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29.12.10

Chesterholm Rest Home Britten Road Lee on Solent PO13 9JU

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Dr A W Matthews

Dictated: 01.8.95
Typed: 11.8.95

Diagnosis: 1. Digoxin toxicity

This 84 year old lady presented with a one week history of non-specific malaise, retching and generally feeling unwell. She denied any chest pain or increasing shortness of breath although she did report some scanty ankle oedema.

PAST MEDICAL HISTORY:
Hysterectomy for fibroids, ischaemic heart disease with an MI in March, 1995.

DRUGS ON ADMISSION:
Digoxin 250mcgm, Spironolactone 100mg per day and Frusemide at 40mg per day.

SOCIAL HISTORY:
She is an ex-smoker of 30 years standing, she does not drink, she lives in a Rest Home. She was formerly and Nursing Auxiliary in a hospital.

ON EXAMINATION:
She was rather down, her pulse was 60 in controlled atrial fibrillation, BP 150/110, she was apyrexial. Her apex beat was not displaced, her venous pressure was not visualized. There was an ejection systolic murmur and also an early diastolic murmur audible over the precordium. Peripheral pulses were present and intact, carotids were normal. Her chest was clear. Abdominal examination was unremarkable and she was neurologically intact.

INVESTIGATIONS:
Urea 28.2 with a creatinine of 189, LFTs were normal, serial cardiac enzymes were normal also. Her Digoxin level was reported as being 3.6 which is way above the therapeutic range. Thyroid function was normal, she had a normal FBC.

TREATMENT & PROGRESS:
She was gently rehydrated and her Digoxin was stopped. Her clinical condition subsequently improved considerably and most her symptoms subsided.

DRUGS ON DISCHARGE:
Frusemide 40mg per day, Amiloride 5mg per day, Digoxin reduced to 62.5mcgm per day and Magnesium Hydroxide 20mls b.d.

We have made no arrangements to see her again.

M BACON
Registrar

The Health Centre
Manor Way
Lee-on-Solent