Complete Heart Attack & Recovery Report

Mr. Abdul Latif | Full record of events, tests, treatment, the plan ahead, and prescribed diet

Updated 17 July 2026 • includes discharge summary, echo, medicines & hospital diet chart

Patient	Mr. Abdul Latif (S/o Abdul Majeed)	**Age/Sex**	65 yrs / Male • Blood group A+
Diagnosis	Heart attack (Inferior/Posterior-wall MI) from 100% blocked LCX; plus blockages in LAD, D-1, RCA	**Procedure**	Primary angioplasty (PTCA) + 2 drug-eluting stents to LCX, via right wrist
Admitted	14/07/2026 (symptoms from eve of 13/07)	**Discharged**	16/07/2026 — condition improved
Hospital	Mittal Hospital & Research Centre, Ajmer	**Doctor**	Dr. Rahul Gupta, MD DM FACC — Sr. Interventional Cardiologist
Heart pump (EF)	**45% (reduced, recoverable range)**	**Next review**	**27/07/2026 with Dr. Gupta**

1. What happened — step by step

He felt uneasy for about a day; on the evening of 13/07 the discomfort began, and on 14/07 it became severe chest pain with sweating and ghabrahat — a heart attack. The full sequence:

Timeline — what happened on 14 July 2026

~4 days before	Feeling unwell, uneasy — cause unknown
14 Jul, afternoon	Severe unbearable chest pain + vomiting episodes
3:40 PM	Jai Clinic, Beawar — BP 160/80, ECG done
~4:01 PM	ECG: ongoing heart attack (Inferior MI) → emergency medicines given (Aspirin, Clopidogrel, Statin)
4:50–5:15 PM	Family coordinates; referred to Mittal Hospital, Ajmer; Dr. Rahul Gupta chosen (senior interventional cardiologist)
6:48 PM	Cardiac blood test: Troponin >10, CK-MB >80, BNP 511 — heart attack confirmed
Evening	Angiogram: LCX 100% blocked with clot; LAD 80–85%, D-1 80–85%, RCA 70–75%
Same evening	EMERGENCY ANGIOPLASTY via right wrist: balloon + 2 drug-coated stents opened the LCX artery
8:46 PM	Reports issued; procedure successful; patient shifted for recovery/observation

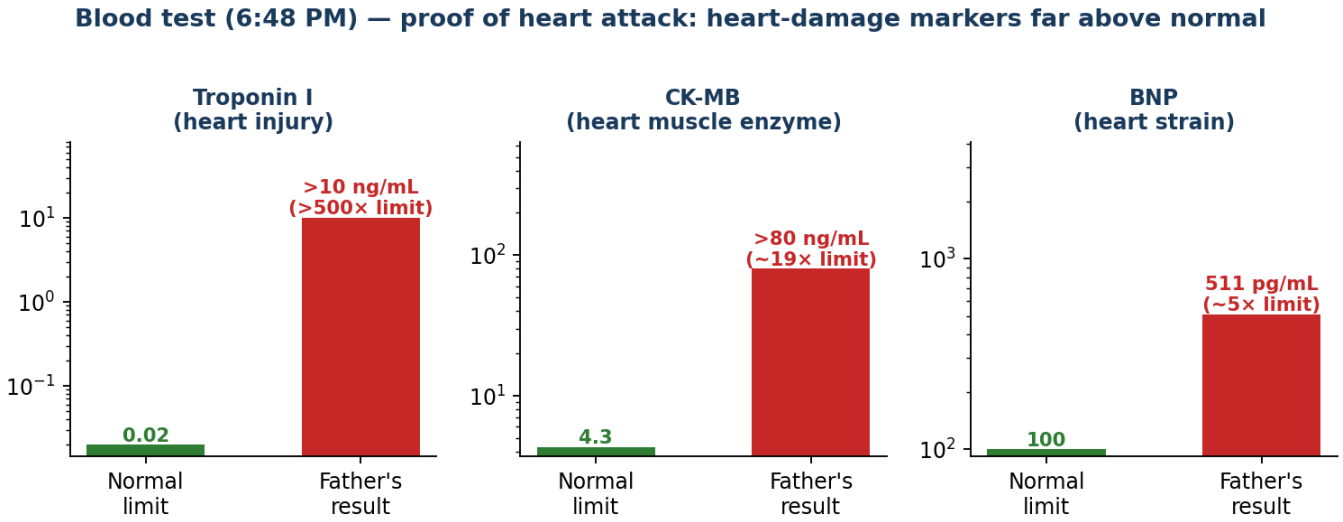
ECG to opened artery in roughly 5 hours. In a heart attack "time is muscle" — fast action saves heart muscle, and this was fast.

