**MEDICAL RECORD FOR PUNCTUATION**

**KEY**

The patient is a 54 year old Nigerian male who was admitted with chest pain. The patient has a history of diabetes mellitus. He presented here on May 19, 2003, with nausea, vomiting, and chest pain, and a large anterior myocardial infarction. He was several hours into the infarct and was found to have a 99% proximal stenosis of the left anterior descending which required stenting. A 2.5 X 23 stent was placed by Dr Brown. The patient had an ejection fraction that was said to be 30% to 35%. The patient had an intra-aortic balloon inserted and apparently had fever postoperatively. The left anterior descending actually had some mid-stenosis of about 50% and was diffusely diseased. The right coronary was also severely and diffusely diseased with multiple 50% to 70% stenoses throughout the entire proximal mid-portion of the right coronary. There were multiple 50% to 70% narrowings in the distal right coronary and 70% to 80% stenosis in the PDA. The PDA was of small caliber. The interventricular branch also had a 90% stenosis. The circumflex was diffusely diseased with a 30% to 40% ostial narrowing. There was a third obtuse marginal with a 70% to 80% stenosis. His ejection fraction was estimated at 30%.

Other than the fever, the patient did quite well during his hospitalization. He was discharged yesterday on Plavix, aspirin, Lasix, potassium, and Metformin. The patient did well until this morning at around 1:30 when he started having central substernal pressure. This was fairly intense. He broke out in a sweat as he came to the emergency room. He actually called, and after a friend called in some nitroglycerin without complete relief, the patient came to the emergency room. The patient continued to have chest pain. He was started on i.v. nitroglycerin. His chest x-ray showed vascular congestion.

The patient has diffuse coronary disease and has recently had a left anterior descending stent. He now is having recurrent chest pain. He has developed a new right bundle with left axis, and I suspect he could be occluding his stent. I have explained this to the family. We will proceed with diagnostic catheterization and probably intra-aortic balloon insertion. The risks and rationale have been explained. I also explained this to his nephew, who is apparently a physician.