St. Aldwyn General Hospital

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Registered provider HSP-2291-DE

DISCHARGE SUMMARY

Ward 6B · Cardiology
Under Dr. Ravi Chandrasekar

PATIENT NAME **Gerald N. Moss**		UHID **SAG-118-44207**	IP NUMBER **IP-2026-07-2214**
AGE / SEX **63 y / M**	BLOOD GROUP **B positive**	DATE OF ADMISSION **26 Jul 2026, 22:40**	DATE OF DISCHARGE **02 Aug 2026, 11:15**
ADDRESS **14 Barrow Close, Ashcombe, Devon EX7 4RN**		LENGTH OF STAY **6 days**	DISCHARGE STATUS **Discharged home, stable**
KNOWN ALLERGIES **Sulphonamides — documented rash**		NEXT OF KIN **Eileen Moss (spouse) · +44 7700 900 118**	

DIAGNOSIS

Non-ST-elevation myocardial infarction (NSTEMI), inferior territory

ICD-10 I21.4

- Type 2 diabetes mellitus, previously diet-controlled (E11.9)
- Essential hypertension (I10)
- Dyslipidaemia (E78.5)

PRESENTING COMPLAINTS

Central chest heaviness radiating to the left arm for four hours before admission, accompanied by sweating and nausea. No syncope. Symptoms began at rest and did not settle with antacids.

PAST HISTORY

Type 2 diabetes for eleven years, hypertension for eight years, both managed in primary care. Ex-smoker, stopped 2018 after a 20 pack-year history. No prior cardiac admissions or interventions.

COURSE IN HOSPITAL

The patient was admitted through the emergency department with a raised high-sensitivity troponin (412 ng/L, rising to 1 860 ng/L at six hours) and inferior-lead ST depression. He was loaded with dual antiplatelet therapy and started on a low-molecular-weight heparin. Coronary angiography on day 2 showed a 90% mid-right-coronary-artery stenosis with mild disease elsewhere; a drug-eluting stent was deployed with a good angiographic result. Recovery was uncomplicated: he remained in sinus rhythm on telemetry, echocardiography showed mild inferior hypokinesia with an ejection fraction of 48%, and he mobilised on the ward from day 4. Glycaemic control was suboptimal on admission (HbA1c 8.4%) and metformin was started with dietetic input. Cardiac rehabilitation assessment was completed before discharge.

INVESTIGATIONS — KEY FINDINGS

INVESTIGATION	DATE	FINDING
High-sensitivity troponin T	26 Jul	412 → 1 860 ng/L (rising pattern, consistent with myocardial infarction)
12-lead electrocardiogram	26 Jul	ST depression 1.5 mm in leads II, III and aVF; sinus rhythm at 92 /min

INVESTIGATION	DATE	FINDING
Transthoracic echocardiogram	28 Jul	Mild inferior wall hypokinesia; ejection fraction 48%; no significant valve lesion
HbA1c	27 Jul	8.4% — above target, therapy escalated
Fasting lipid profile	27 Jul	LDL 3.9 mmol/L, HDL 0.9 mmol/L, triglycerides 2.4 mmol/L
Serum creatinine / eGFR	01 Aug	88 µmol/L, eGFR greater than 60 mL/min/1.73 m² — stable post-contrast

PROCEDURES PERFORMED

PROCEDURE	DATE	PERFORMED BY	NOTES
Coronary angiography, right radial approach	28 Jul 2026	Dr. Ravi Chandrasekar	90% mid-RCA stenosis; LAD and circumflex mildly diseased
Percutaneous coronary intervention with drug-eluting stent to mid-RCA	28 Jul 2026	Dr. Ravi Chandrasekar	3.0 × 24 mm stent, TIMI 3 flow restored, no complication

CONDITION AT DISCHARGE

Pain free and haemodynamically stable. Blood pressure 128/76 mmHg, pulse 68 /min regular, oxygen saturation 98% on room air. Ambulating one flight of stairs without symptoms. Wound at the right radial access site is clean and dry.

MEDICATION ON DISCHARGE

DRUG	DOSE	ROUTE	FREQUENCY	DURATION	INSTRUCTION
Aspirin 75 mg Acetylsalicylic acid	1 tab	Oral	Once daily	Continue	After food, lifelong
Ticagrelor 90 mg Ticagrelor	1 tab	Oral	Twice daily	12 months	Do not stop without cardiology advice
Atorvastatin 80 mg Atorvastatin	1 tab	Oral	Once at night	Continue	Lipids to be rechecked at 8 weeks
Bisoprolol 2.5 mg Bisoprolol fumarate	1 tab	Oral	Once daily	Continue	Hold if pulse below 50 /min
Ramipril 2.5 mg Ramipril	1 cap	Oral	Once at night	Continue	Up-titrate at review if tolerated
Metformin 500 mg Metformin hydrochloride	1 tab	Oral	Twice daily	Continue	With meals; report persistent diarrhoea
Glyceryl trinitrate 400 µg spray GTN	1–2 sprays	Sublingual	As required	Continue	Sit down before use; call 999 if pain persists past 15 minutes

FOLLOW-UP PLAN

REVIEW APPOINTMENT	CLINIC	BRING WITH YOU
18 Aug 2026, 09:45	**Cardiology out-patients, Clinic C, Level 2**	**This summary, all medication boxes, home BP diary**

- Attend the cardiac rehabilitation programme starting 11 Aug 2026 at the Ashcombe Community Centre; a place has been reserved.
- Keep the radial puncture site dry for 48 hours and report any swelling, numbness or bleeding.
- No driving for one week; notify the licensing authority and your motor insurer as advised in the enclosed leaflet.
- Avoid lifting more than 5 kg for two weeks; walking distance may be increased daily as tolerated.
- Check capillary blood glucose twice daily and record the readings for the diabetes nurse.
- The general practitioner is requested to review renal function and potassium two weeks after discharge.

RETURN TO HOSPITAL IMMEDIATELY IF ANY OF THE FOLLOWING OCCUR

- Chest pain at rest lasting more than 15 minutes or unrelieved by two doses of GTN spray.
- Sudden breathlessness, or breathlessness when lying flat.
- Fainting, palpitations with dizziness, or a pulse persistently below 45 /min.
- Bleeding that does not stop, black tarry stools, or blood in vomit or urine while on antiplatelet therapy.
- Swelling, expanding lump or loss of sensation at the wrist puncture site.

Dr. Anya Petrova
Cardiology Registrar
Reg. No. GMC-8823117

Dr. Ravi Chandrasekar
Consultant Interventional Cardiologist
Reg. No. GMC-5510923

Summary explained to
Patient and Mrs. Eileen Moss (spouse)
02 Aug 2026, 11:15