2. Every test explained

ECG (Jai Clinic, 4:01 PM)

Showed an active heart attack of the lower heart wall (Inferior MI, II/III/aVF) with ST changes. Emergency medicines (Aspirin, Clopidogrel, Atorvastatin) were started immediately — textbook-correct.

Cardiac blood markers (6:48 PM)



Troponin I above 10 (normal <0.02), CK-MB above 80 (normal <4.3), BNP 511 (normal <100): definite, significant heart attack with strain on the heart.

Coronary angiogram (dye X-ray of the arteries)

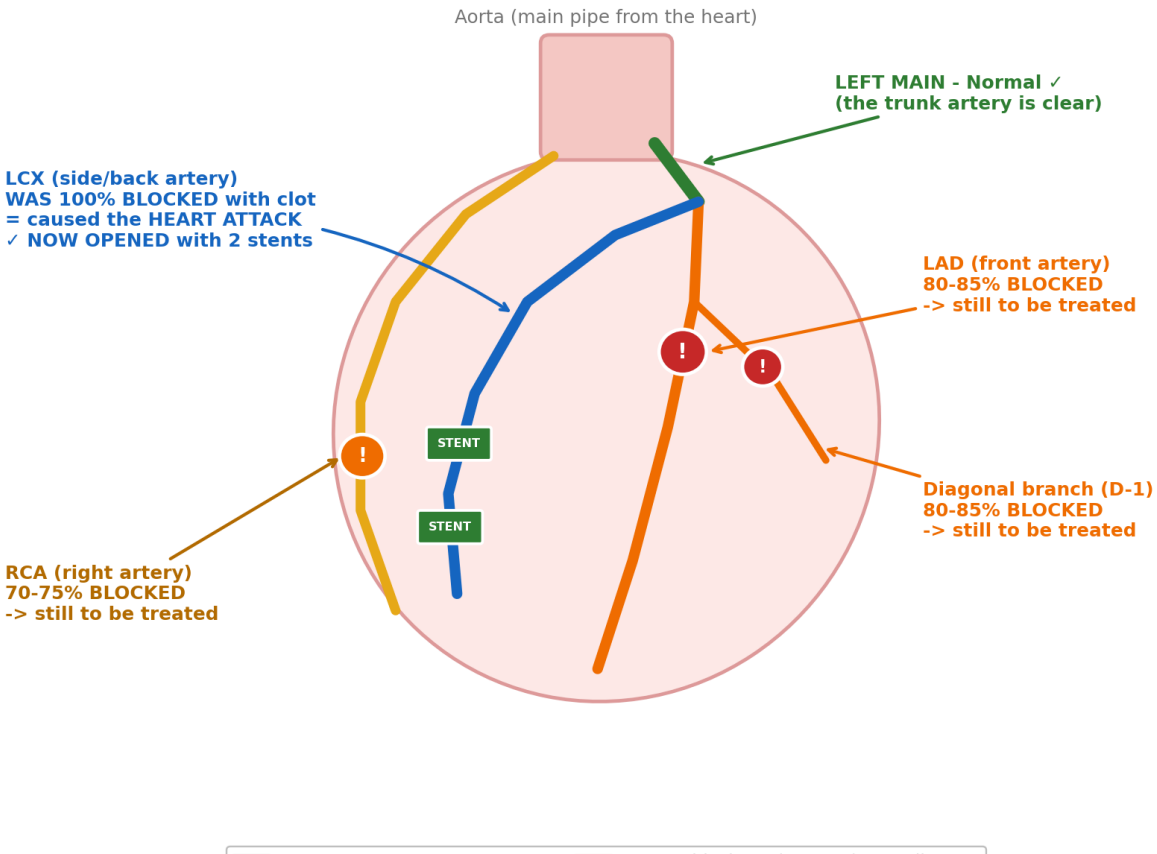
Left Main normal (good); LCX 100% blocked with fresh clot (the culprit); LAD 80–85%; Diagonal 80–85%; RCA 70–75%. Kidneys were excellent (creatinine 0.60, eGFR 107) — so the dye was safe.

