Raja Rammohan Roy Road,
Prarthana Samaj, Girgaon,
Mumbai - 400004
Call Centre : 1800221166
Website : www.rfhospital.org

Name	Sameer Ansari		
Patient Id	0010469365	Case No	1002909053
Age/Sex	46 years/Male	D O B	30/06/1977
Attn Phy	Neeraj Kamat		
ID Mark	not known		

Sir H. N. Reliance Foundation Hospital And Research Centre

Date: 18/04/2024

TO WHOMSOEVER IT MAY CONCERN

On 7/4/2024 a 46 year old gentleman presented to RFH Emergency with complains of fever since 2 days. Patient had fever with chills, body-ache since night along with cough and white sputum. Patient had a history of previous admission in RFH when he was shifted from an outside hospital post-thrombolysis in a case of acute myocardial infarction. During the last admission, patient had a PEA (pulse-less electrical activity) cardiac arrest following a right heart catheterization.

Patient was admitted under the care of Dr Neeraj Kamat (Cardio-vascular and thoracic surgery). Dr Vasant Nagvekar (Infectious disease) was referred for antibiotic management. Accordingly, intravenous antibiotics were added to the treatment regimen. Dr Talha Meeran (Cardiology) was referred in view of previous history. Echocardiography of the patient was suggestive of ischaemic cardiomyopathy with severely compromised heart function.

Patient was shifted to the intensive care unit (ICU) for further care and management. Fluid management was done and metabolic parameters corrected daily as required. A negative fluid balance was maintained with intravenous diuretics. Intermittent NIV (non-invasive ventilation) support was given. In view of patient history of diabetes mellitus, Dr David Chandy (Endocrinology) was consulted for management.

High resolution CT scan (HRCT) chest was done which was suggestive of changes consistent with infective bronchopneumonia. On 10/4/2024 bronchoscopy was done by Dr Richa Mittal (Pulmonology) to rule out infective pathology. Samples (BAL – bronchoalveolar lavage) were taken and sent for investigative purposes. Antibiotic management based on sample findings were done by the infectious disease team. Chest xrays showed worsening daily.

Relatives of the patient were counseled about the critical condition of the patient in complete detail along with guarded prognosis and further care plan. All their doubts were answered in complete detail in the language best known to them. Patient required continuous NIV support. After discussing with the relatives and primary team, patient was electively intubated in view of respiratory distress and worsening hypoxia on 14/4/2024.

Patient had intermittent runs of non-sustainable ventricular tachycardia along with hypotension. Intravenous vasopressor support was started for the patient. A repeat CT scan of the chest was done which was suggestive of collapse consolidation at bases and mid-zone with ground glassing in upper zone – a possibility of secondary infection being high.

On 15/4/2024 patient underwent KOJI-VAD insertion by the primary team in the operating room. Patient was shifted to ICU for further care and management post-surgery on sedation, mechanical ventilation and intravenous vasopressor support.

Sedation was gradually tapered off and neurology assessment was done. Vasopressor support was titrated and tapered off as per improving blood pressure.

At present, patient in intubated and on mechanical ventilation. Anti-coagulant infusion is ongoing in view of KOJI VAD circuit. A negative fluid balance is continuously maintained with intravenous diuretic support

Dr. Fatima Pathare
2014/07/3351

"MEDICAL SUMMARY"

PATIENT NAME – MR. SAMEER SHAMIM ANSARI

AGE – 46YRS/MALE

CONSULTANT NAME –DR. HAMDULAY Z.I.

