ENT REFERRAL RECOMMENDATIONS

Diagnosis / Symptomatology	Evaluation	Management Options	Referral Guidelines
General problems include: 1. Upper airway obstruction. 2. Throat pain. 3. Hoarseness. 4. Dysphagia. The following diagnoses or symptoms are considered under ENT: • Ear • Nose • Salivary Gland Disorders • Throat • Pharynx Tonsil & Adenoid • Neck	These general symptoms may include any and/or all of the general or specific problems noted. A thorough history and physical examination is required to determine the specific diagnosis. Smoking history is seen as particularly important. (See below).	Specific treatments depend on the specific problems identified, as noted below.	1. If the problems resolve in less than three treatment attempts, specialty referral is **not indicated.** 2. If symptoms or findings persist, or recur a third time, or there is incomplete resolution, referral is **indicated**.

Diagnosis / Symptomatology	Evaluation	Management Options	Referral Guidelines
EAR			
1. Dizziness and Facial Palsy			
Tinnitis			
A. Chronic bilateral	Any associated symptoms? Cerumen?	Clear cerumen and check TM. If TM clear, if normal no treatment.	No referral indicated unless tinnitus is disabling, or associated with hearing loss, aural discharge or vertigo – Category 3.
B. Unilateral, or recent onset	Any associated symptoms? Cerumen?	Clear cerumen and check TM. If symptoms persist, refer.	Referral indicated, especially if it is disabling, or associated with hearing loss, aural discharge or vertigo – Category 3.
C. Pulsatile	TM normal or (vascular) mass behind drum. Auscultation of carotid vessels.	Referral.	Referral is indicated in all cases. If there is a middle ear mass, there is a strong possibility of a glomus tumour.
2. Dizziness / Vertigo			
A. Orthostatic	Symptoms mild, brief and only on standing up (usually a.m.).	Evaluate cardiovascular system, reassurance.	No referral indicated unless atypical or associated with other ear symptoms and this should normally be medical.
B. BPPV and vestibular neuronitis (VN)	Associated with an URTI, may be positional and/or persistent.	Self limiting over a few weeks. Symptomatic medication, eg Stemetil may help VN.	Referral with: Associated hearing loss, increased severity, persistence over 2 months – Category 3.
C. Chronic or episodic	Significant vertigo. May have associated hearing loss, tinnitus, aural fullness, nausea. History of previous ear surgery.	Symptomatic treatment acutely.	Otolaryngology referral is indicated – Category 3.

Diagnosis / Symptomatology	Evaluation	Management Options	Referral Guidelines
3. Ear Discharge / Pain			
	Swab discharge and determine culture and sensitivity Monitor for cellulitis	Topical treatment If systemically unwell with elevated temperature then treat with antibiotics If no improvement or pain persists refer	
4. Facial paralysis			
	Weakness or paralysis of movement of all (or some) of the face. May be associated with otalgia, otorrhoea, vesicles, parotid mass or tympanic membrane abnormality.	Protection of the eye from a corneal abrasion is paramount. Lacrilube and taping the eye shut at night. Steroid therapy may be initiated if no associated clinical findings. Consider anti-viral treatment if associated with vesicles.	Urgent Otolaryngology referral is indicated if otologic cause suspected – Category 2.
5. Ear – Infections			
A. Chronic suppurative otitis media	Symptoms: Chronic discharge from the ear(s), hearing loss. Examination: Perforation of drum (especially attic or postero-superiorly granulation tissue and/or bleeding). Complications suggested by: Postauricular swelling/abscess, facial palsy, vertigo, headache – refer Category 1.	Aural toilet (not syringing). Culture directed antibiotic therapy: systemic and copious aural drops. Protect ear from water exposure.	Otolaryngology referral indicated for persistent symptoms despite appropriate treatment. Associated symptoms suggest urgency needed – Category 3.
B. Acute otitis externa	Symptoms: Otalgia, significant ear tenderness, swollen external and canal +/- hearing loss. Examination: Ear canal always tender, usually swollen and may be inflamed. Often unable to see TM because of debris or canal oedema. *NB: Fungal otitis externa may have a large fungal pad and spores visible.*	Topical treatment is optimal and systemic antibiotics alone are often insufficient. systemic antibiotics indicated when there is cellulitis around the canal. Insertion of an expandable wick with topical antibacterial medication useful when the canal is narrowed. In fungal OE, thorough cleaning of the canal is indicated, plus topical antifungal therapy. (Kenacomb, Locorten-Vioform).	Referral to an Otolaryngologist when: Canal is swollen shut and wick cannot be inserted – Category 1. Cerumen impaction complicating OE – Category 1. Unresponsive to initial course of a wick and antibacterial drops – Category 2. Necrotizing otitis externa due to pseudomonas in diabetics requires urgent referral – Category 1.

