PROCEDURE PERFORMED:, Insertion of a VVIR permanent pacemaker.,COMPLICATIONS:, None.,ESTIMATED BLOOD LOSS: , Minimal.,SITE:, Left subclavian vein access.,INDICATION: , This is an 87-year-old Caucasian female with critical aortic stenosis with an aortic valve area of 0.5 cm square and recurrent congestive heart failure symptoms mostly refractory to tachybrady arrhythmias and therefore, this is indicated so that we can give better control of heart rate and to maintain beta-blocker therapy in the order of treatment. It is overall a Class-II indication for permanent pacemaker insertion.,PROCEDURE:, The risks, benefits, and alternative of the procedure were all discussed with the patient and the patient's family in detail at great length. Overall options and precautions of the pacemaker and indications were all discussed. They agreed to the pacemaker. The consent was signed and placed in the chart. The patient was taken to the Cardiac Catheterization Lab, where she was monitored throughout the whole procedure. The patient was sterilely prepped and draped in the usual manner for permanent pacemaker insertion. Myself and Dr. Wildes spoke for approximately 8 minutes before insertion for the procedure. Using a lidocaine with epinephrine, the area of the left subclavian vein and left pectodeltoid region was anesthetized locally.,IV sedation, increments, and analgesics were given. Using a #18 gauge needle, the left subclavian vein access was cannulated without difficulty. A guidewire was then passed through the Cook needle and the Cook needle was then removed. The wire was secured in place with

the hemostat. Using a #10 and #15 scalpel blade, a 5 cm horizontal incision was made in the left pectoral deltoid region where the skin was dissected and blunted down into the pectoris major muscle fascia. The skin was then undermined used to make a pocket for the pacemaker. The guidewire was then tunneled through the pacer pocket. Cordis sheath was then inserted through the guidewire. The guidewire and dilator were removed. ___ cordis sheath was in placed within. This was used for insertion of the ventricular screw and steroid diluted leads where under fluoroscopy. It was placed into the apex. Cordis sheath was then split apart and removed and after the ventricular lead was placed in its appropriate position and good thresholds were obtained, the lead was then sutured in place with #1-0 silk suture to the pectoris major muscle. The lead was then connected on pulse generator. The pocket was then irrigated and cleansed. Pulse generator and the wire was then inserted into the ____ pocket. The skin was then closed with gut suture. The skin was then closed with #4-0 Poly___ sutures using a subcuticular uninterrupted technique. The area was then cleansed and dried. Steri-Strips and pressure dressing was then applied. The patient tolerated the procedure well. there was no complications.,These are the settings on the pacemaker:,IMPLANT DEVICE: , Pulse Generator Model Name: Sigma, model #: 12345, serial #: 123456.,VENTRICLE LEAD:, Model #: 12345, the ventricular lead serial #: 123456.,Ventricle lead was a screw and steroid diluted lead placed into the right ventricle apex.,BRADY PARAMETER SETTINGS ARE AS FOLLOWS:, Amplitude

was set at 3.5 volts with a pulse of 0.4, sensitivity of 2.8. The pacing mode was set at VVIR, lower rate of 60 and upper rate of 120.,STIMULATION THRESHOLDS: ,The right ventricular lead and bipolar, threshold voltage is 0.6 volts, 1 milliapms current, 600 Ohms resistance, R-wave sensing 11 millivolts.,The patient tolerated the procedure well. There was no complications. The patient went to recovery in stable condition. Chest x-ray will be ordered. She will be placed on IV antibiotics and continue therapy for congestive heart failure and tachybrady arrhythmia.,Thank you for allowing me to participate in her care. If you have any questions or concerns, please feel free to contact.