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S1-Leitlinie

Ösophagoskopie

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Deutsche Gesellschaft für Hals-Nasen-Ohren-Heilkunde,
Kopf- und Hals-Chirurgie e. V.

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Verfahren zur Konsensbildung
im Auftrag des Präsidiums entworfen und bearbeitet (Konsens im Delphi-Verfahren) von Dr. H. Schmidt, Prof. Dr. N. Stasche (Kaiserslautern), Univ.-Prof. Dr. C. Arens (Magdeburg)

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Inhalt

1 Methodische Vorbemerkung

Die Erstfassung der Leitlinie Ösophagoskopie wurde 1997 erstellt. Entsprechend den methodischen Empfehlungen zur Erarbeitung von Leitlinien für Diagnostik und Therapie der Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF) erfolgten Überarbeitungen 2004, 2009 und 2015.

Diese jetzige Aktualisierung der Leitlinie erfolgte durch o.g. Autoren. Es wurde eine umfassende, Literaturrecherche zum Themengebiet durchgeführt. Als Hauptinformationsquellen dienten dabei: Medline, Cochrane Library. Es wurde die internationale Literatur von 1960 bis 2020 erfasst. Als Suchwörter wurden "flexible Ösophagoskopie", "starre Ösophagoskopie", „Leitlinie", "flexible esophagoscopy", "rigid esophagoscopy" und „guideline“ eingesetzt.

Alle aktiven Beteiligten wurden um Stellungnahmen gebeten, die in diese Fassung eingearbeitet wurden, die Grundlage der Konsensuskonferenz vom 03.02.2021 war. Diese wurde coronabedingt als digitale Veranstaltung durchgeführt. Die Autoren der Leitlinie haben an der Konsensuskonferenz teilgenommen.

Die Leitlinie wurde dem Präsidium der Deutschen Gesellschaft für Hals-Nasen-Ohren-Heilkunde, Kopf- und Hals-Chirurgie (DGHNO-KHC) zugeleitet, das diese am 31.05.2021 angenommen hat.

2 Ziele der Leitlinie

Ziel dieser Leitlinie ist die Förderung einer qualitativ hochwertigen fachärztlichen Versorgung von Patientinnen und Patienten mit entzündlichen, verletzungsbedingten, angeborenen, degenerativen und tumorösen Erkrankungen, sowie Fremdkörpern im Bereich des Ösophagus. Da die Leitlinie Ösophagoskopie ein diagnostisches und therapeutisches Verfahren erfasst, verfolgt sie andere Intentionen als Leitlinien zu bestimmten Krankheitsbildern. Sie soll ärztlichem, pflegerischen und technischem Personal in überschaubarer Form eine Hilfestellung zu möglichen Indikationen, Komplikationen, Kontraindikationen und organisatorisch-technischen Abläufen im Arbeitsfeld der Hals-Nasen-Ohren-Heilkunde und seiner Grenzgebiete sein. Sie dient als Hilfestellung für die indikationsbezogene Auswahl des Instrumentes, seine Reinigung und Desinfektion und geht auf Verfahren der Sedierung und Anästhesie ein.

Besonderheiten, die bei der Ösophagoskopie im Zusammenhang mit der aktuellen Covid-19- Pandemie zu beachten sind, wurden in die Leitlinie aufgenommen.

Ebenfalls berücksichtigt wurden die Vorgaben der S2k Leitlinie: Qualitätsanforderungen in der gastrointestinalen Endoskopie (2015) sowie mehrere internationalen Leitlinien, die zur Ösophagoskopie im Zeitraum ab 2015 veröffentlicht wurden.

Dies soll in besonderem Maße zur Reduktion der assoziierten krankheitsbedingten Morbidität, zu einem rationellen Einsatz diagnostischer und therapeutischer Verfahren sowie zur Reduktion der krankheitsbedingten sozioökonomischen Faktoren beitragen. Angestrebt wird eine sinnvolle Diagnostik und Therapie auf dem derzeitigen Stand fachlicher Erkenntnisse. Eine lückenlose Darlegung aller

speziellen Behandlungsmaßnahmen und Indikationen der Ösophagoskopie liegt jedoch außerhalb der Möglichkeiten dieser Leitlinie. Hierzu wird auf bestehende Leitlinien auch anderer Fachgebiete und die spezifische Literatur verwiesen.

