ENT for GPs

Chris Webb

Consultant ENT Surgeon

Royal Liverpool and Broadgreen Hospitals

Topics (learning outcomes)

- Dizziness
- Tinnitus
- Deafness
- Ear discharge
- OME in kids
- Rhinosinusitis
- Reflux
- Head and Neck cancer

Dizziness

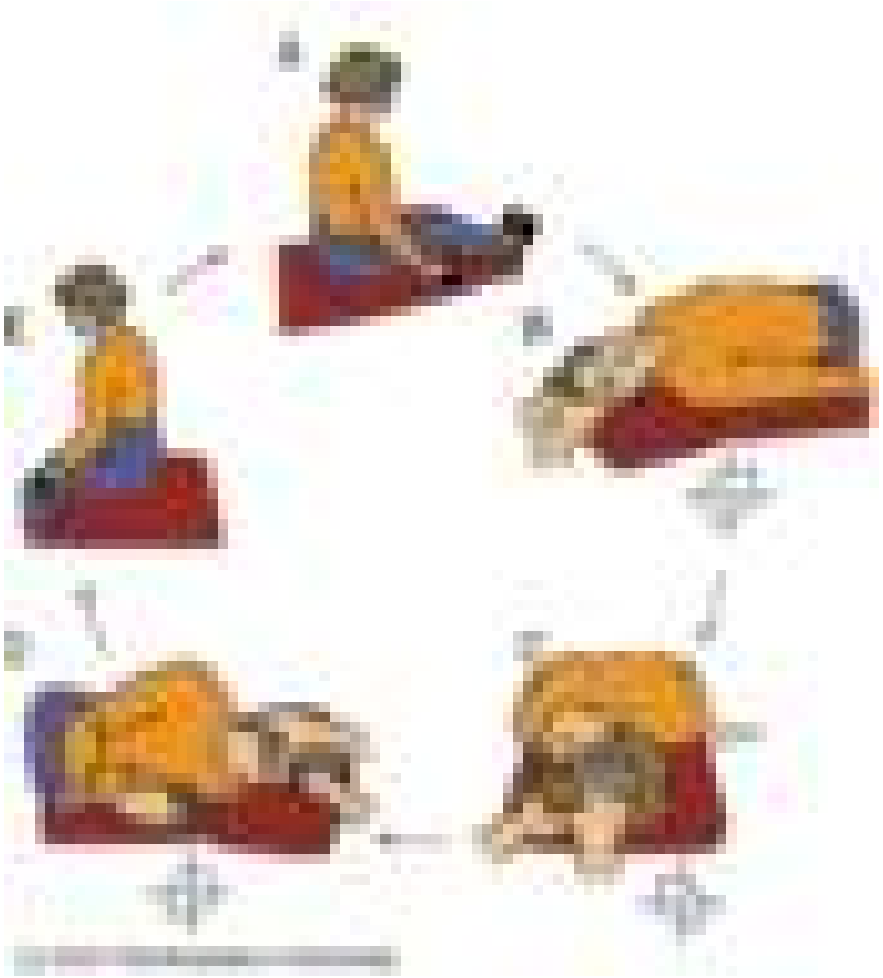
Diagnosis	Duration	Other symptoms (excluding nausea/vomiting)
BPPV	Few seconds up to a couple of minutes	No
Meniere's	Hours	Aura (increasing tinnitus, pressure in ear) Deafness
Vestibular Neuronitis	Days	No
Labyrinthitis	Days	Occasionally tinnitus Occasionally deafness
Migraine	Hours	Headaches Hyperacusis Visual disturbances

Dizziness

- Primary care tests
  - Otoscopy
  - Hearing tests
  - Balance
  - Hallpike’s
  - Gait
  - Cranial nerves (nystagmus)
  - Cerebellar tests
  - Peripheral nerves

