

INDICATION:, Acute coronary syndrome.,CONSENT FORM: , The procedure of cardiac catheterization/PCI risks included but not restricted to death, myocardial infarction, cerebrovascular accident, emergent open heart surgery, bleeding, hematoma, limb loss, renal failure requiring dialysis, blood loss, infection had been explained to him. He understands. All questions answered and is willing to sign consent.,PROCEDURE PERFORMED:, Selective coronary angiography of the right coronary artery, left main LAD, left circumflex artery, left ventricular catheterization, left ventricular angiography, angioplasty of totally occluded mid RCA, arthrectomy using 6-French catheter, stenting of the mid RCA, stenting of the proximal RCA, femoral angiography and Perclose hemostasis.,NARRATIVE: , The patient was brought to the cardiac catheterization laboratory in a fasting state. Both groins were draped and sterilized in the usual fashion. Local anesthesia was achieved with 2% lidocaine to the right groin area and a #6-French femoral sheath was inserted via modified Seldinger technique in the right common femoral artery. Selective coronary angiography was performed with #6 French JL4 catheter for the left coronary system and a #6 French JR4 catheter of the right coronary artery. Left ventricular catheterization and angiography was performed at the end of the procedure with a #6-French angle pigtail catheter.,FINDINGS,1. Hemodynamics systemic blood pressure 140/70 mmHg. LVEDP at the end of the procedure was 13 mmHg.,2. The left main coronary artery is a large with mild diffuse disease in the distal third resulting in less than

20% angiographic stenosis at the take off of the left circumflex artery. The left circumflex artery is a large caliber vessel with diffuse disease in the ostium of the proximal segment resulting in less than 30% angiographic stenosis. The left circumflex artery gives rise to a high small obtuse marginal branch that has high moderate-to-severe ostium. The rest of the left circumflex artery has mild diffuse disease and it gives rise to a second large obtuse marginal branch that bifurcates into an upper and lower trunk.,The LAD is calcified and diffusely disease in the proximal and mid portion. There is mild nonobstructive disease in the proximal LAD resulting in less than 20% angiographic stenosis.,3. The right coronary artery is dominant. It is septal to be occluded in the mid portion.,The findings were discussed with the patient and she opted for PCI. Angiomax bolus was started. The ACT was checked. It was higher in 300. I have given the patient 600 mg of oral Plavix.,The right coronary artery was engaged using a #6-French JR4 guide catheter. I was unable to cross through this lesion using a BMW wire and a 3.0x8 mm balloon support. I was unable to cross with this lesion using a whisper wire. I was unable to cross with this lesion using Cross-IT 100 wire. I have also used second #6-French Amplatz right I guide catheter. At one time, I have lost flow in the distal vessel. The patient experienced severe chest pain, ST-segment elevation, bradycardia, and hypotension, which responded to intravenous fluids and atropine along with intravenous dopamine.,Dr. X was notified.,Eventually, an Asahi grand slam wire using the same 3.0 x 8 mm Voyager balloon

support, I was able to cross into the distal vessel. I have performed careful balloon angioplasty of the mid RCA. I have given nitroglycerin under the nursing several times during the procedure.,I then performed atherectomy using #5-French export catheter.,I performed more balloon predilation using a 3.0 x16 mm Voyager balloon. I then deployed 4.0 x15 mm, excised, and across the mid RCA at 18 atmospheres with good angiographic result. Proximal to the proximal edge of the stent, there was still some persistent haziness most likely just diseased artery/diffuse plaquing. I decided to cover this segment using a second 4.0 x 15 mm, excised, and two stents were overlapped, the overlap was postdilated using the same stent delivery balloon at high pressure with excellent angiographic result.,Left ventricular catheterization was performed with #6-French angle pigtail catheter. The left ventricle is rather smaller in size. The mid inferior wall is minimally hypokinetic, ejection fraction is 70%. There is no evidence of aortic wall stenosis or mitral regurgitation.,Femoral angiography revealed that the entry point was above the bifurcation of the right common femoral artery and I have performed this as Perclose hemostasis.,CONCLUSIONS,1. Normal left ventricular size and function. Ejection fraction is 65% to 70%. No MR.,2. Successful angioplasty and stenting of the subtotally closed mid RCA. This was hard, organized thrombus, very difficult to penetrate. I have deployed two overlapping 4.0 x15 mm excised and with excellent angiographic result. The RCA is dominant.,3. No moderate disease in the distal left main.

Moderate disease in the ostium of the left circumflex artery.  
Mild disease in the proximal LAD.,PLAN: , Recommend  
smoking cessation. Continue aspirin lifelong and continue  
Plavix for at least 12 months.