March 12, 2019

FILED

MAR 15 2019

ELIZABETH A. BROWN
CLERK OF SUPREME COURT
BY D. Richards
DEPUTY CLERK

Re: Expedite Divorce Appeal Request # 7606-COA & 76206 - COA

Dear Nevada Supreme Court Judges,

I Wilbert R Holmes, humbly request to 'expedite my divorce appeal' matter to be reviewed and decided upon soon. I am a 72 year old retired, handicapped veteran with a debilitating medical affliction, an inoperable 'Brain Tumor'. Besides my divorce, I have suffered and experienced numerous medical and physical occurrences, taking a toll on me psychically. Also, my mental health definitely has taken a downward turn, based on the divorce not being finalized. It is very close to almost '4 years' now, since my divorce was filed.

All this time has been mentally excruciating, depressing and feels like I am living in a nightmare at times, since the divorce initial filing was on 11/7/2015 and still going on as of March 12, 2019. I pray this court matter will be settled soon without my divorce hanging over my head daily, so I can have a clean new beginning.

I am not seeking sympathy. I am asking for justice in this divorce matter. The final decree is delayed because of a 'property equity dispute' due to substantial mistakes made by the original judge and legal recorded instrument not taken into legal consideration on my side, in the original marital decree.

There was supposed to be a 'certified licensed appraisal' done by a certified licensed appraiser, for the years stated in our prenuptial agreement, ordered by the original judge, to be completed by a 'licensed and certified appraiser'. Instead, a non-certified, non-licensed 'broker's price opinion' was done by a realtor who was not licensed or not certified to do appraisals in Nevada, brought in by my ex-wife's attorney. The appraisal should be a 'Third Disinterested Party'. .According to 'The Nevada Real Estate Division, Department of Industry', a 'property appraiser' must be licensed and certified to do property values in the State of Nevada. Also, my ex-wife was never on my home mortgage originally, nor was she ever on any loans. No funds ever came from my ex-wife, to buy my home or make any monthly payments.

My ex-wife also signed a 'quit claim deed, and 'quit claimed' off my property in 1999, at the time of my original purchase and also signed off my home on an additional 'quit claim deed' in 2013, when my home was refinanced in a 'reverse mortgage' in my own TRUST naming my property. My ex-wife was not named in my trust.

RECEIVED
MAR 15 2019
ELIZABETH A. BROWN
CLERK OF SUPREME COURT
DEPUTY CLERK

19-11669

Between our marriage prenuptial, my ex-wife signing off my property by her recorded 'quit claim deed, then purchased in my trust for my 'reverse mortgage, there should be NO property equity distribution to my ex-wife. I followed the advice of my attorney in 2013 with my ex-wives knowledge she would not be on the property, when my ex-wife 'signed and recorded her 'quit claim' deed off my home. I submitted my attorney's explanation and details about my property in 2013.

I truly believe the original judge did not have full capacity for real estate laws, real estate math or correct knowledge of the documents presented at the time of my divorce and or documents added during my divorce. **I know the 'broker's price opinion' was 'one sided,** as the realtor was brought by my ex-wife's attorney, to do a 'Brokers Price Opinion'. He was not a licensed and certified appraiser, needed in this situation, originally ordered by the judge.

Recorded Quit Claim Deeds and Property Trusts are legal binding instruments. These items were presented to the original judge, but not rightfully handle, nor legally taken into fair legal consideration for my divorce in all fairness.

A **quitclaim deed** is a legal instrument that is used to transfer interest in real **property**. The entity transferring its interest is called the grantor, and when the **quit claim deed** is properly completed and executed, it transfers any interest the grantor has in the **property** to a recipient, called the grantee.

The trustee is the legal **owner of the property** in **trust**, as fiduciary for the beneficiary or beneficiaries who is/**are** the equitable **owner**(s) of the **trust property**. ... A trustee **can** be a natural person, a business entity or a public body. A **trust** in the United States may be subject to federal and state taxation.

I also have additional detail that supports my argument and apparel, that there should be no property equity distribution supported for the reasons stated within this letter.

Most important, I need to add, I live alone. I have a very large 4813 sq. ft. home with a pool, I can barely take care of, or afford on my fixed income at 72 years old, especially in my debilitating health situation. It is a 2 story floor plan with many stairs I can no longer go up. My reverse mortgage balance goes up monthly....and my home maintenance, utilities, plus my HOA fees and yearly taxes I am behind on and responsible to pay, since taxes are not included in my reverse mortgage, are all taking away the equity monthly over $3,000.00 a month. Though my home is listed for sale ordered by the original judge in my divorce marital decree, I cannot sell my home until the liens are removed and my divorce is settled. Many repairs are needed to sell my home I will need to pay. Due to the reverse mortgages increasing monthly interest and principal balance going up and up each month, over almost 4 years since the divorce lien. Soon there will be NO equity.

