COAP Inter-Rater Reliability Testing Case

For 2004 QI Measurement Cycle

PCI and CABG

NOTE: Please fill out one form for the PCI and one form for the CABG.

Do not abstract both procedures to the same form.

BAYSHORE MEDICAL CENTER

PATIENT INFORMATION

Name:	Angela B. Lansbury
SSN:	123-45-6789
DOB:	4-16-1929
ER Arrival:	July 26, 2003
ER Arrival	10:33 p.m.
Hospital Admit:	July 26, 2003
Hospital Admit:	11:43 p.m.
Cardiac Cath:	July 27, 2003
Surgery:	July 28, 2003
Discharge:	August 01, 2003

ER RECORD

*** Final Report ***

Patient: LANSBURY, ANGELA B.

HOSPITAL ADMISSION

HISTORY OF PRESENT ILLNESS
The patient is a 74-year-old female complaining of chest pain. The patient had angioplasty after a small lateral myocardial infarction on 4/09/03. She has had occasional exertional chest pain since that time but no prolonged episodes until tonight when she developed substernal chest pain and pressure with radiation to the left arm and diaphoresis that lasted about 1 hours. She took nitroglycerin at home with improvement, and ultimately she became pain-free after aspirin, three nitroglycerin, and morphine given by medics en route after about 1 hour of pain. No shortness of breath and no nausea or vomiting.

REVIEW OF SYSTEMS
Additional systems reviewed and negative including no headache, abdominal pain, fevers, or chills.

CURRENT MEDICATIONS
Lisinopril, ranitidine, sublingual nitroglycerin p.r.n., atenolol, aspirin, Zocor.

ALLERGIES
Erythromycin.

SOCIAL HISTORY
Patient reports she is a former smoker, quit approximately 15 years ago. Reports no alcohol use. She is accompanied by her daughter. They came over from the Islands, where she lives.

PHYSICAL EXAMINATION
General: She is in no acute distress.
Vital Signs: Vital signs are stable.
HEENT: Conjunctivae are pink with moist mucous membranes.
Neck: Supple with no masses.
Heart: Regular rate and rhythm with no murmur.
Abdomen: Soft with bowel sounds and nontender.
Neurologic: Alert, oriented, and nonfocal.
Height and weight: 5’3”, 145 lbs. (patient reported)

LABORATORY AND X-RAY DATA
Electrocardiogram shows sinus rhythm. She has ST depressions laterally in V4 through V6 which are new compared to the last electrocardiogram done on 4/10/03 the day after her small myocardial infarction.

EMERGENCY DEPARTMENT COURSE
I talked with Dr. Brolin, on call for Cardiology, and the patient will be admitted for chest pain, rule out myocardial infarction. She is pain-free now with nitroglycerin paste, aspirin, and heparin. She is already on a beta blocker. She was admitted to the house staff.

ASSESSMENT AND PLAN
Admit as noted above.

