Emergency ENT

Hot Tips!

There are wall-mounted ophthalmoscopes and auroscopes in most of the Minor Injuries cubicles and in Resus. For the rest of the Department there are mobile scopes attached to drip stands. Please return these to a visible place where the next practitioner can find and use it.

If a scope is not working please don't just swap the head with another. This leads to losses of equipment and lack of functioning equipment when required. Report the malfunction to the nursing staff or Dept housekeeper who can replace bulbs if necessary or arrange repair.

Follow-up of displaced nasal fractures is shared between Plastics and ENT.

1^{s} –15th of month	Plastics in Central Treatment Suite 5 days from injury
16th-end of month	Cas ENT clinic 5 days from injury

The Ear

Acute Sensori Neural Hearing Loss

This is an otological emergency

Majority are idiopathic and the commonest other causes are viral, vascular and traumatic in origin.

Clinical features:

- Acute SNHL, tinnitus with or without vertigo
- Tuning fork tests suggest SNHL and ear drums are usually normal.

Management:

- Refer immediately to on call ENT SHO for investigation and treatment.
- Admit – IV access FBC/U&E's/Calcium/VDRL/immunology/ESR.
- Dextran 40 500mls IV over 4 hours
- IV Hydrocortisone 200mg
- Call Registrar.

Acute Conductive Hearing Loss

Cause:

- Wax impaction
- Otitis externa
- Tympanic membrane perforation
- Otitis media
- Glue ear
- Ossicular discontinuity following trauma.

Clinical Features:

- Acute hearing loss
- Tinnitus with or without vertigo
- Usually outer or middle ear pathology visible.

Management:

- Refer to next available ENT out-patient clinic for investigation and treatment
- Microsuction
- If infective i.e. otitis externa
- If wax – microsuction then course of sodium bicarbonate drops
- All else – see in Consultant clinic

Acute Facial Palsy

Causes:

- LMN: Bells palsy commonest (diagnosis of exclusion), Ramsay Hunt syndrome, acute or chronic otitis media, skull base fracture, post operative, neck, middle ear or cerebello pontine angle tumour - Refer ENT
- If UMN causes CVA, cerebral tumour, polio - Refer to medics

Clinical Features:

- Ascertain if LMN (complete one half of face does not move) or UMN.
- Examine ears, neck, oropharynx and do a full neurological exam. Look for vesicles in pinna or tympanic membrane or palate (herpes zoster).

Management:

- Refer to next available ENT out-patient clinic – get audiogram.
- Advise re eye care (eye pad, hypromellase eye drops)
- If Bells palsy suspected and presentation is within one day of onset – start Prednisolone 60mg daily (reduce slowly over 10 days).
- If Ramsey Hunt syndrome suspected (vesicles) start topical and oral Acyclovir and Prednisolone (as above).
- If traumatic origin – refer to SpR.

Acute Otitis Externa

Clinic features:

- Painful discharging ear – Reddened oedematous external canal with mucopus and squamous debris.
- Ear drum normal and no mastoid tenderness.

Management:

- Swab for C and S, microscopy
- Use Pope wick if canal narrow
- Topical antibiotics (Gentisone HC, Otosporin or Sofradex ii tds x 7 days) and oral antibiotics (Augmentin) if severe.
- Adequate analgesia and water avoidance.
- If ear canal filled with debris or pus – refer to next available ENT out-patient clinic for microsuction
- If very severe (pyrexia, facial cellulites) refer to on call ENT SHO for admission.

Acute Mastoiditis

Clinical Features:

- Usually babies and young children
- Painful discharging ear, hearing loss, systemically unwell, not eating or sleeping.
- Pyrexial, looks “toxic”, red tender swelling behind ear, protruding ear, ear canal filled with pus, ear drum is sometimes abnormal or perforated.
- Check for intracranial complications.

Management:

- Refer immediately to on call ENT SHO for admission
- FBC, blood cultures and swab for C and S, microscopy
- IV access/Augmentin
- Analgesia - Brufen (child) Voltarol (adults)
- Inform Registrar
- CT mane
- I & D mane NBM overnight

Acute Otitis Media

Clinical Features:

- Acute earache and hearing loss.
- Ear discharge if TM perforates.
- Red and bulging TM
- Pyrexia.

