Cauterization - Epistaxis

Description

Cauterization of epistaxis, left nasal septum. Fiberoptic nasal laryngoscopy. Atrophic dry nasal mucosa. Epistaxis. Atrophic laryngeal changes secondary to inhaled steroid use. (Medical Transcription Sample Report)

Preoperative Diagnosis

Epistaxis and chronic dysphonia.

Postoperative Diagnoses

- 1. Atrophic dry nasal mucosa.
- 2. Epistaxis.
- 3. Atrophic laryngeal changes secondary to inhaled steroid use.

Procedure Performed

- 1. Cauterization of epistaxis, left nasal septum.
- 2. Fiberoptic nasal laryngoscopy.

Anesthesia

Neo-Synephrine with lidocaine nasal spray.

Findings

- 1. Atrophic dry cracked nasal mucosa.
- 2. Atrophic supraglottic and glottic changes likely secondary to inhaled steroids and recent endotracheal tube intubation.

Indications

The patient is a 37-year-old African-American female who was admitted to ABCD General Hospital with a left wrist abscess. The patient was taken to the operating room for incision and drainage. Postoperatively, the patient was placed on nasal cannula oxygen and developed subsequent epistaxis. Upon evaluating the patient, the patient complains of epistaxis from the left naris as well as some chronic dysphonia that had become exacerbated after surgery. The patient does report of having endotracheal tube intubation during anesthesia. The patient also gives a history of inhaled steroid use for her asthma. The patient was extubated after surgery without difficulty, but continued to have some difficulty and the Department of Otolaryngology was asked to evaluate the patient regarding epistaxis and dysphonia.

Procedure Details

After the procedure was described, the patient was placed in the seated position. The fiberoptic nasal laryngoscope was then inserted into the patient's left naris. The nasal mucosal membranes were dry and atrophic throughout. There was no evidence of any mass lesions. The nasal laryngoscope was then advanced towards the posterior aspect of the nasal cavity. There was no evidence of mass, ulceration, lesion, or obstruction. The nasolaryngoscopy continued to be advanced into the oropharynx and the vallecula and the base of the tongue were evaluated and were without evidence of mass lesion or ulceration. The fiberoptic scope was further advanced and visualization of the larynx revealed some atrophic, dry, supraglottic, and glottic changes. There was no evidence of any local mass lesion, nodule, or ulcerations. There was no evidence of any erythema. Upon phonation, the vocal cords approximated completely and upon inspiration, the true vocal cords were abducted in a normal fashion and was symmetric. The airway was stable and patent throughout the entire examination. The nasal laryngoscope was then slowly withdrawn from the supraglottic region and the scope was further advanced into the oropharynx and nasopharynx. The eustachian tube was completely visualized and was patent without obstruction. The scope was then further removed without difficulty. The patient tolerated the procedure well and remained in stable condition.

Recommendations And Plan

The patient would benefit from Ocean nasal spray as well as bacitracin ointment applied to the anterior naris. At this time, we were unable to discontinue the patient's inhaled steroids that she is using for her asthma. If this becomes possible in the future, this may provide her some relief of her chronic dysphonia. The patient is to follow up with Department of Otolaryngology after discharge from the hospital for further evaluation of these problems.