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Saturday Live Cases

GF

57 year old male with hyperlipidemia;

MEDICAL HISTORY;

Depression

CARDIAC RISK FACTORS:

Hyperlipidemia

CARDIAC HISTORY:

Negative stress test 2/06

MEDICATIONS:

Zoloft

GF 11-05-49

The ascending aorta was normal in size. There were mild aortic calcifications of the ascending aorta. Misregistration artifact was present but did not interfere with scan interpretation. The left system was dominant. The coronary arteries were normal, including the LAD, diagonal, ramus and circumflex arteries. The right coronary artery was nondominant and normal. There was normal perfusion and the ejection fraction was 55-60%, which is normal. There were no cardiac structural abnormalities noted.

DF

52 year old male with CAD – CABG, MVR.

MEDICAL HISTORY:

- # Cervical stenosis
- # Sleep apnea – C-PAP
- # Arthritis
- # Right ACL-PCL repair
- # Septoplasty

CARDIAC RISK FACTORS:

- # Remote tobacco abuse
- # Hyperlipidemia

CARDIAC HISTORY:

- # 11/10/03 Normal stress echo. ECHO – LVEF 68%. MVP, severe MR
- # 2/3/05 Recurrent syncope since childhood – Positive tilt table (severe sinus bradycardia, asystole, loss of consciousness). 2/18/05 –Medtronic ppm inserted.
- # 7/6/05 RHC/ LHC – RAP= 9mmHg. RVP=37/9 mmHg. PAP= 34/12 mmHg , mean 24 mm Hg. PCWP = 18 mm Hg. LVEF 55%. Severe MR. LAE. Mildly enlarged aortic root, no AI. RCA= nondom. , minimal disease. LAD = minimal plaque. CX= mid, 80% stenosis.
- # 11/28/05 ECHO – LVEF normal. Severely dilated LV. Probable bicuspid aortic valve with mild thickening and trivial aortic regurgitation. , Severe posterior mitral valve prolapse with severe 4+ anteriorly directed MR.
- # 11/29/05 MVR repair, CABG (LIMA to posterolateral branch) at the Cleveland Clinic. PAF noted post op.
- # 8/2/06 ECHO – LVEF 50%. Increased LV size. Mild aortic root dilatation (4.19 cm) Mitral annuloplasty ring . Bicuspid aortic valve. Trace aortic regurgitation.

MEDICATIONS:

- Lipitor 80 mg daily
- Zolof 100 mg daily
- Ambien

DF 08-08-55

Normal left ventricular size and function. Ejection fraction 63%. Annuloplasty ring noted. This is in the mitral position. Pacemaker wires noted. Bicuspid aortic valve without stenosis. LAD and RCA, nonobstructive disease. Mid circumflex, obstructive soft plaque. There is patent-free left internal mammary artery to posterolateral branch. Both anastomoses are patent.

MM

67 year old male with history of CAD – CABG.

CARDIAC RISK FACTORS:

- # Hyperlipidemia
- # Remote tobacco abuse – quit tobacco 20 years ago

CARDIAC HISTORY:

- # 8/25/03 LBBB – noted on EKG
- # 11/3/97 CABG – LIMA to proximal LAD. RIMA to OM. Left radial artery free graft to distal RCA. (Patient was asymptomatic prior to surgery)
- # 7/19/06 Echo – LVEF 45 – 50% . Mild concentric LVH. BAE. Mild MR. Mild aortic regurgitation.
- # 8/19/06 Adenosine dual isotope stress test – LVEF – 39%. Global HK. Normal perfusion study. Apical thinning artifact. As compared to the 8/14/02 study, the LVEF dropped from 50 to 39%.

MEDICATIONS:

- Altace 10 mg daily
- Lipitor 20 mg daily
- ASA
- Coreg 25 mg daily
- Zetia 10 mg daily

MM 01-09-40

Ejection fraction is 60%. Apical hypokinesis. Paradoxical septal motion. LIMA to LAD patent. Distal left main heavily calcified. Native LAD is occluded. RCA heavily diseased. Radial graft to distal RCA is patent with good visualization of anastomosis. Right internal mammary artery to obtuse marginal is patent. Distal anastomosis was very well visualized. Body of radial graft was not visualized due to proximity of sternal wires.

JS

64 year old male with multiple risk factors.

MEDICAL HISTORY:

- # Gout
- # Non Hodgkin's lymphoma in remission x 7 years

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia
- # Positive family history – father MI, age 60's, died age 89 of CHF

CARDIAC HISTORY:

- # PAF – lasting 2 -6 hours , self resolving. No episodes for the past two years.
- # 10/21/05 Echo – LVEF 60%. Concentric LVH. Diastolic dysfunction. Trace PR.

MEDICATIONS:

- Toprol XL 25 mg daily
- Prinivil
- Niacin
- Mevacor
- Allopurinol

EG

43 year old male with history of increased calcium score.

CARDIAC RISK FACTORS:

- # IDDM
- # HTN
- # Hyperlipidemia
- # Positive family history

CARDIAC HISTORY:

- # 2/16/2002 Calcium Score- 218
 - Calcium score
 - LM - 101.0
 - CX - 11.5
 - RCA - 105.5

5/28/02 GXT/ dual isotope stress test – exercised 10 minutes 13 seconds, peak heart rate achieved 176 bpm, (96% pred. max.) 12 METS LVEF 64% Normal perfusion.

6/6/07 GXT/dual isotope stress test – exercised 9 minutes, peak heart rate achieved 172 bpm (97% pred. max.) 10.2 METS LVEF 51% Normal perfusion.

MEDICATIONS:

- ASA 81 mg daily
- Insulin pump
- Multi vitamins
- Lipitor 10 mg dailyj
- Lisinopril 10 mg daily

EG 3-01-64

Calcium score total is 562 with a score of a 305 in the LAD and 257 in the RCA. Ejection fraction is 79%. Wall motion is normal. The RCA, there are calcifications proximally in mid but no obstructive disease. Left main is calcified but unobstructed. Proximal LAD contains proximal calcified plaque but is nonobstructive. There are two diagonal branches off of the LAD which appear free of significant obstructive disease. The left circumflex is tortuous and is coarse. There are calcified plaques proximally which appear nonobstructive. There is a large obtuse marginal branch which is unobstructed.

TK

63 year old male with multiple cardiac risk factors.

MEDICAL HISTORY:

- # Arthritis
- # Leg pain

CARDIAC RISK FACTORS:

- # Remote tobacco abuse
- # Positive family history – father died, age 50 of MI
- # HTN

CARDIAC HISTORY:

- # No cardiac testing has been performed.

MEDICATIONS:

- # Benecar
- # Cymbalta
- # Celebrex
- # Advil
- # Neurotin

TK 08-18-44

Coronary artery calcium score 320. Left main coronary artery was unremarkable. Left anterior descending artery demonstrated mild to moderate mixed calcified lesions involving the proximal midportion of the left anterior descending artery which were nonobstructive. Left circumflex artery had mild calcific plaque in its proximal portion that was nonobstructive and mild calcific disease in the distal portion. The distal circumflex was a small vessel. The right coronary artery demonstrated mild nonobstructive calcification of the ostium. Normal left ventricular systolic function.

BS

57 year old female with multiple cardiac risk factors.

MEDICAL HISTORY:

- # Depression
- # Diverticulosis
- # Pons meningoma

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia
- # Positive family history - 2 brothers MI's age 50's

CARDIAC HISTORY:

12/21/01 chest pain, abnormal graded exercise tolerance test – LHC =LVEF 56%. Normal coronaries

MEDS:

- Norvasc 5 mg daily
- Zetia 10 mg daily
- Cymbalta 60 mg daily
- Aspirin 81 mg dailyj
- Robaxin prn

BS 7-17-50

Calcium score was zero. There was some attenuation artifact. There were minor calcifications in the ascending aorta. Lipomatous hypertrophy of the interatrial septum. Coronary vessels were essentially free of significant obstructive disease.

DR

77 year old male with known CAD – PCI.

MEDICAL HISTORY:

- # GERD
- # Chronic back pain
- # Glaucoma

CARDIAC RISK FACTORS:

- # Hyperlipidemia
- # Remote tobacco abuse – quit in 1975

CARDIAC HISTORY:

- # RBBB noted by EKG
- # 10/04 NSTEMI
- # 10/7/04 PTCA/STENT (3.5 x 13 mm cipher) ostium RCA. LVEF 60%. RCA = dominant, 60 -70 % tubular lesion , clarified to be 80 -90% by intravascular ultrasound. Mid RCA and distal diffuse disease. LAD= diffuse, 30% disease. CX =diffuse 30% disease. Ostium of first OM 40% disease. Ostium of second OM 40 – 50% disease.
- # 10/22/04 GXT/dual isotope stress test – exercised 4 minutes 36 seconds, peak heart rate achieved 141 bpm, (98% pred. max.). 6.5 METS LVEF 65%. Normal wall motion. Fixed inferior wall defect in RCA territory with minimal extent of peri-infarct ischemia.
- # 5/16/05 Unstable angina – Dobutamine dual isotope stress test – LVEF 64%. Negative for ischemia with relatively fixed defect along the inferior wall.

MEDICATIONS:

- | | |
|----------------------|------------------------|
| ASA 81 mg daily | Co-Enzyme Q10 |
| Atenolol 25 mg daily | Vytorin 10/40 mg daily |
| Xalatan eye drops | |
| Cazaar 25 mg daily | |

PP

52 year old male with hyperlipidemia, DOE.

MEDICAL HISTORY:

Obesity

CARDIAC RISK FACTORS:

Hyperlipidemia

Positive family history – father PCI's

CARDIAC HISTORY:

8/29/07 GXT/dual isotope stress test – maximum heart rate achieved 152 bpm. LVEF – 64%. Normal wall motion. Normal perfusion.

