The Nose and Throat in General Practice

Rakesh Chopra
MBBS MS FRCS FRCGP
ENT Tutor–RCGP
Council member RSM
GP-Eccleston Medical Centre

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Nasal Obstruction

From structures that are normally present inside the nose – septum , turbinates, mucosa, adenoids.

From those that are not – polyps, tumours, granulomatous lesions, foreign bodies

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Rhinitis – allergic and non-allergic

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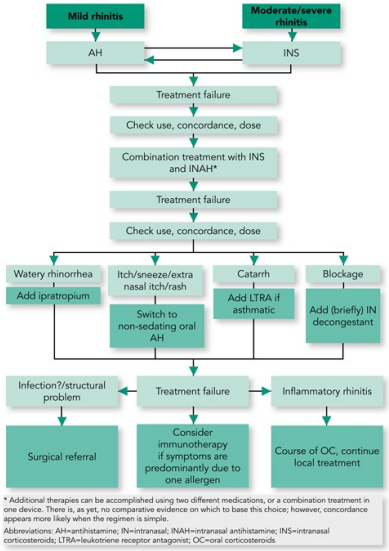

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Rhinitis

- Allergic / non-allergic
- Autonomic (formerly called vasomotor)
- Infective
- Drug induced
- Hormonal/Occupational/Granulomatous
- Rhinitis medicamentosa

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Bioavailability/Side Effects of INS

Systemic steroid affectation? Glaucoma!!!!!!!?

Newer sprays mometasone and fluticasone

Less bioavailability

Oral steroids- If symptoms are severe and/or impairing quality of life

For adults — prednisolone 0.5 mg/kg in the morning for 5–10 days.

For children — prednisolone 10–15 mg in the morning for 3–7 days

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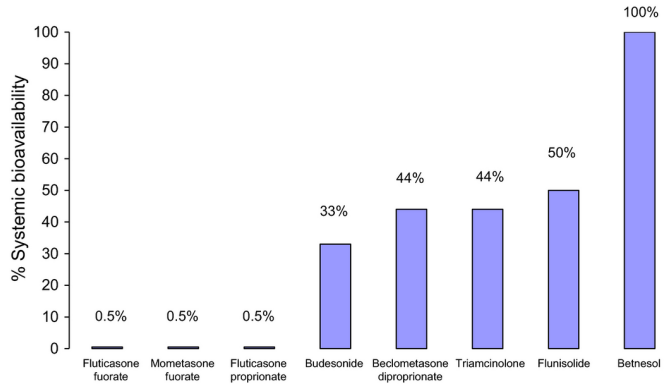
Systemic Bioavailability



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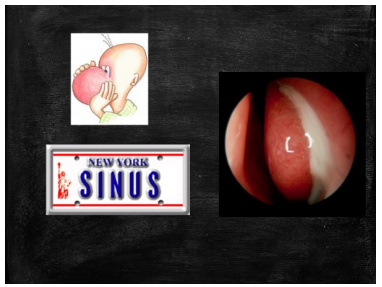
Sinusitis- Rhinosinusitis

- Acute
- Chronic



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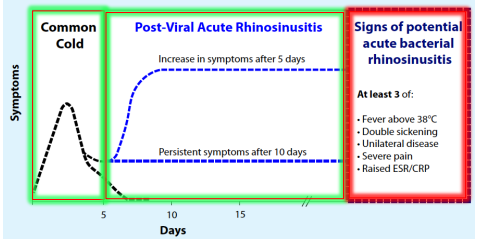
Definition of Acute Rhinosinusitis

Increase in symptoms after 5 days, or **persistent symptoms after 10 days** with less than 12 weeks duration



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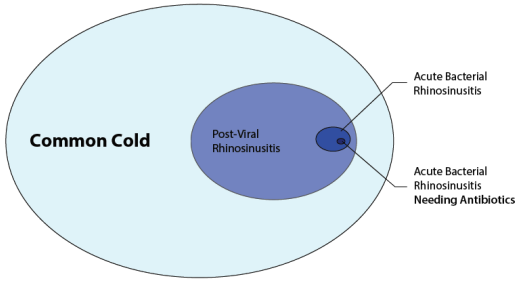
Acute Rhinosinusitis



