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Chapter 1 : Genell J. Subak-Sharpe: used books, rare books and new books @ www.nxgvision.com

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It is important to be informed about the surgery being recommended, particularly if it is elective surgery an operation you choose to have done , rather than an emergency surgery. All surgeries have risks and benefits. Some people find it helpful to write their questions down ahead of time. It is important to remember that a well-informed patient tends to be more satisfied with the outcome or results of a procedure: What is the operation being recommended? Your healthcare provider should clearly explain the surgical procedure, such as the steps involved and provide you with examples. You should ask if there are different methods for doing this operation and why he or she favors one way over another. Why is the procedure needed? Reasons to have surgery may vary from relieving or preventing pain to diagnosing a problem to improving body function. Ask your healthcare provider to specifically explain why this procedure is being recommended for you and make sure you understand how this may improve your medical condition. What are my alternatives to this procedure? Are there other treatment choices available based on my current medical condition? In some cases, medicine or nonsurgical treatments, such as lifestyle changes, may be as helpful in improving a condition as surgery. Your healthcare provider should clearly explain the benefits and risks of these choices so that you can make an informed decision about whether or not surgery is necessary. You may still need surgery, or if your condition improves or stabilizes, you may be able to postpone surgery. After a period of "watchful waiting," it may be determined that surgery is still the best choice. What are the benefits of the surgery and how long will they last? It is important that your healthcare provider outline the specific benefits of having surgery for you. You should also ask how long the benefits typically last. Some benefits only last a short time, and could possibly need a second operation, while others may last a lifetime. Also, ask your healthcare provider about published information regarding the outcomes of the recommended procedure. This will allow you to make an informed decision and have realistic expectations about the surgery. What are the risks and possible complications of having the operation? Surgery always carries some risks, so it is important to weigh the benefits against the risks before surgery. Ask your healthcare provider to outline the possible complications, such as infection and bleeding, and possible side effects that could follow the procedure. Be sure to understand when you should notify your healthcare provider or seek immediate medical attention for complications. You should also discuss pain and ways to manage any pain that may follow the procedure. What happens if you do not have the operation? If you decide, after weighing the benefits and risks of the surgery, not to have the operation, what will happen? You need to know whether the condition will worsen or if there is a possibility that it may resolve itself. Should I get a second opinion? Your healthcare provider should be able to supply you with the names of qualified individuals who also do the procedure. You can minimize the risks of surgery by choosing a healthcare provider who is thoroughly trained and experienced in doing the procedure. You may ask the healthcare provider about his or her experience with the procedure being done, including the number of times he or she has done it, and his or her record of successes, as well as complications. Where will the surgery be performed? Until recently, most surgery was done in hospitals. This lowers the cost of these procedures since you are not paying for a hospital room. Certain procedures may still need to be done on an inpatient basis. Your overall health is also considered when making a decision as to where the operation will be done. Be sure to ask your healthcare provider why he or she recommends either setting. What type of anesthesia will be administered? Your healthcare provider should tell you whether a local, regional, or general anesthesia will be given and why this type of anesthesia is recommended for your procedure. You should also ask who will be giving the anesthesia such as an anesthesiologist or a nurse anesthetist; both of whom are highly qualified to give anesthesia and ask to meet with that person before your operation. What can I expect

during recovery? Ask your healthcare provider what to expect in the first few days following surgery, as well as in the weeks and months that follow. You need to know how long you will be hospitalized, what limitations will be placed on you, and if there are special supplies or equipment you will need when discharged. Knowing ahead of time what to expect will help you to cope and recover more quickly following the surgery. You should also ask about the typical length of time it takes for a full recovery to resume work and your everyday activities. What are the costs of this operation? Because health plans vary in their coverage of different procedures, there may be costs you will be responsible for. You will need to know what the specific costs of the operation will be and how much your insurance or health plan will cover. This information is not typically available to the healthcare provider. Tips for communicating with your healthcare provider It is important to communicate your feelings, questions, and concerns with your healthcare provider before having surgery. The following suggestions may help to improve communication between you and your healthcare provider: Ask your healthcare provider to write down his or her instructions, if necessary. Ask your healthcare provider where you can find printed material about your condition. Many healthcare providers have this information in their offices. If you still have questions, ask the healthcare provider where you can go for more information. Learning about your surgeon It is important to have confidence in the healthcare provider who will be doing your surgery. Whether this is someone you have chosen yourself, or a healthcare provider or surgeon you have been referred to, you can make sure that he or she is qualified. This may include any or all of the following: Make certain the healthcare provider or surgeon is affiliated with an accredited healthcare facility. When considering surgery, where it is done is often as important as who is doing the procedure. These costs may include the following: Your healthcare provider or surgeon should be able to give you an approximate idea of how long you will be in the hospital. Separate billing for other services. You will also be billed separately for the professional services of others who might be involved in your care, such as the assisting surgeon, anesthesiologist, and other medical consultants. Check with your health plan before surgery to be certain of what portion of the costs you will be responsible for. If your anticipated costs present a problem, discuss other financial solutions with your healthcare provider before the surgery. Getting a second opinion Asking another healthcare provider or surgeon for a second opinion is an important step in making sure that this particular procedure is the best choice for you. A second opinion can help you make an informed decision about the best treatment for your condition and can help you weigh the risks and benefits against possible alternatives to the surgery. Several health plans now require and will pay for patients to obtain a second opinion on certain nonemergency procedures. Medicare may also pay for patients to obtain a second opinion. Even if your plan does not require this, you still can ask for a second opinion. If you decide to get a second opinion, check with your health plan to see if it is covered. Your primary healthcare provider or hospital can provide you with names of qualified healthcare providers. Be sure to get your medical records from your first healthcare provider so that the second one does not need to repeat tests and procedures. Remember, in the case of emergency surgeries, the surgery should be done as quickly as possible. Most likely, there will not be time to get a second opinion. The necessity of getting a second opinion should always be weighed against the severity and urgency of the medical condition.

