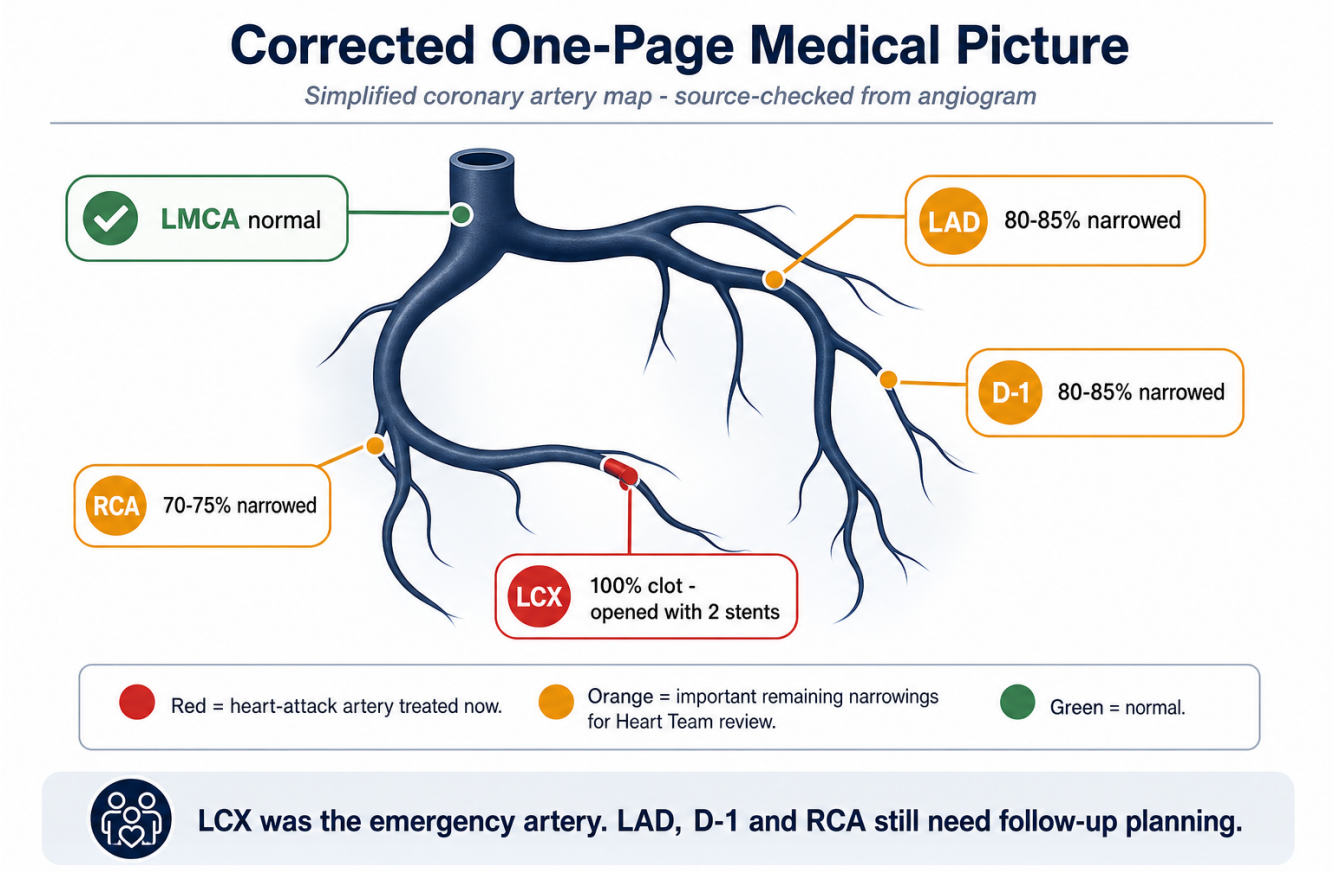
Complete Heart Attack & Recovery Report

Mr. Abdul Latif - audited and corrected version, updated 19 July 2026

Prepared for family understanding and second-opinion handover. This version corrects the earlier AI report after checking the available hospital scans. It does not replace the treating cardiologist, physician, endocrinologist, dietician, or emergency care.

