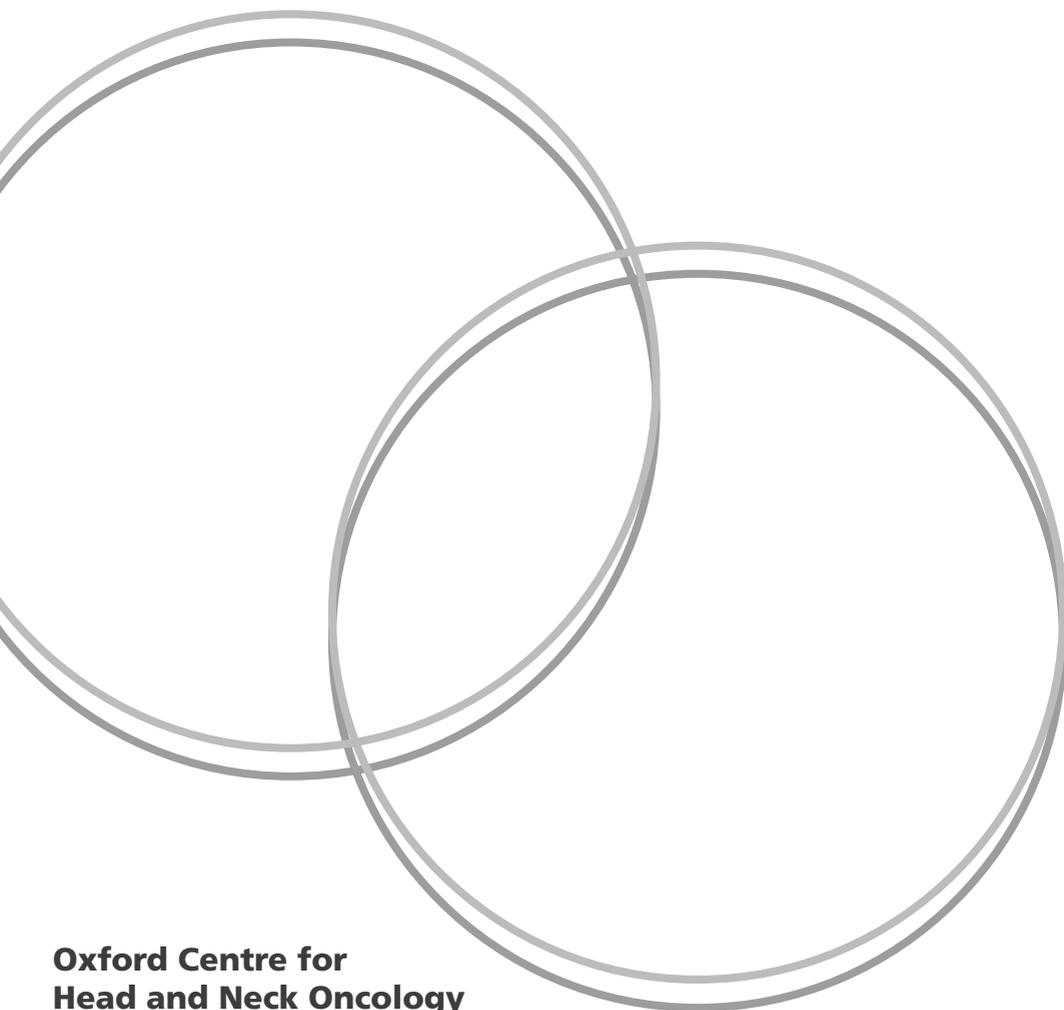




Oxford University Hospitals
NHS Foundation Trust

Maxillectomy and Partial Maxillectomy

Information for patients



Oxford Centre for
Head and Neck Oncology

Introduction

This booklet has been written to give you information about having maxillectomy surgery. This may include one or a combination of the following operations:

- maxillectomy with split skin graft and obturator
- partial maxillectomy to remove part of the maxilla
- maxillectomy (removal of the whole maxilla) with bone or soft tissue reconstruction.

The aim of this leaflet is to answer the questions most people having maxillectomy surgery will ask. If you need more detailed information your health care team will be happy to help. We hope that you will find the information helpful and reassuring.

What is a maxillectomy?

The upper jaw is known as the maxilla. A maxillectomy is an operation to remove a primary tumour in this area. Your surgeon will need to cut through your upper jaw (maxilla) to remove the tumour.

The operation involves removing of some of the bone in your maxilla, part of the roof of your mouth, and possibly some of your teeth. This will allow your surgeon to remove the tumour and a margin of healthy tissue around it.

