GUIDELINES FOR MANAGEMENT OF COMMON ENT CONDITIONS IN PRIMARY CARE
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>How to use this guideline</td>
<td>3</td>
</tr>
<tr>
<td>On Call Arrangements for ENT</td>
<td>4</td>
</tr>
<tr>
<td><strong>Pathways</strong></td>
<td></td>
</tr>
<tr>
<td>nasal blockage / discharge +/-facial pain in adults</td>
<td>5</td>
</tr>
<tr>
<td>Nasal trauma (adults)</td>
<td>6</td>
</tr>
<tr>
<td>Hearing problems in children</td>
<td>7</td>
</tr>
<tr>
<td>Hearing problems in adults</td>
<td>8</td>
</tr>
<tr>
<td>Infectious sore throat in adults</td>
<td>9</td>
</tr>
<tr>
<td>Non-infectious sore throat in adults</td>
<td>10</td>
</tr>
<tr>
<td>Acute nose bleeds</td>
<td>11</td>
</tr>
<tr>
<td>Chronic recurrent nose bleeds</td>
<td>12</td>
</tr>
<tr>
<td>Vertigo</td>
<td>13</td>
</tr>
<tr>
<td>Hoarse voice in adults</td>
<td>14</td>
</tr>
<tr>
<td>Feeling of something stuck in the throat</td>
<td>15</td>
</tr>
<tr>
<td>Management of discharging ear</td>
<td>16</td>
</tr>
<tr>
<td>Primary care management of snoring in adults</td>
<td>17</td>
</tr>
<tr>
<td>Tonsil size grading</td>
<td>18</td>
</tr>
<tr>
<td>Examination of pharynx</td>
<td>19</td>
</tr>
<tr>
<td>Malocclusion examples</td>
<td>20</td>
</tr>
<tr>
<td><strong>Appendices</strong></td>
<td>21</td>
</tr>
<tr>
<td>Direct Access Audiology Leaflet</td>
<td></td>
</tr>
<tr>
<td>Community Microsuction Service</td>
<td></td>
</tr>
<tr>
<td>Case Studies</td>
<td></td>
</tr>
<tr>
<td>Membership of the guideline development group</td>
<td></td>
</tr>
<tr>
<td>Date of review</td>
<td></td>
</tr>
</tbody>
</table>
INTRODUCTION

This guidance is intended to inform initial management of common ENT conditions and has been developed as a consensus between representatives from primary and secondary care, with reference to national guidelines, including from NICE and SIGN.

It is intended to guide clinical management, but every patient should be assessed and managed individually.

This guideline is intended for all clinicians in the Nottinghamshire area involved in managing patients with ENT conditions.

HOW TO USE THE GUIDELINES

The guideline is a set of flow charts covering a variety of ENT conditions. Each of these can be printed and laminated for easy reference if preferred.

The BNF and the local Formulary should be referred to as appropriate.

USEFUL TELEPHONE NUMBERS

ENT CONSULTANTS

Mr S Ali’s secretary 01623 672328
Mrs M Morgan’s secretary 01623 672329
Mr N Fergie’s secretary 01623 622515 ext 3922

Audiology Department 01623 622515 ext 6171/3036

Community Microsuction Service 01623 664821
### On Call Arrangements

**ENT Department, Kings Mill Hospital**

**(Sherwood Forest Foundation Trust)**

<table>
<thead>
<tr>
<th>Day</th>
<th>Time</th>
<th>Arrangements</th>
</tr>
</thead>
</table>
| Monday to Thursday| 8.00 am – 12.00 pm (midnight)| ENT Department Kings Mill Hospital  
  *Contact via switchboard – 01623 622515*  |
| Monday to Thursday| 12.00 pm (midnight) to 8.00 am| ENT Department Queens Medical Centre (Nottingham University Hospitals)  
  *Contact via switchboard 0115 924 9924*  |
| Friday            | 8.00 am – 6.00 pm            | ENT Department Kings Mill Hospital  
  *Contact via switchboard – 01623 622515*  |
| Weekends          | Friday 6.00 pm – Monday 8.00 am | ENT Department Queens Medical Centre (Nottingham University Hospitals)  
  *Contact via switchboard 0115 924 9924*  |
| Bank Holidays     |                              | ENT Department Queens Medical Centre (Nottingham University Hospitals)  
  *Contact via switchboard 0115 924 9924*  |
Nasal Blockage / Discharge +/- Facial Pain in Adults