Other pre-procedure bloods (14/07)

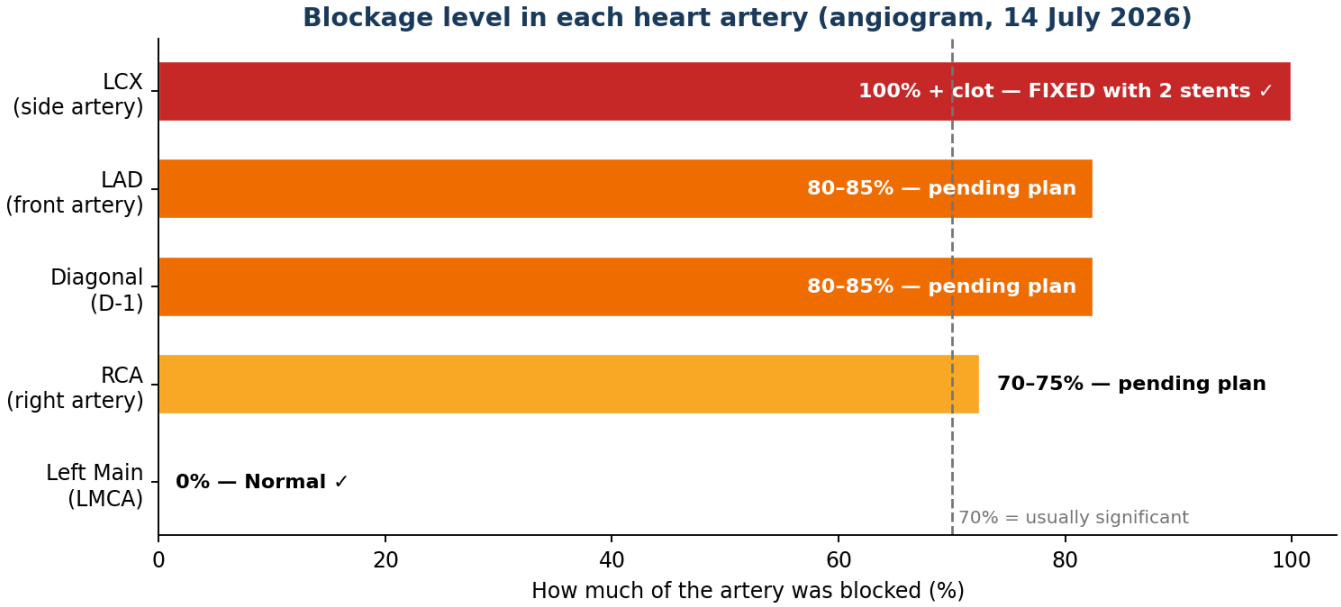
Haemoglobin 13.2 (mildly low — fits possible early iron deficiency); white cells raised at 13,490 (common stress response during a heart attack; an antibiotic course was given); platelets 241 and clotting INR 1.20 (normal — safe for blood thinners); HIV / Hepatitis B & C non-reactive.

