ENT for the busy GP

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"If you had a mate working in ENT, what would you text them about?"

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Setting the Scene

Why is ENT important?

- Over 300 million GP consultations per annum
- 25% Adult Consultations
- Up to 50% Paediatric Consultations

- Niche surgical specialty
- No longer mandatory rotation in medical schools
- Expectation is to gain competence elsewhere
- GP Land – The pressure is on!

What my ‘mates’ text me about

- What can I refer to Acute/Emergency ENT Clinic?
- What really is OSA and a brief overview
- How do you treat/manage sudden onset hearing loss?
- Nosebleeds that don’t need A&E – triage and treatment(s)
- What drops are safe for tympanic membrane perforations?
- Bell’s Palsy and Facial Nerve Palsy
- Questions and Open Forum
- Dinner

Acute/Emergency Clinic

- Junior Doctor Led/Delivered – FY2, CT1/CT2/GPVTS
- Physician Associate in some places
- Aim is for urgent review, treat and discharge (Maybe one f/up)
- Most hospitals/ENT departments have one

- Call the ENT SHO on call at respective hospital
- Some places have direct email access for referral(s)
- NOT a shortcut to speed-up routine referrals or suspected cancer

Acute/Emergency Clinic - Yes

- Certain criteria for what is/isn't appropriate
- Care delivery/treatment is dependent on the doctor
- Usually multiple times per week, not OOH service

- Otitis Externa that requires micro-suction or is severe/narrow etc.
- Hard, impacted, ear wax that is causing the patient discomfort
- Nasal Injury with cosmetic deformity (Within 14 days of injury)
- Epistaxis that does not need A&E, but has not settled with creams
- Foreign Body in the ears – beads, bugs, other and earring in earlobe
- Sudden Sensorineural Hearing Loss and Facial Palsy (Lower Motor)

Acute/Emergency Clinic - No

- Suspicion of new cancer including lumps and bumps
- Patients with known cancer for urgent review(s)
- Expediting patients already referred due to delays

- Foreign Body in the nose
- Epistaxis which does not stop with conservative measures
- Hoarseness or changes in voice
- FOSIT or Globus for re-assurance
- Vertigo – Ongoing (Acute BPPV – Yes Please!)
- Tonsillitis or Quinsy – reduced oral intake or failed response to Rx

Obstructive Sleep Apnoea

- **UK prevalence of mild to severe obstructive sleep apnoea (OSA) in adults aged 30-69 years: 8 million (The Lancet Respiratory)**
- **Severe OSA has cumulative incidence of cardiovascular events of 35% at 10 years (The Lancet)**
- **CPAP is an effective 1st line treatment option but has a non-compliance rate of 34%**
- **Obstructive sleep apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s NICE guideline [NG202]Published: 20 August 2021 have now shifted to support referral of adult patients for consideration of ENT sleep surgery**
- **We receive tertiary sleep surgery referrals across North Central London and the UK**

Benjafield, A. V. et al. (2019) 'Estimation of the global prevalence and burden of obstructive sleep apnoea: a literature-based analysis', The Lancet Respiratory Medicine, 7(8), pp. 687–698. doi: 10.1016/S2213-2600(19)30198-5.

Marin, J. M. et al. (2005) 'Long-term cardiovascular outcomes in men with obstructive sleep apnoea-hypopnoea with or without treatment with continuous positive airway pressure: An observational study', Lancet, 365(9464), pp. 1046–1053. doi: 10.1016/S0140-6736(05)74229-X.

Obstructive Sleep Apnoea

THE LANCET

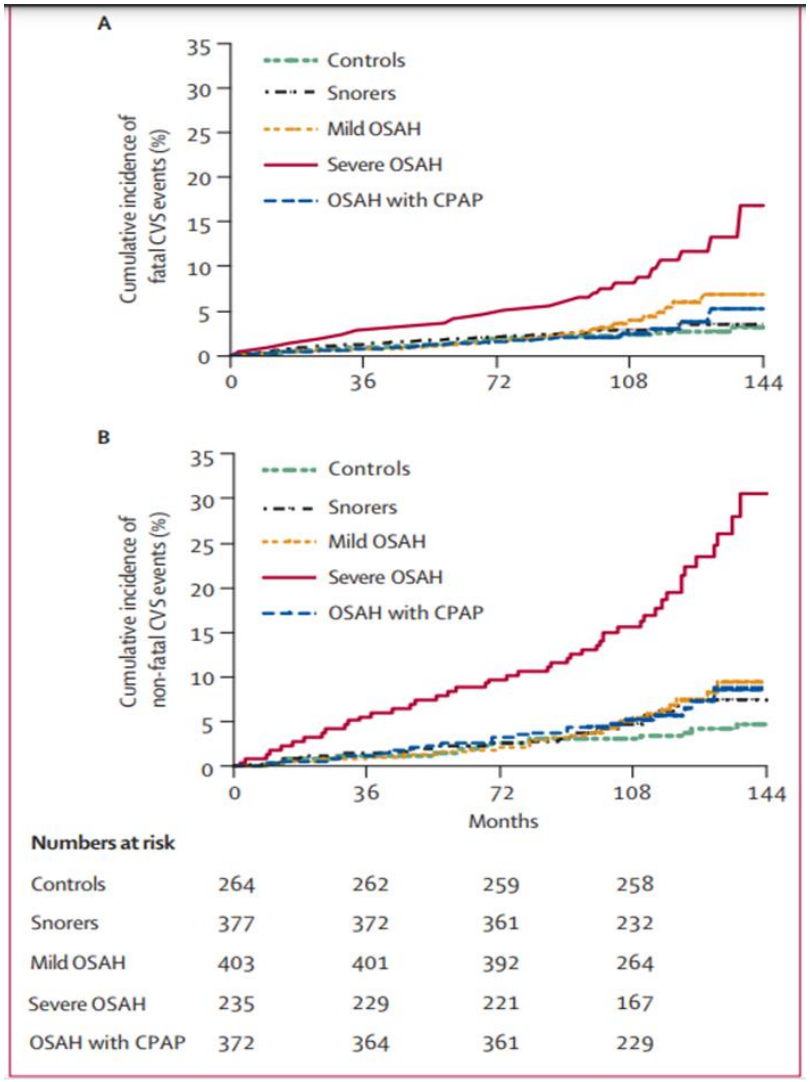
ARTICLES | VOLUME 365, ISSUE 9464, P1046-1053, MARCH 19, 2005

Long-term cardiovascular outcomes in men with obstructive sleep apnoea-hypopnoea with or without treatment with continuous positive airway pressure: an observational study

Dr Jose M Marin, MD • Santiago J Carrizo, MD • Eugenio Vicente, MD • Alvar GN Agusti, MD

Published: March 19, 2005 • DOI: https://doi.org/10.1016/S0140-6736(05)71141-7

Obstructive Sleep Apnoea



Numbers at risk

Controls	264	262	259	258
Snorers	377	372	361	232
Mild OSAH	403	401	392	264
Severe OSAH	235	229	221	167
OSAH with CPAP	372	364	361	229

