ENT Emergencies
What and When to Refer

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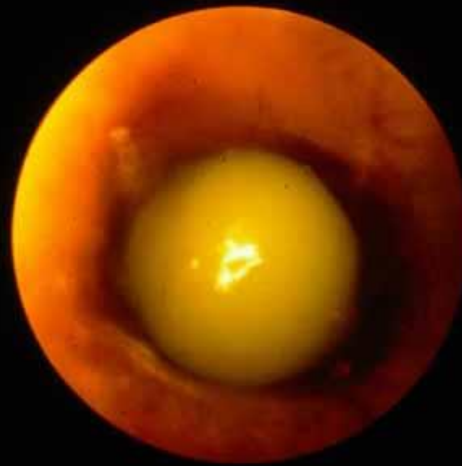
Aims of this talk

- Common ENT conditions
- What and When to refer
- Red flags
- Guidelines on why we do what we do

Ears

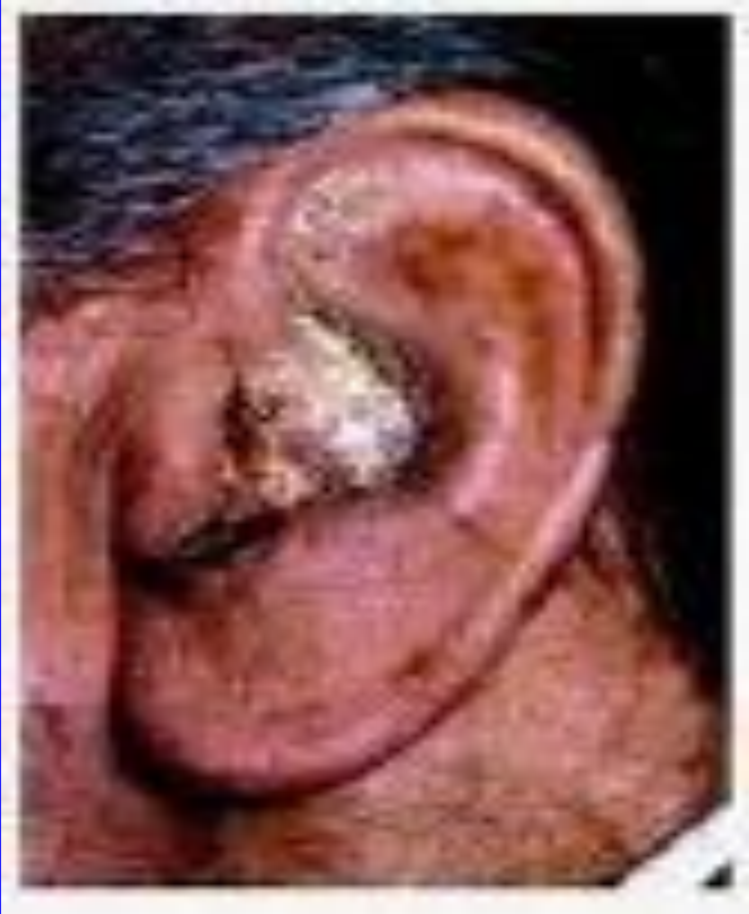
- Foreign body
  - Usually children. Unless you can see the FB sticking out of the ear DO NOT try to remove.
  - Refer to ENT clinic
  - Reassure the patient an inert FB will do no harm. If caustic eg a battery refer straight away

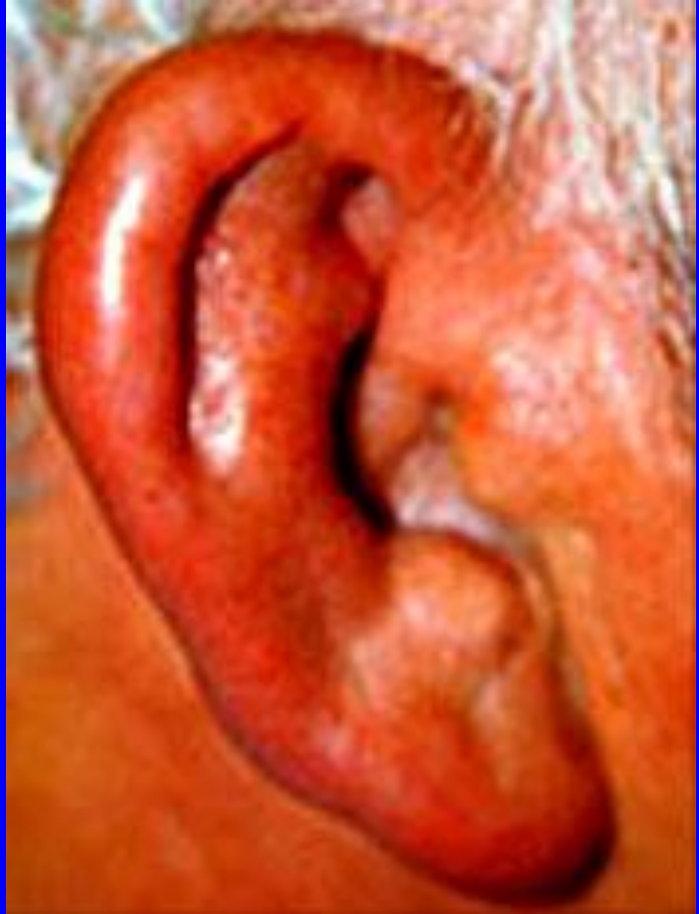
FB Ear



Ear Infections

- Confusing but as long as you remember the terms they are descriptive
- OTITIS EXTERNA
  - Infection of outer ear
    - Painful (especially on moving pinna)
    - Red swollen ear canal and pinna
    - Drum (if you can see it) is normal





