Cardiac Catheterization Laboratory
[Name of facility]
[Logo of facility]

Patient: Last name, first name [middle initial /name]

MRN: xxxxxxxxx **DOB:** xx/xx/xxxx **Age:** xx
Gender: M/F
Procedure Date: xx/xx/xxxx
Cine Number: xxxxx
Cath Attending: xxxxxxxxx xxxxxxxxx
Referring Provider(s): xxxxxxxxxx xxxxxxxxx

Cardiac Catheterization Procedure Report Summary

Primary Indication
Chest pain (786.50)

History
A 57-year old man with hyperlipidemia, hypertension, and a positive family history who presents with typical chest discomfort with exertion relieved with rest. A stress echocardiogram was positive for a large area of ischemia involving the anterior and anterolateral distributions.

Procedures
Left heart cath + ventriculogram + coronary angiography (93458)
Percutaneous coronary intervention: prox LAD, prox-mid LCX (92928, 92929)
Intra-aortic balloon pump (33967)

Vascular Access
Location: right radial artery, right femoral artery
Sheath: 5Fr (right radial), 6Fr (right femoral)
Disposition (end of case): radial – TR band; femoral – hemostasis with Brand EE closure device

Catheters
Diagnostic: JL4, JR4, Amplatz 1, pigtail
Intervention: XB 3.5, Amplatz 2

Diagnostic Findings
Box 1

Hemodynamics (mm Hg)
Aorta: 134/78, mean 92
LV: 134/4, EDP 18

Coronary arteries
Left dominant
Prox LAD: 90%
Prox-mid LCX: diffuse 80%
OM3: 60%
RCA: normal

Left ventricle
EF: 61%
MR: 1+ mild
Wall motion: mild anterior hypokinesis, moderate apical hypokinesis

Interventions
Box 2

Prox LAD: Brand MM 3.0mm x 18mm (drug eluting) stent: 90% pre to 0% post
Prox-mid LCX: Brand NN 3.0mm x 28mm (bare metal) stent: diffuse 80% pre to 10% post

Adverse Events
Ventricular fibrillation

Medication Totals

Diphenhydramine: 25 mg	Heparin: 5000 units
Hypdromorphone: 1 mg	Clopidogrel: 600 mg
Midazolam: 1 mg	Antacid: 30 ml

