Endoscopic Sinus Surgery

Description

Ethmoidectomy, antrostomy with polyp removal, turbinectomy, and septoplasty. (Medical Transcription Sample Report)

Preoperative Diagnosis

- 1. Left chronic anterior and posterior ethmoiditis.
- 2. Left chronic maxillary sinusitis with polyps.
- 3. Left inferior turbinate hypertrophy.
- 4. Right anterior and posterior chronic ethmoiditis.
- 5. Right chronic maxillary sinusitis with polyps.
- 6. Right chronic inferior turbinate hypertrophic.
- 7. Intranasal deformity causing nasal obstruction due to septal deviation.

Postoperative Diagnosis

- 1. Left chronic anterior and posterior ethmoiditis.
- 2. Left chronic maxillary sinusitis with polyps.
- 3. Left inferior turbinate hypertrophy.
- 4. Right anterior and posterior chronic ethmoiditis.
- 5. Right chronic maxillary sinusitis with polyps.
- 6. Right chronic inferior turbinate hypertrophic.
- 7. Intranasal deformity causing nasal obstruction due to septal deviation.

Name Of Operation

Bilateral endoscopic sinus surgery, including left anterior and posterior ethmoidectomy, left maxillary antrostomy with polyp removal, left inferior partial turbinectomy, right anterior and posterior ethmoidectomy, right maxillary antrostomy and polyp removal, right partial inferior turbinectomy, and septoplasty.

Anesthesia

General endotracheal.

Estimated Blood Loss

Approximately 20 cc.

History Of Present Illness

The patient is a 55-year-old female who has had chronic nasal obstruction secondary to nasal polyps and chronic sinusitis. She also has a septal deviation mid posterior to the left compromising greater than 70% of her nasal airway.

Procedure

The patient was brought to the operating room and placed in the supine position. After adequate endotracheal anesthesia was obtained, the skin was prepped and draped in sterile fashion. Lidocaine 1% with 1:100,000 epinephrine was injected into the region of the anterior portion of the nasal septum. Approximately 10 cc total was used. A #15 blade and the Freer elevator were used to help make a standard hemitransfixion incision. A mucoperichondrial flap was carefully elevated, and the junction with the cartilaginous bony septum was separated with the Freer elevator. The bony deflection was removed using Jansen-Middleton forceps. The cartilaginous deflection was created by freeing up the inferior attachments to the cartilaginous septum, placing it more on the midline maxillary crest. The initial incision was placed in its anatomical position and secured with a 4-0 nylon suture for stabilization effect. Attention then was directed toward the left side. Lidocaine 1% with 1:100,000 epinephrine was injected in the region of the anterior portion of the left middle turbinate and uncinate process and polyps. Approximately 10 cc total was used. The polyps were removed using the Richards essential shaver to help identify the middle turbinate and uncinate process better. The uncinate process was removed systematically superiorly to inferiorly with back-biting forceps. Next, the maxillary antrostomy was identified and expanded with the back-biting forceps and showed polypoid accumulation in the mucosal disease on its opening site. The sinus linings were edematous but did not have any polyps in the inferior, lateral, or superior aspects. The anterior and posterior ethmoid air cells were entered primarily and dissected with the Richards essential shaver followed by the use of a 30-degree endoscope and up-biting forceps for the superior and lateral dissection. Bright mucosal disease and small polypoid accumulations were noted through the sinuses also. The inferior turbinates had some polypoid changes on them also and showed marked mucosal irritation and hypertrophy. The mucosal polypoid accumulations were cleared using the Richards essential shaver. The turbinate was partially resected from mucosally but with good shape to it. It was not desirable to remove it in its entirety. Any obvious bleeding points along the edge were controlled with the suction Bovie

apparatus. The same procedure and findings were noted on the right side with 1% lidocaine with 1:100,000 epinephrine injected into the anterior portion of the right middle turbinate, polyps, and uncinate process; 10 cc total were used. The polyps were removed. The Richards essential shaver was used to allow better exposure of the uncinate process. The uncinate process was removed superiorly to inferiorly with back-biting side-biting forceps. Next, a maxillary antrostomy was identified and expanded with the back-biting and side-biting forceps and showed all plate accumulations there also. The anterior and posterior ethmoid air cells were then entered primarily and dissected with Richards essential shaver followed by the use of the 30-degree scope and up-biting forceps for the superior and lateral resection. The inferior turbinates showed mucosal disease, polypoid accumulations, and changes. These were removed using the Richards essential shaver followed by a submucosal resection of the hypertrophied portion of the turbinate. Any obvious bleeding points were controlled with the suction Bovie apparatus. A thorough irrigation was then carried out in the nasal cavity, and Gelfilm packing was used to coat the linings in the middle meatal regions. The patient tolerated the procedure well and returned to the recovery room in stable condition.