

Evidence Summary

Clinical rationale and source guide for physician review

This companion explains the evidence behind the revised PCC and PEd handouts. It covers the 20 original documents plus the new, separate branchial-cleft cyst sheet. Patient handouts remain one or two pages; clinical references are collected here to keep them readable.

This is a targeted literature assessment, not a systematic review of every database or a legal validation of consent. Guidelines and trials inform treatment selection; product monographs inform medication use; hospital leaflets support practical aftercare wording. Each source has different limits. Published complication rates are not the clinic's audited rates. The documents are prepared for the physician's review before clinical use.

Tonsil surgery and pediatric sleep

Applies to: Tonsil Adenoid Turbinoplasty PCC; Adults Tonsillectomy PCC; TAT PEd; bleeding advice in UPPP.

The 2019 pediatric tonsillectomy guideline recommends counseling about persistent/recurrent sleep-disordered breathing and overnight monitoring for children under 3 or with severe OSA (AHI at least 10 events/hour or oxygen nadir below 80%). It supports acetaminophen/ibuprofen for postoperative pain and does not support routine perioperative antibiotics. The handout points to an individualized written dosing plan.

PATS (2023 randomized trial, 459 children with snoring and mild sleep-disordered breathing) found no significant benefit on its primary executive-function/attention outcomes at 12 months, although symptoms, behavior and quality of life improved. This supports balanced counseling and observation in selected mild cases; it does not mean surgery is ineffective for severe OSA.

NATTINA (2023 adult randomized trial) supports tonsillectomy for selected recurrent acute tonsillitis. It does not establish equivalent benefit for stones alone. Reported bleeding in 19% of operated participants is an any-bleeding outcome, not a return-to-theatre rate. V2 removes misleading reassurance about small throat bleeds and directs emergency assessment even when bleeding stops. Royal Cornwall provides an example of that practical aftercare approach.

Sources: [\[1\] 2019 pediatric tonsillectomy guideline](#); [\[2\] NATTINA randomized trial](#); [\[3\] Royal Cornwall's adult advice](#); [\[6\] PATS randomized trial](#)

Palatal surgery and snoring

Applies to: Tonsillectomy UPPP PCC; Snoring PEd.

AASM 2021 guidance recommends objective follow-up sleep testing after non-PAP treatment of established OSA. Improvement in snoring does not establish cure. V2 includes repeat testing after healing and an individualized perioperative CPAP plan.

The 2023 Australasian primary-snoring position statement supports individualized conservative measures, oral appliances and selected procedural options. Definitions and study populations vary, including some with AHI below 15; findings cannot all be assumed to concern strictly negative-study primary snoring. The numbered handout is not a mandatory treatment ladder.

AASM diagnostic guidance (2017) recommends polysomnography after a negative, inconclusive or technically inadequate home sleep apnea test when OSA is being investigated. The handout prompts reassessment for persistent concerning symptoms; it does not label every snorer with a negative study as having OSA.

The Cochrane myofunctional review (2020) found small studies with variable certainty and limited follow-up. Snoring-intensity benefit is more plausible than a guaranteed reduction in snoring frequency.

V2 retains exercises as an option with variable response. Nonablative palate-laser evidence is less established for long-term durability than its promotional claims may suggest.

eXciteOSA is daytime tongue stimulation for adults with snoring or mild OSA; it is not a substitute for treatment of moderate/severe OSA. FDA clearance, Canadian instructions and manufacturer updates describe indication and suitability, not comparative superiority. Older metal-dental-work exclusions changed in the US in 2023; suitability should follow current local labeling. The previous sale price was removed because it was retailer-specific and unstable; obtain a current quote and maintenance costs.

Sources: [\[4\] AASM longitudinal guidance](#); [\[5\] primary-snoring guidance](#); [\[34\] AASM diagnostic guidance](#); [\[36\] Cochrane 2020 review of myofunctional therapy](#); [\[37\] FDA eXciteOSA clearance and indication 2024](#); [\[38\] eXciteOSA Canadian instructions for use](#); [\[39\] Signifier dental contraindication update 2023](#)

Pediatric nasal procedures

Applies to: TAT PEd; Tonsil Adenoid Turbinoplasty PCC.

The 2024 pediatric inferior-turbinate consensus supports diagnosis-based, individualized management. It is expert consensus with a heterogeneous evidence base, not proof that every child having adenotonsillectomy benefits from turbinate reduction. V2 retains case-by-case selection and requires the possible procedure to be discussed beforehand.

