

# ENT/OTOLARYNGOLOGY

## HOSPITAL REFERRAL & MANAGEMENT GUIDELINES

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# THE ALFRED SPECIALIST CONSULTING CLINICS APPOINTMENT PRIORITY GUIDE

ENT/Otolaryngology

The Alfred Specialist Consulting Clinics New Appointment

**Priority Definitions:**

- Immediate** - phone ENT registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre
1. **Urgent** - likely to receive an appointment within 1-2 weeks
  2. **Soon** - likely to receive an appointment within 2-6 weeks
  3. **Intermediate** - likely to receive an appointment within 6-12 weeks
  4. **Non-urgent**
- Not seen**

**Please note:** The times to assessment may vary depending on size and staffing of the hospital department.

Urgent cases must be discussed with the ENT registrar on call to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.

Priority	Criteria	Examples (not an exhaustive list)
<b>IMMEDIATE</b> Contact ENT registrar and/or send to The Alfred Emergency & Trauma Centre	<ul style="list-style-type: none"> <li>▪ Failure of immediate treatment would result in significant morbidity</li> </ul>	<ul style="list-style-type: none"> <li>▪ Severe or persistent epistaxis</li> <li>▪ Tonsillar haemorrhage</li> <li>▪ Hoarseness associated with neck trauma or surgery</li> <li>▪ Laryngeal obstruction and/or fracture</li> <li>▪ Acute nasal fracture with septal haematoma.</li> <li>▪ Complicated mastoiditis/cholesteatoma or sinusitis (periorbital cellulitis, frontal sinusitis with persistent frontal headache)</li> <li>▪ Pharyngeal/laryngeal foreign body</li> <li>▪ Abscess or haematoma, eg peritonsillar abscess, septal or auricular haematoma, paranasal sinus pyocele.</li> <li>▪ Nasal foreign body – battery</li> <li>▪ Barotrauma with sudden onset vertigo</li> </ul>
<b>1. URGENT</b>	<ul style="list-style-type: none"> <li>▪ Cancer, suspected or actual</li> <li>▪ Major functional impairment</li> <li>▪ Trauma or condition where there is moderate risk of permanent damage if treatment is delayed</li> </ul>	<ul style="list-style-type: none"> <li>▪ Malignant neoplasm of the head and neck, eg larynx, nasopharynx, oral cavity, tonsil, unexplained cervical lymphadenopathy</li> <li>▪ Sub acute dyspnoea/airways problems, eg laryngeal papilloma, laryngeal stridor</li> <li>▪ Acute facial nerve trauma</li> <li>▪ Documented sinusitis not responding to conservative management</li> <li>▪ Paranasal sinus mucocele</li> <li>▪ Fracture of paranasal sinus</li> <li>▪ Nasal fracture with external nasal deformity</li> <li>▪ Hoarseness with significant dysphagia or present for more than 4 weeks</li> <li>▪ Progressive or persistent dysphagia</li> <li>▪ Neck masses</li> </ul>
<b>2. SOON</b>	<ul style="list-style-type: none"> <li>▪ Low-grade malignancy or benign neoplasm</li> <li>▪ Conditions causing recurrent infective episodes with morbidity</li> <li>▪ Trauma or lesions resulting in moderate physical, social or economic disruption</li> </ul>	<ul style="list-style-type: none"> <li>▪ Documented sinusitis with morbidity</li> <li>▪ Progressive middle ear disease, eg cholesteatoma, chronic suppurative otitis media, erosive retraction pockets</li> <li>▪ Recurrent increasing tonsillitis or sinusitis</li> <li>▪ Infected preauricular sinus</li> <li>▪ Infected thyroglossal tract cyst/fissula</li> <li>▪ Granulomas, polyps of the vocal cords</li> <li>▪ Recurrent otitis media</li> <li>▪ Adenoiditis/hypertrophy with associated sleep apnoea</li> </ul>
<b>3. INTERMEDIATE</b>	<ul style="list-style-type: none"> <li>▪ Trauma or condition leading to minimal physical, social or economic disruption to daily living activities</li> </ul>	<ul style="list-style-type: none"> <li>▪ Recurrent/chronic tonsillitis</li> <li>▪ Nasal obstruction eg polyps, deviated septum</li> <li>▪ Snoring procedures (no apnoea)</li> <li>▪ Exostoses of the ear canal</li> <li>▪ Conductive hearing loss; ossicular discontinuity, otosclerosis, tympanic membrane perforation</li> <li>▪ Recurrent sinusitis</li> </ul>
<b>4. NON-URGENT</b>	<ul style="list-style-type: none"> <li>▪ Congenital or acquired aesthetic disabilities of a minor nature</li> </ul>	<ul style="list-style-type: none"> <li>▪ Elective tonsillitis after quinsy</li> <li>▪ Chronic tonsillitis</li> <li>▪ Adenoiditis</li> </ul>
<b>NOT SEEN</b>	Children under 16 years are not treated at The Alfred.	

