# Case 1, Patient Name: Jerry Tylor

## Situation:

A 56-year-old male with a history of presents to the emergency department with sudden onset of severe chest pain.

## Background:

PMHX: hypertension and type 2 diabetes.

Medication : metformin 1000 mg twice daily, lisinopril 20 mg once daily.

Events: While In the gym 2 hours ago, he developed sudden onset central chest pain, heavy in nature , Radiating to his left arm. It was relieved by rest and GTN given to him by the ambulance crew.

This was associated with SOB and sweating.

## Assessment:

His vital signs are BP 180/110, HR 110, RR 24, SpO2 95% on room air, and Temp 36.6C. Physical exam reveals diaphoresis, cool extremities, and distant heart sounds.

Chest examination was clear.

Cardiac: Normal heart sounds with no lower limb edema, and his JVP was Normal.

Abdomen : soft lax.

ECG: showed ST elevation on the inferior lead II, III aVF

Differential diagnosis: Acute Myocardial Infarction (AMI).

## Recommendation:

1. FBC clotting UE, LFT , Troponin.
2. Two nitro-glycerine sublingual puffs+aspirin 300 mg.
3. Contact cardiology team for PCI(Percutaneous Coronary Intervention).