Medical Specialty:Cardiovascular / Pulmonary

Sample Name: Heart Catheterization, Ventriculography, & Angiography - 10

Description: Left heart catheterization, left and right coronary angiography, left ventricular angiography, and intercoronary stenting of the right coronary artery.

(Medical Transcription Sample Report)

PROCEDURE:  Left heart catheterization, left and right coronary angiography, left ventricular angiography, and intercoronary stenting of the right coronary artery.PROCEDURE IN DETAIL: The patient was brought to the Catheterization Laboratory. After informed consent, he was medicated with Versed and fentanyl. The right groin was prepped and draped, and infiltrated with 2% Xylocaine. Percutaneously, #6-French arterial sheath was placed. Selective native left and right coronary angiography was performed followed by left ventricular angiography. The patient had a totally occluded right coronary. We initially started with a JR4 guide. We were able to a sport wire through the total occlusion and saw a very tight stenosis. We were able to get a 30 x 13 mm power saver balloon into the stenosis and dilated. We then attempted to put a 30 x 12 mm stent across the stenosis, but we had very little guide support, the guide kept coming out. We then switched to an AL1 guide and that too did not enable us to get anything to cross this lesion. We finally had to go an AL2 guide, we were concerned that this could cause some proximal dissection. That guided seated, we did have initial difficulty getting the wire back across the stenosis, and we did see a little staining suggesting we did have some tearing from the guide tip. The surgeons were put on notice in case we could not get this vessel open, but we were able to re-cross with a sport wire. We then re-dilated the area of stenosis and with good guide support, we were able to get a 30 x 23 mm Vision stent, where the lesion was and post-dilated it to 18 atmospheres. Routine angiography did show that the distal posterolateral branch seems to be occluded, whether this was from distal wire dissection or distal thrombosis was unclear, but we were able to re-wire that area and get a 25 x12 Vision balloon and dilate the area and re-establish flow to the small segment. We then came back because of the residual dissection proximal to the first stent and put a 30 x15 mm Vision stent at 18 atmospheres. Final angiography showed resolution of the dissection. We could see a little staining extrinsic to the stent. No perforation and excellent flow. During the intervention, we did give a bolus and drip of Angiomax. At the end of the procedure, we stopped the Angiomax and gave 600 mg of Plavix. We did a right femoral angiogram; however, the Angio-Seal plug could not take, so we used manual pressure and a Femostop. We transported the patient to his room in stable condition.ANGIOGRAPHIC DATA: Left main coronary is normal. Left anterior descending artery has a fair amount of wall disease proximally about 50 to 60% stenosis of the LAD before it bifurcates into diagonal. The diagonal does appear to have about 50% osteal stenosis. There is a lot of plaquing further down the diagonal, but good flow. The rest of the LAD looked good pass the proximal 60% stenosis and after the diagonal branch. Circumflex artery was nondominant vessel, consisting of an obtuse marginal vessel. The first obtuse marginal had a long 50% narrowing and then the AV groove branch was free of any disease. Some mild collaterals to the right were seen. Right coronary angiography revealed a total occlusion of the right coronary, just about 0.5 cm after its origin. After we got a wire across the area of occlusion, we could see some thrombosis and a 99% stenosis just at the curve. Following the balloon

angioplasty, we established good flow down the distal vessel. We still had about residual 70% stenosis. When we had to go back with the AL2 guide, we could see a little bit of staining in the proximal portion of the vessel that we did not notice previously and we felt that the tip of the guide caused a little bit of intimal dissection. We re-dilated and then deployed. Repeat angiography now did show some hang up off dye distally. We never did have the wire that far down, so this was probably felt to be due to distal embolization of some thrombus. After deploying the stent, we had total resolution of the original lesion. We then directed our attention to the posterolateral branch, which the remainder of the vessel was patent giving off a large PDA. The posterolateral branch appeared to be occluded in its mid portion. We got a wire through and dilated this. We then came back and put a second stent in the proximal area of the right coronary proximal and abutting to the previous stent. Repeat angiography now showed no significant dissection, a little bit of contrast getting extrinsic to the stent probably in a little subintimal pouch, but this was excluded by the stent. There were no filling defects in the stent and excellent flow. The distal posterolateral branch did open up, although it was little under-filled and there may have been some mild residual disease there.IMPRESSION:  Atherosclerotic heart disease with total occlusion of right coronary, successfully stented to zero residual with repair of a small proximal dissection. Minor distal disease of the posterolateral branch and 60% proximal left anterior descending coronary artery stenosis and 50% diagonal stenosis along with 50% stenosis of the first obtuse marginal branch.