ORL, HNS

National Referral Guidelines

SPECIFIC OTOLARYNGOLOGY, HEAD AND NECK SURGERY REFERRAL LETTER GUIDELINES

Midwives, Audiologists, ENT specialist nurses, audio-visual and mobile hearing caravan testers may refer but with reference to the patient's GP.

Category Definitions : These are recommended guidelines for health professionals referring patients for assessments/treatment in a HHS.

1. Immediate - *phone call*
2. Urgent - *within 2 weeks*
3. Semi-urgent - *within 8 weeks*
4. Routine - *within 26 weeks*

Immediate and Urgent cases must be discussed with the Specialist or Registrar in order to get appropriate prioritisation and then a referral letter sent with the patient, faxed or e-mailed. The times to assessment may vary depending on size and staffing of the hospital department.

Note: *These national referral guidelines have been prepared to provide guidelines for referral to specialist otolaryngology services. They should be regarded as examples or guidelines for referring health professionals and are not an exhaustive list.They are not intended to preclude a referral where the diagnosis is unclear or a second opinion for management options is requested.*

They contain some management options to assist the general practitioner. It should be noted it is a consensus document produced in the absence of hard evidence based guidelines.

The referring health professional should ensure that in using these national referral recommendations generally accepted clinical practice should be properly taken into account. If there is a conflict between the national referral recommendations and generally accepted clinical practice, then generally accepted practice should prevail.

NATIONAL REFERRAL GUIDELINES : ORL, HNS

Diagnosis	Evaluation	Treatment Options	Referral Guidelines
Pharyngeal, Tonsil & Adenoid			
Acute Tonsillitis	Throat pain & odynophagia + any of: 1. Fever 2. Tonsillar exudate 3. Cervical Lymphadenopathy 4. Positive Strept. test	1. Penicillin VK 25-50mg/kg/day for 10/7. 2. Cephalosporin or macrolide if allergic to Penicillin or if initial treatment fails.	Acute referral if unable to orally hydrate. Documented episodes: • 7 or more in the preceding 12 months • 5 per year in preceding 2 years • 3 per year in preceding 3 years Persistent Strept. carrier state with or without acute tonsillitis - category 4.
Peritonsillar Cellulitis/Quinsy	Abscesses take >4 days to develop: 1. Unilateral tonsillar displacement. 2. Trismus 3. Fever 4. Cervical lymphadenopathy 5. Severe odynophagia	IM Penicillin (3 Megaunits for adults) and review in 24 hrs.	Acute referral to Otolaryngology with: • Abscess - category 1. • Peritonsillar cellulitis if not resolving - category 1. Elective tonsillectomy later in patients with preceding/subsequent tonsillitis/quinsy – category 4