Therefore, I am kindly asking to PLEASE expedite my divorce appeal so I may sell my home soon and begin my life over, for the time I have left here. Your expeditious review and decision of my appeal will be appreciated and respected. Thank you

Sincerely,

Wilbert R. Holmes

(702) 281-5752

NOTE: PLEASE SEE THE FOLLOWING DOCUMENTS

DEPARTMENT OF VETERANS AFFAIRS

VA Southern Nevada Healthcare System
Mental Health Clinic
Southwest Primary Care Clinic
7235 South Buffalo Drive
Las Vegas, NV

January 28, 2019

Mr. Holmes has been coming to the VA Mental Health Clinic for the treatment of mental health issues from July 2016 until the present. Mr. Holmes has disclosed emotional distress related to his long term divorce proceedings. Mr. Holmes reports an increase in mental health symptoms and emotional distress related to multiple legal matters and court proceedings. Please consider Mr. Holmes for early release from his legal probation in order to increase his quality of life and decrease emotional stress.

Thank you,

Keely Brown BSN, RN-BC
Mental Health Treatment Center

DEPARTMENT OF VETERANS AFFAIRS
VA Southern Nevada Healthcare System
Southwest Primary Care Clinic
7235 South Buffalo Drive
Las Vegas, NV 89113
(702) 791-9040

October 29, 2018

To Whom it May Concern:

My name is Elizabeth (Beth) Briggs, PsyD and I am a licensed psychologist practicing at the VA Southern Nevada Healthcare System. This letter is to confirm that Wilbert Holmes (DOB 11/21/1946) is being seen by myself and other mental health providers at the VA Southern Nevada Healthcare System.

He is being treated for an Adjustment Disorder related to ongoing legal stressors. He has met with me a total of 3 times on the following dates: 09/25/18, 10/12/18, and 10/29/18. He has also met with a psychiatrist Shawn Odtohan, MD on the following dates: 10/03/17, 03/14/18, 04/18/18, 06/13/18, 06/24/18, and 10/22/18.

If you have any questions, please do not hesitate to contact me at 702-791-9040.

Sincerely,

Beth Briggs, PsyD

Beth Briggs, PsyD
Licensed Psychologist

DEPARTMENT OF VETERANS AFFAIRS

VA Southern Nevada Healthcare System
Mental Health Clinic
Southwest Primary Care Clinic
7235 South Buffalo Drive
Las Vegas, NV

April 30, 2018

To whom it may concern,

Mr. Holmes has been coming to the VA Mental Health Clinic for the treatment of mental health issues from July 2016 until the present. Mr. Holmes has disclosed emotional distress related to his marital discourse and recent long-term divorce proceedings. Mr. Holmes reports an increase in mental health symptoms and emotional distress related to multiple legal matters and court proceedings contributed by these marital issues.

Shawn Odtohan, MD

DEPARTMENT OF VETERANS AFFAIRS

VA Southern Nevada Healthcare System
6900 North Pecos Road
North Las Vegas, Nevada 89086
(702) 791-9000

Date: 6/14/2018

In Reply Refer To: H0666

To whom this may concern,

This letter is written to verify the Veteran, Mr. Wilbert Holmes, has been seen by the behavioral health staff at the VA Southern Nevada Healthcare System for approximately three years. His primary trigger for anxiety is caused by enclosed spaces as well as court rooms at this time. He is participating in both psychotherapy and psychiatry services to address these anxiety triggers at this time. His medical records also show he fainted at his most recent court date. If you have any questions regarding the information provided on this letter or if there is any additional information I can provide to assist with this Veteran's care, please feel free to contact me at the number provided below.

Best,

Dr. Brian Potts, PsyD
(702) 791-9040x11780

DESERT PARKWAY BEHAVIORAL HEALTHCARE HOSPITAL
PSYCHIATRIC EVALUATION

DATE OF EVALUATION: May 28, 2017
TIME OF EVALUATION: 13:50 hours.

I believe this patient requires inpatient hospitalization. I do not believe this patient could be adequately and appropriately treated in a less restrictive environment. I have based my decision on the following information.

