Emergency Department Management of Common ENT Presentations

This document serves as a critical guide for ED and ENT clinicians addressing various ENT conditions in the Emergency Department. The conditions outlined within this document are categorized into three distinct groups based on urgency and severity:

Red Category:
Diseases in their most severe form, posing an immediate threat to the airway, breathing, circulation, or neurological condition of the patient. Complications have been taken into account, and cases in this group require **coordinated resuscitation and immediate consultation with the on-call ENT clinician.**

Yellow Category:
Includes urgent presentations that are currently stable but have the potential to deteriorate. **Consultation with ENT is essential during operational hours (7 AM to 10 PM).**

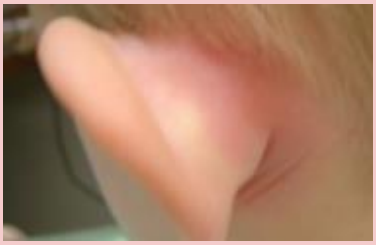
For patients presenting after 10 PM who are stable, overnight observation in the ED should be considered. If this is not feasible, the most senior ED clinician must evaluate the risks and benefits of contacting the on-call ENT to admit versus discharging the patient with instructions to return to the ED in the morning for review by ENT registrar.

For patients presenting after 10 PM the ED clinician will call ENT on-call around 7 am to discuss night cases

Green Category:
Includes uncomplicated presentations that require a **referral to the ENT clinic.**
These cases can be efficiently managed and referred to the clinic using the yellow referral form.

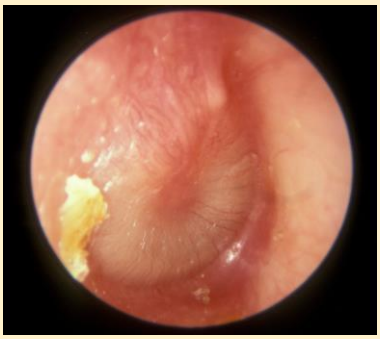
COMMON ENT PRESENTATIONS: **EARS**

RED - URGENT REVIEW (Call ENT on-call immediately)

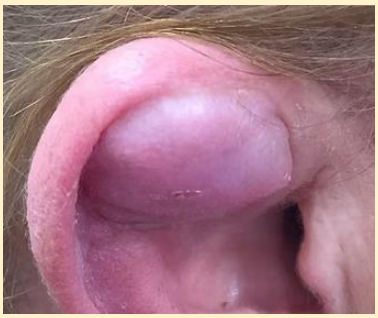


Mastoiditis
Features: sepsis, features of AOM, boggy/red/pain to touch behind the ear, affected ear pushed down & out, symptoms of meningism, cranial nerve palsy.
Actions: IV antibiotics, ear drop, CT head, NBM, bloods (UEC, FBC, CRP, blood culture), ear swab if discharging.

YELLOW - REVIEW WITHIN 12 - 24 HOURS (Call ENT on-call between 7am to 10pm)

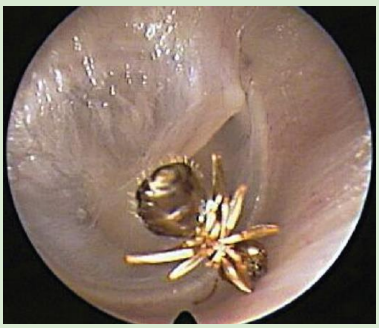


Acute Otitis Media (AOM)
Features: increasing earache with no discharge, red & bulging eardrum +/- hearing loss, tinnitus, fever or history of recent URTI.
Acute suppurative otitis media (ASOM): 'pop' sound before ear discharge +/- ear canal swelling, otitis externa.
Actions: ear swab if discharging, bloods if systemically unwell, ear drops (i.e. ciproxin 0.3%), PO antibiotic, analgesia.
Complications of AOM: facial palsy, mastoiditis, petrositis (Gradenigo's Syndrome: purulent otorrhoea, eye pain, lateral rectus palsy), meningitis, sigmoid sinus thrombosis.
Red - call ENT immediately if suspected of any complications of AOM.