MEDICATIONS:

Tricor

PP 04-12-55

Coronary artery calcium score 33. Left main coronary artery is unremarkable. Left anterior descending artery was notable for mild soft plaque involving the ostium which is nonobstructive. Left circumflex artery demonstrated mild soft plaque involving the proximal mid portion which is nonobstructive. The ramus intermedius branch demonstrated moderate nonobstructive soft plaque involving the proximal portion. The right coronary artery had mild soft plaque involving the proximal portion, the artery which is nonobstructive. Normal left ventricular systolic function. Ejection fraction estimated at 57%.

MH

48 year old male with hyperlipidemia.

MEDICAL HISTORY:

ACL injury with surgery

CARDIAC RISK FACTORS:

Hyperlipidemia – 3/02 = TC =202 HDL= 32 Triglycerides = 94 LDL = 151

CARDIAC HISTORY:

4/3/02 Treadmill stress echo – Exercised 13 minutes, 20 seconds. Peak heart rate achieved 155 bpm (> 90% predicated max.) 16 METS. Normal resting and stress echocardiogram. Negative ischemia.

MEDS:

None

MH 07-10-59

Coronary artery calcium score of 20. Left main coronary artery normal. Left anterior descending artery normal. Left circumflex artery, mild calcific plaque involving the proximal portion of the left circumflex which is nonobstructive. Right coronary artery normal. Normal left ventricular systolic function.

MM

56 year old male with history of intermittent left arm pain , hyperlipidemia.

MEDICAL HISTORY:

- # Hypothyroidism - thyroid cancer
- # Reflux esophagitis
- # Arthritis
- # Depression

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia - 8/24/07 - TC = 184 TG = 85 HDL= 44 LDL = 123
- # Positive family history – father died of MI at age 59 , several brothers with hypertension, mother with CHF.

CARDIAC HISTORY:

9/2/05 GXT – Exercised 10 minutes, 57 seconds, peak heart rate achieved 141 bpm. EKG PVC's noted. Negative arm pain, negative ST changes. Normal GXT

MEDS:

- Actonel
- Prilosec
- Synthroid
- Maxide HCT

MM (No DOB)

The calcium score was 1. There was mild nonobstructive calcification of the LAD. No significant soft plaque noted. The LAD had a minor myocardial bridge. There were misregistration artifacts of the circumflex and obtuse marginal, but these did not preclude accurate reading and the circumflex and obtuse marginal were normal. The RCA was dominant and normal. Of note, there was lipomatous hypertrophy of the interatrial septum. The ejection fraction was 67%. There were no wall motion abnormalities.

CB

60 year old male with history of MI, CABG.

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia
- # Former tobacco abuse

CARDIAC HISTORY:

12/4/05 NSTEMI - LHC = LVEF 45% moderate HK of mid anterior wall. Mild HK of anterior base and distal anterior wall. LV dilated. LM = 40-50% mid portion. LAD = entire vessel had mod. calcification. Proximal vessel had 80% stenosis extending into the first diagonal. First diagonal branch had 60% proximal. LAD after bifurcation of the first diagonal was subtotally occluded at 99% with competitive flow from collaterals. These collaterals which fill the mid distal vessel arise from the septal perforators. RCA = mid vessel 70% disease. The distal RCA and proximal PDA had mild diffuse disease and the posterior descending artery gave rise to grade 111 collaterals to mid-distal LAD. There is a filling defect in the mid to distal RCA which may represent calcium or intracoronary thrombus.

12/7/05 Off pump Coronary Artery Bypass Grafting x 4 . LIMA to distal LAD. Left internal mammary Y graft to diagonal. SVG to OM1. SVG to right PDA.

5/25/06 Echo – LVEF 45 -50%. Mild concentric LVH. Mild generalized HK. Mild MR. Mild TR. Mild PR.

MEDICATIONS:

- Cozaar 100 mg daily
- ASA
- Niacin 1500 mg HS
- Coreg CR 80 mg daily
- Caduet 10/20 mg daily
- Multi vitamins

CB 5-05-47

Ejection fraction was 48%. There is hypokinesis of the left ventricular apex. There is evidence of coronary artery bypass graft surgery. There is a LIMA graft which is patent to the LAD and skips to the first diagonal branch which is patent. The proximal native LAD is occluded. There is a saphenous vein graft which is patent to the obtuse marginal branch. There is a saphenous vein graft to the RCA in the area of the PDA which has a good anastomosis and is patent. All proximal native vessels are occluded.

PW

76 year old male with known CAD.

CARDIAC RISK FACTORS:

- # HTN
- # Former tobacco abuse
- # Hyperlipidemia

CARDIAC HISTORY:

5/8/03 Inferior MI PTCA/STENT (3.5 x 13 HepaCoat velocity) mid RCA (99% lesion with thrombus). LAD = 30 – 40% disease proximal across diagonal. First diagonal 70% ostial stenosis. CX= nondom, OM2 60 -70 % proximal eccentric stenosis. LVEF 45% inferior HK 1+MR.

3/10/04 Unstable angina LHC = LVEF 55%. RCA= dominant, stent site patent, moderate wall irregularity throughout. LM= 30% diffuse distal stenosis. LAD = 30% diffuse proximal disease, straddling origin of diagonal. LCX = 60% ostial stenosis high lateral branch, 40% smooth proximal stenosis OM .

8/16/05 GXT/dual isotope stress test = exercised 3 minutes 30 seconds. Peak heart rate achieved 141 bpm, (97% pred. max.) 5.2 METS LVEF 53% Normal perfusion.

MEDICATIONS:

- Toprol XL 100 mg daily
- Metamucil
- Plavix 75 mg daily
- Lisinopril 40 mg daily
- Zocor 40 mg daily
- ASA

PW 8-12-31

Ejection fraction is normal. The left ventricular ejection fraction calculated to be 55%. There is a stent in the RCA which is patent. There is mild calcification which is nonobstructive located in the RCA. There is proximal calcification in the LAD which is nonobstructive. The first diagonal branch is poorly visualized due to motion artifact. The circumflex is a heavily calcified vessel and also contains mixed disease with some soft plaque; it is nonobstructive.

JE

52 year old male with abnormal EKG, positive risk factors.

MEDICAL HISTORY:

GERD

CARDIAC RISK FACTORS:

Positive family history
Tobacco abuse – quit 1/06
HTN

CARDIAC HISTORY:

9/06 Chest pain / tightness episodes – # while taking a medication for erectile dysfunction (Cialis) with some ST-T wave changes in inferior leads noted in ER. # substernal chest pain after meals. No further workup done secondary to insurance concerns.
Palpitations – PVC's

MEDS:

Norvasc
Aspirin

JE 10-25-54

Coronary artery calcium score of 5. Left main normal. LAD has minimal calcification in the proximal/minimal portion. Left circumflex demonstrated minimal calcific plaquing, nonobstructive. The left circumflex was an anomalous vessel which arose from the diagonal branch of the LAD, but otherwise normal. Normal left ventricular systolic function. Of note, the left pulmonary vein was noted to demonstrate a single os.

TA

59 year old male with known CAD – CABG, PCI.

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia
- # Positive family history
- # Remote tobacco abuse

CARDIAC HISTORY:

3/21/03 Unstable angina – LHC = LVEF 25-30%, global HK with apical DK. LM –mild diffuse disease. LAD – long, ostial 90% stenosis followed another 90% stenosis. First diagonal has sequential 80% lesions. LCX –large first OM branch totally occluded and fills from left to left collaterals. Just after the take off of this vessel, 95% stenosis on body of CX. RCA – totally occl. prox. Right coronary fills from collaterals from the left system.

3/21/03 Emergent CABG x 7 = LIMA to LAD, SVG to diagonal #1 side- to- side and diagonal #2 side-to-side, the intermediate side-to-side, the obtuse marginal of the CX end-to-side and separate vein graft to the acute marginal branch of the right side-to-side and onto the posterior descending branch of the right end-to-side.

3/23/05 GXT/ dual isotope stress test – exercised 7 minutes. 8.1 METS. Max. heart rate achieved 146 bpm (90% pred. max.). Negative chest pain. LVEF = 53%. Small to moderate sized, mild to moderate severity, inferolateral reversible defect consistent with ischemia in the territory of mid and distal LCX, and RCA graft.

3/30/05 PTCA prox/mid CX . Highly calcified vessel, difficult to cross. After multiple attempts to cross lesion a 2.0 x 8 mm Quantum was advanced across lesion. Marginal improvement (95% lesion – 85% residual). Patent SVG to RCA. SVG graft to diagonal #1 and diagonal #2 with 99% proximal lesion in body of the graft and totally occluded after insertion D#2. This formerly extended to OM2 and OM3. LIMA graft to LAD patent, with 60% lesion in the mid segment of LAD.

4/18/05 PTCA/STENT proximal CX - 95% stenosis to 0% . TAXUS STENT 3.5 x12 mm.

3/14/07 GXT dual isotope stress test = exercised 7 minutes. 8.1 METS Peak heart rate achieved 135 bpm (84 % pred. max.) LVEF 67%. Lateral partially reversible at the margins defect consistent with infarction in mid LCX territory.

MEDICATIONS:

Prinivil 5 mg daily	Lopressor 25 mg BID	Prozac 20 mg daily
Lipitor 40 mg daily	ASA 325 mg daily	Niacin 1500 mg daily
Fish oil 2 gms daily	Multi vits.	

TA (No DOB)

The LAD is occluded. There is heavy mixed plaque. The ostial circumflex stent is patent. The circumflex is otherwise occluded in the midvessel and the obtuse marginal is occluded. The distal vessel is seen filling either from slow antegrade flow or collateral flow. The ostial RCA has significant calcified heavy plaque obstructing visualization of the lumen. There is diffuse mixed disease. The LIMA to the LAD is patent and the anastomosis is well visualized and looks fine. The SVG to the posterolateral vessel is well visualized and patent. The SVG to jump graft to the D1, D2 and obtuse marginal is patent. All limbs are patent. There is inferoapical akinesis. The dyskinesis of the ejection fraction is diminished.

