Management and referral guidelines for ENT in Primary Care

North Cumbria University Hospitals Trust

Contents

Chronic Rhinosinusitis

Red flags

Unilateral blockage

Unilateral discharge

Bloodstained discharge

Crusting

Eye symptoms/signs

Focal facial swelling

- esp in elderly
- smokers
- woodworkers

Diagnostic criteria

2 or more symptoms, 1 of which must be 'hard';

Hard symptoms	*Soft symptoms*
Nasal block/congestion	Loss of smell
Nasal discharge	Facial pain

N.B. Facial pain in absence of nasal symptoms is *not* suggestive of rhinosinusitis.

ACUTE = <12 wks; complete resolution
CHRONIC = >12 wks; incomplete resolution

Diagnosis is confirmed by;

- Endoscopic signs (oedema, pus or polyps) and/or
- CT findings (mucosal disease)

Primary Care management

If no polyps evident;

Saline nasal douche/spray
Intranasal **steroid** spray
± **antihistamine** (if allergy)
} for 3/12

→ if no response add **oral macrolide** for 3/12

If polyps evident;

Mild symptoms - steroid **spray** for 3/12
Moderate symps - steroid **drops** for 3/12
Severe symps - steroid **tablets** for 1 week

When to refer

- Any red flags
- No response to medical therapy as across
- If pt willing to consider surgery

NB

- Consider allergy tests in parallel with referral
- Plain XR films **not** used for either acute or chronic rhinosinusitis nor for facial pain.

Evidence based guidelines available in summary form at www.ep3os.org

Globus Pharyngeus

Red flags

Pain (throat or ear)

Dysphagia

Persistent hoarseness

Lateralising symptoms

Diagnostic criteria

- Clinical diagnosis based on history
- Feeling of something in the throat;
  - tickle/hair
  - lump
  - constriction
- Often exacerbated by e.g. stress
- Usually in non-smokers
- May have reflux symptoms

Primary Care management

Reassurance is key

Address life issues

Discourage throat clearing → ice water sips

If reflux symptoms;

- raise end of bed
- Consider b.d. proton pump inhibitor
  + Gaviscon Advance 3/12

When to refer

Any red flags

Persistent symptoms > 3/12

Need for further reassurance

– but stress to pt when this is the intention rather than for further investigation

NB globus sensation alone does not require 2WW referral.

Hoarseness

Red flags

Persistent hoarseness > 3 weeks

Pain

Dysphagia

Haemoptysis

Otalgia

Neck lump

Especially in - smokers

- over 40yrs

Diagnostic criteria

- Persistent hoarseness more suggestive of pathology than intermittent hoarseness.
- Enquire about voice use/abuse
  - Public speaking
  - Amateur dramatics
  - Karaoke
  - Pitch-side coaching
- ? Reflux symptoms

Primary Care management

- Lifestyle measures e.g. control voice abuse/overuse
- Stop smoking
- Review inhaler use ± rinsing
- Consider effects from occupation e.g. teacher, lecturer, singer, call centre operator

When to refer

- Red flags
- Intermittent hoarseness >12 weeks and not responding to lifestyle measures across

Red flags through 2WW path or urgent C&B

Dizziness

Red flags

Otalgia

Ear discharge

Headache

Diagnostic criteria

VERTIGO = perception of room spinning
v's
IMBALANCE = light-headedness/drunk/fuzziness

Generally unlikely to be vestibular pathology if no vertigo.

History is suggestive when otological cause – onset, duration, frequency e.g.

- recurrent vertigo for secs/mins = BPPV
- recurrent vertigo for hours = Menieres
- persistent vertigo for days = labyrinthitis / neuronitis

Inquire about associated ear symps eg HL / tinnitus

Otoscopy + tuning for tests

? Nystagmus present during symptomatic phase.

Unterberger's rather than Romberg's for vestibular pathol

Dix-Hallpike test for BPPV

Primary Care management

Lifestyle measures – caution with driving/activities

Trying stopping meds before starting new ones.

BPPV - Epley manoeuvre 80% success rate

Meniere's disease (actually quite rare);
- reduce salt, chocolate, red wine
- bendrofluazide 2.5mg
- Betahistine 8-16mg tds (prophylaxis)

Labyrinthitis/neuronitis - self-limiting but often recurs with decreasing frequency/intensity. Symptomatic treatment only but:

No longterm vestibular sedatives e.g. cinnarizine or prochlorperazine – these dampen the compensatory mechanisms and prolong symptoms in the recovery phase.

