

REASON FOR CATHETERIZATION:, ST-elevation myocardial infarction.,PROCEDURES UNDERTAKEN,1. Left coronary system cineangiography.,2. Right coronary system cineangiography.,3. Left ventriculogram.,4. PCI to the left circumflex with a 3.5 x 12 and a 3.5 x 8 mm Vision bare-metal stents postdilated with a 3.75-mm noncompliant balloon x2.,PROCEDURE: , After all risks and benefits were explained to the patient, informed consent was obtained. The patient was brought to the cardiac cath suite. Right groin was prepped in usual sterile fashion. Right common femoral artery was cannulated with the modified Seldinger technique. A 6-French sheath was introduced. Next, Judkins right catheter was used to engage the right coronary artery and cineangiography was recorded in multiple views. Next, an EBU 3.5 guide was used to engage the left coronary system. Cineangiography was recorded in several views and it was noted to have a 99% proximal left circumflex stenosis. Angiomax bolus and drip were started after checking an ACT, which was 180, and an Universal wire was advanced through the left circumflex beyond the lesion. Next, a 3.0 x 12 mm balloon was used to pre-dilate the lesion. Next a 3.5 x 12 mm Vision bare-metal stent was advanced to the area of stenosis and deployed at 12 atmospheres. There was noted to be a plaque shift proximally at the edge of the stent. Therefore, a 3.5 x 8 mm Vision bare-metal stent was advanced to cover the proximal margin of the first stent and deployed at 12 atmospheres. Next, a 3.75 x 13 mm noncompliant balloon was advanced into the margin of the stent and two inflations

at 20 atmospheres were done for 20 seconds. Final images showed excellent results with initial 99% stenosis reduced to 0%. The patient continues to have residual stenosis in the mid to distal in the OM branch. At this point, wire was removed. Final images confirmed initial stent results, no evidence of dissection, perforation, or complications.,Next, an angled pigtail catheter was advanced into the left ventricular cavity. LV pressure was measured. LV gram was done in both the LAO and RAO projections and a pullback gradient across the aortic valve was done and recorded. Finally, all guides were removed. Right femoral artery access site was imaged and Angio-Seal deployed to attain excellent hemostasis. The patient tolerated the procedure very well without complications.,

DIAGNOSTIC FINDINGS,

1. Left main: Left main is a large-caliber vessel bifurcating in LAD and left circumflex with no significant disease.,
2. The LAD: LAD is a large-caliber vessel, wraps around the apex, gives off multiple septal perforators, three small-to-medium caliber diagonal branches without any significant disease.,
3. Left circumflex: Left circumflex is a large-caliber vessel, gives off a large distal PDA branch, has a 99% proximal lesion, 50% mid vessel lesion, and a 50% lesion in the OM, which is a distal branch.,
4. Right coronary artery: Right coronary artery is a moderate-caliber vessel, dominant, bifurcates into PDA and PLV branches, has only mild disease. Otherwise, no significant stenosis noted.,
5. LV: The LVEF 50%. Inferolateral wall hypokinesis. No significant mitral regurgitation. No gradient across the aortic valve on pullback.,

ASSESSMENT

AND PLAN: , ST-elevation myocardial infarction with a 99% stenosis of the proximal portion of the left circumflex treated with a 3.5 x 12 mm Vision bare-metal stent and a 3.5 x 8 mm Vision bare-metal stent. Excellent results, 0% residual stenosis. The patient continues to have some residual 50% stenosis in the left circumflex system, some mild disease throughout the other vessels. Therefore, we will aggressively treat this patient medically with close followup as an outpatient.