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NHS Foundation Trust

Newcastle upon Tyne ENT GP Referral Guidelines March 2022

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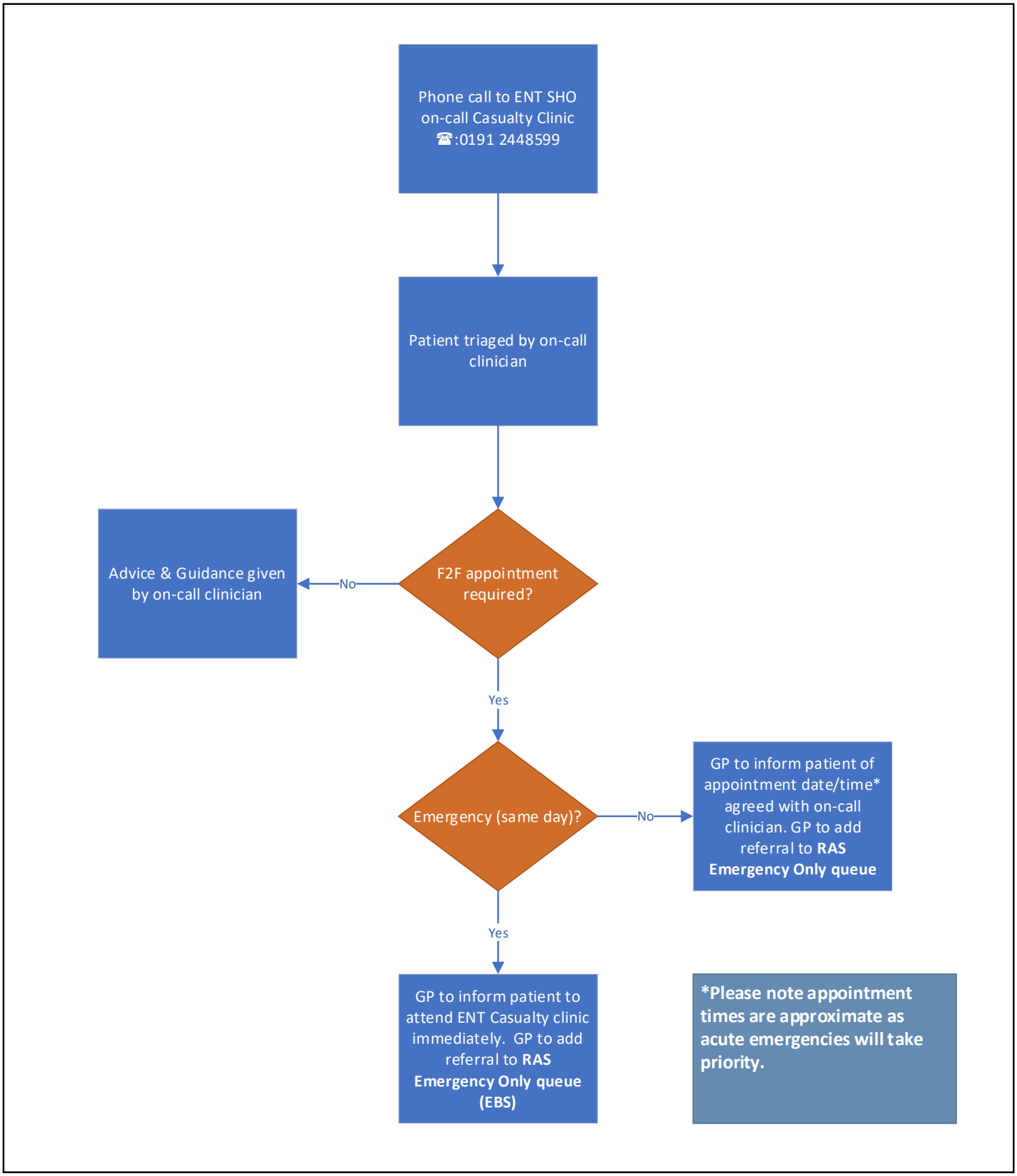
Referral Process for ENT Casualty Clinic



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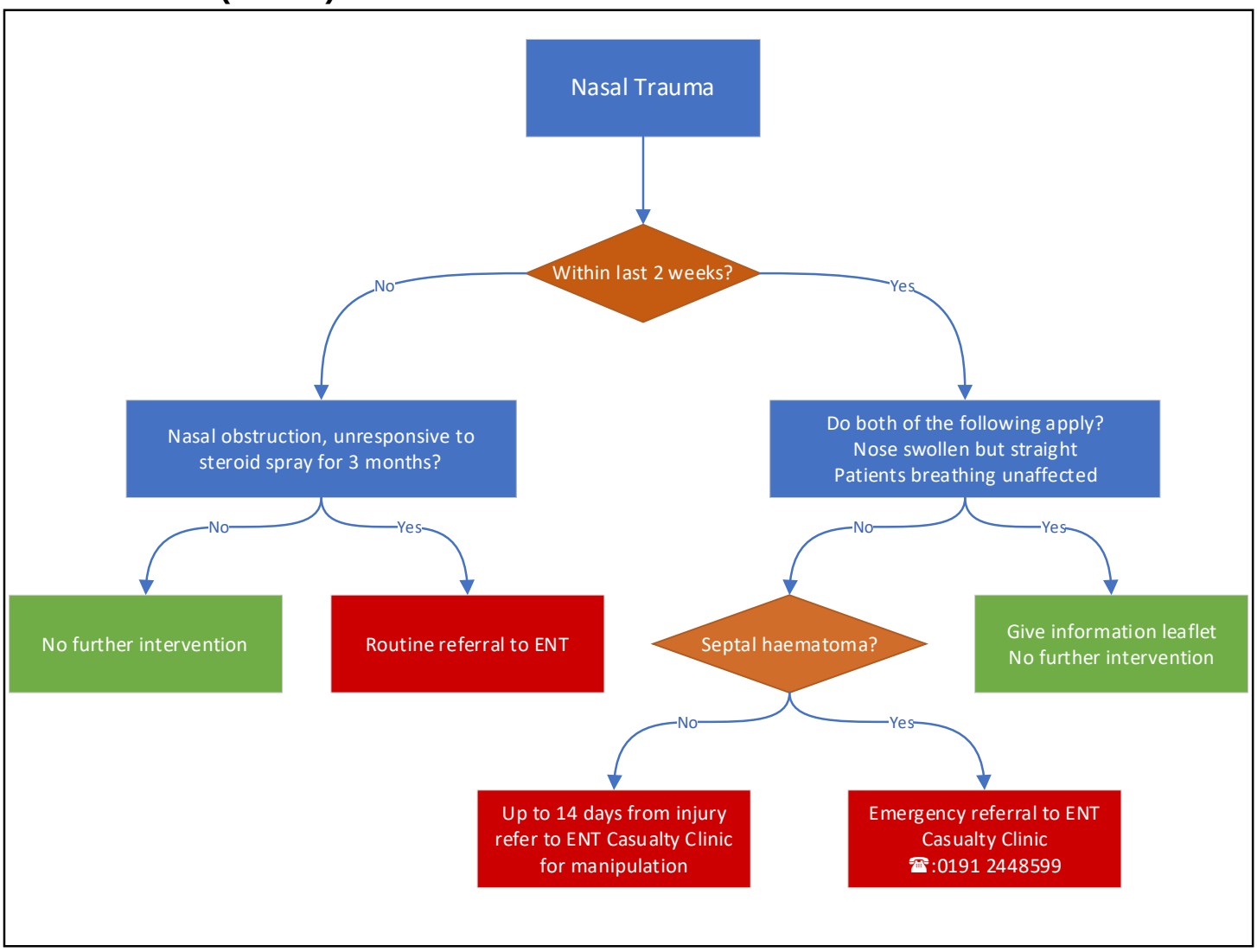
Nasal Trauma (adults)



Patient information at: https://www.entuk.org/patients/conditions/40/nasal_injuries