OMPLAINT: "I went to VA to consult about my ears and has dreams of .....

HISTORY OF PRESENT ILLNESS: The patient is a 70-year-old separated African American male, who was admitted from VA Hospital on a Legal 2000 for having ..... thoughts.

On face-to-face interview, the patient states that he does not know why he had to be brought to lock down facility, which he states "incarceration." He states that he went to the VA Hospital to have his ears checked because it seemed clogged and verbalized that he has been suffering through painful separation and impending divorce from his wife. The patient states that his wife has been making false claims, stating that he has been stalking her on social media and put him on TPO. He admitted that he expressed anger and ..... and would like to. — but claims he does not have any violence in his heart. The patient states that the process of divorce has been 3 years since it was filed in 2015 and the judge has not made any decision on the finalization of the divorce. He states that this has resulted in his suffering financially and emotionally. The patient minimizes recent incarcerations for violation of TPO. He currently denies suicidal or homicidal thoughts and was trying to vent about his troubling dreams.

The patient admits of having horrible dreams of .....

JUSTIFICATION FOR 24-HOUR CARE: Danger to others with need for controlled environment.

PAST PSYCHIATRIC HISTORY: The patient denies any treatment for any psychiatric

PATIENT NAME:	Holmes, Wilbert
DATE OF BIRTH:	NOVEMBER 21, 1946
MEDICAL RECORD #:	106667
ADMISSION #:	1703672
ADMISSION DATE:	MAY 27, 2017
ATTENDING PHYSICIAN:	Amitabh Singh, MD

Family Doctors
OF GREEN VALLEY
We have your family covered first.

Holmes, Wilbert R.

69 Y old Male, DOB: 11/21/1946
10550 PATRINGTON CT, LAS VEGAS, NV 89183-4562
Home: 702-281-5752
Provider: Ramanathan, Ravi S

Telephone Encounter

Answered by Kotlarsky, Yaakov David

Date: 12/16/2015
Time: 01:53 PM

Message

To whom it may concern,

Mr. Wilbert Holmes is a patient of ours, here at FDOGV since 2006. He has a significant medical history of Trigeminal Neuralgia, and chondroblastoma, for which he currently takes chronic pain medications for. He was diagnosed with Chondroblastoma in 2009, and underwent surgery and *subsequent radiation therapy to treat his condition.*

Though this condition may be terminal, Mr. Holmes is doing exceptionaly well and has responded positively to surgery and radiation treatments. If you have any questions, please do not hesitate to contact us.

Sincerely,

Yaakov D. Kotlarsky PA-C

Patient: Holmes, Wilbert R. DOB: 11/21/1946 Provider: Ramanathan, Ravi S 12/16/2015

Note generated by eClinicalWorks EMR/PM Software (www.eClinicalWorks.com)

Documents for: HOLMES, WILBERT R

8W 8325 A 393-16-84 WW
HOLMES, WILBERT R
Inpatient Operation Report
SURGERY/Head & Neck

Date of Operation: Tuesday, March 24, 2009
Pre-Operative Diagnosis: Skull base chondroblastoma, right side.
Post-Operative Diagnosis: Skull base chondroblastoma, right side.
Operation Title(s): 1. Transparotid excision of right skull base tumor (- 22) .
2. Right superficial parotidectomy with isolation and preservation of the facial nerve (- 22) .
3. Composite resection (temporomandibular joint and soft tissue) .
4. Electromyography (facial nerve monitoring) .
Surgeon: Elliot Abemayor, M.D., PHD.(P07912)
First Assistant Surgeon: Renee J Penn, M.D.(P26177)
Assistant Surgeon(s): Jennifer Long, M.D.(P23054)

Indications For Surgery: This is a 62-year-old male who has undergone multiple surgeries of the right and left temporal mandibular joint (TMJ) for recurrent pain and trismus. Most recently, an operation of the right side revealed a benign chondroblastoma.

The data were reviewed at the UCLA Tumor Board. The films show a tumor of the right inferotemporal fossa involving the zygoma and TMJ filling the skull base. The consensus of the conference was that the patient should undergo surgical excision of this area with as gross total removal of this tumor as possible to prevent further growth and superior extension.

Findings:

1. The tumor resection was made extremely difficult due to the patient's multiple prior surgeries.

2. There was a great deal of scar tissue in and around the area of the external auditory canal.

3. The tumor involved the right temporomandibular joint area, went medially towards the inferotemporal fossa, involved the zygoma and all the soft tissue therein. Gross total removal was achieved but no attempts at surgical margins was obtained.

