MEDICATIONS (continued)

Discharge Summary by Van Schyndel, David Brent, MD at 2/23/2019 12:47 PM (continued)

Aflutter with RVR
History of HF from 10/2009 with initial EF of 25% on TTE. Etiology likely 2/2 to hypertensive dilated cardiomyopathy. Amyloidosis work up negative including negative proteinuria. Started then on carvedilol, lisinopril, and HCTZ. He had been following with cardiology. TTE 3/15/2012 showed EF 34%. Patient had another acute exacerbation of HF 4/7/2018 with EF 10% which was worse compared to EF 30% 3/20/2017 and BNP 14,860. He was aggressively diuresed with lasix 80 mg IV BID for 2 days ~4L urine/day with resolution of symptoms including SOB. Discharged with 80 mg PO lasix. Patient followed up with Cardiology 4/17/2018 with plans to follow up regarding possible ICD for low EF but never followed up. No changes to his meds were made at the time. No repeat TTE. Echo on 2/20 with stable EF and no new WMA.

Patient has been in A flutter on RVR since admission (HR 120s despite high dose of PTA BB), HD stable but SOB on exertion. Suspect this is the most likely etiology of his new CHF exacerbation as there is no suspicion of new ischemic event, he is compliant to his medication, no hx suggestive of active or recent infection. EP and Cardiology on board. Was placed on 2L fluid restriction and diuresed with lasix 40 mg IV daily for 2 days and the 80 mg IV for the next 2 days with about 5L urine output 2/21. Patient underwent TEE and ablation 2/22 for atrial flutter (new since 01/2018) which was tolerated well. Was continued on his home PTA simvastatin while inpatient.
- Continue PTA coreg, eplerenone, hydralazine, and isordil
-Continue Xarelto 20 mg HS (Started 2/20)
-Needs f/u with HF NP next week, then Dr. Carlson in 4-6wks (we will order both for you)

R leg edema
1 day of R calf edema. He has hx of R ankle injury s/p fusion surgery 4 months ago and always has some ankle swelling but calf swelling is new. No other symptoms. Minimal pain in calf. D dimer negative. DVT US negative. Improved with diuresis.

Elevated troponin: 0.133 noted on admission. Has been around 0.1 on multiple checks. No chest pain, EKG stable. Possibly Type II MI/demand ischemia in the setting of possible CHF exacerbation. Additionally, he does have CKD III which would affect clearance.

At the time of discharge pt's pain was ambulating independently w/out difficulty, tol' PO intake w/o N/V, voiding w/out difficulty, and bowel function present.

PENDING TESTS RESULTS:
None

RECOMMENDATIONS AND FOLLOWUP:
Started Xarelto 20 mg HS 2/20 for aflutter and will need follow up with cardiology and PCP in next week.

RECOMMENDATIONS OF ANY SUB-SPECIALTY CONSULTANTS:
Cardiology: Follow up with heart failure NP next week, then Dr. Carlson in 4-6wks

READMISSION PLANNED WITHIN 30 DAYS OF DISCHARGE? No

Interpreter Needed: no

Active Problems:
CHF (congestive heart failure) (**)
Overview: EF 10% in 4/2018