PREOPERATIVE DIAGNOSIS:
1. Nasal septal deviation.
2. Chronic sinusitis.

POSTOPERATIVE DIAGNOSIS:
1. Nasal septal deviation.
2. Chronic sinusitis.

OPERATION PERFORMED:
1. Nasal septal reconstruction.
2. Endoscopic maxillary antrostomy, bilateral.
3. Endoscopic complete ethmoidectomy, bilateral.

ANESTHESIA: General endotracheal anesthesia.

COMPLICATIONS: None apparent.

FINDINGS: The patient had septal deviation causing bilateral obstruction. The patient’s inferior turbinates are normal. The middle turbinates are normal. The uncinate processes are long. The ostiomeatal units are somewhat congested due to aberrant ethmoid air cells. The maxillary sinuses contain no infection or polypoidal changes. The posterior ethmoid cells have edematous mucosa, but no acute inflammation or infection.

CLINICAL: The patient is a 26-year-old female who reports a long history of sinusitis. She has had multiple infections. She has had trouble for many years. She has pain and pressure in her face which affects her most of the time. She is unable to breathe through her nose well on either side. Her upper maxillary teeth often are tender and she has constant painful drainage. She is here for endoscopic sinus surgery to improve sinus function and septoplasty to improve her airway.

DESCRIPTION OF PROCEDURE: After consent was obtained, the patient was taken to the operating room and given anesthetic by general endotracheal technique. When a suitable state of anesthesia had been achieved, her head was placed into a reverse Trendelenburg position. The nasal mucosa was decongested with topical oxymetazoline. In infiltrated the nasal septum with 1% lidocaine with 1:100,000 units of epinephrine. After vasoconstrictive effects, a left side hemitransfixion incision was created. I elevated a subperichondrial plane on the left side, exposing the left side of the septum. I then removed a posterior bony spur, created a superior incision in the bony septum posteriorly and repositioned this in the midline. In the mid region of the septum, there is a cartilage deflection which I separated superiorly and removed a piece of cartilage. I used a scalpel to shave this down to a thin, straight shape and then replaced this back into the nasal septum. Following these maneuvers, her septum was much improved and her airway now appeared to be good on both sides. I closed the incision with an interrupted stitch and then a through-and-through chromic to close the septal tissue layers. At this time, the nose was irrigated and suctioned. I then inspected the nasal cavities bilaterally. Using a 0-degree sinus surgical endoscope, complete endoscopy was performed. The left middle turbinate was identified. I then identified the uncinate process and removed it. The maxillary ostia was identified with a ball-tip probe. This was somewhat difficult due to enlargement of an ethmoidal cell posterior to the ostia. This was taken down and an adequate-sized opening created. The maxillary sinuses were inspected, irrigated and suctioned. I then opened up the ethmoid bulla and proceeded to open ethmoid cells in an anterior posterior direction. I worked along the inferior region of the ethmoid cells until the skull base had been identified. I then worked superiorly, taking these down between the lamina papyracea, septum and skull base. Having removed the ethmoid cells, I placed a cottonoid into this side of the nose and attention was directed to the right side. In a similar fashion, I first removed the uncinate process. I then identified the maxillary ostia, created an adequate-sized opening with the microdebrider and inspected within it. This was irrigated and suctioned. I then removed the remaining ethmoid air cells until a complete ethmoidectomy had been achieved. Having done so, the nose was irrigated, suctioned, and re-examined. Several small
areas of tissue were removed on each side. At this point, I filled the ethmoid defect and maxillary sinuses with Bactroban ointment. The patient was permitted to awaken. She was extubated in the operating room and transferred to recovery in good condition. She did have normal pupillary function. She had no bruising of her face or orbital region and appeared to have no complications.

What are the CPT® and ICD-10-CM codes reported?