Management and referral guidelines for ENT in Primary Care

North Cumbria University Hospitals Trust
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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’;

<table>
<thead>
<tr>
<th>Hard symptoms</th>
<th>Soft symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nasal block/congestion</td>
<td>Loss of smell</td>
</tr>
<tr>
<td>Nasal discharge</td>
<td>Facial pain</td>
</tr>
</tbody>
</table>

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
- Intransal **steroid spray** for 3/12
  + **antihistamine** (if allergy)

→ 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](http://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
- IMBALANCE = light-headedness/drunken/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

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 long term 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
- **Otoscop**y
  - **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.

- Refer to ENT if:
  - unilateral symptoms
  - associated ear symptoms (other than tinnitus)
  - abnormal tympanic membrane

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**Direct referral criteria**
## Snoring / sleep apnoea

### Red flags
- Daytime somnolence
- 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](http://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.