

A Guide to the Referral of Common ENT Conditions

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Many ENT departments have introduced their own referral guidelines. Using these documents as a starting point, the authors have attempted to provide a consensus of opinion. Where evidence based guidelines e.g. Cochrane exist, these have been incorporated. It is hoped that the guide will provide information to doctors and nurses in Primary Care on the management of some common ENT conditions and when to refer to the local ENT department. The authors are grateful to all the ENT departments which allowed use of their literature.

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Wax Impaction

If the normal migration of wax out of the ear canal is inhibited in some way, then a build up can occur. 30% of people over the age of 64 years will suffer wax impaction and wax removal can improve the hearing.

Treatment: Wax can be removed by ear irrigation, aural toilet or microsuction. Sodium bicarbonate drops or olive oil can reduce build up and soften wax, although water and saline drops appear to be as good as more costly products.

When to refer: *Refer to the routine ENT clinic if there is difficulty removing the wax despite olive oil. Refer if a child is uncooperative or there is uncertainty about the condition of the tympanic membrane. The local ENT department may have a direct referral ear care clinic. Patients will require microsuction if contraindications to syringing exist.*

Do not syringe if :

- *The patient has a tympanic membrane perforation or a mucoid discharge which may suggest a perforation.*
- *The patient has had otitis media or acute otitis externa in the last six weeks.*
- *The patient has had previous ear surgery, seek advice.*
- *The patient has suffered complications with previous ear irrigation.*
- *The patient has a profound hearing loss in the other ear as it would be inadvisable to risk complications in the only hearing ear.*
- *The patient has had a cleft palate as he is more prone to middle ear disease.*

Otitis Externa

Otitis externa is extremely common. Predisposing factors are scratching of the external canal with cotton buds or other implements and narrow external auditory canals. A particularly important factor is wet ears (humid climates, swimming, syringing without drying the canal, frequent hair washing or lying in the bath to wash the hair).

Symptoms and signs: Whatever the predisposing factor, the skin of the external auditory canal becomes oedematous. Otagia, otorrhoea and a blocked sensation in the ears with a mild hearing loss are common in the acute stage. In the chronic form itching is a frequent complaint.

Treatment: It is essential that debris in the ear canal is removed so that the ear drops can penetrate effectively. If the practice nurse is not trained in aural toilet, the patient may need to be referred for suction clearance. Systemic antibiotics are not usually required unless there are signs of associated lymphadenitis, perichondritis or cellulitis. Advise the patient to keep the ears dry and not to insert implements.

The first line of treatment is a combination steroid and antibiotic (eg. neomycin) drop or spray. If the patient does not respond to this within a few days, take a swab, change to an alternative antibiotic / steroid combination and repeat the aural toilet. Consider fungal infection. For recurrent mild conditions, proprietary diluted acetic acid can be used in primary care to prevent the condition progressing.

When to refer: *If the patient does not respond to the second line treatment, refer to the emergency ENT clinic. Refer if there is persistent discharge or pain, diagnostic doubt about the condition of the tympanic membrane or if the patient is immuno-compromised or a poorly controlled diabetic as there is a risk of “malignant “ otitis externa (temporal bone osteomyelitis). If the skin of the external canal is so swollen that drops will patently not enter the canal, then a dressing or wick may need to be inserted.* [Please see the IFR policy](#)

Recurrent Acute Otitis Media (RAOM)

Approximately 40% of children will suffer one or more episodes before the age of 7 years. At least 85% will resolve within 72 hours without treatment and it is uncommon in adults. A significant proportion of children with RAOM failing medical management appear to have a partial maturational IgA deficiency. Children with RAOM may require long-term low-dose antibiotic treatment or grommet insertion until they grow out of the condition. Grommet surgery in children with RAOM can prevent infection, pain and the need for antibiotics.

Symptoms and signs: Earache, hearing loss and a red bulging drum prior to tympanic membrane rupture. The child may be irritable with a fever and sickness. After rupture there will be relief of pain and a purulent discharge.

Treatment: Analgesia such as a combination of ibuprofen and Paracetamol. If unresolved after three days prescribe amoxicillin or erythromycin. If antibiotics are prescribed the length of the course should be reviewed after three days. Encourage nose blowing.

If treatment fails with the first line antibiotics, prescribe co-Amoxiclav or Clarithromycin.