## REFERRAL & MANAGEMENT GUIDELINES: ENT/OTOLARYNGOLOGY

DIAGNOSIS	EVALUATION	MANAGEMENT	REFERRAL GUIDELINES
<b>PHARYNGEAL, TONSIL AND ADENOID</b>			
<b>Acute Tonsillitis</b>	Throat pain and odynophagia, plus any of: <ul style="list-style-type: none"> <li>▪ Fever</li> <li>▪ Tonsillar exudate</li> <li>▪ Cervical lymphadenopathy</li> </ul>		<ul style="list-style-type: none"> <li>▪ Acute referral if unable to tolerate oral fluids, not responding to treatment or failure to cope, contact ENT registrar or send to the Alfred Emergency &amp; Trauma Centre</li> </ul>
<b>Recurrent Tonsillitis</b>	<ul style="list-style-type: none"> <li>▪ ?documented pus on tonsils in each episode</li> </ul>		<ul style="list-style-type: none"> <li>▪ Refer to ENT OPD if 4 or more episodes in preceding 12 months, depending on severity or circumstances</li> </ul>
<b>Peritonsillar Cellulitis/Quinsy</b>	Abscesses take >4 days to develop: <ul style="list-style-type: none"> <li>▪ Unilateral tonsillar displacement</li> <li>▪ Trismus</li> <li>▪ Fever</li> <li>▪ Cervical lymphadenopathy</li> <li>▪ Severe odynophagia</li> </ul>	IM Penicillin and review in 24 hours	<ul style="list-style-type: none"> <li>▪ Acute referral to Otolaryngology with:</li> <li>▪ Abscess – Immediate, contact ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>▪ Peritonsillar cellulitis if not resolving</li> <li>▪ Elective tonsillectomy later in patients with preceding/subsequent tonsillitis/quinsy – PRIORITY 3</li> </ul>
<b>Chronic Tonsillitis</b>	Frequent or chronic throat pain and odynophagia; may include: <ul style="list-style-type: none"> <li>▪ Intermittent exudate</li> <li>▪ Adenopathy</li> <li>▪ Improvement with antibiotic</li> </ul>		<ul style="list-style-type: none"> <li>▪ Referral is indicated if problem recurs following adequate response to treatment – PRIORITY 3</li> </ul>
<b>Infectious Mononucleosis /Viral Pharyngitis</b>	Throat pain and odynophagia with: <ul style="list-style-type: none"> <li>▪ Fatigue</li> <li>▪ Membranous tonsillitis</li> <li>▪ Posterior cervical lymphadenopathy</li> <li>▪ CBC, Mono test</li> </ul>	<ul style="list-style-type: none"> <li>▪ Supportive care</li> <li>▪ Consider systemic steroids if severe dysphagia</li> </ul>	<ul style="list-style-type: none"> <li>▪ Airways obstruction, dehydration or failure to cope– refer urgently - contact ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> </ul>
<b>Adenoiditis/Hypertrophy</b>	<ul style="list-style-type: none"> <li>▪ Purulent rhinorrhoea</li> <li>▪ Nasal obstruction +/- snoring</li> <li>▪ Chronic cough</li> </ul>		<ul style="list-style-type: none"> <li>▪ Persisting symptoms and findings after two courses of antibiotics – PRIORITY 3</li> <li>▪ Associated sleep apnoea – PRIORITY 2</li> </ul>
<b>Upper Airways Obstruction From Adenotonsillar Hypertrophy (Especially In Children)</b>	<ul style="list-style-type: none"> <li>▪ Nasal obstruction</li> <li>▪ Severe snoring +/- sleep apnoea</li> <li>▪ Daytime fatigue</li> </ul>		<ul style="list-style-type: none"> <li>▪ Referral indicated with any significant symptoms of upper airway obstruction especially sleep apnoea – PRIORITY 1</li> </ul>
<b>Tonsillar Haemorrhage</b>	<ul style="list-style-type: none"> <li>▪ Spontaneous bleeding from tonsil</li> <li>▪ Post-tonsillectomy (secondary haemorrhage usually occurs within 2 weeks post op)</li> </ul>	Penicillin + Flagyl	<ul style="list-style-type: none"> <li>▪ Immediate referral indicated if bleeding persists, recurs or is <b>significant</b> – contact ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> </ul>
<b>Neoplasm</b>	<ul style="list-style-type: none"> <li>▪ Progressive enlargement of mass or ulceration in the oral cavity or pharynx. Often painless initially but may be pain, odynophagia or dysphagia</li> </ul>		<ul style="list-style-type: none"> <li>▪ Urgent referral to ENT OP indicated – PRIORITY 1</li> </ul>
<b>HOARSENESS</b>			
<b>Hoarseness: Associated With Upper Respiratory Tract Infection</b>	<ul style="list-style-type: none"> <li>▪ Throat pain, may radiate to ear</li> <li>▪ Dysphagia</li> <li>▪ Constitutional symptoms</li> <li>▪ Stridor/airways obstruction</li> </ul>		<ul style="list-style-type: none"> <li>▪ ENT referral indicated if:</li> <li>▪ Stridor or airway distress – Immediate referral – Contact ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>▪ Associated with significant dysphagia – PRIORITY 1</li> <li>▪ Hoarseness present &gt;4 weeks – PRIORITY 1</li> </ul>
<b>Hoarseness: Associated With Neck Trauma Or Thyroid Surgery</b>	History of neck trauma preceding hoarseness May or may not have: <ul style="list-style-type: none"> <li>▪ Skin laceration</li> <li>▪ Ecchymoses</li> <li>▪ Tenderness</li> <li>▪ Subcutaneous emphysema</li> <li>▪ Stridor</li> </ul>		<ul style="list-style-type: none"> <li>▪ Urgent referral indicated in all cases – contact ED registrar and send to The Alfred Emergency &amp; Trauma Centre</li> </ul>
<b>Hoarseness: Associated With Respiratory Obstruction And Stridor</b>			<ul style="list-style-type: none"> <li>▪ Immediate referral indicated in all cases – contact ENT registrar and send to The Alfred Emergency &amp; Trauma Centre</li> </ul>
<b>Hoarseness: Without Associated Symptoms Or Obvious Aetiology</b>	<ul style="list-style-type: none"> <li>▪ History of tobacco and alcohol use</li> </ul> Evaluation when indicated for: <ul style="list-style-type: none"> <li>▪ Hypothyroidism</li> <li>▪ Diabetes Mellitus</li> <li>▪ Gastro-oesophageal reflux</li> <li>▪ Rheumatoid disease</li> <li>▪ Pharyngeal/oesophageal tumour</li> <li>▪ Lung neoplasm</li> <li>▪ Chest XR</li> </ul> <a href="#">The Alfred Radiology request form</a>		<ul style="list-style-type: none"> <li>▪ ENT referral is indicated if recent onset hoarseness persists over four weeks despite medical therapy – especially in a smoker – PRIORITY 1</li> </ul>

