

PROCEDURES UNDERTAKEN,1. Left coronary system cineangiography.,2. Right coronary system cineangiography.,3. Cineangiography of SVG to OM.,4. Cineangiography of LIMA to LAD.,5. Left ventriculogram.,6. Aortogram.,7. Percutaneous intervention of the left circumflex and obtuse marginal branch with plano balloon angioplasty unable to pass stent.,NARRATIVE:, After all risks and benefits were explained to the patient, informed consent was obtained. The patient was brought to the cardiac catheterization suite. The right groin was prepped in the usual sterile fashion. Right common femoral artery was cannulated using a modified Seldinger technique and a long 6-French AO sheath was introduced secondary to tortuous aorta. Next, Judkins left catheter was used to engage the left coronary system. Cineangiography was recorded in multiple views. Next, Judkins right catheter was used to engage the right coronary system. Cineangiography was recorded in multiple views. Next, the Judkins right catheter was used to engage the SVG to OM. Cineangiography was recorded. Next, the Judkins right was advanced into the left subclavian and exchanged over a long exchange length J-wire for a 4-French left internal mammary artery which was used to engage the LIMA graft to LAD and cineangiography was recorded in multiple views. Next, an angled pigtail catheter was advanced into the left ventricular cavity. LV pressures were measured. LV gram was done and a pullback gradient across the aortic valve was done and recorded. Next, an aortogram was done and recorded. At this point, I decided to proceed with

percutaneous intervention of the left circumflex. Therefore, AVA 3.5 guide was used to engage the left coronary artery. Angiomax bolus and drip was started. Universal wire was advanced past the lesion and a 2.5-balloon was advanced first to the proximal lesions and predilations were done at 14 atmospheres and then to the distal lesion and predilatation was done at 12 atmospheres. Next, we attempted to advance a 3.0 x 12 stent to the distal lesion; however, we were unable to pass the stent. Next, second dilatations were done again with the 2.5 balloon at 18 atmospheres; however, we are unable to break the lesion. We next attempted a cutting balloon. Again, we are unable to cross the lesion, therefore a buddy wire technique was used with a PT choice support wire. Again, we were unable to cross the lesion with the stent. We then try to cross with a noncompliant balloon, which we were unsuccessful. We also try to cutting balloon again, we were unsuccessful. Despite multiple dilatations, we were unable to cross anything beyond the noncompliant balloon across the lesion; therefore, finally the procedure was aborted. Final images showed no evidence of dissection, perforation, or further complication. The right groin was filled after taking an image to confirm sheath placement above the bifurcation with excellent results. The patient tolerated the procedure very well without complications, was taken off the operating table and transferred back to cardiac telemetry floor.,

**DIAGNOSTIC FINDINGS,**1. The LV. LVEDP was 4. LVES is approximately 50%-55% with inferobasal hypokinesis. No significant MR. No gradient across the aortic valve.,2. Aortogram. The ascending

aorta shows no significant dilatation or evidence of dissection. The valve shows no significant aortic insufficiencies. The abdominal aorta and distal aorta shows significant tortuosities.,3. The left main. The left main coronary artery is a large caliber vessel, bifurcating the LAD and left circumflex with some mild distal disease of about 10%-20%.,4. Left circumflex. The left circumflex vessel is a large caliber vessel gives off a distal branching obtuse marginal branch. The upper pole of the OM shows retrograde filling of the distal graft and also at that point approximately a 70%-80% stenosis. The mid left circumflex is a high-grade 80% diffuse tortuous stenosis.,5. LAD. The LAD is a totally 100% occluded vessel. The LIMA to LAD is patent with only a small-to-moderate caliber LAD. There is a large diagonal branch coming off the proximal portion of the LAD and that proximal LAD showed some diffuse disease upwards of 60%-70%. The diagonal shows proximal 80% stenosis.,6. The right coronary artery: The right coronary artery is 100% occluded. There are retrograde collaterals from left to right to the distal PDA and PLV branches. The SVG to OM is 100% occluded at its take off. The SVG to PDA is not found; however, presumed 100% occluded given that there is collateral flow to the distal right.,7. LIMA to LAD is widely patent.,ASSESSMENT AND PLAN: , Attempted intervention to the left circumflex system, only able to perform plano balloon angioplasty, unable to pass stents, noncompliant balloons or cutting balloon. Final images showed some improvement, however, continued residual stenosis. At this

point, the patient will be transferred back to telemetry floor and monitored. We can attempt future intervention or continue aggressive medical management. The patient continues to have residual stenosis in the diagonal; however, due to the length of this procedure, I did not attempt intervention to that diagonal branch. Possible consideration would be a stress test as an outpatient depending on where patient shows ischemia, focus on treatment to that lesion.