When to refer: Refer to a routine ENT clinic if:

- a) *there is a failure of the infection to resolve despite the above treatment.*
- b) *there is a persistent perforation.*
- c) *there are more than 6 attacks in one year for a period of more than one year.*

Otitis Media with Effusion (OME) 'Glue Ear'

85% of children experience glue ear at some stage. 50% will resolve spontaneously within three months. Peak ages are two and five years and a hearing assessment quantifies severity. Winter, URTIs, child care settings and passive smoking are accepted environmental risk factors.

Symptoms and signs: There will be a noticeable hearing impairment and/or speech and language difficulties and behavioral problems. There may be an association with recurrent acute otitis media. The salient features on otoscopy are a drum that appears dull, retracted or poorly mobile. There may be an air-fluid level or bubbles visible behind the tympanic membrane. Such changes, which are usually bilateral are best seen using a pneumatic otoscope. Tympanometry can be used to confirm the presence of an effusion.

Treatment: Reduce exposure to cigarette smoke. Persistent effusions do not respond to oral decongestants or mucolytics. Treatment of rhinitis may be appropriate and helpful. Auto-inflation of the eustachian tube has been shown to produce short term improvement in older children. Generally, a three month period of watchful waiting is recommended prior to referral. If the condition persists and there is a clinically obvious effect on speech, language, learning or behaviour, then children over 3 1/2 years may benefit from adenoidectomy and/or ventilation tube (grommet) insertion. For children younger than 3 1/2 without gross airway obstruction due to adenoid or tonsillar enlargement, the treatment options are ventilation tubes or possibly the use of a hearing aid. Consider the possibility of a sensori-neural hearing loss. (1 in 1000 neonates will have a profound hearing loss).

When to refer: *Refer children to the routine ENT clinic if there have been 8-12 weeks of hearing problems, associated speech delay or behavioural problems (4 weeks if the child has other disabilities making correction of the hearing loss more urgent). Referral should take into account parental concerns or those raised by the school or health visitor. Refer adults urgently if there is no history of URTI or barotrauma and especially if oriental (higher risk of nasopharyngeal carcinoma).*

Dizziness

The majority of dizziness in the elderly is of vascular or degenerative origin. Unsteadiness and lightheadedness are usually non-otological.

Medical: Cardiovascular, metabolic and neurological conditions, anaemia, ocular disease, medications and cervical spine problems.

Psychological: Anxiety and hyperventilation.

Otological: Benign paroxysmal positional vertigo, acute vestibular failure (labyrinthitis), Mènière's disease, some middle ear disease and very rarely acoustic neuroma.

Symptoms: If the symptoms are from the inner ear then the patient will describe an hallucination of movement, usually rotational in nature and frequently accompanied by nausea, vomiting and nystagmus. Mènière's syndrome consists of a triad of episodic vertigo, associated tinnitus and a fluctuating hearing loss. In benign paroxysmal positional vertigo (BPPV), short-lived episodes of rotational vertigo usually occur when turning over in bed. Loss of consciousness is unlikely to be caused by inner ear problems.

Treatment: A general medical examination, a careful history and blood pressure measurement may point to the cause of the dizziness. If "the room is spinning" the patient may find it helpful to focus on a fixed object. Maintain hydration if nausea and vomiting are a feature. Vestibular sedatives such as Prochlorperazine or Cinnarizine are usually helpful in acute vertigo (eg. acute labyrinthitis, acute episode of Mènière's), but long term use does not help with vestibular rehabilitation. Longer term treatment with Betahistine may be helpful in Mènière's disease.

When to refer: *Some ENT departments run special neurotology clinics. Refer to ENT if there are ear symptoms or signs such as a discharging ear as some chronic ear disease can cause vertigo. For patients with BPPV, most can be helped by "repositioning" manoeuvres, performed in the ENT/audiology department. In the absence of otological signs or symptoms accompanying the dizziness the patient may benefit from a neurological opinion.*

DRAFT DIZZINESS/VERTIGO/UNSTEADINESS PATHWAY

Adults with dizziness; referral pathway after initial care fails or is inappropriate

UNDER 75
DEFAULT PATHWAY:
ENT Clinic

UNLESS

Cardiology

Predominant Symptoms

- Palpitations
- Arrhythmias
- Postural hypotension
- Orthostatic hypotension
- Vaso-vagal attacks

Neurology

Predominant Symptoms

- Ataxia/incoordination
- Epilepsy
- Migraine
- Neuro signs
- Central nystagmus

75 & OVER
DEFAULT PATHWAY:
FALLS Clinic

UNLESS

Cardiology

Predominant Symptoms

- Palpitations
- Arrhythmias
- Postural hypotension
- Orthostatic hypotension
- Vaso-vagal attacks

