South East London Integrated Care System

Ear Nose & Throat (ENT) Paediatric Primary and Secondary Care Interface Guidelines

August 2024

South East London Integrated Care System

South East London Acute Provider Collaborative

NHS Guy's and St Thomas' NHS Foundation Trust | NHS King's College Hospital NHS Foundation Trust | NHS Lewisham and Greenwich NHS Trust

User information (1 of 2):

Purpose:

- This document has been produced utilising published guidance and in collaboration with clinical and non-clinical staff across South East London (SEL). It is intended to assist Primary and Secondary care colleagues in decision making and does not replace clinical judgement
- We encourage users of this document to seek advice from primary or secondary care colleagues when they are unsure, the latter using established communication channels such as Consultant Connect or advice and guidance (A&G)
- We suggest speaking with a local clinician (not the National Consultant Network) via Consultant Connect for advice or the on-call clinician via the hospital switchboard for same day referrals or out of hours advice

Prescribing:

All prescribing should be in line with the SEL Paediatric Formulary - accessible through Clinibee – clinicians will have to create an account with an nhs.net account, selecting organisation as your local NHS Trust. We recommend downloading the app. To find the SEL Paediatric Formulary go into "discover libraries" and "follow" Paediatric Formulary (visible in "Publicly available libraries" hosted by GSTT). For paediatric prescribing, dose and duration of treatment need to be checked in the BNFc / local antibiotic guidelines – for Bexley, Lewisham & Greenwich this is Microguide (planned to roll out across SEL). Many medications need the patients weight for accurate dosing.

Overview of Paediatric ENT services in SEL:

- Primary care colleagues should refer to/contact their closest service
- **Community ENT service**: go live date expected June 2024. **e-RS Single Point of access** across SEL for non-cancer related referrals. Local hubs in each borough across SEL. **Providing A&G and Consultant Connect**. Aims to see Paediatric cases within 6 weeks for: Ear Wax, Blacked nose, Otitis Media, Otitis Externa, Epistaxis. **Other cases will be triaged and referred on to the local hospital within SEL**.
- **Pharmacy First Scheme**: Some pharmacies require referrals from GP surgeries, some see walk-ins (locally agreed) availability is dependant on enrolled Pharmacist availability. Assesses and treats: Acute sore throat (Children over 5 years old), Acute Sinusitis (Children over 12 years old), Acute Otitis Media (Children over 1 years old)
- **Lewisham Hospital:** the ENT team covers paediatric and adult patients
- **Guy's and St Thomas' Hospital:** have a paediatric ENT team at the Evelina London Children's Hospital, separate from the adults service
- **Princess Royal University Hospital: the** ENT team covers paediatrics and adult patients (please note at time of publication this hospital is not accepting routine e-RS referrals, however they are providing in-patient care, liaison with other specialisms & telephone advice)
- **Kings College Hospital:** at the time of publication does not have a dedicated ENT team – please contact/refer to the next closest hospital with an ENT team

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User information (2 of 2):

Authors and Governance:

This guide was a collaborative effort, led by Dr Alexandra Armstrong (GP, SEL ICB Lead ENT) and Miss Victoria Possamai (ENT Consultant, Evelina Hospital) and Jin On (Associate Chief Pharmacist SEL ICB)

This guide has been reviewed & approved by:

- South East London ICB Board
- The medicines and prescribing recommendations have been reviewed and approved by SEL Integrated Medicines Optimisation Committee (IMOC)
- Primary Care: LMC, Planned Care Leads, Paediatric Leads
- Secondary Care: Consultants from Lewisham & Greenwich NHS Trust, Kings College NHS Foundation Trust (Princess Royal University Hospital) and Guys & St Thomas' NHS Foundation trust

Abbreviations:

- Accident & Emergency or Emergency Department (A&E)
- Advice and guidance (A&G)
- Ears Nose & Throat medical specialism (ENT)
- Electronic Referral System (e-RS)
- General Practice or General Practitioner (GP)
- Integrated Care Board (ICB)
- Local Medical Committee (LMC)
- Obstructive Sleep Apnoea (OSA)
- Over the counter medication/medical device (OTC)
- Single Point access (SPA)
- South East London (SEL)

Table of Contents

This guide has been produced utilising published guidance and in collaboration with clinical and non-clinical staff across the South East London. It is intended to be a guide to assist Primary and Secondary care colleagues in decision making and does not replace clinical judgement.

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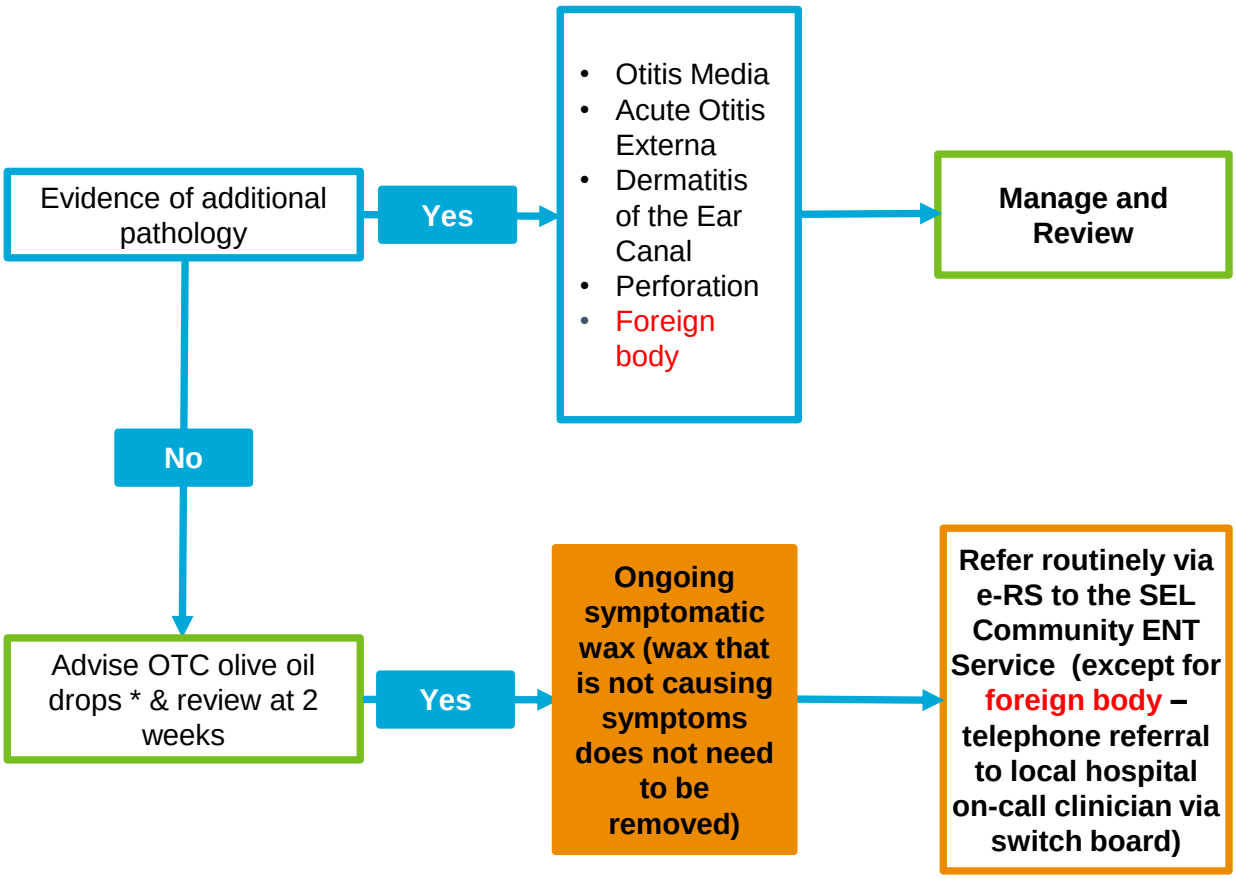
Version	Date signed off	Date of next review
V0.1		