Otitis Externa ctd

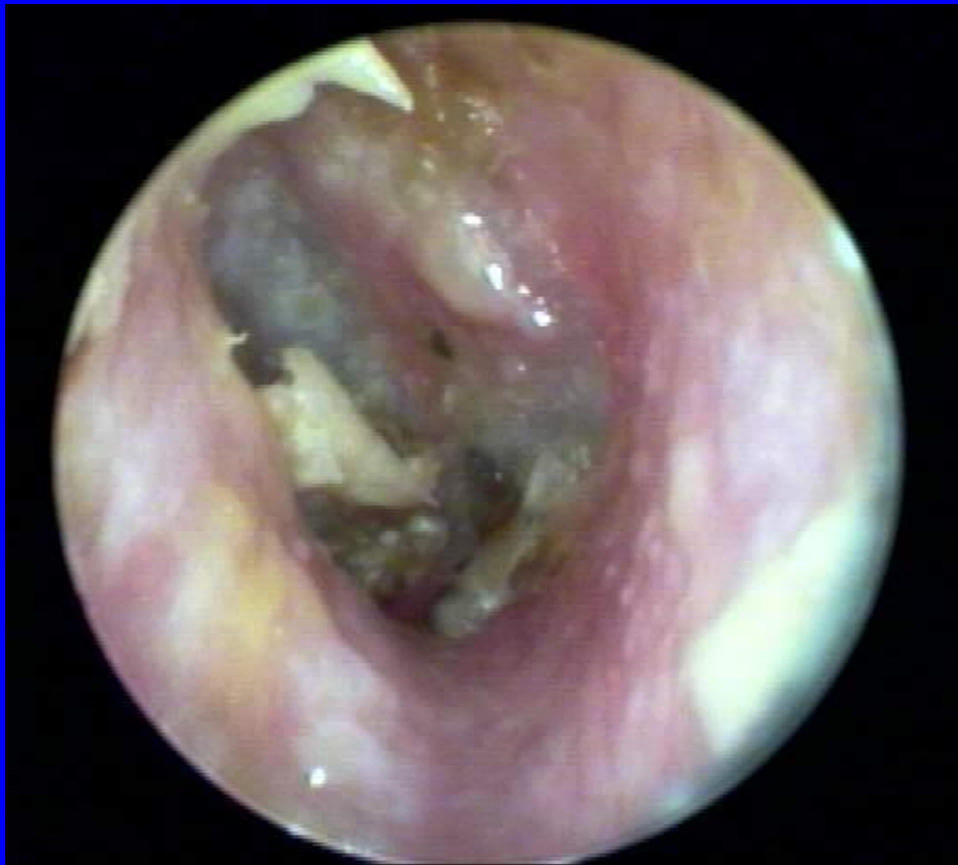
- Treatment
  - Local with drops (sofradex or gentisone)
  - Analgesia
  - Refer if a lot of debris and /or very swollen canal

Not Winning?

- Consider fungus
- Swab

Malignant otitis externa

- Immunocompromised
- Pain out of proportion to appearance
- Refer –will need microscopic examination and possibly CT and are in for the long haul (weeks of antibiotics)