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Chapter 2 : The well-informed patient's guide to bunion and other foot surgery (edition) | Open Library

*Well-Informed Patient's Guide to Breast (Dell Surgical Library) [Eugene J. Nowak] on www.nxgvision.com *FREE* shipping on qualifying offers.*

Transportation Deciding To Have Surgery If your loved one is considering surgery, make sure you both have all the information you need to make the right decision. If a doctor recommends that your loved one undergo elective, or non-emergency, surgery, you both need to weigh the options very carefully before making a decision. Find out why the procedure is necessary, and if there are any alternative treatments available. Ask the doctor what risks are involved and what the possible benefits will be. All surgeries have both risks and benefits. They are only worth doing if the benefits are greater than the risks. Questions To Ask Before Surgery Doctors should always welcome questions, and the answers to these questions will help you make informed decisions. If you do not understand the answers, ask the doctors to explain them clearly. People who are well informed about their treatment tend to be more satisfied with the outcome. What operation are you recommending? Ask the doctor to explain the surgical procedure. Is something going to be repaired or removed, or is this procedure intended to diagnose a problem? The doctor or surgeon can draw a diagram and explain the steps involved in the procedure. Are there different ways of doing the operation? One way may require more extensive surgery than another. Why is the operation necessary? There are many reasons to have surgery. Some operations can relieve or prevent pain. Others can reduce a symptom or improve some body function. Some surgeries are performed to diagnose a problem. The surgeon will tell you the purpose of the procedure. Are there alternatives to surgery? Medicines or other non-surgical treatments, such as a change in diet or special exercises, might help just as well or more. Ask the surgeon or doctor about the benefits and risks of these other choices. Your loved one needs to know as much as possible to make the best decision. What are the benefits of having the operation? For example, a hip replacement may mean that your loved one will be able walk again with ease. How long the benefits are likely to last? For some procedures, the benefits may last for a short time only. There might be a need for a second operation at a later date. For other procedures, the benefits may last a lifetime. When finding out about the benefits of the operation, be realistic. Sometimes patients expect too much and are disappointed with the results. Ask the doctor if there is any published information about the outcomes of the procedure. What are the risks of having the operation? All operations carry some risk. This is why the benefits of the operation should be weighed against the risks of complications or side effects. Complications are unplanned events, such as infection, too much bleeding, reaction to anesthesia, or accidental injury. Some people have an increased risk of complications due to other medical conditions. In addition, there may be side effects after the operation. For the most part, side effects can be anticipated. For example, the surgeon knows that there will be swelling and some soreness at the site of the operation. Ask the surgeon about the possible complications and side effects of the operation. There is almost always some pain with surgery. Ask how much there will be and what the doctors and nurses will do to reduce the pain. Controlling the pain will keep your loved one more comfortable while healing, help him or her recover faster, and improve the results of the operation. What if my loved one chooses not to have the operation? After weighing the benefits and risks of the operation, your loved one might decide against it. Ask the doctor what will be gainedâ€”or lostâ€”if your loved one decides not to have surgery. Could the condition get worse? Could the problem go away? Where can we get a second opinion? Getting a second opinion is a very good way to make sure that surgery is the best alternative. Many health insurance plans require patients to get a second opinion before they have certain non-emergency operations. Check with your insurance company to see if it will pay for a second opinion. If your loved one is eligible for Medicare, it will pay for a second opinion. What has been your experience in doing the operation? To reduce the risks of surgery, choose a surgeon who has been thoroughly trained and has plenty of experience doing the procedure. Where will the operation be done? Most surgeons practice at one or two local hospitals. Have many of the same operations