Neurology

Predominant Symptoms

- Ataxia/incoordination
- Epilepsy
- Migraine
- Neuro signs
- Central nystagmus

ENT

Predominant Symptoms

- Earache
- Ear discharge
- Conductive hearing loss
- Sudden deafness
- Unilateral deafness/tinnitus

Tinnitus

Tinnitus is the sensation of sound which does not come from an external source. Tinnitus is a troublesome and common condition which is not always curable. It can occur in any age group but is more common with increasing age. Persistent tinnitus occurs in about 10% of the population. It is essential to exclude serious pathology (such as an acoustic neuroma if the tinnitus is unilateral) and then to treat and to support the sufferer as best one can.

Aetiology

Local: Any hearing loss.

General: Hyperdynamic circulations (as in hypertension or anaemia), carotid bruits (associated with a carotid artery stenosis).

Drugs : eg. NSAIDs, caffeine, alcohol.

Symptoms: Tinnitus affects people in different ways. On the one hand it may be non intrusive, or on the other hand it can contribute to suicide. Most patients recognise the link between their level of emotional and physical stress and the perceived "loudness" of the tinnitus.

Treatment: A full otological and general history must be taken to exclude other pathologies. Exclude obvious local causes such as wax impaction. A pure tone audiogram is of use in establishing the degree of hearing loss that may be associated with the tinnitus. The importance of unilateral tinnitus (versus bilateral symmetrical tinnitus) is that it is sometimes a symptom of an acoustic neuroma. Direct the patient towards specialised help such as a hearing therapist, self help groups and the British Tinnitus Association. Relaxation techniques help some patients.

When to refer: *Refer to the routine ENT clinic if the tinnitus becomes intrusive (sleep disturbance), if it is unilateral, or if the tympanic membranes are abnormal.*

Adult Deafness

Sudden-onset conductive hearing loss (usually unilateral)

After URTI / air flights / diving. The patient is unable to 'pop' the ear (no movement of the drum on performing the Valsalva manoeuvre). There may be the appearance of fluid behind the drum. The bone conduction is better than air conduction in that ear.

Treatment: Decongest the nose and encourage auto-inflation of the ears.

When to refer: *If there are continued problems despite nasal treatment then refer to a routine ENT clinic.*

Sudden-onset unilateral sensori-neural hearing loss

The patient will usually report suddenly going deaf in one ear. There is a normal looking tympanic membrane.

Treatment: Treatment remains controversial because of the lack of high quality evidence. Many doctors in the UK use a short course of prednisolone, possibly combined with antivirals. Spontaneous recovery is seen in 50% of patients.

When to refer: *Refer to the ENT emergency clinic within a week of onset.*

Presbycusis

A symmetrical, gradual, high frequency hearing loss in old age.

When to refer: *Direct referral to the audiology department should be used if this facility exists. If the hearing loss is asymmetrical then refer routinely to ENT as further investigations may be required to exclude an acoustic neuroma.*

Facial Palsy

Weakness on one side of the face, including the muscles of the forehead (lower motor neurone palsy). Note any associated middle ear disease, parotid swelling and other neurological deficits. Intense pain around the ear and vesicles on the pinna or soft palate suggest Ramsay Hunt syndrome (herpes zoster). If there is no associated disease then “Bell’s palsy” is likely to be due to HSV infection.

Treatment: Early treatment with prednisolone improves the chance of complete recovery. There is no evidence of benefit of adding an antiviral. Protect the eye with artificial tears and nighttime tape.

When to refer: *Refer urgently if there is a parotid mass, middle ear disease, a suspicion of Ramsay Hunt syndrome or doubt about the diagnosis.*

Epistaxis

Recurrent nose bleeds are common in all age groups. Young children usually bleed from Little's area on the anterior septum, elderly patients from higher or further back in the nose. Common risk factors include nose picking, high blood pressure and aspirin / NSAID / warfarin usage.

Treatment: First aid measures; apply ice and pressure on the anterior, soft part of the nose. Sit the patient upright with the head forward to avoid swallowing blood. If a bleeding point is visible on the anterior septum, consider cautery with silver nitrate sticks. Topical vasoconstrictors may be helpful. Petroleum jelly or anti-staphylococcal ointment can be used in minor cases. For severe bleeding attempt packing with ribbon gauze or nasal tampons and refer to ENT.