DM

60 year old female with multiple cardiac risk factors.

MEDICAL HISTORY:

- # Ulcerative colitis
- # Asthma
- # Glaucoma
- # Osteoarthritis
- # Chronic sinusitis – sinus surgery
- # Degenerative disc disease ---laminectomy

CARDIAC RISK FACTORS:

- # DM
- # HTN
- # Hyperlipidemia – diet management

CARDIAC HISTORY:

- # 3/11/05 admission for chest pain LHC – LVEF 60% . LM= normal. LAD= 30 -40% proximal. LCX= normal. RCA= dom., normal.
- # 9/29/06 Dobutamine dual isotope stress test – LVEF 56%. Normal perfusion.

MEDICATIONS:

- Aldactone 50 mg daily
- Singulair
- Serevent
- Insulin pump
- ASA
- Eye drops

DM 03-11-47

Normal left ventricular size and function. Ejection fraction 65%. Calcium score zero. There is proximal nonobstructive LAD soft plaque; otherwise, normal vessels.

JC

65 year old male with a positive family history, MVP.

MEDICAL HISTORY:

Prostate cancer s/p prostatectomy

CARDIAC RISK FACTORS:

Positive family history – father died of MI age 62 , brother MI

CARDIAC HISTORY:

? MVP noted approximately 12 years ago by echo

8/9/00 Ventriculogram, exercise and rest = resting LVEF 69%. Normal wall motion. Supine bicycle exercise limited by fatigue, SOB- exercised 14 minutes, 24 seconds, peak heart rate achieved 130 bpm. LVEF 76%. Negative study.

11/24/00 Palpitations – holter monitor = SR, average 70 bpm, Rare APC's , one episode of atrial tachycardia (6 beats) with heart rate 126 bpm. Frequent PVC's with multiple runs of ventricular bigeminy. Occasional ventricular couplets and triplets, longest 3 beats.

MEDICATIONS:

ASA 81 mg dailyj

Multi vitamins daily

JC 11-05-42

Coronary artery calcium score of 228. Left main coronary artery normal. Proximal and mid portions of the left anterior descending artery demonstrated mild mixed plaque of a nonobstructive nature. Left circumflex was a nondominant artery that demonstrated mild calcific plaque, nonobstructive. Ramus intermedius branch was normal. Right coronary artery demonstrated mild calcific plaque involving the proximal portions. Mitral valve demonstrated mild mitral prolapse. Normal left ventricular systolic function.

MY

55 year old male with CAD – MI, PCI.

MEDICAL HISTORY:

- # GERD
- # Sleep apnea

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia
- # Positive family history – father died age 58 of MI, mother (3) MI's

CARDIAC HISTORY:

3/16/88 Inferior MI – given Streptokinase – PTCA OM2 – LVEF normal. Mild inferior wall hypokinesia. Mild MR. LAD- minor nonocclusive plaquing in its proximal segment. CX- dom. OM2 tight 90% stenosis, but patent. Posterolateral left ventricular branch has 30% narrowing. RCA- normal.

12/30/99 GXT/dual isotope stress test - negative ischemia

#4/20/07 GXT/dual isotope stress test – exercised 9 minutes. Peak heart rate achieved 163 bpm,(99% pred. max.) 13.5 METS LVEF 65% . Partially transient defect in the inferior wall with overall mild amount of ischemia.

MEDICATIONS:

- Nexium 40 mg daily
- Vytorin 10/40 mg daily
- Lisinopril 10 mg daily
- Acebutolol 200 mg daily
- ASA 81 mg daily
- Niacor 4 gms daily

MY 08-28-52

Coronary artery calcium score 704. Of note, study was of poor technical quality due to significant breathing and motion artifact. Left main coronary artery demonstrated no significant disease. Left anterior descending artery was heavily calcified throughout without obstructive disease. The first diagonal branch of the LAD was heavily calcified. However, due to motion artifact, diagnostic interpretation was not possible. Left circumflex demonstrated a significant motion and misregistration artifact and as a result diagnostic interpretation was not possible. Right coronary artery was nondominant. Normal left ventricular systolic function.

VH

61 year old female with history of CHF, idiopathic dilated cardiomyopathy, and biventricular ICD placement.

MEDICAL HISTORY:

- # Arthritis
- # Appendectomy
- # Hernia repair

CARDIAC HISTORY:

12/9/98 CHF Echo – LVEF 20%. thinning, akinesis of intraventricular septum, biatrial enlargement, right ventricular enlargement, mod.- severe MR, mild TR, trivial PI, mild pulmonary hypertension.

LBBB

10/10/01 RHC / LHC (Cleveland Clinic) RA= a-6 v-16 LV-92/22 Aorta-92/56 CO- 3.05 CI- 1.8 LVEF 10%. Severe MR. LHC – Norm

al coronaries

4/19/02 Biventricular pacemaker (metronic)

2/3/05 upgraded biventricular pacemaker to biventricular ICD

1/07 Paroxysmal afib started on amiodarone.

8/16/07 Echo – LVEF 25-30% Dilated LV. Mild concentric LVH. Akinesia of inferior and lateral wall,. LAE. Minor thickening in the mitral valve leaflets. Severe MR which is a eccentric jet directed posteriorly. Moderate TR. RVSP 69 mmHg with evidence of pulmonary hypertension.

MEDICATIONS:

Amiodarone 100 mg daily

Spirolactone 25 mg daily

KCL

Coumadin

Coreg 3.125 mg daily

Furosemide 40 mg am, 20 mg pm

Zaroxolyn 2.5 mg prn

Multi vitamins

VH 10-02-45

There is four-chamber dilatation. There is a dilated mitral annulus as well as papillary muscle dysfunction. There is severe generalized hypokinesis throughout the left ventricle. There is a biventricular ICD present. There is no significant coronary artery disease seen.

FS

MEDICAL HISTORY:

Sinus problems

CARDIAC RISK FACTORS:

HTN

Hyperlipidemia

Former tobacco abuse

CARDIAC HISTORY:

11/3/97 Syncope -- PPM placed at age 13

Dextrocardia, sinus inversus totalis, and de transposition

6/27/07 Echo – Mild ascending aortic dilatation. Aortic valve thickness mildly increased.

Overall, LVSF normal . No LV regional wall motion abn. RV mildy to mod. Dilated. RVSF mod. educed.

FS 08-31-68

L transposition with dextrocardia. Systemic ventricle (morphologically right ventricle) severely depressed with ejection fraction of 25% and global hypokinesis. Pulmonic ventricle (morphologically left ventricle) pacemaker wire not at normal function. Markedly dilated main pulmonary artery measuring 6 cm. Mildly dilated aortic root. Normal coronary vessels.

MB

69 year old male with CAD – MI, CABG, ISCMOP, VT, ICD.

MEDICAL HISTORY:

- # COPD
- # Reflux eosphagitis

CARDIAC RISK FACTORS:

- # Tobacco abuse
- # Hyperlipidemia 12/1/06 TC- 206 TG-112 HDL- 61 LDL- 123
- # Positive family history

CARDIAC HISTORY:

- # 1997 Inferior MI
- # 10/31/03 Unstable Angina. LHC = LVEF 20 -25%. Calcification of inferior wall , mild to moderate mitral insufficiency, RCA completely occluded with high grade disease of LAD, diagonal , intermediate branch of the left, and the CX PDA. VT noted post cath.
- # 11/1/03 Emergent CABG (hemodynamic instability) - LIMA to LAD. SVG to CX, PL, CX OM, Diagonal branch of the left.
- # 12/24/03 ICD Guidant
- # Echo – LVEF 53%. Inferior and posterolateral hypokinesis, mild TR, mild PR, Moderate MR.

MEDICATIONS:

- | | |
|-----------------------|----------------------|
| Protonix 40 mg daily | Lexapro 10 mg daily |
| ASA | Coreg CR 80 mg daily |
| Furosemide 80 mg daiy | Combivent prn |
| Fluticasone prn | Zocor 40 mg daily |

MB (no DOB)

Ejection fraction is 30-35%. Inferior akinesis with scar and calcified infarct. ICD wires noted. SVG to first diagonal is occluded. Continuation of the jump graft from first diagonal to OM1 is patent. Continuation from OM to PDA is occluded. LIMA to LAD is patent. Unable to assess proximal LIMA due to ICD wires crossing. Native vessel severely diseased.

RH

71 year old male with known CAD.

MEDICAL HISTORY:

- # GERD
- # TIA

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia 3/06 LDL <60

CARDIAC HISTORY:

- # 8/27/07 LHC – LVEF 56% RCA= 30-40% luminal irregularity. LAD = first diagonal branch has a secondary branch 60-70% narrowed at its origin. LCX = widely patent.
- # 7/28/07 Echo – LVEF normal . Mild to moderate Aortic regurgitation.

MEDS:

- Benecar
- Zocor
- Plavix
- Aspirin

RH 11-26-35

Coronary artery calcium score of 391. Left main unremarkable. Left anterior descending artery demonstrated mild nonobstructive calcific plaque in its proximal portion as well as the diagonal branch of the LAD. Left circumflex was notable for mild calcific plaque. The first marginal branch demonstrated moderate calcific disease that was nonobstructive. Right coronary artery was a dominant vessel with minimal calcific plaque. Normal left ventricular systolic function. Ejection fraction 61%.

TA

68 year old male with multiple risk factors.

CARDIAC RISK FACTORS:

- # Hyperlipidemia
- # HTN

CARDIAC HISTORY:

7/29/05 Chest pain – LHC = LVEF 60 % . LM = normal. LAD = proximal 30% stenosis. LCX= no significant disease. RCA= small, nondominant without obstruction.