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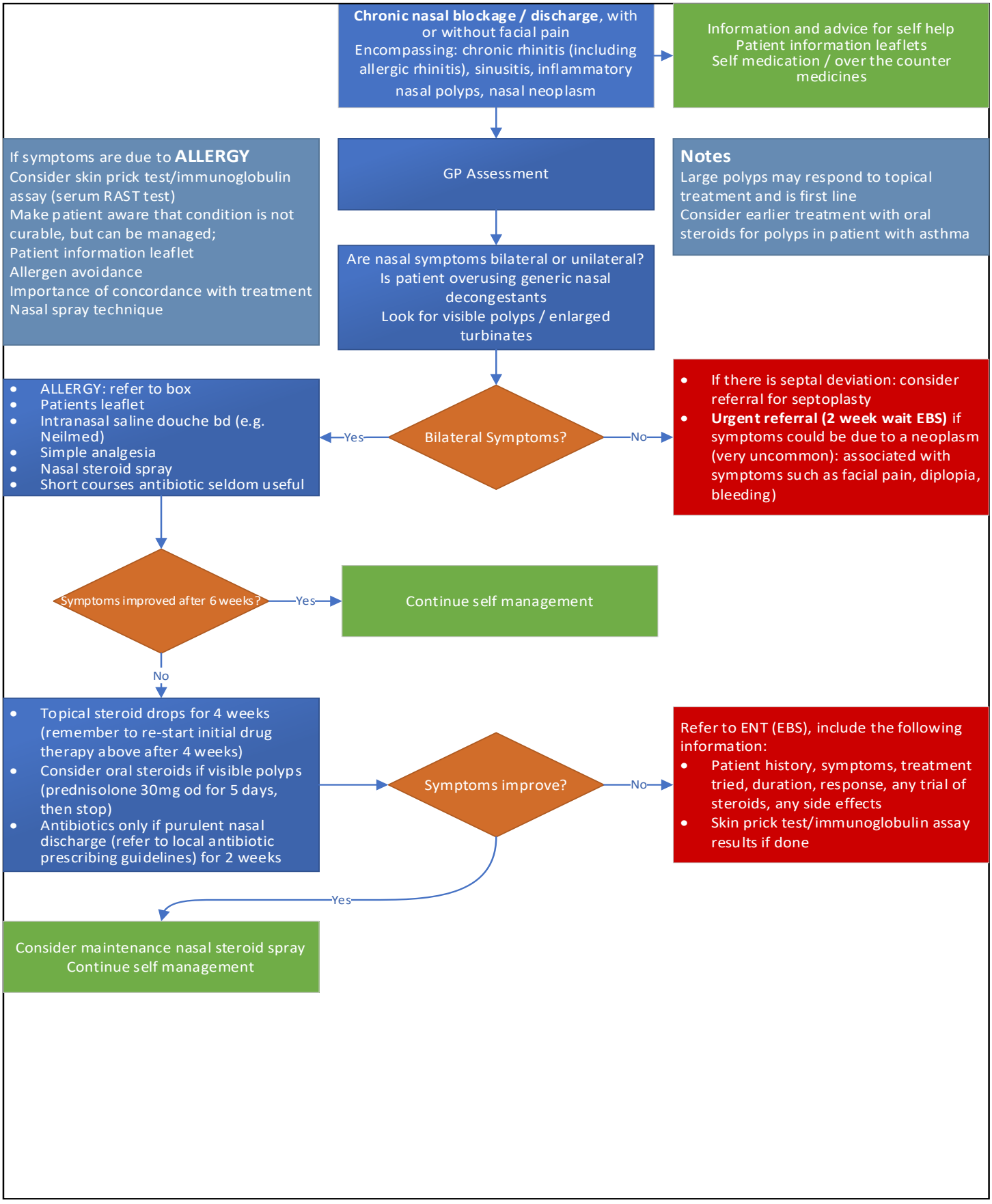
Nasal Blockage / discharge with or without facial pain



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Hearing Problems in Children

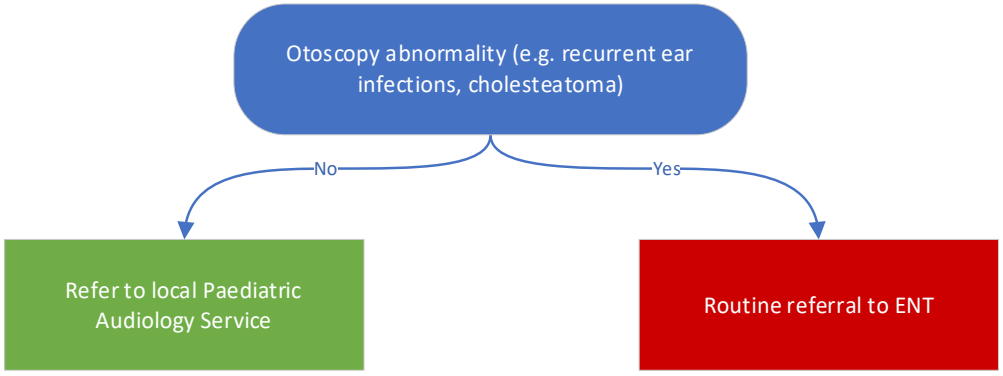
Local Paediatric Audiology Service Arrangements

Children resident in Northumberland, Newcastle, or North Tyneside aged ≤ 4 years and/or has special needs: refer to Freeman Hospital audiology department (referral form included in appendix)

Specialist paediatric audiology facilities are only available at Freeman Hospital in Newcastle, Newcastle Hospitals@Manor Walks in Cramlington, or North Tyneside Hospital and appointments will be allocated at the most local available facility.

Management tips for children with grommets:

- Child can swim but no deep diving
- No difference in infection rates between swimmers/non-swimmers
- Persistent perforation occurs in <1% of cases – further surgery may be required later
- Grommets should fall out in 6-9 months and perforation heal concurrently



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Guidelines for Paediatric Referrals to Audiology

Please use these guidelines for making a referral for a hearing assessment.

- **Parental or professional concern about a child's hearing, or development of auditory or vocal behaviour, should always be taken seriously.**

- Genuine concern can be determined by asking the following questions.
  1) Is the child able to follow age-appropriate instructions when spoken to, in a normal voice, from behind or out of sight. See Reaction to sounds checklist p.35 of Parent Child Health Record (PCHR) (appendix i)
  2) Is the child's babbling or speech and language age appropriate? See Making sounds checklist p.36 PCHR to establish if there is speech and language delay (appendix ii)

If there is concern after ascertaining the above information, then consider immediate referral to Audiology.

General Information

- Children are routinely offered a newborn hearing screen at <3 months old. Results can be found in the PCHR and on the child health information system.
- School hearing screening is no longer offered, therefore do not delay, and refer immediately if there is genuine concern about the hearing.
- If a recent fluctuating hearing loss associated with a cold is reported, consider monitoring the hearing for at least 3 months prior to referral.
- If strong parental / professional concern refer immediately.
- If the child has repeated ear infections refer to ENT, not audiology.

Other criteria used for referral to Audiology are:

- Confirmed or strongly suspected bacterial meningitis, or meningococcal septicaemia
- Temporal bone fracture
- Severe unconjugated hyperbilirubinemia

Although the clinician in charge is responsible for referring the above, it is important to be aware when a hearing assessment is required.

Referral Procedure

- All GP referrals should be via the Electronic Booking System (EBS) using the Paediatric Audiology Hearing Assessment Referral form (appendix iii).
- All non EBS referrals should be made by emailing Paediatric Audiology Hearing Assessment Referral form (appendix iii) to **nuth.AudiologyReferrals@nhs.net**

Referrals will only be accepted from GPs, HVs, School Nurses, Speech and Language Therapists and Paediatricians.

