STEPHEN A. LANDERS, M.D.
DIPLOMATE, AMERICAN BOARD OF OTOLARYNGOLOGY
HEAD AND NECK SURGERY

PEDIATRIC AND ADULT
EAR, NOSE & THROAT

LASER-ASSISTED UVULOPALATOPLASTY - CONSENT FOR SURGERY

I hereby authorize Stephen A. Landers, M.D. to treat the following condition(s):

SNORING AND/OR SLEEP APNEA

The procedures planned for the treatment of my condition(s) have been explained to me by my physician and are listed below:

PLASTIC REPAIR OF PALATE (UVULOPALATOPLASTY)

Patient Information:

Uvulopalatopharyngoplasty (UPPP) is an operation to improve certain sleep disorder symptoms such as obstructive sleep apnea and snoring. Because there may be several causes occurring at the same time, this procedure may only give partial relief, depending on the relative importance of palate and uvula size. The success rate in treating apnea cases has been reported to be greater than 50%, and the expectation for snoring improvement may be greater than 80%. The most common complications include bleeding after surgery, infection, and temporary airway obstruction due to postoperative swelling. Occasionally patients with severe obstruction or added risk due to obesity may require a temporary tracheostomy. Some patients also have complaints due to an inability of a shortened palate to make contact with the back of the throat. This may cause some nasal regurgitation and a hyponasal or hollow-sounding voice. The opposite effect due to narrowing of the space behind the nose (nasopharynx) is even less likely. As a general rule, the more carefully patients with sleep disorders are studied and selected, the greater the likelihood of improvement after UPPP.

Known potential adverse effects include:

POSSIBLE NEED FOR FURTHER SURGICAL PROCEDURES
DIFFICULTY IN SWALLOWING
CHANGE IN VOICE
DIFFICULTY IN BREATHING
ALTERNATIVE THERAPY MAY INCLUDE: OBSERVATION, MEDICAL TREATMENTS

I/We have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of nontreatment, the procedure to be used, and I/we have sufficient information to give this informed consent.

I/We certify this form has been fully explained to me/us, and I/we understand its contents.

I/We understand every effort will be made to provide a positive outcome, but there are no guarantees.

_____Date_____Time_____
Patient/Legal Guardian

Name(print)_____Witness_____

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