**Patient information at:** [http://www.entuk.org/patient_info/](http://www.entuk.org/patient_info/)

Chronic nasal blockage/discharge, with or without facial pain
Encompassing: chronic rhinitis (including allergic rhinitis), sinusitis, inflammatory nasal polyps, nasal neoplasm

**GP assessment**

Are nasal symptoms bilateral or unilateral?

**Bilateral**

- If symptoms are due to ALLERGY, refer to box
- Initial drug therapy with topical nasal spray +/- antihistamine for 2 to 3 months. Broad spectrum antibiotics if appropriate
- Information and advice for self help
- Patient information leaflets
- Self-medication/over the counter

If symptoms are improved after 6 weeks?

No

- Topical steroid drops for 4 weeks (remember to start initial drug therapy after 4 weeks)
- Consider oral steroids (prednisolone 30mg od for 5 days, then stop)
- Broad spectrum antibiotics only if purulent nasal discharge (amoxicillin, doxycycline or clarithromycin) for 2 weeks

Yes

**Symptoms improved?**

Yes

Consider maintenance nasal steroid spray
Continue self-management

No

Refer to ENT surgeon, include the following information:
Patient history, symptoms
Treatment tried, duration, response, any trial of steroids, any side effects
Skin prick test/immunoglobulin assay results if done

**ENT assessment, investigation, diagnosis and treatment**

Discharge with advice for on-going management in primary care, including management of any recurrences

**Unilateral**

If symptoms are due to ALLERGY
Perform skin prick test/immunoglobulin assay (serum RAST test)
Make patient aware that condition is not curable, but can be managed;
- Patient information leaflet
- Allergen avoidance
- Importance of concordance with treatment
- Nasal spray technique

If there is septal deviation, and no other symptoms consider referral for septoplasty
Urgent referral (fax 01623 672305) if symptoms could be due to a neoplasm (very uncommon): associated with symptoms such as facial pain, diplopia, bleeding)

**Notes**

- Large polyps may respond to topical treatment and is first line
- Consider earlier treatment with oral steroids for polyps in patient with asthma
Nasal Trauma (Adults)

Patient information at: http://www.entuk.org/patient_info/nose/injuries_html

1. **Nasal trauma**
2. **Is this within last 2 weeks?**
   - No
     - **Patient first presents more than 2 weeks after nasal trauma**
       - **Is there nasal obstruction and or nasal deformity?**
         - No
           - **No further intervention**
         - Yes
           - **Routine referral to ENT**
   - Yes
     - **Patient history and examination**
       - **Do all of the following apply?**
         - Patients nose swollen, but straight
         - Patients breathing normal
         - Patient is satisfied
       - **With any of the following**
         - New nasal obstruction
         - New nasal deformity
         - Patient concerns
         - Practitioner concerns
       - **Is there a septal haematoma?**
         - No
           - **Telephonic referral for consideration of manipulation**
           - Contact on call ENT at KMH via switchboard 01623 622515
         - Yes
           - **Contact on call ENT surgeon at KMH/QMC 01623 622515 01159 249924**
           - Or refer the patient to A&E

**Patient information leaflet**
**No further follow up**
Hearing Problems in Children

**Concern about child’s hearing**

- **Normal tympanic membranes?**
  - **No**
    - Refer to ENT
  - **Yes**
    - Refer to Local Paediatric Audiology Service at KMH
      - Health visitor/school testing not sufficient
        - Hearing test failed?
          - **Yes**
            - Consider early referral to ENT if:
              - Neonatal test was not done
              - Definite or suspected delayed development milestones
              - Parental concerns
            - Otherwise repeat hearing test will be arranged
          - **No**
            - Repeat hearing test will be arranged
            - Hearing test failed?
              - **Yes**
                - Refer to ENT
              - **No**
                - Reassure

