AFFIDAVIT

I, Wuwen Guo, translator in the City of Toronto, Province of Ontario, make oath and say:

1. I am fluent in both Chinese and English.

2. I have translated the annexed documents and carefully compared the translations from Chinese into English with regard to the following documents:

   Surgery Note, The Home Page of Inpatient Medical Records

3. The said translations are, to the best of my knowledge and ability, the complete and correct translations of said documents.

SWORN before me at the City of Toronto
In the Regional Municipality of Metropolitan Toronto)
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This 30th day of Oct, 2024

Wuwen Guo

A Notary Public in and for the
Province of Ontario

JOSEPH JOHN FAUST
Barrister, Solicitor and Notary Public
Tel: 416-409-2071
Add:87 Legends Way, Markham, ON. L3R 5Z9

Rizhao People's Hospital

Surgery Note

Ward: Emergency care unit Name. Be Inpatient No

Date of surgery

Surgery time:

Preoperative diagnosis: 1. Cerebral infarction; 2. Arrhythmia (1) Atrial fibrillation; 3. Coronary atherosclerotic heart disease (1) Cardiac function grade II.

Intraoperative diagnosis: 1. Occlusion of left common carotid artery; 2. Occlusion of left middle cerebral artery; 3. Left vertebral artery originates from the aortic arch with a slender lumen.

Surgery name: Percutaneous intracranial artery thrombectomy + carotid stent implantation.

Anesthesia method: Local anesthesia.

Surgery instructor: Assistant:

Operation process, intraoperative findings and treatment:

The patient lay supine. After disinfection and draping, 5ml of Lidocaine injection was used for local anesthesia. An 18G puncture needle was used to puncture the right femoral artery. After successful puncture, the guide wire was inserted into the femoral artery from the end of the puncture needle. The puncture needle was removed. A 5F arterial sheath was inserted along the guide wire. The arterial sheath was aspirated with a syringe. Good blood return confirmed that it was in the artery. Heparin saline was injected to flush the arterial sheath. Under the guidance of a super-smooth guide wire, the contrast catheter connected to the pressurized infusion was selectively advanced to the bilateral common carotid arteries and bilateral vertebral arteries respectively. A high-pressure injector was connected for multi-angle angiography. The angiography showed: Occlusion of the middle segment of the left common carotid artery, multiple filling defects could be found in the lumen. No obvious abnormality was found in the lumen of the right common carotid artery; the whole segment of the left internal carotid artery was not displayed. No obvious abnormality was found in each segment of the right internal carotid artery; the left external carotid artery was supplied by the left vertebral artery. No obvious abnormality was found in each branch of the right external carotid artery; no obvious abnormality was found in each branch of the right anterior and middle cerebral arteries. The anterior communicating artery was open. The A1 segment of the right anterior cerebral artery supplied blood to the left anterior cerebral artery and the M1 segment of the left middle cerebral artery through the anterior communicating artery. The distal segment of the M1 segment of the left middle cerebral artery was occluded; the left vertebral artery originated from the aortic arch with a slender lumen. It supplied blood to the left external carotid artery through collateral circulation. No obvious abnormality was found in each segment of the right vertebral artery. No obvious abnormality was found in each branch of the basilar artery and bilateral posterior cerebral arteries. Under the assistance of a multifunctional tube, an 8F balloon guide catheter was selectively advanced to the proximal segment of the cervical segment of the left common carotid artery. After inflating the balloon to block the common carotid artery, several emboli were aspirated under negative pressure through the balloon guide catheter. Then the tip of a 5F intracranial support catheter was pushed to the left internal carotid artery through the balloon guide catheter. Negative pressure aspiration was performed multiple times from near to far until reaching the M1 segment of the middle cerebral artery. A large amount of thrombus was aspirated. Angiography showed that the branches of the left internal carotid artery distal to the cervical segment and the left middle cerebral artery were opened. The end of the left common carotid artery and the origin of the left internal carotid artery were still occluded. Repeated aspiration cannot open it.

