NAME OF PROCEDURE,1. Selective coronary angiography.,2. Placement of overlapping 3.0 x 18 and 3.0 x 8 mm Xience stents in the proximal right coronary artery.,3. Abdominal aortography.,INDICATIONS: ,The patient is a 65-year-old gentleman with a history of exertional dyspnea and a cramping-like chest pain. Thallium scan has been negative. He is undergoing angiography to determine if his symptoms are due to coronary artery disease.,NARRATIVE: ,The right groin was sterilely prepped and draped in the usual fashion and the area of the right coronary artery anesthetized with 2% lidocaine. Constant sedation was obtained using Versed 1 mg and fentanyl 50 mcg. Received additional Versed and fentanyl during the procedure. Please refer to the nurses' notes for dosages and timing.,The right femoral artery was entered and a 4-French sheath was placed. Advancement of the guidewire demonstrated some obstruction at the level of abdominal aorta. Via the right Judkins catheter, the guidewire was easily infiltrated to the thoracic aorta and over aortic arch. The right Judkins catheter was advanced to the origin of the right coronary artery where selective angiograms were performed. This revealed a very high-grade lesion at the proximal right coronary artery. This catheter was exchanged for a left #4 Judkins catheter which was advanced to the ostium of the left main coronary artery where selective angiograms were performed.,The patient was found to have the above mentioned high-grade lesion in the right coronary artery and a coronary intervention was performed. A 6-French sheath and a right Judkins guide was

placed. The patient was started on bivalarudin. A BMW wire was easily placed across the lesion and into the distal right coronary artery. A 3.0 x 15 mm Voyager balloon was placed and deployed at 10 atmospheres. The intermediate result was improved with TIMI-3 flow to the terminus of the vessel. Following this, a 3.0 x 18 mm Xience stent was placed across the lesion and deployed at 17 atmospheres. This revealed excellent result however at the very distal of the stent there was an area of haziness but no definite dissection. This was stented with a 3.0 x 8 mm Xience stent deployed again at 17 atmospheres. Final angiograms revealed excellent result with TIMI-3 flow at the terminus of the right coronary artery and approximately 10% residual stenosis at the worst point of the narrowing. The guiding catheter was withdrawn over wire and a pigtail was placed. This was advanced to the abdominal aorta at the area of obstruction and small injection of contrast was given demonstrating that there was a small aneurysm versus a small retrograde dissection in that area with some dye hang up after injection. The catheter was removed. The bivalarudin was stopped at the termination of procedure. A small injection of contrast given through arterial sheath and Angio-Seal was placed without incident.,It should also be noted that an 8-French sheath was placed in the right femoral vein. This was placed initially as the patient was going to have a right heart catheterization as well because of the dyspnea.,Total contrast media, 205 mL, total fluoroscopy time was 7.5 minutes, X-ray dose, 2666 milligray.,HEMODYNAMICS: , Rhythm was sinus throughout

the procedure. Aortic pressure was 170/81 mmHg.,The right coronary artery is a dominant vessel. This vessel gives rise to conus branch and two small RV free wall branches and PDA and a small left ventricular branch. It should be noted that there was competitive flow in the posterior left ventricular branch and that the distal right coronary artery fills via left sided collaterals. In the proximal right coronary artery, there is a large ulcerative plaque followed immediately by a severe stenosis that is subtotal in severity. After intervention, there is TIMI-3 flow to the terminus of the right coronary with better fill into the distal right coronary artery and loss of competitive flow. There was approximately 10% residual stenosis at the worst part of the previous stenosis.,The left main is without disease and trifurcates into a moderate-sized ramus intermedius, the LAD and the circumflex. The ramus intermedius is free of disease. The LAD terminates at the LV apex and has elongated area of mild stenosis at its mid segment. This measures 25% to 30% at its worst point. The circumflex is a large caliber vessel. There is a proximal 15% to 20% stenosis and an area of ectasia in the proximal circumflex. Distally, this circumflex gives rise to a large bifurcating marginal artery and beyond that point, the circumflex is a small vessel within the AV groove.,The aortogram demonstrates eccentric aneurysm formation. This may represent a small retrograde dissection as well. There was some dye hang up in the wall.,IMPRESSION,1. Successful stenting of subtotal stenosis of the proximal coronary artery.,2. Non-obstructive coronary artery disease in

the mid left anterior descending as described above and ectasia of the proximal circumflex coronary artery.,3. Left to right collateral filling noted prior to coronary intervention.,4. Small area of eccentric aneurysm formation in the abdominal aorta.