South East London Integrated Care System

ENT Adult Primary and Secondary Care Interface Guidelines

November 2023

User Information:

Purpose:

- This Guideline 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 later using established communication channels such as **Consultant Connect** or **advice and guidance** (in some areas A&G has been replaced by single point of referral on ERS). If there is no local clinician available via Consultant we recommend contacting the on-call clinician via the local hospitals switch board
- **Prescribing:** All prescribing should be in line with the SEL Joint Medicines Formulary. Please refer to the BNF, Summary of Product Characteristics and local antibiotic guidelines for any drug considered, particularly in pregnancy and Breastfeeding
- The IMOC Guideline Allergic Rhinitis (2019) is replaced by this Guideline

Authors & Governance:

This guide has been produced utilising published guidance and in collaboration with clinical and non-clinical staff across the Acute Provider Network (South East London's Secondary Care providers), South East London Integrated Care Board, South East London Integrated Medicines Optimisations Committee (IMOC) and has undergone Primary Care review through the LMC, Planned Care Leads, Primary Care Bulletin and Secondary Care review through ENT Consultants at each trust and Neurology Consultant input where relevant.

This guide was a collaborative effort from the above parties, led by Dr Alexandra Armstrong (GP) and Mr Antonio Aymat (ENT Consultant), the SEL ICB ENT leads.

This guide has been 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 SLN, Planned Care 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

Glossary of terms

A&E – Accident & Emergency (/Emergency Department)
ICB – Integrated Care Board
OTC – over the counter
POM – Prescription only Medication
SEL – South East London
2ww – Two Week Wait Suspected Cancer

Version	Date signed off	Date of next review
1	October 2023	October 2025

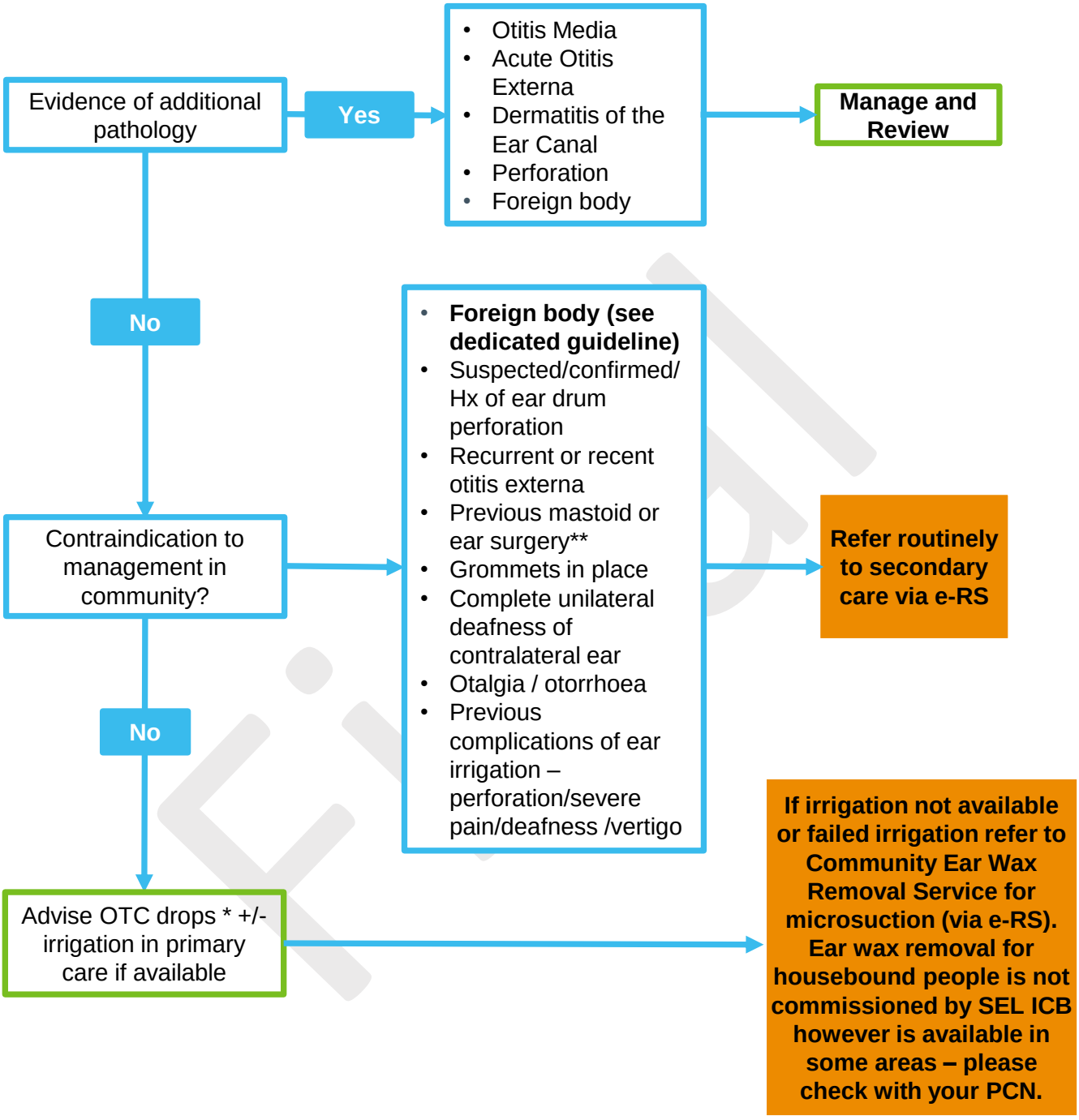
Table of contents

Version	Date signed off	Date of next review
V0.1		

Final

Ear Wax

Ear wax only needs to be removed if causing symptoms or if the tympanic membrane needs to be visualised
Advise not to use cotton buds, to avoid recurrence continue olive oil drops twice weekly



Self care advice: https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/
*Ear drop choice: Olive oil or Sodium Bicarbonate. Both TDS for 3-5 days. Olive oil may take up to 2 weeks to soften. Side effects: transient hearing loss, discomfort, dizziness, skin irritation. **ear surgery: excludes cosmetic pinna surgery & grommets which have been extruded for more than 2 years AND the individual has been discharged from secondary care

References: SEL Treatment Access Policy 2022 (1), NICE CKS Earwax (2), SEL Community Ear Wax removal referral criteria (3)

Foreign Body of the Ear or Nose

RED FLAGS

- Foreign body in the Nose = in an airway, therefore should be seen in **A&E**
- If it is a battery consider if need to call **999 (button batteries swallowed / inhaled can cause serious burns < 2 hours**)(First aid for button batteries – swallow 10mls honey if available whilst waiting for ambulance, do not delay calling 999)
- Foreign Body in Ear **speak to on-call ENT** via switch board/Consultant Connect for review (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

Final

Otalgia

Local pathology:

- Otitis Media/Otitis Externa/**Foreign Body**/Trauma/Wax/skin conditions/**mastoiditis**/eustachian tube dysfunction
- Referred pain:
- TMJ/Salivary gland disease/Dental abscess/Sinus inflammation/Tonsillitis /**peri-tonsillar abscess**/trigeminal neuralgia/ Cervical spine disease/oesophageal reflux/foreign body/atypical migraine/ **rarely Cancers**: oropharyngeal/laryngeal/nasal
- Treat underlying cause, if does not resolve this is persistent otalgia and consider **2ww Head and Neck** (see below)
- If no identifiable cause advise analgesia, review after 1-2 weeks and then refer **2ww Head and neck** if non-resolved & unexplained

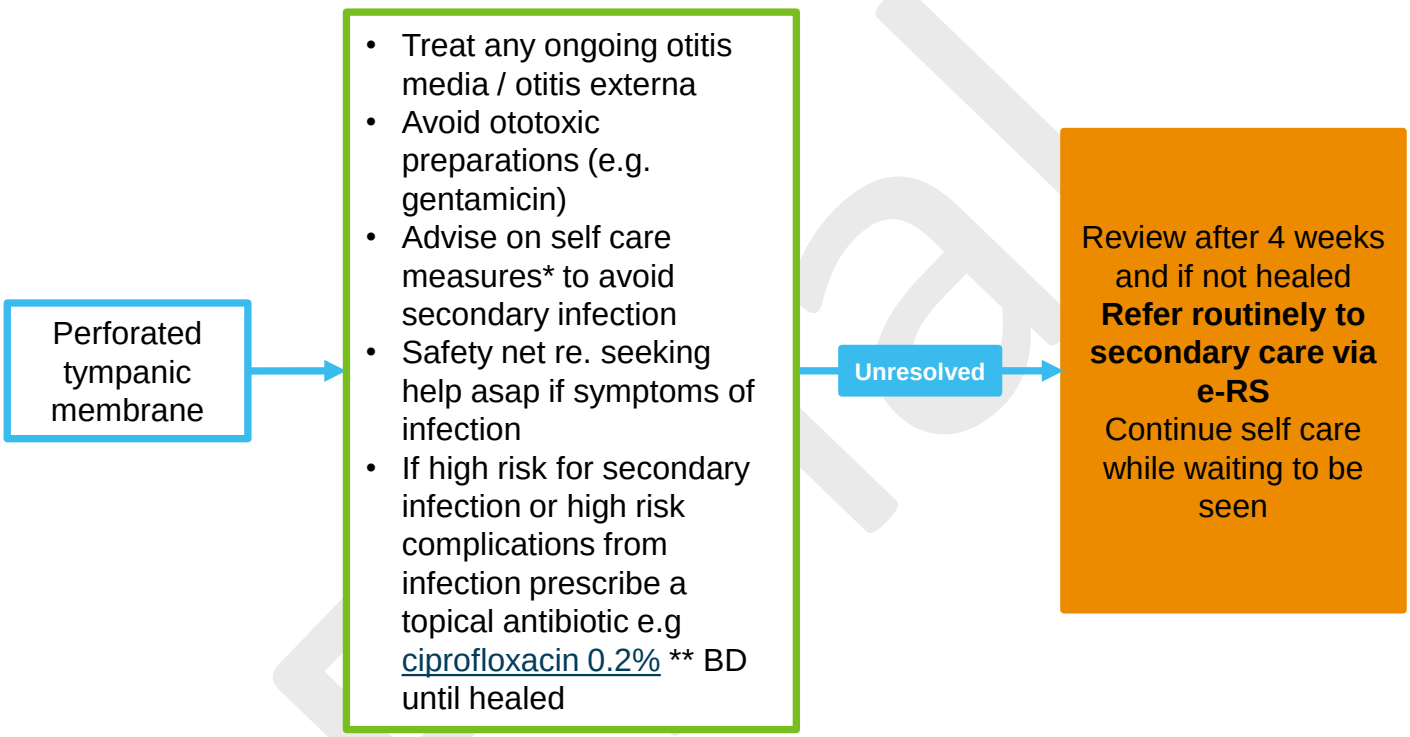
RED FLAGS

- Persistent unilateral otalgia in the absence of localised ear findings (**2ww Head and Neck** – for laryngeal cancer: otalgia ≥ 40 years old for ≥ 3 weeks; for Ear/Nose/Sinus cancer the Pan-London 2ww criteria does not specify time frame or age – use clinical judgement and discuss if unsure, consider RFx such as smoking/alcohol/immunocompromise)
- Suspected Mastoiditis: Mastoid swelling/erythema/tenderness/bogginess **speak to on-call ENT** (switch board/Consultant Connect) for same day assessment **or via A&E** if unstable
- Peri-tonsillar abscess **speak to on-call ENT** (switch board/Consultant Connect) for same day assessment **or via A&E** if unstable
- Weight loss, persistent voice change, lymphadenopathy, neck mass, dysphagia – **2ww to appropriate specialist** – (Head and neck/Gastroenterology/Haematology/unknown primary)

