ENT Things that make you go Hmmm?

What and When to Refer

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Multi-storey Car Park
Maternity
Lister Education Centre
Mental Health Unit
Pre-Operative Assessment Unit

Aims of this talk

- Common ENT conditions
- Conditions that we both find hard to manage
- What and When to refer
- Red flags
- Guidelines on why we do what we do

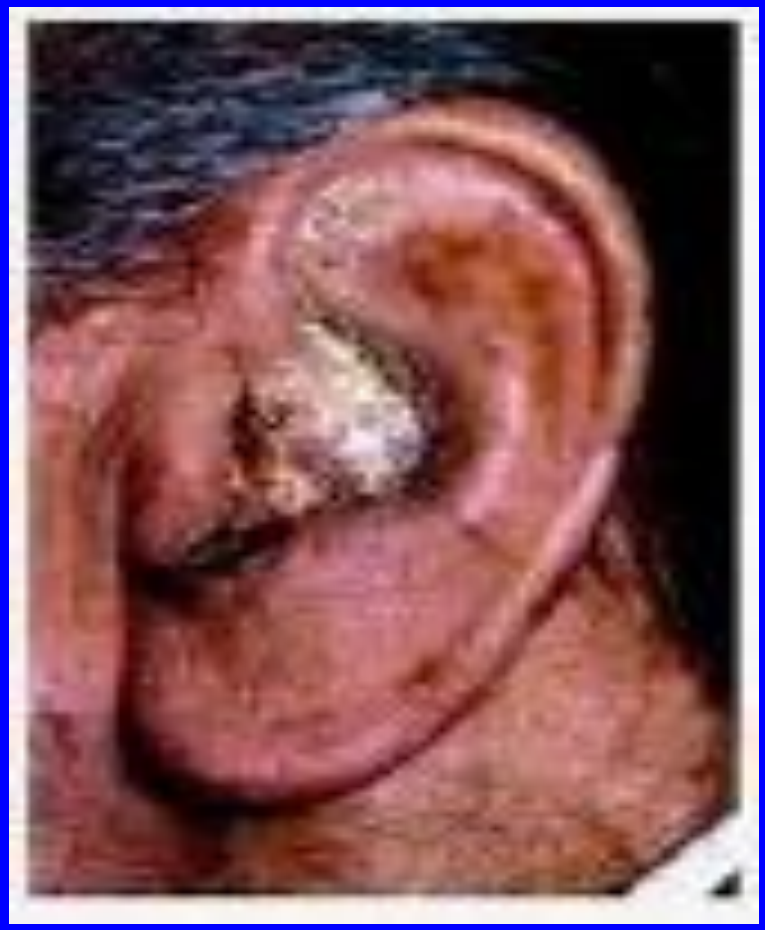
Sudden Onset Hearing loss

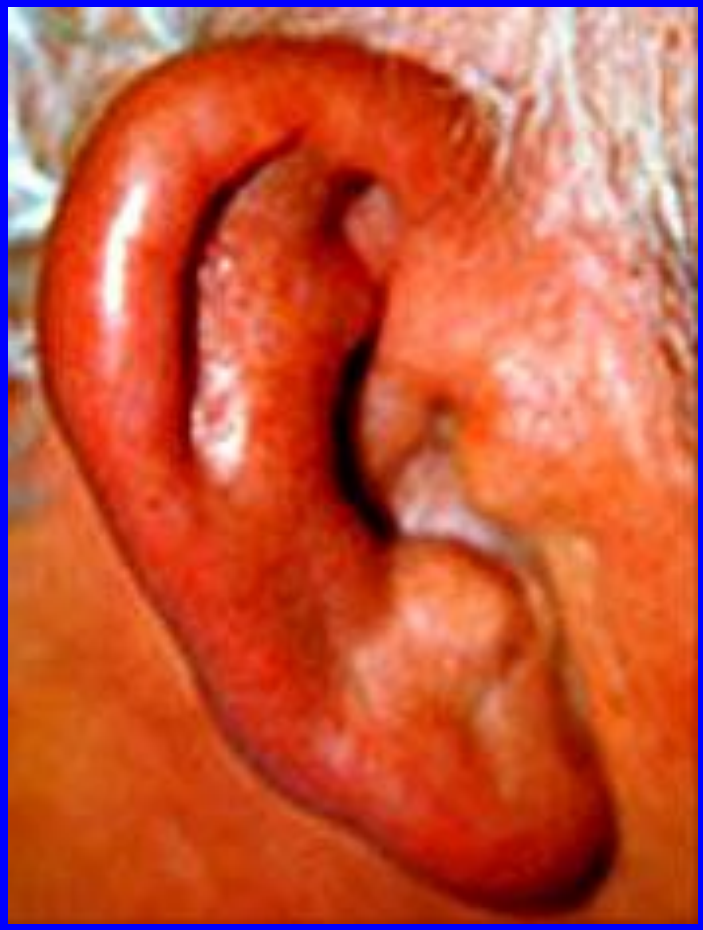
- Hx- THIS IS A MEDICAL EMERGENCY IF SENSORINEURAL
- Examination (wax, infection FB) Rinne's and Weber's to distinguish between conductive and sensorineural.
- If conductive send home and refer for outpatient review
- If sensorineural refer that day for steroids etc (oral or intratympanic)

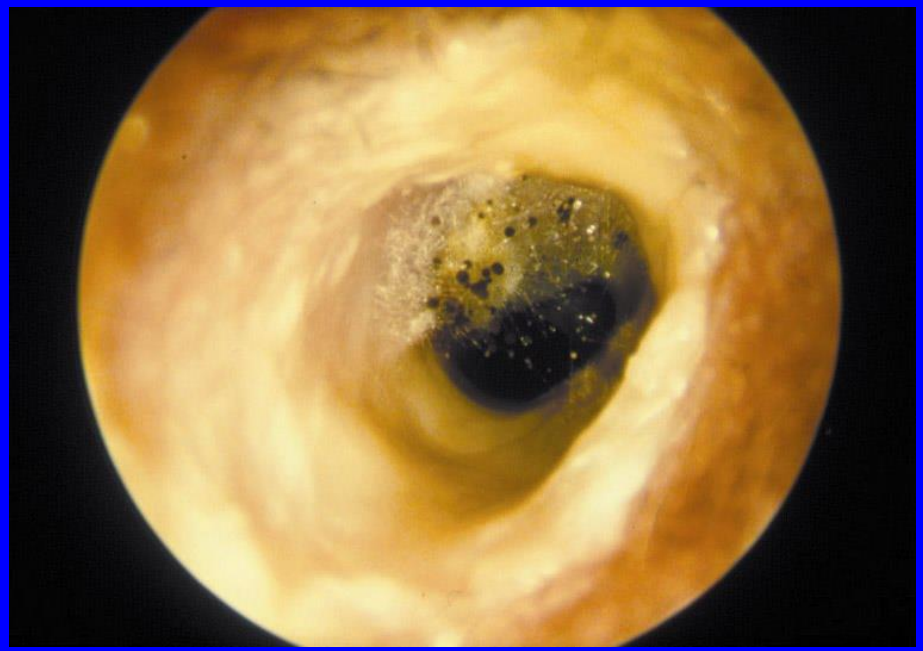
While on the subject of ears- Ear Infections

- 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

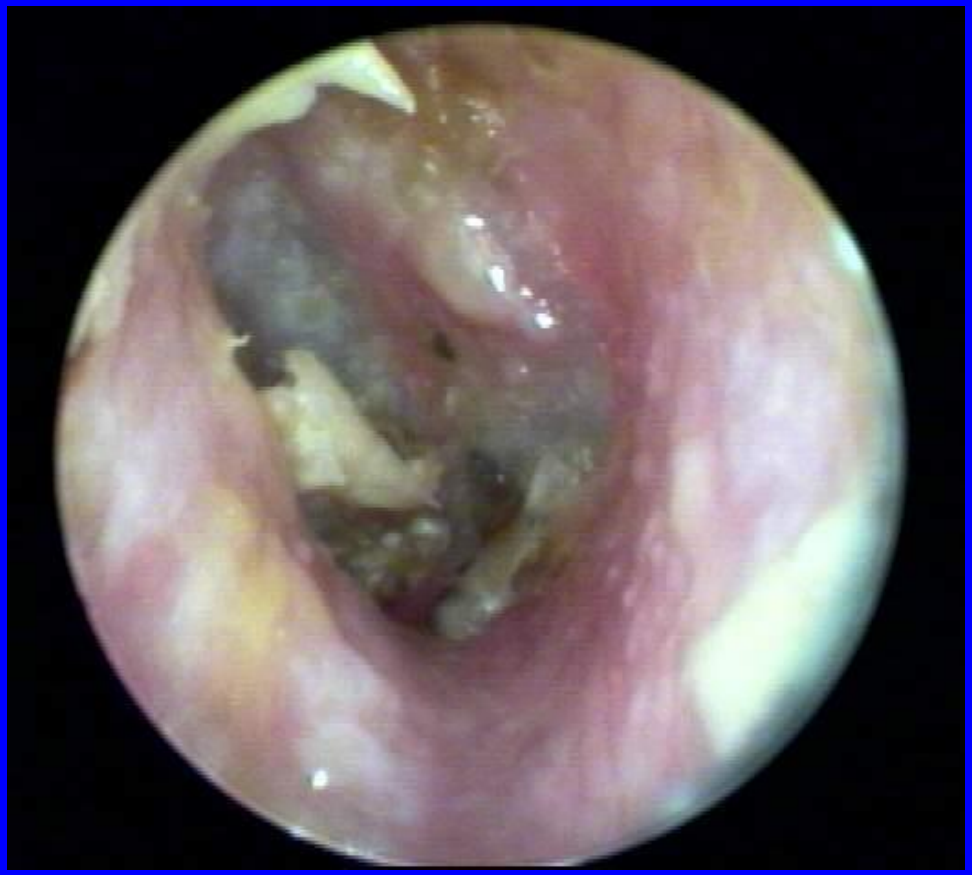
- Treatment
  - Local with drops (sofradex or gentisone)
  - Analgesia
  - Refer if a lot of debris and /or very swollen canal

Not Winning?