Patient	Mr. Abdul Latif, 65/M, blood group A positive
Hospital / doctor	Mittal Hospital & Research Centre, Ajmer - Dr. Rahul Gupta
Dates	Admitted 14/07/2026; discharged 16/07/2026; symptoms began around 5 PM on 13/07/2026
Diagnosis	CAD / ACS / PWMI. Heart attack due to LCX artery 100% blockage with thrombus.
Emergency procedure	Primary PTCA + 2 drug-eluting stents to LCX through right radial artery.
Heart pump	LVEF 45%. Mildly reduced; may improve, but repeat echo is needed to know.
Main pending decision	How to treat LAD, D-1, and RCA remaining disease: staged PCI vs CABG vs medicines.

1. Corrected One-Page Medical Picture



Plain meaning: one artery, LCX, was fully blocked by clot and caused the heart attack. It was reopened with two drug-eluting stents. Three other arteries still have important narrowings, so the follow-up question is not whether the attack was treated - it was - but what the safest long-term plan is for the remaining disease.

2. What Happened

Time / date	Document-supported event	Family meaning
13/07/2026 evening	Discharge summary: chest pain, uneasiness, ghabrahat, sweating from around 5 PM.	These were warning symptoms of a heart attack.
14/07/2026	Emergency treatment at Jai Clinic; loading dose given, then shifted to Mittal Hospital.	Early medicines and transfer to cath lab were appropriate.

Time / date	Document-supported event	Family meaning
14/07/2026	Coronary angiogram showed LCX 100% blocked with thrombus and other major narrowings.	The LCX was the culprit artery.
14/07/2026	Primary PTCA + two Promus Premier drug-eluting stents to LCX.	The blocked artery was opened without chest surgery.
16/07/2026	Discharged improved with medicines and review date 27/07/2026.	Now the priority is strict medicines, monitoring, and planning remaining artery treatment.

3. Source-Checked Test Results

Item	Verified source value	Note
Angiogram	LMCA normal; LAD proximal-mid 80-85%; D-1 ostio-proximal 80-85%; LCX distal 100% thrombus++; RCA mid 70-75%.	Matches source exactly.
Cardiac markers	CK-MB >80.0, TNI/Troponin I >10.0, BNP 511.	Values are from discharge summary. Reference ranges were not readable in the provided source scans; treat ranges as lab-dependent.
Echo	LVEF 45%; concentric LVH; RWMA positive; LCX territory severely hypokinetic; chamber clot not seen.	EF 45% is mildly reduced. Recovery is possible, not guaranteed.
Blood count	Hemoglobin 13.2 g/dL, TLC 13490, platelets 241.	Hb mildly low by lab range; TLC high, common with acute stress/inflammation but doctor should interpret.
Kidney	Creatinine 0.60 mg/dL, eGFR 107.13.	Good kidney function in the available lab report.
HbA1c	Only verified value in provided scans: handwritten 6.7 on discharge summary line where printed report says awaited.	The earlier 8.2 claim is removed. Ask for the official printed HbA1c report.

4. Procedure Details - Corrected

Step	Source document says	Plain meaning
Access	Right Radial Artery.	Small wrist artery route.
Angiogram catheter	Tiger 5F.	Used to look at arteries with dye.
PTCA guiding catheter	EBU 3.5 (6F).	Correction: this is the catheter for the stent procedure, not Tiger 5F.
Wire	BMW Extra Floppy 0.014" x 190 cm.	Thin wire crossed the blocked artery.
Balloon	Artimes PTCA Balloon 2.0 x 12 mm inflated up to 14 atm.	Opened a small channel before stent placement.
Stent 1	Boston Scientific Promus Premier 2.50 x 28 mm, mid to distal LCX.	Medicine-coated metal scaffold.
Stent 2	Boston Scientific Promus Premier 2.75 x 20 mm, proximal to mid LCX.	Second scaffold to cover remaining treated segment.
Post-dilatation	Done.	Stents seated/expanded after deployment.

5. Medicines at Discharge - What to Know

Golden rule: do not stop Ecosprin or Brilinta on your own after drug-eluting stents. If bleeding, surgery, dental work, or side effects happen, call the cardiologist urgently rather than stopping silently.