46YRS/MALE KNOWN CASE OF RECENTLY DIAGNOSED TYPE II DIABETES MELLITUS WITH RECENT HISTORY OF AWMI ON 10.03.2024 FOR WHICH PATIENT GOT ADMITTED IN NAIR HOSPITAL WHERE PATIENT WAS THROMBOLYSED WITH INJ STREPTOKINASE 15 LAC I.U. 2D ECHO DONE S/O LVEF-30%, CAG DONE S/O TRIPLE VESSEL DISEASE ADVISED REVASCULARISATION AFTER CARDIAC VIABLITY.
CARDIAC MRI-VIABLITY DONE ON 20.03.2024.
PATIENT ON 21.03.2024 HAD SYNCOPE HENCE, GOT ADMITTED TO MHI IN CARDIOGENIC SHOCK, PATIENT STARTED ON HIGH DOSE OF INJ. NORAD.
PATIENTS CARDIAC VIABLITY S/O LARGE NON VIABLE LAD TERRITORY WITH INFARCT AND STUNNED MID INFERIOR WALL WITH LVEF – 12%
PATIENT MAINTAINS GOOD PRESSURE HENCE, INOTROPES GRADUALLY TAPERRED AND OMITTED.
PATIENT UNDERWENT CATH STUDY ON 26.03.2024 BY DR NAGESH WAGHMARE
POST CATH STUDY PATIENT HAD CARDIO-RESP ARREST CPR GIVEN AS PER ACLS PROTOCOL PATIENT REVIVED
PATIENT AGAIN HAD CARDIO RESPIRATORY ARREST CPR GIVEN AND REVIVED.
PATIENT STARTED ON INOTROPIC SUPPORT- NORAD (4/50)@5ML/HR MAINTAINING BP- 120/80 MMHG
PATIENT ON NIV SUPPORT WITH 100% FIO2 MAINTAINING 99% SATURATION HENCE, PATIENT IS POSTED FOR URGENT HEART TRANSPLANT

DR. HAMDULAY Z.I.

Masina Heart Institute
Sant Savata Mali Marg,
Byculla East, Mazgaon,
Mumbai, Maharashtra - 400 027.

DEPARTMENT OF RADIOLOGY
B. Y. L. Nair Charitable Hospital & T. N. Medical College
Dr. A. L. Nair Road, Mumbai-400 008. India
Tel. No. : (022) 23027303 / 23027304

Name : Sameer Ansari
Age / Sex :
Unit :

Procedure No. :
Date : 11/3/2024
IP / OPD No.

S/D/B: Dr. Sangeetha (SVR)

USG KUB

Right Kidney:

10.7 x 5.6 cm

Normal in size, shape, echo.
CMD intact

No HN/HU/CAL

Left kidney:

10 x 5.8 cm

Normal in size, shape, echo.
CMD intact.

No HN/HU/CAL
- cortical irregularity (+).

- There are few (atleast 5) hyperechoic calculi noted in mid and lower pole, largest (m) 9mm in lower pole
- mild cortical irregularity (+).

Urinary Bladder: Empty/ Minimally/Partially/Over distended, normal.
- circumferential irregular thickening of bladder wall, max thickness (m) 6mm
- Prostate (m) 15cc - (N) in size, shape, echo, vascularity.

Impression:

- (R) sided non-obstructive renal calculi as described
- Circumferential irregular thickening of bladder wall as described.
  Adv: URM correlation

Dr. SVR Radio.

11/3/24

USG - Reassessment

S/D/B - Dr. Ishir (Reg.)
Dr. Mikrant (AP)

- Urinary Bladder - Distended,
  settled debris in bladder. - possibly, settled blood contents.
  However, no e/o any obvious clots noted in present scan.
- Rest findings consistent ~ prev. scan.

JR ↓ Radio

14/3/24

USG Reassessment

S/D/B :- Dr. Nikhil (FYR)
Dr. Fathima (SR)

* Urinary Bladder - Distended
  - No e/o any settled debris, clots noted in present scan.
  - Rest findings consistent ~ previous scan.