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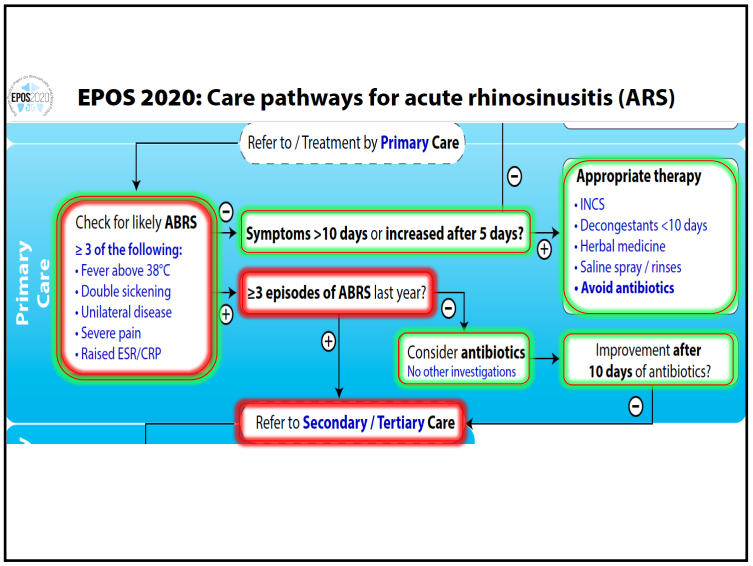

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Acute Bacterial Rhinosinusitis

Antibiotics for adults aged 18 years and over

Antibiotic[1]	Dosage and course length for adults
First choice	
Phenoxymethylpenicillin	500 mg four times a day for 5 days
First choice if systemically very unwell, symptoms and signs of a more serious illness or condition, or at high risk of complications	
Co-amoxiclav	500/125 mg three times a day for 5 days
Alternative first choices for penicillin allergy or intolerance	
Doxycycline	200 mg on first day, then 100 mg once a day for 4 days (5-day course in total)
Clarithromycin	500 mg twice a day for 5 days
Erythromycin (in pregnancy)	250 mg to 500 mg four times a day or 500 mg to 1000 mg twice a day for 5 days
Second choice (worsening symptoms on first choice taken for at least 2 to 3 days)	
Co-amoxiclav[2]	500/125 mg three times a day for 5 days

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Chronic rhinosinusitis – cardinal symptoms

Nasal obstruction

- Nasal purulence
- Anosmia
- Facial discomfort/pain

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Chronic Rhinosinusitis (Old Classification)

Chronic rhinosinusitis
with nasal polyps (CRSwNP)

Chronic rhinosinusitis without nasal polyps (CRSsNP)

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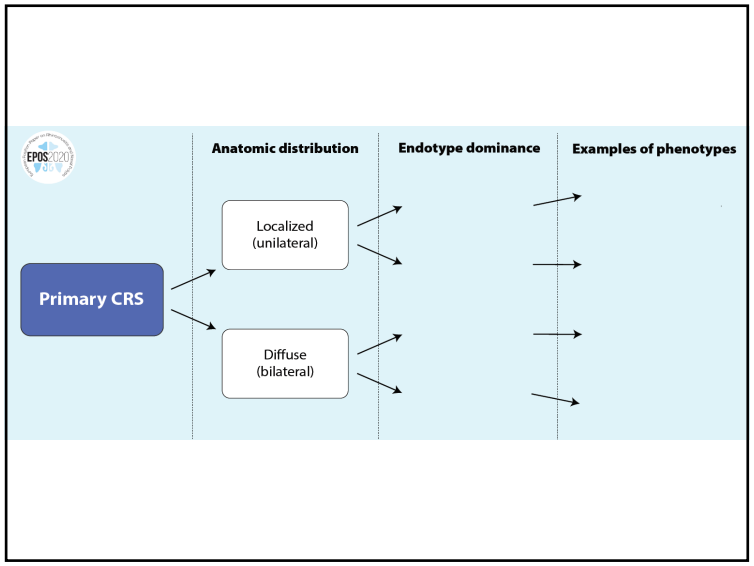

