

Case Report : A Man, 65 Years Old with Congestive Heart Failure NYHA III

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Case Report : A Man, 65 Years Old with Congestive Heart Failure NYHA III

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ABSTRAC

A man 65 years old, come to Dr. Kariadi hospital semarang, with a complaint of shortness of breath. Shortness of breath since a month before admission. Shortness of breath when the patient was advancing on walking by foot, and decreases when resting. Patients often wake up at midnight because of shortness of breath, sleep with two pillows, foot oedem (-); palpitations (+), chest pain(-), fever(-). The JVP R +3 cm; ronchi (+/+); The liver is palpable 4 cm below the arcus costae. Laboratory finding support, hemoglobin 13.8g/ dL; MCH 2657 pg; MCV77,26fL; MCHC 34.39 g/ dL; platelets 126.000 / mm³; ROW 16.99%; urea 45 mg /dL; ALP 210 U/L; GGT 259 U/L, Bilirubin Total 3,41 mg /dl, Bilirubin Direk 1, 67 mg /dl. Rontgen examination: Thorax Cardiomegaly And Calcification Arcus Aorta, Edema Pulmonum. Conclusion: based on history, physical examination and laboratory results and other investigations, concluded that patients suffering from CHF NYHA III and nephrolithiasis. Suggestion: examination is CKMB, NT Pro BNP to confirm the diagnosis of congestive heart failure and to assess the prognostic of disease. Examination of urine culture to see the complications and progresivity of the disease.

CASE REPORTS

I. PATIENTS IDENTITY AND HISTORY

Mr. S, 65 years old, come to Dr. Kariadi hospital Semarang, with a complaint of shortness of breath. Shortness of breath since a month before admission. Shortness of breath when the patient was advancing on walking by foot, and decreases when resting.

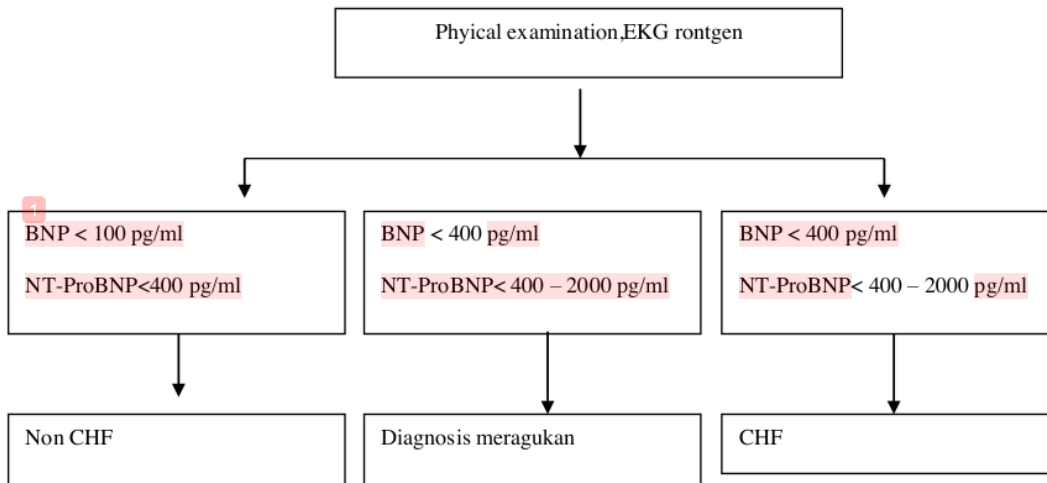
II. PHYSICAL EXAMINATION:

Patients often wake up at midnight because of shortness of breath. sleep with 2 pillows, foot oedem (-);palpitation(+), chest pain (-), lever t-). The JVP R +3 cm; ronchi (t I+); The liver is palpable 4 cm below the arcus costac.

III. LABORATORY FINDING SUPPORT:

Hemoglobin 3.8 g / dL; MCH 26.57 pg; MCV77,26 fL; MCHC 34.39 g / dL; platelets 126.000 / mm³; RBC 6.99%; urea 45 mg /dL; ALP 20 U /L; GGT 259 U /L. Bilirubin Total 3.41 mg /dL, Bilirubin Direk I. 67 mg /dL. Rontgen examination: Thorax Cardiomegaly And Calcification Arcus Aorta. Edema Pulmonum.

Algorithm examination, as seen in this figure below :



IV. TREATMENT HEART FAILURE:

Management of heart failure consists of diuretics oral or parenteral remains the spearhead of cardiovascular medicine till edema or ascites lost (achieved euvolaemic). Angiotensin ACE inhibitor or receptor blocker (ARB) small dose can be started after euvolaemic to optimal dose. Beta blockers small doses until the optimal can be started after diuretics and ACE inhibitors are given. Digitalis is given

When there is a supraventricular arrhythmias (atrial fibrillation or other SVT) or three drugs above does not give a satisfactory result. Aldosterone antagonist used to amplify the effect of diuretics or in patients with hypokalemia.

