Surgery of the Inside of the Nose and/or Sinuses

It is recommended that you undergo a surgery for the inside of the nose and/or sinuses called:

- _______ functional endoscopic sinus surgery ("FESS") (includes sinus polypectomy)
- _______ septoplasty
- _______ inferior turbinate reduction
- _______ intranasal polypectomy
- _______ other: _______________________

This information must be read completely before signing the surgical consent form. The information serves as the "informed consent" regarding the risks and benefits of the procedure. Please initial the risks on the last 2 pages, sign the last page, and bring the last 2 pages with you on the day of surgery.

The Anatomy and Inflammation of the Nose, Septum, Sinuses, and Turbinates

The septum is a wall of bone and cartilage that separates one nasal air passageway from the other. It usually goes straight back through the center of the nose but can be deviated to one side or the other, or even both sides (an "S-shaped" deviation) since birth or due to trauma such as a nasal fracture. A badly deviated or crooked septum can cause difficulty breathing through the nose. The symptoms are usually worse on one side, and sometimes can occur on the side opposite the deviation. In some cases the crooked septum can interfere with the drainage of the sinuses, resulting in repeated sinus infections.

The sinuses are air chambers located inside the bones of the skull. They are located within the cheek on either side of the nose (maxillary sinuses), in between the eyes (ethmoid sinuses), in the forehead (frontal sinuses), and much further back in the head (sphenoid sinuses). They have multiple roles, including reducing the weight of the skull, creating resonance to the voice, and humidifying incoming air before it gets to the lungs. The sinuses are lined with very fine hair-like projections called cilia. As the cilia wave or beat back and forth, they sweep mucus (which is normally produced by the sinus) towards the tiny drainage hole (ostium) of each sinus.

Sinusitis (inflammation of the mucous membranes lining the sinuses) starts as a result of blockage of the hole. This blockage can occur as a result of an anatomical obstruction, swelling due to a cold or allergy, drying of the mucus, or a foreign body. When this occurs, mucus that normally is expelled from the sinus builds up in the sinus. This can cause pressure or pain. In addition the mucus is an excellent culture medium for bacteria, potentially resulting in a sinus infection. Sinusitis can be acute or chronic. Chronic sinusitis may or may not have the classic face pain and pressures felt during an acute sinus infection.

Turbinates are long boney shelves that protrude into the nasal air passageway from the sidewalls of the nose. They are covered with a thick mucous membrane. The main ones are the middle and inferior turbinates. Each middle turbinate is about the size and shape of a pinky finger and
each inferior turbinate is about the size and shape of an index finger. The middle turbinates can be enlarged and contribute to sinus blockage and sinusitis. The mucous membrane of the inferior turbinates can become so enlarged and swollen as to cause significant nasal airway blockage. This is often seen in "allergic rhinitis" and "chronic non-allergic rhinitis" ("rhinitis" means inflammation of the mucous membranes of the septum and turbinates within the nose, but not including the sinuses.)

What type of anesthesia is given?
For the vast majority of patients, surgery is an outpatient procedure performed under general anesthesia. If you have certain other medical conditions which make general anesthesia a greater risk, certain limited nasal and sinus surgeries may be performed under local injections with sedation.

How is a septoplasty performed?
A 3/4-inch high incision is made on the inside of the nose. The membranes covering the cartilage and bone of the septum are lifted away and the bent portions of cartilage and bone are removed. The membranes are then placed back together in the middle and "sandwiched" together with dissolvable stitches and two thin, elliptical sheets of plastic called "splints" (one is placed in each nasal passageway.) There is a stitch holding the splints in place that is removed about one week later when the splints are removed in clinic. The splints have a built-in channel to allow air through ("air tube"). This tends to get clogged with mucous and dried blood but can theoretically remain open with sufficient irrigation (see below).

How is FESS performed?
Functional endoscopic sinus surgery is performed through the nose without incisions on the face. Using microtelescopes and state-of-the-art equipment, the nasal passageways and natural sinus openings are visualized and sources of obstruction are removed. The technique includes delicate cutting, shaving, and removal of diseased tissue, polyps, and obstructing bone, while maintaining a safe distance from critical nearby anatomical structures such as nerves, major blood vessels, and the bony walls protecting the eye and brain.

