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Printed by on Jul 11, 2011 10:25

Centre universitaire de sante McGill

McGill University Health Centre Hôpital Neurologique de Montreal - Montreal Neurological Hospital

PROTOCOLE OPERATOIRE - OPERATIVE PROCEDURE

DATE DE L'OPERATION OPERATION DATE:	02/19/2009	**DOSSIER/MRN:**	1566145
		NOM/NAME:	BANAT, MOHAMMED
CHIRURGIEN SURGEON:	Dr. Del Maestro,	**NAM**/MEDICARE#:	
ASSISTANT (S):	Dr. Al-Atassi,	**ANESTHESISTE** ANESTHETIST:	Dr. Angle,

OPERATION/OPERATION:	LEFT TEMPORAL CRANIOTOMY AND EXCISION OF TUMOR.
DIAGNOSTIC PRE-OPERATOIRE PRE-OPERATIVE DIAGNOSIS:	LEFT TEMPORAL MASS, NONENHANCING, QUERY LOW- GRADE GLIOMA.
DIAGNOSTIC POST-OPERATOIRE POST-OPERATIVE DIAGNOSIS:	LEFT TEMPORAL MASS, NONENHANCING, QUERY LOW- GRADE GLIOMA WITH DIAGNOSIS OF ASTROCYTOMA GRADE II.
ANESTHESIE/ANESTHESIA:	NEUROLEPTIC.

HISTORY:

This 31-year-old patient presented with a series of issues that were most likely associated with a partial complex seizure disorder. He has had problems since he was relatively young but because of these abnormal partial complex seizures he underwent investigations including an MR scan.

The MR scan demonstrated a mass involving the mid portion of the temporal lobe that was nonenhancing. One could identify the mass relatively easily on T2 but there was also some abnormal T2 away from the area of the mass.

Because of this abnormality, I initially saw him in the fall of 2008. At that time, he underwent both a PET scan and a functional MR and these demonstrated the tumor had posteriorly displaced his speech area and there was no definite evidence of speech activity within the tumor itself.

We discussed the issues and he understood that the options he had were:

1. He could continue to be followed. There was some evidence that the tumor may have been slightly larger in size and he also understood that over time this tumor would grow.
2. He could consider a stereotactic biopsy but the problems with stereotactic biopsies are that sometimes it is difficult to actually get an accurate diagnosis with stereotactic biopsy; it is difficult to do 1p and 19q LOH, and also MGMT methylation could not be done effectively on a biopsy consistently.
3. He also understood that if the underwent an operative procedure there was about a 1% chance of infection, a 2% to 5% chance that he would have some problems with speech after the operation, about a 1% chance that this would be a permanent difficulty. He owned his own business and clearly this was an issue. He also understood that there was a small risk somewhere in the range of 1/500 of actually dying from the operative procedure because of his severe cardiac issue or pulmonary problem.

After discussing all these issues, he did not initially decided to proceed with an operation but he went back to Jordan, which is his home country and then let me know that he would like to have the operative procedure. He was therefore brought in electively on February 19, 2009, to undergo the operation.

PROCEDURE (S) OPERATOIRE (S)/OPERATIVE PROCEDURE (S):

The patient was brought to the operating room and after an IV was started and an arterial line was placed, a catheter was inserted. He was given 350 cc of 20% mannitol, one gram of Ancef, and also 10 milligrams of Decadron.

The supraorbital and supratrochlear nerves were injected with 0.5% Marcaine and epinephrine and the posterior pin sites of the Mayfield were also injected with 0.5% Marcaine and epinephrine. The area of the incision was marked out after neuronavigation had identified the area of the lesion well. A very small amount of hair was removed from the incision and the superficial temporal, postauricular, and occipital nerves were injected with 0.5% Marcaine and epinephrine and the incision itself was injected with 0.33% Marcaine and epinephrine. Using Proviodine we then draped and prepped him in our typical fashion.

He was draped in such a way that he would be able to function in computer programs that had previously been organized for him associated with his functional MR and Dr. Klein was also in the operating room to assess his speech during the operation.

The incision was opened without difficulty, a number of burr holes were placed, and the bone flap was removed.

The dura was opened and it was difficult to actually see the tumor; however, the middle temporal gyrus was clearly somewhat thickened and was somewhat whiter than one would have expected. The inferior temporal gyrus also appeared to be involved in the mass. We could see the vein of Labbe posterior to the lesion. The area of abnormality involving the middle temporal gyrus was initially biopsied and the frozen section appeared to be consistent with low-grade astrocytoma.

We then proceeded to resect the tumor. It was difficult to actually find a plane around the tumor initially; however, when we were more anteriorly placed we could see that we were much more into normal tissue than the somewhat harder and more grayish mass that was associated with the tumor. We removed the middle and inferior temporal gyri in the area of the abnormality using neuronavigation. We then resected more posteriorly.

On resecting somewhat more posteriorly, he began to have some difficulty with his speech. The abnormality was in identifying words rather than counting and it was mild but certainly present.

At this particular point in time, we had removed the vast majority of the tumor, and it was my feeling that I did not want him to have significant problem with speech after the operation. He was still doing his cognitive testing well but his speech clearly was slower and his problem with identifying words was of concern.

We, therefore, irrigated the whole area. There was no evidence of any bleeding.

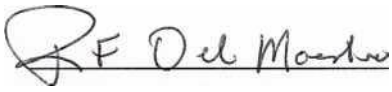
The dura was closed with a duraplasty and 3-0 silk sutures were used to close the dura. The bone flap was tied into position with 3-0 silk sutures and the wound was closed using 3-0 Vicryl sutures for the subcutaneous tissues and 3-0 Vicryl Rapide sutures for the skin.

SUMMARY:

In summary, this 31-year-old patient presents with a seizure disorder and a left temporal mass involving the posterior portion of the temporal lobe.

The tumor has been substantially resected and the initial diagnosis appears to be grade II astrocytoma.
The patient did very well during the operative procedure. He had mild difficulty with speech and my expectation would be that this will improve.

CLEANING AGENT: **Proviodine** DICT.PAR/BY: **Dr. Del Maestro,**



Signature Date

Dict: 03/24/2009
Tran: 03/26/2009\transmed
Document ID:306279