**Management tips for children with grommets**
- Child can swim but no deep diving
- No difference in infection rates between swimmers and non-swimmers
- Persistent perforation occurs in <1% cases and further surgery may be required at a later stage
- Grommets should fall out in 6 to 9 months and the perforation heal concurrently

**Consider early referral to ENT if:**
- Neonatal test was not done
- Definite or suspected delayed development milestones
- Parental concerns

**Otherwise repeat hearing test will be arranged**
Hearing Problems in Adults

Adult with hearing problem with or without tinnitus

Examine ears. Identify if gradual onset, not fluctuating and without other ear symptoms

- NORMAL appearance of canals and tympanic membranes, **and**
- Wax removed

If unilateral, acute onset with normal ear examination, refer as emergency

Acute onset

- Consider referral to ENT
- Refer to audiology for hearing assessment and assessment for hearing aid

Criteria for direct referral to audiology

- Patients with non-fluctuating hearing loss of gradual onset
- Reassessment of hearing aid
- Patient known to the service
- Any ear wax has been removed
- NORMAL appearance of canals and tympanic membranes, **and**
- Any pre-existing ear condition has been investigated by ENT surgeon or audiology physician
Infectious Sore Throat in Adults
Patient information at: http://www.entuk.org/patient_info/throat/sorethroat_html

Recurrent Tonsillitis
Patient information about tonsillectomy at: http://www.entuk.org/patient_info/throat/tonsil_html

**Notes**
If antibiotics are indicated: Phenoxymethylpenicillin 500mg qds first line if not penicillin allergic, not amoxycillin

---

**Acute pharyngitis and simple tonsillitis**

**Routine management**

---

**Recurrent tonsillitis**

Does the patient meet the following criteria?

- Recurrent sore throats due to acute tonsilitis with 6 or more well documented, clinically significant, adequately treated episodes in the last year, or 4 or more episodes in each of the preceding 2 years, or 3 or more episodes in each of the preceding 3 years
- Minimum of 12 months of symptoms
- Or
- Two or more episodes of peritonsillar (quinsy)
- And
- Had the information leaflet

---

**Yes**

- Allow patient time to consider surgery and the risks
- Review patient (by telephone or face to face) after 1 month

---

**Patient wishes to consider tonsillectomy**

**Yes**

Refer to ENT clinic

**No**

Continue conservative management

---

**Consider alternative diagnosis (see “Non-infectious sore throat”)**

**Continue conservative management**

**If no improvement, refer to ENT for pharyngoscopy**

---

**Peritonsillar abscess (quinsy) +/- airway obstruction**
**Neck abscess**
**Stridor**

**Patient likely to require emergency admission**

Refer to A&E or contact on call ENT surgeon at KMG/QMC
Non-Infectious Sore Throat in Adults

Persistent sore throat for >3 weeks with no upper respiratory tract infection

History and examination, including oral examination

Does the patient have any of the following?
- SMOKING/ALCOHOL HISTORY
- Neck lumps (unilateral or bilateral)
- Hoarseness (see hoarseness pathway)
- Stridor
- Dysphagia
- Weight loss
- Oral ulcer/swelling
- Unable to comprehensively examine oral cavity/oropharynx AND/OR
- Clinical suspicion of malignancy

Yes

Urgent referral to ENT under 2 week rule
Fax 01623 672457

No

Symptomatic treatment for 6 weeks

Symptoms resolve

Yes

Reassure

No

Routine referral to ENT
Acute Nose Bleed

First aid measures for acute nose bleeds
- Sit patient down
- Lean patient forward (ideally over sink or table)
- Pinch the lower part of the nose between thumb and forefinger
- Pinch nose for 5 minutes. DO NOT release the pressure <5 minutes. If persists repeat x2.
- Consider inserting nasal tampon if familiar with its use
- Spit out any blood
- Check if the patient is taking aspirin, clopidogrel, prasugrel or warfarin. If so, bleeding is less likely to stop easily