- Consider fungus
- Swab specifically ask for fungal culture
- Treatment for fungus to continue for 2 weeks post symptom improvement

Malignant otitis externa

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



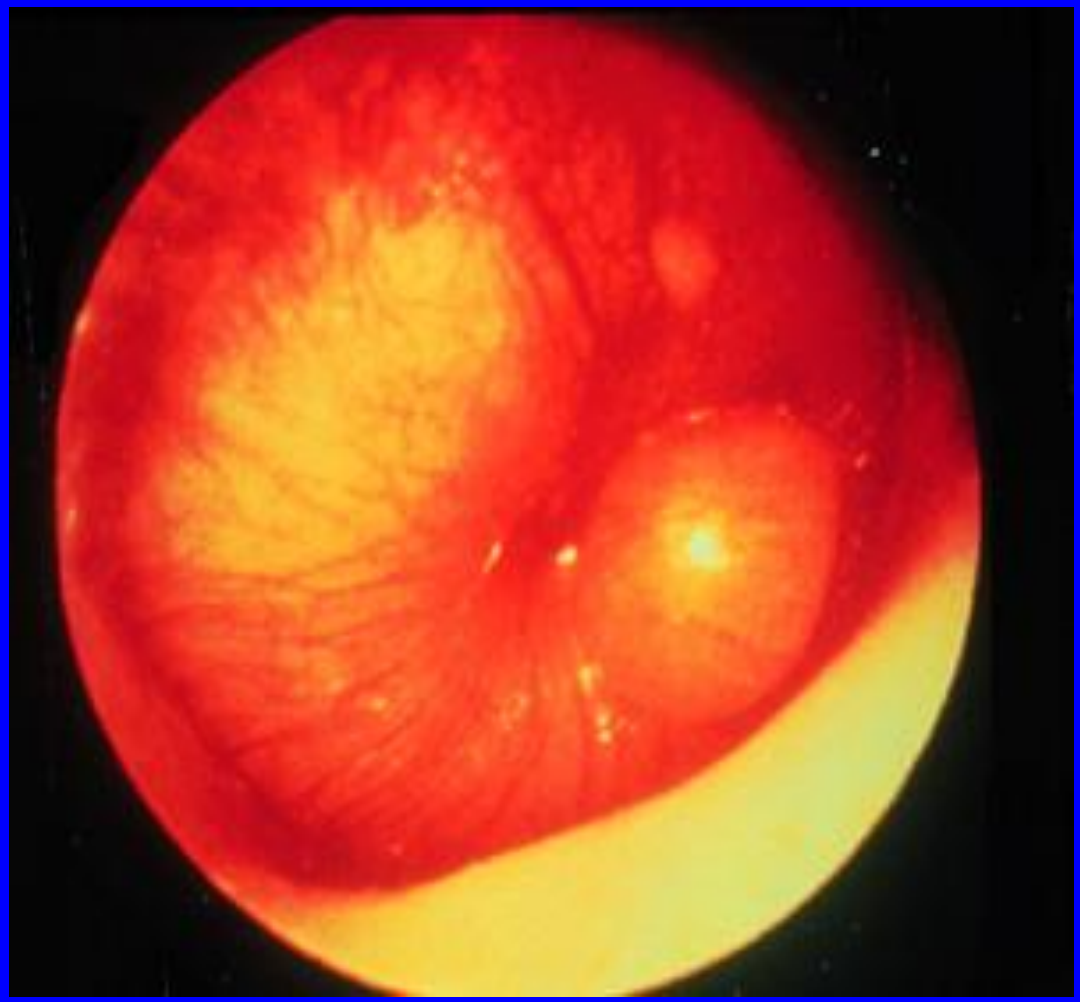
Acute Otitis Media

- 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 : Expectant (? Give prescription to fill in later)

Systemic antibiotics if high temp

Consider referral if recurrent



Refer for grommets??

- >5 episodes in a year
- Febrile convulsions
- Possibly consider screening for immunocompromise? (IgA)
- Long term antibiotics

