Ear, Nose and Throat
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GP education event
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Solutions

Pathways

Referral criteria

Fast Track Clinics
ENT

Topics

- Tonsillitis
- Rhinitis
- Sinusitis
- Hearing Loss & Tinnitus
- Vertigo
Tonsillitis

Indications for Surgery

Recurrent Infection

Quinsy

Obstruction

Suspected malignancy
Indications for consideration for tonsillectomy

Paradise criteria

≥ 7 episodes in the preceding year, or ≥ 5 episodes in each of the preceding 2 years, or ≥ 3 episodes in each of the preceding 3 years.

Extraordinary circumstances e.g., excessive time off work (> 3 weeks per year), or school (> 4 weeks per year) documented.

Episodes must be well documented, clinically significant and adequately treated.
Rhinitis

Treatment mainly medical

Allergic

Non Allergic

Rinar
Rhinitis

History – Atopy, Asthma, Triggers

Examination – Rhinoscopy

Investigations – Skin test / RAST
Rhinitis

- Allergy test
  - Immunology review if significant abnormality
- 6 week Trial Intranasal steroid
  - Refer ENT if nasal obstruction persists
Sinusitis

Acute vs Chronic

Spectrum of disease - Rhinosinusitis

Same underlying pathophysiology

Hallmark is NASAL OBSTRUCTION, FACIAL PAIN, HEADACHE
Differential Diagnosis

Migraine

Tension Headache

Midfacial Pain Syndrome

TMJ Arthropathy
Midfacial Pain Syndrome

Common

Analagous to tension headache

Presentation similar to CRS

No nasal obstruction or rhinorrhoea

No improvement with antibiotics
Midfacial Pain Syndrome

Exclude CRS (Normal CT)

Low dose TCA for min 6/52
Chronic Sinusitis

Intranasal Steroids

Saline Irrigation

Second line treatments – antihistamines, Atrovent

Antibiotics – 6 week course of Roxithromycin

POLYPS
Chronic Sinusitis

CT Paranasal Sinuses
Facial Pain

Nasal Symptoms eg Obstruction, Mucus, Postnasal drip

6 week trial of intranasal steroids, Saline irrigation 4 weeks of antibiotic therapy

CT paranasal sinuses if no improvement

Refer ENT

No nasal obstruction

Consider alternate diagnoses eg myofascial pain, tension headache,

CT paranasal sinuses

Refer ENT if significant abnormality

Refer orofacial pain specialist if CT negative
Systemic symptoms

Severe, persistent frontal headache

Periorbital oedema or erythema

Facial cellulitis

Altered visual acuity or diplopia
Hearing Loss and Tinnitus

Common

Audiology

When to refer and where?
Hearing Loss and Tinnitus

DIAGNOSIS – Air and Bone Conduction Audiometry

TREATMENT – SNHL – Hearing Aid

-- CHL – Hearing aid / surgery

? NOTHING
Hearing Loss and Tinnitus

ENT Review
- Conductive HL
- SNHL not responsive to aids
- Unable to wear aid eg infection
- Asymmetric SNHL with imaging abnormalities
Tinnitus

Pulsatile vs non-pulsatile

Unilateral vs bilateral

Hearing status
Tinnitus

Non-Pulsatile

Bilateral

Normal Examination

Abnormal examination

Refer Audiology for audiogram and tinnitus management

Refer ENT

Pulsatile

Audiogram

Contrast CT Brain, Skull Base and Neck

Refer ENT

Unilateral

Audiogram

MRI IAM

MRI Normal

MRI Abnormal

Refer audiology for tinnitus therapy +/- hearing aid

Refer ENT
MRI ACCESS??
MR. DIZZY

by Roger Hargreaves

Ladybird
Balance Clinic

Long wait

Undifferentiated referrals

Many treatable
Problems

Wrong diagnosis ie NOT vertigo
  - Postural hypo tension
  - Arrhythmia – VT!!!
  - Migraine

Symptoms gone
Balance Clinic

Vestibular Physio review

Disc w ENT Consultant – d/c or review

Review in combined Balance Clinic if required
Balance Clinic

Does it work??
Key points – Health Pathways

Shift in approach

Improve access

Reduce unnecessary follow up