OPERATIVE REPORT

PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Frontal Dilation 31296-50 and Bilateral Sphenoid Dilation 31297-50)

PREOPERATIVE DIAGNOSES: Chronic Frontal Sinusitis and Chronic Sphenoid Sinusitis

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

BOISE ENT™

Don J Beasley, MD
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Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, since the patient had prior FESS, the root of the middle turbinate and the anterior portion of the middle turbinate and the sphenoid rostrum were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced medially to expose the anterior ethmoid region and frontal sinus infundibulum. Scar was present at the left frontal sinus ostium with polypoid change. The Entellus "Path Assist" (curved, lighted frontal sinus probe) and the Entellus lighted guide wire were used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and scar and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium/infundibulum/scar. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Significant polypoid change was present at the frontal sinus cavity and fluid was suctioned from the sinus. Next, the left middle turbinate was gently displaced laterally to expose the sphenoid sinus rostrum. The natural ostium of the sphenoid sinus was identified with direct visualization just inferior and medial to the inferior aspect of the superior turbinate. Then the malleable tip of the XprESS device was advanced into the left sphenoid sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening/ very slight polypoid change was present within the sphenoid sinus. The exact same XprESS Balloon dilation procedures (Frontal and Sphenoid dilations) were repeated at the contralateral (right) side in the exact same fashion, and the findings were similar, except that the right frontal sinus cavity was significantly smaller (hypoplastic) than the left. Nevertheless, adequate Balloon Dilation of the right frontal was achieved. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): None

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 2 weeks.

OPERATIVE REPORT

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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Maxillary 31295-50, Bilateral Sphenoid 31297-50, Right Frontal 31296-Rt) and Bilateral Anterior Ethmoidectomy (31254-50) with nasal polypectomy

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Sphenoid Sinusitis, Chronic Frontal Sinusitis, Chronic Ethmoid Sinusitis, Sinonasal Polyps

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced laterally to expose the superior turbinate and the superior meatus. Polyps were atraumatically removed from this region with a blakesly forceps. The natural ostium of the sphenoid sinus was then identified with direct visualization just inferior and medial to the inferior aspect of the superior turbinate. Then the malleable tip of the XprESS device was advanced into the left sphenoid sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening was present. The Freer elevator was then used to gently displace the left middle turbinate medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. Finally, the anterior ethmoid bulla, a few anterior ethmoid air cells and small polyps were taken down with the Blakesly Forceps given the radiographic evidence of ethmoid sinusitis noted preoperatively. The same procedures were repeated at the contralateral (right) side in the exact same fashion and the findings were the same. However, on the right, in addition to the right maxillary and right sphenoid dilation and right anterior ethmoidectomy and polypectomy, the right frontal sinus ostium was dilated as well in the following fashion: The right middle turbinate was gently displaced medially to expose the anterior ethmoid region and frontal sinus infundibulum. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening/slight polypoid change was present at the frontal sinus. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): Bilateral Sinonasal Contents (including polyps/ethmoid contents)

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

BOISE ENT™

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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Maxillary 31295-50, Bilateral Frontal 31296-50) and Bilateral Anterior Ethmoidectomy (31254-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Frontal Sinusitis and Chronic Ethmoid Sinusitis

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS in the operating room), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced medially to expose the anterior ethmoid region and frontal sinus infundibulum. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening/slight polypoid change was present at the frontal sinus. The Freer elevator was then used to gently displace the left middle further medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. Finally, the anterior ethmoid bulla and a few anterior ethmoid air cells were taken down with the Blakesly Forceps given the radiographic evidence of ethmoid sinusitis noted preoperatively. The same procedures were repeated at the contralateral (right) side in the exact same fashion and the findings were the same. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): Bilateral Sinonasal Contents

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

BOISE ENT™

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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Right Sphenoid 31297-Rt, Bilateral Maxillary 31295-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary and Sphenoid Sinusitis