RICHARD CHAMBERLAIN, M.D./cmc14
dd: 07/27/03
dt: 07/27/03

CATH LOG

Patient: Angela Lansbury

Date_Field	Time_Field	Note
07/27/2003	10:03:41	PATIENT IN LAB
07/27/2003	10:03:43	CASE STARTED: ROOM AIR, REST
07/27/2003	10:10:37	HR: 60 SpO2: 99 NIBP: 216/116
07/27/2003	10:19:02	RACE: CAUCASIAN
07/27/2003	10:19:02	FAM HX CAD: YES
07/27/2003	10:19:02	SMOKING: FORMER
07/27/2003	10:19:13	PATIENT READY
07/27/2003	10:19:13	PHYSICIAN IN LAB
07/27/2003	10:19:13	MED: LIDOCAINE 1% DOSE: U: RTE: SC
07/27/2003	10:19:13	RIGHT FEMORAL ARTERY PUNCTURE
07/27/2003	10:19:13	SHTH: 6 FR INTRODUCER SHEATH 10CM LENGTH V:B
07/27/2003	10:20:19	SAMPLE: 1 = AoA 194/78, 123
07/27/2003	10:20:39	DCTH: 6 FR JL-4 CATHETER V:M
07/27/2003	10:20:39	CORONARY ANGIOGRAMS
07/27/2003	10:22:29	DCTH: 6 FR 3D RC CATHETER V:C
07/27/2003	10:24:15	SAMPLE: 2 = AoA 199/89, 133
07/27/2003	10:28:12	MED: FENTANYL DOSE: 25 U: MCGS RTE: IV
07/27/2003	10:28:12	MED: VERSED DOSE: 1 U: MG RTE: IV
07/27/2003	10:28:21	SHTH: 7 FR INTRODUCER SHEATH 10CM LENGTH V:B
07/27/2003	10:29:42	ACT RESULT = 126 SEC
07/27/2003	10:29:59	PROCEED WITH PCI
07/27/2003	10:29:59	ICTH: JL-4 6 FR CORDIS .067" ID VISTA V:C
07/27/2003	10:30:07	IWRS: .014/190 CM ACS BMW UNIVERSAL GUIDE V:G
07/27/2003	10:31:35	SAMPLE: 3 = AoA 205/88, 133
07/27/2003	10:34:41	MED: HEPARIN DOSE: 5 U: K-UNITS RTE: IA
07/27/2003	10:37:58	IWRS: .014/190 CM ACS BALANCE GUIDE V:G
07/27/2003	10:39:53	IWRS: .014/190 CM ACS HI-TORQUE FLOPPY GUIDE V:G
07/27/2003	10:45:27	CT SURG CALLED/CONSULTED
07/27/2003	10:47:11	IWRS: .014/190 CM ACS WHISPER WIRE
07/27/2003	10:50:21	DCTH: 6 FR PIGTAIL CATHETER V:M
07/27/2003	10:51:50	SAMPLE: 5 = LV 200/17, 19
07/27/2003	10:52:38	22 ML ISOVUE 370 CONTRAST INJECTED LV GRAM
07/27/2003	10:55:01	PULLBACK: 6 = LV 210/11, 13 AoA 221/102,151
07/27/2003	10:55:22	100 ML CONTRAST USED FOR PROCEDURE
07/27/2003	10:55:22	12.3 MINUTES OF FLUORO TIME USED FOR PROCEDURE
07/27/2003	10:55:22	32 Gycm2 TOTAL DOSE
07/27/2003	10:55:22	ACT RESULT = SEC
07/27/2003	10:55:22	INTRODUCER SHEATHS SUTURED IN PLACE
07/27/2003	10:55:22	ACU DYNE OINTMENT/TEGADERM DRESSING APPLIED
07/27/2003	10:55:22	ARTERIAL SHEATH TO PRESSURIZED/HEPARINIZED FLUSH
07/27/2003	10:55:22	ACC: LEFT HEART CATH/PCI
07/27/2003	10:55:22	REPORT CALLED TO RN
07/27/2003	10:55:22	PATIENT TRANSPORTED TO LEVEL 8
07/27/2003	11:21:05	CASE STOPPED

CATH REPORT

*** Final Report ***

Patient: LANSBURY, ANGELA B.
Procedure Date: 07/27/03

PROCEDURE
Left heart catheterization, coronary angiography, left ventriculography, attempted circumflex angioplasty.

PROCEDURE START TIME: 10:03

OPERATOR
James Brolin, M.D.

COMPLICATIONS
None.

REFERRING PHYSICIAN
Goran Visnjic, M.D.

SURGICAL BACK-UP
Donald Faison, M.D.

INDICATIONS
Angela Lansbury is a 74-year-old female with a known history of coronary artery disease who had presented in April with unstable angina. She underwent attempted angioplasty of the circumflex vessel where there was a narrowing just at bifurcation of two distal marginals. Angioplasty was performed. She still had intermittent chest pain and over the past week had noted chest discomforts with minimal exertion and prolonged at rest. Some were relieved with nitroglycerin. She was admitted to the hospital with prolonged chest pain and had ST depression on EKG as well as elevated cardiac enzymes. Considering her presentation, urgent cardiac catheterization with possible intervention was recommended.

PROCEDURE
The patient was brought to the Cardiac Catheterization Laboratory where she was prepped and draped in the usual sterile fashion. Ten cc of 1% Xylocaine were used for local anesthesia in the right femoral region. Arterial access was obtained using the right femoral artery with placement first of a #6 introducer followed by #6 French JL-4 and 3D right catheters for coronary angiography. It was decided to proceed with

attempted intervention to the circumflex. A #6 French JL-4 Cordis Vista guiding catheter engaged the left main. The restenotic lesion in the mid circumflex was hazy and very irregular with an unusual angle at the mid portion of the lesion. Attempts at passage of guide wires were unsuccessful through the lesion. An ACS Balance, Hi-Torque floppy, Traverse, and Whisper wires would all get to the lesion but appeared to be near extraluminal and any further aggressive pushing could result in dissection of the vessel. The patient tolerated the procedure well, and it was decided to stop at this point with no significant change in the lesion's angiographic appearance and still normal flow distally to the large marginal distribution. Her sheaths were sewn in place, and she was ready for transport to the telemetry floor.

During the procedure, the patient denied any chest pain and was quite stable. She did receive 4,000 units of heparin in addition to her previous heparin drip, one aliquot of 200 mcg of intracoronary nitroglycerin, and a total of 100 cc of non-ionic contrast, Isovue, were used. Of note, after the attempted angioplasty, a #6 French pigtail catheter was passed for left- sided pressure determinations and a single RAO left ventriculogram. She was quite stable when she was transferred to the floor with her sheaths sewn in place.