References: Pan-London urgent Suspected cancer referral forms (4)

Tympanic Membrane Perforation

- Secondary to Otitis Media, Trauma, Barotrauma, Surgical
- **>90% heal within 4 weeks** & Hearing loss usually recovers once healed
- If high risk for secondary infection or high risk complications from infection prescribe a topical antibiotic e.g ciprofloxacin unit dose ear drops 0.2% ** BD until healed



- *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/

- **ensure no allergies. Note this is off-label usage and the BNF / 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

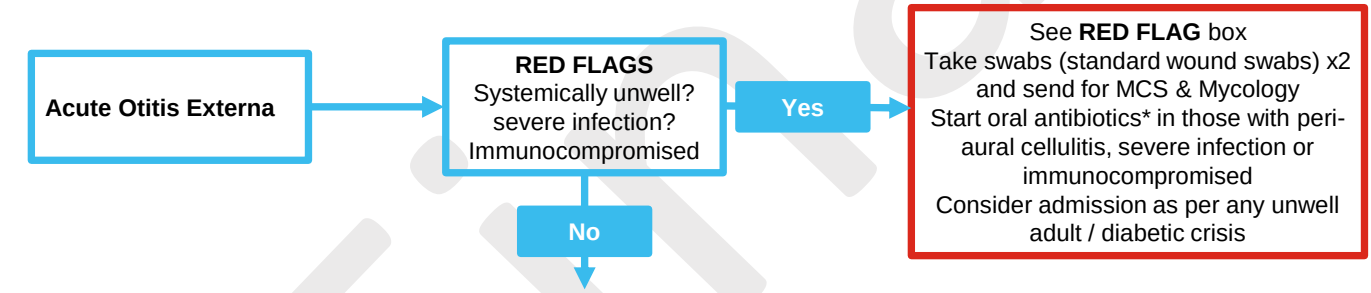
Ear Discharge & Otitis Externa 1 of 2 (Acute Otitis Externa)

- Discharge can be: discharging wax (normal), discharging ear drops, infection – pus/mucous/blood (otitis externa or media +perforation), **CSF Leak** – clear/blood stained (trauma or surgery), **Cholesteatoma**
- Otitis Externa can be: Acute or Chronic. Bacterial or Fungal
- 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

- Suspected necrotising (malignant) otitis externa: Older than 50 or immunocompromised (including diabetes) presenting with Otitis externa +/- severe ear pain +/- Cranial Nerve Palsy +/- offensive discharge +/- failed treatment x2 for otitis externa +/- peri-aural cellulitis **speak to on-call ENT** (switch board/Consultant Connect) for same day review
- Discharge following head trauma or cranial surgery (**refer to A&E** for consideration CT Head)
- Foreign Body in Ear Foreign Body in Ear/Nose **A&E as an emergency: for batteries in nose**, **speak to on-call ENT** switch board/Consultant Connect to organise review (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: 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 (referral to ENT via e-RS)



Mild cases e.g, minimal erythema, no significant discharge or canal narrowing: OTC acetic acid 2%
Moderate e.g. erythema, discharge: Topical Antibiotics*
Canal narrowing or significant itch/pain: Combination treatment: Topical Antibiotics + topical steroid*

Unresolved

Reassess for features of severe infection or red flags
Send Swabs x 2 (standard wound swabs) – MCS and Mycology & rationalise treatment
Consider discussion with **on-call ENT** if would benefit from microsuction
Consider necrotising otitis externa
Review adherence and consider changing formulation e.g. if difficulty administering drops, consider spray

*Follow local or NICE Antibiotic Guidelines

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 (5)

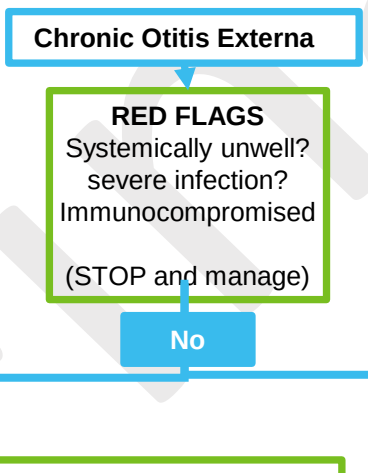
Ear Discharge & Otitis Externa 2 of 2 (Chronic Otitis Externa)

- 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**
- Otitis Externa can be: Acute or Chronic. Bacterial or Fungal
- 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 2% after swimming

https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/

RED FLAGS

- Suspected necrotising (malignant) otitis externa: Older than 50 or immunocompromised (including diabetes) presenting with Otitis externa +/- severe ear pain +/- Cranial Nerve Palsy +/- offensive discharge +/- failed treatment x2 for otitis externa +/- peri-aural cellulitis **speak to on-call ENT** (switch board/Consultant Connect) for same day review
- Discharge following head trauma or cranial surgery (**refer to A&E** for consideration CT Head)
- Foreign Body in Ear Foreign Body in Ear/Nose **A&E as an emergency: for batteries in nose**, **speak to on-call ENT** switch board/Consultant Connect to organise review (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: 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 (referral to ENT via e-RS)



- **Consider Fungal Infection:** especially if intense itch, **swab and treat**: topical* antifungals – Can treat empirically whilst waiting for swab results if classic appearances: candida: off white. Aspergillus – fungal hyphae in canal – yellow/grey/black.
- Manage Risk Factors.
- Consider **testing for diabetes**
- Manage skin conditions & consider routine referral to Dermatology
- Consider **Cholesteatoma**

Consider **seeking advice and guidance +/- routine referral via e-RS** if no red flags, does not require urgent treatment, not more appropriate to refer to Dermatology and if there is a failure to respond to bacterial / fungal treatment in Primary care

*such as clotrimazole 1% solution applied 2–3 times a day, to be continued for at least 14 days after infection has resolved. Oral antifungals can be considered in confirmed cases which do not respond to topical treatment – use clinical judgement and consider discussion with micro.

If Otitis Media with perforation is suspected (acute pain which is suddenly relieved followed by ear discharge) treat as per dedicated guidelines 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

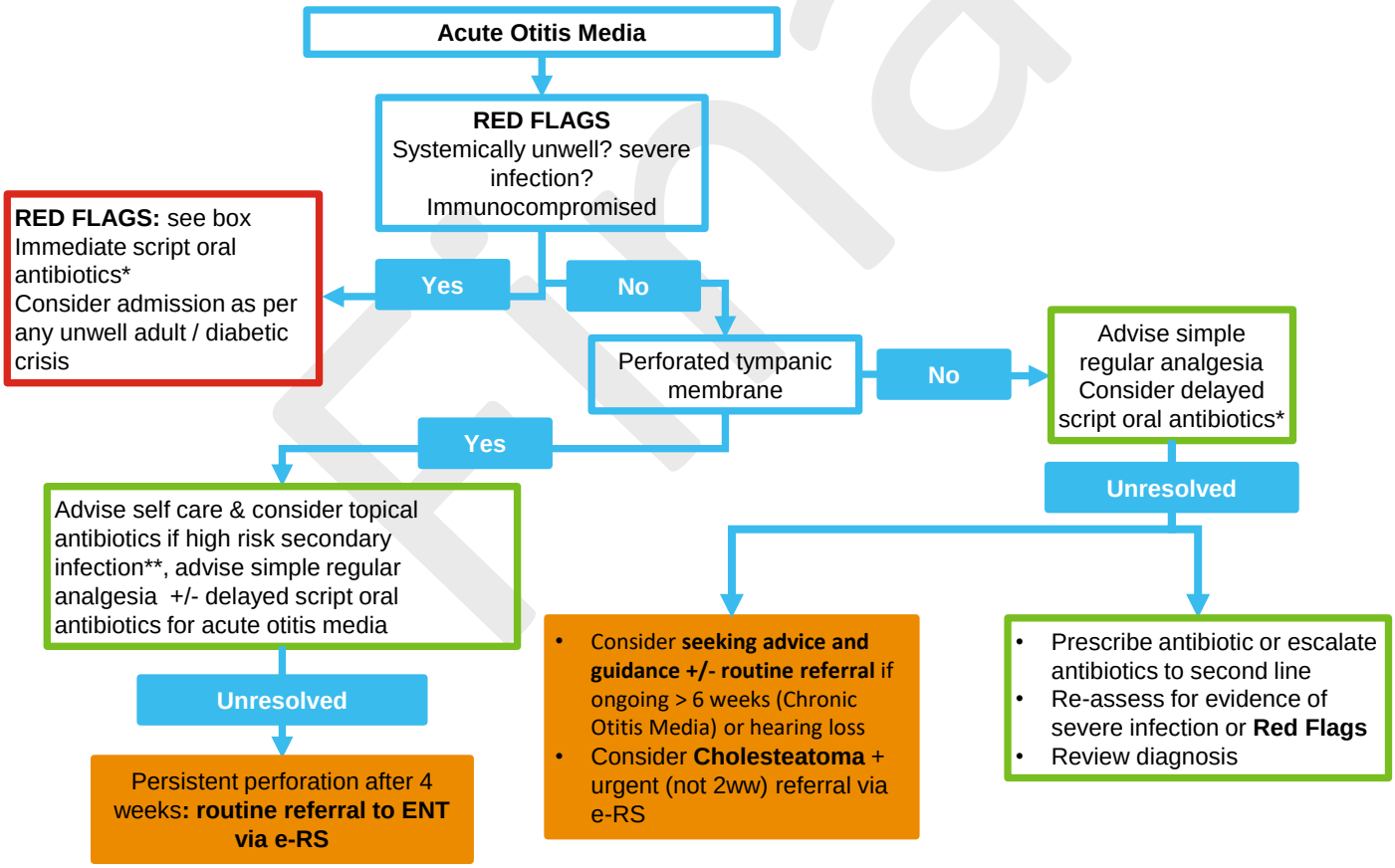
References: NICE CKS Otitis Externa (5)

Otitis Media 1 of 2

- **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
- Complications: chronic suppurative otitis media, hearing loss (no evidence that antibiotics prevent), perforation, mastoiditis (mostly children), meningitis, intracranial abscesses, sinus thrombosis, facial nerve palsy
- Risk Factors: Smoking
- **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 **speak to on-call ENT** (switch board/Consultant Connect) for same day assessment **or via A&E** if unstable
- Suspected complications: severe pain, severe headache, meningism, evidence of sepsis, facial nerve palsy or abnormal neurological examination (**refer to A&E** for consideration of IV antibiotics and Imaging)
- Visible nasal mass (**2ww Head and Neck**) or if suspected nasal mass (e.g. unexplained persistent unilateral nasal blockage / bloodstained or offensive nasal discharge) consider discussing with **ENT via A&G** for urgent review / referring outside of 2ww criteria
- Discuss with **ENT via A&G** for urgent review / referring outside of **2ww Head and Neck** criteria: recurrent or non-resolving otitis media with symptoms between episodes/ with persistent cervical lymphadenopathy/Unexplained persistent otitis media with effusion
- Suspected Cholesteatoma: Usually originates at the top, inner edge of the tympanic membrane as a retraction/keratinous build up +/- discharge into the canal (**Urgent [not 2ww]** referral via e-RS)



- *Follow local or NICE Antibiotic Guidelines or NICE.
- **see dedicated guideline on Tympanic Membrane Perforation (slide 7)
- References: NICE Otitis media (acute): antimicrobial prescribing (6); NICE Otitis Media (acute) (7); Pan-London urgent Suspected cancer referral forms (4); NICE CKS Head and neck cancers (8)
- Self-care https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/

Otitis Media 2 of 2

Recurrent Acute Otitis Media

- Consider discussion with ENT for **urgent review** / e-RS referral outside of 2ww referral Head and Neck **if suspicious** of nasopharyngeal cancer