Obstructive Sleep Apnoea

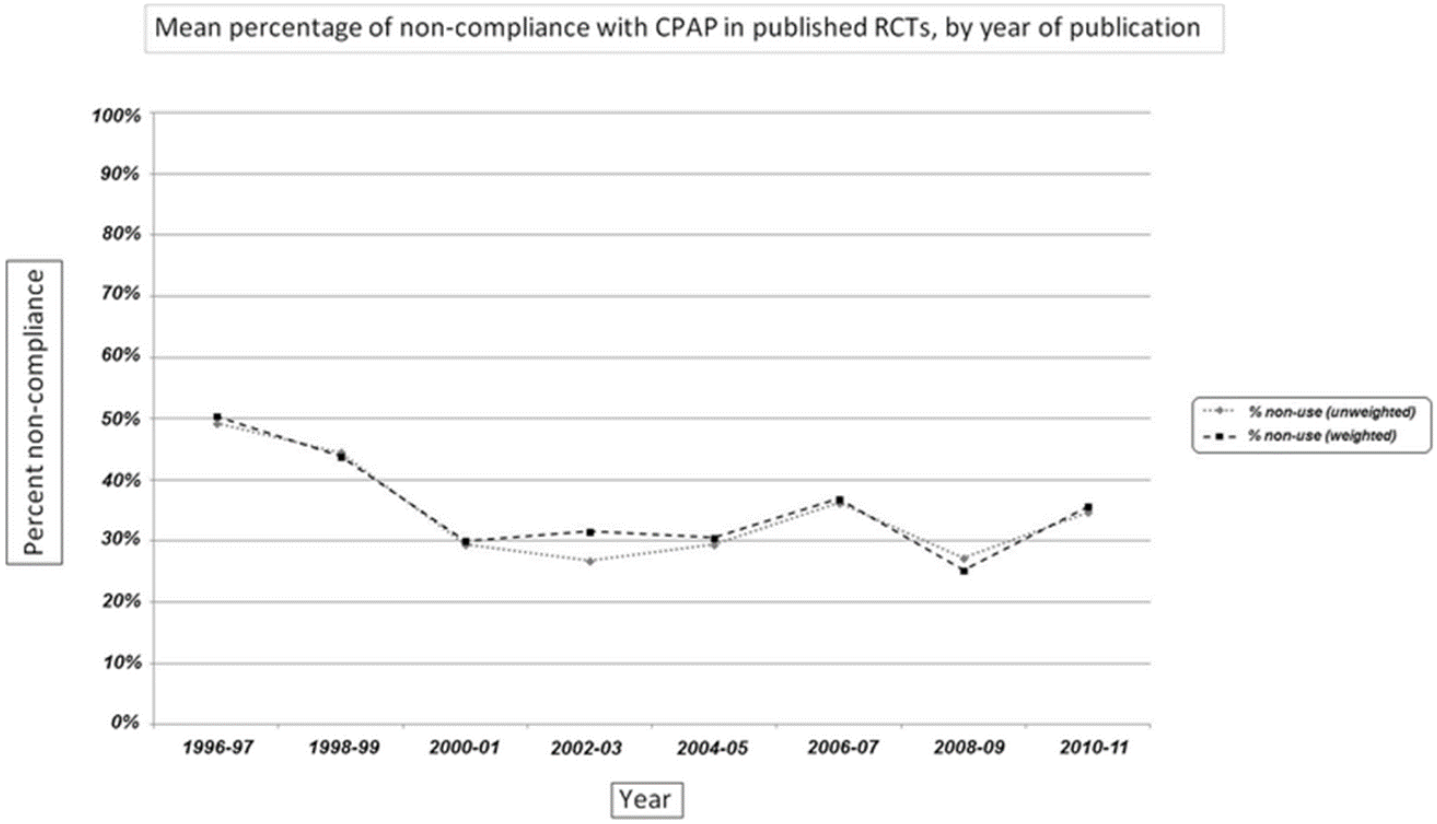
Original research article | Open Access | Published: 19 August 2016

Trends in CPAP adherence over twenty years of data collection: a flattened curve

Brian W. Rotenberg, Dorian Murariu & Kenny P. Pang

Journal of Otolaryngology - Head & Neck Surgery **45**, Article number: 43 (2016) | Cite this article

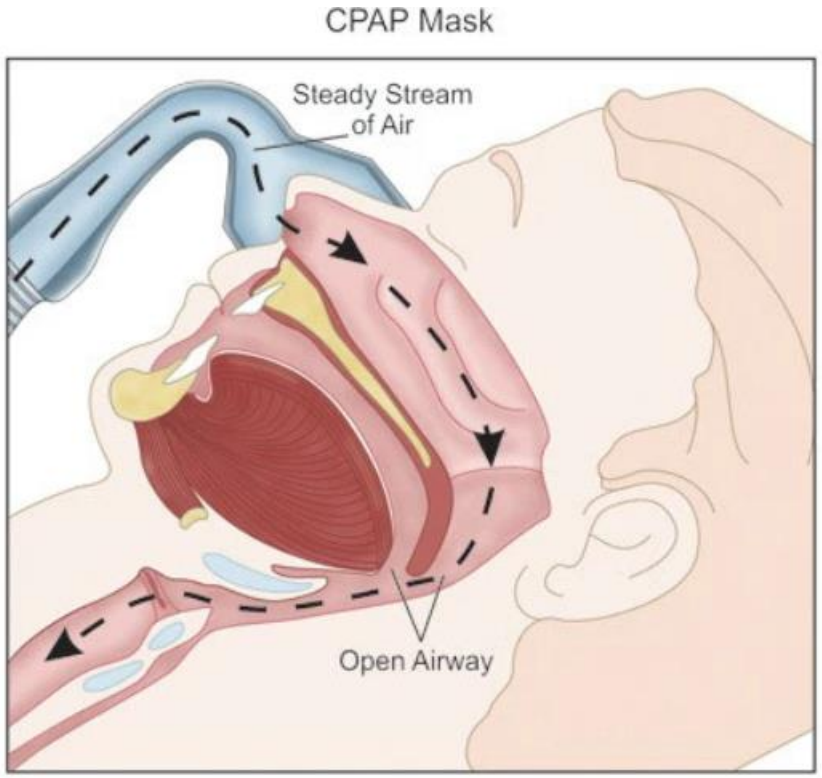
Obstructive Sleep Apnoea



WatchPAT One Home Sleep Study

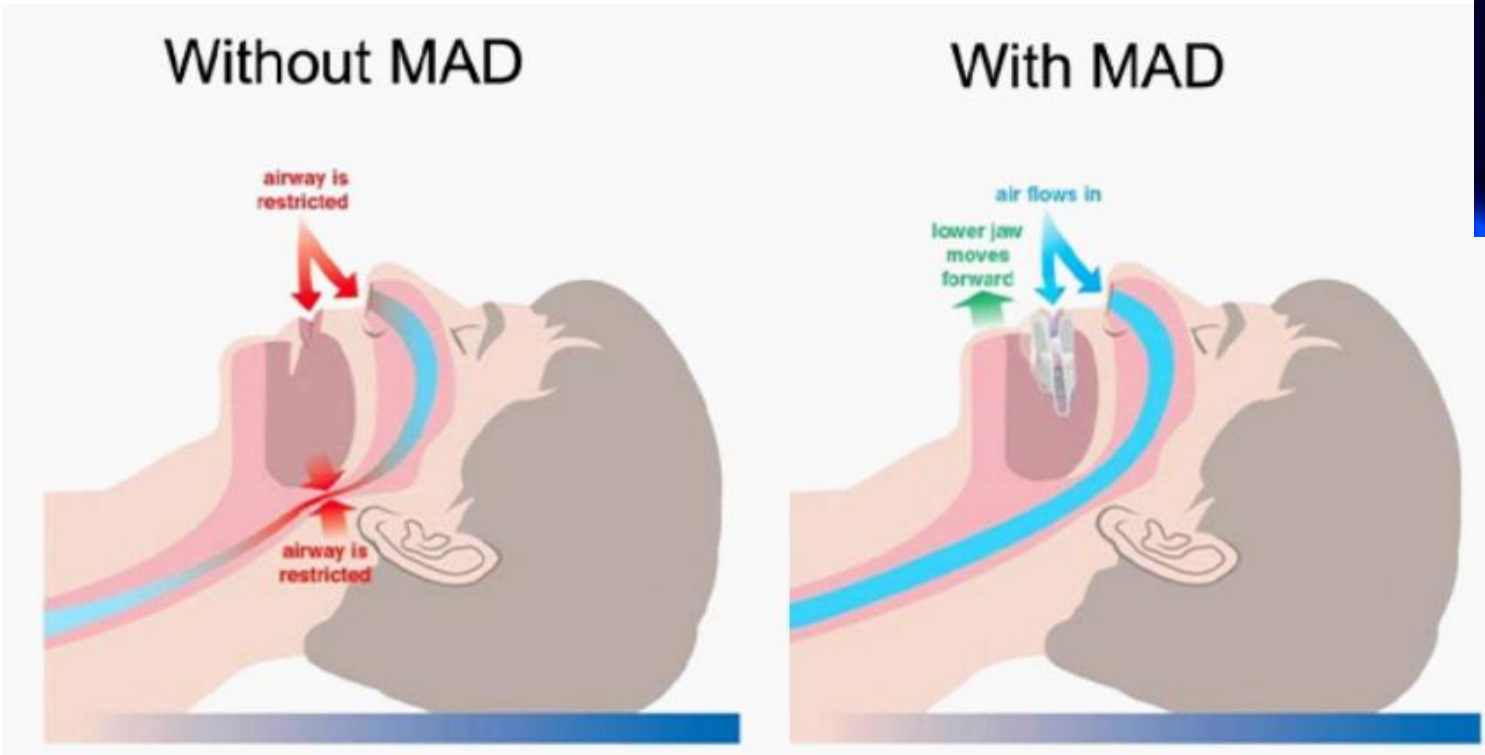
In-patient sleep study polysomnogram (PSG)

