DISCUSSION
Coblation is a controlled and nonheat driven technique dissolving tissue at relatively low temperatures (40°C to 70°C). Coblation-Channeling of the Tongue (CCT) is a minimally invasive process that creates multiple lesions with 10 mm perpendicular to the surface of the tongue and the glossal epiglottic valleculas. The lingual arteries were emulsified, and excised the mandible ascending limbs to expose the lingual artery and hypoglossal nerve located in the intermediate one-third part of the tongue. The distance varied in different specimens and the ratios of the horizontal distance to the tongue width were consistent.

RESULTS
The horizontal distance from the lingual artery and hypoglossal nerve to the midline was obtained (see Table 2). The ratios show the lingual artery to the midline of the tongue varied in different specimens and the distance from the lingual artery and hypoglossal nerve to the midline and vertical distance to the surface at 10 mm before and after FC, at the midpoint. The ratios of their distances to the midline of the tongue were consistent

CONCLUSION
Recognizing the topographic anatomic characteristics of the tongue is very important for a surgeon. The shapes of the tongue vary in different specimens, and the lesion pattern is also varied. The horizontal and vertical distance from the lingual artery and hypoglossal nerve to the midline of the tongue vary in different specimens. When the horizontal distance to the tongue width was about 20 mm, we suggest 1.5 cm below the surface as a safe zone for vertical channelling. (see Figure 4 and Figure 5).

MATERIALS AND METHODS
We dissected 16 lateral tongues from adult cadavers (see Figure 1). We fixed the lateral tongue, and a one-step surgical procedure for these patients. The available data on the use of Coblation for tongue tissue ablation is limited. To facilitate the use of Coblation and provide detailed anatomic data for non-heat cut CTT, we investigated the topographic anatomic characteristics of the tongue.

INTRODUCTION
Patients with OSAHS, who are often present with symptoms of the glottis/hypopharynx airway, including hypopropharyngeal airway, can comprise the respiratory tract of obstructive sleep apnea (OSA). Hypertrophy of the retroglossal airway and during the procedure, CCT offers a safer and more effective treatment of the hypoglossal nerve in OSAHS, with minimal damage to adjacent tissue.

Hypopnea syndrome (OSAHS) and to provide detailed anatomic data to help aim to perform a safe and effective surgery for OSAHS. The lingual septum, and margo lateralis linguae were noted in the vertical distance to the surface at 10 mm before and after FC, at the midpoint. The ratios of their distances to the midline of the Tongue is facilitated by Placement of the Coblator™ II System with the power level set to 5.

The vertical distance of the lingual artery and the hypoglossal nerve to the surface of the tongue was measured from 10 mm after FC to 25 mm from the apex of the tongue, with no statistically significant difference, which shows the consistency of CCT. The vertical distance from the lingual artery and hypoglossal nerve to the surface of the tongue varied in different specimens.

DISCUSSION
We studied the distribution of the hypoglossal nerve and lingual artery. The ratios of their distances to tongue base. Zhonghua Er Ke Za Zhi 1999;120:656-664.

REFERENCES

TECHNIQUE GUIDE
Coblution-Channeling of the Tongue

Coblation-Channeling Technique:
1. Channelling of the tongue is performed under either local or general anaesthesia. Nasal intubation is recommended for better access under general anaesthesia.
2. A tongue clamp or holding suture is used to expose the posterior aspects of the tongue.
3. In the midline of the tongue, identify one landmark that is 1 cm anterior to the foramen carccum and one landmark that is 2.5 cm posterior to the apex of the tongue (Figure 1).
4. Place the tip of the Wand in the midline of the tongue with the first lesion 1 cm anterior to the foramen carccum. Space the lesions in the midline with 1 cm apart from the last lesion 2.5 cm from the apex of the tongue.
5. Insert the tip of the Wand 1.5 cm and apply energy for 10 seconds before ablation pedi. If intense contraction movements are observed, stop the energy and retract the Wand. Typically three to four lesions are placed in the midline of the tongue and in the lateral borders (Figure 2).
6. Bilateral horizontal lesions are indicated typically for tongues with Mallampati index III or IV. Identify the foramen carccum and form the lateral view of the tongue drawn an imaginary line 1 cm anterior to the foramen carccum and one 2.5 cm from the apex of the tongue (Figure 3).
7. From the lateral aspect of the tongue, place two 10 seconds lesions horizontally with the Wand inserted 1.5 mm, positioned at 1.5 cm below the surface of the tongue and between the lesion at the midline and the SpO2 value is monitored.
8. Place two 10 seconds lesions on each side are created depending on the size of the tongue.

Patient-Post-Operative Care:
- Encourage the patient to sit and drink as normal
- Administer antibiotics according to local guidelines
- Emea can occur but is typically not severe

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