- Consider **seeking advice and guidance +/- routine referral** if there is a craniofacial abnormality, if episodes are distressing or unexplained
- Seek advice by **speaking to on-call ENT** (switch board/Consultant Connect) if tympanostomy tube in situ and send MCS swab

Otitis Media with effusion

- If acutely following Viral Upper Respiratory Tract infection watchful waiting for 2-4 weeks is appropriate
- Please note evidence base is limited for medical treatment, NICE advocate for watchful waiting or surgery in non-resolving cases
- As ongoing symptoms are likely to be due to: Impaired eustachian tube function causing poor aeration of the middle ear, Low-grade viral or bacterial infection or Persistent local inflammatory reaction we believe it is reasonable to trial:
- Advise on auto-inflation 3 times a day for 1-3 months. Can buy a device over the counter or attempt to blow up a balloon with each nostril in turn.
- Nasal decongestants (e.g. Xylometazoline 0.1%)TDS for 1 week max (warn about developing a reliance and worsening symptoms if overuse)
- Trial of nasal steroids for 8 weeks see SEL formulary for options: e.g fluticasone or mometasone
- Consider one off course of oral antibiotics*

- Consider **seeking advice and guidance +/- routine referral** ongoing > 6 weeks

- *Follow local or NICE Antibiotic Guidelines or NICE guidelines for Upper Respiratory Tract infections – Otitis Media
- References: NICE Otitis media (acute): antimicrobial prescribing (6); NICE Otitis Media (acute) (7); Pan-London urgent Suspected cancer referral forms (4); NICE CKS Head and neck cancers (8)

Final

Hearing Loss

- History: Acute/gradual? Unilateral/bilateral? Associated features: tinnitus/vertigo, popping/clicking, otalgia, discharge, history of infection, Family History
- It can be difficult to differentiate between sensorineural hearing loss and conductive hearing loss. **Treat unilateral unexplained hearing loss as sensorineural**
- Conductive Hearing Loss differential diagnosis: wax, perforation, **foreign body**, otitis media with effusion, otosclerosis, **cholesteatoma**, **necrotising (malignant) otitis externa,** rarely **glomus tumour**
- Sensorineural Hearing Loss (SNHL) differential diagnosis : presbycusis, **vestibular schwannoma (acoustic neuroma)**, noise induced, after cerebral infection, **sudden SNHL**, labyrinthitis, Meniere's, ototoxic drugs/toxins, infections: meningitis, Ramsay Hunt syndrome, mumps

RED FLAGS

- Suspected Cholesteatoma: Usually originates at the top, inner edge of the tympanic membrane as a retraction/keratinous build up +/- discharge into the canal (**Urgent** [not 2ww] referral via e-RS)
- Suspected vestibular schwannoma (acoustic neuroma): Unexplained constant unilateral tinnitus > 6 weeks (referral to ENT)
- Foreign Body in Nose= airway, **refer to A&E**, consider **999 if a battery.** All other foreign bodies **speak to on-call ENT** (switch board/Consultant Connect) do not try and manipulate without specialist equipment or training) Cover with oral antibiotics if evidence of cellulitis whilst waiting to be seen

Sudden Unilateral Hearing Loss (hearing loss that develops within <72 hours) → **RED FLAG symptom** If no clear cause e.g **Foreign body**/ acute otitis media (see dedicated guidelines) **speak to on-call ENT** (switch board/Consultant Connect) for urgent review & start treatment: Prednisolone 1mg/kg up to 60mg OD for 10 days with PPI cover. If evidence of herpetic infection and presentation < 72 hours start Aciclovir as per NICE shingles guidance

Unilateral Hearing Loss with neurology → **RED FLAG symptom** neurological signs e.g. severe headache, cranial nerve involvement, motor/sensory deficit of limb or face, convulsions, severe nausea/vomiting/instability, very sudden onset (**refer to A&E or call 999 if acute stroke** suspected – please note hearing loss is not a common stroke symptom, use clinical judgement or call the local stroke team for guidance)

Rapidly worsening hearing loss → Rapidly worsening hearing loss (Seek advice from ENT via **advice and guidance or speak to on-call ENT** Consultant Connect/telephone, normally needs ENT assessment <2 weeks)

Gradual Unilateral Hearing Loss → History and examination Exclude **Red Flags**

- → Unexplained gradual unilateral hearing loss → Normally pathological and requires **routine referral to ENT via e-RS** if no **Red Flag** features (onset <72 hours is a Red Flag). **Safety net advice**: acute worsening or additional symptoms
- → Clearly visible pathology suggesting conductive cause → Treat any **Foreign Body**, Excessive wax, Infection, perforation*, Otitis Media with effusion * → After 4 weeks **refer to ENT routinely via e-RS** **Safety net advice**: acute worsening or additional symptoms

Gradual bilateral Hearing Loss →

- Can be difficult to differentiate between Conductive & Sensorineural
- Gradual: wax / otitis media with effusion / presbycusis / noise induced / ototoxic drugs / Otosclerosis
- Acute: **Red Flag**, unless consistent with Otitis Media with effusion*, **speak to on-call ENT** (switch board/Consultant Connect) for urgent review
- Treat any underlying cause. Assess for **Red Flags**.

→

- After 4 weeks if unresolved: **refer directly to audiology** (Community provider in SEL via e-RS).
- **If less than 55 please also consider if a direct refer to ENT routinely via e-RS**

- *see dedicated Guideline (slide 11 Otitis Medea slide 2 of 2)
- For more detail please consider referring to the RCGP Deafness and hearing loss toolkit https://elearning.rcgp.org.uk/mod/book/view.php?id=12532

References: NICE CKS Hearing loss in Adults (10); RCGP deafness and hearing loss toolkit (11)

Vertigo 1 of 3

Traditionally we have considered Vertigo (vestibular/neurological) & dizziness (cardiovascular/ systemic/medications) to be separate. For some patients this is helpful, for others (especially when there is co-morbidity/older adults) it is not– history should focus on **timing and triggers.** There can also be overlap between the two. Vertigo – motion/rotatory/spinning/nystagmus. Syncope/pre-syncope –lightheaded/faint/giddy. Always consider **red flags & rule out significant cardiac pathology**

For people presenting with suspected vertigo:

1. perform a neurological + HINTS exam (if meeting criteria- see table below and consider watching a video online if unfamiliar as parts of the exam are counter intuitive)
2. ENT exam + Dix-Hallpike to assess for BPPV. If Dix-Hallpike is negative manage as for acute unilateral vestibulopathy
3. Cardiovascular exam – pulse, murmurs, sitting/standing BP

All central causes (Abnormal neuro exam or HINTS positive) need urgent neurological assessment.
If stroke within 4 hours is suspected **call 999** or if more than 4 hours with local stroke team.
If stroke is not suspected speak with on-call neurologist/ admit if necessary or refer 2ww neurology if meeting criteria

Recurrent Vertigo:

1. BPPV Is the commonest cause, suspect if short episodes (less than 1 min) triggered by head movement in the vertical plane (Dix Hallpike)
2. Vestibular migraine is the second commonest cause – suspect if longer episodes, spontaneous or with recognized migraine triggers
3. Vascular causes are rare – suspect if any associated neurological features or high vascular risk
4. Other causes to consider – if triggered by exertion/recognized syncopal triggers, other cardiac symptoms e.g. chest pain/palpitations

Chronic dizziness/imbalance: consider **referral to ENT MDT Balance clinic via e-RS** if neurological & cardiac causes excluded or considered unlikely (dedicated referral form)

RED FLAGS

- Severe headache, cranial nerve involvement, motor/sensory deficit of limb or face, convulsions, severe nausea/vomiting/instability, sudden onset (**refer to A&E or call 999 if acute stroke suspected <4 hours onset**)
- Suspected stroke (posterior circulation symptoms – vertigo, severe imbalance, limb weakness, slurred speech, double vision, headache, nausea/vomiting) (**999 if <4 hours or A&E/discuss with stroke on-call**)
- New-onset persistent headache or prolonged, severe vertigo (suspect central cause, discuss with Neurology, **refer to A&E** in an emergency)
- Head injury preceding vertigo/head or other significant injury as a result of severe vertigo/Loss of Consciousness (**refer to A&E**)
- Cardiovascular risk factors or FHx Sudden cardiac death (consider cardiac causation e.g. acute ischaemia, arrhythmia, follow appropriate guidelines, discuss with cardiology or **call 999** in an emergency)
- Sudden unilateral hearing loss (occurring in under 72 hours). See dedicated guidance (new onset unilateral hearing loss and vertigo – **consider possibility of a stroke**)

HINTS exam to distinguish between peripheral and central causes of acute vestibular symptoms exam when:

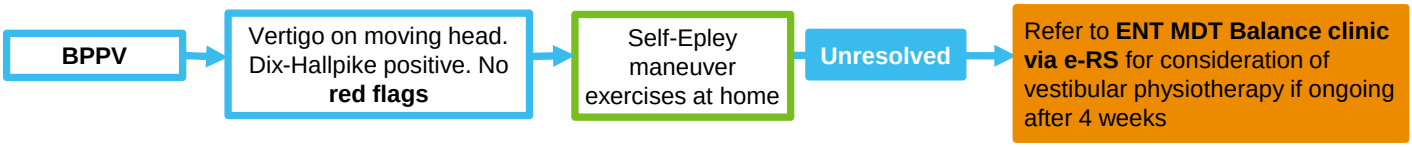
1. **normal neurological exam (other than nystagmus)**
2. **current, constant vertigo over hours or days**
3. **nystagmus**

	Peripheral Vertigo	Central Vertigo
Head impulse test	Abnormal: corrective saccade to midline with rotation of head	Normal; no corrective saccade
Nystagmus	Unidirectional: horizontal	Horizontal & direction changing; vertical; torsional
Test of Skew	No skew deviation	Skew deviation present

- * HINTS exam – if not familiar with this please consider watching a video online as can be counterintuitive (e.g. abnormal head impulse is a sign of peripheral disease)

References: NICE CKS Vestibular neuronitis (12); NICE CKS Meniere's disease (13)

Vertigo 2 of 3



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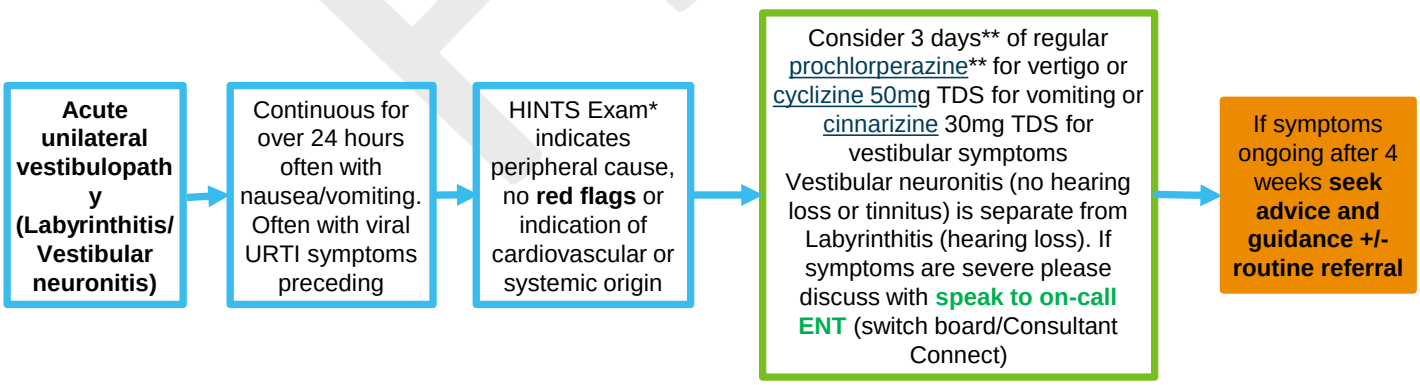


