PREOPERATIVE DIAGNOSIS: , Metopic synostosis with trigonocephaly.,POSTOPERATIVE DIAGNOSIS: , Metopic synostosis with trigonocephaly.,PROCEDURES PERFORMED: , ,1. Bilateral orbital frontozygomatic craniotomy with bilateral orbital advancement with Z-osteotomies.,2. Bone grafts.,3. Bilateral forehead reconstruction with autologous graft.,ANESTHESIA: , General endotracheal anesthesia.,COMPLICATIONS:, None.,CONDITION OF THE PATIENT AT THE END OF THE PROCEDURE: , Stable, transferred to recovery room.,ESTIMATED BLOOD LOSS: , 300 mL.,CRYSTALLOIDS: , Packed red blood cells 440 mL, FFP 100 mL.,URINARY OUTPUT: , 160 mL.,INDICATIONS FOR PROCEDURE: , The patient is a 9-month-old baby with a history of trigonocephaly and metopic synostosis. We have discussed locations, the nature of trigonocephaly's repair, metopic synostosis repair with bilateral fronto-orbital advancement, forehead reconstruction, and bone graft. We have discussed risks and benefits. Risks included, but not limited to risk of bleeding, infection, dehiscence, scarring, need for future revision surgeries, minimal possibility of death, the alternatives, devastating bleeding, anesthesia, death, dehiscence, infection. The parents understand, decide to proceed with surgery. Informed consent was obtained and we proceed with surgery.,DESCRIPTION OF PROCEDURE: , The patient was taken into the operating room, placed in the supine position. General anesthetic was administered. Prophylactic dose of antibiotic was given. Lines were placed

by Anesthesia and then the head of the bed was turned to 100 degrees. The patient was once more positioned and padded in the usual manner. The incision was marked with the help of a marking pen and local anesthetic was infiltrated after prepping the area one time, then the definitive prep and draping of the area was done.,The procedure began with an incision through the full-thickness of the skin into the subcutaneous tissue down to the subgaleal plane. The subgaleal plane was developed and reflected anteriorly and slightly posteriorly. Hemostasis achieved with electrocautery. Raney clips were applied to both flaps to prevent significant bleeding. Then, we proceed with craniotomy part and Dr. Y proceeded with this part of the procedure. I assisted her and this will be described in a different operative report. Then, the area corresponding to the C-shaped osteotomy was marked and then we proceed in conjunction with Dr. Y to develop these osteotomies with the help of the Midas by retracting the contents of the skull at the level of the anterior fossa as well as the orbital contents with the help of a ribbon retractor. The osteotomies were done with the Midas and some irrigation. There was an osteotomy done at the level of the frontozygomatic suture just posterior to the frontozygomatic suture and then these osteotomies continued down intraorbitally and lateral through the zygoma to the level of the intraorbital rim. This was done on both sides. Hemostasis achieved with bone wax and electrocautery. Once the osteotomies were completed, _____ of the osteotomy sites allowed advancements. On the left side, there was a

minor fracture to the superior orbital rim that was plated. The bone grafts were customized placing these at the level of the sphenoid bone in the posterior aspect of the orbital rim. The temporalis muscle was advanced and attached to the orbital rim with holes that have been drilled with Midas and a 3-0 Vicryl interrupted stitches. The forehead flaps were attached with the help of absorbable mesh. The forehead portions were applied to the fronto-orbital advancement of fronto-orbital piece with the help of Synthes mesh and 3-mm screws. Hemostasis was checked. The flaps were retracted back into position.,The wound was closed with 3-0 Vicryl interrupted sutures, 4-0 Vicryl interrupted stitches, and 5-0 running fast absorbing gut. Dressing was applied with Xeroform, bacitracin, and ABDs and a burn net. The patient tolerated the procedure well without complications and was transferred to the recovery room in stable condition. I was present and participated in all aspects of the procedure. Sponge, needle, and instrument counts were completed at the end of the procedure.