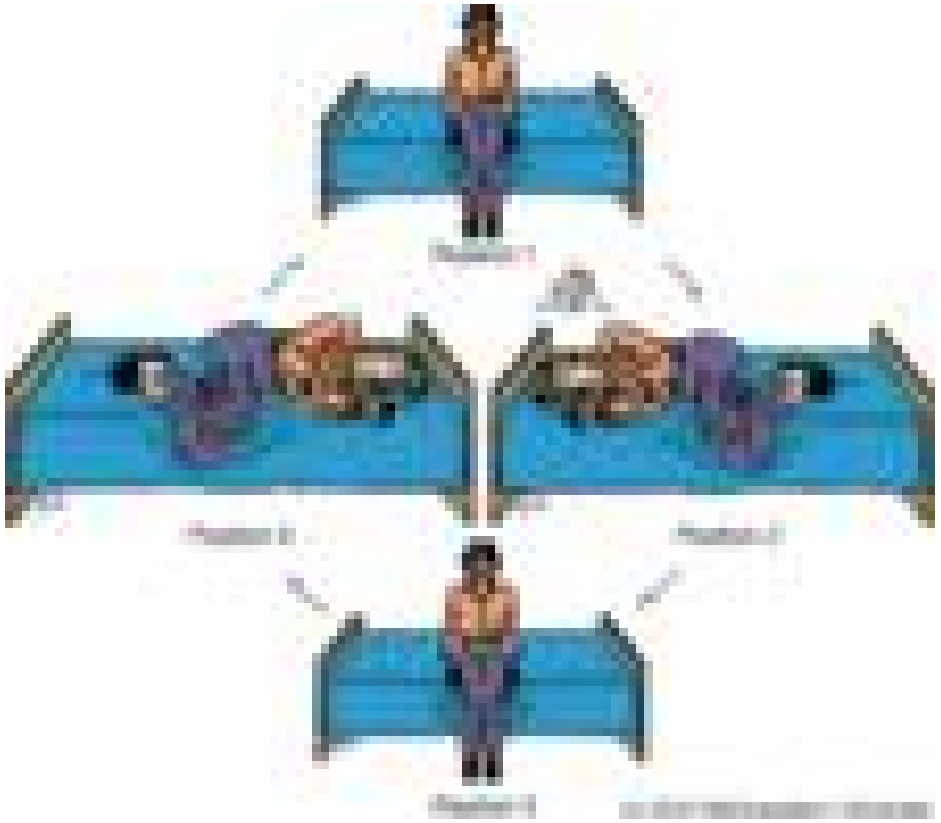
Dizziness

- Epley Manoeuvre



Dizziness

Brandt-Daroff



Dizziness

- Meniere's
  - Often preceding warning e.g. increasing tinnitus
  - Sensorineural deafness during attack
  - Aural fullness
  - Rotatory vertigo
  - Episodes last few hours – a day or two
  - Recurrent episodes over a few weeks
  - Remission for months

Dizziness

- Meniere’s
  - Reduced salt intake?
  - Reduced caffeine?
  - Reduced alcohol?
  - Betahistine hydrochloride?
  - (Prochlorperazine)
  - Transtympanic steroid injection
  - Natural history of ‘burnout’ in 80%

Dizziness

- Labyrinthitis
  - Preceding URTI or similar in some cases
  - Sudden onset
  - Occ deafness
  - Occ tinnitus
  - Very severe for a week or so
  - Subsides after six weeks
  - Stemetil helpful in first week only

Dizziness

- Vestibular neuronitis
  - Preceding URTI or similar in some cases
  - Sudden onset
  - No deafness
  - No tinnitus
  - Very severe for a week or so
  - Subsides after six weeks
  - Stemetil helpful in first week only

Dizziness

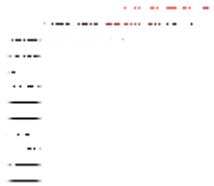
- Remember non-ENT causes:
  - Cardiac
    - Palpitations
    - Syncope “light-headedness”
    - Postural effects
  - Neurological
    - Vertical nystagmus
    - Headaches (migraine)

Dizziness

- Migraine
  - Aura
  - Headache
  - Visual disturbance
  - Lasts up to 24 hours
  - Can be recurrent over a few days
  - Remission for a few months
  - Hormonal

Dizziness

- Urgent ENT referral
  - Sudden deafness
  - Middle ear suppuration
  - Facial palsy



- Which conditions need advice about driving
  - Any sudden and disabling dizziness – Patient must inform DVLA

Tinnitus

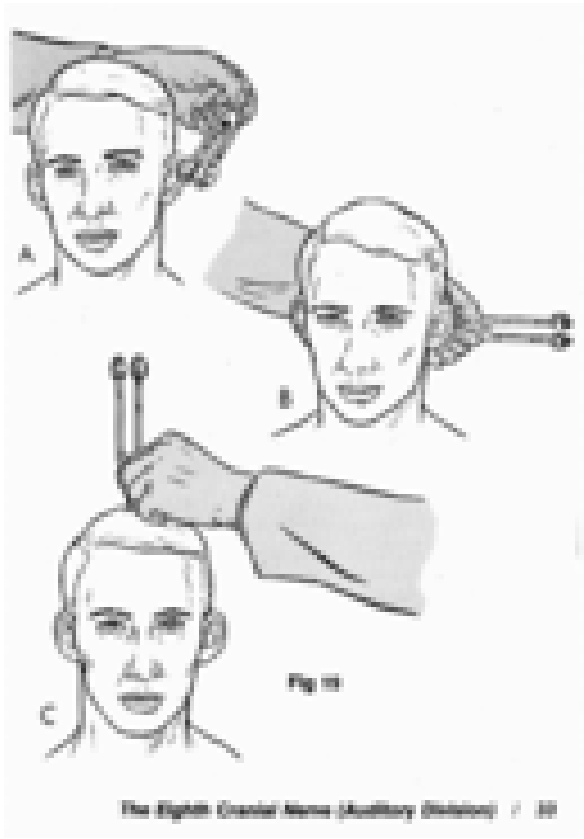
- Bilateral/unilateral
- Pulsatile/non-pulsatile
- Constant/intermittent
- Onset gradual/sudden
- Other ear symptoms

Tinnitus

- Primary care tests
  - Otoscopy
  - Neck/heart auscultation
  - Hearing tests
- Management
  - Reassurance
  - Sound enrichment (apps)
  - CBT

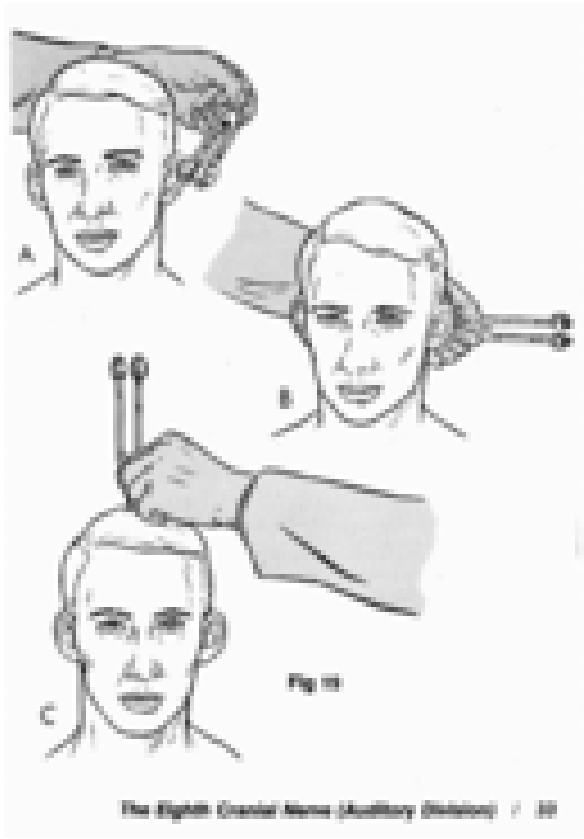
Deafness

- Conductive
  - Wax
  - Infection
  - FB
  - Perforated TM
  - OME
  - Otosclerosis
- Sensorineural
- Mixed



