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

Operative Note

Signed Jan 16, 2024

Operative Note signed by Stacey Gray, MD at 1/16/2024 11:14 AM

DATE OF SURGERY: 01/16/2024

PREOPERATIVE DIAGNOSES:
1. History of clival chordoma (revision resection in 2021 at MGH and postoperative radiation therapy).
2. Left middle turbinate mass.

POSTOPERATIVE DIAGNOSES:
1. History of clival chordoma (revision resection in 2021 at MGH and postoperative radiation therapy).
2. Left middle turbinate mass.

PROCEDURES PERFORMED:
1. Endoscopic biopsy and debulking of left middle turbinate mass.
2. With image guidance.

SURGEON: Stacey T. Gray, MD

ASSISTANT: Christopher McHugh, MD

ANESTHESIA: General endotracheal anesthesia.

ESTIMATED BLOOD LOSS: Less than 10 mL.

COMPLICATIONS: None.

SPECIMEN REMOVED:
1. Left middle turbinate biopsy (frozen section consistent with myxoid tumor).
2. Left sinus contents.

FINDINGS: The left posterior middle turbinate was enlarged submucosally and filling the posterior nasal cavity. This was covered by normal appearing mucosa. The mucosa was removed and the interior of the

enlarged posterior middle turbinate was filled with gelatinous type material. Frozen section was obtained and was consistent with a myxoid neoplasm. The left middle turbinate was then resected anteriorly above this area using through-cutting instruments and the rest of the posterior mass was resected using the microdebrider. The attachment point was at the left pterygopalatine fossa. This was left in place and gently cauterized using the Bovie suction cautery.

INDICATIONS FOR PROCEDURE: Mr. Washington is a 63-year-old gentleman who had a history of prior transsphenoidal surgery at an outside institution for a suprasellar/sellar/clival mass in 2019 followed by chemotherapy. He was found to have residual tumor and underwent endoscopic endonasal resection in July 2021 and the pathology was consistent with chordoma. He underwent a subsequent craniotomy with resection of residual chordoma in November 2021 with Dr. Curry and then completed postoperative radiation therapy. He has been followed by Radiation Oncology for this, and I have not seen him since March 2022. Interval imaging studies have noted increasing size of an enhancing lesion in the left posterior middle turbinate. Because of this, he now presents for endoscopic biopsy.

DESCRIPTION OF PROCEDURE: Mr. Washington was identified in the holding area and brought to the operating room. He was placed supine on the operating room table. General anesthesia was induced. He was intubated without difficulty. His nasal cavity was sprayed with Afrin. His CT scans were loaded and verified on the Stealth system. The point matching system was used for registration and accuracy was visually confirmed. He was prepped and draped in the standard fashion. His eyes were protected and a time-out procedure was performed.

The 0-degree endoscope was used for visualization of the nasal cavity. On the right, the middle turbinate had been resected. The maxillary antrostomy was clear as was the partially dissected ethmoid cavity.

The large posterior septectomy and sphenoid cavity were reviewed. The skull base reconstruction was intact and there was no accumulated mucus within the sphenoid cavity. The cystic structure was visible in the left posterior nasal cavity through the posterior septectomy. It was not mucosally attached. On the left, the middle turbinate was intact. The posterior aspect of the middle turbinate was enlarged, but covered by normal appearing mucosa. The lateral nasal wall was injected with 1% lidocaine with 1:100,000 epinephrine. The nasal cavity was then packed with pledgets soaked with Afrin.

After adequate vasoconstriction had been obtained, attention was turned to biopsying the left posterior middle turbinate abnormality. The mucosa was removed using the microdebrider. The interior of the expanded middle turbinate posteriorly was filled with gelatinous type of material. Biopsies of this were obtained. Frozen section was consistent with a neoplastic process that appeared myxoid likely consistent with his prior history of chordoma. Therefore, the abnormality was closely examined with the intent of debulking the tumor to identify the attachment point. The anterior middle turbinate was incised using Thru-cut forceps above the abnormality. The posterior mass had a well-defined capsule. There was no attachment along the septectomy or the face of the sphenoid cavity - the anatomy was confirmed with stealth. The interior of the sphenoid sinus and the area of skull base prior resection was intact with no mucosal abnormalities. The mass was then resected using the microdebrider. It was not attached to the lateral wall at the level of the maxillary sinus. The attachment point was at the area of the sphenopalatine foramen laterally and this was confirmed using image guidance. A remnant of approximately 1 cm of tumor was left in place so that a complete resection with margins could be performed after the diagnosis was confirmed on final pathology. The tumor remnant was cauterized gently using Bovie suction cautery. No packing was necessary. He tolerated the procedure well, was extubated and taken to the recovery room in good condition.

ATTESTATION: I was present for the entire procedure and performed all key portions of this.