Ear Wax

Ear wax only needs to be removed if causing symptoms e.g. hearing loss or if the tympanic membrane needs to be visualised
Advise not to use cotton buds, to avoid recurrence continue olive oil drops twice weekly
Direct Parents to NHS Website: Earwax build-up



*Ear drop choice: Olive oil TDS for 3-5 days. Olive oil may take up to 2 weeks to soften. Possible side effects: transient hearing loss, discomfort, dizziness, skin irritation

References: SEL Treatment Access Policy 2022 (1), NICE CKS Ear Wax 2021 (2)

Foreign Body of the Ear or Nose

RED FLAGS

- Do not try and manipulate without specialist equipment or training
- Cover with oral antibiotics if evidence of cellulitis whilst waiting to be seen as per local antibiotic guidelines
- Foreign Body in Ear **: batteries (999),** evidence of **severe infection requiring IV antibiotics (A&E/999), call on-call ENT clinician** at local hospital via switch for other materials and non-severe infection
- Foreign body in Nose: (the nose is considered to be an airway)- **call on-call ENT clinician** at local hospital via switch to refer or send to the **A&E as an emergency (999 for batteries)**

Tympanic Membrane Perforation

- Secondary to Otitis Media, Trauma, Barotrauma, Surgical (e.g after grommets)
- **>90% heal within 8 weeks** & Hearing loss usually recovers once healed
- **Antibiotics are not necessary** in the vast majority of cases. Exceptions are those children at high risk of secondary middle ear infection e.g. large perforation, existing middle ear pathology or immunocompromised, in these cohorts prescribe a topical antibiotic (e.g. Ciprofloxacin** advise parents off license) until healed
- Chronic Tympanic Membrane perforation (e.g. non-healed post grommets) – refer routinely to ENT
- Information for parents: NHS Website Perforated eardrum

Perforated tympanic membrane

- Consider Non-accidental injury
- Treat any ongoing otitis media / otitis externa
- Advise on self care measures* to avoid secondary infection
- Give safety net advice: to seek review if symptoms of infection develop (e.g. pain, discharge, hearing loss, fever, redness of outer ear or mastoid process)
- If high risk (use clinical judgment, see top box) for secondary middle ear infection or high risk complications from infection prescribe a topical antibiotic (non-ototoxic) e.g ciprofloxacin (Cetraxal) ** BD until healed
- Please note we do NOT recommend routinely prescribing antibiotic drops to those with perforation

Unresolved

Review after 8 **weeks** and if not healed refer **routinely** via e-RS to the SEL Community ENT Service

Continue self care while waiting to be seen

- *Self care advice to try and stop secondary infection of the inner ear: keep it dry, particularly no shampoo/soap to enter ear canal. Ear plugs or coat cotton wool in petroleum jelly before bathing. Use hairdryer on low heat to dry ears after bathing:
- **https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/**
- **aminoglycosides e.g. gentamicin are contraindicated in perforation. When prescribing antibiotic drops ensure no allergies. For ciprofloxacin drops please note this is off-label usage and the BNFc / SPC advises caution in perforation. If otitis externa develops consider swabbing gently (care not to come in contact with tympanic membrane) and rationalizing treatment based on results

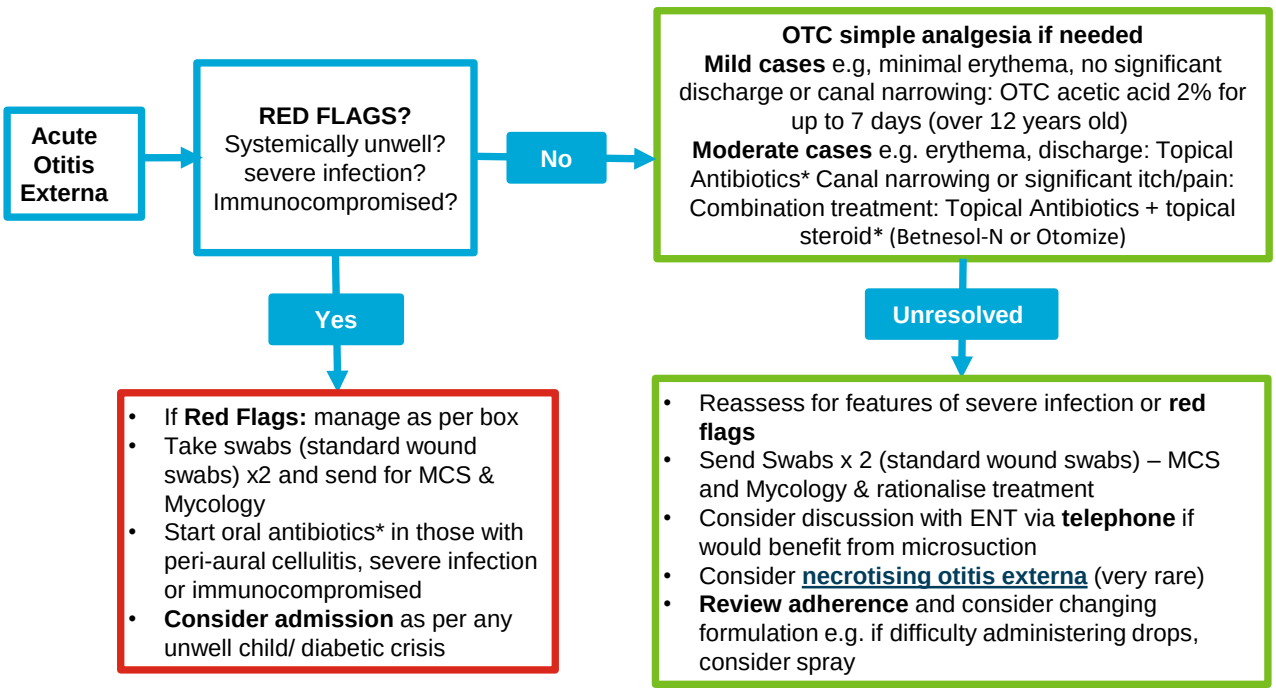
- References: BNF Ear, Treatment summary (3)

Ear Discharge & Otitis Externa 1 of 2 (Acute Otitis Externa)

- Discharge can be: discharging wax (normal), discharging ear drops, infection – pus/mucous/blood (otitis externa or media +perforation), **Foreign body, CSF Leak** – clear/blood stained (trauma or surgery), **Cholesteatoma** (rare in children. Can be congenital. Can occur after repeated ear infections)
- Otitis Externa can be: Acute or Chronic (more than 6 weeks). Bacterial or Fungal. **Less common than in adults**. Can occur as a secondary infection from otitis media.
- Risk Factors for Otitis Externa: Swimming, dry skin conditions, diabetes/immunosuppression, trauma (ear buds/scratching), hearing aids/in-ear headphones
- **Self care**: keep ears dry (ear plugs/swim cap/ cotton wool coated in petroleum jelly), blow dry on low heat after bathing, OTC Acetic acid after swimming https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/ NHS Website: Ear infections