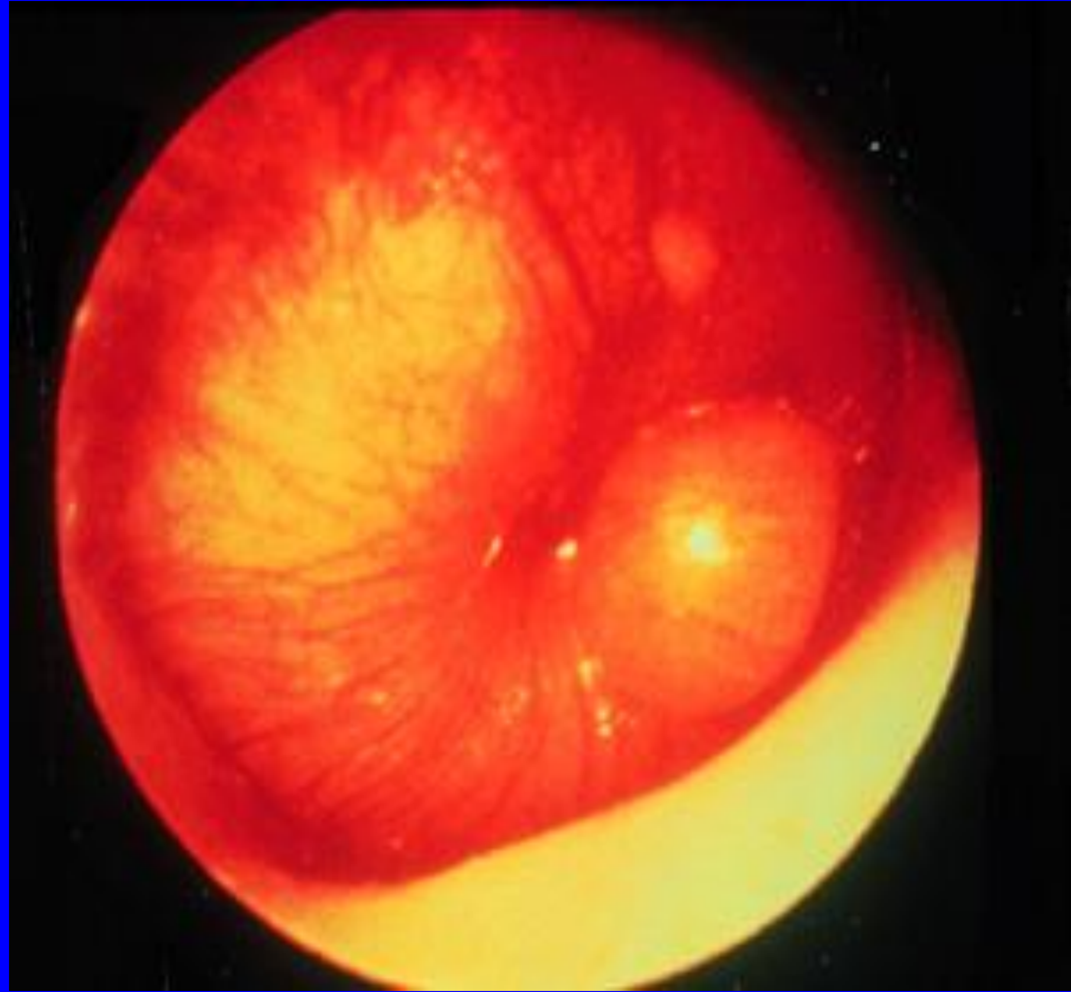


Acute Otitis Media

- Infection of the Middle ear
  - Not usually painful to move pinna (although otitis media and externa can coexist)
  - Canal normal
  - Drum red bulging featureless

Treatment : Systemic antibiotics if high temp

Consider referral if recurrent



Refer for grommets??

- >5 episodes in a year
- Febrile convulsions
- Possibly consider screening for immunoconpromise?