Medicine	Schedule from discharge	What it is for	Important safety note
Ecosprin 75	0-1-0, after lunch	Aspirin antiplatelet.	Prevents clotting; confirm duration with cardiologist.
Brilinta 90	1-0-1	Ticagrelor antiplatelet.	Very important after stents; do not miss doses.
Atorva 40	0-0-1	Atorvastatin, cholesterol plaque stabilizer.	Usually long-term after MI unless doctor changes.
Concor COR 1.25	0-1-0	Bisoprolol beta blocker, slows/protects heart.	Monitor pulse/BP as advised.
Angiwell 2.6	1-0-1	Long-acting nitrate.	Helps angina symptoms; avoid dose changes without doctor.
Sorbitrate 5	S/L 1 tab SOS if chest pain	Emergency nitrate under tongue.	Use only for chest pain as prescribed; persistent pain means hospital.
Ajaduo 25/5	0-1-0 before lunch	Empagliflozin + linagliptin for type 2 diabetes.	Confirm HbA1c and targets with physician/endocrinologist.
Pantocid DSR	1-0-0 empty stomach, 10 days	Stomach protection.	Common with antiplatelets.
Monocef-O 200	1-0-1, 5 days	Antibiotic.	Complete only as prescribed.
Zedex-SF syrup	1-1-1, 2 tsp TDS	Sugar-free cough syrup.	Use as prescribed.

6. Remaining Arteries and Second Opinion

Because he has diabetes/raised sugar status, multivessel coronary artery disease involving LAD/D-1/RCA, and EF 45%, the choice between more stents, bypass surgery, or medicines is a real cardiology decision. Current ACC/AHA/SCAI guidance says Heart Team review is recommended when the best revascularization strategy is unclear, and diabetes with multivessel CAD often favors CABG in suitable surgical candidates, especially with LAD involvement. PCI can still be appropriate in selected anatomy or if surgery risk is high.

Practical family wording for the doctor: 'The LCX culprit artery has been treated. Please review the angiogram films and advise the best complete revascularization plan for LAD/D-1/RCA considering diabetes, EF 45%, anatomy complexity, surgical risk, and patient preference.'

7. Corrected 1800 kcal Hospital Diet Chart

Use one option where the chart shows alternatives. Drinks are without sugar. The dietician handwrote multigrain roti. Keep oil and salt low unless the dietician says otherwise.

Time	Food options	Correct quantity / amount
6:30 AM	Tea without sugar + biscuits	Tea 1 cup/100 ml + biscuits 2/25 g
8:30 AM	Choose one: upma, poha, dalia, oats, cornflakes, roti, vegetable sandwich; plus milk without sugar	Upma/poha/dalia/oats/cornflakes: 1 bowl/120 g. Roti: 1/30 g. Vegetable sandwich: 2/200 g. Milk: 1 glass/200 ml.
11:30 AM	Milk without sugar OR chaas OR lemon water without sugar + fruit	Drink 1 glass/200 ml + fruit 1/150 g.
1:30 PM	Multigrain roti + dal + sabzi + dahi + salad	Roti handwritten count; printed amount 90 g. Dal 1 bowl/160 g; sabzi 1 bowl/120 g; dahi 1 bowl/120 g; salad 1 bowl/150 g.
3:30 PM	Tea/milk/coffee/chaas/lemon water without sugar + one snack option	Tea/coffee 1 cup/100 ml OR milk/chaas/lemon water 1 glass/200 ml. Snack: roasted chana 1 bowl/30 g OR sprouts 1 bowl/120 g OR biscuits 2/25 g OR suji toast 2/15 g.
8:00 PM	Soup + multigrain roti + dal + sabzi + dahi + salad	Soup 1 cup/100 ml; roti handwritten 2 No with printed amount 90 g; dal 160 g; sabzi 120 g; dahi 120 g; salad 150 g.
10:00 PM	Milk without sugar + biscuits	Milk 1 glass/200 ml + biscuits 2/15 g.

8. Simple Diet Explanation for Family

Why this diet is structured	Simple meaning
Fixed meal timings	Keeps sugar and energy steady. Long gaps can cause weakness or sugar swings.
No sugar in drinks	Sugar in tea, milk, juice, or lemon water raises glucose quickly. Use plain drinks unless dietician allows otherwise.
Multigrain roti / dal / sprouts / salad	These give slower energy and fiber, better for diabetes and cholesterol than sweets, fried snacks, or refined flour.
Low oil and low salt	Less load on heart and blood pressure. Avoid fried food, pickle, papad, namkeen, packaged salty snacks unless doctor/dietician allows.
Fruit, not juice	Whole fruit has fiber. Juice can raise sugar fast.
Carry the diary	BP and sugar readings help the doctor decide medicines and diet changes.

