

Food and Drug Administration  
Center for Food Safety and Applied Nutrition  
Office of Special Nutritionals

ARMS#

12844



5 - SUMMARIES

**000001**

[REDACTED]

**HISTORY-PHYSICAL EXAMINATION**

Patient: [REDACTED]

Case No.: [REDACTED]

MR No.: [REDACTED]

Attending: [REDACTED] M.D.

Room No.: [REDACTED]

Admission Date: 3/20/98

**HISTORY OF PRESENT ILLNESS:** [REDACTED] is a 47 year old male who is admitted through the Emergency Room with sustained ventricular tachycardia with spontaneous cardioversion. The patient has had similar problem for the past 18 months and has been worked up extensively by Dr. [REDACTED] with coronary arteriograms which were normal and ultimately electrophysiologic testing which led to a conclusion that his ventricular tachycardia was non-inducible. The patient was treated with Cardizem CD for his hypertension and his arrhythmia and the patient discontinued the Cardizem because he did not feel well. He continues on Hydrochlorothiazide 25 mg daily. On admission, his potassium was 3.3. He has been given supplemental potassium.

The onset of his arrhythmia was noted yesterday when he was loading horses to a trailer. With his straining, a sudden onset of palpitations. His last evaluation was in January of this year. Upon arrival in the Emergency Room while at rest, he was found to have the rapid sustained ventricular tachycardia which is documented on strips in the back of the chart. Interestingly, the patient had a urine screen that was positive for Cocaine and Opiates but denies this adamantly and states he is on herbs for the past six weeks.

**CORONARY RISK PROFILE:** Family history is positive. Mother died with an MI and her siblings died with myocardial infarctions. He has no siblings with heart disease. No history of sudden death in the family. The patient has hypertension. His lipid status is unknown. At the present time, he is a non-smoker.

**SOCIAL HISTORY:** He works and lives with his wife and does not consume alcohol and is a non-smoker.

**HISTORY-PHYSICAL EXAMINATION**

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4-1-98 DED  
Exhibit-1

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**HISTORY-PHYSICAL  
EXAMINATION**

Patient: [REDACTED]

Case No.: [REDACTED]

MR No.: [REDACTED]

Attending: [REDACTED] M.D.

Room No.: [REDACTED]

Admission Date: 3/20/98

**ALLERGIES:** No allergies to Cardizem but felt poorly on Cardizem.**REVIEW OF SYSTEMS:** He denies any chest pain. No shortness of breath. No melena. No abdominal pain. No arthritis. No symptoms of congestive heart failure. Review of systems otherwise unremarkable.**PHYSICAL EXAMINATION****VITAL SIGNS:** Blood pressure 140/100, resting pulse is 60-70, he is afebrile.**GENERAL:** He is an alert and oriented times three male in no acute distress, well developed and well nourished.**HEENT/NECK:** Neck veins are flat. No thyromegaly.**CHEST:** No rales or rhonchi.**CARDIAC:** No S3 was heard. No murmurs. No rubs were present. S1 and S2 were normal. Pulses were strong and equal in all extremities. No bruits were heard.**ABDOMEN:** Soft, non-tender. No hepatosplenomegaly. No masses.**EXTREMITIES:** No edema. No cyanosis or clubbing.**NEUROLOGIC:** Intact.**LABORATORY/DATA:** EKG - normal, normal sinus rhythm. Chest x-ray per the Emergency Room physician was normal.**ASSESSMENT:** Ventricular tachycardia.**HISTORY-PHYSICAL EXAMINATION**

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Exhibit-1

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**HISTORY-PHYSICAL  
EXAMINATION**

[REDACTED]  
[REDACTED]

Patient: [REDACTED]

Case No.: [REDACTED]

MR No.: [REDACTED]

Attending: [REDACTED] M.D.

Room No.: [REDACTED]

Admission Date: 3/20/98

RECOMMENDATIONS: Will replete his potassium and defer the rest of the work up to Dr. [REDACTED]

D: 03/21/98

T: 03/23/98 [REDACTED]

[REDACTED] M.D.

**HISTORY-PHYSICAL EXAMINATION**

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Exhibit-1