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HLGMC
8634097
28531/9v89
9/8/1994 12:00:00 AM
MYOCARDIAL INFARCTION .
Unsigned
DIS
Report Status :
Unsigned
ADMISSION DATE :
9/8/94
DISCHARGE DATE :
9/10/94
PRINCIPAL DIAGNOSIS :
Myocardial infarction .
ASSOCIATED DIAGNOSIS :
Coronary artery disease .
2. Hiatal hernia .
3. Anxiety .
SPECIAL PROCEDURES AND OPERATIONS :
1. Coronary angioplasty (9/9/94) .
DOCTORS DISCHARGE ORDERS AND MEDICATIONS :
1. Zantac , 150 mg. , po , b.i.d.
2. Isordil , 10 mg. , po , t.i.d.
3. Ecotrin , 325 mg. , po , qD.
4. Nitroglycerin , 0.4 mg. , sublingual , prn.
HISTORY OF PRESENT ILLNESS :
Mr. Little is a 53 year old male who is under the care of Dr. Royendchaelmares , at Hend Geadcoastcar Hospital , with the diagnosis of coronary artery disease .

He has a history of an old inferior myocardial infarction .
He was well until three days prior to admission , when he developed an episode of shoulder and arm pain , with minimal exertion .
The night prior to admission , he slept well , but the following day , he had a prolonged episode of chest pain .
He went to the Emergency Ward of Hend Geadcoastcar Hospital , where was found , on electrocardiogram , to have a right bundle branch block , and ST-segment elevations in the inferior and apical leads .
He was treated with intravenous Streptokinase , intravenous heparin , intravenous nitroglycerin .
He had a brief episode of bradycardia and hypotension , which responded to atropine and dopamine .
He had some ventricular ectopy that responded to Xylocaine .
He did well , without recurrent chest pain , congestive heart failure , or further arrhythmias .
He ruled in for myocardial infarction , with a peak CPK of 660 units , 16% mB .
An echocardiogram revealed an ejection fraction of 52% .
He had cardiomegaly .
He underwent an exercise tolerance test with Thallium , where he exercised for 2 minutes .
The test was positive .
Coronary angiography was performed on Sep 8 , which demonstrated a mean pulmonary capillary wedge pressure of 7 millimeters of mercury .
There was a 30% stenosis of the main left coronary artery .
There was a 50% stenosis of the left anterior descending .
The circumflex artery had a total occlusion .
His right coronary artery had a severe 95% stenosis .
The left ventricle has normal size , and an ejection fraction of 65% .
His PAST MEDICAL HISTORY is remarkable for an old Q-wave myocardial infarction .

He has a hiatus hernia .
He had prior surgery for hernia .
PHYSICAL EXAMINATION revealed a pleasant man in no acute distress .
His blood pressure was 120/60 millimeters of mercury .
His pulse was regular at 68 beats per minute .
The jugular venous pressure was normal .
The carotids were normal .
The chest was clear .
His cardiac examination revealed an apical impulse that was not displaced .
The first sound was normal .
The second sound was normally split .
He had no murmurs and no gallops .
Examination of the abdomen was benign .
Examination of the extremities showed no _____ .
He had good pulses bilaterally .
His electrocardiogram reveals sinus bradycardia , a right bundle branch block , and non-specific ST-T wave abnormalities .
HOSPITAL COURSE :
The patient was admitted to the Medical Service .
On 9/9/94 , he underwent successful coronary angioplasty of the two lesions in t he right coronary artery , with an excellent result .
He had no post-percutaneous transluminal coronary angioplasty complications .
He was discharged stable , and was advised to get a follow-up appointment with D r. Saha Royendchaelmares at Hend Geadcoastcar Hospital .
RENLAN N. FYFEZEIS , M.D.
TR :
ywj / bmot
DD :
9/12/94
TD :
09/13/94
CC :
Medical Records , to Dr. Saha Royendchaelmares , and to Ms. Rashard Kotehuie .
[report_end]