

# Patient agreement to investigation or treatment

## Botulinum toxin injection for hemifacial spasm

**Authors:** Dr G Lennox, Sister M Hulett Neurology

### Brief description:

- Botulinum toxin is a chemical produced by bacteria, which can be used in minute quantities to reduce 'stiffness' or spasm in individual muscles.
- Here, we explain some of the aims, benefits, risks and alternatives to this procedure (treatment). We want you to be informed about your choices to help you to be fully involved in making any decisions.
- Please ask about anything you do not fully understand or wish to have explained in more detail.
- If you would like this information in another format or language or would like help completing the form, please ask a member of our staff.

### Please bring this form with you to hospital

- You will be asked to read this form carefully, and you and your doctor (or other appropriate healthcare professional) will sign it to document your consent.
- All our consent forms are available on the Addenbrooke's website: <http://www.addenbrookes.org.uk/consent>
- Remember, you can change your mind about having the procedure at any time, even after you have signed the form.

### For staff use:

Does the patient have any special requirements? (For example, requires an interpreter or other additional communication method)

.....  
.....

## About botulinum toxin injection for Hemifacial spasm

### Before your procedure

- Most patients attend a neurology clinic where they see a doctor who will discuss the risks and benefits of the botulinum toxin injections, and decide on the site and the number of injections required. Botulinum toxin injections are a minor procedure and take place in the clinic.
- At this clinic, we shall ask you for details of your medical history and carry out any necessary clinical examinations and investigations. Please inform the doctor if you have had any recent health problems, and discuss any questions regarding the injections that you might have.
- You will be asked if you are taking any tablets or any other types of medication- these might have been prescribed by a doctor or bought over the counter at a pharmacy. For instance, if you are taking anti- coagulants such as warfarin you may **not** be suitable for the treatment.
- This procedure does not involve the use of a local anaesthetic before the injections.
- You **do not** need to fast before your botulinum injections.
- Botulinum toxin is not a suitable treatment if you are pregnant or 'trying' for a baby.
- If to your knowledge the answer to any of the following is **yes**, it is important that you tell us. Have you ever
  - received Human Growth Hormone
  - had brain surgery prior to 1992
  - or has anyone in your family been diagnosed with CJD

A positive answer will not preclude any treatment, it will however allow us to plan your treatment so as to minimise any risks.

- **Prevention of Surgical Site Infection (SSI) (for applicable procedures only)**

In order to prevent infection, hair from the area where you are being operated on may need to be removed.

Hair removal from the site of the operation up to sixty minutes before surgery reduces the risk of infection. This means that the hair removal procedure is usually carried out on the operating table. The skin is then cleaned with an appropriate skin preparation solution. This can leave a colouration to the skin which can be washed off.

You must not shave the area that is being operated on yourself; this will be carried out in the operating theatre. Shaving at home, or the night before surgery, increases the risk of infection as no matter how careful you are the skin may become irritated and this could increase the risk of infection.

It may be necessary during the procedure to shave other areas of your body if appropriate to allow equipment/machines, for example diathermy machines (used to seal blood vessels), to stick to your skin to achieve the best and safest performance.

Reference:

Department of Health. High Impact Intervention No 3: Preventing surgical site infection. Saving Lives: reducing infection, delivering clean and safe care: DH June 2005.

## During the procedure (operation/treatment) itself

- You will be seated or reclined on a couch. Depending on the severity of the spasm, small doses of botulinum toxin are injected just under the skin into the muscle surrounding the eye at two to three sites. The exact dose may be varied dependent on your response to previous treatments. After three to four days, the injection causes temporary weakness to the muscle surrounding the eye, which relieves the symptoms of hemifacial spasm for approximately two to three months.

## After the procedure (operation/treatment)

- **When can you leave hospital:** After the procedure, which takes five to ten minutes you will be able to return home.
- The toxin takes three to four days to be effective.
- **When you can resume normal activities including work:** Most of these people who have had this procedure can resume normal activities straight away.
- **Special measures you need to take after the procedure:** None but try to avoid touching or rubbing the sight that has been treated.
- **Check-ups and results:** Before you leave the clinic you will be given details of when you need to return to see us. At this appointment we will check your progress and discuss with you any further treatment.

## Intended benefits of the procedure

- Botulinum toxin is an effective way to control the symptoms caused by the eye spasm and works well in the majority of affected individuals. Its effect is only temporary and not a cure. For continued relief from symptoms you will need repeated injections.

## Who will perform my procedure?

- The initial set of injections will be given by a Neurologist. Once the response to the injections is apparent subsequent injections will be given by the Nurse specialist.

## Alternative procedures that are available

- No other treatments are available for the treatment of eye spasm.

## Serious or frequently occurring risks

- Following this procedure, the majority of individuals with eye spasm experience relief from their symptoms.
- However occasionally some bruising may develop around the injection site, this can be relieved by a cold compress.
- Sometimes the muscles around the eye can become weaker than expected following your injection.
- Occasionally you may experience drooping of the eyelid and rarely double vision. This excessive weakness will resolve as the effects of the toxin in the muscle are only temporary but may last two to three months. If you experience these problems please contact the clinic for advice and inform the nurse at your next appointment, so that the dose can be modified in future.

## Information and support

- You might be given some additional patient information before or after the procedure  
for example: leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask to speak to the nurse specialist.
- Further information is available from the Dystonia Society: Tel 0207 490 or website [www.dystonia.org.uk](http://www.dystonia.org.uk)



We are currently working towards a smoke-free site. Smoking is only permitted in the designated smoking areas.