Diagnosis / Symptomatology	Evaluation	Management Options	Referral Guidelines
C. Otalgia without significant clinical findings	Symptoms: ear pain without tenderness or swelling. Physical examination: normal ear canal and TM. *NB: Mastoiditis in the presence of a normal drum and without previous infection is almost impossible.*	Requires a diagnosis and appropriate treatment. Possible aetiologies include: TMJ syndrome; neck dysfunction; referred pain from dental pathology, tonsil disease, sinus pathology and head and back malignancy.	Referral to an Otolaryngologist indicated if pain persists and aetiology not identified – Category 2.
6. Hearing loss			
Note: **DO NOT** syringe an ear with a drum known to have perforated in the past or known to be abnormal. Use Ciloxan ear drops afterwards if infected.			
A. Bilateral, symmetrical, in adults	Symptoms: Diminished hearing associated symptoms, eg tinnitus, discharge, vertigo etc? Examination: Cerumen, effusion, or normal findings.	Cerumen dissolving drops and possible suction or irrigation. Oral decongestant, Valsalva manoeuvres and re-evaluate in three weeks. Requires audiometry +/- referral.	Referral indicated if: Cerumen, and/or significant hearing loss persists – Category 3. Otolaryngology referral indicated if: Effusion, or unilateral hearing loss persists – Category 3. Severe hearing loss – Category 3
B. Acute ("Sudden Hearing Loss")	Normal drum with Weber to good ear.	Expectant treatment if > 1 week. Audiometry if available.	Urgent Otolaryngology referral if < 2 weeks for acute treatment – Category 2. Semi-urgent referral if > 2 weeks with incomplete recovery. Non-urgent if complete recovery for investigation – Category 3.
C. Unilateral long standing hearing loss in adults	May have associated tinnitus and vertigo.	Audiometry if available.	Non-urgent referral – Category 3.
D. Chronic	Symptoms: Difficulty hearing, esp. only in a crowded environment; difficulty localising sound. Examination: Cerumen. Abnormal tympanic membrane.	Cerumen dissolving drops and possible suction or irrigation. *NB: Unilateral effusions in adults? Sinus disease or nasopharyngeal tumour (especially in Chinese).*	Otolaryngology referral if the ear has not been previously assessed by an Otolaryngologist or the symptoms and/or clinical findings have changed – Category 3.

Diagnosis / Symptomatology	Evaluation	Management Options	Referral Guidelines
NOSE			
Nasal and Sinus: General problems include: • Nasal congestion, uni- or bilateral. • Nasal discharge, uni- or bilateral. • Diminished sense of smell and taste.	These general symptoms may include any and all of the general or specific problems noted. Thorough history and physical exam of the head and neck is required for determining the diagnosis, as below.	Specific treatments depend on the specific problem identified, as below.	1. If problems resolve in less than three episodes, referral not indicated. 2. If the symptoms recur a third time, resolve incompletely or persist, specialty referral is indicated – Category 3. 3.
1. Epistaxis - Persistent or recurrent			
	1. Determine whether bleeding is unilateral or bilateral. 2. Determine whether bleeding is anterior or posterior. 3. Determine if any bleeding diathesis or hypertension is present.	Immediate control may occur with: 1. Pressure on the nostrils (> 5 mins). 2. If bleeder is visible in Little's area, consider cautery with silver nitrate (after applying topical anaesthesia). 3. Intranasal packing coated with antibiotic ointment only if done by appropriate person with good equipment. Humidification, Vaseline or Bactroban for protective layer to prevent drying.	Referral to an Otolaryngologist is indicated if: 1. Bleeding is posterior – Category 1. 2. Bleeding persists – Category 1. 3. Bleeding recurs – Category 2. Refer to Ed if bleeding severe , posterior Refer to ENT if persistent
2. Persistent nasal obstruction			
	1. Symptoms: Nasal obstruction (uni/ bilateral, alternating), postnasal discharge, recurrent sinusitis. 2. Physical examination requires intranasal examination after decongestion: deviated septum, enlarged turbinates, nasal polyps.	Treat any associated allergy or sinusitis. If persistent CT of sinus and refer	Otolaryngology referral is imperative if there is an offensive, bloody discharge – Category 2. *Note:* In unilateral nasal obstruction with an offensive, bloody discharge: – in an adult – consider a malignancy.

