

MINISTRY OF EDUCATION AND SCIENCE OF THE KYRGYZ REPUBLIC

Osh International Medical University


Department of Clinical Disciplines

Department of Therapeutic Specialties Programs

REVIEWED

At the department meeting, protocol No. \_\_\_\_\_

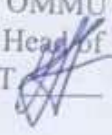
From "27" 11 2024

Department, Nurlanova N.N. 

APPROVED

Chair of the UMS OMMU

Pr No. 3 dated 20/11 2024 Head of

Toktonazarova N.T. 

EXAMINATION STATION PASSPORT

"Acute myocardial infarction"

Discipline: Therapy

Compiled by: Sadikova G.

2024

## Cardiology Station

### Materials and equipment for the station:

1. Pulse oximeter
2. Blood pressure monitor
3. Stethoscope
4. ECG

### Clinical case

A 65-year-old man was admitted to the emergency room complaining of intense, sometimes unbearable burning, constricting, and distending pain behind the breastbone, radiating to the precordial region, left arm, interscapular space, and lower jaw, accompanied by motor restlessness, shortness of breath, weakness, cold sweat, and shortness of breath when walking. He has suffered from hypertension for the last 20 years. Maximum blood pressure up to 220/120 mmHg. Heart rate 98. He does not take antihypertensive medication regularly (larista, bisoprolol, and thrombo-pol). Periodically, over the last 2 years, he has been bothered by pain and heaviness in the chest. He did not pay particular attention to this.

Objectively: skin is cold to the touch, condition is serious, breathing is labored, moist rales in the lower sections of the lungs. Respiratory rate is 23 per minute. Cervical veins are slightly swollen, heart sounds are sharply muffled, rhythmic, heart rate is 98 per minute. Blood pressure 160/100 mm Hg. Abdomen soft and painless. Stool and diuresis regular. The latest deterioration in condition occurred after severe psycho-emotional stress. What is your next step?

You have 10 minutes to collect a focused medical history, conduct a focused examination, and prescribe treatment. 1. Standardized patient assessment sheet.

Resident \_\_\_\_\_ Year \_\_\_\_\_

№	Stages	Mark of completion		Patient response and action
		Points	Points	
<b>A true medical case history. The examinee.</b>				
1.	Did the examinee ask what complaints the patient had?	0-1		Burning, constricting, bursting pains behind the breastbone radiating to the precordial region, left arm, interscapular space, lower jaw, accompanied by motor restlessness, shortness of breath, weakness, and cold sweat.
2.	Did the examinee ask when they got sick?	0-1		The patient has considered himself ill for 20 years.
3.	Did the examinee ask what kind of pain they were experiencing?	0-1		Yes, burning, constricting, and distending.
4.	Did the examinee ask what they thought was causing the illness?	0-1		After severe psycho-emotional stress.
5.	He asked if there was shortness of breath and heart palpitations.	0-1		Yes
6.	Did the examinee ask what medications he was taking?	0-1		larista, bisoprolol, and thrombo-pol
<b>Physical examination. The examinee.</b>				
7.	Did the examinee wash their	0-1		Yes

