

Case Histories 2008

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Case 1: Chest Pain

- Male aged 53
- Comes to see you because of 1 hour of chest discomfort at rest last night. Developed at 2200 when he lay down to go to sleep. Made him feel anxious. The discomfort described as a dull ache in the lower chest and epigastrium. Associated with belching. Had a glass of milk – didn't make any difference, eventually settled. No sweating or SOB. No past history of reflux.

Case History 1 - continued

- Currently pain free, feeling fine.
- Past history, mild hypertension on accupril 5mg, gout on allopurinol 300mg.
- Lipids 2003, TC 5.7, HDL1.0, TG 1.7, LDL 3.4 Ratio 5.7.
- Family History Positive – father MI at 59, still alive
- Non Smoker
- Examination BP150/95, central obesity, waist 107cm weight 108kg,

Case History 1 - Options

1. Send him immediately to hospital, if so by car or ambulance
2. Do an ECG then decide what to do
3. Send blood off for troponin
4. Prescribe ASA and a B Blocker and nitro spray
5. Give him Losec
6. Refer him for an outpatient appointment

Rational Thought Process

- What is the chance that this patient has IHD irrespective of the presenting complaint- "how many risk factors are there" – age, sex, smoking, diabetes, dyslipidaemia, hypertension, family history,
- Can I confidently say this chest pain is not cardiac, "how typical is it"

Case History 1- actual management

- Probably GI.
- Concerned because of intermediate in risk for IHD (poor ratio, HT, Fhx)
- ECG normal
- Bloods including Troponin n, glucose 6.9
- Given Somac 40mg and cartia
- Referred for semi-urgent ETT

Specialist Findings

- Further 45 mins of pain overnight
- ECG normal
- Admitted to CCU
- Troponin 0.05. TC 5.9, HDL 1.0 LDL 4.2
- Angio – single vessel LAD lesion, 1 drug eluting stent
- Given Plavix, B Blocker, statin and Aspirin, already on ACE and allopurinol

Case 1 – post hospital treatment

- Sees you 3 weeks after hospital discharge, not happy – taking 6 tablets and never felt worse, a few drinks each night
- Complains of itchy rash over entire body, feels a bit tired
- Body generally stiff, joints ache a bit
- Depressed about having heart trouble
- No further chest pains

Case 1- Post stenting

- Meds- accupril 5mg, Cartia, lipex 40mg, Plavix 75mg, metoprolol 47.5mg, allopurinol
- BP 145/90
- Weight 110kg
- Lipids TC 4.2, HDL 1.0 LDL 2.6
- LFT's AST 59, ALP 100 GGT 170
- Glucose – fasting 8.6

Case 1 - Issues

- Rash
- Fatigue, general body ache, depression
- Lipid Management, diet
- Blood pressure management
- Glucose

Actual Management

- Specialist contacted about rash, changed to ticlopidine, plavix stopped
- Switched to lipitor 40mg,
- Changed to cilizapril 2.5mg
- Referred to dietitian
- Encouraged to walk
- told to stop drinking, LFTs to be checked in a week

Follow up 1 week later

- LFTs better, GGT 65, others enzymes normal
- Glucose 6.4
- Rash resolved
- BP 150/95
- Painful R great toe treated with diclofenac 100mg by A and E clinic
- Waiting to see dietitian

Case 2 – Lipid Management

- Female aged 64, non smoker, BP normal, no family history
- Fibromyalgia longstanding
- NON STEMI NSH 2004, stent to LAD other arteries OK
- On Cartia, Betaloc 47.5mg, Lipex 40mg
- Complains of excessive fatigue, muscle aching worse than previously
- Lipids TC 4.1, HDL 1.5, LDL 2.6. LFTs normal CK normal, FBC and thyroids OK, ESR 11,
- Feels her medications are responsible for her problems
- ?? management

Case 2 - Management

Would you

1. Stop her B Blocker, ?slowly or abruptly
2. Stop her Lipex ? Slowly or abruptly
3. Increase her Lipex
4. Change to Lipitor
5. Leave her meds alone and reassure her it is the Fibromyalgia
6. Other ? Vitamins

Case 2 – Actual Management

- Betaloc halved for 2 weeks, no better, so stopped altogether. After 2 weeks no better so Betaloc restarted.
- Lipex stopped and felt much better after 1 week
- Applied for Lipitor and started 3 weeks later in a dose of 20mg. TC 7.1 prior to starting.
- After 1 week worse than ever severe muscle aches – patient stopped Lipitor.

