ENT in General Practice

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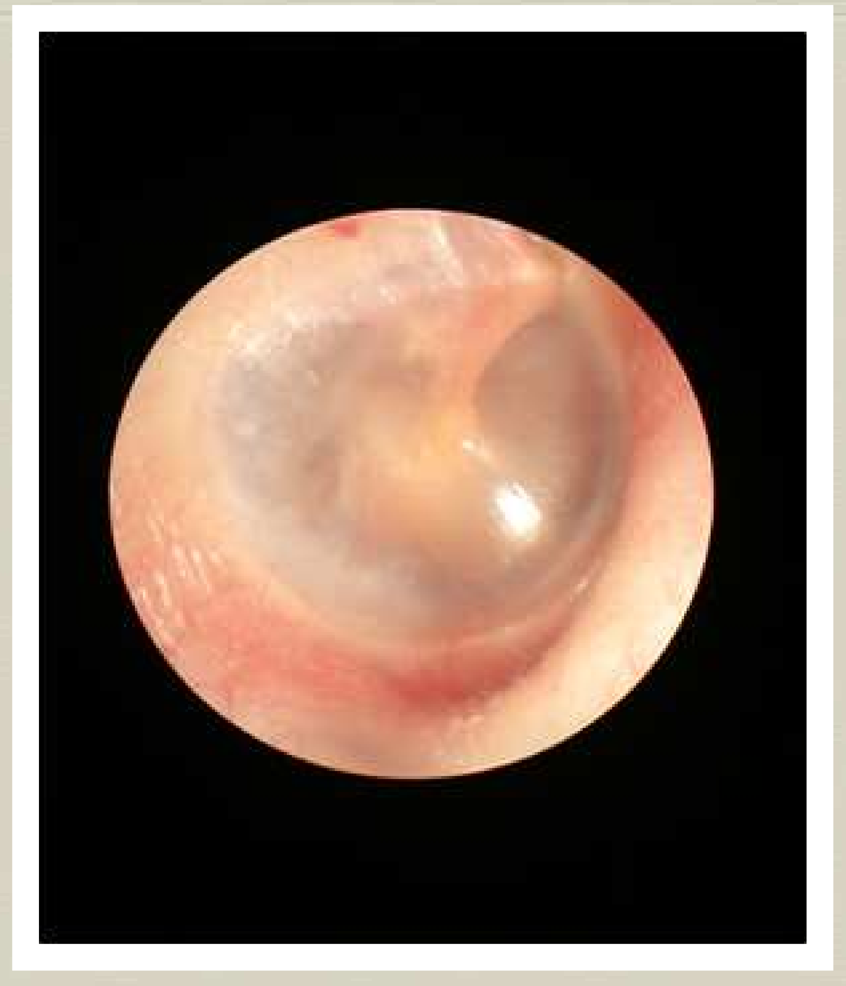
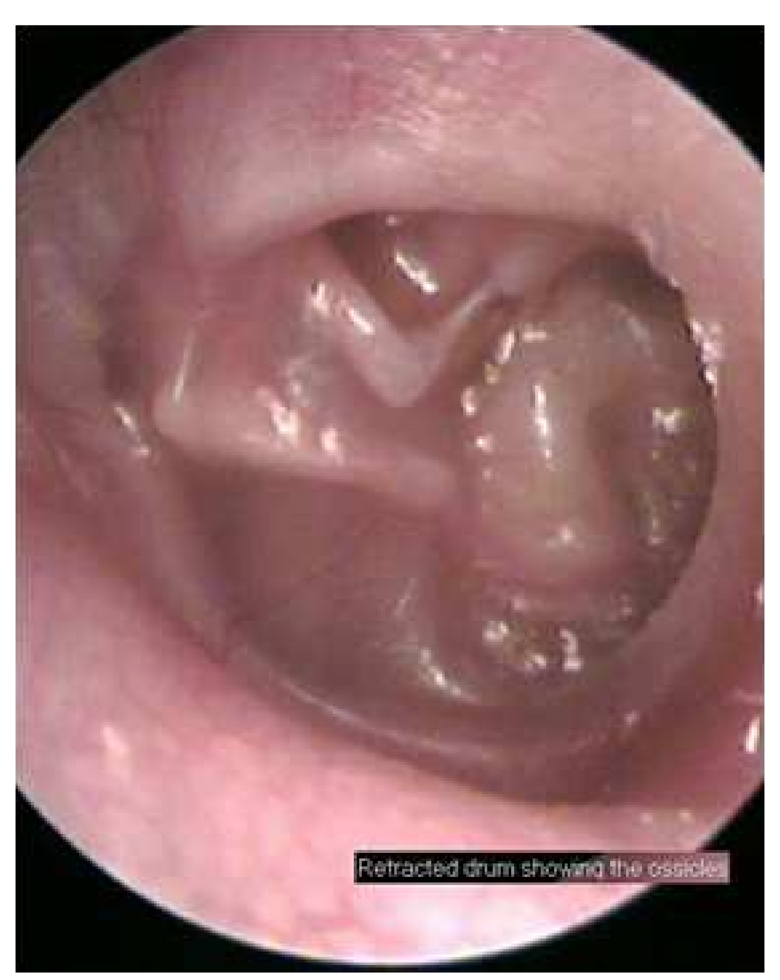
Clinical Tips