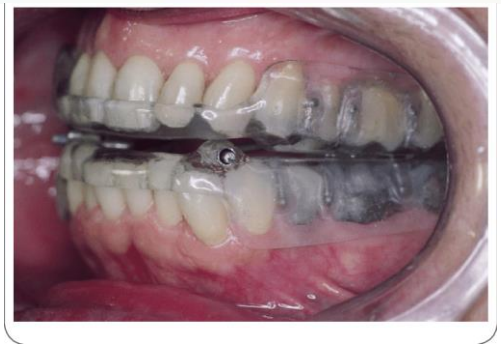
Continuous Positive Airway Pressure (CPAP)



CPAP mask fitting

Mandibular Advancement Device





Sleep Surgery that we all/Ryan Cheong offers on NHS

Drug induced sleep endoscopy (DISE)
Septoplasty
External septorhinoplasty
Turbinate reduction
Functional endoscopic sinus surgery

Tonsillectomy
Anterior palatoplasty
Expansion Sphincter Pharyngoplasty
Barbed Repositioning Pharyngoplasty
Lateral Pharyngoplasty

Coblation/radiofrequency tongue base reduction
Inspire hypoglossal nerve stimulator implant

NHS
University College London Hospitals
NHS Foundation Trust

ASIASLEEP CENTRE

Venue: University College Hospital Education Centre, 250 Euston Road, London, NW1 2PG

COURSE DIRECTORS	Mr. Ryan Cheong, UK	Dr. Kenny Pang, Singapore
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CONTACT US

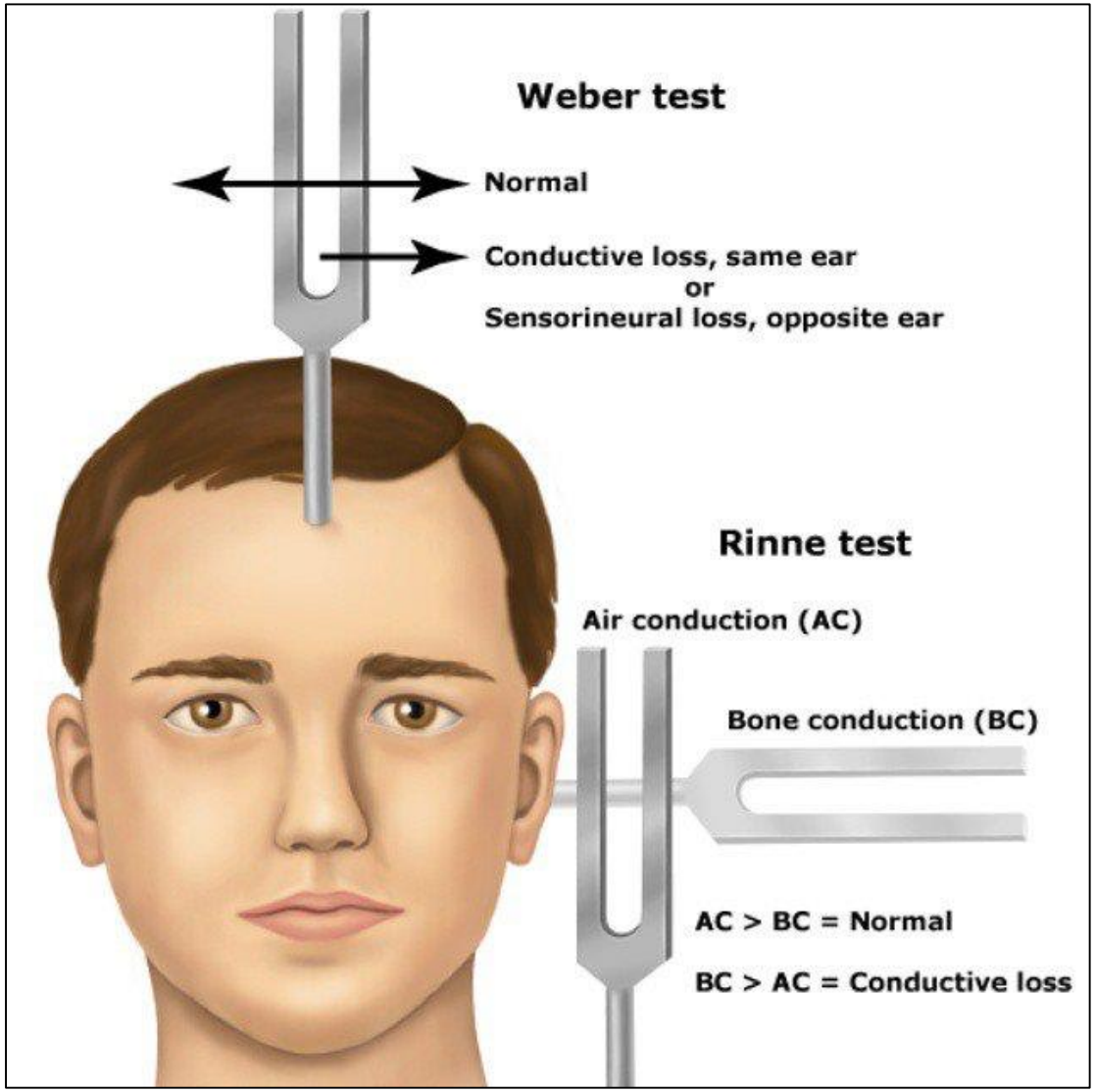
E-MAIL: courses@asiasleepcentre.com REGISTER: https://rsvp.sleepsurgerycourses.com

Sudden Onset Hearing Loss

- Difficult to assess over the phone
- Slightly easier in person – history is key
- Sudden is 'within 72 hours', usually same day
- Assess for any vertigo/dizziness – tinnitus is common

Test	Normal	Conductive hearing loss	Sensorineural hearing loss
Rinne's	AC>BC	BC>AC	AC>BC false positive
Weber's	heard in midline	heard in bad ear	heard in good ear