V. THEORETICAL / DISCUSSION:

Laboratory tests for heart failure consists of a blood tests: (Ib, leukocytes, and platelets), serum electrolytes, serum creatinine, glomerular filtration rate, blood glucose, liver function and urinalysis. A blood test marker for heart failure are: B-type natriuretic peptide (BNP) and N-terminal pro-BNP (NT-proBNP) are used for the diagnosis and management of heart failure.

In heart failure NYHA I, where the clinical diagnosis is less clear than the levels of pro-BNP already showed abnormalities, it is advantageous to make early diagnosis. Pro BNP will also increase in accordance with the severity of the disorder, so it can be used for staging and prognosis. Additionally, Pro BNP also can be used to get rid of asphyxiation due to the differential diagnosis of respiratory tract disorders in which the Pro-BNP levels are not increased. Pro-BNP is the prohormone BNP in myocardial cells mainly left ventricle of the heart with a 108 amino acid chain and secreted into the circulation and split into 1 NT-proBNP molecule with the amino acids 1-76 sequence inactive and one pro-BNP molecule with the sequence 77-108 32 active amino acids. Pro-NT BNP has a half life of 1-2 hours while the biologically active BNP has a half-life of 20 minutes. Heart failure is a clinical syndrome that arises as a result of the inability of the heart to pump blood due to functional or structural failure. Heart failure has a wide spectrum of disorder from mild to severe disturbances. The main manifestation of heart failure are shortness of breath, fatigue, limit physical labor, and is accompanied by fluid retention that led to the damage of pulmonary and peripheral

edema

Diagnosis: is made based on history, physical examination, ECG, chest X-ray,

ECG and catheterization. Framingham criteria are major criteria paroxysmal

nocturnal dyspnea, distended neck veins, pulmonary crackles, cardiomegaly,

acute pulmonary edema, S3 gallop, elevation of the jugular venous

pressure, reflux hepatojugular. Minor criteria: extremity edema and nighttime

cough. Dyspnea d'effort, hepatomegaly, pleural effusion. Obedience V.I

normal vital

capacity (Tachikardi $> 120 \times / \text{min}$). The diagnosis is made with at least one
major criterion and 2 minor criteria.

the functional" classification of heart failure who used the New York Heart

Class	Definition
I	Heart defects without physical limitations. Physical activity does not cause fatigue, palpitation, chest tightness or pain
II	Heart defects: there are mild physical limitations, disappears at rest. Strenuous physical activity causes fatigue, palpitation, chest tightness or pain.
III	Limitations on during physical activity, disappears at rest. Physical activity was lighter already causing fatigue, shortness of palpitations or chest pain
IV	Heart abnormalities that cause discomfort in physical activity. Symptoms of heart disease or illness in ironium been found in a resting state.

Differential diagnosis: The clinical symptoms of heart failure are shortness of breath. The differential diagnosis of shortness of breath (dyspnea) are bronchial asthma, pneumonia, bronchitis, congestive heart failure, pulmonary embolism pleural effusion, pneumothorax.

Heart failure in type 2 diabetes: cardiovascular disease is the leading cause of death in diabetes. Patients with type 2 Dm can suffer coronary heart two times larger and causing myocardial infarction, heart failure, shock, and death. Patients with type 2 Dm may also develop cardiomyopathy, heart disease without coronary heart disease with abnormal myocardial relaxation and clinically proven with left ventricular filling pressure is increased.

VI. CLINICAL DIAGNOSIS :

CHF WITH NYHA IIJ

VII. THERAPY IN CHRONIC HEART FAILURE:

Management of heart failure comprises: oral and parenteral diuretics remain the spearhead of cardiovascular medicine till edema or ascites lost (achieved euvolaemic). Angiotensin ACE inhibitor or receptor blocker (ARB) small dose can be started after euvolaemic samapai optimal dose. Beta blockers small doses until the optimal can be started after diuretics and ACE inhibitors are given. Digitalis is given when there is a supraventricular arrhythmias (atrial fibrillation or other SVT) or three drugs above do not result. Aldosterone antagonist is used to improve the effect of diuretic or to prevent with it) potassium.

VIII. CONCLUSION & SUGGESTION:

Conclusion: based on history, physical examination and laboratory results and other investigation., concluded that patients suffering from CI If NYHA III and nephrolithiasis. Suggestion: examination is CKMB, NT Pro BNP to confirm the diagnosis of congestive heart failure and to assess the prognostic of disease.

Examination or urine culture to see the complications and progresivity of the disease.

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