The advantage of "FESS" comes from the philosophical recognition that the surgical goal is to open the natural drainage channels, thereby restoring normal physiologic function. This differs greatly from past procedures, which were ablative and destructive. Other advantages over past sinus surgeries are: diminished post operative discomfort, minimal nasal packing, decreased bleeding, shorter recover time, and most importantly, a 90% success rate.

On rare occasion, a patient with severe allergies or other chronic mucous membrane disorders may have irreversible sinus membrane changes. In these circumstances, endoscopic sinus surgery may still be helpful to make extra large sinus openings which allow for periodic washouts in clinic.

About 30% of FESS patients will require some form of sponge-like "packing" that needs to be removed anywhere from 1 to 5 days after surgery. The packing is most commonly used in very inflamed sinus cavities to prevent undue bleeding after surgery.

How is inferior turbinate reduction surgery performed?
There are several types of inferior turbinate reduction surgery. 1) Transecting across the lower half of each turbinate and using aggressive cautery along the exposed raw surface. I rarely perform this procedure since the risk of bleeding is very high. Additionally, there is a much
greater risk of removing too much turbinate leading to a condition called "atrophic rhinitis." The nose needs a certain amount of membranous surface area to trap germs and humidify/moisturize the incoming air. If too much surface area is resected, the nasal secretions can become stagnant with chronically infected crusting. Despite these risks, I occasionally have a patient that requires this procedure.

2) Pushing the turbinates bones outwards ("lateralization") with subsequent gentle cauterization underneath the surface membrane to induce intentional shrinking and scarring within the soft tissue that overlies the bone ("submucosal cauterization"). This is the most common technique I employ.

3) Making an incision into the front of the turbinate and removing the bone from the inside while maintaining the full thickness of surface covering and/or shaving away some of the submucosal tissue from within. This is also an excellent technique and I will perform this if I do not believe the turbinates will be sufficiently reduced with procedure #2.

4) Nasal polyps or "polypoid" tissue can form from the membranes of the inferior turbinate as well as the middle turbinates. During an intranasal polypectomy, a gentle shaving device is used to remove this tissue. This may be combined with procedures 1, 2, or 3 above.

Do I need blood work or other tests before surgery?
According to your age, other medical conditions, and the type of surgery planned, you may need to have blood work, an EKG, a chest x-ray, and/or see another specialist for "medical clearance" before the surgery. We will let you know your requirements when surgery is scheduled.

What happens at the time of surgery?
This is considered a major surgical procedure. On the day of surgery, the anesthesiologist (or nurse anesthetist), operating room nurse, and myself will see you at the pre-operation holding area. An I.V. may be placed and sedation may be given. Once under anesthesia a breathing tube is placed. The surgery is detailed above. Following the surgery, we go to the recovery room and I will go talk to your family, whom you will see once you are more fully awake.

In the recovery room you may be awake enough to notice EKG (heart monitor) wires, an oxygen probe on the fingertip, a blood pressure cuff, a mask on your face blowing humidified oxygen, a lot of nurses, technicians, beeping, and buzzing. All of this is normal! It is not uncommon for you to be very nauseous and vomit. You may spit out or vomit blood. We give the best medicines to prevent this but it is still common.

Do I need to stay the night?
This is usually an outpatient procedure. You will spend one or two hours in the recovery room.

What can I expect after surgery? The pain after nose and sinus surgery is considered only mild to moderate (see below under Medications). Much more troublesome is the severe nasal blockage and the bloody, mucousy, thick drainage both out the nose and down the throat. This can last for several weeks after surgery. Furthermore, you are not permitted to blow your nose until you are 5 days after surgery. Even then, only gentle blowing or sniffing is allowed to loosen mucus. You may not blow your nose forcefully until 2 weeks after surgery. Nasal salt water irrigations will help greatly with keeping your nose as clear as possible (see below.)

