

# THE ALFRED REFERRAL GUIDELINES: ENT / OTOLARYNGOLOGY

## Referral priority guide

### Pharynx, tonsil and adenoid:

Acute tonsillitis

Recurrent tonsillitis

Peritonsillar cellulitis / quinsy

Chronic tonsillitis

Infectious mononucleosis / viral pharyngitis

Adenoiditis / hypertrophy

Upper airways obstruction from adenotonsillar hypertrophy

Tonsillar haemorrhage

Neoplasm

### Hoarseness:

Associated with upper respiratory tract infection

Associated with neck trauma or thyroid surgery

Associated with respiratory obstruction and stridor

Without associated symptoms or obvious aetiology

### Dysphagia:

### Neck mass:

Inflammatory ie painful

Non-inflammatory ie painless

Thyroid mass

### Salivary gland disorders:

Sialadenitis / sialolithiasis – acute or recurrent

Salivary gland mass

### Nasal and sinus:

Epistaxis – persistent or recurrent

[Persistent nasal obstruction](#)

[Acute sinusitis](#)

[Chronic sinusitis / polyposis](#)

[Facial pain](#)

[Allergic rhinitis / vasomotor rhinitis](#)

[Acute nasal fracture](#)

[Foreign bodies](#)

[Ear – foreign body](#)

[Ear infections:](#)

[Acute otitis media](#)

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[Otalgia without significant clinical findings in the ear canal or drum](#)

[Hearing loss:](#)

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[Chronic or episodic](#)

[Facial paralysis](#)

## THE ALFRED REFERRAL GUIDELINES ENT / OTOLARYNGOLOGY

### Referral priority guide

<b>Immediate</b> <ul style="list-style-type: none"> <li>▪ Severe or persistent epistaxis</li> <li>▪ Tonsillar haemorrhage</li> <li>▪ Hoarseness associated with neck trauma or surgery</li> <li>▪ Laryngeal obstruction and/or fracture</li> <li>▪ Acute nasal fracture with septal haematoma.</li> <li>▪ Complicated mastoiditis/cholesteatoma or sinusitis (peri-orbital cellulitis, frontal sinusitis with persistent frontal headache)</li> <li>▪ Pharyngeal/laryngeal foreign body</li> <li>▪ Abscess or haematoma, eg peritonsillar abscess, septal or auricular haematoma, paranasal sinus pyocele.</li> <li>▪ Nasal foreign body – battery</li> <li>▪ Barotrauma with sudden onset vertigo</li> </ul>	<p>Phone the ENT Registrar on call on 9076 2000 and/or send to The Alfred Emergency &amp; Trauma Centre.</p>
<b>Urgent</b> <ul style="list-style-type: none"> <li>▪ Malignant neoplasm of the head and neck, eg larynx, nasopharynx, oral cavity, tonsil, unexplained cervical lymphadenopathy</li> <li>▪ Sub acute dyspnoea/airways problems, eg laryngeal papilloma, laryngeal stridor</li> <li>▪ Acute facial nerve trauma</li> <li>▪ Documented sinusitis not responding to conservative management</li> <li>▪ Paranasal sinus mucocele</li> <li>▪ Fracture of paranasal sinus</li> <li>▪ Nasal fracture with external nasal deformity</li> <li>▪ Hoarseness with significant dysphagia or present for more than 4 weeks</li> <li>▪ Progressive or persistent dysphagia</li> <li>▪ Neck masses</li> </ul>	<p>Urgent cases must be discussed with the ENT Registrar to obtain appropriate prioritisation and then a referral letter faxed to 9076 6938.</p> <p>Likely to receive an appointment within 1-2 weeks.</p>
<b>Soon</b>	<p>Likely to receive an appointment within 2-6 weeks.</p>
<b>Intermediate</b>	<p>Likely to receive an appointment within 6-12 weeks.</p>
<b>Non-urgent</b> <ul style="list-style-type: none"> <li>▪ Elective tonsillitis after quinsy</li> <li>▪ Chronic tonsillitis</li> <li>▪ Adenoiditis</li> </ul>	
<b>Not seen</b>	<p>Children under 16 years of age are not seen at the Alfred.</p>
<p><b>Please note:</b> The times to assessment may vary depending on size and staffing of the hospital department.</p> <p>If you are concerned about the delay of the outpatient appointment or if there is any deterioration in the patient's condition, please contact the ENT Registrar on call on 9076 2000.</p>	