Rinnes and Webers Tests



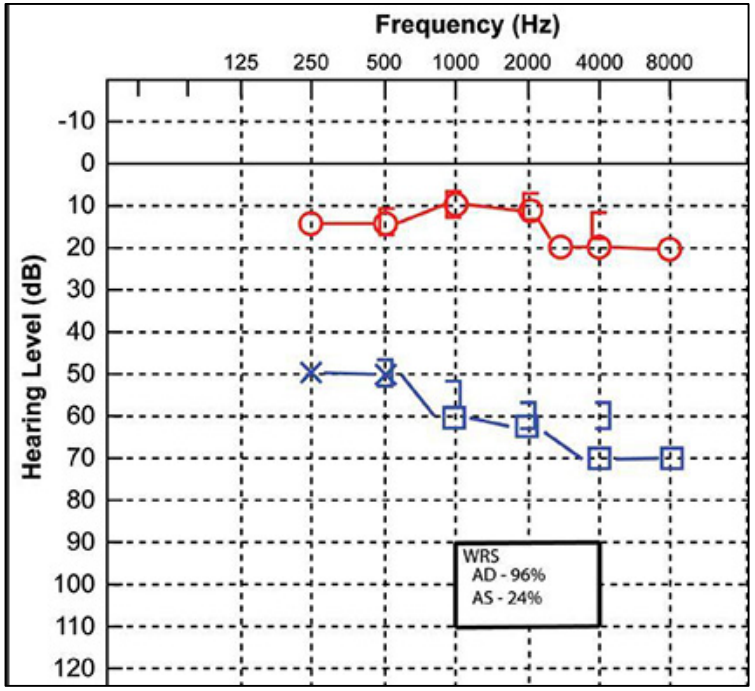
Hearing Loss - Sudden

- In this situation – Sudden Onset Sensorineural Loss
- Remember – It is a diagnosis of exclusion
- Acute – Temporary or Permanent (Cause dependent)

- Hearing loss is not uncommon
- Rule out traumatic/temporal bone fracture
- Rule out infection such as AOM/OE/OME
- Rule out foreign bodies/wax

Hearing Loss - Sudden

- History is Key – Unilateral/Bilateral, Timing, Changes
- Tinnitus
- Dizziness
- Facial Pain or Weakness
- Neurological Deficit
- Rash/Vesicles
- Any other symptoms



Hearing Loss - Sudden

- Sudden SensoriNeural Hearing Loss (SSNHL)

- FULL Ear, Nose, Throat and Head and Neck Examination
- Check the Facial Nerve
- Tuning Fork – Rinne's and Weber's Assessments
- Nasoendoscopy – PNS and Eustachian Tubes
- Audiogram with Tympanometry
- Consider the cause and decide the treatment(s)

Hearing Loss - Sudden

- Sudden SensoriNeural Hearing Loss (SSNHL) – Viral
- History and Examination
- Bloods – Routine, Autoimmune (Full), HIV/Syphilis, TFT
- Imaging – MRI of the Internal Auditory Meati (IAM)

- Start Treatment ASAP (preferably within 72 hours, but up to 7 days)

SSNHL - Treatment

- Treat any other/obvious causes prior to diagnosis
- High dose steroids – Prednisolone 60mg, PO, OD with PPI Cover
- 7 to 10 days initially, then review/repeat audiogram
- We will consider Intra-tympanic Steroid (Methylprednisolone)
- If improved subjectively and/or repeat audiograms
- Await imaging and blood test results to confirm diagnosis