Management:

- Oral antibiotics (Amoxicillin or Augmentin)
- Adequate analgesia (Voltarol/Brufen/Co-codamol) and antipyretics send home review in 2 weeks.
- If very unwell or if VII palsy – refer for admission
- IV access for FBC/ (BC)
- IV Augmentin
- Analgesia

Acute Tympanic Perforation

Clinical Features:

- Acute hearing loss and bloody otorrhoea (trauma)
- Acute earache followed by bloody otorrhoea, hearing loss and sudden relief of pain (acute otitis media)
- Perforation visible with or without infection

Management:

- If not infected – advise water avoidance, no antibiotics, ENT out-patient appointment for 4-6 weeks.
- If infected – prescribe topical antibiotics (Otosporin or Sofradex) and oral if severe, ENT out-patient appointment in one week.
- If possibility of litigation and/or unusual hearing test –refer ENT for audiogram next day.

Discharging Mastoid Cavity

Clinical Features:

- Painful discharging ear
- Mastoid cavity filled with mucopus and debris.
- Look for neurological signs: meningism, headaches, localising sings, VII, VIII, IX affected.

Management:

- Swab for C&S, microscopy
- Topical and oral antibiotics and review in ENT out-patient clinic in 2 to 4 weeks.
- If very severe or neuro signs – refer to on call ENT SHO for admission.
- IV access FBC/U&E's/glucose/BC's
- IV Augmentin/Metronidazole
- Consider CT
- Inform Registrar

Foreign Body in The Ear

Clinical Features:

- Examine ear thoroughly to assess if any underlying TM damage.
- Ensure no FB in other ear or nose
- If present for some time there may be associated infection

Management:

- If no TM perforation and FB is not vegetable matter – attempt syringing ear with water at body temperature.
- If insect – insert olive oil to drown it
- If patient is uncooperative or if you have no skill in dealing with these – refer to next available ENT out patient clinic or to ENT ward clinic.
- If infected – start topical antibiotics e.g. Sofradex
- Corrosive material e.g. battery – this needs to be removed the same night.
- Inform Registrar.

Acute Vertigo

Clinical Features:

NB Have to have lateral nystagmus to be ENT
NB Normally would not have LOC if ENT problem

- **Meniere's syndrome:** Episodic vertigo, nausea and vomiting, tinnitus and hearing loss < 24 hr duration.
- **Vestibular Neuronitis – viral labyrinthitis:** Vertigo, nausea and vomiting, no tinnitus or hearing loss > 24 hours, recent history of URTI
- **Benign positional vertigo:** Acute vertigo on sudden head movement only
- **Trauma:** If history of trauma – rule out skull base fracture (CSF otorrhoea, haemotympanum, facial palsy, hearing loss)
- If no ENT cause found consider a systemic cause e.g. anaemia, hypotension
- TM's normal except in some traumatic cases
- Do thorough neurological examination

Management:

- If mild, symptoms – advise bed rest, oral fluids and Stemetil, contact GP. If vomiting – prescribed Buccastem
- If severe symptoms – refer to on-call ENT SHO for admission, arrange FBC, U & E's, IV fluids
- If positive neurological signs – refer immediately to on-call Neurology SHO / Reg
- IV access NB fluid
- Stemetil im
- Serc

Auricular Haematoma

Clinical features:

- Acute painful swelling of pinna following trauma

Management:

- Refer to on-call ENT SHO for evacuation of haematoma
- If not clotted ie less than 24 hours – Aspiration, aseptic technique, with anaesthetic and analgesia and pressure dressing x 24 hours – can go home – review ward/clinic next morning
- If clotted incise along convexity of helix and squeeze plus pressure dressing – home with review
- Advise keep clean and dry
- Complication: Perichondritis – viral and bacterial, Augmentin or IV antibiotics

Skull Base Fracture

Clinical Features:

- Usually history of trauma
- Acute hearing loss (senorineural or conductive), tinnitus, vertigo with or without clear coloured otorrhoea (CSF otorrhoea)
- TM perforation or haemotympanum, VII palsy, Battle's sign, (bruising over mastoid bone)
- Signs of raised intracranial pressure occasionally found
- Exclude cervical spine injury

Management:

- Refer immediately to on-call Neurosurgery
- Arrange skull and cervical spine X-ray
- Advise against water contamination, no ear drops and no aural toilet
- Commence neuro-obs in A & E
- If neurological signs present refer immediately to on-call Neurosurgical SHO/REG and arrange urgent CT scan head and temporal bones

ENT SHO called: because of bleeding from the ear
no suction
no drops
review mane by ENT team
does not need to see that night

NB If acute facial palsy – may need surgical exploration
Ascertain time of onset and degree (total or partial). Inform SpR

NB If facial palsy occurs a few hours after trauma, probably due to oedema – Inform SpR

The Larynx and Pharynx

Acute Tonsillitis

Clinical Features:

- Severe sore throat
- Referred otalgia and neck pain (due to enlarged JD nodes)
- Dysphagia especially for solids but in severe cases may be absolute
- Difficulty in breathing if very enlarged tonsils
- Symmetrically enlarged hyperaemic tonsils often with pus in the crypts
- Enlarged tender JD nodes

Management:

- **Mild cases:** (slight sore throat, able to swallow medication) apyrexial
- Penicillin V 500mgm qds orally or Erythromycin in patients allergic to Penicillin, analgesia, (Voltarol 50mgm tds) and bed rest
- Ampicillin and derivatives are contraindicated unless infectious mononucleosis has been ruled out by Paul Bunnell test
- **Severe cases:** (severe sore throat and dysphagia, pyrexial)
- Refer to on-call ENT SHO for admission and IV antibiotics/fluids
- IV access FBC/Paul Bunnell/U & E, LFT
- Benzylpenicillin 1.2 qds IV
- Analgesia – Voltarol and Co-Codamol (dispersible)
- FBC/Glandular fever screen (including Paul Bunnell)

Infectious Mononucleosis (Glandular Fever)

Clinical Features:

- Range from slight illness to severe systemic illness
- Similar to presentation of acute tonsillitis. Mainly affects young adults
- Prodromal malaise, fatigue and headaches
- Tender enlarged cervical lymph nodes (hence synonym glandular fever)
- Sore throat (indistinguishable from acute tonsillitis), tonsils are enlarged and coated with a thick white exudates
- Rarely respiratory distress
- Pyrexia
- Hepatosplenomegaly (uncommon)
- Difficult to differentiate between infections mononucleosis and tonsillitis give Benzylpenicillin

Management:

- FBC (mononucleosis), Paul Bunnell & monospot test, LFT
- Symptomatic treatment with analgesics and bed rest
- Antibiotics orally if secondary bacterial infection (pus in the tonsils) Benzylpenicillin IV or Penicillin V (500 mgm qid)
- If patient unable to swallow or if in respiratory distress refer to on-call ENT SHO for admission
- If tonsils very large causing respiratory distress – give 8-12 mgm of Dexamethasone IV and repeat 6-12 hours later if necessary.
- Inform Registrar

Peritonsillar Abscess (Quinsy)

A quinsy usually arises as a complication of an untreated or partially treated episode of acute tonsillitis. The infection, in these cases, spreads to the peritonsillar area (peritonsillitis). This region comprises of loose connective tissue and is hence susceptible to formation of abscess. A quinsy can also occur *de novo*. Both aerobic and anaerobic bacteria can be causative. Commonly involved species include streptococci, staphylococci and hemophilus.

History:

- Initially the same as tonsillitis, pain then becomes worse and is localized to one side.
- Patients usually have trismus, decreased mouth opening, caused by the spasm of the masseter muscle in response to the local inflammation.
- Rigors are often present.