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the right middle turbinate was gently displaced laterally to expose the superior turbinate and the superior meatus. The natural ostium of the right sphenoid sinus was then identified with direct visualization just inferior and medial to the inferior aspect of the superior turbinate. Then the malleable tip of the XprESS device was advanced into the right sphenoid sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening/fluid was present. The sinus was suctioned. There was no pus. The Freer elevator was then used to gently displace the right middle turbinate medially to fully expose the uncinate process. The right uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the right maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. The same maxillary balloon dilation procedure was then repeated at the contralateral (left) side in the exact same fashion as on the right and the findings were the same. Left sphenoid balloon dilation was not carried out.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): None

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

BOISE ENT™

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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (bilateral maxillary 31295-50, right sphenoid 31297-Rt, and bilateral anterior ethmoidectomy 31254-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Sphenoid Sinusitis and Chronic Ethmoid Sinusitis

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the right middle turbinate was gently displaced laterally to expose the superior turbinate and the superior meatus. The natural ostium of the right sphenoid sinus was then identified with direct visualization just inferior and medial to the inferior aspect of the superior turbinate. Then the malleable tip of the XprESS device was advanced into the right sphenoid sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening/fluid was present. The sinus was suctioned. There was no pus. The Freer elevator was then used to gently displace the right middle turbinate medially to fully expose the uncinate process. The right uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the right maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. The right anterior ethmoid bulla was taken down with pediatric 0, 45, & 90 degree Blakesly forceps. The same maxillary balloon dilation procedure was then repeated at the contralateral (left) side in the exact same fashion as on the right and the findings were the same. The left anterior ethmoid bulla was also taken down with pediatric 0, 45, & 90 degree Blakesly forceps. Left sphenoid balloon dilation was not carried out.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): Bilateral sinonasal contents

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Maxillary 31295-50) with Irrigation of Maxillary Sinuses (31000-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis and Chronic Ethmoid Sinusitis

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

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Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS in the operating room), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenopalatine region and the anterior middle turbinate were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced medially to expose the uncinate process, anterior ethmoid bulla and the infundibulum. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. Finally, the left maxillary sinus was irrigated with 40cc of sterile saline via the balloon dilation site/antrostomy and via the accessory maxillary sinus ostium using the XprESS device. The same procedures were repeated at the contralateral (right) side in the exact same fashion and the findings were the same. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): none

Cultures: left maxillary sinus

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

BOISE ENT™

Don J Beasley, MD
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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Left Frontal 31296-Lt, Right Sphenoid 31297-Rt, Bilateral Maxillary 31295-50) with removal of left nasal polyp

PREOPERATIVE DIAGNOSES: Chronic Maxillary, Chronic Sphenoid, and Chronic Frontal Sinusitis

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. The Freer elevator was then used to gently displace the left middle turbinate medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to the same configuration as the ostium seeker. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. Next, the left frontal sinus ostium was dilated in the following fashion: The frontal sinus infundibulum and ostium were exposed using visualization with the 45 degree rigid endoscope. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium using the lighted fiber wire for additional illumination/transillumination and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening was present at the frontal sinus. Wide dilation was achieved. A small nasal polyp was also excised from the left nasal cavity at the superior meatus region. Next, After allowing for adequate topical and local anesthesia, the right middle turbinate was gently displaced laterally to expose the superior turbinate and the superior meatus. The natural ostium of the right sphenoid sinus was then identified with direct visualization just inferior and medial to the inferior aspect of the superior turbinate. Then the malleable tip of the XprESS device was advanced into the right sphenoid sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening was present. The sinus was suctioned. There was no pus. The Freer elevator was then used to gently displace the right middle turbinate medially to fully expose the uncinate process. The right uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the right maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): Left nasal polyp

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

BOISE ENT™

Don J Beasley, MD
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208-229-2368

PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (bilateral maxillary 31295-50) and bilateral anterior ethmoidectomy 31254-50 with bilateral maxillary sinus irrigation 31000-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Ethmoid Sinusitis