Die Leitlinie wurde konzipiert für die Anwendung im Rahmen der ambulanten und stationären fachärztlichen Versorgung und richtet sich daher im Speziellen an Fachärzte für Hals-Nasen-Ohren-Heilkunde bzw. deren nachgeordnete Ärzte in der Weiterbildung. Die Leitlinie dient nicht als Ersatz für Lehrbuchinhalte. Sie ist nicht in der Lage, die Kenntnisse des erfahrenen Untersuchers zu ersetzen. Die umfangreiche Literaturliste soll dem Nutzer die Möglichkeit geben, spezielle Fragestellung ohne großen Aufwand zu recherchieren.

3 Definition

Unter der Ösophagoskopie versteht man die direkte Betrachtung der Speiseröhre durch ein Endoskop zu diagnostischen und therapeutischen Zwecken.

4 Ziele der Ösophagoskopie

Die Ösophagoskopie ist ein gering invasives Verfahren, welches in der Hals-Nasen-Ohren-Heilkunde sehr häufig durchgeführt wird. Sie hat die diagnostische Betrachtung und die diagnostische und therapeutische Behandlung von entzündlichen, infektiösen, traumatischen, degenerativen und tumorbedingten Erkrankungen der Speiseröhre, sowie der Entfernung von Fremdkörpern, zum Ziel.

5 Instrumentarium

Die Ösophagoskopie kann als starre oder als flexible Untersuchung durchgeführt werden. Die Auswahl des Instrumentes richtet sich nach dem Alter des Patienten, der vorliegenden Indikation, aber auch nach der Ausstattung der durchführenden Institution und der Erfahrung des Untersuchers. Flexible Instrumente stellen heute für die Mehrzahl der Indikationen die erste Wahl dar und die Nutzung der virtuellen Chromoendoskopie ist sinnvoll. Möglichkeiten einer Video- und/oder Fotodokumentation sollten vorhanden sein und routinemäßig genutzt werden; vor allem pathologische Befunde sollten im Bedarfsfall in Bildform dokumentiert werden.

Die Vor und Nachteile starrer und flexibler Instrumente fasst die nachfolgende Tabelle zusammen.

	Vorteile	**Nachteile**
starre Instrumente, ggfs. Video HR	optimale Sicht proximal	technische Erfahrung notwendig
	bessere Sicht bis proximaler Ösophagus insbesondere Postkrikoid und Ösophagusmund	i.d.R. Narkose notwendig eingeschränkt bei HWS-Erkrankungen größere Perforationsgefahr
Flexible hochauflösende (HR-) Videoendoskopie	i.d.R. Lokalanästhesie geringe Belastung des Patienten u/o. Analgosedierung/Kurznarkose leichter erlernbar Einblick in Magen und Duodenum möglich	Kleine(re) Biopsien schlechtere Sicht (Postkrikoidregion)

Neue Verfahren, die auch in der HNO-Heilkunde Eingang finden, sind die diagnostischen Techniken der virtuellen Chromoendoskopie, die Endomikroskopie und die Vergrösserungsendoskopie. An therapeutischen Verfahren existieren neben der photodynamischen Therapie verschiedene Verfahren der Injektionstherapie und thermische Verfahren, (Hochfrequenzchirurgie, insbesondere Argonplasmakoagulation, die Anwendung unterschiedlicher Lasertypen) die Bougierung und Ballondilatation und die Einlage von Stents sowohl für die starre als auch für die flexible Ösophagoskopie. Auch die Einlage von transnasalen oder transabdominellen Ernährungs-Sonden (PEGs) gehören zu den therapeutischen Optionen.

6 Indikationen

Der Einsatz starrer und/oder flexibler Technik orientiert sich situationsabhängig an der Indikation und der Erfahrung des Untersuchers. Man unterscheidet zwischen diagnostischem und therapeutischem Eingriff. Häufige Indikationen sind mit Bewertung der Untersuchungstechniken in nachfolgender Tabelle dargestellt.

