NATIONAL HEART INSTITUTE

PTCA REPORT

Patient No.	:	65630	Name	:	Mr.Virendra Kumar
Age	:	48	Sex	:	Male
Date	:	18.10.2010	Performed by:		Dr.Vinod Sharma
Cath No.	:	18093			

Clinical Diagnosis : Systemic hypertension, CAD, old ASMI

Indication for PTCA : Single vessel disease

Target Vessel : Left circumflex artery – Sub total occlusion after large OM branch

Approach : Right femoral artery

Hardware :

- Catheter – EBU 3.5 x 6 F guiding catheter
- Wire – BMW wire 190 cm x 0.014"
- Balloon – 1.5 x 10 mm Filao balloon
- Stent – 2.5 x 11 mm Matrix stent

Procedure : **PTCA of LCx**

The left circumflex artery was engaged with EBU guiding catheter and LCx lesion was crossed by BMW wire. The lesion was dilated with 1.5 x 10 mm Filao balloon at 8 atm. pressure for 30 seconds. A 2.5 x 11 mm Matrix stent was deployed at 14 atm. pressure. There wa no evidence of dissection / thrombus. Patient was shifted to ICCU fo further follow up.

Result : Successful dilatation of LCx lesion with deployment of stent.

Complication : Nil

Post Procedural Protocol: Medical follow up

(Dr.Vinod Shar
Conslt. Cardiolo

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CORONARY ANGIOGRAPHY DISCHARGE SUMMARY

PATIENT INFORMATION

NAME OF PATIENT	Mr. Virendra Kumar	AGE/SEX	48/Male

HOSPITAL INFORMATION

DATE OF ADMISSION	18.10.10	IPD NO.	50917
DATE OF DISCHARGE	20.10.10	CR. NO	65630
WARD	C - II	BED NO.	224-B
CONSULTANT IN CHARGE	Dr. V. Sharma	CATEGORY	Self

CLINICAL DIAGNOSIS:

1. Essential Hypertension
2. CAD Old ASMI
3. Unstable Angina
4. Post CAD – SVD (18.10.10)
5. Post PTCA with stent to LCx (19.10.10)

PRESENTING COMPLAINTS

	Symptoms	Duration
1.	Chest heaviness (off and on)	one year

PAST HISTORY :

Disease	Duration	Drugs being taken
Hypertension	6 years	Tab. Cardace
CAD	1 year	

PREVIOUS PROCEDURE : CT Angiography significant 90-95% luminal stenosis in LCx

PERSONAL HISTORY :		Details
H/O Smoking	Yes	20 years (reformed since one year)

FAMILY HISTORY : Non contributory.

PHYSICAL EXAMINATION ON ADMISSION:	INVESTIGATIONS
Afebrile PR – 62/min BP – 100/60 mmHg Resp- B/L clinically clear CVS – S1, S2 (Normal) No murmur/gallops P/A – Soft, BS (+), no organomegaly CNS - No neurological deficit Ht: 162cm, wt - 68kg, BMI : 25.95kg/m²	**FEMORAL DOPPLER :** Normal flows; no haematoma. **ECG :** Mild ST ↑ in V2-V4, Tall T in V2-V3, sinus rhythm. **CXR :** WNL.

BIOCHEMICAL TEST: -

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CARDIAC CATH / ANGIOGRAPHY REPORT

Patient No.	:	65630	Name	:	Mr.Virendra Kumar
Age	:	48	Sex	:	Male
Date	:	18.10.2010	Performed by:		Dr.Vinod Sharma
Cath No.	:	18093			

Parameters	Value	
Ao Syst.	110	mm Hg
Ao Dias.	70	mm Hg
Ao Mean	(90)	mm Hg

Clinical Diagnosis: Systemic hypertension, CAD, Old ASMI

Study Protocol: -
1. Left sided pressure study
2. Selective left and right coronary angiography

Observation:

(A) Pressure Study: -
- Normal aortic systolic pressure

(B) Coronary Angiography: -

1) Selective left coronary angiography:-
Left main coronary artery is normal.
Left anterior descending artery is having 20% plaquing in the middle.
Left circumflex artery is having sub total occlusion after the origin of large OM branch.
Faint antegrade opacification of distal OM branch.

2) Selective right coronary angiography: -
Right coronary artery is free of disease

(C) Left ventriculography:- Not done

Final Diagnosis : CAD, single vessel disease

Recommendations : PCI

(Dr. Vinod Sharma)
Consult. Cardiologist

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