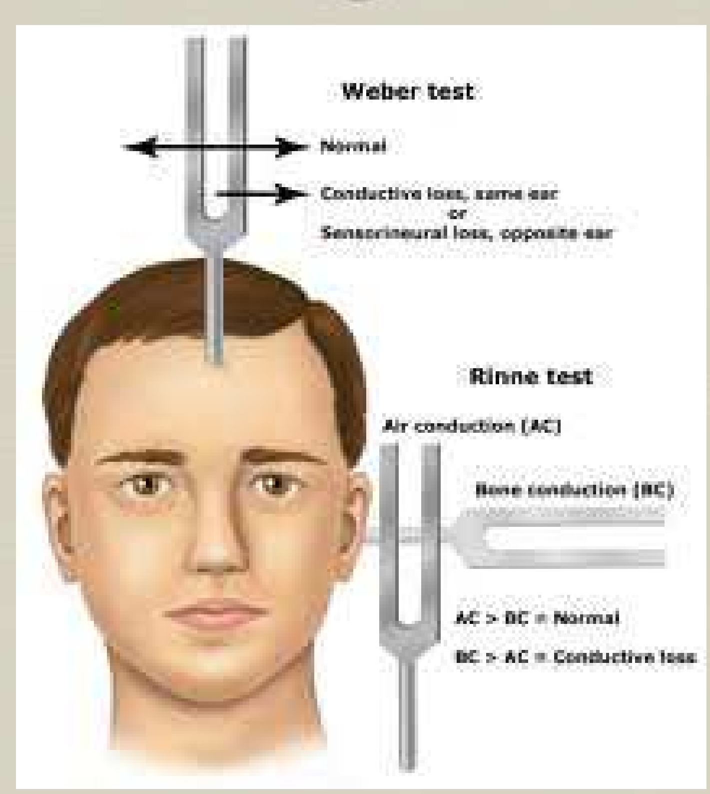
Audiology

- When is it best to refer just for audiology?
  - Reported hearing loss
  - History: no other ass symptoms, no Fhx, not sudden loss
  - Examination: normal TM, rinne/weber
- When to refer to ENT with audiology?
  - Sudden hearing loss – seen within 12 hours – red flag
  - History – Ass symptoms, FHx of otosclerosis, SNHL
  - Examination – abnormal TM




Retracted drum showing the ossicles

Assessing Hearing Loss



- Over 55 years normally would be referred under AQP – providing there are no red flags (see AQP Proforma)
- Currently looking at ways of testing hearing loss in practice
  - GN Otometrics provide equipment that use a headset and computer to test hearing in GP practices
  - Currently being trialed in N. Ireland
  - Can be done by practice nurse
  - May offer a form of triage before referral to AQP
  - So far 68% have required further testing/audio, while 32% reassured and did not need referral

AQP Age Related Hearing Loss: Audiology Referral Proforma (Adults) – CONFIDENTIAL

[illegible]

GP Proforma (EMIS Web) Oxfordshire

Please complete this proforma and fax to provider of choice OR attach to a Choose and Book Referral

Patient's details		Patient's background and culture	
Surname	**Surname**	Ethnicity	**Ethnic Origin**
Forename	Given Name	1st language	Main Language
DOB	**Date of Birth**	Interpreter required? Y ☐ N ☐	
Sex	Gender	**GP details**	
Title	**Title**	Referring Clinician	
Pt Address Postcode	Home Full Address (single line)	GP address	Organisation Name Organisation Full Address (single line)
		GP Tel no:	**Organisation Telephone Number**
NHS No	NHS Number	GP Fax no	Organisation Fax Number
Hospital No	**Hospital Number**	GP Email	**Organisation E-mail Address**
Home tel	Patient Home Telephone	[illegible]	
Work tel	Patient Work Telephone	Date ref	
Mobile tel	Patient Mobile Telephone	received	

Patients who do not meet any of the criteria below should be referred to a specialist service or ENT/A & E as appropriate (see referral advice below), all other patients should be referred under AQP to their chosen provider

Referral Advice	REFER TO:
Ear wax partially occluding or blocking the ear canals	GP / ENT
Noticeable asymmetry in hearing Fluctuating hearing loss other than associated with colds Complex hearing loss: Severe/profound, all non-age related, conductive, processing disorder Vertigo including spinning, swaying or floating sensations Unilateral, pulsatile or distressing tinnitus (e.g. causes sleep disturbance, anxiety or depression) Patient groups: registered blind, adults with learning disability, domiciliary Any patient under 55	Acute Audiology (Oxford University Hospitals Trust)
Sudden (less than 7 days) or rapid (90 days or less) loss or deterioration of hearing	Urgent referral ENT A & E
Aural discharge or pain lasting > 7 days in the last 90 days	ENT
Abnormal appearance of the outer ear or the eardrum including middle ear fluid	ENT

Please ensure that the patient has NONE of the following:	
Wax partially or totally occluding or blocking the ear canals	No ☐
Noticeable asymmetry in hearing	No ☐
Fluctuating hearing loss (other than associated with colds)	No ☐
Complex hearing loss: Severe/profound, all non-age related, conductive, processing disorder	No ☐
Vertigo (including spinning, swaying or floating sensations)	No ☐
Unilateral, pulsatile or distressing tinnitus (e.g. causes sleep disturbance, anxiety or depression)	No ☐
registered blind, adults with learning disability, domiciliary visits	No ☐
Sudden (≤7 days) or rapid (≤90 days) deterioration of hearing	No ☐
Aural discharge or pain lasting > 7 days (in the last 90 days)	No ☐
Abnormal appearance of the outer ear or the eardrum including middle ear fluid	No ☐

Please answer the following questions		
Does the patient have any significant physical problems?	Yes ☐	No ☐
Does the patient have any significant memory or cognitive problems?	Yes ☐	No ☐
Is an interpreter required? State language:	Yes ☐	No ☐
Does the patient already wear a hearing aid?	Yes ☐	No ☐

Additional Information / Comments

AQP

- Currently a 3 year pathway so patients do need re-referral after this time
- No patients do not always need 2 hearing aids. Very patient dependent. However if patient require 2 aids then there is a greater benefit than one.
- The Thames Valley Priorities Committee are currently reviewing the use of 2 vs 1 hearing aids and other ways to reduce demand.
- As GPs best screening is to ask if they are referred for hearing test would they consider a hearing aid.

Unilateral Tinnitus

- Current guidance on OCCG website advises referral to ENT if there has been a constant unilateral tinnitus for over 20 weeks duration.
- Last year there were 251 referrals made for MRI for unilateral tinnitus – from ENT
- Work is still in progress to see if this can be a direct referral from GP
- The concern is an underlying acoustic neuroma. This is a rare **benign** tumour.
- Most often presents between **ages of 40-60 yrs**. Annual incidence is **approx 1 in 100,000**.