2/2/07 Carotid Duplex = RICA - < 20%. LICA= 50 – 60% . Bilateral vertebral arteries patent with normal antegrade flow.

7/17/07 Echo – LVEF – 65%. Moderate concentric LVH. Normal wall motion. Impaired relaxation filling pattern for age. Dynamic gradient in mid LV cavity in late systole (75 mmHg) Dilated LA. Mild systolic anterior motion of mitral valve chordae. Mild MR. Mild thickening of aortic valve leaflets without reduced excursion. Mild AR. Trace TR.

MEDICATIONS:

- ASA 81 mg daily
- HCTZ 12.5 mg daily
- Mevacor 40 mg daily
- Albuterol
- Lisinopril 40 mg daily
- Viagra
- Minocycline

TA 10-21-39

Calcium score total was 453 with a score of 369 in the LAD, 6 in the RCA and a score of 79 in the left circumflex. Functional parameters indicate an ejection fraction in excess of 70%. Wall motion is normal. There is systolic anterior motion of the anterior mitral valve leaflet. Left main is normal. The LAD contains calcification of the proximal segment but is unobstructed. There is a high first diagonal vessel that appears unremarkable but does contain some calcification of the proximal segment that again is unobstructed. The circumflex appears to be a codominant vessel. It is calcified proximally but unobstructed. The RCA is unremarkable. A large obtuse marginal branch contains proximal calcification but is unobstructed.

HB

76 year old male with past medical history of CAD – CABG, PCI.

MEDICAL HISTORY:

- # COPD
- # Colon resection
- # Small AAA

CARDIAC RISK FACTORS:

- # Hyperlipidemia 3/07 TC-90 TG-53 HDL – 38 LDL -41
- # HTN
- # Former tobacco abuse – quit 1998

CARDIAC HISTORY:

- # 1981 CABG = SVG –LAD. SVG to RCA . SVG to CX.
- # 12/4/92 PTCA of first of two tandem lesions in CX, with failure to dilate second lesion.
- # 4/8/98 Acute MI , redo CABG x5 = LIMA to LAD. Left radial free graft to CX OM and diagonal of left. SVG to PDA of right and marginal wall of right.
- # 12/16/02 PTCA/STENT (4.0 x 32 mm Express 11) – CX VG
- # 10/15/04 Recurrent angina LHC = LVEF 25%. 2+MR.
- # LAD – proximal obstructed and graft dependent. Patent LIMA graft inserting into mid LAD. Occluded SVG which is a stump occluded at its origin, but slightly back fills into distal vessel.
- # LCX- OM1 and OM2 occluded. OM1 filled by patent radial free graft. OM2 filled by patent SVG. SVG diffusely atherosclerotic. Several areas of previous stenting, diffuse plaque.
- # RCA – occluded mid. Distal vessel is graft dependent, filled by patent SVG with sequential inserts into PL and PDA branches.
- # 3/17/05 ICD – Metronic .
- # Carotid stenosis -- LCEA
- # 6/7/06 Adenosine dual isotope stress test – LVEF 31%. Fixed anteroapical and inferolateral defect corresponding to scar in LAD, RCA or CX territory.
- # 2/15/07 ECHO – LVEF 30 -35% AK apical wall. Severe HK mid anterior wall. Severe HKmid anteroseptal wall. Mild to moderate MR.

MEDICATIONSS;

- | | | |
|------------------------|---------------------|----------------|
| Coreg CR 80 mg daily | Imdur 120 mg daily | ASA |
| Lisinopril 20 mg daily | Lipitor 40 mg daily | Ranexa 500 qid |
| Plavix 75 mg daily | Niacin 500 mg BID | |

HB 11-22-47

The calcium score was normal. The coronary arteries were normal without any plaque. No calcium noted. Normal left ventricular function with an ejection fraction of 55-60%. No cardiac structural abnormalities noted.

PE

61 year old male with no significant medical history.

CARDIAC RISK FACTORS:

LDL – 124

CARDIAC HISTORY:

No previous testing

MEDICATIONS:

None

PE (no DOB)

Normal left ventricular size and function. Normal ejection fraction. Calcium score is zero. No coronary artery disease. RCA is dominant.

OK

57 year old male with medical history of CVA.

MEDICAL HISTORY:

CVA – 2004

CARDIAC HISTORY:

7/5/05 Echo – LVEF 60 – 65 %. No wall motion abnormalities.

7/11/05 Adenosine dual isotope stress test – LVEF 55%. Mildly decreased anteroseptal perfusion suggestive of mild stress induced ischemia.

9/07 exercises daily without symptoms.

MEDICATIONS:

ASA daily

OK 57

Exam aborted secondary to patient vaso-vagal with IV start

MP

50 year old male with known CAD – PCI.

MEDICAL HISTORY:

Hypothyroidism

CARDIAC RISK FACTORS:

Hyperlipidemia

NIDDM

Positive family history

CARDIAC HISTORY:

MI

2000 PTCA /STENT - proximal LAD, septal branch in New York

6/2005 Chest pain , new EKG changes. LHC – University of KY. LHC – patent stents. LM- 20 -30% before bifurcation. LAD – large stent in primary LAD. 40% in-stent restenosis, but widely patent lumen. Small stent patent in the septal LAD. Moderate in-stent restenosis in this septal branch. Minimal luminal irregularities in distal LAD. CX- no significant disease. RCA- dominant, 40% mid RCA. This stenosis is unchanged from the LHC 2000.

8/29/07 GXT/dual isotope stress test - exercised 9 minutes 10 seconds. Peak heart rate achieved 150 bpm (88% pred. max.) 12.1 METS. LVEF 46%. Anterior apical HK. Fixed defect in anteroapical wall. No areas of reversible ischemia.

MEDICATIONS:

ASA

Plavix 75 mg daily

Synthroid

Toprol XL 50 mg daily

Altace

Lipitor

MP 50

LM heavily calcified with soft plaque noted. LAD patent stent proximally and small stent patent in septal LAD. Dual LAD?. Apical infarct - dyskinetic with perfusion defect noted. RCA dominant with mild disease.

SS

60 year old male with history of tobacco abuse

CARDIAC RISK FACTORS:

Tobacco abuse

CARDIAC HISTORY:

No history of any cardiac testing performed

MEDICATIONS:

None

SS 04-01-47

Coronary artery calcium score 22. Left main coronary artery unremarkable. Left anterior descending artery had mild nonobstructive calcific plaque. Left circumflex normal. Right coronary artery minimal calcified plaque. Normal left ventricular systolic function.

LS

55 year old male with no significant medical history.

CARDIAC RISK FACTORS:

None

CARDIAC HISTORY:

Dobutamine stress test 8 -10 years ago in St. Louis = negative results

MEDICATIONS:

None

Sunday Live Cases

TM

63 year old male with known CAD history.

MEDICAL HISTORY:

- # Benign prostate hypertrophy
- # Herniated lumbar disc

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia
- # Tobacco abuse – smokes 1 ½ pack daily since age 17
- # Positive family history – father + MI age 48

CARDIAC HISTORY:

- # 1999 Anterior MI
- # 1999 PTCA/Stent LAD
- # Abdominal aortic aneurysm
- # RBBB
- # 11/15/02 PTCA/STENT(4.0 x 12 S7 stent x two) mid –distal RCA LVEF 20% . Globally HK. Mid abdominal aortography- single renal arteries bilaterally with small infrarenal aneurysm at level of bifurcation. LAD= 100% occlusion at the stent site in mid vessel area. Distal LAD fills by septal and diagonal collaterals as well as CX collaterals.

MEDS:

- Lipitor 20 mg daily
- Metoprolol 50 mg BID
- Lotrel 10/40 daily
- Aspirin 325 mg daily
- Flomax .4mg BID

TM (No DOB)

It should be noted that the heart rate was markedly elevated and unable to be slowed despite aggressive attempts with IV beta blocker. As a result, there is significant misregistration artifact. Left main has mild calcifications distally and is without significant obstruction. The proximal LAD stent is patent with occlusion at the distal portion of the stent. The distal LAD is barely visible. The circumflex is occluded in the midvessel. The RCA is patent. However, there is significant misregistration artifact and motion artifact noted which hinders diagnostic quality interpretation of the RCA. It can be said that the mid and proximal RCA stents are at least patent, but the lumen is not well visualized. An apical infarct is noted with thinned apical myocardium. There is a mildly thickened pericardium surrounding the apex. The ejection fraction is diminished but cannot accurately be interpreted due to the severity of the misregistration artifact.

JD

49 year old male with no significant medical history.

CARDIAC RISK FACTORS:

None known

CARDIAC HISTORY:

None known

MEDICATIONS:

ASA 81 mg daily

JD 07-18-58

Calcium score is 5. There is mild calcified plaque of the proximal LAD without any luminal obstruction noted. The remainder of the coronary tree was normal. There was normal LV function with an ejection fraction estimated at 59%. There were no cardiac structural abnormalities.

LS

76 year old male with known CAD – PCI.

MEDICAL HISTORY:

- # Prostate cancer
- # NIDDM
- # CRI
- # Sleep apnea
- # Seizure disorder

CARDIAC RISK FACTORS:

- # Hyperlipidemia
- # HTN
- # Pipe tobacco smoker

CARDIAC HISTORY:

7/11/02 – Palpitations – Holter monitor – SR, average 82 bpm, rare premature SVE, one premature VE.

9/4/02 – Abnormal GXT/dual isotope stress test (reversible ischemia inferior wall, LVEF 58%) PTCA/STENT (3.5 x 13 mm) mid LAD.

3/3/03 -Syncope = PTCA/STENT mid LAD (in stent restenosis) , cutting balloon angioplasty and brachytherapy . LVEF 55%. RCA-dominant, 35% mid stenosis. LM normal. LCX – normal.