Sources: [\[7\] 2024 consensus](#)

Nasal medications and rinse safety

Applies to: Nasal Steroid Spray PEd; FESS; nasal adjuncts in Snoring PEd.

Canadian Nasonex labeling supports indication- and age-specific use. Nasal steroids are generally safe when used correctly, but dryness, epistaxis, ulceration and rare septal perforation are relevant. “Never damages the lining” was too absolute. Technique should direct spray away from the septum.

Canadian Pulmicort Nebuamp labeling is for inhalation; nasal irrigation is off-label. The 2018 randomized budesonide-irrigation trial supports possible symptom benefit in CRS but does not validate every dose, duration or subgroup. V2 separates prescribed rinses from ready-to-use sprays and leaves the actual dose/mixing plan to the prescriber.

FDA rinse-safety advice supports distilled, sterile or previously boiled-and-cooled water and device cleaning. Oxymetazoline labeling limits use to 3 days because prolonged use can cause rebound congestion. US ipratropium labeling includes scheduled dosing, so a blanket “as-needed only” rule was inappropriate. Canadian product instructions remain the prescribing authority.

Sources: [\[8\] Canadian Nasonex monograph](#); [\[9\] Canadian product monograph](#); [\[10\] budesonide-irrigation trial](#); [\[11\] oxymetazoline labeling](#); [\[12\] US ipratropium 0.03% labeling](#); [\[35\] FDA](#)

Ear drops and tube care

Applies to: Ear Drops PEd; Tympanostomy tubes PCC.

Canadian Ciprodex patient information supports warming/shaking the bottle, correct positioning and tragal pumping for tube-associated infection. The prescription determines dose and duration. US DermOtic labeling identifies refined peanut oil and a limited treatment course; Canadian formulation and allergy suitability must be checked rather than assumed identical.

The 2022 tympanostomy guideline applies to children. Recurrent acute otitis media generally requires effusion at candidacy assessment; persistent effusion is evaluated with duration, hearing and attributable symptoms. Earlier individualized assessment may be appropriate for children at developmental risk. Hearing improvement does not guarantee language improvement.

The guideline recommends review within 3 months, no routine prophylactic water precautions, no routine postoperative antibiotic drops, and topical antibiotic drops without oral antibiotics for uncomplicated acute

tube otorrhea. Complicated illness requires separate assessment. Adult tube indications are not identical to pediatric criteria.

Sources: [\[13\] Canadian patient information](#); [\[14\] US DermOtic label](#); [\[15\] 2022 guideline](#)

Eardrum repair

Applies to: Myringoplasty PCC; Cartilage Tympanoplasty PCC.

The 2023 reconstruction systematic review shows outcome variation by patient and surgical factors. Formal graft tympanoplasty findings should not be converted into a universal office-patch success rate. The older AAO-HNS tympanoplasty indicators are useful for procedural distinctions and hearing follow-up, not contemporary local complication percentages.

V2 distinguishes a paper/Gelfoam patch from cartilage reconstruction, and eardrum closure from hearing improvement. It adds side, graft/packing details, postoperative hearing assessment and explicit discussion of occasionally severe permanent hearing loss. A hearing aid improves hearing but does not close a perforation.

Sources: [\[16\] 2023 reconstruction review](#); [\[17\] AAO-HNS tympanoplasty indicators](#)

Nasal cautery

Applies to: Nasal Cautery PEd.

The 2020 epistaxis guideline supports further evaluation for bleeding that recurs after treatment or repeatedly occurs on one side. Hospital aftercare advice varies on compression intervals: Dorset uses a 20-minute brisk-bleeding threshold, whereas other pathways allow repeated compression. V2 retains the original two 15-minute cycles for lesser persistent bleeding, with an explicit emergency override for heavy bleeding, faintness or breathing difficulty.

NHS aftercare supports small amounts of moisturizer at the front of the nostril for a short course. This is different from deep or prolonged petroleum use. Restarting prescription sprays is individualized rather than automatically withholding all sprays for two weeks.

Sources: [\[18\] Dorset's advice](#); [\[19\] epistaxis guideline](#); [\[20\] NHS aftercare](#)

Functional nasal and sinus surgery

Applies to: Functional nasal surgery PCC; Functional endoscopic sinus surgery PCC.