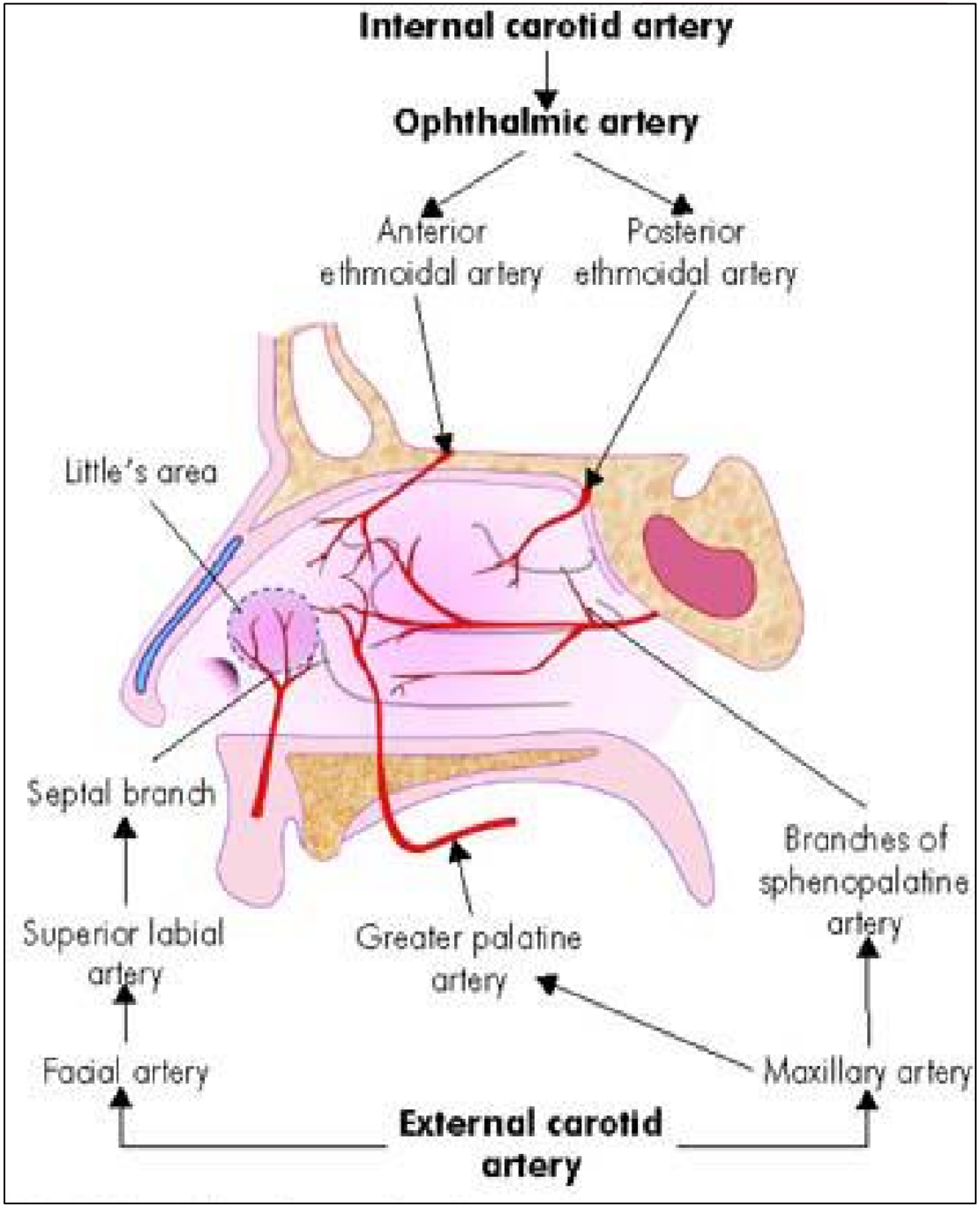
Epistaxis

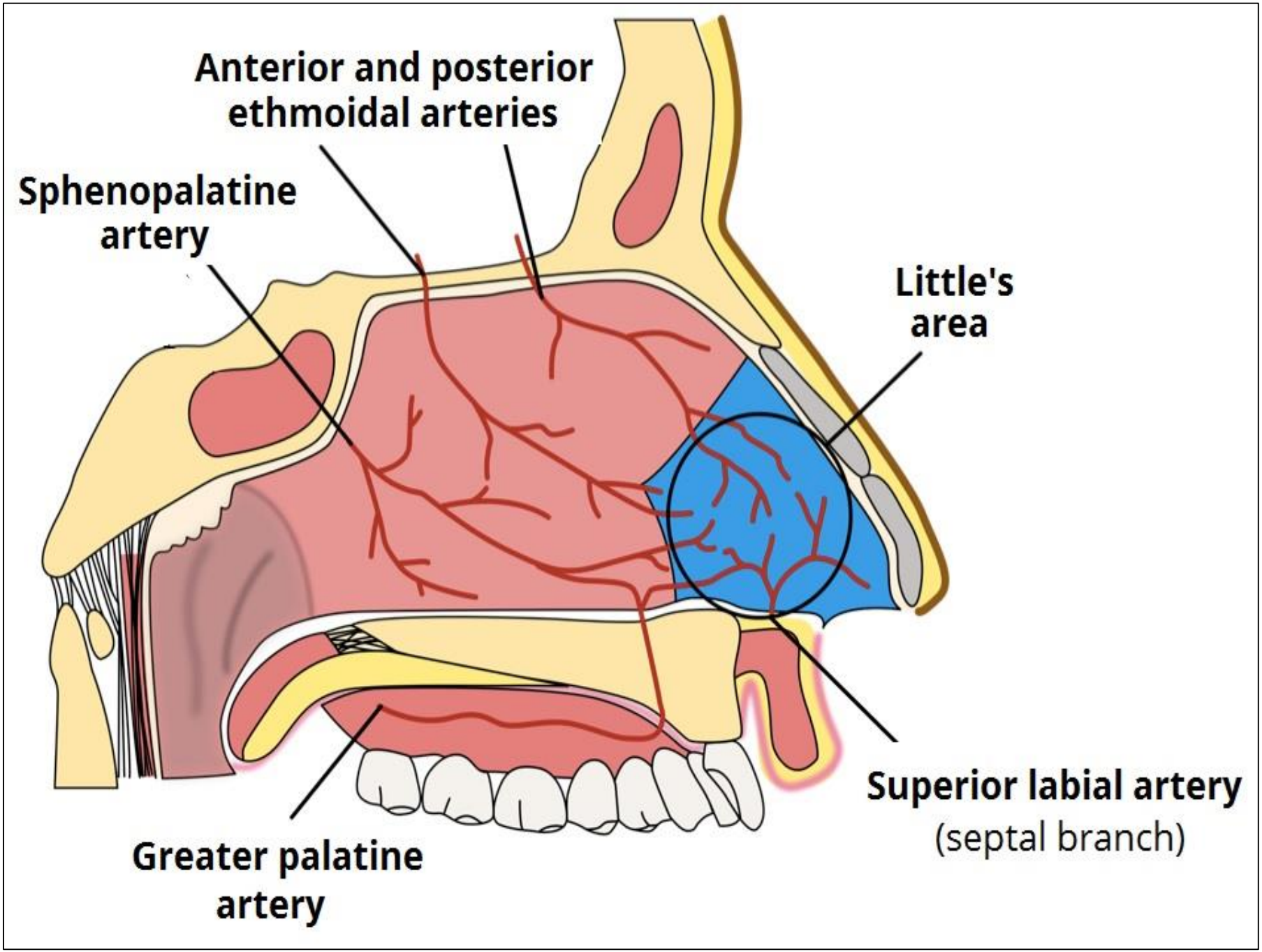
- Nosebleed (AKA)
- Common Presentation
- Usually Self-Limiting
- Multi-Factorial

- Anterior / Posterior
- Life-Threatening (Rare)

Anatomy

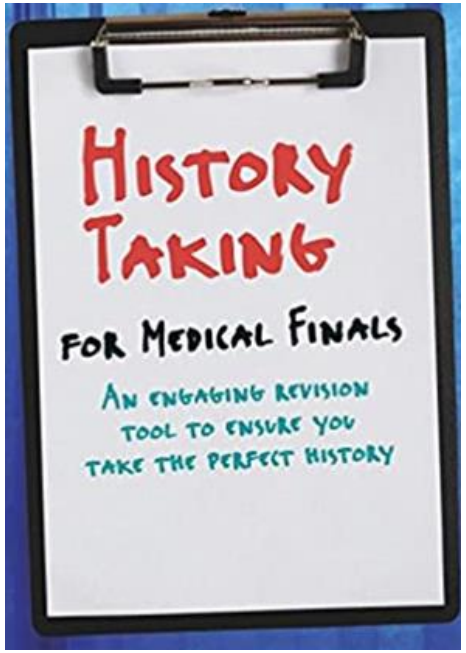
- Anterior / Posterior
- 70% are anterior
- Highly Anastomotic
- Littles / Kiesellbach's
- In elderly / over 70 yrs
- Usually posterior
- Sphenopalatine Artery
- More difficult to manage




Anterior and posterior ethmoidal arteries
Sphenopalatine artery
Little's area
Superior labial artery (septal branch)
Greater palatine artery

Epistaxis – Risk Factors

- Local – Trauma (Foreign Body and Nose Picking)
  - Iatrogenic (Recent Nasal Surgery)
  - Cocaine
  - Inflammatory (Rhinitis/Environment)
  - Neoplastic
- General – Hypertension
  - Anticoagulation or Coagulopathy
  - Antiplatelets
  - HHT / Bleeding Disorders



Epistaxis – Clinical History

- History is key – Where is the patient?
- Unilateral or Bilateral
- Swallowing blood or trickling down throat
- Self-limiting or required packing/intervention
- Estimated volume of blood loss – how can we quantify?
- Obs – HR, RR and BP (High/Low!)
- Age and PMH
- Medications
- Remember the risk factors

Ladder of Treatment - Stable

Pinch soft part of nose for 20 minutes, head forward
Apply ice pack to forehead and nape of neck
Suck on an ice cube

Suction the blood and clots and clean the nose
Adrenaline soaked gauze into anterior nose - 10 mins
Consider medication if high blood pressure

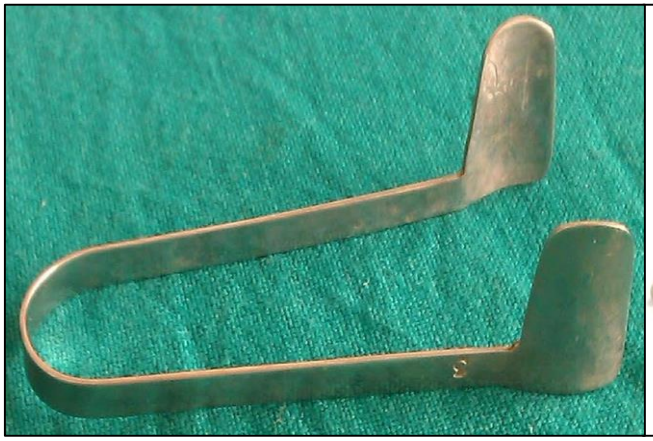
Examine the nose to assess for the bleeding point(s)
Cauterise with silver nitrate (Cautery Stick)

If doesn't stop/looks unstable, can insert Surgicel
Can insert Nasopore with Naseptin cream into nostril

If bleeding stops, send home with Naseptin cream
Book into emergency ENT clinic in 1-2 weeks time

Epistaxis – Nasal Cautery

- Anterior bleeds only – Easy to Learn and replicate
- Direct visualisation of vessel required
- Tools - Nasal Thudichum speculum and a headlight
- Topical adrenaline and Lignocaine/Co-Phenylcaine Spray
- Cauterise bleeding point and 5mm radius – Out to In
- Consider Surgical/Nasopore with Naseptin cream