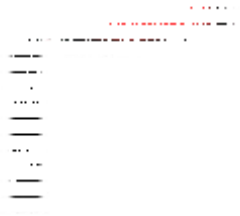
Deafness

- Conductive
- Sensorineural
  - Presbyacusis
  - NIHL
  - Ototoxicity
  - TORCHES
  - Acoustic neuroma
- Mixed

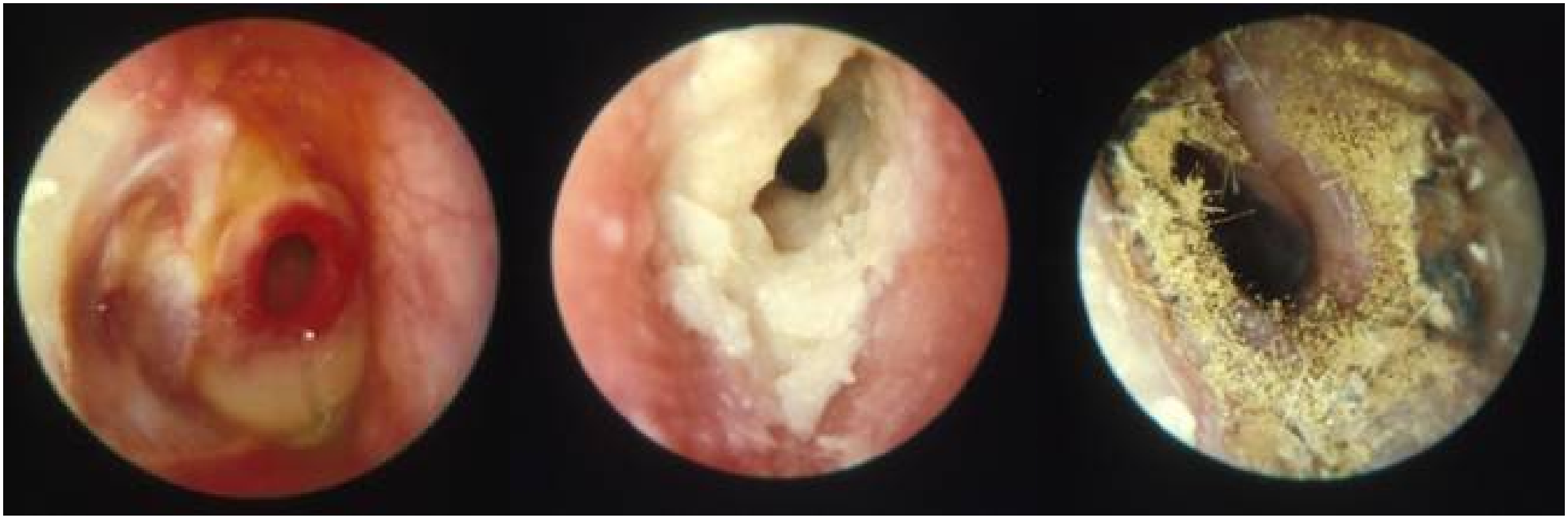


Deafness

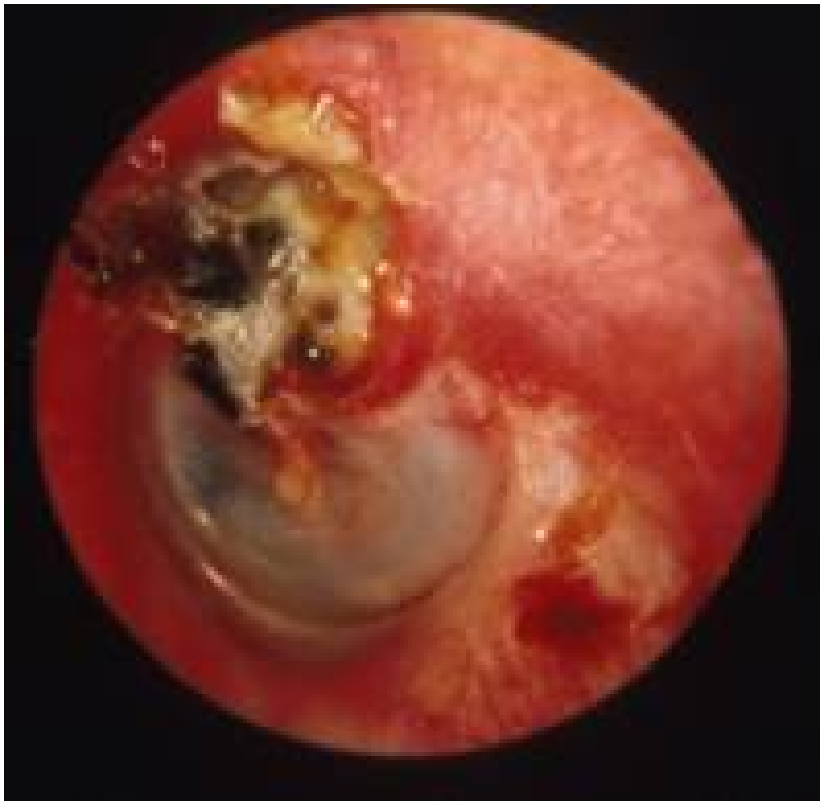
- Sudden sensorineural = emergency
  - Forget tuning forks!
  - Ask patient to hum
  - If heard in deaf ear = conductive
  - If heard in good ear = sensorineural
    - Oral prednisolone 60mg od 1/52 (taper by 10mg every 3 days thereafter)
    - Refer to emergency ENT clinic (via on-call SpR)