NAIROS (2023 randomized trial, 378 adults with at least moderate obstruction and septal deviation) found septoplasty more effective than a defined nasal steroid/saline regimen. It does not establish equal benefit from every reconstruction technique or justify automatic turbinate surgery. V2 selects each component and identifies donor sites and related risks.

The 2025 surgical CRS guideline requires an established diagnosis and individualized assessment; a fixed prerequisite medication course is not mandated for every patient. Surgery improves access and disease management but does not remove the inflammatory tendency. The 2025 adult sinusitis update adds education about biologics for eligible nasal-polyp disease after prior treatment failure or when surgery is not viable.

V2 separates optional nasal reconstruction from sinus risks and emphasizes urgent assessment for visual change, concerning clear drainage or neurologic symptoms. Skull-base injury can lead to CSF leak and intracranial infection. These are serious consent disclosures; the handout does not estimate a personal risk from mixed-procedure studies.

Sources: [\[21\] NAIROS randomized trial](#); [\[22\] 2025 surgical CRS guideline](#); [\[23\] 2025 adult sinusitis guideline](#)

Thyroid and parathyroid surgery

Applies to: Thyroid Surgery PCC; Parathyroidectomy PCC.

The ATA patient summary of its 2025 differentiated-thyroid-cancer guidance describes an expanded role for lobectomy and selected active surveillance. This is a patient-facing summary, not the full surgical guideline; individual extent and nodal treatment still require diagnosis-specific assessment. Radioiodine is not needed for every cancer.

The Fifth International Workshop (2022) distinguishes biochemical diagnosis of primary hyperparathyroidism from imaging used for localization. Its primary-disease recommendations should not be applied wholesale to renal secondary/tertiary disease. V2 explicitly separates these groups, planned extent and calcium-support needs.

V2 replaces vague calcium monitoring with fields for supplementation, symptom action, test timing and the responsible team. Rates of permanent hypocalcemia or voice injury depend on operation and patient group. Emergency neck swelling and rare bilateral vocal-fold dysfunction are distinguished from same-day calcium or wound concerns.

Sources: [\[24\] 2025 ATA guidance](#); [\[25\] Fifth International Workshop guideline](#)

Salivary gland surgery

Applies to: Submandibular gland excision PCC; Parotidectomy PCC.

An older 139-patient submandibular cohort reported xerostomia in 22.1%. This is not a local risk estimate, but it argues against dismissing persistent dryness after unilateral removal. V2 qualifies reassurance and distinguishes a seroma from a saliva collection/leak.

ASCO 2021 salivary malignancy guidance supports nerve preservation when oncologically appropriate, with resection considerations for involved nerves. A superficial benign operation and deep/total cancer surgery should not share an unqualified risk statement. V2 identifies extent and any pre-discussed nerve/neck procedure.

AAO-HNS parotid indicators and Ohio State aftercare support explicit eye-protection planning when closure is impaired. First-bite pain, saliva collection/leak and contour effects are included. Institutional patient material supports practical counseling; it is not an incidence study.

Sources: [\[26\] older 139-patient cohort](#); [\[27\] ASCO salivary malignancy guidance](#); [\[28\] AAO-HNS indicators](#); [\[29\] Ohio State's patient sheet](#)

Neck dissection and branchial cleft surgery

Applies to: Neck Dissection PCC; Branchial Cleft Cyst Excision PCC.

The 2017 adult neck-mass guideline says a cystic mass at risk for malignancy should be evaluated until a diagnosis is obtained, rather than presumed benign. This is why V2 separates branchial-cyst surgery from oncologic nodal dissection and removes infection alone as a neck-dissection indication.

MedlinePlus describes excision after treatment of active infection. The 2022 systematic review of second-branchial cyst techniques and a 2026 first-branchial series illustrate variable anatomy, recurrence and nerve risks; findings from one cyst type cannot be generalized to all. The new sheet identifies the lesion type, side, nearby structures and contingencies. It avoids a universal recurrence percentage.

Sources: [\[30\] adult neck-mass guideline](#); [\[40\] Branchial cyst patient information MedlinePlus](#); [\[41\] Second branchial cyst surgical systematic review 2022](#); [\[42\] First branchial cleft surgery case series 2026](#)

Skin cancer and laryngeal cancer

Applies to: Skin Ca PCC; CO2 Laser Partial Laryngectomy PCC.