- Majority are unilateral, 5% are bilateral and are often ass with multiple neurofibromatosis type 2 (NF2)
- They can present in many ways but a gradual and progressive unilateral deafness is the presenting symptom in 90% of cases.
- The deafness is often ass with tinnitus in 70% of cases
- Sudden onset hearing loss occurs in 10%
- 5% of patients will have normal hearing
- 10% will have markedly asymmetrical tinnitus
- Vertigo is an unusual complaint as compensation for vestibular nerve damage usually keeps pace with the slow rate of neural destruction
- Tumours grow slowly – 1mm a year. However approx only 1/3 will grow, annual MRI scans show 60% of acoustic neuromas are not growing

Tinnitus Management

- Tinnitus is a sensation of hearing a sound in the absence of any external sound.
- Common, 1/3 of adult population will experience it at some time in their life time.
- Determine the sound: constant/intermittent, pulsatile or non-pulsatile. Effects on sleep, mood, concentration
- Exclude local causes – full ENT exam, audiogram
- Exclude general causes:
  - CVS – hypertension, cardiac failure
  - Hyperdynamic circulation – anaemia, thyroid, fever, drugs (salicylates)
  - Neurological conditions – MS, Neuropathy

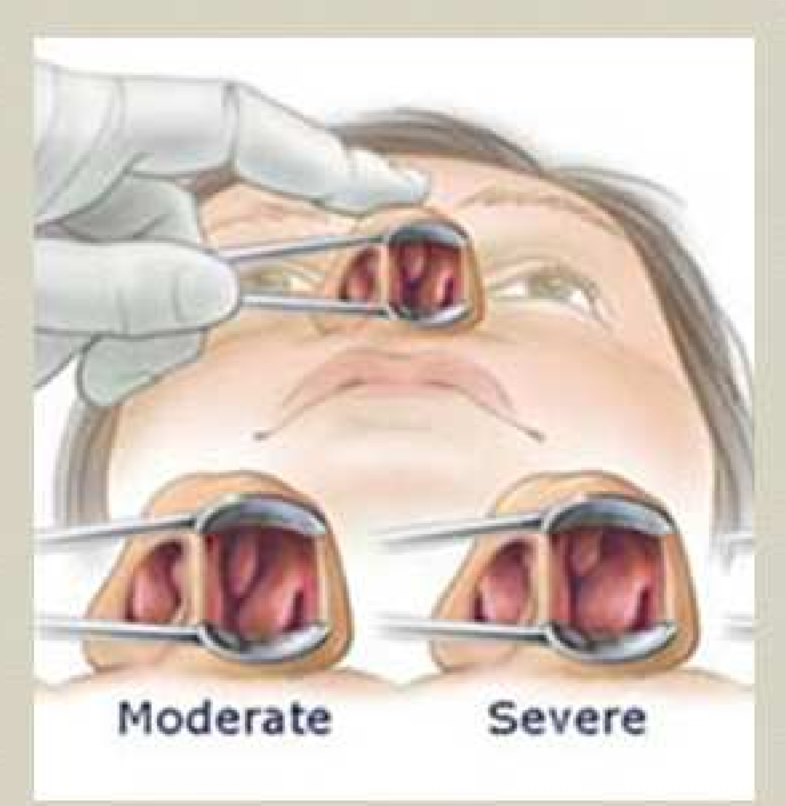
Links

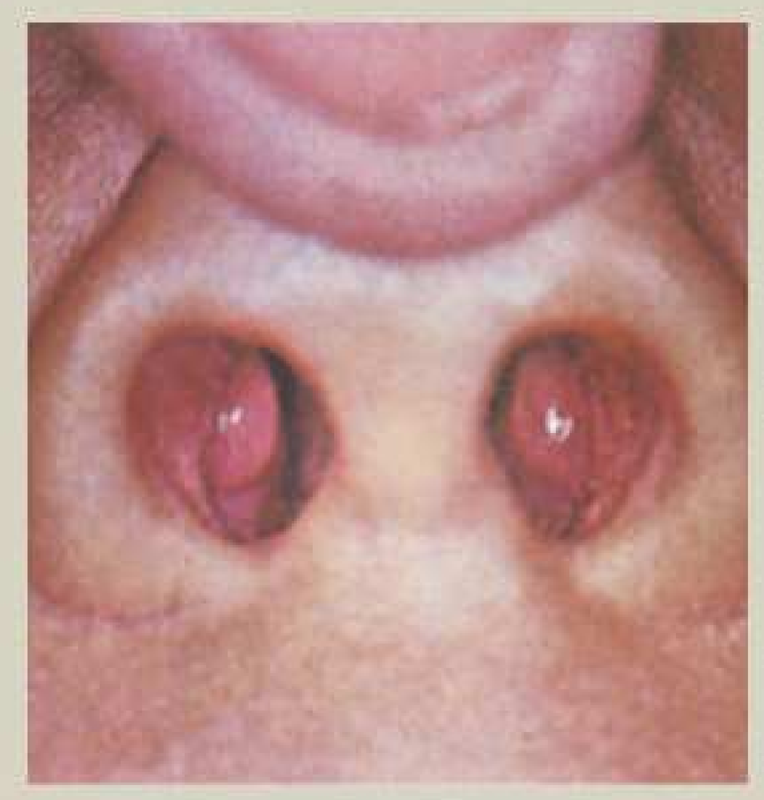
- http://www.tinnitus.org.uk
- If patients have hearing loss – hearing aids may help
- White noise generators – see link
- There is a hearing therapist/tinnitus nurse at the OUH

Chronic Rhinosinusitis

Assessment

- OCCG guidelines currently under review as those listed are not detailed to provide appropriate management in GP. Mr Rob Almeyda (ENT) has provided this guidance:
- 2 or more persistent symptoms for at least 12 weeks, one of which should be either nasal obstruction and/or nasal discharge, and/or facial pain/pressure or anosmia.
- Look for visible nasal polyps (consider turbinate hypertrophy in differential diagnosis)


Moderate
Severe



- Consider diagnosis of allergic rhinitis in patients(especially those with FHx of atopy) with associated epiphora, itching, sneezing in addition to rhinorrhoea
- Assess for lower airway symptoms and control asthma
- Consider alternate diagnosis in presence of unilateral symptoms – 2ww if needed
- No role for X ray in assessment of CRS. Imaging only used in those who fail medical treatment or who have complicated infection/more serious conditions – secondary care.

Management

- Offer all patients:
- Saline irrigation: commercially available positive pressure squeezing bottles or irrigation jugs (Netti pots) available to aid douching. High volume irrigation more effective than saline sprays.