Discharging ear



Discharging ear

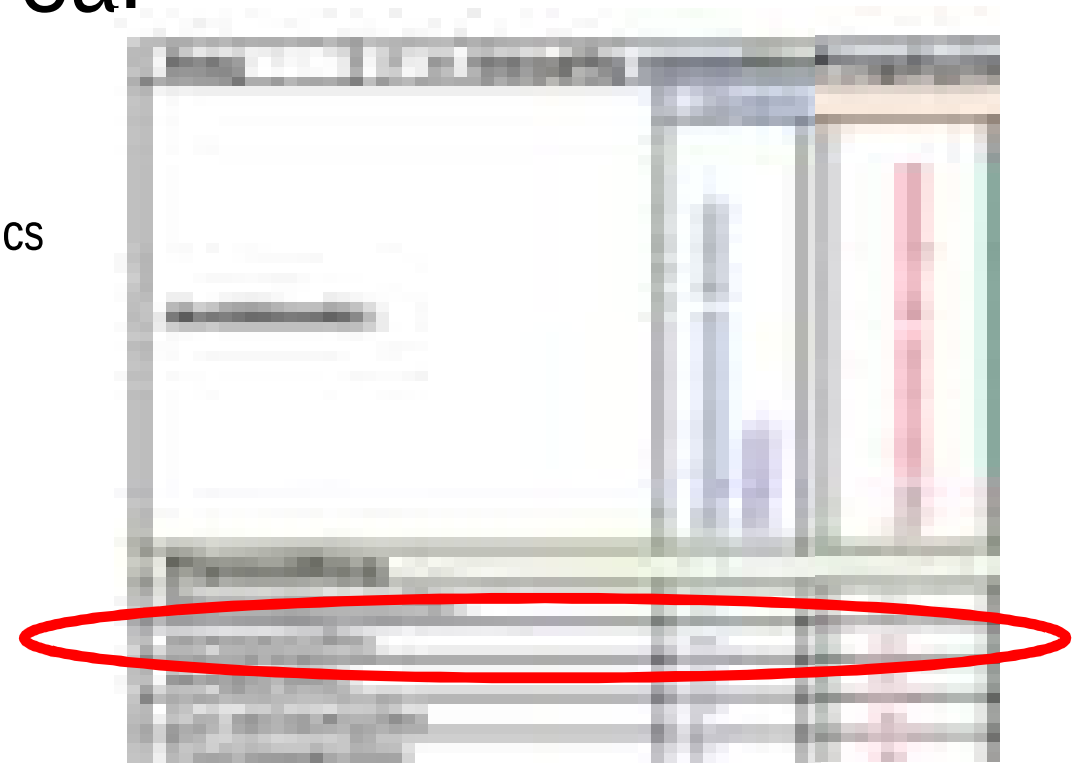


Discharging ear

- Microbiology of Otitis Externa
  - Psuedomonas aeruginosa
  - S. aureus
  - Enterococcus sp
  - Fungi

Discharging ear

- Antibiotics



- http://www.microbiologynutsandbolts.co.uk/how-to-choose-an-antibiotic.html

Discharging ear

- Microbiology of Otitis Externa
  - Psuedomonas aeruginosa
  - S. aureus
  - Enterococcus sp
  - Fungi
- Amoxicillin is NOT the correct choice
- Don’t forget ear calm
- Ciprofloxacin is better

Otitis media (in kids)

- Persisting OM guidelines
  - https://cks.nice.org.uk/otitis-media-with-effusion#!scenario
- Parental smoking increases risk of OME
- Observe 3/12 (except Down's/cleft palate)
- If OME persists at 3/12 refer to ENT