4. It should be noted that the EMG (facial nerve monitoring) was mandatory during the entire six hours of the procedure in order to maintain the integrity of the facial nerve.

5. The difficulty of the resection was exacerbated by the patient's multiple prior surgeries.

6. A large soft tissue defect resulted from this excision. For this reason, I asked Dr. Vishad Nabili, plastic reconstruction, to recontour the area as he will separately dictate.

Procedure In Detail: After undergoing adequate informed consent, the patient underwent general endotracheal anesthesia uneventfully. The left eye was taped shut. A right eye tarsorrhaphy was placed. The table was turned.

Leads were then taken from the face and attached to the capital Nim monitor.

Gentle tapping on the face showed a good signal. The area on the right face was then infiltrated with 1:50,000 epinephrine. A Blair incision was outlined and then the head and neck was prepped and draped in usual sterile fashion.

Once the prepping and draping was over, the parotid flap was raised in the usual fashion. This proved extremely difficult, especially in the preauricular area due to the patient's prior surgeries. However, we were able to go through all of the scar tissue uneventfully.

The sternocleidomastoid muscle was laterally retracted. The digastric muscle was dissected free. This was then followed proximally towards the tympanomastoid suture.

After about two hours of dissection through dense scar tissue, multiple surgical clips from prior resections and inflammatory tissue, we were finally able to palpate the tympanomastoid suture. This amount of dissection is certainly twice as long as normal for this area. However, once the level of the tympanomastoid suture was uncovered, as well as the level of the digastric muscle, the main trunk of the facial nerve was dissected free.

That nerve was then followed anteriorly with a sharp hemostat. Bipolar cautery was then used to create tunnels lateral to the main trunk of the facial nerve and its branches. This was with a sharp knife. The upper branches of the facial nerve were dissected free. The lateral portion of the parotid was sent off as a separate specimen.

Once the upper branch of the facial nerve was dissected free, we were able to retract the parotid anteriorly. Using the bipolar and unipolar cautery, we then cut down on the TMJ from a superior to inferior direction. Anteriorly, the zygoma was uncovered using Bovie cautery.

Once this area was uncovered, the facial nerve and the entire parotid was then put on gentle tension with Army-Navy retractors. The skull base was then revisualized.

Removing soft tissue by dissecting along the skull base from posterior to anterior and then medial to lateral, the well-encapsulated tumor began to be delivered into the wound. This was assisted using dissection using loupe magnification and a Freer elevator. This allowed us to hug the fossa of the TMJ and all of the skull base bone superiorly, which was intact. The anterior-most limit of the resection was the zygomatic bone, itself, which was followed beyond the area of the tumor capsule.

The TMJ was then dissected free of soft tissue going inferiorly towards the ascending ramus of the mandible. Brisk bleeding ensued which was easily controlled. The entire soft tissue along the ascending ramus and the TMJ was then uncovered free. The oscillating saw was then brought into the wound and the TMJ was then severed free of surrounding soft tissue. Final cuts were made with osteotomes.

Once the composite resection of bone, TMJ and soft tissue was performed, sharp scissors were then used to further remove the TMJ from the glenoid fossa. This was sent off as separate specimen.

The skull base was, again, visualized and, going medial to the main trunk of the facial nerve and to the upper branches, the parotid gland was then anteriorly retracted. The capsule of the tumor was then followed anteriorly until it blended into the deep musculature of the inferotemporal fossa. This allowed us to free up all of the soft tissue of the inferotemporal fossa and the capsule and allowed to be delivered posteriorly. This allowed us to deliver the main

portion of the specimen.

The wound was copiously irrigated. Multiple bleeding points were arrested. The main trunk of the facial nerve was stimulated and stimulated all branches.

A large soft tissue defect resulted from this excision. Dr. Nabili's closure will separately be dictated. At this point, there were multiple specimens to Pathology, less than 200 cc blood loss and no complications.

Specimen(s): Multiple specimens to Pathology.

Estimated Blood Loss: Less than 200 cc blood loss.

Complication(s): No complications.