Indikation	**starr**	**flexibel**
Gastroösophagealer Reflux	o	xxx
Ösophagusverätzung	x	xxx
Ösophagitis (infektiös, Arzneimittel, Strahlen)	o	xxx
Motilitätsstörungen (Achalasie, Ring- u. Segelbildungen)	o	xxx
Zenkerdivertikel; diagnostisch	xx	xx
Zenkerdivertikel; therapeutisch	xx	xx
Ösophagusvarizen	o	xxx
Ösophagusperforation	x	xxx
Hypopharynxtumor; postkrikoid	xxx	x
Ösophagustumor; intrathorakal	x	xxx
Ösophagusfremdkörper	xx	xx
Ösophagusbougierung	xx	xx
Stenteinlage	x	xxx
postoperative Kontrolle	x	xxx
funktionelle Beurteilung	o	xxx
PEG-Anlage	o	xxx
Panendoskopie	xx	xx

(xxx:Methode der Wahl; xx: gleichwertige Methode;
x: Alternativmethode; o: keine Indikation)

Eine der häufigsten Indikationen stellt die Fremdkörperentfernung dar. Unterschieden werden muss zwischen dem Fremdkörper beim Kind und dem Fremdkörper beim Erwachsenen.
Die retrospektive Aufarbeitung (Ferrari, 2018) von 5 Studien zum Ösophagusfremdkörper beim Erwachsenen aus der Zeit von 1993-2015 ergab bei insgesamt 1402 Fällen in 72,6% eine Lokalisation in der oberen Ösophagusenge, in 11,1% in der mittleren und in 16,3% in der unteren Ösophagusenge. 736 Fälle wurden durch eine flexible. Endoskopie und 666 durch eine starre Endoskopie mit einer Erfolgsquote von 97,0%/97,3% behandelt.

Prospektive Studien zum Ösophagusfremdkörper finden auch in der Literatur der letzten 5 Jahre nicht.

Fremdkörper beim Kind sind i.d.R. zufällig erreichbare Gegenstände. Beim Erwachsenen stellen der Fleisch- oder Nahrungsbolus, Knochen und Gräten sowie Zahnersatzprothesen häufige Fremdkörper dar. Bei Gefängnisinsassen oder psychiatrischen Patienten muss mit ungewöhnlichen oder auch mehreren Fremdkörpern gerechnet werden, da die Einnahme i.d.R. mit Absicht erfolgt. Drogenkuriere stellen die Endoskopie vor eine besondere Herausforderung.

Die Diagnostik vor einer Intervention bei Fremdkörpern kann je nach Röntgendichte und Perforationsrisiko in einer Röntgenaufnahme der Halsweichteile, des Thorax und/oder eines Kontrastmitte-Schluckes bestehen, wobei ausschließlich isoosmolare Kontrastmittel zu verwenden sind. Bariumsulfat gilt hier wegen des Aspirationsrisikos und bei Perforationsverdacht als strikt kontraindiziert.

Bei klinischen Zeichen einer kompletten Obstruktion (Hypersalivation, Passagestopp für Flüssigkeiten) sollte auf eine Kontrastdarstellung verzichtet und direkt endoskopiert werden.

In seltenen Fällen kann auch ein CT weiterhelfen. Während die Sensitivität für Fischgräten im konventionellen Röntgen nur bei 32% liegt, besteht im CT eine Sensitivität von 90-100%. Absolute Indikation für ein CT besteht bei Perforationsverdacht.

Lässt sich ein Fremdkörper im Ösophagus lokalisieren, so sollte eine Entfernung zeitnahe durchgeführt werden.

Es wird unterschieden zwischen
Notfallendoskopie (<2-6h):
Bei kompletter Obstruktion und scharfen Gegenständen und Batterien im Ösophagus.

Dringender Endoskopie (<24h):
Für andere Fremdkörper im Ösophagus ohne komplette Obstruktion und scharfe Fremdkörper, Magnete, Batterien und große (>2,5cm) und lange (>6 cm) Fremdkörper die im Magen liegen.

