EAST AND NORTH HERTFORDSHIRE GUIDELINES FOR MANAGEMENT OF COMMON ENT CONDITIONS IN PRIMARY CARE

December 2012
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INTRODUCTION

This guidance is intended to inform initial management of common ENT conditions and has been developed at the Newcastle upon Tyne Hospitals (NUTH) 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 East and North Hertfordshire areas involved in managing patients with ENT conditions. We are planning to obtain the approval for these guidelines from the local GP network in the near future.

How to use the guideline
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.
For any clinical question the general practitioners are encouraged to contact and discuss. The BNF should be referred to as appropriate.

Referrals
When referral to ENT is recommended in the guideline, referral for patients to be seen at a local outreach clinic may be preferred. It is anticipated that clinicians in localities where such clinics are available will be aware of them, but further information can be obtained from the ENT department at the Lister Hospital.

Acknowledgement
We wish to thank the Department of Otolaryngology at the Freeman Hospital in Newcastle for allowing to us the use of the guideline.
Nasal Blockage / Discharge +/- Facial Pain in Adults


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

Information and advice for self help
Patient information leaflets
Self medication / over the counter medicines

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 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

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

Symptoms 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
  - Continue Self management

Bilateral

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  - Broad spectrum antibiotics only if purulent nasal discharge (amoxicillin, doxycycline or clarithromycin) for 2 weeks

- Yes
  - 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 ongoing management in primary care, including management of any recurrences

Unilateral

- 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 ongoing management in primary care, including management of any recurrences

Notes
- Large polyps may respond to topical treatment and is first line
- Consider earlier treatment with oral steroids for polyps in patient with asthma

- If there is septal deviation, and no other symptoms consider referral for septoplasty
- Urgent referral (fax 01438 781849) if symptoms could be due to a neoplasm (very uncommon): associated with symptoms such as facial pain, diplopia, bleeding
Nasal Trauma (Adults)

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

Nasal trauma

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

Patient history and examination
Do all of the following apply
- Patient’s nose swollen but straight
- Patient’s breathing normal
- Patient is satisfied?

No

With any of the following
- New nasal obstruction
- New nasal deformity
- Patient concerns
- Practitioner concerns

Yes

Patient information leaflet
No further follow up

Yes

Is there a septal haematoma?

No

Routine referral to ENT

Yes

Refer for consideration of manipulation
Contact on call ENT at Lister Hospital via switchboard 01438314333

Yes

Contact on call ENT surgeon at Lister Hospital within 24 hours via switchboard 01438314333
Hearing Problems in Children

Concern about child’s hearing

Normal tympanic membranes?

No

Refer to ENT

Yes

Refer to Local Paediatric Audiology Service

Hearing test failed?

Yes

Child aged < 4 years?

Consider early referral to ENT if;
- Neonatal test was not done
- Definite or suspected delayed developmental milestones
- Parental concerns
Otherwise repeat hearing test at 6 weeks

Repeat hearing test at 6 weeks

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

Normal tympanic membranes?

Yes

Refer to ENT

No

Reassure
### Hearing Problems in Adults

**Adult with hearing problem with or without tinnitus**

Examine ears
Identify if unilateral or symmetrical bilateral hearing loss

- **Unilateral hearing loss or bilateral hearing loss aged < 55 years**
  - Refer to ENT

- **Bilateral hearing loss and > 55 years**
  - NORMAL appearance of canals and tympanic membranes, and criteria met (see below)
    - Consider referral to ENT
    - Yes: Refer to audiology for hearing assessment and assessment for hearing aid
    - No: Consider referral to ENT

### Criteria for direct referral to audiology
- Patients with symmetrical 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 audiological physician
Infectious Sore Throat in Adults


**Acute pharyngitis + simple tonsilitis**

**Routine management**

**Notes**

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

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**Recurrent Tonsilitis**

Patient information about tonsillectomy at: [http://www.entuk.org/patient_info/throat/tonsil.html](http://www.entuk.org/patient_info/throat/tonsil.html)

**Recurrent tonsilitis**

Does the patient meet the following criteria:
- Recurrent sore throats due to acute tonsilitis with
  - 7 or more well documented, clinically significant, adequately treated episodes in the last year, or
  - 5 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 abscess (quinsy) and
- Had the information leaflet

**No**

- Consider alternative diagnosis (see "Non-infectious sore throat")
- Continue conservative management
  - If no improvement, refer to ENT for pharyngoscopy

**Yes**

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

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**Patient likely to require emergency admission**

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

**Contact on call ENT surgeon at Lister Hospital via switchboard 01438314333**

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Non-infectious Sore Throat in Adults

1. Persistent sore throat for > 3 weeks with no upper respiratory tract infection
2. History and examination including oral examination

- Does the patient have any of the following:
  - SMOKING / ALCOHOL HISTORY
  - Referred otalgia
  - 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

3. Yes
   - Urgent referral to ENT under 2 week rule
   - Fax 01438 781849

4. No
   - Symptomatic treatment for 6 to 8 weeks
   - Symptoms resolve
     - No
       - Routine referral to ENT
     - Yes
       - Reassure
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 x 2.
- 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

First aid measures
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- Check if the patient is taking aspirin, clopidogrel, prasugrel or warfarin. If so, bleeding is less likely to stop easily

Yes
- Apply ointment / cream (e.g., naseptin), to the nosebleed side twice daily for 1 week

No
- Emergency referral to nearest A&E department

Bleeding stops and patient haemodynamically well?