- * HINTS exam – if not familiar with this please consider watching a video online as can be counterintuitive (e.g. abnormal head impulse is a sign of peripheral disease)
- **Courses 3-7 days, standard release 5mg PO TDS (max 30mg daily dose). Buccal prochlorperazine can be considered in nausea/vomiting. If cases are mild consider no drug treatment as this can prolong symptoms by delaying physiological compensatory mechanisms. Long term courses are not recommended as they lead to dependence and do not have an evidence base

References: NICE CKS Vestibular neuronitis (12); NICE CKS Meniere's disease (13)

Vertigo 3 of 3

Meniere's (see box below) → Episodic attacks vertigo/tinnitus/ SN hearing loss. Fullness/pressure → Unless having an attack examination is often normal → Diagnosis made in secondary care when there is a clear episodic history over time **. Initial presentation may need to be assessed for stroke (if acute unilateral hearing loss and vertigo) Seek advice if unclear..**Exclude red flags.**
Recurrent attacks to be considered for intratympanic treatment

- **Meniere's is an uncommon cause of vertigo.** Attacks last 20 mins – 12 hours. Attacks are often clustered. Symptoms include: Fluctuating hearing loss, perception of aural fullness, tinnitus (not necessarily at the same time as vertigo). As the disease progresses the tinnitus and hearing loss may become more continuous. May be unilateral or bilateral. There may be residual unsteadiness for days after an acute vertigo attack. Diagnosis requires definitive history and **suspected early cases (e.g. less than 3 episodes) should be managed in primary care** until the history is clear. ENT review is required to confirm diagnosis- **routine referral via e-RS**

Vestibular Migraine → Most common cause of non-positional recurrent vertigo attacks → Examination is usually normal +/- classic migraine history

First Episode

Suggest **A&E / Ambulatory emergency clinic (AEC) where available**

Discussion with **on call Neurologist** via Consultant Connect/switch board according to severity and any **red flags**

Future episodes can be managed in primary care with prochlorperazine** for vertigo plus standard migraine management for acute attacks / prophylaxis

Consider referral to **referral to ENT MDT Balance clinic via e-RS** if symptoms persist between attacks or are poorly controlled on migraine prophylaxis

- * HINTS exam – if not familiar with this please consider watching a video online as can be counterintuitive (e.g. abnormal head impulse is a sign of peripheral disease)
- **Courses 3-7 days, standard release 5mg PO TDS (max 30mg daily dose). Buccal prochlorperazine can be considered in nausea/vomiting. If cases are mild consider no drug treatment as this can prolong symptoms by delaying physiological compensatory mechanisms. Long term courses are not recommended as they lead to dependence and do not have an evidence base

References: NICE CKS Vestibular neuronitis (12); NICE CKS Meniere's disease (13)

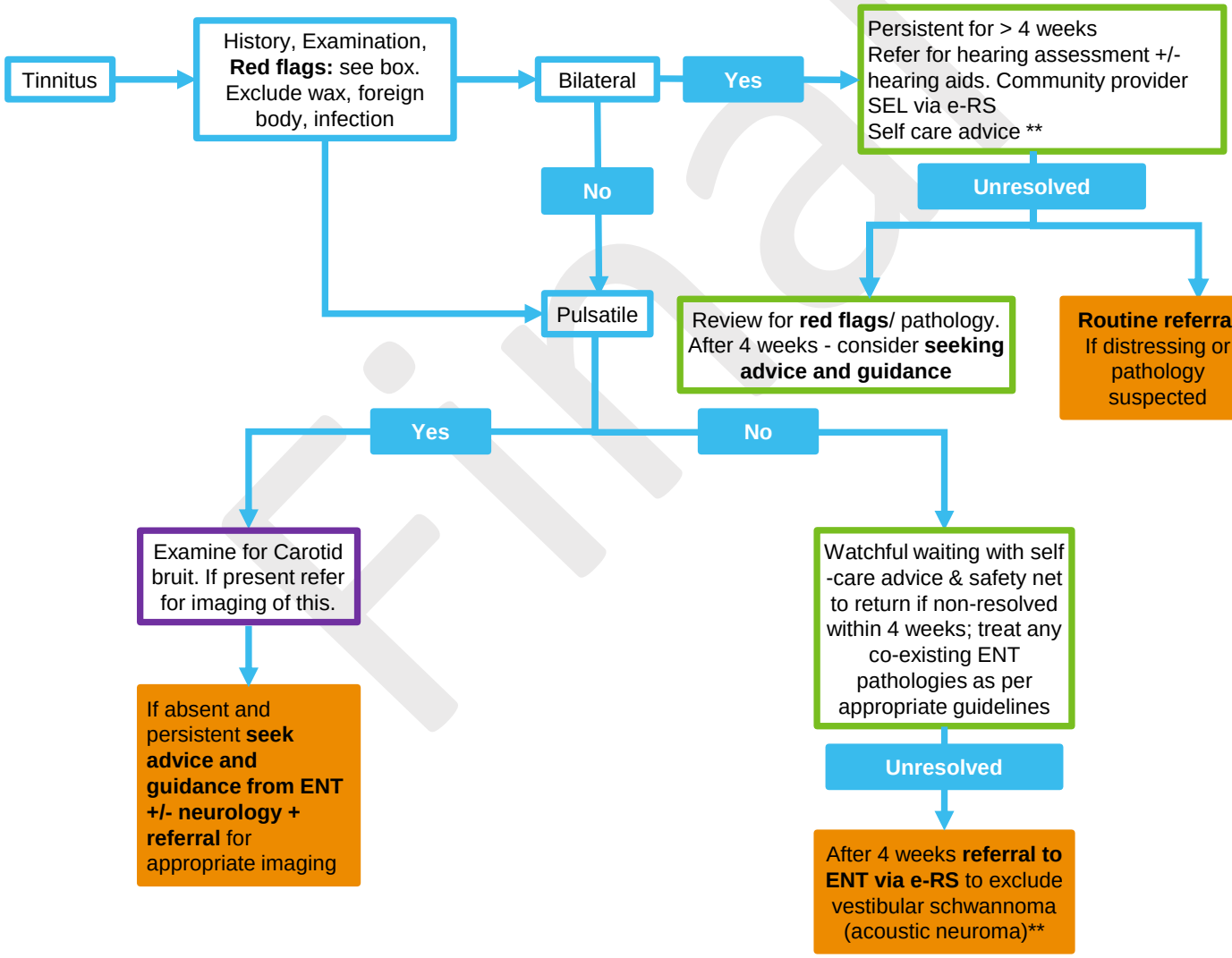
Final

Tinnitus

- Is a symptom and is experienced differently. Ringing / hissing / roaring / clicking / buzzing / pulsing / humming / whistling
- Confirm history: Unilateral/bilateral. Associated features. Constant or episodic. How long does each episode last. Review medications and relationship to onset.
- Examination: ear, cranial nerves, carotid bruits (murmur if pulsatile tinnitus)
- Impact on quality of life – sleep, concentration, mental health, suicidality
- Pulsatile tinnitus = beating with heart. If constant/frequent it requires imaging. DDx: atherosclerosis, A-V malformations. Tumours. Pagets disease. Otosclerosis. Idiopathic intracranial hypertension

RED FLAGS

- Suicidal ideation or at risk of suicide (previous attempts, insomnia, history severe mental illness). Refer to mental health services. **999** if immediate danger. Make a crisis plan * refer for **urgent ENT review via e-RS** / **discuss with on-call ENT**
- Significant vestibular symptoms (see Vertigo guidelines)
- History of head trauma preceding onset of tinnitus (**refer to A&E**)
- Sudden onset or fluctuating hearing loss or sudden deterioration in hearing (see Hearing loss guideline)
- Unilateral pulsatile tinnitus which is continuous/persistent without obvious cause **speak to on-call ENT** (switch board/Consultant Connect)
- Neurological symptoms/signs. Evaluate for intracranial pathology (discuss with neurology via **Consultant Connect/on-call via switch**)
- Suspected vestibular schwannoma (acoustic neuroma): Unexplained constant unilateral tinnitus > 6 weeks (Urgent [not 2ww] referral to ENT)



- * Crisis support services: Should contact own GP in-hours. Out of hours helplines: SANEline, Samaritans, SLAM crisis line 0800 731 2864 and choose option 1. Crisis information available from SLAM in different languages: https://slam.nhs.uk/crisis/. **Advise to call 999 or go to A&E if in immediate danger**. The Listening Place is a suicide prevention charity which usually requires a self-referral for face to face support: https://listeningplace.org.uk/
- ** self care advice & support services – https://www.tinnitus.org.uk/ or https://rnid.org.uk/information-and-support/tinnitus/
- ** vestibular schwannoma (acoustic neuroma)s are rare and slow growing and are therefore not a 2ww referral

References: NICE CKS Tinnitus (14)

Eustachian Tube Dysfunction

- Usually causes mild-moderate intermittent symptoms, can be unilateral but usually bilateral
- Can be associated with infection (current or recent), nasal inflammation (allergies or sinus issues), smokers, acid reflux, nasal blockage – deviated septum, large polyps, (rarely) cancer, scarring post-operative or post-radiotherapy
- Symptoms: Reduced or muffled hearing / pressure / fullness / popping / crackling / intermittent discomfort/ tinnitus / abnormal sound own voice / feeling slightly off balance/ dizzy (for dizziness this is a diagnosis of exclusion – please exclude other pathologies such as cardiac/systemic)
- Examination may show: inflamed nasal mucosae consistent with infection/inflammation, dull non-motile tympanic membranes (ask to gently perform Valsalva maneuver while examining)
- Typically worsened by changes in pressure or altitude e.g. flying or scuba diving

RED FLAGS

- Visible nasal mass (**2ww Head and Neck**) or if suspected nasal mass (e.g. unexplained persistent unilateral nasal blockage / bloodstained or offensive nasal discharge) consider discussing with **ENT via A&G** for urgent review / referring outside of 2ww criteria
- Discuss with **ENT via A&G** for urgent review / referring outside of 2ww Head and Neck criteria: recurrent or non-resolving otitis media with symptoms between episodes/ with persistent cervical lymphadenopathy/Unexplained persistent otitis media with effusion
- Suspected vestibular schwannoma (acoustic neuroma): Unexplained constant unilateral tinnitus > 6 weeks (Urgent [not 2ww] referral to ENT)
- Unilateral pulsatile tinnitus which is continuous/persistent without obvious cause **speak to on-call ENT** (switch board/Consultant Connect)
- Sudden onset or fluctuating hearing loss or sudden deterioration in hearing (see Hearing loss guideline)
- Any severe symptoms are not consistent with Eustachian Tube Dysfunction, refer to appropriate guidelines

Suspected Eustachian Tube Dysfunction

→ History, examination (including nasal passageways), exclusion of **Red Flags**

→
- Treat underlying cause:
- Viral URTI - watchful waiting, self-care advice *
- Otitis Media – refer to guideline
- Allergic Rhinitis – refer to guideline
- Sinusitis – refer to guideline
- Consider managing any co-existing acid reflux

Unresolved

- Reassess for **Red Flags**
- Consider short course of nasal or oral decongestants 1 week only **
- Self care advice to be continued
- Consider 8 week trial of nasal steroids***