PCHR at: https://www.healthforallchildren.com/wp-downloads/79534v3.02-PCHR.pdf

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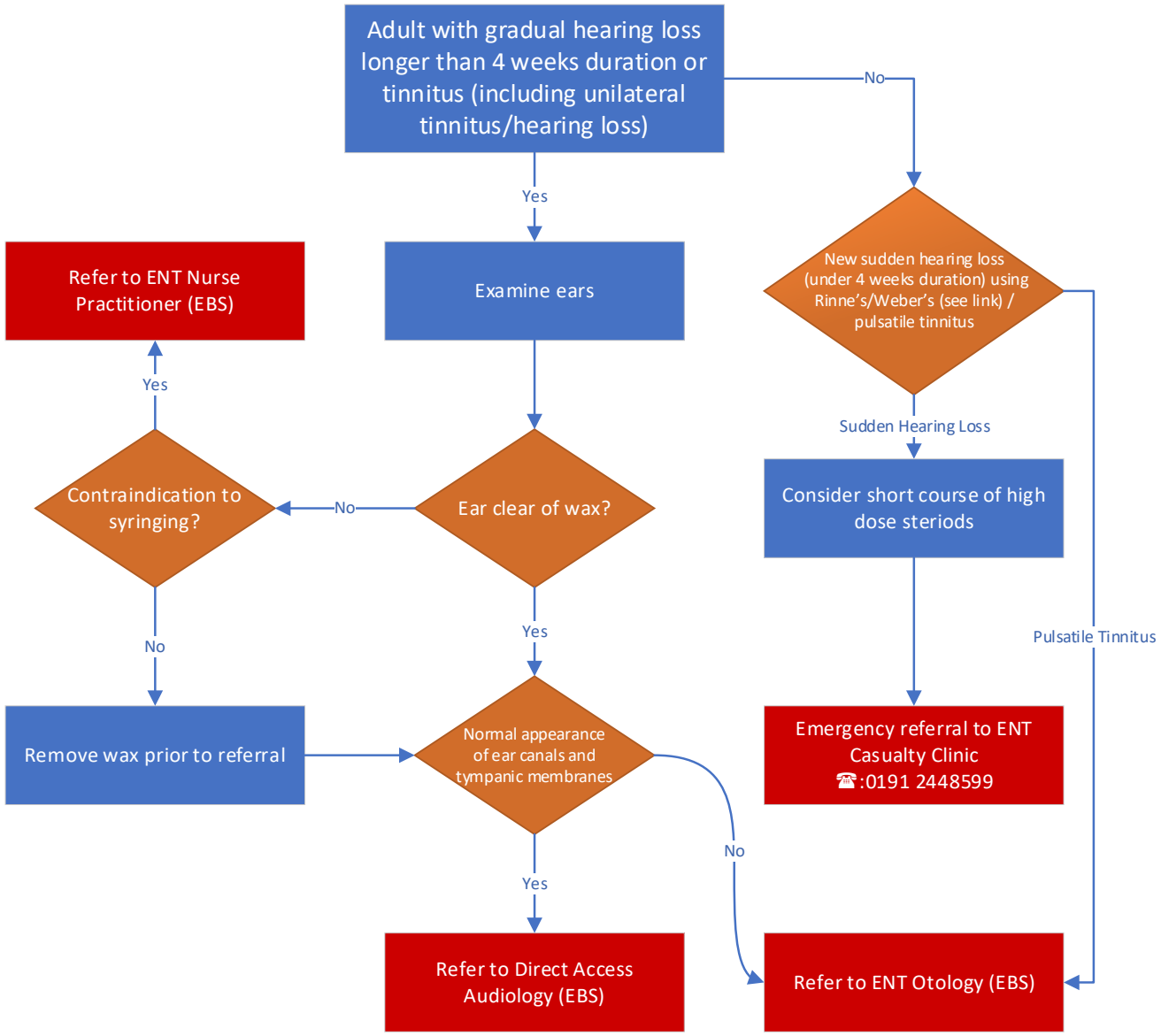
Adult Hearing Loss / Tinnitus



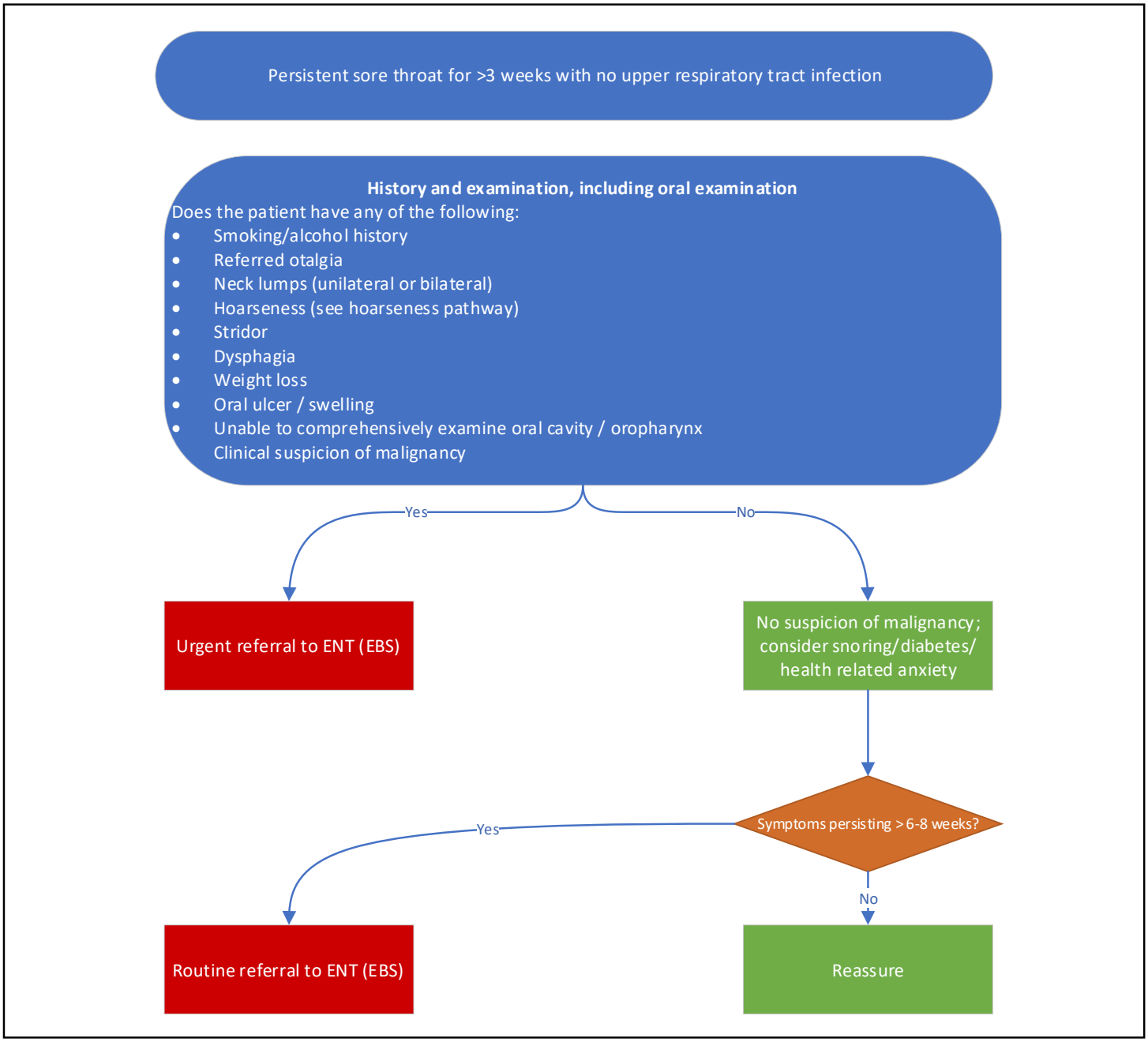
Criteria for direct referral to audiology

- Patients with symmetrical non-fluctuating hearing loss of gradual onset
- Patients with unilateral tinnitus, unilateral hearing loss
- Reassessment of hearing aid
- Patient known to the service
- Any ear wax has been removed
- NORMAL appearance of canals and tympanic membranes, **and** any pre-existing ear condition has been investigated by ENT surgeon or audiological physician

Rinne's/Weber's Tuning Fork Tests:

https://oxfordmedicaleducation.com/clinical-examinations/tuning-fork-rinnes-webers-test

Non-infectious Sore Throats in Adults



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Infectious Sore Throats in Adults

Acute pharyngitis + simple tonsillitis → Routine management

Notes

Consider use of Fever Pain Score (https://ctul.phc.ox.ac.uk/feverpain/index.php) or Centor Score (https://www.mdcalc.com/centor-score-modified-mcisaac-strep-pharyngitis)

If antibiotics are indicated: Phenoxymethylpenicillin 500mg qds first line if not penicillin allergic, not amoxycillin. Refer to local antibiotic prescribing guidelines

Recurrent tonsilitis

Does the patient meet the following criteria;

- Recurrent sore throats due to acute tonsilitis with
- 7 or more well documented, clinically significant, adequately treated episodes in the last year, or 5 or more episodes in each of the preceding 2 years, or 3 or more episodes in each of the preceding 3 years
- Minimum of 12 months of symptoms

or

- Two or more episodes of peritonsillar abscess (quinsy)

and

Had the information leaflet

Yes

- Allow patient time to consider surgery and the risks
- Review patient (by telephone or face to face) after 1 month

Patient wishes to consider tonsillectomy?

