Guidelines for initial management and referral for common ENT conditions

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Useful resources:

**Hoarseness**

**When to refer**

* Red flags – send via 2WW or urgent C&B.
* Intermittent hoarseness >12 weeks and not responding to initial measures.

**Primary Care management**

* Stop smoking.
* Modify any vocal abuse.
* Good vocal hygiene (avoid too much caffeine, more water etc).
* Review inhaler technique +/- rinsing
* Consider effects from and on occupation (e.g. teacher, singer etc).
* Chest radiograph to exclude chest pathology.
* Consider trial of maximal dose anti-reflux treatment (e.g. omeprazole or Lansoprazole and gaviscon liquid qds for 8 weeks) – especially if reflux symptoms.

**Diagnosis**

* Persistent hoarseness is more indicative of pathology than intermittent hoarseness.
* Enquire about voice use / abuse.
* Reflux symptoms?
* Risk factors for cancer – smoking.

**Red flags**

* Persistent hoarseness > 6 weeks. (voice constantly hoarse).
* Pain on swallowing.
* Dysphagia.
* Haemoptysis.
* Otalgia.
* Neck lump.

2 or more of above is highly indicative of sinister pathology.

Higher risk groups: Smokers and age > 45yrs.

Useful resources:

**Globus Pharyngeus**

**When to refer**

* Any red flags.
* Persistent symptoms > 3 months.
* Need for further reassurance
	+ But stress to patient when this is the intention rather than for further investigation.
* Globus alone does not require 2WW referral.

**Primary Care management**

* Reassurance is key.
* Address life issues.
* Discourage throat clearing.
* Consider trial of maximal dose anti-reflux treatment (e.g. omeprazole or Lansoprazole and gaviscon liquid qds for 8 weeks) – especially if reflux symptoms.

**Diagnosis**

* Clinical diagnosis based on history.
* Feeling of something in the throat:
	+ Tickle / hair
	+ Lump
	+ Constriction
	+ Usually midline cricoid level.
* Often exacerbated by stress.
* Usually in non-smokers.
* May have reflux symptoms.

**Red flags**

* Pain
* Dysphagia
* Persistent hoarseness
* Lateralising symptoms
* Neck lump
* Otalgia

Useful resources:

**Chronic Catarrh**

**When to refer**

* Only for reassurance / closure
	+ Explain this is the case.
* Investigations rarely indicated or fruitful in chronic catarrh.

**Primary Care management**

* Reassurance that this is a common harmless but difficult condition to treat. Current belief is that this is a sensory abnormality.
* Symptom coping strategies.
* Saline nasal irrigation (Sterimar / Neilmed)
* May try intra-nasal steroid but expect little benefit.
* Consider trial of anti-reflux treatment (omeprazole 40mg od and gaviscon liquid qds for 8 weeks) – especially if reflux symptoms.

**Diagnosis**

* Delineate if true discharge present.
* Often cluster of classical symptoms:
	+ Phlegm in throat
	+ Postnasal drip
	+ Choking sensation
	+ Ineffective nose blowing
	+ Nasal congestion.
* Commonly preceded by a cold.
* Invariably in non-smokers.
* Usually symptomatic for years.

**Red flags**

* Blood stained discharge.
* Unilateral discharge.

Useful resources:

<http://cks.nice.org.uk/earwax#!scenario>

**Ear wax**

**When to refer**

* Failure of initial treatment.

**Primary Care management**

* Olive oil softens wax.
* Sodium bicarbonate ear drops more effective at dissolving wax.
* Use 3-4 drops 3-4 x a day for 2 weeks.
* Syringing if:
	+ No perforation
	+ Not prone to otitis externa
	+ Not only hearing ear
	+ No previous middle ear operations.

**Diagnosis**

* Simple wax occlusion.
* Need complete blockage of canal with wax to have any effect on hearing.
* Pain indicates possible added infection.

**Red flags**

Useful resources:

<http://cks.nice.org.uk/otitis-externa>

**Otitis Externa**

**When to refer**

* Any red flags.
* Suspected cholesteatoma – painless or recurrent discharge, or abnormal looking drum.
* Protracted symptoms resistant to topical therapy.
* Infections interfering with hearing aid use.