	hands before and after examining the patient?			
8.	Did the examinee assess the patient's general condition?	0-2		Yes
9.	Did the examinee examine the skin?	0-2		Cold
10.	Did the examinee give the patient a thermometer to measure their body temperature?	0-2		Yes. Temperature 36.5°C
11.	Did the examinee assess the condition of the respiratory organs? Did the examinee listen to the lungs with a stethoscope and count the respiratory rate?	0-2		Breathing is labored in the lungs, with moist rales in the lower sections and isolated dry scattered rales. RR 24
12.	Did the examinee palpate the heart area and determine the boundaries of relative cardiac dullness using percussion?	0-2		The borders of relative cardiac dullness are enlarged upward and to the right
13.	Did the examinee listen to the heart? Heart sounds and murmurs. Heart rhythm, heart rate, pulse, blood pressure.	0-2		Respiratory rate 23 per minute, heart rate 98 per minute. Blood pressure 160/100 mmHg
14.	Did the examiner perform percussion and palpation of the liver?	0-2		Percussion reveals no enlargement of the liver.
	<b>Laboratory tests.</b>			
15.	Complete blood count (CBC). Rheumatology tests.	0-3		<b>Complete blood count:</b> 1. Accelerated ESR (erythrocyte sedimentation rate); 2. Total cholesterol 8.5 mmol/L. LDL-2.2 mmol/L. 3. Blood troponin 8.6 mmol/L.
16.	ECG	0-3		On ECG: Sinus rhythm, heart rate 98 beats per minute. Normal EOS position. ST segment elevation V1-V3. ST segment depression in leads II, III, AVF.
17.	Echocardiogram	0-3		Hypokinesis of the anterior septal, apical anterior, and apical septal walls of the LV.
18.	Chest X-ray	0-3		Signs of chronic bronchitis.
	<b>Communication skills. The examinee.</b>			
19.	Greeted and introduced himself? Said goodbye?	0-1		Yes
20.	Asked permission to examine him?	0-1		Yes, the patient agreed.
21.	Did the examinee inform the patient of the preliminary diagnosis, possibly rheumatic heart disease with damage to a specific valve?	0-5		ACS with ST segment elevation.
22.	Did the examinee explain the consequences if the patient does not undergo dispensary observation?	0-1		Worsening of heart failure symptoms.
23.	Did the examinee discuss further treatment tactics (conservative or surgical treatment)?	0-5		Initial stabilization of condition, then PCI.

Did the examinee explain the consequences of not undergoing treatment?

0-4

Yes. Since there is a risk of serious complications such as cardiogenic shock and ventricular fibrillation.

**TOTAL:**

*If the examinee scored:*

45-50 points - "excellent"

36-44 points - "good"

26-35 points - "satisfactory"

25 points and below - "failed"

Observer's full name and signature \_\_\_\_\_

Date and time \_\_\_\_\_

**Patient history:** A. 63-year-old man was admitted to the emergency room complaining of intense, sometimes unbearable burning, constricting, and distending pain behind the breastbone, radiating to the precordial region, left arm, interscapular space, and lower jaw, accompanied by motor restlessness, shortness of breath, weakness, cold sweat, and shortness of breath when walking. He has suffered from hypertension for the last 20 years. Maximum blood pressure up to 220/120 mmHg. Heart rate 98. He does not take antihypertensive medication regularly (Iarista, bisoprolol, and thrombo-pol). Over the last two years, he has periodically experienced pain and heaviness in his chest. He did not pay particular attention to this.

**A general examination of the patient revealed the following:** objectively, his skin was cold to the touch, his condition was serious, his breathing was labored, and there were moist rales in his lower lungs. Respiratory rate 23 per minute. The jugular veins are slightly swollen. Auscultation of the heart reveals sharply muffled, rhythmic sounds. Heart rate is 98 per minute. Blood pressure 160/100 mm Hg. Abdomen soft and painless. Stool and diuresis regular. The latest deterioration in condition occurred after severe psycho-emotional stress. What is your next step?

**Pulse oximetry:** SPO<sub>2</sub> – 92%, heart rate – 98 beats per minute.

**ECG:** Sinus rhythm, heart rate – 98 beats per minute. Normal EOS position. ST segment elevation V1-V3. ST segment depression II, III, AVF.

**Echocardiogram:** Conclusion: Hypokinesis of the anterior septal, apical anterior, and apical septal walls of the left ventricle.

**Diagnosis:** Coronary artery disease. Acute non-Q-wave myocardial infarction of the anterior septal wall of the left ventricle. Atherosclerosis of the aorta and coronary arteries. Hypertensive disease stage 3, grade III, very high risk (target blood pressure 120/80 mmHg).

**Examination plan (check the appropriate box).**

1. Interview.
2. Medical history.
3. Patient examination.
5. Objective data: palpation, auscultation.
6. Laboratory data.
7. Discussion of the diagnosis, treatment tactics, etc.
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

**Doctor (Last name, first name, initials, legibly)**

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