SSG CASE REVIEW

Clinical Presentation

The patient is a 72-year-old right-handed male with a history of smoking cigarettes. He presented after experiencing weakness of his right side over the course of one week. A CT scan of the head revealed a **left parietal tumor**. Further CT evaluation of the chest and bronchoscopic biopsy of a mass on the right lung revealed **non-small cell lung cancer**. The patient was disoriented to date and year and experienced slowed speech with repetition and naming difficulty. Grade 4+ power in the right upper extremity and grade 3 power in the right lower extremity was measured.

Surgical Management

CT evaluation showed extensive vasogenic edema surrounding the 3.1 x 2.9 x 3.6cm mass, believed to be associated with sulcal effacement along the left posterior temporal and parietal lobes. The mass was centered in the lateral left parietal lobe and extended to the left lateral ventricle causing a midline shift of 6mm. A large vein was safely mobilized to allow for cannulation down the selected sulcus. **A posterior parietal approach was taken to ensure the access device was behind sensory and above optic radiation.** The tubular retractor was cannulated to one quarter the diameter of the metastasis to avoid entry into the ventricle. The metastasis as poorly differentiated squamous cell carcinoma.
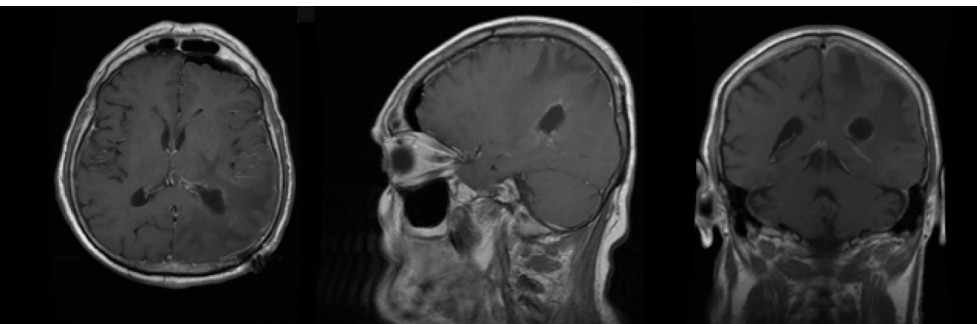
Clinical Course and Outcomes

The patient spent **one night in the ICU** with an **overall hospital stay of one day**. At his two week follow-up, the patient was fully oriented and his speech had improved. Visual fields were intact and he was able to ambulate independently with a cane.

Pre-Op Scans
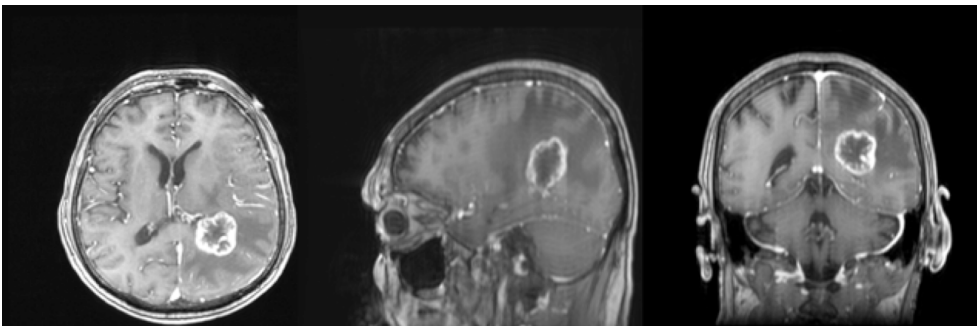
Post-Op Scans

If you have a notable case review to share, please contact us at info@SubcorticalSurgery.com