Contrast Total

Iopamidol: 140 ml

Impressions

2 vessel coronary artery disease
Successful PCI x2

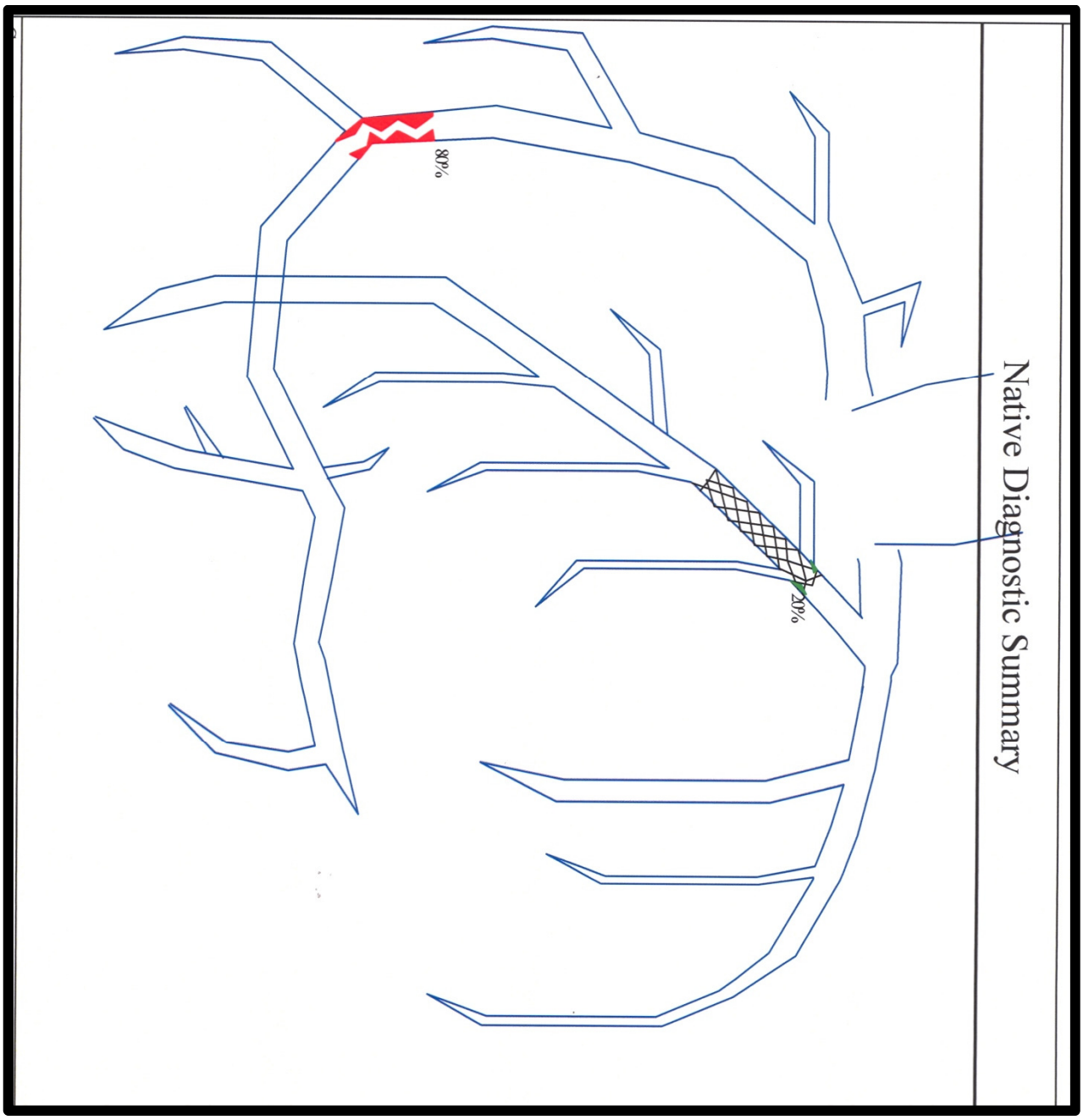
Recommendations

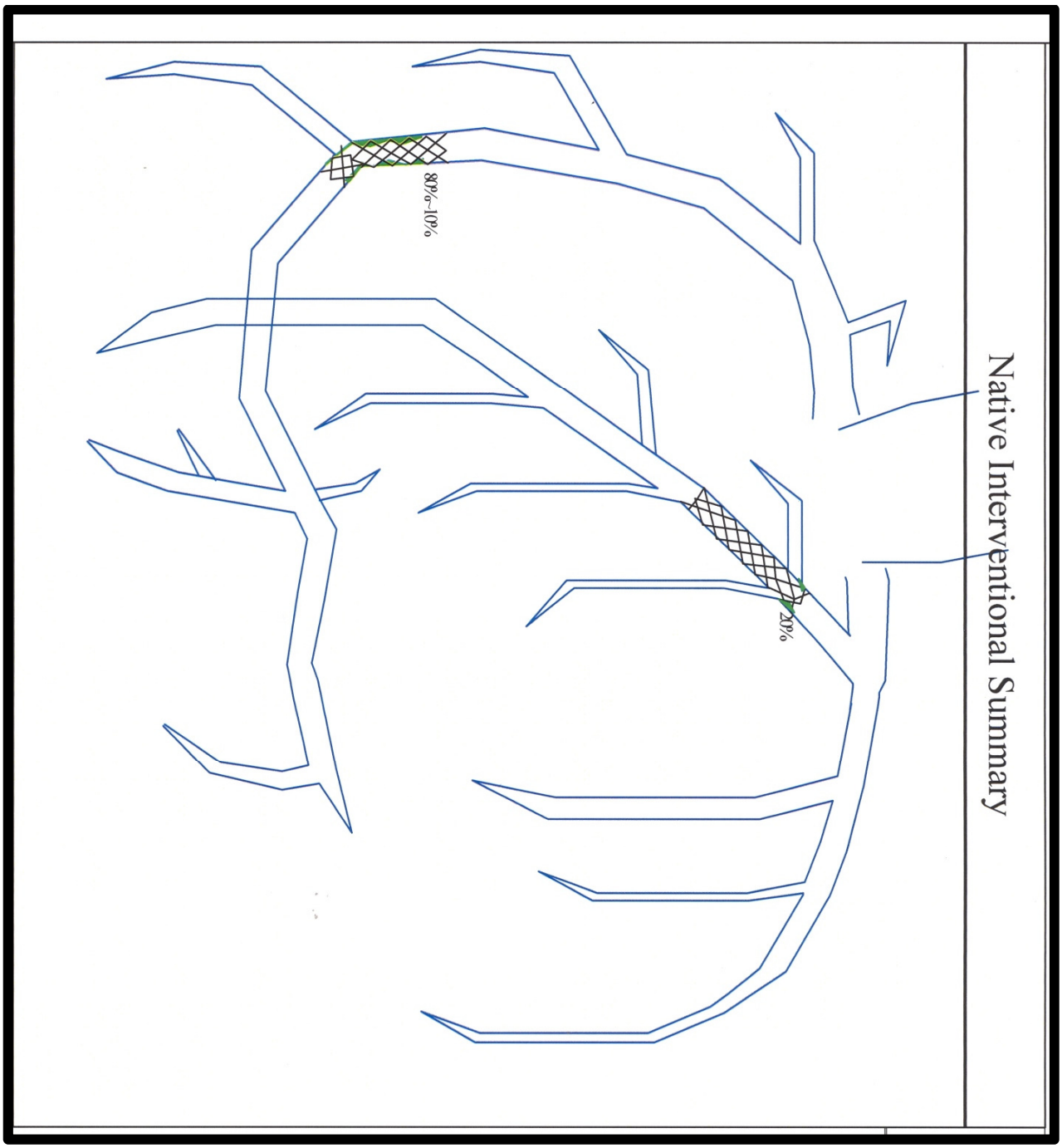
Risk factor modification
Routine post-PCI care
Refer for cardiac rehab
Aspirin 81 mg lifelong
P2Y12 inhibitor for at least 6 months
Avoid elective surgery while receiving a P2Y12 inhibitor

Physician

<eSignature>	<eSignature>
Richard Green, MD	Pamela Blue, DO

Attending attestation: I was present for the entire procedure.


Native Diagnostic Summary
80%
20%


Native Interventional Summary
80%~10%
20%

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Patient

Last name, first name middle name / initial
Date of birth, age, gender
Race, ethnicity
Medical record number
Case accession number
Insurance

Healthcare Facility

The Heart Hospital
Adult Cardiac Catheterization Laboratory
2000 Applewood Lane
Eureka, Texas 75100
(555) 555-1111
FAX: (555) 5555-1234
Laboratory: Cath Lab 2

Operator

Richard Green, MD
Pamela Blue, DO (fellow)

Staff

Carrie Brown, RN
Samuel White, CVT
Samantha Rose, RN
Deborah Black, RN

Care Providers

Referred by: John Grey, MD
2000 Southfork Ranch Road
Dallas, TX 71234
(813) 555-1212

Primary Care Provider: Barney Redd, MD
1000 Cahuna Ranch Boulevard
Arlington, TX 72345
(714) 555-1212

Cardiologist: Ray Ivory, DO
3000 Workman Ranch Street
Irving, TX 73456
(615) 555-1212

Reason for request: evaluation of decompensated heart failure with chest pain.
Procedure requested: left heart cath
Date of request: January 2, 2013
Requested by: John Grey, MD