Unresolved

Seek advice and guidance via e-RS +/- routine referral

- Self care advice*:
- Yawning or opening mouth widely, swallowing whilst pinching nostrils.
- Valsalva maneuver: take a deep breath, pinch your nose and close your mouth, and gently pop your ears, for 10-15 seconds, repeat as needed. Over the counter devices can be bought to do this - Auto-inflation devices e.g. such as the Otovent. Doing it too forcefully can perforate the tympanic membrane
- Salt water rinses once a day – twice a day
- Flying: can buy OTC earplugs which aim to equalise pressure, can use nasal decongestant sprays 30 mins before flying, continue valsalva maneuver, chewing gum/sucking a sweet
- Diving: avoid when suffering with blocked Eustachian tubes as risk perforation of the tympanic membranes

https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/

- ** nasal decongestants (e.g. xylometazoline) should only be used continuously for one week. Longer courses risk worsening symptoms and reliance on decongestant. Oral decongestants e.g. pseudoephedrine or phenylephedrine may not be as effective however they do not lead to rebound nasal congestion on withdrawal.
- *** 1st line are intranasal mometasone or fluticasone
- References: Pan London Urgent Suspected Cancer Referral forms (4); NICE CKS. Head and Neck cancers – recognition and referral (8); NICE CKS Otitis media with effusion (15)

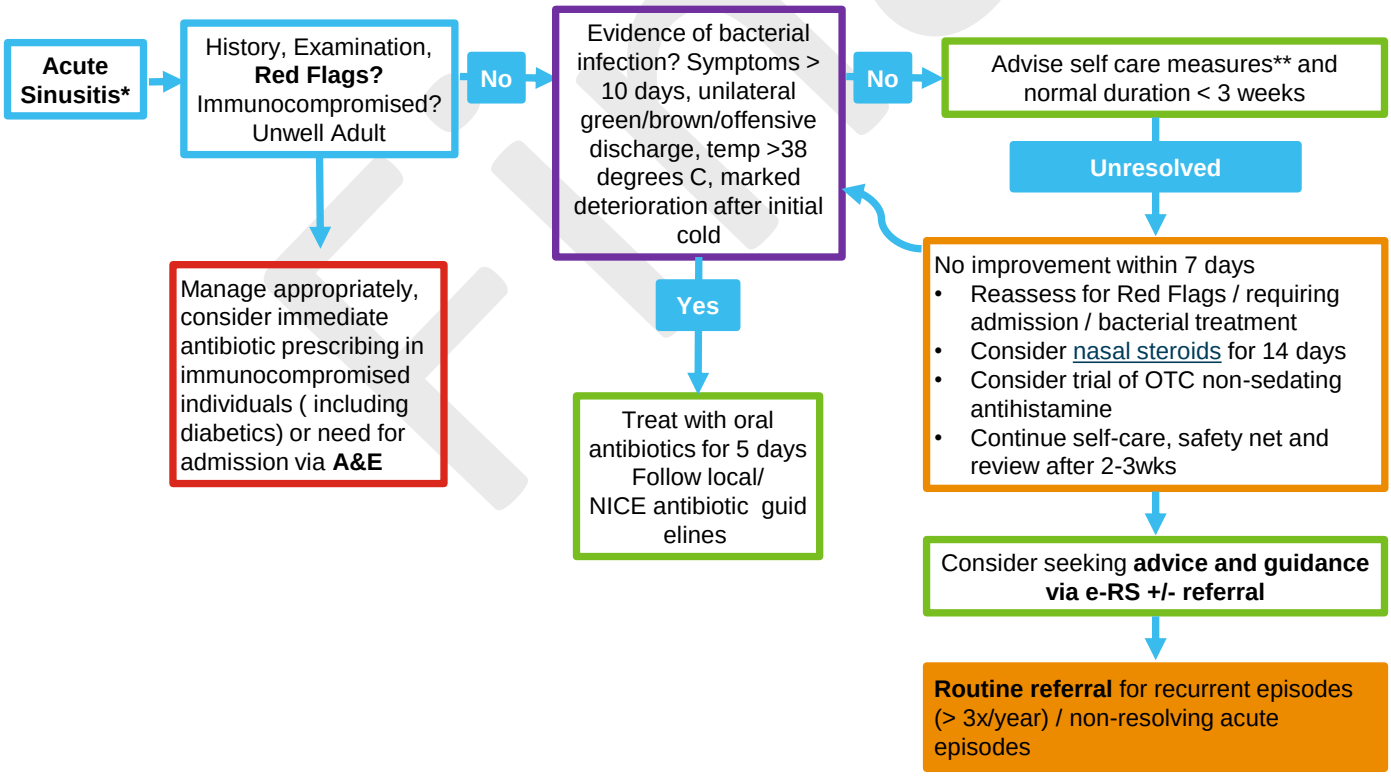
Sinusitis 1 of 2

- Inflammation of paranasal sinuses & lining of nose
- Presentation: nasal discharge/ post-nasal drip, nasal congestion/blockage, facial pain, changes in sense of smell, eyes watering, toothache, fever
- Acute or Chronic or Chronic with Polyps – managed differently
- Infective, Inflammatory or Allergic
- More than 90% of cases are viral and self limiting with self care – do not routinely prescribe antibiotics
- Complications: chronic sinusitis (more than 12 weeks), rarely severe complications: orbital abscess, intracranial abscess, sepsis :

https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/

RED FLAGS

- Visible nasal mass (**2ww Head and Neck**) or if suspected nasal mass (e.g. unexplained persistent unilateral nasal blockage / bloodstained or offensive nasal discharge) consider discussing with **ENT via A&G** for urgent review / referring outside of 2ww criteria
- Discuss with **ENT via A&G** for urgent review / referring outside of 2ww Head and Neck criteria: recurrent or non-resolving otitis media with symptoms between episodes/ with persistent cervical lymphadenopathy/Unexplained persistent otitis media with effusion
- Suspected orbital abscess: Proptosis of eye, double vision, ophthalmoplegia, new reduction in visual acuity or facial mass (ocular emergency, **refer to on-call ENT** (switch board/Consultant Connect) or to **A&E** out of hours)
- Peri-orbital oedema or cellulitis (pre-septal cellulitis can be managed in primary care if high confidence in diagnosis, systemically well and follow up <48 hours, if unsure or for orbital cellulitis **refer to A&E**)
- Suspected intracranial infection: severe frontal headache, swelling over forehead, symptoms/signs meningitis, altered consciousness, vomiting, seizure, neurological signs (**A&E or 999**)



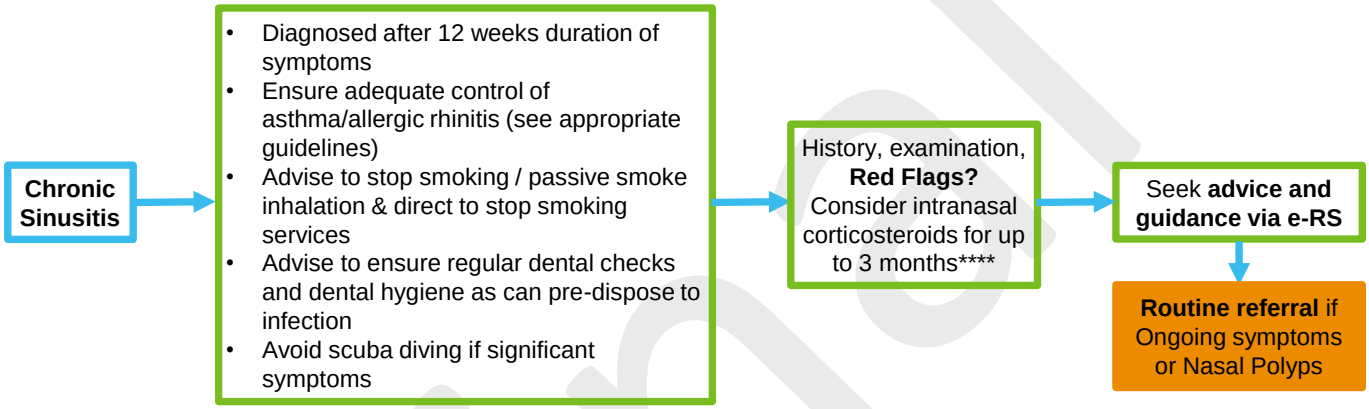
- *Acute sinusitis normally follows a cold – is defined as an increase in symptoms after 5 days or persistent symptoms after 10 days, lasts less than 12 weeks. Diagnose: nasal blockage or nasal discharge WITH facial pain/headache and/or reduction/loss of sense of smell
- ** self care measures – over the counter: simple painkillers, nasal saline rinses can be very effective, nasal decongestants have limited evidence but if chooses to use advise max duration 7 days or can cause reliance and worsening

https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/

- *** Follow local or NICE antibiotic guidelines

References: NICE CKS Sinusitis (16); Pan London Urgent Suspected Cancer Referral forms (4); NICE CKS. Head and Neck cancers – recognition and referral (8)

Sinusitis 2 of 2



Final

- *Acute sinusitis normally follows a cold – is defined as an increase in symptoms after 5 days or persistent symptoms after 10 days, lasts less than 12 weeks. Diagnose: nasal blockage or nasal discharge WITH facial pain/headache and/or reduction/loss of sense of smell
- ** self care measures – over the counter: simple painkillers, nasal saline rinses can be very effective, nasal decongestants have limited evidence but if chooses to use advise max duration 7 days or can cause reliance and worsening

https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/

- *** Follow local or NICE antibiotic guidelines
- **** intranasal steroids: see formulary beclomethasone or fluticasone propionate/fuoate or mometasone furoate

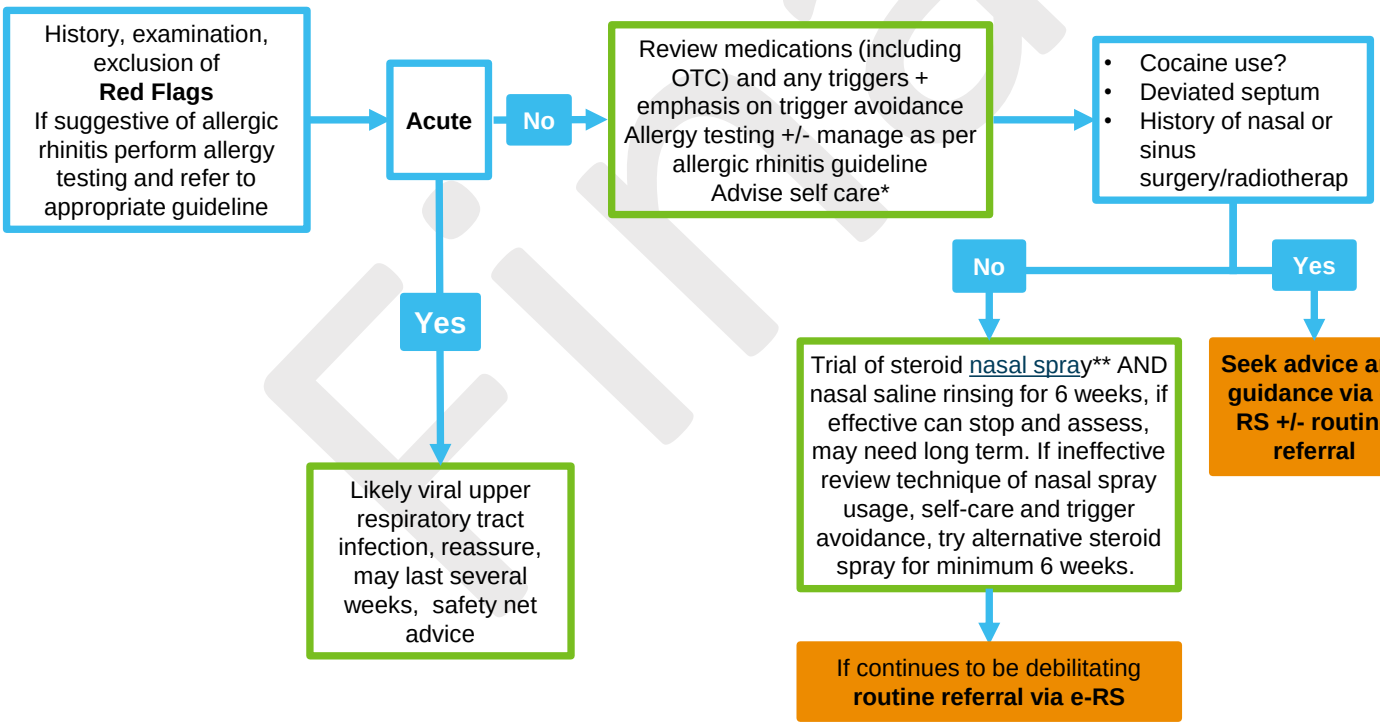
References: NICE CKS Sinusitis (16); Pan London Urgent Suspected Cancer Referral forms (4); NICE CKS. Head and Neck cancers – recognition and referral (8)