Diagnosis / Symptomatology	Evaluation	Management Options	Referral Guidelines
3. Acute viral upper respiratory tract infection			
	1. Short duration, often sore throat at onset. 2. Nasal congestion. 3. Clear nasal discharge. 4. May be associated with systemic viral symptoms.	1. Systemic decongestants, anti-pyretics, supportive therapy. *NB: Antihistamines thicken secretions with possible adverse effects.* 2. Topical decongestant sprays may be used to a maximum of 5 days.	If symptoms persist, or if sinusitis develops, see section on "acute sinusitis" – Category 3.
4. Acute sinusitis			
	Diagnosed by: 1. Facial pain 2. Purulent rhinohoea 3. Headache 4. Increased congestion History and physical examination may be non-contributory.	1. Initial treatment: a) Broad spectrum antibiotics, eg Augmentin, Rulide for 2 weeks. b) Systemic decongestants, antipyretics, supportive therapy. *NB: Antihistamines may cause adverse effects.* c) Topical decongestant sprays to a maximum of 5 days. 2. If treatment fails – CT of sinus and refer	Otolaryngology referral indicated if: 1. Secondary antibiotic treatment fails, clinically or radiologically – Category 3. 2. Complications occur: Periorbital cellulitis, persistent headache – Category 1. 3. Recurrent infections: Over three episodes in a one year period – Category 3.
5. Facial pain			
Consider: Myofacial pain syndrome Atypical facial pain	May be an isolated symptom or may be associated with significant nasal congestion or discharge. Potentially relations to intranasal deformity, sinus pathology, dental pathology, TMJ dysfunction.	If there is evidence of acute sinusitis, treat with appropriate antibiotics.	Referral indicated for persisting anterior facial pain. May include dental and Otolaryngology opinions – Category 3.

Diagnosis / Symptomatology	Evaluation	Management Options	Referral Guidelines
6. Allergic rhinitis/VMR			
	1. Symptoms – seasonal or perennial: a) Congestion, nasal obstruction. b) clear rhinohea. c) Sneezing fits. d) Watery eyes. e) Itchy eyes and/or throat. 2. Physical examination: a) Boggy, swollen, bluish turbinates. b) Mouth breathers. c) Allergic "salute".	1. Antihistamines. 2. Topical steroid sprays. 3. Topical Chromolyn sprays. 4. Topical Livostin spray. 5. Atrovent sprays	Consider Otolaryngology referral if symptoms do not respond to medical management and especially if there is an associated physical deformity – Category 3.
7. Traumatic nasal fracture			
	1. Immediate changes: oedema, Ecchymosis, epistaxis. 2. Evaluate for associated nasal congestion, septal fracture or septal haematoma. 3. Nasal x-rays usually unnecessary only usually helpful for detecting associated fractures or for medico-legal reasons.	1. Early treatment: cool compresses to reduce swelling. 2. Re-evaluate at 5 days to assess deformity and airway	Immediate Otolaryngology referral that day if acute septal haematoma (usually significant nasal obstruction) – Category 1. Otolaryngology referral initiated now if there is a new external nasal deformity. *Note*: Nasal fractures must be reduced < 2 weeks for best results.
8. Foreign bodies			
.	Acute or chronic: History alone or visible on examination.	Don't attempt removal unless experienced and with good equipment.	Urgent referral for removal – Category 2. Immediate referral if battery (corrode). Otolaryngology referral for removal – Category 2.