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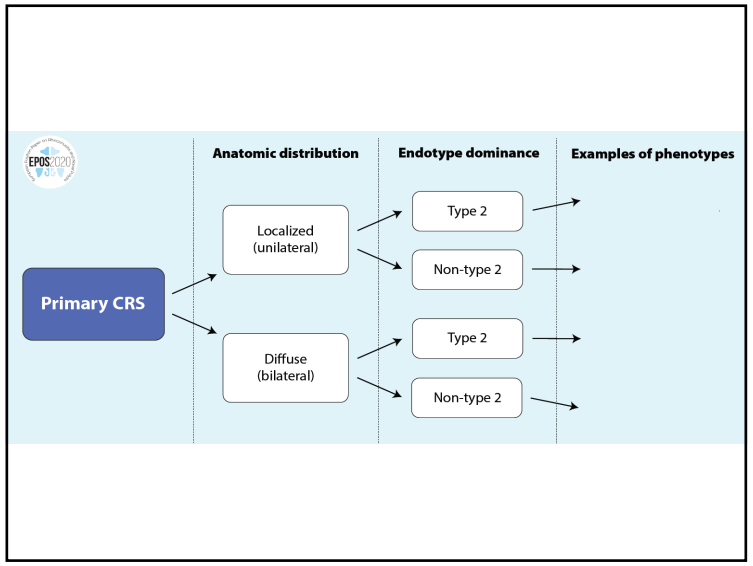

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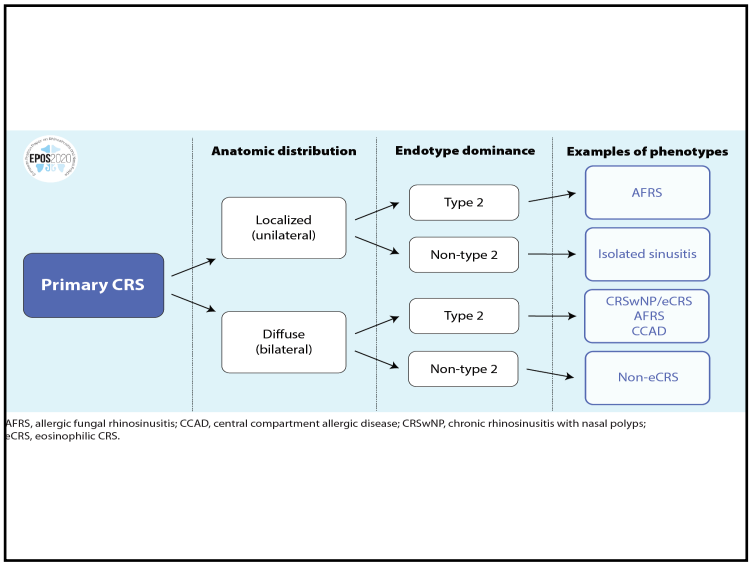

AFRS, allergic fungal rhinosinusitis; CCAD, central compartment allergic disease; CRSwNP, chronic rhinosinusitis with nasal polyps; eCRS, eosinophilic CRS.

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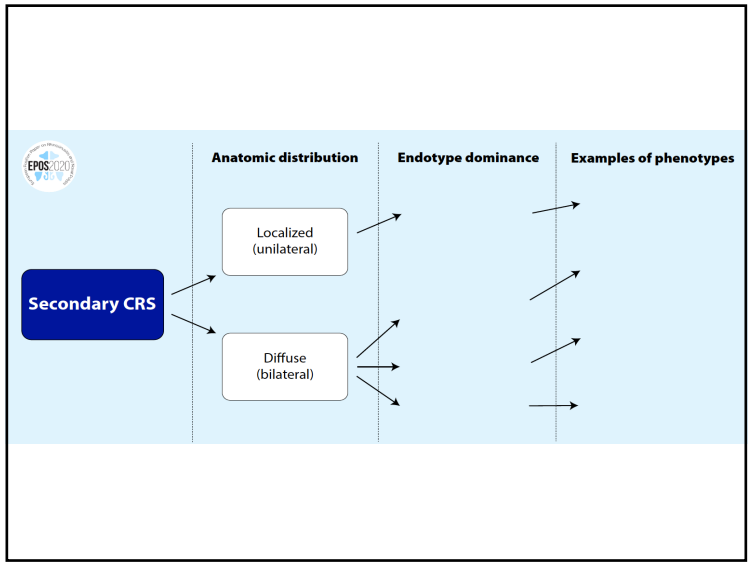