You must avoid strenuous exercise, lifting over 10 pounds, and bending over (e.g. to tie your shoes…consider slip-ons) for 10 days after. At that time increase activity level as tolerated.
Sleep with your head elevated on extra pillows. Most patients prefer to sleep in a recliner the first few nights after surgery.

If you must sneeze or cough, do so with the mouth open (i.e. do not try to "suppress" a sneeze as this will generate potentially harmful air pressures inside your sinuses).

You will most likely be breathing out of your mouth. A cool mist humidifier may help keep your mouth/throat from drying up.

Your ears may feel clogged or pop a lot for 4 to 6 weeks after surgery.

Your may wear eyeglasses or contacts starting the evening of surgery.

If you have splints, you will gradually develop more redness, swelling and tenderness at the front of the nose. This is normal and expected and will subside once the splints are removed. If at any time it becomes frankly painful or bright red, you should call the clinic.

You may be given a gauze drip pad to wear to catch bloody drainage so that you do not need to wipe your nose as often. If these drip pads become saturated with blood continuously such that you are changing them every few minutes, you need to contact the clinic.

*What are Hypertonic saline/baking soda nose and sinus irrigations?*

Using saline irrigations in the nose is critical for healing after nose and sinus surgery. You will receive a one page instruction sheet reminding you of this with your surgical packet. It lists the MINIMUM use of saline (salt water) spray and Afrin.

Ideally I also would like you to use “hypertonic saline/baking soda irrigations” twice a day after surgery as well. In fact, you may already have been instructed in this while being treated in the past. You may be asked to use it up for up to 2 months after surgery. In fact, there is occasionally a patient who will need to use it much longer. *Ideally you should start some type of saline irrigation regimen at least one week before surgery so that you become accustomed to it.*

The high-concentration of salt water flushes mucous crusts and other debris from your nose, and shrinks the membranes as it pulls fluid from them. This decongests and improves airflow into your nose, which, in turn, opens the sinus passages. Studies show that it improves cell function by increasing movement of the cilia (small hairs) in the sinuses. The cilia help keep mucous flowing and prevent mucous from pooling in the sinuses. It is pooled mucous that gives bacteria a chance to grow.

Any of the nose salt water regimens can be used in and around the nose splints.

**Hypertonic saline/baking soda recipe:**
- Thoroughly clean a one-quart glass jar.
- Fill with tap water that has been boiled and allowed to cool.
- Add 3 teaspoons of salt (kosher, canning, or pickling salt...not table salt).
- Add 1 teaspoon of baking soda.
- Mix and store tightly sealed at room temperature. Discard after one week.

**Irrigation instructions:**
- Use an ear syringe, baby's bulb syringe, or a water pik with an irrigation tip.
- *Gently* flush some solution into one nostril (aim slightly upwards within the nose).
* Tilt the head slightly backward and to the same side when flushing.
* Repeat on other side. Let the fluid run out.
* **Do not blow your nose until you are at least 5 days after surgery.** Then gentle blowing.
* May burn the nose, may need lower concentration of salt.

**Most patients prefer to purchase pre-made sinus irrigation kits instead of making the recipe. My favorite is "Sinus Rinse" by Neilmed (www.neilmed.com).** It is available over-the-counter.

**How frequently should I use the irrigations?**
You should be using regular salt water nasal spray at least 4 times a day (as much as every 30 minutes) and Afrin twice a day (the Afrin is only for 3 days). Ideally you should also use hypertonic saline/baking soda irrigations twice a day.

If you have splints in your nose, you should try to irrigate both in and around the air tube. You can gently lift the side of your nose away from the splint to fit the tip of the saline mist bottle or irrigator. **Most of the saline will hit the splints and come back out over your upper lip.** This is normal and expected; be assured that at least some of the saline will make it in deeper. The more you can flush through the air tube, the less it will become clogged with mucous and dried blood.

**What other medications will I be sent home with?**
A narcotic pain medication, an antibiotic, and possibly a prednisone taper (a type of oral steroid which is a strong anti-inflammatory). You can expect mild to moderate pain. It may be controlled by regular or extra-strength Tylenol (acetaminophen). You should use the narcotic for breakthrough pain. It, too, contains Tylenol so you should not use the narcotic within 4 hours of any other Tylenol-containing product.

