CASE PRESENTATION
ACUTE CHEST PAIN (ANGINA)

DR. EMOTU SOLOMON
MEDICAL DOCTOR
JINJA RRH

- Mr H.J, 43 y/M, known hypertensive on unknown medication (no documentation), not diabetic, presented with c/o left sided chest pain 2 hrs prior to hospital arrival.
- Reports woke up with excruciating chest pain of sudden onset, squeezing in nature, radiating to the ipsilateral neck, shoulder, upper arm; worsened with minimal exertion,- WALKING; no known alleviating factors.
- a/w SoB- fast breathing, no cough /fever/ dyspepsia/vomiting
- Background h/o EtoH use, however, does not smoke cigarette or any other substance of abuse, no h/o trauma to the chest.

Primary survey

Airway	**PATET** **PT Able to talk**	
Breathing	RR-32cpm,SP02-94% RA Chest is symmetrical, Bilateral equal air entry, no added sounds normal percussion	Oxygen therapy-NP-SPO2-99%-100%
Circulation	Normal JVP no pallor no edema. brachycardia 44 bpm thready pulse, BP=80/40mmHg, CRT >3s	2 IV large bore cannulae Iv fluids 1.5l N/s Blood samples taken:-CBC, D-DIMER, lipid profile, GXM, Troponin, RBS, H.pylori Ab Serum electrolytes

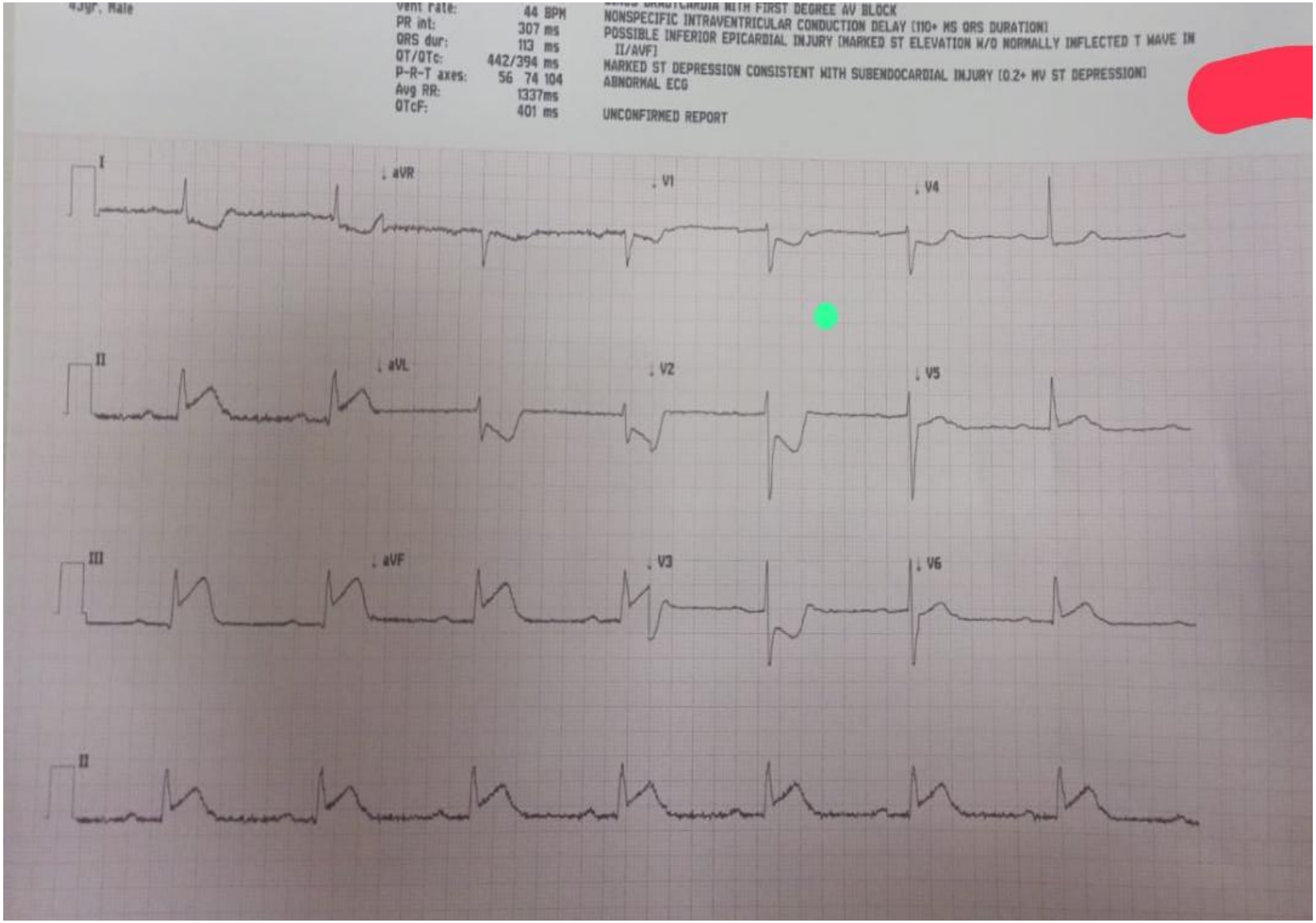
Disability / Drugs	**Anxious and restless in pain oriented in T.P.P. RBS-5.4mMol/L**	**Iv Morphine 5mg, PO Clopidogrel 300mg, PO M/ASA 300mg PO Ranolazine 500mg, PO Atorvastatin 40mg iv Omeprazole 40mg iv hydrocortisone 200mg,**
Exposure	Abdomen-normal fullness, soft , no palpable organomegaly	
ECG	ATTACHED BELOW	**PO Clopidogrel 300mg, M/ASA 300mg, Ranolazine 500mg, Atorvastatin 40mg iv Omeprazole 40mg iv hydrocortisone 200mg,**