Examination:

- Uvula is pushed to opposite side, tonsils are often not visible.
- Usually have upper cervical lymph nodes in neck

Management:

- Needle aspiration as an outpatient is effective in 94-96%.
- Need to be shown method.
- Iv antibiotics – benzylpenicillin and metronidazole, usually for 24 hours, then home on oral antibiotics (penicillin V and metronidazole)

Long term:

Only 13% develop a recurrence. Tonsillectomy if 2 attacks on the same side.

Post Tonsillectomy Haemorrhage

- Primary (less than 24 hours) in theatre/recovery
- Reactionary - on ward 6 – 8 hours after operation – 99% of patients that will bleed in this time
- Secondary is normally due to infection – occurs 7-10 days post-operatively

Management

- H2 02 gargles
- IV Augmentin
- Analgesia
- NBM
- Consent for theatre

If new clot – can remove it – may arrest haemorrhage and gauze coated in 1:10,000 adrenaline pressed into the tonsillar fossa

If old clot – leave alone H2 02 gargles

All post tonsillectomy bleeds should be admitted to ENT ward
They should all have IV access and bloods taken for FBC, clotting, G & S

Globus syndrome

Globus sensation, a feeling of something in the throat, from latin *globus,* a ball, was observed by Hippocrates.
? due to reflux, disorder pharyngeal motility, lingual tonsils.

History

- Usually women in 5th decade.
- Never have actual difficulty eating.
- Sensation of a lump or discomfort in the throat when none is found
- Sensation is present when not eating or drinking. No dysphagia, odynophagia.

Examination

- Examination is normal.

Management

- Opinions vary from discharge to investigate. If concerning features in history – lateralization of symptoms, heavy smoker, heavy alcohol, weight loss etc – worth investigating. Barium swallow, ?rigid scope

Treat with PPI if evidence of reflux.

Foreign Bodies – Ingested

From the history it is important to determine the FB ingested eg: food bolus, bone/sharp object, corrosive matter eg battery

Soft food bolus

History: Usually wears dentures ? prev history of food obstruction

Management:

- Lateral neck soft tissue X-ray (air in upper oesophagus)
- Conservative treatment with Buscopan and Diazepam and fizzy drinks
- Refer to ENT if doesn't pass through oesophagus
- Will need imaging of oesophagus as an out-patient if recurrent

Bone/sharp object

History: Fish/meat bone

Management:

- Explore tonsil/tongue base usual site for fish bones – can be removed
- Lateral neck soft tissue X-ray (loss of Cx curvature) widening of prevertebral space

Foreign Body - Inhaled

HISTORY is important:
Initially inhaled FB may cause stridor or a cough due to bronchial spasm, which SETTLES after a few minutes. This is followed by an asymptomatic period of several hours or days (may have been discharged by GP or A&E). Secondary pulmonary symptoms then occur: bronchial obstruction, consolidation, collapse of distal segment. Hyperinflation of the lung or pneumothorax may also occur.

Clinical Features:

- Any age but more common in children (especially peanuts)
- Acute onset of stridor and choking spasms which may settle spasmodic coughing common.
- Apyrexial
- Auscultation for signs of lung collapse or consolidation
- Lateral soft tissue neck x ray and chest x ray useful even for non radio-opaque FB
- Inspiratory/expiratory chest x ray – increase inflation on affected side of expiratory chest x ray.

Management:

- Humidified Oxygen and IV access
- Refer immediately to on-call ENT SHO may need urgent bronchoscopy.
- Neck and chest x-ray [consolidation or hyperinflation]
- Call Registrar – NBM
- Consent for bronchoscopy
- May need referral to Cardiothoracic – discuss with Registrar

Croup

See Paediatrics information on croup

Acute Epiglottitis

See Paediatrics information on epiglottitis

Acute Submandibular Sialo-Adenitis

Clinical Features:

- Secondary to salivary calculi (commonest in SM gland)
- Sudden colic like pain and swelling of the gland in association with eating.
- If salivary outflow is completely obstructed the gland swelling may not subside.
- Secondary infection may cause development of an abscess
- Stone may be palpated intra-orally in the duct and x ray (occlusal view) may show radio-opaque calculi.