## REFERRAL & MANAGEMENT GUIDELINES: ENT/OTOLARYNGOLOGY

DIAGNOSIS	EVALUATION	MANAGEMENT	REFERRAL GUIDELINES
<b>DYSPHAGIA</b>			
	May include history or findings of: <ul style="list-style-type: none"> <li>▪ Foreign body ingestion</li> <li>▪ Gastro-oesophageal reflux</li> <li>▪ Oesophageal motility disorder</li> <li>▪ Scleroderma</li> <li>▪ Neoplasm</li> <li>Thyroid enlargement</li> </ul>	Diagnostic studies may include: <ul style="list-style-type: none"> <li>▪ Soft tissue studies of the neck including lateral XR</li> <li>▪ Chest x-ray</li> <li>▪ Barium swallow</li> </ul> Thyroid studies if appropriate <a href="#">The Alfred Radiology request form</a>	ENT referral indicated if: <ul style="list-style-type: none"> <li>▪ Hypo-pharyngeal or upper oesophageal foreign body suspected (mid-lower oesophageal lesions and foreign bodies normally referred to General Surgery/Gastroenterology) – refer immediately to The Alfred Emergency &amp; Trauma Centre if acute</li> <li>▪ Dysphagia with hoarseness – PRIORITY 1</li> </ul> Progressive dysphagia or persistent dysphagia for three weeks PRIORITY 1-2 depending on circumstances.
<b>NECK MASS</b>			
<b>Inflammatory:</b> i.e. painful	<ul style="list-style-type: none"> <li>▪ Complete head and neck examination indicated for site of infections.</li> <li>Optional investigations (if indicated):</li> <li>▪ FBE</li> <li>▪ Cultures when indicated</li> <li>▪ Consider TB and cat scratch disease</li> <li>▪ HIV testing if indicated</li> <li>▪ Toxoplasmosis titre if indicated</li> <li>▪ USS or CT neck</li> <li>Glandular fever investigations</li> </ul>		ENT referral indicated if mass persists for four weeks without improvement – PRIORITY 1
<b>Non-Inflammatory:</b> i.e. painless	<ul style="list-style-type: none"> <li>▪ Is there dyspnoea, hoarseness or dysphagia?</li> <li>▪ Complete Head and Neck exam indicated. Consider Ultrasound +/- Fine needle aspirate.</li> </ul> Open Biopsy is contra indicated. <a href="#">The Alfred Radiology request form</a>		Thyroid masses usually referred to a head and neck surgical department or general (Breast and Endocrine) surgery– PRIORITY 1 <a href="#">General Surgery Referral and Management Guidelines</a>
<b>Thyroid Mass</b>	<ul style="list-style-type: none"> <li>▪ Are there symptoms of dyspnoea, hoarseness or dysphagia?</li> <li>▪ Complete head and neck exam indicated. Is it a generalised or localised thyroid enlargement?</li> <li>▪ TFTs</li> <li>▪ Thyroid USS</li> </ul> <a href="#">The Alfred Radiology request form</a>		<ul style="list-style-type: none"> <li>▪ Generalised thyroid enlargement with no compression symptoms can be referred to ENT or BES clinic – PRIORITY 2 (See General Surgery (BES) Guidelines)</li> <li>▪ Those with compressive symptoms or discrete swelling should be referred to ENT either immediately or PRIORITY 1. Contact ENT registrar</li> </ul>
<b>SALIVARY GLAND DISORDERS</b>			