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# THE ALFRED REFERRAL GUIDELINES ENT / OTOLARYNGOLOGY

## Pharynx, tonsil and adenoid

Evaluation

Management

Referral Guidelines

### Acute tonsillitis

Throat pain and odynophagia, plus any of:

- Fever
- Tonsillar exudate
- Cervical lymphadenopathy

Acute referral if unable to tolerate oral fluids, not responding to treatment or failure to cope - contact ENT registrar on 9076 2000 or send to the Alfred Emergency & Trauma Centre.

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### Recurrent tonsillitis

- ?documented pus on tonsils in each episode

- Refer to ENT OPD if 4 or more episodes in preceding 12 months, depending on severity or circumstances

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### Peritonsillar cellulitis / quinsy

Abscesses take >4 days to develop:

- Unilateral tonsillar displacement
- Trismus
- Fever
- Cervical lymphadenopathy
- Severe odynophagia

IM Penicillin and review in 24 hours

- Acute referral to Otolaryngology with:
- Abscess – Immediate, contact ENT registrar or send to The Alfred Emergency & Trauma Centre
- Peritonsillar cellulitis if not resolving
- Elective tonsillectomy later in patients with preceding/subsequent tonsillitis/quinsy – PRIORITY 3

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### Chronic tonsillitis

Frequent or chronic throat pain and odynophagia; may include:

- Intermittent exudate
- Adenopathy
- Improvement with antibiotics

Referral is indicated if problem recurs following adequate response to treatment – PRIORITY 3

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### Infectious mononucleosis / viral pharyngitis

Throat pain and odynophagia with:

- Fatigue
- Membranous tonsillitis
- Posterior cervical lymphadenopathy
- CBC, Mono test

- Supportive care
- Consider systemic steroids if severe dysphagia

Airways obstruction, dehydration or failure to cope– refer urgently - contact ENT registrar on 9076 2000 or send to The Alfred Emergency & Trauma Centre

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### Adenoiditis / hypertrophy

- Purulent rhinorrhoea
- Nasal obstruction +/- snoring
- Chronic cough

- Persisting symptoms and findings after two courses of antibiotics – PRIORITY 3
- Associated sleep apnoea – PRIORITY 2

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### Upper airway obstruction from Adenotonsillar hypertrophy (especially in children)

- Nasal obstruction
- Severe snoring +/- sleep apnoea
- Daytime fatigue

Referral indicated with any significant symptoms of upper airway obstruction especially sleep apnoea – PRIORITY 1

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### Tonsillar haemorrhage

- Spontaneous bleeding from tonsil
- Post-tonsillectomy (secondary haemorrhage usually occurs within 2 weeks post op)

Penicillin + Flagyl

- Immediate referral indicated if bleeding persists, recurs or is **significant** – contact ENT registrar or send to The Alfred Emergency & Trauma Centre

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### Neoplasm

Progressive enlargement of mass or ulceration in the oral cavity or pharynx. Often painless initially but may be pain, odynophagia or dysphagia