JR ↓ Radio

BRIHANMUMBAI MUNICIPAL CORPORATION

TOPIWALA NATIONAL MEDICAL COLLEGE & B. Y. L. NAIR CH. HOSPITAL

A L Nair Road, Mumbai Central, Mumbai - 400 008
Phone: 022-2308 1758 Telegraphic address: 'NAMECOL' Byculla

DEPARTMENT OF CARDIOLOGY

Name : Sameer Ansari

Age : 46 yrs Sex : Male Date : 11/08/24

2D ECHO AND COLOUR DOPPLER REPORT

S/B cardio Reg

1. Chamber Dimensions : IVS (d) = 7.5 mm AA = mm
   PW (d) = 9.5 mm LA = mm
   LVID (d) = 51 mm LVID (s) = mm
2. RWMA- AW/AS/AL severely hypokinetic at all 3 levels apex akinetic & ballooned out.
3. LVEF- 30 %
4. Cardiac Valve : Trivial MR
   Aortic Sclerosis No AS/ AR
   Mild TR
5. Diastolic Function- Type II DD
6. No PH / PASP by TR Jet - 35 mm Hg
7. LV Apical clot +/-
8. No e/o clot / Vegetation / Effusion
9. IAS / IVS Intact

- IVC collapsing c respiration

IMP : ISCHEMIC HEART DISEASE
REGIONAL WALL ABNORMALITY PRESENT
Severely depressed LV systolic function
Diastolic function : Type II DD
Pulmonary Hypertension mild PH

Cardiologist

11/3/24

DEPARTMENT OF CARDIOLOGY

BYL NAIR CH. HOSPITAL & T.N.M.C

S/B CARDIO REG

Samir Ansari 42yr/male

UD chest pain on 10/3/24 diagnosed as IWD-AWMI Thrombolysed with STK

HTN & renal stones CDNAS

DM ⊕ (new)

HTN ⊖

CVA ⊖

SEIZURE D/O ⊖

BLEDDING D/O ⊖

TOBACCO ⊖

SMOKING ⊖

DRUG ALLERGY ⊖

~~LMP~~

O/E

BP- 140/90

P- 84/min

S/E

RS – CLEAR

CVS- S1S2 +

PA- SOFT NT

CNS –CONCIOUS ORIENTED

PRE CATH ORDERS

NBM FROM MIDNIGHT

IV LINE LEFT UPPER LIMB

IV AUGMENTIN 1.2 GM

IV EFFCORLIN 100 MG

IV AVIL 2CC

CARDIO REG

Inj. Heparin (5000) 9pm – 3am

DEPARTMENT OF CARDIOLOGY

BYL NAIR CH. HOSPITAL & T.N.M.C
AL Nair road, Mumbai Central, Mumbai 8.
Phone: 022-23081758

PROF&HEAD OF DEPT : DR. AJAY S. CHAURASIA
ASSO PROF : DR.NIKHIL BORIKAR
ASST PROF : DR. SANDEEP KAMAT
: DR. PANKAJ KASHYAP
: DR. SHREYAK KADU
: DR. ARJUN MALI

CATH No: 503/2024
DATE : 12/03/2024

CORONARY ANGIOGRAPHY REPORT

NAME : SAMEER ANSARI

AGE :46 YEARS SEX :MALE

OPD No : 764026 IPD No : 9437

ADDRESS : MANDVI Ph No : 9224412780

CLINICAL DIAGNOSIS: IHD-AWMI (THROMBOLYSED WITH STK)

RISK FACTORS: DM

ANGIOGRAPHIC CONCLUSION:
ATHEROSCLEROTIC CORONARY ARTERY DISEASE

ADVICE:

1. LIFESTYLE MODIFICATION
2. RISK FACTOR MODIFICATION
3. MYOCARDIAL VIABILITY SCAN

Dr. Ajay S. Chaurasia
Prof. & Head
Cardiology Dept.,
Mumbai

DR AJAY S CHAURASIA
PROF & HEAD

HISTORY

H/o DM (newly diagnosed)
No H/o HTN
No H/o Smoking
No H/o Tobacco use
H/o chest pain on 10-03-2024 diagnosed as IHD- AWMI S/P thrombolysed with Streptokinase
USG KUB- Right kidney- non obstructive renal calculi.
H/o- Hematuria post STK. (Hematuria present)
HbA1C-7.79 %

PHYSICAL EXAMINATION

P - 76 bpm
BP- 130/80 mm Hg
CVS-JVP-normal,S1,S2-normal
RS-clear
P/A-NAD

ECG- EVENT-
ST elevation in V2-V5, I, aVL
NOW-
qS with ST elevation with T inversion in V2-V3
T inversion in V4-V6.