3. The blockages, in one picture

Mr. Abdul Latif's heart arteries - simplified map from the angiogram (14 July 2026)



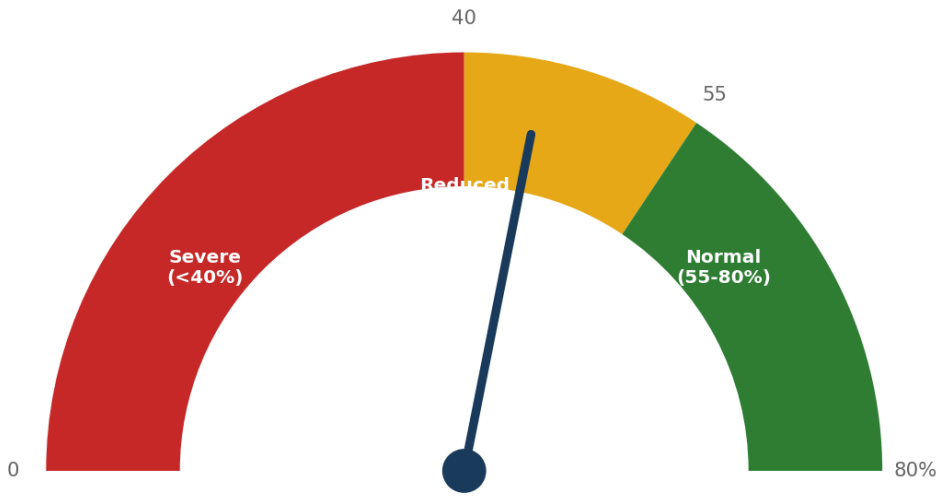
Simplified map from the angiogram — one pipe fully shut (now reopened with stents), three others significantly narrowed and awaiting a plan.



4. Heart pumping strength (EF) — a key new finding

The echo done on 15/07 measured how strongly the heart pumps — the "Ejection Fraction" (EF).

Heart pumping strength (LVEF) after the attack — Echo 15/07/2026



EF = 45%

Reduced but in the recoverable range — often improves over 1–3 months. Repeat echo will track it.

His **EF is 45%** (normal 55–80%). The wall supplied by the blocked LCX is moving weakly ("severely hypokinetic"), which is expected right after a heart attack. The echo also showed **concentric LVH** (thickened heart walls, usually from long-standing high blood pressure) and — reassuringly — **no clot inside the heart chambers** and no significant valve problem.

What this means: 45% is reduced but in the recoverable range. "Stunned" muscle after a heart attack often improves over the next 1–3 months with good medicines and blood flow. That is why a **repeat echo in about 1–3 months is one of the most important upcoming tests** — it will strongly influence the decision on the remaining arteries.

