Case Study – 3 & 4

A 40-year-old male patient presents to your consultation today for chest pain that started 24 hours ago. The patient does not have any PMH of cardiovascular disease. Pt is non-smoker.

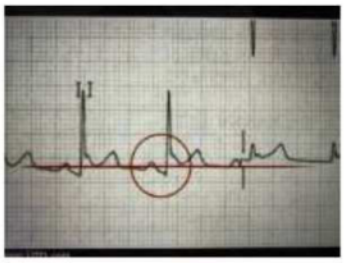
Vital Signs:

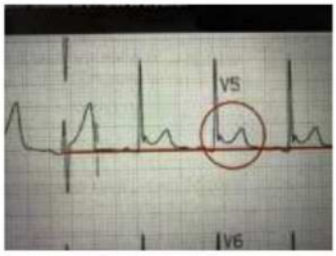
Tº: 97.8 Pulse 105 B/P 140/90 O2 Sat 98-99% Pain 10/10 (Chest)

HPI: Pt states the chest pain started 24 hours ago, but it has been increasingly more painful in the last hours. Pain worsens when he lays down and relieves a little bit when he sits down. During the last couple of hours, he could not breathe well and started feeling SOB and decided to come to the clinic.

Pt states the chest pain is constant and worsens when laying down. It feels as if he had something "sharp in his chest. On the heart auscultation, you instructed your patient "not to breathe. Then you notice a "rhonchi" sound, but this sound is not coming from the lungs because you have instructed the patient *not* to breathe. Lungs are clear bilaterally.

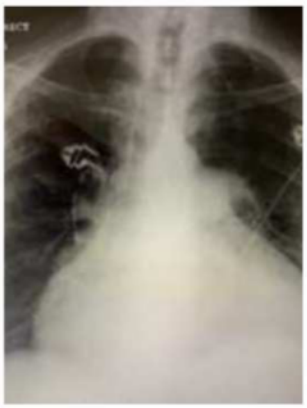
Then, you order an EKG and Chest X-ray, with the following results:





EKG Report: slight elevation of the ST segment with a positive T wave and a decrease in the PR segment

A Chest X-Ray result:



Chest X-Ray Report: Lungs clear bilaterally, no signs of consolidation

Based on the information collected, **please answer the following questions:**

1) What would be the initial diagnosis for this patient?

2) Please mentioned the 4 (four) most important elements that support the diagnosis mentioned above.

3) What diagnostic test, including labs, would you order to establish the vital risk of this patient?

4) What EKG changes have you noticed (in the strip presented above) that support your initial diagnosis?

5) How would you treat this patient? Inpatient (in hospital) or outpatient? Please provide the rationale for your answer.

6) What would it be the initial treatment for this patient? Please provide the rationale for your answers.