3/17/04 Unstable angina-PTCA/STENT (3.5 x 12 mm Express 11) – ostium of LAD. LVEF 60%. 10 -20% insignificant in- stent restenosis. Rest of LAD diffuse plaque disease. RCA – 30 % stenosis. CX – minimal plaque disease. Ramus intermedius branch minimal plaque disease.

2/23/07 GXT/dual isotope stress test – exercised 7 minutes, peak heart rate achieved 131 bpm (90% pred. max.). 10.2 METS LVEF 63%. Normal Perfusion

MEDICATIONS:

- Vytorin 10/80 mg daily
- Plavix 75 mg daily
- ASA 325 mg daily
- Lisinopril 10 mg daily
- Glipizide 5 mg daily
- Prozac 20 mg daily
- Trileptal 600mg two tabs daily
- Flomax

LS 7-28-31

Ejection fraction 61%. There is mild calcification in the aorta. There is an ostial stent in the LAD which appears patent. There is a midvessel stent in the LAD which is also patent. There is mild soft plaque in the mid LAD. First diagonal vessel is unremarkable. Left circumflex, it appears normal. There are two obtuse marginal branches which contain myocardial bridges, but otherwise are normal. The RCA contains mild mixed disease. It is a dominant vessel and appears to have only nonobstructive disease present appearing.

DF

52 year old male with a history of hyperlipidemia.

CARDIAC RISK FACTORS:

- # Hyperlipidemia
- # Positive family history – brother PCI at age 42

CARDIAC HISTORY:

- # Negative stress test 3 – 4 years ago

MEDICATIONS:

- Pravachol 40 mg daily
- ASA
- Multi vitamins

DF 05-16-55

The calcium score was 99. The LAD calcium score was 46. The RCA calcium score was 53. This places the patient in the 50-75 percentile. The ostial LAD had nonobstructive calcified plaquing. The proximal LAD had mild nonobstructive calcified plaque. There was a shallow mid LAD bridge (normal variant). The RCA had mild nonobstructive plaque. The cardiac function was normal with an ejection fraction in the 55-60% range. There were no noncardiac structural abnormalities.

TB

49 year old male with known CAD – CABG .

MEDICAL HISTORY:

- # Sleep apnea
- # Uvulopalatopharyngoplasty
- # Umbilical hernia

CARDIAC RISK FACTORS:

- # Hyperlipidemia -7/30/07 TC – 130 TG -93 HDL – 44 LDL-67
- # Positive family history – Mother died of MI , age 62
- # HTN

CARDIAC HISTORY:

9/15/06 Exertional angina, abnormal treadmill stress echo – underwent LHC –LVEF 55% No wall motion abnormalities. LM- normal LAD-prox, mid 90% narrowed. CX – OM 50% obstructed, PL branch 80% obstructed, PDA 100% obstructed, filled distally by left to left and right to left collaterals. RCA- nondom, sequential 90% proximal to mid obstruction.

9/18/06 CABG x5 – LIMA to LAD with patch angioplasty, and diagonal branch of the left. Left radial artery free graft to the completely occluded CX posterior descending, CX OM , CX posterolateral with proximal to the mammary.

MEDS:

- Lipitor 80 mg daily
- Aspirin

TB 03-21-58

Normal left ventricular size and function. Ejection fraction is 55%. LIMA to first diagonal and jump to distal LAD is patent. Distal anastomosis well visualized. No problems. Anastomosis to first diagonal not well visualized due to clip. Radial graft, proximal portion, from the aorta to OM1 is occluded. Jump graft from OM1 to OM2 to PDA is patent.

DT

60 year old male with known CAD.

MEDICAL HISTORY:

Right knee problems

CARDIAC RISK FACTORS:

Remote tobacco abuse – quit 2003, 1 ppd x 30 years

HTN

Hyperlipidemia – elevated triglycerides

CARDIAC HISTORY:

2004 PCI –proximal LAD , proximal CX

2/2/06 Unstable Angina - PTCA/Stent – proximal RCA, CX. LVEF 55%. No wall motion abnormalities. RCA- 70% proximal below the ostium. The RCA shows atherosclerotic changes throughout the artery. LAD – patent with patent stent in proximal portion. CX – proximal portion has a stent , mildly stenotic. Below the stent there is an 80% long segmental narrowing up to the bifurcation. The distal portion of the CX is patent. LM patent.

2/19/07 Dyspnea - Echo = LVEF 50 % . LVH. Diastolic dysfunction, Aortic sclerosis. Mitral annular calcification. Thickened mitral valve leaflets. Trace MR, TR.

MEDICATIONS:

Aspirin

Multi vitamins

Plavix 75 mg daily

Vytorin 10/40 mg daily

Accupril 20 mg daily

Cartia 180 mg daily

DT 60

EF 79%. RCA proximal portion is patent. Mid RCA stent appears patent but unable to visualize inside. LCX proximal has 2 tandem stents that appear to be patent but again can not visualize inside stent, there is calcific plaque beyond the stent. LAD is heavily calcified but patent. Mid LAD myocardial bridge. D1 unobstructive calcific plaque. D2 normal.

TK

63 year old male with known CAD – CABG.

CARDIAC RISK FACTORS:

- # Hyperlipidemia
- # HTN

CARDIAC HISTORY:

- # 1983 MI
- # 10/99 Unstable angina - LHC – high grade disease in LAD, and diagonal. CX- very small system. RCA- high grade disease, involving posterior descending artery.
- # 10/20/99 CABG x 4 = LIMA to LAD, diagonal. Radial T graft to the posterolateral, posterior descending artery.
- # 12/8/03 Abnormal myoview stress test – LHC = LVEF 35%. Dilated LV with inferoapical akinesia, and anterior wall hypokinesia. LVEDP 22 mmHg. RCA =multiple areas of narrowing. LAD = 100% stenosed. CX =proximal portion has severe atherosclerotic changes. Distal portion of LCX patent. Radial artery graft to the posterolateral branch not visualized. VG to RCA and PDA not visualized. LIMA sequential to diagonal and LAD patent.
- # 6/21/07 Adenosine dual isotope stress test – coexisting myocardial fibrosis and ischemia in apical LV new since 12/12/05. Posterolateral ischemia previously was equivocal on 12/12/05 now more definite. LVEF 64%. Thinning of anteroseptal LV consistent with nontransmural myocardial fibrosis. LV mod. dilated, right ventricle hypertrophied.
- # 6/28/07 Echo – LVEF 45%. LVE. Distal portion of interventricular septum, apex, and the inferior wall HK. Bilateral atrial enlargement. Aortic valve sclerotic with normal opening. Mitral valve leaflets thickened with normal opening. Trivial MR.

MEDICATIONS:

- | | |
|----------------------------|-------------------------|
| ASA | Imdur 30 mg daily |
| Foltx | Vytorin 10/40 mg daily |
| Diovan HCT 160/25 mg daily | Nabumetone 750 mg daily |

TK 63

EF 60%. Mid, Distal and Anterior septum is hypokenetic. LIMA-D1 clip obscures contrast but appears patent. LIMA-LAD good contrast. Radial T-graft good contrast with LIMA-LAD occluded. RCA occluded proximally.

FP

53 year old male with known CAD – PCI, currently experiencing episodes of chest pain.

CARDIAC RISK FACTORS:

HTN

Hyperlipidemia 10/10/06 TC -156 TG -206 HDL – 52 LDL – 63

Former tobacco abuse

CARDIAC HISTORY:

9/10/96 Chest pain, positive stress test revealing moderate anteroseptal ischemia. PTCA proximal LAD. LVEF 60%. RCA – 50% stenosis of distal RCA beyond acute marginal branch. LM normal. LAD – prox. 80% pre PTCA, post residual 20%. LCX free of disease

#1/12/00 Chest pain – GXT/ dual isotope stress test –peak heart rate achieved 163 bpm, 10 METS, Negative ischemia. Slight heterogeneous uptake in inferior wall suggestive of diaphragmatic attenuation and less likely fibrosis.

4/30/01 LHC – LVEF 60%. RCA occluded midway in right AV groove. PDB and moderate posterior left ventricular branch filled via left collaterals. LM- normal. LAD 40% ostial stenosis of the moderate diagonal branch. LCX – normal.

MEDICATIONS:

Lipitor 80 mg daily

Zestril 10 mg daily

Atenolol 50 mg daily

Advair

ASA 81 mg daily

FP 2-26-54

Ejection fraction 69%. Wall motion is normal. There is poor contrast timing of this study. There are scattered calcified plaques in the proximal and mid LAD which are nonobstructive. The first diagonal branch is heavily calcified proximally and cannot rule out significant obstruction but the amount of calcium precludes reliable analysis of this vessel. There is calcified disease proximally in the left circumflex. There is also a myocardial bridge involving the obtuse marginal branch. The RCA is occluded.

LC

58 year old male with known CAD.

MEDICAL HISTORY:

- # Bilateral hernia repair
- # NIDDM

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia
- # Positive family history

CARDIAC HISTORY:

- # 8/30/02 Anterior MI , given ReoPro, Retavase. Emergent LHC – PTCA/STENT (3.0 x 15 mm Penta) to proximal LAD, PTCA/STENT (3.0 x 8 mm Penta) CX LVEF 43%
- #7/5/05 GXT/dual isotope stress test = LVEF 55-60% Normal perfusion. Exercised 7 minutes, peak heart rate achieved 150 bpm (91% pred. max). 8.5 METS
- # 2/4/03 Palpitations – 24 holter monitor – SR, average rate 66 bpm, min 52 , max. 99 bpm. Rare PSVE – 7, one nonsustained atrial run 4 beats at 135 bpm. Rare multiformed PVE's – 12

MEDS:

- Atenolol 100 mg daily
- Aspirin 81 mg daily
- Lisinopril 40 mg daily
- Metformin
- Simvastatin 20 mg daily

LC 6-16-49

Ejection fraction 58%. There is hypokinesis of the inferior apex. Coronary angiography: The RCA is the dominant vessel. There is calcified plaque in the RCA. The RCA is poorly opacified with IV contrast. There appears to be at least moderate disease within the RCA. There is a stent in the proximal portion of the LAD which appears to be patent. There is some calcification proximal to the stent but it appears to be unobstructive. Left circumflex, there is a stent in the midvessel which appears patent. There is some calcification in the proximal portion of the left circumflex which is nonobstructive. There is a large obtuse marginal branch calcified proximally, but it is patent.