NCI PDQ summaries are regularly maintained evidence syntheses. Melanoma excision and nodal assessment depend on tumor features; topical treatment and observation are not equivalent alternatives for invasive disease. Basal/squamous cancer options differ. V2 records diagnosis, lesion site, likely

closure/donor sites and immediate versus staged reconstruction, with sentinel-node planning when indicated.

NCI laryngeal guidance supports stage- and site-dependent selection among transoral surgery, radiation and open procedures. V2 distinguishes cordectomy from supraglottic resection, functional expectations and inadequate-exposure contingencies. Tissue may be removed in one or more pieces; margin uncertainty and subsequent treatment remain explicit.

Sources: [\[31\] NCI melanoma guidance](#); [\[32\] NCI nonmelanoma guidance](#); [\[33\] NCI laryngeal guidance](#)

Clinic review before use

Confirm the selected procedures, sites, contingencies, analgesia and calcium plans, blood-test ownership, pathology tracking and postoperative CPAP instructions. Fill patient-specific fields at consultation or discharge; these are intentionally not universal prescriptions.

Confirm local admission criteria, restrictions and emergency pathways against the hospital discharge instructions. Office hours were not independently established. The phone number 306-974-2676 is supported by the CPSS and University of Saskatchewan profiles; confirm it is the preferred patient-contact number.

Use audited local complication figures only when the endpoint, denominator, procedure and follow-up are clear. Any bleeding, emergency attendance, admission and return to theatre are different outcomes.

All copies carry Version 2.0 and a review date. The TAT illustrations were retained from the original document; this evidence summary does not add new image permissions or claims of ownership. Recheck drug/device labeling and commercial costs when updating the sheets.

Linked resource list

The following are the clinical and operational resources used in the review and V2 revisions. Search results not relied upon are excluded. Clinical implications and limitations are summarized above.

[\[1\] 2019 pediatric tonsillectomy guideline](#)

[\[2\] NATTINA randomized trial](#)

[\[3\] Royal Cornwall's adult advice](#)

[\[4\] AASM longitudinal guidance](#)

[\[5\] primary-snoring guidance](#)

[\[6\] PATS randomized trial](#)

[\[7\] 2024 consensus](#)

[\[8\] Canadian Nasonex monograph](#)

[\[9\] Canadian product monograph](#)

[\[10\] budesonide-irrigation trial](#)

[\[11\] oxymetazoline labeling](#)

[\[12\] US ipratropium 0.03% labeling](#)

[\[13\] Canadian patient information](#)

[\[14\] US DermOtic label](#)

[\[15\] 2022 guideline](#)

[\[16\] 2023 reconstruction review](#)

[\[17\] AAO-HNS tympanoplasty indicators](#)

[\[18\] Dorset's advice](#)

[\[19\] epistaxis guideline](#)

- [\[20\] NHS aftercare](#)
- [\[21\] NAIROS randomized trial](#)
- [\[22\] 2025 surgical CRS guideline](#)
- [\[23\] 2025 adult sinusitis guideline](#)
- [\[24\] 2025 ATA guidance](#)
- [\[25\] Fifth International Workshop guideline](#)
- [\[26\] older 139-patient cohort](#)
- [\[27\] ASCO salivary malignancy guidance](#)
- [\[28\] AAO-HNS indicators](#)
- [\[29\] Ohio State's patient sheet](#)
- [\[30\] adult neck-mass guideline](#)
- [\[31\] NCI melanoma guidance](#)
- [\[32\] NCI nonmelanoma guidance](#)
- [\[33\] NCI laryngeal guidance](#)
- [\[34\] AASM diagnostic guidance](#)
- [\[35\] FDA](#)
- [\[36\] Cochrane 2020 review of myofunctional therapy](#)
- [\[37\] FDA eXciteOSA clearance and indication 2024](#)
- [\[38\] eXciteOSA Canadian instructions for use](#)
- [\[39\] Signifier dental contraindication update 2023](#)
- [\[40\] Branchial cyst patient information MedlinePlus](#)
- [\[41\] Second branchial cyst surgical systematic review 2022](#)
- [\[42\] First branchial cleft surgery case series 2026](#)
- [\[43\] CPSS physician profile and clinic telephone](#)
- [\[44\] University of Saskatchewan clinic contact](#)