ENT Referral

Austin Health ENT Clinic holds fortnightly multidisciplinary meetings with Plastics/ Maxillary Facial & Oncology units to discuss & plan the treatment of patients with cancerous conditions.

Department of Health Clinical Urgency Categories for Specialist Clinics
URGENT: Referral should be categorised as URGENT if patient has a condition that has potential to deteriorate quickly, with significant consequences for health & quality of life, if not managed promptly.
SEMI URGENT: Referral should be categories as SEMI URGENT if patient has a condition that has potential to deteriorate within 30-90 days.
ROUTINE: Referral should be categorised as ROUTINE if patient has condition that is unlikely to deteriorate quickly or have significant consequences on health & quality of life if specialist assessment is delayed beyond one month.
EXCLUSIONS: Out of catchment area policy.

*****Instruct patient to bring all imaging films/CDs including reports & diagnostic results to Specialist Clinic appointment*****

Cases to be sent to Emergency Department

ADULT

EAR

- ENT conditions with associated neurological signs
- Sudden onset hearing loss in absence of clear aetiology &/or associated with vertigo & tinnitus
- Sudden onset debilitating constant vertigo where patient very imbalanced (vestibular neuritis/stroke)
- Sudden onset facial weakness
- Barotrauma with sudden onset vertigo
- Foreign body
- Complicated mastoiditis/cholesteatoma or sinusitis (periorbital cellulitis, frontal sinusitis with persistent frontal headache)
- Ear canal oedema/unable to clear discharge
- Trauma

NOSE

- Acute bacterial rhinosinusitis – visual disturbance/diplopia, neurological signs, frontal swelling, severe unilateral or bilateral headache
- Acute nasal fracture with septal haematoma
- Severe or persistent epistaxis

THROAT

- Airway compromise – stridor/drooling, breathing difficulty/acute or sudden voice change/severe odynophagia
- Ludwig's angina
- Acute tonsillitis with airway obstruction &/or unable to tolerate oral intake &/or uncontrolled fever
- Tonsillar haemorrhage
- Acute hoarseness associated with neck trauma or surgery
- Laryngeal obstruction and/or fracture
- Pharyngeal/laryngeal foreign body
- Accidental dislodgement or obstruction of permanent tracheostomy
- New onset of bleeding or shrinkage of laryngectomy stoma
- Abscess or haematoma, (e.g. peritonsillar abscess/quinsy, salivary abscess, septal or auricular haematoma, paranasal sinus pyocele) with or without associated cellulitis

PAEDIATRIC

EAR

- Foreign body
- Trauma
- ENT conditions with associated neurological signs e.g. facial nerve palsy, profound vertigo &/or sudden deterioration in sensorineural hearing
- Acute &/or complicated mastoiditis
- Otitis externa with uncontrolled pain &/or cellulitis extending beyond ear canal &/or ear canal swollen shut
- Auricular haematoma

NOSE

- Foreign body (button batteries)
- Trauma
- Periorbital cellulitis with or without swelling with or without sinusitis
- Severe or persistent epistaxis
- Septal haematoma

THROAT

- Foreign body (button batteries – inhaled or ingested)
- Airway compromise: severe stridor/drooling/ breathing difficulty/acute, sudden voice change/ severe odynophagia
- Trauma
- Abscess or haematoma (e.g. peritonsillar, parapharyngeal (quinsy), salivary, neck or retropharyngeal abscess)
- Post-tonsillectomy haemorrhage
- Hoarseness associated with neck trauma or surgery

	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome
NECK MASS			
Paediatric		**Clinical history & examination:** Detailed history of mass **Imaging:** US +/- FNA, MCS, AFB, no CT neck **Diagnostics:** FBE, CRP, EBV, CMV serology Consider Bartonella serology, Toxoplasmosis, HIV titre if indicated,	**Urgent:** Increasing size Not responding to antibiotics Persisting > 6 weeks **Semi-urgent:** Suspected thyroid mass All other neck masses
Adult	Should not routinely prescribe antibiotics unless there are signs & symptoms of bacterial infection	**Clinical history & examination:** Dysphagia, odynophagia, neck/throat pain, otalgia, dysphonia, loss of weight risk factors (smoker, alcohol), increased risks of malignancy (fixation, firm, >1.5cm, skin ulceration), previous history malignancy **Imaging:** US neck + FNA, CT neck *Open biopsy is contraindicated*	**Urgent:**

