Name: Brice Washington | DOB: 5/12/1960 | MRN: 6684939 | PCP: Michelle Marilyn Craddock, NP | Legal Name: Brice Washington

Operative Note

Signed Aug 8, 2021

Operative Note signed by William Curry, MD at 8/8/2021 8:02 AM

DATE OF SERVICE: 07/29/2021

PREOPERATIVE DIAGNOSIS: Chordoma of the mid and upper clivus with retrosellar and suprasellar extension.

POSTOPERATIVE DIAGNOSIS: Chordoma of the mid and upper clivus with retrosellar and suprasellar extension.

PROCEDURE PERFORMED: Endoscopic endonasal resection of this parasellar and posterior fossa mass.

CO-SURGEONS: William T. Curry, MD and Stacy Gray, MD. We used frameless stereotaxy. I also harvested fat from the subcutaneous tissues of the abdomen, which we used to help with our multilayered repair.

INDICATIONS FOR PROCEDURE: Mr. Washington presented having had a biopsy of this mass. We reviewed his case in multidisciplinary fashion and determined that he should have a significant debulking of it prior to proton beam radiation. Therefore, we brought him into the operating room and planned out this procedure.

DESCRIPTION OF PROCEDURE: After anesthesia was induced and he was intubated, we fixed his head in pins. We registered a stereotactic imaging to a surface anatomy and I was happy with the accuracy. We then prepped and draped and Dr. Gray began the endonasal approach. There was significant scar tissue and no opportunity for vascularized mucosal flap. She will dictate in greater detail. I came into the case fully working together with Dr. Gray

and I drilled down the floor of the sphenoid sinus a bit, we mobilized mucosa and we drilled down the intersinus septations to the point that we had a nice view of all of the anatomy, including the clival recess.

I confirmed the location of the paraclival carotids. I mobilized the mucosa and began drilling out the clivus at its junction with the sphenoid floor. I took down a bit more the floor to help with the angles, we got down to the dura here. I then also began to drill away the bone at the face of the sella extending this widely and exposed the dura up towards the tuberculum and in this fashion, I also removed the bone, with biting instruments and with a drill on the floor of the sella to the one long communication. I widened this out from carotid to carotid. I then removed a lot of the scar tissue, left over from where he had his prior biopsy and I cut open some of the floor through the dura at the floor of the sella. This allowed me to lift up the pituitary gland and provided access to the tumor, which I began to remove with suction and curettes.

We worked for several hours, first removing the tumor that was down low and working our way superiorly. In the inferior aspects we were able to get the dura including on the left where the tumor extended. I drilled away a bit of the petrous apex behind the carotid in order to get better access here. We worked much of the case with a 30-degree endoscope working superiorly. I got to the point where I used the drill to remove the remnant of the dorsum sella and we got to the point where the dura gave out and we had just arachnoid. I used that to plan to help clear away from the tumor on the way out. Now that we were I removed much of the tumor and using the 30-degree endoscope, I was able to extract tumor somewhat lateral on either side and pull it midline and remove it. As I got near the top of the tumor, the texture of it changed and became a little bit more suckable. I could see the arachnoid, I could make out both posterior cerebral arteries.

We used visual evoked potentials throughout the case and there was a bit of reduction and the leads in the area that might relate to the left optic tract, but potentials were still present.

We spent a great deal of time working on the periphery of the tumor and removing it and ultimately I felt like we had gotten to meninges land arachnoid everywhere. I paid attention to try to work behind the pituitary gland just to get that tumor away from the optic structures, optic chiasm in particular. We irrigated and we had good hemostasis. I had reached all the tumor that I was able to reach by this route.

We then harvested fat from using his old incision in the abdomen. We used this to fill the defect from the sellar floor up to about the level of the sella. Dr. Gray then completed the layered closure and we put the ____ and we took him out of pins and he woke up and we transferred him to the recovery room.

ATTESTATION: I was present for the entire case and I performed the key portions together with Dr. Gray.

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