S	Signs and symptoms	left sided chest pain FAST BREATHING
A	Allergies	None
M	Medications	Antihypertensive(unknown) >12hrs ago
P	Past medical history	Known Hypertensive, Index admission with similar complaints.
L	Last meal	Supper- 3 Hours Ago
E	Events	Was ASLEEP NO h/o trauma

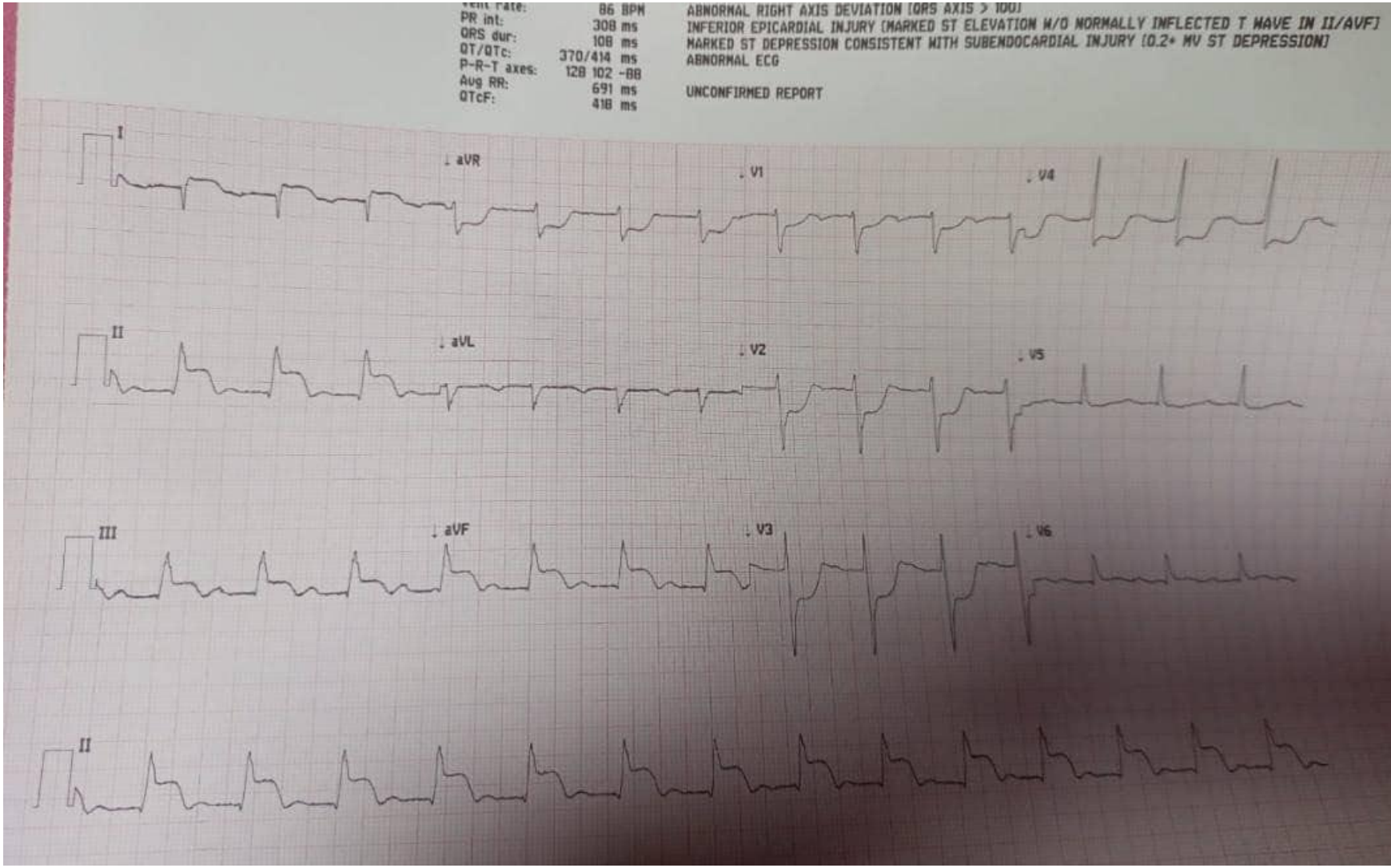
Follow- up after 30 mins

Airway	Patent	
Breathing	RR- 29cpm Equal chest excursions normal air entry bilaterally SPO2-100%	Tapered O2 therapy
Circulation	BP-100/65mmHg,PR-46-50, CRT-2-3s	INR/PT Done
Disability /Drug	Still in pain, restless	Physician informed Iv TNK 40mg
ECG	Serial ECGs done q 30 mins	Physician REVIEWED