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, post-operative adhesions, septal deformities – acquired (trauma or cocaine use) or congenital, acute post-traumatic (e.g. septal haematoma), rarely cancer, Medication side effects (aspirin, NSAIDs, beta-blockers, contraceptive pills, overuse of decongestants, antidepressants, urological drugs), pregnancy, Irritants (e.g. 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 or others depending on history) and refer to allergic rhinitis pathway if suggestive of allergic cause

RED FLAGS

- Visible nasal mass (**2ww Head and Neck**) or if suspected nasal mass (e.g. unexplained persistent unilateral nasal blockage / bloodstained or offensive nasal discharge) consider discussing with **ENT via A&G** for urgent review / referring outside of 2ww criteria
- 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**)
- Unilateral symptoms e.g anosmia + nasal symptoms or facial/orbital pain. Suspect mass (nasal/paranasal/intracranial) refer to appropriate specialism 2ww or **speak to on-call ENT** (switch board/Consultant Connect)
- Suspected orbital abscess: Proptosis of eye, double vision, ophthalmoplegia, new reduction in visual acuity or facial mass (ocular emergency, refer directly to ENT via Consultant Connect/telephone or to A&E out of hours)
- Peri-orbital oedema or cellulitis (pre-septal cellulitis can be managed in primary care if high confidence in diagnosis, systemically well and follow up <48 hours, if unsure or for orbital cellulitis refer to A&E)
- Foreign Body in Ear Foreign Body in Ear/Nose (**consider 999: for batteries in nose, A&E for FB in Nose**, **Consultant Connect/telephone** for ear 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



- *self care: nasal rinsing with homemade salt water solution or OTC solutions e.g. Sterimar spray or NeilMed rinse. Various OTC nasal devices such as douches may be beneficial. 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/
- ** see NICE guidelines & SEL formulary. 1st line are OTC intranasal fluticasone propionate or alternatives are prescription only medicines: fluticasone furoate or mometasone furoate. Drop dose once symptoms controlled. Information on how to use nasal sprays and flixonase nasules is available from the NHS website

References: References: NICE CKS Sinusitis (16); Pan London Urgent Suspected Cancer Referral forms (4); NICE CKS. Head and Neck cancers – recognition and referral (8)

Allergic Rhinitis 1 of 2

- Note separate Nasal congestion/Rhinorrhea guideline which contains **advice on allergen avoidance, nasal rinsing and nasal steroids**
- Symptoms: sneezing/running nose/itchy nose, throat, mouth/nasal congestion – mouth breathing, snoring/post-nasal drip/cough
- Common, can cause significant impact on quality of life
- Screen for eczema, food allergy, asthma - uncontrolled allergic rhinitis increases risk of asthma exacerbations
- ARIA 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. Treat eye symptoms*
- **Sedating antihistamines, Nasal decongestants and depot steroids are not recommended**

RED FLAGS

- Visible nasal mass (**2ww Head and Neck**) or if suspected nasal mass (e.g. unexplained persistent unilateral nasal blockage / bloodstained or offensive nasal discharge) consider discussing with **ENT via A&G** for urgent review / referring outside of 2ww criteria
- Suspected raised Intracranial pressure: Progressive headache / vomiting / abnormal optic discs / blurred vision / behavior change (**refer to A&E**)
- Unilateral symptoms e.g anosmia + nasal symptoms or facial/orbital pain. Suspect mass (nasal/paranasal/intracranial) refer to appropriate specialism 2ww **or speak to on-call ENT (**switch board/Consultant Connect)
- Suspected orbital abscess: Proptosis of eye, double vision**,** ophthalmoplegia, new reduction in visual acuity or facial mass (ocular emergency, refer directly to ENT via **on-call ENT or to A&E out of hours)**
- Peri-orbital oedema or cellulitis (pre-septal cellulitis can be managed in primary care if high confidence in diagnosis, systemically well and follow up <48 hours, if unsure or for orbital cellulitis **refer to A&E**)
- Foreign Body in Ear Foreign Body in Ear/Nose (**999: for batteries in nose, A&E for FB in Nose**, **on-call ENT** for ear 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

Allergic Rhinitis 2 of 2

History, examination (including nasal), exclusion of **red flags**, if suggestive of allergic rhinitis perform allergy testing, if polyps are present refer to specific guidance

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

Assess severity

Mild/intermittent: not affecting daily activities, sleep not affected, seasonal

Moderate-severe or persistent Impaired daily activities, sleep disturbance, perennial

Mild and intermittent → Trial of nasal rinsing and allergen avoidance only → **Unresolved** → **Add in PRN** topical treatment: intranasal azelastine / OTC sodium cromoglicate eye drops **OR** OTC non-sedating oral antihistamines (fexofenadine is now OTC but is second line after cetirizine or loratadine)
Review after 2-3 weeks

Mod/ Severe or persistent → Nasal rinsing and allergen avoidance in addition to other measures

At every stage check compliance with self care, oral and intranasal preps and spray techniques and
Consider alternative diagnosis
Step 1: Regular oral antihistamine (fexofenadine is now OTC but is second line after cetirizine or loratadine) **OR** regular intranasal antihistamine (Azelastine) +/- OTC sodium cromoglicate eye drops **Review after 2-3 weeks**
Step 2: add a regular intranasal corticosteroid***
Review after 2-3 weeks
Step 3: continue oral antihistamine and add in combination nasal spray azelastine/fluticasone (formulary recommendation)
Step 4: for refractory symptoms as adjuncts: In asthmatics consider adding Montelukast, nasal decongestants (short term use only), intranasal ipratropium bromide
Significant eye symptoms: evidence supports intranasal antihistamines, if not effective consider olopatadine (formulary recommendation) 0.1%

Unresolved →

At every stage check compliance with self care, oral and intranasal preps and spray techniques.
Consider alternative diagnosis

If there are severe symptoms which are uncontrolled consider a **ONE OFF** short course of oral prednisolone. Adult dosing: 0.5mg/kg in the morning for 5 - 10 days. Consider risk factors for adrenal insufficiency and PPI cover.

→ Refer:
Structural nasal problem: **ENT via e-RS**
Allergen: **to specialist allergy clinic** for consideration of immunotherapy

- *nasal rinsing advice from NHS website
- **allergen avoidance
- *** 1st line are OTC intranasal beclomethasone or fluticasone propionate or alternatives are prescription only medicines: fluticasone furoate or mometasone furoate. For severe obstruction consider fluticaseone furoate drops. Drop dose once symptoms controlled.
- How to use nose drops & sprays

https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/

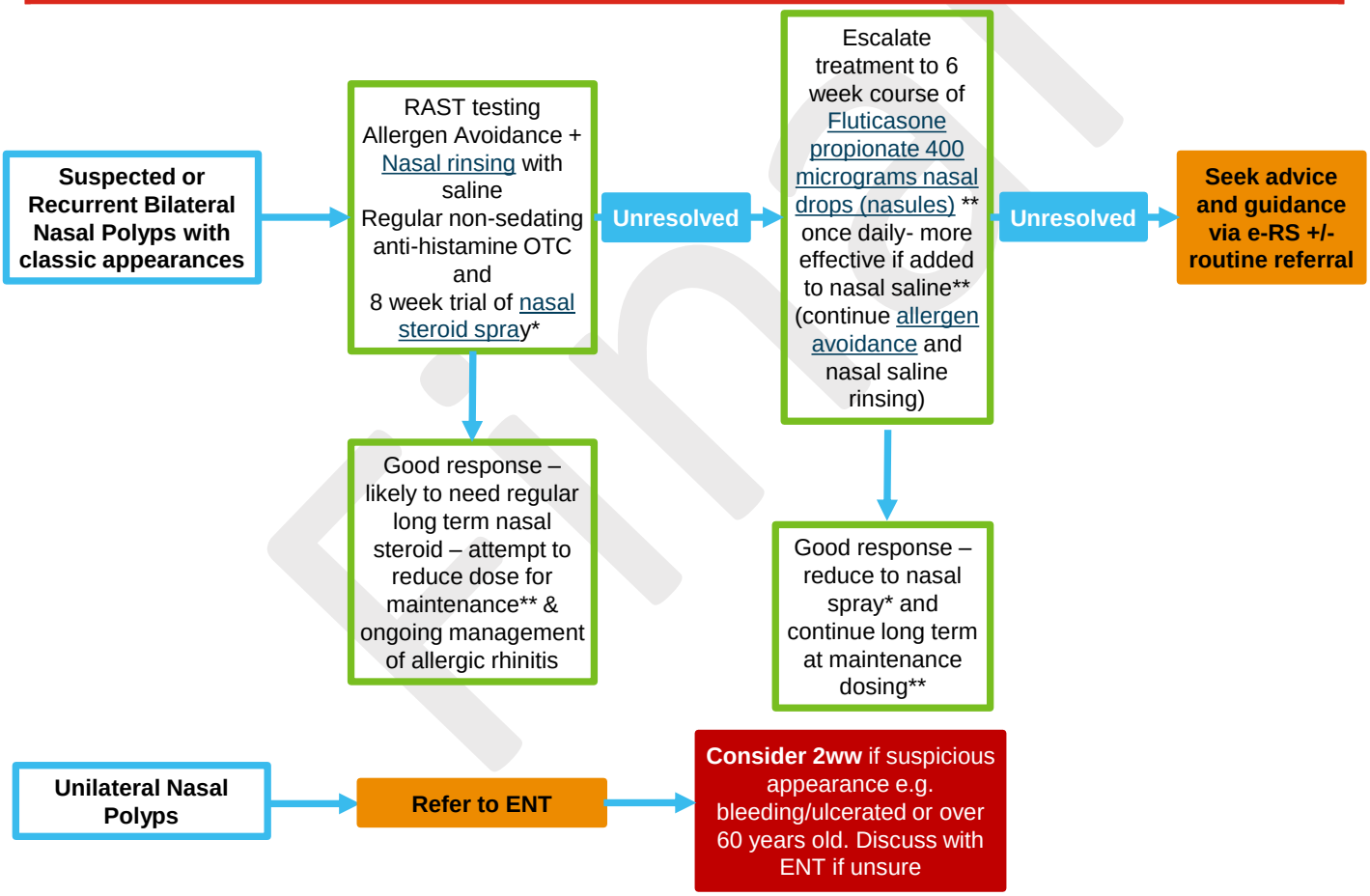
References: NICE CKS Allergic Rhinitis (17); Pan-London Allergic Rhintitis guideline 2023 (18)