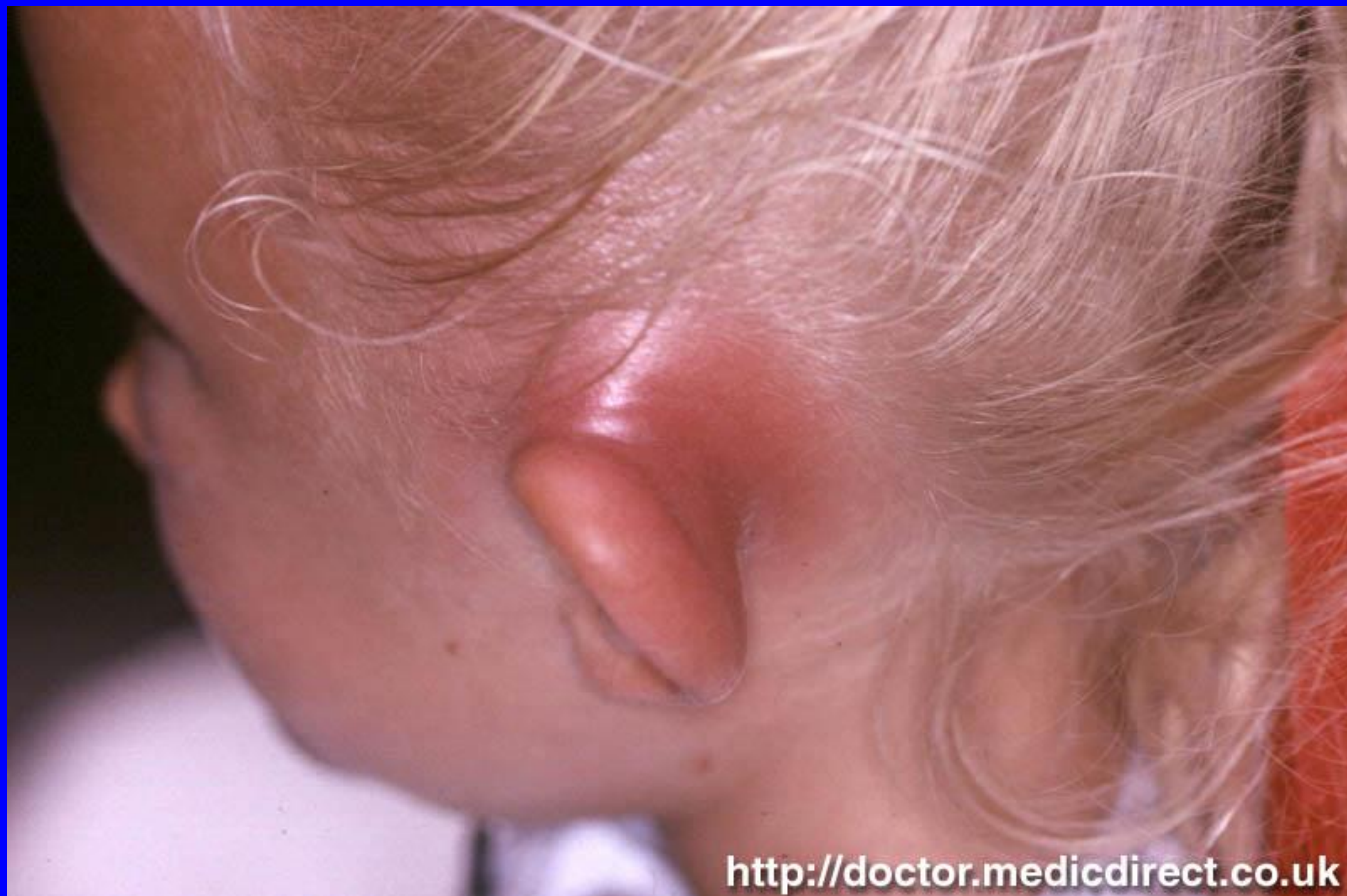
Infected grommet

- BNF advice on ear drops- not to be used without supervision
- Ciprofloxacin not licenced for ears in this country-used extensively in the US and no harm to hearing

Mastoiditis

- Complication of Otitis Media
  - Pt unwell, high temperature. Ear “like the world Cup”
  - Boggy swelling behind ear (May be obvious abscess)
  - Can often have a fairly normal TM or glue ear

All must be admitted IV ABX. Note GCS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Treatment

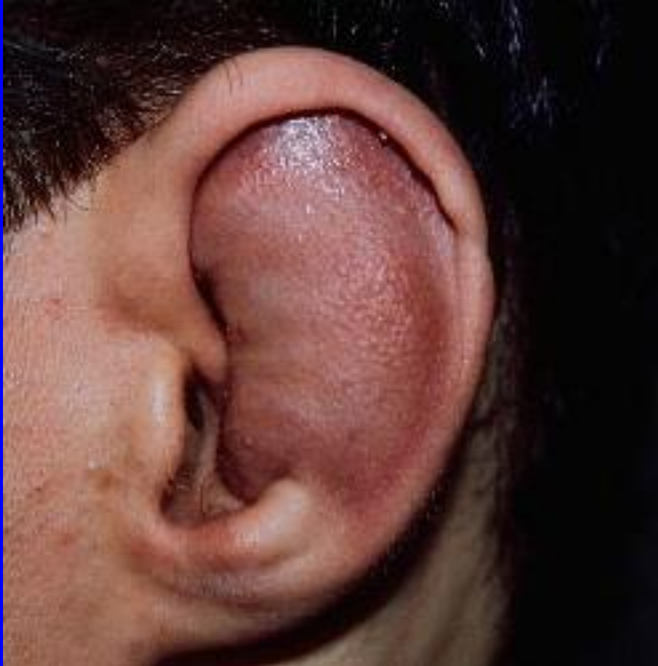
- Refer
- This patient had I&D some settle with iv's

Trauma

- Sharp or blunt
  - Sharp
    - Laceration like any other. Can be repaired under Local anaesthetic. Repair skin only and try not to stitch through cartilage
    - Pressure dressing, antibiotics and review

Trauma ctd

- Blunt
  - Vessels under skin get damaged, bleed under the skin and cause pinna haematoma.
  - Can cause necrosis of cartilage and “cauliflower ear”
  - Treatment
    - Aspirate as a first aid measure with pressure dressing REFER needs ENT supervision and I&D



Trauma to ear canal temporal bone etc

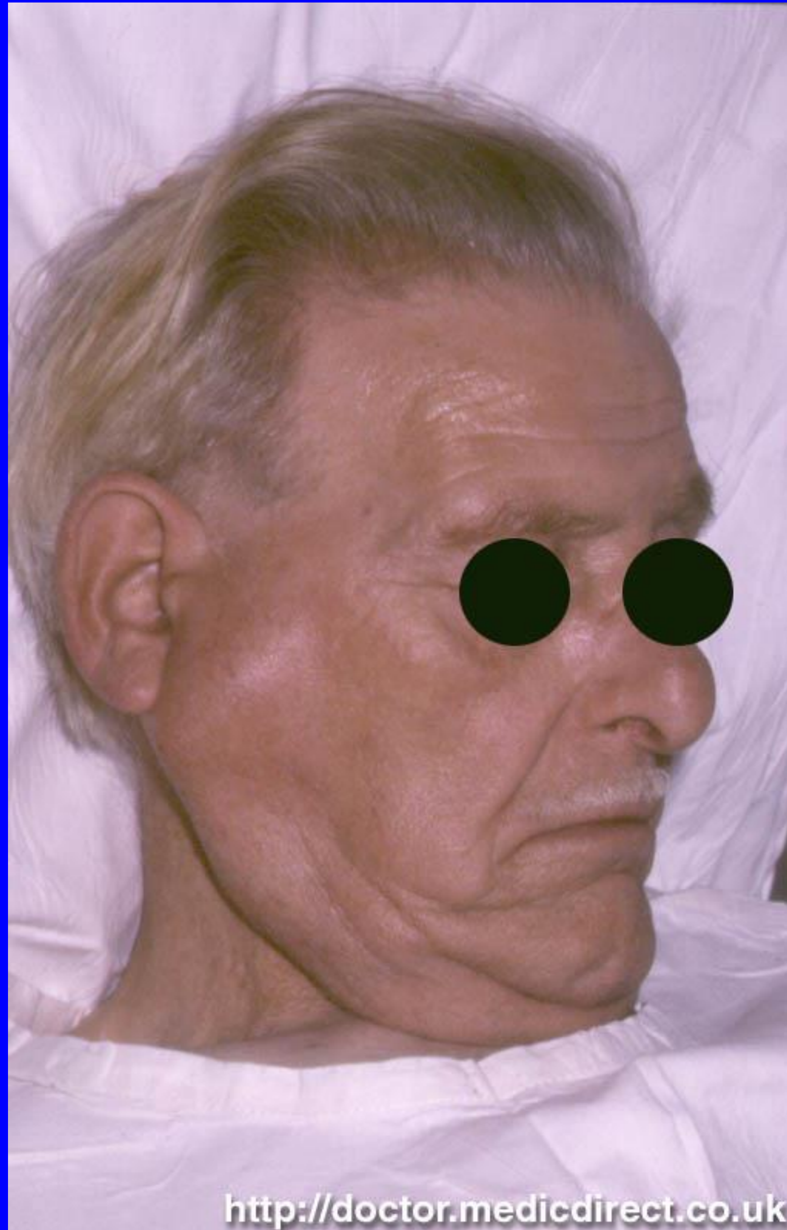
- Ear canal and TM Examine carefully. Advise to keep dry. Refer for outpatient review. Reassure it will probably heal even if perf in TM.
- Temporal bone: deafness facial nerve palsy, haemotympanum. Head injury takes priority. Occasionally facial nerve needs to be decompressed