Epistaxis – Easy way out

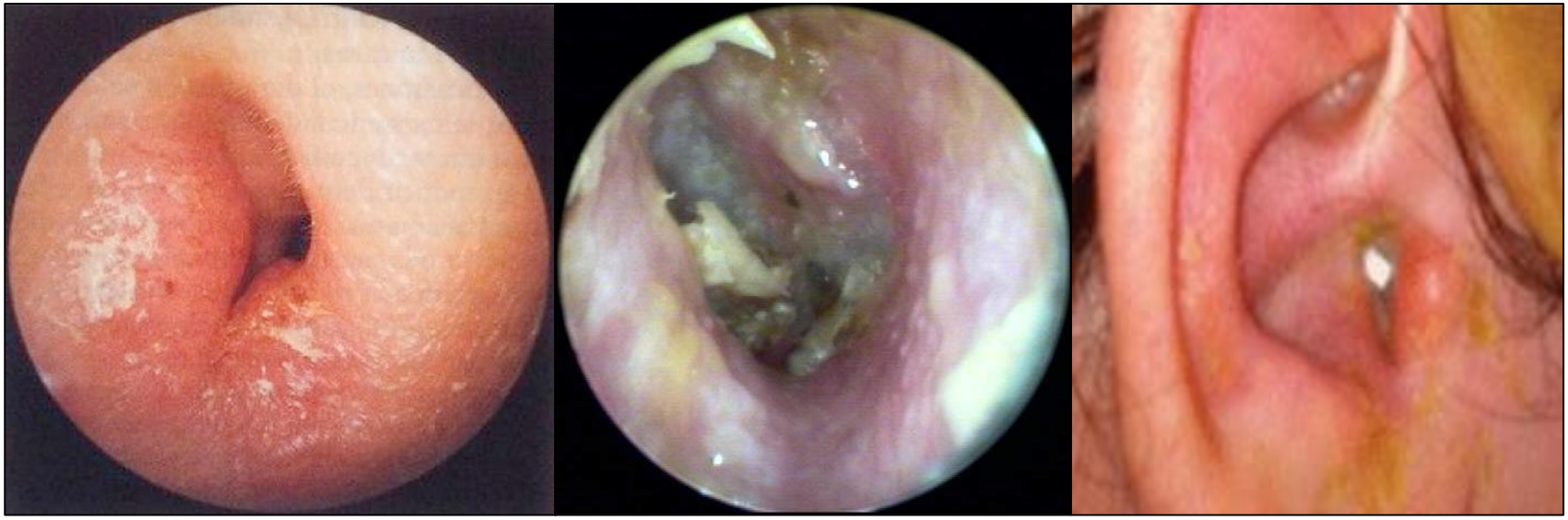
Trial Triple Cream therapy, 2 weeks each:

- Naseptin (Ensure not allergic to peanut)
- Fucidin
- Bactroban
- Nasal Douching is helpful

- Lifestyle advice – avoid heavy lifting and picking!
- If this does not work – refer to ENT emergency clinic
- Unilateral epistaxis, intermittent, elder patient – 2ww please

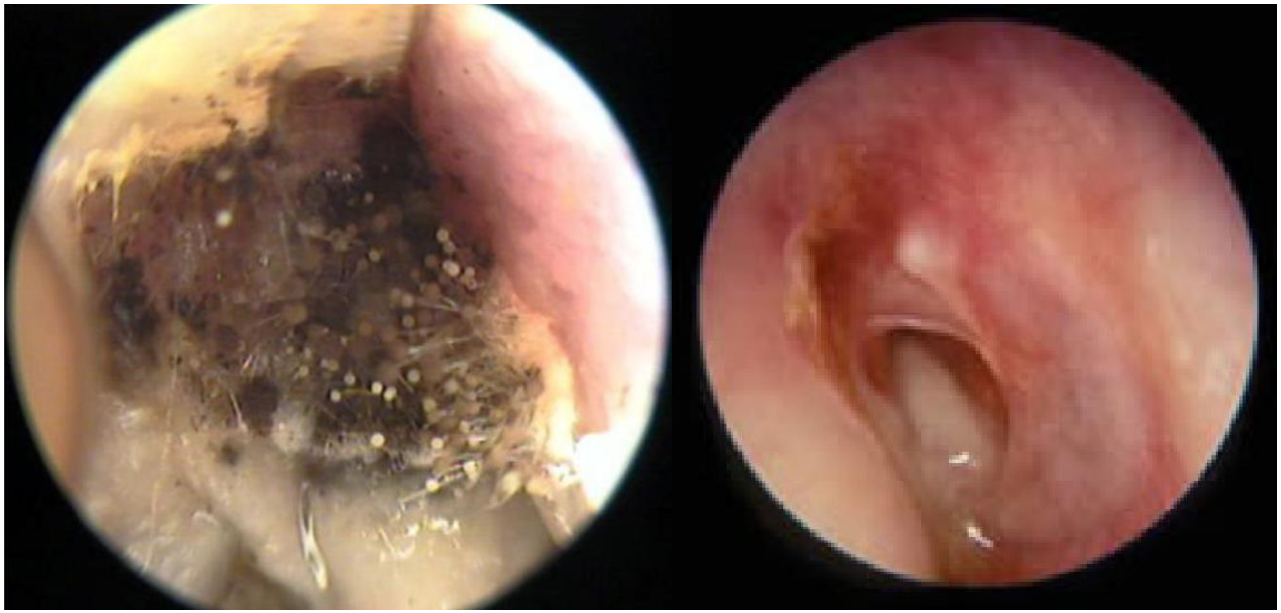
Ear Drops – What can I use?

- Ear drops are excellent for Otitis Externa
- Assess if Bacterial or Fungal – Itching ++
- Usually fullness, discharge, hearing loss, pain
- Almost always due to water exposure history



Ear Drops – What can I use?

- Think Fungal if itching ++
- Often due to excess antibiotic/steroid drops
- Water exposure is still most common cause



TM Perforations – What is safe?

- Acute or Chronic
- Acute – Trauma or Infection

- Trauma – Penetrating Injury or Head Injury (Skull Base Fracture)
- Infection – Otitis Externa in a known chronic TM perforation
- Infection – Acute Otitis Media or OME with Infection

- What drops are safe to us – Answer is: All of them?!

TM Perforations – What is safe?

- ENT UK Guidelines suggest that infection is ototoxic
- Therefore leaving infection without drops is harmful
- Perhaps even more harmful than using an ototoxic ear drop
- Steroid based ear drops are only really needed if lots of oedema

None of us want a deaf/unhappy patient, therefore, batting order:

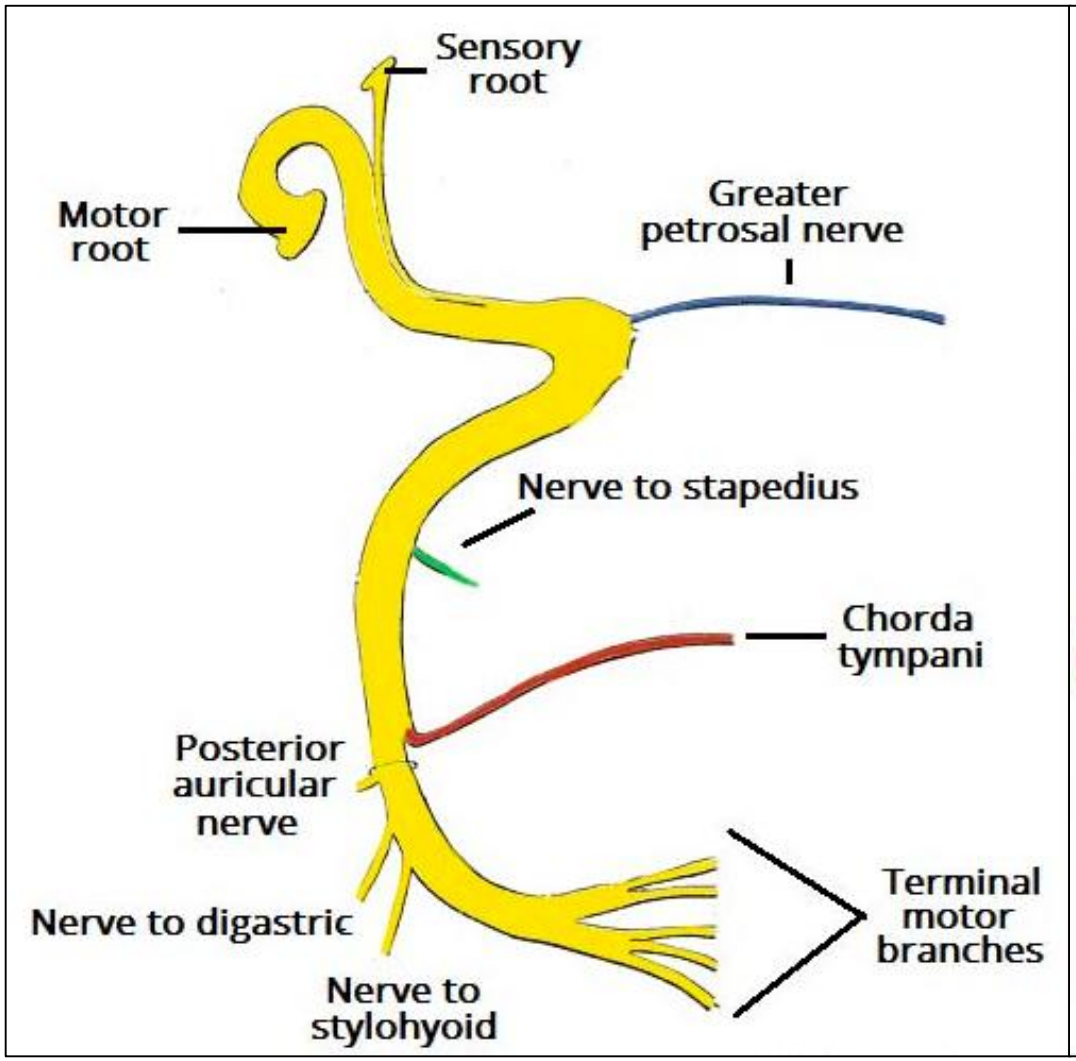
- Ciprofloxacin
- Betnesol-N
- Sofradex
- Gentamycin based ear drops

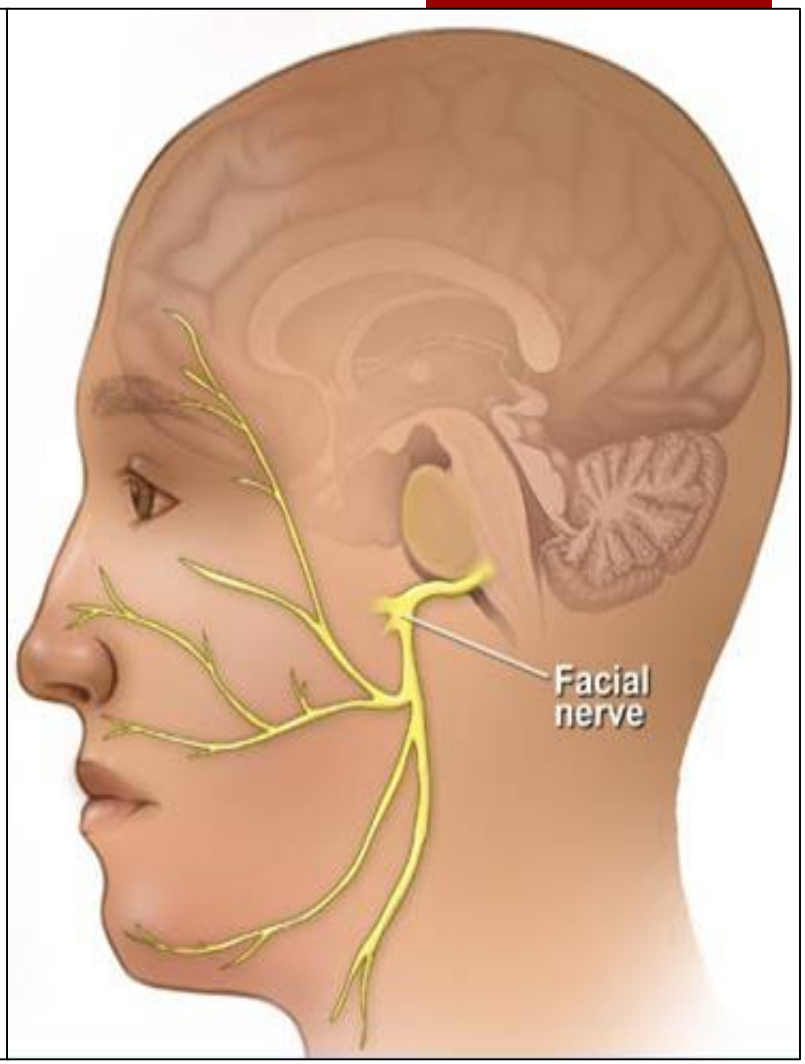
Facial Nerve Palsy

- Partial of Total Paralysis of the Facial Nerve
- Usually isolated cranial nerve palsy – but must check
- Mostly unilateral – check for subtle weakness opposite
- Can be a Central or Peripheral cause

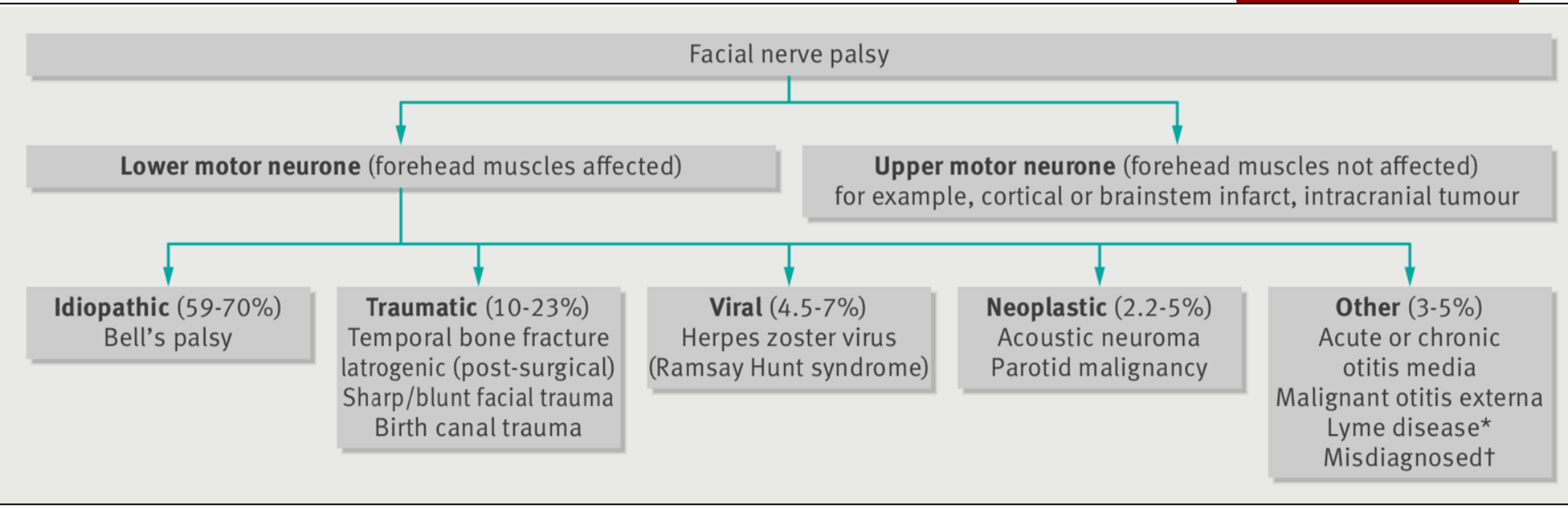
- Facial Nerve is important in communication/expression
- Can impact and affect ones quality of life

The Facial Nerve





Facial Nerve Palsy - Causes



- Bell's Palsy – Idiopathic – Most Common – Exclude others
- Differentiate Upper* from Lower ASAP – Refer Early*
- Take a very good history