RED FLAGS

- Suspected necrotising otitis externa: very rare in children. Usually child is immunocompromised (including diabetes) presenting with Otitis externa +/- severe ear pain +/- Cranial Nerve Palsy +/- offensive discharge +/- failed treatment x2 for otitis externa +/- peri-aural cellulitis/mastoiditis (**call on-call ENT clinician** at local hospital via switch for same day advice and to arrange urgent review +/- admission)
- Discharge following head trauma or cranial surgery (**refer to A&E** for consideration CT Head, **consider non-accidental injury**)
- Foreign Body in Ear/Nose (**A&E as an emergency: for nose, for batteries (999), or if evidence of severe infection requiring IV antibiotics**, **call on-call ENT clinician** at local hospital via switch for other materials - do not try and manipulate without specialist equipment or training) Cover with oral antibiotics if evidence of cellulitis whilst waiting to be seen as per local antibiotic guidelines
- Suspected Cholesteatoma: very rare in children, can be congenital or after repeated infections. Chronic unilateral offensive discharge with hearing loss or typical tympanic membrane - Usually originates at the top, inner edge of the tympanic membrane as a retraction/keratinous build up +/- discharge into the canal (**Urgent: referral to ENT via e-RS**)



- *Follow NICE or local antibiotic guidelines (Betnesol-N or Otomize are on local formulary and Microguide)
- Prescribe a non-ototoxic preparation if the person has a known or suspected perforation of the tympanic membrane, including a tympanostomy tube in situ
- References: NICE CKS Otitis Externa (4)

Ear Discharge & Otitis Externa 2 of 2 (Chronic Otitis Externa)

- Discharge can be: discharging wax (normal), discharging ear drops, infection – pus/mucous/blood (otitis externa or media +perforation), **CSF Leak** – clear/blood stained (trauma or surgery), **Cholesteatoma** (rare in children. Can be congenital. Can occur after repeated ear infections)
- Otitis Externa can be: Acute or Chronic (more than 6 weeks). Bacterial or Fungal. **Less common than in adults**. Can occur as a secondary infection from otitis media.
- Risk Factors for Otitis Externa: Swimming, dry skin conditions, diabetes/immunosuppression, trauma (ear buds/scratching), hearing aids/in-ear headphones
- **Self care**: keep ears dry (ear plugs/swim cap/ cotton wool coated in petroleum jelly), blow dry on low heat after bathing, OTC Acetic acid after swimming https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/

RED FLAGS

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Chronic Otitis Externa

- **Unusual in Children** – consider **early advice & guidance and testing for any co-morbidities, managing co-existing dermatological conditions**
- Consider Fungal Infection, especially if intense itch, swab and discuss with micro if positive.
- Manage any Risk Factors e.g. swimming, dry skin conditions, in ear headphones / ear plugs
- Consider testing for diabetes
- Manage skin conditions & consider referral to Dermatology
- Consider **Cholesteatoma** (rare in children, can be congenital)

Consider **routine referral via e-RS** to the SEL Community ENT Service if:

1. no red flags
2. does not require urgent treatment
3. is not more appropriate to refer to Dermatology
4. and if there is a failure to respond to bacterial / fungal treatment in Primary care

- If Otitis Media with perforation is suspected (acute pain which is suddenly relieved followed by ear discharge) treat as per dedicated guidelines (slide 9) and then review Prescribe a non-ototoxic preparation if the person has a known or suspected perforation of the tympanic membrane, including a tympanostomy tube in situ
- References: NICE CKS Otitis Externa (4)

Acute and Recurrent Otitis Media

- **Acute otitis media:** acute onset of unilateral pain and infective symptoms with characteristic abnormal tympanic membrane: red / bulging / effusion +/- perforation. May be viral (approx. 2/3 of cases) or bacterial. Consider no/delayed script of antibiotics in those who are systemically well without diabetes or otherwise immunocompromised. Advise on natural course: 3-7 days & on regular simple analgesia (ibuprofen preferable if no contraindications)
- **Complications are rare**: chronic suppurative otitis media, hearing loss (no evidence that antibiotics prevent), perforation, mastoiditis, meningitis, intracranial abscesses, sinus thrombosis, facial nerve palsy
- Risk Factors: Household smokers
- **Otitis Media with Effusion**: pressure, popping/clicking sensation +/- conductive hearing loss. TM dull/fluid level/non-motile. Causes: persistent inflammation post infection, low grade ongoing infection, impaired Eustachian tube function, allergic rhinitis

RED FLAGS

- Suspected Mastoiditis: Mastoid swelling/erythema/tenderness/bogginess (**call on-call ENT clinician** at local hospital via switch for same day assessment **or via A&E** if unwell)
- Suspected complications: severe pain/headache, meningism, evidence of sepsis, facial nerve palsy or abnormal neurological examination (**refer to A&E** for consideration of IV antibiotics and Imaging)
- Suspected Cholesteatoma: very rare in children, can be congenital or after repeated infections. Usually originates at the top, inner edge of the tympanic membrane as a retraction/keratinous build up +/- discharge into the canal (**Urgent referral via e-RS**)

Acute Otitis Media
Note: Children over 1 can be referred to the Pharmacy First scheme

RED FLAGS?
Systemically unwell?
severe infection?
Immunocompromised

No

Perforated tympanic membrane

No

1. OTC simple analgesia 72 hours
2. +/- topical phenazone 40mg/lidocaine hydrochloride 10mg/g (Otigo) (up to 7 days)*
3. Consider a delayed script of oral antibiotics**
4. Children <2 with bilateral infection consider immediate oral antibiotic prescription

Unresolved

- Prescribe antibiotic or escalate antibiotics to second line
- Re-assess for evidence of severe infection or **Red Flags**
- **Review diagnosis**

Consider routine referral via e-RS to SEL Community ENT if ongoing > 6 weeks or if any hearing loss

Yes

For management of Red Flags: see box above

For unwell/severe infection/ immunocompromised:

Immediate script oral antibiotics*

Consider admission as per any unwell child/ diabetic crisis
Consider admission for children **under 3 months**

Yes

See dedicated guideline slide 7

Recurrent Acute Otitis Media

Consider **seeking advice and guidance +/- routine referral** if there is a craniofacial abnormality, if episodes are distressing or unexplained, if there have been 3 or more episodes < 6 months or 4 or more < 1 year
Seek advice via **telephone** if tympanostomy tube in situ and send MCS swab

- NICE guidelines: When Otigo™ (Phenazone 40 mg/g with lidocaine 10 mg/g) is considered, it is recommended for up to 7 days and when an immediate oral antibiotic is not given
- **Follow NICE or local Antibiotic Guidelines
- https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/