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Thyroid Mass		**Clinical history & examination:** compressive sx (dysphagia, dyspnoea or hoarseness) **Imaging:** US thyroid +/- neck **Diagnostics:** TFTs (TSH, T4)	**Urgent** - FNA positive or suspicious for malignancy - Dominant nodule >4cm - Compressive sx - Neck nodes positive for malignancy Semi-urgent - Generalised thyroid enlargement without compressive sx - Recurrent thyroid cysts Routine - Benign
NASAL & SINUS			
Epistaxis - persistent or recurrent	First aid: Sustained pressure on nostrils Head forward Icing Control SBP <140 Consider cautery with silver nitrate (in setting anticoagulation?) Nasal precautions - No nose picking / blowing - Avoid straining / heavy lifting - Nasal cream (eg. Vaseline, paw paw cream)	**Clinical history & examination:** anticoagulants, bleeding disorder Laterality, anterior or posterior,	**Refer to ED if** - Large volume epistaxis - Haemodynamically unstable Urgent: - Suspicion of tumour Semi-urgent: - Unilateral epistaxis in adolescent male/suspicion of juvenile nasopharyngeal angiofibroma (JNA) Routine: - Not responding to maximal medical treatment (topical cream, cautery)
Salivary Gland Mass		**Clinical history & examination:** Rapid (inflammatory) vs slow growing (neoplastic), Association with food (sialadenitis), Hx of sarcoidosis,	**Urgent:** - Confirmed or suspected tumour

	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome
		Sjögrens disease Oral (parapharyngeal space involvement, saliva expression, stones), Facial nerve function, neck nodes **Imaging:** Parotid: US FNA +/- CT Submandibular gland: US ? + CT scan	
Acute Sinusitis	Treat acute bacterial infection (Augmentin DF) Nasal decongestant spray (max 5 days) Intranasal saline irrigations Intranasal steroid spray Consider course of oral steroids (3 weeks)	**Clinical history & examination:** Imaging: CT sinuses (non-contrast)	Send to emergency if any complications - Periorbital cellulitis - Orbital abscess - Rapidly evolving symptomatology in immunosuppressed patient **Urgent:** - Treatment not successful **Routine:** - Treatment relieving symptoms
Chronic Sinusitis/Polyposis	Treat acute bacterial infection (Augmentin DF) Nasal decongestant spray (max 5 days) Intranasal saline irrigations Intranasal corticosteroid spray Consider course of oral steroids (3 weeks) Treat asthma, underlying allergies & consider referral to Allergy/Immunology Unit	**Clinical history & examination:** **Imaging:** CT sinuses (non-contrast)	**Routine:** - Chronic & recurrent not responding to maximal medical management
Facial Pain		**Clinical history & examination:**	**Routine:**

GP Management		Investigations Required Prior to Referral	Expected Triage Outcome
		Nasal sx (obstruction, anosmia, nasal discharge), TMJ dysfunction, Dental hx, Migraine **Imaging:** CT sinuses (non-contrast) (if nasal symptoms)	- Consider referral to neurology +/- dentist in the absence of nasal symptomatology or normal CT sinus
GENERAL PROBLEMS			
Nasal Congestion /Obstruction	- Manage co-existing allergies / asthma - Antihistamine for allergic rhinitis - Saline rinse/irrigation - Intranasal steroid sprays (e.g. mometasone)	**Clinical history & examination:** Document symptoms, duration & treatments trialled **Diagnostics:** Consider skin prick/RAST/IgE CT sinuses (non-contrast)	**Urgent:** - Unilateral polyps - Bloody discharge **Routine:** - Bilateral polyps - Allergic rhinitis not responding to maximal medical management
PHARYNGEAL,TONSILITIS & ADENOID			
Acute tonsillitis	Treat with antibiotics (as per Antibiotic Therapeutic Guidelines)	**Clinical history & examination:** Frequency of attacks, previous peritonsillar abscess/quinsy, any bleeding history **Diagnostics:** Not routinely indicated	**Refer to ED if** - Not tolerating oral intake - Airway concerns - Evidence of peritonsillar abscess/quinsy
Chronic tonsillitis	Treat with antibiotics	**Clinical history & examination:** Frequency of attacks, previous peritonsillar abscess/quinsy, tonsillar haemorrhage **Diagnostics:** Not routinely indicated	**Urgent:** - More than 7 episodes in 1 year