**Primary Care management**

* Immediate
	+ Dry mop conchal bowl / distal ear canal if able
	+ Treatment is **topical** with antibiotic/steroid drops.
	+ If pinna cellulitis then add oral antibiotics.
* Longer term
	+ Keep ear dry
	+ Close diabetic control
	+ Consider skin conditions or aggravating products
	+ For eczematous canals use mild steroid cream.
* Topical antibiotics OK to use with perforation if infection present and use limited to 7 days.

**Diagnosis**

* Itch / pain and discharge.
* If one without the other, unlikely to be simple otitis externa.
* History of scratching ear, cotton buds or water ingress into the ear.
* Infection can spread to bone in immune compromised patients (e.g. diabetics) leading to severe deep boring pain with granulation in canal and possible cranial nerve palsy – Osteomyelitis / “malignant otitis externa”.

**Red flags**

* Painless discharge.
* Pain out of keeping with findings.
* Protracted otalgia (especially in diabetics).
* Recurrent / persistent infections.
* Cranial nerve weakness.
* Granulation in the canal.
* Cellulitis spreading onto face – would benefit from admission for IV antibiotics.

Useful resources:

<https://www.nice.org.uk/guidance/cg60/chapter/1-Guidance>

**Glue ear**

**When to refer**

* Persistent documented glue ear > 3 months
* Concerns that glue ear is causing significant speech & language delay.
* Other abnormalities of the ear drum.

**Primary Care management**

* Remove any wax:
	+ Olive oil softens wax
	+ Sodium bicarbonate ear drops more effective at dissolving wax
	+ Use 3-4 drops 3-4 x a day for 2 weeks.
* Could try otovent balloon if tolerated.
* Reassure most glue ear self resolves – 50% every 3 months in children.
* Tympanometry / audiology if available to document glue ear.
* Watch for 3 months initially.
* Treat rhinitis is present.

**Diagnosis**

* TV loud / close to TV.
* Speech / language delay.
* Recurrent acute otitis media (AOM) - glue ear is common after AOM.
* Nasal blockage.
* Teacher / parental concerns.
* Clinical evidence of dull or retracted ear drums.
* Hearing test confirms hearing loss (conductive).
* Type b (flat) tympanograms.

**Red flags**

* Significant drum retraction

Useful resources:

**Hearing Loss (& normal ear drum)**

**When to refer**

* Red flags.
* Children aged <4yrs with hearing loss and no other ear symptoms or signs can be referred direct to Audiology.
* Children aged 4-16yrs with hearing loss need to be referred to ENT.
* Aged >16yrs with sensorineural hearing loss and no other ear symptoms or signs can be referred to audiology direct.
* Unilateral sensorinueral hearing loss or unilateral tinnitus will usually require an MRI scan to rule out acoustic neuroma.

**Primary Care management**

* Remove any wax:
	+ Olive oil softens wax
	+ Sodium bicarbonate ear drops more effective at dissolving wax
	+ Use 3-4 drops 3-4 x a day for 2 weeks.

**Diagnosis**

* Children: sitting close to TV or TV loud, parental / school concern, delay in speech and language.
* Otoscopy – check no abnormality
* Tuning fork test and free field test or in house audiology if available.
* Free field testing: Ask to repeat series of whispered numbers/ letters/ words while standing behind and rubbing tragus of non-test ear. Able to hear >50% – hearing probably near normal.
* Tuning fork tests:
* SNHL AC >BC. Weber away from bad ear.
* CHL BC>AC. Weber towards bad ear
* AC = Air Conduction, BC = Bone Conduction)

**Red flags**

* Sudden sensorineural hearing loss (SNHL) – treat with high dose prednisolone (0.5-1mg / kg) for 7 days – caution in diabetics and glaucoma. Arrange ENT OPD referral.
* Cranial nerve signs.
* Unilateral sensorineural hearing loss or unilateral tinnitus – **routine** referral to ENT for consideration of MRI to rule out acoustic neuroma. GP can arrange MRI IAMs direct if confident of audiology findings arranged locally.