For advice and support in quitting, contact your GP or the free NHS Stop Smoking helpline on 0800 169 0 169

### Help with this leaflet:



If you would like this information in another language, large print or audio format, please ask the department to contact

Patient Information: 01223 216032 or  
[patient.information@addenbrookes.nhs.uk](mailto:patient.information@addenbrookes.nhs.uk)



## Document history

Authors	Neurology Department
Department	Cambridge University Hospitals NHS Foundation Trust, Hills Road, Cambridge, CB2 0QQ <a href="http://www.cuh.org.uk">www.cuh.org.uk</a>
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Consent form 1

# Patient agreement to investigation or treatment

<b>For staff use only:</b>
<b>Surname:</b>
<b>First names:</b>
<b>Date of birth:</b>
<b>Hospital no:</b>
<b>Male/Female:</b>
<b>(Use hospital identification label)</b>

Responsible health professional/job title

Special requirements.....  
(For example, other language/other communication method)

**Name of proposed procedure or course of treatment**

Botulinum toxin for Hemifacial spasm Side (left/right)

**Statement of health professional**

(To be filled in by a health professional with an **appropriate knowledge of the proposed procedure**, as specified in the Hospital's consent policy)

I have explained the procedure to the patient. In particular, I have explained:

- The intended benefits of the procedure .....  
..... to control the symptoms caused by the eye spasm .....
- Any serious or frequently occurring risks from the procedures including those specific to the patient .....  
.....some bruising, muscles around the eye can become weaker, you may experience drooping of the eyelid and rarely double vision
- Any extra procedures that might become necessary during the procedure
- Blood transfusion  Other procedure (please specify) .....

I have discussed what the treatment / procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

- The following information leaflet has been provided: Botulinum toxin injection for hemifacial spasm.....  
..... Version/Date/Ref: 3/July 2011/CF086.....

This procedure will involve:

- General and/or regional anaesthesia       Local anaesthesia       Sedation

Health professional's signature: ..... Date: .....

Name (PRINT): ..... Job title: .....  
Contact details (if patient wishes to discuss details later)

I have offered the patient information about the procedure but s/he has declined information.

**Statement of the interpreter (if appropriate)**

I have interpreted the information to the best of my ability, and in a way in which I believe s/he can understand:

Interpreter's signature..... Date: .....

Name (PRINT): .....

**Important notes: (tick if applicable)**

- The patient has withdrawn consent (ask patient to sign/date here) .....
- See also advance directive/living will (eg Jehovah's Witness form)

Copy accepted by patient: yes / no (please circle)

**For staff use only:**  
**Surname:**  
**First names:**  
**Date of birth:**  
**Hospital no:**  
**Male/Female:**  
**(Use hospital identification label)**

**Statement of patient**

Please read this form carefully. If your treatment has been planned in advance, you should already have your own copy, which describes the benefits and risks of the proposed treatment. If not, you will be offered a copy now. Do ask if you have any further questions. The staff at Addenbrooke's are here to help you. **You have the right to change your mind at any time before the procedure is undertaken, including after you have signed this form.**

Training doctors and other health professionals is essential to the continuation of the Health Service and improving the quality of care. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a senior doctor. You may, however, decline to be involved in the formal training of medical and other students without this adversely affecting your care and treatment.

**Please read the following:**

**I understand** that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia.)

**I understand** that you cannot give me a guarantee that a particular person will perform the procedure. The person undertaking the procedure will, however, have appropriate experience.

**I understand** that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

**I have been told** about additional procedures which may become necessary during my treatment. I have listed below any procedures that **I do not wish, without further discussion, to be carried out.**

.....  
**I understand** that any tissue (including blood) removed as part of the procedure or treatment will be anonymised and may be used for teaching or quality control, and stored or disposed of in a manner regulated by appropriate, ethical, legal and professional standards.

**I understand** that all research will be approved by a research ethics committee and undertaken in accordance with appropriate ethical, legal and professional standards.

**I understand** that the research may be conducted within a hospital, university, not for profit organisation or a company laboratory.

**Please tick boxes to indicate you either agree/disagree to the three points below.**      **Yes**      **No**

**I agree** that tissue (including blood) not needed for my own diagnosis or treatment can be used for **research which may include genetic research.** **If you wish** to withdraw your consent for the use of your tissue (including blood) for research, please contact the Patient Advice and Liaison Service at Addenbrooke's Hospital.           

**I agree** to the use of photography for the purpose of diagnosis and treatment.           

**I agree** to anonymised photographs being used for medical teaching.           

**I confirm** that the risks, benefits and alternatives of this procedure have been discussed with me and I have read and understood the above and agree to the procedure (or course of treatment) on this form.

**Patient's signature:** ..... **Date:** .....

**Name (PRINT):** .....

If the patient is unable to sign but has indicated his/her consent, a witness should sign below. Young people may also like a parent to sign here (see guidance notes).

**Witness' signature:** ..... **Date:** .....

**Name (PRINT):** .....

**Confirmation of consent** (to be completed by a health professional when the patient is admitted for the procedure, if the patient has signed the form in advance)

On behalf of the team treating the patient, I have confirmed with the patient that s/he has no further questions and wishes the procedure to go ahead.

Signature      Date: .....

Name (PRINT): ..... Job Title: .....