Saline irrigation recipe

- How to make one pint of salt solution
- 1. You will need:
  - Salt (sea salt, canning, or pickling salt)
  - Baking soda
  - Nasal irrigation pot
  - Measuring spoon (1 teaspoon, ½ tsp)
  - Pint container

2. Mix the solution

- Measure 1 tsp of salt and ½ tsp of baking soda into the pint container
- Add one pint of cooled boiled water (lukewarm tap water may be safe in some areas)
- Stir
- From one-pint container of solution, fill nasal pot
- Link: http://www.ouh.nhs.uk/patient-guide/leaflets/files%5C110811nasaldouching.pdf

- Intranasal corticosteroids – advise how to apply
- There is negligible systemic uptake with Nasonex and Flixonase
- Routinely try Beconase first line however if not effective move to Nasonex (once a day prep) or Flixonase (bd prep)
- Do not recommend the routine use of antibiotics, due to low evidence of efficacy in unselected groups, low specificity of symptomatic diagnosis without endoscopy and imaging, plus risk of increasing antibiotic resistance

- If bilateral large nasal polyps visible consider medical polypectomy if not contra indicated:
  - Trial of oral prednisolone (0.5mg/kg for 5-10 days) followed by
  - Topical drops (fluticasone proprionate 400mcg bd or beclomethasone tds) applied in the head upside down position.
  - Review after 4 weeks of treatment and refer to secondary care if no improvement.

- For CRS without obvious nasal polyps, reassess symptom control after 3 months.
- If mild symptoms – continue with medical treatment – nasal spray/saline douching
- If ongoing symptoms mod/severe – check compliance, refer to secondary care.

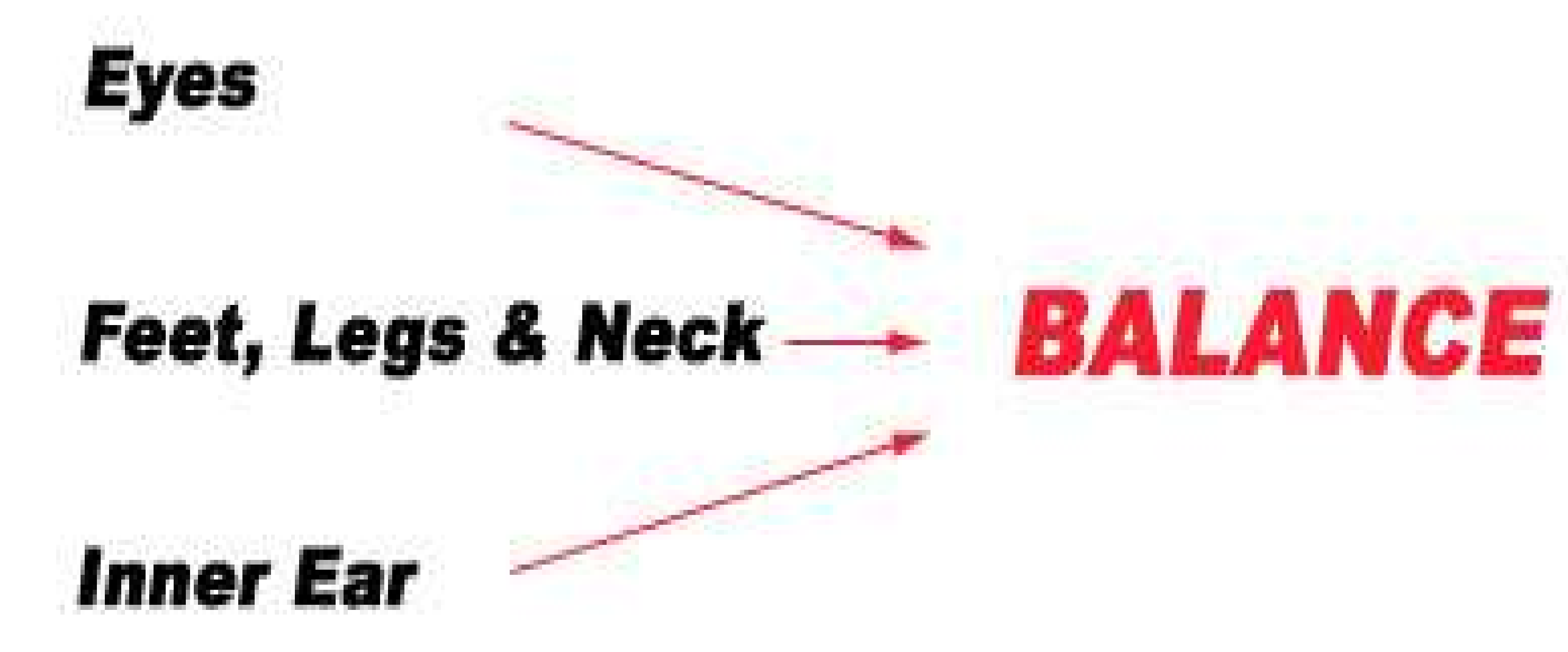
Paediatrics

- Under 6 years, condition is rare
- Start with simple saline douching (Sterimar paed version)
- Nasocort is licensed in 2 years and over
- Flixonase is licensed in 4 years and over
- Need to consider alternative diagnosis (rare)
  - Cystic fibrosis
  - Primary ciliary dyskinesia

Dizziness in General Practice

- OCCG ENT guidelines advice referral if symptoms of true vertigo are present for over 2 months with ass neurological, hearing loss or tinnitus symptoms.
- But what do you do with patients when they present, who has true vertigo?

