated with a right ureteric stent. He did spend about 2 weeks in hospital with urosepsis and some hypotension and a complicating GI bleed, all of which resolved. Early after hospitalization, he developed atrial flutter. with ventricular rates of about 150 and ultimately was scheduled for urgent cardioversion but converted to sinus rhythm on the cardioversion table before the shock was administered. He was discharged on Warfarin and beta-blocker and now comes to the office for follow-up. It is now approximately 2 months or more since his hospital discharge. He has gradually recovered his physical strength and wellbeing and is now able to climb four flights of stairs without dyspnea, presyncope, syncope, palpitations, chest pain, or symptoms suggesting myocardial ischemia or arrhythmias. His general wellbeing is good.

His blood pressure has apparently been in good control. He is monitored by the diabetic clinic and is on Metformin 50 mg b.i.d. in this regard.

For his coronary disease, he is on Metoprolol 50 mg b.i.d., Ramipril 5 mg a day, Lipitor 40 mg a day, Warfarin as adjusted, and Norvasc 2.5 mg a day.

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He had a follow-up upper GI gastroscopy in January 2010 under Dr. Ottaway, and the test apparently showed no ulcers or gastritis. A breath test is now scheduled.

His general wellbeing is good. He is quite anxious about his future risk of recurrent cardiac events and safety with respect to travel. He finds the Warfarin a substantial hardship and is particularly concerned about difficulties with anticoagulation during planned trips to the Middle East and other far flung places.

Pending this consultation, we did arrange for a persantine Cardiolite scan which showed moderate left ventricular enlargement and a nonreversible lateral wall defect with a lateral hypokinesis but no reversible ischemia demonstrated. The post stress ejection fraction is 38%. I believe this may be an under estimate of the true EF.

On examination today, the blood pressure is 142/79. The heart rate is 57 per minute and regular. The chest is clear, and the jugular venous pressure is normal. The heart sounds are distant without added sounds, and there is a soft basal systolic ejection murmur of mild aortic sclerosis without other added sounds or murmurs.I should add that he has had a repeat CT scan of the abdomen, and this showed a very small renal stone of 2 mm in diameter, and it is to be followed up by Dr. Pace with an office visit.

Today's electrocardiogram shows sinus bradycardia, occasional atrial premature beats, and nonspecific ST-T wave changes without acute signs of ischemia.

IMPRESSION:
Mr. Lenskyj has had an episode of persistent atrial flutter but which nevertheless stops spontaneously in the context of a relatively severe acute illness. One would classify this as "atrial flutter due to a potentially reversible cause," and I believe the future risk of atrial flutter occurrence, although not negligible, is quite small. I do not think that anti-arrhythmic therapy is indicated. With respect to stroke prevention strategies, he is in CHADS classification of 2 with hypertension and diabetes but is probably at very low stroke risk given the single episode of atrial flutter from reversible causes, and thus according to guidelines, permanent anticoagulation is probably not indicated.

Given the potential risks of bleeding, the individual risk related to his travel schedule, and the uncertain indication, I have asked him to stop the Coumadin and substitute Aspirin 75 mg daily. I do not believe that the addition of Clopidogrel to Aspirin is required because of the relatively low stroke risk and the additional risk of bleeding. There is a small risk of Gl bleeding with the Aspirin, and Dr. Ottaway will verify that this is safe to continue at the next clinic visit.

He should of course remain on all his other medications for the secondary prophylaxis of coronary artery disease. There is no evidence for heart failure, so other medications are not required. We will do an echocardiogram to get an additional independent measure of LV function since I believe that his ejection fraction is probably in the 40-50% range.

He is at low-to-moderate risk of a future recurrence of cardiovascular events, and of course we will need a very close follow-up of his blood pressure, blood sugars, and LDL cholesterol to make sure that It is at target.

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With permission, I will see him in follow-up in 1 year's time. In the meantime, I have recommended that he continue his currently relatively active lifestyle and indeed travel and do more vigorous activities Ifhe wishes. Thank you for allowing me to participate in his care.

Yours sincerely,

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Electronically Signed by
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D: Feb-12-2010 12:31 P T: Feb-12-2010 PCI678724-616804 Doc: 1527426

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