ACT Government | Canberra Health Services

Discharge Summary

Discharge Summary

Patient Details	NOK Details	Hospital Details
Name: Nicholas Samaras MRN: 19803627 DOB: 22/8/1958 Age: 64 y.o. Gender: male Address: 3 Braim Place Isaacs ACT 2607 Phone: 0410 182 554	Name: Samaras,Lisa Phone: Data Unavailable Relation: Partner/Spouse (incl married/defacto)	Canberra Hospital Yamba Dr, Garran ACT 2605

Recipients	Author	Date/Time
Fisher Family Practice	Abedin Al Jannati	5/6/2023 3:06 PM

Admission Details

Admission Date	Discharge Date	Length of Stay	Specialty	Consultant	Discharge Destination
23/5/2023 7:24 AM	6/6/23	13	Cardiology	Mohammad Paymard	

Problems and Diagnoses

Principal and Additional Diagnoses (managed this admission)	Principal Problem: STEMI (ST elevation myocardial infarction) Resolved Problems: nil
Complications	Nil
Other Ongoing Medical Problems (not actively manged this admission)	There are no active non-hospital problems to display for this patient.

Operating Theatre Procedures

-

Past Procedures (23/5/2023 to Today)

Date	Procedures	Providers
23/05/2023	Coronary Angiography - RightPerc Coronary Intervention (PCI) - Primary	Moyazur Rahman (Primary)Charles Itty

Clinical Summary

64 year old male transferred to ICU with cardiogenic shock post emergency PCI for inferior STEMI.

#Inferior STEMI
- PCI: Primary PCI to RCA 3 x stents
- Triple vessel disease - 100% occlusion Mid LAD, 100% Zdist RCA, 90% third OM
- tirofibran infusion for ~24 hours
- Remains on DAPT

Mixed shock state- cardiogenic, distributive
- Mixed segmental dyskinesia, EF ~40%, fat pad noted L LV free wall, small effusion
- Mild RV impairment
- initially requiring noradrenaline, slowly weaned

#AKI
- Persistent hyperkalaemia and acidosis
- Oliguria
- severe fluid overload
- CRRT for 24/5 to 28/5, SCUFF protocol on 30/1
- Renal input for IHD
- Tunnelled vascath 31/5
- Remains oligo-anuric, due for dialysis 1/6
-haemodialysis on 3/6/23

#Encephalopathy
- multifactorial
- AKI/perfusion related
- dexmed commenced then weaned
- resolved as clinically improved

#hypocalcaemia
- Replaced IV
- Commenced on PO calcium and calcitriol

Plan from Renal: Continue dialysis in the community and follow up renal clinic in 2-4 week
Plan from Cardiology: Repeat coronary angiogram in few weeks to reassess RCA

Recommendations
Dear Doctor,

Thank you for your ongoing care of Nicholas Samaras who was admitted under Cardiology for STEMI (ST elevation myocardial infarction). Please note the following plan:

MEDICATIONS:
- Complete list below

FOLLOW-UP:
- We have asked them to see you in 1 week for review and scripts

- Cardiology follow-up with Dr wong in 6-8 weeks in his room in Canberra Hospital Outpatient B1L3. Please organise a referral for this purpose if needed.

Kind regards,
Cardiology team
Canberra Hospital

Medications on Discharge

Your medication list

START taking this medication

	Instructions	Last Dose Given	Next Dose Due
aspirin 100 mg enteric-coated capsule	Take one capsule in the morning.		
atorvastatin 40 mg tablet	Take one tablet at bedtime.		
bisOPROLOl fumarate 2.5 mg tablet Start taking on: **8 June, 2023**	Take one tablet in the morning.		
calcitriol 0.25 microgram capsule	Take one capsule in the morning.		
calcium carbonate 1500 mg (600 mg of calcium) tablet	Take two tablets two times a day (morning and evening). Take with food.		
clopidogrel 75 mg tablet Notes to patient: For review in 12 months time.	Take one tablet in the morning.		
pantoprazole 20 mg tablet Start taking on: **8 June, 2023**	Take one tablet in the morning.		