Urgent referral to ENT OP indicated – PRIORITY 1

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# THE ALFRED REFERRAL GUIDELINES ENT / OTOLARYNGOLOGY

## Hoarseness

Evaluation	Management	Referral Guidelines
<b>Hoarseness associated with upper respiratory tract infection</b>		
<ul style="list-style-type: none"> <li>▪ Throat pain, may radiate to ear</li> <li>▪ Dysphagia</li> <li>▪ Constitutional symptoms</li> <li>▪ Stridor/airways obstruction</li> </ul>		ENT referral indicated if: <ul style="list-style-type: none"> <li>▪ Stridor or airway distress – Immediate referral – Contact ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>▪ Associated with significant dysphagia – PRIORITY 1</li> <li>▪ Hoarseness present &gt;4 weeks – PRIORITY 1</li> </ul> <p style="text-align: right;"><a href="#">Return to contents page</a></p>
<b>Hoarseness associated with neck trauma or thyroid surgery</b>		
History of neck trauma preceding hoarseness May or may not have: <ul style="list-style-type: none"> <li>▪ Skin laceration</li> <li>▪ Ecchymoses</li> <li>▪ Tenderness</li> <li>▪ Subcutaneous emphysema</li> <li>▪ Stridor</li> </ul>		Urgent referral indicated in all cases – contact ED registrar and send to The Alfred Emergency & Trauma Centre <p style="text-align: right;"><a href="#">Return to contents page</a></p>
<b>Hoarseness associated with respiratory obstruction and stridor</b>		
		<ul style="list-style-type: none"> <li>▪ Immediate referral indicated in all cases – contact ENT registrar and send to The Alfred Emergency &amp; Trauma Centre</li> </ul> <p style="text-align: right;"><a href="#">Return to contents page</a></p>
<b>Hoarseness without associated symptoms or obvious aetiology</b>		
<ul style="list-style-type: none"> <li>▪ History of tobacco and alcohol use</li> </ul> Evaluation when indicated for: <ul style="list-style-type: none"> <li>▪ Hypothyroidism</li> <li>▪ Diabetes Mellitus</li> <li>▪ Gastro-oesophageal reflux</li> <li>▪ Rheumatoid disease</li> <li>▪ Pharyngeal/oesophageal tumour</li> <li>▪ Lung neoplasm</li> <li>▪ Chest XR</li> </ul> <p><a href="#">The Alfred Radiology request form</a></p>		<ul style="list-style-type: none"> <li>▪ ENT referral is indicated if recent onset hoarseness persists over four weeks despite medical therapy – especially in a smoker – PRIORITY 1</li> </ul> <p style="text-align: right;"><a href="#">Return to contents page</a></p>
<b>Dysphagia</b>		
Evaluation	Management	Referral Guidelines
May include history or findings of: <ul style="list-style-type: none"> <li>▪ Foreign body ingestion</li> <li>▪ Gastro-oesophageal reflux</li> <li>▪ Oesophageal motility disorder</li> <li>▪ Scleroderma</li> <li>▪ Neoplasm</li> <li>▪ Thyroid enlargement</li> </ul>	Diagnostic studies may include: <ul style="list-style-type: none"> <li>▪ Soft tissue studies of the neck including lateral XR</li> <li>▪ Chest x-ray</li> <li>▪ Barium swallow</li> </ul> Thyroid studies if appropriate <a href="#">The Alfred Radiology request form</a>	ENT referral indicated if: <ul style="list-style-type: none"> <li>▪ Hypo-pharyngeal or upper oesophageal foreign body suspected (mid-lower oesophageal lesions and foreign bodies normally referred to General Surgery/Gastroenterology) – refer immediately to The Alfred Emergency &amp; Trauma Centre if acute</li> <li>▪ Dysphagia with hoarseness – PRIORITY 1</li> <li>▪ Progressive dysphagia or persistent dysphagia for three weeks PRIORITY 1-2 depending on circumstances.</li> </ul> <p style="text-align: right;"><a href="#">Return to contents page</a></p>



## THE ALFRED REFERRAL GUIDELINES ENT / OTOLARYNGOLOGY

### Nasal and sinus

#### Evaluation

#### Management

#### Referral Guidelines

### Epistaxis – persistent or recurrent

- Determine whether bleeding is unilateral or bilateral
- Determine whether bleeding is anterior or posterior
- Determine if coagulopathy, platelet disorder or hypertension is present
- Medications – NSAIDS, aspirin, Warfarin?

- Immediate control may occur with:
- Pressure on the nostrils (>5 mins)
  - If bleeder is visible in Little's area consider cautery with silver nitrate (after applying topical anaesthesia) using firm pressure for 60 seconds
- Intranasal packing coated with antibiotic ointment only by skilled person with good equipment

- Referral to an Otolaryngologist if:
- Bleeding is posterior –refer immediately – contact The Alfred Emergency & Trauma Centre registrar or send to The Alfred Emergency & Trauma Centre, or PRIORITY 1
  - Bleeding persists – refer immediately to The Alfred Emergency & Trauma Centre or phone ENT registrar
  - Bleeding recurs – PRIORITY 1

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### Persistent nasal obstruction

