

## Case 5

### BRIEF HISTORY

**1. Mr SRB, aged 56 years, visited us on 11/08/2000 with the following complaints :-**

- (a) CAD with unstable angina and TIA.
- (b) TVD
- (c) HTN for the past ten years.
- (d) DM (controlled by diet and oral medication).
- (e) Bronchial Asthma contracted before 1990.
- (f) Breathlessness on walking for more than five minutes or if climbing stairs.
- (g) Occasional pain in the left shoulder that comes and goes by itself.

**2. The patient suffered a MI in December 1995. He was subsequently under medical treatment in Apollo Hospitals. On 01/06/96 he underwent an angiography with the following results :-**

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LV Angio : in RAO	Relatively large ventricular with marked hypokinesis of posterobasal and diaphragmatic Segments. There is mild MR. LVEF = 45 %.
Left Main Coronary Artery	Normal.
LAD	By and large normal.
DI	Mild plaquing after origin. Distal vessel normal.
Left Circumflex	Non-dominant. 99% block in proximal part. Distal vessel is faintly seen.
RCA	Dominant. Arising abnormally from posterior sinus. It has 40-50% multiple blocks in mid and distal parts
PDA	Small artery normal
PLV	Small artery has 75% stenosis at origin.
FINAL DIAGNOSIS	<ul style="list-style-type: none"> <li>• Coronary Artery Disease.</li> <li>• 99% proximal LCX block.</li> <li>• 40-50% mid and distal RCA block.</li> <li>• 75% PLV block.</li> <li>• Impaired LV functions.</li> </ul>

### RECOMMENDATIONS

**Advised to optimise Medical Management. If symptomatic despite optimal management, to be considered for revascularisation.**

**3.** On 25/08/2000 the patient was admitted to Apollo Hospitals with complaints of a left sided chest pain and after one fainting attack at around 7:30 PM with transient loss of consciousness. He had also suffered loose motions, fever and vomiting for 2 - 3 days. A CAG was performed on 26/08/2000 with the following results :-

#### Angiography Report :

<b>LV Angio (Rao View)</b>	-	<b>Normal sized ventricle with hypokinesis of inferior segment. Mild MR. LVEF = 45%</b>
<b>(a) Coronary Angiogram :</b>		
LM	-	40-50% stenosis before bifurcation.
LAD	-	Type III, 30% stenosis after D2, distal vessel is normal.

D 1	-	Small, normal.
D 2	-	Large, normal
LCX	-	Non-dominant, 99% stenosis before OM 1.
OM 1	-	Filling slowly.
OM 2	-	Filling slowly.
RCA	-	Dominant ,50% and 70% intandem lesion in mid segment and 50% stenosis before PDA.
PDA	-	Normal, small.
PLV	-	50% ostial stenosis.

**(c) Final Diagnosis :**

- Coronary Artery Disease.  
99% proximal LCX block.  
40-50% mid and distal RCA block.  
75% PLV block.  
Impaired LV functions

**4.** Plaquex therapy commenced on 03/09/2000 after having undergone a complete blood profile test wherein his serum creatinine values were 1.8 mg/dl. After 11 sittings, blood test samples taken on 21/10/2000 indicated sugar, cholesterol and triglyceride levels as completely normal. After 22 sessions of plaquex therapy, the serum creatinine value came down to 1.43 mg/dl. An ECG also carried out on the same day indicated "marked symptomatic improvement". Blood sugar remains totally normal and urine samples have nil sugar indications. The patient has resumed all normal activities. He maintains regular essential medication, a sugar free diet and has been advised to lessen salt intake by 50%. He has also been advised to avoid "hurry and worry". He carries out regular walking exercises.