	Instructions	Last Dose Given	Next Dose Due
paracetamol 500 mg tablet	Take two tablets three times a day (morning, midday and bedtime).		
sodium bicarbonate 840 mg capsule	Take one capsule two times a day (morning and bedtime).		

CONTINUE taking this medication

	Instructions	Last Dose Given	Next Dose Due
NON FORMULARY			

Booked Follow Up Appointments and Waiting List Entries
Future Appointments

Date	Time	Provider	Department	Centre
6/6/2023	8:30 AM	TCH 8A DIA HAEMODIALYSIS BAY 4	TCH 8A	TCH
8/6/2023	8:30 AM	TCH 8A DIA HAEMODIALYSIS BAY 4	TCH 8A	TCH
10/6/2023	8:30 AM	TCH 8A DIA HAEMODIALYSIS BAY 4	TCH 8A	TCH

Information Provided to the Patient
We wish you well with your ongoing recovery. Please note the following:

FOLLOW-UP:

- Please see your GP within 1 week for review, monitoring of your angio puncture site and ongoing scripts
- Cardiology follow-up with Dr wong in 6-8 weeks in his room in Canberra Hospital Outpatient B1L3. Please ask your Gp to organise a referral for this purpose if needed.
-follow up renal clinic in 2-4 week
-Repeat angiogram in few weeks

MEDICATIONS:

- NEW aspirin lifelong (prevents stent clotting)
- NEW clopidogrel 12 months (prevents stent clotting)
- NEW bisoprolol to reduce heart rate
- NEW atrorvastatin to reduce cholesterol

INSTRUCTIONS:

1. Resume activities gradually. Do not lift, pull or push heavy objects for one week, and do not strain during a bowel motion for 48 hours.
2. Discuss with your GP regarding lifestyle and risk factor changes.
3. Do not drive for 2 weeks. If you drive commercially, do not drive for 4 weeks - you will also need clearance from your GP/cardiologist to restart commercial driving. If you were not driving prior to this admission, please see your GP to check your driving eligibility before recommencing driving.
4. If you have any pain, redness, swelling of your puncture site, expansion of bruise or bleeding, please seek medical attention
5. If you have any chest pain, breathlessness, palpitations, light-headedness or are otherwise unwell, please seek medical attention.

Kind regards,

Cardiology team
Canberra Hospital

Selected Investigation Results
Haematology and Chemical Pathology
Results

Pathology	Units	03/06/23 10:59	01/06/23 04:12	31/05/23 05:17	30/05/23 03:28	29/05/23 22:24	29/05/23 03:16	28/05/23 03:15	27/05/23 02:08	26/05/23 03:13
CRP	mg/L	321.8*	339.4*	339.0*	245.7*	--	191.7*	205.5*	286.8*	358.4*
HAEMOGLOBIN	g/L	94*	108*	113*	109*	--	116*	115*	113*	111*
PLATELETS AUTO	x 10*9/L	422*	207	201	149*	--	144*	135*	130*	103*
TROPONIN I	ng/L	--	--	--	14,081*	14,187*	--	22,011*	31,649*	45,908*
WBC AUTO	x 10*9/L	14.3*	11.8*	15.5*	13.0*	--	13.0*	11.9*	9.9	7.9

Results

Pathology	Units	03/06/23 10:59	01/06/23 04:12	31/05/23 05:17	30/05/23 03:28	29/05/23 22:24	29/05/23 03:16
CALCIUM	mmol/L	1.86*	1.85*	2.55	1.84*	1.88*	2.05*
CREATININE	umol/L	965*	842*	605*	725*	669*	446*
EGFR	mL/min/1.73m2	4*	5*	8*	6*	7*	11*
GLUCOSE	mmol/L	5.6	5.9	5.8	6.6	6.8	7.8*
POTASSIUM	mmol/L	5.4*	--	4.3	4.9	5.1	5.0
SODIUM	mmol/L	133*	132*	136	134*	135	136

Microbiology

Imaging
Coronary Angiography, Coronary Angiography 23/05/2023

Conclusion

- 3rd Mrg-1 lesion is 50% stenosed.
- 3rd Mrg-2 lesion is 90% stenosed.
- Prox LAD lesion is 80% stenosed.
- 2nd Diag lesion is 90% stenosed.
- Mid LAD lesion is 100% stenosed.
- Prox RCA lesion is 40% stenosed.
- Mid RCA lesion is 95% stenosed.
- Dist RCA lesion is 100% stenosed.
- Mid RCA to Dist RCA lesion is 95% stenosed.
- Mid RCA reduced to 0% stenosed.
- Dist RCA reduced to 0% stenosed.

