

PROCEDURE PERFORMED:, 1. Left heart catheterization with coronary angiography, vein graft angiography and left ventricular pressure measurement and angiography., 2. Right femoral selective angiogram., 3. Closure device the seal the femoral arteriotomy using an Angio-Seal., INDICATIONS FOR

PROCEDURE: , The patient with known coronary atherosclerotic heart disease and multiple risk factors of coronary disease, who had her last coronary arteriogram performed in 2004. She has had complaints of progressive chest discomfort, and has ongoing risks including current smoking, diabetes, hypertension, hyperlipidemia to name a few. The decision was made to proceed on with percutaneous evaluation and possible intervention given her known disease and the possibility of disease progression., DESCRIPTION OF

PROCEDURE:, After informed consent was obtained, The patient was taken to cardiac catheterization lab where her procedure was performed. She was prepped and prepared on the table; after which, her 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 guide wire.

Coronary angiography and left ventricular measurement and angiography 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 groin and her artery and the saphenous vein graft conduit. Subsequently, a 6-French angled pigtail catheter was used to measure left ventricular pressures and to perform a power injection, a left ventriculogram at 8 mL per second for a total of 30 mL. At the

conclusion of the diagnostic evaluation, the patient had selective arteriography of her right femoral artery, which showed the right femoral artery to be free of significant atherosclerotic plaque. Did have a normal bifurcation into the superficial femoral and profunda femoris arteries and to have an arteriotomy that was in the common femoral artery away from the bifurcation. As such, an initial attempt to advance a Perclose device failed to allow the device descend to \_\_\_\_\_ tract and into the appropriate position within the artery. As such, the Perclose was never deployed and was removed intact over the wire from the system. We then replaced this with a 6-French Angio-Seal which was used to seal the femoral arteriotomy with achievement of hemostasis. The patient was subsequently dispositioned back to the MAC Unit where she will complete her bedrest prior to her disposition to home.,HEMODYNAMIC DATA:, Opening aortic pressure 125/60, left ventricular pressure 108/4 with an end-diastolic pressure of 16. There was no significant gradient across the aortic valve on pullback from the left ventricle. Left ventricular ejection fraction was 55%. Mitral regurgitation was less than or equal to 1+. There was normal wall motion in the RAO projection.,CORONARY ANGIOGRAM:, The left main coronary artery had mild atherosclerotic plaque. The proximal LAD was 100% occluded. The left circumflex had mild diffuse atherosclerotic plaque. The obtuse marginal branch which operates as an OM-2 had a mid approximately 80% stenosis at a kink in the artery. This appears to be the area of a prior anastomosis, the saphenous vein graft to the OM. This is a

very small-caliber vessel and is 1.5-mm in diameter at best. The right coronary artery is dominant. The native right coronary artery had mild proximal and mid atherosclerotic plaque. The distal right coronary artery has an approximate 40% stenosis. The posterior left ventricular branch has a proximal 50 to 60% stenosis. The proximal PDA has a 40 to 50% stenosis. The saphenous vein graft to the right PDA is widely patent. There was competitive flow noted between the native right coronary artery and the saphenous vein graft to the PDA. The runoff from the PDA is nice with the native proximal PDA and PLV disease as noted above. There is also some retrograde filling of the right coronary artery from the runoff of this graft. The saphenous vein graft to the left anterior descending is widely patent. The LAD beyond the distal anastomosis is a relatively small-caliber vessel. There is some retrograde filling that allows some filling into a more proximal diagonal branch. The saphenous vein graft to the obtuse marginal was known to be occluded from the prior study in 2004. Overall, this study does not look markedly different than the procedure performed in 2004.

**CONCLUSION:** 100% proximal LAD mild left circumflex disease with an OM that is a small-caliber vessel with an 80% lesion at a kink that is not amenable to percutaneous intervention. The native right coronary artery has mild to moderate distal disease with moderate PLV and PDA disease. The saphenous vein graft to the OM is known to be 100% occluded. The saphenous vein graft to the PDA and the saphenous vein graft to the LAD are open. Normal left

ventricular systolic function.,PLAN:, The plan will be for continued medical therapy and risk factor modification. Aggressive antihyperlipidemic and antihypertensive control. The patient's goal LDL will be at or below 70 with triglyceride level at or below 150, and it is very imperative that the patient stop smoking.,After her bedrest is complete, she will be dispositioned to home, after which, she will be following up with me in the office within 1 month. We will also plan to perform a carotid duplex Doppler ultrasound to evaluate her carotid bruits.