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Diagnosis	**Evaluation**	**Treatment Options**	**Referral Guidelines**
Chronic Tonsillitis	Frequent or chronic throat pain and odynophagia; may include: - intermittent exudate - adenopathy - improvement with antibiotic	Augmentin 20 – 40mg/kg/day for 10/7 Clindamycin 10-25mg/kg/day for 10/7	Referral is indicated if problem recurs following adequate response to treatment – category 4.
Mononucleosis/Viral pharyngitis	Throat pain and odynophagia with: - fatigue - membranous tonsillitis - posterior cervical lymphanopathy - CBC, Mono test.	Supportive care Systemic steroids if severe dysphagia	Airways obstruction & Dehydration - category 1 Consider medical assessment for continued symptoms for > two weeks.
Adenoiditis/Hypertrophy	1. Purulent rhinorrhoea 2. Nasal obstruction +/- snoring 3. Chronic cough 4. +/- otitis media	At least two weeks of therapy with B-lactamase stable antibiotic: - Augmentin 20-40mg/kg/day Q8H	1. Persisting symptoms and findings after two courses of antibiotics - category 4 2. Associated sleep apnoea - category 3.
Upper Airways Obstruction from adenotonsillar hypertrophy (especially in children)	1. Mouth breathing 2. Nasal obstruction 3. Dysphonia 4. Severe snoring +/- sleep apnoea 5. Daytime fatigue 6. Dysphagia/eating difficulties 7. Weight +/- height below normal 8. Dental maldevelopment 9. Adenoid facies 10.Cor pulmonale	1. Optional lateral soft tissue X-ray of nasopharynx 2. Allergy evaluation where indicated.	Referral indicated with any significant symptoms of upper airway obstruction especially sleep apnoea - category 2.
Croup & Epiglottitis	See Paediatric Guidelines		Refer Paediatrician
Tonsillar Haemorrhage	1. Spontaneous bleeding from tonsil 2. Post-tonsillectomy (secondary haemorrhage usually occurs within 2 weeks post op).	Bed rest and treat secondary infection with Augmentin (or Ceclor).	Referral - category 2. Referral indicated if persists or recurs. Immediate referral indicated if bleed persists, recurs or is **significant** - category 1.
Neoplasm	Progressive enlargement of mass or ulceration in the oral cavity or pharynx. Often painless initially but may be pain, odynophagia or dysphagia.		Urgent referral indicated - category 2. Outpatient assessment.

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Diagnosis	Evaluation	Treatment Options	Referral Guidelines
HOARSENESS			
Hoarseness : Associated with Upper Respiratory Tract Infection	1. Throat pain, may radiate to ear. 2. Dysphagia 3. Constitutional symptoms 4. Stridor/airways obstruction.	1. Humidification 2. Increase hydration 3. Voice rest, if possible 4. Antibiotics, when appropriate 5. Inhalant steroids sprays 6. ? tapering oral steroids	Otolaryngology referral indicated if: 1. stridor or airway distress - category 1. 2. Associated with significant dysphagia - category 2. 3. Hoarseness present > 4 weeks - category 2-3.
Hoarseness : Associated with Neck Trauma or Thyroid surgery	History of neck trauma preceding hoarseness. May or may not have: 1. Skin laceration 2. Ecchymosis 3. Tenderness 4. Subcutaneous emphysema 5. Stridor	Immediate treatment with: 1. Humidification , oxygen 2. Parenteral and/or inhaled steroids / neb adrenaline.	**Immediate** Otolaryngology referral indicated in all cases - category 1.
Hoarseness : Associated with Respiratory Obstruction	Stridor	1. Immediate treatment with humidification; parenteral steroids / neb.adrenaline. 2. Soft tissue lateral of neck with neck hyperextended only if patient stable. 3. Blood cultures if patient febrile	**Immediate** Otolaryngology referral indicated in all cases - category 1.
Hoarseness : Without Associated Symptoms or Obvious Aetiology	1. History of tobacco and alcohol use. 2. Evaluation when indicated for: - Hypothyroidism - Diabetes Mellitus - Gastro-oesophageal reflux - Rheumatoid disease - Pharyngeal/oesophageal tumour - Lung neoplasm	1. Humidification 2. Increase fluid uptake 3. Voice rest, if possible 4. Antibiotics, where appropriate 5. Inhalant steroid sprays 6. Treat any medical illnesses diagnosed on evaluation. 7. Chest Xray.	Otolaryngology referral is indicated if recent onset hoarseness persists over four weeks despite medical therapy - especially in a smoker - category 3.
DYSPHAGIA	May include history or findings of: 1. Foreign body ingestion 2. Gastro-oesophageal reflux 3. Oesophageal motility disorder 4. Scleroderma 5. Neoplasm 6. Thyromegaly	Diagnostic studies may include: - Soft tissue studies of the neck including lateral XR - Chest Xray - Barium swallow - Thyroid studies - Lab tests for autoimmune disease Management may include: - Antireflux management - Speech-language therapy assessment.	Otolaryngology referral indicated if: 1. Hypopharyngeal or upper oesophageal foreign body suspected (mid-lower oesophageal lesions and foreign bodies normally referred to General Surgery/ Gastroenterology) - category 1. 2. Dysphagia with hoarseness - category 2. 3. Progressive dysphagia or persistent dysphagia for three weeks - category 3.