HB

59 year old male with hyperlipidemia.

MEDICAL HISTORY:

GERD

CARDIAC RISK FACTORS:

Hyperlipidemia

Father heart transplant at age 59 years

CARDIAC HISTORY:

No previous cardiac testing

MEDICATIONS:

Lipitor

Nexium

Aspirin

Multi vitamins

HB (no DOB)

Markedly depressed LV systolic function. Ejection fraction 30%. Apex is dyskinetic. ICD wire noted. SVG to LAD occluded. LIMA to LAD patent. Distal anastomosis well visualized. SVG to OM has multiple stents. Stents are patent. Proximal and distal anastomosis are not well visualized. Radial graft to first diagonal patent. Continuation from first diagonal to first obtuse marginal occluded.

LH

62 year old male with known CAD – PCI.

CARDIAC RISK FACTORS:

HTN

Hyperlipidemia = 7/13/07 TC -124 TG – 46 HDL – 49 LDL – 66

CARDIAC HISTORY:

7/13/05 Atypical chest pain --Treadmill stress echo – exercised 9 minutes, peak heart rate achieved 150 bpm, Occasional PAC's, PVC's, and ventricular couplets with ventricular trigeminy and bigeminy at peak exercise, which decreased with rest. Resting echo 55 -60%. Negative stress echo. Baseline echo revealed LVH.

1/4/06 CT chest – calcium score 274. Moderate amount of calcium in three vessel distribution.

1/19/06 CT angiography - LVEF 58%. RCA – proximal at origin of first marginal mixed calcific and soft plaque . LM – normal. LAD – multiple calcific plaques in proximal LAD without sign. luminal stenosis. Just proximal to first diagonal origin there is mixed calcific and soft plaque resulting in > 70% stenosis. Proximal CX – patent, with mid CX calcific plaque. Large first OM with eccentric soft plaque prox. to mid portion .

1/26/06 PTCA/STENT (3.0 x 24 mm Taxus) proximal LAD, PTCA of diagonal branch. LVEF normal. LCX – no sign. stenosis. RCA – some proximal plaque, no sign. stenosis.

7/18/06 GXT – exercised 8.5 minutes, peak heart rate achieved 135 bpm, (85% pred. max.). Negative EKG. Occasional PVC's

MEDICATIONS:

Toprol XL 50 mg daily

ASA

Cozaar 50 mg daily

Vytorin 10/20 mg daily

Plavix 75 mg daily

Fish oil

LH (No DOB)

The LAD has nonobstructive calcifications noted. The LAD stent is patent. There is a jailed diagonal which is mildly pinched but no significant stenoses noted. There is nonobstructive calcification of the circumflex and a significant obtuse marginal is without significant disease. The RCA has nonobstructive calcification. There is a mid LAD myocardial bridge noted. Ejection fraction is normal and estimated at 56%. Perfusion is normal.

OM

67 year old male with history of cardiomyopathy, chest pain.

MEDICAL HISTORY:

- # OA
- # Nephrolithiasis
- # Pancreatitis

CARDIAC RISK FACTORS:

- # HTN
- # Tobacco abuse

CARDIAC HISTORY:

#3/7/00 Chest pain, SOB – LHC = LVEF 25-30% LV enlarged. Moderate diffuse HK. Normal coronaries.

10/4/04 GXT dual isotope stress test – exercised 6 minutes,44 seconds, peak heart rate achieved 141 bpm (90% pred. max.) 8.1 METS LVEF 33% Inferior wall AK, remainder LV hypokinetic. Moderate sized defect inferior wall.

8/21/06 Echo – LVEF 20 – 25% Mild concentric LVH. AK LV apex, remainder of LV severely HK. Impaired relaxation filling pattern for age. Dilated left atrium. Trace MR. Aortic valve leaflets mildly thickened. Mild to moderate aortic regurgitation.

MEDS:

- Cozaar 100mg daily
- Alprazolam
- Coreg 25 mg BID
- Lanoxin .125mcg daily
- Aspirin 81 mg daily

OM 12-10-39

The calcium score is 206 total. Function parameters indicate an ejection fraction of 42%. Left main, there appears to be significant soft plaque with small islands of calcium in the left main coronary artery. LAD, there is an ostial lesion of uncertain significance. There is a large calcified plaque in the mid LAD which appears nonobstructive. The RCA is a dominant vessel and appears unremarkable. The left circumflex is unremarkable and free of significant obstructions

JB

64 year old male with known CAD, positive stress test (mild reversible ischemia inferolateral wall).

MEDICAL HISTORY:

#Gout

MEDS: Vytorin

Niacin

Allopurinol

Aspirin

CARDIAC RISK FACTORS:

Hyperlipidemia

Remote tobacco abuse

CARDIAC HISTORY:

1993 CABG – LIMA to the diagonal, SVG to the LAD, RCA , sequential SVG to two branches of posterolateral branch of CX

9/8/99 LHC – Patent LIMA to diagonal, SVG to LAD, SVG to RCA, sequential VG to CX has 30 – 40 % mid narrowing. LVEF 65%

#12/03 noted increased fatigue, DOE, chest pain . Positive treadmill test

12/03 Echo – EF 55%, Severe AS, trivial AI

12 /11/03 RHC, LHC – LIMA to diagonal patent. The distal diagonal diffusely narrowed. SVG to LAD patent, free of disease. Distal LAD diffusely narrowed, no disease. SVG sequentially to two branches of PLB of LCX, 70% proximal obs. and a >90% obstruction mid. SVG to RCA 50 -60% prox. and 50 -60% obs. mid. This was anastomosed to PDA. This filled the PDA, A-V groove branch in retrograde fashion. Native RCA diffusely diseased in proximal one-half , completely obstructed mid. LCX OM artery 50% lesion . A branch of OM has high grade orifice lesion, supplied by bypass graft. LAD completely obstructed after large D1 and small D2 and the diagonal artery filled by LIMA graft.

12/17/03 CABG, AVR, ascending aorta - 25 mm homograft . Radial graft to the lateral CX, free internal mammary artery to posterior descending artery

6/30/06 Echo LVEF 55-60% No wall motion abn. Borderline concentric LVH. LAE. AVR – homograft functioning normally. Trace MR, TR.

7/3/07 GXT cardiolute isotope stress test – EKG portion positive for ischemia. Exercised 16 minutes, 2 seconds, peak heart rate achieved 142 bpm, (91% pred. max). 18.8 METS Mild reversible ischemia inferolateral wall. LVEF 65% No obvious regional wall motion abnormality.

JB (No DOB)

There is heavy mixed disease of the LAD which is then occluded after the first diagonal. The circumflex has severe mixed plaque noted with significant luminal obstruction. The RCA is occluded. The SVG to the LAD is visualized nicely and is patent with the distal LAD filling nicely. There is a small LIMA to the diagonal which is patent. The body of the LIMA is obscured by clips. The distal anastomosis is not well visualized due to clips. The RIMA to the PDA is occluded. The radial to the circumflex coronary artery is occluded. The initial SVG to the circumflex and then to the PDA is occluded. The ejection fraction is approximately 50% with normal perfusion. There is aortic atherosclerosis noted.

NL

27 year old female with known CAD – PCI.

MEDICAL HISTORY:

Hypothyroidism

CARDIAC RISK FACTORS:

HTN

Hyperlipidemia

Positive family history

CARDIAC HISTORY:

7/8/99 PTCA/STENT (3mm multi –length UF 30 mm long) – mid LAD

12/11/01 Recurrent chest pain – LHC = LVEF normal. RCA-patent. LAD – stent site patent.
LCX – patent.

MEDICATIONS:

ASA

Synthroid 125 mec. daily

Crestor

Toprol XL 50 mg daily

Triglide 160 mg daily

Altace 2.5 mg daily

NL 27

EF 65%. Marked misregistration artifact. LM normal. LAD calcium noted proximally proximal stent is patent. Mid LAD cannot exclude possibility of lesion due to misregistration. RCA is dominant and nonobstructed. LCX and OM are normal.

SS

59 year old female with history of chest tightness, palpitations, dyspnea.

MEDICAL HISTORY:

- # Osteoporosis
- # Depression
- # Breast augmentation – bilateral breast implants

CARDIAC RISK FACTORS:

- # Positive family history – father MI
- # Hyperlipidemia 3/9/07 TC-158 TG- 42 HDL-68 LDL-82

CARDIAC HISTORY:

10/13/04 Chest pain, dyspnea - Treadmill stress echo = exercised 8 minutes, peak heart rate achieved 147 bpm, (89% pred. max.) 9 METS. LVEF 55 -60% No wall motion abnormalities. Mild MR. Trace TR. Mitral valve inflow suggestive of diastolic dysfunction. Negative ischemia.

8/31/07 Holter monitor – SR, average 69 bpm, min.53 bpm, max 132 bpm. Occasional premature SVE, 140 with 3 couplets, and 1 nonsustained atrial run containing 3 beats at 118 bpm. Occasional multiformed premature VE, total 132 with one bigeminy run.

MEDICATIONS;

- Effexor SR 75 mg daily
- Lipitor 10 mg dailyj
- Forteo
- Estrogen patch
- ASA 81 mg daily

SS 02-05-48

Coronary artery calcium score 25. Left main coronary artery normal. Left anterior descending artery demonstrated mild calcification proximally with no obstructive lesions. Left circumflex normal. Right coronary artery normal. The chest wall was noted to have a reduced anteroposterior diameter with close proximity of the right ventricle to the sternum. This would be consistent with cardiac compression syndrome with mild compression of left atrium. Normal left ventricular systolic function.