#### Symptoms:

- Nasal obstruction (uni/bilateral, altering), postnasal discharge, recurrent sinusitis
- Physical examination requires intranasal examination after decongestion: deviated septum, enlarged turbinates, nasal polyps

- Treat any associated allergy or sinusitis

- Refer if simple measures fail – PRIORITY 3
  - ENT referral is imperative if there is an offensive bloody discharge – PRIORITY 1
- NOTE:** In unilateral nasal obstruction with an offensive, bloody discharge:
- In a child – consider a foreign body
  - In an adult – consider a malignancy – particularly in wood workers

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### Acute sinusitis

Unilateral or bilateral nasal congestion, usually evolving from a viral URTI. Signs of sinusitis include:

- Purulent discharge
- Facial, forehead or periorbital
- Dental pain
- Persisting URTI > 7 days

History and physical examination may be non-contributory

- CT scan rarely indicated

[The Alfred Radiology request form](#)

#### Initial treatment:

- Broad spectrum antibiotics eg Augmentin, Rulide or Ceclor for at least 2 – 4 weeks
  - Systematic decongestants, antipyretics, supportive therapy
  - Consider steroid therapy
- NOTE:** Antihistamines may cause adverse effects
- Topical decongestants sprays to a maximum of 5 days

#### Otolaryngology referral indicated if:

- Antibiotic treatment fails, clinically PRIORITY 1-2
- Complications occur: periorbital cellulitis, persistent frontal headache – refer immediately – contact ENT registrar or send to The Alfred Emergency & Trauma Centre
- Recurrent infections: over three episodes in a one year period – PRIORITY 3
- Consider early referral for acute frontal sinusitis

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### Chronic sinusitis / polyposis

#### Symptoms:

- Persistent or recurrent nasal congestion (unilateral or bilateral)
- Postnasal discharge
- Epistaxis
- Recurrent acute sinusitis
- Anterior facial pain, migraine and cluster headache
- Physical examination requires intranasal examination after decongestion
- CT scan at The Alfred is indicated (NB The Alfred has a 64 slice multislice CT scanner available, and clinicians can access results immediately via the PACS system)

[The Alfred Radiology request form](#)

- Antibiotics
- Nasal decongestant sprays (5/7)
- Topical steroid sprays
- Consider short course of steroids (eg 20mg daily/2 weeks)

- Consider Otolaryngology referral if symptoms persist
  - Persisting abnormal symptoms, abnormal findings and/or abnormal radiographs warrant referral – PRIORITY 3
  - In some cases an earlier appointment may be required
- NOTE:** in unilateral nasal obstruction with an offensive, bloody discharge:
- In a child – consider a foreign body – PRIORITY 1
  - In an adult – consider a malignancy – PRIORITY 1

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# THE ALFRED REFERRAL GUIDELINES

