PREOPERATIVE DIAGNOSES,1. Dyspnea on exertion with abnormal stress echocardiography.,2. Frequent PVCs.,3. Metabolic syndrome.,POSTOPERATIVE DIAGNOSES,1. A 50% distal left main and two-vessel coronary artery disease with normal left ventricular systolic function.,2. Frequent PVCs.,3. Metabolic syndrome.,PROCEDURES,1. Left heart catheterization with left ventriculography.,2. Selective coronary angiography.,COMPLICATIONS: , None.,DESCRIPTION OF PROCEDURE: , After informed consent was obtained, the patient was brought to the Cardiac Catheterization Laboratory in fasting state. Both groins were prepped and draped in the usual sterile fashion. Xylocaine 1% was used as local anesthetic. Versed and fentanyl were used for conscious sedation. Next, a #6-French sheath was placed in the right femoral artery using modified Seldinger technique. Next, selective angiography of the left coronary artery was performed in multiple views using #6-French JL4 catheter. Next, selective angiography of the right coronary artery was performed in multiple views using #6-French 3DRC catheter. Next, a #6-French angle pigtail catheter was advanced into the left ventricle. The left ventricular pressure was then recorded. Left ventriculography was the performed using 36 mL of contrast injected over 3 seconds. The left heart pull back was then performed. The catheter was then removed.,Angiography of the right femoral artery was performed. Hemostasis was obtained by Angio-Seal closure device. The patient left the Cardiac Catheterization Laboratory in stable condition.,HEMODYNAMICS,1. LV pressure was

163/0 with end-diastolic pressure of 17. There was no significant gradient across the aortic valve.,2. Left ventriculography showed old inferior wall hypokinesis. Global left ventricular systolic function is normal. Estimated ejection fraction was 58%. There is no significant mitral regurgitation.,3. Significant coronary artery disease.,4. The left main is approximately 7 or 8 mm proximally. It trifurcates into left anterior descending artery, ramus intermedius artery, and left circumflex artery. The distal portion of the left main has an ulcerated excentric plaque, up to about 50% in severity.,5. The left anterior descending artery is around 4 mm proximally. It extends slightly beyond the apex into the inferior wall. It gives rises to several medium size diagonal branches as well as small to medium size multiple septal perforators. At the ostium of the left anterior descending artery, there was an eccentric plaque up to 70% to 80%, best seen in the shallow LAO with caudal angulation.,There was no other flow-limiting disease noted in the rest of the left anterior descending artery or its major branches.,The ramus intermedius artery is around 3 mm proximally, but shortly after its origin, it bifurcates into two medium size branches. There was no significant disease noted in the ramus intermedius artery however.,The left circumflex artery is around 2.5 mm proximally. It gave off a recurrent atrial branch and a small AV groove branch prior to terminating into a bifurcating medium size obtuse marginal branch. The mid to distal circumflex has a moderate disease, which is relatively diffuse up to about 40% to 50%.,The right coronary artery is around 4 mm in diameter. It gives off conus

branch, two medium size acute marginal branches, relatively large posterior descending artery and a posterior lateral branch. In the mid portion of the right coronary artery at the origin of the first acute marginal branch, there is a relatively discrete stenosis of about 80% to 90%. Proximally, there is an area of eccentric plaque, but seem to be non-flow limiting, at best around 20% to 30%. Additionally, there is what appears to be like a shell-like lesion in the proximal segment of the right coronary artery as well. The posterior descending artery has an eccentric plaque of about 40% to 50% in its mid segment.,PLAN: ,Plan to consult cardiovascular surgery for consideration of coronary artery bypass surgery. Continue risk factor modification, aspirin, and beta blocker.