GENERAL TEACHING HOSPITAL

Division of Cardiovascular Medicine
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CARDIOLOGY CONSULTATION

PATIENT INFORMATION

Name: John A. Doe (FICTIONAL)
DOB: 01/15/1985
Age: 40 years
Sex: Male
MRN: 1234567890
Consultation Date: 11/02/2025

CONSULTATION INFORMATION

Referring Physician: Sarah Therapy, PT, DPT
Consulting Physician: Dr. Richard Heartwell, MD
Date/Time: 11/02/2025, 14:00
Reason for Consult: Chest pain during physical therapy
Urgency: Urgent

HISTORY OF PRESENT ILLNESS

40-year-old male with no prior cardiac history presents for urgent cardiology consultation due to chest discomfort experienced during physical therapy session on 11/01/2025. Patient is 12 weeks status post motor vehicle accident with left hip fracture (surgically repaired), cervical strain, and lumbar strain. He has been participating in physical therapy 3x/week since August with good tolerance until yesterday.

During routine PT session involving treadmill walking at 2.5 mph for 15 minutes, patient developed substernal chest pressure described as "tight squeezing sensation" with radiation to left arm. Associated symptoms included mild shortness of breath and diaphoresis. Pain rated 6/10 intensity. Episode lasted approximately 8 minutes and resolved with rest and discontinuation of exercise. Patient denied palpitations, nausea, vomiting, or lightheadedness. Vital signs during episode: BP 165/95, HR 125, RR 24, O2 sat 96% on room air.

This is the first episode of chest pain patient has experienced. He reports being somewhat deconditioned due to prolonged recovery period but denies any previous cardiac symptoms, including chest pain, shortness of breath, palpitations, or syncope.

PAST MEDICAL HISTORY

Cardiovascular: Hypertension diagnosed 2018, well controlled
Current Incident: MVA 07/30/2025 with multiple traumatic injuries as noted
Surgical History: Left hip ORIF 07/31/2025, appendectomy 2010
Hospitalizations: Current injuries only
Family History: Father - MI at age 58, diabetes; Mother - hypertension; no sudden cardiac death
Social History: Former occasional smoker (quit 2020), rare alcohol use, sedentary since accident
Review of Systems: Denies orthopnea, PND, pedal edema, claudication, prior chest pain

CURRENT MEDICATIONS

Cardiac:
• Lisinopril 10mg daily

Pain Management:
• Tramadol 50mg q6h PRN
• Gabapentin 600mg TID

• Ibuprofen 600mg TID
• Tizanidine 4mg BID

GI Protection:
• Omeprazole 20mg daily

Allergies: No known drug allergies

PHYSICAL EXAMINATION

Vital Signs: BP 148/88 (repeat 142/84), HR 78, RR 16, T 98.4°F, O2 sat 98% RA, Wt 185 lbs
General: Well-appearing male in no acute distress, comfortable at rest
HEENT: Normocephalic, atraumatic, no JVD, carotids with normal upstroke, no bruits
Cardiovascular: Regular rate and rhythm, normal S1/S2, no murmurs, rubs, or gallops. PMI not displaced. No peripheral edema.
Pulmonary: Clear to auscultation bilaterally, no rales, wheezes, or rhonchi
Abdomen: Soft, non-tender, no organomegaly
Extremities: No cyanosis, clubbing, or edema. Pulses 2+ throughout. Left hip with surgical scar, well healed.
Neurological: Alert and oriented, no focal deficits

DIAGNOSTIC STUDIES

Electrocardiogram (12-lead):

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Sinus rhythm at 78 bpm
PR interval: 0.16 seconds
QRS duration: 0.08 seconds
QT/QTc: 420/435 milliseconds
Axis: Normal (60 degrees)
No ST-segment changes
No T-wave abnormalities
No Q-waves present
INTERPRETATION: Normal sinus rhythm, no acute changes
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Laboratory Results:
• Troponin I: <0.01 ng/mL (normal <0.04)
• CK-MB: 1.2 ng/mL (normal <5.0)
• BNP: 45 pg/mL (normal <100)
• Complete Metabolic Panel: Within normal limits
• Lipid Panel: Total chol 195, LDL 118, HDL 48, TG 145
• HbA1c: 5.8% (pre-diabetic range)

