Hôpital St-Boniface Hospital
409 Taché Ave, Winnipeg MB Canada R2H 2A6

Department of Internal Medicine
Section of Cardiology
Phone: 204-235-3826 Fax: 204-233-2157

November 27, 2017

[redacted]

[redacted]

[redacted]

Thank you for your kind referral of this very pleasant 73 year old lady who has had a life-long history of fainting. Her past medical history is significant for Type II diabetes, dyslipidemia, remote breast cancer treated with lumpectomy and radiation, and an upper GI bleed secondary to an ulcer in 2006. She takes metformin, B_{12}, and Crestor. She drinks very occasionally and has never smoked.

She has described fainting spells since her teenage years. They have occurred a couple times per year since then. Originally, they were associated with her menstrual periods. Since then, they have been associated with triggers such as heat or exertion. She is always standing when the symptoms start and has never had syncope while laying or sitting. There are no warning signs to her episodes. She feels a sudden weakness and if unable to sit or lie in a few seconds she faints. She denies any palpitations or chest pains with these episodes. She feels completely normal after. They only occur when standing. She has no physical limitations at all between episodes.

She had one witnessed faint by her daughter while they were at church. It was hot in the church and she feels that this may be what triggered it. At the time, she was noticed to be pale and diaphoretic. She regained consciousness and had no residual symptoms.

On examination today, her blood pressures are in the 150s and low 160s. Her pulse rate is in the 70s. These parameters do not significantly change whether lying or standing. There is a normal S1 and S2. There are no extra heart sounds. The lungs are clear and there is no edema.

EKG is normal sinus rhythm.

Echocardiography conducted in November did not show any significant abnormalities aside from mild to moderate tricuspid regurgitation.

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DT: 07/Dec/2017
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Adult Medicine Clinic Letter

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ASSESSMENT AND PLAN:

We feel that her history is most consistent with vasovagal syncope. We note that she says she only drinks about two cups of water per day. We have encouraged her to increase her fluid intake. In addition, we have advised her that when she starts to feel her symptoms coming on, to actively contract her hands and leg muscles. This should help to increase her blood pressure and perhaps prevent syncope.

At this time, we are not concerned about any particular arrhythmia. She is in agreement to attempt the conservative measures that we discussed. We have not arranged any specific follow up, but if the symptoms persist, worsen or become more concerning, we would be happy to see her in clinic again. Until that time, we will leave her care in your hands.

Thank you for allowing us to be involved in Ms. Harder's care.

Sincerely,

Reviewed and signed on 12/18/2017 15:54:48 by

[redacted]

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December 9, 2016

[redacted]

[redacted] Province: MB

I assessed this patient in clinic on December 9, 2016. He is an 18-year-old male with a history of recurrent palpitations. He describes these as a slow thumping pulsation. These have been intermittent since approximately the age of 8. He has had occasional syncopal episodes associated with injuring himself. The syncope occurs following a painful injury. He will feel lightheaded and woozy if he stands up quickly, particularly in the morning.

His past history is previously investigated for asthma, but does not use an inhaler regularly. He is a nonsmoker. He takes about 2-3 alcohol drinks every couple of weeks. He works for a company that installs fireplaces. In his family history, his mother attended his appointment with him today, she says both Richard's sister and father faint at the sight of blood or having intravenous cannula placed. Also, his father has a history of what is likely a bicuspid aortic valve as he was told he had a heart murmur at age of 16 and had his aortic valve replaced at the age of 33. There are no allergies and no regular medications.

On examination, his weight was 79 kg and height was 180 cm. Blood pressure was 123/56 mmHg, heart rate was 60 bpm. There was no orthostatic hypotension or postural tachycardia.

His 12-lead EKG shows sinus rhythm with QRS of about 106 ms, no evidence of left ventricular hypertrophy.

He had a Holter monitor and this documented occasional brief 2:1 heart block likely consistent with Type I (Wenkebach), and no significant pauses. These episodes are asymptomatic.