Nicht dringender (elektiver) Endoskopie (<72h):
Bei mittelgroßen stumpfen Fremdkörpern im Magen.

Während hochsitzende Fremdkörper einfacher für Patient und Untersucher mittels starrer Ösophagoskopie entfernt werden können, lassen sich tief sitzende Fremdkörper leichter und sicherer mit flexibler Ösophagoskopie extrahieren.

Bei unklarer Ursache einer Fremdkörperingestion ohne das Vorliegen einer objektivierbaren strukturellen Schleimhautveränderung sollte zum Ausschluss einer eosinophilen Ösophagitis (EoE) immer eine Biopsie erfolgen.

ESGE-Leitlinie (European Society of Gastrointestinal Endoscopy), NASPGHAN-Endoscopy Committee (North American Society for Pediatric Gastroenterology, Hepatology & Nutrition) und WSES Guideline (World Society of Emergency Surgery) sehen die therapeutische flexible Endoskopie als Verfahren der ersten Wahl beim persistierenden Ösophagusfremdkörper.
Während NASPGHAN und WSES die flexible und starre Endoskopie als komplementäre Techniken bezeichnen und die starre Endoskopie als second line Therapie aufführen, wird die starre Ösophagoskopie bei der ESGE gar nicht erwähnt und die Chirurgie als zweite Linie der Therapie

aufgeführt. Für qualifizierte Zentren ist zu empfehlen, dass beide Methoden angewendet werden können, da sie sich bisweilen komplementär ergänzen.

Bei einem Fleisch- oder Nahrungsbolus kann situationsabhängig in den ersten Stunden nach Ingestion ein Spontanabgang abgewartet werden. Die Wirksamkeit von krampflösenden Medikamenten z.B. Buscopan® (Butylscopolamin) oder Diazepam ist bislang nicht bewiesen, kann aber zeitnahe versucht werden, jedoch ohne die endoskopische Entfernung zu verzögern.

Nach ESGE-Leitlinie ist die primäre Methode beim Nahrungsbolus mit 90% Erfolgsquote die Push-Technik, bei der unter Luftinsufflation der Nahrungsbolus in der Magen vorgeschoben wird. Bestehen Hinweise auf eine Engstelle nach dem Fremdkörper oder der Verdacht auf Knochenanteile im Nahrungsbolus, sollte eine Extraktion durchgeführt werden. Eine Fremdkörperentfernung kann mit Alligator-(Fremdkörper)zangen oder Dormia-Körbchen durchgeführt werden, mit denen sich auch stumpfe Fremdkörper wie Münzen oder Batterien entfernen lassen. Für metallische Fremdkörper (auch Knopf-Batterien) sind die heute verfügbaren sehr effektiven Magnetsonden ideal. Stumpfe Fremdkörper unter 2 cm Durchmesser, die den Magen erreicht haben, können in Abhängigkeit vom Alter des Patienten einer konservativen Therapie unter radiologischer Verlaufskontrolle zugeführt werden. Eine Ausnahme hiervon betrifft Batterien, die immer entfernt werden sollten.

Während früher das Auslaufen der alkalischen Bestandteile der Batterien für eine Schädigung im Vordergrund stand, steht heute durch die technische Weiterentwicklung der hohe Stromfluss durch die sehr leistungsfähigen Batterien und Akkumulatoren auf Lithium-Basis im Vordergrund. Dies und die zum Teil erhebliche Wärmeentwicklung führen zu tiefen Nekrosen nach Verkleben der Batterie mit oder in der Schleimhaut bis hin zur Perforation. Dieser Prozess beginnt unmittelbar nach der Ingestion.
Das Schädigungspotential von frei im Magen liegenden Knopfbatterien ist deutlich geringer. Eine Entfernung ist auch hier im Intervall von 24 h anzustreben.