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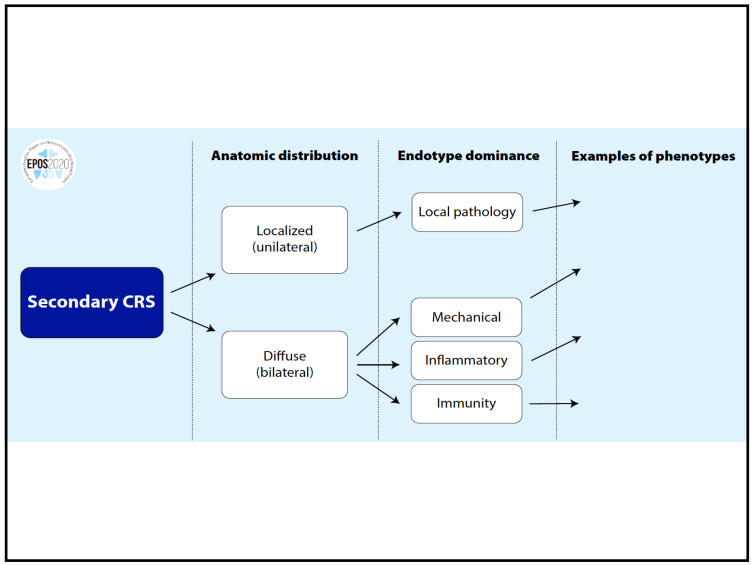

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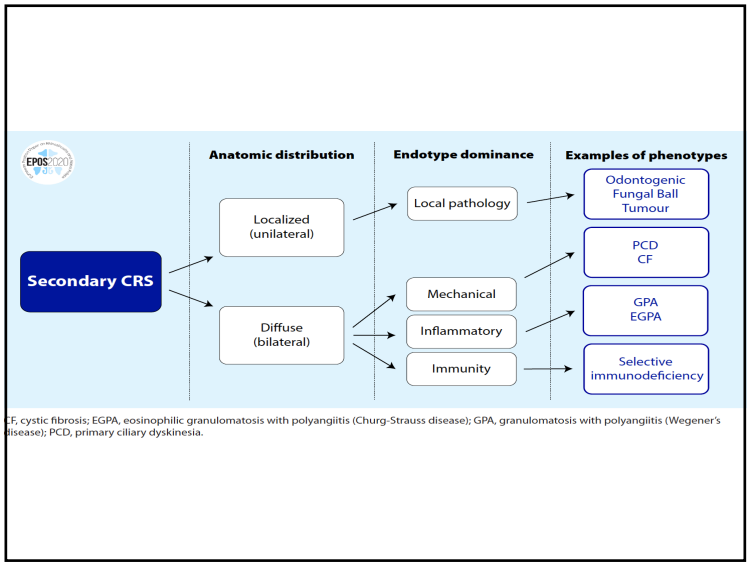

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Nasal Polyposis with chronic rhinosinusitis

- Fluid-filled sacs characterized by oedematous tissue with infiltrating cells; develop on the lining of sinuses.
- Persistent unilateral or bilateral nasal obstruction/hyponasality/anosmia
- Etiology unknown – Immunological!
- Occur in 0.2% to 4% of population
- 4:1 male to female predominance
- Incidence increases with age

- Aspirin sensitivity, Asthma, cystic fibrosis(AERD)
- Unilateral vs bilateral

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Nasal Polyps - Management

- Medical + surgical (medical polypectomy)
- Topical Corticosteroids (drops + INS)
- Nasal douche
- Oral Corticosteroids (dose variable 0.5 mgm/kgBW OD/5-10 days)
- Antibiotics (doxycycline 3 weeks, Primary Care X)
- Surgical treatment: Minimally invasive
- Recurrence (Natural history – avg 4 years)
- Future – Immunological intervention