2D ECHO- LVID(d)-49 mm
PW (d)-9.5 mm
IVS (d)-9.5 mm
Anterior wall, anterior septum and anterolateral wall hypokinetic at all 3 levels
Apex akinetic and ballooned out.
LVEF-30%
Type II DD
Trivial MR
No AS/AR
Mild TR
PASP by TR jet 35 mm Hg
IAS/IVS intact
No clot/effusion/vegetations

CATH DATA

VASCULAR ACCESS: Right Radial Artery, Mod. Seldinger Technique,

INTRODUCER : 5 F Terumo Sheath.

CATHETERS: 5 F TIGER

CONTRAST : OMNIPAQUE

ANGIOGRAPHIC FINDINGS

a) Coronary anatomy-Right dominance

b) Left Coronary Artery:
   1. LMCA-normal
   2. LAD-Type III
      - Proximal-total occlusion with distal vessel filling retrogradely via collaterals from RCA

   3. LCX-non dominant
      - Proximal- normal
      - Distal- normal
      - OM 1 –normal
      - OM 2 – 70% long segment stenosis with 70% discrete stenosis in branch

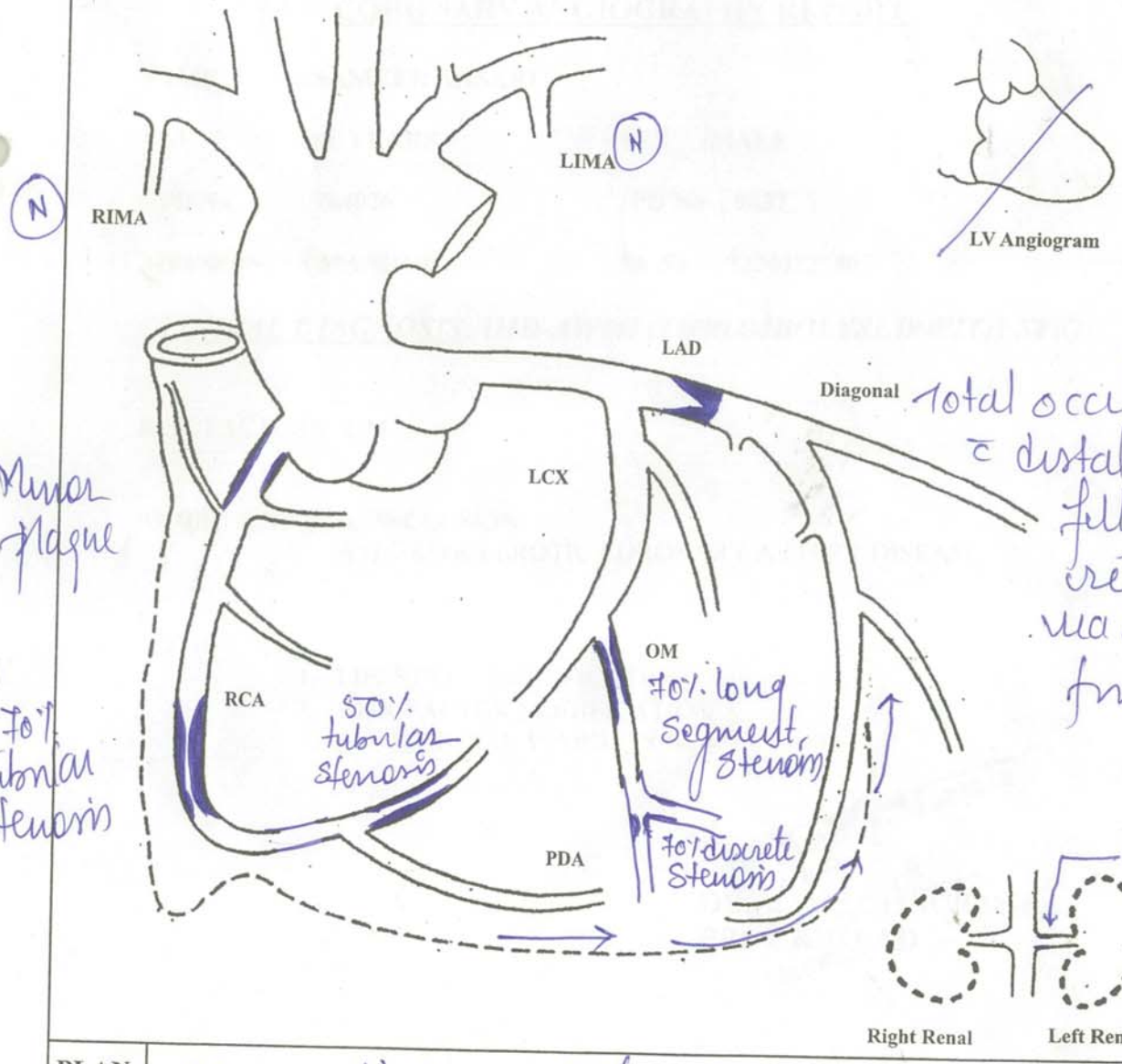
c) Right Coronary Artery: dominant
   - Proximal- minor plaque
   - Mid -70% tubular stenosis
   - Distal- normal
   - PDA- normal
   - PLV-50% tubular stenosis