Nasal Polyps

- Chronic inflammatory condition of the nose and paranasal sinuses
- Symptoms – nasal obstruction +/- reduction in sense of smell
- Yellow/gray in appearance , usually bilateral, unilateral polyps all need investigating. Not to be confused with large inferior turbinates' – look on the internet for comparison photos / ask a colleague for an opinion if in doubt
- 1/3 have asthma. Other associations are cystic fibrosis, aspirin intolerance
- Considered to be a sub-type of allergic rhinitis & **allergy testing and management of allergic rhinitis is necessary**
- Confidence in diagnosis is key before starting on long-term steroid sprays. High dose nasal steroids are absorbed systemically and usually should be used short term
- If the person is also taking oral or inhaled corticosteroids they may be at further **risk of adrenal insufficiency**
- Surgery to remove polyps often relieves symptoms however recurrence of the polyps is common

RED FLAGS

- Unilateral polyps especially those with atypical appearances e.g. ulcerated or bleeding or in people over 60 years old (**2ww Head and Neck**)
- Visible nasal mass (**2ww Head and Neck**) or if suspected nasal mass (e.g. unexplained persistent unilateral nasal blockage / bloodstained or offensive nasal discharge) consider discussing with **ENT via A&G** for urgent review / referring outside of 2ww criteria



- *nasal steroids: Consider initial higher dose such as - fluticasone furoate 200 micrograms 1–2 times a day, to be administered into each nostril or 100 micrograms daily for 5–6 weeks, dose to be sprayed into each nostril, then increased if necessary to 100 micrograms twice daily, dose to be sprayed into each nostril. For both: ** consider alternative treatment if no improvement after further 5–6 weeks, reduce to the lowest effective dose when control achieved.
- **ENT consultants find better response if this is added to a Nasal saline sinus rinse e.g. NeilMed (OTC)/see NHS website for homemade solution then applied. Flixonase (Fluticasone propionate) nasules are being discontinued but another manufacturer is taking over. If there is a shortage an alternative is budesonide 0.5mg which comes in a 2ml ampoule twice daily, added to sinus rinse
- Information on how to use nasal sprays and fluticasone propionate nasules is available from the NHS website
- References: NICE CKS Chronic Sinusitis (19)

Epistaxis & Broken Nose

- Common presentation in primary care however to remain alert as in rare cases is life threatening. 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 more common in the elderly or those with hypertension
- Acute epistaxis history – one or both nostrils, down back of throat, duration of bleeding, any trauma, any anticoagulants, previous epistaxis/abnormal bleeding, in heavy bleeding signs of hypovolaemia

RED FLAGS

- Septal haematoma (in the context of trauma - refer for same day ENT assessment **speak to on-call ENT** (switch board/Consultant Connect)
- Large volume of blood loss / haemodynamically unstable (refer to **A&E / 999** in an emergency)
- Visible nasal mass (**2ww Head and Neck**) or if suspected nasal mass (e.g. unexplained persistent unilateral nasal blockage / bloodstained or offensive nasal discharge) consider discussing with **ENT via A&G** for urgent review / referring outside of 2ww criteria
- Nose bleeds under 2 years old (after examination consider bloods +/- referral to appropriate specialism – ENT or Haematology)

Acute epistaxis → History, examination, **Red Flags?** unwell & requiring admission? → Advise 1st aid – pinch the soft part of the nose and keep head in neutral, if available apply ice or cold compress between the eye brows or suck ice cubes

- **Unresolve** → After 15-20 mins Take vital signs and transfer to **A&E,** particularly if on anticoagulation
- If stopped advise not to blow nose or remove dried blood from nose for at least 48 hours & safety net advice if returns

Recurrent epistaxis →

- Trial of antiseptic nasal ointment * for 14 days to reduce crusting and nasal bacterial infection
- consider need for investigations for anaemia, clotting abnormalities
- review of medications
- Management of hypertension

→ **Unresolved** → **Seek advice and guidance via e-RS +/- routine referral**

Broken Nose →

RED FLAGS

Broken Nose

- Septal haematoma (refer for same day ENT assessment via Consultant Connect/telephone)
- Large volume of blood loss / 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)**

→ **No** →

- Broken noses where there is a deformity need to be reviewed by ENT 5-7 days post-injury as if MUA is needed this occurs within 2-3 weeks
- **Refer to ENT emergency clinic by speaking with on-call ENT**
- **For late presentations**: Septo-rhinoplasty is a restricted procedure on the NHS. There needs to be both:

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

- If the individual is meeting both these criteria: **routine referral via e-RS**

- *Naseptin QDS for 10 days or if there is a peanut allergy the alterative is Bactroban (unliscenced use. Licenced for nasal infection with carriage of Staphylococcus aureus)
- References: NICE CKS epistaxis (20)

Snoring

- Simple snoring is noisy breathing during sleep without irregular breathing / apnoeas and daytime sequelae
- In **Adults simple snoring is not treated by ENT** under the SEL Treatment access policy
- Assess for Sleep apnoea e.g with Epworth sleepiness scale, physical examination and assessment of risk factors +/- **refer to Sleep Disorders Clinic** - there are commercially available smartphone apps which will record /track snoring if its unclear if apnoeas are occurring
- Assess for and manage as appropriate **any associated conditions**: hypothyroidism, acromegaly, nasal obstruction, septal deviation
- Advise on factors that increase chance of snoring: alcohol intake, sedative medications, smoking, sleeping on back, increasing age, male gender

RED FLAGS

- Visible nasal mass (**2ww Head and Neck**) or if suspected nasal mass (e.g. unexplained persistent unilateral nasal blockage / bloodstained or offensive nasal discharge) consider discussing with **ENT via A&G** for urgent review / referring outside of 2ww criteria

Snoring

History
- Any **Red Flags?**
- Onset, continuous or intermittent, any reported apnoeas
- Weight changes
- Systemic symptoms
- Nasal symptoms / history of issues
- Impact on relationship/socially
- Alcohol/smoking/sedative medications history & impact these have on symptoms
- Epworth Sleepiness scale

Examination
- Nasal passages
- Neck masses, throat
- Neck circumference
- Blood pressure
- BMI

- If consistent with **simple snoring,** reassure and direct to self care measures*
- If consistent with **Obstructive Sleep Apnoea refer to Sleep Disorders Clinic locally**
- Consider the need to exclude thyroid pathology / acromegaly
- Manage any associated Hypertension, Mental Health Conditions, substance misuse or **consider weight management referral**
- Refer to specific ENT guidelines for management of ENT conditions

- *self care strategies: alcohol/smoking/sedative advice as appropriate. Tennis ball taped to back of PJs to prevent rolling onto back, ear plugs for partner/white noise, there are various devices available over the counter e.g. nasal strips – these do not have a clear evidence base and its unclear which if any are beneficial

https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/

References: SEL treatment access policy 2022 (1); NICE CKS Obstructive Sleep apnoea (21)

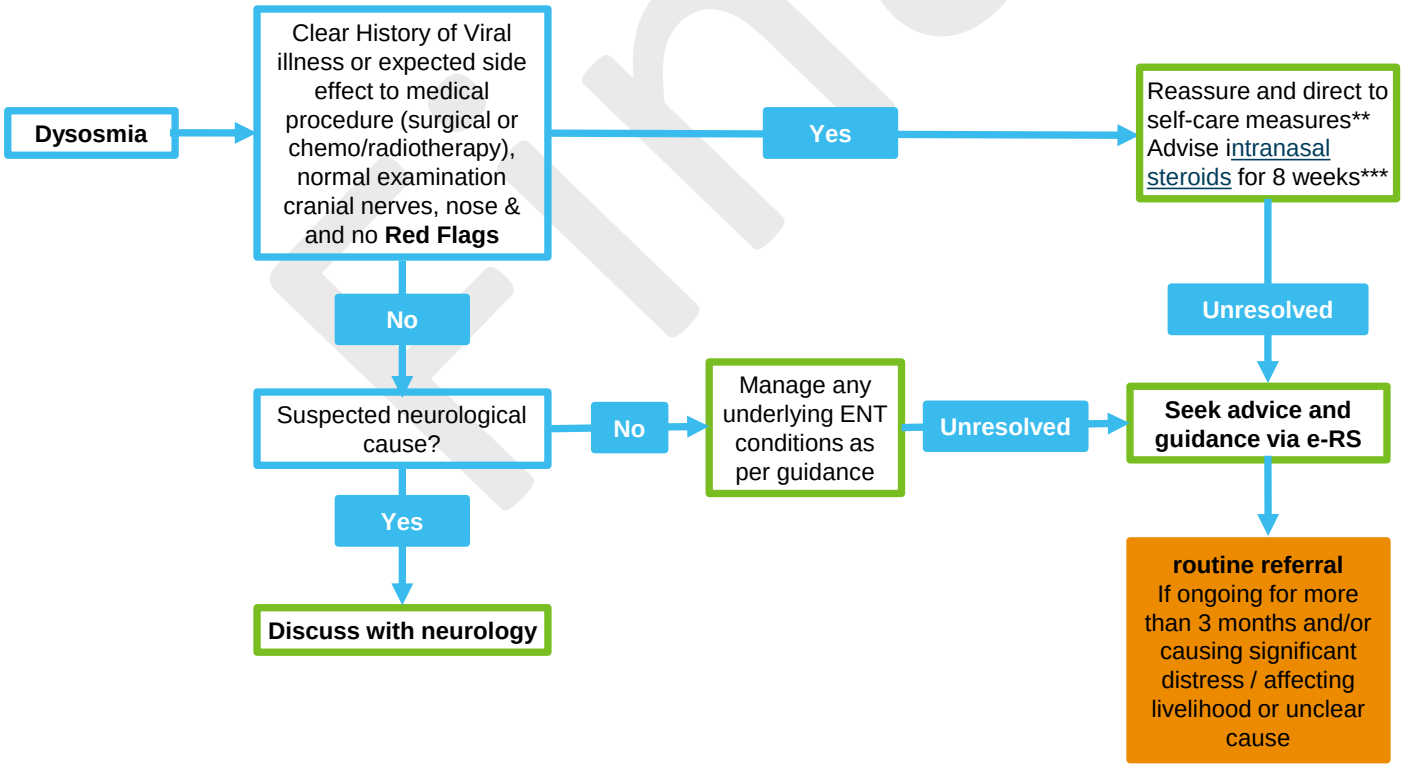
Final

Altered Smell (Dysosmia)

- Anosmia – total loss of sense of smell
- Hyposmia – reduced sense of smell
- Parosmia – distortions in sense of smell – usually intermittent with anosmia
- Phantosmia - olfactory hallucinations – smelling scents that are not there – usually intermittent with anosmia
- Differential: post-viral, post-traumatic including post-operative, exposure to toxins – prescribed medication*, chemo/radiotherapy, cocaine, alcohol, smoking, neurological: MS, temporal lobe Epilepsy, Parkinson's, Alzheimer's, Space occupying lesion, nasal blockage: rhinitis, polyps, tumours, congenital – Kalman's
- History: duration, onset, triggers/preceding events, nasal symptoms such as discharge, recreational drugs, alcohol, medications, neurological symptoms

RED FLAGS

- Unilateral symptoms e.g anosmia + nasal symptoms or facial/orbital pain. Suspect mass (nasal/paranasal/intracranial) refer to **appropriate specialism 2ww or speak to on-call ENT** (switch board/Consultant Connect)
- Cacosmia: foul smell in one nostril – consider foreign body or dental disease
- Phantosmia rarely can indicate a space occupying lesion e.g. temporal lobe lesion – normally few seconds of intense smell, same smell each time – **A&G neurology who may recommend referral or MRI**
- Visible nasal mass (**2ww Head and Neck**) or if suspected nasal mass (e.g. unexplained persistent unilateral nasal blockage / bloodstained or offensive nasal discharge) consider discussing with ENT via A&G for urgent review / referring outside of 2ww criteria
- Severe frontal headaches, persistent nausea/vomiting, meningism, neurological symptoms (**refer to A&E** or **2ww Neurology** as appropriate)
- Visual symptoms, ophthalmoplegia, orbital swelling/proptosis (**refer to A&E to consider urgent imaging**)



