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MyChart™ Report
Patient Name: LENSKYJ ADAM
Patient DOB: 1940-Dec-02

Transcription Report
Amb. Consult

Observation Date : March 25, 2019

Status : F

Reported Date : March 26, 2019

Summary Data :

Heart Failure Ambulatory Consult

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

March 25, 2019

Dr. Aisha Lofters
St. Michael's Hospital
Family Practice Unit
61 Queen Street East Floor 3
Toronto, ON M5C 2T2

Dear Dr. Lofters:

Thank you very much for referring Mr. Adam Lenskyj to the St. Michael's Hospital Heart Failure Clinic. This gentleman was last seen by the heart failure clinic in January 2018. He was originally referred for ischemic cardiomyopathy. His ejection fraction has increased over time to above 40% based on echocardiography in March 2018. He was therefore deemed not a candidate for primary ICD. There was attempt to recruit him into the ADMIRE-ICD, but he declined. His prior ejection fraction was 36% by echocardiography on March 7, 2017. He had history of coronary artery disease.

He had stents placed to the circumflex and RCA in 2006. In March 2017, he had a drug-eluting stent placed to the mid LAD. He distinctly recalls the angina type of sensation that he felt prior to the procedure. There is also history of type

2 diabetes, dyslipidemia, hypertension, and obesity. He lives alone. However, he claims that he exercises regularly doing treadmill at home as well.

He came to the Emergency Department on March 21 with angina sensation that reminds him of the discomfort he felt prior to his percutaneous coronary intervention. He also describes symptoms of orthopnea. Interestingly, without any therapy, the symptom has disappeared. His orthopnea did last for several days. Right now, he is not symptomatic.

His current medications are Insulin, Atorvastatin 40 mg daily, Bisoprolol 2.5 mg daily, Clopidogrel 75 mg daily, Nitroglycerin spray on a p.r.n. basis, Lansoprazole 30 mg daily, Aspirin 81 mg daily, Irbesartan 300 mg daily, Metformin 850 mg daily, Amlodipine 5 mg daily, and Furosemide 20 mg daily. Functional inquiry was otherwise unremarkable.

On physical examination this morning, the patient was in no acute distress. Head and neck examination was normal. Venous pressure was not increased. Carotid upstrokes are brisk and there were no bruits. Chest was clear. Heart sounds were normal. There was no peripheral edema. Body weight was 208 pounds.

Electrocardiogram today demonstrated possible sinus rhythm with a heart rate of 100 beats per minute. There were nonspecific ST-T abnormalities.

His chest x-ray from March 21 did not reveal any congestion. Laboratory report from the same day revealed serum sodium 140, potassium 4.4, random glucose 9.1, creatinine 86. Troponin 0.028, and there was no natriuretic peptide measured.

In summary, this gentleman appears to have acute coronary syndrome with low risk. I think he deserves further investigation along the line. I would therefore arrange for an exercise perfusion imaging study. I will reassess his cardiac function by doing an echocardiogram. Last but not least, I would check his electrolytes and biomarker today. I will see the patient again after completed these investigation

The patient was reviewed today in detail by our team for 70 minutes.

Sincerely,

Gordon Moe, MD FRCPC
Phone: 416-864-5319
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Electronically Signed by
Gordon Moe, MD FRCPC 26/03/2019
04:11 P

cc: Aisha Kamilah Lofters, MD
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