d) LIMA – normal RIMA – normal

e) Renal Angiography: Right renal-Normal Left renal- Normal

BRIHANMUMBAI MUNICIPAL CORPORATION
TOPIWALA NATIONAL MEDICAL COLLEGE & B. Y. L. NAIR CH. HOSPITAL
Coronary Angiography Report

Name: SAMEER ANSARI
Date: 12 / 3 /20 24
Age: 46 Yrs. Sex: Male
Cath. No.: 503/2024
Diagnosis: IHD – AWMI (TxC STK)
Route: Rt Radial
LVEF (Echo): 30 %
Catheters: 5F TIG



PLAN Myocardial viability Scan

Registrar | Asst. Prof. | Assoc. Prof. | Prof. and H.O.D.

NS2062-HC-BMPP-57870-2022-23-5,000 Copies (M-2)

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TOPIWALA NATIONAL MEDICAL COLLEGE
& B. Y. L. NAIR CH. HOSPITAL

A. L. Nair Road, Mumbai Central, Mumbai - 400 008.
Phone : 022 - 23081758 Telegraphic Address : 'NAMECOL' Byculla

DISCHARGE SUMMARY

Faculty Members - Dr. Ajay Chaurasia (Prof. & Head) Dr. Nikhil Borikar (Lect.)
Dr. Sandeep Kamat (Lect.) Dr. Arjun Susar (Lect.)

Name : Sameer Ansari

Age : 46 Sex : Male / Female OPD/IPD : 764026/9437

Date of Admission : 10 / 3 / 2024 Date of Discharge : 16 / 3 / 2024

Diagnosis : IHD- AWMI S/P Tx c STK
Post CAG done on 12/2/24

Plan: Early revascularization

History :- H/o chest Pain on 10/3/24 Δed as IHD- AWMI
S/P Tx c STK
USG KUB- Right kidney non-obstructive calculi
H/o Hematuria post STK

DM ⊕ New
HTn ⊖

CAG on 12/3/24

HOSPITAL COURSE : Done by Dr. A.S.C. / Dr. N.B. / Dr. S.K. / Dr. A.S. Procedure and post procedure was uneventful.