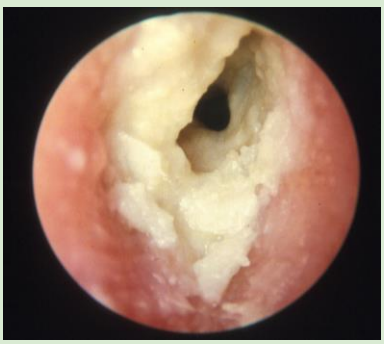


Ear Laceration, Haematoma, Pinna Cellulitis, Perichondritis
Features: history of trauma, ear swelling, erythema, pain, hot to touch, boggy/soft fluid collection if recent haematoma +/- systemically unwell, OE, soft tissue necrosis, localised abscess. Rule out associated head trauma/injury.
Action: bloods, analgesia, IV antibiotic +/- NBM if need surgical management.
Lacerations - stop bleeding, clean & bandage open wounds.
Haematoma - needle aspiration, tight bandage.
Infections - ear drops if OE.
Green - Discharge if minor superficial laceration (see 'facial laceration').

GREEN - DISCHARGE +/- ENT OUTPATIENT REVIEW (GP follow-up OR outpatient referral to ENT)



Foreign Body (FB)
Features: history of FB in ear, can visualise on otoscope, +/- otalgia, discharge.
Action: attempt to remove in ED, if successful - no need for GP/ENT follow-up. Ear drop if suspect secondary infection (discharge, foul smell) + GP follow-up. Submerge in oil if FB is an insect and alive.
Yellow - Call ENT during daytime if unable to retrieve +/- NBM if suspect difficult removal or patient won't tolerate removal.
Red - Call ENT immediately if FB is button battery.



Otitis Externa (OE)
Features: discharging ear, thick white discharge in ear canal, otalgia, tinnitus, hearing loss +/- external ear swelling, redness. Consider: diabetes? Immunocompromised?
Action: ear swab, ear drop for 1 week, +/- PO antibiotic, analgesia, GP follow-up.
Complications of OE: necrotising/malignant OE (osteomyelitis, purulent discharge, severe pain, CN involvement), abscess formation (localised collection), occlusive ear canal, pinna cellulitis.
Yellow - call ENT during daytime if you suspect any complications.

Regular ENT hours: 8am - 4pm, Monday to Friday. After hours: off-site, on-call phone held by a Registrar.

COMMON ENT PRESENTATIONS: NOSE (& FACE)

RED - URGENT REVIEW (Call ENT on-call immediately)

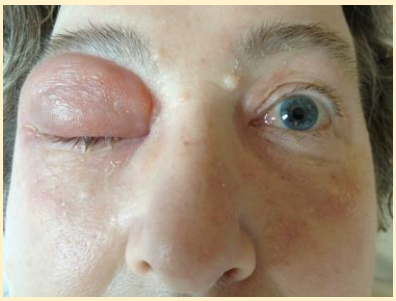
Severe Epistaxis (Nosebleeds)
Features: uncontrolled/severe bleeding, active bleeding in back of oropharynx, history (started anterior or back of throat; duration; trauma or coagulopathic).
Actions: Sit upright, lean forward, spit out blood, bloods (G&H, coags), tranexamic acid, withhold anticoagulation medications if appropriate, +/- massive transfusion protocol. Always re-check regularly for bleeding (nose + back of mouth).

1. Mild: First aid management (pressure over soft part of nose for 15 mins).
2. Medium: Nasal packing (type, length, if bilateral).
3. Severe: Bilateral packing (long rapid rhino) + foley catheter + massive transfusion protocol activated + ENT present.

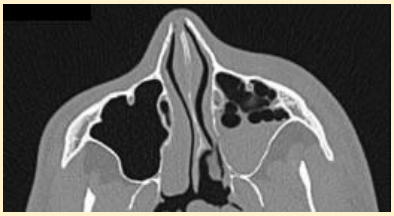
Yellow - call ENT during daytime if bleeding is managed & nasal packing in-situ.
Green - discharge if bleeding stopped with first aid or packing removed.

YELLOW - REVIEW WITHIN 12 - 24 HOURS (Call ENT on-call between 7am to 10pm)

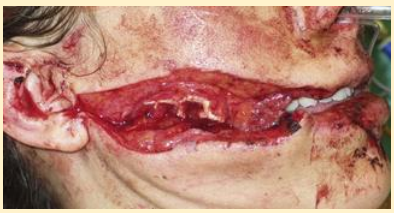
Foreign Body (FB)
Features: assess airway (obstruction, air entry into lungs), foul smell, history (What? When? Where? Who/Witnesses).
Actions: mother's kiss, nasal speculum exam +/- forceps/suction, limit attempts to remove if not tolerated, keep NBM if suspect difficult access or button battery.
Red - Call ENT immediately if suspected button battery or airway obstruction.