When to refer

- Red flags
- For Epley if practitioner unfamiliar
- Meniere's unresponsive to trial of betahistine

Lay information available at www.menieres.co.uk

Hearing loss

Red flags

Unilateral loss with no past ear surgery

Sudden onset hearing loss

Other cranial nerve signs

Diagnostic criteria

Ensure ears free of wax

Otoscopy

Free-field speech:

- ask to repeat series of numbers/letters/words whilst standing behind and rubbing tragus of non-test ear.
- >50% correct is acceptable.

Tuning fork tests:

SNHL: AC better than BC (Rinne +ve)
Weber away from bad ear

CHL: AC worse than BC (Rinne –ve)
Weber towards bad ear

(AC= air conduction, BC= bone conduction)

Primary Care management

Lifestyle tips & aids:

- face to face conversations
- telephone amplifier
- doorbell amplifier

When to refer

If >60yrs with bilateral hearing loss and no ear pathology/abnormality, refer directly to audiology.

Direct referral criteria

Refer to ENT if:

- unilateral symptoms
- associated ear symptoms (other than tinnitus)
- abnormal tympanic membrane

Snoring / sleep apnoea

Red flags

Daytime somnolesence

Witnessed apnoeas

Diagnostic criteria

Apnoea = breath-holding episode lasting >10 seconds terminated by a snort/rousal.

Epworth Sleepiness Score assesses symptoms of daytime somnolence.
ESS <10 makes OSA unlikely even if witnessed apnoeas/hypopnoeas.

Children with OSA tend to be hyperactive during the day rather than somnolent.

Primary Care management

- Active weight loss
- Stop smoking
- Avoid alcohol 4 hours before bed
- Review sedative prescription
- Treat rhinitis

Suggest trial of mandibular advancement device e.g. Snoreban

All of above need attention prior to referral for sleep studies / snoring surgery

Patient's responsibility to inform DVLA when OSA suspected/investigated.
Doctors responsibility to inform DVLA if untreated OSA pt is witnessed driving.

When to refer

Suspected sleep apnoea

Snoring refractory to above conservative measures

Patient willing to be considered for (painful) snoring surgery

BMI <29/30

General lay information available at www.britishsnoring.co.uk

Otitis externa

Red flags

Painless discharge

Pain out of keeping with findings

Protracted otalgia (esp in diabetic)

Recurrent/persistent unilateral infection

Cranial nerve weakness

Diagnostic criteria

Pain/itch + discharge

If one without the other, unlikely to be simple OE

Mastoid tenderness in adults is more often OE than true mastoiditis.

Malignant OE = severe, deep boring pain
+ granulations in canal
+/- cranial nerve palsy
in diabetic patient

Primary Care management

Immediate
- Ear swab for microbiology
- Dry mop conchal bowl/distal canal
- Treatment is **topical** with drops/spray
- If pinna involved, oral ab's can be added

Longterm/prophylaxis
- consider underlying skin condition
- close diabetic control
- water precautions
- review shampoo
- Earcalm spray (acetic acid) regularly

Topical ab's OK to use with perforation if infection present and only used short term (<10days)

When to refer

Any red flags

Suspected cholesteotoma e.g. abnormal attic, painless discharge

Protracted symptoms resistant to topical therapy

Cellulitis spreading onto face

Infections interfering with hearing aid use

Chronic catarrh

Red flags

Blood stained discharge

Unilateral discharge

Diagnostic criteria

Delineate if true discharge present

Often cluster of classical symptoms:

- phlegm gathering in throat
- postnasal drip
- choking sensation
- ineffective nose blowing
- nasal congestion

Commonly proceeded by a cold

Invariably non-smokers

Usually symptomatic for years

Primary Care management

Reassurance that this is a common but difficult condition to treat. Current belief is that it is a sensory abnormality.

Symptom coping strategies.

Saline nasal irrigation – Sterimar, Neilmed

May try intranasal steroid but expect little benefit.

When to refer

Only for reassurance/closure

- and explain that this is the case

Investigations rarely indicated nor fruitful in chronic catarrh.