When to refer: *Refer to the emergency ENT clinic if there is persistent or severe bleeding, or a suspected clotting disorder*

Fractured Nose

Symptoms: Traumatic injury to the nose resulting in peri-nasal swelling, black eyes and nasal tenderness.

Treatment: On initial presentation, examine the nose to exclude a septal haematoma (a cherry – red bilateral tender swelling with blockage) or a deviated nasal septum. Review the patient in the practice in one week when the swelling has subsided. X-rays are unnecessary unless there are concerns about other facial fractures.

When to refer: *Patients with an uncomplicated or undisplaced fractured nose or those unconcerned with cosmesis do not require ENT follow-up. Refer a patient with a septal haematoma to the emergency ENT clinic. Patients who are unhappy with the cosmesis of the nose should be referred to the emergency ENT clinic at 7 days post injury as a manipulation is possible up to 14 days after trauma.*

Snoring and Obstructive Sleep Apnoea

The prevalence of snoring and obstructive sleep apnoea (OSA) is high and under-recognised. Twenty four percent of men and 14% of women are habitual snorers and 5% of men have OSA. In children, tonsil and adenoid hypertrophy is the commonest cause of OSA and adenotonsillectomy frequently completely relieves the condition. OSA causes multiple awakenings during sleep. This has a serious impact on wakefulness and intellectual capacity. There is mounting evidence that OSA can cause significant cardiovascular disease.

Treatment: Weight loss, cessation of smoking and reduction in alcohol intake should be encouraged. Try simple solutions to avoid sleeping on the back. Treat any nasal obstruction and consider nasal dilator strips. A good proportion of snorers and patients with moderate sleep apnoea respond to a mandibular advancement device, available from the dentist or maxillofacial department. The treatment of OSA in adults is nasal CPAP which is a service best provided by the sleep disorder clinic or respiratory physician.

When to refer: *If the above simple measures have failed and snoring is the primary complaint, refer to ENT. If there is substantial obesity and OSA, refer to a specialist sleep centre for initial assessment. Mouth breathing and snoring in children rarely warrant surgery, however refer children with OSA to ENT.*

Nasal Obstruction

Over a fifth of the population has nasal complaints, of whom two thirds report nasal obstruction. Nasal blockage may be associated with a decrease in quality of life, loss of work productivity, sleep disorders and, occasionally eustachian tube dysfunction.

Causes: Rhinitis, septal deviation, nasal polyps, adenoid hypertrophy, alar collapse, foreign bodies and rarely, tumors of the sinonasal region.

When to refer:

Rhinitis: Allergen avoidance, particularly of house dust mite is crucial in the treatment of chronic allergic rhinitis. In addition, a 3 month trial of a topical nasal steroid spray should be used. This may be combined with a topical or systemic antihistamine. Failure to resolve warrants a routine ENT referral.

Septal deviation: If an obvious septal deviation exists, then a routine ENT referral is appropriate.

Nasal polyps: A one month course of steroid nose drops may be more effective than sprays but they are more difficult to instill properly. Short courses of oral steroids may also be effective. If there is no resolution of symptoms or if there is gross polyposis then refer to a routine ENT clinic.

Foreign bodies: If a child presents with a unilateral nasal blockage or foul / bloody discharge, then a foreign body should be suspected and a referral to the emergency ENT service is appropriate.

Sinonasal malignancy: This is extremely rare, but, if this diagnosis is entertained, then an urgent referral to the ENT clinic is appropriate. Suspicious symptoms are persistent facial swellings, loosening of teeth, proptosis, paresthesia of the cheek and unexplained nosebleeds.

Sinusitis

Symptoms:

Acute sinusitis: Acute facial pain following an URTI (maxillary/upper dentition, frontal or nasal bridge pain). The pain is usually unilateral and associated with purulent rhinorrhoea and fever.

Chronic sinusitis: is associated with less pain and a purulent rhinorrhoea or post-nasal drip. It is often accompanied by chronic rhinitis symptoms.

Treatment: In acute sinusitis, pain relief and decongestants such as ephedrine or xylometazoline nasal drops and/or intranasal steroids may be sufficient. If an antibiotic is required, amoxicillin (or erythromycin) for 7 days is usually adequate. For chronic sinusitis (symptoms lasting longer than 4 weeks), use an antibiotic covering both aerobic and anaerobic organisms for 3 to 6 weeks. Plain sinus x-rays have limited use in the routine management of rhinosinusitis.