Balance



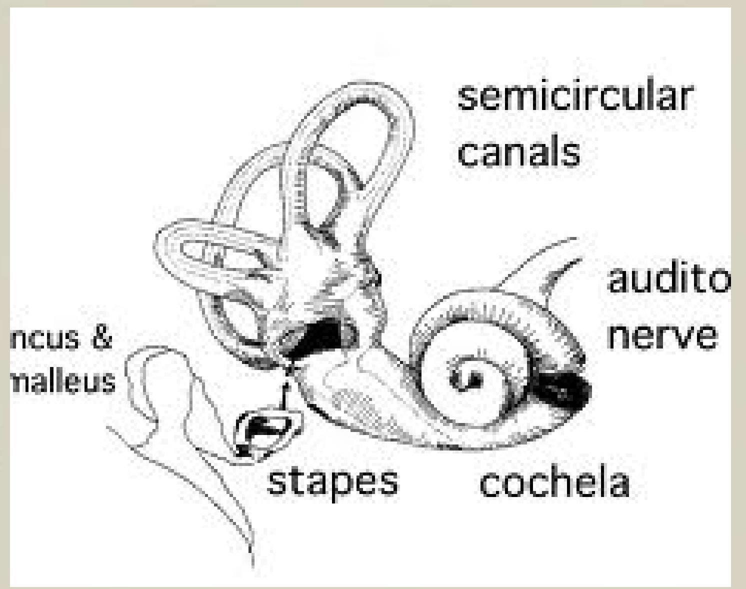
Dizziness

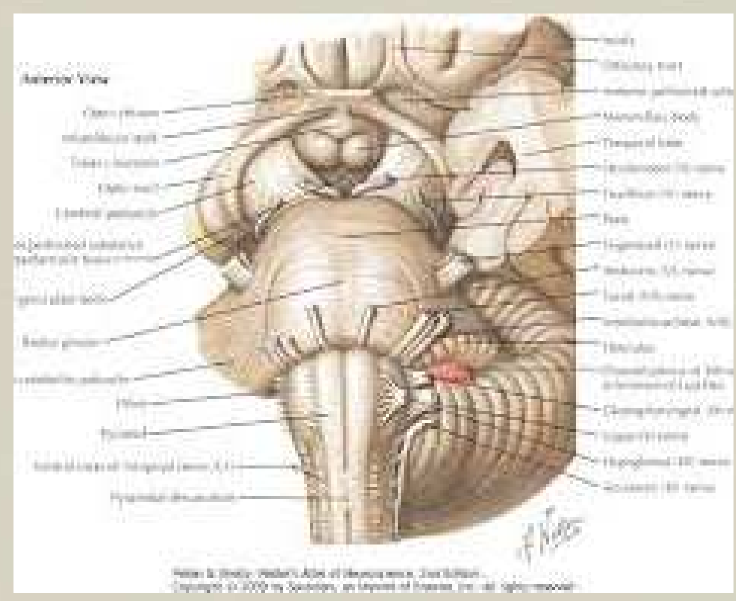
- Vertigo (vestibular)

- Dysequilibrium

There is only a limited number of diagnoses of vertigo

Peripheral	Central





Peripheral causes of Vertigo

- Benign paroxysmal positional vertigo (BPPV)
- Acute labyrinthitis/vestibular neuronitis
- Meniere's Disease
- Peripheral vestibulopathy
  - Cerebral pontine angle – acoustic neuroma
  - Ototoxicity (secondary to aminoglycosides)
  - Middle ear disease eg cholestotoma, acute otitis media
  - Herpes zoster oticus (Ramsay Hunt Syndrome)
- Vertebro-basilar insufficiency – cervical spondylosis

Central causes of Vertigo

- Brainstem and cerebellum
  - Multiple Sclerosis
  - Stroke
  - TIA
- Cerebral cortex
  - Intrinsic tumour eg medulloblastoma
  - Epilepsy – aura of temporal lobe seizures
- Migraine

Causes of Dysequilibrium

- Any cause of vertigo – in forme fruste
- Syncope or pre-syncope
- Drugs/toxins
- Psychogenic:
  - Panic disorder/hyperventilation
  - Dissociation/somatisation
  - Delusional states

Assessing the Dizzy Patient

- **Duration of symptoms**
  - Seconds to minutes – BPPV
  - Minutes to Hours – Menieres Disease
  - Prolonged vertigo >24 hours
    - Peripheral lesion – viral labyrinitis
    - Central lesion – usually other signs: MS, migraine, stroke

Assessing the Dizzy Patient

Associated symptoms:

- Otological
  - Hearing loss
  - Tinnitus
  - Ear discharge/full sensation in ear
- Neurological
  - Headache, diplopia, dysarthria, dysphagia, ataxia
- General autonomic symptoms
  - Nausea, vomiting, sweating or palpitations

Assessing the dizzy patient

Past medical history

- Head trauma/recent labyrinthitis -?BPPV
- Recent URTI -?vestibular neuronitis or labyrinitis
- CV risk factors – increase likelihood of stroke
- FHx of migraine/Menieres
- Drugs – antipsychotics, aminoglycoscides, furosemide, antidepressants, anticonvulsants (carbomazepine/phenytoin)

Examination

- Check ears
  - Is the TM normal?
- Cranial nerve examination
- Look for nystagmus
  - Suppression of nystagmus on fixed gaze – peripheral
  - Pure vertical nystagmus - central
- Cerebellar function
- CVS – BP/postural, arrhythmia, bruits

Examination

Specific tests

- Rhombergs
- Unterberger's
- Heel toe walk
- Dix-Hallpike manoeuvre
- Head thrust test

