Dear

Re: **A 78 Year old male patient**

Diagnoses:

1. *Mild aortic valve disease. Peak gradient 26 mm. Hg with good LV systolic function, no other significant valvular abnormalities*
2. *Lumbar spinal stenosis treated with decompression surgery*
3. *Hypertension*
4. *Asthma*
5. *Rhinitis*
6. *Degenerative right hip disease*

Thank you very much for asking me to review this gentleman in view of his recent falls and for monitoring his aortic valve disease. I understand he is being considered for right hip replacement surgery sometime in October.

From a cardiac point of view there is no history of chest pain or increasing shortness of breath on exertion or palpitations. At the beginning of August he climbed up three stairs with some gardening tools and he felt himself falling backwards when he hit his head and sustained a laceration to his scalp. He was not sure if he was dizzy and he

did not believe he lost consciousness. He apparently quickly recovered and his lacerations were treated at the [redacted] Hospital where it was glued.

Three days ago whilst at a public meeting he was sitting down in a warm, stuffy environment. He stood up to give a small speech. Following his speech he turned around and the next thing he knew he started to fall. Again he believed he did not lose consciousness and there were no associated palpitations or feeling of dizziness prior to this episode. Recently, he has been experiencing intermittent dizziness up to three times a week, particularly if he looks up and down. He has had no symptoms whilst driving or sitting.

His current medication consists of Felodipine 10 mgs. daily, Bendroflumethiazide 2.5 mgs. daily, Lisinopril 10 mgs. daily, Gabapentin 600 mgs. t.d.s. and Co-Codamol.

On examination pulse 66 beats per minute, regular with a normal character. JVP not elevated. Heart sounds S1 plus an audible S2 plus a 3/6 ejection systolic murmur that radiated to the base of his neck. His chest was clear. Lying blood pressure 120/80 mm. Hg., standing at one minute 110/80 mm. HG., standing at three minutes 120/80 mm. Hg. His 12 lead ECG showed sinus rhythm with first degree AV block (PR interval 204 msecs.), with left axis deviation and decreased R wave progression across the pre-cordial leads most likely due to counter clockwise rotation of the heart about the longitudinal axis. Right sided carotid massage whilst lying down showed a 3.76 second pause during which he was not symptomatic. I then stood him up and repeated right carotid massage and he had a 9.92 second pause with one ventricular escape beat that occurred at five seconds into the pause. During this time his eyes started to roll back. He was not communicative. However, he did not fully lose consciousness. I quickly asked him to lay down and interestingly he could not remember the event. This may explain why with his previous two episodes he could not recall exactly what happened.

His echocardiogram showed normal LV cavity size with isolated basal septal hypertrophy causing a sigmoid shaped septum with normal wall thickness in the other regions. He has good LV systolic function. The aortic valve was tricuspid with calcified edges and a peak gradient of 26 mm. Hg. across it. The RVSP was 23 mm. Hg and his IVC was normal in size with normal inspiratory collapse. He has normal pulmonary artery pressure. The aortic root was mildly dilated measuring 4.1 cms. at the sinuses.

This gentleman has carotid hypersensitivity syndrome and there is no doubt he will require a dual chamber pacemaker. This will need to be done prior to his orthopaedic surgery. Further to our telephone conversation, I will arrange this as soon as possible. Thanks very much for your referral and should you have any queries please do not hesitate to contact me.