

DEPARTMENT OF CARDIOLOGY

Patient Name : [Redacted] Age : 70Y Sex : Female
UHID : [Redacted] Request No : [Redacted]
IP NO. : [Redacted]
Completed on : [Redacted]
Consultant Name : [Redacted]

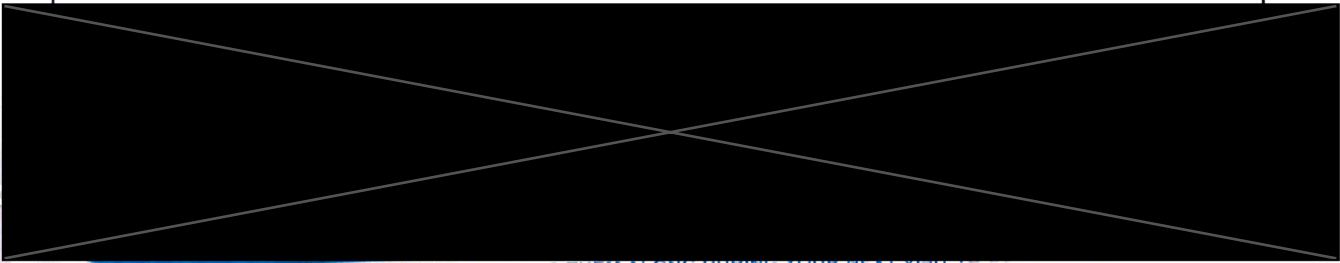
CORONARY ANGIOGRAM

Cath Lab No. : [Redacted]
Clinical Diagnosis : HTN
DM
LRTI
CAD -ACS -PWTI
SEVERE MR
SR, MILD LV DYSFUNCTION
Procedure : CORONARY ANGIOGRAM
Contrast Agent : VISIPAQUE
Contrast Volume : 50 ML
Catheter used : TIG, 5-FRENCH
Approach : Radial
Fluroscopy time : 3 MINUTES
LV Angiogram : NOT DONE

Hemodynamics

Chamber 1	Pre Angio (mm Hg)	Post Angio (mm Hg)	O2 Saturation%
HSVC	-	-	-

LMCA : BIFURCATES, NORMAL



CORONARY ANGIOGRAM

LAD	: TYPE III VESSEL, PROXIMAL LAD 30% STENOSIS, MID LAD 30-40% STENOSIS, DISTAL LAD MILD PLAQUE
Diagonal Branches	: DIAGONAL-1 -40-50% OSTEOPROXIMAL STENOSIS,
Ramus	: -
LCX	: NON-DOMINANT VESSEL, PROXIMAL LCX NORMAL, FOLLOWED BY TOTAL OCCLUSION
OM Branches	: -
RCA	: DOMINANT VESSEL, PROXIMAL RCA MILD PLAQUE, MID RCA 40-50% STENOSIS, DISTAL RCA -NORMAL
RV	: -
PDA	: NORMAL
PLB	: NORMAL
Left subclavian artery	: -
Lima	: -
Qualitative	: -
Others	: -
Renal Angiogram	: -
Carotid angiogram	: -
Peripheral Angiogram	: -
LM	: -
Final Diagnosis	: CAD -DVD
Recommendation	:

CORONARY ANGIOGRAM

--- END OF THE REPORT ---

MD, DM (AIIMS), FACC, Director of
Cathlab