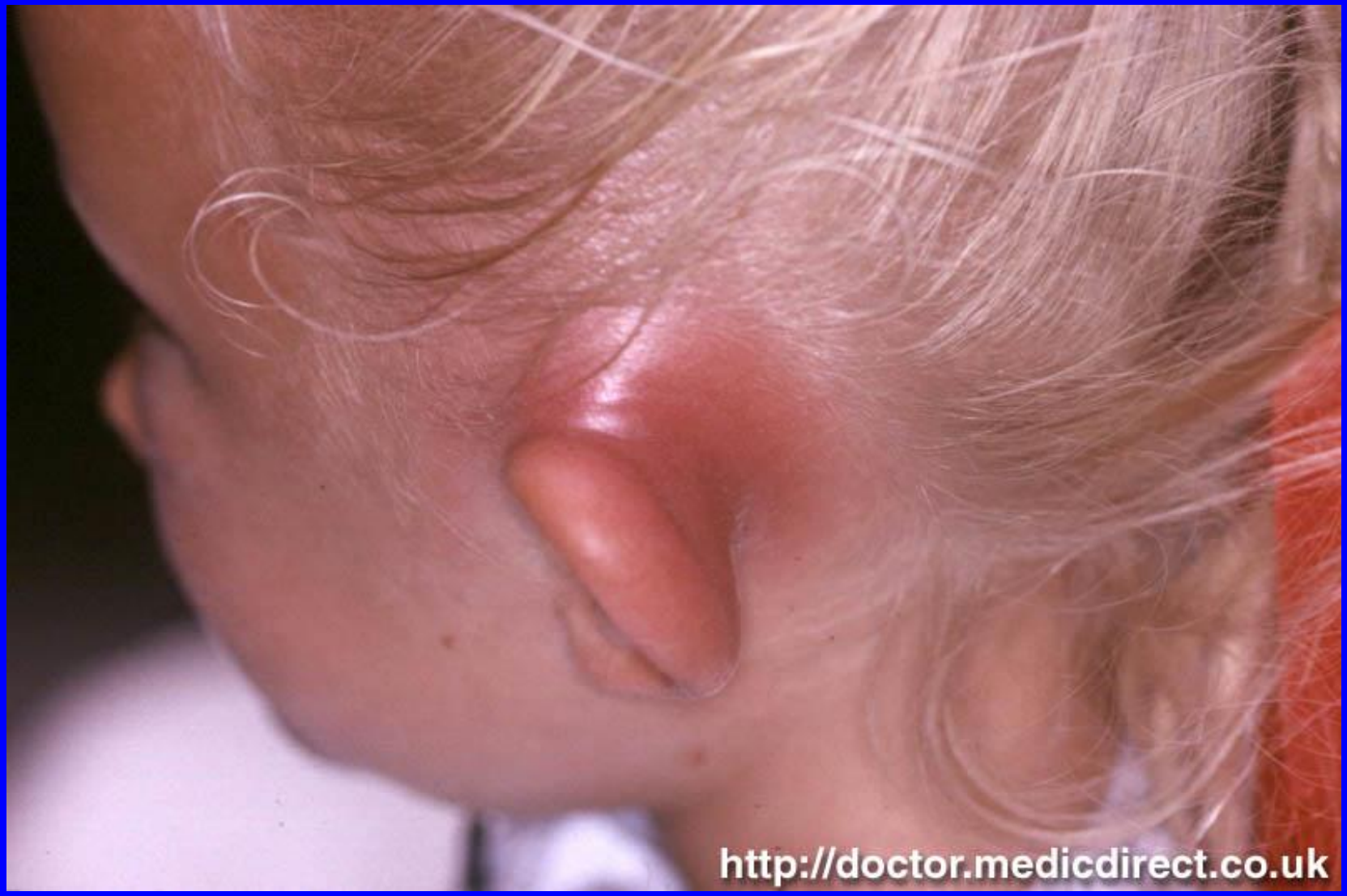
Infected grommet

- 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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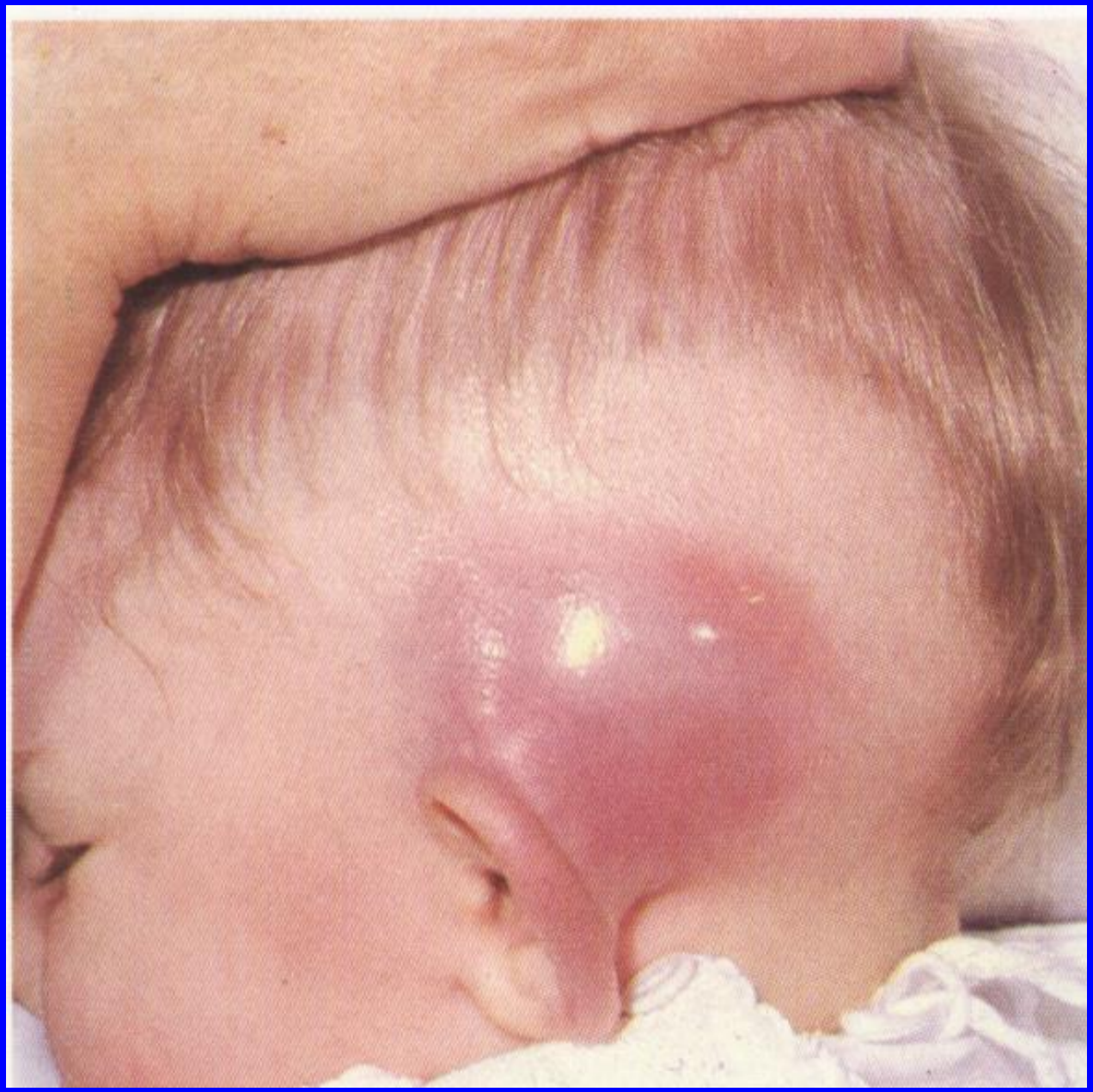


Treatment

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

Balance

- 3 elements
  - Eyes
  - Ears
  - Joint position sense
  - Brain integration with connections to vomiting centre
- Potentially can manage without 1 – but then taking another out (e.g. in the dark causes severe symptoms)

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

What we do

- History
  - Dizziness – delay after moving , lasts seconds
  - BPPV – Hallpikes and Epley
  - Dizziness mins-hours- associated with fullness of ear, tinnitus, aural fullness hearing loss- Menieres
  - Acute onset after a cold – persistent- ?vestibular neuronitis

What we do continued

- Examination – neurological, rhombergs and Untebergers tests
- Diagnosis – MRI, calorics (here) ENG's EcochG at specialist centres

Treatment

- BPPV – Epley is magic!!
- Menieres- ladder of treatment
  - Betahistine, bendrofluazide, IT steroids for dizziness, Grommet (protective?), specialist saccus decompression
  - Any surgery will take a long time to resolve symptoms completely (Brain compensations)
  - PHYSIO

Tinnitus

- Perception of noise when no stimulus present
- Subjective (most) or objective

Tinnitus

- Uni or bilateral
- Type of noise – pulsatile raised more questions than white noise of hum
- Ear questions- pain, discharge, vertigo
- Extra questions- being kept awake, ?depression

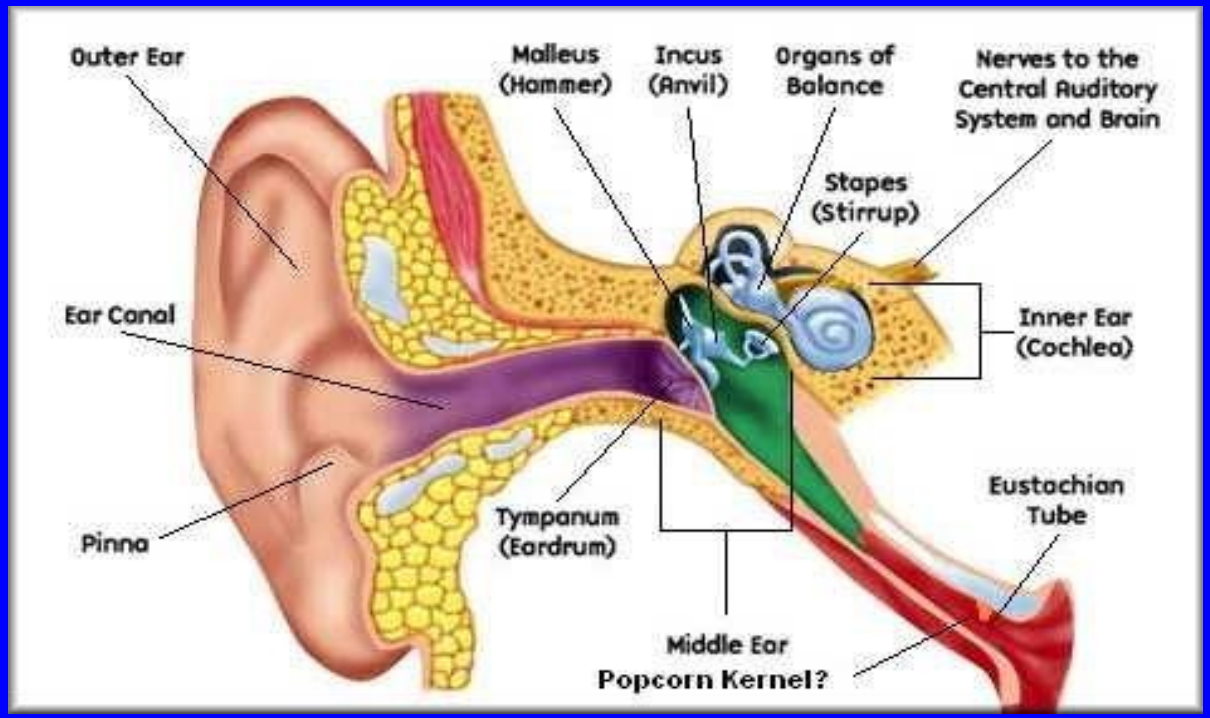
Examination

- Ears (wax impaction, glomus, carotid or mastoid bruits if pulsatile)
- Neuro
- PTA tymps

Decision

- Bilateral tinnitus with symmetrical hearing – explanation, referral for tinnitus retraining
- Unilateral – MRI scan
- Tinnitus retraining, British Tinnitus association, tinnitus support groups, Sleep pillow etc.
- Neuromodulation (expensive and only privately

Eustachian tube dysfunction



Anatomy

- 2/3 cartilage. 1/3 bony
- Allows fresh air into the middle ear
- Acted on by palatal muscles

Purpose

- Equalise pressure
- Protect form reflux of nasopharyngeal contents
- Drain middle ear contents