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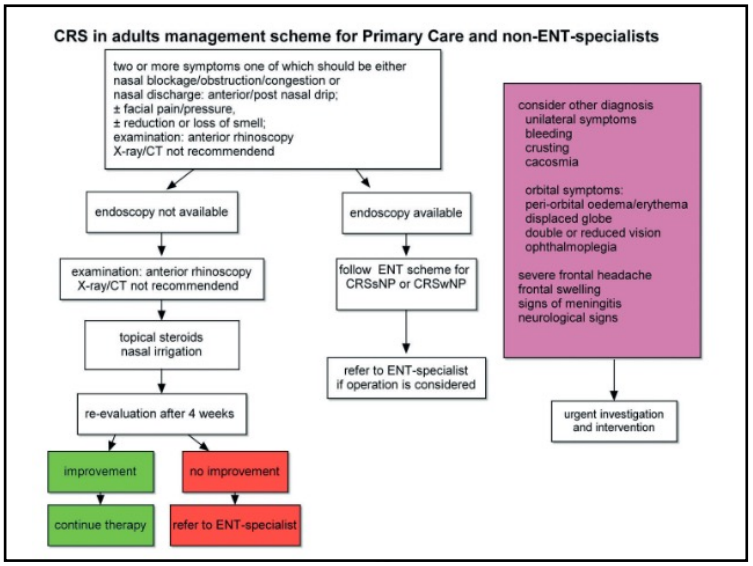

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CRS w Nasal Polyps

- Continue nasal saline irrigation
- Short course oral steroids (0.5mg/kg 5 - 10 days)
- Consider topical drops (fluticasone propionate 400mcg bd or beclamethasone tds) or continue intranasal corticosteroid spray
- Consider doxycycline (100mg od 3 weeks)
- Review after 3 months for moderate disease, 1 month for severe disease

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CRS s Nasal Polyps

- Continue intranasal corticosteroid spray
- Consider long term macrolide antibiotics (most likely to be effective when IgE levels NOT elevated).
- Do not use macrolides in patients with significant history of cardiorespiratory disease or those taking statins
- Review after 3 months

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FE$$

Functional Endoscopic Sinus Surgery

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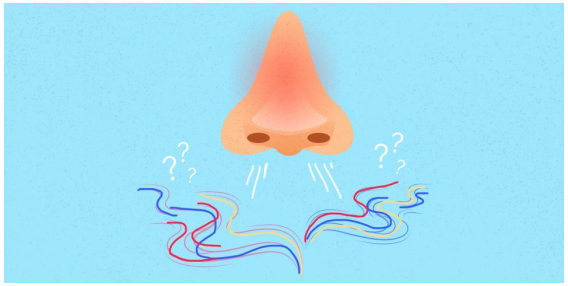
Anosmia



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Anosmia

- Conductive - Polyps/Chronic sinusitis/Tumours
- Sensorineural – Post-Viral Olfactory Loss (PVOL)

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COVID Anosmia – Key Points

- Half of patients with covid-19 may lose sense of smell; Delta (Omicron 13%) guidance states that a new change or loss in sense of smell should prompt a period of self-isolation.
- Nine in 10 patients can expect substantial improvement in their sense of smell within four weeks.
- Most patients with loss of smell do not require further investigations or referral, although their covid-19 status should be established if possible.
- Do NOT use oral corticosteroids if COVID related anosmia suspected.
- Refer if persistent anosmia

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Steroids in COVID anosmia

- Consider topical corticosteroid drops (fluticasone nasules or betamethasone drops) in patients with loss of smell lasting longer than two weeks
- Offer topical corticosteroid sprays to patients with associated nasal obstruction
- Do not offer oral steroids to patients in the first two weeks after covid-19 diagnosis or suspicion (because of likelihood of spontaneous recovery, and risk of side effects and delayed viral clearance).
- Make personalised patient centred decisions for a short course of oral steroids in patients with a persistent loss of smell not related to covid-19 and in those patients with persistent loss of sense of smell following covid-19 after at least two weeks since diagnosis, and discuss with the patient the risks and benefits.

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Management of Anosmia

- Smell training -Nasal physiotherapy (Fifth sense/AbScent)
- Omega 3 supplements
- Vitamin A nasal spray
- Zinc
- Investigation if persists- ENT referral

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Epistaxis –Key Points

- Commonest ENT emergency requiring admission
- Majority of nose bleeds are from the anterior nasal septum- Little's area
- Majority are primary (idiopathic)
- Hypertension does not cause epistaxis -can prolong/aggravate it.
- Good history important – anti-platelet/warfarin/NOAC
- Significant or prolonged epistaxis needs investigation
- 'Suspicion' of other pathology if associated naso-sinus symptoms

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Epistaxis advice

- No nose picking or blowing
- Sneeze with mouth open
- Avoid food that is hot (in temperature)
- Do not bend/strain/lift
- Naseptin (note- peanut oil extract)/Mupirocin (Bactroban)
- Excessively dry and hot
- Trotter's manoeuvre
- Anti-platelet therapy/other agents

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When to refer in epistaxis?