Dizziness

- Full medical History ask about hearing and tinnitus, ear discharge
- Full examination including neurological
- If not vertigo not likely to be ENT cause
- Serc or Buccastem if being sick
- Refer if ENT suspected cause and cannot safely go home

Facial nerve palsy

- Hx Examination (all cranial nerves is it an upper or lower motor neuron lesion)
- Look in the ear (vesicles and infection)
- If no obvious cause give 40mg prednisolone od, 800mg acyclovir five times a day, eye protection and refer to BOTH eyes and ENT (Eye referral is actually more important.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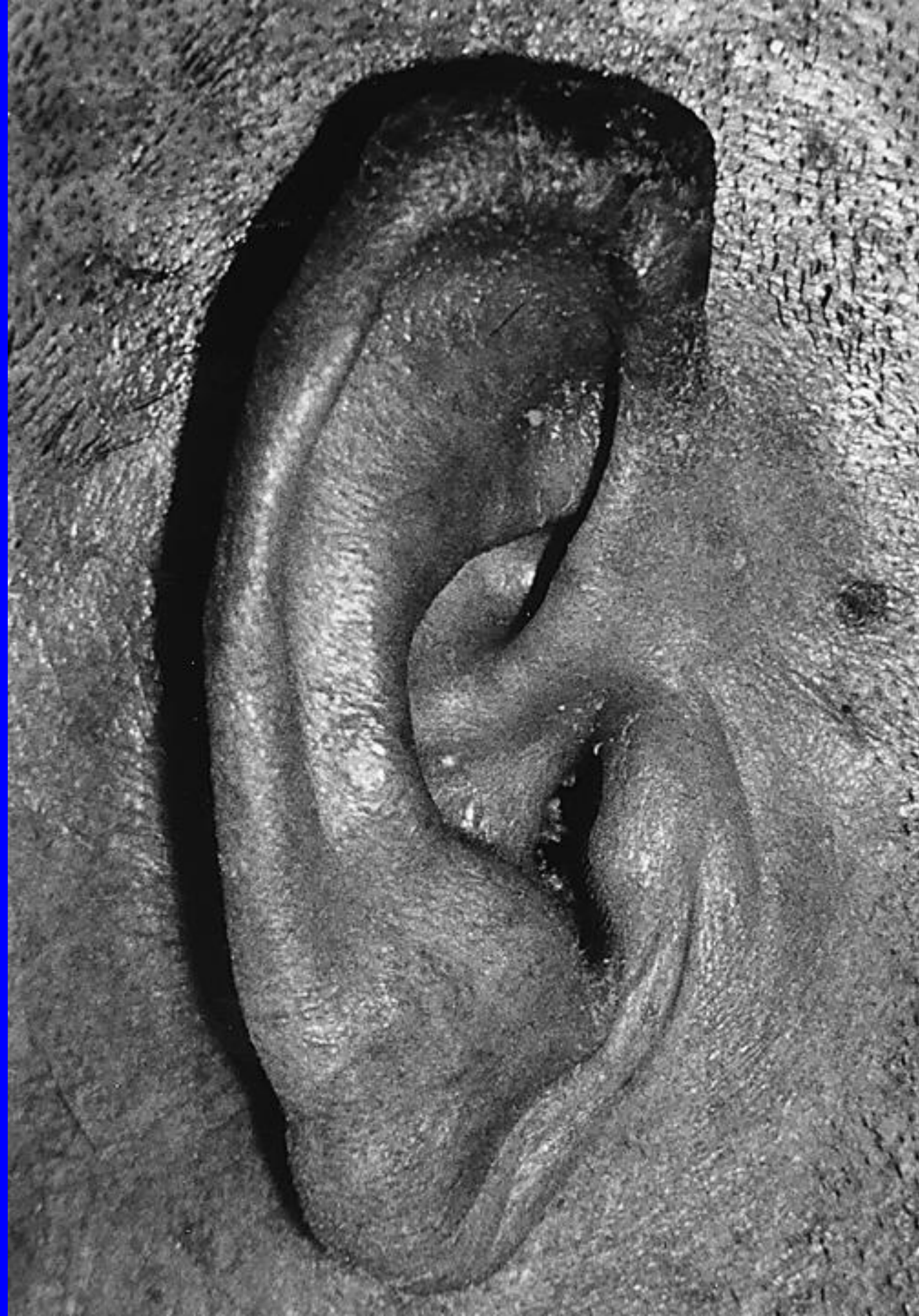
Sudden Onset Hearing loss