been done in this hospital? Some operations have higher success rates if they are performed in hospitals that do many of those procedures. Until recently, most surgery was performed on an inpatient basis and patients stayed in the hospital for one or more days. Find out whether the operation will be done in the hospital or in an outpatient setting. If the doctor recommends inpatient surgery for a procedure that is usually done on an outpatient basis, or vice versa, ask why. You want your loved one to be in the right place for the operation. What kind of anesthesia will be needed? Anesthesia is used so that surgery can be performed without unnecessary pain. Local anesthesia numbs only a part of the body for a short period of time. Not all procedures done with local anesthesia are painless. Regional anesthesia numbs a larger portion of the body for a few hours. In most cases, patients are awake with regional anesthesia. General anesthesia numbs the entire body for the entire time of the surgery. Patients are unconscious under general anesthesia. Anesthesia is quite safe for most patients and is usually administered by a specialized physician anesthesiologist or nurse anesthetist. Both are highly skilled and have been specially trained to give anesthesia. After deciding to have the operation, ask to meet with the person who will administer the anesthesia. Find out what his or her qualifications are. How long will it take to recover? The surgeon can tell you how your loved done might feel and what he or she will be able to do during the days, weeks, or months following surgery. Ask how long your loved one will be in the hospital. Find out what kind of supplies, equipment, and any other help your loved one will need when he or she goes home. Knowing what to expect can help your loved one cope better with recovery. How much will the operation cost? Surgical fees often also include several visits after the operation. You also will be billed by the hospital for inpatient or outpatient care and by the anesthesiologist and others providing care related to the operation. Health insurance coverage for surgery and hospital stays can vary, and there may be some costs that you or your loved one will have to pay. Before your loved one has the operation, discuss all of these questions with his or her insurance company or employee benefits office. Adapted from Be Informed: After The Flood Download this free, to-the-point, guide to help flood victims protect themselves against diseases and other hazards in the days and weeks following a flood.

Chapter 3 : Understanding the Procedure - Touro Infirmary

Title Well-Informed Patient's Guide to Prostate (Dell Surgical Library) ISBN Author Shapiro, Charles Binding Mass Market Pa Publisher Dell Pub.

All articles analyzed only patients suffering from middle ear cholesteatoma with no history of previous ear surgeries. The disease status at last control was available in all patients, and the mean follow time was Analyzing the articles chosen for our review, it can be noted that three authors Tarabichi, Migirov and Barakate exclusively performed transcanal endoscopic surgeries, while in the other five reports a combined technique was also applied if necessary. During the follow-up period, a total of 48 patients showed residual pathology: Discussion The exposure and visualization of the entire middle ear space are sometimes difficult using only microscopic vision. With recent advances in minimally-invasive surgery, the use of the endoscope has led to new treatment options for middle ear pathologies 4 5. Moreover, the anatomy of the middle ear is particularly complex and an endoscopic approach represents an improvement with regard to the anatomic concepts of this region because it guarantees round-the-corner views of hidden areas such as the sinus tympani, facial recess, anterior epitympanic spaces, attic, hypotympanum and protympanum 6. Cholesteatoma surgery primarily aims to eradicate the disease process and provide the patient with a safe and dry ear. The main problems regarding attic cholesteatoma removal are residual and recurrence. The former is due to insufficient primary resection of the epidermal matrix, and classically presents a pearl-like aspect. Insufficient resection may be due a very fine epidermal matrix or middle-ear inflammation, in addition to limited exposition of hidden areas such as the epitympanic space and sovratubal recess. Actually, the view during microscopic surgery is defined and limited by the narrowest segment of the ear canal; this basic limitation has forced surgeons to create a parallel port through the mastoid to gain keyhole access to the attic. Despite the illumination and magnification offered by the operating microscope, it has distinct limitations. The persistence of physiopathologic phenomena that determined cholesteatoma development, presents as a new attic retraction that requires a further surgical approach to avoid the reformation of attic cholesteatoma. Recurrence consists in a new, dangerous tympanic retraction pocket caused by inadequate reconstruction of the scutum and tympanic loss of substance inducing persistence of the physiopathologic process of middle-ear depression. While recurrence can be diagnosed otoscopically, residual cholesteatoma is classically independent of the eardrum and only surgical revision can determine definite diagnosis; this is the rationale of second look procedures, in addition to functional issues. This review focuses on surgical improvements related to the mini-invasive treatment of middle ear cholesteatoma. At the moment, the main treatment options for this pathology are two basic, well-standardized microscopic surgical procedures: Both these traditional approaches to the attic have mainly provided limited access through postauricular mastoidectomy, with many surgeons using the ear canal to access the anterior part of the attic 7. The intact canal wall approach has traditionally been favoured for its simpler postoperative care and maintenance 8. Moreover, by preserving the anatomy of the middle ear, the cavity is permitted to get wet and, thereby, does not limit patients in future activities 9. Because of these disadvantages, others prefer to remove the posterior canal in their treatment of cholesteatoma 12 This group conjectures that improved visualization of the disease and affected middle ear anatomy, including the sinus tympani and anterior attic that are the most frequent sites of residual cholesteatoma in traditional intact canal wall surgery 14 15 , result in greater long-term disease-free states. Although open tympanoplasty decreases the rate of recurrence, nevertheless, in our opinion, the removal of the posterior canal does not always ensure complete visualization of sinus tympani that often remain hidden from surgical view. This situation may strongly be connected with the high rate of residual disease observed after this procedure. These observations suggest that there is no single procedure to treat all cases of cholesteatoma, and that the otologic surgeon should be flexible in chosing a procedure depending on the individual case. Over a follow-up period ranging from 4 to 15 years mean follow-up, 8 years , de Zinis et al. Nevertheless, 17 patients 9. In their

