UVULECTOMY

WHY DO I NEED THIS PROCEDURE?

This is a surgery that is often done in for relief of snoring. Often times an uvulectomy is done in conjunction with a tonsillectomy as well as other possible procedures to help resolve the snoring complaints. This surgery consists of modification and/or removal of the uvula which is the small piece of tissue dangling between the tonsils in your throat.

WHAT IS THE FUNCTION OF THE UVULA?

It is said that the uvula’s main function is to clean the mucous and post nasal drainage that exists in the posterior portion of the nasopharyngeal area. This is often cleaned by retroversion of the uvula. With symptoms of chronic snoring, the uvula is often elongated and as a result may also be touching the larynx causing throat irritation as well.

WHAT HAPPENS DURING SURGERY?

This surgery is done through your mouth. Often times, the tonsils are removed at the same time. The length of the uvula will be measured and if necessary, an appropriate amount of redundant tissue will be excised.

WHAT ARE POSSIBLE RISKS AND COMPLICATIONS OF THE SURGERY?

There are minimal complications during the operation. However, the surgery is somewhat painful and thus appropriate medication will be provided during the procedure. You may also experience a foreign body sensation after the operation due to a collection of mucous and phlegm.

WHAT TO EXPECT AFTER SURGERY?

Treatment during the recovery is simple. Ice chips and frozen yogurt are often helpful after the surgery. Things like potato chips or pretzels are not recommended. The recovery period is approximately 10-14 days.

IT IS MANDATORY TO BRING A FAMILY MEMBER OR FRIEND WITH YOU TO THE PREOPERATIVE VISIT. THIS IS BECAUSE PATIENTS, AFTER THE SURGERY, DUE TO THE GENERAL ANESTHESIA MAY FORGET THE INFORMATION PROVIDED TO THEM BEFORE THE SURGERY.

PLEASE SIGN AND RETURN THIS FORM TO OUR OFFICE WHEN YOU COME FOR YOUR PREOPERATIVE VISIT.

Please feel free to contact our office with any questions you might have at 714-441-0133.
UVULECTOMY

Respectfully yours,

JAMES J. LEE, M.D., F.A.C.S.

I understand the above information and consent to the surgery.

______________________________________
Patient Signature

______________________________________
Patient Name-Printed

______________________________________
Date