PREOPERATIVE DIAGNOSES:,1. Ischemic cardiomyopathy.,2. Status post redo coronary artery bypass.,3. Status post insertion of intraaortic balloon.,POSTOPERATIVE DIAGNOSES:,1. Ischemic cardiomyopathy.,2. Status post redo coronary artery bypass.,3. Status post insertion of intraaortic balloon.,4. Postoperative coagulopathy.,OPERATIVE PROCEDURE:,1. Orthostatic cardiac allograft transplantation utilizing total cardiopulmonary bypass.,2. Open sternotomy covered with Ioban.,3. Insertion of Mahurkar catheter for hemofiltration via the left common femoral vein.,ANESTHESIA: , General endotracheal.,OPERATIVE PROCEDURE: , With the patient in the supine position, he was prepped from shin to knees and draped in a sterile field. A right common femoral artery vein were then exposed through a longitudinal incision in the right groin and prepared for cardiopulmonary bypass. A sternotomy incision was then opened and the lesions from the previous operative procedures were lysed and they were very dense and firm, freeing up the right atrium and the ascending aorta and anterior right ventricle. The patient was heparinized and then a pursestring suture was placed in the right atrium superior and inferior just above the superior and inferior vena cava. A percutaneous catheter for arterial return was placed using Seldinger technique through exposed right femoral artery and then two 3-mm catheters were inserted with two pursestring sutures in the right atrium just superior to inferior vena cava. After satisfactory heparinization has been obtained, the patient was placed on cardiopulmonary bypass

and another pursestring suture was placed in the right superior pulmonary vein and a catheter was placed for suction in the left atrium. After the heart was brought to the operating room and triggered, the patient had the ascending aorta clamped and tapes were placed around superior and inferior vena cava and were secured in place. A cardiectomy was then performed by starting in the right atrium. The wires from the pacemaker and defibrillator were transected coming from the superior vena cava and the Swan-Ganz catheter was brought out into the operative field. Cardiectomy was then performed, first resecting the anterior portion of the right atrium and then transecting the aorta, the pulmonary artery, the septum between the right and left atriums, and then the heart was removed. The right and left atrium, aorta, and pulmonary artery were prepared for the transplant. First, we did a side-to-side anastomosis, continued to the left atrium and this was performed using 3-0 Prolene suture and a right atrial anastomosis side-to-side was performed using 3-0 Prolene suture. The pulmonary artery was then anastomosed using 5-0 Prolene and the aorta was anastomosed with 4-0 Prolene. The arterial anastomosis in the pulmonary artery and aorta were not completed until the heart was filled with blood. Air was evacuated and the sutures were tied down. The clamp on the ascending aorta was removed and the patient was gradually overtime weaned from cardiopulmonary bypass. The patient had a postoperative coagulopathy which prolonged the period of time in the operating room after completion and weaning off of the cardiopulmonary bypass.

Blood factors and factor VII were given to try and correct the coagulopathy. Because of excessive transfusions that were required, a Mahurkar catheter was inserted through the left common femoral vein, first placing a needle into the vein and then guidewire removed, and the needle dilators were then placed and then the Mahurkar catheter was then placed with 2-0 nylon suture. Hemofiltration was started in the operating room at this time. After he had satisfactory hemostasis, we decided to do the chest open and cover it with Ioban, which we did, and one chest tube was inserted into the mediastinum through a separate stab wound. The patient also had an intraaortic balloon for counterpulsation which had been inserted into the left subclavian vein preoperatively. This was left in place and the pulse generation, the pacemaker was in a right infraclavicular position, which was left in place because of the coagulopathy. The patient received 11 units of packed red blood cells, 7 platelets, 23 fresh-frozen plasma, 20 cryoprecipitates, and factor VII. Urine output for the procedure was 520 mL. The preservation time of the heart is in the anesthesia sheet. The estimated blood loss was at least 6 L. The patient was taken to the intensive care unit in guarded condition.