- Hx
- Examination (wax, infection FB) Rinnes and Webers to distinguish between conductive and sensorineural.
- If conductive send home and refer for outpatient review
- If sensorineural refer that day for carbogen steroids etc



Nose

- Trauma
  - Sharp or blunt

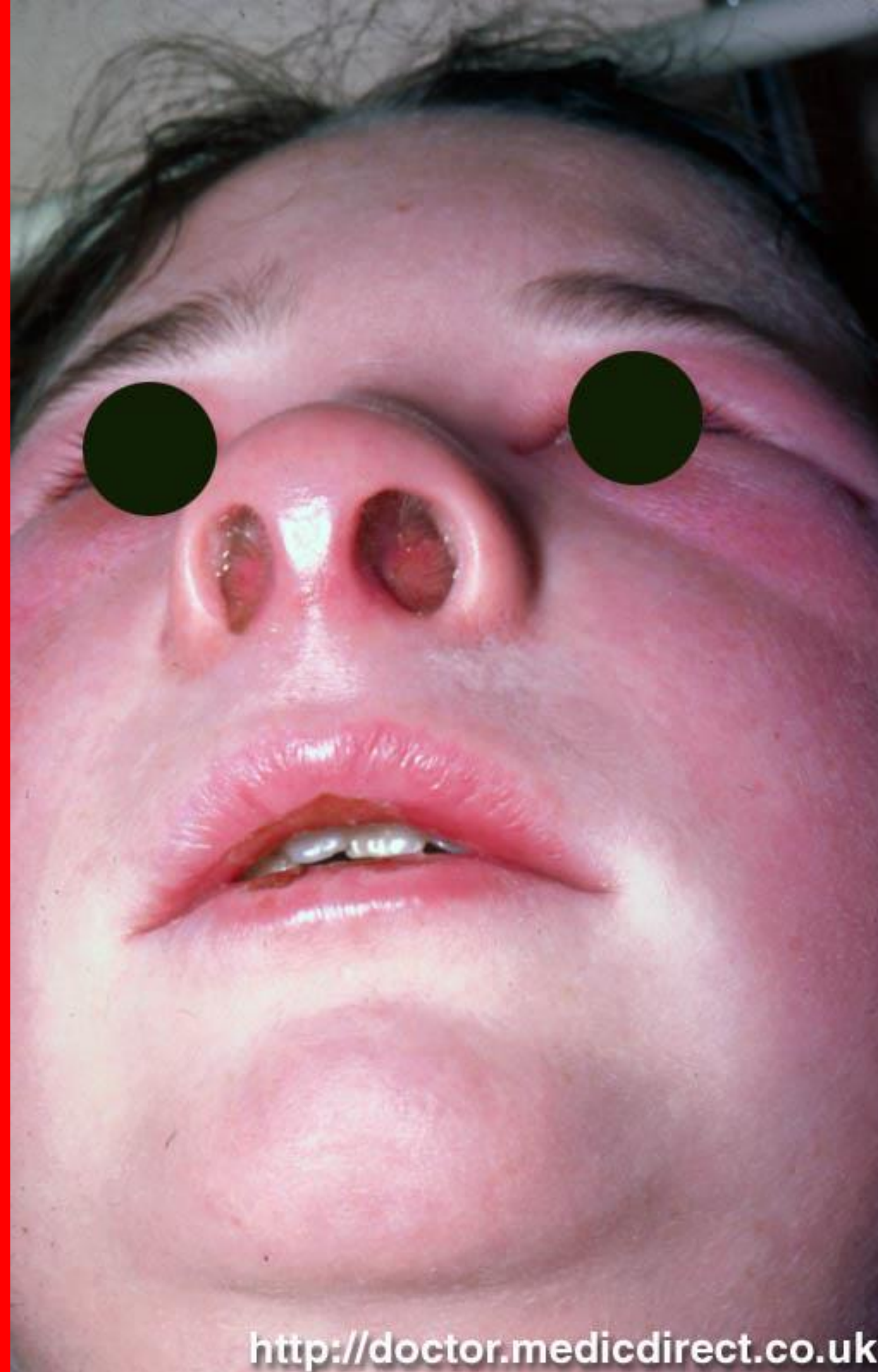
  Sharp

    Laceration sitich like any other laceration

  Blunt

    Fractured nose DO NOT X-Ray unless suspecting other facial fractures (zygoma etc)

    Look for septal hasematoma refer straight away if present otherwise at 5/7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Epistaxis