Why goes wrong

- Nasal problems
- Cleft palate
- Change in sensitivity

Symptoms

- Crackling
- Pressure
- Muffled hearing
- Otitis media

Examination

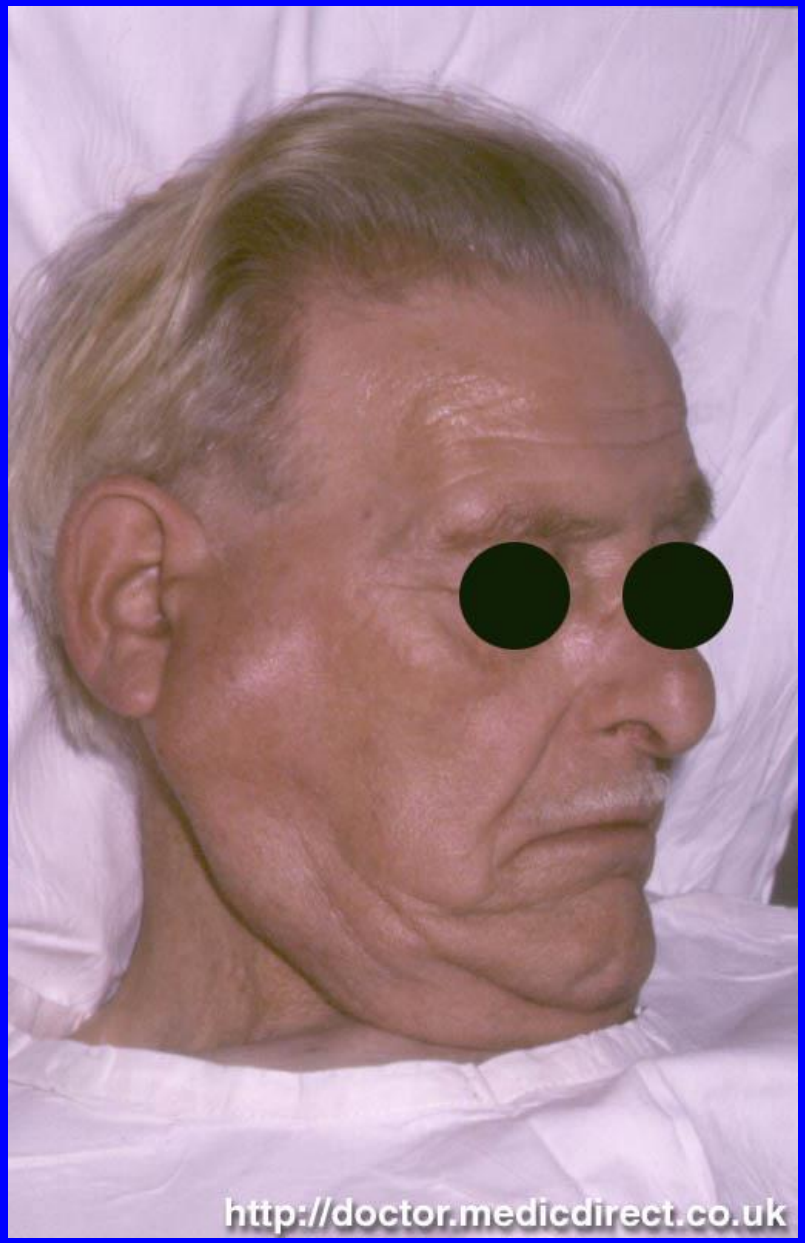
- Ear
- PTA tymps
- Flexi scope

Treatment

- If crackling – reassurance (hearing the eustachian tube opening)
- Nasal problems- treat that
- Otovent
- Grommet (rarely and under duress!!- seems to exacerbate/cause tinnitus unless obvious glue or retraction)
- Eustachian tube ballooning

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 (?60 or even 80) prednisolone od (gastric protection), 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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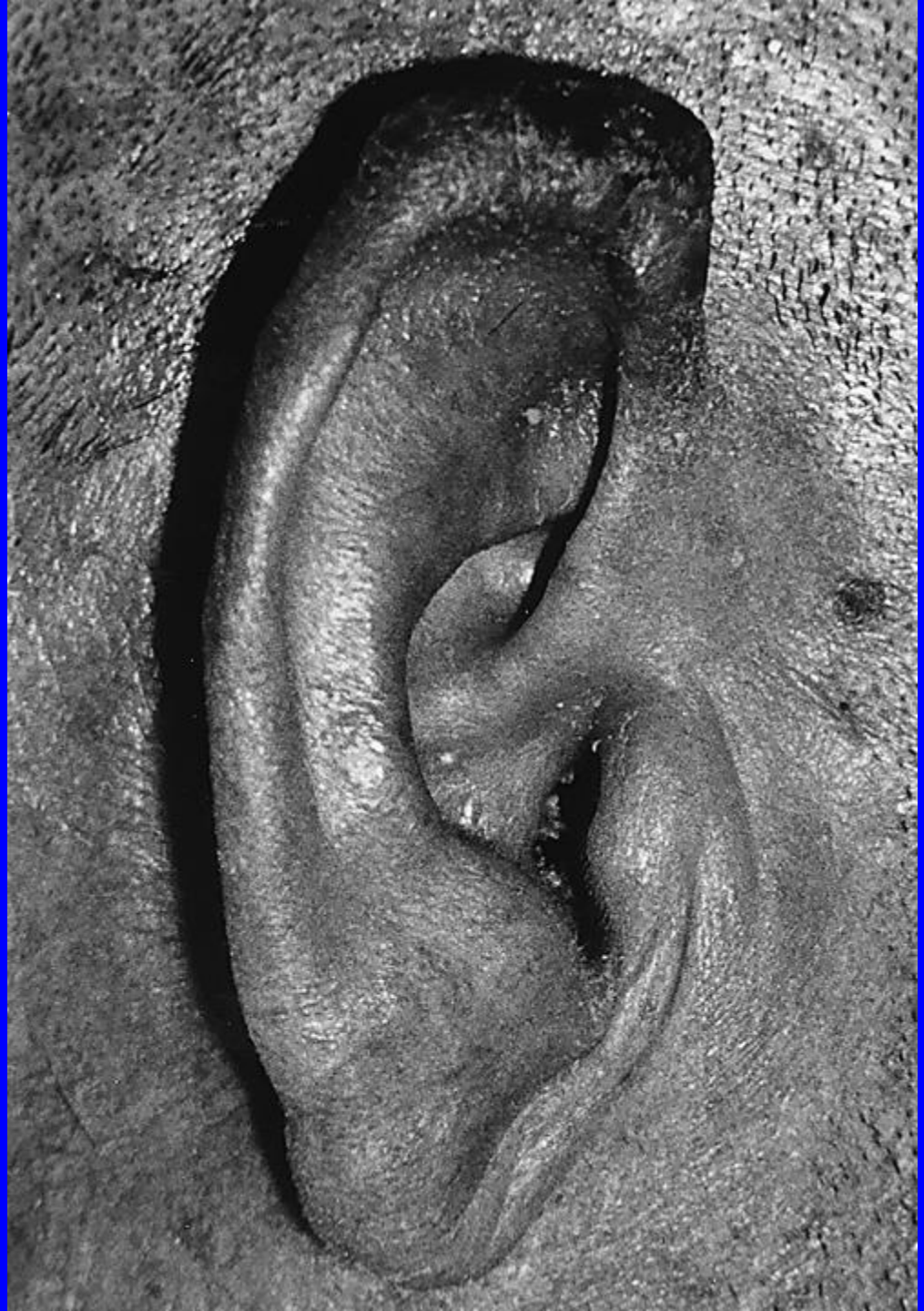