RESULTS

Hemodynamics: The left ventricular end-diastolic pressure was 16 following coronary angiography, and there was no significant aortic valve systolic gradient noted on pullback from LV to aorta. She is hypertensive at rest with a baseline blood pressure of 194/78 with a mean of 123, and heart rate was in the 60s in sinus rhythm.

CORONARY ANGIOGRAPHY

1. The left main coronary artery is free of significant narrowing and bifurcated into the LAD and nondominant circumflex vessels.
2. The left anterior descending artery gave off a first diagonal vessel, which had a 60% origin narrowing. There was then a 50% to 60% stenosis in the mid portion of the LAD just after the takeoff of a second small diagonal vessel. There was normal flow to the distal LAD, which wrapped around the apex and had tortuosity. The distal vessel was of good size.
3. The circumflex vessel had a greater than 90% very eccentric and tortuous focal narrowing in its mid portion just prior to a trifurcation into two large marginal vessels and then the small continuation of the circumflex. The origin of the first marginal had a 40% narrowing, and the origin of the second marginal had a 40% to 50% narrowing at its origin.The second marginal vessel gave off a superior branch, which had a 99% narrowing, and there was slow flow into this distal branch. There was no change in this small diameter branch compared to her last angiogram. The 90% more proximal narrowing was quite hazy.
4. The right coronary artery was dominant with a 65% narrowing just prior to the takeoff of the first RV marginal branch. There was normal flow to the mid and distal RCA, which gave off branching post left ventricular and posterior descending arteries.

ATTEMPTED CIRCUMFLEX ANGIOPLASTY
Guide wires were attempted to be passed through the very eccentric mid narrowing, and there was no change in the lesion or distal blood flow after attempted wire passage.

LEFT VENTRICULOGRAPHY
Left ventricular systolic function overall was preserved with an ejection fraction estimated to be 64%. There was slight mid anterior hypokinesis, and other walls appeared to move normally. There was no significant mitral insufficiency.

SUMMARY
This catheterization demonstrated 3-vessel coronary atherosclerosis with a severe narrowing in the mid circumflex vessel accounting for her recent presentation with acute coronary syndrome. This represented restenosis from attempted angioplasty three months ago. Left ventricular function is as noted above.

RECOMMENDATIONS
Considering her anatomy, inability to perform catheter intervention therapy to the circumflex, and very unstable coronary syndrome, bypass surgery will be considered on this admission.

James Brolin, M.D.

D: 07/30/03
T: 07/30/03
d+a: James Brolin, M.D.

cc: Goran Visnjic, M.D.

OPERATIVE RECORD

*** Final Report ***

Patient: LANSBURY, ANGELA B.
Operative Date: 07/28/03
Time into OR: 13:00
Procedure start: 13:21
Procedure end: 15:00
Time out of OR: 15:30

PREOPERATIVE DIAGNOSIS
Acute myocardial infarction with unstable angina.

POSTOPERATIVE DIAGNOSIS
Same.

PROCEDURE
Off-pump coronary artery bypass graft x 3 with a reverse saphenous vein graft to the obtuse marginal 1 and 3 sequentially and separate vein graft to the right coronary artery.

SURGEON
Donald Faison, M.D.

ASSISTANTS
Noah Wyle, M.D.
Sherry Stringfield, PA-C

ANESTHESIA
General endotracheal.

INDICATIONS
This is a 74-year-old female who previously had angioplasty of her circumflex with residual narrowing in April and has not felt well since. She has had chest, neck, and arm pain in a crescendo pattern now unstable symptoms with positive enzymes and troponin up to 24. She was unable to have a wire passed, and therefore stenting of the circumflex could not be performed. Post-cath she experienced several episodes of chest pain at rest. She was reviewed and considered from a surgical standpoint. She wished to proceed after informed consent.

FINDINGS
Vein graft flows in the sequential OM1 and OM3 graft were 51 cc per minute, and in the right graft was 26 cc per minute. Very diseased OM1, and therefore OM1 and OM3 were sequenced. The LAD was palpably okay. It had some mild angiographic abnormality. The right coronary artery had soft plaque. The patient tolerated the procedure well.

