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**CTA Coronary  
Bypass Graft  
Report****SOUTH TAMPA  
CARDIOLOGY****ADVANCED IMAGING CENTER***South Tampa Cardiology  
3704 W Euclid Ave  
Tampa, FL 33629*

Patient name: <b>SIMMONS, SHAWN</b>		Patient ID: <b>45371</b>	
DOB: 05/18/1969	Chart#:	Referring Physician:	Tommy McElroy, MD
Age: 54Y	Inpt/Outpt: Outpatient	CT Technologist:	C. Alberto Morales, MD, FACC, FSCCT, FSCMR
Sex: M	B/P: /		RPVI
Weight: 195 lb	BSA:	Interpreting physician:	C. Alberto Morales, MD, FACC, FSCCT, FSCMR
Height: 68.9 in	DLP:	Location:	
CTDI:	Rhythm: Sinus Bradycardia	Examination date:	01/31/2024
		Previous Study:	

**Impressions**

**Procedure:** A Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material using 560 slice Arineta Cardiotop scanner. (CPT code: 75574). Data was transferred off-line for 3D image post-processing. (including curved MPR and Multi-Planar Imaging, evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed). Images were acquired at and reconstructed at 0.5 mm slice thickness.

**Indication:** Chest pain, hypertension, CAD

**Acquisition:** Prospective ECG triggering was used. Heart rate at the time of acquisition was approximately 74 bpm.

**Medications:** The patient received 65 cc of Omnipaque 350 contrast at a rate of 6.0 cc/sec. Patient was premedicated at the time of the scan with of a total of 0.4 mg sublingual Nitroglycerin.

**Complications:** There were no adverse side effects to the administration of medications or contrast.

**Dosimetry:** The Total DLP was 426. The total Msv dose of 5.9.

**Technical Quality:** Excellent, with no artifacts.

**Extracardiac Findings:**

Please note that this study is focused primarily for cardiovascular findings.

Limited field of views of the lungs and mediastinum were obtained for assessment of cardiovascular structures.

**LUNGS and MEDIASTINUM;**

No focal parenchymal opacities seen in visualized segments.

No evidence of mediastinal or hilar adenopathy in visualized segments.

**Pulmonary Artery;**

No central pulmonary artery embolism seen. The segmental and subsegmental arteries are not well visualized on this study.

**AORTA;**

The thoracic aorta is normal in size in the visualized sections.

There is no dissections involving the thoracic aorta in visualized sections.

There is no aortic atherosclerosis present.

**CARDIAC MORPHOLOGY;**

The pericardium is normal in appearance with no pericardial effusion.

Systemic and pulmonary venous drainage is normal with no mal-connections or shunts present.

The left atrial appendage is well visualized with no evidence of thrombus.

Left Ventricle: The ventricular cavity size is within normal limits. There are no stigmata of prior infarction. There is no abnormal filling defect.

**VALVES;**

The aortic valve tricommissural with no thickening and mild calcification present.

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Int. Physician: C. Alberto Morales, MD, FACC,

The mitral valve is normal in appearance with no thickening or calcification present.

**CORONARIES;**

The right artery is the dominant vessel.

The left main artery arises from the left aortic cusp. The left main artery has a minimal (<15% stenosis) partially-calcified plaque present and bifurcates in the normal fashion into the left anterior descending artery and left circumflex artery.

The left anterior descending artery (LAD) arises from the left main and is a large sized caliber vessel that supplies 2 diagonal branches. The proximal LAD has a moderate (<50% stenosis) partially-calcified plaque present, the mid LAD has mild (<25% stenosis) partially-calcified plaque present, the distal LAD is angiographically normal. The first diagonal artery is large in size and is sub-totally occluded (>90% stenosis) with partially calcified plaque. The second diagonal artery is medium in size and is angiographically normal.

The left circumflex artery (LCX) arises from the left main and is a large sized caliber vessel that supplies 1 obtuse marginal (OM) branches. The proximal LCX has a minimal (<15% stenosis) partially-calcified plaque present, the mid LCX is angiographically normal, the distal LCX is angiographically normal. The OM artery is large and branching in size and is angiographically normal.

The right coronary artery (RCA) arises from the right aortic cusp and distally RCA supplies the posterior descending artery (PDA) and posterior lateral-ventricular branch (PLV). The proximal RCA has a moderate (<50% stenosis) partially-calcified plaque present, the mid RCA is sub-totally occluded (>90% stenosis) with partially calcified plaque and distal to the lesion there is a stent with severe in-stent restenosis, the distal RCA is angiographically normal. The PDA is small in size and is angiographically normal. The PLV is small in size and is angiographically normal.

**IMPRESSION:**

1. Severe Coronary Artery Disease (CAD) as described above.

**RECOMMENDATIONS:**

- Goal LDL-C <40 mg/dl (for every 40 mg/dl drop in LDL-C with STATIN leads to 25% relative risk of major adverse CV events and all cause mortality by 10%)
- High-Intensity Statin: Rosuvastatin 40mg QD or Atorvastatin 80mg QD (50-55% risk reduction in CV events)
- Other Lipid-Lowering Medications: PCSK-9 Inhibitors, Icosapent ethyl, Inclisiran, bempedoic acid
- Antiplatelet: Plavix 75 mg daily or Aspirin 81 mg QD
- Consider Rivaroxaban 2.5mg BID with ASA 81mg daily (24% risk reduction in CV events)
- Consider Colchicine 0.6mg QD (23% risk reduction in CV events)
- Consider GLP1 receptor agonist (Semaglutide/Ozempic) if diabetic and/or overweight (20% risk reduction in CV events)
- Serial CCTA every 1-2 years

Electronically signed by: C. Alberto Morales, MD, FACC, FSCCT, FSCMR, RPVI

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