<b>Sialadenitis/Sialolithiasis – acute or recurrent</b>	<ul style="list-style-type: none"> <li>▪ Assess patient hydration</li> <li>▪ Palpate floor of mouth for stones</li> <li>▪ Observe for purulent discharge from salivary duct when palpating gland</li> <li>▪ Evaluate mass for swelling, tenderness and inflammation</li> </ul> Occlusal view of floor of mouth for calculi <a href="#">The Alfred Radiology request form</a>	<ul style="list-style-type: none"> <li>▪ Culture or purulent discharge in mouth</li> <li>▪ Hydration</li> <li>▪ Anti Staphylococcal antibiotics: Augmentin</li> <li>▪ Occlusal view of floor of mouth for calculi</li> </ul>	ENT referral indicated if: <ul style="list-style-type: none"> <li>▪ Poor antibiotic response within one week of diagnosis – refer immediately to The Alfred Emergency &amp; Trauma Centre or phone ENT registrar, or PRIORITY 1, depending on severity</li> <li>▪ Calculi suspected on exam, x-ray or ultrasound – PRIORITY 1-3, depending on circumstances</li> <li>▪ Abscess formation – immediate referral – contact The Alfred Emergency &amp; Trauma Centre registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>▪ Recurrent sialadenitis – PRIORITY 3</li> <li>▪ Hard mass present – neoplasm? – PRIORITY 1</li> </ul>
<b>Salivary Gland Mass</b>	<ul style="list-style-type: none"> <li>▪ Complete head and neck exam indicated</li> <li>▪ Evaluate facial nerve function with parotid lesions</li> <li>▪ Check for local skin lesions eg SCCs</li> </ul> Consider referring to AH radiology for FNA		<b>NOTE:</b> 20% of adult parotid masses are malignant & 50% of submandibular gland masses are malignant. <ul style="list-style-type: none"> <li>▪ ENT referral indicated in all cases of salivary gland tumours – PRIORITY 1</li> </ul>
<b>NASAL &amp; SINUS</b>			
<b>Epistaxis –persistent or recurrent</b>	<ul style="list-style-type: none"> <li>▪ Determine whether bleeding is unilateral or bilateral</li> <li>▪ Determine whether bleeding is anterior or posterior</li> <li>▪ Determine if coagulopathy, platelet disorder or hypertension is present</li> <li>▪ Medications – NSAIDS, aspirin, Warfarin?</li> </ul>	Immediate control may occur with: <ul style="list-style-type: none"> <li>▪ Pressure on the nostrils (&gt;5 mins)</li> <li>▪ If bleeder is visible in Little's area consider cautery with silver nitrate (after applying topical anaesthesia) using firm pressure for 60 seconds</li> </ul> Intranasal packing coated with antibiotic ointment only by skilled person with good equipment	Referral to an Otolaryngologist if: <ul style="list-style-type: none"> <li>▪ Bleeding is posterior –refer immediately – contact The Alfred Emergency &amp; Trauma Centre registrar or send to The Alfred Emergency &amp; Trauma Centre, or PRIORITY 1</li> <li>▪ Bleeding persists – refer immediately to The Alfred Emergency &amp; Trauma Centre or phone ENT registrar</li> <li>▪ Bleeding recurs – PRIORITY 1</li> </ul>
<b>Persistent Nasal Obstruction</b>	Symptoms: <ul style="list-style-type: none"> <li>▪ Nasal obstruction (uni/bilateral, altering), postnasal discharge, recurrent sinusitis</li> <li>▪ Physical examination requires intranasal examination after decongestion: deviated septum, enlarged turbinates, nasal polyps</li> </ul>	<ul style="list-style-type: none"> <li>▪ Treat any associated allergy or sinusitis</li> </ul>	<ul style="list-style-type: none"> <li>▪ Refer if simple measures fail – PRIORITY 3</li> <li>▪ ENT referral is imperative if there is an offensive bloody discharge – PRIORITY 1</li> </ul> <b>NOTE:</b> In unilateral nasal obstruction with an offensive, bloody discharge: <ul style="list-style-type: none"> <li>▪ In a child – consider a foreign body</li> <li>▪ In an adult – consider a malignancy – particularly in wood workers</li> </ul>

