

Food and Drug Administration  
Center for Food Safety and Applied Nutrition  
Office of Special Nutritionals

ARMS#

13009



5 - SUMMARIES

**000001**



[REDACTED]

DISCHARGE SUMMARY

13009  
EXH E 30-45

[REDACTED]  
[REDACTED] M.D.

[REDACTED]  
02/04/98

PAGE 2

She was given the following instructions:

1. DIET: Low fat (40 fat grams or less).
2. ACTIVITY: The patient is to gradually increase her activity, she is to begin her exercising level at a 70 percent of her target heart rate, which was estimated to be 160. She is gradually over the next six to eight weeks to increase it to exercising at 85 percent of her maximum heart rate.
3. MEDICATIONS: Aspirin 81 mg q. day; Lasix 20 mg q. day; Cardizem CD 300 mg q. day; Imdur 60 mg b.i.d.; nitroglycerin p.r.n.; and some Darvocet for some left shoulder pain.
4. She is to followup with Dr. [REDACTED] in one to two weeks.
5. She is to have a thallium GXT in Dr. [REDACTED] office in one month.
6. She may return to work when she is cleared after her repeat thallium.

[REDACTED]  
[REDACTED] M.D.

DT: 02/05/98

cc: [REDACTED] D.O.  
[REDACTED] M.D.

000003

MEDICAL RECORD DEPARTMENT

13009  
EXH E4 OF 45

HISTORY AND PHYSICAL

PATIENT NAME: [REDACTED]

MR#: [REDACTED]

ACCT#: [REDACTED]

DATE OF ADMISSION: 01/28/98

ADMITTING PHYSICIAN: [REDACTED]

REFERRING PHYSICIAN: [REDACTED]

CHIEF COMPLAINT: Substernal chest pain.

**HISTORY OF PRESENT ILLNESS:** This is a 38-year-old, obese female with no significant past medical history. She has been in her usual state of health until today. She is a nurse working in a doctor's office in [REDACTED]. While at work this afternoon about 4:15, while she was wheeling a patient out of the office, she developed precordial substernal chest pain radiating to her left arm associated with shortness of breath and nausea. She described the pain as 10/10. In the office, they did an electrocardiogram which showed significant ST elevation and she was given sublingual nitroglycerin and aspirin and was transferred to the Emergency Room by ambulance. In the Emergency Room, electrocardiogram showed acute inferior myocardial infarction and she received Reptilase. Fifty minutes into thrombolytic therapy, the pains resolved and patient symptomatically improved. Currently she is pain free. The patient described mild substernal discomfort and left arm discomfort about a week ago on mild exertion that resolved spontaneously. She denies any illicit drug abuse but she stated that two days ago she started taking Herbalyte, which is a diet medication over the counter. Coronary risk factors are negative for hypertension, negative for diabetes, negative for family history, negative for hypercholesterolemia, negative for tobacco abuse.

**PAST MEDICAL HISTORY:** GERD and questionable gastritis.

**PAST SURGICAL HISTORY:** Back and knee surgery in the past.

**ALLERGIES:** Allergic to morphine, sulfa and Compazine.

**MEDICATIONS:** None.

**SOCIAL AND PERSONAL HISTORY:** The patient is married; works in a doctor's office. She has two children, they are fairly healthy. She denies tobacco or alcohol abuse. No illicit drug use.

**REVIEW OF SYSTEMS:** Unremarkable except as mentioned in History of Present Illness.

**PHYSICAL EXAMINATION:** Alert and oriented, very pleasant female in no acute distress at the moment.

**HEENT:** Normocephalic, atraumatic. Oropharynx is unremarkable. The tympanic membranes are intact.

**NECK:** Neck is supple. No jugular venous distention, no bruits. No adenopathy.

**MEDICAL RECORD DEPARTMENT**

13009  
EXH E 50045

**HISTORY AND PHYSICAL**

PATIENT NAME: [REDACTED]

MR#: [REDACTED]  
ACCT#: [REDACTED]

LUNGS: Lungs are clear to auscultation.  
HEART: Regular S1 and S2. No gallop or murmur.  
ABDOMEN: Soft and benign and nontender. No hepatosplenomegaly.  
RECTAL: Negative.  
EXTREMITIES: Full range of motion. No peripheral edema.  
NEUROLOGIC: Intact, nonfocal.

