AlfredHealth

REFERRAL GUIDELINES: ENT / OTOLARYNGOLOGY

Essential Referral Content

Demographic

- Date of birth
- Contact details (including mobile phone)
- Referring GP details
- Interpreter requirements
- Medicare number

Clinical

- Reason for referral
- Duration of symptoms
- Relevant pathology & imaging reports
- Past medical history
- Current medications

The Alfred Outpatient Referral Form is available to print and fax to the Outpatient Department on 9076 6938

Exclusion Criteria

The following conditions are not routinely seen at The Alfred:

- Patients who are being treated for the same condition at another Victorian public hospital
- Children under 18 years of age are not seen at The Alfred
- Cosmetic surgery other than those meeting the specific indications outlined in the Dept. of Health "Guidelines for Aesthetic Surgery on the Public Hospital Waiting List"
- Snoring without sleep apnoea (sleep study must be performed prior to referral)
- Halitosis
- Drooling
- Allergic or vasomotor rhinitis - refer to Asthma, Allergy & Clinical Immunology
- Chronic sinusitis unless proven on CT scan and medical management has failed
- Septal deviation
- Post nasal drip or simple persistent nasal obstruction
- Headache/migraine—refer to Neurology or dentist as appropriate

Please note: If nasal obstruction is unilateral with an offensive, bloody discharge, consider malignancy in an adult (particularly wood workers) and refer **urgently.**

REFERRAL PROCESS: ENT / OTOLARYNGOLOGY

STEP 1

You will be notified when your referral is received by outpatients.

Essential referral content will be checked and you may be contacted if further information is required.

STEP 2

The referral is triaged by the specialist unit according to clinical urgency.

This determines how long the patient will have to wait for an appointment.

STEP 3

Patients with **urgent** conditions are scheduled to be seen within 30 days. Patients with **routine** conditions are given the next available appointment according to clinical need.

Both the referrer and patient are notified.

Please note: The times to assessment may vary depending on size and staffing of the hospital department. Due to high level of demand, there may be a significant delay in appointments for non-urgent conditions.

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.

The Alfred gratefully acknowledges the assistance of the Canterbury and District Health Board in New Zealand in developing these guidelines.
They are intended as a guide only and have been developed in conjunction with the Heads of Unit of The Alfred.

Date Issued: March 2006
Last Reviewed: August 2017

AlfredHealth

REFERRAL PRIORITY: ENT / OTOLARYNGOLOGY

The clinical information provided in your referral will determine the triage category. The triage category will affect the timeframe in which the patient is offered an appointment.

IMMEDIATE **Direct to the Emergency & Trauma Centre**	URGENT **Appointment timeframe within 30 days**	ROUTINE **Appointment timeframe greater than 30 days depending on clinical need**
• Severe or persistent epistaxis • Tonsillar haemorrhage • Hoarseness associated with neck trauma or surgery • Stridor • Laryngeal obstruction and/or fracture • Acute nasal fracture with septal haematoma. • Complicated mastoiditis / cholesteatoma or sinusitis (peri orbital cellulitis, frontal sinusitis with persistent frontal headache) • Pharyngeal/laryngeal foreign body • Abscess or haematoma, eg peritonsillar abscess, septal or auricular haematoma, paranasal sinus pyocele. • Nasal foreign body – battery • Barotrauma with sudden onset vertigo	• Malignant neoplasm of the head and neck, eg larynx, nasopharynx, oral cavity, tonsil, unexplained cervical lymphadenopathy • Sub acute dyspnoea/airways problems, eg laryngeal papilloma, laryngeal stridor • Acute facial nerve trauma • Documented sinusitis not responding to conservative management • Paranasal sinus mucocele • Fracture of paranasal sinus • Nasal fracture with external nasal deformity • Hoarseness with significant dysphagia or present for more than 4 weeks • Progressive or persistent dysphagia • Neck masses	• Elective tonsillectomy after quinsy • Chronic tonsillitis • Adenoiditis • Minor epistaxis • Deafness • Tinnitus • Throat irritation if no malignancy suspected **Please note:** For non-urgent conditions there may be a significant delay in appointments, please consider alternative referral. Please contact the ENT registrar on 9076 2000 if you are concerned about the delay in your patient's appointment.
Phone the ENT Registrar on call on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre.	Urgent cases must be discussed with the ENT Registrar on call to obtain appropriate prioritisation and a referral letter faxed to 9076 6938.	Fax referral to 9076 6938

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.