- **No** → Continue conservative management
- **Yes** → Consider IFR/Value Based Commissioning Policy https://ifr.necsu.nhs.uk/referrals/checklist_dry_run/34. If treatment agreed → Refer to ENT/ ENT Nurse Practitioner Clinic (EBS)

No

Consider alternative diagnosis (see "Non-infectious sore throat") → Continue conservative management → If no improvement, refer to ENT (EBS) for pharyngoscopy

Peritonsillar abscess (quinsy) +/- airway obstruction
Neck abscess
Stridor

→ Patient likely to require emergency admission → Emergency referral to ENT Casualty Clinic ☎:0191 2448599

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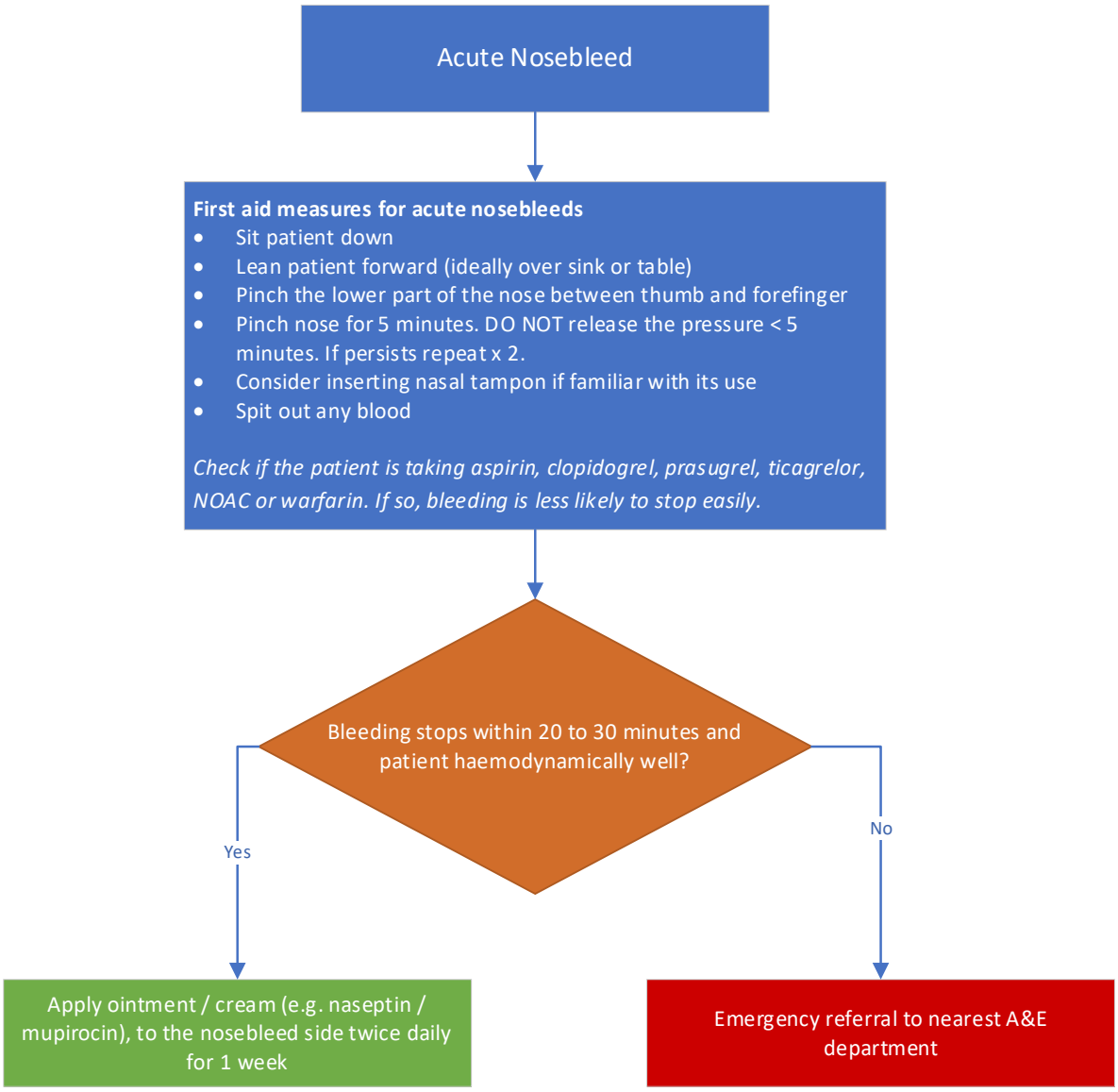
Acute Nosebleed



Notes

Treatment options for persistent nosebleeds;
Nasal cautery if bleeding site can be identified
Nasal packing e.g. nasal tampons
Admit to hospital

Nosebleeds can be serious and life threatening.

Patients who have had serious, prolonged, recurrent nose bleeds should be given the information leaflet about prevention of nose bleeds

Patient information at: https://www.entuk.org/patients/conditions/42/nosebleeds_epistaxis_update

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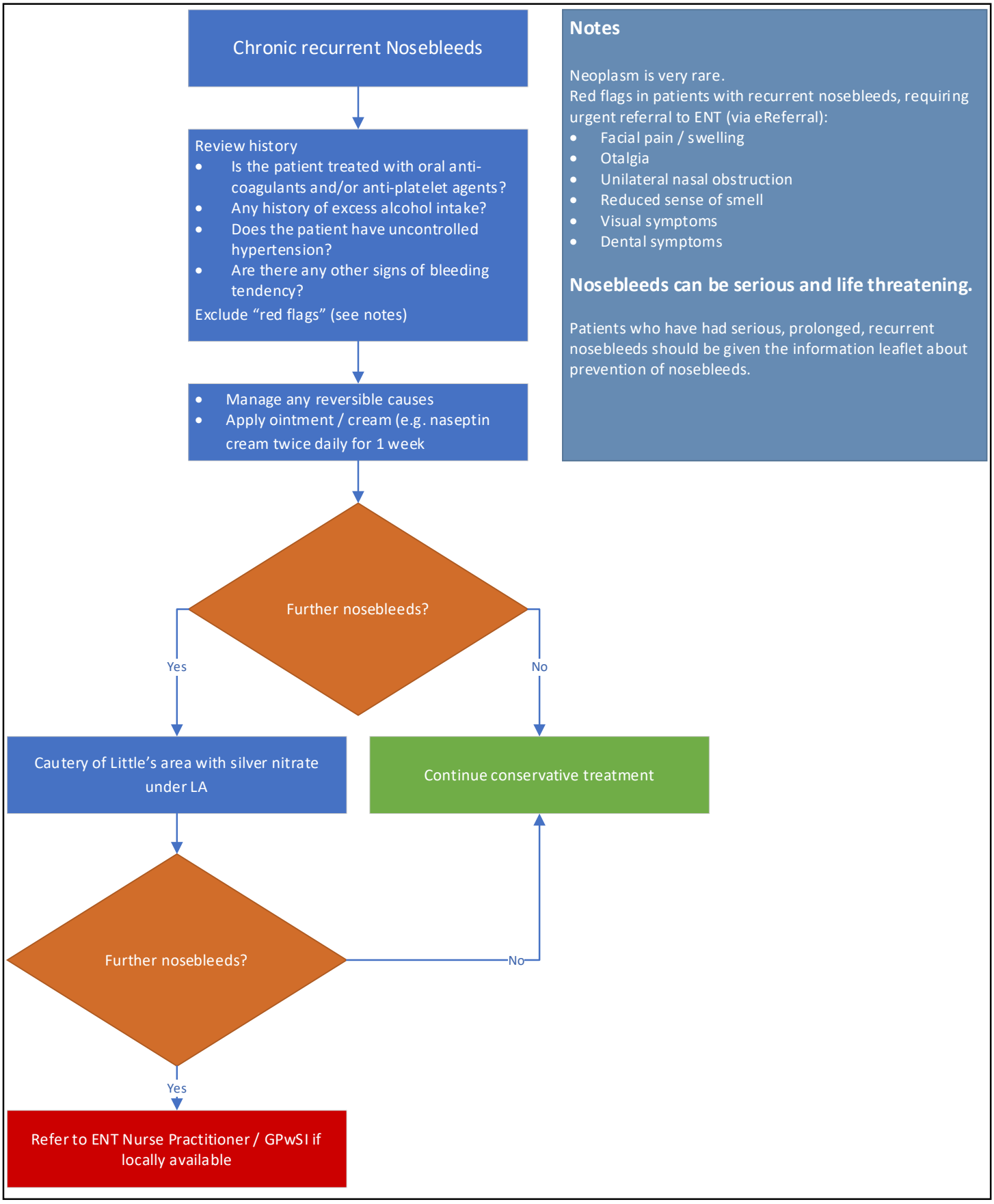
Chronic Nosebleed



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Otitis Externa in Adults and Children

