

# Rhinectomy & Nasal Endoscopy

## Description

Nasal endoscopy and partial rhinectomy due to squamous cell carcinoma, left nasal cavity. (Medical Transcription Sample Report)

## Preoperative Diagnosis

Squamous cell carcinoma, left nasal cavity.

## Postoperative Diagnosis

Squamous cell carcinoma, left nasal cavity.

## Operations Performed

- 1. Nasal endoscopy.
- 2. Partial rhinectomy.

## Anesthesia

General endotracheal.

## Indications

This is an 81-year-old gentleman who underwent septorhinoplasty many years ago. He also has a history of a skin lesion, which was removed from the nasal ala many years ago, the details of which he does not recall. He has been complaining of tenderness and induration of his nasal tip for approximately two years and has been treated unsuccessfully for folliculitis and cellulitis of the nasal tip. He was evaluated by Dr. A, who performed the septorhinoplasty, and underwent an intranasal biopsy, which showed histologic evidence of invasive squamous cell carcinoma. The preoperative examination shows induration of the nasal tip without significant erythema. There is focal tenderness just cephalad to the alar crease. There is no lesion either externally or intranasally.

## Procedure And Findings

The patient was taken to the operating room and placed in supine position. Following induction of adequate general endotracheal anesthesia, the left nose was decongested with Afrin. He was prepped and draped in standard fashion. The left nasal cavity was examined by anterior rhinoscopy. The septum was midline. There was slight asymmetry of the nares. No lesion was seen within the nasal cavity either in the area of the intercartilaginous area, which was biopsied by Dr. A, the septum, the lateral nasal wall, and the floor. The 0-degree nasal endoscope was then used to examine the nasal cavity more completely. No lesion was detectable. A left intercartilaginous incision was made with a #15 blade since this was the area of previous biopsy by Dr. A. The submucosal tissue was thickened diffusely, but there was no identifiable distinct or circumscribed lesion present. Random biopsies of the submucosal tissue were taken and submitted to pathology for frozen section. A diagnosis of diffuse invasive squamous cell carcinoma was rendered. An alar incision was made with a #15 blade and the full-thickness incision was completed with the electrocautery. The incision was carried more cephalad through the lower lateral cartilage up to the area of the upper lateral cartilage at the superior margin. The full unit of the left nasal tip was excised completely and submitted to pathology after tagging and labeling it. Frozen section examination again revealed diffuse squamous cell carcinoma throughout the soft tissues involving all margins. Additional soft tissue was then taken from all margins tagging them for the pathologist. The inferior margins were noted to be clear on the next frozen section report, but there was still disease present in the region of the upper lateral cartilage at its insertion with the nasal bone. A Joseph elevator was used to elevate the periosteum off the maxillary process and off the inferior aspect of the nasal bone. Additional soft tissue was taken in these regions along the superior margin. The frozen section examination revealed persistent disease medially and additional soft tissue was taken and submitted to pathology. Once all margins had been cleared histologically, additional soft tissue was taken from the entire wound. A 5-mm chisel was used to take down the inferior aspect of the nasal bone and the medial-most aspect of the maxilla. This was all submitted to pathology for routine permanent examination. Xeroform gauze was then fashioned to cover the defect and was sutured along the periphery of the wound with interrupted 6-0 nylon suture to provide a barrier and moisture. The anesthetic was then discontinued as the patient was extubated and transferred to the PACU in good condition having tolerated the procedure well. Sponge and needle counts were correct.