On examining Richard today, he had no significant murmurs, but he may have had an aortic click.

In summary, the syncope Richard describes seems most consistent with vasovagal syncope. The palpitations I am not sure but are likely premature atrial or ventricular complexes. Given his family history of presumed bicuspid aortic valve and possible ejection click on examination, I will to arrange for him to have an echocardiogram and exercise stress test. I will follow up with him after these tests.

Yours sincerely,

This document has been electronically signed on 01/09/2017 07:40:17 by

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January 17, 2017

[redacted]

Province: MB

I assessed this 64 year old female in clinic on January 17, 2017. She is referred for further assessment of a single syncopal episode and multiple prior presyncope. The patient's symptoms are typical for vasovagal syncope. She gets a warning of lightheadedness, ringing in her ears, sweating and if she doesn't sit down she feels she will lose consciousness. Her blood pressure at the time of the episode for which she was referred was 80/40 when checked by EMS. She has not found any specific triggers. Although she feels she doesn't adequately hydrate. She feels more under stress lately because of significant pain in her left knee and she is waiting for a knee replacement. In her past history, she also has IBS, fibromyalgia, asthma, Lichen Planus, and has had a tonsillectomy and a right total knee replacement as well as a hysterectomy for endometriosis. She has a drug allergy to sulfa which causes a rash.

Current medications include: Paxil 20 mg daily, omeprazole 20 mg daily, iron and Vitamin B12. She does also use marijauna for pain in her knee.

Her mother passed away of pancreatic cancer and otherwise there is no significant family history. She is a non-smoker and has minimal alcohol intake.

On examination, her height was 170 cm, weight was 83.7 kg. The blood pressure was 134/88 with a heart rate of 68. She had no orthostatic hypotension or postural tachycardia. Otherwise, her cardiovascular examination was unremarkable.

Her 12-lead electrocardiogram today shows sinus rhythm at 65 beats per minute.

In summary, she is a 64 year old female with recurrent episodes of typical vasovagal syncope. I reviewed the diagnosis with her. I reviewed triggers as well as taught her counterpressure maneuvers. If

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these are not helpful then midodrine or fludrocortisone could be considered but hopefully these conservative measures will be helpful. Marijuana can cause hypotension and exacerbate vasovagal symptoms.

I have not arranged a routine follow up to see her again but if her symptoms worsen I would happy to reassess her.

Yours sincerely,

This document has been electronically signed on 01/26/2017 09:05:22 by

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March 7, 2017

[redacted]

I assessed this 30-year-old female in clinic on the 7th of March 2017. She was referred for further episode of recurrent lightheadedness. The spells usually happen while she is standing or moving from sitting to standing. Very rarely they have occurred with exertion. However, she exercises regularly and does not really remember the last time she had an episode. She sometimes gets an atypical left submammary pain. She has no shortness of breath, no palpitations. These episodes of lightheadedness generally last a few seconds and improve with deep breathing. Prior to the episodes, she will feel frequently warm and sweating.

She has a past history of depression and is taking citalopram for it. She works as an executive assistant. She has four children who are in good health. She is a nonsmoker, no drug use, and just takes occasional alcohol. She has no known drug allergies. In terms of her family history, her both parents are alive and no significant cardiovascular history.

On examination, her height was 170 cm, weight was 69.9 kg. Blood pressure was 114/67 and heart rate was 84 bpm. There was no orthostatic hypotension or postural tachycardia on 2-minutes standing. When she first stood up, her blood pressure decreased from 114 to 109 and she felt a little woozy but no significant symptoms. Otherwise, there was no hemodynamic abnormality on 2-minutes standing.

In summary, she is a 30-year-old female with symptoms that are most consistent with a vasovagal etiology. Her 12-lead EKG today showed normal sinus rhythm. Her clinical findings are suggestive of a primary vasovagal etiology. I have gone over conservative advice including hydration, salt in her diet and counter-pressure maneuvers. I have not arranged routine follow-up but I would be happy to reassess her should her symptoms worsen.

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Yours sincerely,

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