The operation will leave a gap in the roof of your mouth which will need to be sealed so that you can speak and swallow. We can replace the soft tissue in your mouth by using a split skin graft. This uses the top layer of an area of your skin to line inside of your maxillectomy wound. We may also use an obturator (device to fill the gap), or bone and soft tissue from elsewhere in your body.

What is a split skin graft?

This is an area of skin that is removed from elsewhere on your body (normally the thigh) and used to replace tissue which has been removed. The place where the skin comes from is known as the donor site; the place where it goes to is called the recipient site.

The donor site will look and feel like a large graze when the dressings come off, and will need to be treated similarly. You will need to thoroughly moisturise the area daily, once it has healed, and always use sunblock when it is exposed outdoors.

You may need part of your jaw to be replaced with bone taken from elsewhere in your body; this could be from your leg, hip, or shoulder blade.

What is an obturator?

An obturator is a device specially made to fit your mouth. It is put in during the operation. It works like a dental plate, to seal any gaps in the roof of your mouth and hold skin grafts in place. The obturator will help you to eat, speak and swallow as normally as possible.

After about 3 weeks, you will need brief procedure under a general anaesthetic to remove the obturator, clean the cavity and adjust the fit. You will have several outpatient appointments with a specialist called a restorative dentist to get the best long-term fit. Eventually you will be able to remove the obturator and clean it yourself, like a denture.

Advanced reconstruction

This uses free tissue (skin and/or bone) from another area of your body for reconstruction. If we think you will need advanced reconstruction we will discuss this with you and will give you a further leaflet to explain this procedure.

When will I be admitted for surgery?

You will be asked to come for an appointment in the pre-assessment clinic before your surgery. During this appointment we will assess your fitness to undergo a major operation.

You are likely to be admitted on the day of surgery via the day surgery unit. Sometimes, if you have other medical conditions you may need to come before this. You are likely to stay in hospital for 1 to 3 weeks after the operation, depending on the type of surgery that you have had.

What happens after the operation?

After the operation you will be taken to the Recovery Area, where you will gradually wake up from the anaesthetic. You may have a face mask which will give you oxygen to help you recover more quickly.

During the operation you may have had a urinary catheter inserted. This is a narrow tube which is inserted into your bladder through your urethra. It can be used to monitor your fluid output, depending on the length of the operation and your general fitness.

If you have had a neck dissection (an operation to remove disease in your neck) you will also have two or three drainage tubes coming out through your skin on your neck, to remove any excess body fluids. (See our separate booklet about this operation.)

These drains will be removed a few days after the operation. If you have had more extensive surgery, you will have a number of stitches and possibly clips (staples) in your skin; these will usually be removed a week after the operation.

To protect your airway and help you breathe after the operation, it is sometimes necessary to insert a tracheostomy tube. This is a tube which is put into your windpipe (trachea) through a hole in your neck during the operation. It will remain in for about a week or until the swelling goes down. During this time your nurse or physiotherapist will use a fine tube to remove any chest secretions from the tracheostomy tube. Initially you will not be able to speak with the tube in place, but you can use a pen and paper for a few days to communicate with others.

If your surgeon needs to remove one of the large muscles from your neck, it will look a little flatter on this side.

You may also have a tube inserted in your nostril/s to help you breathe through your nose. This may be left in for 24 to 72 hours after the operation.

Will I have any pain post-operatively?

During the operation, if we need to make a cut through your skin, the nerve supply to your skin will be affected; this will leave an area of numbness. This means that you are not likely to have as much pain as you may expect after the operation.

To help control your pain you may have a hand held device to use, which will deliver you a measured dose of pain relief medication. This system is known as patient controlled analgesia (PCA) and your nurse will show you how it works.

Will I have a scar?

A partial maxillectomy is normally carried out from inside the mouth.

If your surgery is more extensive, you may have a scar which goes from your top lip and along the side of your nose.

If we need to make a cut through your upper lip you may have a scar that goes up and along the side of your nose. If you also have a neck dissection during your maxillectomy, to look for and remove any disease in your neck, you will also have a neck scar (see separate information booklet). We will try to make all the cuts in your natural skin creases, so they are less obvious. They will also fade in time.

If you are uncomfortable about the appearance of any scars or marks, the charity 'Changing Faces' has a service which can teach you how to camouflage marks effectively. Please ask your Specialist Nurse for details or visit www.changingfaces.org.uk/Skin-Camouflage.

What are the risks?

Infection

There is a risk of infection associated with any surgery. This could include a wound infection or a chest infection, which can develop if you remain still for long periods whilst you recover. You may be given antibiotics to help prevent infections from developing.