5. The procedure Dr. Gupta performed

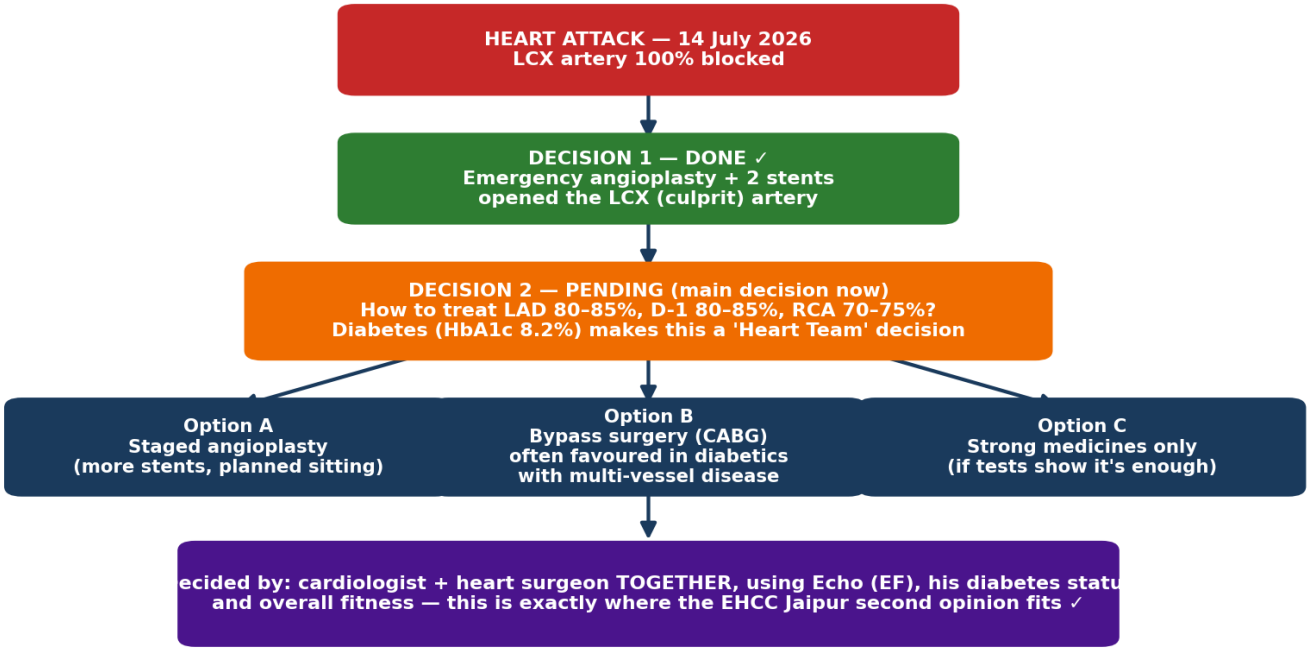
Step	Detail	In plain words
Access	Right radial artery, Tiger 5F	Through a small wrist puncture — no chest surgery, faster recovery
Wire	BMW Extra Floppy 0.014" x 190cm	A hair-thin wire steered across the clot
Balloon	Artimes 2.0 x 12mm at 14 atm	Tiny balloon opened a channel through the blockage
Stent 1	Promus PREMIER 2.50 x 28mm (mid-distal LCX)	Medicine-coated mesh tube, left permanently to hold the artery open
Stent 2	Promus PREMIER 2.75 x 20mm (proximal-mid LCX)	Second stent covering the rest; post-dilatation done to seat both

Stents are Boston Scientific drug-eluting stents (well-established brand). Report notes standard risks: re-narrowing 1–2%, stent clotting ~1% — which is exactly why the blood thinners must not be stopped.

6. Decisions — done, and still pending

Already done (all correct, standard practice): treat as heart attack immediately; refer to a cath-lab hospital; choose the senior cardiologist; open only the culprit LCX in the emergency; place two stents to cover it fully.

Decision map — what was decided, what is pending



The pending decision — how to treat the three remaining arteries (staged stents vs bypass vs medicines) — should be a Heart-Team decision, and depends partly on the repeat EF and the diabetes status. This is the main question for the follow-up and the second opinion.

7. Second opinion — Eternal Hospital / EHCC, Jaipur

Item	Detail
Why	Multi-vessel disease + diabetes + EF 45% makes the stent-vs-bypass choice a genuine one, best reviewed by a Heart Team (cardiologist + heart surgeon).
Hospital	Tertiary cardiac hospital, founded 2013 by Dr. Samin K. Sharma (Mount Sinai, New York); has interventional cardiology, cardiac surgery AND endocrinology together.
Contact	OPD appointments: +91-95491-58888 | Board: +91-141-5174000
Address	3A Jagatpura Road, Near Jawahar Circle, Jaipur 302017 (~3 hrs from Beawar)
Carry	Discharge summary, angiogram + PTCA reports, angiogram CD/films, echo report, all blood reports (incl. both HbA1c values), and the current medicine list.
Timing	Not an emergency — within 2–4 weeks is fine; sooner if symptoms. Do NOT stop or change any medicine while waiting.

8. Diabetes & other findings — one point to clarify

Important: two different HbA1c (3-month sugar average) figures appear in the papers. Please confirm the correct one with the doctor and get the printed HbA1c report — it affects both the diabetes plan and the artery decision.

Finding	Value	Meaning / action
HbA1c (version A — discharge summary)	**6.7%**	Reasonably controlled diabetes. CONFIRM which value is correct.
HbA1c (version B — other lab note)	**8.2%**	Poorly controlled. CONFIRM which value is correct.
Random / fasting glucose	176 / 195	Raised — consistent with diabetes; home monitoring needed.
Vitamin D	12.07	Low — supplement as prescribed.
Haemoglobin / iron pattern	13.2, low MCV/MCH	Possible early iron deficiency — iron studies if advised.
Kidney / liver / thyroid / lipids / Hep B,C	Normal	Reassuring; kidneys excellent (eGFR 107).
Pending (advised earlier)	Urine routine & culture	Do before next visit.