- If the person has recurrent episodes and is at high risk of having a serious underlying cause
- Adolescent males 12–20 years of age — angiofibroma is possible (but rare).
- Middle-aged people of Chinese origin — due to the high incidence of nasopharyngeal cancer.
- People older than 50 years of age — as nasal, sinus, and nasopharyngeal cancers are more common (although they usually present with associated symptoms).
- People with any symptoms suggestive of cancer — such as nasal obstruction, facial pain, hearing loss, eye symptoms (proptosis or double vision), or palpable neck glands.
- People with a family history of hereditary haemorrhagic telangiectasia and suggestive features upon examination — telangiectasia on the lips, mucous membranes, and fingers.
- People with occupational exposure to wood dust or chemicals.
- **Consider referral to a paediatrician for children younger than 2 years of age who present with epistaxis.**

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Nasal Fracture

Rx: Consider other
Max-fax fractures- orbital,
Le Fort, Mandible
Exclude CSF rhinorrhoea

Refer if

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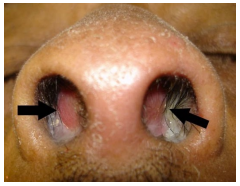
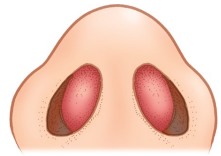
Septal Haematoma





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Red Flags in ENT

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What we will cover today?

- Asymmetric tonsils
- Glandular fever
- Oral lesions
- Globus symptom
- Hoarseness
- Red Flags in head and Neck

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Antibiotic prescribing in sore throat

- Fever PAIN Score – 4–5 (PHE)
- Centor Score 3–4
- Vulnerable group Fever PAIN – 2-3/ or delayed prescription
- Candidial Pharyngitis - mild to moderate Nystatin
- - severe or prolonged Fluconazole
- Penicillin/Clarithromycin, Pregnancy Erythromycin

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- You decided to do a GFST
- THIS IS REPORTED AS POSITIVE
- What advise will you give her?

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To confirm a diagnosis of glandular fever (CKS NICE)

- **In children older than 12 years of age and in immunocompetent adults, arrange a full blood count with differential white cell count *and* a Monospot test (heterophile antibodies) in the second week of the illness.**
- Glandular fever is likely if the full blood count has more than 20% atypical lymphocytes, *or* more than 10% atypical lymphocytes and the lymphocyte count is more than 50% of the total white cell count. Some laboratories use the term 'reactive' instead of 'atypical'.
- If the Monospot test is negative and it is clinically indicated, repeat 7 days later, *or*
- If a rapid diagnosis is needed (for example if a urgent return to sports is desired), send blood for Epstein–Barr viral serology.
- If two Monospot tests are negative, test for cytomegalovirus and toxoplasmosis only if the person is immunocompromised or pregnant. Test for HIV in at-risk people (after appropriate counselling).
- **In children younger than 12 years of age and in people who are immunocompromised at any age, arrange blood tests for Epstein–Barr viral serology after the person has been ill for at least 7 days.**
- Taking a throat swab routinely is not recommended.
- **Consider checking liver function tests.**
- Usually aspartate aminotransferase, and alanine aminotransferase are elevated to a level two to three times the upper limit of normal. Consider alternative possible diagnoses if they are 10 times the upper limit of normal.

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Glandular Fever

- It's estimated that 90% of all adults are infected with EBV.
- Majority cases-young people aged between 15 and 25
- Incubation period of glandular fever is about 4–7 weeks
- Glandular fever is not particularly contagious.
- Rash with ampicillin/amox/co-amox, does not mean allergic – is a hypersensitivity reaction

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Glandular Fever

- Fatigue will end after three months. It's estimated that 9-22% of people will experience symptoms of fatigue that last up to six months (usual 2-4 weeks)
- Ruptured Spleen

-particularly careful during the second and third week of your illness, when the spleen is most vulnerable. Beware abdominal pain.