Useful resources:

<http://dizziness-and-balance.com/disorders/index.html>

**Dizziness**

**When to refer**

* Red flags
* For Epley manoeuvre if unsure how to do.
* No response to initial management.
* Sensorineural hearing loss >24hrs

**Primary Care management**

* Advise re safety to drive / work.
* Adjust any potential drug causes (e.g. low BP).
* Treat migraine.
* Epley manoeuvre for BPPV (80% cure).
* Labyrinthitis – usually resolves with time, but may get occasional dizzy spells after. Vestibular sedative (e.g. prochlorperazine or cinnarizine) use only for 1-2 weeks – longer may delay recovery.
* Menieres disease (Dizziness 20 mins to hours +/- tinnitus, pressure and temporary hearing loss) is uncommon
	+ Reduce salt, caffeine, stress levels
	+ Betahistine 8-16mg tds .
* Betahistine is only indicated if Menieres is suspected.
* If any sensorineural hearing loss lasting >24hrs then treat with high dose prednisolone.

**Diagnosis**

Vertigo = perception of room spinning – vestibular cause possible.

Imbalance / fuzzy head / drunk feeling - probably not vestibular cause.

History Key:

Recurrent vertigo for seconds / mins with head movement = BPPV.

Recurrent vertigo for hours (+hearing loss and tinnitus) = Menieres (rare).

Vertgo for days = labyrinthitis / neuronitis.

Any ear symptoms.

Migraine history – 20% have dizzy symptoms.

Check BP (standing & laying) & pulse (?cardiac cause).

Check neurology (?central cause).

Otoscopy and tuning fork tests – check for hearing loss.

Romberg, Unterberger, Dix Halpike test.

Check medications (?drug cause).

**Red flags**

* Otalgia
* Ear discharge
* Severe or persistent headache
* Cranial nerve palsy – contact ENT on call to discuss if emergency admission required.
* New sensorineural hearing loss
	+ If sudden sensorineural hearing loss (SNHL) – treat with high dose prednisolone (0.5-1mg / kg) for 7 days – caution in diabetics and glaucoma. Arrange ENT OPD referral.

Useful resources:

<http://www.surreydownsccg.nhs.uk/media/57069/procedures-with-restrictions-and-thresholds_sdccg.pdf>

<http://cks.nice.org.uk/sore-throat-acute>

**Recurrent tonsillitis**

**When to refer**

* Previous quinsy
* Obstructive sleep apnoea (OSA)
* Unilateral tonsil enlargement
* Recurrent Tonsillitis. Local CCG criteria limits funding of tonsillectomy. Requirement is:

“Sore throats that are due to acute tonsillitis

AND

Episodes of sore throat that are disabling and prevent normal functioning

AND

Seven or more well documented, clinically significant, adequately treated sore throats in the preceding year.

OR

Five or more such episodes in each of the preceding two years.

OR

Three or more such episodes in each of the preceding three years.”

**Primary Care management**

* Treat and document individual episodes accordingly.
* Be aware of complications of acute episodes:
	+ Neck abscess
	+ Quinsy
	+ Airway compromise

**Diagnosis**

* Recurrent episodes of genuine tonsillitis
	+ Odynophagia
	+ Fever
	+ Associated lymph nodes swelling
	+ Swollen inflamed tonsils
* “Centor” criteria helpful:
	+ Presence of tonsillar exudate.
	+ Presence of tender anterior cervical lymphadenopathy or lymphadenitis.
	+ History of fever.
	+ Absence of cough.
* 3-4 or these indicate Group A b-haemolytic strep likely and therefore consider antibiotics.

**Red flags**

* Suspicion of tonsil cancer -unilateral tonsil enlargement . Usually obviously abnormal looking tonsil. Refer under 2WW or urgent C&B.
* Severe OSA symptoms thought to be as a result of huge tonsils. Refer to ENT clinic.
* Complications of acute episodes:
	+ Neck abscess
	+ Quinsy
	+ Airway compromise.

Useful resources

<http://cks.nice.org.uk/epistaxis-nosebleeds>

**Recurrent Epistaxis**

**When to refer**

* Failure of initial treatment.