- Take this seriously people die
- Examine as much as possible (an auroscope is V useful)
- Try naseptin for 1/12 (beware peanut allergy)
- In a child unilateral bleeding with discharge is a FB unless disproven
- If not winning refer (especially young teenage boys and the elderly)

Foreign Body

- Often Children. Have One go.
- A hook is often better than a forceps
- If you cannot remove refer the same day

Sinusitis

- Hx. Fever, blocked nose, rhinorrhoea, localised facial discomfort.
- If severe may need admission for Abx
- If mild antibiotics and NASAL DECONGESTANTS

Periorbital Cellulitis

- Often children. Mostly caused by sinusitis.
- Swelling and pain around eye. Proptosis
- Assess eye movements (you may have to prise eye open)
- Refer all must be admitted (unless very mild) for IV Abx and decongestants
- Note GCS this condition can lead to cavernous sinus thrombosis

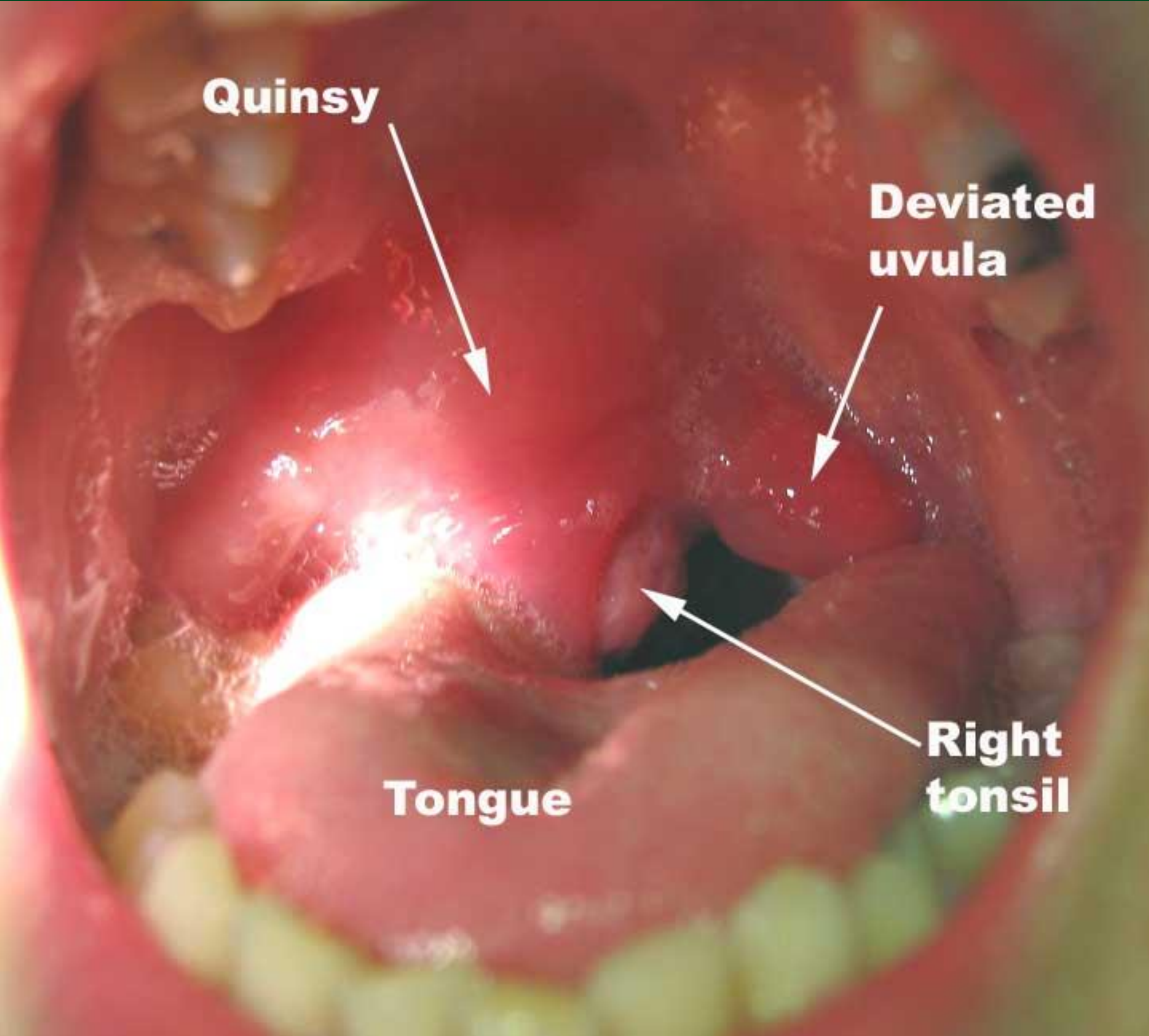
Periorbital cellulitis

Throat

- Tonsillitis
  - Sore throat, dysphagia, high temperature, pus on tonsils
  - Give analgesia. Many patients forget about this and can often go home once given adequate analgesia.
  - If cannot swallow will need admission
  - Beware the “tonsillitis” with normal tonsils refer

Quinsy

- Once seen not forgotten. It is a peritonsillar abscess.
- Symptoms severe pain, often unilateral, trismus, otalgia
- Signs Fever, one tonsil pushed toward the midline uvula pushed over
- Treatment, drainage, admission for IV Abx