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NECK MASS			
Inflammatory (ie, painful)	Complete Head and Neck examination indicated for site of infection. Consider FNA, if unsure of diagnosis Optional investigations (if indicated): 1. CBC 2. Cultures when indicated 3. Intradermal TB test 4. Possible cat scratch disease 5. HIV testing if indicated 6. Toxoplasmosis titre if indicated 7. Lateral Xrays of neck (hyperext) 8. Glandular fever monospot tests	1. Augmentin 20-40mg/kg/day 2. Clindamycin 10-25mg/kg/day	Otolaryngology referral indicated if mass persists for four weeks without improvement - category 2. Urgent referral if painless, progressive enlargement or if suspicion of metastatic carcinoma - category 1.
Noninflammatory (ie, painless)	Complete Head and Neck exam indicated Consider Ultrasound Open Biopsy is contraindicated. Is there dyspnonea, hoarseness or dysphagia?	Trial of antibiotic therapy may be considered if an inflammatory mass is suspected. NB - 80% of all non-thyroid and non-inflammatory masses are malignant.	Thyroid masses usually refered to a head and neck surgical department or surgeon - category 2-3.
Thyroid Mass	Complete Head and Neck exam indicated Is it a generalized or localised thyroid enlargement Are there symptoms of dyspnonea, hoarseness or dysphagia?		Generalized Thyroid enlargement with no Compression Symptoms can be referred to a Thyroid clinic - category 3. Those with compressive symptoms or discrete swelling should be referred to ORL, HNS - category 2
SALIVARY GLAND DISORDERS			
Sialadenitis/Sialolithiasis	1. Assess patient hydration. 2. Palpate floor of mouth for stones. 3. Observe for purulent discharge from salivary duct when palpating gland. 4. Evaluate mass for swelling, tenderness and inflammation.	1. Culture of purulent discharge in mouth 2. Hydration 3. Occlusal view Xray of floor of mouth for calculi. 4. Anti-Staphylococcal antibiotics : Augmentin, Erythromycin.	Otolaryngology - referral indicated for: 1. Poor antibiotic response within one week of diagnosis - category 1-2. 2. Calculi suspected on exam, Xray, or U/Sound - category 4. 3. Abscess formation - category 1. 4. Recurrent sialadenitis - category 4. 5. Hard mass present - neoplasm? Category 2.
Salivary Gland Mass	1. Complete Head and Neck exam indicated. 2. Evaluate facial nerve function with parotid lesions.		*Note: 20% of adult parotid masses are malignant & 50% of submandib. gland masses are malignant.* Otolaryngology referral indicated in all cases of salivary gland tumours - category 2-3.

