Ethmoidectomy & Nasal Polypectomy

Description

Functional endoscopic sinus surgery, bilateral maxillary antrostomy, bilateral total ethmoidectomy, bilateral nasal polypectomy, and right middle turbinate reduction. (Medical Transcription Sample Report)

Procedures Performed

- 1. Functional endoscopic sinus surgery.
- 2. Bilateral maxillary antrostomy.
- 3. Bilateral total ethmoidectomy.
- 4. Bilateral nasal polypectomy.
- 5. Right middle turbinate reduction.

Anesthesia

General endotracheal tube.

Blood Loss

Approximately 50 cc.

Indication

This is a 48-year-old female with a history of chronic sinusitis as well as nasal polyposis that have been refractory to outpatient medical management. She has underwent sinus surgery in the past approximately 12 years ago with the CT evaluation revealed evidence of chronic mucosal thickening within the maxillary and ethmoid sinuses as well as the presence of polyposis within the nasal cavities bilaterally.

Procedure

After all risks, benefits, and alternatives have been discussed with the patient in detail, informed consent was obtained. The patient was brought to the operative suite where she was placed in supine position and general anesthesia was delivered by the Department of Anesthesia. The patient was rotated 90 degrees away where cotton pledgets saturated with 4 cc of 10% cocaine solution were inserted into the nasal

cavity. The nasal septum, as well as the turbinates were then localized with a mixture of 1% lidocaine with 1:100,000 epinephrine solution. The patient was then prepped and draped in the usual fashion. Attention was directed first to the left nasal cavity. A zero-degree sinus endoscope was inserted into the nasal cavity down to the level of the nasopharynx. The initial examination revealed a gross polypoid disease emanating from the sphenoid sinuses as well as off the supreme turbinate. There was also polypoid disease present within the left middle meatus. Nasopharynx was visualized with a patent eustachian tube. At this point, the XPS micro debrider was used to take down all the polyps emanating from the inferior surface of the left middle turbinate as well as from the supreme turbinate. The ostium to the sphenoid sinus was visualized and was not entered. At this point, the left middle turbinate was localized and then medialized with the use of a freer elevator. A ball-tip probe was then used to localize the openings for the natural maxillary ostium. Side-biting forceps were used to take down the uncinate process and was further taken down with the use of the microdebrider. The opening of the maxillary sinus was visualized. The posterior fontanelle was taken down with the use of straight line forceps. It should be mentioned that tissue was very thick and polypoid with chronic inflammatory changes evident. The maxillary sinus ostia was then suctioned with Olive-tip suction and maxillary wash was performed. The remainder of the anterior ethmoid was then cleaned again removing excess polypoid tissue. The basal lamella was visualized and the posterior ethmoid air cells were then entered with use of the microdebrider as the surgical assistant palpated the patient's eyes for any vibration. All polypoid tissue was collected in the microdebrider and sent as a surgical specimen. Once all polypoid tissue has been removed, the cocaine pledgets were reinserted into the ethmoid air cells for hemostatic purposes. Attention was then directed to the right nasal cavity. Again, a sinus endoscope was inserted. Inspection revealed a grossly hypertrophied turbinate. It was felt that this enlarged and polypoid turbinate was contributing the patient's symptoms. Therefore, the turbinate was localized and a hemostat was used to crush the mid portion of the turbinate, which was then resected with use of side-biting scissors as well the Takahashi forceps. Sinus endoscope was then inserted all the way down through the nasopharynx. Again, the eustachian tube was visualized without any obstructing lesions or masses. Upon retraction, there was again polypoid tissue noted within the ethmoid sinuses. The ball-tip probe was again used to locate the right maxillary ostium. The side-biting forceps was used further take down the uncinate process. The maxillary ostium was then widened with use of a XPS microdebrider. A maxillary sinus wash was then performed. Now, the attention was directed to the ethmoid air cells. It should be mentioned again that the tissue of the anterior ethmoid was very thickened and polypoid. This was again taken down with the use of XPS microdebrider while the surgical assistant carefully palpated the patient's eye. Once all polypoid tissue have been removed, some bleeding that was encountered was controlled with the use of suction cautery in a very conservative manner. Once all bleeding has been controlled, all surgical instruments were removed and Merocel packing was placed in the bilateral nasal cavities with the intent to remove in the recovery room. At this point, the procedure was felt to be complete. The patient was awakened and taken to the recovery room without incident.