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenopalatine region and the anterior middle turbinate were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. The left anterior ethmoid bulla was then taken down with pediatric 0, & 90 degree Blakesly forceps. The same maxillary balloon dilation procedure was then repeated at the contralateral (right) side in the exact same fashion as on the left and the findings were the same. The right anterior ethmoid bulla was also taken down with pediatric 0, & 90 degree Blakesly forceps. The maxillary sinuses were irrigated with 20cc of sterile saline bilaterally at the end of the procedure and Stammberger sinus foam was placed at the middle meatus region.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): Bilateral sinonasal contents

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

BOISE ENT™

Don J Beasley, MD
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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Frontal Dilation 31296-50 and Right Sphenoid Dilation 31297-50), left anterior ethmoidectomy 31254-Lt, right anterior and posterior ethmoidectomy 31255-Rt, Bilateral Endoscopic Concha Bullosa Resection 31240-50

PREOPERATIVE DIAGNOSES: Chronic frontal, ethmoid and sphenoid sinusitis and middle turbinate concha bullosa anomalies.

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the root of the middle turbinate and the anterior portion of the middle turbinate and the sphenoid rostrum were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced medially and then the lateral half of the left middle turbinate (concha bullosa anomaly) was surgically excised using a sickle knife. Then the left anterior ethmoid bulla was taken down with the zero, 45 and 90 degree Blakesly forceps. Next the frontal sinus infundibulum was exposed. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium/infundibulum. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening was present at the frontal sinus cavity and fluid was suctioned from the sinus. After allowing for adequate topical and local anesthesia on the right, the right middle turbinate was gently displaced medially and then the lateral half of the right middle turbinate (concha bullosa anomaly) was surgically excised using a sickle knife. Then the right anterior and posterior ethmoid air cells were taken down/extirpated with the zero, 45 and 90 degree Blakesly forceps. Next the right frontal sinus infundibulum was exposed. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the right frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the right frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium/infundibulum. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening was present at the right frontal sinus cavity and fluid was suctioned from the sinus. Next, the right middle turbinate was gently displaced laterally to expose the sphenoid sinus rostrum. The natural ostium of the sphenoid sinus was identified with direct visualization just inferior and medial to the inferior aspect of the superior turbinate. Then the malleable tip of the XprESS device was advanced into the right sphenoid sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening/very slight polypoid change was present within the sphenoid sinus and a small polyp was removed from the rostrum. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): Bilateral Sinonasal Contents.

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Nasal/sinus endoscopy, surgical with transnasal dilation of maxillary sinuses 31295-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis

POSTOPERATIVE DIAGNOSIS: Chronic Maxillary sinusitis

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

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Description of Operative Procedure:

After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, and then 1:1000 topical Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with approx 3 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, and the posterior aspect of the middle turbinate at the sphenopalatine region were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced medially with a Freer elevator to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. The same procedure was repeated at the contralateral (right) side in the exact same fashion. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): None

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (bilateral maxillary 31295-50, left sphenoid 31297-Lt, bilateral anterior ethmoidectomy 31254-50, bilateral excision of concha bullosa anomalies 31240-50, bilateral sinonasal polypectomy)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Sphenoid Sinusitis, Chronic Ethmoid Sinusitis, concha bullosa anomalies, bilateral sinonasal nasal polyposis

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 topical Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the right middle turbinate was gently displaced laterally to expose the superior turbinate and the superior meatus. The natural ostium of the right sphenoid sinus was then identified with direct visualization just inferior and medial to the inferior aspect of the superior turbinate. Then the malleable tip of the XprESS device was advanced into the right sphenoid sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening/fluid was present. The sinus was suctioned. There was no pus. The Freer elevator was then used to gently displace the right middle turbinate medially to fully expose the uncinate process. The right uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the right maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the right maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. The right anterior ethmoid bulla was taken down with pediatric 0, 45, & 90 degree Blakesly forceps. The same maxillary balloon dilation procedure was then repeated at the contralateral (left) side in the exact same fashion as on the right and the findings were the same. The left anterior ethmoid bulla was also taken down with pediatric 0, 45, & 90 degree Blakesly forceps. Left sphenoid balloon dilation was not carried out.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): Bilateral sinonasal contents

