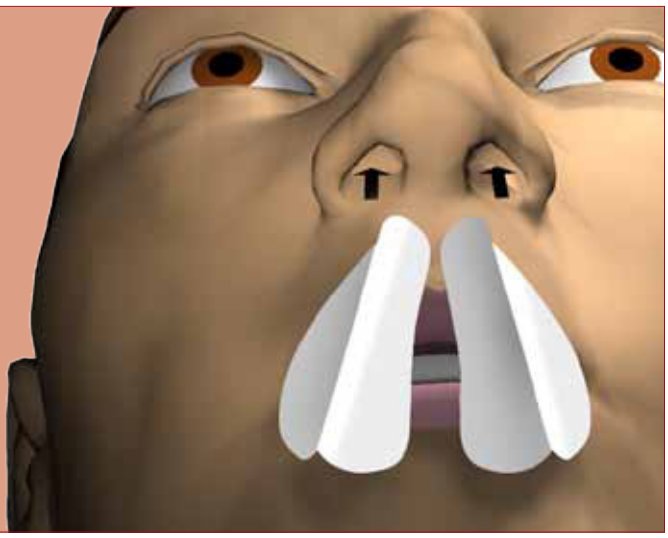
Nasal Valvular Splint for Septoplasty and Functional Rhinoseptoplasty

The splints grant surgical success despite elastic memory of deviated nasal septum and in case of valve stenosis

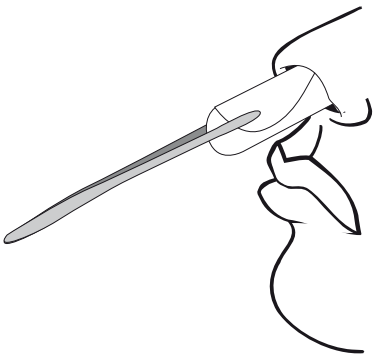


Audio septal-valvular splints are made in polypropylene, a bio inert material which can remain in the nose for all the time required for the post-surgery recovery. The splints prevent the tissue to shift the septum in the pre-surgery position because of its elastic memory. The splints also prevent stenosis scars of the valves (pic 1).

Each box contains a pair of sterile and pre-folded right and left splints. The nasal-valvular fold can be adjusted with forceps or a needle holder. The splint can be cut to the desired length to achieve easy nasal insertion (pic 2).
Once placed, the splint is fixed by one or two transfixed suturing points (pic 3): the polypropylene will not break and will not impair the passage of the surgical needle. To maximize the aesthetic result, it's suggested to use tampons Stip 75208F or Stip 75215F.

The splint can stay in place for 7/10 days, unless it causes discomfort to the patient. If so, it can be easily removed by cutting the transfixion sutures and slowly slipped off. Protect the nostril edge to prevent the splint sheet from cutting the skin. To ease splint removal it's possible to use topic anesthetic, cut the splint and remove it in pieces. Warn the patient that the splint can form scabs, which will be removed definitively when the device will be removed.

The splint can be tailored with scissors



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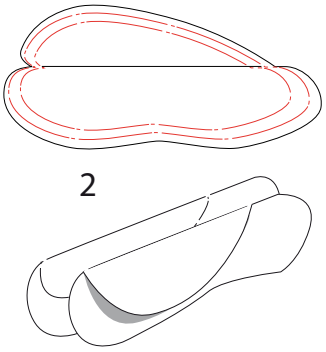

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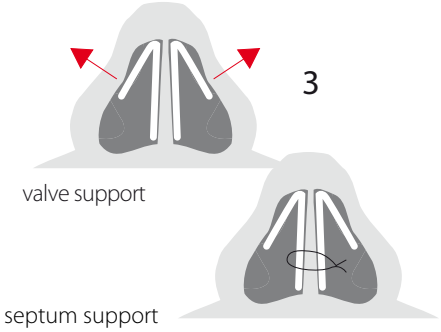
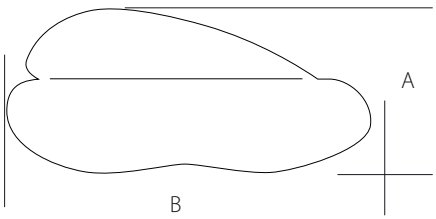


CODE		A mm	B mm
FB 65/85 LL	extra large	33	73
FB 55/70 L	large	28	55
FB 50/65 M	medium	26	52
FB 45/60 S	small	24	50

