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Central Melbourne Cardiology

24 August 2022

Dr Luiz Cavalcante
PVH Medical
124 Kent Road
PASCOE VALE VIC 3044

Dear Luiz,

Re: **Renee SOWMAN**
71 Campbell Street COBURG VIC 3058
Date of Birth: 2/6/1978
Date of Consultation: 24 August 2022

I reviewed Renee today. Renee has had episodes of atypical chest pains. Her transthoracic echocardiograph revealed no evidence of pericarditis with trivial-to-mild mitral regurgitation. I have explained these findings to Renee. She has had constitutional symptoms of tingling sensation as well as a warm sensation affecting her heart and chest pain which was all in the setting of generalised aches. I will consequently schedule her for a cardiac MRI. I will review her following this investigation.

Kind regards,

(Sighted but not signed)

Dr Wally Ahmar
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Central Melbourne Cardiology

15 July 2022

Dr Luiz Cavalcante
PVH Medical
124 Kent Road
PASCOE VALE VIC 3044

Dear Luiz,

Re: **Renee SOWMAN**
71 Campbell Street COBURG VIC 3058
Date of Birth: 2/6/1978
Date of Consultation: 15 July 2022

Thank you for referring Renee today for cardiovascular assessment. Renee is a 44-year-old lady who had her Pfizer COVID-19 vaccinations last year, second dose was in November. In February of this year, three months later, she developed symptoms of chest discomfort which was progressive involving her left shoulder, back, neck and right upper limb subsequently. Her symptoms are constant. They are not positional and not exacerbated by deep inspiration. She has been short of breath at rest and is not exercising. She has recently experienced abdominal discomfort and has presented to Emergency on two occasions, with her troponin levels all being normal. Her ECGs have not shown features of pericarditis. She has had no episodes of palpitations. She does not exercise regularly. She has, on the blood test, very marginally elevated ESR and she informs me she has a weakly positive ANA and has been referred for a Rheumatology assessment. Interestingly, she had fallen over and injured her wrist. At that stage, she had no symptoms of chest pain for a six-week period. She is a cigarette smoker.

She does have thyroid dysfunction and irritable bowel syndrome. She was commenced on thyroxine and meloxicam; however, she did experience abdominal discomfort and ceased taking both medications.

Socially, she has a partner. She has two adult children and works for an insurance company in claims. This is a stressful job.

On examination, her pulse rate was 70 beats per minute, blood pressure was 132/80 mmHg. Her JVP was not elevated. Heart sounds were dual and chest clear.

Renee has experienced symptoms of atypical chest pain without classical pericarditis-type symptoms, I will schedule her for a transthoracic echocardiograph and I will review her following these investigations.

Kind regards,

(Sighted but not signed)

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Central Melbourne Cardiology

Echocardiogram

Patient: SOWMAN, Renee
Patient ID: 45210
DOB: 2/06/1978 (44 yrs)
Sex: Female

Date: 19/07/2022
Ht / wt: 163 cm / 82 kg
BSA: 1.93 BMI: 30.9
HR: 57

Reported by: Dr Wally AHMAR
Referred by: Dr Luiz Cavalcante

Staff

Role	Staff Name	Role	Staff Name
Echo Technician	Karapanagiotidis, Sofie (Mrs)	Reporting MO	AHMAR, Wally (Dr) [R]

Indications Chest pain FI, ? pericarditis

Presenting Rhythm: Sinus rhythm HR: 57 bpm

MMode / 2D / Doppler

M Mode / 2D		Mitral Valve Doppler		Aortic Valve Doppler	
LV Diastole (38-52)	40 mm	E Velocity	1 m/sec	LVOT Diameter	1.8 cm
LV diastole /BSA (23-31)	20.7 mm/m²	Deceleration Time	214 ms	LVOT Integral	24 cm
LV diastole (\Height)	24.5 mm/m	IVRT	105 ms	LVOT Velocity	1.3 m/sec
LV Systole (22-35)	23 mm	A Velocity	0.7 m/sec	Peak Velocity	1.6 m/sec
LV Systole /BSA (13-21)	11.9 mm/m²	E:A Ratio	1.4	Peak Gradient	10 mmHg
IV Septum (6-9)	7 mm	**Pulmonary Veins**		LV Stroke Volume	61 mL
Inferolateral Wall (6-9)	7 mm	Systolic Velocity	0.6 m/sec	LV Stroke Volume /BSA	31.6 mL/m²
RWT	0.35 %	Diastolic Velocity	0.5 m/sec	Cardiac Output	4 L/min
TAPSE (> 1.6)	2 cm	Atrial Reversal	0.32 m/sec	**Tricuspid Valve Doppler**	
Aortic Root (27-33)	31 mm	**Mitral Annular TDI**		Peak TR Gradient	18 mmHg
Asc Aorta (23-31)	34 mm	Medial E' Velocity	12 cm/s	Peak TR Velocity	2.1 m/sec
Left Atrium (27-38)	32 mm	Medial E : e'	8	RA Pressure	3 mmHg
Left Atrium /BSA	16.6 mm/m²	Lateral E' Velocity	14 cm/s	RVSP	21 mmHg
Fractional Shortening	42 %	Lateral E : e'	7	**Pulmonary Valve Doppler**	
LV Mass (2D) (66-150)	78 g	Average e' Velocity	13 cm/s	Max Velocity	1 m/sec
LV Mass /BSA (44-88)	40.4 g/m²	Average E:e'	7.5	Max Gradient	4 mmHg
2D				PA Acceleration	126 ms
LA Area 2 chamber (<=20)	18 cm²			**RV DTI**	
LA Volume	53 mL			RV S' (>9.5)	13 cm/sec
LA Volume /BSA (16-34)	27.5 mL/m²				
RV Basal Diam. (25-41)	34 mm				
RA Area (<=18)	13 cm²				

Aorta

Aortic Sinuses 31 mm (27-33) **Sinuses /BSA** 16.1 mm/m² (16-20)
Ascending Diameter 34 mm (23-31) **Ascending Diam. /BSA** 17.6 mm/m² (13-19)

THE ECHOCARDIOGRAM TEST WAS EXPLAINED TO THE PATIENT AND A VERBAL CONSENT WAS OBTAINED.

Summary

Fair procedure tolerance.
Left ventricle is of normal size, thickness and overall systolic function.
Normal diastolic Doppler parameters, normal filling pressures (E/E' av 8).
Left and right atria are normal size (LAA cm^2, LAESVI ml/m^2, RAA $13cm^2$)
Right ventricle is of normal size and function (RVSa 13.00cm/sec., TAPSE 2.0cm)
Aortic valve is trileaflet, unrestricted. Normal size aortic root (31mm) and borderline size ascending aorta (34mm).
Mitral leaflets are mobile and unrestricted. Trivial to mild MR.
Other valves are unrestricted. Trivial TR and PR. Estimated RVSP is 21mmHg (assuming a RAP of 3mmHg).
Normal size IVC with normal respiratory change.
No pericardial effusion.

Conclusions

Normal biventricular size and function.
Trivial to mild mitral regurgitation.

Distribution

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