Treatment options for persistent nose bleeds
- Nasal cautery if bleeding site can be identified
- Nasal packing e.g. nasal tampons
- Admit to hospital

Nose bleeds can be serious and life threatening.
Patients who have had serious, prolonged recurrent nose bleeds should be given the information leaflet about prevention of nose bleeds
Chronic Recurrent Nose Bleeds

Review history
- Is the patient treated with warfarin, aspirin, clopidogrel and or prasugrel?
- Any history of excess alcohol intake?
- Does the patient have uncontrolled hypertension?
- Are there any other signs of bleeding tendency?
- Exclude 'red flags' (see notes)

Manage any reversible causes
Apply ointment/cream (e.g. naseptin or Vaseline) 4 times daily for 1 week

Further nose bleeds?

Yes
- Cautery of only visible vessels in Little’s area with silver nitrate

Further nose bleeds?

Yes
- Refer to ENT

No
- Continue conservative treatment

Notes
Neoplasm is very rare. Red flags in patients with recurrent nose bleeds, requiring urgent referral to ENT (fax 01623 672457):
- Facial pain/swelling
- Otalgia
- Unilateral nasal obstruction
- Reduced sense of smell
- Visual symptoms
- Dental symptoms

Nose bleeds can be serious and life threatening. Patient who have had serious prolonged, recurrent nose bleeds should be given the information leaflet about prevention of nose bleeds.
Vertigo

Patient information at: http://www.entuk.org/patient_info/ear/dizziness_html

Red flags which suggest a brain stem stroke or other central cause
Any central neurological symptoms or signs, particularly cerebellar signs
New type of headache (especially occipital)
Acute deafness
Vertical nystagmus

Have a high index of suspicion of cerebellar pathology in those with severe symptoms, including unable to stand at all unaided, and no improvement within a few hours

For more information about determining the cause of vertigo, refer to the CKS website (http://www.cks.nhs.uk/vertigo/management#-407680)
Hoarse Voice in Adults

Patient information at: http://www.entuk.org/patient_info/throat/hoarseness_html

Hoarse Voice

Any of the following, particularly ages >40 years and >3 weeks of symptoms:
- History of smoking
- Referred Otalgia
- Dysphagia
- Stridor
- Neck examination abnormal e.g. enlarged nodes

Hoarseness persisting for >6 weeks = 2ww referral

Yes

Consider:
Urgent referral to ENT under 2 week wait, fax 01623 672457

No

History of:
- Occupational voice user
- Steroid inhaler use
- Recent respiratory tract infection

Check thyroid status

No, and after 4 weeks of persistent hoarse voice

Yes

Treatment:
- Voice care – provide patient information leaflet (see above)
- Optimum steroid dose and inhaler device and technique
- Hydration

Follow up 6-8 weeks or sooner if any worsening symptoms

Symptoms resolved?

No

Refer to ENT

Yes

No further intervention
Feeling of Something Stuck in the Throat

Feeling of something stuck in the throat

Are symptoms:
- Noticed between rather than during meals?
- Not aggravated by swallowing food?
- Noticed at midline or suprasternal notch?
- Intermittent?

On physical examination, does the patient have:
- Normal oral cavity, head and neck examination?
- No pain?
- Normal voice quality?

No

If the patient has any of the following:
- Smoking/alcohol history
- Significant referred Otalgia
- Dysphagia
- Hoarseness (see hoarseness pathway)
- Stridor
- Persistently unilateral symptoms
- Abnormal neck examination e.g. enlarged nodes

Refer to ENT. Use clinical judgement to determine the urgency of referral

Yes

- Reassure the patient, no further intervention
- Advise the patient to return if they develop any new symptoms
- Trial of PPI (Proton Pump Inhibitor) and Gaviscon

If new symptoms develop
Management of Discharging Ear

Patient information at: http://www.entuk.org/patient_info/ear/infections_html

Patient with discharging ear: green, yellow fluid eliminating from the ear canal

Does the patient have acute symptoms of otitis externa: pain, non-mucoid discharge, hearing loss, swollen ear canal?

