- ## Demographic Data:

Patient's name	A.E.A
CPR	49*******
Age	68 years old
Date of admission	28/03/2017
Hospital, ward, Bed	BDF, CCU, 6
Name of consultant	Dr. Haitham Amin

- ## Chief Complaint (CC):
  - Chest pain of 1 hour duration.

- ## History of Present Illness:
  - A.E.A is a 68 years old Bahraini male who presented to A/E department in BDF Hospital with a history of retrosternal chest pain. The pain occurred at rest when the patient was watching TV with his children. It was continuous and described by the patient as heaviness/tightness over the chest. Pain lasted for more than 30 minutes (nearly 1 hour) and was radiating to the back and both shoulders. The pain was severe and A.E.A gave it a score of 8 out of 10.

  - Patient mentioned that the pain increases when lying down and it was not relieved by sublingual nitroglycerin or rest. His chest pain was associated with Shortness of Breath (SOB), nausea (but no vomiting) and palpitations.

  - Patient has no fever. His chest pain was not reproduced with movement or chest wall palpation (excluding costochondritis). In addition, he had no epigastric pain or reflux and no hemoptysis (excluding pulmonary embolism).

  - Patient has no history of dyspnea when sleeping (orthopnea) or wakening up at night with SOB (PND)

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- **Past Medical History:**

Medical conditions	• Hypertension: patient was diagnosed with HTN at the age of 53 years by routine check-up in Arad Local Health Center. He is compliant with his medications, checks his blood pressure everyday and pays attention to his diet (salt-restricted). He had no complications of HTN such as kidney problems, retinopathy or stroke. • Diabetes: he was diagnosed with diabetes at the age of 55 years when he complained of polyuria and polydypsia. Paying attention that patient is obese and with investigations which were done in Arad Local Health Center he was diagnosed as having type-2 diabetes. At the beginning, he was set on oral hypoglycemic but could not be controlled. Therefore, he is currently on insulin injections. Patient checks his blood sugar level daily with gluco-meter. • Dyslipidemia: he was diagnosed with dyslipidemia at the age of 55 years (same time of HTN). He is on statins (Lipitor).
Major childhood illnesses	• He doesn't remember having any childhood illnesses. • He had a car accident before 2 years with no fractures or other injuries.
Surgical procedures	• Cholecytectomy: at the age of 41 years due to cholecystitis. This operation was done in SMC with no complications.
Previous hospitalizations	• He was admitted to the hospital 2 years ago due to an attack of hypoglycemia. There are no other previous admissions.
Current medications	• HTN: ACE inhibitor. • Diabetes: insulin injections (3 ASPART injections during the day and 1 Glargine at bed time) • Dyslipidemia: Lipitor (1 tablet at bed time).
Allergies	• He has no known allergies to drugs or food.
Immunizations	• A.E.A is fully immunized.

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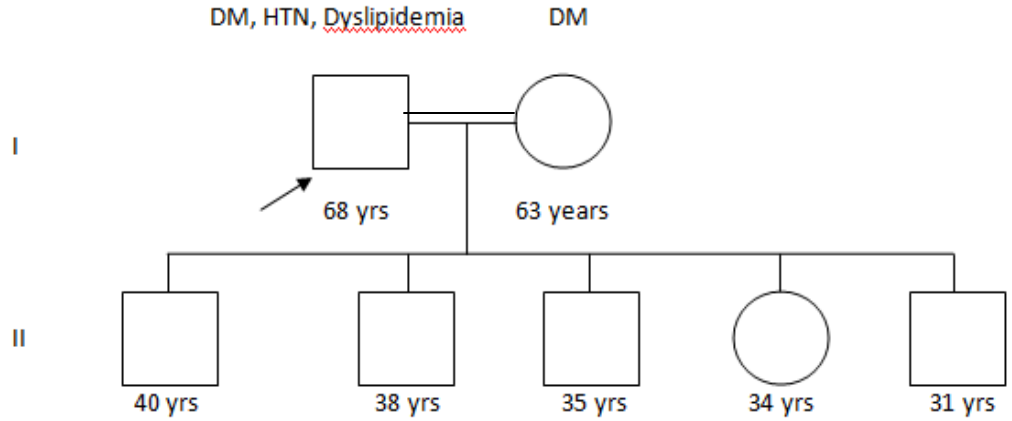
- **Family History:**
  - A.E.A is married to his cousin. His wife has type-2 diabetes but no other chronic medical conditions or genetic diseases.
  - He has 5 children. All of them are healthy.
  - There is no family history of heart diseases or surgeries.



- **Social History:**
  - A.E.A is living in a house with his wife and youngest son. He has good relationships with his family members. He works as a taxi driver and has a good income. He doesn't smoke and doesn't consume alcohol. He owns a cat and a bird. There is no history of recent travel and the patient do daily exercise for 1 hour.