Elliot Abemayor, M.D., PHD. (P07912)
Electronically signed (3/26/2009 9:51:25)
MD5 checksum: 00ed371ee0da8ce3b4e209207c806198

cc:
Jennifer Long, M.D.(P23054)

Vishad Nabili, M.D.(P20958)

Dictated: 3/24/2009 14:13
  By: Elliot Abemayor, M.D., PHD. (P07912)
  Reference number: M5-903240992479100
Transcribed: 3/25/2009 3:23
  By: /EDIX
  Reference number: 03242479.100
Received: 3/25/2009 3:27
Document ID Number: 8119116
Patient UI Number: 104695982
Filing number: 009
Confirmation number: 2969151

*** END OF DISPLAY #08119116 ***

Documents for: HOLMES, WILBERT R

PACU PACU 6 393-16-84 WW
HOLMES, WILBERT R
Inpatient Operation Report
SURGERY/Head & Neck
H&N Reconstructive Surgery

Date of Operation: Tuesday, March 24, 2009
Pre-Operative Diagnosis: Neoplasm of the left parotid gland.
Post-Operative Diagnosis: 1. Neoplasm of the right infratemporal fossa.
2. Open wound of right infratemporal fossa, right parotid (superior and deep lobe) bed, and zygomatic root and TMJ space.
3. Chronic trismus
Operation Title(s): 1. Right sternocleidomastoid muscle flap, superiorly based.
2. Right partial cervico-facial skin advancement flap.
3. Neurolysis of spinal accessory nerve, right side.
4. Mandibulo-maxillary distraction, lysis of adhesions/fibrosis.
Surgeon: Vishad Nabili, M.D.(P20958)
First Assistant Surgeon: Renee Penn, M.D. (p26177)
Assistant Surgeon(s): Jennifer Long, M.D. (p23054)
Anesthesia: General endotracheal anesthesia via fiberoptic nasal intubation.

Service: Department of Surgery/Head and Neck.

Indications: Mr. Holmes is a 62yo male with long standing trismus, and bilateral TMJ problems s/p previous open joint surgeries in the past with severe trismus to 5mm. He more recently presented to Dr. Abemayor with a progressively growing right preauricular mass located in the infratemporal fossa with path suggesting benign tumor. He presents today for resection of this mass by Dr. Abemayor followed by reconstructionby me.

The patient consented to undergo the procedures stated above and as will be dictated below. He was brought to surgery today by Dr. Abemayor to undergo a right superfical superior deep lobe parotidectomy with facial nerve dissection followed by resection of this infratemporal fossa mass. These portions of the resection will be dictated separately by Dr. Abemayor. My portion of the procedure dealt with closure of the presenting wound defect and reconstruction of the open space defect.

Significant Findings: After the resection, the patient presented to me with a right superior and deep lobe parotid space and infratemporal fossa and TMJ space defect that principally involved the preauricular area.
His TMJ condylar head was resected as part of the resection as well as the root of the zygoma. I proceeded to make an intraoperative consultation via calling Dr. Blackwell and Dr. Felsenfeld to discuss the best reconstructive options for both the zygomatic root and the condylar head. With regards to the zygomatic root, since the bone defect is at most 1 to 1.5cm at the root then only a filling defect is created and any bony reconstruction would be difficult as the root of the zygoma is missing and the bone would have to oppose the mastoid tegmen. As such, a local soft tissue flap as in a sternocleidomastoid muscle flap is ideal to fill the defect and correct any disfigurement. Given the patients severe trismus that is long standing and also possibly related to fibrosis after previous open joint operations, then reconstructing the TMJ by way of a free rib graft would likely not improve the trismus. In addition, a free rib graft would require further resection of the upper half of the ascending ramus of the mandible with little benefit. As such the consensus was to allow the resected condylar head to remain free and swing with the TMJ space being occupied by the sternocleidomastoid muscle flap.

Lastly, at the end of the case, I attempted to open the patients jaw manually and noted improved trismus to 1cm. In distracting the mandible from the maxilla, his preoperatively noted loose dental cap of the left central upper incisor was removed for protection from aspiration. The patient warned us preop that the cap is loose and may need to be removed. The cap was given to the patient's wife postop so that he can allow his dentist to replace this. Anesthesia provided short term paralysis prior to extubation which allowed for manual mandibulo-maxillary distraction with successful improvement in trismus up to 2.5cm inter-incisor opening.

Informed Consent: A discussion took place between myself and the patient regarding the risks, benefits, rationale, and alternatives of the above-named procedures. The patient understood the risks, benefits, rationale, and alternatives and agreed to proceed with surgery.

Description Of Procedure: The patient was taken to the Operating Room and placed on the operating table. Anesthesia was induced. The patient was intubated. The bed was rotated 90 degrees from the anesthesia table. Dr. Abemayor proceeded with the resection of this tumor.

