Operative Record

[redacted] Operative Record [redacted] | MRN: [redacted]

Visit and Patient Information

Contact Information

Date	Time	Provider	Department	Encounter #
[redacted]				

Patient Information

Name	MRN	Sex	DOB	Pt Account #:
[redacted]	[redacted]	Male	[redacted]	

Transcription

Type	ID
Operative Record	[redacted]

[redacted]

PREOPERATIVE DIAGNOSIS: Recurrent parasagittal meningiomas.

POSTOPERATIVE DIAGNOSIS: Recurrent parasagittal meningiomas.

PROCEDURE: Bifrontal and bi-occipital craniotomies and excision of recurrent meningiomas.

ANESTHESIA: General.

COMPLICATIONS: None.

OPERATIVE INDICATIONS: This 27-year-old man had undergone multiple prior operations for parasagittal meningiomas. These were limited in the past by patency of the sagittal sinus. A recent scan however, obtained because of increasing seizures, showed recurrence of the tumor in two major areas and occlusion of the sagittal sinus.

OPERATIVE TECHNIQUE: After satisfactory anesthesia was induced, the patient was placed prone in pins and prepped and draped. The navigational unit was calibrated and found to be accurate. Using the navigational unit, the anterior posterior extent of the two large meningiomas were outlined. A complex scalp flap was devised incorporating elements of his prior flap that essentially involved a very large trap door-type incision extending from the left over to the right side across the midline. Once the flap was turned, the decision was made to take the craniotomy in two portions due to the extreme thickness of the bone. Initially, the posterior meningioma was addressed first. Multiple bur holes were made overlying the mass extending across

the midline. Posteriorly, this abutted the acrylic cranioplasty. Because of the thickness of the bone, a high-speed drill was used to create a trough, and then along the parasagittal midline, the craniotomy was opened using Kerrison punches. The remaining portions of the craniotomy were opened with a craniotome, and the bone flap was elevated. Using loupes and a headlight the dura was then opened laterally and reflected toward the sagittal midline. The meningioma was readily apparent. It was dissected free from the surrounding brain. No major draining veins were sacrificed, and the tumor was resected down to the level of the falx. It was felt that a gross total resection had been accomplished. The overt lying dura was sacrificed. Attention was now directed to the more anterior and larger tumor. Additional bur holes were made anteriorly, and again the parasagittal limb of the craniotomy was carried out with a high-speed drill and Kerrison punches. The lateral portions were opened with the craniotome, and the bone flap removed. The dural opening from posteriorly was extended in the lateral portion and again reflected toward the sagittal midline where it was involved with the meningioma. The tumor grossly involved the falx. Therefore, the dura was now opened on the left side. This allowed the falx itself, along with the occluded sinus, to be resected along with the tumor. Again, it was felt that a gross total resection was accomplished, and again no major draining veins were sacrificed. The wound was copiously irrigated. The large dural defect, resulting from the two craniotomies, was covered with Duragen and then AlloDerm sutured to the dural edge. A very very thickened bone flap was reduced in size by a split cranial bone technique and only the outer table was replaced. The two craniotomy flaps were secured with absorbable plates and wires. The scalp was then closed in layers with absorbable stitches and antibiotic ointment.

DICTATED BY: [redacted]

_____
Surgeon

[redacted]

cc:

[redacted]

Encounter-Level Documents:

There are no encounter-level documents.