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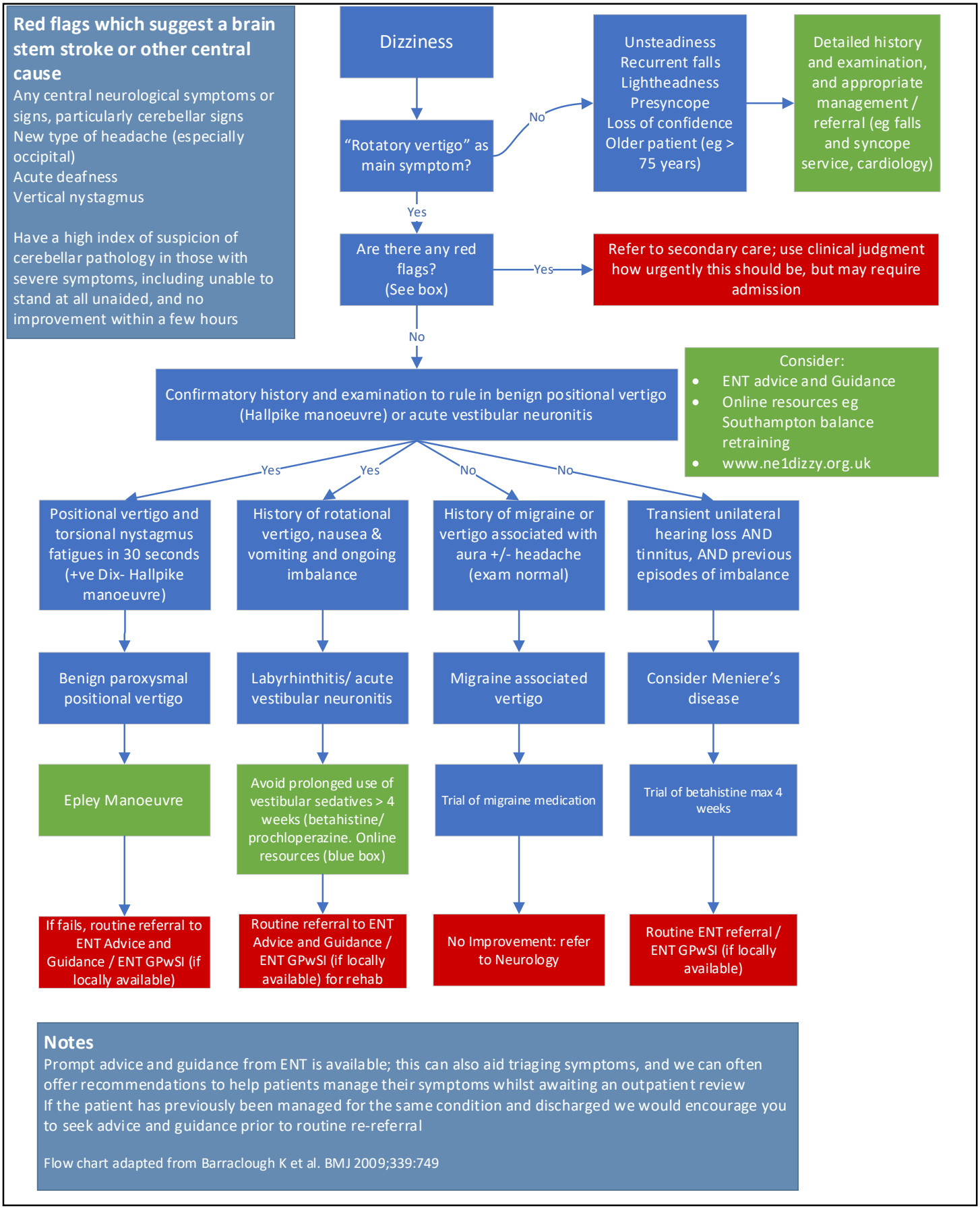
Balance



Notes

Prompt advice and guidance from ENT is available; this can also aid triaging symptoms, and we can often offer recommendations to help patients manage their symptoms whilst awaiting an outpatient review
If the patient has previously been managed for the same condition and discharged we would encourage you to seek advice and guidance prior to routine re-referral

Flow chart adapted from Barraclough K et al. BMJ 2009;339:749

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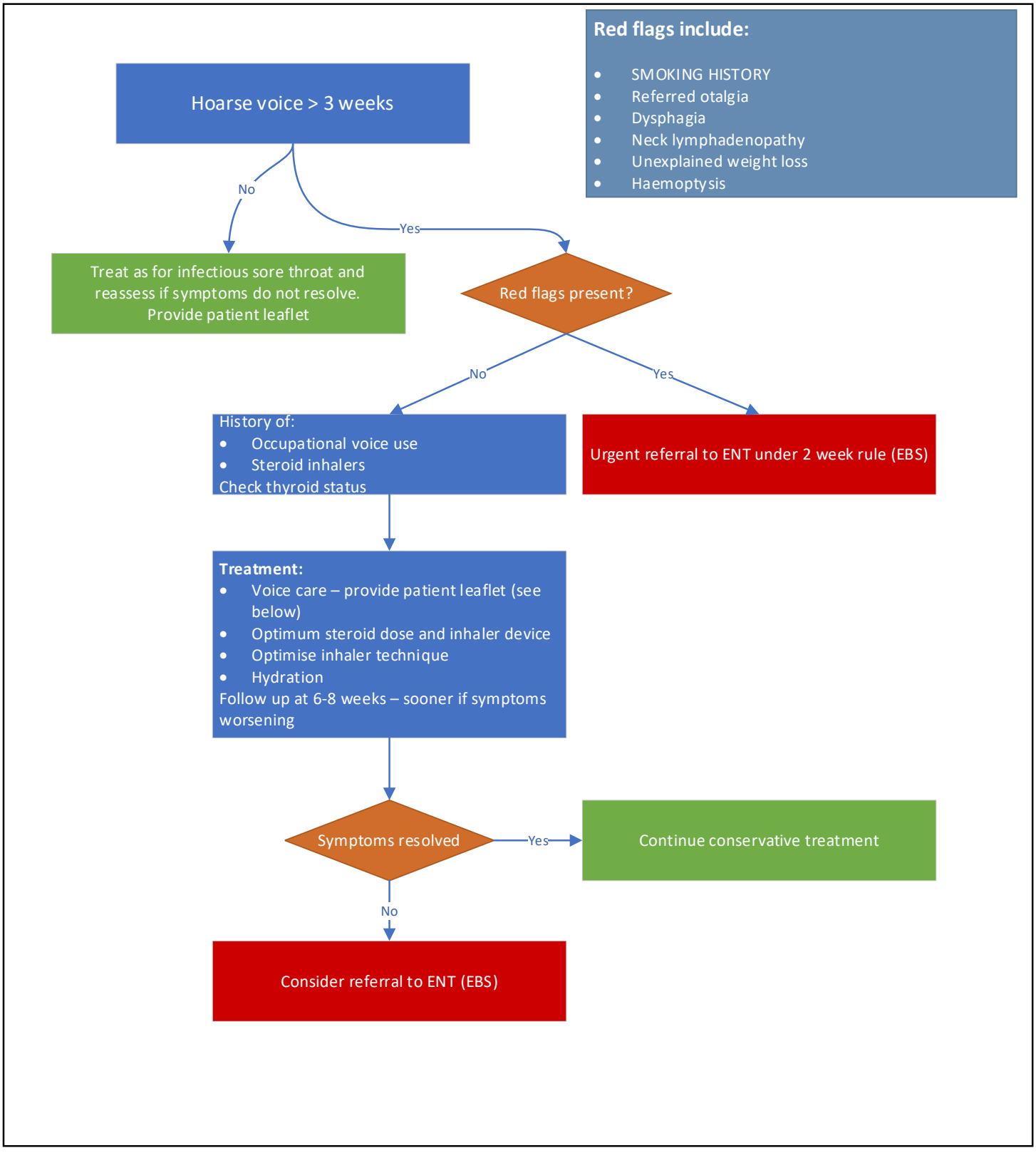
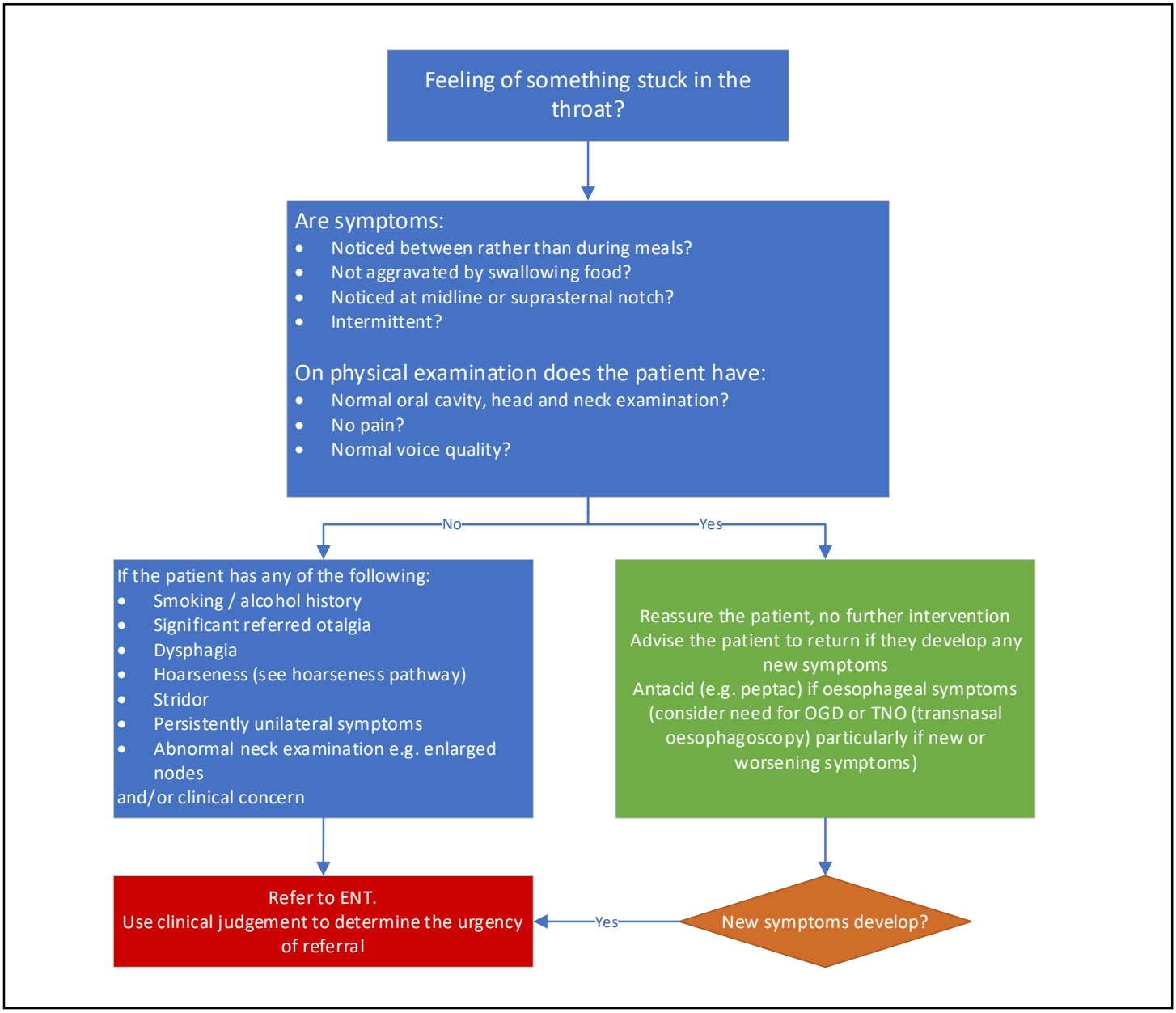
Hoarse Voice in Adults



