Admission Date	Admission Type	Discharge Date	Discharge Disposition
Oct 11, 2012	Elective	Oct 13, 2012	Home

OR Surgeon electronically signed by Patil, Chirag G, MD at 10/12/2012 10:15 AM

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PATIENT:

MED REC:

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

OPERATION REPORT

DATE OF OPERATION: 10/11/2012

PREOPERATIVE DIAGNOSIS: Right frontal recurrent glioblastoma.

POSTOPERATIVE DIAGNOSIS: Right frontal recurrent glioblastoma.

OPERATION(S) PERFORMED:
1. Right frontal redo craniotomy and resection of recurrent glioblastoma.
2. Use of intraoperative microscope.
3. Use of frameless stereotactic image guidance system.

SURGEON: Chirag Patil, M.D.

ASSISTANT: Doniel Drazin, M.D.

ANESTHESIA: General anesthesia.

COMPLICATIONS: None.

EBL: 50 mL

BACKGROUND: is a delightful, 29-year-old woman who had a previous gross total resection of her glioblastoma on April 25, 2012. She completed radiation and Temodar. Most recent MRI revealed a new enhancement at the deep margin of the resection cavity as well as some

increase of FLAIR. The alternatives were presented and surgical resection was recommended. The risks of surgery specifically including weakness in the left leg and arm due to the premotor SMA location of the tumor and FLAIR abnormality was fully discussed. Other complications include bleeding, stroke, infection, CSF leak were also thoroughly discussed. The patient understood the risks and wished to proceed with surgery.

OPERATIVE FINDINGS: A small area of grayish-appearing region most consistent with recurrent glioblastoma.

PROCEDURE IN DETAIL: was brought in the operating room and general anesthesia was induced. She was positioned with the right side up with the head lateral. All pressure points were padded. Her head was fixated with Mayfield pins. The image guidance system was registered and used throughout the operation for aid in tumor resection. Her old incision was prepped and draped in usual sterile fashion. A 10 blade was used to incise the skin. The old cranial plating system was removed and the old frontal craniotomy bone was gently lifted out. Epidural hemostasis was achieved. A 15 blade was used to incise the dura overlying the old resection cavity. The operative microscope was brought in and the rest of the tumor resection was carried out using the operative microscope using micro instruments and navigation. First the enhancing region was identified. A wide circumferential resection of this region was carried out to the deep white matter. Frozen section was sent from this region and also the deep white matter. The frozen section was consistent with a persistent glioma.

A circumferential resection of the mesial aspect of the resection cavity was carried out in a subpial type dissection posteriorly. We were a bit conservative because of the proximity to the motor area. A

circumferential anatomic dissection was carried out with a deep pial
plane that was then joined to the deep resection cavity of the enhancing
portion of the tumor. Anterior, posterior, lateral, and medial edges
were all confirmed to be normal-appearing white matter and brain.
Hemostasis was achieved. The dura was closed with a dura repair graft.
The craniotomy bone was fixated back using standard cranial plating
system. The galea was closed with a 2-0 Vicryl. The skin was closed
with a 4-0 Monocryl baseball-type running stitch. All needle, sponge,
and instrument counts were correct at the end of the case. Mari was
taken out of the Mayfield pins. I was present during all key portions
of the case.

CHIRAG G. PATIL, M.D.

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Revision History