## REFERRAL & MANAGEMENT GUIDELINES: ENT/OTOLARYNGOLOGY

DIAGNOSIS	EVALUATION	MANAGEMENT	REFERRAL GUIDELINES
<b>Acute Sinusitis</b>	Unilateral or bilateral nasal congestion, usually evolving from a viral URTI. Signs of sinusitis include: <ul style="list-style-type: none"> <li>▪ Purulent discharge</li> <li>▪ Facial, forehead or periorbital</li> <li>▪ Dental pain</li> <li>▪ Persisting URTI &gt; 7 days</li> </ul> History and physical examination may be non-contributory <ul style="list-style-type: none"> <li>▪ CT scan rarely indicated</li> <li>▪ <a href="#">The Alfred Radiology request form</a></li> </ul>	Initial treatment: <ul style="list-style-type: none"> <li>▪ Broad spectrum antibiotics eg Augmentin, Rulide or Ceclor for at least 2 – 4 weeks</li> <li>▪ Systematic decongestants, antipyretics, supportive therapy</li> <li>▪ Consider steroid therapy</li> </ul> <b>NOTE:</b> Antihistamines may cause adverse effects <ul style="list-style-type: none"> <li>▪ Topical decongestants sprays to a maximum of 5 days</li> </ul>	Otolaryngology referral indicated if: <ul style="list-style-type: none"> <li>▪ Antibiotic treatment fails, clinically PRIORITY 1-2</li> <li>▪ Complications occur: periorbital cellulitis, persistent frontal headache – refer immediately – contact ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>▪ Recurrent infections: over three episodes in a one year period – PRIORITY 3</li> <li>▪ Consider early referral for acute frontal sinusitis</li> </ul>
<b>Chronic Sinusitis/Polyposis</b>	Symptoms: <ul style="list-style-type: none"> <li>▪ Persistent or recurrent nasal congestion (unilateral or bilateral)</li> <li>▪ Postnasal discharge</li> <li>▪ Epistaxis</li> <li>▪ Recurrent acute sinusitis</li> <li>▪ Anterior facial pain, migraine and cluster headache</li> <li>▪ Physical examination requires intranasal examination after decongestion</li> <li>▪ CT scan at The Alfred is indicated (NB The Alfred has a 64 slice multislice CT scanner available, and clinicians can access results immediately via the PACS system)</li> </ul> <a href="#">The Alfred Radiology request form</a>	<ul style="list-style-type: none"> <li>▪ Antibiotics</li> <li>▪ Nasal decongestant sprays (5/7)</li> <li>▪ Topical steroid sprays</li> <li>▪ Consider short course of steroids (eg 20mg daily/2 weeks)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Consider Otolaryngology referral if symptoms persist</li> <li>▪ Persisting abnormal symptoms, abnormal findings and/or abnormal radiographs warrant referral – PRIORITY 3</li> <li>▪ In some cases an earlier appointment may be required</li> </ul> <b>NOTE:</b> in unilateral nasal obstruction with an offensive, bloody discharge: <ul style="list-style-type: none"> <li>▪ In a child – consider a foreign body – PRIORITY 1</li> <li>▪ In an adult – consider a malignancy – PRIORITY 1</li> </ul>
<b>Facial Pain</b>	<ul style="list-style-type: none"> <li>▪ May be an isolated symptom or may be associated with significant nasal congestion or discharge</li> <li>▪ Potential relations to intranasal deformity, sinus pathology, dental pathology, TMJ dysfunction, altered V nerve function and skull base lesions</li> <li>▪ Consider CT scan at The Alfred if appropriate NB The Alfred has a 64 slice multislice CT scanner available, and clinicians can access results immediately via the PACS system)</li> </ul> <a href="#">The Alfred Radiology request form</a>	<ul style="list-style-type: none"> <li>▪ If there is evidence of acute sinusitis treat with appropriate antibiotics</li> </ul>	<ul style="list-style-type: none"> <li>▪ Referral indicated for persisting facial pain. May include dental and otolaryngology opinions – PRIORITY 2</li> </ul>
<b>Allergic Rhinitis/ Vasomotor Rhinitis</b>	Symptoms – seasonal or perennial: <ul style="list-style-type: none"> <li>▪ Congestion esp. alternating</li> <li>▪ Watery discharge</li> <li>▪ Sneezing fits</li> <li>▪ Watery eyes</li> <li>▪ Itchy eyes and/or throat</li> <li>▪ Physical examination: <ul style="list-style-type: none"> <li>▪ Boggy, swollen, bluish turbinates</li> <li>▪ Allergic shiners</li> <li>▪ Allergic "salute"</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▪ Avoidance</li> <li>▪ Skin prick testing or RAST testing</li> <li>▪ Topical steroid sprays</li> <li>▪ Antihistamines</li> <li>▪ Oral steroids up to 10/7</li> <li>▪ For acute cases consider five days nasal decongestants</li> <li>▪ Avoid prolonged use of decongestants due to risk of rhinitis medicamentosa</li> </ul>	<ul style="list-style-type: none"> <li>▪ Consider ENT referral if symptoms do not respond to medical management – PRIORITY 3</li> </ul>
<b>Acute Nasal Fracture</b>	<ul style="list-style-type: none"> <li>▪ Immediate changes: oedema, ecchymosis, epistaxis</li> <li>▪ Evaluate for septal fracture or septal haematoma</li> <li>▪ Nasal x-rays unnecessary</li> <li>▪ Check for # zygoma, dental injury or middle third #</li> <li>▪ CT scan if suspect facial #</li> <li>▪ OPG for suspected jaw fracture</li> </ul> <a href="#">The Alfred Radiology request form</a>	<ul style="list-style-type: none"> <li>▪ Early treatment: cool compresses to reduce swelling'</li> <li>▪ Re-evaluate at 3-4 days to ensure nose looks normal and if breathing is normal</li> </ul>	<ul style="list-style-type: none"> <li>▪ Immediate ENT referral if acute septal haematoma (usually significant nasal obstruction)– contact ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>▪ ENT referral initiated now if there is a new external nasal deformity.</li> </ul> <b>NOTE:</b> Nasal fractures must be reduced <2 weeks for best results
<b>Foreign Bodies</b>	<b>Acute:</b> <ul style="list-style-type: none"> <li>▪ History alone or visible on examination</li> </ul> <b>Chronic</b> <ul style="list-style-type: none"> <li>▪ Persistent, offensive unilateral nasal discharge in a child</li> </ul>	<ul style="list-style-type: none"> <li>▪ Don't attempt removal unless experienced and with good equipment</li> </ul>	<ul style="list-style-type: none"> <li>▪ Urgent referral for removal – REFER IMMEDIATELY TO The Alfred Emergency &amp; Trauma Centre – contact ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>▪ <b>Immediate referral if battery (corrode)</b></li> <li>▪ Otolaryngology referral for removal – PRIORITY 1</li> </ul>