Recommendations:
1. DAPT, ICU, Inotropes.

2. Consider CABG for other lesions.

XR Chest Mobile

Result Date: 2/6/2023
Narrative: Clinical History: icu Referrer's Provisional/Differential Diagnosis: icu Comparison: Radiograph dated 31/5/2023. Findings: Interval removal of right and left IJV CVC and insertion of right IJV tunnelled line. The tip of the tunnelled line is projecting into the right atrium. There is ongoing left basal collapse consolidation and small pleural effusion.

Persistent central pulmonary venous congestion. Otherwise no interval change.

IR Tunnelled Line Insertion Dialysis

Result Date: 31/5/2023
Narrative: Clinical History: Anuric renal failure secondaryto cardiogenicshock. Remains dialysis dependent with IHD requirement on ward Referrer's Provisional/Differential Diagnosis: aneuric renal failure Technique: Tunnelled Right IJ Vas Cath. Patient consent obtained Questions answered. Procedure performed under sterile technique. Local anaethetic in skin up to lateral aspect of right IJV. Needle puncture and wire inserted below the diaphragm. Local anaesthetic along tunnel tract. Vas cath (tunnelled and inserted through (15F 23cm arrow dialysis catheter) peel-away sheath. Vas cath tip terminating in superior aspect of right atrium. No procedural complications. Patient tolerated procedure well.

XR Chest Mobile

Result Date: 31/5/2023
Narrative: Clinical History: renal failure, overload Referrer's Provisional/Differential Diagnosis: renal failure, overload Comparison: 29/5/2023 Findings: (Mobile AP erect) Unchanged position of both IJVs. Worsening atelectasis/consolidation at the left base obliterating the left hemidiaphragm with probable small associated pleural effusion. Persisting plate atelectases right mid and lower zones. Mild cardiomegaly suspected.

XR Chest Mobile

Result Date: 31/5/2023
Narrative: Clinical History: icu Referrer's Provisional/Differential Diagnosis: icu Comparison: X-ray from yesterday Findings: No change in 1 day.

XR Chest Mobile

Result Date: 31/5/2023
Narrative: Clinical History: ICU patient Referrer's Provisional/Differential Diagnosis: D6 post STEMI with MODS, ?APO Comparison: The previous study from the previous day. Findings: No significant change.

XR Chest Mobile

Result Date: 30/5/2023
Narrative: Clinical History: STEMI + overload Referrer's Provisional/Differential Diagnosis: STEMI + overload Comparison: The previous study from the previous day. Findings: No significant change.

XR Chest Mobile

Result Date: 27/5/2023
Narrative: Clinical History: ICU patient Referrer's Provisional/Differential Diagnosis: STEMI, intubated, ?collapse/consolidation Comparison: 26 May 2023 Findings: Bilateral basal pleural effusions, improved in extent since the previous x-ray. Improved perihilar and

basal aeration, in keeping with resolving pulmonary oedema. Endotracheal tube projected over the mid trachea, unchanged, right IJV line appropriately positioned projected over the right main bronchus, left IJV Vas-Cath appropriately positioned tip at the cavoatrial junction, nasogastric tube tip below the diaphragm, also appropriately positioned.

XR Chest Mobile

Result Date: 26/5/2023
Narrative: Clinical History: progress cxr Referrer's Provisional/Differential Diagnosis: STEMI wit MOF Comparison: Mobile AP semierect dated 25/5/2023 Findings: (Mobile AP semi erect) View taken in part expiration. Right IJV, ETT, NGT and left venous line are in unchanged position. The expiratory view and dense overlying chest wall tissue most likely accounts for the apparent increase in opacity over the lower lung fields. There are possible associated small pleural effusions. Essentially no change from prior.