Encounter Category
Elective cath, possible PCI

History and Physical Data

Symptom Class – Angina
Onset: 12/??/2007
Current CCS class: asymptomatic

Symptom Class – Heart Failure
Onset: 12/??/2007
Current NYHA class: asymptomatic

Medical History
Diabetes mellitus, type II: on oral meds
Total cholesterol >200
LDL >100
Cigarette smoking: average of 2.5 packs per day x 25 year
Hypertension
Renal insufficiency: CKD stage 3
Cardiac transplant: 1/4/2009
Steroid use, chronic

Previous Procedures / Previous Events

12/18/2007	High Point Regional Hospital: acute MI
12/18/2007	High Point Regional Hospital: LHC, PCI - mid LAD
7/10/2008	Duke University Medical Center: LHC
9/21/2008	Duke University Medical Center: RHC, LHC
1/4/2009	Duke University Medical Center: cardiac transplant
1/11/2009	Duke University Medical Center: RHC, biopsy
2/11/2009	Duke University Medical Center: biopsy
5/15/2009	Duke University Medical Center: stress echo, anterior and anterolateral ischemia

Allergies and Sensitivities
Penicillin: rash (moderate)

Physical Examination
Lungs: clear
Heart: normal S1 and S2
Pulses:

	carotid	femoral	DP	PT
left	2	2	2	2
right	2	2	2	2

Bruits:

left	0	0
right	0	0

Neurologic: alert & oriented x3

Laboratories
Hemoglobin 12.2 g/dL [13.7-17.3] 11/30/2011

Hematocrit	36 L/L	[0.39-0.49]	11/30/2011
Platelets	349 X10^9	[150-450]	11/30/2011
Sodium	138 mmol/L	[135-145]	11/30/2011
Potassium	4.5 mmol/L	[3.5-5.0]	11/30/2011
Urea nitrogen	33.0 mg/dL	[7-20]	11/30/2011
Creatinine	1.9 mg/dL	[0.6-1.3]	11/30/2011
Prothrombin	11.9 sec	[9.5-13.1]	11/30/2011

ICD Diagnoses (*indicates primary indication)

*V42.1 Heart replaced by transplant
585.3 Chronic kidney disease, stage 3 (GFR 59-30)
401.1 Benign essential hypertension
426.4 Right bundle branch block (RBBB)
V58.65 Steroids, long term (current) use of
V58.66 Aspirin, long term (current use)

AUC Indications

Diagnostic cath: criterion 101 (post heart transplant patient)
Intervention: criterion 10 (UA/NSTEMI and intermediate risk features)

PROCEDURE DETAILS

Procedures

Endomyocardial biopsy
Right heart catheterization
Fick cardiac output
Aortic pressure measurement
Left heart catheterization
Coronary angiogram - left
Coronary angiogram - right
Drug-eluting stent – single vessel

Logistics

Time arrived in lab: 11:40, from CVSSU
Consent signed: yes
Sedation consent: yes
Timeout performed: yes
Time departed from lab: 13:11, to CVSSU
Final patient condition: stable

Baseline Data

Height: 172.0 cm
Weight: 73.7 kg
BSA: 1.80 m2
Initial blood pressure: 125/67 mmHg
Initial pulse: 66 bpm
eGFR: 77 mL/min

Vascular Access

Right femoral vein: SheathCo 7Fr Slider sheath, Hemo 7Fr Intro 85cm (biopsy sheath)
Disposition: removed, hemostasis via manual compression
Right femoral artery: SheathCo 5Fr Slider sheath
Disposition: removed, hemostasis via manual compression

Hemodynamic Support

Left femoral artery: Datascope 40 cc intra-aortic balloon pump, inserted at 11:45

Disposition: left in place

Diagnostic Findings

Box 3

Right Heart Catheterization

Instruments: Bard 7Fr Pulmonary Wedge Pressure Catheter

Oximetry, Cardiac Output, and Calculated Data

Assessment conditions: rest

Patient height: 172.0 cm, weight: 73.7 kg, body surface area: 1.80 m²

Vital signs: HR: 92 bpm, BP: 131/104 mmHg

Inspired O2: room air

Vasoactive agents: none

Oximetry samples (rest)

