BOISE ENT™

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CONSENT FOR CRYOSURGICAL POSTERIOR NASAL TISSUE ABLATION FOR CHRONIC RHINITIS

Treatment of persistent posterior nasal drainage (PND) that has not been improved with standard treatment using antihistamines, nasal sprays and allergy desensitization, and has proved difficult, either continuing unresolved or requiring invasive surgery. Now, an in-office procedure performed under local anesthesia is available with proven effectiveness for drainage and congestion caused by both allergic and nonallergic rhinitis. Long-term improvement of drainage and congestion has been seen in 4 out of 5 patients using cryosurgical ablation of posterior nasal tissue. This procedure is well-tolerated and safe. With any procedure, risks are present, and it is important to understand those before undergoing this procedure; these include:

1. Pain and discomfort – with any procedure some pain or discomfort may be experienced. Headache or facial pain during or after the procedure may occur, but 75% of patients note mild or no pain during or after this procedure.
2. Bleeding -bleeding with this procedure is uncommon. It may be experienced soon after the procedure or on a delayed basis. In rare occasions you may need to seek medical treatment to stop the bleeding.
3. Ear fullness -this is fairly common after the procedure, but it is transient, usually resolving in several weeks or less.
4. Nasal dryness -this is an uncommon side effect of this procedure, but like ear fullness, this is transient and usually resolves in days to weeks. In rare circumstances it may persist long-term.
5. Nasal congestion -this may be experienced transiently soon after the procedure but typically resolves spontaneously.

Your consent:

The procedure and description of the procedure, the more common risks associated with it and the potential complications have been described to me. I have had an opportunity to ask questions. I am satisfied with my understanding and the responses that I have received. I hereby authorize Boise ENT personnel to perform a sinus/nasal endoscopy. I hereby authorize the doctor and his associates to provide such additional services as he may consider to be medically advisable, including but not limited to suctioning, culturing the drainage, biopsies and packing if needed. I also consent to the use of photographs/video images to advance medical education and understand that if any photographs are used, I will not be identified by name.

Note: I am aware as the patient that my insurance may cover all, a portion, or none of the fees associated with the procedure and additional services performed. Any portion not covered by insurance is patient responsibility and I agree to make this payment.

Date _____ Patient Signature/Legal Guardian _____