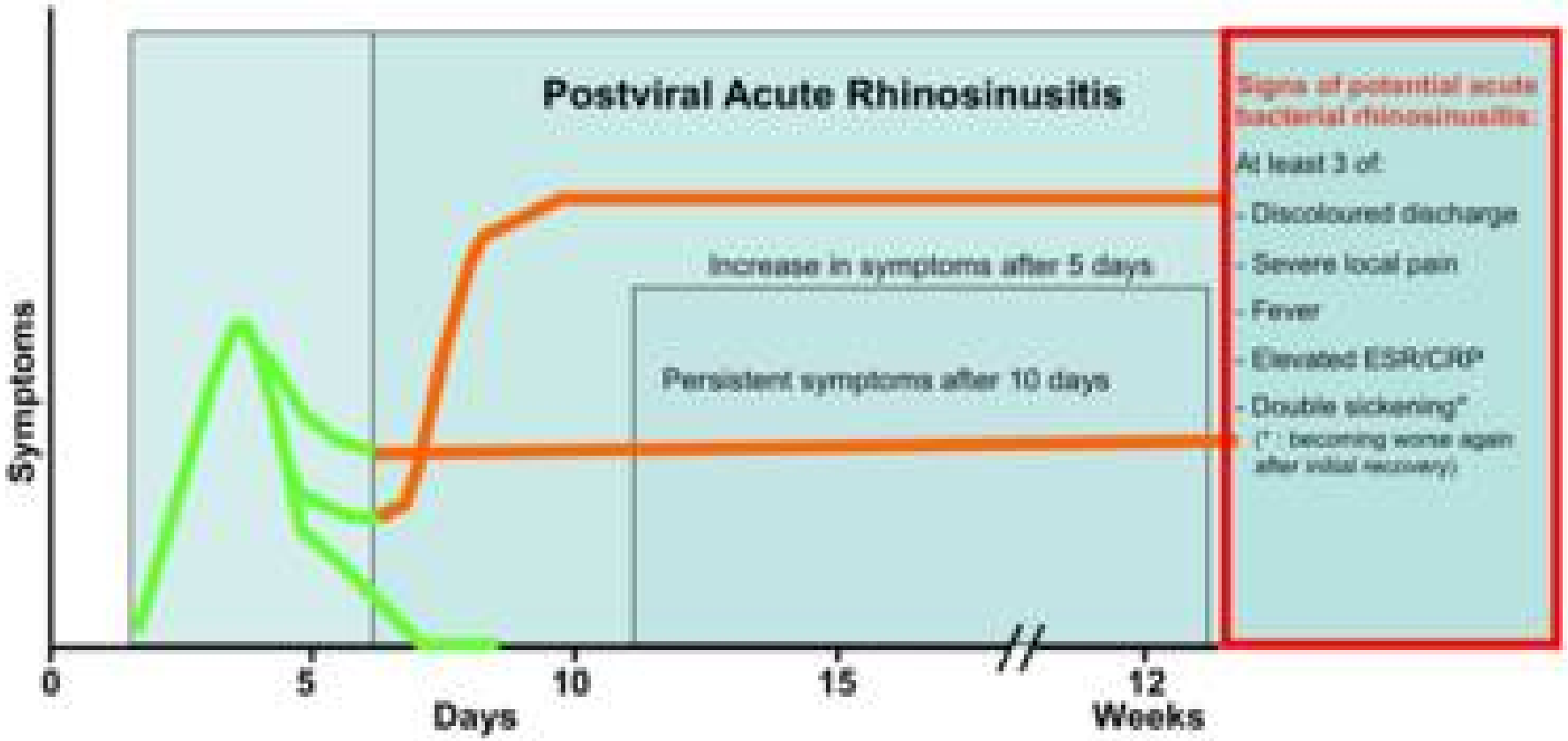
Ear questions?