Eine absolute Notfallindikation besteht bei spitzen und scharfen Fremdkörpern (Nägel, Glasscherben, Rasierklingen, etc.), bei denen auch ein Extraktionsversuch durchgeführt werden sollte, wenn diese den Magen erreicht haben, da in einem Drittel der Fälle eine Perforationsgefahr besteht. Die Entfernung erfolgt deshalb immer unter Verwendung einer Latex-Bergekappe. Besondere Vorsicht besteht bei einer Ingestion von in Plastik oder Latex eingewickelten Drogenpäckchen (body packing). In solchen Fällen sollte - wenn möglich - ein Spontanabgang abgewartet werden, da eine Beschädigung der Päckchen bei der endoskopischen Entfernung für den Patient tödliche Folgen haben kann.

Die absolut häufigste Indikation zur Ösophagoskopie erfolgt im HNO-Fach im Rahmen der Panendoskopie. Die Inzidenz von Zweitkarzinomen im HNO-Bereich und im Ösophagus wird in USA und Europa mit 2-3% und in Asien mit 4-7% angegeben. Von Weber (2020) konnte die Sicherheit der starren Ösophagoskopie im Rahmen der Panendoskopie gezeigt werden. Insbesondere das obere Ösophagusdrittel, die Achillesferse der flexiblen Endoskopie, kann damit besser visualisiert werden.

Zweifelsfrei ist die Abbildungsqualität der flexiblen HD-Endoskopie der der starren Ösophagoskopie überlegen, aber eben auch nur da, wo sich der Ösophagus entfaltet.
Für die HNO ist die Nutzung beider Techniken im Rahmen der Panendoskopie wünschenswert.
Da außerhalb der HNO kaum Erfahrungen mit der starren Ösophagoskopie bestehen, lassen sich mit diesem Vorgehen die Skills für die starre Technik erhalten und weitergeben.

7 Absolute und relative Kontraindikationen

Therapeutische Ösophagoskopie:	bei akuter lebensbedrohlicher Situation keine, sonst siehe diagnostische Ösophagoskopie
Diagnostische Ösophagoskopie:	schlechter AZ, respiratorische Insuffizienz, Blutungsneigung, schwere Begleiterkrankung inadäquate Oxygenierung während der Untersuchung, schwere Koagulopathie, instabile Hämodynamik mit Arrhythmie, ASA IV

8 Voraussetzungen

	starr	**flexibel**
Anamnese, Fragestellung, Medikamente	obligat	obligat
Klin. Untersuchung	obligat	obligat
i.v. Zugang	obligat	obligat
Monitoring (RR, EKG, O2)	obligat	obligat
Gerinnungsstatus	fakultativ	fakultativ
Blutbild	fakultativ	fakultativ
Röntgenthorax	fakultativ	fakultativ
Ösophagusbreischluck	fakultativ	fakultativ

9 Anästhesieverfahren

	starr	**flexibel**
Oberflächenanästhesie (OA)	x	x
Analgosedierung/ Kurznarkose	x	xxx
ITN	xxx	x

(xxx:Methode der Wahl; xx: gleichwertige Methode;
x: Alternativmethode; o: keine Indikation)

Die Sedierung zur Einleitung der Allgemeinanästhesie obliegt der Verantwortlichkeit der Anästhesie. Die Sedierung während Analgosedierung sollte bei kritischen Patienten ebenfalls in Zusammenarbeit mit der Anästhesie erfolgen. Ansonsten orientiert sich die Sedierung nach den Vorgaben der S3-Leitlinie: Sedierung in der gastrointestinalen Endoskopie.