Dix-Hallpike Manoeuvre

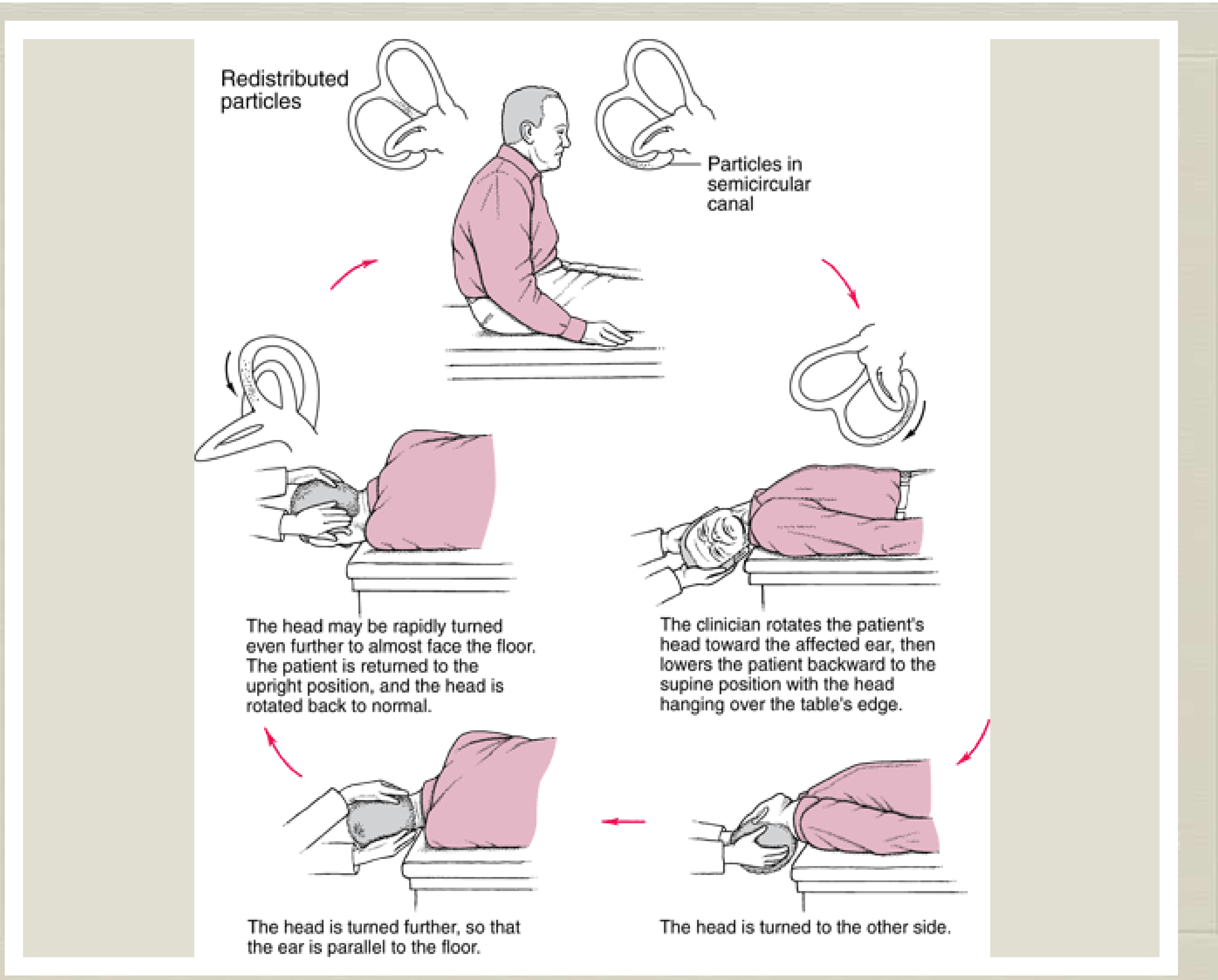
Benign Paroxysmal Positional Vertigo (BPPV)

- Affects women x2 > men, peak 50-70 years
- Causes: idiopathic, post head trauma/labyrinthitis/ear infection
- Rotatory vertigo after head movement (secs-mins)
- Usually no other otological/neurological manifestations

Diagnosis – Dix Hallpike manoeuvre

Treatment – Epley manoeuvre

http://www.youtube.com/watch?v=eOuzUi5ckrk


Redistributed particles
Particles in semicircular canal
The head may be rapidly turned even further to almost face the floor. The patient is returned to the upright position, and the head is rotated back to normal.
The clinician rotates the patient's head toward the affected ear, then lowers the patient backward to the supine position with the head hanging over the table's edge.
The head is turned further, so that the ear is parallel to the floor.
The head is turned to the other side.

Post procedure

- Someone to drive them home
- May feel unsteady for 48 hours
- Sleep upright as able
- Do not lie on affected side for one week
- Procedure can be repeated if needed

Meniere's Disease

- Affects 50 people in 100,000, young to middle aged adults
- Acute episodes of vertigo, tinnitus, hearing loss and sense of pressure in the ear (aural fullness)
- Durations: >20mins – 2-4 hours with nystagmus, dysequilibrium possible for a few days after
- Usually starts in one ear but 30-50% have bilateral symptoms by 3 years
- Cause: endolymphatic hydrops (raised pressure in the membranous labyrinth of the inner ear)