Nose

- Trauma
  - Sharp or blunt

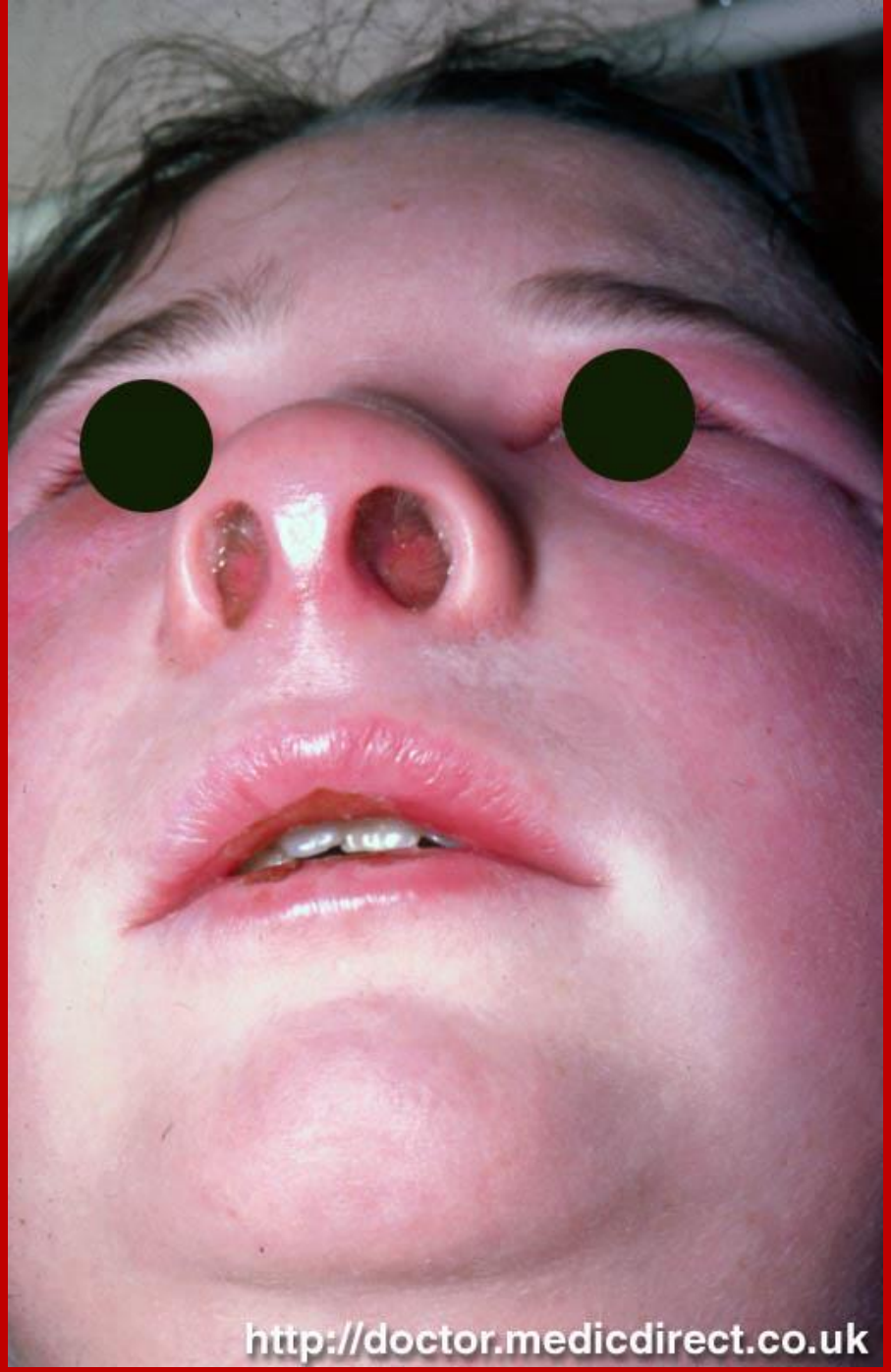
  Sharp

  Laceration stitch like any other laceration

  Blunt

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

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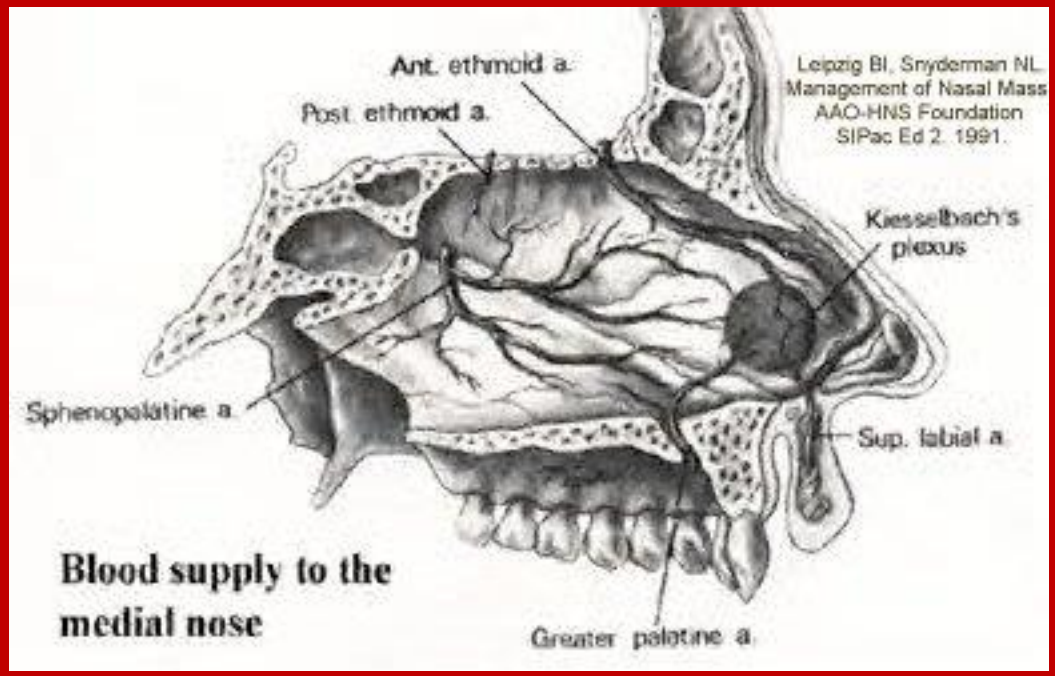
Epistaxis


Ant. ethmoid a.
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Leipzig BI, Snyderman NL.
Management of Nasal Mass
AAO-HNS Foundation
SIPac Ed 2. 1991.
Kiesselbach's plexus
Sphenopalatine a.
Sup. labial a.
Blood supply to the medial nose
Greater palatine a.

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

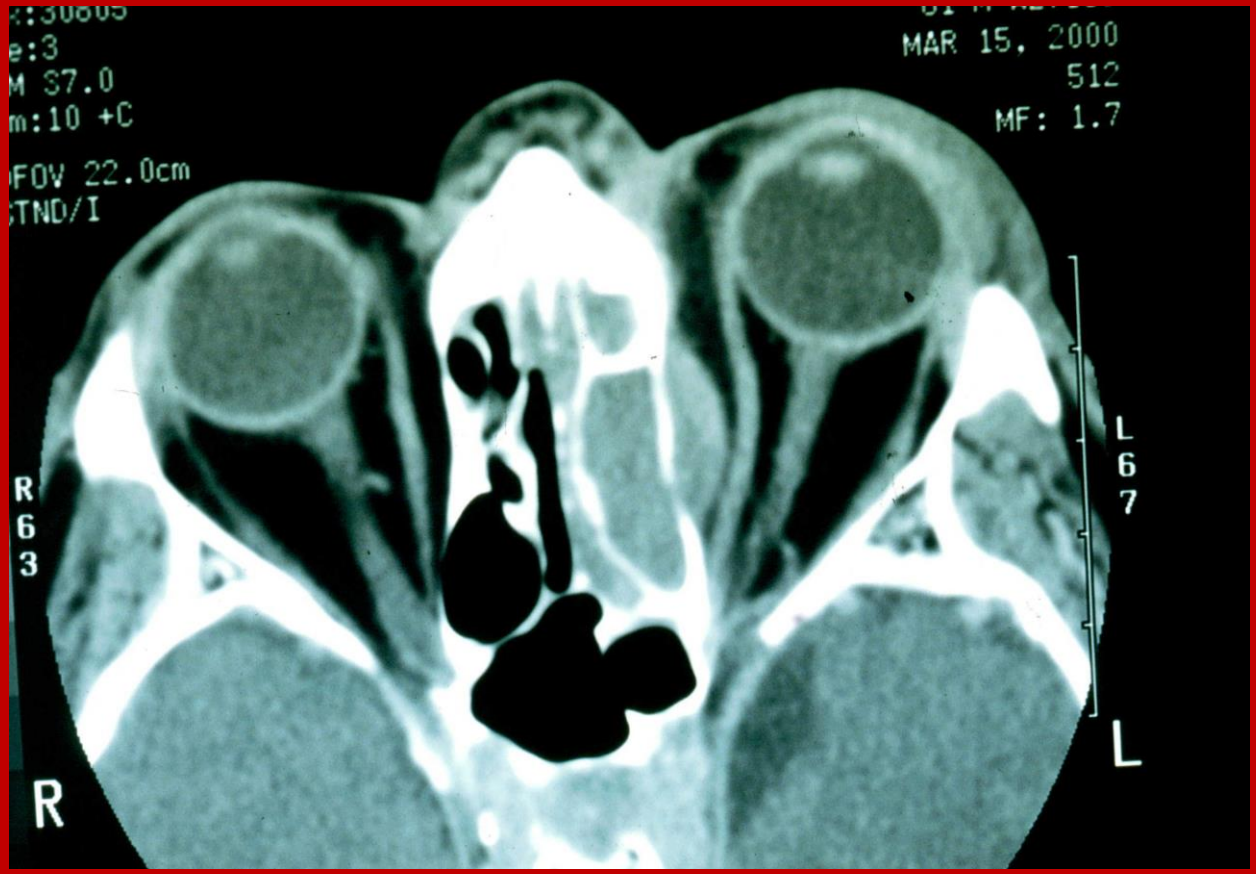
- Hx. Fever, blocked nose, rhinorrhoea, localised facial discomfort.
- If severe may need admission for Abx
- If mild antibiotics and NASAL DECONGESTANTS