No

Is it acute otitis media?

Treat according to other guidelines (SIGN/NICE, Acute otitis media)

Yes

Is it chronic suppurative otitis media? i.e. persistent mucoid smelly discharge, with or without deafness

No

Consider alternative diagnosis - (ie furunculosis, granular myringitis, malignant otitis externa etc)

Yes

2 week course of topical antibiotic/steroid drops and review

Symptoms resolve and cause clearly identified and not serious?

Yes

Refer to ENT with the following information
- Patient history
- Treatments tried: duration, side effects, response
- Results of any investigations

No

Refer to ENT with the following information
- Patient history
- Treatments tried: duration, side effects, response
- Results of any investigations

Discharge from ENT clinic with specific management plan

Note:
Aminoglycoside ear drops may in theory be ototoxic in the presence of a non-intact tympanic membrane, but in general are safe to use for up to 2 weeks in the presence of definite infection. However, aminoglycoside ear drops are not recommended in the better or only hearing ear in patients with pre-existing hearing loss. Consider ofloxacin drops as an alternative (unlicensed indication).
Primary Care Management of Snoring in Adults/ Sleep Apnoea

Patient information:

- The British Snoring and Sleep Apnoea Association website at: www.britishsnoring.co.uk

### History, include:
- Loudness of snoring
- Excessive/intrusive daytime sleepiness
- Witnessed apnoea’s
- Impaired alertness
- Nocturnal choking episodes
- Waking unrefreshed
- Co-morbidity e.g. hypothyroidism, ischaemic heart disease, cerebrovascular disease, diabetes, hypertension
- Smoking history
- Alcohol consumption
- Medication history
- Consider psycho-social impact

### Examination, include:
- BMI
- Collar size
- Tonsil grade (refer to diagram)
- Pharynx (refer to diagram)
- Bite? Recessed mandible, under-projected maxilla (refer to diagram)

### Epworth Sleepiness Scale

Use the following scale to choose the most appropriate number for each situation:

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>0 = No chance of dozing</th>
<th>1 = Slight chance of dozing</th>
<th>2 = Moderate chance of dozing</th>
<th>3 = High chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting, inactive in a public place (e.g. a theater or a meeting)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after lunch without alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In car, while stopped for a few minutes in traffic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To check your sleepiness score, total the points:

1-6 = Congratulations, you are getting enough sleep!
7-8 = Your score is average
9+ = Seek the advice of a sleep specialist without delay
**Clinical Examination of Snoring**

**Tonsil Size: Graded 1 to 4**

- **Grade 1**: Tonsils hidden within pillars
- **Grade 2**: Tonsils extend to edge of pillars
- **Grade 3**: Tonsils beyond pillars but not to midline
- **Grade 4**: Tonsils meet in midline
Snoring in Primary Care: Examination of the Pharynx (Malampatti)

A = Grade I: full view of oropharynx
B = Grade II: pillars still visible
C = Grade III: only base of uvula seen
D = Grade IV: tongue obscures whole oropharynx
Examples of Malocclusion:

PATIENT INFORMATION

There are various sources of patient information. None are specifically endorsed. Some relevant website links are included with the flow charts.
APPENDICIES

Direct Access Audiology leaflet

Community Microsuction Service

Case Studies

Development of the ENT Referral Guidelines

The following people were involved in the development of these guidelines:

Mr N Fergie  ENT Consultant, Sherwood Forest Foundation Trust
Ms M Morgan  ENT Consultant, Sherwood Forest Foundation Trust
Dr M Tadpatrikar  GP, Mansfield & Ashfield Clinical Commissioning Group
Dr H Field  GP, Mansfield & Ashfield Clinical Commissioning Group
Mr S Ali  ENT Consultant, Sherwood Forest Foundation Trust

Thanks go to NHS North of Tyne for use of their original referral guidelines