

Intranasal Splints: Use Of A Readily Available Material

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Abstract

Splinting the nasal cavity after nasal surgeries is a common practice to prevent nasal synechiae formation. Silicone rubber splint is common but usually not readily available. We describe the use of polyethylene containers as a cheap and readily available alternative. Our experience showed that it is safe and well tolerated by patients.

INTRODUCTION

Nasal synechia is a challenging complication following nasal surgeries, splinting the nasal cavity is usually done to prevent this complication¹.

Silicone rubber splints are in common use¹, though other substitutes such as x-ray films, Teflon have been described in medical literature^{2, 3}. In our practice environment there is scarcity of silicone splints because of high costs of importation. We describe the use of empty containers of intravenous (IV) fluids and drugs as a nasal splint.

METHODS

An empty plastic container of intravenous drug or fluid is collected.

A scissors is used to fashion the splint from the container appropriate to the nasal cavity after surgery. Fig.1 Care is taken to prevent sharp points by ensuring rounded ends at all sides. The splints is then cleaned thoroughly with cetrimide and rinsed with normal saline.

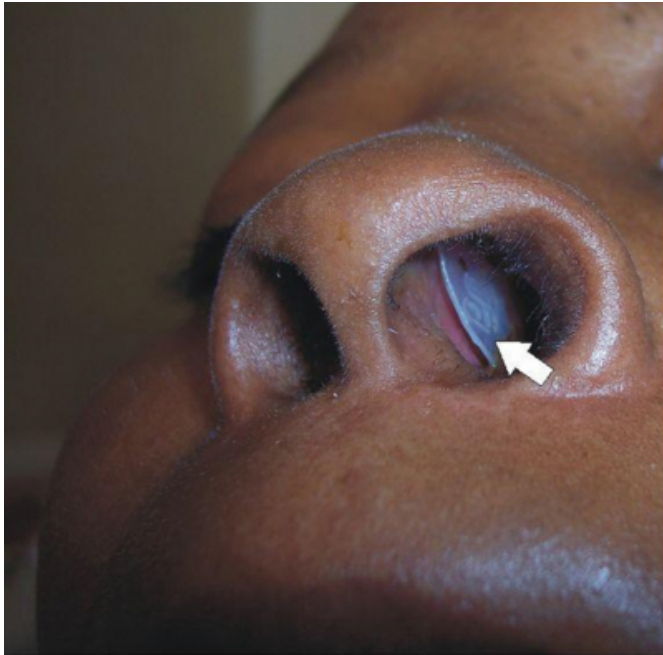
The patient is seated comfortably and the procedure thoroughly explained to the patient. The nasal cavity is sprayed with a local anaesthetic agent: 10% xylocaine with 1:100 000 adrenaline. After a wait of ten minutes for the anaesthesia to take effect, the splint is inserted into each cavity with the aid of a Killian's nasal speculum, Tilley's nasal forceps and headlight. The splint is coated with a lubricant before insertion and it should be slid along the floor of the nasal cavity gently, it must never be forced in. Care is taken to ensure that the splint stays between the septum and the lateral nasal wall. The edges of the splint must not protrude into the vestibule as this might cause

discomfort, the anterior end lies at the level of the posterior edge of the columella. Fig.2 The splint must not be tiny relative to the nasal cavity to avoid inhalation. Topical decongestants are prescribed post operatively for five days. The splints stay in situ for an average of 2weeks before removal.

Figure 1



Figure 2



DISCUSSION

The splints are custom fashioned to each nasal cavity. Nasal cleaning is possible with the splint in situ, the mucosa can

also be observed through the splint because of its transparent nature. We have used this splint in all patients that require them in our department for three years with no complications except for occasional discomfort from incorrectly sited splints which is easily resolved.

We suggest the use of Polyethylene drug and IV fluids containers as custom made intranasal splints. They are readily available, free, inert, efficient, completely safe and well tolerated by the patients. The splints retain their shape and can be used on one or both sides.

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