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

Subperiosteal Abscess



Runny noses

- Colds
- Rhinitis (allergic, non allergic, vasomotor)
- Polyps
- Rarely CSF

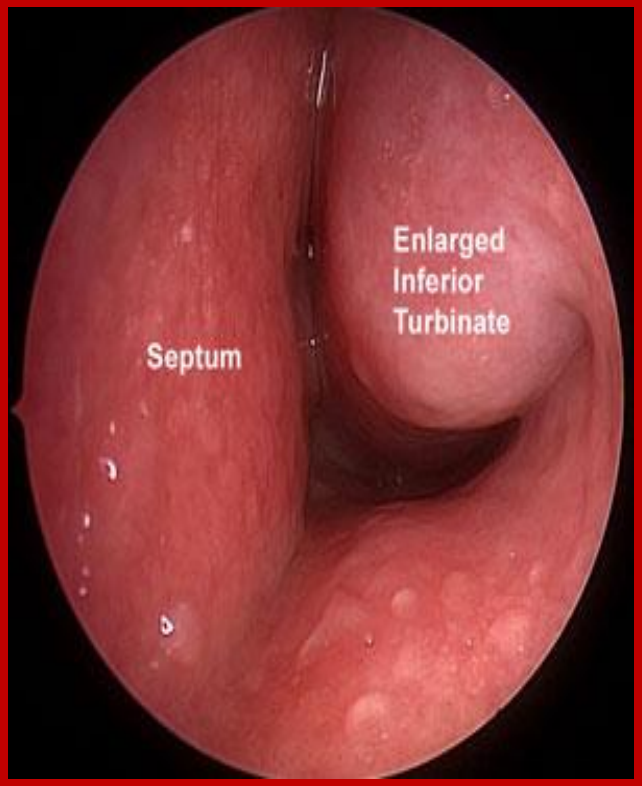
Assessment

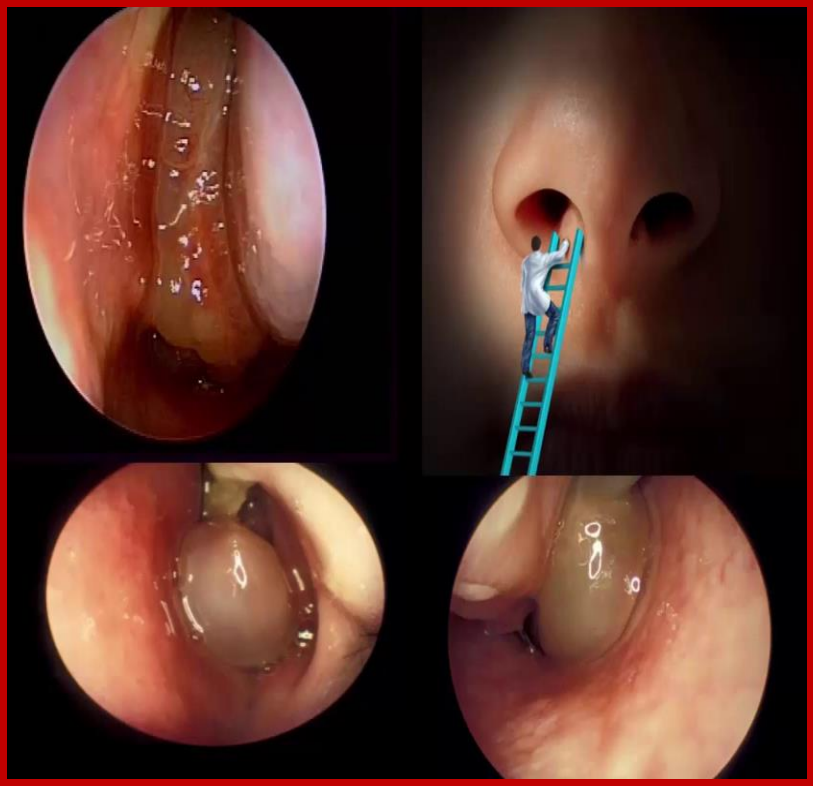
- The NOSE questions
- Blockage (one side or both?)
- Sense of smell
- Rhinorrhoea
- Post nasal drip
- Facial discomfort

Examination

- Auroscope

Turbinate or polyp?





Turbinate or Polyp?

- Pink
- Attached to lateral wall
- Tender and firm when touched with a probe

- Grey-gold
- Under the middle turbinate
- Softer and insensate to palpation

Treatment

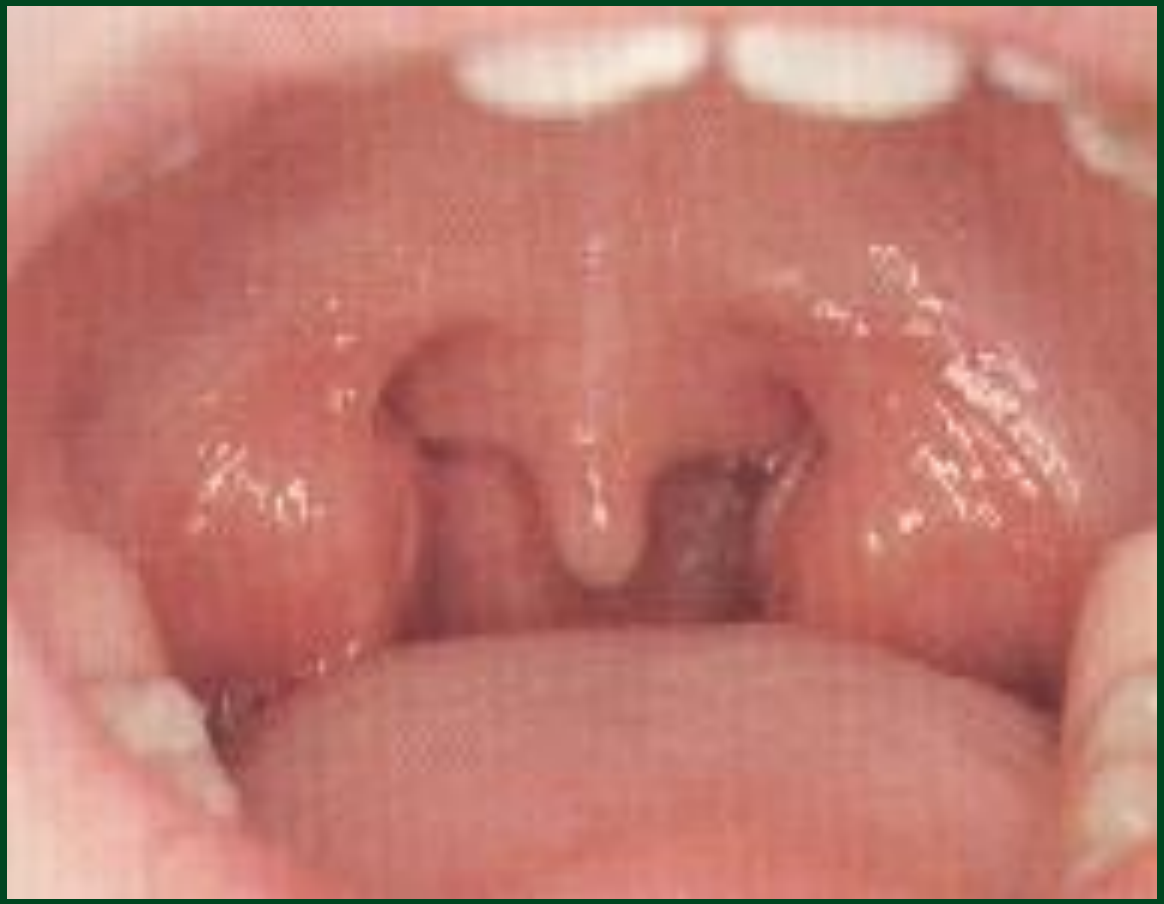
- Nasal sprays /drops
- Sinurinse
- Reducing turbinates
- ?oral steroids (if it looks like drops would float out again
- Nasal drops followed by spray
- Managed not cured

What we do

- Steroids antihistamines
- Consider reduction of turbinates

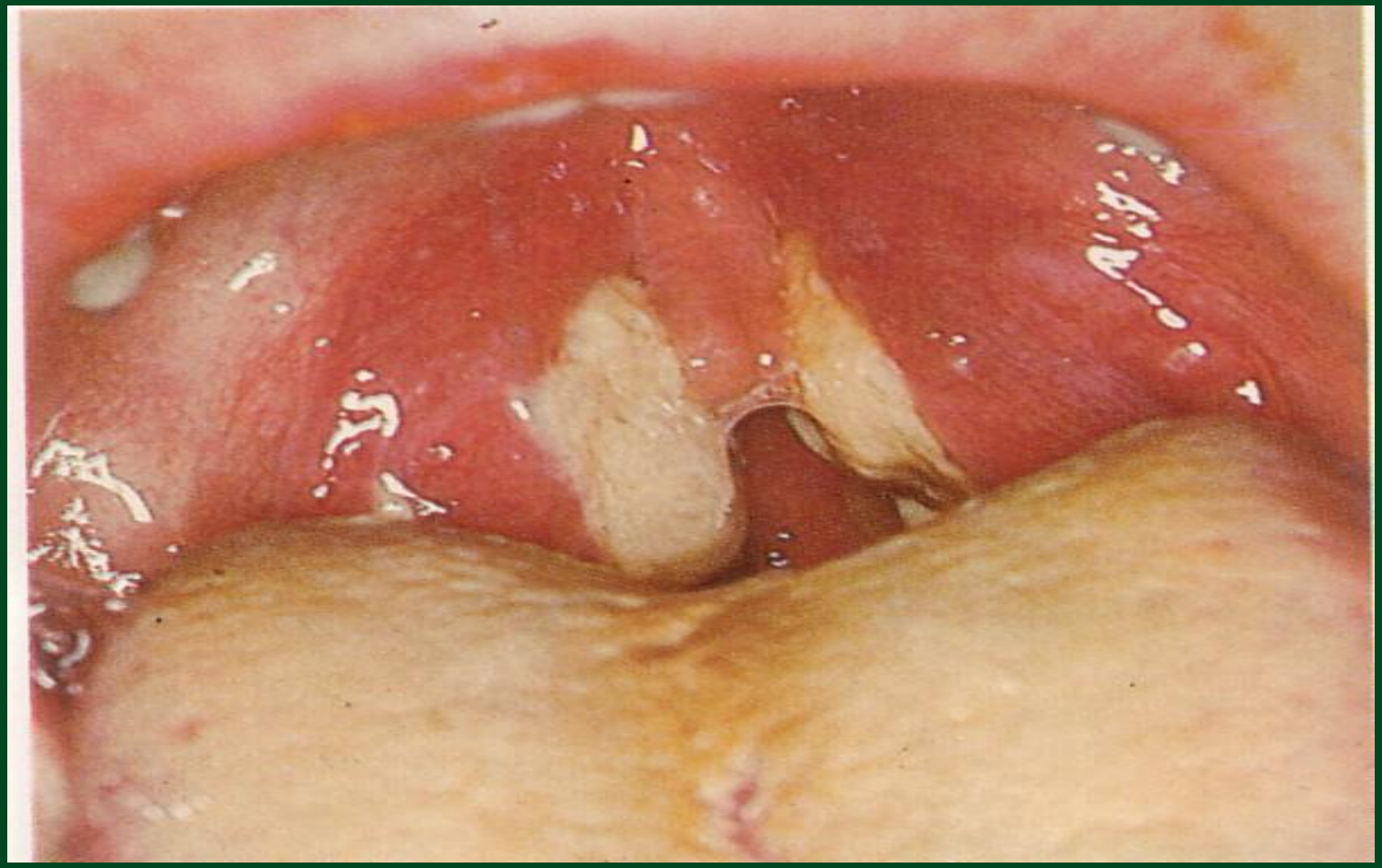
- Oral/nasal steroids
- FESS
- Managed not cured –
- If after FESS
- Nasal steroids – long term if recurrent
- Drops for exacerbations