Meniere's Disease

- To confirm diagnosis refer to ENT

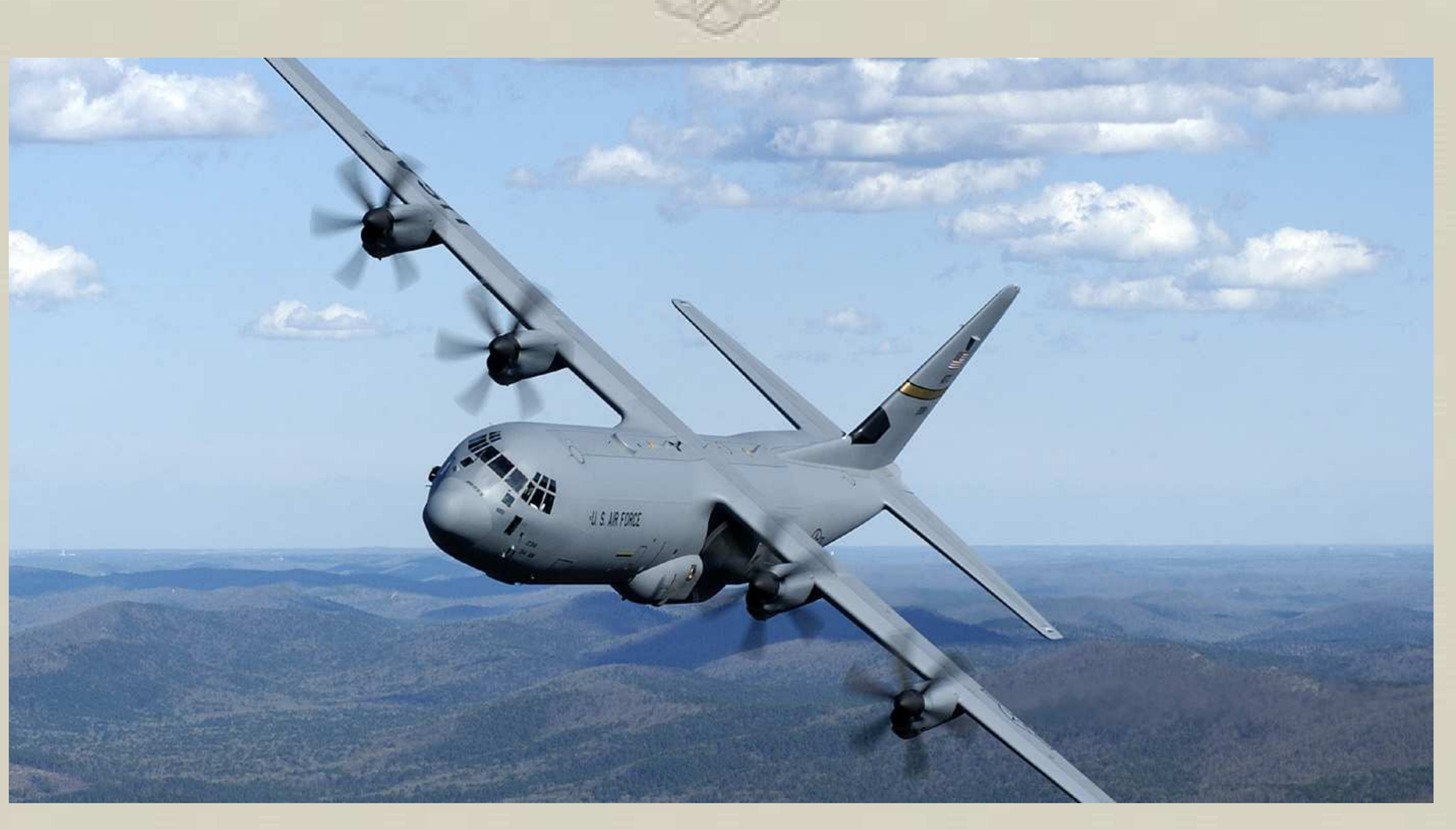
Treatment

- Acute
  - labyrinthine sedatives (cyclizine/prochlorperazine)
- Prevention
  - Beta histine 8-16mg tds regularly may reduce attacks
  - Thiazide diuretics – bendroflumethiazide 2.5mg daily
  - Stop smoking, low salt diet, stop caffeine and etol

Vestibular neuronitis/Labyrinthitis

- Vestibular neuronitis (Common)
  - Inflammation of the vestibular nerve
  - Severe vertigo with nausea and vomiting
  - No hearing problems
  - Nystagmus
- Labyrinthitis
  - As above with associated hearing loss

Vestibular neuronitis/Labyrinthitis



Vestibular neuronitis/Labyrinthitis

Treatment

- Acute
  - Labyrinthine sedatives (cyclzine/prochlorperazine) regularly for 3 days but then only as required
- Longterm
  - Vestibular rehabilitation
    - Cawthorne-Cooksey exercises

Cawthorne - Cooksey Exercises

- http://foi.avon.nhs.uk/Download.aspx?r=1&did=7775&f=CawthorneCookseyExercises-3.pdf
- Perform for 5 mins sessions twice a day
- Progress through each stage week by week
- If they course excessive discomfort, stop and go back a stage for another week

Vertebro-basilar insufficiency

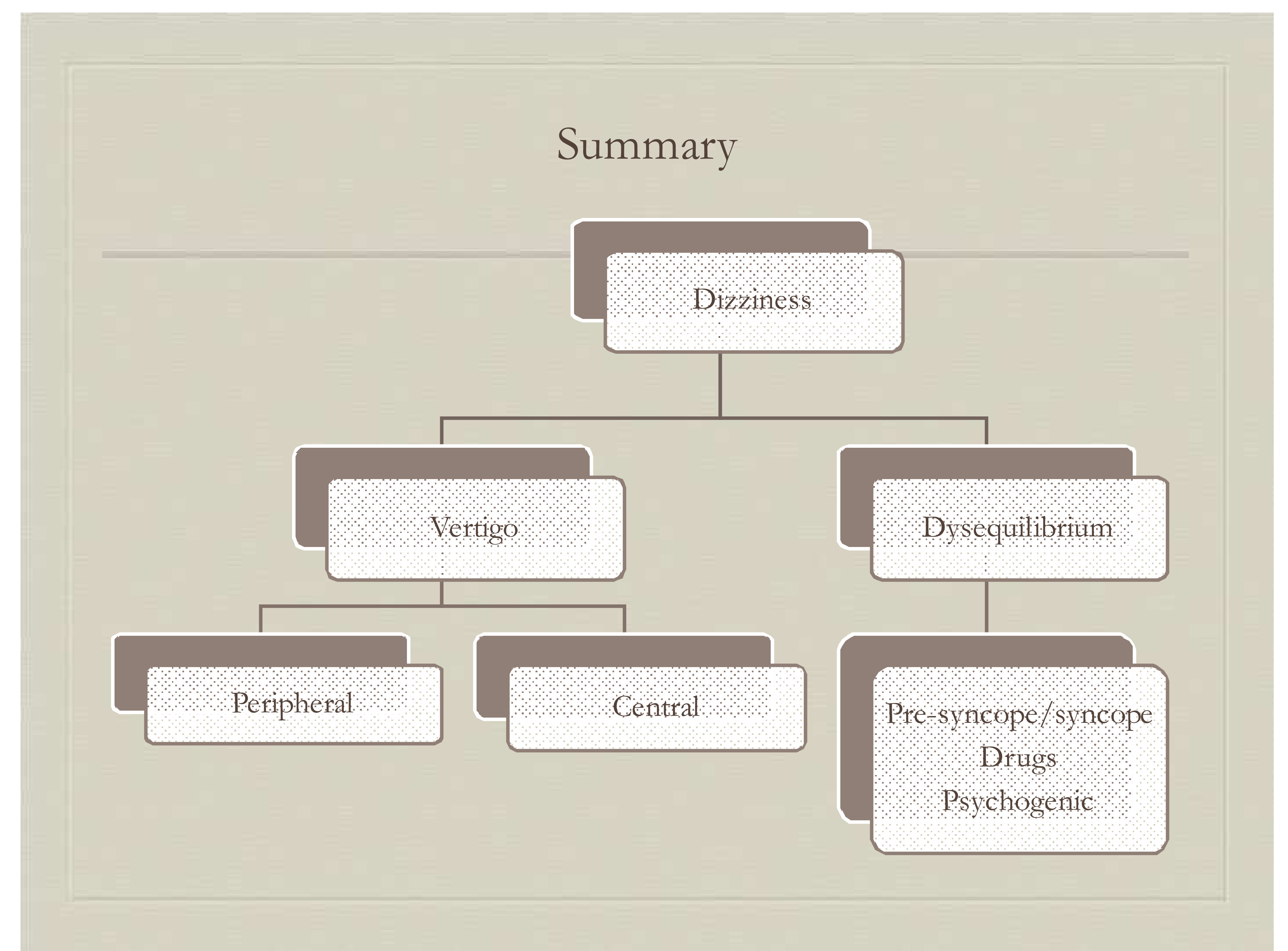
- Constriction of the vertebral artery by osteophytes causing fleeting imbalance as a result of cerebral ischaemia

