| Admission Date | Admission Type | Discharge Date | Discharge Disposition |
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**Operative Report electronically signed by Patil, Chirag G, MD at 1/22/2014 2:38 PM**

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| Author: | Patil, Chirag G, MD | Service: | Surgery Neurosurgery | Author Type: | Physician |
| Filed: | 1/22/2014 2:38 PM | Note Time: | 1/21/2014 1:01 PM | Note Type: | Operative Report |
| Trans ID: | MDQ596222351 | Trans Status: | Available | | |
| Dictation Time: | 1/20/2014 5:08 PM | Trans Time: | | Trans Doc Type: | Operative Report |

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

OPERATION REPORT

DATE OF OPERATION: 01/20/2014

PREOPERATIVE DIAGNOSIS: Recurrent right frontal glioblastoma.

POSTOPERATIVE DIAGNOSIS: Recurrent right frontal glioblastoma.

OPERATION(S) PERFORMED:
1. Redo right frontal craniotomy and resection of recurrent glioblastoma.
2. Use of operative microscope.
3. Use of Medtronic frameless stereotactic image guidance system.
4. Motor and subcortical motor mapping and neuro electrophysiologic monitoring.

SURGEON: Chirag G. Patil, M.D.

ASSISTANT: Kurtis Birch, M.D.

ANESTHESIA: General anesthesia.

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: 100 mL

BACKGROUND: was previously diagnosed with glioblastoma. At that time, she had presented emergently with a blown pupil. She underwent a gross total resection. She underwent immunotherapy. However, most

recently
was found to have a large recurrence in the right frontal region spanning all
the way down to the corpus callosum. Surgical resection was recommended.
The risks of surgery, especially motor weakness given the proximity to the
motor fibers, was explained to Ms. McKinstry. She understood the risks and
wished to proceed with surgical resection.

OPERATIVE FINDINGS: Tumor consistent with a recurrent glioblastoma.

OPERATIVE PROCEDURE: was brought into the operating room
and general anesthesia was induced after correct identification. She was
positioned with her head in the lateral position with a small bump. All
pressure points were padded. Her previous curvilinear incision was shaved,
prepped and draped in the usual sterile fashion. The image guidance system
was registered and used throughout the surgery for aid in tumor resection.
After a time-out, the previous incision was opened using a 10 blade. The
skin flap was rotated inferiorly and anteriorly and the old cranial plate was
removed. The recurrence was more medial than the previous craniotomy and a
small strip of bone medially to the sagittal sinus was drilled out with a
Midas Rex footplate. Epidural hemostasis was achieved. The dura was then
opened and reflected medially towards the sagittal sinus. Some adhesions of
the previous scar and tumor were taken down. The operative microscope was
then brought in. Circumferential sulcus-to-sulcus resection was started
anteriorly and followed inferiorly and then posteriorly. Medially the tumor
was dissected all the way to the falx cerebri. Using micro instruments
circumferential tumor resection down to the white matter was carried out.
Prior to the resection, motor mapping defined the motor strip to be posterior

to the tumor. Subcortical mapping was also undertaken to make sure that subcortically the motor fibers were not being compromised. The tumor resection was carried out deeper to the white matter. The large portion of the tumor was resected en bloc. The deepest portion of the white matter going down to the level of the ventricle was then resected using suction and bipolar and CUSA. The ventricle was visualized and resection down to the ventricle was carried out. We circumferentially looked around the cavity and made sure that there was no gross tumor remaining. Hemostasis was achieved. The dura was closed with 4-0 Monocryl. The bone was replaced back using standard plating system. The skin was closed with 3-0 Vicryl and 4-0 Monocryl baseball type observable stitch. All needle, sponge, and instrument counts were correct at the end of the case. I was present during all key portions of the case.

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CHIRAG G. PATIL, M.D.

CGP/MEDQ/596222351 D: 01/20/2014 T: 01/21/2014 JOB#: 624110

cc: Kurtis Birch, M.D.

Electronically Signed By Patil, Chirag G, MD on 1/22/2014 2:38 PM