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Peritonsilar cellulitis **Peritonsillar abscess / Quinsy**	Treat with antibiotics	**Clinical history & examination:** Stridor, voice change, trismus, airway concerns	**Refer to ED if** - Not tolerating oral intake - Airway issues - Evidence of abscess / quinsy
Infectious Mononucleosis **Viral Pharyngitis**	Monospot / EBV serology if suspect EBV tonsillitis	**Clinical history & examination:** **Diagnostics:** Monospot test / EBV serology FBE, UE, CRP	**Refer to ED if** - Not tolerating oral intake - Airway issues - Evidence of quinsy
Adenoiditis	Treat with antibiotics	**Clinical history & examination:** Nasal obstruction, nasal discharge, systemic features **Diagnostics** Imaging not indicated	**Urgent:** - Severe symptoms present directly to ED
Neoplasm		**Clinical history & examination:** Risk factors: smoking, alcohol intake, airway issues, previous malignancy **Diagnostics:** CT neck (with contrast), US neck + FNA	**Urgent - please call ENT Registrar via Austin Switchboard to discuss**
HOARSENESS			
Hoarseness/dysphonia	Commence where indicated: - Rest voice - Antibiotics - Inhalant steroid sprays - Humidification - Smoking cessation - Reduce caffeine intake	**Clinical history & examination:**	**Refer to ED** - Stridor - Airway obstruction **Urgent:** If symptoms persisting over 4wks & any of following:

GP Management		Investigations Required Prior to Referral	Expected Triage Outcome
			- History of smoking - xecessive alcohol - Recent intubation/previous tracheostomy - Recent cardiac or neck surgery Semi-urgent: - Recurrent symptoms in patients with no risk factors
EARS			
Acute Otitis Media	Oral antibiotics Analgesia	**Clinical history & examination:** otalgia, fever, otorrhea **Diagnostics:** Ear swab MCS if discharging	**Refer to ED if** - Facial nerve palsy - Acute mastoiditis - Subperiosteal abscess (pinna protrusion) - Meningitis/encephalitis **Semi-urgent:** - Cholesteatoma - Recurrent AOM - Syndromic, craniofacial abnormalities, cleft palate **Routine:** - AOM with TM perforation with persisting concerns >6weeks - Recurrent AOM (>3 episodes in 6 months or > 4 episodes in 12 month)
Otitis Media with Effusion ('Glue Ear')		**Clinical history & examination:** URTI, hearing loss, speech/developmental delay, indigenous background **Diagnostics:**	**Semi-urgent** - TM abnormalities (choelsteatoma, TM retraction) - Speech / developmental delay - Severe hearing loss

