In this study anatomical variation of coronary arteries were done by three different ways in 100 human hearts. It was observed that 82% of heart showed right coronary predominance, 17% showed left coronary artery predominance and 1% were of balanced type. SA nodal artery was arising from right coronary artery in 62% and from left coronary artery in 38%. Right conus artery was found in all cases arising from right coronary artery, but only in one case it was originating directly from anterior aortic sinus means third coronary artery. Posterior interventricular artery was arising from right coronary artery in 82% of hearts. In 17% of hearts it was arising from circumflex artery, branch of left coronary artery. That shows in 82% cases right coronary predominance and in 17% cases left coronary predominance. The left coronary artery, main trunk has very short course between 5mm to 15 mm. It was bifurcated in 84% of hearts, trifurcated in 14% of hearts, in one heart ir quadrifurcate and in one case it immediately divide in two branch.

In present study we found coronary artery diseases commonly involves left anterior descending artery in 66% cases (P < 0.001), right coronary artery in 38% cases, circumflex in 29% cases. So we conclude that LAD disease is common looking at our results. We were unable to establish any clinical correlation between anatomical variation and CAD due to small group of patients with limited study period.

Risk factors for CAD like hypertension (t = 0.22), diabetes mellitus (t = 0.15) and smoking (t = 0.77) also studied. They are found not significant in present study.
Though our study group was small and limited to only one geographical area, we suggest extension of our study with large group of patients and to be conducted at various hospitals to look for relationship between anatomical variations - risk factors and CAD. That can be a real help to the clinicians in managing the coronary artery disease.