Training Standards for Endonasal DCR (EN-DCR)

Introduction:

Endoscopic dacryocystorhinostomy. NICE February 2005. Interventional Procedure Guidance 113

NICE have considered the evidence for endoscopic dacryocystorhinostomy and recommended that Ophthalmic and Otorhinolaryngology surgeons who wish to carry out this procedure undertake training.

This document is prepared for the Royal College of Ophthalmologists (RCOphth) and the British Association of Otorhinolaryngology – Head and Neck Surgeons (BAO-HNS) by Jane Olver, Consultant Oculoplastic Surgeon, (RCOphth and British Oculoplastic Surgery Society - BOPSS) and Matthew Yung, Consultant Otolaryngologist and Head and Neck Surgeon, (BAO-HNS). It forms the basis for the RCOphth and BAO-HNS setting joint training standards.

The aim is to provide general guidelines for Consultant Ophthalmologists (and Post-CCT Oculoplastic Fellows) and Otorhinolaryngologists who wish to perform endonasal DCR for the first time.

Background:

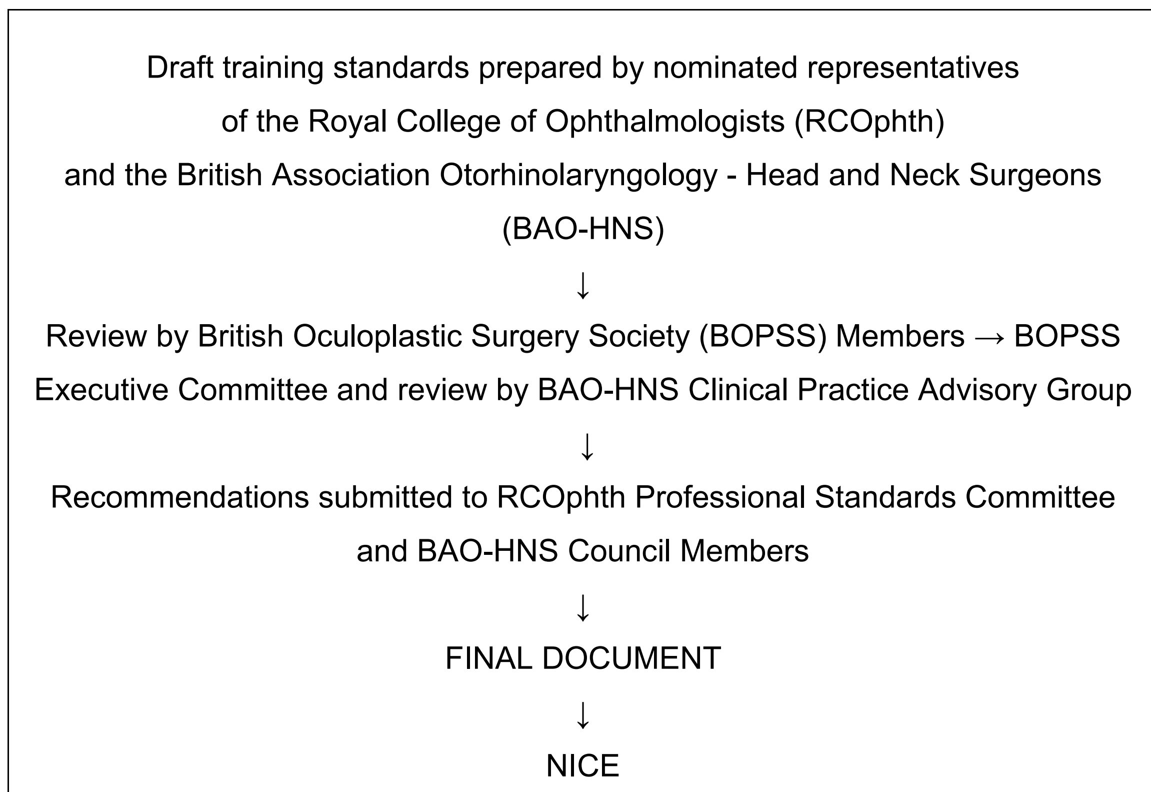
- Endoscopic endonasal DCR (EN-DCR) is now an established technique
- Both Ophthalmologists and Otorhinolaryngologists perform EN-DCR
- NICE have recommended that formal education and teaching courses need to be established and publicized

Aims:

- Consultants undertaking EN-DCR as a new procedure must be competent in performing the new technique
- The competence can be demonstrated by either attending a structured course or by assisting a competent practitioner until trusted by that mentor to operate independently

Pre-CCT core training is considered in a separate document in preparation by the British Oculoplastic Surgery Society (BOPSS) and the RCOphth. Similarly core training for pre-CCT Otorhinolaryngologists is not included in this document.

