Case Study for Wessex Conference November 2009

Mrs GT, 75 years old
Admitted to the medical assessment unit via A&E with severe central chest pain

HPC Gradual onset of severe central chest pain, started at 4am
Pain radiated down both arms, not relieved by GTN spray in ambulance

PMH Hypertension, hiatus hernia

SH Lives at home with husband, smokes 15 cigarettes per day and drinks 10 units of alcohol a week

DHx Bendroflumethiazide 2.5mg OM
Omeprazole 20mg OM
Amlodipine 5mg OM

OE Pulse 46 bpm, BP 120/98mmHg
ECG shows ST depression
Mild ankle swelling

Blood results:
Na 138mmol/L (135-145)
K 4.5mmol/L (3.5-5)
Cr 120 micromol/L (50-125)
Cholesterol 5.5mmol/L (<5)
Blood glucose 16.2mmol/L (4-11)
Troponin I raised

Diagnosis: NSTEMI

1. What initial drug treatment should the patient be prescribed and what changes should be made to Mrs GT's regular medication?

2. What secondary prevention medication should be given and why, and what lifestyle changes should be advised?

3. What potential interactions should be considered?

The patient is stabilised and her pain managed appropriately. The following day she is taken to the catheter lab and two stents are inserted into her coronary arteries. She is discharged home three days later.

The patient recovers well and has no further chest pain. Three months later she is readmitted to hospital with severe central chest pain, raised troponin I and ECG changes. Stent thrombosis is diagnosed.

4. What drug treatment could be prescribed and at what dose?

The patient is again stabilised and managed appropriately with medication. Unfortunately though she develops acute atrial fibrillation (AF)

5. What drug should be prescribed to manage this and how should it be administered?

6. The patient continues to be in AF, what implications does this have for her current drug treatment and what possible changes will the team make?