7316-2192

OP Note - Complete (Template or Full Dictation)

OP Note - Complete (Template or Full Dictation) signed by at

SURG. DATE:

TIME OF PROCEDURE:

SURGEON:

ASSISTANT:

PREOPERATIVE DIAGNOSIS: Quadriceps weakness, suspected femoral nerve tumor.

POSTOPERATIVE DIAGNOSIS: Quadriceps weakness, suspected femoral nerve tumor.

PROCEDURE: Retroperitoneal exposure.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: Minimal.

COMPLICATIONS: None.

DRAINS: None.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and placed on the operating table in the supine position. A general endotracheal anesthetic was administered. Appropriate lines and neuromonitoring were placed. An identification and time-out was performed to

identify the patient and the procedure. This patient had developed weakness in his quadriceps muscle group and was found to be what was thought to be enlargement of his femoral nerve in the retroperitoneum in the iliac fossa. To allow for assessment of his nerve and potential biopsy, from the neurosurgery team asked if I could provide exposure to this retroperitoneal structure. For this reason, I performed a retroperitoneal dissection to expose the nerve and allow him to perform his assessment. To access to the retroperitoneum a right lower quadrant curvilinear incision was made approximately 1 fingerbreadth inside the iliac. The incision was carried down paralleling the rectus within the internal and external obliques. Distally the incision curved medially. The incision was carried down to the abdominal wall and the fascia was divided. Care was taken as the transversalis was incised to avoid entering the peritoneal cavity. This then accessed the retroperitoneal space. The perineum and abdominal contents were reflected medially. Through this incision, the iliacus and psoas were visible as well as the fat stripe suggesting the location of the femoral nerve. The iliac artery and vein were easily visualized and remained medial to the dissection which ensued. The ureter was also visible. Once the nerve was exposed, Dr. and his team scrubbed in to perform their portion of the procedure. Once he performed his assessment and biopsy I did scrub back in to close the wound. The internal and transversus were reapproximated using a running 0-PDS suture. The external oblique was reapproximated using a running 0-PDS suture. The deep subcutaneous tissues were reapproximated using interrupted 0-Vicryl sutures. The shallow subcutaneous tissues were reapproximated using interrupted 3-0 Vicryl sutures. The skin was reapproximated using a running 5-0 Monocryl suture. Dermabond was applied. The patient tolerated the procedure well and was taken to the recovery room extubated and in good condition.

DICTATED BY:

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Surgeon

Chart Review Routing History

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SURG. DATE:

TIME OF PROCEDURE:

SURGEON:

ASSISTANT:

CO-SURGEON:

PREOPERATIVE DIAGNOSIS: Right femoral nerve lesion.

POSTOPERATIVE DIAGNOSIS: Right femoral nerve lesion.

PROCEDURE: Right femoral nerve exploration in retroperitoneum, with internal and external neurolysis and partial fascicular biopsy.

SUMMARY OF PREOPERATIVE COURSE: Patient is an 11-year-old male with past medical history significant for progressive weakness in his proximal lower extremity. The patient had an MRI and studies performed which demonstrated a femoral neuropathy above the inguinal ligament and a lesion in his MRI consistent with a possible nerve sheath tumor in this location. As part of his procedure, it was determined the patient would benefit from neurolysis of this area, with an examination of the nerve and a nerve biopsy. The patient required a retroperitoneal exposure to be performed by General Surgery as part of this procedure.