Normal Tonsils



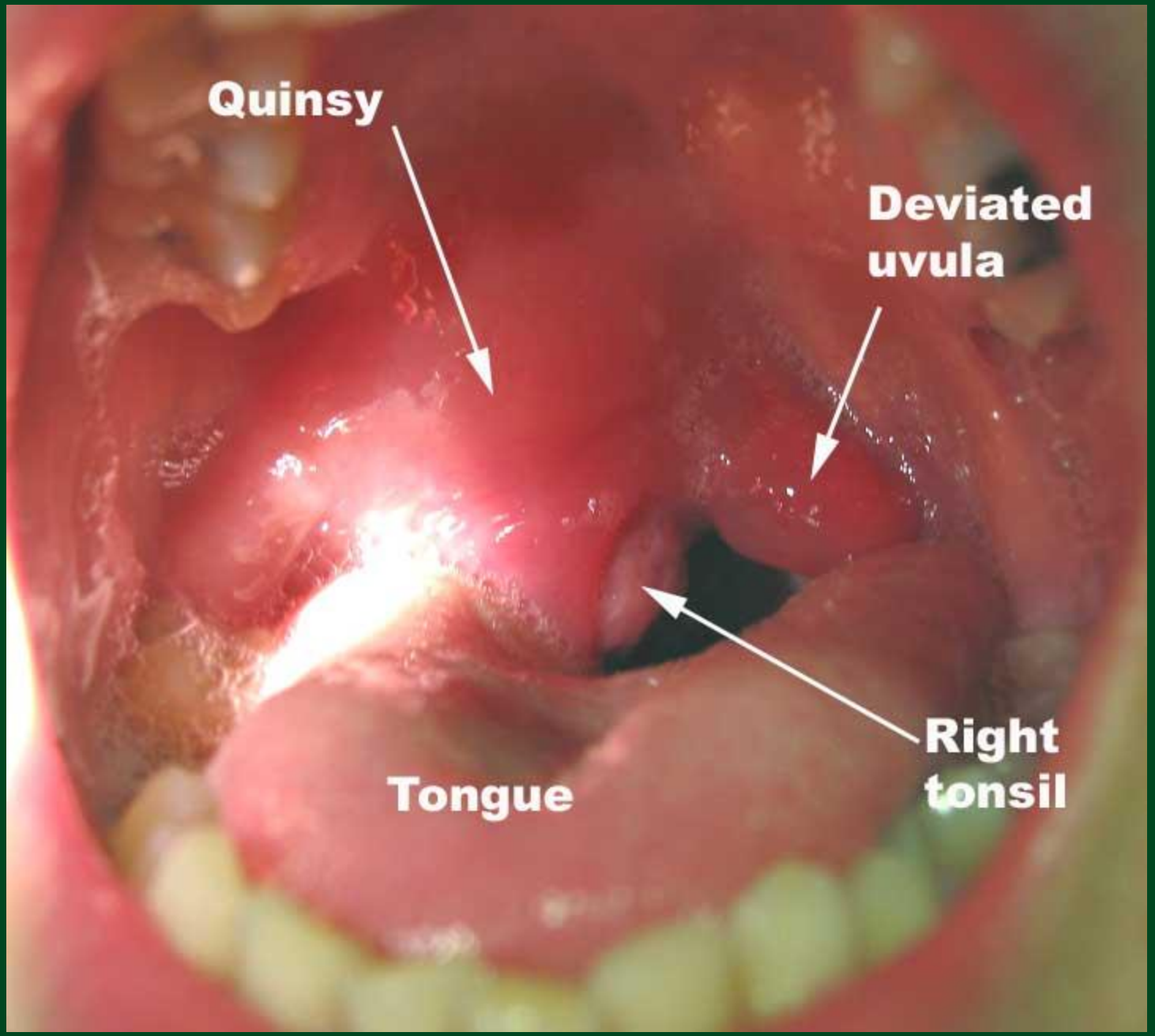
Throat

- 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



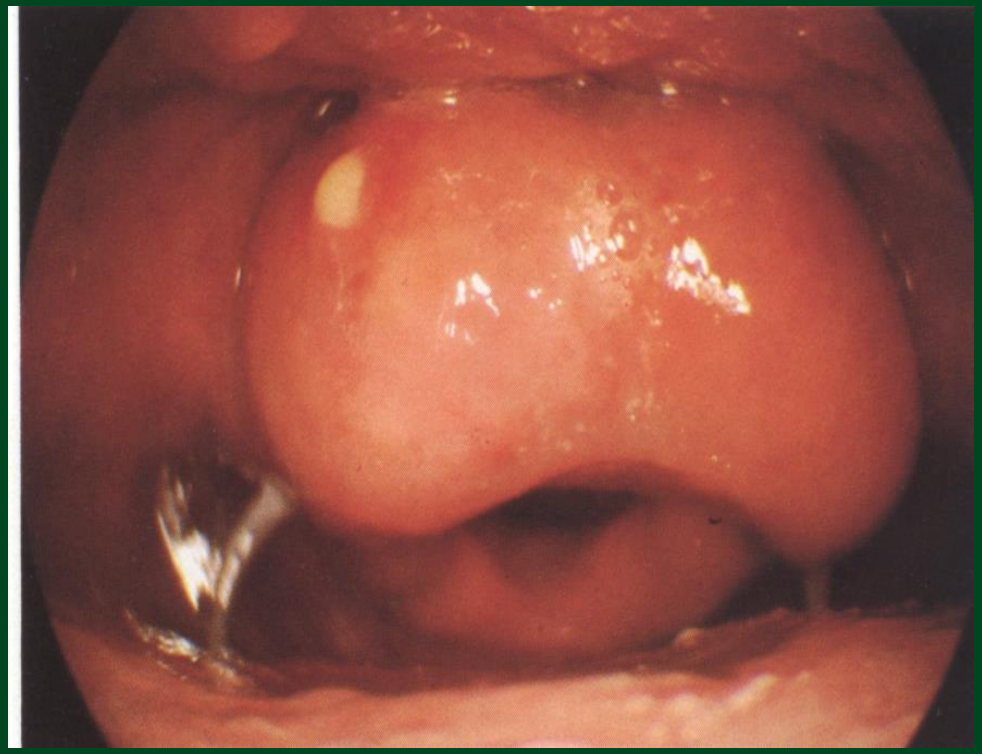
Quinsy

- 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

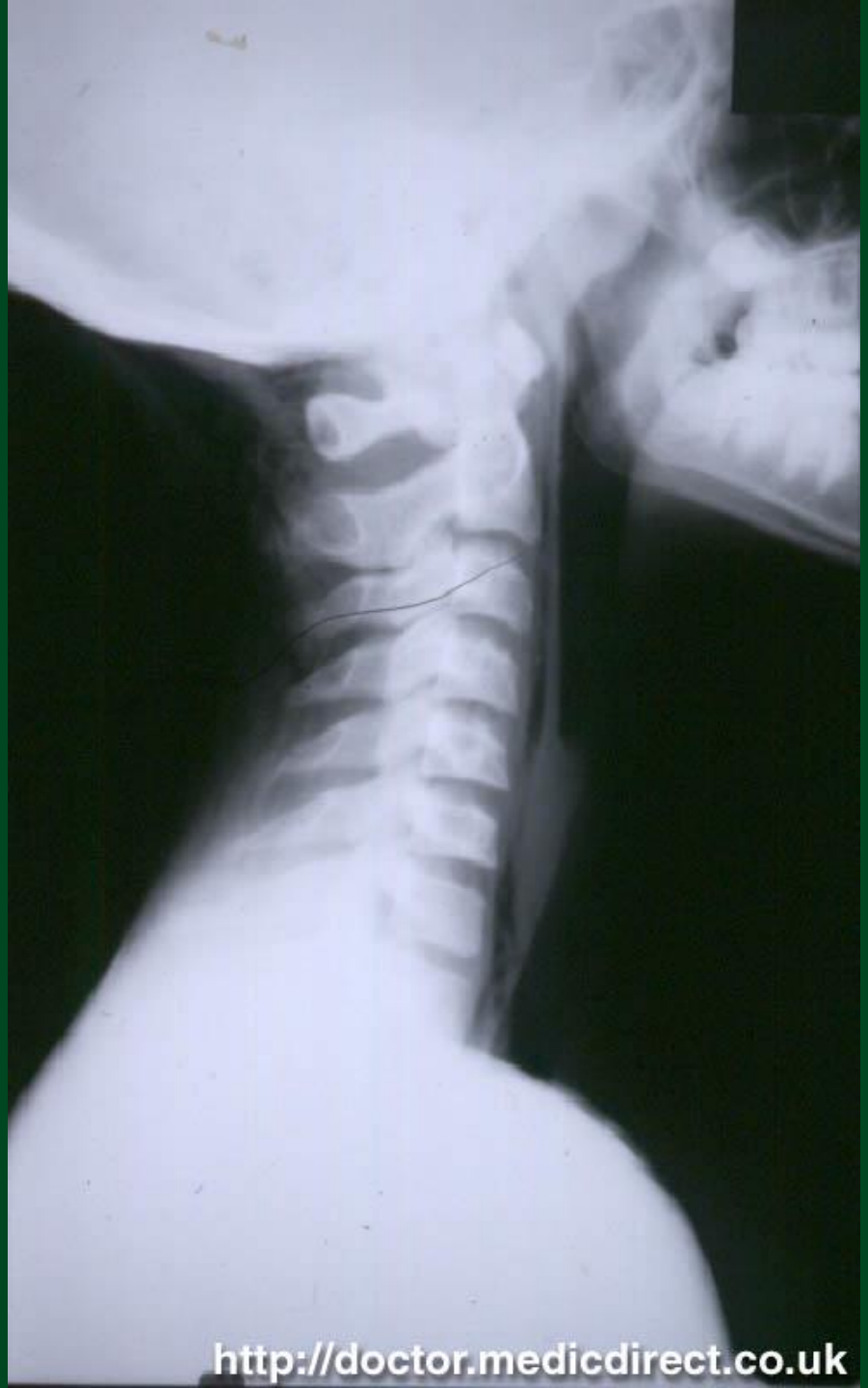


Supraglottitis

- Adults no need to be so careful but need emergent treatment- they can decompensate- ITU need to know about these patients