Assessment

- Take a very good history
- Thorough ENT examination including oral cavity/parotid
- Examine Facial Nerve – House Brackmann Grading
- Upper or Lower Motor Neurone
- Examine other Cranial nerves
- Audiogram and Tympanogram

Grading – House Brackmann

Grade	Description	Characteristics
I	Normal	Normal facial function in all areas
II	Mild dysfunction	Slight weakness noticeable on close inspection; may have very slight synkinesis
III	Moderate dysfunction	Obvious, but not disfiguring, difference between 2 sides; noticeable, but not severe, synkinesis, contracture, or hemifacial spasm; complete eye closure with effort
IV	Moderately severe dysfunction	Obvious weakness or disfiguring asymmetry; normal symmetry and tone at rest; incomplete eye closure
V	Severe dysfunction	Only barely perceptible motion; asymmetry at rest
VI	Total paralysis	No movement

- Please document at initial presentation

Eye Care Advice

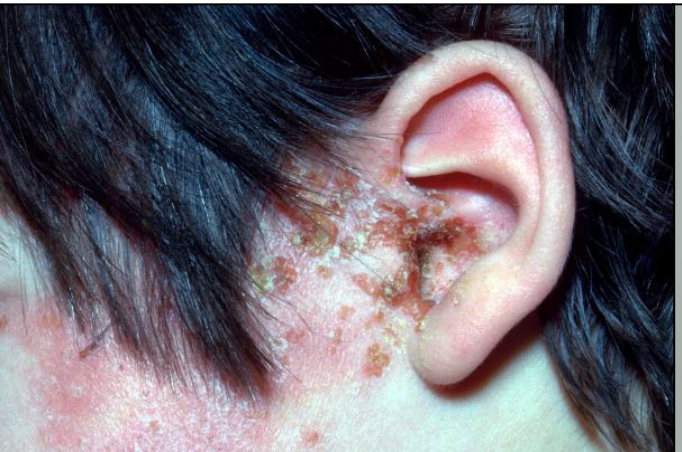
- If cannot fully close their eye, need to protect
- Document eye examination

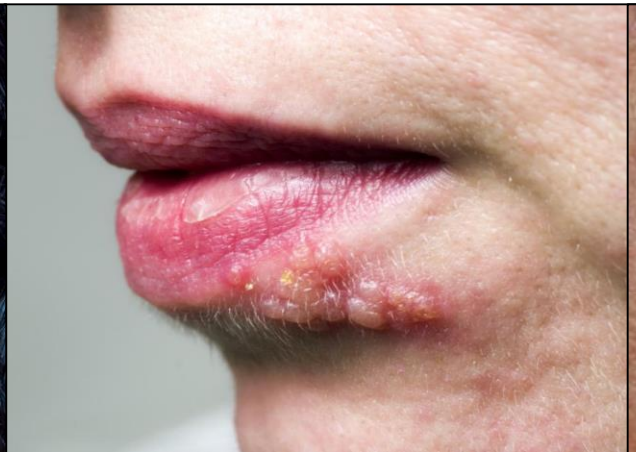
- Viscotears – 2 drops, four times per day
- Lacrilube – 1 application, twice daily
- Tape eye closed at night
- Keep a close eye, monitor for deterioration

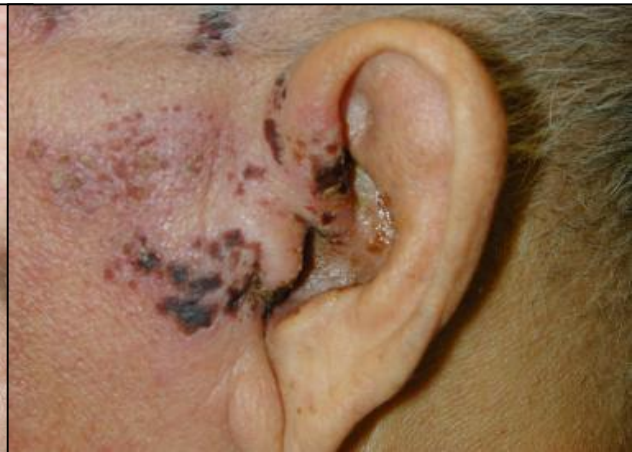
- Referral to Ophthalmology: On-going care and management

Ramsay Hunt Syndrome

- Caused by Varicella Zoster Virus (VZV)
- Re-activation of VZV in Geniculate Ganglion (CN-VII)
- Combination of Vesicles/OE with Facial Nerve Palsy
- Look for vesicles on ear, in ear canal, face, oral cavity
- Always ensure to grade the facial nerve palsy

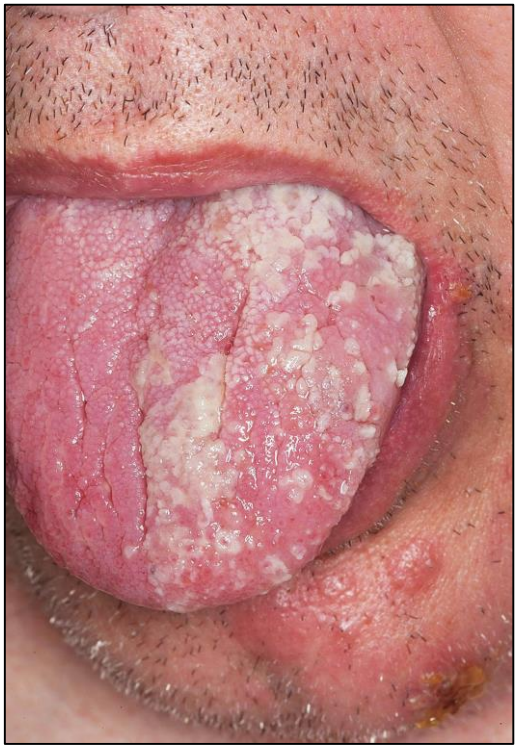






Ramsey Hunt Syndrome

- Otalgia with burning type pain/sensation
- Hearing Loss/Tinnitus/Dizziness - Vestibulocochlear
- Vesicles or Crusting
- Taste Disturbance
- Facial Weakness
- Facial Paraesthesia – Trigeminal
- Prednisolone
- Famciclovir / Aciclovir



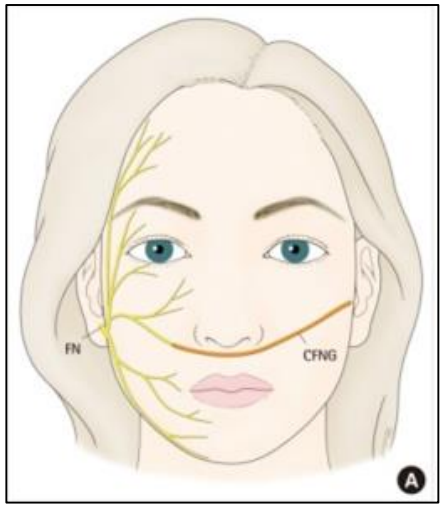
Bell's Palsy

- Diagnosis of exclusion, despite being the commonest
- Thought to be idiopathic with viral component
- Inflammatory process
- Benign course with good chance of recovery
- Prednisolone – Start as early as possible (<72 hours)
- Facial muscle exercises
- Organise ENT follow-up in 2 to 3 weeks
- Consider early referral to Ophthalmology, if indicated

ENT Management

- Ensure has had steroids for 7-10 days, consider 14 days
- Ensure has had hearing test and full examination
- If weakness is NOT improving, MRI of the IAM
- Strict, regular, outpatient monitoring with grading
- Referral to Tertiary Centre – Facial Function/Palsy Clinic (UCLH)

- Botox Injections
- Gold Weight insertion into eyelid
- Facial reanimation surgery



Thank You to you ALL!