PH

42 year old male with several risk factors:

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia

CARDIAC HISTORY:

- # 2004 stress test – reportedly normal

MEDICATIONS:

- Lisinopril 20 mg daily
- Hydrochlorot 25 mg daily
- Crestor 10 mg daily
- Tricor
- Nasonex 2 puffs daily

PH 01-05-65

Coronary artery calcium score zero. Left main normal. Left anterior descending artery normal. Left circumflex normal. Right coronary artery normal. Left ventricular systolic function normal.

JD

69 year old male with known primary cardiomyopathy.

MEDICAL HISTORY:

- # Peripheral neuropathy
- # HTN

CARDIAC RISK FACTORS:

- # Negative tobacco
- # Family history – mother afib
- # Lipid – TC = 206 HDL = 59 LDL = 131 Trig=53

CARDIAC HISTORY:

6/23/06 Echo – LVEF 35 – 40% Moderate HK of anteroseptal and anterior wall with mild thinning. Mild MR. Aortic valve moderate sclerotic, normal function. Mild to moderate TR.

12/28/06 Adenosine Dual Isotope – LVEF 41% fixed defect inferoseptal wall, suggesting prior scar in RCA.

#1/5/07 LHC – LVEF mildly reduced. LM = normal. LAD = normal. CX= normal, OM1 (mid) 90% , small, and < 1 mm size. RCA= normal.

5/4/07 Resting muga – LVEF 39% . LV cavity size normal.

MEDS:

- Metanx
- Carnitor
- Hyzaar
- Coreg 6.25 mg BID

JD 11-23-37

Coronary artery calcium score 358. I think the quality of the study was suboptimal due to significant misregistration and motion artifact. Left main coronary artery unremarkable. Left anterior descending was heavily calcified in the proximal mid portion. Proximal mid portion, this was nonobstructive. The first and second diagonal branch of the LAD had mild to moderate nonobstructive calcific disease. The left circumflex artery demonstrated mild to moderate calcified plaque without obstruction. There was mixed soft plaque and calcified plaque in the right coronary artery with significant motion artifact which precluded diagnostic interpretation. Moderate left ventricular dysfunction with ejection fraction estimated at 40%.

GJ

66 year old male with known CAD – PCI.

CARDIAC RISK FACTORS:

- # Hyperlipidemia
- # Past tobacco abuse – quit 5 years ago, 1 ppd x 35 years
- # HTN

CARDIAC HISTORY:

4/22/03 Chest pain – GXT/ dual isotope stress test – LVEF 59%. Exercised 10 minutes. Peak heart rate achieved 157 bpm. (99% pred. max.). Negative ischemia
8/3/2004 PTCA/STENT (3.5 x 8 mm Taxus) – proximal LAD, PTCA/STENT (3.5 x16 mm Taxus)
CX

8/15/06 LHC – LVEF 55%, no wall motion abn. RCA – diffuse atherosclerotic changes with patent stent. 40% mid portion. LAD – minor luminal irregularities with patent stent in proximal portion. Septal perforators and diagonal branches were atherosclerotic. Distal portion of LAD shows luminal irregularities. LCX – shows atherosclerotic changes with 30% luminal narrowing in the distal portion. LMCA patent. Recommended medical management.

MEDICATIONS:

ASA 325 mg daily	Toprol XL 50 mg daily
Cozaar 25 mg dailyj	Renexa 500 mg BID
Plavix 75 mg daily	Ambien prn
Tricor 145 mg daiy	
Vytorin 10/40 mg daily	

GJ 66

LAD with stent is patent. LCX stent appears patent but can not visualize inside stent. OM nonobstructive calcific plaque.

JH

67 year old male with CAD. CMOP

MEDICAL HISTORY:

- # Chronic low back pain
- # Severe depression
- # Mild asthma, COPD

CARDIAC RISK FACTORS:

- # HTN
- # Tobacco abuse
- # Hyperlipidemia
- # Positive family history – father 3 MI's

CARDIAC HISTORY:

11/03 Inferior MI PTCA/STENTS (overlapping 4.0 x 18, 4.0 x 23, 4.0 x 18, and 3.5 x 18 mm ZETA), Angiojet thrombectomy from ostium through the mid to distal RCA. Ostially occluded dominant RCA with large amount of thrombus burden as well as 90% eccentric stenosis of mid LAD after the first diagonal branch touchdown. CX small, non-dominant vessel with several branches, no focal severe lesions. LM without significant stenosis. LVEF 40% inferior akinesis. Anterolateral wall hyperkinetic.

12/23/03 PTCA/STENT (3.0 x 18 mm Cypher) mid LAD RCA – proximal to mid long stent segment widely patent. Distally 20% stenosis followed by 30% stenosis in posterior left ventricular branch. LM – without stenosis. LAD eccentric focal 90% stenosis mid LAD immediately after the take-off of the first diagonal branch. Diffuse 30 – 40% disease past 90% lesion extending to second diagonal branch.

8/18/06 GXT dual isotope stress test – exercised 4 minutes 3 seconds , peak heart rate achieved 127 bpm (83 % pred. max.). 4 METS LVEF 36% akinesis of inferior and lateral wall. Large sized, severe intensity defect involving the inferior and lateral wall which is fixed and does not reverse on the resting images.

7/9/07 Echo – LVEF 25 -30%. Severe, generalized LV hypokinesis. “:pseudonormal” filling pattern for age. Mild concentric LVH. BAE. Mild MR. Mild mitral annular calcification. Mild TR. RVSP 41 to 46 mmHg. Inferior vena cava slightly enlarged measuring 26 mm. Blunted respiratory-phasic changes. Mild aortic root dilatation.

- # Currently, refusing ICD placement.

MEDICATIONS:

- | | |
|------------------------|----------------------|
| Plavix 75 mg daily | Coreg 12.5 mg BID |
| Protonix 40 mg daily | ASA 81 mg daily |
| Lipitor 40 mg daily | Zoloft 200 mg daily |
| Lisinopril 25 mg daily | Lithium 300 mg daily |

JH 6-02-40

Ejection fraction 45%. There is an inferior wall hypokinesis. The RCA contains multiple proximal stents, including an ostial as well as a mid stent which appear to be patent. The PDA has a small amount of calcified plaque but is not obstructive. LAD, there is calcification in the proximal portion of the LAD which is nonobstructive. The proximal stent located in the LAD is patent. Two diagonal branches both of which are normal. Circumflex is normal.

BC

59 year old male with history of lipidemia.

MEDICAL HISTORY:

- # Asthma
- # BPH

CARDIAC RISK FACTORS:

- # Hyperlipidemia – unable to take statins secondary to elevated LFT's

CARDIAC HISTORY:

7/24/03 Treadmill dual isotope stress test – exercised 11minutes, 19 seconds. 13.40 METS. Slight inferior wall soft tissue artifact. Negative ischemia. LVEF 65%.

MEDICATIONS:

- Singulair 10 mg daily
- Advair
- Albuterol
- Zetia 10 mg daily
- Flomax .4 mg daily

BC 01-18-48

The calcium score for this patient was 200. The right coronary artery had mild nonobstructive calcified plaque. The left main arose normally from the left sinus Valsalva and gave rise to an LAD and circumflex. The left main had no significant stenoses or plaquing. The LAD had proximal nonobstructive calcification and mild 0-25% mixed soft plaque. The first diagonal had nonobstructive calcification and the circumflex had mild mixed proximal disease. The ejection fraction was normal in the 55-60% range, and there were no notable structural abnormalities to the heart or great vessels.

LB

63 year old male with known CAD – CABG.

MEDICAL HISTORY:

Hypothyroidism

CARDIAC RISK FACTORS:

Increased lipids

Remote tobacco abuse

Positive family history – mother, brother

CARDIAC HISTORY:

#3/21/00 CABG x 5 = LIMA sequenced to the second diagonal and LAD, free RIMA to first marginal, and SVG sequenced to the PDA and right posterolateral.

11/20/06 Echo – LVEF 55% No wall motion abn. LAE. Aortic valve mildly thickened, with normal opening. Mitral valve leaflets mildly thickened with normal opening. Trace of mitral annular calcification. Trace MR. Mild TR. RVSP 35 mmHg.

11/20/06 chest pain – GXT/dual isotope stress test = LVEF 74% (increased EF compared to prior study 9/19/05 LVEF 48%) Negative for ischemia.

MEDICATIONS:

Crestor 20 mg daily

Diovan 40 mg daily

Synthroid 75 mcg daily

Multi vitamins

Tricor 145 mg daily

Zetia 10 mg daily

ASA 325 mg daily

LB 63

EF 61%. LIMA to D1 to LAD good contrast. Radial free graft appears patent to distal LCX. SVG to PDA appears patent.

JS

40 year old male with cardiac history of AI – bicuspid valve, ascending aortic aneurysm s/p AVR (On – x), with Medox graft.

MEDICAL HISTORY:

- # GERD
- # Asthma

CARDIAC RISK FACTORS:

- # Tobacco – chews
- # Family history – father died age 65 of MI

CARDIAC HISTORY:

- # Coartation Repair

6/4/07 AS, bicuspid aortic valve, ascending 5.6 – 5.8 cm aneurysm -Coronary CT Angiogram = Calcium score 0. LVEF 64%. Left dominant coronary system. LM- normal. LAD – normal. LCX – normal. RCA – normal, small vessel, Mitral valve normal. Aortic valve – bicuspid . There is calcium in aortic valve leaflets. There does not appear to be significant aortic stenosis. Aorta – dilated ascending aorta consistent with aneurysm 5.3 x 5.6 cm.