<table>
<tr><th>Diagnosis / Symptomatology</th><th>Evaluation</th><th>Management Options</th><th>Referral Guidelines</th></tr>
<tr><td colspan="4">SALIVARY GLAND DISORDERS</td></tr>
<tr><td>A. Sialadenitis/sialolithiasis</td><td>1. Assess patient hydration.
2. Palpate floor of mouth for stones.
3. Observe for purulent discharge from salivary duct when palpating gland.
4. Evaluate mass for swelling, tenderness and inflammation.</td><td>1. Culture of purulent discharge in mouth.
2. Hydration.
3. CT scan or ultrasound.
4. Anti-staphylococcal antibiotics: Augmentin, erythromycin.</td><td>Otolaryngology – referral indicated for:
1. Poor antibiotic response within one week of diagnosis – Category 2-3.
2. Calculi suspected on exam, x-ray or ultrasound – Category 3.
3. Abscess formation – Category 1.
4. Recurrent sialadenitis – Category 3.
5. Hard mass present – neoplasm? – Category 3.</td></tr>
<tr><td>B. Salivary gland mass</td><td>1. Complete H & N exam indicated.
2. Evaluate facial nerve function with parotid lesions.</td><td>FNA may give useful information (negative FNAs are not diagnostic.)

NB: Open biopsy is contraindicated.</td><td>Note: 20% of adult parotid masses are malignant and 50% of submandibular gland masses are malignant.
Otolaryngology referral indicated in all cases of salivary gland tumours – Category 3.</td></tr>
<tr><td colspan="4">THROAT</td></tr>
<tr><td colspan="4">1. Dysphagia</td></tr>
<tr><td></td><td>May include history or findings of:
1. Smoking
2. Duration
3. Hoarseness
4. Foreign body ingestion

Exclude by palpation mass of:
Thyroid
Neck</td><td>Diagnostic studies may include:
CT neck / MRI neck
Ultrasound of thyroid.
Barium swallow.
Thyroid studies.</td><td>Otolaryngology referral indicated if:
1. Hypopharyngeal foreign body suspected (oesophageal lesions and foreign bodies normally referred to General Surgery/ Gastroenterology – Category 1.
2. Dysphagia with hoarseness – Category 1-2.</td></tr>
</table>

Diagnosis / Symptomatology	Evaluation	Management Options	Referral Guidelines
2. Hoarseness			
A. *Associated with upper respiratory tract infection*	1. Throat pain, may radiate to ear. 2. Dysphagia. 3. Constitutional symptoms. 4. Stridor/airways obstruction.	1. Humidification. 2. Increase hydration. 3. Voice rest, if possible. 4. Antibiotics, when appropriate. 5. Inhalant steroids sprays. 6. ? tapering oral steroids.	Otolaryngology referral indicated if: 1. Stridor or airway distress – ring on call specialist. Refer to ED 2. Associated with significant dysphagia – Category 2. 3. Hoarseness present > 4 weeks – Category 3.
B. *Associated with neck trauma*	History of neck trauma preceding hoarseness. **May or may not** have: 1. Skin laceration. 2. Ecchymosis. 3. Tenderness. 4. Subcutaneous emphysema	Immediate treatment with: 1. Humidification. 2. Parenteral and/or inhaled steroids.	**Immediate** Otolaryngology referral indicated in all cases – ring on call specialist. Refer to ED.
C. *Associated with respiratory obstruction*	Stridor.	1. Immediate treatment with humidification; parenteral steroids. 2. Blood cultures if patient febrile. 3. C1 esterase inhibitor levels (if history of angioneurotic oedema).	**Immediate** Otolaryngology referral indicated in all cases – ring on call specialist. Refer to ED.
D. *Without associated symptoms or obvious aetiology*	1. History of tobacco and alcohol use. 2. Evaluation when indicated for: – Hypothyroidism. – Diabetes mellitus. – Gastro-oesophageal reflux. – Rheumatoid disease. – Pharyngeal/oesophageal tumour. – Lung neoplasm.	1. Humidification. 2. Increase fluid uptake. 3. Voice rest, if possible. 4. Antibiotics, where appropriate. 5. Inhalant steroid sprays. 6. Treat any medical illnesses diagnosed on evaluation. 7. Chest x-ray.	Otolaryngology referral is indicated if recent hoarseness persists over four weeks despite medical therapy – especially in a smoker – Category 2.

