PREOPERATIVE DIAGNOSIS: , Brain tumors, multiple.,POSTOPERATIVE DIAGNOSES:, Brain tumors multiple - adenocarcinoma and metastasis from breast.,PROCEDURE:, Occipital craniotomy, removal of large tumor using the inner hemispheric approach, stealth system operating microscope and CUSA.,PROCEDURE:, The patient was placed in the prone position after general endotracheal anesthesia was administered. The scalp was prepped and draped in the usual fashion. The CUSA was brought in to supplement the use of operating microscope as well as the stealth, which was used to localize the tumor. Following this, we then made a transverse linear incision, the scalp galea was reflected and the quadrilateral bone flap was removed after placing burr holes in the midline and over the parietal areas directly over the tumor. The bone flap was elevated. The ultrasound was then used. The ultrasound showed the tumors directly I believe are in the interhemispheric fissure. We noticed that the dura was quite tense despite that the patient had slight hyperventilation. We gave 4 ounce of mannitol, the brain became more pulsatile. We then used the stealth to perform a ventriculostomy. Once this was done, the brain began to pulsate nicely. We then entered the interhemispheric space after we incised the dura in an inverted U fashion based on the superior side of the sinus. After having done this we then used operating microscope and slight self-retaining retraction was used. We obtained access to the tumor. We biopsied this and submitted it. This was returned as a malignant brain tumor - metastatic tumor,

adenocarcinoma compatible with breast cancer.,Following this we then debulked this tumor using CUSA and then removed it in total. After gross total removal of this tumor, the irrigation was used to wash the tumor bed and a meticulous hemostasis was then obtained using bipolar cautery. The next step was after removal of this tumor, closure of the wound, a large piece of Duragen was placed over the dural defect and the bone flap was reapproximated and held secured with Lorenz plates. The tumors self extend into the ventricle and after we had removed the tumor, we could see our ventricular catheter in the occipital horn of the ventricle. This being the case, we left this ventricular catheter in, brought it out through a separate incision and connected to sterile drainage. The next step was to close the wound after reapproximating the bone flap. The galea was closed with 2-0 Vicryl and the skin was closed with interrupted 3-0 nylon sutures inverted with mattress sutures. The sterile dressings were applied to the scalp. The patient returned to the recovery room in satisfactory condition. Hemodynamically remained stable throughout the operation.,Once again, we performed occipital craniotomy, total removal of her large metastatic tumor involving the parietal lobe using a biparietal craniotomy. The tumor was removed using the combination of CUSA, ultrasound, stealth guided-ventriculostomy and the patient will have a second operation today, we will perform a selective craniectomy to remove another large tumor in the posterior fossa.