Patient information at: https://www.entuk.org/patients/conditions/31/hoarseness

Feeling of something in throat



Feeling of something stuck in the throat

Important considerations –

Q1 is there actually obstruction to the passage of food -is the patient having to change or liquidise their diet?

Yes - if people are not able to swallow solid there may need either an urgent head and neck or an urgent GI referral. Obstructive dysphagia and early satiety are key symptoms of lower oesophageal cancer.

No - with globus sensation people may be aware of a lump on swallowing that sometimes is better when they swallow food and worse with dry or saliva swabs. Globus sensation is in fact a negative predictor for oesophageal cancer in those undergoing diagnostic OGD.

Q Is the patient obese? Some globus patients have sleep related breathing disorders; snoring, even sleep apnoea. At times such patients are literally running out of space down which to swallow or breathe due to the increase in neck fat deposition. This presents a challenging conversation but obviously one which belongs in primary care.

Q Should I prescribe a trial of proton pump inhibitors? No. Proton pump inhibitors are of no proven benefit over placebo in persistent throat symptoms. While the said placebo response approaches a 30% fall in symptom intensity, this does not justify giving a drug with the PPI side-effect profile and most patients would not be happy if you disclosed that they were being given the treatment because of its placebo effect

Q Are there other symptoms? Globus is rarely an isolated experience. It is much more commonly associated with for example throat clearing, catarrh, mucus, mild loss of voice from time to time, throat discomfort. This is a well-recognised family of interrelated functional throat symptoms.

Q Does the patient complained of postnasal drip? Explain that this is an impossible phenomenon as there is no open space below the nasopharynx down which anything can drip. The symptom is due to heightened awareness of the natural upper respiratory mucus blanket often due in adequate hydration. Consider using NeilMed sinus rinse in addition to the throat advice

Q Does the patient have throat clicking? Reassure that this is due to an awareness of contact between laryngeal cartridges and the anterior vertebral bodies during dry swallows.

Patients with persistent throat symptoms are best managed on **a cognitive behaviour therapy model.** Negative cognitions are principally catastrophizing over suspected cancer, symptom monitoring and amplification through anxiety, dry mouth and increasingly difficult saliva swallows. Drug induced xerostomia and dryness due to other causes such as diabetes may be relevant.

Recognised aetiological factors include neurotic personality trait, symptom monitoring, anxiety, health-related anxiety, external stressors e.g., major adverse life events or minor daily hassles.

Q – Has the patient suffered from other issues of health-related anxiety? Have they already been seen with physical symptoms for which no medical explanation could be round?

Yes - supplement behavioural change with reattribution of negative cognitions and address underlying health-related anxiety as a primary treatment approach rather than as an afterthought when all else fails

No - if seems to be a one-off episode perhaps triggered by physical change refer to the behavioural guidance for a minimum of eight weeks

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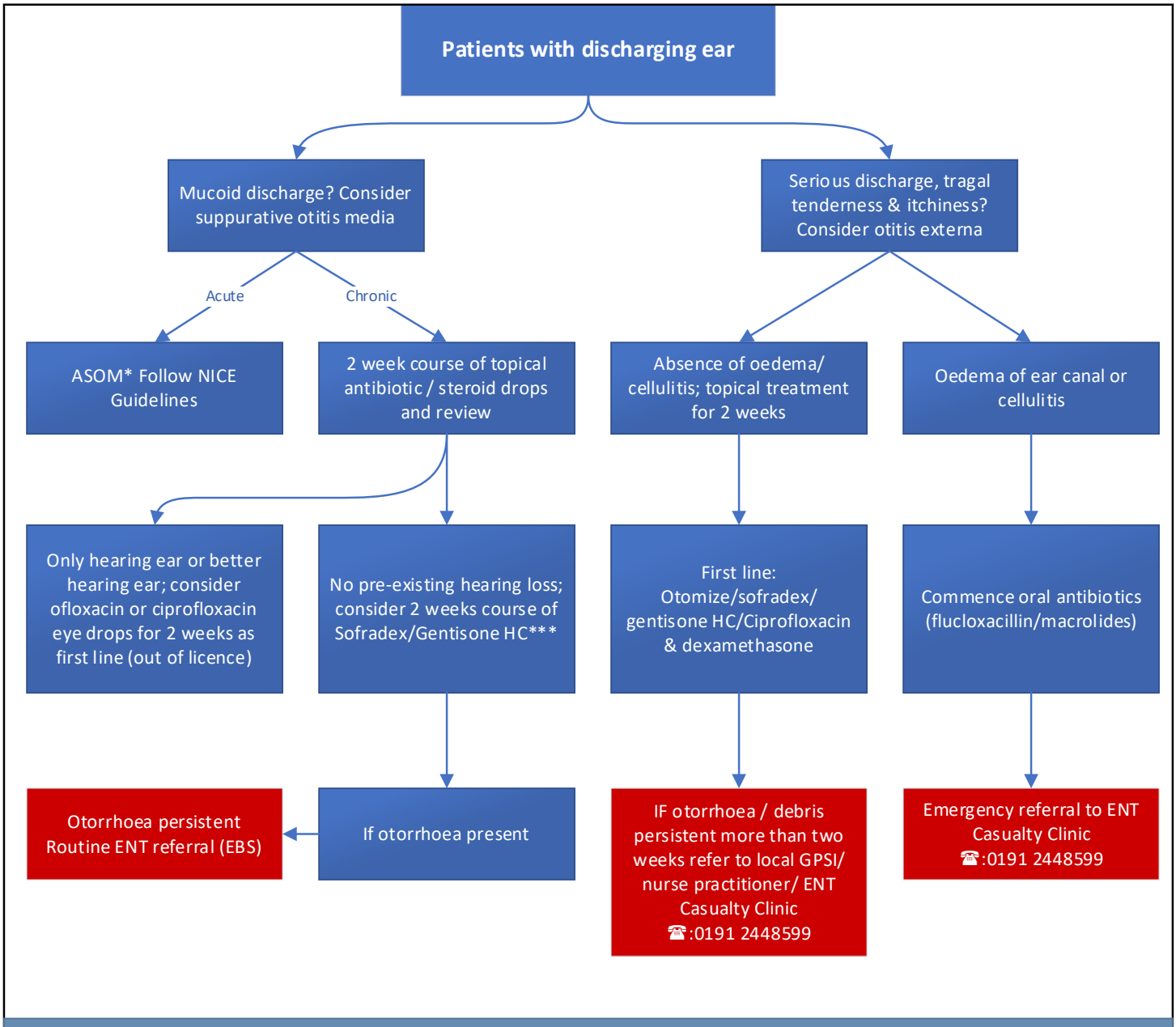
Management of Discharging Ear



***ASOM:** new onset otalgia/otorrhoea +_ URTI

** **CSOM:** persistent discharge over 6 weeks following ASOM or recurrence of discharge from previous known perforation.

