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ACADEMIC HEALTH SCIENCE NETWORK

Q&A

with Mr James Barraclough, Ear Nose and Throat (ENT) Consultant, Nuffield Health Wolverhampton Hospital

Q1. How are patients identified for awake surgery?

Eustachian Balloon Tuboplasty

1. History (any history of eustachian tube dysfunction)
2. EDTQ-7 scoring system.
3. Nasal endoscopy to assess for access to the eustachian tube (ET) openings, assess nasal health and look at the postnasal space and ET openings themselves.
4. Audiometry and tympanometry for documentation

Balloon Sinuplasty

1. History

- Intermittent sinus related pain that does not fit a neuralgic type of pattern
- Failed medical management - 3 months of good use of nasal steroids
- No contra-indications (see below)

2. Examination with scope - low disease load, no polyps, no access issues

For both

If there are no contra-indications (see below) then we offer XprESS.

We then decide if Local Anaesthetic (LA) or General Anaesthetic (GA) is more appropriate. LA is the default unless:

- Access is difficult and the patient needs a septoplasty as well for access (needing a GA)
- They are anxious about LA (best question is how they are at the dentists!)
- They choose GA over LA

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Q2. When XprESS is not appropriate?

Eustachian Balloon Tuboplasty

- If the nasal health is poor and needs medical optimisation (douche/nasal steroids)
- If the ET openings are patulous
- If they need another procedure first (septoplasty or other balloon sinuplasty can be done at the same time but not anything that may cause inflammation around the ET openings such as nasal polypectomy or adenoidectomy)

Balloon Sinuplasty

- Nasal polyps/significant inflammatory disease/poor medical management
- Access problems (deviated nasal septum)
- History of neuralgic type pain/atypical facial pain
- History of anxiety/claustrophobia

Q3. How are they identified either from existing waiting lists or new patients?

We get referrals from colleagues in the Trust and from the neighbouring Trusts.

Q4. How are patients informed so they know what to expect from awake surgery?

We go through the XprESS balloon dilation process in detail with patients face to face. We are also thinking to develop patient information leaflet, so they have something to go home with too on the day of listing.

Q5. What are the expected proportions of those without polyps vs those with polyps (who won't be appliable for surgery)?

So, for the non-Eustachian tube patients, most patients have significant inflammatory disease and /or nasal polyps as they have already failed medical management. This is why it is not common to just do a balloon sinuplasty on someone. We have done a small number of patients in the last year for balloon sinuplasty whereas hundreds of patients have GA endoscopic sinus surgery each year.

Q6. Will patients who have had XprESS need FESS in later life?

Hopefully not. Patient selection should be good enough for balloon sinuplasty so that they get the right procedure first time. Some patient's disease progresses of course and so they are informed of this possibility and the need for revision balloon or further invasive surgery (FESS).

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Q7. What are patients told to expect post-surgery, benefits, side effects etc?

- Can go back to normal activities that day (the main benefit of the service)
- The benefits may take a few weeks appreciate
- There are no significant side effects (the other main benefit of the service) but any problems then we give them a general advice sheet and contact number to call us if there any problems

Q8. What training is provided and at what cost?

There is no cost for the product training provided for the safe and effective use of the XprESS balloon. Also, Stryker ENT can provide training in the Local Anaesthesia protocol. Stryker can provide this training in the following forms:

- 1:1 training with a head model, demo balloon and endoscope at a location of the clinicians choosing
- Cadaver training generally held at one of two sites in England
- Videos and tutorials
- Peer to peer visits
- Peer to peer webinars and discussions

Q9. What is the path to becoming proficient?

Experience, discussing with colleagues who also do this and learning from mistakes. Stryker have really helped with access to colleagues in other countries who perform this regularly.

Q10. Some honest narrative to inform others of the challenges of moving to awake surgery.

It's a very different way of thinking to be honest. I now try to think of offering Awake surgery to all patients if possible. The advantages are big - for the patients, for the surgeon and for the Trust. It does require an honest conversation with the patients, but many can be persuaded, and the vast majority have excellent outcomes and find it comfortable (we now have formalised feedback to prove this).

One of the challenges is to get colleagues to think differently themselves so that patients can be identified and referred to us. Slowly this is changing. One of the other challenges is to persuade patients that awake surgery using Local Anaesthetic is a possibility - I think in the UK there is a traditional thinking that all procedures within a body cavity need to be under General Anaesthetic. This is certainly not the case in the US where patients demand Ambulatory Care and to go to work the same day! There is a stigma attached to Local Anaesthetic surgery I think, and we should really strive to correct this.

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