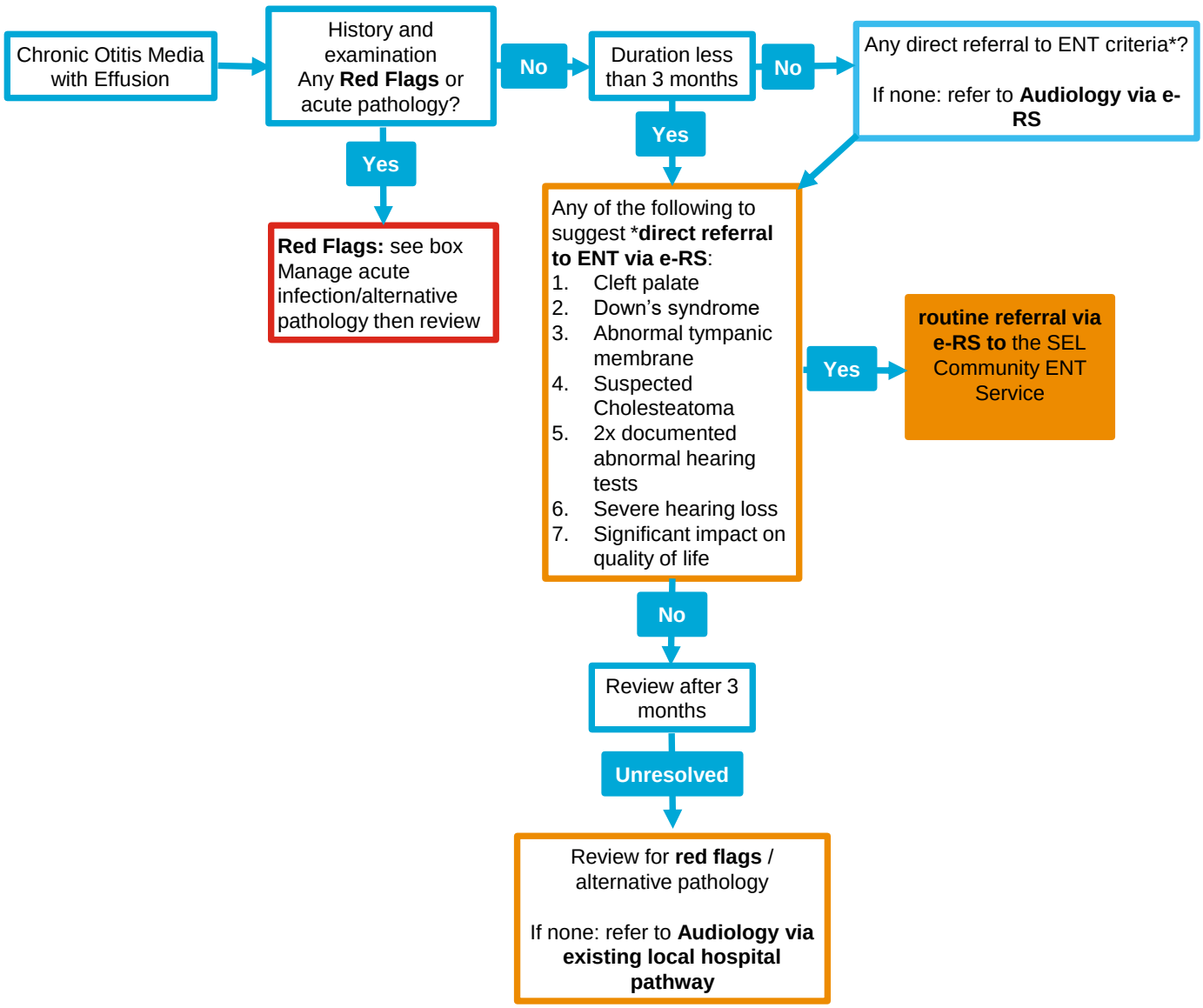
- References: NICE Otitis media (acute): antimicrobial prescribing (5); NICE Otitis Media (acute) (6)

Chronic Otitis Media with Effusion (Glue Ear)

- Common – up to 8/10 children will have an episode before aged 5
- Can occur following an infection (most commonly otitis media) or due to enlargement of adenoids/impaired eustachian tube function
- Suspect: parents/teachers complaining of hearing issues. Speech delay. Behavioral issues (e.g. poor attention). Complaining of sore ears
- Risk factors: Family History, allergic rhinitis, reflux, pollution, Downs syndrome, cleft palate, cystic fibrosis, recurrent upper respiratory tract infections
- Watchful waiting is a safe option for most children as many cases will self resolve <3 months. There is no evidence to support other treatments over watchful waiting
- Complications: speech delay, conductive hearing loss. Very rarely: long term damage to the tympanic membrane

RED FLAGS

- Suspected Mastoiditis: Mastoid swelling/erythema/tenderness/bogginess (**call on-call ENT clinician** at local hospital via switch for same day assessment **or via A&E** if unstable)
- Suspected complications: severe pain/headache, meningism, evidence of sepsis, facial nerve palsy or abnormal neurological examination (**refer to A&E** for consideration of IV antibiotics and Imaging)
- Suspected Cholesteatoma: very rare in children, can be congenital or after repeated infections Usually originates at the top, inner edge of the tympanic membrane as a retraction/keratinous build up +/- discharge into the canal (**Urgent referral via e-RS**)



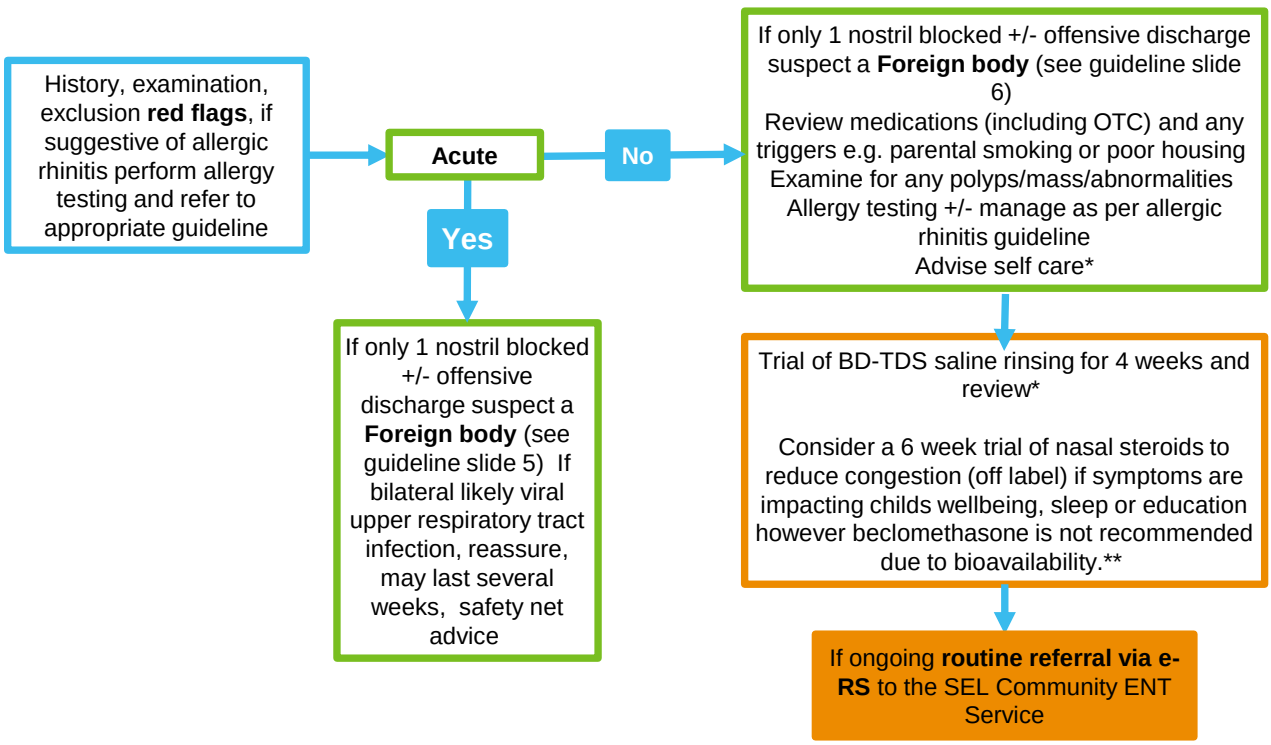
References: NICE Otitis media with effusion (8)

Nasal Congestion/ Rhinorrhoea

- Note separate Allergic Rhinitis guideline
- Symptoms: sneezing/running nose/nasal congestion/post-nasal drip/cough/mouth breathing/snoring
- Differential diagnosis: Acute infections, allergic, enlarged adenoids, **foreign body,** septal deformities – acquired (trauma) or congenital, acute post-traumatic (e.g. septal haematoma), **rarely tumour**, Medication side effects, Irritants (e.g. passive cigarette smoke, pollution, wood burning stoves, cleaning agents, strongly scented products, weather changes)
- In **chronic rhinitis** order **allergy testing** for common allergens (Allergen specific IgE blood testing – tree pollen, grass pollen, dust mites, pets, mould depending on history) and refer to allergic rhinitis pathway if suggestive of allergic cause