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Frontal 31296-50 and Bilateral Maxillary 31295-50)

PREOPERATIVE DIAGNOSES: Chronic Frontal Sinusitis and Chronic Maxillary Sinusitis

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

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Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, since the patient had prior FESS, the root of the middle turbinate remnant, the uncinate process and the sphenopalatine region were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left frontal sinus infundibulum was exposed just lateral to the middle turbinate remnant. Scar was present at the left frontal sinus ostium with polypoid change and there was adhesion between the remnant of the left middle turbinate and the superior portion of the uncinate process. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead after adhesiolysis. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and scar and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium/infundibulum/scar. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Minor polypoid change was present at the frontal sinus cavity and fluid was suctioned from the sinus. Next, the left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. The exact same XprESS Balloon dilation procedures (frontal and maxillary dilations) were repeated endoscopically at the contralateral (right) side in the exact same fashion, and the findings were the same. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): None

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Nasal Sinus Endoscopy with Bilateral Frontal Sinus Balloon Dilation 31296-50)

PREOPERATIVE DIAGNOSES: Chronic Frontal Sinusitis

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

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Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, since the patient had prior FESS, the root of the middle turbinate remnant were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the anterior ethmoid region and frontal sinus infundibulum were identified with the 45 degree endoscope. Scar was present at the left frontal sinus ostium with polypoid change. The Entellus "Path Assist" (curved, lighted frontal sinus probe) were used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and scar and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium/infundibulum/scar. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Significant polypoid change was present at the frontal sinus cavity and fluid was suctioned from the sinus. The exact same XprESS Balloon dilation procedures (Frontal dilation) was repeated at the contralateral (right) side in the exact same fashion, and the findings were similar, except that the right frontal sinus ostium was significantly smaller/more stenotic than the left. Nevertheless, adequate Balloon Dilation of the right frontal was achieved. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): None

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT:

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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Frontal 31296-50, Bilateral Sphenoid 31297-50, Bilateral Maxillary 31295-50), Bilateral Anterior Ethmoidectomy (31254-50), left endoscopic concha bullosa excision (31240-LT) and bilateral inferior submucosal turbinate resection (30140-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Sphenoid Sinusitis, Chronic Frontal Sinusitis, Chronic Ethmoid Sinusitis, Concha bullosa anomaly, and bilateral inferior turbinate hypertrophy.

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using zero degree 3mm rigid endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. The Freer elevator was used to gently displace the left middle turbinate medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. Then the left middle turbinate was gently displaced medially and then the lateral half of the left middle turbinate (concha bullosa anomaly) was surgically excised using a sickle knife and Karl Storz 4.0 micro debrider blade. Next, the left anterior ethmoid air cell labyrinth was extirpated along with a few ethmoid polyps using the standard Blakesly 0, 45, and 90 degree Forceps as well as the Karl Storz 4.0 40 degree and 0 degree micro debrider blade. All of the pertinent landmarks of the fovea ethmoidalis, the cribriform plate and the lamina papyracea were identified and not injured. Next, the left frontal sinus ostium was dilated in the following fashion: The frontal sinus infundibulum and ostium were exposed using visualization with the 45 degree rigid endoscope. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening was present at the frontal sinus and mucous was suctioned. Wide dilation was achieved. The left superior turbinate was then identified as was the left sphenoid sinus rostrum and the ostium was located and cannulated with a sphenoid probe. Next, the malleable tip of the XprESS device was reshaped to a 10 degree angle and the XprESS device Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium at the appropriate depth. Next, the XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The sphenoid ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Moderate mucoperiosteal thickening was present and mucous was suctioned. The left inferior turbinate was then submucosally resected using a 2.0mm Storz inferior turbinate submucosal resection blade in the usual fashion resecting soft tissue and bone until the desired therapeutic effect was achieved. Next the same procedures were repeated at the contralateral (right) side in the exact same fashion and the findings were the same except no concha bullosa excision was performed on the right. There were no complications.