Two pieces in each envelope (R+L). 10 envelopes in each box



Nasalvalvular Splint for Nasal and Ethmoid Surgery

CODE MM

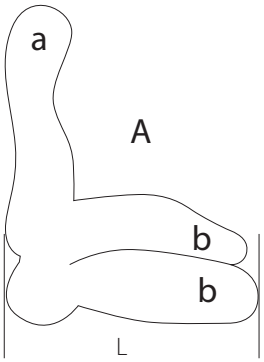
Device to immobilize the nasal septum and avoid adherences during surgery in the ethmoid region

The splint is made of a bioinert polymer There isn't a standard time for the device to remain in place. However, it's suggested to keep the splint in the nose for 2-3 weeks; this period can vary depending by the extent of the injured mucosa which has been operated in the rhino-sinus surgery. Weekly controls are needed to check the correct position of the device and prevent possible complications. Early removal of the devices is recommended in cases of high patient's discomfort.

The splint should be sutured to the nasal septum with one or two transfixing points. The use of a topic anesthetic is recommended during the removal.

CODE		L mm
MM 75 L	large	75
MM 70 M	medium	70
MM 65 S	small	65

Two pieces in each envelope (R+L). 10 envelopes in each box



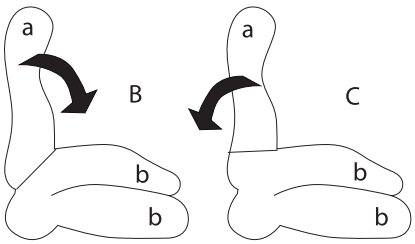
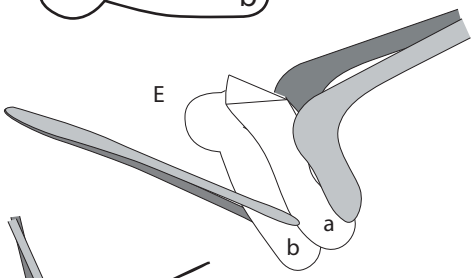
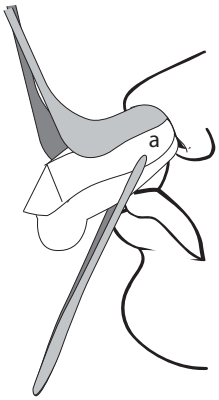
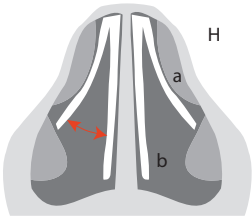


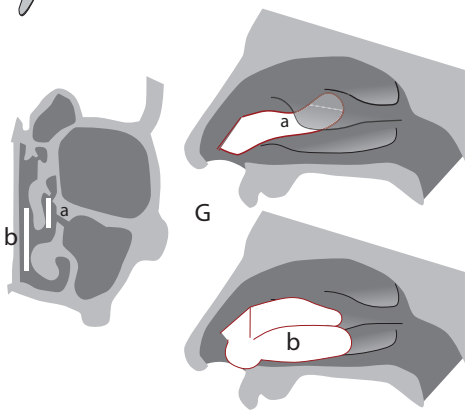
Table illustrating the correct positioning of the device

Figure A: septal-valvulo-middle-meatus lamina (SVMM): lateral wing (a), medial-paraseptal wing (b)
Figure B: lateral wing (a) is folded on to medial-paraseptal wing (b)
Figure C: a second fold on the lateral wing (a) allows the creation of the valvular portion, to support the triangular cartilage.
Figure D: the 2 folds created form a suitable angle, that can vary depending on the anatomic conformation of the lateral wing (a), which allows it to penetrate the middle meatus and the ethmoid cavity, if required.
Figure E: bayonet forceps and nasal speculum required to introduce the device.
Figure F: positioning the device in the left cavity.
Figure G: crown section of the nasal cavity and paranasal sinuses (ethmoid) of the left which shows where the device must be placed. The forceps are used to guide the extremity of the lateral wing through the middle meatus.
Figure H: maintenance of internal nasal valve angle by the device.









Note:
The left lamina is fixed to the right controlateral, positioned with a similar procedure, using a trans-septal 3-0 nylon suture secured by at least 4 knots. To take out the device cut and remove the trans-septal nylon suture, separate the lateral wing from the medial-paraseptal wing cutting it with scissors for its full height along the front fold (below the triangular cartilage) and then remove (slipping them out one at a time and gripping them with forceps or a small Klemmer) the lateral wing (a) followed by the medial-paraseptal wing (b). If necessary, reduce the dimensions of the single portions of the lamina to adapt it to the individual anatomic conformation. Keep wing edges consistent or rounded to avoid possible causes of decubitus.

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