PREOPERATIVE DIAGNOSIS: , Coronary occlusive disease.,POSTOPERATIVE DIAGNOSIS: , Coronary occlusive disease.,OPERATION PROCEDURE: , Coronary bypass graft x2 utilizing left internal mammary artery, the left anterior descending, reverse autogenous reverse autogenous saphenous vein graft to the obtuse marginal. Total cardiopulmonary bypass, cold-blood potassium cardioplegia, antegrade for myocardial protection.,INDICATION FOR THE PROCEDURE: ,The patient was a 71-year-old female transferred from an outside facility with the left main, proximal left anterior descending, and proximal circumflex severe coronary occlusive disease, ejection fraction about 40%.,FINDINGS: , The LAD was 2-mm vessel and good, mammary was good, and obtuse marginal was 2-mm vessel and good, and the main was good.,DESCRIPTION OF PROCEDURE: ,The patient was brought to the operating room and placed in the supine position. Adequate general endotracheal anesthesia was induced. Appropriate monitoring devices were placed. The chest, abdomen and legs were prepped and draped in the sterile fashion. The right greater saphenous vein was harvested and prepared by 2 interrupted skin incisions and by ligating all branches with 4-0 Surgilon and flushed with heparinized blood. Hemostasis was achieved in the legs and closed with running 2-0 Dexon in the subcutaneous tissue and running 3-0 Dexon subcuticular in the skin.,Median sternotomy incision was made and the left mammary artery was dissected free from its takeoff of the subclavian to its bifurcation at the diaphragm and surrounded

with papaverine-soaked gauze. The pericardium was opened. The pericardial cradle was created. The patient was fully heparinized and cannulated with a single aortic and single venous cannula and bypass was instituted. A retrograde cardioplegic cannula was placed with a pursestring suture of 4-0 Prolene suture in the right atrial wall into the coronary sinus and tied to a Rumel tourniquet. An antegrade cardioplegic needle sump combination was placed in the ascending aorta and tied in place with 4-0 Prolene. Cardiopulmonary bypass was instituted and the ascending aorta was crossclamped. Antegrade cardioplegia was given at a total of 5 mL per kg through the aortic route. This was followed by something in the aortic route and retrograde cardioplegia through the coronary sinus at a total of 5 mL per kg. The obtuse marginal coronary was identified and opened.,End-to-side anastomosis was performed with a running 7-0 Prolene suture and the vein was cut to length. Cold antegrade and retrograde potassium cardioplegia were given. The mammary artery was clipped distally, divided and spatulated for anastomosis. The anterior descending was identified and opened. End-to-side anastomosis was performed with running 8-0 Prolene suture and the warm blood potassium cardioplegia was given antegrade and retrograde and the aortic cross-clamp was removed. The partial occlusion clamp was placed. Aortotomies were made. The veins were cut to fit these and sutured in place with running 5-0 Prolene suture. A partial occlusion clamp was removed. All anastomoses were inspected and noted to be

patent and dry. Ventilation was commenced. The patient was fully warm and the patient was then wean from cardiopulmonary bypass. The patient was decannulated in routine fashion. Protamine was given. Good hemostasis was noted. A single mediastinal chest tube and bilateral pleural Blake drains were placed. The sternum was closed with figure-of-eight stainless steel wire plus two 5-mm Mersiline tapes.,The linea alba was closed with figure-of-eight of #1 Vicryl, the sternal fascia closed with running #1 Vicryl, the subcu closed with running 2-0 Dexon, skin with running 4-0 Dexon subcuticular stitch. The patient tolerated the procedure well.