PATIENT NAME : MARK E. SCHNEIDER
MRN : 00022677
DATE OF BIRTH : 11/08/1995
DATE OF SERVICE : 12/05/2014
HOSPITAL SERVICE : Oral and Maxillofacial Surgery.
PREOPERATIVE DIAGNOSES :
1.Impacted wisdom teeth #s 1, 16, 17, and 32.
2.Impacted supernumerary wisdom teeth # 17A.
3.Left mandibular cyst associated with impacted teeth #s 17 and 17A.
POSTOPERATIVE DIAGNOSES :
1.Impacted wisdom teeth #s 1, 16, 17, and 32.
2.Impacted supernumerary wisdom teeth # 17A.
3.Left mandibular cyst associated with impacted teeth #s 17 and 17A.
OPERATIVE PROCEDURE : Extraction of partial bony impacted teeth #s 1, 16, and 32, extraction of full bony impacted teeth #s 17 and 17A and enucleation and curettage of left mandibular cyst.
SURGEON : Michael Scott Connor, DDS, MD
ASSISTANT : Betty Schmidt, LPN
Anesthesia : General endotracheal anesthesia.
IV FLUIDS : Less than 100 cc crystalloid.
ESTIMATED BLOOD LOSS : Minimum.
URINE OUTPUT : Not measured.
SPECIMENS : One sent for permanent pathology.
DRAINS : None.
COUNTS : Count correct x 2.
COMPLICATIONS : None.
INDICATION FOR PROCEDURE : The patient is a 19-year-old white male who on routine panoramic radiography was noted to have impacted teeth #s 1, 16, 17, and 32. In addition he had a supernumerary tooth # 17A. Both 17 and 17A were in a kissing molars fashion in the left mandibular ramus with some associated pericoronal radiolucency signifying a cyst. Given the significant degree of impaction as well as the presence of cyst it was felt that removal of these teeth and the cyst under a general anesthetic setting in surgery center will be in the patients best interest. The patient and his father had all the risks and complications of the procedure explained in detail. These were written on an operative permit and this permit was signed preoperatively.
DESCRIPTION OF THE PROCEDURE IN DETAIL : On 12/05/2014, the patient was brought to the operating room #3 where he was transferred from the gurney on to the operating room table. The patient was laid in the supine position and anesthesia attached all the appropriate monitoring

devices. The patient was then IV induced under general anesthesia and orotracheally intubated. Intubation was confirmed by bilateral breath sounds and end-tidal CO2. The tube was then secured by the anesthesia service and the patient was then prepped and draped in a sterile fashion. At the onset of the procedure, the patient had 5 carpules of 2% lidocaine with 100,000 epinephrine and 2 carpules of 0.5% Marcaine with 1 : 200,000 epinephrine given as bilateral inferior alveolar nerve blocks, maxillary infiltrations, and greater palatine blocks. While hemostasis was taking effect, a moistened Ray-Tec was placed in the posterior pharynx as a throat pack. Our attention was started with teeth #s 1and 16 where oblique releasing incisions were made over the bilateral tuberosities. Mucoperiosteal flaps were elevated. Buccal ostectomy was performed at the periosteal elevator and then teeth #s 1 and 16 were elevated out of the sockets. Sockets were curetted, irrigated. Gelfoam was placed in each socket and these mucoperiosteal flaps were replaced and closed with 3-0 chromic interrupted sutures. Our attention was then turned to the site # 32, where a buccal hockey stick incision was made where site #32 a mucoperiosteal flap was elevated. Tooth #32 was troughed around the buccal and then this tooth was able to elevated out of the socket. Socket was curetted, irrigated, Gelfoam was placed and closed with 3-0 chromic interrupted sutures. Our attention was then turned to the left posterior mandible where a buccal hockey incision was made with an extension in a buccal sulcular aspect of tooth #30. Buccal mucoperiosteal flap was then elevated with elevation of this flap. Exposure of the cyst was noted at the alveolar crest in site #17. The superior aspect of the alveolus in site #17 as well as portion of the semi-ramus was removed with a 700 burr on a hole drill. This exposed the crown of tooth #17 as well as portion of its root structures. The crown was sectioned off of the roots. This crown was removed in partial with a large section of the cyst and this was to be handed off for permanent specimen. A purchase point was made in the residual roots at 17 and these were elevated on other socket. Once tooth #17 was out of the crown of tooth #17A was invisible. Using cone beam imaging that was obtained preoperatively we were able to unroof a large part of tooth #17, which was buccal and inferior to tooth #18. Tooth #17A was then serially sectioned and removed from its socket. Remaining cyst was noted along the lingual and inferior portions. These were removed with a curette and handed off for permanent specimen. At that time, the remaining bony walls were aggressively curettaged, irrigated. Evaluation of our surgical defect did not show exposure of the inferior alveolar nerve at any location. There were good three bony walls remaining the entire lingual inferior and almost all of the buccal plate. Gelfoam was then placed in this surgical defect and a flap was replaced and closed with 3-0 chromic interrupted sutures. The patients mouth was irrigated, suctioned. Throat pack was removed. He was handed back to anesthesia where he was taken to the recovery room in stable condition.

Michael Scott Connor, DDS, MD

MSC/Humbhi : Connor120814_113322

Signed By Kevin James Connor at 12/22/2014 23:26