Sowohl der diagnostische oder therapeutische Eingriff als auch die Sedierung sind eigenständige medizinische Verfahren. Es ist daher für jede Endoskopie unter Sedierung erforderlich, dass neben dem endoskopierenden Arzt und seiner Endoskopieassistenz eine weitere Person, die nicht in die Endoskopie involviert ist, diese Aufgabe zuverlässig wahrnimmt. Diese qualifizierte Person soll in der Überwachung von Patienten, die Sedativa, Hypnotika und/oder Analgetika erhalten, speziell und nachweislich geschult und erfahren sein. Wann immer der Patient ein erhöhtes Risiko aufweist oder ein langwieriger und aufwendiger Eingriff zu erwarten ist, soll ein zweiter, entsprechend qualifizierter Arzt zugegen sein, der ausschließlich die Durchführung und Überwachung der Sedierung sicherstellt. Das Monitoring während der Untersuchung muss dokumentiert werden.
Das Dokumentationsblatt muss eine zeitabhängige Dokumentation der Vitalparameter (Herzfrequenz, Blutdruck und Sauerstoff-Sättigung), der verwendeten Medikamente mit Namen und Dosierung, sowie der Gabe intravenöser Flüssigkeit enthalten und Angaben darüber machen, ob und in welcher Flussrate der Patient Sauerstoff erhalten hat. Idealerweise sollen periodisch auch der Sedierungsgrad und Schmerzangaben des Patienten dokumentiert werden.
Eine geeignete apparative Ausstattung für Reanimationsmaßnahmen muss stets griffbereit sein. Dies gilt insbesondere für die Anwendung des Narkotikums Propofol dessen Wirkung nicht antagonisiert werden kann.
Für das häufig als Sedativum eingesetzte Midazolam existiert ein Antidot (Imidazobenzodiazepin (Anexate®)), bei dem die kürzere Halbwertszeit im Vergleich zu Midazolam (Rebound-Phänomen) beachtet werden muss.

10 Endoskopische Technik

	starr	**flexibel**
transnasal	o	xxx
transoral	xx	xx

(xxx:Methode der Wahl; xx: gleichwertige Methode;
x: Alternativmethode; o: keine Indikation)

11 Lagerung

In Regel Linksseitenlage bei transoraler Endoskopie, halbsitzend bei transnasaler Endoskopie Rückenlage bei ITN (Intubationslaryngoskop kann bei flexibler Untersuchung als Einführhilfe dienen)

12 Komplikationen

Komplikationen der Ösophagoskopie sind:

Blutung, Ösophagusläsion/-perforation, Zahnschäden,
Larynxödem, Kehlkopfverletzung, Hypopharynxverletzung, Mediastinitis
Aspiration , Medikamentennebenwirkungen durch LA u./o. Analgosedierung (s.o.)

13 Kinderösophagoskopie

Die Anwendung der Ösophagoskopie bei kleinen Kindern erfordert große Erfahrung.

14 Nachsorge des Patienten

Aufwachraum oder Äquivalent

1h Nahrungskarenz
Kardiorespiratorisches Monitoring bis Patient stabil und ausreichend wach
Hinweis auf Verkehrs- und Geschäftsunfähigkeit (24h Fahruntüchtigkeit nach Prämedikation oder Analgosedierung).
Auf Schmerzäußerungen achten.

15 Struktur-Qualität

Apparative, personelle und organisatorische Ausstattung

			starr	**flexibel**
Personal	Arzt	Facharztstandard	x	x
		Anästhesist	x	o
	Assistenzpersonal	Instrumentier-Fkt.-Personal	x	x
		Anästhesie-Fkt.-Personal	x	o
Raum	Eingriffsraum / (OP für „Operationen mit geringem Risiko postoperativer Wundinfektionen“)		x	x
Apparative Ausstattung	diagnostische Ösophagoskopie		x	x
	therapeutische Ösophagoskopie		x	x
Hygiene	mechanische Reinigung/ Vorreinigung		x	x
	Manuelle Desinfektion		o	x
	Automatendesinfektion (RDG-E)		o	*x*
	Sterilisation		x	o

(x: erforderlich; (x): wünschenswert; o: nicht erforderlich)

Die Aufbereitung der starren und flexiblen Instrumente muss sich an den Vorgaben des RKI orientieren. Diese erfolgt nach der RKI-Empfehlung: „Anforderungen an die Hygiene bei der Aufbereitung von Medizinprodukten“ [2012]

und für flexible Endoskope orientiert sich die Aufbereitung zusätzlich nach der „S2k Leitlinie Qualitätsanforderungen in der gastrointestinalen Endoskopie“ [2015] und dem Positionspapier der European Society of Gastrointestinal Endoscopy (ESGE) und der European Society of Gastroenterology Nurses and Associates (ESGENA): Reprocessing of flexible endoscopes and endoscopic accessories used in gastrointestinal endoscopy - Update 2018

16 Ösophagoskopie während der Covid- 19 Pandemie

Der Covid-19 Ausbruch im Dezember 2019 in Wuhan, China hat sich über das Jahr 2020 zu einer weltweiten Pandemie ausgebreitet.
Auch im Rahmen der Ösophagoskopie besteht ein erhöhtes Übertragungsrisiko. Nur triagierte und möglichst aktuell negativ getestete Patienten sollten endoskopiert werden. Eine kritische Indikationsstellung ist angebracht.

