Case Studies in the Management of Hyperlipidemia
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Case #1

- 53 year old male who presents for prevention evaluation for coronary artery disease due to the fact that his closest friend recently died of sudden death and was found to have severe CAD at autopsy.
- He has no symptoms of CP or DOE.
- PMH: positive for hypothyroidism
- FH: Adopted
- SH: History of smoking for 20 years at a PPD, quit at age 38, eats reasonably well but does eat out a lot and has fast food 4-5 times per week, exercises regularly, jogging 20+ miles per week

Case #1

- PE: BP 138/88, P 68 and regular, Weight 210, Height 70 inches, otherwise unremarkable
- Medications: Multivitamin and Synthroid 50 mcg daily
- Baseline Labs: TSH 3.801, Free T4 1.1, FBS 109, TC 219, HDL-C 41, LDL-C 124, TG 270, Uric Acid 7.9, Urine analysis unremarkable

Case #2

- 55 Year old female who has a strong family history of coronary artery disease and Diabetes Mellitus but has no known disease herself. She denies any cardiovascular symptoms. She went through menopause at 49 and has been on HRT since.
- PMH: History of elevated BS not treated, elevated cholesterol not treated
- FH: Father died sudden death at 46, brother 48 s/p PTCA and stent, sister 52 with DM and Hyperlipidemia
- SH: Smokes ½ PPD, 1-3 beers per day, no exercise, diet high in meat, fat, sugar and salt
- Medications: Prempro 0.45/1.5 mg daily and multivitamin daily
- PE: BP 148/96, P 78, Weight 224, Height 64 inches, Fundi show mild arteriolar narrowing and increased light reflex, soft right carotid bruit, Gr 3/6 harsh SEM at the LLSB that radiates to the base, S4, bilateral decreased distal pulses

Case #2

- Baseline Labs: FBS 136, TSH 5.208, Cr 1.3, BUN 26, Uric Acid 9.1, TC 256, HDL-C 36, TG 486