RED FLAGS

- Unexplained persistent unilateral nasal blockage / bloodstained or offensive discharge suspect foreign body and refer to A&E, if any visible mass refer via e-RS and select ”urgent” and explain 2ww
- Suspected CSF leak: Head injury followed by clear nasal discharge (**refer to A&E**)
- Suspected raised Intracranial pressure: Progressive headache / vomiting / abnormal optic discs / blurred vision / behavior change (**refer to A&E**)
- Suspected orbital cellulitis: Proptosis of eye, double vision, ophthalmoplegia, new reduction in visual acuity or facial mass (surgical emergency, **refer to A&E, consider 999** if meningism, altered consciousness, severe pain)
- Peri-orbital oedema or cellulitis (pre-septal cellulitis can be managed in primary care if high confidence in diagnosis, systemically well and followed up <48 hours, if unsure or for orbital cellulitis **refer to A&E**)
- Foreign Body in Nose: call on-call ENT clinician at local hospital (**999 for batteries**) do not try and manipulate without specialist equipment or training)



- *self care: nasal rinsing with homemade salt water solution or OTC solutions e.g. Sterimar spray or NeilMed rinse. Trigger avoidance and rinsing nose, face, hands, hair and changing clothes as soon as possible after exposure. Information on how to make a homemade salt water solution is available from the NHS website: https://www.nhs.uk/conditions/sinusitis-sinus-infection/
- https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/
- ** Check BNFc for dosing. Nasal steroids are licenced for allergic rhinitis, this is off label prescribing. For allergic rhinitis Mometasone is licensed for 3 years and over, Fluticasone for 4 years and over. Information on how to use nasal sprays and is available from the NHS website
- References: NICE CKS Sinusitis (9)

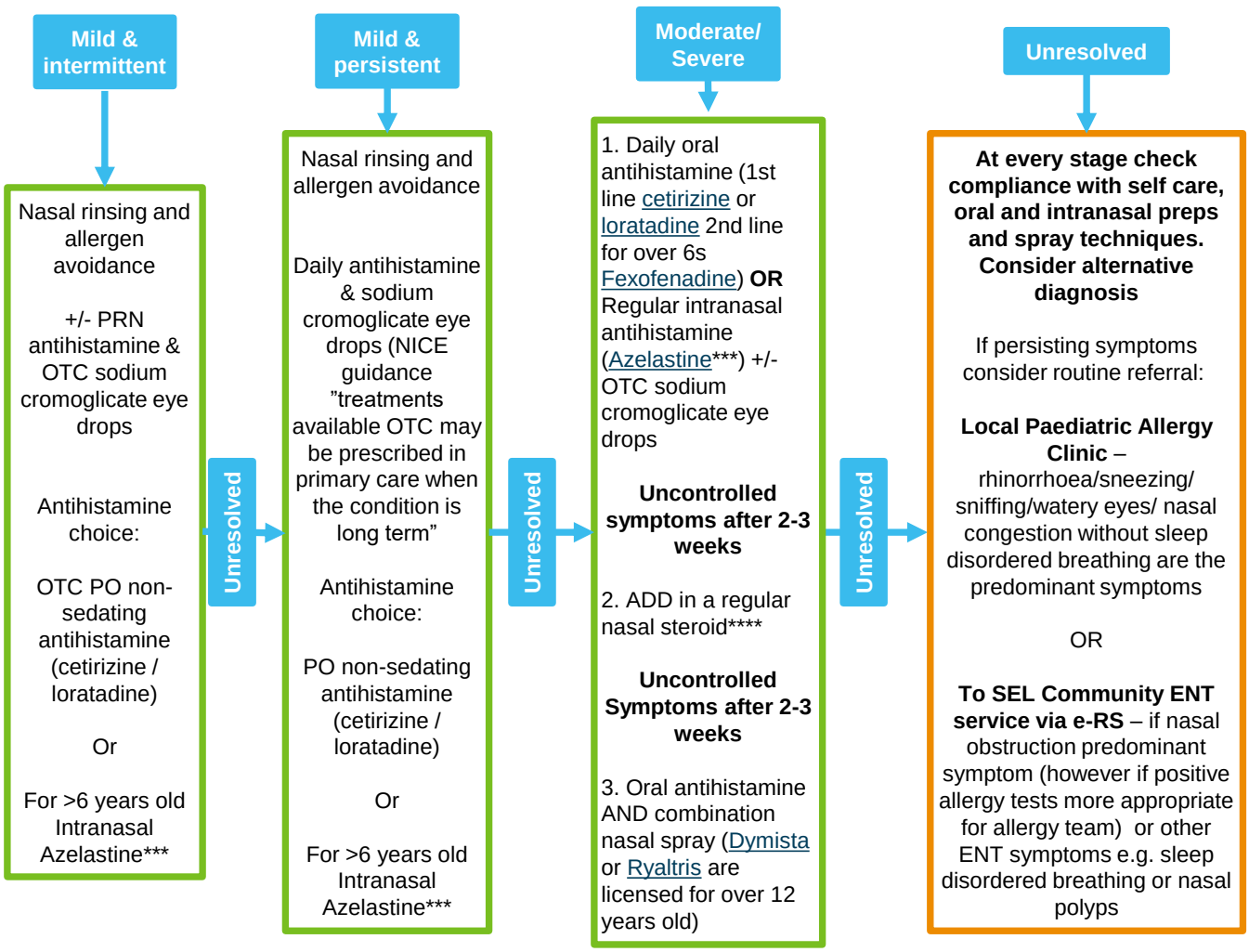
Allergic Rhinitis

- Note separate Nasal congestion/Rhinorrhea guideline which also contains advice on **red flags** **allergen avoidance, nasal rinsing and nasal steroids**
- Allergic Rhinitis is common and can cause a significant impact on quality of life
- Seasonal Allergic Rhinitis (Hay fever) is normally a clinical diagnosis, however consider allergy testing in General Practice if history is unclear and confirmation will aid allergen avoidance
- Symptoms: sneezing/running nose, itchy nose/throat, nasal congestion (mouth breathing, snoring/post-nasal drip/cough), itchy, watery eyes
- Screen for eczema, food allergy, asthma (uncontrolled allergic rhinitis increases risk of asthma exacerbations)
- ARIA (Allergic Rhinitis and its Impact on Asthma) have produced a Classification of Allergic Rhinitis: Splits into intermittent, persistent, mild, moderate-severe & can be helpful to guide treatment
- Establish adherence to therapy and check nasal spray technique before stepping up treatment
- Start nasal sprays 1-2 weeks before pollen season.
- **Sedating antihistamines, Nasal decongestants and depot steroids are not recommended**
- Signpost parents to Allergy UK website: Hay fever & Indoor Air Quality

History, examination (including nasal), exclusion of **red flags** (e.g. nasal mass). Hay fever is usually a clinical diagnosis.
If allergen is unclear **perform blood test if available (e.g. pollen, pets, dust)** to aid allergen avoidance, if polyps are present **seek advice and guidance +/- routine referral to Community ENT service**

1. Always advise on **nasal rinsing*** and **allergen avoidance**** – **these must be continued at all stages of the pathway**
2. **Assess severity**

- Intermittent: <4 days a week for <4 weeks
- Persistent: >4 days a week and > 4 consecutive weeks
- Ask about impact on daily activities, sleep, work / school and how troublesome they find the symptoms. Mild = no impact, not troublesome. Moderate / severe: impact, troublesome.