A 7-10mm*40mm stent was positioned and released at the origin of the left internal carotid artery through the balloon guide catheter. Angiography showed that the origin of the left internal carotid artery was opened. The end of the left common carotid artery was still not opened. Then a 7-10mm*40mm stent was pushed through the balloon guide catheter. The stent was stuck in the catheter and cannot be pushed out. So after replacing an 8F Guiding catheter, a 6-8mm*40mm stent was released from the origin of the left internal carotid artery to the end of the common carotid artery. Angiography review showed that the blood flow of the left common carotid artery and internal carotid artery were restored and unobstructed. The operation was successful. About 130ml of contrast agent (iodixanol) was used during the operation. Tirofiban injection 8ml was intravenously injected to prevent stent thrombosis. After the operation, the femoral artery sheath was removed. After the puncture site of the right femoral artery was blocked and hemostasis was achieved, it was compressed and bandaged and then the patient was returned to the Neurosurgical intensive care unit. Postoperative precautions: 1. Compress the puncture site of the right femoral artery for 6 hours and immobilize the right lower limb for 12 hours; 2. Observe whether there is bleeding or hematoma at the puncture site and pay attention to the pulsation of the dorsal artery of the right foot; 3. Monitor vital signs and maintain systolic blood pressure at 120-130mmHg; 4. Tirofiban injection is pumped in at 7-9 ml/h.

Surgeon's signa

Recording tin

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日照市人民医院

手术记录

病区：急诊监护病房　　姓名：　　床号.　　住院号：

手术日期：

手术时间：

术前诊断：1.脑梗死2.心律失常1)心房颤动3.冠状动脉粥样硬化性心脏病1)心功能Ⅱ级

术中诊断：1.左颈总动脉闭塞；2.左大脑中动脉闭塞；3.左椎动脉起源于主动脉弓，管腔纤细

手术名称：经皮颅内动脉取栓术+颈动脉支架置入术

麻醉方法：局部麻醉

手术指导者：　　手术者：　　助手：

手术经过、术中发现的情况及处理：

患者平卧，消毒铺巾，采用利多卡因注射液5ml局部麻醉，采用18G穿刺针穿刺右股动脉，穿刺成功后将导丝自穿刺针尾端送入股动脉内，撤去穿刺针，沿导丝置入5F动脉鞘，以注射器回抽动脉鞘，回血良好确认在动脉内，注入肝素盐水冲洗动脉鞘。在超滑导丝引导下将连接加压滴注的造影导管分别超选至双侧颈总动脉、双侧椎动脉，连接高压注射器进行多角度造影，造影所示：左侧颈总动脉中段闭塞，管腔可见多发充盈缺损，右侧颈总动脉管腔未见明显异常；左侧颈内动脉全段未显示，右颈内动脉各段未见明显异常；左侧颈外动脉由左椎动脉代偿供血，右侧颈外动脉各分支未见明显异常；右侧大脑前、中动脉各分支未见明显异常，前交通动脉开放，右大脑前动脉A1段通过前交通动脉向左侧大脑前动脉及左大脑中动脉M1段代偿供血，左侧大脑中动脉M1段远段闭塞；左椎动脉起源于主动脉弓，管腔纤细，通过侧枝循环向左颈外动脉代偿供血，右侧椎动脉各段未见明显异常，基底动脉及双侧大脑后动脉各分支未见明显异常。在多功能管辅助下将8F球囊导引导管超选择至左颈总动脉颈段近段，充盈球囊阻断颈总动脉后经球囊导引导管负压抽吸出栓子数枚，再经球囊导引导管将5F颅内支持导管头端推送至左颈内动脉，由近及远多次负压抽吸，直至抽吸至大脑中动脉M1段，抽吸出大量血栓，造影示左颈内动脉颈段以远及左侧大脑中动脉各分支开通，左颈总动脉末端及左颈内动脉起始部仍闭塞，反复抽吸不能开通，经球囊导引导管将1枚7-10mm*40mm支架定位于左颈内动脉起始部释放，造影示左颈内动脉起始部开通，左颈总动脉末端仍未开通，再经球囊导引导管推送1枚7-10mm*40mm支架，支架嵌顿于导管内无法推出，遂更换8F Guiding导管后将1枚6-8mm*40mm支架释放于左颈内动脉起始部至颈总动脉末端，造影复查左颈总动脉及颈内动脉血流恢复通畅。手术顺利，术中应用对比剂（碘克沙醇）约130ml，静脉注射替罗非班注射液8ml预防支架内血栓，术后拔除股动脉鞘，右股动脉穿刺点封堵止血后加压包扎后返回神经监护病房。术后注意：1.右股动脉穿刺点压迫6小时，右下肢制动12小时；2.观察穿刺点有无出血、血肿，注意右侧足背动脉搏动情况；3.监测生命体征，收[illegible]0-130mmHg；4.替罗非班注射液7 9ml/h泵入。

手术者签名[illegible]

记录时间[illegible]01-

I certify that this is a true copy
of the original document
Date 30th day of Oct, 2024