& Team

ADVICE ON DISCHARGE :

- T. CLOPITAB A 150/75 OHO
- T. TONACT 80 OOH
- T. PAN 40 1-0-0
- T. NIKORAN 5 1-1-1
- T. RANOZEX 500 1-0-1
- S. DUPHALAC 30ml OOH
- T. SPLOMET XL 25 1-0-1
- T. LASILACTONE 20/50 1-0-0
- T. MTF 500mg 1-1-1
- T. DAPATURN 10 1-0-0

1 month

FOLLOW UP IN CARDIOLOGY O.P.D. NO. 45 ON MONDAY / FRIDAY AFTER 01 MONTH

(CARDIO REG.)

INVESTIGATION :

Hb : 15.7 TLC : 14610 PLATELETS : 275

ESR : _____ HIV : _____

RBS : 212 HBsAg : NR

BUN : 22 HCV : _____

Sr. CRATININE : 1.4

Sr. ELECTROLYTES : _____ Na : 139 K : 4.2 Cl : _____

LIPID PROFILE : _____ Sr. CHOLESTEROL : 216 Sr. TRIGLYCERIDES : 123

LFTs : _____ BILIRUBIN : 1.4 SGOT : 429 SGPT : 101

X RAY CHEST :

ECG : Event : ST↑ in $V_2 - V_5$, I, aVL
Now : QS with ST elevation in $V_2 - V_3$
T inv $V_4 - V_6$

CARDIAC EZAYMES : TROPONIN t : _____ CPK MB : _____

ECHOCARDIOGRAPHY : CHEMBER DIMENSIONS : LVID (d) : 49

IVS (d) : 9.5

PW(d) : 9.5

RWMA : PW, AS, AL Hypo at all 3 levels
Apex akinetic & ballooned out

LVEF : 30-1.