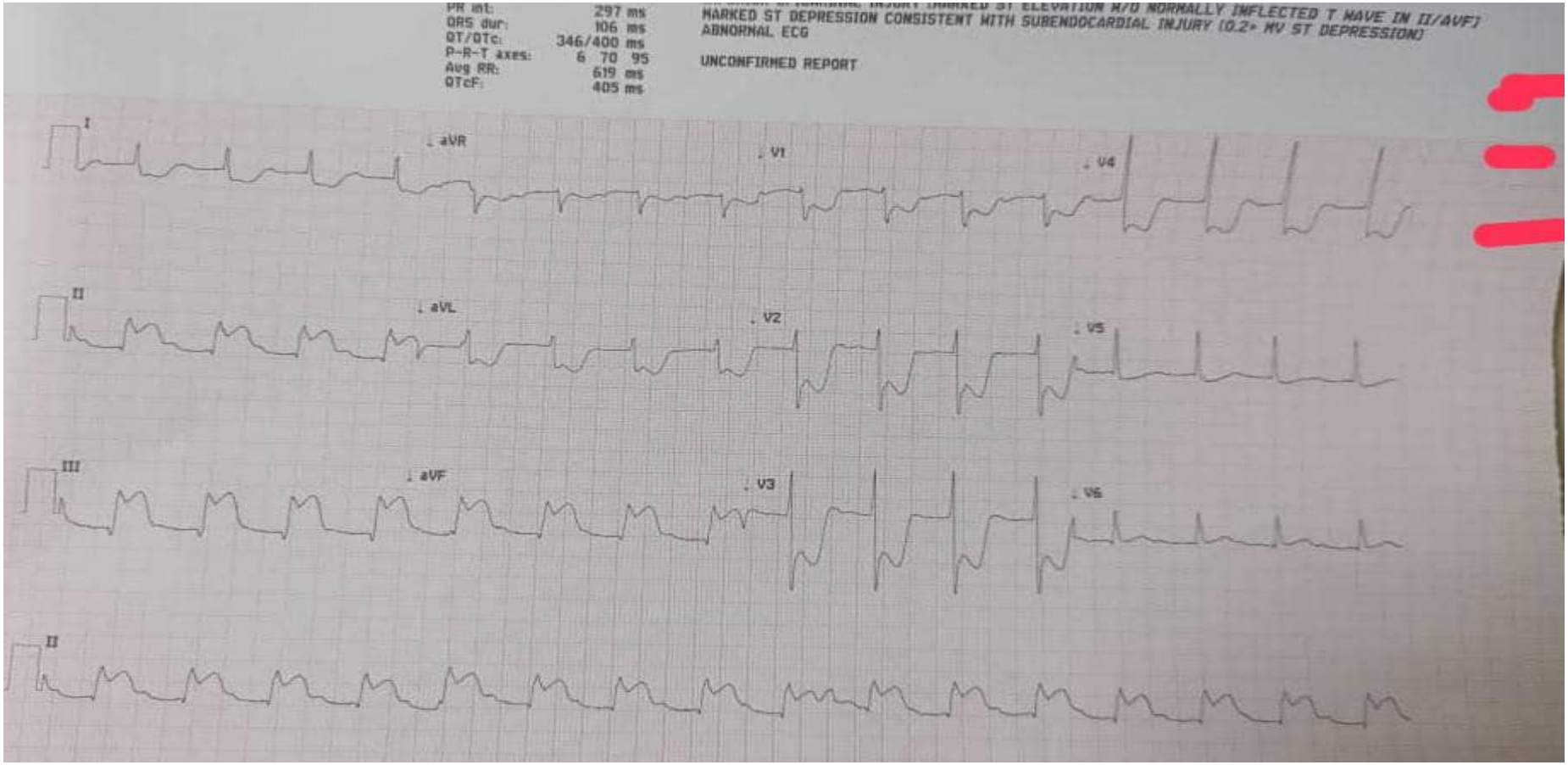
ADMISSION EKG



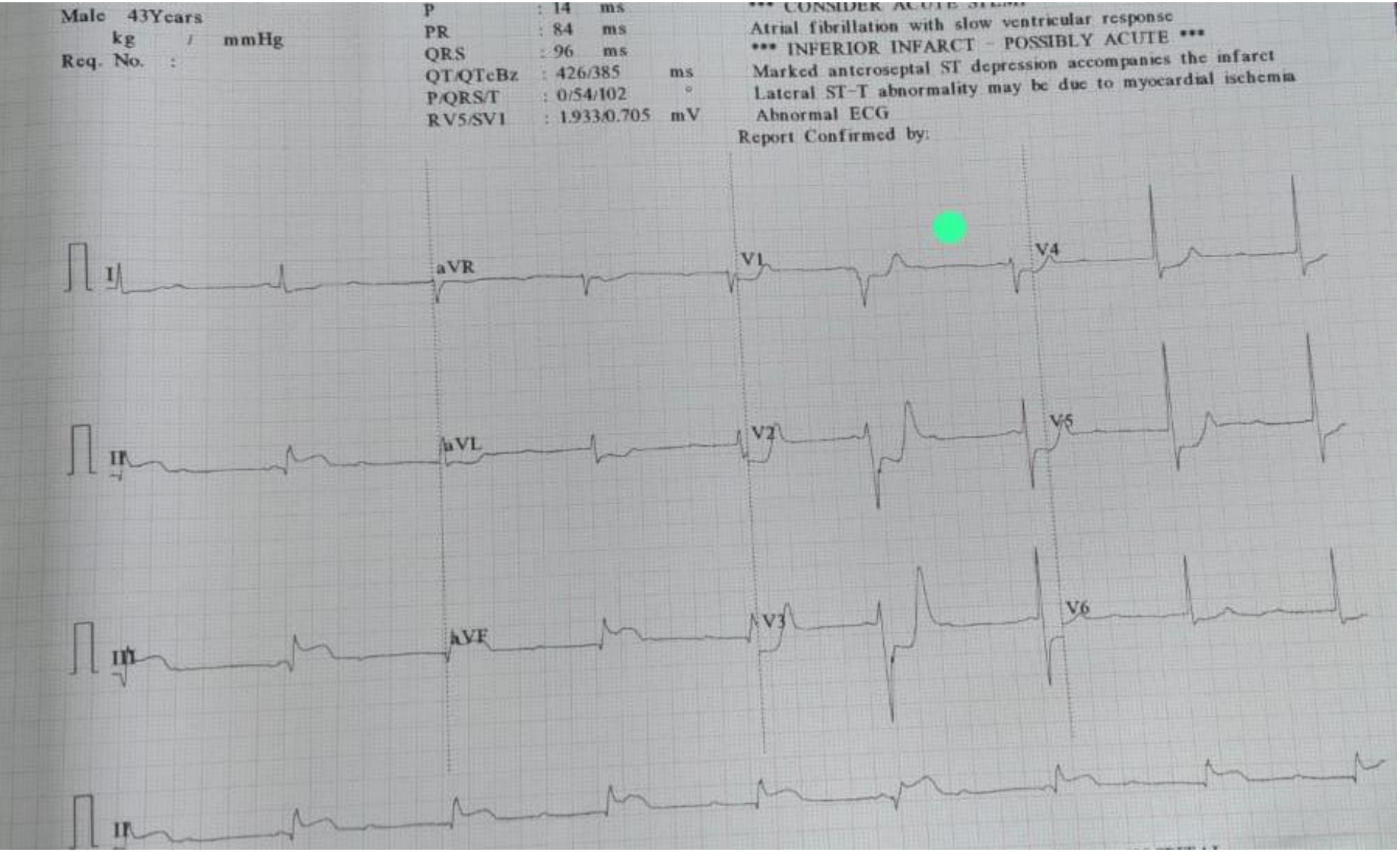
Post Lytic Therapy With TNK



REFERRAL EKG



Post PCI EKG


Male 43Ycars
kg / mmHg
Req. No. :
P : 14 ms
PR : 84 ms
QRS : 96 ms
QT/QTcBz : 426/385 ms
P/QRS/T : 0/54/102 °
RV5/SV1 : 1.933/0.705 mV
Atrial fibrillation with slow ventricular response
*** INFERIOR INFARCT - POSSIBLY ACUTE ***
Marked anteroseptal ST depression accompanies the infarct
Lateral ST-T abnormality may be due to myocardial ischemia
Abnormal ECG
Report Confirmed by:
I
aVR
V1
V4
II
aVL
V2
V5
III
aVF
V3
V6
II