Rhinosinusitis

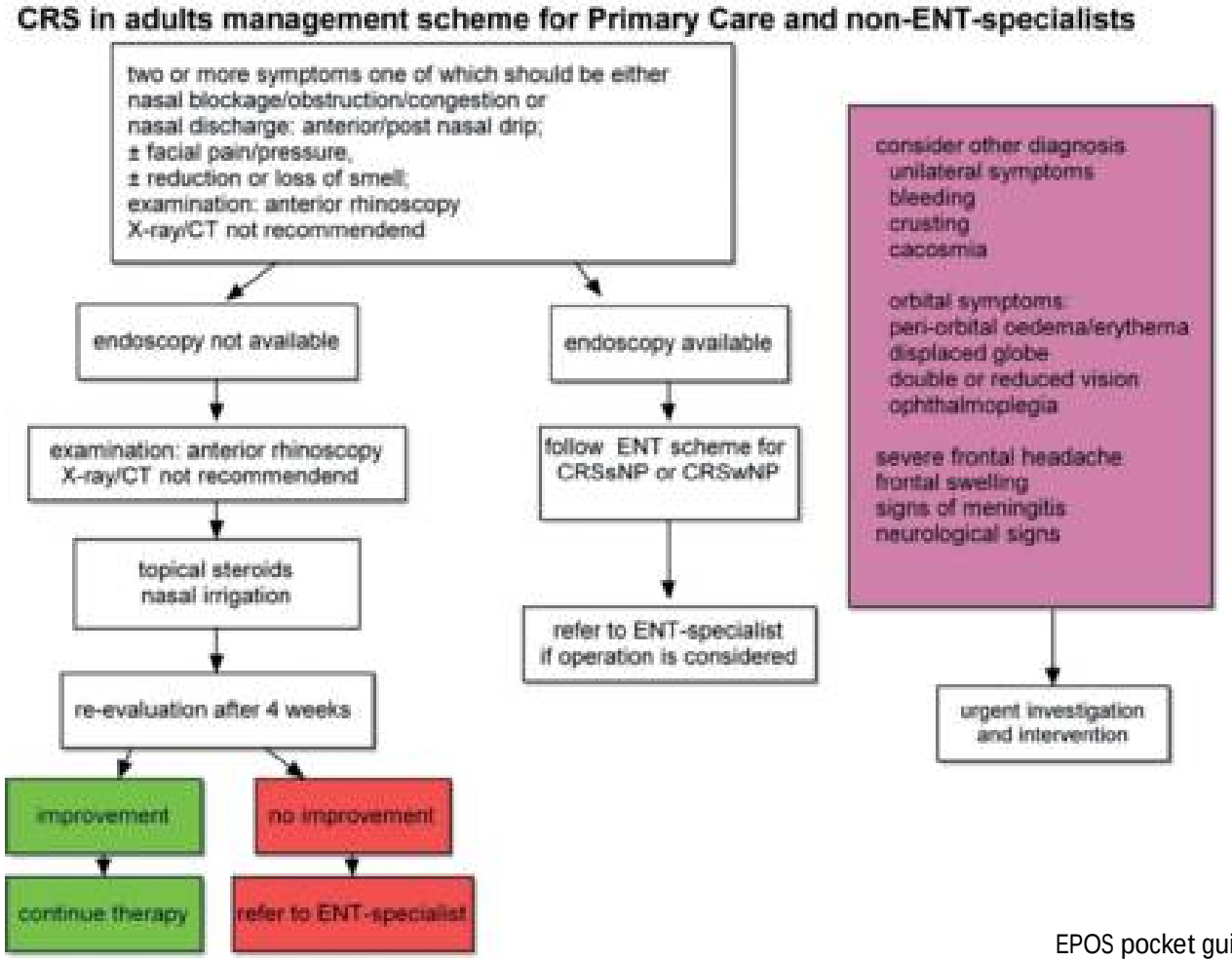
www.rhinologyjournal.com

- Rhinosinusitis – Inflammation of the nose and paranasal sinuses characterised by **two or more symptoms**, one of which should be either **nasal blockage**/obstruction/congestion **or nasal discharge**
  - +/- **facial pain/pressure**
  - +/- **reduction or loss of smell**
- **Endoscopic findings** of nasal polyps/middle meatal oedema or pus
- **CT evidence** of mucosal disease affecting the OMC or paranasal sinuses

EPOS pocket guide 2012

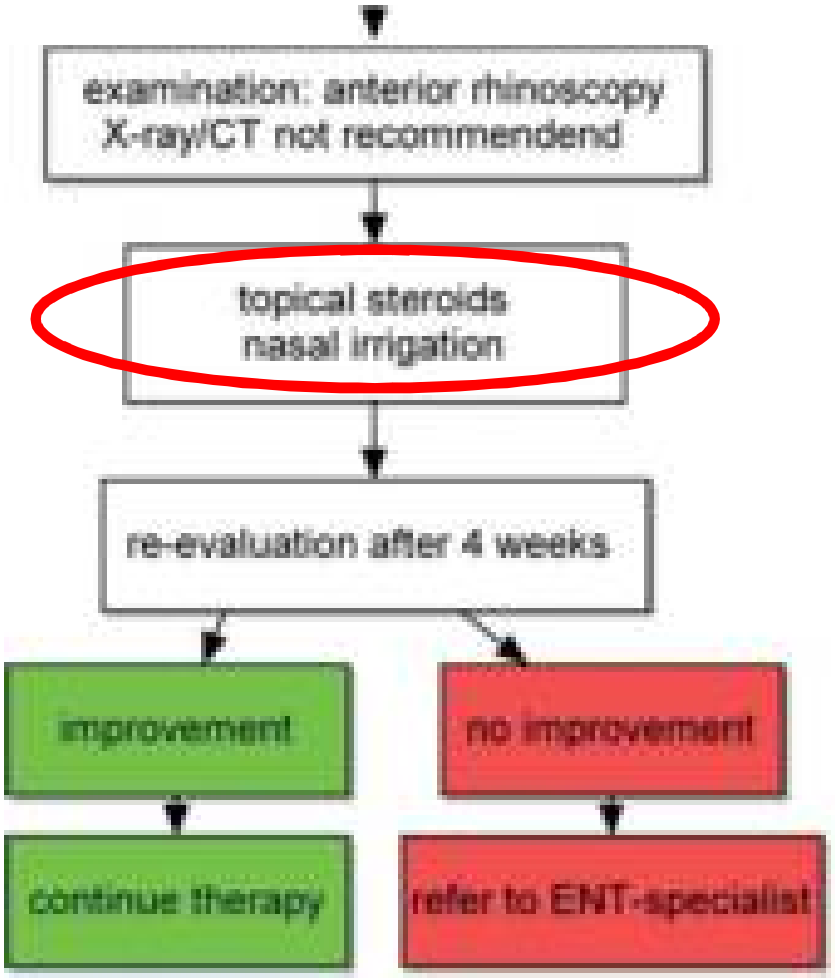

Postviral Acute Rhinosinusitis
Increase in symptoms after 5 days
Persistent symptoms after 10 days
Signs of potential acute bacterial rhinosinusitis:
At least 3 of:
- Discoloured discharge
- Severe local pain
- Fever
- Elevated ESR/CRP
- Double sickening*
(* : becoming worse again after initial recovery)
Symptoms
0
5
10
15
12
Days
Weeks