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NASAL & SINUS **General problems include:** - Nasal congestion, uni- or bilateral , or alternating - Nasal discharge, uni- or bilateral - Diminished sense of smell & taste. - Facial pain - Postnasal drip	These general symptoms may include any and all of the general or specific problems noted. Thorough history and physical exam of the head and neck is required for determining the diagnosis, as below.	Specific treatments depend on the specific problem identified, as below.	1. If problems resolve in less than three episodes, referral not indicated. 2. If the symptoms recur a third time resolve incompletely or persist, specialty referral is indicated - category 4 , or earlier if severe .
Specific problems include: Epistaxis - persistent or recurrent	1. Determine whether bleeding is unilateral or bilateral. 2. Determine whether bleeding is anterior or posterior. 3. Determine if any bleeding diathesis or hypertension is present.	Immediate control may occur with: 1. Pressure on the nostrils (> 5 mins) 2. If bleeder is visible in Little's area consider cautery with silver nitrate (after applying topical anaesthesia). 3. Intranasal packing coated with antibiotic ointment only if done by appropriate person with good equipment. Afterwards - steam or humidification, Vaseline or Bactroban for protective layer to prevent drying.	Referral to an Otolaryngologist is indicated if: 1. Bleeding is posterior - category 1-2. 2. Bleeding persists - category 1. 3. Bleeding recurs - category 3.
Persistent Nasal Obstruction	1. Symptoms : Nasal obstruction (uni/bilateral, alternating), Postnasal discharge, Recurrent sinusitis. 2. Physical examination requires intranasal examination after decongestion : deviated septum, enlarged turbinates, nasal polyps. .	Treat any associated allergy or sinusitis.	Refer if simple measures fail - category 4. Otolaryngology referral is imperative if there is an offensive bloody discharge - category 2. Note: In unilateral nasal obstruction with an offensive, bloody discharge: - in a child - consider a foreign body - in an adult – consider a malignancy.
Acute Viral Upper Respiratory Tract Infection	1. Short duration, often sore throat at onset. 2. Nasal congestion 3. Clear nasal discharge. 4. May be associated with systemic viral symptoms	1. Systemic decongestants, anti-pyretics, supportive therapy, NB Antihistamines thicken secretions with possible adverse effects. 2. Topical decongestant sprays may be used to a maximum of 5 days.	ENT referral not generally indicated unless sinusitis develops, see section on "acute sinusitis" - category 4.

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Acute Sinusitis	1. Unilateral or bilateral nasal congestion, usually evolving from a viral URTI. Signs of sinusitis include: a) Purulent discharge b) Facial, forehead or periorbital pain c) Dental pain d) Persisting URTI >7 days. 2. History and physical examination may be non-contributory. 3. Sinus Xrays rarely indicated.	1. Initial treatment: a) Broad spectrum antibiotics, eg Amoxycillin, Rulide for 2 weeks b) Systemic decongestants, antipyretics, supportive therapy, *NB Antihistamines may cause adverse effects.* c) Topical decongestants sprays to a maximum of 5 days. 2. Secondary treatment : when primary treatment fails, try B-lactamase resistant antibiotic.	Otolaryngology referral indicated if: 1. Secondary antibiotic treatment fails, clinically - category 3-4. 2. Complications occur : periorbital cellulitis, persistent frontal headache – category 1. 3. Recurrent infections : over three episodes in a one year period - category 4.
Chronic Sinusitis/Polyposis	1. Symptoms: a) Persistent or recurrent nasal congestion (unilateral or bilateral) b) Postnasal discharge c) Epistaxis d) Recurrent acute sinusitis e) Anterior facial pain, migraine, and cluster headache. 2. Physical examination requires intranasal examination after decongestion.	1. Antibiotics 2. Nasal Decongestant sprays (5/7) 3. Topical steroid sprays. 4. Consider short course of steroids. (eg. 20mgs daily/2 weeks)	Consider Otolaryngology referral if symptoms persist. Persisting abnormal symptoms, abnormal findings and/or abnormal radiographs warrant referral - category 4. In some cases an earlier appointment may be required. Note : In unilateral nasal obstruction with an offensive, bloody discharge: - in a child – consider a foreign body - category 2. - in an adult – consider a malignancy - category 2.
Facial Pain	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.	If there is evidence of acute sinusitis treat with appropriate antibiotics.	Referral indicated for persisting facial pain. May include dental and otolaryngology opinions - category 3.
Allergic Rhinitis/VMR	1. Symptoms - seasonal or perennial: a) Congestion esp. alternating b) Watery discharge c) Sneezing fits d) Watery eyes e) Itchy eyes and/or throat 1. Physical Examination: a) Boggy, swollen, bluish turbinates b) Allergic shiners c) Allergic "salute"	1. Avoidance 2. Skin Tests with view to desensitisation 3. Topical steroid sprays 4. Antihistamines 5. Oral Steroids up to 10/7 6. For acute cases consider 5 days nasal decongestants.	Consider Otolaryngology referral if symptoms do not respond to medical management - category 4.

