ENT RED FLAGS

EAR
- Persistent unilateral hearing loss/tinnitus
- Discharging ears [espec in immunocompromised =malignant otitis externa]
- Pain
- Facial nerve palsy

NOSE:
- Blood stained mucous
- Facial pain [esp unilateral, persistent, getting worse]
- Orbital symptoms [epiphoria]
- Sinusitus in immunocompromised ??fungal
- CSF leak
- Nasal skin cancer

THROAT
- Dysphonia – one month duration
- Dysphagia
- Odynophagia
- Pain [can radiate to ear]
- Any persistent growing lump

ENT emergencies

<table>
<thead>
<tr>
<th>Facial palsy</th>
<th>Caused by problem in middle ear/parotid o/e: other cranial nerves, vesicles on pinna[ramsey hunt]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bell's palsy</td>
<td>80% resolve by 3 months</td>
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<tr>
<td></td>
<td>More common in diabetes</td>
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<tr>
<td>TX:</td>
<td>Eye care [patch to prevent drying out and eye lubricants]</td>
</tr>
<tr>
<td></td>
<td>Oral sterooids: 40mg for 5 days then stop</td>
</tr>
<tr>
<td></td>
<td>No evidence for antivirals</td>
</tr>
<tr>
<td>Who to refer:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other CN palsy</td>
</tr>
<tr>
<td></td>
<td>No improv at 3 weeks</td>
</tr>
<tr>
<td></td>
<td>Incomplete recovery</td>
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</tbody>
</table>
### Sudden hearing loss:

**Aetiology:**
- Unknown
- Rare: acoustic neuroma, perilymph leak

**Refer immediately**

**Tx:** oral steroids

### Allergic response to BIPP:

[BIPP is used to pack ear after surgery. Can develop very severe allergic reaction the second time it is used in subsequent operation]

### AOM + headache

?ABSCESS

### Epistaxis

Use 1 in 10,000 adrenaline with 1% lignocaine on cotton bud

Nasal vestibulitis: cautery vs naseptin are equally effective

### Periorbital cellulitis

will lose colour vision first

### Unilateral rhinorrhoea

FB until proven otherwise

### FB in bronchus

likely right main bronchus

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### Examination in ENT

Central structures in neck = thyroid and thyroglossal cyst and will move with swallowing

Lymphatic drainage: Posterior triangle: lymphoma/TB

**Tongue:**
- Cracked/deep fissuring = iron defic/crohn's
- Red flat = pernicious anaemia
- Geographic – different area of proliferation = benign
- Nerve palsy = deviate to side of lesion

Nose: if touch the turbinate will be sore and patient will move backwards!

Mucousal retention cyst = benign

Don't bother with Rinne and Weber tests – not clinically helpful

- Rinne -ve: BC>AC [i.e. abnormal] = conductive loss
- Weber: to side of sensorineural loss or away from side of conductive hearing loss

**Dizziness:**
- Nystagmus, cranial nerves, romberg [will fall to side of pathology], dix-hallpike [BPPV],
- Finger nose, dysdiadokineses, bp [postural, ECG]
**EAR**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
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</table>
| **Otitis externa:**           | bacterial: staph, pseudomonas, proteus  
|                                | fungal: aspergillosis, candida  
|                                | TX: sofradex, gentisone [use for 5 days]. Ofloxacin is not ototoxic  
|                                | SWAB                                                                                             |
|                                | Beware MALIGNANT otitis externa [this actually osteomyelitis of temporal bone]                    |
|                                | • Immunocompromised [e.g. diabetic]  
|                                | • Usually pseudomonas  
|                                | • Pain++, CN palsy  
|                                | • REQUIRE IV Abs for 6 weeks                                                                    |
| **Furuncolosis**              | Staph: requires I+D                                                                                |
| **Ramsey Hunt Syndrome**      | PAIN!!!!  
|                                | Vertigo  
|                                | Vesicular rash                                                                                   |
| **Perichondritis:**           | Ear piercing, laceration, surgery, connective tissue disease  
|                                | can cause: cauliflow ear                                                                          |
| **Pre-aurical sinus:**        | if become infected require IV antibiotics!!!                                                      |
| **Dizziness:**                | Affects 20% of population  
|                                | 75% don't required Ix                                                                             |
|                                | Key points in the history:  
|                                | Room spinning:  
|                                | • Horiz [more common]  
|                                | • Vertical [indicates central cause]  
|                                | Better with eyes open  
|                                | • peripheral i.e. ear  
|                                | • closed [central]                                                                                 |
|                                | Duration:  
|                                | • Menierre's=hours/all day  
|                                | • BPPV- dizzy only on turning head  
|                                | Positional trigger? turning head quickly  
|                                | Deafness + tinnitus  
|                                | Other symptoms: syncope/headache  
|                                | ?Recent viral illness  
|                                | ?past history migraine [often co-exist with menierre's]  
|                                | any assoc aura?                                                                                   |
| **BPPV**                      | Test is Dix-hallpike = causes rotational vertigo  
|                                | Tx: Epley manoeuver                                                                               |
## RHINOLOGY