Facial Cellulitis, Periorbital Cellulitis
Features: swelling, erythema, hot to touch, +/- associated skin abrasion site (trauma, insect bite, ingrown hair etc) +/- systemic features.
Erysipelas: more firm, raised, shiny red appearance.
Orbital cellulitis: proptosis, restricted eye movement, RAPD, vision change.
Cavernous sinus: thrombosis: bilateral periorbital swelling, proptosis, ophthalmoplegia, neurological signs.
Actions: bloods (UEC, CRP, FBC), skin swab, IV antibiotic, analgesia, +/- CT.
Red - Call ENT immediately if suspected cavernous sinus thrombosis. Call Ophthalmology if orbital cellulitis.

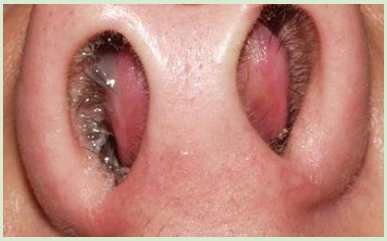


Acute Sinusitis/Rhinosinusitis
Features: nasal discharge, nasal blockage, facial pain/pressure, loss of smell +/- systemic features, recent URTI features, may cause secondary facial cellulitis.
Actions: CT sinuses, sinus rinse, otrivin nasal spray, IV antibiotic, bloods (UEC, CRP, FBC), nasal swab if discharge seen.
Green - Discharge + GP follow-up (GP to refer ENT if needed) for simple rhinosinusitis i.e. no systemic features, no secondary cellulitis.



Facial Laceration
Features: AMPLE history. Assess for structural damage (nerves, vessels, glands).
Actions: manage bleeding, clean site, IV antibiotic, tetanus booster, dress, +/- NBM if suspect needing repair under general anaesthesia.
Red - call Plastics if structural damage +/- ENT after if not appropriate for Plastics.
Yellow - call ENT during daytime for through & through lacerations if ED is unable to repair.
Green - simple/superficial laceration (ED repair + GP follow-up suture removal).

GREEN - DISCHARGE +/- ENT OUTPATIENT REVIEW (GP follow-up OR outpatient referral to ENT)



Nasal Fracture

Features: history of trauma, confirmed fracture on CT, associated swelling.

Septal Haematoma: boggy, red swelling on septal surface (*left picture*).

Epistaxis: manage as per other nosebleeds (above).

Actions: complete ACC form, follow-up with private ENT (not urgent: 6-8 weeks), monitor for septal haematoma (can develop in next few days).

Red - initiate trauma protocol if base of skull fracture (battle's sign, CSF leak).

Yellow - Call ENT during daytime if septal haematoma (NBM + IV antibiotic).

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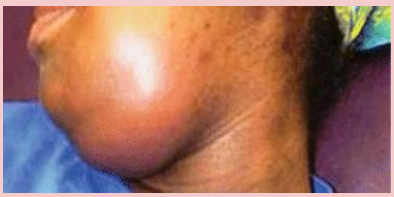
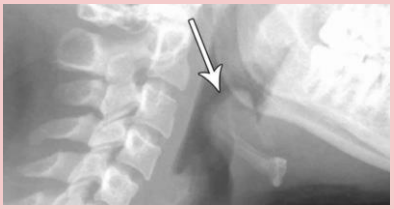
COMMON ENT PRESENTATIONS: THROAT

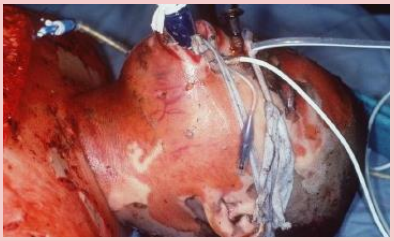
RED - URGENT REVIEW (Call ENT on-call immediately)
******Airway disaster triad**: 1) rapid onset aphagia/severe dysphagia; 2) voice change: hoarse, croaky, none; 3) systemically unwell****



Deep Neck Space Infections (DNSI)
Features: airway disaster triad, stridor, trismus, drooling, neck swelling.
Ludwig's angina: raised floor of mouth, dental infection.
Severe peritonsillar abscess: severe quinsy features, septic.
Actions: Follow ABCDE, close monitoring, septic workup, IV antibiotics, IV dexamethasone, PRN adrenaline nebs, oxygen, keep patient upright, NBM.