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Acute Nasal Fracture	1. Immediate changes : oedema, ecchymoses, epistaxis. 2. Evaluate for septal fracture or septal haematoma. 3. Nasal Xrays unnecessary 4. Check for malar/maxilla # 5. Facial bone Xrays if suspect facial #.	1. Early treatment : cool compresses to reduce swelling. 2. Re-evaluate at 3-4 days to ensure nose looks normal and if breathing is normal.	Immediate Otolaryngology referral if acute septal haematoma (usually significant nasal obstruction) - category 1. Otolaryngology referral initiated now if there is a new external nasal deformity. Note : Nasal fractures must be reduced <2 weeks for best results.
Foreign Bodies	a) Acute : History alone or visible on examination. b) Chronic : Persistent, offensive, unilateral nasal discharge in a child.	Don't attempt removal unless experienced and with good equipment.	Urgent referral for removal - category 1. Immediate referral if battery (corrode). Otolaryngology referral for removal - category 2.
EAR - CHILDREN			
Acute Otitis Media	1. Symptoms : Otalgia, hearing loss, aural discharge, fever. 2. examination : Inflamed tympanic membrane (TM), bulging TM, desquamated epithelium on TM, middle ear effusion. *NB : a tender, swollen ear canal usually indicates otitis externa rather than otitis media.* 3. Audio : Tympanogram may show B or C pattern (not required if 1 & 2 present.	1. Initial treatment:[consider with-holding ABs] a) Broad spectrum antibiotic, Amoxycillin, Co-trimoxazole. b) Analgesia : Paracetamol c) Topical nasal decongestants and in adults, systemic decongestants. d) If there is associated allergy, topical nasal steroid sprays could be considered. 2. Secondary treatment : If primary treatment fails, try a B-Lactamase resistant antibiotic, eg Augmentin.	1. Immediately if complications noted : mastoiditis, facial weakness, dizziness, meningitis - category 1. 2. Secondary antibiotic treatment fails to control acute symptoms - category 1-2.
Recurrent Acute Otitis Media with resolution between episodes	Recurring episodes of AOM which respond to medical management with clearance of the middle ear between episodes -A tympanograms.	Alternatives: 1. Antibiotic prophylaxis at the onset of each URTI : Amoxycillin or Co-trimoxazole. 2. 4-6 months antibiotic prophylaxis with Amoxycillin or Co-trimoxazole.	Consider Otolaryngology referral if : 1. Infections continue despite antibiotic prophylaxis (6+ per year) category 3. 2. Middle ear effusion occurs and persists (see below) - category 3.