## ENT / OTOLARYNGOLOGY

### Nasal and sinus continued

Evaluation	Management	Referral Guidelines
<b>Facial pain</b>		
<ul style="list-style-type: none"> <li>▪ May be an isolated symptom or may be associated with significant nasal congestion or discharge</li> <li>▪ Potential relations to intranasal deformity, sinus pathology, dental pathology, TMJ dysfunction, altered V nerve function and skull base lesions</li> <li>▪ Consider CT scan at The Alfred if appropriate NB The Alfred has a 64 slice multislice CT scanner available, and clinicians can access results immediately via the PACS system) <a href="#">The Alfred Radiology request form</a></li> </ul>	<ul style="list-style-type: none"> <li>▪ If there is evidence of acute sinusitis treat with appropriate antibiotics</li> </ul>	<ul style="list-style-type: none"> <li>▪ Referral indicated for persisting facial pain. May include dental and otolaryngology opinions – PRIORITY 2</li> </ul> <p style="text-align: right;"><a href="#">Return to contents page</a></p>
<b>Allergic rhinitis / vasomotor rhinitis</b>		
<p>Symptoms – seasonal or perennial:</p> <ul style="list-style-type: none"> <li>▪ Congestion esp. alternating</li> <li>▪ Watery discharge</li> <li>▪ Sneezing fits</li> <li>▪ Watery eyes</li> <li>▪ Itchy eyes and/or throat</li> <li>▪ Physical examination:</li> <li>▪ Boggy, swollen, bluish turbinates</li> <li>▪ Allergic shiners</li> <li>▪ Allergic "salute"</li> </ul>	<ul style="list-style-type: none"> <li>▪ Avoidance</li> <li>▪ Skin prick testing or RAST testing</li> <li>▪ Topical steroid sprays</li> <li>▪ Antihistamines</li> <li>▪ Oral steroids up to 10/7</li> <li>▪ For acute cases consider five days nasal decongestants</li> <li>▪ Avoid prolonged use of decongestants due to risk of rhinitis medicamentosa</li> </ul>	<ul style="list-style-type: none"> <li>▪ Consider ENT referral if symptoms do not respond to medical management – PRIORITY 3</li> </ul> <p style="text-align: right;"><a href="#">Return to contents page</a></p>
<b>Acute nasal fracture</b>		
<ul style="list-style-type: none"> <li>▪ Immediate changes: oedema, ecchymosis, epistaxis</li> <li>▪ Evaluate for septal fracture or septal haematoma</li> <li>▪ Nasal x-rays unnecessary</li> <li>▪ Check for # zygoma, dental injury or middle third #</li> <li>▪ CT scan if suspect facial #</li> <li>▪ OPG for suspected jaw fracture <a href="#">The Alfred Radiology request form</a></li> </ul>	<ul style="list-style-type: none"> <li>▪ Early treatment: cool compresses to reduce swelling'</li> <li>▪ Re-evaluate at 3-4 days to ensure nose looks normal and if breathing is normal</li> </ul>	<ul style="list-style-type: none"> <li>▪ Immediate ENT referral if acute septal haematoma (usually significant nasal obstruction)– contact ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>▪ ENT referral initiated now if there is a new external nasal deformity.</li> </ul> <p><b>NOTE:</b> Nasal fractures must be reduced &lt;2 weeks for best results</p> <p style="text-align: right;"><a href="#">Return to contents page</a></p>
<b>Foreign bodies</b>		
<p><b>Acute:</b></p> <ul style="list-style-type: none"> <li>▪ History alone or visible on examination</li> </ul> <p><b>Chronic</b></p> <ul style="list-style-type: none"> <li>▪ Persistent, offensive unilateral nasal discharge in a child</li> </ul>	<ul style="list-style-type: none"> <li>▪ Don't attempt removal unless experienced and with good equipment</li> </ul>	<ul style="list-style-type: none"> <li>▪ Urgent referral for removal – REFER IMMEDIATELY TO The Alfred Emergency &amp; Trauma Centre – contact ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>▪ <b>Immediate referral if battery (corrode)</b></li> <li>▪ Otolaryngology referral for removal – PRIORITY 1</li> </ul> <p style="text-align: right;"><a href="#">Return to contents page</a></p>

# THE ALFRED REFERRAL GUIDELINES ENT / OTOLARYNGOLOGY

## Ear

### Evaluation

### Management

### Referral Guidelines

## Foreign body

Usually visible if acute

Remove only if technically easy

Otolaryngology referral– PRIORITY 1

## Ear infection

### Acute otitis media

Symptoms:

- Otolgia, hearing loss, aural discharge, fever.
- Examination
- Inflamed tympanic membrane TM, bulging TM, desquamated epithelium on TM, middle ear effusion.

Initial treatment (consider withholding antibiotics):

- Broad Spectrum antibiotic, Amoxycillin, Co-trimoxazole
- Analgesia: Paracetamol
- Topical nasal decongestants and in adults, systematic decongestants
- If there is associated allergy, topical nasal steroid sprays could be considered

Secondary treatment:

- If primary treatments fail, try a B-Lactamase resistant antibiotic, eg Augmentin

- Immediately if complications noted: mastoiditis, facial weakness, dizziness, meningitis – REFER IMMEDIATELY TO The Alfred Emergency & Trauma Centre
- Secondary antibiotic treatment fails to control acute symptoms – refer immediately to The Alfred Emergency & Trauma Centre /phone ENT registrar or PRIORITY 1 depending on severity

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### Chronic suppurative otitis media

Symptoms:

- Chronic discharge from the ear/s, hearing loss

Examination

- Perforation of drum (especially attic or postero-superiorly granulation tissue and/or bleeding)

Complications suggested by:

- Post auricular swelling/abscess, facial palsy, vertigo, headache – refer immediately – phone ENT registrar or send to The Alfred Emergency & Trauma Centre

- Aural toilet (not syringing)
- Culture directed antibiotic therapy: systemic and copious aural drops (Sofradex)
- Protect ear from water exposure

- Otolaryngology referral indicated for persistent symptoms despite appropriate treatment – PRIORITY 2-3.
- Associated symptoms suggest urgency needed – PRIORITY 1

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### Acute otitis externa

Symptoms:

- Otolgia, significant ear tenderness, swollen external auditory canal +/- hearing loss

Examination

- Ear canal always tender, usually swollen. Often unable to see TM because of debris or canal oedema

- Swab for org./fungi.

**NOTE:** Fungal Otitis Externa may have spores visible

- Topical treatment is optimal and systemic antibiotics alone are often insufficient. Systemic Antibiotics indicated when there is cellulitis around the canal
- Insertion of an expandable wick with topical antibacterial medication useful when the canal is narrowed
- In fungal OE, thorough cleaning of the canal is indicated, plus topical antifungal therapy (Kenacomb, Locorten-Vioform)

**NOT for syringing**

Referral to an Otolaryngologist when:

- Canal is swollen shut and wick cannot be inserted – immediate referral
- Cerumen impaction complicating OE – PRIORITY 2
- Unresponsive to initial course of wick and antibacterial drops – PRIORITY 1
- Diabetics, suspected malignancy and immunosuppressed on examination require urgent referral – phone ENT registrar or send to The Alfred Emergency & Trauma Centre

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### Otolgia without significant clinical findings in the ear canal or drum

Symptoms:

- Ear pain without tenderness or swelling

Examination

- Normal ear canal and TM
- Type A Tympanogram

**NOTE:** Mastoiditis in the presence of a normal drum and without previous infection is almost impossible

- Requires a diagnosis and appropriate treatment. Possible aetiologies include:
- TMJ syndrome; neck dysfunction; referred pain from dental pathology, tonsil disease, sinus pathology and head and neck malignancy; particularly tonsil/hypopharynx/larynx

Referral to an Otolaryngologist indicated if pain persists more than three weeks and aetiology not identified – PRIORITY 2

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## THE ALFRED REFERRAL GUIDELINES ENT / OTOLARYNGOLOGY

### Hearing loss

Evaluation	Management	Referral Guidelines
<b>Bilateral symmetrical hearing loss</b>		
Symptoms: <ul style="list-style-type: none"> <li>▪ Diminished hearing any associated symptoms eg tinnitus, discharge, vertigo etc?</li> </ul> Examination <ul style="list-style-type: none"> <li>▪ Cerumen, effusion, or normal findings</li> </ul>	<ul style="list-style-type: none"> <li>▪ Cerumen dissolving drops and possible suction or irrigation</li> <li>▪ Oral decongestant, Valsalva manoeuvres and re-evaluate in three weeks</li> <li>▪ Requires audiometry +/- referral</li> </ul>	Referral indicates if: <ul style="list-style-type: none"> <li>▪ Cerumen, and/or significant hearing loss persists – PRIORITY 3</li> <li>▪ Urgent Otolaryngology referral if &lt; 1 week for acute treatment – phone ENT registrar or send to The Alfred Emergency &amp; Trauma Centre</li> <li>▪ If onset more than one week refer</li> </ul> <p style="text-align: right;"><a href="#">Return to contents page</a></p>

### Unilateral hearing loss in adults including sudden hearing loss

Normal drum with Weber to good ear	<ul style="list-style-type: none"> <li>▪ Expectant treatment if &gt;2 weeks</li> <li>▪ Audiometry if available</li> </ul>	<ul style="list-style-type: none"> <li>▪ Immediate referral if onset less than 1 week</li> <li>▪ Semi-urgent referral if &gt;1 week with incomplete recovery – PRIORITY 1-2</li> <li>▪ Non-urgent if complete recovery but for investigation – PRIORITY 2</li> </ul> <p style="text-align: right;"><a href="#">Return to contents page</a></p>
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### Chronic hearing loss

