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

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

Sudden hearing loss:	Normal TM Aetiology: • Unknown • Rare: acoustic neuroma, perilyph leak REFER IMMEDIATELY TX: oral steroids
Allerigc 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

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

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-auricalar 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 manouver

RHINOLOGY

Septal deviation:	Trauma/unilateral blockage especialy during the day. Correction usually makes no difference to snoring
Nasal crusting:	Think vasculitis e.g. Wegener's [unwell often with joint pains] Sarcoid
Perforation	bleeding, whistling, blockage
Epistaxis	Risks: Hypertension/clopidogrel Tx: • stop aspirin if prophylactic • Vaseline on earbud • [if doesn't settle with above refer]
Nasal trauma	Refer 1 week after trauma Beware: Septal haematoma, CSF leak, Head injury/facial fracture

RHINO SINUSITIS	Caused by:
	• mucousal damage: strept, haemophilus,moraxella
	• ciliary impairment
	• allergy
	• reflux
	• intubation/ng tube
	
	2 or more symptoms plus 1 sign
	• Symptoms:
	    ○ 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 oxytetracydcline. 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]

Quinsy	Can have symptoms of trismus [difficulty opening mouth]
Recurrent tonsillitis	5>= episode of sore throat/year for at least 1 year Watch for 6 months
Throat pain	Unilateral, no fever, persistent = CANCER until proven otherwise
Dysphagia	Duration, progressive, regurg site: high/low ?voice changes
Salivary gland	Recurrent tender with meals = stones Persistent slow growing = ?tumour
Thyroid	Most benign USS + FNA
Paediatric lump	Think lymphoma if progressive night sweats If persistent cervical lymphadenopathy >2cm: give 2 weeks of antibiotics and do virology: EBV, CMV, toxoplasmosis
Pharyngitis	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]
Obstuvie sleep apnoea	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. Trea3tment 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 >=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.

Paediatric ENT

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

Laryngomalacial 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], labryinthitis
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.