DIASTOLIC DYSFUNCTION : II

PASP BY TR JET : 35

IAS / IVS INTACT

NO CLOT / EFFUSION / VEGETATION

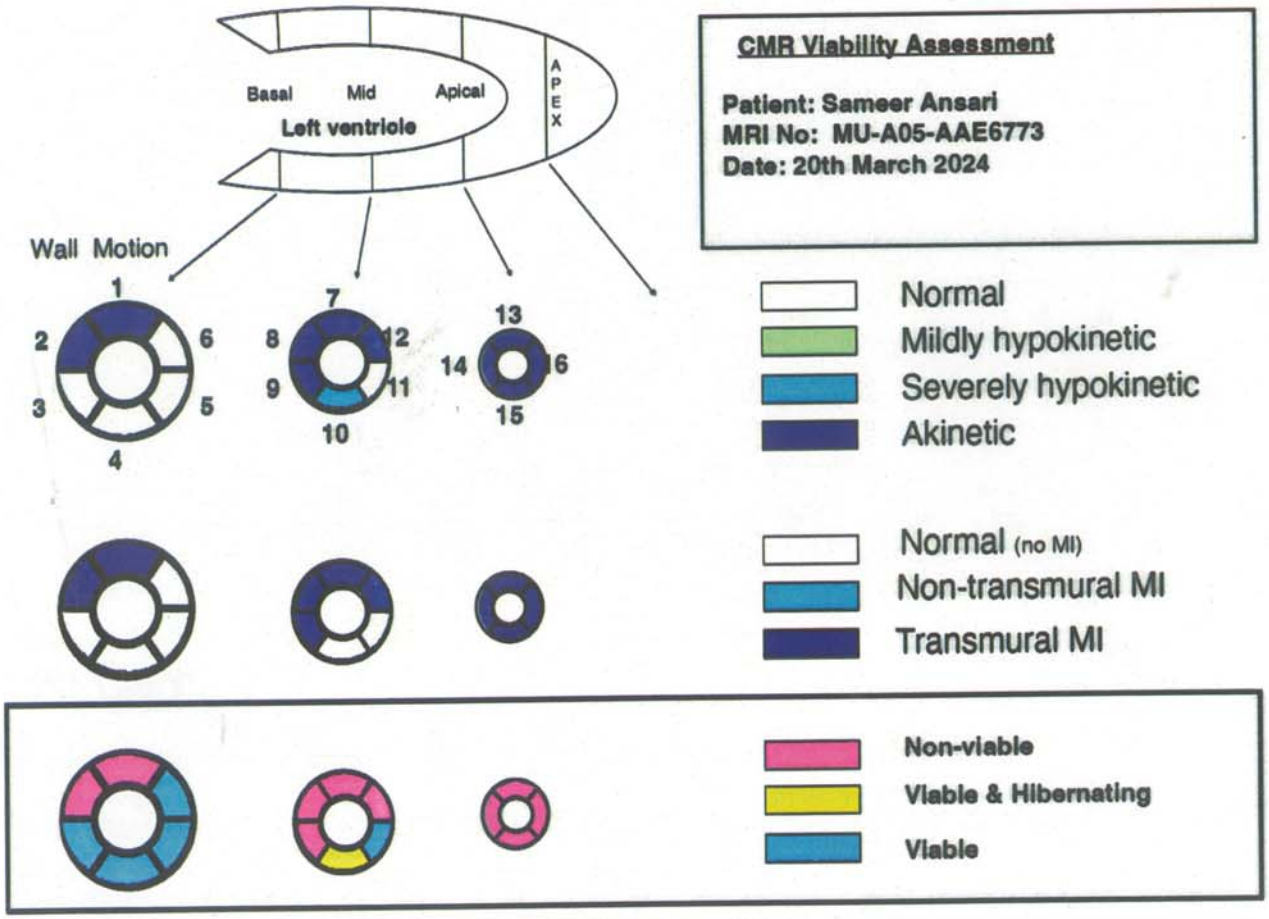
Trivial MR

Picture This
Imaging & Beyond
by Jankharia

Patient: Sameer Ansari
Patient ID: MU-A05-AAE6773
Referral Dr.: Hamdulay Zain-Ul-Abedin

Sex: Male
Age: 46 Year(s)

Visit ID: 625278
Date: 20-03-2024



Picture This by Jankharia

Main Clinic
383 | Bhaveshwar Vihar | Sardar V.P. Road | Prarthana Samaj | Charni Road | Mumbai 400 004 | T:022 6617 3333

Cardiac, Chest & Interventional CT
461 | Nishat Business Centre | Arya Bhavan | Sardar V.P. Road | Mumbai 400 004 | T: 022 68486666

PET/CT, Organ Optimized 3T MRI
Gr. Floor | Piramal Tower Annexe | G.K. Marg | Lower Parel | Mumbai 400 013 | T: 022 6617 4444

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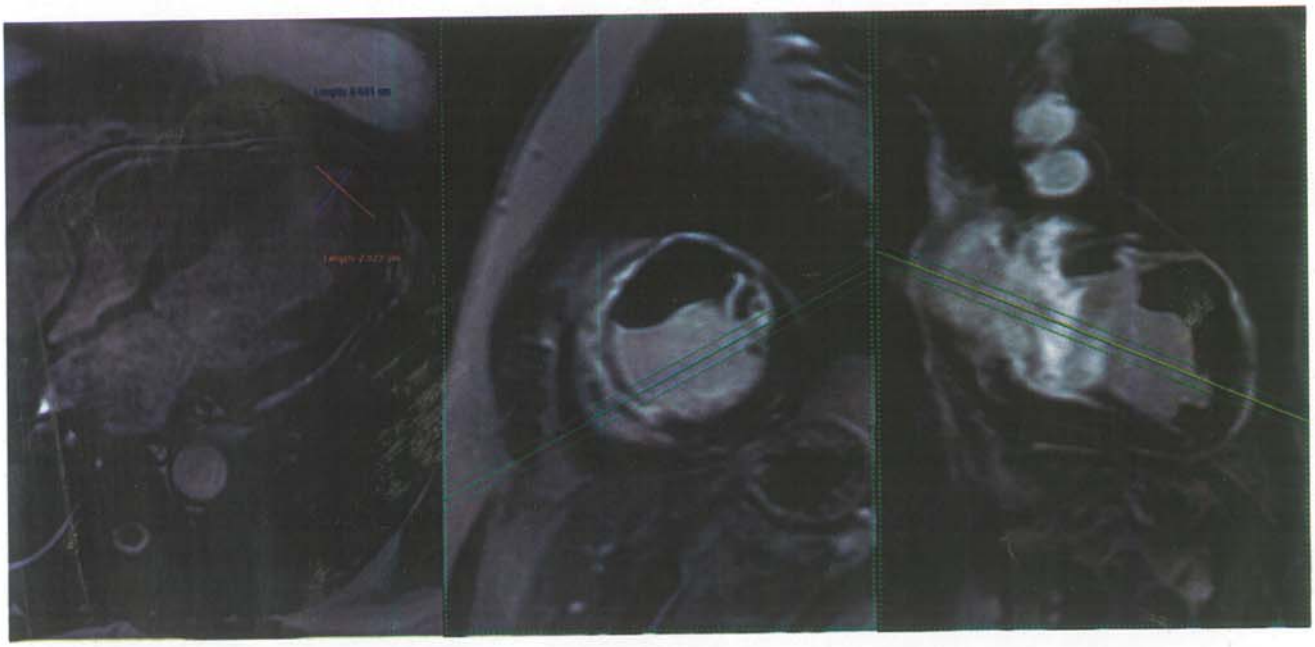

