right lateral wall was achieved in all patients. All tachycardias, including scar-related AT and typical AFL were ablated successfully. There was no complication during procedure. No recurrences of AT was observed during follow-up.

**Conclusion** Under conventional electrophysiological mapping, linear ablations from scar area to anatomic barrier and/or isolation of scar area from right lateral wall, could be successfully abolish IARTs and all potential circuits with reentry around or related to the scar.

**e0716** AN 81-YEAR-OLD MAN WITH DIZZINESS, FATIGUE AND SHORTNESS OF BREATH

Nan Li. Honorary Clinical Research Associate, Department of Medicine, University of Hong Kong

**Case** An 81-year-old man presented with dizziness, fatigue and shortness of breath one day after a min-invasive neck spine surgery. The patient said the surgery had been successful, and he was able to get up and walk on the first day, but on the second day he felt dizzy, tired, and dyspnoea. He also found his two hands were swelling. He denied chest pain, unconsciousness, vomiting and other symptoms. The patient was on medication of hypertension and diabetes before the surgery, and both of his wife and son have hypertension. The patient does not smoke nor drink. After surgery, the patient was given antibiotics by venous infusion. On physical examination, the patient looked conscious, well nourished but having a big belly. His temperature was normal. His four extremities were swelling. He had jugular retention. His blood pressure was 164/83 mm Hg, heart rate was 86 bpm and respiratory rate was 24. Heart auscultation revealed no heart murmur and normal heart rhythm. Pulmonary auscultation found some moist rales at the lower part of two lungs. Chest x-ray showed his heart was boot-shaped, lungs were clear and there was a little pleural effusion in the thorax. Cervical vertebra x-ray showed that the third and fourth spine cords were fixed by steel and there was ossification of nuchal ligament. ECG was almost normal. Echocardiography showed that the internal diameter of left atrium was 50 mm at diastolic phase; the right atrium was enlarged and the left ventricular posterior wall a bit thicker; the aortic sinus and proximal ascending aorta were widened; the left ventricular ejection fraction was 66%; the diastolic function was slightly reduced. The complete blood count showed: white-cell count 6.11×10⁹/l, neutrophil-cell count 4.22×10⁹/l, percentage of neutrophil-cell 69.1%, red-cell count 4.24×10¹²/l, haemoglobin 125.0 g/l, haematocrit 37.6%, platelet count 136×10⁹/l. The biochemistry test showed: serum potassium 4.1 mmol/l, serum sodium 142.0 mmol/l, serum chloride 99 mmol/l, carbon dioxide 24.0 mmol/l, serum calcium 2.53 mmol/l, creatinine 124.0 umol/l, blood urea nitrogen 8.2 mmol/l, uric acid 527.0 umol/l. Serum brain natriuretic peptide level: 548 pg/ml. Blood glucose level: 6.88 mmol/l. The diagnosis of this patient was based on his symptoms of fatigue, and shortness of breath at rest; physical examination of jugular retension, lung rales at lower part and ankle oedema; chest x-ray of pleural effusion. These symptoms and findings indicated the patient had pulmonary congestion and systemic congestion. Though ECG was normal, echocardiography showed diastolic dysfunction, and the serum BNP level was significantly raised. Thus the patient was diagnosed as: acute heart failure, diastolic heart failure, NYHA IV, Stage C; hypertension, grade 3; type 2 diabetes mellitus; cervical spondylopathy, post mini-invasive spine surgery. The treatment included blood pressure monitoring, urinary volume monitoring and electrocardiographic monitoring. Medications included vasodilator nitrate to relief cardiac workload; loop diuretic furosemide to induce diuresis; ACE inhibitor fosinopril to control hypertension; statin atorvastatin to lower lipid level; Insulin to control glucose level. The patient stayed in hospital for 10 days and discharged with no dyspnoea and low extremity oedema, no pulmonary rales, blood pressure 139/69 mm Hg and heart rate 57 bpm. During the 3 months follow-up after discharge, the patient strictly followed doctor’s written instructions on diet restriction and exercise. He measured blood pressure, heart rate and weight and then recorded