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Name: Brice Washington

Operative Note

Signed Nov 24, 2021

Operative Note signed by William Curry, MD at 11/24/2021 8:08 AM

DATE OF SERVICE: 11/18/2021.

SURGEON: William Curry, MD

PREOPERATIVE DIAGNOSIS: Residual chordoma.

POSTOPERATIVE DIAGNOSIS: Residual chordoma.

PROCEDURE PERFORMED: Left frontotemporal craniotomy for resection of the chordoma.

DESCRIPTION OF PROCEDURE: I used the exoscope for enhanced visualization. In the operating room anesthesia was induced, and he was intubated. We turned his head to the right, extended and fixed him then pins. We then planned our incision and prepped and draped. We planned the left frontotemporal incision and infiltrated it with 0.5% Marcaine with epinephrine. We incised down and reflected the skin flap in the divided temporalis muscle anteriorly. We had exposure of the key hole and a bur hole was placed. Two more bur holes were placed and a flap was cut. We got epidural hemostasis and then removed some of the bone at the sphenoid wing. Once I was happy with this, we put some Floseal down in front of the field and sponges and towels. We opened the dura and reflected it anteriorly, tacking it up. We then looked subfrontally, first with loops and we identified the olfactory tract. We followed that back and found the optic nerve and drained some CSF from the optical carotid triangle. We then brought the _____ exoscope into the field and started working. I began by retracting the frontal lobe over the optic nerve and continuing to drain CSF. I identified the ipsilateral carotid and followed it posteriorly

sharply dissecting attachments in the way, which allowed the frontal lobe to separate out further.

I was able to split a bit of the sylvian fissure, though this was thickened, but this allowed me to get continued exposure. I identified the tumor as expected in the cleft between the carotid artery and the left optic nerve. It was fairly firm at least in its capsule, and I started moving it away from the optic nerve, et cetera. and continued to bounce back. I coagulated and cut into it and did a bit of internal debulking. I sharply cut a part of the capsule, which allowed a little bit more movement of the rigid parts. As I continued to work posteriorly, there were portions that were softer that had pushed up the anterior cerebral artery and up into the frontal lobe. I was able to get around this by retracting the frontal lobe and started to mobilize it forwards. At the same time, I was able to pull it away from the left optic tract.

Once I had the tumor on the move a bit, I was able to continue to reach laterally and posteriorly and mobilize significant amount. We very clearly achieved our goal of decompressing the left optic tract, which I had complete visualization of. I also looked in the space above the optic chiasm at the level of the anterior communicating artery and the anterior cerebral arteries and did not see any tumor there. I removed some of the material that was underneath the optic chiasm. This was more rigid firm fibrous. I looked at the space before that anterior to the optic chiasm and there was only scar there. There was only a connective tissue and adhesions there. I felt like we had achieved significant debulking and certainly at the goals of decompressing the optic apparatus. At this point, I irrigated for a while and make sure we had good hemostasis. We went back to loupe magnification and tacked the dura together and covered that with DuraMatrix. We irrigated and fastened the bone flap back into place using titanium plates and screws. We irrigated again and then cover that with 1 gram of vancomycin powder. We tacked the temporalis muscle

and fascia back together and then closed the wounds in layers culminating with staples in the skin. Dressing was applied and he was taken out of pins. Upon awaking, he was able to count fingers with both eyes and he was moving all four extremities to command. This case was greater than the usual complexity because of its engagement with the vessels of the circle of Willis, the optic apparatus and also the scar associated with the previous endonasal surgery.

ATTESTATION: I was present throughout this case, and I performed the key portions myself.

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