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Emergency Department Guidance: Ear Nose and Throat Emergencies

Working Together Programme – V1 - November 2016

Purpose of the Guidance

This guidance was put together by the ENT Managed Clinical Network (MCN), set up by the Working Together Programme. The ENT MCN were looking at the configuration of the on-call across the patch and have developed a model for Chesterfield ENT emergencies to be treated in Sheffield at weekends and to implement separate Adult and Children rotas.

Therefore, the MCN agreed that the ED protocols for contacting the ENT on-call and referring patients to Sheffield would need to be standardised across the patch.

This document has been developed to be used by clinicians working in front line emergency medicine to aid decision making when looking after patients with ENT presentations. It is not intended as a teaching tool, but instead as a tool to enable appropriate onward care of the patient.

We have used a traffic light system to guide the clinician through various conditions. This generally follows the following pattern.

Presentation	Outcome
Green presentations	To return if necessary (TRIN) or follow up at GP
Orange presentations	To be referred to ENT acute clinic
Red	Immediate referral to on call ENT services for advice and on-going management
ALL POST-OPERATIVE COMPLICATIONS	CONTACT ENT ON-CALL

Local policies should be followed regarding in house senior advice if there are any concerns regarding making the diagnosis.

EAR

Presenting Symptoms	Advise and Treatment
Earache +/- discharge (Child)	
Otherwise well child, associated URTI, eating and drinking, possible pyrexia, small amount discharge, probably mucoid.	Advise fluids by mouth and analgesia (paracetamol and ibuprofen). Antibiotics (amoxicillin or clarithromycin) if under 2 years old. GP follow-up if further problems.
Red: Unwell child particularly <2years old. Swelling around ear especially above and behind ear may suggest mastoiditis.	Any evidence of facial nerve palsy, nystagmus or meningism. Urgent ENT referral.
Earache +/- discharge (Adult)	
Earache in adults often referred from temporomandibular joint or pharynx. Discharge usually due to otitis externa	If scant and serous: keep ear dry, Sofradex drops (3 drops tds for 7 days), review in ENT emergency clinic within 7 days.
Mucoid discharge suggests perforated drum:	Keep ear dry, take swab for culture, antibiotics only if sensitive organism identified, review in ENT emergency clinic within 7 days.
Red: Otitis externa with severe pain, swelling behind the ear, or perichonditis of the pinna. Suspected middle ear disease with facial nerve palsy, dizziness / nystagmus, or meningism.	All need emergency ENT referral.

EAR

Presenting Symptoms	Advise and Treatment
Foreign Body in Ear	
Piece of inert material in ear canal:	Remove hard objects with wax hook, soft material (e.g. cotton wool) with crocodile forceps. If eardrum seen to be intact after FB removal, no FU needed.
	If unable to remove inert FB, ENT emergency clinic within 7 days.
Animate foreign body (i.e. insect), button battery, suspected perforation of drum:	Urgent ENT referral.
Trauma	
Injury to pinna: no evidence of cartilage injury Blood in ear canal from skin wound on external ear / scalp	Simple repair (suture, steristrip etc) as required.
Injury to pinna with cartilage injury, bleeding or CSF otorrhoea following head injury.	Urgent ENT referral.
Sudden Sensorineural Hearing Loss (Unilateral)	
	Adult: Start PO prednisolone (60mg for 7 days then 30 mg for 7 days) and review in next ENT emergency clinic for audiogram.

