PREOPERATIVE DIAGNOSIS:, Cranial defect greater than 10 cm in diameter in the frontal region.,POSTOPERATIVE DIAGNOSIS: , Cranial defect greater than 10 cm in diameter in the frontal region.,PROCEDURE: , Bifrontal cranioplasty.,ANESTHESIA:, General endotracheal anesthesia.,ESTIMATED BLOOD LOSS: , Nil.,INDICATIONS FOR PROCEDURE: , The patient is a 66-year-old gentleman, who has a history of prior chondrosarcoma that he had multiple resections for. The most recent one which I performed quite a number of years ago that was complicated by a bone flap infection and he has had removal of his bone flap. He has been without the bone flap for a number of years now but has finally decided that he wanted to proceed with a cranioplasty. After discussing the risks, benefits, and alternatives of surgery, the decision was made to proceed with operative intervention in the form of a cranioplasty. He had previously undergone a CT scan. Premanufactured cranioplasty made for him that was sterile and ready to implant.,DESCRIPTION OF PROCEDURE: , After induction of adequate general endotracheal anesthesia, an appropriate time out was performed. We identified the patient, the location of surgery, the appropriate surgical procedure, and the appropriate implant. He was given intravenous antibiotics with ceftriaxone, vancomycin, and Flagyl appropriately for antibiotic prophylaxis and sequential compression devices were used for deep venous thromboembolism prophylaxis. The scalp was prepped and draped in the usual sterile fashion. A previous incision was reopened and the scalp flap

was reflected forward. We dissected off the dura and we were able to get a nice plane of dissection elevating the temporalis muscle along with the scalp flap. We freed up the bony edges circumferentially, but except for the inferior frontal region where the vascularized pericranial graft took its vascular supply from we did not come across the base. We did explore laterally and saw a little bit of the mesh on the lateral orbit. Once we had the bony edges explored, we took the performed plate and secured it in a place with titanium plates and screws. We had achieved good hemostasis. The wound was closed in multiple layers in usual fashion over a Blake drain. At the end of the procedure, all sponge and needle counts were correct. A sterile dressing was applied to the incision. The patient was transported to the recovery room in good condition after having tolerated the procedure well. I was personally present and scrubbed and performed/supervised all key portions.