## REFERRAL & MANAGEMENT GUIDELINES: ENT/OTOLARYNGOLOGY

DIAGNOSIS	EVALUATION	MANAGEMENT	REFERRAL GUIDELINES
<b>EAR</b>			
<b>Foreign Bodies</b>	<ul style="list-style-type: none"> <li>Usually visible if acute</li> </ul>	<ul style="list-style-type: none"> <li>Remove only if technically easy</li> </ul>	<ul style="list-style-type: none"> <li>Otolaryngology referral- PRIORITY 1</li> </ul>
<b>EAR INFECTIONS</b>			
<b>Acute Otitis Media</b>	<p>Symptoms:</p> <ul style="list-style-type: none"> <li>Otalgia, hearing loss, aural discharge, fever.</li> <li>Examination</li> <li>Inflamed tympanic membrane TM, bulging TM, desquamated epithelium on TM, middle ear effusion.</li> </ul>	<p>Initial treatment (consider withholding antibiotics):</p> <ul style="list-style-type: none"> <li>Broad Spectrum antibiotic, Amoxycillin, Co-trimoxazole</li> <li>Analgesia: Paracetamol</li> <li>Topical nasal decongestants and in adults, systematic decongestants</li> <li>If there is associated allergy, topical nasal steroid sprays could be considered</li> </ul> <p>Secondary treatment:</p> <ul style="list-style-type: none"> <li>If primary treatments fail, try a B-Lactamase resistant antibiotic, eg Augmentin</li> </ul>	<ul style="list-style-type: none"> <li>Immediately if complications noted: mastoiditis, facial weakness, dizziness, meningitis – REFER IMMEDIATELY TO The Alfred Emergency &amp; Trauma Centre</li> <li>Secondary antibiotic treatment fails to control acute symptoms – refer immediately to The Alfred Emergency &amp; Trauma Centre /phone ENT registrar or PRIORITY 1 depending on severity</li> </ul>
<b>Chronic Suppurative Otitis Media</b>	<p>Symptoms:</p> <ul style="list-style-type: none"> <li>Chronic discharge from the ear/s, hearing loss</li> </ul> <p>Examination</p> <ul style="list-style-type: none"> <li>Perforation of drum (especially attic or postero-superiorly granulation tissue and/or bleeding)</li> </ul> <p>Complications suggested by:</p> <ul style="list-style-type: none"> <li>Post auricular swelling/abscess, facial palsy, vertigo, headache – refer immediately – phone ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> </ul>	<ul style="list-style-type: none"> <li>Aural toilet (not syringing)</li> <li>Culture directed antibiotic therapy: systemic and copious aural drops (Sofradex)</li> <li>Protect ear from water exposure</li> </ul>	<ul style="list-style-type: none"> <li>Otolaryngology referral indicated for persistent symptoms despite appropriate treatment – PRIORITY 2-3.</li> <li>Associated symptoms suggest urgency needed – PRIORITY 1</li> </ul>
<b>Acute Otitis Externa</b>	<p>Symptoms:</p> <ul style="list-style-type: none"> <li>Otalgia, significant ear tenderness, swollen external auditory canal +/- hearing loss</li> </ul> <p>Examination</p> <ul style="list-style-type: none"> <li>Ear canal always tender, usually swollen. Often unable to see TM because of debris or canal oedema</li> <li>Swab for org./fungi.</li> </ul> <p><b>NOTE:</b> Fungal Otitis Externa may have spores visible</p>	<ul style="list-style-type: none"> <li>Topical treatment is optimal and systemic antibiotics alone are often insufficient. Systemic Antibiotics indicated when there is cellulitis around the canal</li> <li>Insertion of an expandable wick with topical antibacterial medication useful when the canal is narrowed</li> <li>In fungal OE, thorough cleaning of the canal is indicated, plus topical antifungal therapy (Kenacomb, Locorten-Vioform)</li> </ul> <p><b>NOT for syringing</b></p>	<p>Referral to an Otolaryngologist when:</p> <ul style="list-style-type: none"> <li>Canal is swollen shut and wick cannot be inserted – immediate referral</li> <li>Cerumen impaction complicating OE – PRIORITY 2</li> <li>Unresponsive to initial course of wick and antibacterial drops – PRIORITY 1</li> <li>Diabetics, suspected malignancy and immunosuppressed on examination require urgent referral – phone ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> </ul>