Management – Adults CRS



EPOS pocket guide 2012

Management – Adults CRS

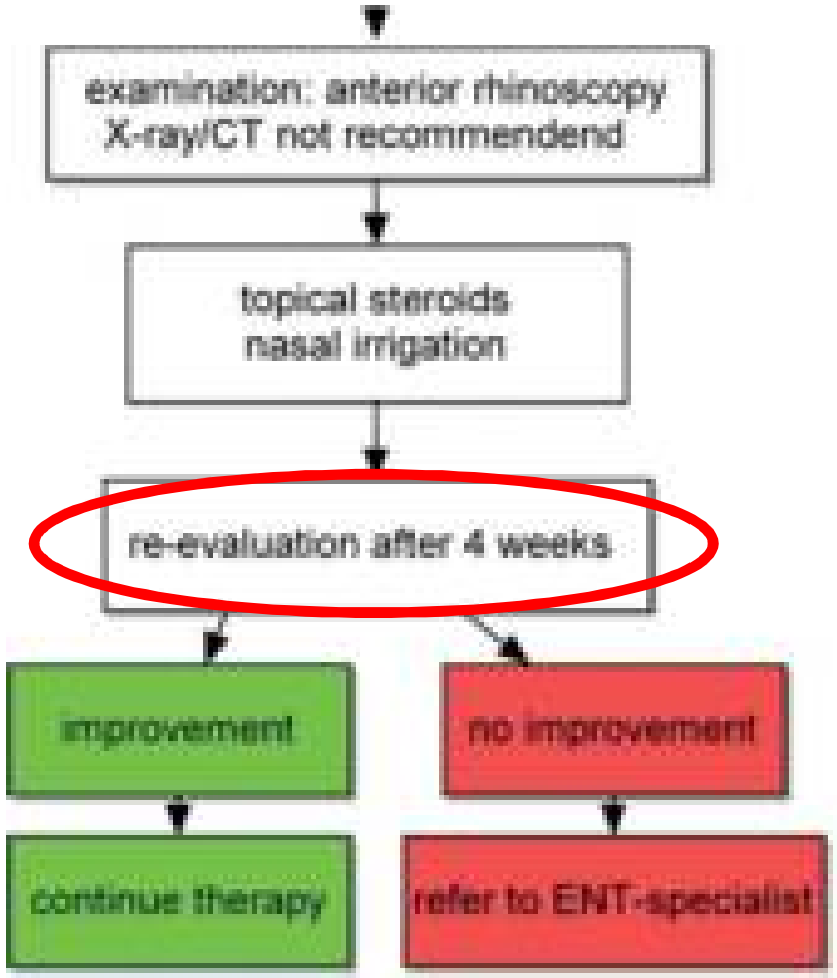


EPOS pocket guide 2012

Management – Adults CRS

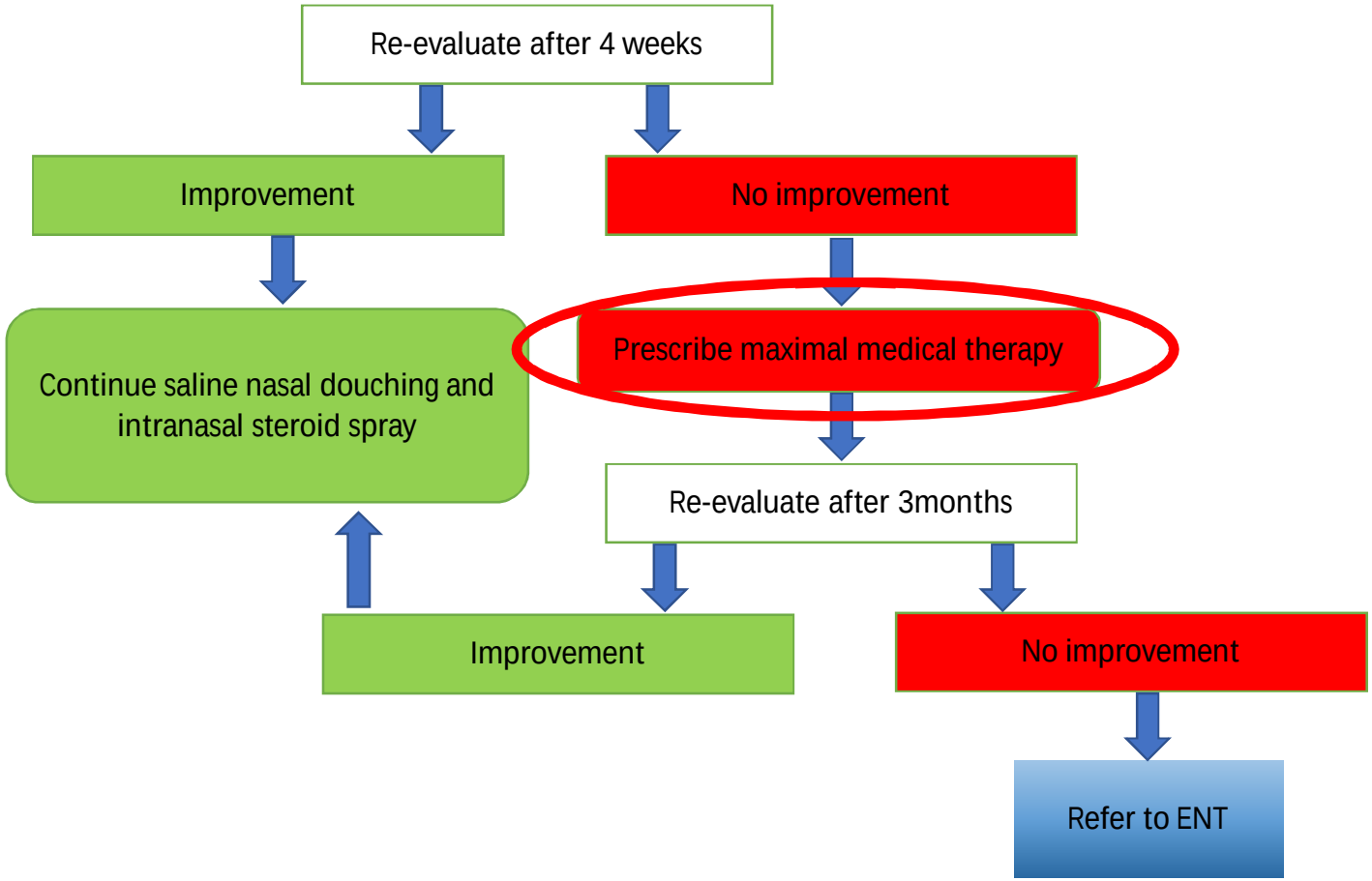
- Beware total daily dose of steroids
  - beclomethasone (beconase) 44% (6+)
  - budesonide (rhinocort) 33% (12+)
  - fluticasone furoate (avamys) 0.5% (6+)
  - fluticasone propionate (flixonase) 0.5% (4+)
  - mometasone furoate (nasonex) 0.1% (6+)
- Saline nasal douching
  - Neilmed Sinusrinse - bd
    - 240mls previously boiled water
    - ½ teaspoon of salt
    - 2-3 drops of baby shampoo