XR Chest Mobile

Result Date: 25/5/2023
Narrative: Clinical History: progress CXR - Intubated ventilated -> STEMI Referrer's Provisional/Differential Diagnosis: STEMI + MODS Comparison: Chest x-ray 24/5/2023 Findings: The tubes and lines are appropriately sited. Increasing bilateral pleural effusion with bibasal atelectasis

XR Chest Mobile

Result Date: 24/5/2023
Narrative: Clinical History: Intubation for resp failure. ETT confirmation Referrer's Provisional/Differential Diagnosis: Resp failure Comparison: Radiograph performed earlier today. Findings: The tip of the ET tube is projecting 4 cm above the carina. The partially captured right IJV CVC, NG tube remain in situ. There is ongoing left basal collapse consolidation and possible small bilateral pleural effusion. Otherwise no interval change in remainder.

XR Chest Mobile

Result Date: 24/5/2023
Narrative: Clinical History: Progress chest xray Referrer's Provisional/Differential Diagnosis: Inferior STEMI + shock Comparison: Radiograph dated 23/5/2023. Findings: The right IJV CVC, NG tube remain in situ. The left IJV CVC tip is projecting over mid SVC. There is left basal atelectasis with some interval improvement in aeration compared to previous study. Otherwise stable cardiopulmonary findings.

XR Chest Mobile

Result Date: 24/5/2023
Narrative: Clinical History: new ngT insertion Referrer's Provisional/Differential Diagnosis: ?position Comparison: Previous radiograph performed 24/5/2023 Findings: The ET tube, right internal jugular CVC and left internal jugular Vas-Cath are unchanged in position. There is an NGT in situ coiling within the stomach. There small bilateral pleural effusions and left basal collapse and consolidation. Right basal atelectasis persists. Upper lobe blood

diversion and prominence of the perihilar vasculature indicating central venous congestion.

XR Chest Mobile

Result Date: 23/5/2023
Narrative: Clinical History: inferior STEMI with haemodynamic instability, post PCI Referrer's Provisional/Differential Diagnosis: check lines Comparison: None available Findings: Mobile AP semi erect projection Allowing for the technical factors Ccardiomediastinal contours are within normal limits-appearance of widened mediastinum is likely related to the technical factors. Conventional aortic arch. No cardiac failure seen. Right internal jugular CVC noted with the tip of the catheter in the SVC just proximal to the right main bronchus level. Nasogastric tube can be traced into the stomach. No areas of consolidation or mass lesions noted in the lungs. Left basal atelectatic changes. No displaced acute rib fractures seen. No pneumothorax. No pneumomediastinum. No pneumoperitoneum seen. Normal position of the gastric air bubble.

Cardiac catheterisation

Result Date: 23/5/2023
Narrative: • 3rd Mrg-1 lesion is 50% stenosed. • 3rd Mrg-2 lesion is 90% stenosed. • Prox LAD lesion is 80% stenosed. • 2nd Diag lesion is 90% stenosed. • Mid LAD lesion is 100% stenosed. • Prox RCA lesion is 40% stenosed. • Mid RCA lesion is 95% stenosed. • Dist RCA lesion is 100% stenosed. • Mid RCA to Dist RCA lesion is 95% stenosed. • Mid RCA reduced to 0% stenosed. • Dist RCA reduced to 0% stenosed. Recommendations: 1. DAPT, ICU, Inotropes. 2. Consider CABG for other lesions.

Echocardiogram

Department of Cardiology

Transthoracic Echo Report

ACT Government | Canberra Health Services

Name:	SAMARAS, NICHOLAS	**MRN:**	19803627	**Study Date:**	26/05/2023 08:57
DOB:	22/08/1958	**Age:**	64	**Gender:**	M **Ward:** ICU
Address:	3 Braun Place Isaacs ACT 2607			**Referring Dr:**	Dr Daniel Sathiamathan
				GP:	Fisher Family Practice

Ht: 175 **Wt:** 90 **B.S.A:** 2.11 m² **HR:** 95 **Rhythm:** Sinus rhythm

CLINICAL DETAILS: Acute inferior STEMI (23/5/23) - Primary stenting to the mid and distal RCA. For consideration of CABG to treat remaining lesions.
Patient currently intubated and sedated in ICU

REPORT:

Left Ventricle: Normal left ventricular size with mild segmental systolic dysfunction; ejection fraction 44 %. GLS -12%. See attached diagram for wall motion abnormalities. Moderate concentric hypertophy. Grade 1 left ventricular diastolic dysfunction with no Doppler evidence of increased filling pressure.