NOSE

Presenting Symptoms	Advise and Treatment
Trauma	
Nasal injury with no swelling, cosmetic deformity or other factors:	No intervention needed.
Minor soft tissue wound with no cartilage involvement::	Suture, glue or steristrip as appropriate.
Nasal injury with swelling and deformity but no active bleeding or other features:	Head injury advice, review ENT emergency clinic in 5-7 days.
Nasal injury with active bleeding, septal haematoma, open wound with cartilage involvement, CSF rhinorrhoea: Associated facial bone fracture, dental damage or reduced eye movements	All need urgent ENT referral. All need urgent OMFS referral.
Foreign Body in Nose	
Small inert foreign body in nostril:	Remove hard object with wax hook, soft object with crocodile forceps. No FU if successfully removed.
Stable foreign body in nose, especially if chronic:	Next available ENT emergency clinic
Unstable foreign body with risk of aspiration, sharp object, button battery:	Urgent ENT referral WITHIN THE HOUR.

NOSE

Presenting Symptoms	Advise and Treatment
Epistaxis	
Minor recurrent bleeds, not actively bleeding, well patient:	Naseptin cream if evidence of vestibulitis / crusting, follow-up in ENT emergency clinic within 7 days.
Active bleeding, severe bleed, unwell patient:	Urgent ENT referral. Will need IV access, FBC, PT/INR if anticoagulants, group and save / X match if severe, consider nasal pack (e.g. Rapid Rhino) prior to transfer.
Inflammatory Conditions	
Rhinitis / sinusitis with no adverse features:	Antibiotics not usually indicated. See GP if problem persist, especially if chronic.
Cellulitis or swelling involving nose, face or eyes:	Urgent ENT referral.

THROAT

Presenting Symptoms	Advise and Treatment
Sore Throat	
Acute minor sore throat in otherwise well patient who is able to eat and drink.	Antibiotics not usually indicated. Advise fluids both mouth, rest and analgesics (paracetamol / ibuprofen in alternating doses every 4 hours). If recurrent sore throats (>5 per year) see GP regarding ENT referral.
Acute sore throat with Centor score 3-4 (score 1 for each of tonsillar exudate, tender lymphadenopathy, fever and absence of cough):	5 day course of phenoxymethylpenicillin or clarithromycin. Consider glandular fever blood test.
Severe sore throat, unable to eat and drink, peritonsillar abscess, significant neck swelling, suspected epiglottis / supraglottitis (do not examine throat in a child).	All require IV access, FBC, U+E, CRP, glandular fever test, urgent ENT referral.
Foreign Body - Swallowed	
Patient aware of having swallowed a FB which went down. Able to eat and drink, no residual discomfort or other symptoms:	Discharge with advice to return if problems develop.
FB “scratched” on the way down but passed: patient able to eat and drink, only minor discomfort. Nothing to see on examination and lateral soft tissue X ray of neck normal:	Allow home but must return if discomfort increases, develops temperature, SOB or dysphagia.
FB still impacted, unable to eat or drink, sharp object (bone, pin etc), ALL dentures: Button batteries swallowed	IV access, urgent ENT referral. Must be removed almost immediately, risk of chemical perforation of oesophagus.

THROAT

Presenting Symptoms	Advise and Treatment
Inhaled	
ALL suspected inhaled FB.	If stable, arrange lateral soft tissue neck X ray and CXR prior to transfer.
Breathing Difficulty	
ALL patients with stridor:	Urgent ENT referral WITHIN THE HOUR. May need assessment by local anaesthetic on call (+ paediatrician if child) prior to transfer.
Stab Wounds to Neck	
	All will need IV access and transfer to ENT as emergency. May require stabilisation of haemorrhage (possibly involving local surgical/vascular team, or ENT middle grade or consultant from centre and / or airway (may need anaesthetic involvement).

OTHER

Presenting Symptoms	Advise and Treatment
Facial Nerve Palsy	
	Adult: Once ruled out any other pathology (middle ear problem or parotid mass) then prescribe PO prednisolone (60mg for 7 days then 30mg for 7 days – if no contraindication), eye care (lacrilube, tape shut at night) and review ENT emergency clinic 5-7 days.
	Child: Urgent transfer to ENT
Adult: Presence of middle ear disease or parotid mass:	Urgent ENT referral
All Post-Operative Complications	
	Contact ENT On Call