Treatment

- Lifestyle advice to avoid movements which bring on symptoms

Red Flags

- Any central neurological symptoms or signs
- New type of headache esp occipital
- Acute deafness (seen within 12 hours)
- Vertical nystagmus


Summary
Dizziness
Vertigo
Dysequilibrium
Peripheral
Central
Pre-syncope/syncope
Drugs
Psychogenic

Current ENT Services

General ENT Meeting

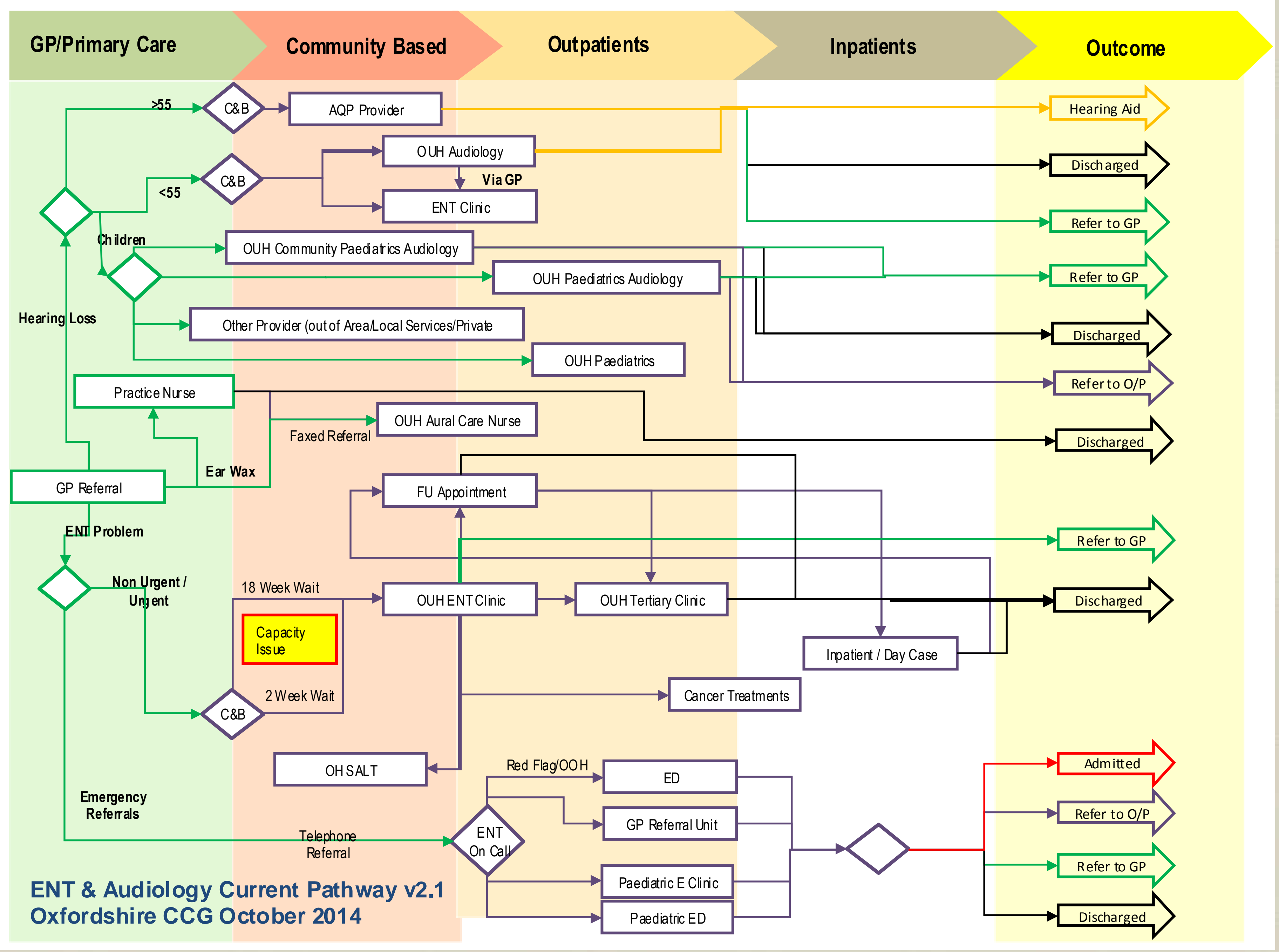
- Clinically ENT services are good however there was a consistent theme of problems:
- 1**) Access into the service** (including location) - this is being looked at with directly bookable choose and book and therefore patients can be given a date for an appointment on the day of calling
- 2**) Capacity problems**, especially with an increasing population. It was defined that the referrals into ENT are appropriate, the first appointment to follow up ratio is low and therefore there is a need to increase the capacity in some way to accommodate increasing demand.
- 3**) Communication of information between ENT and GP**. Currently this seems mismatched and must be addressed - there is a newsletter being produced with information about services, top tips

- GP comments prior to meeting:
- In the North, they have been referring to Warwick as better wait times and communication with GP.
- Asked about Community based services – aural care, endoscopy, audiology. Not keen on GPsI model.
- Better communication between ENT and GP.
- Direct access to MRI for unilateral tinnitus.

What now

- Currently the guidelines for ENT are under review. Ideal is to have more detail on management which can be done in primary care before referral.
- Ongoing ENT pathway review and development of a potential community ENT service. With the overall aim of increasing capacity, better experience for patients and improvement of communication between services.

Current State for ENT Services – Pathway Mapping



ENT & Audiology Current Pathway v2.1
Oxfordshire CCG October 2014

What is happening UK wide?

- In Cardiff they are running a community model ran by the Cardiff Hospital ENT team:http://www.health.org.uk/media_manager/public/75/programme_library_docs/Shine%202012%20final%20report%20web.pdf
- In Southampton they are operating a community based ENT service which was put out to tender and is now ran by InHealth:http://www.networks.nhs.uk/nhs-networks/innovation-south-central/documents/SCPCT%20Community%20ENT%20Service%20for%20Adults.pdf
- http://www.inhealthgroup.com/contract-service/nhs-southampton-city

Thoughts/Discussion

- Next meeting is Monday 10th November.
- Plan to further discuss the best pathway for ENT services.
- What are peoples thoughts?