LABORATORY DATA: CBC: white count 7.3, hemoglobin 12.5, hematocrit 37 with platelets 240. Glucose is 122, BUN 14, creatinine 0.8, sodium 140, potassium 3.9, chloride 105, albumin 3.8, calcium 8.9, phosphorus 2.3, magnesium 1.5, CPK 66. Normal PT and PTT. EKG shows normal sinus rhythm with initial rate of 110 per minute, QRS and T-wave elevation in 2, 3 and AVF which indicates acute inferior wall myocardial infarction and, perhaps, septal myocardial infarction. ST T-wave abnormality resolved after thrombolytic therapy.

**IMPRESSION:**

1. Acute inferior wall myocardial infarction, status post thrombolytics.
2. Hypomagnesemia.
3. History of gastritic.

PLAN: Admit patient to CCU and ICU. Continue aspirin, Beta blocker and Heparin and gentle IV fluids. The patient is hemodynamically stable. Watch for signs of hypomagnesemia. Replace magnesium according to sliding scale. H2 blockers for prophylaxis of GI symptoms. Risks stratify post MI was uncomplicated.

[REDACTED]

R: 01/28/98 7:06 A

T: 01/29/98 7:0

J: [REDACTED]

D#: [REDACTED]

cc: [REDACTED] MD

MEDICAL RECORD DEPARTMENT

13009  
EXH E 6045

CONSULTATION

PATIENT NAME: [REDACTED]

MR#: [REDACTED]

ACCT#: [REDACTED]

DATE OF ADMISSION: 01/28/98

DATE OF CONSULTATION: 01/28/98

ADMITTING PHYSICIAN: [REDACTED]

MD

CONSULTING PHYSICIAN: [REDACTED]

MD

**HISTORY:** Mrs. [REDACTED] is a 38 year old nurse who works for Drs. [REDACTED] and [REDACTED]. Today at work she noticed the sudden onset of severe chest pain associated with dyspnea, diaphoresis, and nausea. She was brought immediately to the Emergency Room at [REDACTED] where an electrocardiogram was compatible with an extensive inferolateral myocardial infarction. She was given thrombolytic therapy in the form of Reteplase within two hours of the onset of her chest pain. Within four hours of the onset of her chest pain her chest pain had subsided and her electrocardiogram had returned to normal. At the present time she feels comfortable. She denies any antecedent history of known coronary disease. There has been no prior history of progressive angina.

There has been no known prior history of hypertension, diabetes, or abnormal lipids. The patient is a non-smoker.

**PAST MEDICAL HISTORY:** Past history reveals a history of gastroesophageal reflux and gastritis. She has undergone back surgery and knee surgery in the past.

**FAMILY HISTORY:** Reveals no family members with early atherosclerosis.

**SOCIAL HISTORY:** The patient works as a nurse. She does not abuse alcoholic containing beverages.

**ALLERGIES:** MORPHINE, SULFA, AND COMPAZINE.

**REVIEW OF SYSTEMS:** Is non-contributory.

**MEDICATIONS:** Her only medication prior to admission was Axid. She was not on birth control pills. She is three weeks into her present menstrual cycle and has not recently been pregnant.

**PHYSICAL EXAMINATION:** Reveals an obese white female in no distress. Blood pressure 136/80, pulse 72 beats per minute and regular. Neck veins are not distended. Both carotids show normal upstroke. Thyroid is not palpable. Chest is clear. Auscultation of the heart revealed the first and second sounds to be normal, no murmur or gallops. Examination of the abdomen is unremarkable. All pulses are palpable.

MEDICAL RECORD DEPARTMENT

13009  
EXH E 70-95

CONSULTATION

PATIENT NAME: [REDACTED]

MR#: [REDACTED]

ACCT#: [REDACTED]

It certainly would appear that Mrs. [REDACTED] has had an aborted inferior myocardial infarction. I certainly concur with the present medical regimen. 38 year old menstruating females don't usually have myocardial infarction's. In view of this, I would suggest we proceed on to cardiac catheterization on Friday to assess her anatomy and perform it with surgical standby so that a significant lesion can be addressed immediately if percutaneous means were felt warranted.

Thank you for the consultation.

[REDACTED]

R: 01/28/98 8:59 A

T: 01/29/98 6:46 A

J: [REDACTED]

D: [REDACTED]

cc: [REDACTED]