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

Patient with 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 cream twice daily for 1 week)

Further nose bleeds?

Yes: Cautery of Little’s area with silver nitrate under LA

Further nose bleeds?

Yes: Refer to ENT

No: Continue conservative treatment

No: Continue conservative treatment

Notes
Neoplasm is very rare.
Red flags in patients with recurrent nose bleeds, requiring urgent referral to ENT (fax 01438 781840):
- Facial pain / swelling
- Otalgia
- Unilateral nasal obstruction
- Reduced sense of smell
- Visual symptoms
- Dental symptoms

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.
Vertigo

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

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**Dizziness**

- "Rotatory vertigo" as main symptom
  - Yes
  - No

- Unsteadiness
- Recurrent falls
- Lightheadedness
- Presyncope
- Loss of confidence
- Older patient (eg > 75 years)

**Are there any red flags?**

- Yes
  - Refer to secondary care; use clinical judgment how urgently this should be, but may require admission

- No

**Confirmatory history and examination to rule in benign positional vertigo (Hallpike manoeuvre) or acute vestibular neuronitis**

- Yes
- No

**Positional vertigo and torsional nystagmus fatigues in 30 seconds (+ve Dix-Hallpike manoeuvre)**

- Benign positional vertigo
  - Epley Manoeuvre
    - If fails, routine referral to ENT

**Sustained vertigo and horizontal nystagmus**

- Not positional
- Nausea and vomiting common

- Acute vestibular neuronitis
  - On-going symptoms
    - Routine referral to ENT

**Consider vestibular migraine if vertigo plus migraine is recurrent and examination normal**

**Symptoms of BPV usually last a short time and are positional eg rolling over in bed, lying down**

**Positional vertigo and torsional nystagmus fatigues in 30 seconds (+ve Dix-Hallpike manoeuvre)**

**Sustained vertigo and horizontal nystagmus**

- Not positional
- Nausea and vomiting common

- Acute vestibular neuronitis
  - On-going symptoms
    - Routine referral to ENT

**Consider Menieres disease**

**Routine ENT referral**

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**Notes**

- To distinguish vertigo from non-rotatory dizziness consider asking; “Did you just feel lightheaded or did you see the world spin round as though you had just got off a playground roundabout”
- Patients with ‘dizziness’ but not vertigo, need history and examination, including cardiovascular and neurological examination. Some may need referral for further investigation eg (FASS, cardiology, elderly care)

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Flow chart adapted from Barraclough K et al. BMJ 2009;339:749

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

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

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**Hoarse voice**

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

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**Consider:**
Urgent referral to ENT under 2 week wait, fax 01438 781849

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

Check thyroid status

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**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

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**Symptoms resolved?**
- **No**
  - Refer to voice clinic
- **Yes**
  - No further intervention
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?

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

No

- Reassure the patient, no further intervention
- Advise the patient to return if they develop any new symptoms
- Antacid (e.g. peptac) if oesophageal symptoms

If new symptoms develop
Management of discharging ear
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:
itch, non-mucoid discharge,
hearing loss

No

Is it acute otitis media

Treat according to other
guidelines, such as SIGN68

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

No

Consider alternative
diagnosis

Yes

Cleanse the ear canal with
gentle syringing / irrigation
Topical antibiotic and steroid
drops
General advice eg do not
poke ears or let shampoo
and soap into ears

If severe pain /
cellulitis

Refer to ENT via
The Lister Hospital,
Stevenage
switchboard
(01438314333)

Yes

If symptoms
do not clear

2 week course of
 topical antibiotic /
steroid drops and
review

Refer to nurse
practitioner ear
care clinic

Symptoms resolve?

Yes

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

No

Discharge from 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

Patient information:
- The British Snoring and Sleep Apnoea Association website at: [www.britishsnoring.co.uk](http://www.britishsnoring.co.uk)

### History, include:
- Loudness of snoring
- Excessive / intrusive sleepiness
- Witnessed apnoeas
- Impaired alertness
- Nocturnal choking episodes
- Restless legs
- Waking muzzy headed
- Co-morbidity e.g. hypothyroidism, ischaemic heart disease, cerebrovascular disease, diabetes, uncontrolled 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)

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**Presentation with snoring to Primary Care Clinician**

**History and examination, Epworth Sleepiness Scale (ESS)**

- **ESS 10+ and or witnessed apnoea**
  - Refer to sleep study service
- **ESS < 10**
  - Offer lifestyle advice, including weight loss, smoking cessation, reduce alcohol consumption

**Lifestyle measures successful?**

- **Yes**
  - Continue lifestyle measures
- **No**
  - Consider providing information from the British Snoring and Sleep Apnoea Association
  - Consider referral for ENT specialist assessment if symptoms severe and or intrusive
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:

Anterior crowding  Anterior protrusion  Spacing  Open bite

Upper anterior protrusion  Deep bite  Lower protrusion (Permanent teeth)  Lower protrusion (Mixed dentition)

PATIENT INFORMATION

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

Membership of the guideline development group

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Date and date of review
August 2010, review date August 2013