Either way, his diabetes medicine (Ajaduo — empagliflozin + linagliptin) is a good, modern, heart-protective choice. An endocrinologist should confirm the regimen and targets.

9. Discharge medicines — what each one is for

Medicine	What it is / does	When	Notes
Ecosprin 75	Aspirin — blood thinner #1	After lunch	**Long-term. Never stop on your own**
Brilinta 90	Ticagrelor — blood thinner #2	Morning + night	**~12 months. NEVER miss a dose**
Atorva 40	Statin — lowers & stabilises cholesterol	Night	Long-term
Concor COR 1.25	Beta-blocker — protects heart, controls rate/BP	Afternoon	Long-term
Angiwell 2.6	Long-acting nitrate — keeps arteries relaxed	Morning + night	Helps the still-narrowed arteries
Sorbitrate 5	Emergency nitrate — under the tongue	ONLY if chest pain	**Keep in pocket always. Pain not gone in minutes -> hospital**
Ajaduo 25/5	Diabetes (empagliflozin + linagliptin); also heart-protective	Before lunch	Modern, good choice
Pantocid DSR	Stomach protector (blood thinners irritate stomach)	Empty stomach, morning	~10 days
Monocef-O 200	Antibiotic	Morning + night	5 days only
Zedex-SF syrup	Sugar-free cough syrup	2 tsp x 3/day	For cough

Golden rules: (1) Brilinta + Ecosprin must never be interrupted — stopping early can suddenly clot a stent. (2) Sorbitrate goes under the tongue only during chest pain. (3) Tell every doctor/dentist about the stents before any procedure. (4) He has only about a week of tablets in hand — buy the next set before they run out, ahead of the 27/07 review.

10. Monitoring calendar

When	What	Purpose
Daily at home	BP (morning & evening), blood sugar (fasting + post-meal), watch wrist site for 1 week; keep a written diary	Catch problems early; the diary guides medicine changes
Before next visit	Urine routine & culture; iron studies if advised; obtain printed HbA1c	Complete pending workup; settle the HbA1c question
27/07/2026	Review with Dr. Gupta	Wound check, medicine review, plan for remaining arteries
2–4 weeks	EHCC Jaipur second opinion; Endocrinologist; (dietician chart already given)	Stents-vs-bypass decision; confirm diabetes regimen
1–3 months	REPEAT ECHO (EF); cardiology review; consider cardiac rehab / graded walking	See if pumping strength recovers — key for next steps
~3 months	Repeat HbA1c & lipid profile	Confirm sugar & cholesterol at target
6–12 months	Planned procedure(s) for remaining arteries per Heart-Team; annual diabetic eye & kidney screening	Complete treatment; prevent complications

11. Prescribed diet chart — Hospital Dietician (1800 kcal/day)

This is the official plan given by the hospital dietician on 17/07/2026, faithfully transcribed. Where items are separated by "or", choose any ONE option for that slot. All tea/coffee/milk is **without sugar** ("pheeka"). Roti is **multigrain**.

