Endoscopic Ear Surgery

DENNIS S. POE, MD, and FRED F. TELISCHI, MD
Boston, Mass., and Miami, Fla.

Educational objectives: To explain the expanding uses of endoscopes for diagnostic and therapeutic use in the operating room and office and to understand the indications, applications, potential problems, risks, and future role of endoscopes in otologic and neurotologic service.

Endoscopy is now being used routinely for surgery of the middle ear, mastoid, and internal auditory canal. Endoscopes deliver the surgeon’s view into the operative field and permit inspection and dissection under direct visualization beyond the normal line of sight limitation of surgical microscopes. In the office, the middle ear may be visualized in its undisturbed state, free of any surgically produced transudate or injected anesthetics. Examinations may be done rapidly and thoroughly in an office setting with minimally invasive techniques. Risks and recovery are minimized, compared with surgical procedures.

Endoscopic explorations have been useful for the evaluation of conductive hearing loss, perilymphatic fistula, middle ear masses, cholesteatoma, eustachian tube disease, and other middle ear or tympanic membrane pathology. It has been used both in place of a surgical exploration and as an adjunct to the preoperative assessment.

Endoscopic middle ear and mastoid surgery can significantly reduce morbidity. Second-look procedures are performed routinely to minimize the surgical incision, operating time, and morbidity. Primary cholesteatoma can often be excised from the epitympanum, sinus tympani, and oval window using endoscopes through postauricular approaches, but sparing the patient from conventional mastoidectomy. Canal wall-down procedures may be avoided by the ability to visualize surgical dissection directly in these recesses.

Acoustic neuroma surgery has been improved with the endoscope’s ability to look far laterally into the internal auditory canal to remove remnants of tumor. Open air cells can be seen directly and sealed to aid in the prevention of cerebrospinal fluid leaks.

Indications, techniques, potential problems, and results of endoscopic surgery will be presented.

Modifications of Neck Dissections

HELmut H. GOEPFERT, MD, JESUS MEDINA, MD, and JAMES Y. SUEN, MD
Houston, Texas, Oklahoma City, Okla., and Little Rock, Ark.

Educational objectives: To understand the new classification for the different types of neck dissections, to understand the indications and contraindications, and to have a good idea of the technique for the different modifications of neck dissections.

The standard radical neck dissection (RND) as defined by Crile in 1906 has had strong proponents and loyal advocates among experienced head and neck surgeons. Because of the complications associated with the RND, some surgeons over the past 20 years began to modify the procedure. During this time, the use of radiation therapy as an adjunct with surgery has been proven to increase the local and regional control of head and neck cancer. This combined treatment has allowed the safe execution of modified neck dissections for clinically positive lymph nodes in a number of select patients.

The modifications of neck dissections primarily involve the preservation of the spinal accessory nerve, internal jugular vein, and the sternocleidomastoid muscle. Over the past 15 years, a number of publications have shown that a modified neck dissection is equal to the RND for controlling neck disease; however, it is crucial that proper indications and contraindications be followed. The results thus far show that the tumor control has not been endangered, and advantages in function and cosmesis for the patient are meritorious.

This course will cover the proposed new classification, rationale, indications, and contraindications, and a step-by-step presentation of the technique for different modifications of neck dissections.

Laser Assisted Minimally Invasive Techniques in FESS

NIKHIL J. BHATT, MD, and WILLIAM CORNAY, MD
Elgin, Ill., and Birmingham, Ala.

Educational objectives: To pinpoint the disease process and improve surgical skills and to improve techniques in the use of power tools (Microdebrider, hummer, etc.) and fiberoptic laser.

We are now entering the tenth year of endoscopic sinus surgery in the United States. These years have now brought us face-to-face with the problems associated with this surgical technique—surgical difficulties, postoperative complications, etc. On the basis of 10 years of experience, we now describe ways to improve on the results:

COURSE 2701-2
Two-period course ($40)
3:00-5:15
Endoscopic Ear Surgery

COURSE 2702-1
One-period course ($20)
3:00-4:00
Modifications of Neck Dissections

COURSE 2703-2
Two-period course ($40)
3:00-5:15
Laser Assisted Minimally Invasive Techniques in FESS