# Deaths due to Heart Disease

**Case 1**

A 68-year-old female was admitted to the ICU with dyspnea and moderate retro-sternal pain of 5-hours duration, and the pain did not respond to nitroglycerin.

 There was a past history of obesity, noninsulin-dependent diabetes mellitus, hypertension, and episodes of non exertional chest pain, diagnosed as angina pectoris, for 8 years.

Over the first 72 hours, she developed a significant elevation of the MB isoenzyme of creatine phosphokinase, confirming an acute myocardial infarction. A Type II second-degree AV block developed, and a temporary pacemaker was put in place.

She subsequently developed dyspnea with fluid retention and cardiomegaly on chest radiograph. She developed a cardiac arrest on the 4th day and she became unresponsive and resuscitation efforts were unsuccessful.

**Case 2**

A 55 year old male presented with left sided chest pain to the emergency department. He was apparently well before the onset of the pain 8 hours prior to the admission. The pain was constricting in type and was radiating to the left arm and the left side of the neck. He experienced severe sweating. He had tried to relieve the pain by using simple analgesia but there was no improvement. He also complained of shortness of breath. He was immediately admitted to the emergency treatment unit and on clinical suspicion of myocardial infarction, a low dose aspirin was administered. On examination he was in pain, dyspnoeic and had cold and clammy extremities. His blood pressure was 90/60 mmHg and pulse rate was 60 beats per minute. ECG showed ST elevation and Cardiac Troponin was found to be high. His wife revealed that he is a heavy smoker and had hypercholesterolaemia for the last 10 years. Oxygen was administered via mask and morphine was also administered.

Despite IV streptokinase and other appropriate treatment his conditioned worsened and he was transferred to the Intensive Care Unit for further management. He died 12 hours after admission.

**Case 3**

A 53-year-old male was admitted to the hospital following 2 days of intermittent mid epigastric and left-sided chest pain. The pain radiated to his left arm and was accompanied by nausea and vomiting.

He gave a history that included 2 years of occasional chest discomfort, a near syncopal episode 6 months prior, hypertension, a 30-year history of one-pack-per-day cigarette smoking, congenital blindness, and insulin-dependent diabetes mellitus. He was noted to be markedly obese and to have severe hypercholesterolemia.

At the time of admission, his enzyme studies were normal, but the ECG suggested myocardial ischemia. Two days later, he experienced an episode of severe chest pain that did not respond to nitroglycerin and was accompanied by ST-segment elevation. A cardiac catheterization demonstrated severe multi vessel coronary artery stenosis. He underwent quadruple coronary artery bypass surgery. Shortly, after being taken off the cardiopulmonary bypass machine, he went into cardiac arrest.

Despite all attempts at resuscitation patient died.