Examination:

- Inspect oral cavity and perform bimanual palpation of submadibular gland.
- Palpate submandibular duct along floor of mouth for any calculi.
- Examine other salivary glands and the neck for any lymphadenopathy.

Investigations:

- FBC
- Radiolgy-plain Xray for calculus, Ultasound helps to differentiate between lymphadenopathy and submandibular gland swelling and to r/o collection
- FNA-C/S, cytology

Management:

- If mild infection (mild pain, apyrexial) start Augmentin and Metronidazole, Corsodyl mouthwash and advise lemon sweets (this increases gland secretion).
- Refer to routine ENT out-patient department (routine appointment) for further investigation and treatment.
- In case of SM abscess formation, refer to ENT SHO for IV antibiotics and/or I&D.
- Admit IV access, FBC/U&E's, glucose IV Augmentin and Metronidazole
- NBM – consider incision and drainage mane

Acute Parotitis

Parotitis is an inflammation of the parotid salivary gland: it can be acute, or chronic with acute exacerbations.

Clinical Features:

- Firm, erythematous swelling of the pre- and post-auricular areas
- Intense local pain and tenderness, trismus
- High fevers, chills, and marked systemic toxicity.
- It is common in the elderly, dehydrated, and malnourished patients, often in postoperative period, after radiotherapy or in patients with a compromised immune system.

Aetiology:

- Bacterial is caused by *Staphylococcus aureus, Enterobacteriaceae,* other gram-negative bacilli and Anaerobes
- The commonest viral cause of parotitis is **mumps**. It usually affects 4 to 10 year olds and causes painful swelling of both parotid glands.

Examination:

- Inpsect the enlarged gland and all the other salivary glands.
- Check the facial nerve function as weakness raises the suspicion of malignant lesion.
- Pressing over parotid gland may express pus from the parotid duct which opens opposite upper second molar.
- Examine the pharynx to look for parapharyngeal lesion which may push the tonsil medially.

Investigations

- Blood tests A full blood count, CRP, blood culture and and test for any relevant medical condition
- Radiography- US helpful to diagnose collection, plain x ray not much helpful as parotid calculi are radiolucent. Request sialogram for recurrent parotid swelling to rule out duct stenosis, calculi and sialectasis
- C/S –send expressed pus from parotid duct or needle aspirate.

Treatment

- Give broad spectrum intravenous antibiotics (usually Ceph and Met).
- Check culture results and seek advice from microbiologist depending on the patient's condition and history.
- Good hydration and analgesia is important.
- Treat underline medical condition like diabetes.
- Drainage-Surgical drainage under GA when there is abscess

Ludwig's Angina

Clinical Features:

- Anaerobic infection in the floor of the mouth and submandibular triangle. Secondary to dental causes usually.
- Swelling in the floor of mouth and below mandible may cause respiratory distress.

Management:

- If dental cause – check OPG refer max fac
- Refer to ENT if no dental cause – will need Fibreoptic laryngoscopy to assess airway.
- IV antibiotics - Cefuroxime – Metronidazole
- Steroids +/- Adrenalin nebuliser

Parapharyngeal Abscess

The parapharyngeal, or lateral pharyngeal space is a pyramidal space which lies adjacent to the nasopharynx and oropharynx and extends from the base of the skull to the submandibular gland and hyoid bone. A parapharyngeal abscess is usually associated with a dental infection, severe tonsillitis or a quinsy.

History:

- Begins usually with tonsillitis or dental infection, pain progressively worsens

Examination:

- Tender diffuse swelling of upper part of the neck
- Associated with swinging temperature and rigors
- Signs of tonsillitis/dental infection

Management:

- CT scan to confirm diagnosis
- Iv antibiotics initially
- If abscess present will require surgical intervention

Retropharyngeal abscess

Space lies immediately anterior to the deep cervical fascia
Majority in children <4 as they have retropharyngeal lymph nodes, adults do not.
Occurs in adults when prevertebral TB abscess ruptures through the prevertebral fascia. In children suppuration of retropharyngeal LN after URTI or FB.