*** out of licence with perforation, however safe to use for one or two weeks.

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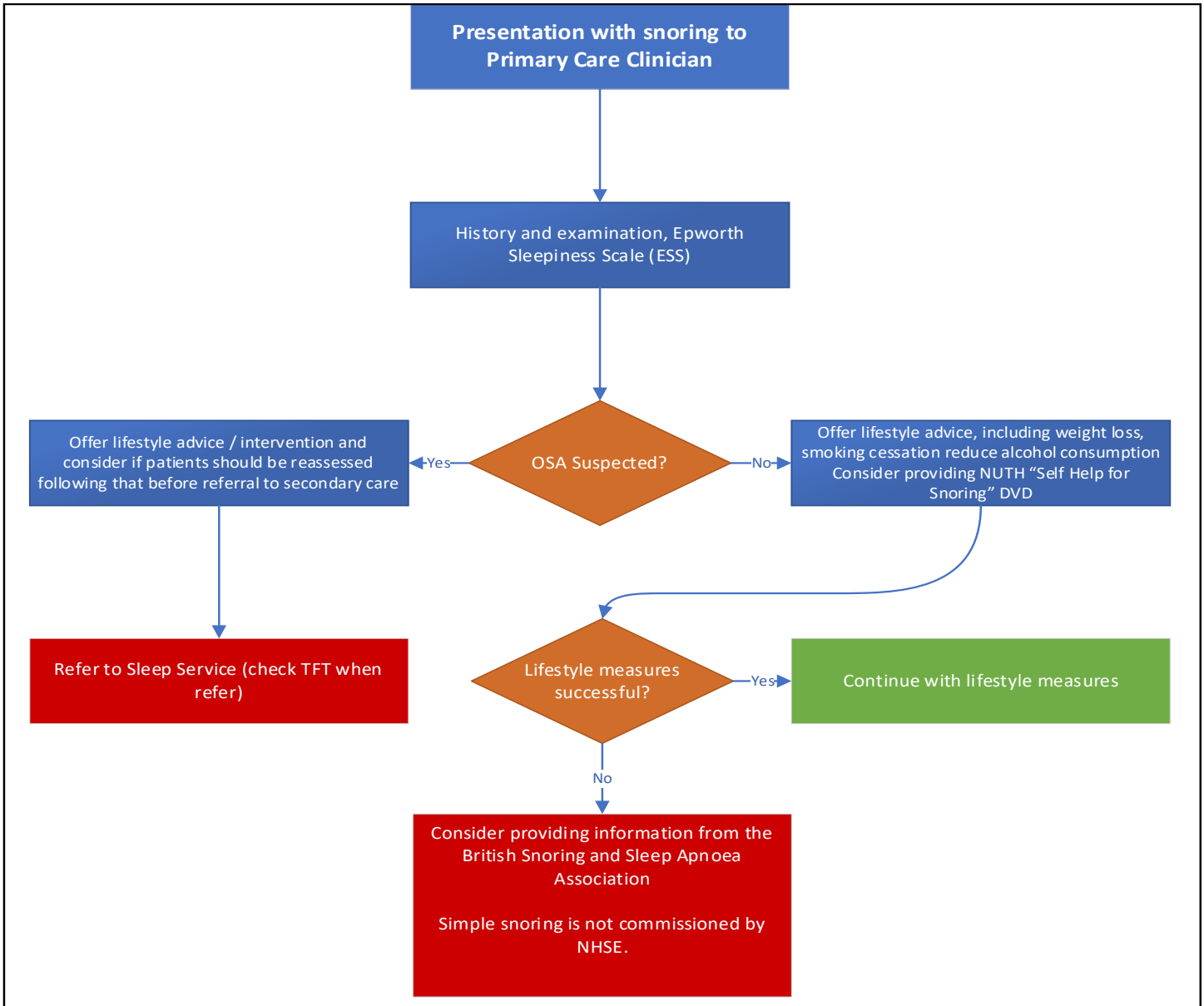
Primary Care Management of Snoring in Adults



History, include:
Loudness of snoring
Excessive / intrusive daytime sleepiness
Witnessed apnoea's
Impaired alertness
Nocturnal choking episodes
Waking unrefreshed
Co-morbidity e.g. hypothyroidism, ischaemic heart disease, cerebrovascular disease, diabetes, hypertension
Smoking history
Alcohol consumption
Medication history
Consider psycho-social impact

Examination, include:
BMI
Collar size

STOP BANG Questionnaire: https://britishsnoring.co.uk/stop_bang_questionnaire.php

Paediatric Obstructive Sleep Apnoea

Paediatric Obstructive Sleep Apnoea

History and examination
Does the patient have the following:

- Habitual snoring
- Witnessed apnoea's
- Restless, sweaty sleeper
- Daytime tiredness/hyperactivity
- Mouth breathing
- Significant co-morbidity (see figure 1 below) – have a lower threshold for referral to tertiary care paediatric ENT service

Assess tonsil size – see figure 2

Occasional snoring
No witnessed pauses
Small tonsils (Grade 1-2)

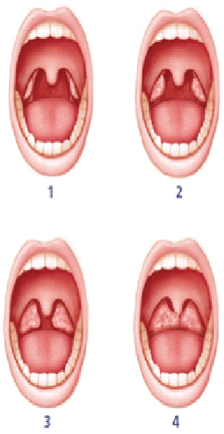
→ Likely primary snoring

Snores most nights
Witnessed pauses
Large tonsils (Grade 3-4)

→ Referral to Paediatric ENT (EBS)
- Include tonsil size in referral
- Please ask parents to bring a short video of child sleeping to clinic appointment

Figure 1. Co-morbidities increasing likelihood of significant OSA

- Craniofacial syndrome
- Chronic respiratory disease
- Congenital cardiac disease
- Neurological/neuromuscular disease



Brodsky Table

(Degree of Tonsils Blockage)	Ratio of the Tonsil in the Oropharynx
Degree 1	Tonsil occupies less than 25% of the Oropharynx
Degree 2	Tonsil occupies from 25 to 50% of the Oropharynx
Degree 3	Tonsil occupies from 50 to 75% of the Oropharynx
Degree 4	Tonsil occupies more than 75% of the Oropharynx

Figure 2. *The Brodsky scale for clinical ton grading in children*[68].

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Recurrent Nosebleeds in Children

Recurrent Nosebleeds in Children

Review History

- Frequency of severity of epistaxis
- Does the child frequently pick his/her nose?
- Is the patient treated with oral anticoagulants/ antiplatelet therapy?
- Is there a family history of bleeding problems?

*First aid measures for acute nosebleeds

- **Sit patient down**
- **Lean patient forward (ideally over sink or table)**
- **Pinch the lower, soft part of the nose between thumb and forefinger as firmly as possible**
- **Do not release pressure on nose for at least 5 minutes**
- **If bleeding persists, repeat process x2**
- **If ongoing bleeding, heavy bleeding or child unwell, present to local A&E department**

Check if patient is taking anticoagulants– if so, bleeding is less likely to stop easily and may need to attend local A&E sooner

- **If high volume brisk bleeding, consider early referral to Paediatric ENT clinic but start naseptin/ mupirocin as below**
- If low volume bleeding, prescribe naseptin cream. Apply to affected nostril 3 times a day for 2 weeks.
- Caution: if peanut allergy, prescribe mupirocin as an alternative.
- Following this, Vaseline moisturisation of nostrils twice a day to moisturise mucosa and act as a barrier cream

Further nosebleeds?