Quinsy
Deviated uvula
Right tonsil
Tongue

Supra/Epiglottitis

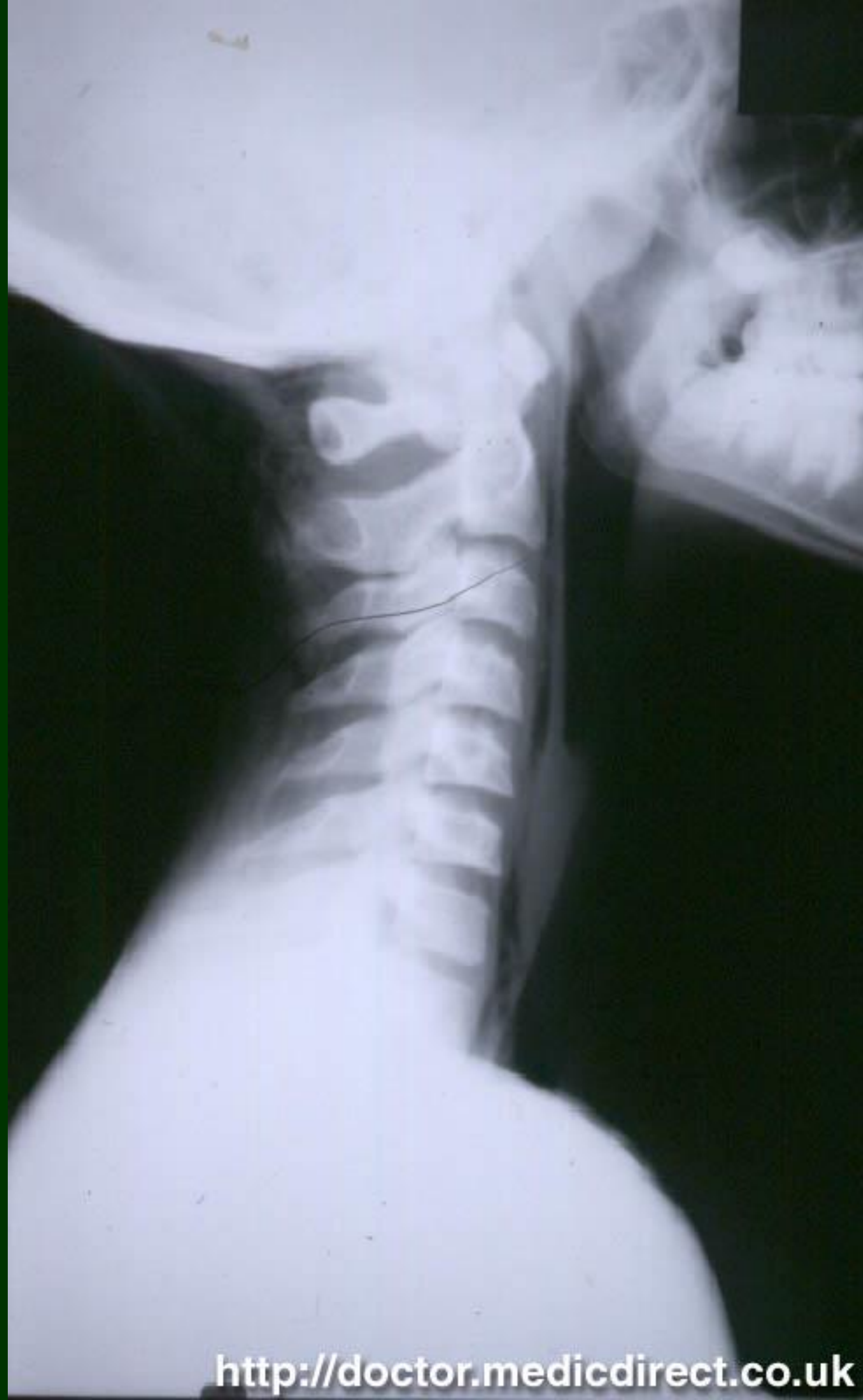
- Epiglottitis rare now since HiB
  - Unwell child, drooling, sitting up and forwards, stridor
  - DO NOT upset the child waft some adrenaline nebs if tolerated Call ENT and ask for Senior help. DO NOT look in mouth

Supraglottitis

- Adults no need to be so careful but need emergent treatment
- Stridor sore throat
- Adrenaline neb (1ml 1:1000Adrenaline in 4 ml saline), 200mg hydrocortisone or 8mg IV dexamethasone, antibiotics
- If first Adr neb doesn't work give another one
- Call ENT urgently
- Trache set

Foreign Body

- Hx Examination Looking for tenderness. Surgical emphysema
- Lateral soft tissue neck and possibly CXR
- If fishbone patient eating and drinking and well can be seen in clinic the next morning
- If sharp bone eg chicken or batteries etc refer to be seen straight away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Abscesses

- DO NOT be tempted to have a go under local refer

Lumps in the neck

- If not gone after 2-3 weeks refer (2/52 wait)

Hoarseness

- Hoarseness of the voice for 3 weeks or more is cancer of the larynx until proven otherwise
- Hx (occupation, fatigueability, reflux)
- If risk group for 2/52 wait.