SUMMARY OF OPERATIVE COURSE: After preop evaluation and informed consents were obtained, the patient was brought in the OR on where general endotracheal anesthesia was achieved. The patient was then positioned, prepped and draped in the usual sterile fashion using ChloraPrep by Dr. A curvilinear lower abdominal incision was then planned and performed by Dr. and the General Surgery team. The dissection was then carried down along the retroperitoneum, identifying the blood vessels and the iliacus muscle laterally. An area of fat could be seen underlying the fascia in this location which corresponded with the presumed location of the femoral nerve. The fascia was then opened laterally and extended for approximately 12 cm. The right femoral nerve was then identified and an area of swollen nerve could be seen by direct inspection. The nerve was decompressed in a 360 degree fashion from all surrounding tissue. There was 1 fascicle in the superior edge which was enlarged and abnormal compared to the other fascicles. With electrical stimulation, this fascicle did not have any activity. Dr. then performed an intraoperative ultrasound, which also confirmed the dilated abnormal portion of the nerve. Next, after an extensive external neurolysis was performed, an internal neurolysis was performed, separating out the abnormal fascicle for approximately 3 cm in length. This was then sectioned and removed. A small portion of this biopsy was sent for frozen section, which was consistent with degenerative nerve tissue and a possible hairy perineurioma. The patient was neurologically stable by neuromonitoring after this biopsy. Next, the wound was copiously irrigated and closed in a layered fashion by the General Surgery service. Prior to closure, a piece of Seprafilm was placed overlying the surgical site to aid in further dissection if it was needed in the future.

I, the attending neurosurgeon, , was present for all critical portions of the OR course and was immediately available for the entire OR course.

DICTATED BY:

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Surgeon

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SURG. DATE:

TIME OF PROCEDURE:

SURGEON:

ASSISTANT

PREOPERATIVE DIAGNOSIS: Right femoral nerve lesion.

POSTOPERATIVE DIAGNOSIS: Right femoral nerve lesion.

PROCEDURE: Right femoral nerve exposure in the retroperitoneum, external and internal neurolysis, and fascicular biopsy.

CO-SURGEONS:

ANESTHESIA: General endotracheal.

INDICATIONS: This 11-year-old boy presented with a 2-year history of progressive weakness in the proximal right lower extremity and was found on exam to have a progressive right femoral neuropathy. Imaging studies identified an abnormal segment of nerve in the retroperitoneum. Because of his progressive deterioration and the abnormal imaging findings, we recommended an open fascicular biopsy for diagnosis. The indications for the procedure, as well as the risks, possible

complications, and alternatives were explained to the patient's family in detail. All questions were answered and they requested that we proceed to surgery.

DESCRIPTION OF PROCEDURE: After informed consent was obtained, the patient was taken to the operating room where general endotracheal anesthesia was induced. He was given prophylactic intravenous antibiotics, and no further muscle relaxant was used so that nerve stimulation and monitoring could be performed. The operative exposure in the retroperitoneum was performed through an oblique right lower quadrant incision by , and this will be described in his operative report.

The neurosurgical portion of the procedure involved opening the fascia overlying the psoas muscle and identifying the right femoral nerve. We dissected the nerve within surrounding fat and encircled it with a vessel loop. The nerve was then exposed proximally and distally over a segment of approximately 7-8 cm. In the mid segment of the exposure, the nerve had abnormal texture and coloration. The nerve was unusually firm and somewhat nodular and dilated in its mid portion. We had from Radiology come into the operating room and performed intraoperative ultrasonography to image the nerve in greater detail. He confirmed the abnormal appearance of the nerve on ultrasound. We stimulated the various fascicles of the nerve with the assistance of the neuromonitoring team and identified an abnormal fascicle on the anterior aspect of the nerve that did not produce any motor response at high current. The other fascicles of the nerve did produce good motor responses in the quadriceps muscle at low current intensities. We then opened the epineurium and performed internal neurolysis, isolating this nonfunctioning fascicle. The fascicle was discolored and unusually fibrotic. We dissected a segment measuring approximately 2-3 cm of this abnormal fascicle, repeated the nerve stimulation, and again found no motor response. We did monitor motor evoked responses throughout the procedure, and they remained stable. We sacrificed this fascicle and sent the specimen for both frozen and permanent section. The pathologist identified a probable perineurioma in the frozen section. At this point the wound was inspected for hemostasis, which was confirmed using Floseal. The wound was irrigated and hemostasis was confirmed. The closure was performed by and will be described in his separate operative report. There were no intraoperative complications, and the procedure was well tolerated.

Attending attestation note: As the attending neurosurgeon responsible for the neurosurgical portion of the procedure, I

was present and scrubbed for its entirety and was immediately available for assistance at all times.

DICTATED BY:

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Surgeon

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