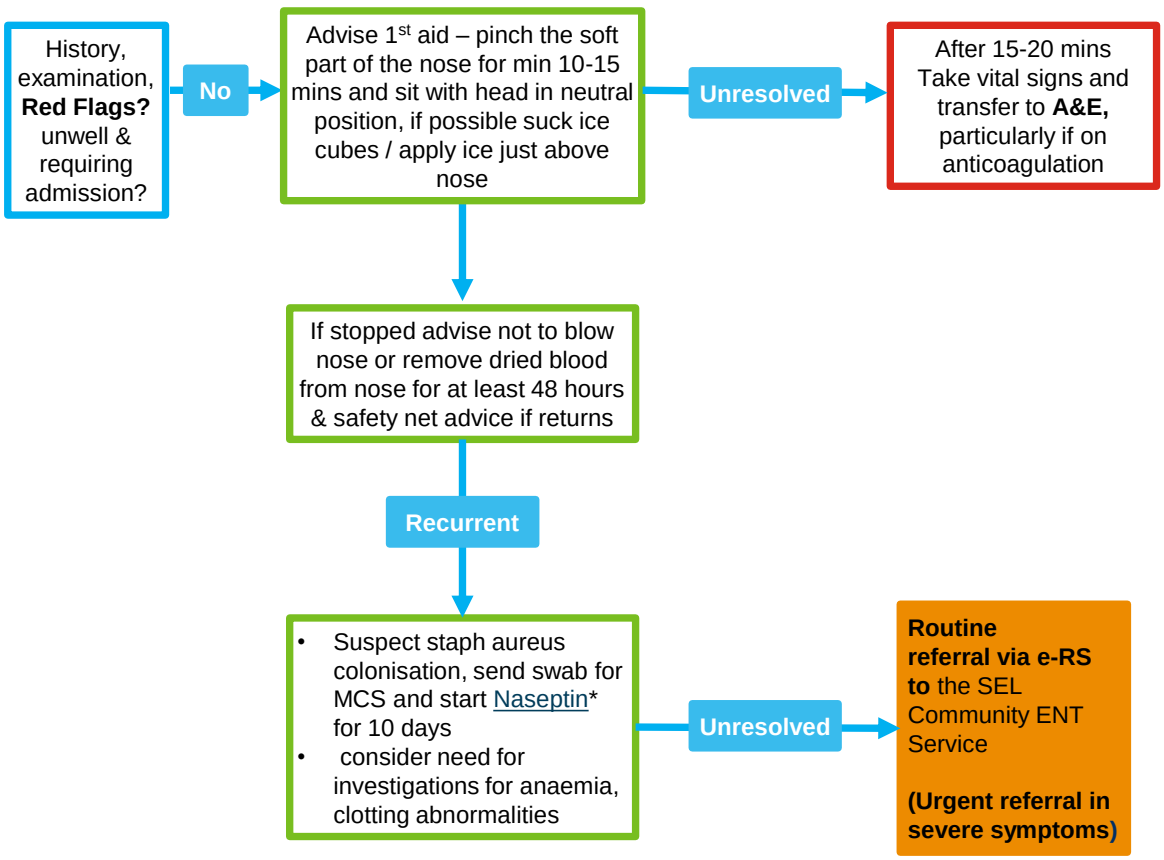
- *nasal rinsing advice from ENT UK
- **allergen avoidance advice available from NHS website
- *** two brands are available and dose varies between them – check BNFc
- **** dosing as per BNFc. Beclomethasone not recommended due to bioavailability. Mometasone licensed for 3+, Fluticasone for 4+
- How to use nose drops, sprays & ointments: ENT UK
- References: References: SEL ENT interface guidelines (9); NICE CKS Allergic Rhinitis (10)

Epistaxis

- Common presentation in primary care. 50% of children 6-15 have regular nose bleeds
- Most can be treated at home and are not the sign of an underlying problem
- 80% are anterior from littles area which is easily damaged e.g. picking nose, blowing nose, minor injury, colds, sinusitis, temperature changes, hay fever, nasal sprays
- 20% are posterior and are less common in children
- Acute epistaxis history – one or both nostrils, down back of throat, duration of bleeding, any trauma, any anticoagulants, previous epistaxis/abnormal bleeding, FHx Bleeding disorders

RED FLAGS

- Consider non-accidental injury
- Septal haematoma (history of local trauma) **call on-call ENT clinician** at local hospital via switch for same day assessment
- Haemodynamically unstable (refer to **A&E / 999** in an emergency)
- Unexplained persistent unilateral nasal blockage / bloodstained or offensive discharge suspect foreign body and refer to A&E, if any visible mass **refer via e-RS** and select ”urgent” and explain 2WW
- Nose bleeds under 2 years old (after examination consider bloods +/- referral to appropriate specialism – ENT or Haematology)
- New onset significant bleeding in male child (>10 years) refer (**urgent via e-RS**), as there is a possibility of juvenile nasal angiofibroma



- **Naseptin QDS for 10 days or alterative is Bactroban (unlicensed use. Licensed for nasal infection with carriage of Staphylococcus aureus)
- References: NICE CKS Epistaxis 2022 (11)

Broken Nose

Any nasal injury with persisting deformity needs to be reviewed by ENT 5-7 days post-injury as if Manipulation under anaesthetic is needed this occurs within 2-3 weeks
Refer to ENT emergency clinic via telephone

For late presentations: Septo-rhinoplasty is a restricted procedure on the NHS and **not considered before age 16-18**. There needs to be both:

1. severe nasal deformity with complete obstruction of at least one nostril
2. causing a severe functional limitation

RED FLAGS

- Consider non-accidental injury
- Septal haematoma (**call on-call ENT clinician** at local hospital via switch for same day assessment)
- Haemodynamically unstable (refer to **A&E / 999** in an emergency)
- Meeting NICE guidelines for CT Head (**refer to A&E**)
- Suspect other facial bone fractures (**refer to A&E**)
- Major trauma (**refer to A&E**)

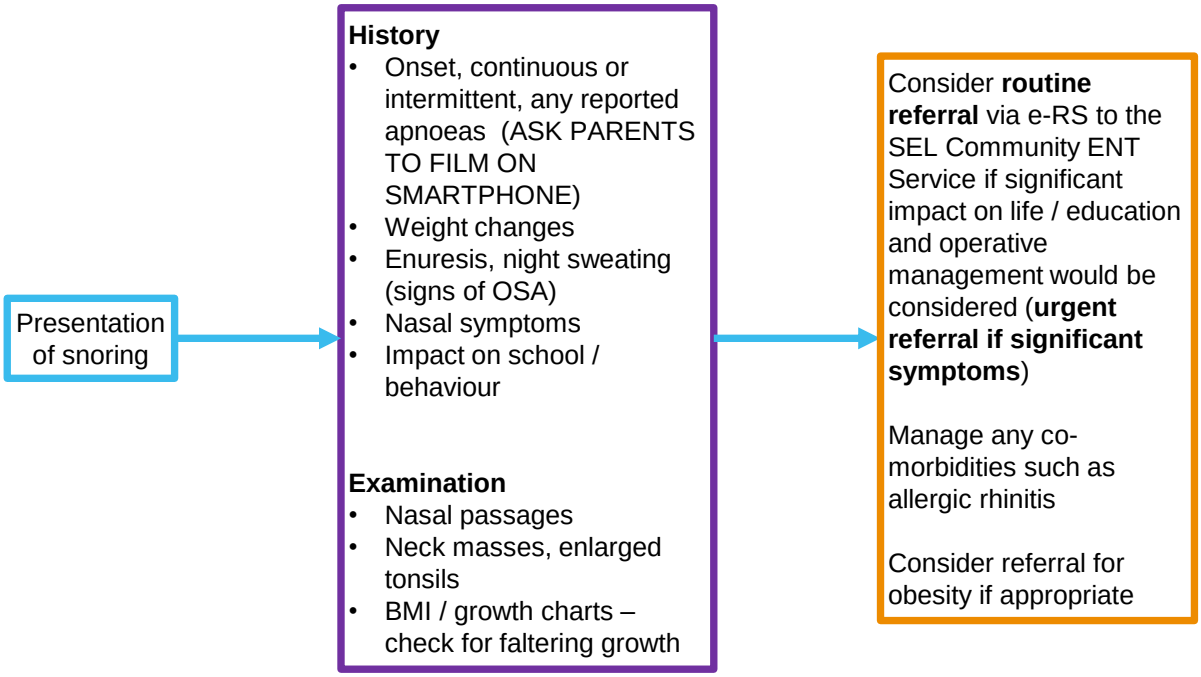
- References: SEL Treatment Access Policy 2022 (1)

