[redacted]

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]

SECOND ASSISTANT: [redacted].

PREOPERATIVE DIAGNOSIS: Brain tumor.

POSTOPERATIVE DIAGNOSIS: Intrinsic brain stem tumor.

PROCEDURES:
1. Ventriculostomy.
2. Suboccipital craniotomy for tumor resection.

INDICATIONS: The patient is a 15-year-old boy who had been developing worsening numbness. He also had some slight facial weakness on the left, as well as subtle sixth nerve paresis on the left. He had a workup which included an MRI which showed a fourth ventricular tumor which initially was felt most consistent with an ependymoma. He was brought to the operating room for resection.

PROCEDURE: Once in the operating room, IV access was obtained. General anesthesia was induced. IV antibiotics were given IV Decadron was continued. He was then placed in a Mayfield head holder and flipped in the prone position. He was then sterilely prepped and draped in the usual fashion. Time-out was taken prior to skin incision.

A 15-blade knife was used to make a curvilinear incision for placement of ventriculostomy, and a midline incision from the inion down to C2. Hudson brace was used to make a burr hole for the occipital ventriculostomy. The dura was then opened in a cruciate fashion with an 11-blade knife after bipolar. The catheter was inserted with excellent

egress of clear CSF. The catheter was then tunneled out, anchored to the scalp with a metal connector and a 0 silk stitch. Incision was closed in layers with absorbable suture.

The midline incision was dissected down to the occipital bone with Bovie and exposure of C1. Burr holes were then placed in the midline at the keel of below the torcular, and the craniotome was then used to turn a craniotomy flap. Kerrison punches and Leksell rongeurs were used to widen the craniotomy defect. The dura was then opened in a Y-shaped fashion. The tumor was seen, it was quite rubbery and did not look like the consistency of an ependymoma. Areas of the tumor were quite stuck, but were freed inferiorly and superiorly with microdissection, extending superiorly. It was clear that the tissue was arising from the brain stem itself. A biopsy was sent and was found to be consistent with a fibrillary astrocytoma confirming our suspicion that this was an exophytic brain stem tumor. It was mobilized as much as possible and then using a Cavitron, it was shaved down to the floor of the fourth ventricle. Meticulous hemostasis was achieved.

The dura was then closed with 4-0 Nurolon. Duragen was placed over the top. The bone was replaced with titanium plates and screws from Synthes, and the incision was then closed in layers with absorbable suture. The patient was extubated and taken to the PICU.

DICTATED BY: [redacted]

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Surgeon

[redacted]

cc:

[redacted]

Display only: Transcription [redacted]

Encounter-Level Documents:

There are no encounter-level documents.