St. Aurelia Medical Center
Department of Cardiology
Prof. Dr. Marcus Lindholm
Lindenstraße 47
D-10115 Berlin

Discharge Summary
Patient: Mr. Jonathan Meyers
Date of Birth: 14.03.1973
Gender: Male
Hospital Stay: 28 May 2025 – 4 June 2025
Patient ID: 220594

Admission Diagnosis:

Acute ST-elevation myocardial infarction (STEMI), anterior wall

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Discharge Diagnoses:

1. Acute myocardial infarction of the anterior wall (treated via PCI)
2. Arterial hypertension (partially controlled)
3. Left ventricular hypertrophy (ECG-confirmed)
4. Obesity (BMI: 31.2 kg/m²)
5. Ventricular heart disease
6. History of prior myocardial infarction (2019)
7. Sinus tachycardia (heart rate at rest: 102 bpm)

History and Reason for Admission:

Mr. Jonathan Meyers, a 52-year-old male, presented to the Emergency Department of St. Aurelia Medical Center on 28 May 2025 with retrosternal chest pain radiating to the left arm, accompanied by nausea and diaphoresis. He had taken no sublingual nitrates prior to presentation. The patient has a known history of arterial hypertension, for which he has been on antihypertensive therapy (perindopril 5 mg qd). He also suffered a myocardial infarction in 2019, managed conservatively. His family history includes cardiovascular disease on the paternal side. There is no history of diabetes or renal dysfunction.

Findings on Admission:

On arrival, blood pressure was 148/94 mmHg, heart rate 102 bpm, BMI 31.2 kg/m². ECG revealed ST-elevation in leads V1–V4 and signs of left ventricular hypertrophy. Troponin-T was significantly elevated (3.42 ng/mL), and bedside echocardiography showed anterior wall motion abnormalities with an ejection fraction of approximately 42%.

Hospital Course:

The patient was transferred immediately to the cardiac catheterization lab. Coronary angiography showed subtotal occlusion of the proximal LAD, which was successfully treated with primary percutaneous coronary intervention (PCI) and drug-eluting stent placement. Post-interventional flow was TIMI III. The patient was monitored in the coronary care unit for 48 hours and remained hemodynamically stable.

During the inpatient stay, Mr. Meyers received optimized medical therapy, including dual antiplatelet therapy (aspirin and ticagrelor), statins, beta-blockers, and ACE inhibitors. His existing antihypertensive medication was adjusted to achieve better blood pressure control.

Notably, the ECG on day 3 still showed voltage criteria for LVH. Given the pre-existing ventricular structural disease, cardiology follow-up and echocardiographic monitoring were recommended.

Discharge Medication:

- Aspirin 100 mg qd
- Ticagrelor 90 mg bid (for 12 months)
- Bisoprolol 5 mg qd
- Ramipril 10 mg qd
- Atorvastatin 80 mg qd
- Pantoprazole 40 mg qd

Recommendations and Preventive Measures:

Given Mr. Meyers' cardiovascular risk profile—elevated BMI, arterial hypertension, previous myocardial infarction, and signs of left ventricular hypertrophy—a strict lifestyle modification program is essential. We recommend:

1. Enrollment in a cardiac rehabilitation program
2. Smoking cessation support (if applicable)
3. Structured dietary counseling to achieve weight reduction
4. Regular blood pressure and lipid monitoring
5. Annual echocardiographic follow-up due to underlying ventricular heart disease
6. Primary care follow-up within one week after discharge

We have informed Mr. Meyers about the importance of medication adherence and early recognition of cardiac symptoms. He was also instructed on self-monitoring of blood pressure and heart rate at home.

Notification:

This report has been forwarded to Mr. Meyers' general practitioner, Dr. Sarah Feldkamp (Medicum Westend, Bonn), and to his outpatient cardiologist, Dr. Leonhard Friesinger (HerzPraxis Rhein-Süd).

Attending Cardiologist:
Dr. med. Eva Riemenschneider
St. Aurelia Medical Center – Cardiology Unit

Date: 06.06.2025