AlfredHealth

Referral Guideline Contents

AlfredHealth

Pharynx, Tonsil and Adenoid:

ACUTE TONSILLITIS

Evaluation	Management	Referral Guidelines
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.

RECURRENT TONSILLITIS

Evaluation	Management	Referral Guidelines
• ?documented pus on tonsils in each episode		Refer to ENT outpatients if 3 or more episodes in preceding 12 months.

PERITONSILLAR CELLULITIS / QUINSY

Evaluation	Management	Referral Guidelines
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 – refer IMMEDIATELY, 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, refer - routine

CHRONIC TONSILLITIS

Evaluation	Management	Referral Guidelines
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, refer - Routine

INFECTIOUS MONONUCLEOSIS/VIRAL PHARYNGITIS

Evaluation	Management	Referral Guidelines
Throat pain and odynophagia with: • Fatigue • Membranous tonsillitis • Posterior cervical lymphadenopathy • CBC, Mono test	• Supportive care • Consider systemic steroids if severe dysphagia	Airway obstruction, dehydration or failure to cope, refer IMMEDIATELY - contact ENT registrar on 9076 2000 and/or send to The Alfred Emergency & Trauma Centre. Otherwise urgent referral.

AlfredHealth

ADENOIDITIS / HYPERTROPHY

Evaluation	Management	Referral Guidelines
• Purulent rhinorrhoea • Nasal obstruction +/ - snoring • Chronic cough		• Persisting symptoms and findings after two courses of antibiotics, refer - Routine • Associated sleep apnoea, refer - Urgent

UPPER AIRWAY OBSTRUCTION FROM ADENOTONSILLAR HYPERTROPHY

Evaluation	Management	Referral Guidelines
• Nasal obstruction • Severe snoring +/- sleep apnoea • Daytime fatigue		Referral indicated with any significant symptoms of upper airway obstruction especially sleep apnoea, refer—Urgent

TONSILLAR HAEMORRHAGE

Evaluation	Management	Referral Guidelines
• 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 on 9076 2000 or send to The Alfred Emergency & Trauma

NEOPLASM

Evaluation	Management	Referral Guidelines
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 clinic indicated—contact the ENT registrar on 9076 2000.

AlfredHealth

HOARSENESS

Hoarseness associated with upper respiratory tract infection

Evaluation	Management	Referral Guidelines
• Throat pain, may radiate to ear • Dysphagia • Constitutional symptoms • Stridor/airways obstruction		ENT referral indicated if: • Stridor or airway distress – IMMEDIATE referral – Contact ENT registrar or send to The Alfred Emergency & Trauma Centre • Associated with significant Dysphagia, refer - Urgent • Hoarseness present >4 weeks, refer - Urgent

Hoarseness associated with neck trauma or thyroid surgery

Evaluation	Management	Referral Guidelines
History of neck trauma preceding hoarseness May or may not have: • Skin laceration • Ecchymoses • Tenderness • Subcutaneous emphysema • Stridor		IMMEDIATE referral indicated in all cases – contact ENT registrar on 9076 2000 and send to The Alfred Emergency & Trauma Centre

Hoarseness associated with respiratory obstruction and stridor

Evaluation	Management	Referral Guidelines
		IMMEDIATE referral indicated in all cases – contact ENT registrar and send to The Alfred Emergency & Trauma Centre

Hoarseness without associated symptoms or obvious aetiology

Evaluation	Management	Referral Guidelines
History of tobacco and alcohol use Evaluation when indicated for: • Hypothyroidism • Diabetes Mellitus • Gastro-oesophageal reflux • Rheumatoid disease • Pharyngeal/oesophageal tumour • Lung neoplasm • Chest XR		ENT referral is indicated if recent onset hoarseness persists over four weeks despite medical therapy – especially in a smoker, refer - Urgent