5/29/07 Echo – LVEF 60 -65% Ascending aorta dilatation measuring up to 5.0 cm. Bicuspid aortic valve with thickening/ calcification. Moderately severe aortic stenosis. Peak gradient 59 mmHg. Mean gradient 35 mmHg. Trace aortic regurgitation. Trace TR.

- # 6/19/07 AVR (On-X 25 mm) placement of 28 mm Medox graft

MEDICATIONS:

- Coumadin
- Aspirin
- Pepcid

JS 12-27-67

Normal left ventricular size and function. Mechanical aortic prosthesis (On-X). Normal function of mechanical prosthesis. Normal coronary vessel. A dominant circumflex. Ascending aortic graft. (Not a composite graft).

RC

62 year old male with CAD and Peripheral Vascular Disease.

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia
- # Positive family history – brother died of Mi age 41, mother CABG age 61
- # Tobacco – ½ ppd x 40 years

CARDIAC HISTORY:

8/3/04 Chest pain, dyspnea. GXT dual isotope stress test – exercised 8 minutes 30 seconds, peak heart rate achieved 137 bpm (85% pred. max.). 10.4 METS - large area of hypo perfusion inferior wall on stress images, suspicious for inferior ischemia. LVEF 65%.

8/12/04 PTCA mid RCA. LAD- wall irregularities, no significant disease. CX – wall irregularities, no significant disease. RCA – diffuse disease proximally to mid to distal portion.

8/19/04 PTCA/STENT (2.5 x 18 mm cipher) ostium of RCA. (2.25 x 13 pixel stent in mid RCA. Adjunctive pharmacotherapy in form of Angiomax used.

RCA –ostial lesion 80 -85 % , mid lesion previously treated with angioplasty had residual stenosis of 70% to 80%. Distal 50 – 60% tubular lesion.

CX – CX and OM1 small vessels, diffuse 40% disease.

LAD – proximal 40% nonobstructive disease

Abdominal aortography – mild plaque disease, of abdominal aorta, mild plaque disease of renal arteries, and mild plaque disease of the common iliac arteries bilaterally.

Common iliac angiography – mild plaque disease right SFA. Left SFA 100% occl. midway, with patent femoral popliteal bypass graft.

9/20/04 GXT/dual isotope stress test – exercised 10 min. 10 seconds, peak heart rate achieved 141 bpm, (87% pred. max.) 12.9 METS LVEF 70% Normal perfusion

#5/2/06 LHC – LVEF 60% CX - CX and OM1 30% disease. LAD –prox. 30 -40 % nonobstructive disease. RCA – 10% instent stenosis ostium, proximal stent site. Proximal to mid RCA conduit diffuse 30 -40% disease. Distal RCA diffuse 30 -40%.

MEDICATIONS:

ASA 325 mg daily

Plavix 75 mg daily

Lipitor 10 mg daily

Lexapro 20 mg daily

RC (No DOB)

The LAD has nonobstructive calcification. The calcification is diffuse and heavy, however. There are two patent small diagonals without significant obstruction. There is nonobstructive mixed plaque of the proximal circumflex. The RCA ostial stent is patent with no significant restenosis. The mid RCA stent is also patent but the lumen is not well visualized. There is heavy RCA calcification. The lumen is not visualized in one single plane and a tight stenosis cannot entirely be excluded at this level. The distal RCA fills normally. The probability of a tight stenosis in this location of calcium is in the 50% range. The ejection fraction is normal in the 55-60% range. There are no other cardiac structural abnormalities.

GW

58 year old female with multiple risk factors.

CARDIAC RISK FACTORS:

- # Hyperlipidemia
- # HTN
- # Intermittent tobacco usage

CARDIAC HISTORY:

- # No history of stress testing, echo's, cath

MEDICATIONS:

- Lisinopril
- Zocor
- Vinelle
- Effexor
- Detrol
- Aspirin

GW 04-01-47

Ejection fraction is 70%. Normal wall motion. Normal LV function. Calcium score is zero. Right coronary artery is dominant. No disease.

FN

70 year old male with hyperlipidemia.

MEDICAL HISTORY:

- # Osteoporosis
- # Septoplasty

CARDIAC RISK FACTORS:

- # Hyperlipidemia

CARDIAC HISTORY:

11/10/03 GXT/Myoview stress test – exercised 9 minutes 13 seconds. Peak heart rate achieved 160 bpm, (104% pred. max.) 13.5 METS. Complete RBBB present on resting EKG. LVEF 57%. Mild inferoposterior LV HK. No ischemia at peak exercise when compared to previous study 10/26/01.

11/10/03 Echo – LVEF 60 % No wall motion abn. LAE – 4.5 cm. Mild MR. Aortic valve sclerotic with normal opening.

MEDICATIONS:

- Vytorin 10/40 mg daily
- Fosamax 70 mg weekly
- Vitamin D
- Tums
- Rozarin
- Viagra

FN 70

EF 59%. RCA dominant and normal. LAD normal although mid segment not well visualized. Calcium score of 2 (RCA). LCX normal. Large OM normal with myocardial bridge.

LM

55 year old male with known CAD – MI, CABG.

MEDICAL HISTORY:

- # Hypothyroidism
- # Depression
- # Sleep apnea
- # Restless leg syndrome
- # Spinal surgery

CARDIAC RISK FACTORS:

- # Hyperlipidemia 812/07 TC -176 TG – 157 HDL – 47 LDL - 98
- # HTN

CARDIAC HISTORY:

10/3/03 Subacute lateral wall MI , cardiogenic shock, pulmonary edema. Placement of intra-aortic balloon pump. LHC = LM – normal. LAD – 90-95% proximal obstruction. Both diagonal branches 90% proximally narrowed. CX- occluded proximally. Distal CX fills by collaterals. RCA – proximal occluded, distal fills by collaterals. Diffuse 70% obstruction of mid portion of PDA branch.

10/03/03 Emergent CABG = LIMA to LAD, SVG to distal RCA with long linear 3 cm patch angioplasty, SVG sequentially to first and second diagonal branches of the left, CX OM, CX posterolateral.

11/7/03 Negative T – Wave Alternans

#12/9/03 CHF – stable, New York Heart Association Class 1. MRI – chest.. LVEF 45 -50%. HK of lateral, midlateral, posterolateral, inferior LV wall, with remaining portions of LV contracting normally.

MEDICATIONS:

- | | |
|------------------------|------------------------|
| Coreg 25 mg BID | Aspirin |
| Synthroid 50 mec daily | Lisinopril 10 mg daily |
| Paxil | Lipitor 40 mg daily |
| Vitamins | Fish oil |

LM 09-07-51

Ejection fraction is 49% with lateral wall hypokinesis. Native vessel, LAD, circumflex and RCA are occluded. LIMA to LAD are patent with good visualization of the proximal portion and distal anastomosis. SVG to distal RCA is patent. Jump graft SVG to D1, D2, OM1, OM2 patent. Anastomosis well visualized.

AB

72 year old male with known CAD – MI, CABG.

MEDICAL HISTORY:

- # Asthma
- # h/o acute cholecystitis

CARDIAC RISK FACTORS:

- # Hyperlipidemia
- # HTN
- # Remote tobacco abuse

CARDIAC HISTORY:

5/16/2000 CABG – LIMA to LAD, SVG to first OM, PD branch of RCA, as well as to the first diagonal branch of LAD.

12/20/05 exertional shortness of breath, abnormal Myoview scan LHC = LVEF 45%. Mild inferior posterior wall HK. RCA -100% stenosis. LAD -100% stenosis. CX-100% stenosis. LM - atherosclerotic left main trunk. SVG to RCA patent. SVG to diagonal branch patent. SVG to CX patent. LIMA to LAD patent.

7/16/07 Adenosine stress test – LVEF 64%. Coexisting myocardial fibrosis and ischemia with only minor to minimal ischemia in the inferoposterior and posterobasal LV.

7/18/07 Echo – LVEF 45%. Inferior wall of LV, most of apex hypokinetic. Diastolic dysfunction. LAE. Aortic valve sclerotic with normal opening. Mitral valve leaflets thickened with normal opening. Mild mitral annular calcification. Trivial MR, AR, TR, mild PR.

MEDICATIONS:

- Lipitor
- Cozaar
- ASA
- Metoprolol

AB 72

EF 45%. LVG to distal RCA patent. LIMA-LAD patent. SVG-Diagonal is an acute angle with narrow ostiom but patent. SVG-LCX/OM normal.

WW

66 year old male with known CAD.

CARDIAC RISK FACTORS:

- # HTN
- # Hyperlipidemia

CARDIAC HISTORY:

1/18/2002 CABG x 5 = LIMA to LAD, RIMA a T-graft to diagonal, VG to distal CX, and VG sequentially to RV marginal on the PDA.

3/17/06 ER admission for chest pain – elevated CPK's, negative MB's. LHC =LVEF 40%. RCA -100% stenosis of RCA with closed SVG. LAD- 100% stenosis. CX- 100% stenosis. LIMA to LAD patent. RIMA to CX poorly visualized. SVG to OM patent. Recommended medical management.

8/14/06 unstable angina Adenosine dual isotope stress test = Minimal adenosine – induced inferoapical myocardial ischemia. LVEF 56% with posterolateral mild HK. Moderate LVH.

MEDICATIONS:

- Toprol 50 mg daily
- Norvasc 10 mg daily
- Hyzaar 100/12.5 mg daily
- Paxil 10 mg daily
- Pletal 50 mg daily
- Plavix 75 mg daily
- Lipitor 10 mg daily
- Tekurna 150 mg daily
- Clonidine .2mg daily
- Aspirin daily

WW 66

RCA is occluded. SVG-RCA is occluded. SVG-OM patent. High grade stenosis proximal to stent in LAD. Proximal LAD stent appears patent. LIMA-LAD limb occluded. RIMA-Tgraft-D1 small vessel.