<b>Otalgia without significant clinical findings in the ear canal or drum</b>	<p>Symptoms:</p> <ul style="list-style-type: none"> <li>Ear pain without tenderness or swelling</li> </ul> <p>Examination</p> <ul style="list-style-type: none"> <li>Normal ear canal and TM</li> <li>Type A Tympanogram</li> </ul> <p><b>NOTE:</b> Mastoiditis in the presence of a normal drum and without previous infection is almost impossible</p>	<ul style="list-style-type: none"> <li>Requires a diagnosis and appropriate treatment. Possible aetiologies include:</li> <li>TMJ syndrome; neck dysfunction; referred pain from dental pathology, tonsil disease, sinus pathology and head and neck malignancy; particularly tonsil/hypopharynx/larynx</li> </ul>	<ul style="list-style-type: none"> <li>Referral to an Otolaryngologist indicated if pain persists more than three weeks and aetiology not identified – PRIORITY 2</li> </ul>
<b>HEARING LOSS</b>			
<b>Bilateral, Symmetrical Hearing Loss</b>	<p>Symptoms:</p> <ul style="list-style-type: none"> <li>Diminished hearing any associated symptoms eg tinnitus, discharge, vertigo etc?</li> </ul> <p>Examination</p> <ul style="list-style-type: none"> <li>Cerumen, effusion, or normal findings</li> </ul>	<ul style="list-style-type: none"> <li>Cerumen dissolving drops and possible suction or irrigation</li> <li>Oral decongestant, Valsalva manoeuvres and re-evaluate in three weeks</li> <li>Requires audiometry +/- referral</li> </ul>	<p>Referral indicates if:</p> <ul style="list-style-type: none"> <li>Cerumen, and/or significant hearing loss persists – PRIORITY 3</li> <li>Urgent Otolaryngology referral if &lt; 1 week for acute treatment – phone ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>If onset more than one week refer</li> </ul>
<b>Unilateral Hearing Loss in Adults includes Sudden Hearing Loss</b>	<ul style="list-style-type: none"> <li>Normal drum with Weber to good ear</li> </ul>	<ul style="list-style-type: none"> <li>Expectant treatment if &gt;2 weeks</li> <li>Audiometry if available</li> </ul>	<ul style="list-style-type: none"> <li>Immediate referral if onset less than 1 week</li> <li>Semi-urgent referral if &gt;1 week with incomplete recovery – PRIORITY 1-2</li> <li>Non-urgent if complete recovery but for investigation – PRIORITY 2</li> </ul>
<b>Chronic</b>	<p>Symptoms:</p> <ul style="list-style-type: none"> <li>Difficulty hearing especially only in a crowded environment; difficulty localising sound</li> </ul> <p>Examination</p> <ul style="list-style-type: none"> <li>Cerumen</li> <li>Abnormal tympanic membrane</li> </ul>	<ul style="list-style-type: none"> <li>Cerumen dissolving drops and possible suction or irrigation</li> </ul>	<ul style="list-style-type: none"> <li>Otolaryngology referral if the ear has not been previously assessed by an otolaryngologist or the symptoms and/or clinical findings have changes – PRIORITY 3</li> </ul> <p><b>NOTE:</b> Unilateral effusions in adults? Sinus disease or nasopharyngeal tumour (especially in patients of Chinese origin)</p>