- **Review of Systems:**

CVS	Refer to history of present illness.
Respiratory	He has no cough, no hemoptysis, no wheezing but he complains of SOB.
Gastrointestinal	He has normal bowel movement (with no diarrhea or constipation). There is some loss of appetite but no heartburn, no hematemesis and no dysphagia.
Genitourinary	There is no difficulty in urinating or hematuria. There is no urgency and no incontinence.
CNS	No syncope, no seizures, no difficulties in walking, no visual disturbances or hearing loss
Musculoskletal	No joint pain, no back pain, no stiffness or joint swelling.
Endocrine	There is no excessive sweating, no heat or cold intolerance

- **Physical Exam:**

General	• Patient is conscious, alert, not in pain but tachypneic. He is connected to an IV line, nasal cannula, pulse oximetry and ECG leads with pressure cuff.
Vital signs	• Temperature: 36.9 C • Pulse: 68 beats/ minute, regular and with normal volume. There is no radio-radial or radio-femoral delay. There is no collapsing pulse. • Blood pressure: 138/95 mmHg • Respiratory rate: 24 breaths/ minute.
Skin	• There is no skin rash, no ulcers, no scars, no lesions and no bruises or discoloration.
Eyes	• There is no squint, no jaundice, no pallor and no conjunctivitis or secretions.
Ear/ nose/ mouth/ throat/ neck	• No positive findings except for mild use of accessory muscles of the neck. There is no central cyanosis, no glossitis, no ulcers in the mouth. Mucous membrane is moist and there is good dental hygiene.
Respiratory	• Inspection: chest is symmetrical, moving with respiration, with no deformities no scars and no rash or discoloration. • Palpation: trachea is centrally located and there is normal chest expansion (more than 5 cm). • Percussion: resonant. • Auscultation: normal air entry to both lungs, vesicular with no detectable added sounds.
Cardiovascular	• Inspection: no peripheral cyanosis, no clubbing, no tobacco staining, no xanthomata or endocarditis lesions. Patient has no xanthelasmata, no corneal arcus and no central cyanosis. He has normal JVP. • Palpation: apex beat was felt in the 5^{th} intercostals space at the mid-clavicular line. Patient has no thrills and no parasternal heave. • Auscultation: normal S1 and S2 with no murmurs.
Gastrointestinal	• It is soft with no tenderness or palpable masses. There is no organomegaly and it is tympanic with percussion.
CNS	• Intact with normal tone, power and sensations.

- **Investigations:**

RBCs	4.41 x 10^{12}/L
HGB	139 g/L
Hct	0.41 L/L
MCV	93.2 fL
RDW	12.7%
Platelets	184 x 10^{9}/L
Neutrophils	49.2%
Lymphocytes	34%
Monocytes	12.4% (increased)
Eosinophils	3.4%
PT	15 seconds
INR	1.14
APTT	> 180 (increased)
Blood sugar	16.4 mmol/L (increased)

Troponin I	0.011 µg/L
CK	588 IU/L (increased)
CK-MB	64.5 IU/L (increased)
Cholesterol	2.84 mmol/L (decreased)
TG	0.55 mmol/L
LDL	1.50 mmol/L
HDL	1.11 mmol/L
Na	137 mmol/L
K	4.61 mmol/L
Urea	8.2 mmol/L
Creatinine	107 µmol/L (increased)
Ca	2.31 mmol/L
Mg	0.88 mmol/L

Total protein	73 G/L
Albumin	38.6 G/L
Globulin	34.4 G/L

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Bilirubin (total)	7.8 µmol/L
Bilirubin (direct)	1.8 µmol/L
Bilirubin (indirect)	6 µmol/L
ALP	53 IU/L
ALT	35.2 IU/L
GGT	32 IU/L

- ✓ ECG:
  - ❖ *Rate*: 66 beats/ minute.
  - ❖ *Rhythm*: regular/ sinus rhythm (P-wave is present in inferior leads and followed by QRS complex).
  - ❖ *Axis*: normal axis.
  - ❖ *P-wave*: normal.
  - ❖ *PR interval*: normal (4 small squares).
  - ❖ *QRS complex*: narrow.
  - ❖ *There is ST-segment depression in leads V3, V4, V5 and V6*

- **Assessment and plan:**
  - Summary: A.E.A is a 68 years old Bahraini male who was admitted to BDF Hospital with a history of retrosternal chest pain of 1 hour duration. Chest pain came at rest, was felt as heaviness, radiating to back and both shoulders and not relieved by rest or sublingual NGT. Patient also had SOB, nausea and palpitations. A.E.A has hypertension, type-2 diabetes and dyslipidemia. He is not a smoker and does not consume alcohol. He had no previous admission to the hospital with same complaint and has no history of cardiovascular disease or previous heart surgery.

  - On examination of his chest, no abnormalities were detected. Apex beat was felt over the 5^{th} ICS at the MCL. Patient has no thrills or parasternal heave. Heart sounds (S1 and S2) are normal with no murmurs. Laboratory investigations showed increased monocytes (12.4%), APTT (>180), blood sugar (16.4 mmol/L), CK (588 IU/L), CK-MB (64.5 IU/L) and creatinine (107 µmol/L). ECG showed regular sinus rhythm with NSTEMI in the following chest leads: V3, V4, V5 and V6.

- Emergency management for this patient (MONACO):
  - ✓ M: Morphine.
  - ✓ O: Oxygen.
  - ✓ N: Nitroglycerin.
  - ✓ A: Aspirin.
  - ✓ C: Clopidogrel.
  - ✓ O: Others (heparin).

  After patient is stabilized he will undergo catheterization to open his arteries.

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