Management – Adults CRS



EPOS pocket guide 2012

Management – Adults CRS



Webb, Leong, Liverpool CCG 2018

Management – Adults CRS

- Maximal medical therapy
- CRS *without nasal polyps*
  - Saline nasal douching bd
    - (NeilMed sinus rinse)
  - Fluticasone propionate nasules 400mcg
    ½ nasule each nostril bd 3/12
  - Clarithromycin 250mg bd 3/12
  - (then continue nasal spray and saline douche long term or refer)

EPOS pocket guide 2012

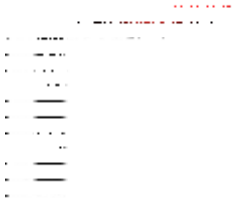
Management – Adults CRS

- Maximal medical therapy
- CRS *with nasal polyps*
  - Prednisolone 0.5mg/kg ~ 30 – 40 mg od 1/52
  - Saline nasal douching bd
    - (NeilMed sinus rinse)
  - Fluticasone propionate nasules 400mcg
    ½ nasule each nostril bd 3/12
  - Doxycycline 100mg od 3/52
  - (then continue nasal spray and saline douche long term or refer)

EPOS pocket guide 2012

Management – Surgery

- Useful in
  - Medical treatment failure
  - Deviated nasal septum
  - Inferior turbinate hypertrophy
  - Unilateral nasal polyposis?
  - Fungal sinusitis
  - Complications of acute or chronic rhinosinusitis



Nose/sinus questions?

Laryngopharyngeal reflux

- Gastric refluxate (liquid *or* aerosolised) reaches larynx
- Not GORD
- Contents?

Laryngopharyngeal reflux

Laryngopharyngeal reflux

- Pepsin
  - Proteolytic enzyme
  - Active at pH <6.5
  - Stable at pH 8
  - Denatured at pH >8
  - Active transport into laryngeal epithelium
  - Intracellular pH ~5

Laryngopharyngeal reflux

- “Heartburn” needs 350 reflux episodes per week
- LPR needs only 3 episodes > 30 seconds per week

Laryngopharyngeal reflux

- Risk factors: reduced competence of LOS
  - Hiatus hernia
  - Smooth muscle relaxants
  - Alcohol
  - Caffeine
  - Spicy foods
  - Fatty foods
  - Smoking

Laryngopharyngeal reflux

- Symptoms
  - Cough/throat clearing
  - Choking episodes (esp. night)
  - Hoarseness
  - Globus pharyngeus
  - Dry throat
  - Sore throat
  - Dysphagia to small items e.g. rice/tablets

Laryngopharyngeal reflux

- Management
  - Self help
  - Medical
  - Surgical

Laryngopharyngeal reflux

- Self help
  - Reduce alcohol, caffeine, spicy or fatty food
  - Avoid cola, fruit juices, tomatoes
  - Stop smoking
  - Lose weight
  - “Tooth whitening” chewing gum
  - Raise head of bed (not pillows)

Laryngopharyngeal reflux

- Medical treatment
  - PPI
  - Gaviscon advance

Laryngopharyngeal reflux

- Surgical treatment
  - Nissen fundoplication
  - Endoscopic techniques
    - Radiofrequency ablation
    - Endoscopic fundoplication

Laryngopharyngeal reflux

High dose PPI ½ hour before breakfast and evening meal. 10 ml (one tab) gaviscon advance at night and after meals

2/12

Low dose PPI ½ hour before breakfast and evening meal. 10 ml (one tab) gaviscon advance at night and after meals

2/12

Low dose PPI ½ hour before evening meal. 10 ml (one tab) gaviscon advance at night and after meals

Laryngopharyngeal reflux

PRN low dose PPI. Gaviscon advance 10ml (one tab) nocte and after meals. Lifestyle changes

Head and Neck Cancer

suspected cancer referral criteria 2015

REFERRAL INFORMATION*	
Laryngeal Cancer ¶ Aged 45 and over with¶ • Persistent unexplained hoarseness¶ or¶ • An unexplained lump in neck ¤	¶ ¶ Yes ☐ No ☐¶ ¶ Yes ☐ No ☐¤
Oral Cancer ¶ • Unexplained ulceration in oral cavity for more than 3 weeks¶	¶ Yes ☐ No ☐¶

http://www.nwcscnsenate.nhs.uk/index.php/download_file/view/2070/1672/

Head and Neck Cancer

suspected cancer referral criteria 2015

http://www.nwcscnsenate.nhs.uk/index.php/download_file/view/2070/1672/

Head and Neck Cancer

- Note that unilateral deafness/tinnitus are NOT part of current guidelines (not since 2003)
- Acoustic neuroma is benign and very slow growing

Head and Neck Cancer

- Laryngeal cancer
  - Persistent unexplained hoarseness in over 45s
  - Or unexplained neck lump

- How long is persistent?
- What about “explained”, is this the cause?

Head and Neck Cancer

- Concerns...
  - No inclusion of dysphagia or odynophagia
  - Dysphagia now on upper GI pathway
  - Risk of delay in diagnosis/treatment for e.g. hypopharyngeal cancer
  - Persistent sore throat not on any pathway I can find!

Head and Neck Cancer

- Suggest instead suspected cancer referral to ENT for…
  - ALL persistent hoarseness lasting >3/52
  - ALL persistent sore throat lasting >3/52
  - ALL persistent neck lumps >3/52
    (be aware that primary care arranged USS never includes FNA and incurs delay in referral/diagnosis)

Head and Neck Cancer questions?