Numb skin

The skin of your neck may be numb after neck dissection or removal of lymph nodes. This will improve to some extent, but you should not expect it to return to normal, as some of the nerve damage will be permanent.

Haematoma

Sometimes blood can collect under the skin and form a clot (haematoma). Further surgery may then be needed to remove the clot. If this happens, we will need to keep you in hospital longer than originally planned.

Marginal mandibular nerve damage

This nerve is a branch of the facial nerve which supplies the facial muscles. If you have neck dissection, this nerve is at risk of being cut or damaged. Your surgeons will try hard to keep the nerve intact. If it is damaged, you will find that your lower lip will be a little weak. This will be most obvious when you smile. The speech and language therapist can suggest exercises and strategies that will help your lip to become stronger. Please be aware that if the nerves in your lip are damaged it won't ever completely return to normal.

Adjustment to tear duct

During the operation the surgeon may need to divide your tear duct. If this is necessary, your tears will then not drain away properly. To help them to drain and prevent a 'watery eye', a small tube known as a 'stent' will be placed in your tear duct. This can be easily removed in an Outpatients appointment approximately six weeks later.

Following surgery

The surgeon will give post-operative diet instructions to the team looking after you. For some of the operations, you will have a period of being 'nil by mouth'. This time period can vary and is decided by your surgeon. The reason for being 'nil by mouth' is to let the surgical wounds in your mouth or throat settle and heal without food or drink contaminating the area.

How will I be fed if I am not allowed to eat?

If it is anticipated that you will be 'nil by mouth' for a period of time, or that you will experience difficulties resuming intake by mouth, then you will be fed through a fine flexible plastic feeding tube which is placed through your nose, down the back of your throat and straight into your stomach. This is called a nasogastric or 'NG' tube.

If medium to longer term feeding is anticipated, you may have an alternative feeding tube placed.

Regardless of which type of feeding tube is present, specialised liquid nutrition will be given to you through the tube directly into your gastrointestinal tract, along with medications and water for hydration.

Your dietitian will make recommendations regarding the type and volume of liquid food given, and the nurses will administer it on the ward. Please let us know if you have any problems tolerating this liquid food and we shall help.

How will my mouth feel while I am not allowed to eat?

When people are 'nil by mouth', a common complaint is an unpleasant dryness in the mouth or thick, sticky saliva. The nurses will help support you with regular mouth care to keep your mouth clean and comfortable, and the use of rinses/swabs will help keep things moist.

You will be told by your surgical team when it is safe to resume brushing your teeth.

Speaking and eating after surgery

Surgical management of head and neck cancers has the potential to alter the way you eat and drink and speak. This may be due to post-operative pain or swelling, physical changes to your anatomy including reconstruction, dental extractions, or potential damage to nerves that support your eating and swallowing. Some of these changes are temporary and some can last longer.

Swallowing and speaking difficulties after surgery

These could potentially include:

- Difficulty chewing
- Difficulty swallowing
- Drooling and dribbling when eating
- The feeling of too much saliva in the mouth
- Difficulty moving and clearing food from the mouth
- Difficulty feeling food in the mouth
- Difficulty chewing due to dental extractions
- Risk of food and drink 'going down the wrong way'
- Food or drink escaping from your nose
- Difficulties producing certain speech sounds
- Difficulties making yourself understood.

The difficulties you will experience are very individual to you and the surgery you have undergone, and not everyone will experience these difficulties. If you wish to know more about these potential problems, please speak to a member of the Head and Neck Team who will be able to give you realistic expectations based on your individual treatment plan.