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Estimated Blood Loss: Minimal

IVF: None

Specimen(s): Bilateral Sinonasal Contents (including polyps/ethmoid contents)

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium 31295 -50, Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium 31296 -50, Submucous resection inferior turbinate 30140 -50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Frontal Sinusitis and Turbinate Hypertrophy

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS in the operating room), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced medially to expose the anterior ethmoid region and frontal sinus infundibulum. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening/slight polypoid change was present at the frontal sinus. The Freer elevator was then used to gently displace the left middle further medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty.The left inferior turbinate was then submucosally resected using a 2.0mm Storz inferior turbinate submucosal resection blade in the usual fashion resecting soft tissue and bone until the desired therapeutic effect was achieved. Next the same procedures were repeated at the contralateral (right) side in the exact same fashion and the findings were the same. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): none

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium 31295 -50, Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium 31296 -50, Submucous resection inferior turbinate 30140 -50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Frontal Sinusitis and Turbinate Hypertrophy

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS in the operating room), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced medially to expose the anterior ethmoid region and frontal sinus infundibulum. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening/slight polypoid change was present at the frontal sinus. The Freer elevator was then used to gently displace the left middle further medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty.The left inferior turbinate was then submucosally resected using a 2.0mm Storz inferior turbinate submucosal resection blade in the usual fashion resecting soft tissue and bone until the desired therapeutic effect was achieved. Next the same procedures were repeated at the contralateral (right) side in the exact same fashion and the findings were the same. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): none

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Nasal/sinus endoscopy, surgical - with dilation of maxillary sinus ostium 31295-50, Nasal/sinus endoscopy, surgical - with dilation of frontal sinus ostium 31296-50, Nasal/sinus endoscopy, surgical - with dilation of sphenoid sinus ostium 31297-50, Endoscopic Ethmoidectomy - Partial (Anterior) 31254-50) with polypectomy, Turbinate Resection w/ Submucosal Approach 30140-50

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Frontal Sinusitis, Chronic Sphenoid Sinusitis, Chronic Ethmoid Sinusitis, Sinonasal Polyps, Turbinate Reduction

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using zero degree 3mm rigid endoscopic visualization. Specifically, since the patient had prior FESS, the root of the middle turbinate remnant, the uncinate process and the sphenopalatine region were injected bilaterally using endoscopic visualization. The Freer elevator was used to gently displace the left middle turbinate medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. A partial uncinectomy was also performed for access. Next, the left anterior and posterior ethmoid air cell labyrinth was extirpated along with a few ethmoid polyps using the standard Blakesly 0, 45, and 90 degree Forceps as well as the through cut forceps. All of the pertinent landmarks of the fovea ethmoidalis, the cribriform plate and the lamina papyracea were identified and not injured. Next, the malleable tip of the XprESS device was advanced into the left sphenoid sinus through the ethmoidectomy cavity performing a transethmoid sphenoidotomy with Balloon dilation in the following fashion. The XprESS device Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Moderate mucoperiosteal thickening was present. Next, the left frontal sinus ostium was dilated in the following fashion: The frontal sinus infundibulum and ostium were exposed using visualization with the 45 degree rigid endoscope. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening and polypoid change were present at the frontal sinus. Wide dilation was achieved. The left inferior turbinate was then submucosally resected using a 2.0mm Storz inferior turbinate submucosal resection blade in the usual fashion resecting soft tissue and bone until the desired therapeutic effect was achieved. Next the same procedures were repeated at the contralateral (right) side in the exact same fashion and the findings were the same. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): Bilateral Sinonasal Contents (including polyps/ethmoid contents)

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

BOISE ENT™

Don J Beasley, MD
Camille Buchmiller, PA-C
208-229-2368

PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Nasal/sinus endoscopy, surgical with transnasal dilation of maxillary sinuses 31295-50, Submucous resection inferior turbinate 30140-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Turbinate hypertrophy