When to refer: Refer to the emergency ENT clinic if there are any complications of acute sinusitis, especially peri-orbital cellulitis/abscess, deterioration of vision, severe systemic illness, drowsiness or vomiting (? intra-cerebral complications). Refer if there has been a failure to respond to medical treatment. Refer chronic rhinosinusitis and recurrent acute sinusitis to the routine ENT clinic.

Recurrent Sore Throats

The majority of sore throats are viral in nature and hence will not respond to antibiotics. The average sore throat lasts between 5 to 7 days and the condition results in significant loss of time from school or work for a large number of patients. A significant percentage of children grow out of tonsillitis at about 5 or 6 years old, however the timescale for this in some individuals may be many years.

Symptoms and signs (of recurrent tonsillitis): Painful dysphagia, systemic upset, fever, inflamed/infected tonsils and cervical lymphadenitis. Children often present with fever, abdominal pain and refusal to eat.

Treatment: There is no effective medical treatment for recurrent sore throat which shortens the duration of the illness or reduces the frequency of attacks. Simple analgesia and plenty of fluids should be advised. A throat swab is unnecessary. Symptomatic management is satisfactory for most patients provided that the episodes of sore throat are not recurring with unacceptable frequency. If antibiotic treatment is indicated, penicillin V or erythromycin for ten days is usually sufficient. Antibiotics should be prescribed if a child has features of marked systemic upset, peri tonsillar cellulitis, a history of rheumatic fever or if he is immunocompromised or a diabetic.

When to refer: *If a patient develops a quinsy (peritonsillar abscess –soft palate swelling, medialisation of the tonsil and trismus) or dehydration, refer to the ENT emergency clinic Refer children if there is an obstructed airway or a history of sleep apnoea. Unilateral tonsillar enlargement or tonsil ulceration should be referred for urgent biopsy. Primary care records should have documented the number of episodes and the associated morbidity. The consensus for routine tonsillectomy is approximately 7 episodes for a single year, 5 or more per year for 2 years or three or more in each of three successive years. However, each patient should be taken on his own merit. If there is doubt, a 6 months tonsil diary should be kept.*

Neck Lumps

The majority of neck lumps are benign. Consider whether the lump is a lymph node, salivary gland or thyroid swelling. Most malignant lymph nodes in the neck arise from a primary tumour in the upper aero-digestive tract. A full and formal ENT examination is essential.

Symptoms: There may be no symptoms other than a lump. Hoarseness, referred otalgia and dysphagia are suspicious as is a hard, fixed, rapidly growing neck lump.

Treatment: Do not biopsy the lesion in the primary setting as seeding of a tumour can occur. The ENT department will assess the patient fully and perform fine needle aspiration of the lump.

When to refer: *Refer neck lumps of more than a few weeks duration for an urgent clinic appointment (or head and neck cancer pathway). Refer unexplained swellings in the salivary glands or thyroid. Document a history of smoking and alcohol abuse*

Hoarse Voice

Most hoarseness in non-smokers is as a result of laryngitis or voice abuse. Acid reflux may play a part.

When to refer: *If the hoarseness lasts longer than 3 weeks or is unassociated with a preceding URTI, refer to the ENT clinic urgently to exclude laryngeal cancer (head and neck cancer pathway). Be particularly suspicious in smokers and heavy drinkers over 50.*

Suspected Pharyngeal Malignancy

Symptoms: Many patients present with a feeling of a lump in the throat and most have the benign condition of globus pharyngeus. There is no true dysphagia, indeed the sensation is less noticeable with meals. Some may have associated reflux disease. Symptoms of pharyngeal malignancy are subtly different.

When to refer: *If the patient complains of food sticking or pain on swallowing, particularly pain referred to the ear, refer to the urgent ENT clinic. Refer if there is ulceration of the pharynx or a neck lump. Other factors raising the index of suspicion are age over 40, smoking, alcohol abuse and weight loss. It is helpful to mention these risk factors in the referral letter.*

Oral Lesions

Symptoms: The patient may complain of pain, dysphagia, bleeding or halitosis. Oral cancer is closely linked to smoking and alcohol abuse.

Treatment: Exclude causes such as poor dentition, badly fitting dentures and trauma. Try a simple mouth wash and advise the patient on oral hygiene.

When to refer: *Leukoplakia (white lesions), erythroplakia (red lesions) and ulceration should be referred for an urgent ENT/Maxillofacial appointment, particularly if present for more than 3 weeks.*