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CARDIOVASCULAR CONSULTANTS, INC.

ADULT AND PEDIATRIC CARDIOVASCULAR DISEASE

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November 21, 1979

Byron W. Walters, M.D.
1030 Avalon Road
Lawrence, Kansas 66044

RE: James W. Bee

Dear Dr. Walters:

Mr. Bee is hospitalized at St. Luke's at the present time. He had his coronary arteriographic study carried out on 11-20-79. The procedure was uneventful.

The catheterization study confirms the presence of rather significant coronary artery disease as anticipated. Mr. Bee has had an old complete occlusion of a dominant right coronary artery with the occlusive process beginning in the first portion of the vessel and extending down to the junction of the middle and distal third. The distal third of the right coronary artery is open and profused by collateral from the left anterior descending. The left main coronary is normal. In the left anterior descending there is a localized area of 60-70% narrowing just proximal to the origin of two rather small diagonal branches. The distal vessel is of good caliber. The circumflex is normal. The left ventricular angiocardiogram reveals a very satisfactory left ventricular contraction with a normal left ventricular end diastolic pressure. The left ventricular angiocardiogram is even slightly hyperkinetic.

In summary then, Mr. Bee has old right coronary occlusion with the distal segment supplied by the left anterior descending and at least a 60% proximal left anterior descending lesion. The left ventricular angiocardiogram is normal. He has mild angina but a significantly abnormal treadmill with 2-2.5 mm ST segment depression post-exercise. In view of the above I have recommended left anterior descending and right coronary artery bypass grafting to him. I am concerned because of the potential impact of occlusion of his left anterior descending. This would deprive him of circulation not only to the anterior wall but also the collateral circulation into the distal right coronary. He is agreeable to consultation and I have asked Dr. Arnold Killen of the Thoracic Surgery Service to see him.

I appreciated your letter of November 16. This information is certainly useful. I think it is obvious from your observations and Mrs. Bee's observations that he does have labile hypertension. I am impressed that his pressure at home has varied from 130-140/70-80. I think his higher pressure while in the office was simply related to the emotional tension of this visit. We were not able to demonstrate any evidence of mitral regurgitation on the left ventricular angiocardiogram and I doubt that he has had any papillary muscle involvement. I would certainly agree that he should be maintained on his present therapeutic program for his hypertension.