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Coronary artery disease has assumed epidemic proportions in industrialized western world. In this part of the world about one third deaths in men between 45 to 64 years occur on account of coronary artery disease (CAD). In USA alone about a million people sustain myocardial infarction and about 6 lac people die of CAD every year. Out of these more than half die suddenly. Economic burden of this scourge has been estimated at a staggering figure of about 57 billion US dollar every year.

As against common belief incidence of CAD is not too low in developing world including India. From whatever limited statistics are available in our country, its incidence has been reported from 1 to 6 per thousand population (Berry, 1976). There is every reason to believe that incidence of CAD is fast increasing in India as indeed in other developing countries, possibly due to the increasing prevalence of coronary risk factors as a result of changing life styles (Krishnaswamy, 1970; Dadu Rao, 1984). Clinical studies have shown that ischaemic heart disease constitutes 10-20 of all cardiac admissions in Indian hospitals (Banarjee, 1966). It usually involves individuals in middle and older age groups, however, recently it has been reported that the incidence in younger individuals is also increasing (Gregory, 1983; Gupta et al, 1987).
Diagnosis of atherosclerosis is almost tantamount to the diagnosis of CAD though there are some rare causes also. There are still many unanswered questions regarding aetiopathogenesis of CAD, however, experimental, epidemiological and clinical evidences suggest its multifactorial aetiology. These aetiological factors are termed as "coronary risk factors (CRF)" coronary risk factors vary tremendously from person to person and from society to society dictating incidence of coronary artery disease in that society. In India not many studies have been carried out, especially prospectively regarding various coronary risk factors. In Indian studies the CRF were not found different from western studies but there could still be some unidentified risk factors peculiar to our masses like bidi smoking and tobacco chewing.

Clinical picture varies widely from patient to patient. On one hand the patient may have very slight chest discomfort and can sustain massive fatal infarction. On the other hand chest pain may be excruciating but there can be only angina or a small infarction. The other features of clinical picture like site, duration, nature of pain etc. are also very variable.

There is widespread ignorance, apathy among masses regarding the nature, outcome and management of "Heart attack". It is astonishing that for hours or even
days patient resorts to household remedies for such a potentially dangerous condition.

Keeping all these facts in mind the present study was carried out in cases of acute transmural myocardial infarction to study:

2. Clinical profile of acute myocardial infarction.
3. To assess patient's impression and attitude towards illness.
4. To determine prognostic factors, if any.