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Diagnosis	**Evaluation**	**Treatment Options**	**Referral Guidelines**
Otitis Media with Effusion "Glue Ear"	May have few or no symptoms, pneumatic otoscopy/tympanometry needed. 1. Symptoms: Otalgia, hearing loss, language delay 2. Examination may include : TM discoloured, thinned or retracted Bubbles behind TM, TM sluggish/retracted on pneumatic otoscopy. 3. Tymp may show effusion (type B) or -ve pressure (type C).[all children] 4. Audio : child > 4yrs	Up to three courses of systemic antibiotics (10+/7 each)and at least one course of B-Lactamase resistant antibiotic : Augmentin. *NB : Therapy with decongestants, antihistamines and steroids have not been shown to be beneficial (unless there are associated allergies).*	Otolaryngology referral with: 1. Persistent hearing loss sufficient to interfere with development - category 3. 2. Effusion, TM retraction or -ve middle ear pressure persist more than 3 months - category 3. 3. Significant language delay in presence of OME - category 3. 4. Uni lateral effusion takes less priority - category 4 if referred.
Infected Ventilation Tube	1. Symptoms Aural discharge with possible otalgia Associated hearing loss	Initial Treatment Treatment with topical antibiotic/steriod drops such as Sofradex. Consider systemic antibiotics such as Amoxycillin if the discharge is profuse and/or there is failure of response to topical antibiotic treatment alone. Treatment must be given for at least one week.	Failure of two weeks of antibiotic treatment, either topical and oral to resolve the discharge - category 2.
Blocked ventilation tube.	Evaluation symptoms often asymptomatic and found at routine examination. There may be complaint of otalgia or hearing loss or tinnitus in that ear. Examination - the ventilation tube can be seen in place either with the lumen filled with either wax of solidified mucous.	Five drops of Sofradex to the affected ear repeated daily for up to two weeks. When drops are tasted in the mouth, the tube is unblocked.	Consider referral if there is recurrent middle ear effusion or the child is symptomatic with the blockage - category 3.
Post Ventilation Tube Management	It is usual for there to be a single post operative check within an ENT Departement following ventilation tube insertion. There is no need for regular assessment within the ENT Department if the child is progressing well and asymptomatic.	Referral to the ENT Department for post extrusion check is desirable to confirm that the tympanic membrane is in a satisfactory condition and that there has not been recurrence of middle ear effusion.	Otolaryngology referral once ventilation tubes are seen to be extruded. Category 3.

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Diagnosis	**Evaluation**	**Treatment Options**	**Referral Guidelines**
Foreign Bodies	Usually visible if acute.	Remove only if technically easy.	Otolaryngology referral especially children - category 2.
EAR - INFECTIONS			
Chronic Suppurative Otitis Media	1. Symptoms : Chronic discharge from the ear(s), hearing loss. 2. Examination : Perforation of drum (especially attic or postero-superiorly granulation tissue and/or bleeding). 3. Complications suggested by : Postauricular swelling/abscess, facial palsy, vertigo, headache - refer category 1.	1. Aural toilet (not syringing). 2. Culture directed antibiotic therapy : systemic and copious aural drops (Sofradex). 3. Protect ear from water exposure.	Otolaryngology referral indicated for persistent symptoms despite appropriate treatment - category 3-4. Associated symptoms suggest urgency needed - category 2.
Acute Otitis Externa	1. Symptoms ; Otalgia, significant ear tenderness, swollen external aud canal +/- hearing loss. 2. Examination : Ear canal always tender, usually swollen . Often unable to see TM because of debris or canal oedema. 3. Swab for org./fungi *NB : Fungal Otitis Externa may have a pad and spores visible.*	1. Topical treatment is optimal and systemic antibiotics alone are often insufficient. Systemic Antibiotics indicted when there is cellulitis around the canal. 2. Insertion of an expandable wick with topical antibacterial medication useful when the canal is narrowed. 3. In fungal OE, thorough cleaning of the canal is indicated, plus topical antifungal therapy. (Kenacomb, Locorten-Vioform).	Referral to an Otolaryngologist when: 1. Canal is swollen shut and wick cannot be inserted - category 1. 2. Cerumen impaction complicating OE - category 3. 3. Unresponsive to initial course of a wick and antibacterial drops - category 2. 4. Diabetics , immunosupressed and suspected malignancy on examination require urgent referral - category 1.
Otalgia without significant clinical findings in the ear canal or drum.	1. Symptoms : ear pain without tenderness or swelling. 2. Physical Examination : normal ear canal and TM. 3. Type A Tympanogram *NB : 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 and aetiology not identified - category 3.