Time	Food (choose one where 'or' is shown)	Qty	Amount
Morning tea 6:30 AM	Tea (no sugar) + biscuits	1 cup + 2	100 ml + 25 g
Breakfast 8:30 AM	Upma **or** Poha **or** Dalia **or** Oats **or** Cornflakes **or** Roti **or** Vegetable sandwich + milk (no sugar)	1 bowl +1 glass	120 g +200 ml
Mid-morning 11:30 AM	Milk (no sugar) **or** Chaas **or** Lemon water (no sugar) + 1 fruit	1 glass +1 fruit	200 ml +150 g
Lunch 1:30 PM	Multigrain roti; Dal; Sabzi; Curd (dahi); Salad	3 roti 1 bowl each	90 g roti; dal 160 g; sabzi 120 g; dahi 120 g; salad 150 g
Evening tea 3:30 PM	Tea **or** Milk **or** Coffee **or** Chaas **or** Lemon water (all no sugar) + roasted chana **or** sprouts **or** biscuits **or** suji toast	1 cup/glass +1 bowl	100–200 ml +30–120 g
Dinner 8:00 PM	Soup; Multigrain roti; Dal; Sabzi; Curd (dahi); Salad	soup 1 cup 2 roti; 1 bowl each	soup 100 ml; roti 90 g; dal 160 g; sabzi 120 g; dahi 120 g; salad 150 g
Bedtime 10:00 PM	Milk (no sugar) + biscuits	1 glass + 2	200 ml + 15 g

How to use it well (heart + diabetes):

- Follow the fixed timings and keep portions as shown — the total is about 1800 calories, spread across the day so blood sugar stays steady.
- Keep everything **low-salt and low-oil** — cook sabzi/dal in minimal oil, avoid pickle, papad and fried food (this isn't printed on the chart but is essential after a heart attack).
- "No sugar" applies to all drinks; choose whole fruit over juice.
- Multigrain roti and dal/curd/salad give steady energy and fibre — good for both the heart and diabetes.
- If his weight, sugar readings or appetite change, the dietician can adjust the 1800 kcal up or down — carry the home sugar diary to that visit.

12. Activity & lifestyle after the stent

- Week 1–2: gentle indoor walking; avoid heavy lifting with the right arm (wrist site); no driving until cleared.
- Weeks 2–6: gradually build to ~30 min walking/day at a comfortable pace; stop if chest discomfort or breathlessness.
- Ask about cardiac rehabilitation — a supervised programme that improves recovery after heart attacks.
- Sleep 7–8 hrs; keep the home atmosphere calm (helps BP); absolutely no tobacco/smoking; no alcohol.

13. RED FLAGS — go to hospital immediately

• Chest pain/heaviness > a few minutes (take Sorbitrate under tongue; if not gone in minutes, rush) • Pain to arm/jaw/back • Sudden breathlessness • Cold sweat • Fainting/severe giddiness • Bleeding or swelling at wrist site • Black stools or blood in vomit • Sugar very high (>300) or very low (<70) with symptoms

14. Questions to ask — by doctor

Dr. Rahul Gupta (27/07 review)
1. Plan & timing for the remaining arteries (LAD, D-1, RCA) — staged stents, bypass, or medicines? 2. When to repeat the echo to recheck EF? 3. Confirm how long Brilinta continues. 4. When can he resume normal activity/travel? 5. Do you advise a Heart-Team / second opinion?
Endocrinologist
1. Which HbA1c is correct (6.7 vs 8.2)? 2. Is the current diabetes medicine right, or adjust? 3. Home sugar targets & testing schedule. 4. Vitamin D dose.
EHCC Jaipur (second opinion)
1. Reviewing the angiogram films & EF 45% — do the remaining blockages need intervention now? 2. For a diabetic with this anatomy — staged stents or bypass, and why? 3. If stents: how many sittings, when? If bypass: timing, risk, recovery? 4. Any change to current medicines?

In one paragraph: A dangerous heart attack from a fully blocked LCX artery was caught and fixed the same evening with two stents — fast, correct care. His heart pump is currently reduced (EF 45%, recoverable), three arteries remain narrowed, and his diabetes status needs one clarification (HbA1c 6.7 vs 8.2). The plan: strict medicines (never stop the blood thinners), a home BP/sugar diary, the prescribed 1800 kcal diet kept low-salt and low-oil, the 27/07 review, an endocrinologist visit, a repeat echo in 1–3 months, and a Heart-Team / EHCC second opinion on stents vs bypass for the remaining arteries.

Disclaimer: Prepared to help the family understand and organise the medical records (14–17 July 2026). This is not medical advice and does not replace the treating doctors. Every medicine, test and treatment decision must be confirmed by Mr. Abdul Latif's cardiologist, physician, endocrinologist and dietician.