AlfredHealth

DYSPHAGIA

Evaluation	Management	Referral Guidelines
May include history or findings of: • Foreign body ingestion • Gastro-oesophageal reflux • Oesophageal motility disorder • Scleroderma • Neoplasm • Thyroid enlargement	Diagnostic studies may include: • Soft tissue studies of the neck including lateral XR • Chest x-ray • Barium swallow • Thyroid studies if appropriate Alfred Radiology request form	ENT referral indicated if: • 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 & Trauma Centre if acute • Dysphagia with hoarseness, refer - Urgent • Progressive dysphagia or persistent dysphagia for three weeks, refer - Urgent

NECK MASS

Inflammatory ie painful

Evaluation	Management	Referral Guidelines
• Complete head and neck examination indicated for site of infections. Optional investigations (if indicated): • FBE • Cultures when indicated • Consider TB and cat scratch disease • HIV testing if indicated • Toxoplasmosis titre if indicated • USS or CT neck • Glandular fever investigations		ENT referral indicated if mass persists for four weeks without improvement, refer - Urgent

Non-inflammatory ie painless

Evaluation	Management	Referral Guidelines
• Is there dyspnoea, hoarseness or dysphagia? • Complete Head and Neck exam indicated. • Consider Ultrasound +/- Fine needle aspirate. **Open Biopsy is contraindicated.**	**Open Biopsy is contraindicated.**	Thyroid masses refer - Urgent to Breast, Endocrine and General Surgery

AlfredHealth

Thyroid Mass

Evaluation	Management	Referral Guidelines
• Are there symptoms of dyspnoea, hoarseness or dysphagia? • Complete head and neck exam indicated. Is it a generalised or localised thyroid enlargement? • TFTs • Thyroid USS:		• Generalised thyroid enlargement with no compression symptoms can be referred to ENT or BES clinic, refer - Urgent—refer to Breast, Endocrine and General Surgery Referral Guidelines • Those with compressive symptoms or discrete swelling should be referred to ENT either IMMEDIATELY or refer—Urgent, depending on severity—contact ENT registrar

Salivary Gland Disorders:

SIALADENITIS / SIALOLITHIASIS - acute or recurrent

Evaluation	Management	Referral Guidelines
• Assess patient hydration • Palpate floor of mouth for stones • Observe for purulent discharge from salivary duct when palpating gland • Evaluate mass for swelling, tenderness and inflammation • Occlusal view of floor of mouth for calculi:	• Culture or purulent discharge in mouth • Hydration • Anti Staphylococcal antibiotics: Augmentin • Occlusal view of floor of mouth for calculi	ENT referral indicated if: • Poor antibiotic response within one week of diagnosis – refer IMMEDIATELY to The Alfred Emergency & Trauma Centre or phone ENT registrar, or refer - Urgent, depending on severity • Calculi suspected on exam, x-ray or ultrasound, refer - Urgent or Routine, depending on circumstances. • Abscess formation, IMMEDIATE referral – contact The Alfred Emergency & Trauma Centre registrar or send to The Alfred Emergency & Trauma Centre • Recurrent sialadenitis, refer - Routine • Hard mass present – ?neoplasm, refer - Urgent

SALIVARY GLAND MASS

Evaluation	Management	Referral Guidelines
• Complete head and neck exam indicated • Evaluate facial nerve function with parotid lesions • Check for local skin lesions eg SCCs Consider referring to AH radiology for FNA		**NOTE:** 20% of adult parotid masses are malignant & 50% of submandibular gland masses are malignant. • ENT referral indicated in all cases of salivary gland tumours, refer - Urgent

AlfredHealth

Nasal and Sinus:

EPISTAXIS - Persistent or Recurrent

Evaluation	Management	Referral Guidelines
• 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 refer - Urgent • Bleeding persists – refer IMMEDIATELY to The Alfred Emergency & Trauma Centre or phone ENT registrar • Bleeding recurs, refer - Urgent

PERSISTENT NASAL OBSTRUCTION

Evaluation	Management	Referral Guidelines
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	• Simple persistent nasal obstruction and post nasal drip are not managed at The Alfred **NOTE**: If unilateral nasal obstruction with an offensive, bloody discharge consider a malignancy – particularly in wood workers; refer—Urgent.