Note:

- *The so called "light reflex" is not a valid indicator of ear disease.*
- *In a crying child there may be uniform injection of the drum without infection being present.*
- *Otoscopy alone often is not capable of identifying a non-infected middle ear effusion or TM retraction. Pneumatic otoscopy is far superior.*
- *Tympanometry is fairly reliable for identifying middle ear effusions and negative middle ear pressure, although it is not infallible. Tympanometry should only be performed on children over the developmental age of six months. It is very reliable in confirming normality. i.e.Type A would over-ride clinical impression of abnormality.*

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HEARING LOSS

Note : *DO NOT syringe an ear with a drum known to have perforated in the past or known to be abnormal. Use Sofradex drops afterwards X 1 "stat" after all syringing.*

Diagnosis	Evaluation	Treatment Options	Referral Guidelines
Neonatal	At Risk Register : - Family history of hereditary SNHL - In utero infection, eg CMV, Rubella - Craniofacial anomalies, incl pinna - Birth weight < 1500g - Hyperbilirubinaemia needing transfusion therapy. - Exposure to Ototoxic drugs - Bacterial meningitis - Apgar < 5 at 1 min; < 7 at 5 min - Mechanical Ventilation > 4 days - Stigmata assoc. with hearing loss.	ABR by a trained Audiologist is the optimal investigation at present.	All hospitals should run a screening programme for at risk neonates and infants. Awareness of changes in approach to neonatal screening for hearing loss.
Bilateral, Symmetrical, in Adults	1. Symptoms : Diminished hearing any associated symptoms, eg tinnitus, discharge, vertigo, etc? 2. Examination : Cerumen, effusion, or normal findings.	a) Cerumen dissolving drops and possible suction or irrigation. b) Oral decongestant, Valsalva manoeuvres and re-evaluate in three weeks. c) Requires audiometry +-/ referral.	Referral indicated if: a) Cerumen, and/or significant hearing loss persists - category 4. Urgent Otolaryngology referral if < 1 week for acute treatment - category 1. If onset less than 1 week refer.
Unilateral Hearing Loss in Adults includes Sudden Hearing Loss	Normal drum with Weber to good ear. Type A Tympanogram	Expectant treatment if > 2 weeks. Audiometry if available.	a. Immediate referral if onset less than 1 week - category 1. b. Semi-urgent referral if > 1 week with incomplete recovery - category 2-3. c. Non-urgent if complete recovery but for investigation – category 4.
Chronic	1. Symptoms : difficulty hearing esp. only in a crowded environment; difficulty localising sound. 2. Examination : a) Cerumen b) 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 changed - category 4. *NB : Unilateral effusions in adults? sinus disease or Nasopharyngeal tumour (especially in Chinese).*

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TINNITUS			
A. Chronic Bilateral	Any associated symptoms? Cerumen? Audio + Tymp	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 - category 3- 4 depending on symptoms.
B. Unilateral, or recent onset.	Any associated symptoms? Cerumen? Audio + Tymp	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 - category 3-4.
C. Pulsatile	TM normal or (vascular) mass behind drum. Audio + Tymp Auscultate carotid vessels.	Referral	Referral is indicated in all cases - category 4. If there is a middle ear mass, there is a strong possibility of a glomus tumour. Category 2
DIZZINESS			
A. Sudden Onset Vertigo - Associated with Barotrauma	Acute onset of vertigo or disequilibrium associated with pressure change usually caused by air flight or driving. 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. Category 1
B. Orthostatic	Symptoms mild, brief and only on standing up (usually am). Review medications	Evaluate cardiovascular system, reassurance.	No referral indicated unless atypical or associated with other symptoms and this should normally be Medical.
C. BPV & Vestibular Neuronitis	Associated with an URTI, may be positional and/or persistent. Audio 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, persistence over 2 months - category 3.
D. Chronic or Episodic	Significant vertigo may have associated hearing loss, tinnitus, aural fullness, nausea. History of previous ear surgery. Audio + Tymp	Symptomatic treatment acutely.	Otolaryngology referral is indicated - category 3-4, dependent on history.
FACIAL PARALYSIS	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. Lacrilube and taping the eye shut at night. Steroid therapy may be initiated if no associated clinical findings. Consider anti-viral treatment.	Urgent Otolaryngology referral is indicated if otologic cause suspected - category 1.