What would you do now

Case 2 – Further Management

Would you

1. Give up on Lipid treatment
2. Start Bezalip
3. Try nicotinic acid
4. Seek specialist approval for Ezetrol

Case 2 – Actual management

- Bezalip 400mg prescribed.
- Patient felt reasonably well
- Lipids after 3 months TC 6.1 LDL 4.6 HDL 1.4, LFTs OK

?Management

Case 2 – Management Options

Would you

1. Continue Bezalip alone
2. Add questran
3. Add nicotinic acid
4. Add a statin again in low dose
5. Send/contact a cardiologist for help

Case 2 – Actual management

- Persuaded patient to try Lipex 10mg
 - After 1 week increasing muscle aches
 - Lipex stopped
 - Specialist contacted
 - Applied for Ezetrol
 - 10mg prescribed and Bezalip stopped
 - Lipids 1 month later, TC 5.9, LDL 4.0, HDL 1.4, patient felt well
- ? What would you do

Case 2 – management options

Would you

1. Accept this result and continue Ezetrol alone
2. Add Bezalip or Questran
3. Add 5mg of Lipex
4. Prescribe Coenzyme Q10

Case 2- Actual management

- Coenzyme Q10 100mg
- Lipex 5mg increased after 1 week to 10mg
- Lipids after 1 month, TC 4.0, HDL 1.4, LDL 2.5
- Patient feels well

Would you increase her meds further?

Actual Management – Case 2

- Lipid treatment not changed
- Felt the risk of causing side effect at higher dose of statin “not worth it”
- 3 monthly monitoring for 1 year then 6 monthly after that.

- Female Aged 50, Asymptomatic, Non Smoker, Family History positive (mother died at 62 of IHD), BP 150/90, glucose – normal, slim, athletic. Post menopausal. Diet low in fat

TC- 6.0

LDL 3.9

HDL 2.0

TG – 0.7

Ratio 3.0

Should she have lipid-lowering therapy? ?

- Male aged 55, central obesity, hypertension treated with inhibace 5mg, gout treated with allopurinol 300mg, Non smoker. Physically inactive. No cardiac history

TC 5.1

HDL 0.7

LDL 3.1

TG 3.4

? Approach to treatment.

- 66-year-old retired man very concerned about his general health. Normal PSA, normal colonoscopy. Wants his heart checked. Has read about new tests for heart disease. He has borderline BP measurements. Family history positive for stroke in older age. Requests a full blood check.

TC 5.4
HDL 1.3
LDL 3.1
TG 0.7
Ratio 4.1

Lpa 485 (n<300)
Homocysteine 11
CRP > 3.0 (upper quartile)