Yes → Refer to Paediatric ENT Clinic (EBS) for consideration of nasal cautery

No → Continue conservative treatment

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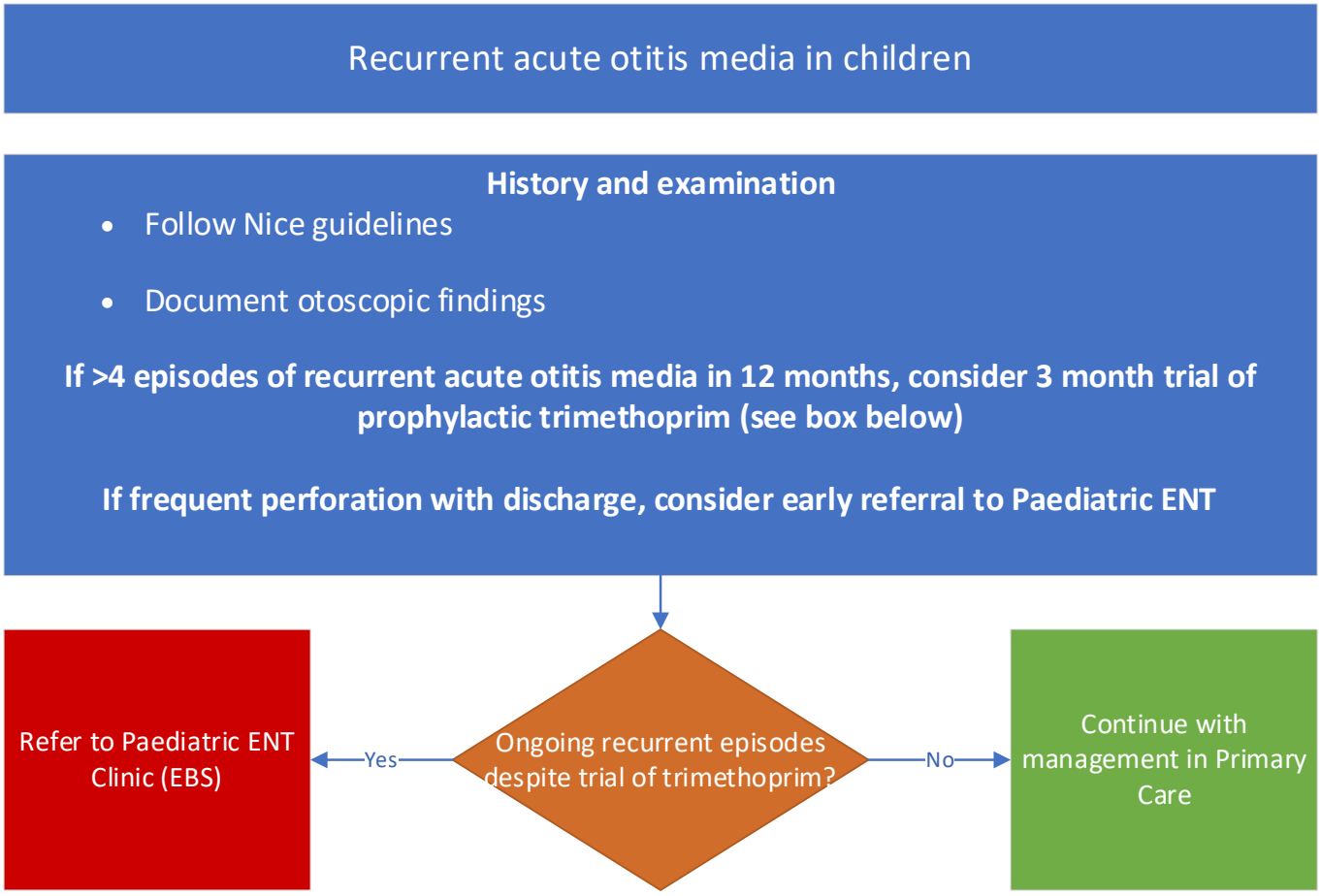
Recurrent acute otitis media in children



Prophylactic Trimethoprim:

- Please refer to BNF for Children for dosage. Prescribe dose as recommended for prophylaxis in recurrent urinary tract infection
- If develops an episode of acute otitis media during the 3 month course of prophylaxis, stop trimethoprim temporarily and treat as an acute infection as per the NICE guidance above.
- Recommence prophylactic trimethoprim following this to complete 3 month course.

Nice Guidelines:

https://www.nice.or.uk/guidance/ng91/resources/visual-summary-pdf-4787282702

Appendix i – Reaction to sounds checklist

NHS

Screening Programmes

Newborn Hearing

Reaction to sounds checklist

This list and the Making Sounds Checklist give pointers about what to look for as your baby grows to check if he/she can hear. Babies differ widely in what they can do at any given age. The ages presented here are an approximate guide only.

Shortly after birth - a baby:

Is startled by a sudden loud noise such as a hand clap or a door slamming. Blinks or opens eyes widely to such sounds or stops sucking or starts to cry.

1 month - a baby:

Starts to notice sudden prolonged sounds like the noise of a vacuum cleaner and may turn towards the noise. Pauses and listens to the noises when they begin.

4 months - a baby:

Quietens or smiles to the sounds of familiar voice even when unable to see speaker and turns eyes or head towards voice. Shows excitement at sounds (e.g. voices, footsteps etc).

7 months - a baby:

Turns immediately to familiar voice across the room or to very quiet noises made on each side (if not too occupied with other things).

9 months - a baby:

Listens attentively to familiar everyday sounds and searches for very quiet sounds made out of sight.

12 months - a baby:

Shows some response to own name. May also respond to expressions like 'no' and 'bye bye' even when any accompanying gesture cannot be seen.

If at any stage in the baby or child's development you think he/she may have difficulties hearing, contact your health visitor or family doctor.

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Adapted from: The 'Can Your Baby Hear You' form, B. McCormick, 1982, Children's Hearing Assessment Centre, Nottingham, UK.

Appendix ii – Making sounds checklist

NHS

Screening Programmes

Newborn Hearing

Making sounds checklist

Introduction

This list and the Reaction to Sounds Checklist give pointers about what to look for as your baby grows to check if he/she can hear. Babies do differ in what they can do at any given age. The ages presented here are approximate only.

Checklist

4 months - a baby:

Makes soft sounds when awake. Gurgles and coos.

6 months - a baby:

Makes laughter-like sounds. Starts to make sing-song vowel sounds (eg: a-a, muh, goo, der, aroo, adah).

9 months - a baby:

Makes sounds to communicate in friendliness or annoyance. Babbles (e.g. 'dada da', 'ma ma ma', 'ba ba ba'). Shows pleasure in babbling loudly and tunefully. Starts to imitate other sounds like coughing or smacking lips.

12 months - a baby:

Babbles loudly, often in a conversational-type rhythm. May start to use one or two recognisable words.

15 months - a baby:

Makes lots of speech-like sounds. Uses 2-6 recognisable words meaningfully (eg: 'teddy' when seeing or wanting the teddy bear).

18 months - a baby:

Makes speech-like sounds with conversational-type rhythm when playing. Uses 6-20 recognisable words. Tries to join in nursery rhymes and songs.

24 months - a child:

Uses 50 or more recognisable words appropriately. Puts 2 or more words together to make simple sentences (for example: more milk). Joins in nursery rhymes and songs. Talks to self during play (may be incomprehensible to others).

30 months - a child:

Uses 200 or more recognisable words. Uses pronouns (e.g. I, me, you). Uses sentences but many will lack adult structure. Talks intelligibly to self during play. Asks questions. Says a few nursery rhymes.

36 months - a child:

Has a large vocabulary intelligible to everyone.

.....

Adapted from: M. D. Sheridan (Revised by M. Frost and A. Sharma), 1997,
Routledge, London, New York.

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Appendix iii – Paediatric Audiology Hearing Assessment Referral

Newcastle upon Tyne Hospitals – Freeman Hospital

PAEDIATRIC AUDIOLOGY HEARING ASSESSMENT REFERRAL

(6 months – 4 yrs old and for children with special needs)

We will only accept **electronic referrals via email or eReferral** from Speech and Language Therapists, GP's, Health Visitors and School Nurses. There must be a genuine parental or professional concern about the child's hearing; this is not a screening service.

Please use eReferral to make this Audiology referral (located under Children and Adolescents – Audiology and choose 4 yrs and under service). For patients UNDER 6 MONTHS please contact the Head of Audiology on tel: 0191 223 1043 for advice.

Only to be used for children resident in Newcastle, North Tyneside and Northumberland

Date Of Referral:					
Patient Name				**Previous name**	
Date of Birth		**Gender**		**NHS Number**	
Address				**Telephone Home:** **Mobile:** **Alt. No:**	
Name, Address and Job Title of Referrer School/Nursery/ Speech Language Therapist/ Health Visitors				**Surgery Phone:** **Surgery Email:**	
Do you require a copy of the results in addition to GP?			**YES/NO**	**Practice Code:**	
Ethnicity			**Interpreter Required?**	**Y/N**	**If Y specify language:**
Special Requirements? If yes please state: (eg Hearing Loop, Wheelchair Access,)					

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Please provide the following information

Outcome of any previous hearing assessments	
Are there any hearing concerns? Or is this assessment part of further investigations?	
Known eyesight difficulties	
Is the child able to sit with minimal support? OR Is the child able to follow simple instructions, including waiting?	
Do they have any sensitivities or dislikes? (noise, new environments, having their ears touched, having items on their head)	
Known behavioural or developmental diagnosis	

All GPs should please process this referral on eReferral. If Health visitors, school nurses or speech and language therapists do not have access to eReferral via the GP, then please email a copy to nuth.AudiologyReferrals@nhs.net via an NHS,net account or .gov account and write "secure" in the subject line.

PAPER COPIES ARE NO LONGER ACCEPTED.

Appointments are available at the following locations / outreach clinics please indicate a preference;

Freeman Hospital		North Tyneside General Hospital		Cramlington Manor Walks	

Contact name for the Audiology Department is Mrs Kate Johnston, Phone: 0191 2231043