Reflection

Initially, the burden of assessing the live patient was high on me as I was dealing for the first time with a real patient aged 78 years. She was not feeling well since 7 am the last morning and detected with the chest discomfort associated with the shortness of breath, dizziness with fatigue and palpitations. Though I have taken the history of the patient and done with all the physical examination, firstly it was not clear to me about the cause of her illness but prior to the time of discharge she was looking graceful ad well independent. She was diagnosed with neuropathy, hypertension, and treatment was followed accordingly before. I have noticed with one of the factors that though the patient was stable with some of her diagnostic parameters although exception with other parameters was there. She was feeling collapse of the muscles and thus suffering from neuropathic pain with increased BP, HR and respiratory rate which are 135/90, 125 and 18 respectively.

The cardio examination of the patient when performed, the patient was found normal with her activities and responses obtained by the skin, head, eyes, nose, ears, teeth neck and abdomen. However, the heart rate was irregular with no heaves and irregular peripheral pulses were present. By addressing the history and present condition of the patient it was evaluated that the increased chest discomfort and occurrence of pain at the place, can be due to the patient history of hypercholesterolemia, hypertension, and stroke. This could result in increased cholesterol level which could affect the blood vessels and results in angina and myocardial infarction. I noticed that the recorded ECG shows a fast-atrial fibrillation with a high Chadvasc score i.e., 6 and HASBLED Score 3, I was in a dilemma that why the patient was not given up with any of the anticoagulant drugs before she was admitted to the hospital.

I remembered with one of our lectures on dealing effectively with the cardiovascular risks and role of anticoagulant in a patient with stroke but in

this case, I was revolted and surprised too that why the practical knowledge of treating a patient was not as same of the theoretical aspects. But at the end, it was decided by the response of other health care physicians and the multidisciplinary team that the patient should be accessed completely before making her on the treatment and was put on apixaban and bisoprolol so that she can be optimized and managed with her newly diagnosed disease of atrial fibrillation before her discharge. The patient as due to having a past medical history of stroke, I personally found the case as interesting though no plan was designed yet to plan for the condition of patient with high atrial fibrillation, I suggested the members of the team that makes the treatment process fast since the patient already was presented with the condition since 48 hours. As an initial clopidogrel was stopped since it could increase the risk of bleeding and the patient, in addition, was referred to the anticoagulation clinic for an outpatient ECHO.