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description/Actions</th>
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<tbody>
<tr>
<td>Septal deviation</td>
<td>Trauma/unilateral blockage especially during the day. Correction usually makes no difference to snoring</td>
</tr>
<tr>
<td>Nasal crusting</td>
<td>Think vasculitis e.g. Wegener's [unwell often with joint pains] Sarcoid</td>
</tr>
<tr>
<td>Perforation</td>
<td>bleeding, whistling, blockage</td>
</tr>
<tr>
<td>Epistaxis</td>
<td>Risks: Hypertension/clopidogrel</td>
</tr>
<tr>
<td></td>
<td>Tx:</td>
</tr>
<tr>
<td></td>
<td>• stop aspirin if prophylactic</td>
</tr>
<tr>
<td></td>
<td>• Vaseline on earbud</td>
</tr>
<tr>
<td></td>
<td>• [if doesn't settle with above refer]</td>
</tr>
<tr>
<td>Nasal trauma</td>
<td>Refer 1 week after trauma</td>
</tr>
<tr>
<td></td>
<td>Beware: Septal haematoma, CSF leak, Head injury/facial fracture</td>
</tr>
<tr>
<td>RHINO SINUSITIS</td>
<td>Caused by:</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>• mucousal damage: strept, haemophillus, moraxella</td>
</tr>
<tr>
<td></td>
<td>• ciliary impairment</td>
</tr>
<tr>
<td></td>
<td>• allergy</td>
</tr>
<tr>
<td></td>
<td>• reflux</td>
</tr>
<tr>
<td></td>
<td>• intubation/ng tube</td>
</tr>
</tbody>
</table>

2 or more symptoms plus 1 sign

- Symptons:
  - blockage/obstruction/congestion
  - discharge: anterior/posterior
  - facial pain, pressure
  - reduction of sense of smell

- Signs: endoscopic [polyp], discharge

Acute<12 weeks
Non-viral usually worse after 5-10 days
Most will get better within 10 days with no treatment, although it may take 2-3 weeks for complete resolution.

Note: give amoxil 500mg tds or Pen v. If allergic doxycycline or oxytetracycline. Note that erythromycin infective against H Influenze which cause 21% of cases.

NNT for antibiotics=15

If pain, purulent discharge, fever likelihood of bacterial cause increases.

Avoid decongestants: will cause rebound congestion [rhinitis medicamentosa].

Nasal/oral steroids can be helpful if pain [nasonex bd, avamys for eye symptoms]

Nasal douching: with STERIMAR drops = saline drops as moisturizer often very HELPFUL.
THROAT

Symptoms
• Pain Beware especially if unilateral. Can refer to ear
• Hoarseness
• Dysphagia initially to solids then liquids
• Neck lumps site, duration, fluctuation[fluct is normally a good sign]

Examination: ASYMMETRICAL TONSILS [REFER URGENTLY]