- Contact sports -1 month
- GFST can be negative early 1st week

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Tonsillectomy EBI guidelines NHSE /NICE/ AMRC

The episodes are disabling and prevent normal functioning AND

- Seven or more, documented, clinically significant, adequately treated sore throats in the preceding year OR
- Five or more such episodes in each of the preceding two years OR

Three or more such episodes in each of the preceding three years.

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Medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the on-going management. In these instances tonsillectomy may be considered beneficial at a lower threshold than this guidance after specialist assessment:

- Acute and chronic renal disease resulting from acute bacterial tonsillitis.
- As part of the treatment of severe guttate psoriasis.
- Metabolic disorders where periods of reduced oral intake due tonsillitis could be dangerous to health.
- PFAPA (Periodic fever, Apthous stomatitis, Pharyngitis, Cervical adenitis)
- Severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

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Other conditions not related to recurrent tonsillitis

- Obstructive Sleep Apnoea / Sleep disordered breathing in Children
- Suspected Cancer (e.g. asymmetry of tonsils)
- Recurrent Quinsy (abscess next to tonsil)
- Emergency Presentations (e.g. treatment of parapharyngeal abscess)

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Referral for suspected laryngeal /H&N cancer

When should I refer a person with suspected laryngeal cancer?

- **Consider a suspected cancer pathway referral** (for an appointment within 2 weeks) for laryngeal cancer in people aged 45 and over with:
  - persistent unexplained hoarseness or
  - an unexplained lump in the neck

Revised August 2020

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Referral for suspected H&N cancer

Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for oral cancer in people with either:

- Unexplained ulceration in the oral cavity lasting for more than 3 weeks or
- A persistent and unexplained lump in the neck(new NICE recommendation for 2015)

Consider an urgent referral (for an appointment within 2 weeks) for assessment for possible oral cancer by a dentist in people who have either:

- A lump on the lip or in the oral cavity or
- A red or red and white patch in the oral cavity consistent with erythroplakia or
- Erythroleukoplakia (new NICE recommendation for 2015)

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Erythroplakia

- Velvety red but not ulcerated area on mucous membrane.
- The texture may be normal or roughened. Size is variable,
- Some so small as to virtually escape discovery, whereas large areas are conspicuous to casual inspection.
- There are usually no symptoms.

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- Erythroplastic lesions
- In at least 85% of cases, show frank malignancy or severe dysplasia. In contrast, most white lesions are not malignant or premalignant.
- Speckled or verrucous leukoplakias are more likely to be premalignant.
- Carcinomas are seen 17 times more frequently in erythroplakias than in leukoplakias,
- Leukoplakias are far more common

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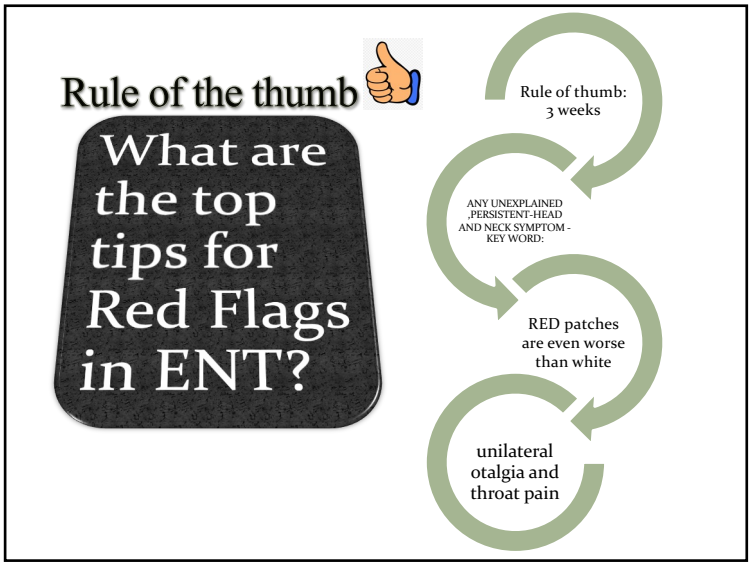
Rule of the thumb
What are the top tips for Red Flags in ENT?
Rule of thumb: 3 weeks
ANY UNEXPLAINED ,PERSISTENT-HEAD AND NECK SYMPTOM - KEY WORD:
RED patches are even worse than white
unilateral otalgia and throat pain

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