**Primary Care management**

* Stop nose picking.
* If using steroid nasal sprays for rhinitis then check correct technique.
* Naseptin nasal cream bd to nose for 2 weeks. Up to 6 weeks if required. Do not use if peanut allergic.
* If familiar; perform silver nitrate cautery to any obvious source of bleeding. Only cauterise one side of the septum at a time. Delay cautery of other side until healed (about 6 weeks).
* If taking anti-coagulants; check not over treated and still indicated.

**Diagnosis**

* History of nose bleeding.
* Evidence of prominent blood vessels / dried blood or crust on nasal septum.

**Red flags**

* Uncontrolled significant bleeding.
* Unilateral nasal blockage persisting after initial management.
* Significant crusting which fails to settle with initial management.

Useful resources:

**Nasal injury / fracture**

**When to refer**

* Red flags or new nasal deformity
	+ **There is a 2 week window in which bones can be manipulated back in place – therefore contact ENT department within 3 days of injury.**
* If injury > 4 weeks old then referral via routine ENT OPD (as it is too late to consider early manipulation).

**Primary Care management**

* Check for septal haematoma
	+ Soft boggy swelling of septum
	+ Nasal blockage.
* Check for any other associated facial injuries.
* If nasal bones straight and no septal haematoma or any other injuries – reassure.

**Diagnosis**

* Mechanism of injury / circumstances.
* New deformity of nasal bones.
* New nasal obstruction.

**Red flags**

* Septal haematoma – requires urgent referral to ENT on call.
* Open wounds need closure / assessment in A&E.

Useful resources:

[www.britishsnoring.co.uk](http://www.britishsnoring.co.uk)

<http://www.britishsnoring.co.uk/sleep_apnoea/epworth_sleepiness_scale.php>

**Snoring & Obstructive Sleep Apnoea (OSA)**

**When to refer**

* Suspected OSA.
* Do not refer for simple snoring without OSA – snoring surgery is not commissioned locally!

**Primary Care management**

* Active weight loss.
* Stop smoking.
* Avoid alcohol 4 hours before bed.
* Review sedative prescription.
* Treat rhinitis.
* Sleep on side.
* Advise patient to inform DVLA when OSA suspected / investigated.
* Do not drive if tired.

**Diagnosis**

* Apnoea = breath holding episode >10 seconds terminated by snort / arousal.
* Epworth Sleepiness Score (ESS) assesses symptoms of daytime somnolence. ESS <10 makes OSA unlikely.
* Check for nasal symptoms / block.
* Measure BMI / BP / Collar size.

**Red flags**

* Daytime somnolence.
* Witnessed apnoeas.

Useful resources:

<http://cks.nice.org.uk/sinusitis>

<http://www.ep3os.org/pdf/EPOSpocketguide2012.pdf>

**Chronic Rhinosinusitis (CRS)**

**When to refer**

* Any red flags
* No response to initial therapy
* NB Facial pain without any nasal symptoms is unlikely to be caused by sinuses – little will be added from an ENT referral.

**Primary Care management**

* Stop smoking.
* Stop over the counter decongestants (rhinitis medicamentosa possible)
* Od – bd saline douche (e.g. Neilmed or Sterimar).
* Topical nasal steroid spray min 6 weeks (teach correct technique to avoid epistaxis) for mild symptoms.
* Topical steroid drops for min 6 weeks if moderate symptoms.
* Consider short course of prednisolone if polyps or severe symptoms.
* Oral antihistamine if allergic symptoms.
* If infective symptoms then trial course of antibiotics.

**Diagnosis**

2 or more symptoms, 1 must be ‘hard’:

**Hard Soft**

Nasal block / congestion Loss of smell

Nasal discharge Facial pain

NB Facial pain in the absence of nasal symptoms is not suggestive of rhinosinusistis.

Acute = <12 weeks; complete resolution

Chronic = >12 weeks; incomplete resolution

Try to determine if CRS is more infective (pus / pain predominant) or allergic (sneeze & itch symptoms)

Examine nose – septal deformity? Polyps?

Any previous nasal surgery

Any co-existent asthma?

**Red flags**

* Unilateral blockage
* Unilateral discharge
* Bloodstained discharge
* Crusting
* Eye symptoms / signs
* Focal facial swelling