If you are having any surgery that includes FESS, you should restart your nasal steroid spray (e.g. Flonase, Nasonex, Rhinocort) the morning after surgery.

**Am I allowed to clean crusts from the front of my nostrils if I have splints in?**
Yes, very gently. You may use 50%:50% diluted hydrogen peroxide:water on a q-tip to dissolve away crusting from the inside of the nostrils and the front of the splints. This might be tender but you will not displace the splints (they are solidly stitched in place). Triple antibiotic amount can also be used in the nostrils.

**Are there any food restrictions?**
You are allowed to eat anything you can tolerate starting the evening of surgery. However, most patients preferred a soft diet for several days. Staying hydrated is also important.

**When can I shower or swim?**
You may shower the evening of surgery. You may get the soapy shower water in your nose. It will not be harmful. You should avoid swimming for at least 2 weeks after surgery.

**When can I return to work/school?**
You may return whenever you feel you are ready. Most patients stay out of work/school for at least 4 to 5 days. As a precaution, however, you should be prepared to take 2 weeks off.

**When will I follow-up in clinic?**
A follow-up appointment will be scheduled for you in clinic for about one week after surgery. If you had a FESS requiring "packing," you may be seen in clinic earlier (from 1 to 5 days after surgery) for packing removal.
If you had a septoplasty, I will remove the splints at the one week appointment. If you had a septoplasty and/or turbinate reduction without FESS, you may only need 1 or 2 more follow-up visits over the next several months.

If you had any surgery that included FESS, I will use numbing spray and an endoscope to examine the sinus openings and remove any crusting, dried blood, or granulation tissue (over exuberant healing tissue) that is present. These "debridements" can be mildly uncomfortable but are critical to the healing process. Depending on the extent of surgery, you will need to return for 2 to 3 more debridements during the first 2 months after surgery. I may also check you 2 or 3 more times during the first year after surgery. Occasionally, a patient will scar more aggressively than anticipated and require numbing injection and removal of an area of scar over or within one of the sinuses openings. This could be done during one of the debridement visits.

What are the risks of surgery?
1) Bleeding - It is possible to have problems with bleeding during or after surgery. Post-operative bleeding may require emergency treatment to stop active bleeding and/or the very rare need for blood transfusion. A very rare complication reported in the literature is carotid artery laceration with massive bleeding during sphenoid sinus surgery. This could result in a stroke. Bloody nasal drainage may occur for 2 to 3 weeks after surgery. This is normal and slowly improves. It will be much more notable if your surgery included FESS. There may be frank bright, red blood on occasion as crusts break off. If this does not settle in a timely fashion, you should notify a physician. High blood pressure, excess physical activity, unrecognized bleeding disorders, and the inappropriate use of aspirin-containing products or anti-inflammatory medicines can all increase the risks of bleeding. Temporary bruising around the eyes is possible.
2) Infection - Should an infection occur, treatment with different antibiotics may be necessary.
3) Scarring - The sinus cavities or the nasal passageways could develop scar bands or scar-like narrowing after any intranasal surgery. This could require a procedure in clinic to cut the scar or could go on to contribute to a recurrence of sinus problems or nasal breathing problems that could require revision surgery. It is not uncommon after septoplasty for the newly straightened septum to slowly develop a slight shift or scarring to one side of the nose. This is usually not associated with any symptoms.
4) Watery eyes (epiphora) - The tear duct that drains tears from each eye into the nose travels in front of the natural opening to the maxillary (cheek) sinus and could be injured during FESS. This could cause sudden episodes of clear drainage from the nose or, if the duct is scarred completely closed, watery eyes. There are surgeries to repair this.
5) Eye injury - During FESS, there is a 0.005% chance of injury to the eye causing vision loss. Also very rare is potential injury to the eyeball muscles causing temporary or permanent double vision ("diplopia"). Bleeding into the eye ("orbital hematoma") can also cause vision change or loss. These risks are possible because the sinuses are very close to the wall of the eye and can be breached. This is very rare with the state-of-the-art equipment and meticulous technique employed. Emergency medications and additional surgery are the theoretic treatments, but complete and permanent vision loss is possible.
6) Brain injury/cerebrospinal fluid (CSF) leakage - CSF is the fluid cushion around the brain and spinal cord. The roof of the ethmoid and sphenoid sinuses forms the floor of the brain cavity and can be breached during FESS. Intracerebral injury is a very rare complication (0.2%) that, should it occur, may create a pathway for infection that could result in meningitis. If noted intraoperatively, the leak could be repaired with packing followed by the administration of strong antibiotics. If noted post-operatively, treatment may include bed rest, antibiotics, hospital admission, possible spinal fluid diversion through a spinal tap, and/or surgery. These complications are very rare with the state-of-the-art equipment and technique employed.
7) Septal perforation - During a septroplasty, there is a <5% chance of putting a through-and-through hole in the septum resulting in a communication between the two nasal air passageways. If small, this could remain without any symptoms or cause a whistling sound during speaking. If large, this could cause a sensation of severe nasal blockage and possibly chronic nosebleeds. There are procedures to repair a septal perforation.