9. Monitoring Calendar

When	What	Why
Daily	BP morning/evening, fasting and post-meal sugar if advised, pulse, symptoms, wrist puncture site for first week.	Catches problems early and helps medicine adjustment.
Before 27/07 review	Get official HbA1c report if possible; urine routine/culture if advised; carry all reports and angiogram films/CD.	Completes pending clarification.
27/07/2026	Review with Dr. Rahul Gupta.	Medicine check and plan remaining arteries.
2-4 weeks	Second opinion/Heart Team review; endocrinologist or physician for diabetes.	Decide staged PCI vs CABG vs medicines; confirm sugar plan.
1-3 months	Repeat echo as advised.	See whether EF improves.
Around 3 months	Repeat HbA1c and lipid profile as advised.	Check diabetes and cholesterol control.

10. Red Flags - Go to Hospital Immediately

- Chest pain/heaviness/pressure lasting more than a few minutes, or returning.

- Pain/discomfort going to arm, jaw, neck, back, shoulder, or upper stomach.

- Sudden breathlessness, cold sweat, nausea/vomiting, fainting, severe dizziness, or unusual weakness.

- New rapid or irregular heartbeat with symptoms.

- Bleeding/swelling at wrist puncture site, black stools, blood in vomit, blood in urine, or severe headache/confusion while on blood thinners.

- Very high sugar with illness or symptoms, or low sugar symptoms such as sweating, confusion, shakiness, fainting.

If chest pain occurs, use Sorbitrate only as prescribed. If pain does not settle quickly or feels serious, do not wait at home - go to emergency care.

11. Questions to Ask Doctors

Doctor	Questions
Cardiologist	1. What is the plan for LAD, D-1, and RCA? 2. Is Heart Team/CABG review advised? 3. How long Brilinta and Ecosprin? 4. When repeat echo? 5. Activity/travel limits?
Second-opinion Heart Team	1. Based on angiogram films and EF 45%, staged stents or bypass? 2. Does diabetes/LAD disease favor CABG? 3. What are risks, timing, and recovery for each option?
Physician/endocrinologist	1. What is the official HbA1c? 2. Is Ajaduo correct? 3. Sugar targets and testing schedule? 4. Vitamin D plan if needed?
Dietician	1. Is 1800 kcal correct for current weight/appetite? 2. Exact roti count at lunch where handwriting is unclear? 3. What snacks are best if sugar is high?

Corrections Made From Previous AI Report

Earlier issue	Updated wording in this report
HbA1c 8.2 conflict claimed	Removed as unverified from provided scans; only 6.7 handwritten was found. Ask for printed report.
PTCA access/catheter table said Tiger 5F	Separated angiogram catheter Tiger 5F from PTCA guiding catheter EBU 3.5 (6F).
Cardiac marker normal ranges stated as certain	Values retained; normal ranges marked lab-dependent because source reference ranges were not readable.
Diet table said faithfully transcribed but collapsed quantities	Corrected roti, vegetable sandwich, snack, and suji toast quantities.
EF described as recoverable range	Changed to mildly reduced and may improve; repeat echo needed.

Sources and Verification Basis

Source scans checked: Mittal Hospital discharge summary, coronary angiogram report, PTCA report, Dr. B. Lal lab pages, echo report, ECG pages, pharmacy/discharge schedule, and dietician photo dated 17/07/2026. External guidance checked from ACC/AHA/SCAI 2021 revascularization guideline, AHA cardiac medication/DAPT pages, AHA heart attack warning signs, and 2025 AHA/ACC ACS guidance summary.

External links: https://www.jacc.org/doi/10.1016/j.jacc.2021.09.006 ; https://www.jacc.org/doi/10.1016/j.jacc.2021.09.005 ; https://www.heart.org/en/health-topics/heart-attack/treatment-of-a-heart-attack/cardiac-medications ; https://www.heart.org/en/health-topics/heart-attack/warning-signs-of-a-heart-attack ; https://professional.heart.org/en/science-news/2025-guideline-for-the-management-of-patients-with-acute-coronary-syndromes/top-things-to-know