How would you manage him and explain the results

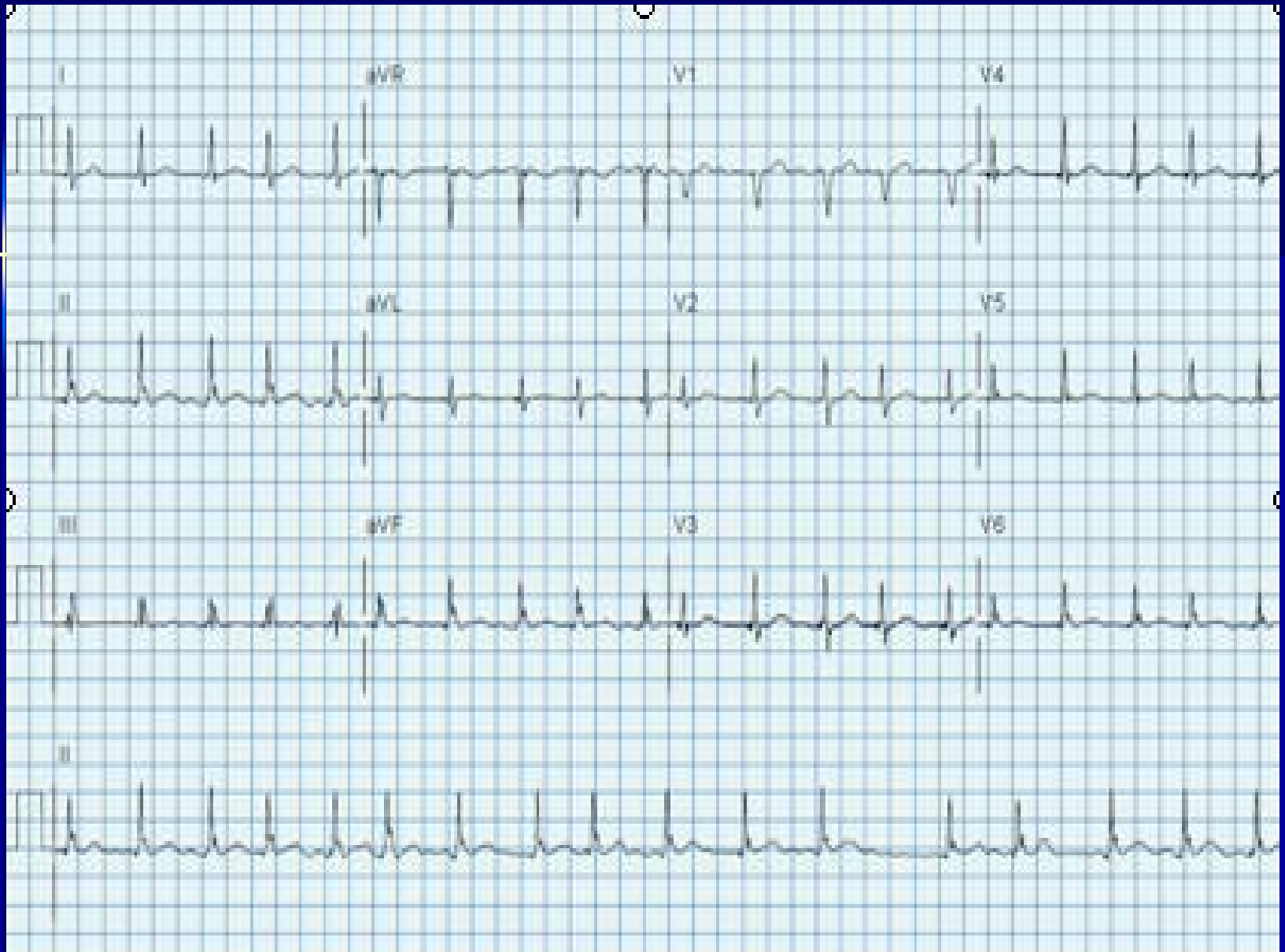
- 73 year old. CABG twice. NIDDM, hypertension, COPD.

Meds Betaloc 97.5mg, accupril 20mg, cartia, allopurinol, Losec, Vioxx, Frusemide 40mg, Lipex 80mg, combivent.

Bloods – Creat 0.16, Hb112,
TC 4.2,
LDL 2.8,
HDL 1.3

Case 3 – A Patient with an URTI

- Male aged 65 attends with an URTI and you notice his pulse is irregular.



Case 3 – Atrial Fibrillation

- He admits to being tired over the last year but puts this down to his job and other stresses
- BP borderline, no family history of heart disease, stopped smoking 15 years ago, drinks 1-2 beers and a whisky most nights, more at the weekends.
- On dosan for BPH and Voltaren 100mg once daily for osteoarthritic back pain (well controlled). Back assessed by Mr. Howie 12 months earlier.
- Previous blood tests 18 months ago were all normal (PSA, FBC, TFTs, glucose, renal and liver function)
- You send him to the lab for repeat blood including TFTs

How would you manage him?

