PROCEDURES PERFORMED:,1. Left heart catheterization with coronary angiography and left ventricular pressure measurement.,2. Left ventricular angiography was not performed.,3. Right posterior descending artery percutaneous transluminal coronary angioplasty followed by stenting.,4. Right femoral artery angiography.,5. Perclose to seal the right femoral arteriotomy.,INDICATIONS FOR PROCEDURE:, Patient presenting with a history of coronary artery disease in the past with coronary angiography in the early 1990s. The patient presented with what appeared to be a COPD exacerbation and had mildly positive cardiac enzyme markers suggestive of a non-ST elevation myocardial infarction. He was subsequently dispositioned to the cardiac catheterization lab for further evaluation.,DESCRIPTION OF PROCEDURE:, After informed consent was obtained, the patient was taken to the cardiac catheterization lab, where his procedure was performed. The patient was appropriately prepped and prepared on the table, after which his right groin was locally anesthetized with 1% lidocaine. Then, a 6-French sheath was inserted into the right femoral artery. Over a standard 0.035 guidewire, coronary angiography and left ventricular pressure measurements were performed using a 6-French JL4 diagnostic catheter to image the left coronary artery, a 6-French JR4 diagnostic catheter to image the right coronary artery, a 6-French angled pigtail catheter to measure left ventricular pressure. At the conclusion of the diagnostic study, the case was progressed to percutaneous coronary intervention, which will be described below. Subsequently,

right femoral artery angiography was performed which showed right femoral artery which was free of significant atherosclerotic plaque, and an arteriotomy that was suitable for a closure device. Then, a Perclose was used to seal the right femoral arteriotomy.,HEMODYNAMIC DATA:, The opening aortic pressure was 91/63. The left ventricular pressure was 94/13 with an end-diastolic pressure of 24. Left ventricular ejection fraction was not assessed, as ventriculogram was not performed. The patient did have some elevated creatinine earlier in this hospital course which warranted limitation of contrast where possible.,CORONARY ANGIOGRAM:, The left main coronary artery was angiographically okay. The LAD had mild diffuse disease. There appeared to be distal tapering of the LAD. The left circumflex had mild diffuse disease. In the very distal aspect of the circumflex after OM-3 and OM-4 type branch, there was a long, severely diseased segment that appeared to be chronic and subtotal in one area. The runoff from this area appeared to be a very small PLOM type branch and continuation of a circ which did not appear to supply much territory, and there was not much to salvage by approaching this lesion. The right coronary artery had mild diffuse disease. The PLV branch was 100% occluded at its ostium at the crux. The PDA at the ostium had an 80% stenosis. The PDA was a fairly sizeable vessel with a long course. The right coronary is dominant.,CONCLUSION:, Mild diffuse coronary artery disease with severe distal left circumflex lesion with not much runoff beyond this lesion. This circumflex appears to be

chronically diseased and has areas that appear to be subtotal. There is a 100% PLV branch which is also chronic and reported in his angiogram in the 1990s. There is an ostial 80% right PDA lesion. The plan is to proceed with percutaneous intervention to the right PDA.,The case was then progressed to percutaneous intervention of the right PDA. A 6-French JR4 guide catheter with side holes was selected and used to engage the right coronary artery ostium. The lesion was crossed with a long BMW 0.014 guidewire. Then, we ballooned the lesion with a 2.5 x 9 mm Maverick balloon. Subsequently, we stented the lesion with a 2.5 x 16 mm Taxus drug-eluting stent with a nice angiographic result. The patient tolerated the procedure very well, without complications.,ANGIOPLASTY CONCLUSION:, Successful percutaneous intervention with drug-eluting stent placement to the ostium of the PDA.,RECOMMENDATIONS:, Aspirin indefinitely, and Plavix 75 mg p.o. daily for no less than six months. The patient will be dispositioned back to telemetry for further monitoring.,TOTAL MEDICATIONS DURING PROCEDURE:, Versed 1 mg and fentanyl 25 mcg for conscious sedation. Heparin 8400 units IV was given for anticoagulation. Ancef 1 g IV was given for closure device prophylaxis.,CONTRAST ADMINISTERED:, 200 mL.,FLUOROSCOPY TIME:, 12.4 minutes.