POSTOPERATIVE DIAGNOSIS: Chronic Maxillary sinusitis, Turbinate hypertrophy

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, and then 1:1000 topical Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with approx 3 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, and the posterior aspect of the middle turbinate at the sphenopalatine region were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced medially with a Freer elevator to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. The left inferior turbinate was then submucosally resected using a 2.0mm Storz inferior turbinate submucosal resection blade in the usual fashion resecting soft tissue and bone until the desired therapeutic effect was achieved. Next the same procedures were repeated at the contralateral (right) side in the exact same fashion and the findings were the same There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): None

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

BOISE ENT™

Don J Beasley, MD
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208-229-2368

PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Frontal 31296-50, Bilateral Sphenoid 31297-50, Bilateral Maxillary 31295-50, Submucous resection inferior turbinate 30140-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Sphenoid Sinusitis, Chronic Frontal Sinusitis, Turbinate Hypertrophy

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using zero degree 3mm rigid endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. The Freer elevator was used to gently displace the left middle turbinate medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. Next, the left sphenoid sinus was dilated in the following fashion. The left superior turbinate was identified/located as was the sphenoid rostrum and natural ostium. The malleable tip of the XprESS device was advanced into the left sphenoid sinus such that the XprESS device 1cm Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Moderate mucoperiosteal thickening was present. Next, the left frontal sinus ostium was dilated in the following fashion: The frontal sinus infundibulum and ostium were exposed using visualization with the 45 degree rigid endoscope. The Entellus "Path Assist" probe (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Wide dilation was achieved. The left inferior turbinate was then submucosally resected using a 2.0mm Storz inferior turbinate submucosal resection blade in the usual fashion resecting soft tissue and bone until the desired therapeutic effect was achieved. Next the same procedures were repeated at the contralateral (right) side in the exact same fashion and the findings were the same. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): None

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

PROCEDURE PERFORMED: Submucous resection inferior turbinate (30140-50)

PREOPERATIVE DIAGNOSES: Turbinate hypertrophy

POSTOPERATIVE DIAGNOSIS: Turbinate hypertrophy

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine

BOISE ENT™

Don J Beasley, MD
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Description of Operative Procedure: After discussing the risks, benefits and alternatives to TR, the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, and then 1:1000 topical Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with approx 3 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. The left inferior turbinate was then submucosally resected using a 2.0mm Storz inferior turbinate submucosal resection blade in the usual fashion resecting soft tissue and bone until the desired therapeutic effect was achieved. Next the same procedure was repeated at the contralateral (right) side in the exact same fashion and the findings were the same There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): None

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

BOISE ENT™

Don J Beasley, MD
Camille Buchmiller, PA-C
208-229-2368

PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Maxillary 31295-50, Left Frontal 31296-LT, Right Anterior Ethmoidectomy 31254-RT, Submucous resection inferior turbinate 30140-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Frontal Sinusitis, Chronic Ethmoid Sinusitis, Turbinate Hypertrophy

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS in the operating room), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. After allowing for adequate topical and local anesthesia and adequate p.o. sedation, the left middle turbinate was gently displaced medially to expose the anterior ethmoid region and frontal sinus infundibulum. The Entellus "Path Assist" (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Mucoperiosteal thickening/slight polypoid change was present at the frontal sinus. The Freer elevator was then used to gently displace the left middle further medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. The left inferior turbinate was then submucosally resected using a 2.0mm Storz inferior turbinate submucosal resection blade in the usual fashion resecting soft tissue and bone until the desired therapeutic effect was achieved. The maxillary dilation and turbinate reduction were repeated at the contralateral (right) side in the exact same fashion and the findings were the same. In addition, the right anterior ethmoid was taken down in the following way: the anterior ethmoid bulla and a few anterior ethmoid air cells were taken down with the Blakesly Forceps given the radiographic evidence of ethmoid sinusitis noted preoperatively. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): Bilateral Sinonasal Contents

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.