The patient then presented to me with a right superior and deep lobe parotid space and infratemporal fossa and TMJ space defect that principally involved the preauricular area.
His TMJ condylar head was resected as part of the resection as well as the root of the zygoma. I proceeded to make an intraoperative consultation via calling Dr. Blackwell and Dr. Felsenfeld to discuss the best reconstructive options for both the zygomatic root and the condylar head. With regards to the zygomatic root, since the bone defect is at most 1 to 1.5cm at the root then only a filling defect is created and any bony reconstruction would be difficult as the root of the zygoma is missing and the bone would have to oppose the mastoid tegmen. As such, a local soft tissue flap as in a sternocleidomastoid muscle flap is ideal to fill the defect and correct any disfigurement. Given the patients severe trismus that is long standing and also possibly related to fibrosis after previous open joint operations, then reconstructing the TMJ by way of a free rib graft would likely not improve the trismus. In addition, a free rib graft would require further resection of the upper half of the ascending ramus of the mandible with little benefit. As such the consensus was to allow the resected condylar head to remain free and swing with the TMJ space being occupied by the sternocleidomastoid muscle flap.
The parotidectomy involved removal of the superior superficial lobe and the deep lobe leaving an approx. 3x3x2cm defect in the preauricular area.

In order to fill this defect, the sternocleidomastoid muscle flap was done. I first retracted the medial border of the sternocleidomastoid muscle (SCM) and with meticulous blunt dissecion just posterior to the internal jugular vein, identified the spinal accessory nerve. I proceeded to dissect the nerve bluntly away from the SCM achieving adequate superior neurolysis of the nerve away from the SCM. Then, I bluntly dissected along the mid-belly of the SCM flap and identified the intemuscular septum. Next, I measured the superior extent of the arc of rotation for this SCM flap which was 5cm. A 5cm superior anterior section of the SCM was marked and the inferior segmant of this measured section of the SCM was excised inferiorly to superiorly, leaving it attached superiorly. The occipital arter branch was not identified and not encountered. After inferior release of the SMC, the muscle flap appeared viable with bleeding edges and good pink color. It was superiorly rotated and sutured with 3-0 vicryl sutures in an interrupted fashion the adjacent residual superior and anterior SMAS, filling the preauricular parotid defect. The entire parotid bed was dry from any bleeding that had been cauterized earlier and irrigated. Next, the inferior segment of the SCM was sutured to the residual inferior half of the SMAS and

remnant parotid tail, obliterating any gross space defect.

A 10 flat JP was placed in the posterior hairline and secured.

Upon re-apposition of the native facial skin, the cervico facial skin advancement created excess skin. A partial preauricular and cervical skin excision of 5mm of native skin was removed along the entire modified blair incision. The wound was closed in a tension free fashion with no gross deep space defect present.

The wound was irrigated with normal saline and hemostasis achieved. All the deep skin layers were closed with 4-0 Vicryl suture in an interrupted fashion. The preauricular skin was closed with 6-0 nylon and the neck skin with 5-0 nylon suture in a running fashion. Triple antibiotic ointment applied to the incisions.

Lastly, at the end of the case, I attempted to open the patients jaw manually and noted improved trismus to 1cm. In distracting the mandible from the maxilla, his preoperatively noted loose dental cap of the left central upper incisor was removed for protection from aspiration. The patient warned us preop that the cap is loose and may need to be removed. The cap was given to the patient's wife postop so that he can allow his dentist to replace this. Anesthesia provided short term paralysis prior to extubation which allowed for manual mandibulo-maxillary distraction with successful improvement in trismus up to 2.5cm inter-incisor opening.

The patient tolerated the entire procedure well. There was no ecchymosis noted, and the drain held suction. The patient tolerated the entire procedure well, was taken to the Recovery Room in stable condition after a successful extubation.

I was present throught the entire reconstructive portion of the case.

All needle and sponge counts correct at the end of the case.
Specimen(s): cervico facial advancement skin trimmings.

Estimated Blood Loss: 25ml for the reconstructive portion.

Complication(s): None

Vishad Nabili, M.D. (P20958)
Electronically signed (3/24/2009 17:3:43)
MD5 checksum: 687ebe92166db14f8b9ef809350dbc0f

Dictated: 3/24/2009 16:34:5
  By: Vishad Nabili, M.D. (P20958)
  Reference number: FreeForm
Transcribed: 3/24/2009 16:34:5
  By: 20958
  Reference number:
Received: 3/24/2009 16:34:5
Document ID Number: 5917276
Patient UI Number:
Filing number: 009