Sample Site	Hgb (g/dL)	O2 Sat (%)
FA	11.1	95.6
PA1	11.0	53.2
PA2	11.0	53.0

Assumed O2 consumption = 226.0 mL O2/min

BMR = 0.5 %

A-V O2 Difference = 6.39 Vol % PBF (Qp) = 3.5 L/min

PVR = 3.1 Wood units SBF (Qs) = 3.5 L/min

SVR = 21.8 wood units Cardiac Index = 1.89 L/min/m2

Hemodynamic and Valve Data (resting state, in mmHg)

RA: a=10, v=10, mean=8

RV: 32/7, EDP 10

PA: 32/17, mean=20

PCW: a=8, v=12, mean =10

Systemic BP: 120/78, mean 95

Coronary Angiography

Instruments: 6Fr JL4, 6Fr JL5, 6 Fr JR4, 6Fr dual lumen pigtail

Coronary anatomy

Dominance: right

Segment	Stenosis	Lesion Type	TIMI Flow (abnormal)
Prox RCA	30%	Discrete	
Mid RCA	40%	Discrete	
RPL1 (Small)	50%	Diffuse	
RPL2 (Small)	50%	Diffuse	
Mid LAD	20%	Discrete	
*Mid LAD	70%	Discrete	
Dist LAD	30%	Tubular	
Left Main	normal		
Left Circumflex	normal		

* Denotes significant lesion

Notes: anterior takeoff of the RCA, unable to seat JR catheter

Left Ventriculography

Instruments: 6Fr dual lumen pigtail

Box 3

Hemodynamics (mm Hg): 182/6, EDP 22
Ejection fraction: 55%
Wall motion: mild inferior hypokinesis, moderate apical hypokinesis
LV dilation: mild global dilation
Mean Ao-LV gradient: 45 mm Hg
Aortic valve area: 0.7 cm2

Interventions

Box 4

Percutaneous Coronary Intervention

Lesion #1: OM2 90% TIMI 3 (pre) to normal TIMI 3 (post) (IRA)
- Guide catheters: Cordis 6Fr XB 3.0 Vista Britetip
- Guide wires: Guidant/ACS .014x300cm Whisper MS
- Devices:
  - Abbott Mini Trek OTW 2.0x20mm (balloon)
  - Medtronic Resolute Integrity 2.25x30mm (drug eluting stent) – max atm: 18
- Notes: Lesion did not open until 24 ATM applied with pre-dilation balloon

Lesion #2: L main body normal TIMI 3 (pre) to 50% TIMI 3 (interval) to normal TIMI 3 (post)
- Guide catheters: Cordis 6Fr XB 3.0 Vista Britetip
- Guide wires: Guidant/ACS .014x300cm Whisper MS, Abbott Balance Middleweight Universal
- Devices:
  - Abbott Xience Rx Everolimus 4.0x12mm (drug eluting) stent
  - Abbott NC Trek Rx 5.0x8mm (balloon)
- Notes: guide catheter trauma to left main; both LAD and LCX were wired

Right Ventricle Biopsy

Instruments: Bioptome Forcep MOB-1
Specimens removed: 4
Pathology slip: 44335544

Medication Totals

Medication	Dose	Route	Time	Comment
Lidocaine	1%, 20 ml	sq	14:10	
Diphenhydramine	25 mg	iv	14:03	
Hydromorphone	0.5 mg	iv	14:03	
Midazolam	1.0 mg	iv	14:03	
0.9% normal saline	50 ml	iv		
Isovue	80 ml			Lot number: 1F31882

Radiation

Fluoroscopy time: 4.5 minutes
Dose area product: 1.1 Gy-cm2
Cumulative air kerma: 1340 mGy

Estimated Blood Loss: 20 ml

Specimens Removed: RV biopsy x4

Final ICD Diagnoses

585.3 Chronic kidney disease, Stage 3 (moderate) - (GFR 59-30)
V42.1 Heart replaced by transplant
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401.1 Benign Essential Hypertension
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Procedure Notes

[This is for any additional text-based notes describing the specifics of the procedure]