Snoring/ OSA/ Sleep disordered breathing

- Sleep disordered breathing/OSA is very common (up to 1/10) in 2-6 year olds, most self-resolve by age 8
- Symptoms: chronic snoring (more than 3 months of continuous snoring, not just with colds); sleeping with head extended, disturbed sleep, daytime sleepiness or hyperactivity/behavioural issues, morning headaches/lethargy/decreased appetite, poor growth, poor school performance (due to poor concentration or behavioural difficulties)
- In children it is often due to enlarged tonsils/adenoids, it is seen in up to 25% of children with Down's syndrome, obesity and sickle cell disease
- Rhinitis can contribute – see rhinitis guidance
- Treatment options: watchful waiting, medical management of rhinitis or operative management

RED FLAGS

- Acute difficulty in breathing/ cyanosis (**999**)
- History of sleep disordered breathing with evidence of daytime obstruction (noisy breathing - stertor) without signs URTI (**urgent referral via e-RS for consideration operative management)**



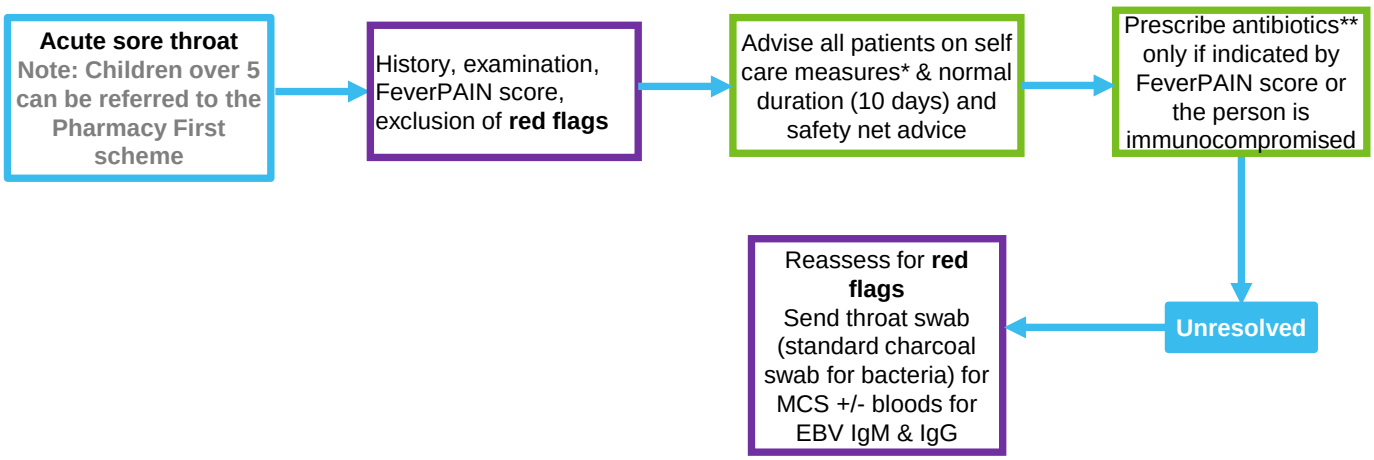
- References: Patient.info: Obstructive Sleep Apnoea in Children (12)

Sore throat

- Approx. 70% are viral and do not require or respond to antibiotics
- Approx. 82% resolve within 1 week without antibiotics and pain is only reduced by 16 hours. **Complications are rare**
- Use **FeverPAIN score** to decide if antibiotic prescription is necessary at all or if a delayed prescription can be considered
- It is common for tonsils to be large in children, they normally shrink in the teenage years/early adulthood
- Peri-tonsillar abscess (Quinsy) can be a complication of tonsillitis or occur spontaneously – requires admission – fever, severe sore throat, usually unilateral, unable to open mouth fully (trismus), "hot potato" voice, in advanced cases can cause drooling and airway compromise. Examination: (can be difficult due to trismus) extensive erythema, soft palate swelling, uvula deviated away from swelling
- Direct parents to: NHS sore throat

RED FLAGS

- Evidence of sepsis or difficulty in breathing (**999**)
- Suspected epiglottitis – sudden onset severe sore throat, stridor, drooling, systemically unwell (**Do not examine mouth, call 999**, nebulised adrenaline if available whilst waiting for ambulance)
- Unable to swallow any fluids (**refer to A&E**)
- Immunocompromised (including diabetics) (consider immediate antibiotics, review at 48hrs or admission if appropriate)
- Evidence of peri-tonsillar abscess (**call on-call ENT clinician** at local hospital via switch for same day assessment, if systemically unwell via **A&E**)
- Suspected retropharyngeal abscess – sore throat, drooling, reduced neck movement (**A&E**)
- Non-resolving symptoms, systemically unwell, neck stiffness, neck tenderness (signs of deep space neck infection, **refer to A&E**)
- Atypical prolonged symptoms: tonsillar mass, tonsillar ulceration either without classic infective symptoms or not resolved after antibiotics (consider **urgent e-RS referral** referral)
- Unexplained neck mass (see dedicated guideline)



Referrals for tonsillectomy for recurrent tonsillitis:
Please discuss tonsillectomy and if they wish to be put forward for surgery before you make a referral and outline the risks and recovery period – Patient information available from ENT UK ***

The NHS does not routinely fund tonsillectomy for recurrent tonsillitis except under the SIGN criteria:

1. Sore throats are due to acute tonsillitis
2. Episodes of sore throat are disabling and prevent normal functioning
3. 7 or more well documented episodes of significant sore throats in the preceding year (requiring treatment)
4. or 5 or more such episodes in each of the preceding 2 years
5. or 3 or more such episodes in each of the preceding 3 years

Tonsillectomy may be considered beneficial at a lower threshold after specialist assessment for certain people for whom recurrent tonsillitis poses a significant risk to their health :

- Acute and chronic renal disease resulting from acute bacterial tonsillitis
- As part of the treatment of severe guttate psoriasis
- Metabolic disorders where periods of reduced oral intake could be dangerous to health
- PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis)
- Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

Tonsillectomy is performed for other indications without these restrictions e.g. Sleep disordered breathing, sleep apnoea, febrile convulsions/ seizures/sickle crises (from recurrent tonsillitis), recurrent Quinsy/need for admission/IV antibiotics

- *self care – OTC paracetamol for pain/fever +/- ibuprofen, adequate fluid intake, there is some evidence for medicated lozenges, no evidence for non-medicated lozenges, mouthwashes or local anaesthetic spray on its own
- **Refer to NICE or local antibiotic guideline
- *** https://www.entuk.org/patients/conditions/59/tonsillectomy_taking_out_your_tonsils_because_of_repeated_infections_new
- *** https://www.entuk.org/patients/conditions/63/helping_you_decide_about_tonsil_surgery_for_your_child_new
- References: NICE CKS Sore Throat 2023 (13)

