Patient Summary

Presentation: Chest Pain

Main Diagnosis: Non ST-elevation Myocardial Infarction

Module number: 4

Case number: 7

History taken by me: Yes

Patient examined by me: Yes

Followed up: Yes

Where seen: Secondary Care – AMU

When seen: 17.10.17

Age: 94

Gender: Female

Occupation: Retired – Worked for NATO

History of Presenting Complaint

- Patient presented to A&E with a **4-hour history of chest pain**
- S – **Central chest**
- O – **After waking, spontaneous**
- C – **Heavy, crushing**
- R – No radiation
- A – **Not had this severely before**
- T – **4 hours – Constant**
- E – **Worse on exertion but present at rest**, not worse on inspiration, not positional, no relieving factors
- S – **7/10**
- Associated with **nausea and feeling generally unwell**
- Specific: No dyspnoea, cough, haemoptysis, palpitations, fever or leg swelling
- Systemic: No weight loss or fatigue
- She had been suffering from intermittent central chest pain on exertion for the last 6 months
- This usually self-resolved and was only on exertion – She did not seek medical attention for this
- As this pain was more severe and prolonged than usual, the patient phoned an ambulance

DDx (initially)

1. Acute Coronary Syndrome
2. Pneumonia
3. Pulmonary Embolism

PMH:

- ✓ **Type II Diabetes Mellitus – Diet controlled**
- ✓ **Hypertension**
- ✓ **Hypercholesterolaemia**
- ✓ Osteoarthritis – Spine & Hip
- ✓ Surgery: Total Abdominal Hysterectomy, Cholecystectomy, Phacoemulsification, Bilateral Knee Replacements, Right Hip Replacement

FH:

- Sister – 3x Myocardial Infarctions (83) & Angina in 20s
- Mother – Breast Cancer

Drugs:

- Doxazocin – 1mg – OD – PO
- Ramipril – 1.25mg – OD – PO
- Simvastatin – 40mg – Nocte – PO
- Paracetamol – 1g – QDS – PO

Social:

- ✓ Smoking: **Ex-smoker – 3/day for 30 years (gave up 50 years ago)**
- ✓ Alcohol – Non-drinker
- ✓ Lives alone in a bungalow
- ✓ No children or husband
- ✓ Completely independent

Allergies: NKDA

Ideas: Initially, the patient thought that she might have been having a heart attack. She knew that she'd had griping chest pains for a while but was "too busy" with her busy social life to see the doctor.
Concerns: Her main concern was that her heart would stop her from being independent.
Expectations: She felt that she knew what to expect as friends of hers had also suffered from heart problems. She felt that she would see the consultant, be given some medication and discharged. She did not want to have a stent inserted as she felt she was "too old" for such things.

Summary of examination – 1 day after admission (I was unable to examine the patient on admission)

General Inspection –

- Up, alert & responsive
- GCS: 15/15
- Seemed comfortable at rest – Not SOB

Cardiovascular Examination – Normal

- Hands: Peripherally warm, no cyanosis or stigmata of endocarditis. Pulse: 80 regular with strong volume, no collapsing pulse or radial-radial delay
- Neck: No raised JVP
- Face: No signs of anaemia, angular stomatitis, poor dentition or central cyanosis
- Chest: No scars. No heaves or thrills. Heart sounds I & II heard – no murmurs
- Legs: No leg swelling or calf tenderness

Observations: 1 day after admission

- ✓ Pulse: 80bpm
- ✓ Blood Pressure: 130/83
- ✓ Temperature: 36.5
- ✓ Respiratory Rate: 16 breaths/min
- ✓ Oxygen Saturations: 96% on air

Respiratory Examination – Normal

- Hands: No CO2 flap, tremor or tar staining
- Chest: Normal chest expansion, resonant/equal percussion, normal chest sounds with no added sounds

Abdominal Examination –

- **Cholecystectomy & Hysterectomy scars seen**. No stigmata of chronic liver disease
- Soft, non-tender abdomen, normal bowel sounds heard

Summary of investigations

- **Urinalysis:** Not Done
- **Blood Tests:**
  - FBC: Normal
  - U+Es: Normal
  - LFTs: Normal
  - Troponin: **89** (12hrs)
  - D-dimer: **330**
  - BM: **6.5**
- **Imaging:**
  - Chest X-ray: Lung Fields Clear, **Cardiomegaly**
- **Special Tests:**
  - ECG: **ST Depression** in leads V2-5

Management (current and planned future)

- Patient was commenced on **ACS protocol** and was given **Aspirin, Ticagrelor & Fondaparinux**
- On follow-up one day after admission (prior to discharge), the patient was pain free, feeling better and was due to be discharged on the current therapy with Cardiology follow-up arranged