Wasserdichter Einmal-Schutzkittel, Augenschutz (Schutzbrille/ Gesichts-Visier), Einmal-Haarschutzkappe und Einmal-Überschuhe sollten immer verwendet werden. Bei Hochrisikopatienten oder positiven getesteten Patienten sollten statt eines einfachen chirurgischen Mundschutzes eine FFP2/FFP3-Maske und doppelte Handschuhe getragen werden. Für die Untersuchung sind möglichst Einmal-Instrumente zu verwenden.

Hochrisikountersuchungen sollten wenn möglich in einem Raum mit Unterdruckbelüftung und unter Nutzung eines chirurgischen Zeltes durchgeführt werden.
Die maschinelle Aufbereitung der flexiblen Endoskope gewährleistet eine Virusinaktivierung.

17 Prozess-Qualität

Frühzeitige Veranlassung der o. g. Untersuchungsvoraussetzungen. Dokumentation des präoperativen Befundes. Rechtzeitige und ausführliche und differentialtherapeutische schriftlich fixierte Aufklärung unter Abwägung räumlicher, personeller und apparativer Möglichkeiten. Erstellung eines Operationsberichtes inklusive Bilddokumentation. Sicherstellung der Nachbehandlung/Überwachung (v.a. bei ambulanten Eingriffen).

18 Ergebnis-Qualität

Beteiligung an Qualitätssicherungsmaßnahmen.

19 Literatur

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22 Anhang

22.1 Redaktionelle Unabhängigkeit

Die Leitlinie hat keine externe Finanzierung erhalten. Die Konsensuskonferenz wurde wegen der Coronapandemie als Online-Veranstaltung abgehalten.

22.2 Erklärung von Interessen und Umgang mit Interessenkonflikten

Alle Teilnehmer legten ihre direkten materiellen und indirekten z.B. akademischen Interessen über das Formblatt der AWMF dar. (Zusammenfassende Tabelle im extra Dokument „Angaben zu Interessenkonflikten“). Die Erklärungen aller Mitglieder der Leitliniengruppe wurden von dem Leitlinienkoordinator auf thematische Relevanz in Bezug auf das Leitlinienthema und auf geringe (Berater/Gutachter, Vorträge/Schulungen, Autorenschaft), moderate (AdBoard, Forschungsvorhaben) und hohe Interessenkonflikte und Bedeutung für die Abstimmung unter Berücksichtigung der pluralistischen Zusammensetzung der Leitliniengruppe. Stimmenthaltungen wurden danach als nicht erforderlich angesehen.

22.3 Gültigkeitsdauer und Aktualisierung

Diese Leitlinie ist gültig bis 5 Jahre nach Veröffentlichung, spätestens zu diesem Zeitpunkt erfolgt eine inhaltliche Überprüfung und gegebenenfalls eine Aktualisierung. Werden dem Leitlinienkoordinator zwischenzeitlich Erkenntnisse bekannt, die eine Überarbeitung der Leitlinie erfordern, so erfolgt die Aktualisierung bereits früher.

22.4 Verabschiedung der Leitlinie

Die vorliegende Fassung der Leitlinie wurde in der Konsensuskonferenz vom 03.02.2021 von den an der Leitlinienerstellung Beteiligten beraten und verfasst. Sie erhielt am 31.05.2021 vom Präsidium der Deutschen Gesellschaft für Hals-Nasen-Ohren-Heilkunde, Kopf- und Hals-Chirurgie (DGHNO-KHC) seine Zustimmung.

Versionsnummer:	**5.0**
Erstveröffentlichung:	**07/1997**
Überarbeitung von:	**05/2021**
Nächste Überprüfung geplant:	**05/2026**