

QUESTION

A 65-year-old man with a long history of hypertension and diabetes mellitus presents to the emergency department with a 2-day history of severe, crushing chest pain. The pain is constant and radiates to his left arm and jaw. He has a history of smoking 20 cigarettes per day for 30 years. His vital signs are stable, and his physical examination is unremarkable. An electrocardiogram (ECG) shows ST-segment elevation in leads V1-V4. A chest X-ray is normal. The patient is diagnosed with an acute myocardial infarction (MI) and is admitted to the cardiac care unit.

On admission, the patient is given aspirin, beta-blockers, and statins. He is also started on a diuretic to manage his hypertension. The patient's symptoms improve, and he is discharged on day 5. However, during his hospital stay, he develops a new-onset cough and shortness of breath. His vital signs are stable, and his physical examination shows bilateral crackles in the lower lung fields. A chest X-ray shows bilateral infiltrates. The patient is diagnosed with congestive heart failure (CHF) and is started on furosemide. His symptoms improve, and he is discharged on day 10.

The patient returns to the emergency department 2 weeks later with a 2-day history of severe, crushing chest pain. The pain is constant and radiates to his left arm and jaw. He has a history of smoking 20 cigarettes per day for 30 years. His vital signs are stable, and his physical examination is unremarkable. An ECG shows ST-segment elevation in leads V1-V4. A chest X-ray is normal. The patient is diagnosed with an acute MI and is admitted to the cardiac care unit.

On admission, the patient is given aspirin, beta-blockers, and statins. He is also started on a diuretic to manage his hypertension. The patient's symptoms improve, and he is discharged on day 5.

ANSWER