ACUTE SINUSITIS

Evaluation	Management	Referral Guidelines
Unilateral or bilateral nasal congestion, usually evolving from a viral URTI. Signs of sinusitis include: • Purulent discharge • Facial, forehead or peri orbital • Dental pain • Persisting URTI > 7 days History and physical examination may be non-contributory • CT scan rarely indicated	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, refer - Urgent • Complications occur: peri orbital cellulitis, persistent frontal headache, refer IMMEDIATE – contact ENT registrar or send to The Alfred Emergency & Trauma Centre • Consider early referral for acute frontal sinusitis

AlfredHealth

Nasal and Sinus:

CHRONIC SINUSITIS / POLYPOSIS

Evaluation	Management	Referral Guidelines
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	• Antibiotics • Nasal decongestant sprays (5/7) • Topical steroid sprays • Consider short course of steroids (eg 20mg daily/2 weeks)	Chronic sinusitis is not managed at The Alfred unless proven on CT scan and medical management has failed. Due to high level of demand, there may be a significant delay in appointments for non-urgent conditions such as chronic sinusitis. **NOTE**: If unilateral nasal obstruction with an offensive, bloody discharge consider a malignancy – particularly in wood workers; refer—Urgent.

FACIAL PAIN/HEADACHE

Evaluation	Management	Referral Guidelines
• May be an isolated symptom or may be associated with significant nasal congestion or discharge • Potential relations to intranasal deformity, sinus pathology, dental pathology, TMJ dysfunction, altered V nerve function and skull base lesions • Consider CT scan or MRI	If there is evidence of acute sinusitis treat with appropriate antibiotics	Referral may be indicated for persisting facial pain/headache/migraine—options may include dental or neurological assessment.

ALLERGIC RHINITIS / VASOMOTOR RHINITIS

Evaluation	Management	Referral Guidelines
Symptoms – seasonal or perennial: • Congestion esp. alternating • Watery discharge • Sneezing fits • Watery eyes • Itchy eyes and/or throat • Physical examination: • Boggy, swollen, bluish turbinates • Allergic shiners • Allergic “salute”	• Avoidance • Skin prick testing or RAST testing • Topical steroid sprays • Antihistamines • Oral steroids up to 10/7 • For acute cases consider five days nasal decongestants • Avoid prolonged use of decongestants due to risk of rhinitis medicamentosa	Please refer to Asthma, Allergy & Clinical Immunology

AlfredHealth

ACUTE NASAL FRACTURE

Evaluation	Management	Referral Guidelines
• Immediate changes: oedema, ecchymosis, epistaxis • Evaluate for septal fracture or septal haematoma • Nasal x-rays unnecessary • Check for # zygoma, dental injury or middle third # • CT scan if suspect facial # • OPG for suspected jaw fracture	• Early treatment: cool compresses to reduce swelling • Re-evaluate at 3-4 days to ensure nose looks normal and if breathing is normal	• IMMEDIATE referral if acute septal haematoma (usually significant nasal obstruction) - contact ENT registrar and/or send to The Alfred Emergency & Trauma Centre • ENT referral initiated promptly if there is a new external nasal deformity. **NOTE**: Nasal fractures must be reduced <2 weeks for best results

FOREIGN BODY IN THE NOSE

Evaluation	Management	Referral Guidelines
Acute: • History alone or visible on examination **Chronic** • Persistent, offensive unilateral nasal discharge in a child	Don't attempt removal unless experienced and with good equipment	• Urgent referral for removal – Refer IMMEDIATELY TO The Alfred Emergency & Trauma Centre – contact ENT registrar or send to The Alfred Emergency & Trauma Centre • **IMMEDIATE referral if battery (due to corrosion)** • Otolaryngology referral for removal, refer - Urgent

FOREIGN BODY IN THE EAR

Evaluation	Management	Referral Guidelines
Usually visible if acute	Remove only if technically easy	Otolaryngology referral, refer - Urgent

AlfredHealth

Ear Infection:

ACUTE OTITIS MEDIA

Evaluation	Management	Referral Guidelines
Symptoms: • Otalgia, 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 refer—Urgent, depending on severity

CHRONIC SUPPURATIVE OTITIS MEDIA

Evaluation	Management	Referral Guidelines
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, refer - Urgent or Routine depending on severity • Associated symptoms suggest urgency needed, refer - Urgent