Joint Document Procedure:



Training Standards

These training guidelines for endonasal DCR (EN-DCR) are for Ophthalmologists and Otorhinolaryngologists who have not been trained previously in such procedure. This document is not directed at the Consultants who already practise endonasal DCRs

1. Trust Level

2. Patients

3. Training

4. Clinical Audit

1. Trust Level

Prior to embarking on endonasal dacryocystorhinostomy (EN-DCR) Consultants should seek approval from the relevant Clinical Director or Lead Clinician for the Directorate or Lead Clinician for the Specialty

2. Patients

The patient's interests should be considered paramount. Ensure that patients and their relatives / carers are aware that EN-DCR is a newly introduced practice before seeking consent and that the established practice of external DCR is fully explained. Inform them of the published outcomes for surgery prior to obtaining their agreement to proceed with EN-DCR

3. Training

Besides learning the surgical skill of EN-DCR the Consultant should have a sound lacrimal and endoscopic foundation, know the outcome measures for DCR surgery and how to deal with surgical complications.

i) Education

a. Lacrimal:

Ophthalmologist:
Lacrimal training for the Ophthalmlogist already forms part of the core higher surgical oculoplastic training.. Selection of patients for EN-DCR is

usually done initially by the ophthalmologist. The Ophthalmologist already does the pre- and post-operative evaluation of lacrimal patients i.e existing external DCR patients, including basic nasal endoscopy techniques.

Aetiology of watering eyes, difference between hypersecretion and epiphora, pre-operative and post-op evaluation of lacrimal patients, history taking, clinical assessment, syringe and probing techniques, radiological imaging, management plans including other causes of lacrimation and epiphora, e.g. punctal abnormalities, lid malposition, canalicular disease, surgical anatomy of the lacrimal system.

Otorhinolaryngologist:
The Otorhinolaryngologist should have a sound understanding of the assessment of epiphora, indications for surgery and lacrimal anatomy.

The final decision for EN-DCR may be made jointly by the ophthalmologist and otorhinolaryngologist.

b. Endoscopic:

Ophthalmologist:
As for rhinology curriculum with step-by-step improvement, observation in rhinology clinic, knowledge of intranasal anatomy.

Use of the rigid endoscope for nasal assessment and recognition of nasal anatomical variations / common nasal pathology. Observation of endoscopic Jones dye tests. Perform bimanual techniques with handling of a second instrument, removal of tubes endonasally. *Endonasal examination and removal of tubes already form part of the core Ophthalmology training.*

Perform basic endonasal procedures (under either ENT or oculoplastic trainer) supervision, and then proceed to advanced procedures including EN- DCR.

Otorhinolaryngologist:
Endoscopic training for the Otorhinolaryngologist already forms part of the core of higher surgical training.

Nasal surgery forms part of the core ENT training as does the diagnosis and treatment of any nasal or sinus pathology that might adversely affect outcome of EN-DCR surgery (e.g. Deviated nasal septum or sinusitis), and could be dealt with at the same time.

Ophthalmologists and Otorhinolaryngologists:

- Familiar with endoscopic endonasal instruments
- Principles of DCR surgery, its indications and limitations, and EN-DCR surgical steps
- Management of complications including migration of stent, nasal bleeding, nasal synechiae, peri-rhinostomy granuloma and closure of lacrimal window

ii) Courses and Mentors

Obtain training in EN-DCR by attending surgical courses and visiting other centres of excellence.

- Observe videos and live surgery of EN-DCR
- Cadaver heads for surgical practice
- Surgical practice to be built up gradually under supervision of a mentor, either ENT or oculoplastic trainer
- The first EN-DCR operation by the Consultant in the Trust should be supervised by an otorhinolaryngologist or ophthalmologist who is competent in the procedure, either from the Trust or other institution.

iii) Instrumentation

Ensure that appropriate instrumentation is available in the operating theatre and in the out-patients for EN-DCR to be performed safely in the Trust by the Consultant

4. Clinical Audit

When EN-DCR is introduced by the Consultant for the first time, his/her results must be audited and progress reviewed in relation to published results.

The Consultant must apply minimal data for clinical audit including:

- Indications for surgery
- Outcome – symptoms, syringing and nasal endoscopic dye tests – see below.

Minimum data form for Endonasal Endoscopic DCR

Patient name: **Surgeons name:**

Hospital no.

Date of Birth: **Date if Operation**

Indications:	Epiphora / mucocoele / dacryocystitis
Laterality:	Right / Left / Bilateral
Level of obstruction:	sac /nasolacrimal duct/ functional nasolacrimal duct
Anaesthetic:	General / Local
Complications per-op:	Nose bleed * / peri-orbital haematoma / orbital fat exposure / orbital penetration / Other :
Complications post-op:	Nose bleed necessitating admission, diplopia temporary / permanent . other :
Outcome at 6 months:	Relief epiphora (complete, partial, none) Syringing patent / blocked (Functional endoscopic dye test +ve / -ve)

(* Needs nasal packing / repacking in recovery, ward or accident and emergency department –

Reference: Good Medical Practice by Royal College Surgeons
Clinical Governance by Royal College Ophthalmologists

Prepared by
Jane Olver, Consultant Oculoplastic Surgeon, (RCOphth and British Oculoplastic Surgery Society - BOPSS) and Matthew Yung, Consultant Otolaryngologist and Head and Neck Surgeon, (BAO-HNS)

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