DESCRIPTION OF PROCEDURE
The patient was brought to the operating room after the induction of general endotracheal anesthesia with central venous and arterial pressure monitoring. She was sterilely prepped and draped in the supine position. A median sternotomy was made with harvesting of the greater saphenous vein from the right leg simultaneously. Systemic heparinization was given followed by division of the vein and preparation of it for bypass. Pericardial stay was placed x 1into the deep left pericardial well with elevation and retraction of the heart. The obtuse marginal branches were easily exposed, and side-to-side to OM1 and end-to-side to OM3 were accomplished without difficulty. The right coronary artery was then grafted again using stabilization devices, and the proximals were performed with a partial occlusion clamp and marked with a radiopaque tape. Flows were checked, and once they were documented as being adequate, the heparin was reversed with protamine. Hemostasis was assured, and the chest was closed with double wires. Subcutaneous layers of the chest and leg were closed in standard fashion.

The patient was taken to the Intensive Care Unit in critical condition with stable hemodynamics.

DISCHARGE SUMMARY

*** Final Report ***

Clinic # 877442
Patient: LANSBURY, ANGELA B.
Admission Date: 07/26/03
Discharge Date: 08/01/03

REASON FOR ADMISSION
The patient is a 74-year-old female with a long history of coronary artery disease, status post four myocardial infarctions.

On the day of admission she developed acute chest pain radiating to the arms and neck. She was admitted to Bayshore cardiology service and ruled in for a myocardial infarction with a peak troponin of 23.9 with a CPK of 223, and a CK MB index of 15.4. She underwent cardiac catheterization which showed 90% circumflex occlusion through which they were unable to pass a wire, and a 65% right main occlusion. The left ventricular ejection fraction was 64%. Because of her anatomy with an inability to perform angioplasty or stenting of her circumflex and her acute coronary systems, she was admitted to the cardiothoracic service for coronary revascularization.

The patient was taken to the operating room on July 28, 2003 where she underwent off-pump coronary artery bypass grafting times three with reverse saphenous vein graft to the first OM and the second OM. She also had a reverse saphenous vein graft to the right coronary artery. For more details of this procedure, please refer to the dictated operative note.

Postoperatively the patient was transferred to the intensive care unit for careful monitoring. She was extubated on 7/28 at 1900 and weaned off her pressors without any difficulties. She had her chest tubes removed on postoperative day one. She was transferred to the telemetry floor on postoperative day one. The patient's stay on the telemetry unit was uneventful. She remained in normal sinus rhythm throughout her stay. She did have labile blood pressures while on the floor with systolic blood pressures ranging from 90 to 180. This was mainly due to transition from her IV meds back to her p.o. blood pressure medicines. On discharge the patient was taking her home blood pressure medications and her pressures were well controlled.

The patient was gradually advanced to a full diet and had normal bowel function.

She participated in physical therapy and initially had difficulties, but by the time of discharge she was doing well. Physical therapy recommended that she have home health physical therapy assist her with strength and conditioning at home, so these arrangements were made.

At the time of discharge she had been afebrile throughout her hospital stay.

CONDITION ON DISCHARGE
Stable.

DISCHARGE DIAGNOSES
1. Coronary artery disease, status post MI, status post CABG.
2. History of transient ischemic attack.
3. Mild emphysema.
4. History of multiple UTIs.
5. Hypertension with concern for possible renal artery stenosis.

DISCHARGE MEDICATIONS
1. Lisinopril 15 mg p.o. q.a.m.
2. Atenolol 50 mg q.p.m.
3. Ranitidine 150 mg p.o. q.d.
4. Aspirin 325 mg q.d.
5. Hydrochlorothiazide 25 mg p.o. q.d.
6. Premarin 0.3 mg p.o. q.d.
7. Simvastatin 20 mg p.o. q.d.
8. Tylenol 30/300 one to two tabs p.o. q. four to six hours p.r.n. for pain.
9. Senna one to two tabs p.o. q.h.s. p.r.n. for constipation.

DISCHARGE INSTRUCTIONS
1. The patient was instructed to follow up with Dr. Faison and also have lab work, EKG and chest x-ray performed on 08/07/03.
2. The patient is released to activities with assist with sternal precautions. Home health physical therapy has been arranged to help her with safety, strength and conditioning.
3. During her hospital stay the patient had to have a renal arteriogram canceled. She will need to have this examination rescheduled in the future.
4. The patient is instructed that if she has any chest pain, shortness of breath, drainage of blood or fluid from her incision or fevers to please call or return to clinic immediately.

Donald Faison, M.D.

D: 08/01/03

PATIENT: Angela Lansbury

LABORATORY & TEST RECORD

	7/22 12:06	7/26 22:40	7/27 05:55	7/28 11:40	8/1 05:58
Creat	0.9			0.7	0.8
Troponin-I		0.9	15.1		
CK		36	146		
CK MB Index			24.3		
MB			16.6		

Reference Ranges:

Creat:	0.6-1.1
Troponin:	0.0-0.4 ng/mL
Serum CK:	8-150 U/L
CK MB Index:	0.0-6.4 ng/mL
MB	0.0-3.0