AlfredHealth

ACUTE OTITIS EXTERNA

Evaluation	Management	Referral Guidelines
Symptoms: • Otalgia, 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 to The Alfred Emergency & Trauma Centre • Cerumen impaction complicating OE, refer - Urgent • Unresponsive to initial course of wick and antibacterial drops, refer - Urgent • Diabetics, suspected malignancy and immunosuppressed on examination require immediate referral – phone ENT registrar or send to The Alfred Emergency & Trauma Centre

OTALGIA WITHOUT SIGNIFICANT CLINICAL FINDINGS IN THE EAR CANAL OR DRUM

Evaluation	Management	Referral Guidelines
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, refer - Urgent

HEARING LOSS

Bilateral symmetrical hearing loss

Evaluation	Management	Referral Guidelines
Symptoms: • Diminished hearing - any associated symptoms eg tinnitus, discharge, vertigo etc? • Examination • Cerumen, effusion, or normal findings	• Cerumen dissolving drops and possible suction or irrigation • Oral decongestant, Valsalva manoeuvres and re-evaluate in three weeks • Requires audiometry +/- referral	Referral indicates if: • Cerumen, and/or significant hearing loss persists, refer - Routine • Urgent Otolaryngology referral if < 1 week for acute treatment – phone ENT registrar or send to The Alfred Emergency & Trauma Centre • If onset more than one week refer

AlfredHealth

Unilateral hearing loss in adults (including sudden hearing loss)

Evaluation	Management	Referral Guidelines
Normal drum with Weber to good ear	• Expectant treatment if >2 weeks • Audiometry if available	• IMMEDIATE referral if onset less than 1 week • Semi-urgent referral if >1 week with incomplete recovery, refer - Urgent • If complete recovery but for investigation, refer - Urgent

Chronic hearing loss

Evaluation	Management	Referral Guidelines
Symptoms: • Difficulty hearing especially only in a crowded environment; difficulty localising sound Examination: • Cerumen • Abnormal tympanic membrane	Cerumen dissolving drops and possible suction or irrigation	• Otolaryngology referral if the ear has not been previously assessed by an otolaryngologist or the symptoms and/or clinical findings have changes, refer - Routine **NOTE:** Unilateral effusions in adults - query sinus disease or nasopharyngeal tumour (especially in patients of Chinese origin)

TINNITUS
Chronic bilateral

Evaluation	Management	Referral Guidelines
• Any associated symptoms? • Cerumen? • Audiometry + Tympanometry	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, refer - Urgent or Routine depending on symptoms

Unilateral or recent onset

Evaluation	Management	Referral Guidelines
• Any associated symptoms? • Cerumen? • Audiometry + Tympanometry	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, refer - Urgent

Pulsatile

Evaluation	Management	Referral Guidelines
• TM normal or (vascular) mass behind drum • Audiometry + Tympanometry • Auscultate carotid vessels of the ear region	Referral	• Referral is indicated in all cases, refer - Urgent • If there is middle ear mass, there is a strong possibility of a glomus tumour, refer—Urgent

AlfredHealth

DIZZINESS

Sudden onset vertigo - associated with barotrauma

Evaluation	Management	Referral Guidelines
Acute onset of vertigo or disequilibrium associated with pressure change usually caused by air flight or diving. 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

Orthostatic

Evaluation	Management	Referral Guidelines
Symptoms • Mild, brief and only on standing up (usually am) • Review medications	Evaluate cardiovascular system, reassurance	ENT referral not indicated unless atypical or associated with other symptoms. Refer to General Medicine for assessment.

Benign positional vertigo and vestibular neuritis

Evaluation	Management	Referral Guidelines
• Associated with an URTI, may be positional and/or persistent • Audiometry • 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, refer - Urgent

Chronic or episodic dizziness

Evaluation	Management	Referral Guidelines
• Significant vertigo • May have associated hearing loss, tinnitus, aural fullness, nausea • History of previous ear surgery • Audiometry + Tympanometry (If available)	Symptomatic treatment acutely	Otolaryngology referral is indicated, refer - Urgent or Routine, dependent on history

FACIAL PARALYSIS

Evaluation	Management	Referral Guidelines
• 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	IMMEDIATE Otolaryngology referral is indicated if otologic cause suspected – phone ENT registrar or send to The Alfred Emergency & Trauma Centre