OPERATIVE REPORT

BOISE ENT™

Don J Beasley, MD
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PROCEDURE PERFORMED: XprESS Balloon Sinuplasty (Bilateral Frontal 31296-50, Bilateral Sphenoid 31297-LT, Bilateral Maxillary 31295-50, Submucous resection inferior turbinate 30140-50)

PREOPERATIVE DIAGNOSES: Chronic Maxillary Sinusitis, Chronic Sphenoid Sinusitis, Chronic Frontal Sinusitis, Turbinate Hypertrophy

POSTOPERATIVE DIAGNOSIS: Same

ANESTHESIA: Topical 4% Lidocaine, topical 1:1000 epi, 1% Lidocaine with 1:100,000 epinephrine, Valium 20 mg PO, Vicodin 15/1000 PO

Description of Operative Procedure: After discussing the risks, benefits and alternatives to XprESS Balloon Sinuplasty (including, but not limited to: facial numbness, visual injury, facial weakness, scar, bleeding, infection, CSF leak, ETC., the option for FinESS Balloon Sinuplasty and Traditional FESS), the patient's face was prepped in the usual fashion. The nasal cavity was topically decongested and anesthetized with Afrin, 1:1000 Epinephrine and 4% topical Lidocaine placed intranasally with cottonoids. Intranasal injections with 6 cc of 1% Lidocaine with 1:100,000 epinephrine were performed using zero degree 3mm rigid endoscopic visualization. Specifically, the uncinate process, the root of the middle turbinate, the sphenoid rostrum and the anterior middle turbinate were injected bilaterally using endoscopic visualization. The Freer elevator was used to gently displace the left middle turbinate medially to fully expose the uncinate process. The left uncinate process was then reflected anteriorly with a ball probe/ostium seeker. The ball probe/ostium seeker was used to locate the natural ostium of the left maxillary sinus and then the malleable tip of the XprESS device was reshaped to a 135 degree angle using the Entellus Bending tool. The tip of the XprESS device was then advanced into the left maxillary sinus antrum through the natural ostium and the Shaft Marker Band of the balloon was positioned at the maxillary ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium/infundibulum was dilated at 12 atm from 10 seconds and then the balloon was deflated and withdrawn without difficulty. Next, the left sphenoid sinus was dilated in the following fashion. The left superior turbinate was identified/located as was the sphenoid rostrum and natural ostium. The malleable tip of the XprESS device was advanced into the left sphenoid sinus such that the XprESS device 1cm Shaft Marker Band of the balloon was positioned at the sphenoid sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Moderate mucoperiosteal thickening was present. Next, the left frontal sinus ostium was dilated in the following fashion: The frontal sinus infundibulum and ostium were exposed using visualization with the 45 degree rigid endoscope. The Entellus "Path Assist" probe (curved, lighted frontal sinus probe) was used to confirm the natural ostium of the left frontal sinus via transillumination at the forehead. Next, the malleable tip of the XprESS device was advanced into the left frontal sinus through the natural ostium and the Shaft Marker Band of the balloon was positioned at the frontal sinus ostium. The XprESS balloon was slowly inflated to a pressure of 12 atm by fully depressing the plunger of the inflation device. The ostium was dilated at 12 atm for 10 seconds and then the balloon was deflated and withdrawn without difficulty. Wide dilation was achieved. The left inferior turbinate was then submucosally resected using a 2.0mm Storz inferior turbinate submucosal resection blade in the usual fashion resecting soft tissue and bone until the desired therapeutic effect was achieved. Next the same procedures were repeated at the contralateral (right) side in the exact same fashion and the findings were the same, except no sphenoid dilation was done on the right. There were no complications.

Estimated Blood Loss: Minimal

IVF: None

Specimen(s): None

Cultures: None

Discharge: The patient was observed in the operative suite until deemed stable for discharge and then discharged to home in the care of a family member in stable condition with specific instructions not to drive or operate machinery for 24 hours.

Follow up: 1 week.