Case 3 – Possible management

Would you

1. Prescribe an antibiotic and review in 2 weeks
2. Refer urgently to hospital
3. Prescribe warfarin or aspirin
4. Prescribe a beta blocker
5. Tell him to stop alcohol
6. Refer him to for an outpatient appointment

Case 3 – actual management

- Given augmentin and asked to return in 3 days
- Given Cartia
- Told to stop drinking
- Referred to private cardiologist – appointment in 1 week

- 3 days later feeling better (URTI), bloods showed HB of 131, comment - occasional hypochromic cells. All other tests normal
- Pulse 80 and irregular.
- Had cut down to 1 beer per day

Case 3 – Possible Management

Would you

1. Prescribe warfarin
2. Prescribe B Blocker
3. Prescribe a Proton Pump Inhibitor
4. Phone consult with cardiologist
5. Give no treatment except the ASA already prescribed and wait for the Outpatient appt

Case 3 – Actual Management

- Reassured and continued on aspirin
- 3 days later your nurse called by patients wife- in NSH having collapsed at the RSA.
- Discharged after 3 days
- Discharge note – HB 97 on admission, extensive superficial gastritis on gastroscopy;
- Voltaren stopped, aspirin stopped, on Losec 40mg and ferrogradumet. Diltiazem 90mg bd prescribed. Told to have a blood test in 1 week then for a check with GP. OPC echo ordered with clinic follow up in 8 weeks.

Case 3 – GP follow up visit

- Feeling awful, not drinking alcohol at all
- Pains in knees and back (from OA), can hardly walk
- Tired, a bit short of breath
- HB 113 g/l
- Pulse 100 and irregular.

Case 3 – Possible management

Would you

1. Prescribe regular panadol
2. Prescribe Celebrex
3. Send to hospital for ?blood transfusion
4. Arrange for private cardiologist ASAP
5. Wait for hospital Cardiologist

Case 3 – Actual management

- Given panadol
- Told might as well go with the public hospital system
- Given sickness form for job – off for a month
- Further blood test in 2 weeks arranged

- 2 weeks later HB124, feeling better, still having a lot of back pain, taking 10 panadol per day.

Case 3 – Actual Progress

- Went back to work at 1 month, but limited by back pain
- Echo at 6 weeks showed mild left Atrial enlargement, otherwise normal
- Saw registrar at NSH who ordered a gastroscopy but made no other changes
- Gastroscopy normal, HB 148 g/l – advised to avoid NSAID's and continue on Losec indefinitely.
- Cardiology opinion "risk of stroke reasonably low, best to stay on Diltiazem and Losec, restart cartia". Cardioversion not indicated.

Case 3 – Actual progress

- Seen for repeat of meds 6 weeks after gastroscopy
- Still struggling with back pain, wants Voltaren again because “it worked”, Sick of taking Panadol. Feels depressed, struggling at work,
- Feeling a bit tired, not doing much exercise
- Drinking a few beers to help him relax
- Pulse 95 at rest, BP 160/100.

Case 3 – Possible Approaches

- Prescribe Celebrex
- Stop him drinking altogether
- Prescribe warfarin to prevent stroke
- Treat his BP with a B Blocker
- Refer to hospital or private cardiologist for another out patient appointment.

Case 3- Actual management

- Seen by WMJ 1 week later
- On Panadol for joint pains, Diltiazem 90bd and cartia for AF, Dosan for BPH.
- Main complaint was back and knee pain, some fatigue and SOB but didn't exercise much
- Examination normal except for AF at 90/min and BP 170/105 (anxious)
- Echo – as per NSH, LA 4.2, otherwise normal
- ETT, HR increased to 155 after 3 mins and stopped with fatigue and SOB. No ST changes

Case 3 – Specialist Management

- Options of Cardioversion versus rate control discussed, avoiding long term warfarin important. Long discussion about alcohol – according to wife, drinking a lot more than admitted to his Dr.
- Heart rate poorly controlled on Diltiazem.
- Changed to metoprolol 47.5mg, warfarin started, ASA stopped, TOE guided Cardioversion performed after 6 days with restoration of sinus rhythm. Warfarin stopped after 3 weeks, Betaloc and Cartia continued, maintained on Losec long term.
- Still complaining of back pain – changed to Celebrex 200mg then 400mg, back not that much better and finally changed to Brufen 800mg- much better,
- Remains in sinus rhythm on Betaloc/Cartia.