[redacted]

Admission Date	Admission Type	Discharge Date	Discharge Disposition
Apr 25, 2012	Emergency	Apr 30, 2012	Home

OR Surgeon electronically signed by Patil, Chirag G, MD at 4/27/2012 9:13 AM

Author:	Patil, Chirag G, MD	Service:	(none)	Author Type:	Physician
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PATIENT: [redacted]

MED REC: [redacted]

CEDARS-SINAI MEDICAL CENTER
DICTATOR: CHIRAG G. PATIL, M.D.

OPERATION REPORT

DATE OF OPERATION: 04/25/2012

PREOPERATIVE DIAGNOSIS:
1. Large Right frontal cystic mass.
2. Malignant cerebral edema with cerebral herniation.
3. Cerebral herniation syndrome and coma.

POSTOPERATIVE DIAGNOSIS:
1. Large Right frontal cystic mass.
2. Malignant cerebral edema with cerebral herniation.
3. Cerebral herniation syndrome and coma.

OPERATION(S) PERFORMED:
1. Right frontotemporal craniotomy and resection of tumor and tumor cyst.
2. Use of intraoperative microscope.
3. Use of frameless stereotaxy image guidance system.

SURGEON: Chirag G. Patil, M.D.

ASSISTANT: Kurtis Birch, M.D.

ANESTHESIOLOGIST: Robert T. Naruse, M.D.

ANESTHESIA: General anesthesia.

ESTIMATED BLOOD LOSS: 100 mL

COMPLICATIONS: None.

[redacted]

BACKGROUND: [redacted] is a 28-year-old young woman who presented with cerebral herniation and coma. According to her boyfriend, she was having severe headaches. She then was incontinent of urine at night and was less and less arousable; therefore, he brought her into the emergency room. By the time she arrived here, she was unarousable and had to be intubated. Her right pupil was dilated and minimally reactive. She was localizing on the right. Her left arm was tonically flexed and her left leg had minimal movement. The CT scan without contrast then with contrast showed a large cyst associated with a solid tumor in the right frontal region. Given the impending herniation, emergency consent was obtained and we proceeded right to the operating room from the CT scanner.

OPERATIVE FINDINGS: A reddish area of abnormality was seen at the cortical surface which was overlying the larger cyst.

OPERATIVE PROCEDURE: [redacted] was brought into the operating room emergently; she had been intubated previously. A large frontotemporal incision was planned because of her impending herniation. The navigation system was registered quickly and the incision was prepped and draped in usual sterile fashion. Local anesthetic was injected. A 10-blade was used to incise the skin all the way to the bone. The temporalis muscle and fascia were also elevated leaving behind a thin rim superiorly to sew back to. A frontotemporal craniotomy was performed after 3 bur holes were placed and a Midas Rex craniotome was used to complete the craniotomy. The image guidance system was used throughout the operation for aid in tumor resection.

The dura was elevated medially and the operative microscope was brought in at this time. Initially there was some swelling of the brain but soon the brain was pulsating and because of the mannitol she had been given she showed good diuresis and pulsations of the brain. Under the

[redacted]

microscope, a small corticectomy was initially performed. The abnormal
tissue and brain tumor were seen; frozen sections were sent immediately.
The cyst was first entered and decompressed.

After the brain had relaxed, attention was then turned to the rest of
the tumor. The tumor was anterior to the primary motor
cortex and the solid portion was quite medial close to the midline. The
corticectomy was extended to the superficial marginal component of
tumor. Using the microscope, circumferential anatomic dissection was
undertaken and the tumor was resected. Pial plane was kept intact to
the adjoining gyrus, especially posteriorly and inferiorly.
Circumferential microdissection and resection of the tumor was carried
out. The large cyst was also decompressed. Hemostasis was achieved and
good brain relaxation was also achieved. After hemostasis achieved, the
dura was closed with a 4-0 Nurolon. Epidural tack-ups were placed and a
piece of Duragen was placed on top. The bone was secured back using
standard cranial plating system. The temporalis muscle was closed with
2-0 Vicryl and galea was closed 2-0 Vicryl and skin was stapled. All
needle, sponge and instrument counts were correct at the end of the
case. I was present during all key portions of the case. The patient
was transferred to the ICU intubated given her serous neurologic
preoperative condition.

CHIRAG G. PATIL, M.D.

CGP/MEDQ/511330948 D: 04/25/2012 T: 04/26/2012 JOB#: 126648

cc: Kurtis Birch, M.D.

Electronically Signed By Patil, Chirag G, MD on 4/27/2012 9:13 AM