Chest X-ray:
Normal cardiac silhouette, clear lung fields, no acute cardiopulmonary process

Echocardiogram (Transthoracic):
• Left ventricular size: Normal
• Left ventricular function: Normal (EF 60-65%)
• Wall motion: Normal in all segments
• Right ventricular size and function: Normal
• Valves: Trivial mitral regurgitation, otherwise normal
• No pericardial effusion

CARDIOVASCULAR ASSESSMENT

Primary Impression:
Atypical chest pain with exertion in 40-year-old male with hypertension and family history of premature CAD. While clinical presentation could suggest possible coronary artery disease, initial cardiac workup including ECG, cardiac enzymes, and echocardiogram are reassuring and normal.

Differential Diagnosis:
1. **Musculoskeletal chest pain** - Most likely given recent trauma history, ongoing neck/back issues, and deconditioning
2. **Exercise intolerance due to deconditioning** - Patient has been sedentary for 12 weeks
3. **Coronary artery disease** - Less likely but cannot be completely excluded given family history and presentation
4. **Medication-related effects** - Possible interaction or side effects from

current pain medications
5. **Hypertensive response to exercise** - Blood pressure elevation noted during episode

Risk Stratification:
• Age: 40 years (intermediate risk)
• Family history: Positive (father MI at 58)
• Hypertension: Present but controlled
• Pre-diabetes: Newly identified (HbA1c 5.8%)
• Smoking: Former smoker (quit 2020)
• Activity level: Severely deconditioned
• 10-year ASCVD risk: Approximately 5-7% (borderline)

PLAN AND RECOMMENDATIONS

Immediate Management:
1. **Exercise stress test** recommended within 1-2 weeks to evaluate for exercise-induced ischemia
2. **Temporary restriction** from moderate-intensity physical therapy pending stress test results
3. **Low-intensity rehabilitation** may continue (walking <2.0 mph, light resistance exercises)
4. Patient educated on cardiac symptoms and when to seek immediate care

Cardiovascular Risk Modification:
1. **Blood pressure optimization:** Increase Lisinopril to 15mg daily, recheck in 2 weeks
2. **Pre-diabetes management:** Nutritionist referral, lifestyle counseling
3. **Lipid management:** LDL borderline high, recommend dietary modification initially
4. **Activity prescription:** Gradual return to exercise with heart rate monitoring

Follow-up Plan:
• Stress test scheduled for 11/10/2025

• Cardiology follow-up in 2 weeks post-stress test
• If stress test normal, clearance for progressive PT program
• If stress test abnormal, further cardiac evaluation (possible cardiac catheterization)

Additional Considerations:
• Consider cardiac rehabilitation program if indicated
• Coordinate care with PM&R and PT for safe exercise progression
• Patient provided with heart rate target zones for exercise
• Emergency action plan discussed

PATIENT EDUCATION

Patient counseled extensively on:
• Recognition of cardiac symptoms requiring immediate medical attention
• Importance of stress testing to ensure safe return to exercise
• Risk factor modification including diet, exercise, and blood pressure control
• Graduated exercise program once cleared
• Medication compliance and blood pressure monitoring
• When to contact cardiology for concerns

PHYSICIAN ATTESTATION

I have personally examined this patient and reviewed all available data. The above represents my cardiovascular assessment and recommendations for safe management of this patient's chest pain episode.

Electronically signed by: Dr. Richard Heartwell, MD, FACC
Date/Time: 11/02/2025, 14:00
Interventional Cardiology
License #: 86420 (FICTIONAL)
Board Certification: Internal Medicine, Cardiovascular Disease

⚠️ END OF FICTITIOUS TESTING DOCUMENT ⚠️
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