## REFERRAL & MANAGEMENT GUIDELINES: ENT/OTOLARYNGOLOGY

DIAGNOSIS	EVALUATION	MANAGEMENT	REFERRAL GUIDELINES
<b>TINNITUS</b>			
<b>Chronic Bilateral</b>	<ul style="list-style-type: none"> <li>▪ Any associated symptoms?</li> <li>▪ Cerumen?</li> <li>▪ Audio + Tymp</li> </ul>	<ul style="list-style-type: none"> <li>▪ Clear cerumen and check TM. If TMS clear, no treatment</li> </ul>	<ul style="list-style-type: none"> <li>▪ No referral indicated unless tinnitus is disabling, or associated with hearing loss, aural discharge or vertigo – PRIORITY 2-3 depending on symptoms</li> </ul>
<b>Unilateral, or recent onset</b>	<ul style="list-style-type: none"> <li>▪ Any associated symptoms?</li> <li>▪ Cerumen?</li> <li>▪ Audio + Tymp</li> </ul>	<ul style="list-style-type: none"> <li>▪ Clear cerumen and check TM. If symptoms persist, refer</li> </ul>	<ul style="list-style-type: none"> <li>▪ Referral indicated, especially if it is disabling, or associated with hearing loss, aural discharge or vertigo – PRIORITY 2</li> </ul>
<b>Pulsatile</b>	<ul style="list-style-type: none"> <li>▪ TM normal or (vascular) mass behind drum</li> <li>▪ Audio + Tymp</li> <li>▪ Auscultate carotid vessels of the ear region</li> </ul>	<ul style="list-style-type: none"> <li>▪ Referral</li> </ul>	<ul style="list-style-type: none"> <li>▪ Referral is indicated in all cases- PRIORITY 2</li> <li>▪ If there is middle ear mass, there is a strong possibility of a glomus tumour – PRIORITY 1</li> </ul>
<b>DIZZINESS</b>			
<b>Sudden Onset Vertigo – Associated with Barotrauma</b>	<ul style="list-style-type: none"> <li>▪ Acute onset of vertigo or disequilibrium associated with pressure change usually caused by air flight or driving. There may be associated hearing loss and tinnitus</li> </ul>	<ul style="list-style-type: none"> <li>▪ Possibility of a perilymph fistula between the inner ear and middle ear must be considered</li> </ul>	<ul style="list-style-type: none"> <li>▪ This condition requires immediate referral for specialist management – phone The Alfred Emergency &amp; Trauma Centre registrar or send to The Alfred Emergency &amp; Trauma Centre</li> </ul>
<b>Orthostatic</b>	<p>Symptoms</p> <ul style="list-style-type: none"> <li>▪ Mild, brief and only on standing up (usually am)</li> <li>▪ Review medications</li> </ul>	<ul style="list-style-type: none"> <li>▪ Evaluate cardiovascular system, reassurance</li> </ul>	<ul style="list-style-type: none"> <li>▪ No referral indicated unless atypical or associated with other symptoms and this should normally be Medical</li> </ul>
<b>Benign Positional Vertigo &amp; Vestibular Neuronitis</b>	<ul style="list-style-type: none"> <li>▪ Associated with an URTI, may be positional and/or persistent</li> <li>▪ Audio</li> <li>▪ TM joint examination</li> <li>▪ ? spontaneous nystagmus</li> </ul>	<ul style="list-style-type: none"> <li>▪ Self-limiting over a few months</li> <li>▪ Symptomatic medication eg Stemetil may help VN</li> </ul>	<ul style="list-style-type: none"> <li>▪ Referral with: Associated hearing loss, increased severity, or persistence over 2 months – PRIORITY 2</li> </ul>
<b>Chronic or Episodic</b>	<ul style="list-style-type: none"> <li>▪ Significant vertigo</li> <li>▪ May have associated hearing loss, tinnitus, aural fullness, nausea</li> <li>▪ History of previous ear surgery</li> <li>▪ Audio + Tympanometry (If available)</li> </ul>	<ul style="list-style-type: none"> <li>▪ Symptomatic treatment acutely</li> </ul>	<ul style="list-style-type: none"> <li>▪ Otolaryngology referral is indicated – PRIORITY 2-3, dependent on history</li> </ul>
<b>FACIAL PARALYSIS</b>			
	<ul style="list-style-type: none"> <li>▪ Weakness or paralysis of movement of all (or some) of the face</li> <li>▪ May be associated with otalgia, otorrhoea, vesicles, parotid mass or tympanic membrane abnormality</li> </ul>	<ul style="list-style-type: none"> <li>▪ Protection of the eye from a corneal abrasion is paramount. Apply Lacrilube and tape the eye shut at night.</li> <li>▪ Steroid therapy may be initiated if no associated findings</li> <li>▪ Consider anti-viral treatment</li> </ul>	<ul style="list-style-type: none"> <li>▪ Urgent Otolaryngology referral is indicated if otologic cause suspected – phone ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> </ul>