8) Change of voice - Due to altered nasal resonance, your voice character may change after any intranasal or sinus surgery. You may have a sense of echoing, hollowness, or hypernasality. This is usually only noticeable by yourself and you would grow accustomed to it quickly. However, public speakers and singers should approach any intranasal surgery with care as you may appreciate a permanent change in voice character.

9) Excess runny nose ("rhinorrhea") - You will have a prolonged bloody/mucousy drainage coming out the nose and down the throat for one to two months. This is normal and expected. Very rarely, "rhinorrhea" can be permanent. The reasons for this are not entirely understood. If you have underlying allergies, you may still need your allergy medication after surgery.

10) Nasal airway obstruction - See below. In addition, you will have a sensation of severe nasal blockage for the first week or two after surgery because of swelling and dried blood/crusts. The splints placed after septroplasty will also cause of severe blockage sensation. This is normal and expected and will steadily improve.

11) Failure for symptoms to improve - On occasion, nasal obstruction, abnormal nasal drainage, and facial pains/pressures may persist after surgery. In planning for surgery, I am tedious in my attempt to narrow down the causes of the symptoms. If I believe you may have some residual symptoms, I will inform you. An example of this is nasal obstruction that arises from both a deviated septum as well as collapse of the cartilage on the side of the nose. Septoplasty will only improve the component caused by the deviated septum.

12) Recurrence of the disease process - There is a 15 to 20% chance of sinus and nasal polyps returning after FESS or intranasal polypectomy. This is minimized with strict adherence to the long-term post-operative care instruction and follow-up visits.

13) Need for revision surgery - See number 3 and number 12 above.

14) Saddle nose deformity - After septroplasty, there is a 1% chance of a sunken appearance to the nose, just above the tip of the nose. This occurs if the remaining cartilage of the septum is inherently weak and cannot provide enough support for the overlying weight of the nose skin.

15) Impaired sense of taste or smell - There is a potential for an altered sense of taste or smell, particularly an overall decrease in the sense of smell. This is expected during the first few weeks after surgery because of swelling. More significant loss may be temporary or permanent.

16) Numbness – 50% of patients have temporary numbness (sometimes tightness) sensation of the upper lip and teeth that lasts about 2 weeks. This is permanent in less than 2% of patients.

17) Death - Death from this surgery or anesthesia is very rare but has been reported.

18) Need for further surgery - Always listed on any informed consent form.

What are the alternatives to surgery? In most cases, medications including antibiotics, nasal sprays, and sinus/nasal irrigations are the first form of treatment for nose and sinus disease. In most cases it is possible to continue to treat the disease medically. Surgery is only offered when medical treatments have either failed completely or have not provided enough improvement in symptoms. The other alternative is to do nothing ("observation").

Please let me know if you have any questions.

Julie A. Berry, M.D.
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I understand the above risks and wish to proceed with surgery.

____________________________________  ______________________
Patient Signature       Date

____________________________________
Print Name