

Case 1

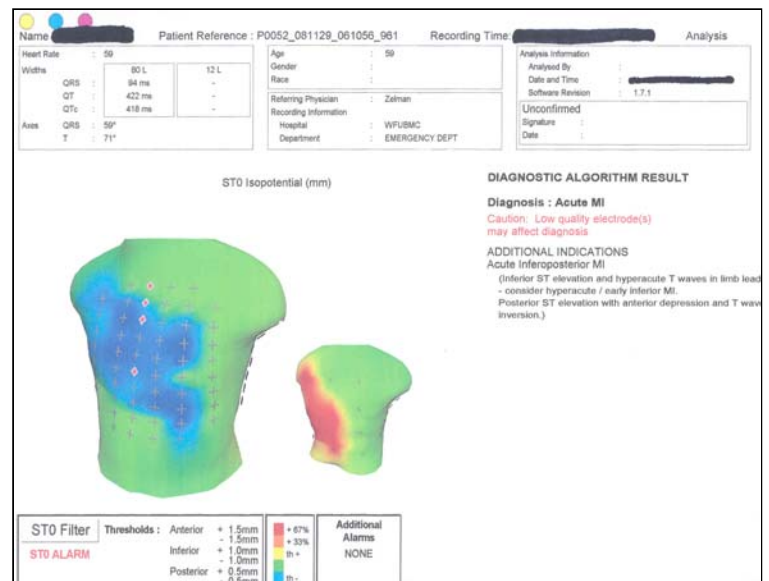
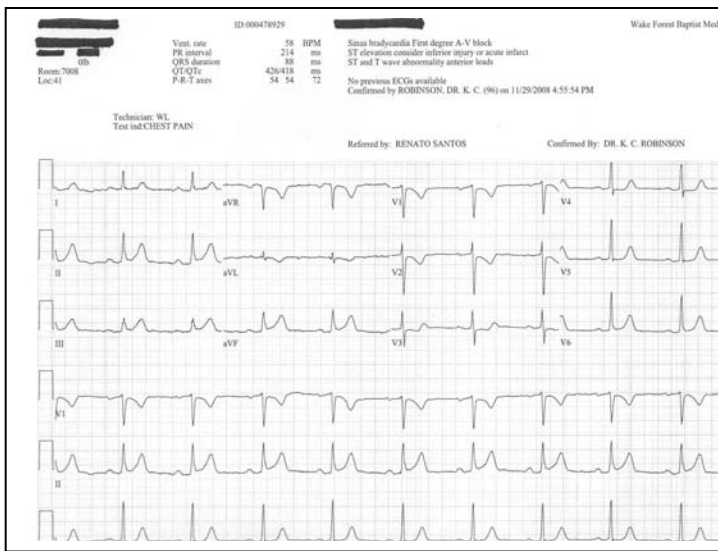
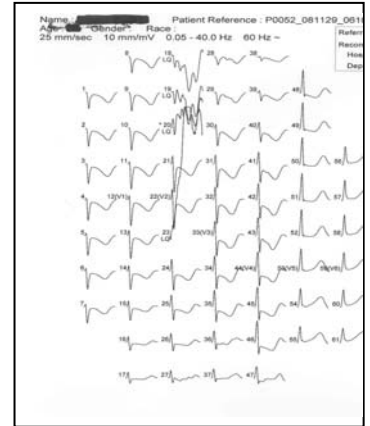
SW is a 59-year old woman with a PMH significant for HLD who presented to the ED after 3 days of central chest pain with associated symptoms. The patient had been seen at an outside hospital 2 days prior, ruled out, and discharged to home. The patient was intermediate risk for ACS given ASA use and ECG changes.

Initial ECG showed inferior ST elevation, which was present but less pronounced on ECG from outside hospital. PRIME ECG was consistent with acute inferior posterior MI.

Cardiology was consulted for evaluation. The patient did not proceed to cath initially. A short time later the patient went into a ventricular fibrillation arrest. She was

intubated and defibrillated with subsequent return of spontaneous circulation. At this point she was taken to the cath lab.

Cath lab findings included a 100% occlusion of the circumflex, 50% blockage in right coronary artery, and 25% blockage to left main artery. The circumflex artery was stented, to follow up in next several months.



Case 2

TH is a 68-year old male with a PMH significant for hypertension, GERD, asthma, who presented to our ED 9 hours after he developed central chest pain while reading the newspaper. He was still having pain upon presentation. He is intermediate risk for ACS given his age and ECG findings.

His ECG showed questionable

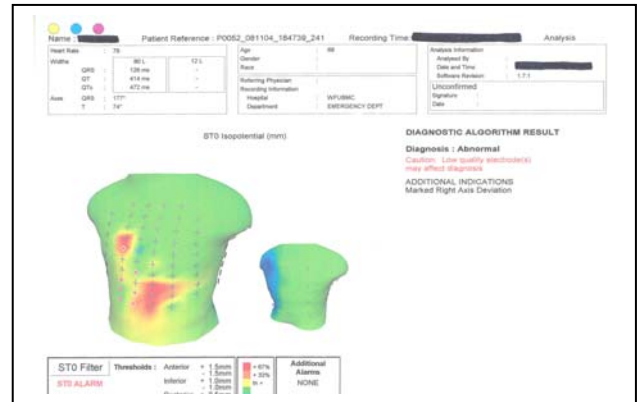
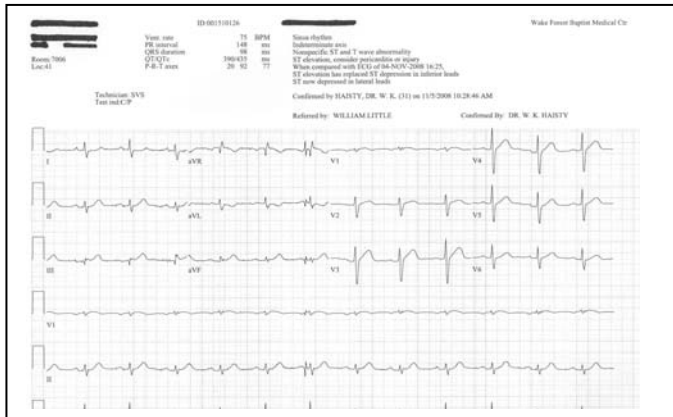
ST elevation inferiorly. Given the patient's ongoing chest pain, risk factors, and ambiguous ECG, PRIME ECG was obtained, that showed right axis deviation with an inferior STEMI.

The patient was not taken to the cath lab at this point, and was admitted to the CCU.

The patient's troponin peaked at 18.6. He had a left heart

catheterization the following day that showed a 98% occlusion to his right coronary artery, with stent placement.

On follow-up, the patient continues to do well.



Case 3

MV is a 95-year old female with a PMH significant for prior STEMI, HTN, CVA, presented to the ED with central and left-sided chest pain that began 5 hours PTA with associated symptoms. She was intermediate risk for ACS. An ECG showed T-wave inversion in lateral leads.

A PRIME ECG was obtained secondary to intermediate risk as

well as ongoing chest pain. The PRIME was interpreted as new LVH and no ischemia or infarction.

The patient was admitted to a cardiology floor and was subsequently ruled out for myocardial infarction. She was discharged, without PCI and had a return visit to the ED a short time later for an unrelated complaint.

The patient failed to follow up for her cardiology clinic appointment, and was found to be expired due to unknown reasons on follow-up.