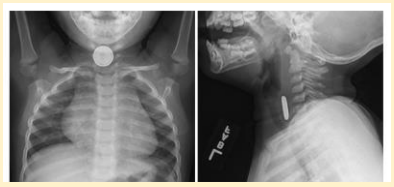


Epiglottitis & Supraglottitis
Features: airway disaster triad, severe sore throat, stridor, drooling, rapid onset, septic looking with high fever, thumbprint sign on XR lateral neck.
Actions: Follow ABCDE, close monitoring, septic workup, IV antibiotics, IV dexamethasone, PRN adrenaline nebs, oxygen, keep patient upright, NBM.

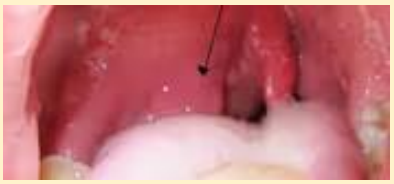


Neck Trauma (penetrating injuries, burns, blunt trauma)
Features (red flags): noisy breathing/laryngeal voice, expanding neck swelling/active bleeding, tracheal deviation, subcutaneous emphysema, frank haemoptysis, circumferential/full-thickness burns, inhalation injury.
Actions: activate trauma protocol, ABCDE + c-spine, bloods, NBM, AMPLE history.
Consider: fluid resus, massive transfusion protocol, IV antibiotics, IV dexamethasone, oxygen, occlusive dressing if sucking/bubbling wound.

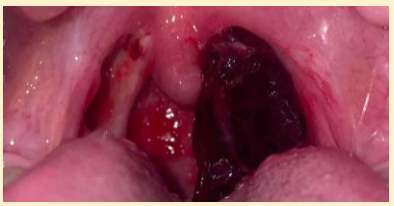
YELLOW - REVIEW WITHIN 12 - 24 HOURS (Call ENT on-call between 7am to 10pm)



Foreign Body (FB)
Features: history of ingestion (What? When? Where? Witnesses?). Ask if there is any vomiting, coughing up of blood, associated pain? Subcutaneous emphysema?
Actions: Keep NBM, consider imaging, IV antibiotics, analgesia, IVF.
Red - Call ENT immediately if suspected button battery, airway obstruction, or penetrating injury.

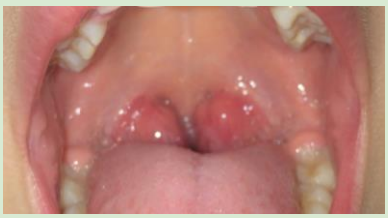


Peritonsillar Abscess (Quinsy)
Features: trismus, uvula deviation, hot potato voice, sore throat (one-side worse), otalgia, systemically unwell, dysphagia.
Actions: bloods (UEC, FBC, CRP, LFT, EBV), throat swab, IV augmentin, stat IV 8mg dexamethasone, IVF, analgesia.
Red - Call ENT immediately if features of airway disaster triad (suggests DNSI).



Post-Tonsillectomy Bleed
Features: severe (active bleeding), moderate (blood clot seen at tonsillar site, coughing blood streaked saliva), mild (history of vomiting blood, surgical site dry).
Actions: IVC & bloods (UEC, FBC, coags, G&H), IV tranexamic acid, IV augmentin, NBM, IVF, keep patient upright +/- massive transfusion protocol if severe.
Red - Call ENT immediately if severe/active bleeding from the surgical site.

GREEN - DISCHARGE +/- ENT OUTPATIENT REVIEW (GP follow-up OR outpatient referral to ENT)



Tonsillitis
Features: sore throat, tonsil swelling +/- white patches on tonsils, uvula midline, surrounding erythema, no trismus, no hot potato voice.
Differential: pharyngitis (associated respiratory symptoms), quinsy (see above).
Actions: analgesia, difflam spray, antibiotic, throat swab, bloods (UEC, FBC, CRP, EBV) +/- IVF, dexamethasone, follow-up with GP.
Yellow - Call ENT during daytime if admission needed (systemically unwell, not tolerating PO intake, failed PO antibiotics, poorly controlled pain). Call General Medicine if pharyngitis with largely respiratory features.

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