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<tbody>
<tr>
<td>Quinsy</td>
<td>Can have symptoms of trismus [difficulty opening mouth]</td>
</tr>
<tr>
<td>Recurrent tonsillitis</td>
<td>5&gt;= episode of sore throat/year for at least 1 year Watch for 6 months</td>
</tr>
<tr>
<td>Throat pain</td>
<td>Unilateral, no fever, persistent = CANCER until proven otherwise</td>
</tr>
<tr>
<td>Dysphagia</td>
<td>Duration, progressive, regurg site: high/low ?voice changes</td>
</tr>
<tr>
<td>Salivary gland</td>
<td>Recurrent tender with meals = stones Persistent slow growing = ?tumour</td>
</tr>
<tr>
<td>Thyroid</td>
<td>Most benign USS + FNA</td>
</tr>
<tr>
<td>Paediatric lump</td>
<td>Think lymphoma if progressive night sweats If persistent cervical lymphadenopathy &gt;2cm: give 2 weeks of antibiotics and do virology: EBV, CMV, toxoplasmosis</td>
</tr>
<tr>
<td>Pharyngitis</td>
<td>Use centor criteria: Tonsillar exudate Tendar anterior cervical lymph nodes Absence of a cough History of fever If 3 out of 4 critera 40-60% sensivity for Strep] Tx: Pen V 500mg bd to qds for 10 days/ erythro 500mg qds Some evidence for use of steroids if severe pharyngitis if used with antibiotic. ONLY IN ADULTS [NNT=4]</td>
</tr>
<tr>
<td>Obstuvie sleep apnoea</td>
<td>Consider if complain of sleepiness (not tiredness), especially if overweight. Important as: 7 times more likely to have a road traffic accident. Associated with hypertension, type 2 diabetes and metabolic syndrome. Treating reduces cardiovascular risk. Affects 1% of men. More common in type 2 diabetics. Refer for sleep study if good history and witnesses [take video!] and high Epworth sleepiness score (scores of &gt;=9 likely significant) SLEEP STUDIES ARE THE ONLY WAY TO DIAGNOSE IT!! Tx: CPAP Driving. Once diagnosed patients must inform DVLA Once on treatment, drivers are allowed to continue driving even HGV.</td>
</tr>
</tbody>
</table>
Paediatric ENT

To get stridor must have 75% reduction in diameter to airflow – SO ALWAYS SIGNIFICANT!!!

Laryngomalacia develops in the first 2-4 weeks of life

| STRIDOR | Hx: Age of onset  
| Type:  
| Inspiratory [obstruction above glottis e.g. haemangioma typically develops at 3-4 months [Tx: propranolol]  
| Biphasic [below glottis]  
| Progressive  
| Previous intubations  
| Feeding difficulty  
| Cyanosis  
| Coughing/choking  
| Weight gain [if cross 2 centile lines problem]  
| Cry/voice  

| Glue ear | Common, often resolves spontaneously. Peaks at ages 2 and 5.  
| Hx: Deafness, poor education, tinnitus, intolerance to loud noise, clumsiness, behavioural problems.  
| Following guidance does not apply to children with Downs/cleft palette [see separate NICE guidance]  
| 50% will be better at 3 months with no intervention.  
| Look for impairment of hearing/speech/language/behaviour  
| Watchful waiting for 3 months [consider offering auto-inflation device if old enough to understand how to use in the meantime]  
| After 3m of watchful waiting: if hearing loss>25-30db or significant impact on development/education REFER [consider grommets/hearing aids]  
| don't give: antibiotics/antihistamine/decongestants/inhal steroids [suggestion if adenoiditis to give trimethoprim for 6 weeks at 2mg/kg]  

| Acute otitis media | 80% children recover with 3 days without antibiotics  
| NNT=NNH for antibiotics  
| Refer if >4 in 6 months  
| Delay Abs if no resolution by 72hours – give 5 days of amoxil  
| Add topical quinolone if perforation or infected grommet.  
| Complications: mastoiditis, facial palsy [red flag], labyninthitis  

| Mastoiditis | Can have proptosis  

| Obstructive sleep apnoea | Take video!  

| Obstruction | Unilateral chest signs. Think foreign body  

| Chronic otitis media | Beware attic crusting: can have congenital acoustic neuroma.  