



# Injection/imaging for supravalvular aortography Study Report

ANGIO DEMO  
December 03, 2015

**Accession/Encounter No:** car  
**DOB:** 1983-01-05      **Age:** 32  
**Gender:** F  
**Height:** 72 in      **Weight:** 240 lbs  
**BSA:** 2.38 m<sup>2</sup>  
**BMI:** 32.55

**Study Time:** 12:10 PM  
**Reading Group:** Studycast Reading Group  
**Referring Group:** Anytown Family Practice

**Study Quality:** Excellent

**Indications:** The patient is a 65-year-old gentleman with a history of exertional dyspnea and a cramping-like chest pain. Thallium scan has been negative. He is undergoing angiography to determine if his symptoms are due to coronary artery disease.

After informed consent, aortogram. Selective bilateral angiography with runoff. Vascular Closure Device (ANGIOSEAL - successful)

### Findings:

The right groin was sterilely prepped and draped in the usual fashion and the area of the right coronary artery anesthetized with 2% lidocaine. Constant sedation was obtained using Versed 1 mg and fentanyl 50 mcg. Received additional Versed and fentanyl during the procedure. Please refer to the nurses' notes for dosages and timing.

Description: Selective coronary angiography. Placement of overlapping 3.0 x 18 and 3.0 x 8 mm Xience stents in the proximal right coronary artery. Abdominal aortography.

The right femoral artery was entered and a 4-French sheath was placed. Advancement of the guidewire demonstrated some obstruction at the level of abdominal aorta. Via the right Judkins catheter, the guidewire was easily infiltrated to the thoracic aorta and over aortic arch. The right Judkins catheter was advanced to the origin of the right coronary artery where selective angiograms were performed. This revealed a very high-grade lesion at the proximal right coronary artery. This catheter was exchanged for a left #4 Judkins catheter which was advanced to the ostium of the left main coronary artery where selective angiograms were performed.

The patient was found to have the above mentioned high-grade lesion in the right coronary artery and a coronary intervention was performed. A 6-French sheath and a right Judkins guide was placed. The patient was started on bivalarudin. A BMW wire was easily placed across the lesion and into the distal right coronary artery. A 3.0 x 15 mm Voyager balloon was placed and deployed at 10 atmospheres. The intermediate result was improved with TIMI-3 flow to the terminus of the vessel. Following this, a 3.0 x 18 mm Xience stent was placed across the lesion and deployed at 17 atmospheres. This revealed excellent result however at the very distal of the stent there was an area of haziness but no definite dissection. This was stented with a 3.0 x 8 mm Xience stent deployed again at 17 atmospheres. Final angiograms revealed excellent result with TIMI-3 flow at the terminus of the right coronary artery and approximately 10% residual stenosis at the worst point of the narrowing. The guiding catheter was withdrawn over wire and a pigtail was placed. This was advanced to the abdominal aorta at the area of obstruction and small injection of contrast was given demonstrating that there was a small aneurysm versus a small retrograde dissection in that area with some dye hang up after injection. The catheter was removed. The bivalarudin was stopped at the termination of procedure. A small injection of contrast given through arterial sheath and Angio-Seal was placed without incident.

It should also be noted that an 8-French sheath was placed in the right femoral vein. This was placed initially as the patient was going to have a right heart catheterization as well because of the dyspnea.

Total contrast media, 205 mL, total fluoroscopy time was 7.5 minutes, X-ray dose, 2666 milligray.

### Conclusions:

1. Successful stenting of subtotal stenosis of the proximal coronary artery.
2. Non-obstructive coronary artery disease in the mid left anterior descending as described above and ectasia of the proximal circumflex coronary artery.
3. Left to right collateral filling noted prior to coronary intervention.
4. Small area of eccentric aneurysm formation in the abdominal aorta.

April 23, 2019 09:32 AM EDT  
CSI Admin Staff  
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