History:

- Child becomes toxic
- dribbles, stertor or dysphagia.

Examination:

- Neck is held extended.
- Lateral neck x-ray will show large space

Management:

- In absence of airway issues, iv antibiotics may avoid need to drain abscess

Laryngeal Trauma

Laryngeal injury is often associated with other injuries [c-spine and intracranial injuries 10-15%]

Clinical Features:

- Uncommon. Patients often have multiple injuries.
- Breathing difficulty or haemoptysis [stridor may be absent]
- Hoarse voice, change in voice or dysphonia [difficulty in breathing
- Dysphagia
- Neck pain or ecchymosis, surgical emphysema
- Surgical emphysema of the neck and abnormal crepitus of laryngeal framework

Management:

- Follow ATLS protocol
- Contact on-call ENT/Anaesthetic SHO.
- If stridor intubation and later surgical reconstruction required.
- Humidified Oxygen
- Analgesia.
- IV access.
- NBM.
- Watch airway
- Contact registrar.
- [Take nasoendoscope and light source to A& E !!]
- Arrange lateral soft tissue neck x-ray and CXR (surgical emphysema, mediastinal widening and other lung injuries).

Angio-Neurotic Oedema

A sudden onset swelling of the face, tongue, lips, oropharynx or the larynx can compromise of the airway.

Allergic angioedema may be precipitated by drugs such as penicillin, aspirin, NSAIDS, ACE-inhibitors, food additives, insect bites or blood transfusion.

Non-allergic or hereditary type is an autosomally dominant inherited deficiency of C1 estrase. Patients with lymphoma can also acquire C1 estrase deficiency.

Clinical Features:

- Recurrent attacks of swelling of the face, larynx and oral cavity. Oedema of the larynx and tongue may be life threatening.
- Allergic form – usually accompanied by urticaria. Present as an acute allergic reaction to food, medicines or inhaled allergens.
- Hereditary forms – due to enzyme deficiency (C1-iNH protein). Minor events such as trauma or emotional strain can release complement in the absence of this inhibitor protein.

Management:

Mild cases: (i.e. minimal swelling, no dysphagia or difficulty in breathing)

- Observe in A & E, discharge with advice, no follow-up required.

Severe cases: (i.e. rapid onset of severe swelling with dysphagia and difficulty in breathing)

- Hydrocortisone 100-200mg IV and Chlorpheniramine 10mg IV or Adrenalin (1 in 1000) 1mg SC.
- If no response to this treatment the patient may require intubation.
- Inform ENT registrar and the anaesthetist ASAP
- In patients known to suffers from hereditary angio-oedema the acute attack is treated with IV C1-iNH 36,000 units
- IV access
- FBC/U&E's – glucose
- NBM
- Watch airway – oxygen saturation
- Consider a mini tracheostomy – call anaesthetic SHO – inform registrar

The Nose

Epistaxis

Aetiology:

- Idiopathic: Majority of cases
- Local causes: Littles area blood vessels
  Infection
  Foreign body
  Tumours including juvenile angiofibroma
- Generalised: Coagulation defects
  Drugs and toxins – eg Aspirin/Warfarin
  Hypertension

Management:

First aid measures:

- Apply pressure manually to cartilaginous part of nasal bridge
- Ice packs to bridge of nose – patient to suck ice cube
- Cold packs of neck

Secondary measures:

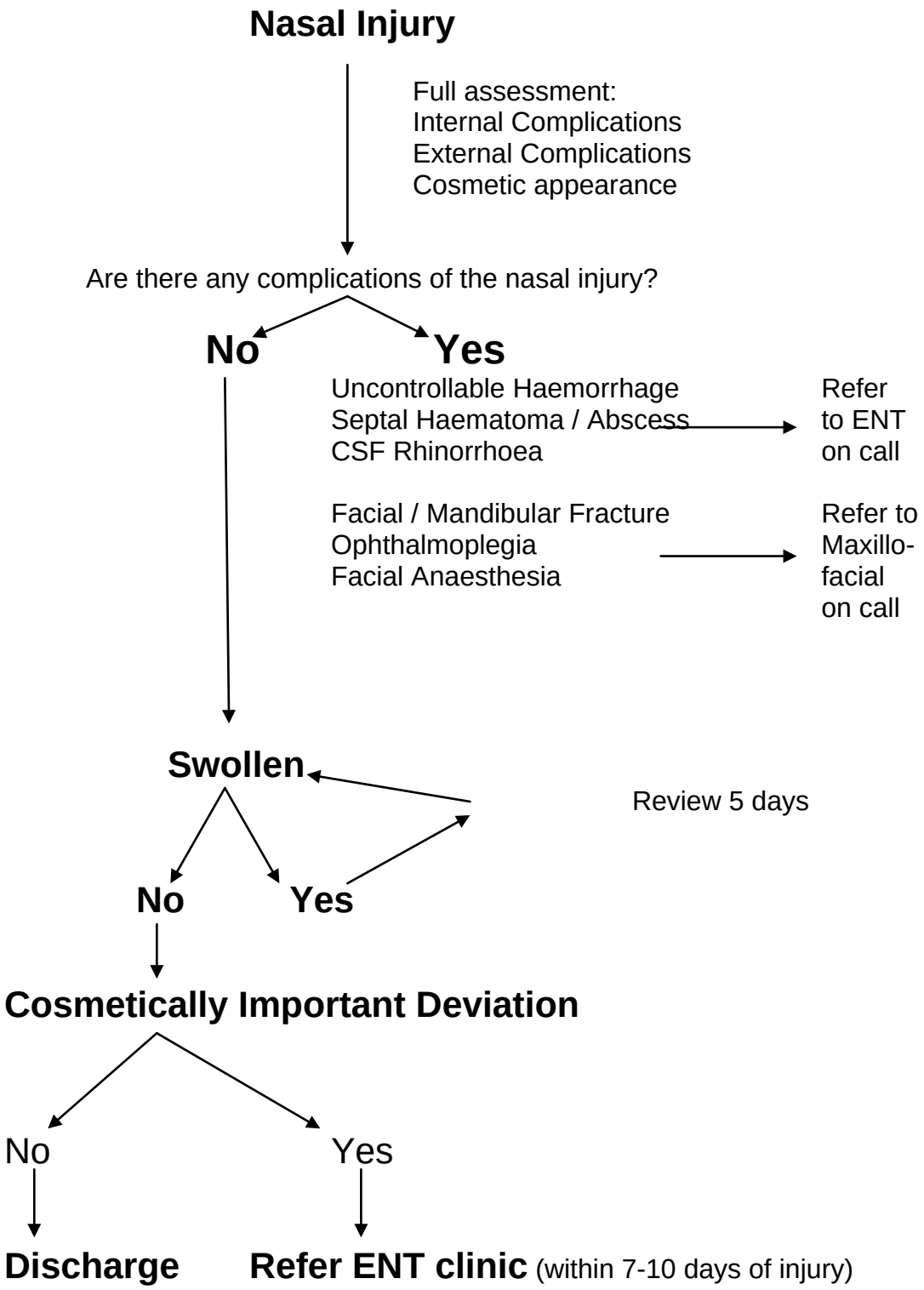
- Measure BP and pulse regularly while in A & E
- Resuscitate if hypotensive/hypovolaemic. Insert IV cannula and commence IV fluid
- Examine nasal cavity to exclude a treatable cause.
- Suction out clots and apply Cocaine 10% solution (2ml) on cotton wool or spray (4 puffs). If no Cocaine available use Xylocaine with Adrenalin. Can use cotton wool soaked with Xylocaine/Adrenalin for five minutes and press nostrils.
- Cauterise obvious bleeding points with silver nitrate sticks
- Suction bilaterally to remove clots
- If cannot see bleeding point, insert 8cm Merocel nasal tampon smeared with Naseptin cream
- If still bleeding – refer to ENT SHO – use Vaseline gauze layered into nasal cavity
- If not settled or you are concerned – call on-call registrar
- If bleeding continues despite these measures:
  * refer to on-call ENT SHO
  * send off urgent FBC, INR Gp & save
- If bleeding stops discharge home on Naseptin cream bd to be used for 10 days and oral antibiotics if recent bacterial URTI. Advise GP visit in one week. If recurrent epistaxis refer to next available ENT out-patient clinic.
- Protect yourself – gloves and apron
- Protect patient – tissue and apron

Remember!