- 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 e.g. chicken or batteries etc refer to be seen straight away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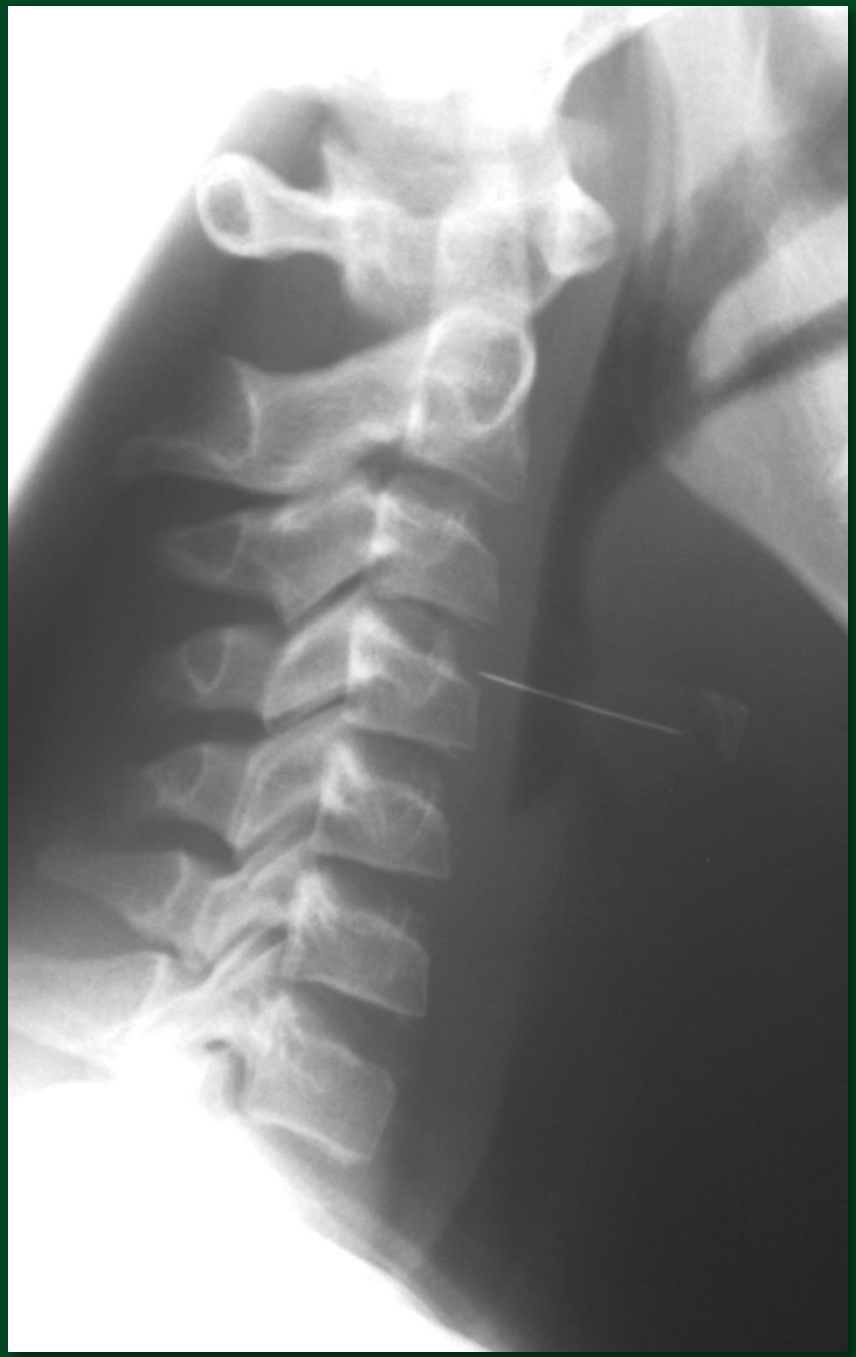

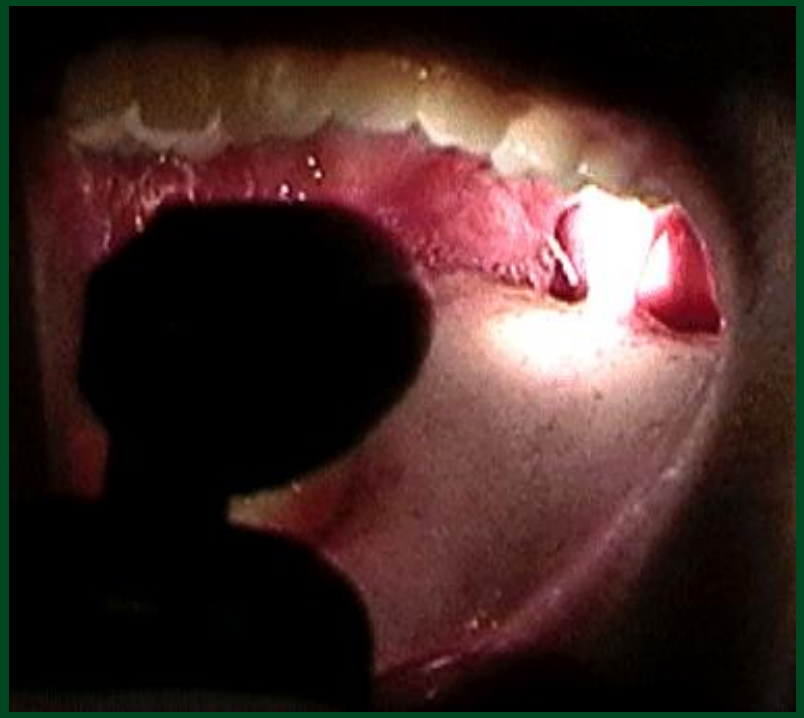

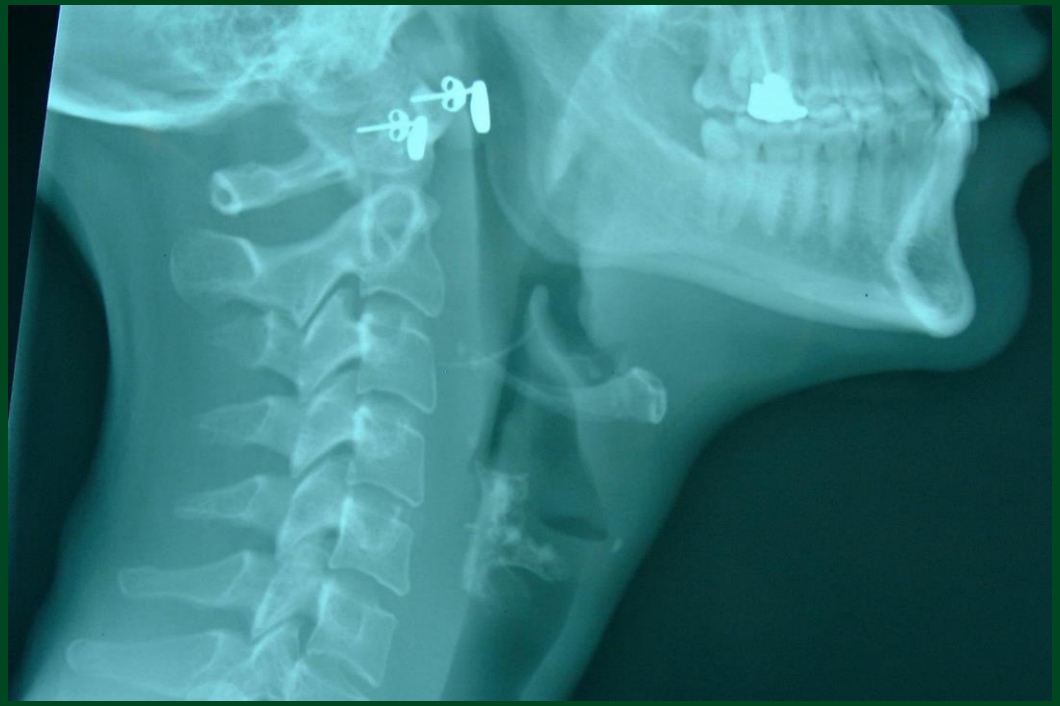

Abscesses

- 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)
- If high risk (smoker etc) don’t wait the 2-3 weeks

Hoarseness

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

Questions?

- Thank you for listening!