Swallowing / inhaled foreign bodies

RED FLAGS

- Acute swallowed foreign body - refer to A&E – **call 999**: **batteries / difficulty breathing / drooling / significant chest pain / cardiovascular unstable.**
- **First aid for button batteries** – call 999, for children over 12 months: can administer 10mls honey (2 teaspoons) every 10 minutes if available whilst waiting for ambulance, do not delay calling 999
- **Suspected airway FB** – presenting with history choking episode +/- respiratory distress or cyanosis, +/- ongoing cough or wheeze, rarely stridor (**999**)

- References: The use of honey in button battery ingestions: a systematic review (14)

Neck Lumps

- Common in children, most will be reactive lymph nodes however there is a wide differential diagnosis
- History/exam: onset, constant or fluctuates, one lump or multiple, anterior triangle/posterior triangle, any lumps in axillae, groins, any organomegaly spleen/liver, any illnesses (URTI/chest) or travel, any infected skin, any close contacts with TB, any B symptoms: night sweats, generalized itching, fatigue, weight loss, shortness of breath, petechial rash, hepato/splenomegaly
- Increased risk of malignancy: Persistent lymphadenopathy, single dominant node > 6weeks, supraclavicular / posterior triangle nodes, B symptoms
- **There is an existing SEL guideline from general paediatrics at the Evelina "General Paediatrics Management of Lymphadenopathy in Children" Please refer to this for lymphadenopathy**
- **Please discuss with ENT** if the neck lump is not thought to be a lymph node e.g. congenital lesion (thyroglossal duct cyst / branchial cyst / vascular abnormality) or originating from the thyroid. We would recommend discussion before investigations are organized in primary care

RED FLAGS

- Stridor, neck stiffness, drooling, trismus, systemically unwell/sepsis (**999**)
- Immunocompromised (including diabetics) (for infective pathology consider immediate antibiotics, review at 48hrs or admission via A&E if appropriate)
- An unexplained lump in the neck i.e. of recent onset or a previously undiagnosed lump that has changed over a period of 3 – 6 weeks, especially if B symptoms: night sweats, generalized itching, fatigue, weight loss, shortness of breath, petechial rash, organomegaly, household TB contact, any nodes >2cm, organomegaly, rubbery nodes, axillary/supraclavicular nodes (**Discuss with General Paediatrics for GSTT and KCH via Consultant Connect/switch, Lewisham & PRUH via switch**)
- Suspicious mass on imaging (refer to appropriate specialism)

- References: NICE CKS Neck Lumps 2020 (15)

Facial Nerve/Bells Palsy

- **Bells palsy** is idiopathic **Facial nerve palsy** with acute (onset < 72 hours), unilateral facial nerve palsy, usually with preceeding pain and a viral illness
- Most commonly occurs between 15-45 years old but can occur at any age
- Complications: corneal ulceration, dry mouth, abnormal facial contractions, sensitivity to loud noises, psychological
- Bells palsy is diagnosed by excluding other causes of Facial nerve Palsy
- **There are other causes of Facial nerve Palsies in Children** – such as: infections (e.g. ear infections, mastoiditis, meningitis, herpes zoster/chickenpox, lyme disease, parotitidits), head trauma, ENT conditions (in rare cases conditions such as cholesteatoma and cerebello-pontine angle tumours), neoplasm, central nervous system causes
- There is less evidence for the treatment of Bells Palsy in children than in adults
- Direct parent to: NHS Bells Palsy

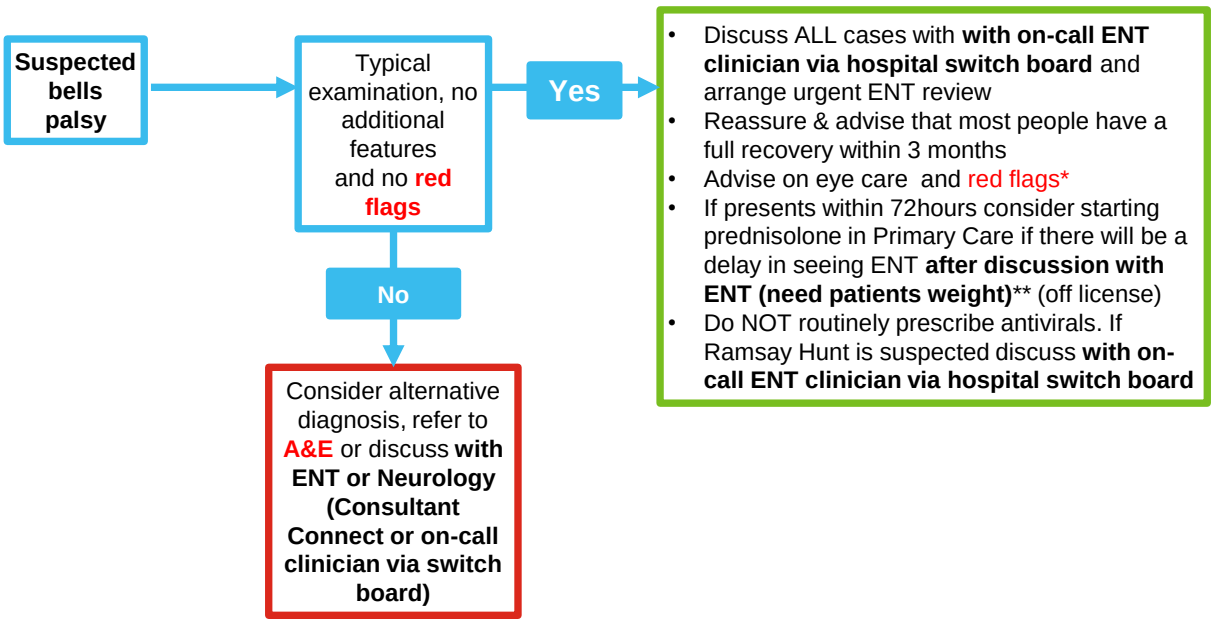
RED FLAGS

Call 999 if serious infection like meningitis is suspected or the child is presenting as unwell

Discuss with on-call clinician via hospital switch board (ENT or Neurology)

- refer to **A&E or call 999** if Nerve Palsy occurs after head trauma
- Otorrhea or signs of otitis media on examination
- abnormalities examining the head/neck e.g. mastoiditis/masses
- trauma preceding (including surgical)
- additional neurological signs
- evidence of cancer

- Vestibular or hearing abnormalities (other than hyperacusis)
- Diplopia
- Bilateral signs (suspect Lyme disease or sarcoidosis)
- Head or neck mass
- Frequent relapses
- Forehead sparing (suspect upper neurological cause)
- Vesicular skin rash (suspect Ramsay Hunt)
- Confusion
- Evidence of cholesteatoma (foul smelling otorrhoea and hearing loss)
- gradual onset or gradual progression
- Known cancer



- *eye care: over the counter lubricating eye drops (such as hyaluronate 0.1% or carmellose 1% eye drops) every 2 hours or more if needed. At night apply lubricating eye ointment (such as paraffin based eye ointment) and tape the eye closed. Dry eye symptoms persisting, **direct to local Minor Eye Condition Services (MECS)** Red Flags: red eye, painful eye, feeling something in eye, blurred vision, photophobia – advise to attend to **eye casualty ?corneal ulcer**
- ** if no contraindications. Unlicensed in Children for Bells Palsy & not on SEL Paediatric Formulary. Less evidence based than in adults. **Suggest discuss with ENT before starting.** Suggested dose: 1mg/kg up to 40mg for 10 days

References: NICE CKS Bells Palsy 2023 (16), NICE CKS Shingles 2024 (17)

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