Right Ventricle: Normal right ventricular size (RVD1 42mm, RVD2 32mm, RVD3 86mm) with preserved systolic function (TAPSE 20mm, RV S' 17cm/s, FAC 35 %). Insufficient tricuspid regurgitation to estimate RVSP. Dilated IVC 25mm (intubated).

Atria: Mildly dilated left atrial volume (LAVI 39ml/m²). Normal right atrial volume (RAVI 18ml/m²). Interatrial septum appears thin and intact.

Mitral valve: Normal structure, trace regurgitation.

Aortic valve: Trileaflet, normal structure, no regurgitation.

Aorta: Normal aortic root (38mm, 18mm/m²), ST junction (29mm) and ascending aorta (33mm, 16mm/m²) dimensions.

Tricuspid valve: Normal structure, trace regurgitation.

Pulmonary valve: Normal structure, trace regurgitation.

Pericardium: Normal pericardium. Trivial circumferential pericardial effusion (6mm posteriorly, 14mm anteriorly) - no echo signs of Tamponade.

CONCLUSIONS:

1- Normal left ventricular size with mild segmental systolic dysfunction withhypokinetic inferior wall.
2- Normal right ventricular size with preserved systolic function.
3- No significant valve abnormalities.
4- Trivial circumferential pericardial effusion with no echo signs of Tamponade.

Sonographer: Melinda Robley AMS 4606

Reported by: Dr Sam Kashkavij

Final Date: 30 May 2023 19:52

Copies To:

MEASUREMENTS

2D ECHO

LV Diastolic Diameter PLAX	47.1 mm	LV Diastolic Vol MOD BP Index	62.2 cm³/m²
LV Systolic Diameter PLAX	33.8 mm	LV Ejection Fraction MOD BP	43.7 %
IVS Diastolic Thickness	14.8 mm	LV Mass (ASE)	281 g
LVPW Diastolic Thickness	14.2 mm	LV Mass (ASE) Index	133 g/m²

Department of Cardiology
Transthoracic Echo Report

ACT Government | Canberra Health Services

Name:	SAMARAS, NICHOLAS	**MRN:**	19803627	**Study Date:**	23/05/2023 10:53
DOB:	22/08/1958	**Age:**	64	**Gender:**	M **Ward:** cath lab
Address:	3 Brann Place Isaacs ACT 2607			**Referring Dr:**	Dr Mohammad Peyvand
				GP:	Fisher Family Practice

Ht: **Wt:** **B.S.A:** **HR:** 99 **Rhythm:** Sinus tachycardia

CLINICAL DETAILS: Focus echocardiogram post inferior STEMI, PCI to RCA
On Noradrenaline

REPORT:

Left Ventricle:	Normal left ventricular size and preserved dysfunction; ejection fraction 55%. See diagram for regional wall abnormalities.
Right Ventricle:	Normal right ventricular size with normal systolic function.
Atria:	Appears normal size. Inversion of left atrium during diastole.
Mitral valve:	Appears normal.
Aortic valve:	Not assessed.
Aorta:	Not assessed
Tricuspid valve:	Not assessed.
Pulmonary valve:	Not assessed
Pericardium:	Normal pericardium. Trace circumferential pericardial effusion. Homogenous echogenic space 17mm seen best in subcoastal view. ?epicardial fat vs mass.
Comments:	IVC dilated and not collapsing.

CONCLUSIONS:

Normal left ventricular size and mild regional systolic dysfunction
Normal right ventricular size and normal systolic function
No significant valvular disease
Circumferential pericardial effusion.

Recommend repeat study, and consider cardiac CT to rule out pericardial mass.

Sonographer: Dr Quan Tran
Reported by: Dr Quinton Yang
Final Date: 23 May 2023 14:06
Copies To:

MEASUREMENTS

DOPPLER Heart Rate	99 bpm

Contact details for GP Liaison Unit
Canberra Health Services: (02) 5124 4183 gpliaison@act.gov.au