meta-analysis performed on 13 studies including a total of patients, Tomlin et al. In general, only 2 of the studies reported no significant differences between the two techniques, while 11 of the 13 data sets statistically favoured the canal wall down approach. However, the rate of cholesteatoma recurrence depends not only on the follow-up period, surgical methods and surgical techniques, but also in the methods used for statistical analysis. For this reason, Mishiro et al. After a mean follow-up period of 5 years, the recurrence rate comprising residual and recurrent cholesteatomas was In our opinion, this observation represents an important point of view that authors should always keep in mind to obtain a more correct analysis of surgical outcomes. Another point of interest is the rate of residual disease and recurrences that appear lower compared to data reported in the literature for canal wall up interventions performed exclusively by mean microscopy. These promising results seem to confirm the usefulness of the endoscope in terms of outcomes. The main limitations related to the seven studies analyzed in our review are the short time of follow-up and the limited number of patients treated by the authors. In fact, with the exception of Tarabichi et al. In general, both these issues are closely connected with the recent introduction of endoscopic middle ear surgery that needs more time to reach a sufficient number of cases and an adequate time of follow-up. Nevertheless, from studies analyzed in our review, the endoscope appears to allow an important reduction of unnecessary mastoidectomies in cases of cholesteatoma limited to the middle ear cavity, favouring the increase of exclusive transcanal middle ear surgeries. Moreover, in cases of pathologies involving the mastoid, endoscopic assistance may promote the choice of canal wall up procedures limiting the rate of recurrences and residual disease typically associated with this approach. Conclusions On the basis of literature data, canal wall down tympanoplasty still remains the most effective procedure in preventing recurrent disease after a single-stage surgery. Nevertheless, because the surgical approach depends on patient preference and lifestyle factors, the maintenance of posterior ear canal should be achieved in young patients, and the endoscopic technique may represent an important tool in obtaining this aim. Our review appears to confirm the importance of this tool in middle ear surgery. Obviously further reports are still needed to confirm and integrate this initial data, increasing the number of patients and organizing an accurate follow-up method to avoid the "drop out" issues. Ann Otolaryngol Chir Cervicofac. Ossicular chain preservation after exclusive endoscopic transcanal tympanoplasty: Selective epitympanic dysventilation syndrome. Endoscopic open technique in patients with middle ear cholesteatoma. Transcanal endoscopic treatment of benign middle ear neoplasms. Endoscopic management of limited attic cholesteatoma. Tos M, Lau T. Hearing after surgery for cholesteatoma using various techniques. Nikolopoulos TP, Gerbesiotis P. Surgical management of cholesteatoma: Int J Pediatr Otorhinolaryngol. Efficacy of the 2-staged procedure in the management of cholesteatoma. Arch Otolaryngol Head Neck Surg. Nyrop M, Bonding P. Surgical treatment of chronic middle ear disease. Canal wall up and canal wall down procedures. Single-stage canal wall-down tympanoplasty: Ann Otol Rhinol Laryngol. Follow-up strategy in adults. Postoperative results for cholesteatoma in children. Surgical technique and recurrence in cholesteatoma: Endoscopic management of attic cholesteatoma: Otolaryngol Clin North Am. Otoendoscopy in cholesteatoma surgery of the middle ear: Value of ear endoscopy in cholesteatoma surgery. Exclusive endoscopic ear surgery for acquired cholesteatoma: Barakate M, Bottrill I. Combined approach tympanoplasty for cholesteatoma: Endoscopic management of acquired cholesteatoma: J Otolaryngol Head Neck Surg.

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Chapter 8 : Deciding To Have Surgery

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