	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome
		Audiogram	Routine: - Mild hearing loss
Acute Otitis Externa	Insert ear wick if canal oedematous Avoid syringing Water precautions Avoid using hearing aids Topical Sofradex drops for bacterial infection & Locacorten Vioform drops for fungal infection	**Clinical history & examination:** Otalgia, otorrhea **Diagnostics:** Ear swab MCS, including fungus	**Urgent** - Confirmed otitis externa & persistent sx & pain - Hearing loss despite maximal medical management Semi-urgent: - Confirmed otitis externa without pain
Foreign Body (ear/nose)	Remove if only technically able, stop immediately if any bleeding	**Clinical history & examination:** Type of foreign body, duration	**Refer to ED if** **- Suspicion of button battery ingestion/inhalation** **Urgent**
HEARING LOSS			
Hearing Loss	If wax, use cerumen dissolving drops (Waxol, Hydrogen Peroxide) For hearing aid users, refer to local hearing aid provider to ensure optimal hearing aid fitting If sudden sensorineural hearing loss & no contraindications, start oral prednisolone 1mg/kg up to 60mg/kg daily	**Clinical history & examination:** Duration, Progression, Vertigo, Tinnitus, Otalgia, Otorrhoea Tuning forks **Diagnostics:** Audiogram	**Urgent:** - Rapid progressive severe unilateral or bilateral SNHL - Unilateral vertigo/tinnitus **Routine:** Bilateral severe to profound HL & any of following: - Poor speech discrimination - Does not receive adequate benefit from hearing aids - Chronic HL

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TINNITUS			
Non-pulsatile	Clear cerumen	**Clinical history & examination:** Vertigo, Hearing loss, Otalgia, Otorrhea Laterality **Diagnostics:** Audiogram	**Urgent:** - Vertigo - Hearing loss - Otalgia - Otorrhea - Recent Barotrauma **Routine** **-** Chronic bilateral
Pulsatile		**Clinical history & examination:** Vascular disease, Neurological history (headache, aneurysm) **Diagnostics:** Audiogram, CTA/CTV neck	**Urgent to rule out tumour**
DIZZINESS			
Chronic or Episodic	Important to rule out central causes Consider possible causes (migraine, medications, orthostatic or cardiac) If Dix Hallpike Test positive, perform repositioning manoeuvre (Epleys, log roll) Consider referring for vestibular physiotherapy Consider safety, falls prevention	**Clinical history & examination:** Seconds to minutes (BPPV, migraine, arrhythmia), hours (Meniere's disease, migraine) Otological sx (tinnitus, aural fullness, ear surgery) Neurological sx (numbness, weakness, blurred vision, headache, ataxia) Contributing factors: medications, hypertension, arrhythmia, DM, thyroid, vascular disease, migraine, trauma, loud noise, flying/diving, visual disturbance/new glasses, falls	**Routine:** - BPPV refractory to repeated repositioning manoeuvre or after seeing vestibular physiotherapist

	GP Management	Investigations Required Prior to Referral	Expected Triage Outcome
		Diagnostic: Neurological exam, Dix Hallpike Test, Head Impulse Test, Audiogram	
FACIAL PARALYSIS			
Facial Paralysis	Eye protection if incomplete colsure - Lacrilube & tape eye shut nocte If suspicious of Bell's palsy or Ramsay Hunt Syndrome, - Commence oral prednisolone 1mg/kg (50mg for 10 days) if no contraindications, within 72 hours of onset - Oral antivirals in addition to oral prednisolone, prescribe within 72 hours of onset, do not prescribe antiviral alone (?only if vesicles seen)	**Clinical history & examination:** Immediate vs delayed, complete vs incomplete, trauma, surgery, otological sx, hx of skin or head/neck malignancy Diagnostic: If relevant, CT temporal bone/neck, Audiogram	**Urgent:** - Lower motor neuron + hearing loss/otalgia/otorrhea/other cranial nerve palsy - Vesicles in ear or oral cavity - Perineural spread from cutaneous SCC - No improvement or worsening palsy despite treatment
DYSPHAGIA			
Dysphagia	**Consider referring to Speech Pathologist +/- Neurology**	**Clinical history & examination:** Solid (obstructive) vs liquid (neurologic), progressive (tumour, scleroderma, achalasia), odynophagia (acute, foreign body, pharyngitis, laryngitis), regurgitation (nasal/gastric), aspiration, drooling, voice changes, neurological sx **Imaging:** Chest XR Barium swallow Thyroid function tests	**Urgent:** Suspicion of oropharyngeal lesion - Hoarseness - Unilateral otalgia - Progressive weight loss - Smoker - Excessive alcohol intake Significant dysphagia + - Gagging/choking/coughing on swallowing - Food or liquid regurgitation - Recurrent chest infections