- * such as ACE inhibitors, diuretics, calcium channel blockers, statins
- **Scent training – information available from: https://www.fifthsense.org.uk/; https://abscent.org; Patient information on parosmia and phantosmia: https://www.fifthsense.org.uk/parosmia-and-phantosmia/ ENT UK suggest that Omega 3 supplementation can be considered (OTC) however there is no definitive evidence
- ***see formulary: intranasal fluticasone propionate/furoate or mometasone furoate or beclometasone

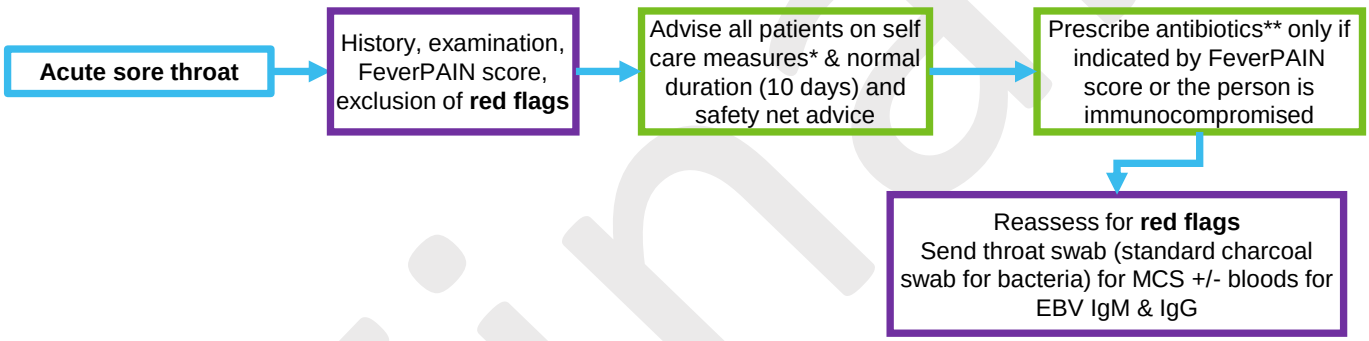
References: Pan-London urgent Suspected cancer referral forms (4); NICE CKS Head and neck cancers (8); BMJ Anosmia and loss of sense of smell in the era of covid-19 (22); BJGP Anosmia: an evidence-based approach to diagnosis and management in primary care (23)

Sore Throat

- 70% are viral and do not require or respond to antibiotics
- 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

RED FLAGS

- Evidence of sepsis or difficulty in breathing **(999)**
- 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 (refer to ENT same day assessment by **discussing with on-call ENT**, if systemically unwell via **A&E)**
- 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)
- 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 (Discuss with **ENT via A&G** for urgent review / refer outside of **2ww Head and Neck** criteria)
- ≥ 4 weeks of persistent, particularly unilateral, discomfort in the throat or throat pain **(2ww Head and neck)**
- ≥ 40 years old with ≥ 3 weeks of one or more: persistent unexplained hoarseness / dysphagia / odonophagia / otalgia **(2ww Head and neck)**
- Unexplained neck mass consider **2ww Head and neck** or imaging as appropriate



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 AND
2. Episodes of sore throat are disabling and prevent normal functioning AND
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 in children, sleep apnoea, recurrent Quinsy, cancer. Check treatment access policy.

- *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 https://www.selondonics.org/icb/your-health/medicines/sel-imoc/sel-imoc-self-care/
- **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 – acute (24); SEL Treatment access policy 2022 (1); Pan-London urgent Suspected cancer referral forms (4); NICE CKS Head and neck cancers (8)

Swallowing issues & Foreign Bodies

- Difficulty swallowing (dysphagia) can be due to ENT, gastrointestinal, neurological causes (Motor Neurone Disease, Myasthenia gravis, stroke) or rarely due to compression from masses (e.g. GI, ENT, thyroid, intrathoracic) or as a complication from procedures such as surgery or radiotherapy

- **Consider if following local guidance for GI causes is most appropriate** or the need for investigating for GI or intra-thoracic malignancies

- Thorough history of swallowing issue: food sticking / regurgitating / coughing after eating / pain on swallowing / solids / liquids / both and which one came first / sudden onset or a gradual worsening / foreign body / systemic features – weight loss, abdominal pain, night sweats, bony pain, lumps, smoking/alcohol history. Family history cancers

- **ENT causes of impaired swallow**: acute infective sore throat/tonsillitis, foreign body, rarely cancers

- **Globus:** suitable for diagnosis and management in primary care; painless sensation of a lump in the throat, centrally, above the level of the sternum, intermittent symptoms, normal neck, nose and oral examination. No pain, **no dysphagia**, no hoarseness/ change in voice, no progressive features, no haemoptysis, no weight loss, not unilateral. Screen for anxiety and reassure. Do not routinely offer PPI unless there are symptoms of oesophageal reflux

RED FLAGS

- **Dysphagia at any age 2ww gastroscopy** –direct access endoscopy or 2ww upper GI, check local guidance)
- 55 with weight loss AND any of the following: upper abdominal pain, reflux, dyspepsia (**2ww gastroscopy** –direct access endoscopy or 2ww upper GI, check local guidance)
- Acute foreign body (refer to A&E – **batteries / difficulty breathing / drooling / significant chest pain / cardiovascular unstable call 999**)
- Dysphagia resulting in complications: dehydration, malnutrition, airway obstruction (**999**), aspiration pneumonia (consider if needs to be admitted via A&E or if it can be managed in the community with any urgent referrals e.g. 2ww, dietician, SALT, GSTT/KCH hospital @home team etc.)
- Sore throat with atypical symptoms such as: Systemically unwell with neck stiffness and/or significant 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 **2ww referral Head and Neck**)
- Unexplained discomfort in the throat for more than 4 weeks, particularly unilateral (**2ww Head and neck**)
- Unexplained neck lump (**2ww Head and Neck**)
- Persistent unexplained hoarse voice > 3 weeks in over 40 year olds (**2ww Head and Neck**)
- 40 years or older with > 3 weeks dysphagia, >3 weeks of odonophagia, > 3 weeks of otalgia (**2ww Head and Neck**)

Neck Lumps

- Neck lumps can be: Dermatological lesions, skin infections, lipoma, Thyroid, Lymphadenopathy, Salivary gland, Carotid, developmental/congenital
- **Risk factors for head and neck cancer:** smoking/tobacco use, alcohol, HPV, HIV, previous irradiation of the head and neck, FHx thyroid cancer
- After history and diagnosis consider need for imaging (e.g. USS or **2ww** based on clinical judgement e.g. lymphoma or head and neck)
- **ENT Causes of neck lumps:** frequently infected sebaceous cysts on ear lobe, scalp around the ear, hairline: firm, mobile, in the skin (not subcutaneous), frequently a yellow/white punctum +/- caseous discharge, appear cellulitic – trismus and systemic illness is NOT typical – if there is no immunocompromise and the individual is fit and well, consider trial or oral antibiotics in the community – follow local guidance as per skin infections – infrequently can require incision and drainage – refer for ENT assessment by **speaking to on-call ENT** (switch board/Consultant Connect)

RED FLAGS

- As for swallowing/foreign bodies
- Evidence of sepsis or airway compromise (**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 **(2ww Head and neck)**
- An unexplained persistent swelling in the parotid or submandibular gland **(2ww Head and neck)**
- Suspicious mass on imaging (refer to appropriate **2ww pathway e.g. lymphoma, Head and neck)**

- References: Pan-London urgent Suspected cancer referral forms (4); NICE CKS Head and neck cancers (8); NICE CKS Neck Lump (25

Facial Nerve (including Bells Palsy)

- **Bells palsy** is idiopathic Facial nerve palsy with acute (onset <72 hours), unilateral facial nerve palsy, usually with preceding pain and a viral illness
- Most common between 15-45 years old
- Complications: corneal ulceration, dry mouth, abnormal facial contractions, sensitivity to loud noises, psychological
- In primary care is primarily a diagnosis of exclusion, MRIs do show changes however are not normally indicated for classic cases
- Affects the **forehead and the lower ½ of the face**. Strokes do not involve the forehead (except in rare cases) and often have accompanying limb weakness
- Ear pain on the affected side, change in taste, incomplete eye closure, eye watering, drooling, speech difficulties, hyperacusis are normal
- **There are other causes of Facial nerve palsy** – these should all be seen in secondary care – **anyone without classic Bells palsy should be discussed with on-call ENT / Neurology +/- review organized**

RED FLAGS

Discuss with on-call doctor (ENT or Neurology)
Refer to A&E or call 999 if acute stroke suspected

- Systemically unwell or local ear infection
- abnormalities examining the head/neck e.g. mastoiditis/masses
- trauma preceding (including surgical)
- additional neurological signs
- evidence of cancer
- gradual onset or progressive symptoms (suspect cancer)
- Previous stroke
- Known cancer
- Vestibular or hearing abnormalities (other than hyperacusis)
- Diplopia
- Bilateral signs (suspect Lyme disease or sarcoidosis)
- Evidence of skin cancer
- Head or neck mass
- Frequent relapses
- Forehead sparing (suspect stroke)
- Vesicular skin rash (suspect Ramsay Hunt)
- Confusion
- Evidence of cholesteatoma (foul smelling otorrhoea and hearing loss)

Suspected bells palsy → Typical examination, no additional features and no **red flags** → **Yes** →
- Reassure & advise that most people have a full recovery within 3 months
- Offer Patient information leaflet
- Advise on eye care* and **red flags**
- If presents within 72hours prescribe prednisolone** if no contraindications

Do NOT routinely prescribe antivirals. If Ramsay Hunt is suspected discuss - **speak to on-call ENT** (switch board/Consultant Connect)

→ **Unresolved** → Advise if there is no evidence of improvement within 3 weeks to make contact with Primary Care and request a **referral to ENT – routine referral via e-RS**

Typical examination, no additional features and no **red flags** → **No** → Consider alternative diagnosis, refer to **A&E** or discuss - **speak to on-call ENT** (switch board/Consultant Connect)

Suspected Ramsay Hunt Syndrome

- reactivation of varicella-zoster virus at geniculate ganglion of facial nerve
- Distinct from other forms of shingles as it causes a motor weakness of the facial nerve that mimics but is not Bells Palsy
- **Presentation:** Vertigo, tinnitus, hearing loss, deep pain in the ear, vesicular rash – present in ear canal /outer ear/inside mouth
- Consider discussing with **on-call ENT/Consultant connect** if there is uncertainty **or A&E if red flags**
- NICE guidelines advocate treating with anti-virals only as per shingles guideline **HOWEVER** local ENT clinicians advocate for co-prescribing prednisolone as per advice for Bells Palsy/ acute hearing loss – **discuss with ENT** if any doubt
- Eye care as for Bell's Palsy
- Complications: corneal ulcers, secondary bacterial infection, post-herpetic neuralgia, chronic tinnitus/vestibular dysfunction

- *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**
- **Adult dosing: Prednisolone 50mg once a day for 10 days OR if a reducing regimen is preferred: 60mg daily for 5 days followed by daily reduction of 10mg for the next 5 days

References: NICE CKS Bell's Palsy (26); NICE CKS Shingles (27)

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Glossary

Abbreviation	Definition
ICB	Integrated Care Board
OTC	over the counter
POM	Prescription only Medication
SEL	South East London
2ww	Two Week Wait Suspected Cancer

Final