Diagnosis / Symptomatology	Evaluation	Management Options	Referral Guidelines
PHARYNGEAL, TONSIL & ADENOID			
A. Acute Tonsillitis	Throat pain and odynophagia + any of: 1. Fever. 2. Tonsillar exudate. 3. Cervical lymphadenopathy. 4. Positive strept. test.	1. Augmentin Forte 2. Cephalosporin or Macrolide if allergic to penicillin or if initial treatment fails.	Documented episodes: 6 or more in the preceding 12 months. 5 per year in preceding 2 years. 3 per year in preceding 3 years. Persistent strept. carrier state with or without acute tonsillitis – Category 3.
B. Peritonsillar cellulitis/quinsy	Abscesses take > 4 days to develop: 1. Unilateral tonsillar displacement. 2. Trismus. 3. Fever. 4. Cervical lymphadenopathy.	Refer to ED	Acute referral to Otolaryngology with: – Abscess – Category 1. – Peritonsillar cellulitis if not resolving – Category 1. Elective tonsillectomy later in patients with preceding/subsequent tonsillitis/quinsy – Category 3.
C.Chronic tonsillitis	Frequent or chronic throat pain and odynophagia; may include: – intermittent exudate. – adenopathy. – improvement with antibiotic.	Augmentin 20 – 40mg/kg/day for 10/7. Clindamycin 10 – 25mg/kg/day for 10/7.	Referral is indicated if problem recurs following adequate response to treatment – Category 3.
D. Mononucleosis/viral pharyngitis	Throat pain and odynophagia with: – fatigue. – posterior cervical lymphanopathy. – CBC, mono test.	Supportive care. Systemic steroids if severe dysphagia. IV hydration.	Airways obstruction } Refer Category 1 Dehydration} Consider medical assessment for continued symptoms for > two weeks.

Diagnosis / Symptomatology	Evaluation	Management Options	Referral Guidelines
E. Upper airways obstruction *from adenotonsillar hypertrophy (especially in children)*	1. Mouth breathing. 2. Nasal obstruction. 3. Dysphonia. 4. Severe snoring +/- sleep apnoea. 5. Daytime fatigue. 6. Dysphagia/eating difficulties. 7. Weight +/- height below normal. 8. Dental maldevelopment. 9. Adenoid facies. 10. Cor pulmonale.	1. Optional lateral soft tissue x-ray of nasopharynx. 2. Allergy evaluation where indicated. 3. Sleep audio tape may be helpful to evaluate possible sleep apnoea.	Referral indicated with any **significant** symptoms of upper airway obstruction, especially sleep apnoea – Category 3.
NECK MASSES			
A. Inflammatory (ie, painful).	Complete H & N examination indicated for site of infection. Consider FNA, if unsure of diagnosis. Optional investigations (if indicated): 1. CBC. 2. Cultures when indicated. 3. Intradermal TB test. 4. Possible cat scratch disease. 5. HIV testing if indicated. 6. Toxoplasmosis titre if indicated. 7. CT neck (hyperext).	1. Augmentin 20-40mg/kg/day. 2. Clindamycin 10-25mg/kg/day.	Otolaryngology/Surgical/Paediatric referral indicated if mass persists for four weeks without improvement – Category 2. Outpatient assessment. Urgent referral if painless, progressive enlargement or if suspicion of metastatic carcinoma – Category 1 - 2.
B. Non-inflammatory (ie, painless).	Complete H & N exam indicated. Consider fine needle aspirate. CT scan Open biopsy is contraindicated.	Trial of antibiotic therapy may be considered **if an inflammatory mass** is suspected. NB: 80% of all non-thyroid masses are malignant.	Otolaryngology referral is indicated in all cases of non-inflammatory neck masses –Category 2
C Thyroid masses	Complete H & N exam indicated. Check TSH levels Consider fine needle aspirate. CT scan Open biopsy is contraindicated.		Thyroid masses are referred to ENT surgeons for assessment of their larynx prior to surgery and management of the thyroid mass