Symptoms: <ul style="list-style-type: none"> <li>▪ Difficulty hearing especially only in a crowded environment; difficulty localising sound</li> </ul> Examination <ul style="list-style-type: none"> <li>▪ Cerumen</li> <li>▪ Abnormal tympanic membrane</li> </ul>	Cerumen dissolving drops and possible suction or irrigation	<ul style="list-style-type: none"> <li>▪ Otolaryngology referral if the ear has not been previously assessed by an otolaryngologist or the symptoms and/or clinical findings have changes – PRIORITY 3</li> </ul> <p><b>NOTE:</b> Unilateral effusions in adults? Sinus disease or nasopharyngeal tumour (especially in patients of Chinese origin)</p> <p style="text-align: right;"><a href="#">Return to contents page</a></p>
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### Tinnitus

Evaluation	Management	Referral Guidelines
<b>Chronic bilateral</b>		
<ul style="list-style-type: none"> <li>▪ Any associated symptoms?</li> <li>▪ Cerumen?</li> <li>▪ Audio + Tympanogram</li> </ul>	Clear cerumen and check TM. If TMS clear, no treatment	No referral indicated unless tinnitus is disabling, or associated with hearing loss, aural discharge or vertigo – PRIORITY 2-3 depending on symptoms <p style="text-align: right;"><a href="#">Return to contents page</a></p>

### Unilateral, or recent onset

<ul style="list-style-type: none"> <li>▪ Any associated symptoms?</li> <li>▪ Cerumen?</li> <li>▪ Audio + Tymp</li> </ul>	Clear cerumen and check TM. If symptoms persist, refer	Referral indicated, especially if it is disabling, or associated with hearing loss, aural discharge or vertigo – PRIORITY 2 <p style="text-align: right;"><a href="#">Return to contents page</a></p>
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### Pulsatile

<ul style="list-style-type: none"> <li>▪ TM normal or (vascular) mass behind drum</li> <li>▪ Audio + Tymp</li> <li>▪ Auscultate carotid vessels of the ear region</li> </ul>	Referral	<ul style="list-style-type: none"> <li>▪ Referral is indicated in all cases- PRIORITY 2</li> <li>▪ If there is middle ear mass, there is a strong possibility of a glomus tumour – PRIORITY 1</li> </ul> <p style="text-align: right;"><a href="#">Return to contents page</a></p>
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## THE ALFRED REFERRAL GUIDELINES ENT / OTOLARYNGOLOGY

### Dizziness

#### Evaluation

#### Management

#### Referral Guidelines

### Sudden onset vertigo – associated with barotrauma

Acute onset of vertigo or disequilibrium associated with pressure change usually caused by air flight or driving. There may be associated hearing loss and tinnitus

Possibility of a perilymph fistula between the inner ear and middle ear must be considered

This condition requires immediate referral for specialist management – phone The Alfred Emergency & Trauma Centre registrar or send to The Alfred Emergency & Trauma Centre  
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### Orthostatic

#### Symptoms

- Mild, brief and only on standing up (usually am)
- Review medications

Evaluate cardiovascular system, reassurance

No referral indicated unless atypical or associated with other symptoms and this should normally be Medical  
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### Benign positional vertigo and vestibular neuronitis

- Associated with an URTI, may be positional and/or persistent
- Audio
- TM joint examination
- ? spontaneous nystagmus

- Self-limiting over a few months
- Symptomatic medication eg Stemetil may help VN

Referral with: Associated hearing loss, increased severity, or persistence over 2 months – PRIORITY 2  
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### Chronic or episodic

- Significant vertigo
- May have associated hearing loss, tinnitus, aural fullness, nausea
- History of previous ear surgery
- Audio + Tympanometry (If available)

Symptomatic treatment acutely

Otolaryngology referral is indicated – PRIORITY 2-3, dependent on history  
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### Facial paralysis

- Weakness or paralysis of movement of all (or some) of the face
- May be associated with otalgia, otorrhoea, vesicles, parotid mass or tympanic membrane abnormality

- Protection of the eye from a corneal abrasion is paramount. Apply Lacrilube and tape the eye shut at night.
- Steroid therapy may be initiated if no associated findings
- Consider anti-viral treatment

Urgent Otolaryngology referral is indicated if otologic cause suspected – phone ENT registrar or send to The Alfred Emergency & Trauma Centre  
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