

Apr/25/2025 12:22:55 PM

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Received by Centene: 2025-04-25 11:03:33 CST

TRIDENT MEDICAL CENTER
9330 MEDICAL PLAZA DRIVE
CHARLESTON, SC 29406

NAME: DE LOS SANTOS MARIN, DANIEL
UNIT #: D000755916
Report Name: Cardiac Catheterization

ROOM #: D.313-A
ACCT #: D00081633618
Pt Loc: D.T3FL

DATE OF SERVICE: 02/05/2025

ATTENDING PHYSICIAN: Ahmad Issa, MD

CONSULTING PHYSICIAN: Christopher P McCarty, MD

PRIMARY CARE PHYSICIAN: KATHERINE GANNON KIESEL, NP

INDICATIONS:

1. Chest pain.
2. Non-ST-elevation MI.

PROCEDURES:

1. Left heart catheterization.
2. Coronary angiography.
3. PCI to obtuse marginal.
4. Difficult PCI to RCA secondary to tortuosity and calcification.
5. Conscious sedation of 133 minutes.

DESCRIPTION OF PROCEDURE:

After informed consent obtained, patient prepped and draped in a sterile fashion. ASA form was completed prior to arrival in the catheterization laboratory. The patient was felt to be a candidate for conscious sedation. The patient also received a total of 3 mg of intravenous Versed and 75 mcg of intravenous fentanyl provided by trained catheterization lab staff. Procedure start time was 1510 with the procedure end time of 1723. This provides for a total face-to-face conscious sedation time of 133 minutes. At this point, a 6-French sheath was placed in the right radial artery. A 5-French TIG catheter was advanced under fluoroscopic guidance into the ascending aorta across the aortic valve. Left ventricular end-diastolic and pullback pressures were obtained. 5-French TIG catheter was then used to engage the left main and right coronary arteries respectively. Coronary angiography was performed in multiple planes. At the conclusion of the procedure, the patient was set up for intervention.

HEMODYNAMICS:

Left ventricular end-diastolic pressure of 6 mmHg. There was no significant gradient upon aortic pullback.

CORONARY ANGIOGRAPHY:

1. Left main, mild disease of 10% to 20% prior to takeoff of an LAD and left circumflex.
2. LAD. Left anterior descending artery has mild disease proximally at 10%. In the mid vessel, there is more diffuse disease upwards of 40%.
3. Left circumflex. Proximal left circumflex has mild disease upwards of 30%.

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In the distal vessel after the takeoff of the 4th obtuse marginal, there is 100% occlusion. There is no collateral filling identified beyond this location. The 1st, 2nd, and 3rd obtuse marginals is a very small branch. The 4th obtuse marginal is a larger branch that appears stenosis upwards of 99% in the mid segment.

4. RCA. The right coronary artery is a large and dominant vessel that has mild disease proximally of 30%. In the mid vessel, there is an area of significant tortuosity with stenosis upwards of 75%. In the distal RCA, there is moderate disease diffusely upwards of 50%. The posterior descending artery has a 99% stenosis that is diffuse in fashion in the mid segment.

PCI TO THE OBTUSE MARGINAL:

Following conclusion of diagnostic procedure, the patient was set up for intervention. A 6-French XB 3.0 guide catheter advanced to the left main. Heparin was administered for anticoagulation. It was opted to probe the distal left circumflex to see if there would be quick passage of the wire as to whether or not this may have been the acute lesion. Wire passage was successful. However, we were unable to pass a balloon into this particular location. At this point, it was opted to pursue intervention to the obtuse marginal. A Runthrough wire then advanced to the obtuse marginal #4. An Emerge 2.0 x 12 mm balloon was passed into the mid OM4 and inflated. This was then followed by stent placement with Onyx 2.0 x 18 mm drug-eluting stent. This was then followed by an NC Emerge 2.0 x 8 mm to assist in postdilatation. There was TIMI-3 flow into the distal OM4. With wire removal, there was also flow into the AV circumflex branch, but this again appeared to be a 1 mm vessel or smaller and not felt to be amenable for PCI. Due to the additional disease, it was opted to pursue intervention to the right coronary artery.

PCI TO THE RCA:

Again, please note that this is difficult intervention due to tortuosity and calcification. At this point, a 6-French JR4 guide catheter was advanced to the right coronary. A Runthrough wire was advanced to the distal PDA system. It was opted to utilize a Coast Guide extension catheter. This was then followed by initial balloon inflation with Emerge 2.0 x 15 mm balloon. Unfortunately, an Onyx 2.0 x 26 mm was unable to cross into the distal RCA. At this point, an Emerge 3.0 x 15 mm balloon was used for initial predilatation at the mid to distal RCA segment. It was opted to attempt intervention to this location. Onyx 3.0 x 22 mm drug-eluting stent was unable to cross. At this point, it was opted to advance a Telemark catheter to the PDA system. The DocWire had been used prior to this to then allow exchange for a Wiggle wire. Unfortunately, the Wiggle wire initially would not allow for the stent to be advanced and attention was turned back to the mid to distal RCA segment with an Emerge 3.0 x 15 mm with multiple inflations being performed. Again, the stent was unable to be deployed into the distal segment. The Telemark had to be advanced down with a run-through wire advanced again into the posterior descending artery for repositioning. At this point, with advancement of the Telemark into the more distal segment of this lesion of the RCA, it did allow for passage of the Onyx 3.0 x 22 mm drug-eluting stent, which was successfully deployed. An NC Emerge 3.25 x 8 mm balloon was used for post dilatation with multiple inflations being performed. This did facilitate the placement of an Onyx 2.0 x 26 mm into the PDA. This was then followed by an NC Emerge 3.5 x 8 mm with multiple inflations being performed. At this point, there was TIMI-3 flow. There was calcification noted of the mid to distal RCA stent. However, due to the prolonged x-ray time and procedure time, it was opted to abandon any

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further attempts of intervention to the right coronary. There was TIMI-3 flow into the distal right coronary system. ACT was 284 at the conclusion of the case. The patient did receive Plavix load at the conclusion of the case. The patient already received aspirin. A Vasc band was placed for hemostasis in the right radial access site. The patient will be taken to the CPRU for further care.

ESTIMATED BLOOD LOSS:
10 cc.

CONTRAST:
230 cc of Isovue.

CONCLUSIONS:

1. Coronary artery disease as described above with significant lesions of the left circumflex, obtuse marginal #4 as well as the RCA.
2. Status post successful PCI to the obtuse marginal #4 with an Onyx 2.0 x 18 mm drug-eluting stent.
3. Status post PCI to the RCA mid to distal vessel with Onyx 3.0 x 22 mm drug-eluting stent.
4. Status post PCI to the PDA with Onyx 2.0 x 26 mm drug-eluting stent.
5. LVEDP of 6 mmHg.

PLAN:

1. Aspirin 81 mg daily.
2. Plavix 75 mg daily for preferably 1 year following drug-eluting stent implantation for myocardial infarction.
3. Aggressive medical therapy for coronary artery disease.
4. Continue cardiovascular risk factor and lifestyle modifications.
5. Vasc band in place for 2 hours. Bed rest for 1 hour.

CC: Katherine Kiesel, NP
Christopher P McCarty, MD

Dictated By: Christopher P McCarty, MD

CPM:MODL

D: 02/06/2025 10:08:03 / T: 02/06/2025 10:56:37

Voice ID: 091607 / Job ID: 1053262503

Authenticated by Christopher X Mccarty, MD On 02/07/2025 09:54:11 AM

Electronically Signed by Christopher P Mccarty, MD on 02/07/25 at 0954

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