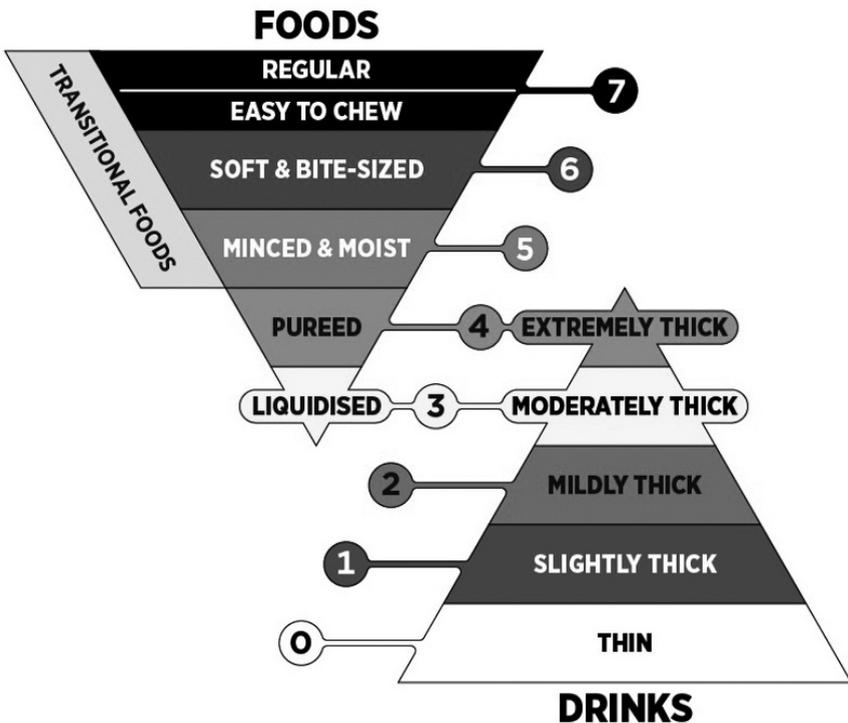
When can I start eating?

Once you are allowed to eat and drink, you may be given specific instructions on what you can eat by the surgical team and/or one of the speech and language therapy team.

You may be recommended a modified texture diet. For clarity, we use international terminology from IDDSI (International Dysphagia Diet Standardisation Initiative) to describe different food and fluid textures.

The IDDSI Framework

Providing a common terminology for describing food textures and drink thicknesses to improve safety for individuals with swallowing difficulties.



If you are advised to follow a modified diet, there are further information booklets available which will give you more guidance in these areas.

The leaflet 'Nutrition Support: Improving your protein and energy intake' contains more information on nutrition and practical tips to help support your eating and drinking' contains helpful, practical advice on nutrition following illness (including surgery).

The charity Macmillan has good, reliable information regarding diet and cancer treatment which can be found at www.macmillan.org.uk. Ask your dietitian if you would like a hard copy of any of the nutrition related Macmillan leaflets

When can I progress with my diet if I am on a modified texture diet?

Progression will be guided by input from the surgical team and/or speech and language therapists.

Oral nutritional supplements

If you are under the care of a dietitian they may suggest a regular intake of oral nutritional supplements. These are high-energy, high-protein enriched drinks. If you are advised to take these after your surgery, you will be given guidance on which product and what quantity to take. If you need these beyond your inpatient stay, you will be provided with a supply to go home with, and the dietitian will discuss with you regarding ongoing supplies as required.

If you do not require oral nutritional supplements but are not eating full meals, or feel you need a top up, you can buy oral nutritional supplements from a chemist or supermarket or alternatively, have homemade nourishing drinks.

Will I be given speech swallow rehabilitation exercises?

If you see the speech and language therapist they may give you rehabilitation exercises as appropriate for your needs.

Pain control at home

If you experience pain once you are home that is negatively affecting your food and drink intake, please take your pain killers as prescribed. If these are not sufficient, please speak to your GP for help regarding this

The information in this leaflet is for guidance only and does not replace personalised advice given to you by a member of our team.

Future nutrition and swallowing plans

If required, you will continue to receive input from the speech therapy and dietetic teams on an outpatient basis. This may either be at the surgical centre or locally. You may receive telephone or video support at home or attend the outpatient department. Please speak to your dietitian or speech therapist to know what will be planned in your case.

Will I need any other treatment?

The aim of the operation is to remove all the tumour and a margin of healthy tissue around the edge, to reduce the risk of cancer cells being left behind. This may not always be possible, due to the position of the cancer or the inability to see microscopic cancer cells that may have begun to form in some of the normal tissue. The laboratory will be able to see these cells under a microscope.

These results, together with other factors, will help your doctors to decide whether you need additional treatment, such as radiotherapy. You will be given the results (histology) of the tumour that is removed during the operation about two weeks after the surgery.

Questions or further information

If you have any questions or concerns, or need any further information, please contact the:

Head and Neck Cancer Specialist Nurses

Telephone: **01865 234 346**

(Monday to Friday, 8.30am to 4.00pm)

Further information

If you would like an interpreter, please speak to the department where you are being seen.

Please also tell them if you would like this information in another format, such as:

- Easy Read
- large print
- braille
- audio
- electronic
- another language.

We have tried to make the information in this leaflet meet your needs. If it does not meet your individual needs or situation, please speak to your healthcare team. They are happy to help.

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Oxford University Hospitals NHS Foundation Trust
www.ouh.nhs.uk/information



Making a difference across our hospitals

charity@ouh.nhs.uk | 01865 743 444 | hospitalcharity.co.uk

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