- If unilateral pack is inserted into the nasal cavity and assuming no contra-indication for patient to go home, then patient may go home to return to ENT ward the next day for removal of the pack
- If bilateral packs are inserted **patient must be admitted** – contact ENT on-call SHO

Nasal Fracture

Clinical Features:
ATLS initially, nasal fracture last injury to be managed. No x-ray needed



If epistaxis treat as epistaxis protocol

Acute Bacterial Sinusitis

Clinical Features:

- Severe throbbing pain related to the sinus/sinuses involved
  1. Maxillary – cheek
  2. Frontal – forehead and orbit
  3. Ethmoid- root of nose
  4. Sphenoid – variable; occipital area, over vertex of skull, retro-orbital
- Foul tasting nasal mucopus
- Pyrexia
- Opacification, fluid level or mucosal thickening seen on sinus x-rays

Management:

Mild (mild pain, apyrexial)

- Oral antibiotics (Amoxicillin) for one week
- Nasal decongestants, Otrivine or Ephedrine 0.5% nose drops, two qds for one week only
- Analgesia

Severe (severe pain, pyrexial, unresponsive to oral antibiotics)

- Refer to on-call ENT SHO for IV antibiotics
- Decongestants and analgesia
- May needs surgical drainage

Orbital Cellulitis

- Commonest cause in children is sinusitis
- If untreated, risks include blindness and frontal lobe abscess

Sources of Infection

- Sinus (most common)
- Facial skin
- Dental

Clinical Features:

- Peri-orbital swelling
- Severe orbital pain and tenderness
- Chemosis
- Proptosis
- Opthalmoplegia and diplopia
- Visual deterioration
- Papilloedema

Management:

- Refer immediately to on call ENT or Ophthalmology SHO for IV antibiotics/decongestants and may require surgical drainage (GA)
- Needs CT scan – if severe or worsening
- Seek ophthalmic opinion

Erysipelas

Raised area – well defined – differential diagnosis cellulitis

Definition:
Acute inflammation of the epidermis and dermis cause by pyogenic streptococci

Clinical Features:

- Usually begins in the nose and spreads rapidly over the entire face as a sharply demarcated, painful, red infiltrating are
- Pyrexia

Management:

Mild (mild pain, apyrexial, limited involvement)

- Swab any possible skin entry portal
- Penicillin V po 500mg qds (7 days)

Severe (very painful facial lesion, pyrexial, unresponsive to oral antibiotics)

- Refer to on-call ENT SHO for admission and treatment with Benzylpenicillin
- IV access and fluids
- Benzylpenicillin
- Analgesia
- Swab

Foreign Body in The Nose

- Usually found in children
- May be long-standing
- Objects include coins, beads, buttons, peas etc.

Clinical Features:

- Usually unilateral
- Foul smelling nasal discharge, nasal blockage, worsening rhinitis or sinusitis

Diagnosis

- Examine the nose thoroughly preferably with decongestion and local anaesthetic (Xylocaine)
- Arrange anterior and posterior nasal x-rays if there is a reliable history of radio-opaque FB insertion but it is not readily visible

Management:

- Only attempt removal of the child is co-operative and the object lies anteriorly in the nose using a blunt wax hook instrument
- If the child is distressed/uncooperative or the object is too difficult to remove then refer immediate to the on-call ENT SHO (?needs GA removal)
- Solid rounded objects – roll along the floor of the nasal cavity with a curved probe eg Jobson-Horne probe
- Other objects – grasp with Tilley's forceps
- If there is any evidence to suggest inhalation refer to on-call ENT SHO and arrange CXR and lateral soft tissue neck x-ray
- If late at night –advise to come back in the morning and NBM in case GA is required