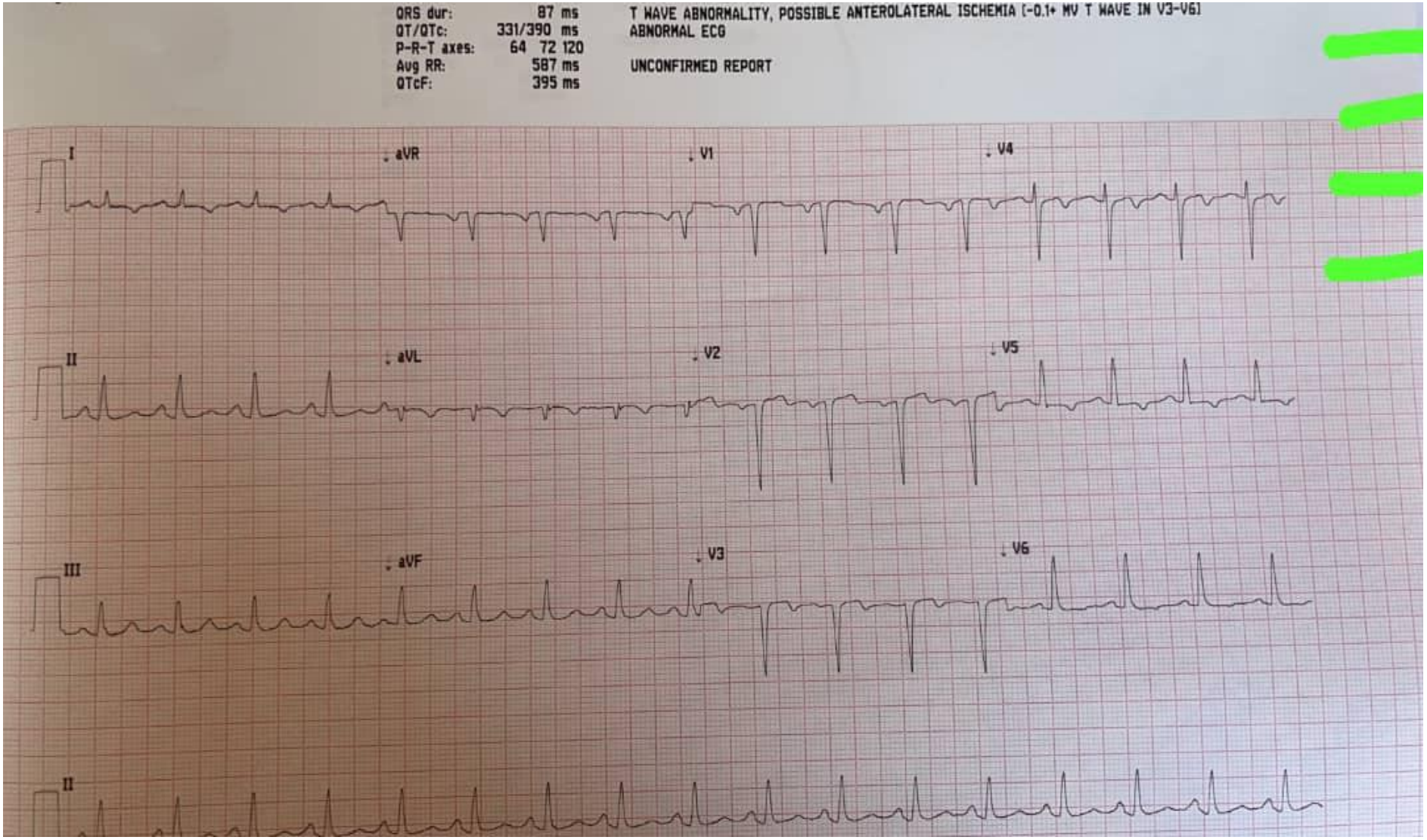
Problem list

- Acute ischemic heart disease/ ACUTE ANGINA PECTORALIS
- STEMI
- 1^{ST} DEGREE AV BLOCK
- CARDIOGENIC SHOCK

Follow up

- **PATIENT REFERRED TO UHI FOR PCI**
- **FEEEDBACK FROM CATH LAB DR**:
  - PCI DONE- RCA OCCLUSION,
  - PATIENT DEVELOPED PAH WHILE IN- PATIENT
  - HAD CARDIAC ARREST (VF) DUE TO HYPERACUTE STENT THROMBOSIS-SHOCKED TO REVERT TO SINUS RHYTHM
  - RCA STENTED WITH 2 STENTS
  - DISCHARGED

FOLLOW-UP EKG AFTER APPROX 1YEAR



- THANK YOU

  - EYALAMA