MRI Cardiac

A plain and contrast enhanced CMR was performed, for viability imaging.

Global Function: The LV ejection fraction is 12% with elevated end-systolic volume. Normal RV function is seen.

Basic cardiac and pericardial anatomy: Moderate pericardial effusion is noted measuring up to 2.2 cm in maximum thickness with mild diffuse smooth pericardial thickening showing most prominent enhancement in the region of the LV apex. Mild right pleural effusion is seen with mild left sided pleural thickening. No mediastinal or hilar adenopathy is seen. No great vessel abnormality is seen.

Segmental wall motion and function: Akinesia of the entire anterior wall (sparing the basal most portion), basal anteroseptal segment, mid septum, mid anterolateral segment, all the apical segments and the LV apex is seen with variable thinning of the mid and apical segments. Mild aneurysmal dilatation of the apical cavity is seen, measuring about 2 x 3 cm in 4 chamber dimensions.

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Imaging & Beyond
by Jankharia

Patient: Sameer Ansari
Patient ID: MU-A05-AAE6773
Referral Dr.: Hamdulay Zain-Ul-Abedin

Sex: Male
Age: 46 Year(s)

Visit ID: 625278
Date: 20-03-2024

The basal inferior wall and inferoseptal segment show normal contractility. The mid inferior wall shows severe hypokinesia to akinesia.

The basal lateral wall and mid inferolateral segment show normal contractility.

All the RV segments show normal contractility.

Left atrium is dilated with mild MR. Right atrium appears normal and shows mild to moderate TR.

Thrombus Imaging: **Extensive thrombus formation is seen along the anterior wall and LV apex measuring up to 3.0 cm in maximum thickness and 5.0 cm in maximum transverse extent along the mid anterior wall on the short axis images. On the two chamber view, it measures about 7.0 cm in overall longitudinal extent.**

Viability and Infarct Imaging: **Transmural infarction is seen involving the entire anterior wall (sparing the basal most portion), basal anteroseptal segment, mid septum, mid anterolateral segment, all the apical segments and the LV apex with underlying microvascular obstruction.**

Remarks:

A large non-viable LAD territory infarct is seen with extensive thrombus formation and underlying microvascular obstruction with aneurysmal dilatation of the apical cavity and associated reactive pericarditis and moderate pericardial effusion with mild right pleural effusion and left pleural thickening.

The mid inferior wall shows is likely "stunned". Normal systolic function without infarction is seen in the rest of the RCA territory and LCx territories.

Reported By: Dr. Nidhi Doshi, Dr. Bhavin Jankharia.

Dr. Bhavin Jankharia

Dr. Nidhi Doshi

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