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CABG IN DIFFUSE CORONARY ARTERY DISEASE

Shyam K Ashok
Aster CMI Hospital, India

Statement of the problem: In India 2.78 million death are due to Cardiovascular diseases of which 50 % are due to CAD. Peculiarities of CAD patterns in Indian patients- Younger age at presentation, high incidence of DVD and TVD, diffuse involvement, distal disease and significant LV dysfunction at presentation

Diffuse CAD: Length of significant stenosis > 20 mm, multiple significant stenosis (> 70% narrowing) in the same artery separated by segment of apparently normal vessel and significant narrowing involving the whole length of coronary artery.

Methodology: We in our institute, perform OP CAB and use LIMA and veins as conduits to perform the surgery. Once the conduits are harvested, we heparinize with I.V. Heparin 3 mg/Kg given to achieve an ACT >300.Using the octopus as stabilizer, we perform an endartrectomy of the LAD first and then use a vein patch to cover the defect. LIMA is then used to anastomose the LAD on the vein patch. Veins are used to bypass the LCX and RCA, as deemed appropriate. The proximal ends of the vein grafts are anastomosed to Ascending Aorta with side clamp and heart beating. Intra op we start Lomodex infusion 20ml/hr which is continued for 24 hours and the inotropes used are Adrenaline and Dobutamine as and when necessary. Postoperatively aspirin 75mg is given and Heparin infusion started after 6hours to maintain ACT of around 150 for 24 hours. Patients are usually extubated after 4 hours provided they are hemodynamically stable. Anticoagulation by Acitrom is commenced orally from day 1 to maintain an INR of 2 for 3 months.

Result: Out of the 20 patients in last 18months outcomes have been excellent with no in-hospital mortality or cerebrovascular incidents.

Conclusion: Off pump CABG with coronary end-arterectomy offers a good solution to the problem of diffuse coronary artery disease.

shyams2u@yahoo.co.uk